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

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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 Thursday 27 September 2012 for **approval**.	Chairman	01
4. Chief Executive's Report To receive this report to **note**.	Chief Executive	17
Quality, Performance and Compliance		
5. Quality and Performance Report To receive the Quality and Performance Report for **review**. a. Patient Experience b. Overview – Director of Strategic Development c. Quality & Outcomes Committee Chair's Report d. Board Review	Director of Strategic Development and Quality & Outcomes Committee Chair	20
6. Infection Control Quarterly Report To receive this report for **review**.	Chief Nurse	84
7. National Cancer Survey and Action Plan To receive this report for **review**.	Chief Nurse	106
8. Complaints Annual Report To receive this report for **review**.	Chief Nurse	121
9. Half-Year Update on Corporate Quality Objectives To receive this report for **review**.	Chief Nurse	145
Finance and Governance		
10. Finance Report To receive the standing Finance Report for **review**. a. Overview – Director of Finance b. Finance Committee Chair's Report c. Board Review	Director of Finance and Finance Committee Chair	167

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11. Board Assurance Framework Report To receive this report for **review**.	Chief Executive	188
12. Corporate Risk Register To receive this report for **review**.	Chief Executive	198
Strategy and Business Planning		
13. Annual Business Planning Guidance 2013/2014 To receive and consider this report for **approval**.	Director of Strategic Development	211
14. Transforming Care Quarterly Report To receive this report to **note**.	Chief Executive	231
15. Quarterly Capital Projects Status Report To receive this report to **note**.	Director of Strategic Development	237
16. Private Patient Services Development To receive this report to **note**.	Chief Operating Officer	245
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17. Quarter 2 Compliance Framework Monitoring & Declaration Report To receive and consider this report for **approval**.	Chief Executive	251
Information and Other		
18. Any Other Business To consider any other relevant matters not on the Agenda.	Chairman	
19. Date of Next Meeting **Public Trust Board meeting**, Thursday 29 November 2012 from 10:30 – 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

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

Board Members Present	
• John Savage – Chairman • Emma Woollett – Vice Chair • Iain Fairbairn – Senior Independent Director • John Moore – Non-executive Director • Lisa Gardner – Non-executive Director • Paul May – Non-executive Director • Kelvin Blake – Non-executive Director • Guy Orpen – Non-executive Director	• Robert Woolley – Chief Executive • Alison Moon – Chief Nurse • Deborah Lee – Director of Strategic Development • James Rimmer – Chief Operating Officer • Paul Mapson – Director of Finance • Sean O'Kelly – Medical Director
Present or In Attendance	
• Claire Buchanan – Acting Director of Workforce & Organisational Development • Charlie Helps – Trust Secretary • Victoria Church – Management Assistant to Trust Secretary • Fiona Reid – Head of External Relations • Anne Ford – Public Governor • Ken Booth – Public Governor • Mo Schiller – Public Governor	• Peter Holt – Patient Governor, Local • Anne Skinner – Patient Governor, Local • Joan Bayliss – Partnership Governor, Community Group • John Steeds – Patient Governor – Local • Clive Hamilton – Public Governor • Sue Silvey – Public Governor • Helen Langton – Appointed Governor, University of the West of England • David Relph – Head of Strategy and Business Planning

Item	*Action*
1. Chairman's Introduction and Apologies John Savage welcomed the Head of Strategy and Business Planning, David Relph, and Dr Richard Brindle, new Director of Infection Prevention and Control, to the meeting. It was noted that a small group of protesters had gathered outside the Trust Head Quarters to voice their concerns about the activities of the South West Pay Terms and Conditions Consortium. Another group was noted to be picketing outside North Bristol NHS Trust. Robert Woolley and John Savage had extended an invitation to union representatives in the group to address the Board, but they had not chosen to do so. John Savage informed the Board that an additional meeting would follow the Board meeting to brief governors on a report received from the Care Quality Commission (CQC) following their inspection of Children's Cardiac Surgical Services on Ward 32 of the Bristol Royal Hospital for Children on 05 September 2012. The Chairman notified the Board that he had agreed a change to the Terms of	

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Reference for the Quality and Outcomes Committee to adopt a monthly meeting cycle in order to conduct a thorough review of the Quality and Performance Report, before bringing any salient issues to Board. The revised terms of reference were on the agenda for approval.	
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 from the Previous Meeting The Board considered the Minutes of the Public meeting of the Trust Board of Directors dated Monday 30 July 2012 and **approved** them as an accurate record.	
4. Chief Executive's Report The Board received and considered a report by the Chief Executive, which included the activities of the Trust Management Executive to **note**. Robert Woolley highlighted the following items: • It was important to record the Trust's position regarding the South West Pay Terms and Conditions Consortium, which had caused concern amongst staff and the unions. Robert clarified that the Trust has joined the Consortium in order to explore how UH Bristol could meet the extraordinary and unprecedented financial challenges that it, and the rest of the NHS would face over the coming years. There was a need to understand how the Trust would meet the financial challenges and make best value for the taxpayer whilst endeavouring to preserve the quality of services for patients. An important and publicised objective of the Consortium was to minimise potential redundancies throughout the NHS transition. It was important to clarify that the Consortium did not make decisions; it had been asked to produce a business case to review a number of options for each of the twenty trusts in the Consortium to consider when taking their own decisions. The business case was expected before the end of the calendar year, and the Board would decide how it wished to respond. Robert stressed that a key priority was working positively with staff and their representatives regarding how to deal with the challenges ahead. • Progress regarding the Bristol Acute Services Project: following the decision in July 2012 to undertake further work on the case for potential integration of acute health services in Bristol, a programme organisational structure was being designed and the appointment of a programme director was being considered. The Integration Programme Board, which was a new entity, had not yet met, but terms of reference were being drafted and preliminary arrangements were under way. A governor representative from UH Bristol was required to sit on the Integration Programme Board and it remained for the Governors to nominate the representative. Robert undertook to regularly report back to the Board and Governors	

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regarding any developments.

- The Board was aware that the Trust was engaged in efforts to establish an Academic Health Science Network for the West of England. The Steering Group decided not to make an application to the Department of Health (DoH) in 'Wave 1', which would have necessitated a full application and business plan by the end of September. Instead, a decision was made to progress greater engagement across the region towards developing a robust proposal for submission in February 2013, and constituents and potential members of the network had welcomed this action.

A successful workshop had been held this week, which was attended by representatives from all sectors, including social enterprises, universities, local authorities, public health, and industry representatives, regarding plans for development of the Network in the West of England. Robert Woolley planned to report back in this regard.

- The Divisional Manager for Specialised Services, Moira Logie, had resigned for health reasons. Jan Bergman was Interim Divisional Manager at present, and would continue in this role until formal recruitment for a permanent replacement.

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

- Robert Woolley clarified to John Steeds, a Local Patient Governor, that there was a distinction between an Academic Health Science Network and the model which was already running, regarding five nationally designated Academic Health Science Centres. The Trust aspired to obtain Academic Health Science Centre status for Bristol Health Partners' collaboration with Bristol University and NHS Partners in the South West. An argument which favoured this integration, was the extent to which it would assist the research development agenda. Guy Orpen gave his opinion that he felt it was the opposite way round, and that there would be no Academic Health Science Centre unless it was imbedded in an Academic Health Science Network, which was "the official line" from the Department of Health. Robert Woolley added that it was critical to establish the Network first.

- In response to a question by Clive Hamilton, a Public Governor for Bristol, Robert Woolley explained that there had been delays in transfers of Head and Neck Services, Oral Maxillofacial Surgery and Ear, Nose and Throat Surgery, which was centralising at UH Bristol. The principle had been agreed for some time, and there had been work to develop the project plan, but at the minute the business case was not stacking-up and had led to some slippage.

Robert was keen to fully understand what the model would be once centralisation was complete, before informing staff of potential changes, and he had written to the Primary Care Trust this week to say that the Trust was confident of closing the gap and expected to complete the transfer in March 2013, subject to consultation with staff.

Breast Service and Urology were scheduled for transfer to North Bristol NHS Trust, but there were interdependencies regarding internal capacity, and a need to free-up space. In addition, further surgical service reviews were planned through the Healthy Futures Programme.

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Quality, Performance and Compliance

5. Quality and Performance Report

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

a. Patient Experience

The Chief Nurse, Alison Moon, presented the Patient Experience report, which recounted the experiences of a woman who had received good care when delivering her baby, but did not feel that the whole care had been a positive experience. English was not the patient's first language and she felt that assumptions were made that she had understood what was being said.

There was a need to improve translation and interpretation services to patients and the Head of Quality (Patient Experience and Clinical Effectiveness), Chris Swonnell, was leading work to improve this. It was also important for practitioners to re-test patients during their treatment, to ensure they understood what was being undertaken. In addition, the Patient Involvement Lead, Tony Watkin, was working with the Head of Midwifery/Nursing Women's Services, Sarah Windfeld, regarding good communication with patients.

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

Discussion included:

- John Savage stressed that improvements in communication with patients did not apply only to people who spoke different languages. Alison Moon agreed with this point and added that the baseline standard was to test the patient's understanding.

b. Overview

The Director of Strategic Development, Deborah Lee, introduced the item, reporting a "mixed picture" with relation to performance.

1. The number of Clostridium Difficile cases that the Monitor Compliance Framework allowed the Trust had been exceeded in the first six months of the year and UH Bristol could not now achieve its mid-year trajectory— though based on last year's seasonal pattern of cases, the Trust was still forecast to achieve the target for the year; Alison Moon noted that whilst we were not achieving the target at the mid-year point we had had fewer cases than the same point last year confirming improvements were continuing to be made. These figures also affected Monitor compliance, and the best the Trust could achieve this quarter was 'Amber-Green'.
2. Another significant risk was the 62-Day Screening Cancer Pathway, which whilst it was only half a breach away from complying with the standard, was currently in breach; further work on validation was under way to secure this target.
3. Falls and Pressure Ulcers remained 'Red' rated. Significant deterioration in the area of pressure ulcers had been seen month-on-month which was a cause for significant concern; actions to address this would be covered by the Chief Nurse in her report.

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4. The financial position was 'Amber', and Cash Releasing Efficiency Savings were 'Red' rated. A robust plan was in-place to incorporate contingencies for indicators that were not 'Green' rated, and therefore the Trust was currently predicting that it would accomplish its predicted Finance Risk Rating of 3 in this quarter.

c. Quality

The Chief Nurse, Alison Moon, and the Medical Director, Sean O'Kelly, presented the quality element of the Quality and Performance report:

- Alison Moon explained that she had been disappointed regarding the position of quality metrics in September, but highlighted the ways that both she and Sean O'Kelly discharged their responsibilities:
  1) To ensure systems and processes in-place Trust-wide to have a transparency and detailed monitor of quality;
  2) For Alison and Sean O'Kelly to work daily with clinical teams towards improvements.
- As Deborah Lee had previously stated, the Trust's performance on pressure ulcers was causing concern. Increased numbers were seen in June and August, in a context of a relatively stable picture. In August, there had been nine Grade 3 and one Grade 4 pressure ulcer, but September numbers had reduced to-date; there had been three Grade 3 and no Grade 4 ulcers to date.

An independent review of the Trust's pressure ulcer position in August had been received, which gave clear recommendations regarding how to improve the care of patients with ulcers. Of the recommendations, the following three were immediate priorities:

1) To ensure right equipment was in the right place, at the right time for the right patient;
2) Microteaching was commended, but needed converting to competency-based training for staff;
3) To change the role and function of the expert team at the Trust, ensuring a proactive approach to the management of pressure ulcers; a detailed action plan would then be brought to the Clinical Quality Group, Trust Management Executive and Quality and Outcomes Committee.

Alison stated that pressure ulcers were always declared as 'serious incidents' and that the Trust always undertook a Root Cause Analysis (RCA). There was a national reporting deadline of 45 working days, which was always adhered to, but immediate learning was fed-back at the weekly Tissue Viability meeting chaired by the Deputy Chief Nurse. These were then addressed in a weekly meeting with the Heads of Nursing.

Referring to the Neonatal Intensive Care Unit (NICU), Alison Moon said that some of the neonates must be kept very still, due to the instability of their conditions. As a consequence of this, babies suffered pressure ulcers to the back of the head. Of note, following discussions with other NICU units, it appeared that the Trust's NICU was the only one in the country to acknowledge that this tissue damage was classifiable as a pressure ulcer.

- Alison Moon discussed the exception reports regarding falls, as there

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had been 159 falls in August 2012. There was an improvement from the previous month was that no fractures were reported, but one patient who had a moderate injury had suffered a cerebral bleed which caused them to fall and therefore this was seen as unavoidable. Work was underway to tease out environmental factors, when considering that 47% of people who fell had cognitive impairment. Bed space was also a key factor in falls, and there were bed space limitations in terms of older bed stock and bed spaces becoming cluttered. Poor lighting was also a factor in falls, and this included all extremes of lighting; staff needed to focus on appropriate lighting in bays. The Royal College of Physicians had produced a "care bundle" regarding falls, which included reference to the quality of lighting. This was being trialled in three high-risk areas in the Division of Medicine, which had the highest number of falls. Immediate action had been distributed regarding bed spaces and lighting, and staff were advised to report back to James Rimmer if they felt that lighting was insufficient, and changes were not being made in a timely manner. The Trust was looking into falls in great detail, and Alison planned to update October's graph in terms of considering if there were any issues regarding staffing levels which might be factors to consider. There was on-going close working with divisions where there might be a problem. • Alison updated the Board on the position regarding Clostridium Difficile, saying that there had been four less cases this year to-date, than this time last year. She remained confident that robust systems were in-place regarding work inside the Trust, and she hoped that Richard Brindle, in his role, could provide the leadership that was required in the community. Richard Brindle spoke in detail to the Exception Report: • **Methicillin-Resistant Staphylococcus Aureus (MRSA)** – The Trust had an unusually low number of bacteraemias last year, which has since increased. These could be controlled, but the Trust was unlikely ever to reach 'zero' as there is a large pool of colonised patients in the community. A reduction of intravenous (IV) line use and improved care of IV lines could help reduce the figures. Wound infection rates are related to blood stream infections and the Trust will be increasing wound surveillance. The Trust was also investigating whether MRSA cases were being generated in hospital or were of community origin. This was possible through the use of specialist genetic profiling of the bacterium. • **Glycopeptide-Resistant Enterococci (GREs)** are relatively uncommon but are only really seen in patients on broad-spectrum antibiotics, such as patients on cancer chemotherapy, who have compromised immunity and complex surgical patients. They could be reduced by moderating glycopeptide usage. • **Antibiotic Compliance** – The Trust had set itself an internal target and improvement had been noted in the last two years from 60% - 70%, up to almost 90%. Antibiotic compliance failures were mainly attributed to 'review dates' and 'stop dates' not being recorded. Microbiologists and pharmacists conduct frequent compliance rounds to educate clinicians about the importance of appropriate prescribing and documentation.	

- **Clostridium difficile (C Diff)** – Sophisticated molecular techniques elsewhere have shown very little cross-infection within hospitals. It was thought that there was a pool of potential patients in the community who were colonised, so when they came to hospital they risked contracting Clostridium difficile. It was possible to change antibiotics, but the downside to providing narrow-spectrum antibiotics was that they might be less successful in treating the infection. A further improvement could be seen in Clostridium difficile, but it was unlikely the Trust would ever eradicate all cases, although much work was on-going to continually improve.

Sean O'Kelly raised some other salient points regarding Quality at the Trust:

- Page 42 of the report referred to a 'Never Event' regarding a swab which had been retained in a patient during a forceps delivery. The case had been discussed with the clinical service lead and having seen a draft of the root cause analysis. Sean explained that it had probably been inserted whilst the patient was in the delivery suite and not recorded; therefore, the standard procedures had not been followed on this occasion. The patient had suffered no long-term harm and actions had been taken to ensure this did not re-occur.
- The exception report on page 71 of the report referred to Fractured Neck of Femur Patients. This area had been monitored for some time and ambitious threshold targets towards achievement had recently been set. Sean had talked to clinical leads and managers to understand what action was being taken to improve capacity to take these patients to theatre within a reasonable timeframe, as there had been issues regarding theatre capacity and balance of priorities. Of note, there was some theatre availability at South Bristol Community Hospital and willingness to move trauma patients to these theatres to free-up space for more significant operations that required laminated flow-theatres. The Surgery, Head and Neck Division were producing a business case to establish greater theatre availability for these patients, and some other efforts were underway to free-up theatre space.

A scheme had been piloted in spring 2012, where a dedicated trainee had commenced a detailed orthogeriatric review of Fractured Neck of Femur patients. Trust performance was noted to be enhanced at times, and the Division and clinical service were working towards recommendations made by the review.

- The final exception report that Sean discussed was regarding Stroke Services, as it was not performing as well as expected in terms of the length of time stroke patients spent on the stroke unit, and also the time that high risk Transient Ischaemic Attack (TIA) patients spent between onset of their symptoms and being assessed in clinic. Issues regarding the length of time spent on the stroke unit were felt to relate to bed occupancy and pressure on beds, and included a requirement to ensure that beds on ward 12, Stroke Unit, were made available while in 'green' escalation status, as the parameters in which the bed was held for stroke patients had recently been changed.

Comments:

- Robert Woolley felt that there had been a "complete paradigm shift" in terms of healthcare acquired infections at the Trust, in comparison to where the service had been. He acknowledged that although things had improved,

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the Trust still had a compliance and contractual framework arrangement which drove targets down each year. He asked what the thinking was with regards to national policy. Richard Brindle responded that he expected that there might be cases of failure to meet targets nationally which might then lead to a review of policy, potentially to address the prevalence of MRSA in the community. He said that although cases were noted to be higher in the community than hospital acquired, the current focus was to review anti-microbial stewardship and control cross-infection. • Alison Moon clarified to Iain Fairbairn that all types of fall were included in figures. The Trust was keen to understand what other organisations were doing with regard to falls and pressure ulcers, and had been in close contact with North Bristol NHS Trust regarding this. • Following a question by Lisa Gardner, Alison Moon explained that there was information about time of day, geographical areas, etc. Some wards put up floor plans, to see if any geographical patterns emerged and to position the most vulnerable patients near nursing stations. • Alison Moon confirmed to Clive Hamilton that the admission assessment looked at a patient's vulnerability to falls. • Kelvin Blake felt that there should be a focus on the contributing factors regarding falls, and asked if patient alarms were being answered quickly enough to prevent vulnerable patients from leaving their beds and falling. Alison Moon explained that she would broaden the report to address certain themes, in this regard. • In response to a question by Mo Schiller, a Public Governor, Alison Moon confirmed that patients had been provided with grip slipper-socks but that this may not improve the rates of falls amongst patients with cognitive impairment who walked around wards at night. • Ann Skinner, a Local Patient Governor, request clarity regarding how much non-slip flooring was used across the Trust. Alison Moon and Deborah Lee both confirmed that it was used widely across the Trust, and was implemented in all new buildings to national standards. The use of colour-coding of bays and routes to toilets was also being reviewed, and Musgrove Park Hospital in Taunton had completed work in this regard. Robert Woolley added that a key factor was the uniformity of the surface when moving from one area to another. • Regarding pressure ulcers, Kelvin Blake queried whether there might be a sense that staff in critical care areas saw pressure ulcers as a secondary problem, if there was something more acute to treat. Alison Moon said that historically there could have been a perception of this, but this was absolutely not the case in intensive care and critical care units within the Trust. Alison continued, saying that when a pressure ulcer occurred staff were often "devastated". • Lisa Gardner requested assurance that the Trust did its best to care for the elderly. Robert Woolley assured Lisa that the Trust aimed to do its best for these patients, but that the way the hospitals were traditionally organised did not necessary look at holistic care of elderly patients with multiple co-morbidities. Strides had been made, but more could be done. The Ortho-	

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geriatrician issue that Sean O'Kelly described was a key part of fundamentally changing the model of cover for patients with certain conditions. Alison Moon added that it was important to be clear regarding staffing levels on elderly care wards, as historically, wards would not be staffed as highly as some other wards. A skill-mix review was completed in 2011 to ensure that the correct nursing levels were in-place, and this should be reviewed annually; it checked that staff had the right skills and expertise to look after these patients. Deborah Lee said that the completion of the hospital re-development in 2014 would eliminate older wards in the Old Building and King Edward Building, towards delivery of better models of care; this would mark a huge step-change in the care of elderly people.

- Emma Woollett said that it was disturbing that performance was falling short across a number of areas of the Trust's activity, and the Trust must consider that there was a "degree of distraction" which might inevitably lead to a "loosening of grip across the organisation". She stated two reasons why this might be the case:

1) The South West Pay Consortium; and,
2) Unhelpful press coverage regarding the acute services review.

Emma suggested that both these issues would inevitably have created uncertainty. She felt the Board was clear that this Trust was in control of its own destiny and that no decisions in either of these areas would be taken without proper and transparent consideration, and she asked how the Board could ensure that this reassurance percolates through the Trust so that focus could be regained.

Robert Woolley reassured Emma that in order to regain the focus of the organisation he would communicate actively with staff at every opportunity; in doing so, he would emphasise that the Trust was "in control of its own destiny" in terms of what the Consortium produced, and entirely in terms of any decisions made regarding potential integration of acute health services in Bristol.

There was a need to mitigate the risk that low morale was affecting patient care, but Robert commented that he could not predict how the NHS would react and respond in future given the level of savings that the Government was expecting.

d. Workforce

The Acting Director of Workforce and Organisational Development, Claire Buchanan, introduced the workforce element of the quality and performance report:

- Appraisal rates were at 86%, which was above the standard of 85%.
- Sickness absence rates remained above target for August, but should have been generally lower in the summer months due to not having the seasonal illnesses associated with the winter months. The divisions of Facilities and Estates, Surgery, Head and Neck and Medicine were noted to be above trajectory (i.e. under-performing).

Targeted support was being provided to divisions to help understand where 'pinch-points' were. The Royal College of Physicians Health and Wellbeing

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Unit had been invited to the Trust in an effort to consider what else could be done to improve the rating, and also to assist in benchmarking against high-performing Trusts.

It was noted that in general, sickness absence in the South West was high at present, and this clearly had an impact on bank and agency staff usage, as the Trust needed to cover shifts.

Comments:

- Paul May requested detail regarding Equality and Diversity – Living the Values training for all staff. Claire Buchanan stated that Equality and Diversity Training was already under way at manager level and was continuing this year. Living the Values training would sweep across all staff groups. As an aside, Equality and Diversity and Health and Wellbeing were being combined to produce programmes to support staff better - this might have implications for rates of sickness absence. Claire confirmed to John Savage that the Trust worked closely with Equality South-West in this regard.

e. Access

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

- The 4-Hour Accident and Emergency standard was achieved in August and was on-track for achievement in September and for the quarter, although it still remained "tight". A detailed action plan was in place to assess:

1. The "front door" (i.e. patient admissions);
2. Flow through the hospital; and,
3. Discharge processes.

- An initiative in the Bristol Heart Institute to address Last Minute Cancellations was expected to yield results to support performance.
- Deborah Lee highlighted the risk to the 62-day Screening Cancer standard, which she said "remained tight"; she was hopeful the Trust would be shown to have achieved the standard for the quarter following further validation of the metrics.

Comments:

- Referring to the Quality and Performance report overall, John Moore asked how the Trust knew that the capacity plan was correct. Deborah Lee explained that the Trust planned prospectively, on the basis of what it understood through the Office of National Statistics regarding the demographic impact on care, which was quite specific. A 'look-back' exercise had just been completed to validate these projections. The Trust had planned for a "worse case" than had actually materialised and thus there was no evidence that under provision of capacity arising from this area was adversely affecting performance. John Savage agreed that Deborah was correct to err on the side of caution, as there was an underestimation of the general population projections in his view.
- Referring to pressure ulcers, Alison Moon stated that there had been an increase in people attending hospital with Grade 2 and Grade 3 ulcers in the last few months. She assured John Moore that the Trust was working closely

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with the Primary Care Trust in this regard.

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

6. Histopathology Action Plan Update

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

The Medical Director, Sean O'Kelly, presented the Action Plan, saying that he received progress reports from divisions. The majority of the action plan was on-schedule and evidence was available to support provide this assurance. Some delays in progress had related to facilities at both North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust, but "finishing touches" were being made and the facility was expected to be in commission by the end of October 2012.

- Issues with the integration of IT systems were proving more intractable, as the Trusts used different systems. At present both Trusts could access the other Trust' system on a PC in each Trust, but this was unsustainable in the long-term, and being reviewed by IT Directors at both Trusts.
- Significant progress had been made with consultant job planning, but there had been delays due to annual leave for some staff delaying the finalisation of plans.
- Draft Specialist Team Work Programmes were in-place for most teams but, again, there had been some delay due to annual leave and recent staff recruitment. These were expected to be finalised and in operation by the end of October 2012.

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

7. Safeguarding Annual Report

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

Alison Moon introduced the report, explaining that it was the combined annual report for child and adult safeguarding. She described the considerable achievements over the year:

- Numbers of safeguarding referrals made by practitioners had increased, which emphasised the value of staff training. A different approach towards staff training was required going-forward, as it was not felt to be sustainable in its present form.
- The Trust was compliant with 'Outcome 7 – Safeguarding'. A planned review had taken place following the annual report timeline of 2011/2012, where the Trust was deemed compliant, but continued focus on staff training was essential.
- Objectives and challenges for 2012/2013 were also outlined in the Report.

Comments:

- Iain Fairbairn asked what progress was being made with regards to reducing multiple versions of patient notes. Alison Moon, saying that the current mitigation was that the details of children who were on protection

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plans were manually uploaded to the Medway system. This work was crucial in identifying those children on plans, and it would continue. There had been considerable work with Medway to quickly progress this work and report back to the Safeguarding Group, but this had not solved the issue of multiple notes. Paul Mapson added that when the Trust moved to Medway, it had put all notes on the system in one place. Paul confirmed that access to the clinical portal could be extended to other institutions under appropriate information sharing agreements.

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

Finance and Governance

8. Committee Chairs' Reports

The Board received and considered reports on the activity of Board Committees by their respective chairs for **review**.

a. Finance Committee dated 24 September 2012, including the report of the Director of Finance

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

1. The income and expenditure summary reports a surplus of £1.460k for the five months to 31 August – this equates to slippage of £0.929m against the proportion of the Annual plan to date. The results lead to a Financial Risk Rating of 3 (actual 2.90).

The position on pay budgets has deteriorated with a cumulative overspending of £2.963m – an increase of £1.127m in August. The increase includes one – off costs of £0.330m. In addition pay costs for directly employed staff were higher (£0.318m) and bank staff costs were up by £0.165m. Agency staff expenditure at c£0.5m was in line with that recorded for previous months. Non pay budgets show a cumulative adverse variance of £0.885m – an improvement of £91k for the month. The Committee noted that the reported position is supported by the distribution of non-recurring central support moneys and the activity over-performance for 2011/12 received in 2012/13. The slippage / unidentified element of non-pay Cash Releasing Efficiency Savings (CRES) schemes to date totals £2.156m.

The principal area of concern for Income from Activities is within the Division of Surgery, Head and Neck Division with activity some £0.6m behind the SLA plan for the four months to 31 July. The Division is developing detailed plans to recover the under-performance on elective and out-patient activity over the remainder of the year. The Committee was advised that the activity volumes in the 2012/13 agreement are of the right order and that the Trust is working to deliver this level of activity to maintain a firm basis for the volumes for the 2013/14 contracting round.

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 first 5 months total £9.368m or 80% of the target for the period. The risk assessed forecast outturn is currently £23.1m or 80% of the CRES Plan.

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The Committee recognised the need to ensure that quality is maintained when looking at different ways of doing things. The only way of making savings via service improvement is through clinical engagement. 3. The Finance Committee received a report from the Director of Finance on the Financial Outlook for the Trust. The report provided an assessment of the projected outturn for 2012/13 leading to the conclusion that mitigation plans of at least £3m are required to counter the risk of under-achievement against the financial plan of between £2m and £3m. For 2013/14, the forward look based on current assumptions around tariff, CRES requirements and Risk Reserves indicates a revised surplus for 2013/14 of £4.3m (currently £5.1m). Lisa highlighted that a "considerable risk" is that the forward look is predicated on a requirement to deliver 100% of the CRES target of £25.3m. The outlook is that there will be no flexibility in the Trust's financial plan for 2013/14. 4. The Committee noted that specialist consultants have been engaged to look at patient flows within the Division of Medicine. 5. The Finance Director advised of plans to provide a mandatory training programme to support clinicians and managers in their management of budgets. The programme will include financial controls and how they should be applied to help manage pay and non-pay budgets effectively, compliance reviews (such as importance of regular checking of nominal rolls), checking and challenging 3rd party suppliers and the use of financial information and benchmarking. **b. Quality and Outcomes Committee dated 25 September 2012** The Chair of the Committee, Paul May, gave a verbal report on the main issues discussed by the Quality and Outcomes Committee. It was noted that significant time was devoted to the operation and focus of the Committee, and that the Quality and performance Report was therefore not considered in any detail. • Paul described the Diabetes report as providing "much more analysis regarding performance information which required a degree of further investigation by Committee". **c. Audit Committee dated 10 September 2012** The acting Chair of the Committee, Iain Fairbairn, gave a verbal report on the main issues discussed at the Audit Committee meeting in September. The Committee considered the following: • External Audit progress report • Internal Audit progress report • Review of the Internal Audit Function • Losses and Compensation report • Counter-Fraud report • Risk Management Group status report • Board Committee chairs' recommendations • Estates (division) Transformation Plan	

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9. Foundation Trust Constitution The Board received and considered this report by the Chief Executive for **approval**. Robert Woolley informed the Board that this item had been brought to Board following endorsement by Governors at the Annual Members Meeting held on 20 September 2012. Robert confirmed that changes made to the Foundation Trust Constitution had been made in accordance with the requirements set out by Monitor. The Board discussed the changes briefly, noting the effect of the two commencement orders, and in particular, the requirement to seek approval of the Council of Governors for any changes to non-NHS income over 5%. *There being no further questions or discussions, the Board resolved to **approve** the Foundation Trust Constitution for onward submission to Monitor for approval.*	
10. Quality and Outcomes Committee Terms of Reference The Board received this report by the Chairman for **approval**. Trust Secretary, Charlie Helps, stated that the Terms of Reference simply reflected that the Committee would now be held on a monthly, as opposed to bi-monthly frequency. *There being no further questions or discussions, the Board resolved to **approve** the Quality and Outcomes Committee Terms of Reference.*	
11. Register of Application of the Trust Seal The Board received this report by the Chief Executive for **review**. Robert Woolley explained that the Register showed all the occasions that the Trust Seal had been applied. *There being no further questions or discussions, the Board resolved to **note** the Register of Application of the Trust Seal.*	
12. Loan Facility Agreements – Conditions Precedent The Board received this report by the Finance Director and considered the recommendations for **approval**. Paul Mapson briefed the Board on the implications of the agreement and confirmed that it had been first been presented to the Finance Committee for scrutiny. *There being no further questions or discussions, the Board resolved to **approve** the Loan Facility Agreements – Conditions Precedent.*	
Strategy and Business Planning	
13. Partnership Programme Board Report The Board received this report by the Chief Executive to **note**. Robert Woolley thanked Deborah Lee for authoring the report. *There being no further questions or discussions, the Board resolved to **note** the Partnership Programme Board Report.*	

14. Electronic Prescribing – Southern Trusts' Collaborative Business Case

The Board received this report by the Finance Director for **approval**.

Paul Mapson explained that it was anticipated the national programme would fund electronic prescribing if the Trust complied with their specifications.

UH Bristol was required to support this business case to remain in the programme, but Paul stressed that it did not commit the Trust, and they could withdraw at any time once the position was reviewed.

Comment:

- In response to a question from Emma Woollett regarding the investment in mobile devices, Paul Mapson stressed that although hand-held devices had limitations, it was possible that they could be used for a range of functions.

*There being no further questions or discussions, the Board resolved to **approve** the Electronic Prescribing – Southern Trusts' Collaborative Business Case.*

Monitor Reports

15. Results of Quarter 1 Compliance Framework Monitoring Exercise

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

Robert Woolley explained that the Trust had declared an 'Amber-Green' status to Monitor for the previous quarter declaration. This was in response to advice from the Regulator that the Trust was able, with commissioner agreement, to re-profile the trajectory for Clostridium Difficile breaches over the year to reflect the seasonal pattern associated with cases.

The Trust was subsequently assessed as 'Amber-Red' by Monitor due to rates of Clostridium Difficile as the original guidance provided to the Trust, by Monitor had been incorrect and the opportunity for profiling cases was no longer afforded to trusts as it had been in previous years. Robert Woolley was aware of no regulatory action between the Board's declaration and Monitor's findings that the governance rating was 'Amber-Red'.

Monitor agreed with the Trust's Finance Risk Rating of 3.

*There being no further questions or discussions, the Board resolved to **note** the Results of Quarter 1 Compliance Framework Monitoring Exercise.*

16. Results of Monitor Annual Plan Review

The Board received this report by the Chairman to **note**.

The Chief Executive, Robert Woolley, explained that Monitor undertook a detailed assessment of the annual plans of all foundation trusts and they had a level of response depending on any concerns regarding the plans.

UH Bristol had not been selected for further review and remained on the lowest level of monitoring; therefore the Trust was not subject to any greater regulatory scrutiny.

*There being no further questions or discussions, the Board resolved to **note** the Results of Monitor Annual Plan Review.*

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Information and Other	
17. Any Other Business There was no other business.	
18. Date of Next Meeting **Public Meeting of the Trust Board of Directors**, Tuesday 30 October 2012 from 10:30 – 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 30 October 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 –OCTOBER 2012

1. INTRODUCTION

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

2. COMMUNICATIONS

The Trust Management Executive **noted** the monthly report on the activities of the Communications Department, particularly that the Recognising Success Staff Recognition awards had attracted almost 200 nominations.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the Trust's performance against the 4-hour accident and emergency standard and that the 95% target had been achieved for Quarter 2 2012/2013. Continued achievement of this target remained a challenge and actions being taken to ensure compliance were noted. There was considerable focus on this issue, particularly around discharge.

There was continued focus on all access targets, particularly the cancer treatment times and infection control.

The report **noted** the Care Quality Commission Main Site Inspection report following their unannounced scheduled inspection of the Bristol Royal Infirmary Emergency Department, Medical Assessment Unit, Bristol Heart Institute and St Michael's Hospital on 21 June 2012, noting the judgement that the Trust was non-compliant with Outcome 13 (staffing) in Maternity Services but compliant with all other Outcomes reviewed: 4 (care and welfare), 5 (nutrition), 6 (co-operation), 7 (safeguarding), 14 (training) and 16 (monitoring quality). An action plan for maternity staffing had been submitted.

The group **noted** progress to date against the Trust's quality objectives for 2012/2013.

The group **noted** the key findings for the Trust from the 2011/2012 National Cancer Patient Experience Survey which demonstrated an improvement from the previous year. A service improvement plan based on the survey results was in place and progress would be monitored at the Cancer Board.

The group **noted** findings from the External Review Report of Pressure Ulcers and the key recommendations and **approved** the Pressure Ulcer Action Plan.

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

- Actions being taken to improve the position in relation to research study performance.
- Four new Health Integration Teams had been approved by Bristol Health Partners to proceed to full business case.
- Dolphin House offices on level 3 had been approved for refurbishment.

4. STRATEGY AND BUSINESS PLANNING

The group **approved** the programme plan and process for the annual business planning 2013/2014 round.

The group **approved** an uplift in the short stay tariffs for patients and visitor parking, subject to clear understanding that the Trust did not earn a surplus from parking charges. A proposed uplift to staff tariffs was **approved** from 1 April 2013 as an impact of the increased costs for use of the NCP car park at Rupert Street.

5. RISK, FINANCE AND GOVERNANCE

The group **noted** progress with the Essential Training review and the Teaching and Learning recovery plan.

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

The group **approved** the Trust's response to recommendations in the Internal Audit reports concerning Data Quality, Rosterpro Central, Network Penetration Testing and Patient Feedback Reviews.

The group **noted** risk exception reports from Divisions. Two Divisions were asked to review the notified risks and controls in place.

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
19 October 2012

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

Item 05 – Quality and Performance Report
Purpose
To review the Trust's performance on Quality, Workforce and Access standards.
Abstract
The monthly Quality & Performance Report details the Trust's current performance on national frameworks, and a range of associated Quality, Workforce and Access standards. Exception reports are provided to highlight areas for further attention. Examples of learning and improvement from complaints, incidents and patient experience are provided to support organisational learning. The report has previously been considered by the Board's Quality and Outcomes Committee.
Recommendations
The Board is recommended to **review** 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)

PATIENT EXPERIENCE: Division of Surgery Head and Neck

Mr Z contacted the Patient Support and Complaints Team on 17 August 2012 by e mail as he wished to make a complaint about a recent experience he had while trying to book an appointment for an endoscopy. He explained that in April he was referred to the endoscopy team by his GP and heard nothing for 3 months. He contacted his GP surgery and after some investigation by them, it was discovered the BRI had sent his appointment letter to the incorrect address.

He described that after a lot of "to-and-froing" between himself, his GP surgery, and the endoscopy department he had finally received a letter from the endoscopy department at the BRI the previous week, which asked him to phone them to book an appointment. He did this and was told that because he was not seen within a certain amount of weeks since his original referral; he had been added to a special list. This meant that an appointment could not now be booked, since the waiting list staff were required to book in more recent referrals and that he'd have to wait for a cancellation, for which a time-scale could not be given.

As it was now almost four months since the original referral and his symptoms had not gone away, the whole process of trying to get an appointment had become thoroughly frustrating for Mr Z. He asked if there was there anything he could do to speed the process along.

We responded to Mr Z within three days and apologised for the long wait he had for his procedure. The responsible Waiting List Co-ordinator reassured Mr Z that he was on her list and that an appointment would be sent as soon as possible. It was explained that unfortunately the waiting list was long and that delays were due to suspected cancer patients needing to be seen urgently.

The Waiting List Co-ordinator also apologised that Mr Z was told that he would be put behind newer referrals after his letter went to the wrong address. She confirmed that this is not the case and that he had not been moved down the waiting list at all. We also confirmed we now had Mr Z's most recent address on record.

Mr Z came back to us by e mail saying that he totally understood being put further down the list due to more urgent cases, but he was given the impression that he was being given less priority than newer referrals, due to the fact that he hadn't been seen inside a certain amount of weeks. As this was not the case, he was satisfied with our response and he thanked us for looking into this for him. Mr Z did have his endoscopy on 04 October.

Organisational Learning:

- The importance of checking patients' details, including addresses, are correct at each point of contact with the service or referral and ensuring records are as up to date as they can be.

- The importance of clear communication with patients when giving explanations in response to their requests. If we had done this we would probably have avoided this complaint.

SUMMARY QUALITY & PERFORMANCE REPORT

October 2012

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PERFORMANCE OVERVIEW

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B Organisational health barometer ....

C Monitor's Compliance Framework ....

1. QUALITY

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1.2 Summary ....

1.3 Changes in the period ....

1.4 Exception reports ....

1.5 Supporting Information ....

2. WORKFORCE

2.1 Summary ....

2.2 Exception Reports ....

2.3 Supporting Information ....

3. ACCESS STANDARDS

3.1 Summary ....

3.2 Access dashboard ....

3.3 Changes in the period ....

3.4 Exception reports ....

PERFORMANCE OVERVIEW

SECTION A – Performance Overview

Summary

Overall, there has been a significant improvement in the ‘health’ of the organisation relative to last month, with a decrease in RED rated indicators by three, and an increase in GREEN rated indicators by three. This net change includes a significant reduction in the Number of Patient Complaints, which now leaves all three measures of Patient Experience GREEN rated. There was also a significant reduction in Inpatient Falls, which moved the indicator from a RED to a GREEN rating.

The Number of Cancer Standards failed in the quarter is now GREEN rated, with all standards expecting to be confirmed as met for the quarter at final reporting. The 95% A&E 4-hour national standard has been met for a fourth consecutive month, and performance against the 18 week Referral to Treatment Time standard, for admitted pathways, remains strong. Two of the measures of Being Efficient are now GREEN rated, following an improvement in elective length of stay. There has been an apparent deterioration in the level of recruitment to NIHR (National Institute for Health Research) trials, although this is thought to reflect incomplete capture of information on the new system, rather than an actual reduction in patients entering research trials, and is being investigated.

Three of the four measures of financial performance have retained an AMBER rating with EBIDTA (Earnings Before Interest, Taxes, Depreciation and Amortization) again showing an improved position on the previous month. There has been a slight improvement in the level of Cash Releasing Efficiency Savings (CRES) achievement in the month, although the forecast year-end achievement has dropped slightly to 81.3% reflecting changes to the expected delivery of CRES schemes coming on-line later in the year. The Financial Risk Rating (FRR) declaration remains at 3.

The Trust is expecting to report an AMBER-GREEN rating against Monitor’s Compliance Framework for Quarter 2. This reflects the achievement of the A&E 4-hour standard, Referral to Treatment Times (RTT) and Cancer standards, but the cumulative C. diff trajectory not being met at quarter-end following slippage in quarter 1.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
A01	Patient Climate Survey (Overall CQUIN Score)	74	75	N/A	Green: >= 73.9 Red: <71.9	↑	Current month is August 2012.
A02	Number of Patient Complaints	158	96	888	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)	10	5	27	Green: 0 Red: > 1	↓	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	6.33	5.02	5.88	Green < 5.6 Red: >= 5.6	↓	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
C01	Number of Serious Incidents (SIs)	11	7	50		↓	
C02	Number of C.Diff cases	6	6	29	Below Trajectory	→	

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
D01	18 Weeks Admitted Pathways	92.1%	93.5%	92.4%	Green: >=90% Red: <85%	↑	
D02	Number of Cancer Standards Failed	0	0	0	Green: 0 Red: >=2	→	Previous is confirmed Quarter 1 2012/13. Current and YTD is expected Quarter 2
D03	A&E 4 Hour Standard	95.34%	95.74%	94.51%	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	362	290	1630	Below 11/12 Readmission Rate (3.4%)	↓	Previous is July's discharges where there was an emergency Readmission within 30 days. Current is August's discharges.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
F01	Elective Length of Stay Reduction	4.1	3.6	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	5.1	5.2	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%	9.5%	10.9%	Green: <=6.0% Red: >=10.7%	↓	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
G01	Appraisal Compliance	86.1%	85.5%	N/A	Green: above target Red: below target	↓	
G02	Staff Sickness	4.2%	4.3%	4.2%	Green: above target Red: below target	↑	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
H01	NIHR Income (£000s)	£1,524	£1,670	£1,670	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-August and Current (and YTD) is April-September
H02	Number of Patients Recruited Into NIHR Trials	1856	2380	2380	Green: Above 10/11 Red: Below 10/11		Current (and YTD) is rolling YTD position to end of September Previous is to end of August

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
J01	Monitor Governance Risk Rating	2	1	N/A	Green: < 1 Red: > = 4	↓	Previous now shows the confirmed Q1 position. Current shows expected Q2 posiiton.

Delivering Our Contracts

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
K01	Financial Performance Against CQUINs (£millions)	£6.20	£6.20	£6.20	> 50% Green < 50% Red	→	YTD and Current is Forecast year-end rewards, assuming BNSSG all payable. Previous is month 4 (July), Current is month 5 assessment.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	£0.41	-£0.88	-£0.88	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 Aug, Previous is YTD for July.

Managing Our Finance

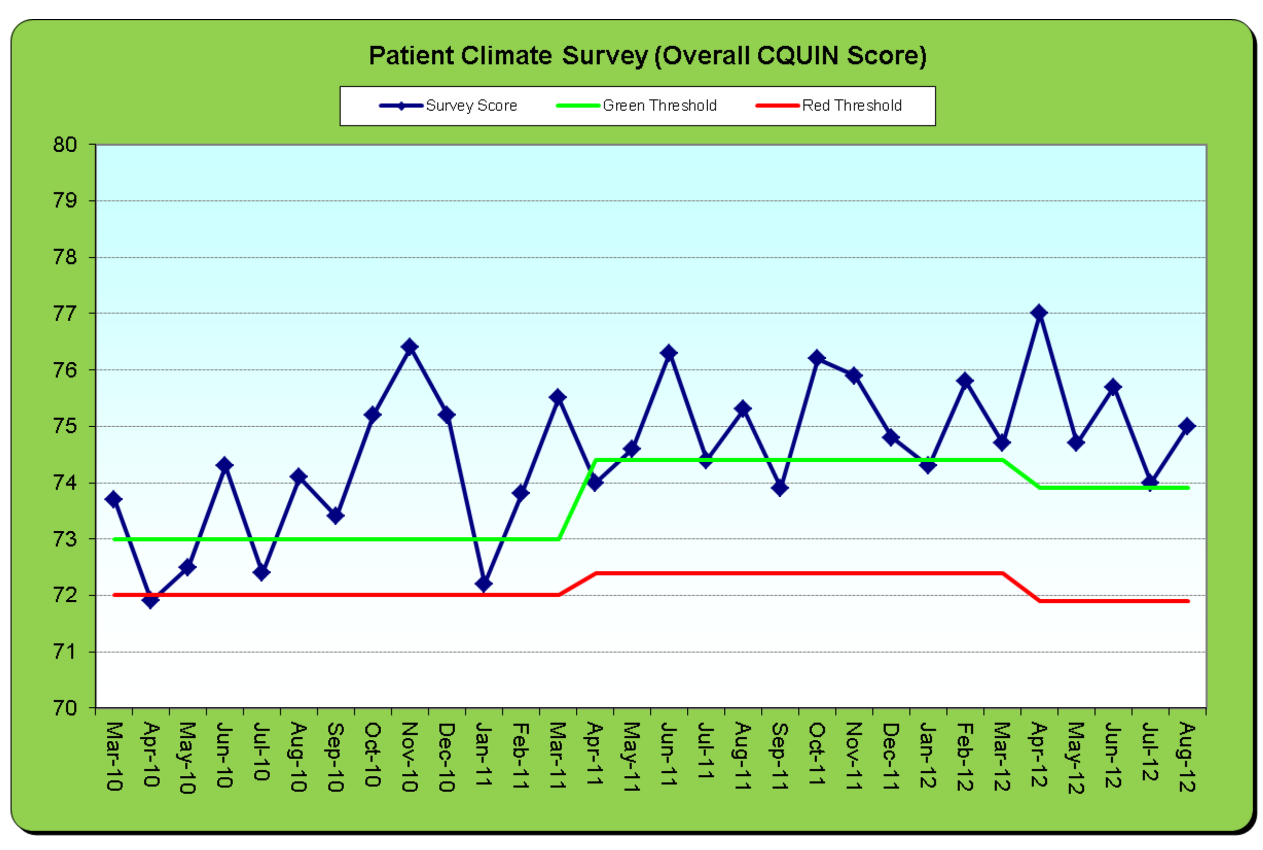
ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
L01	Monitor Financial Risk Rating	3	3	3	Green: >3 Red: <3	→	For financial measures except CRES, Current and YTD is Current Year To Date. For CRES there is a separate total for latest month and YTD. Previous is previous month's reported data.
L02	EBIDTA (Compared To Plan)	91%	95%	95%	Green: 100% Red: <85%	↑	
L03	CRES Achievement	70%	71%	79%	Green: >=90% Red: <75%	↑	
L04	Liquidity (in Days)	20.4	21.1	21.1	Green: 25+ days Red: <=14 days	↑	

Notes

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

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

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



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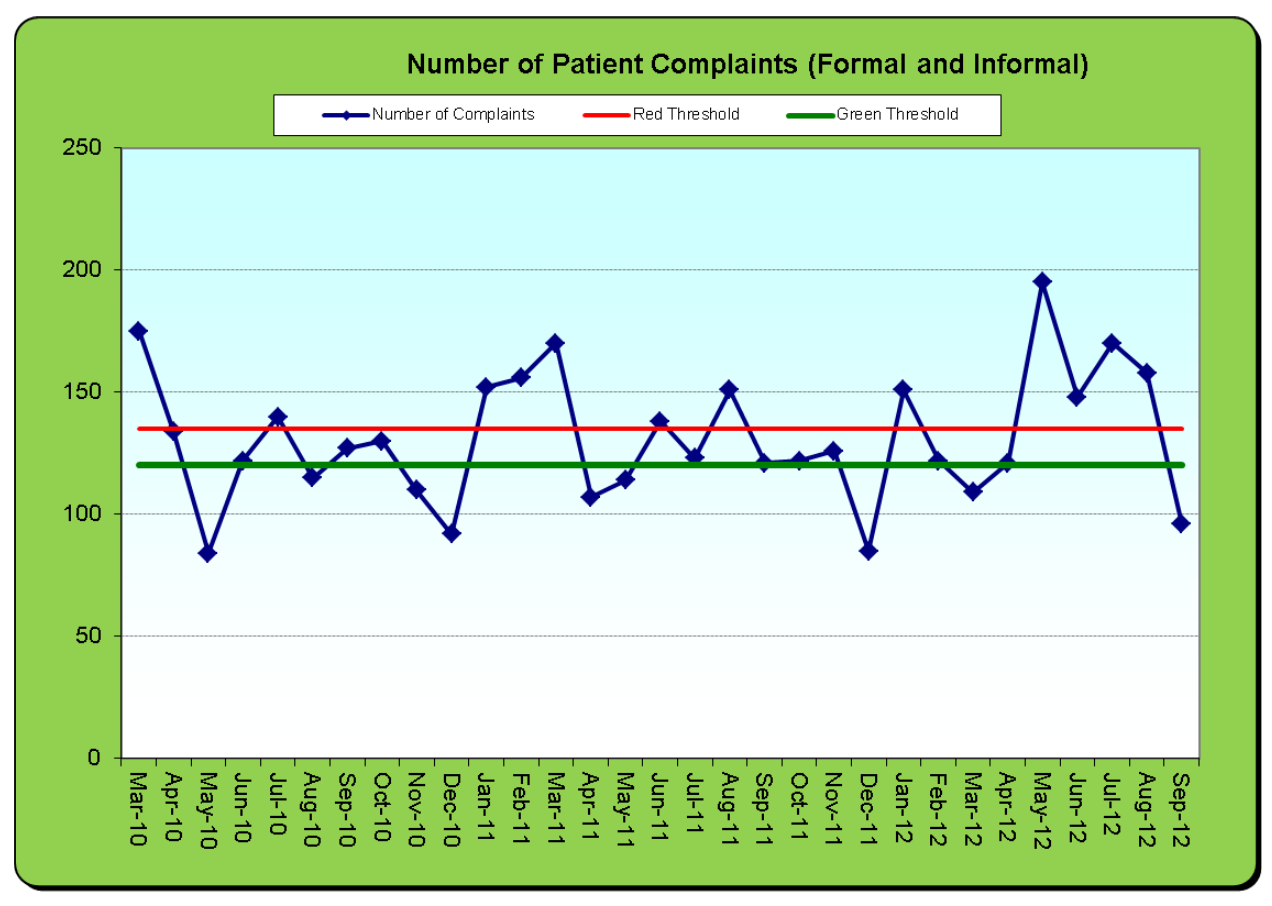
Aug-12



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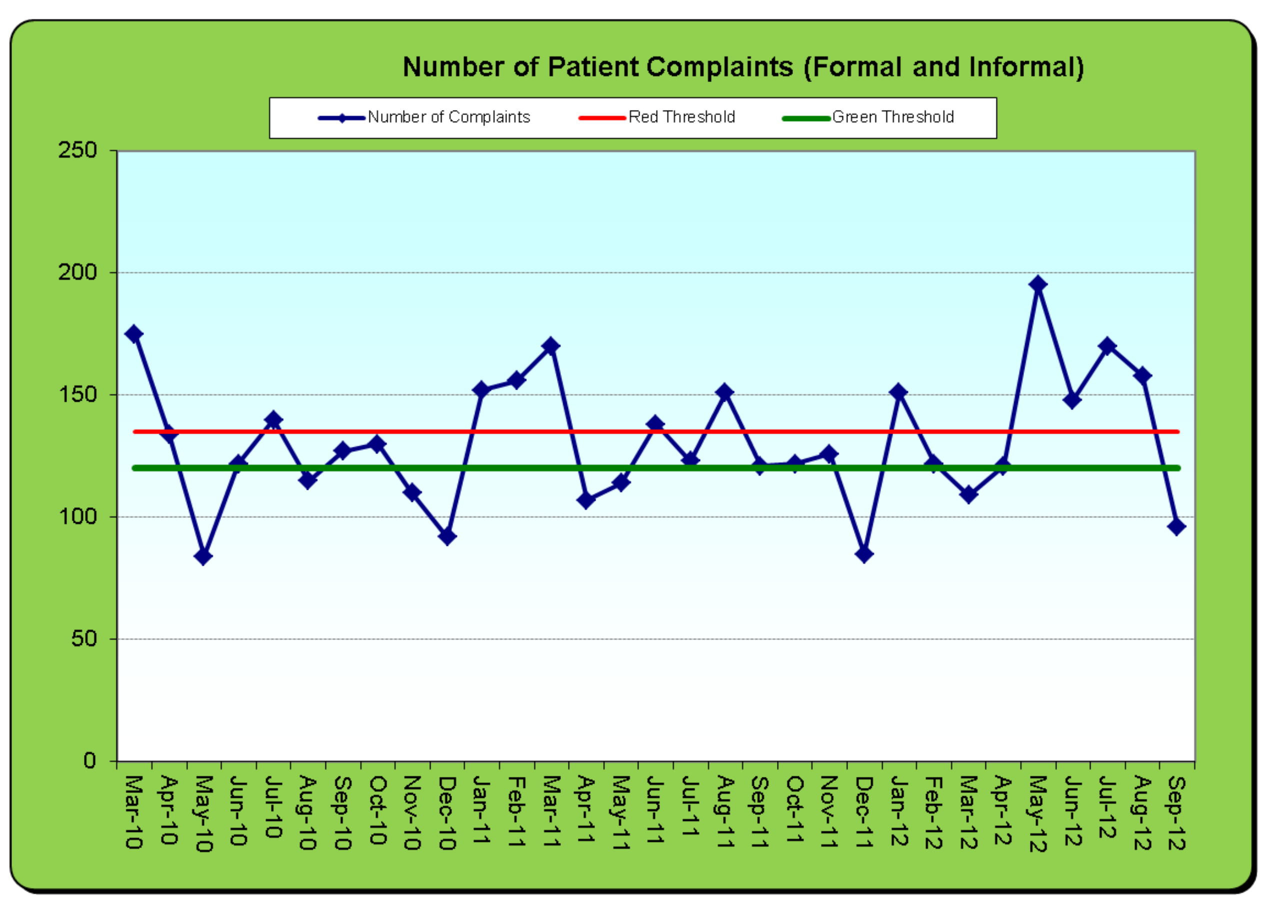
May-12
Jun-12
Jul-12
Aug-12
Sep-12


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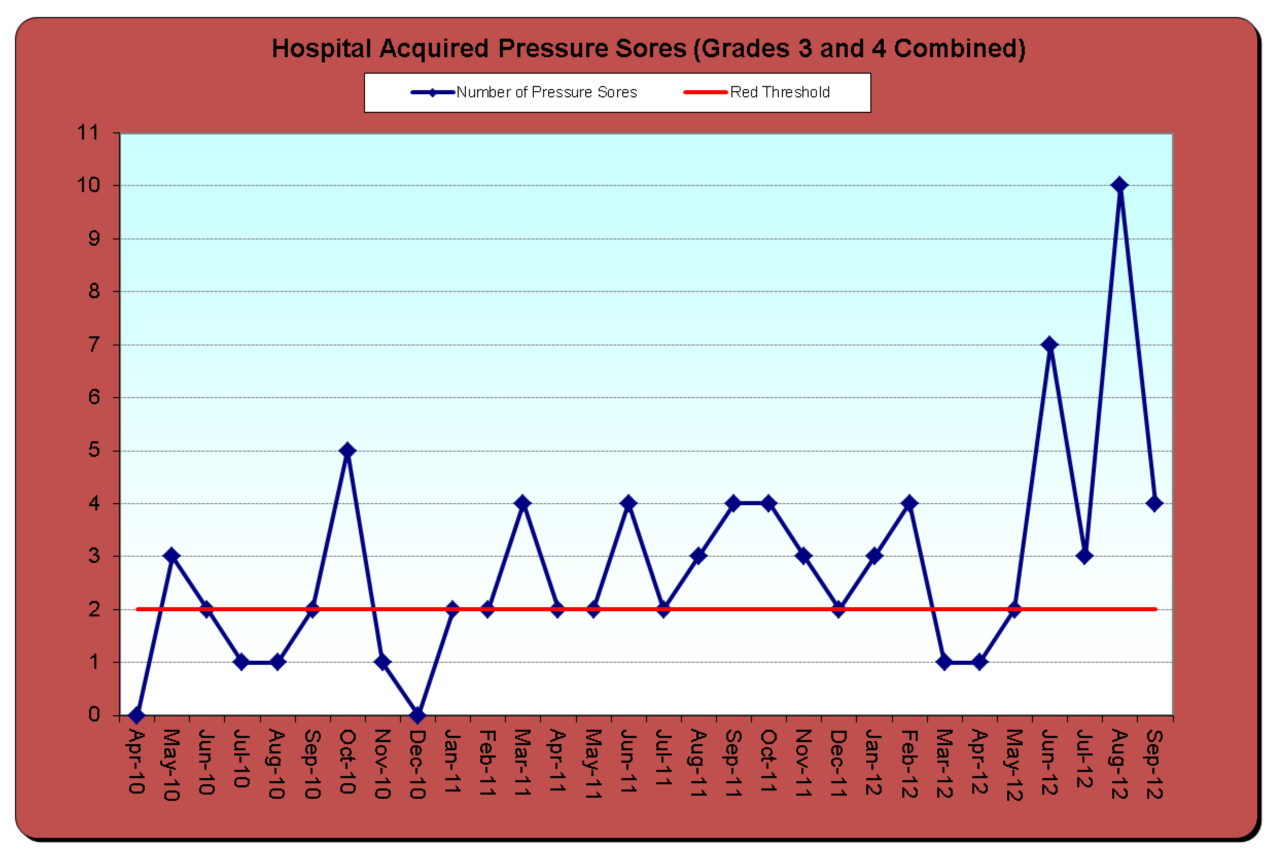
Aug-12
Sep-12


Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Number of Pressure Sores
Red Threshold
11
10
9
8
7
6
5
4
3
2
1
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
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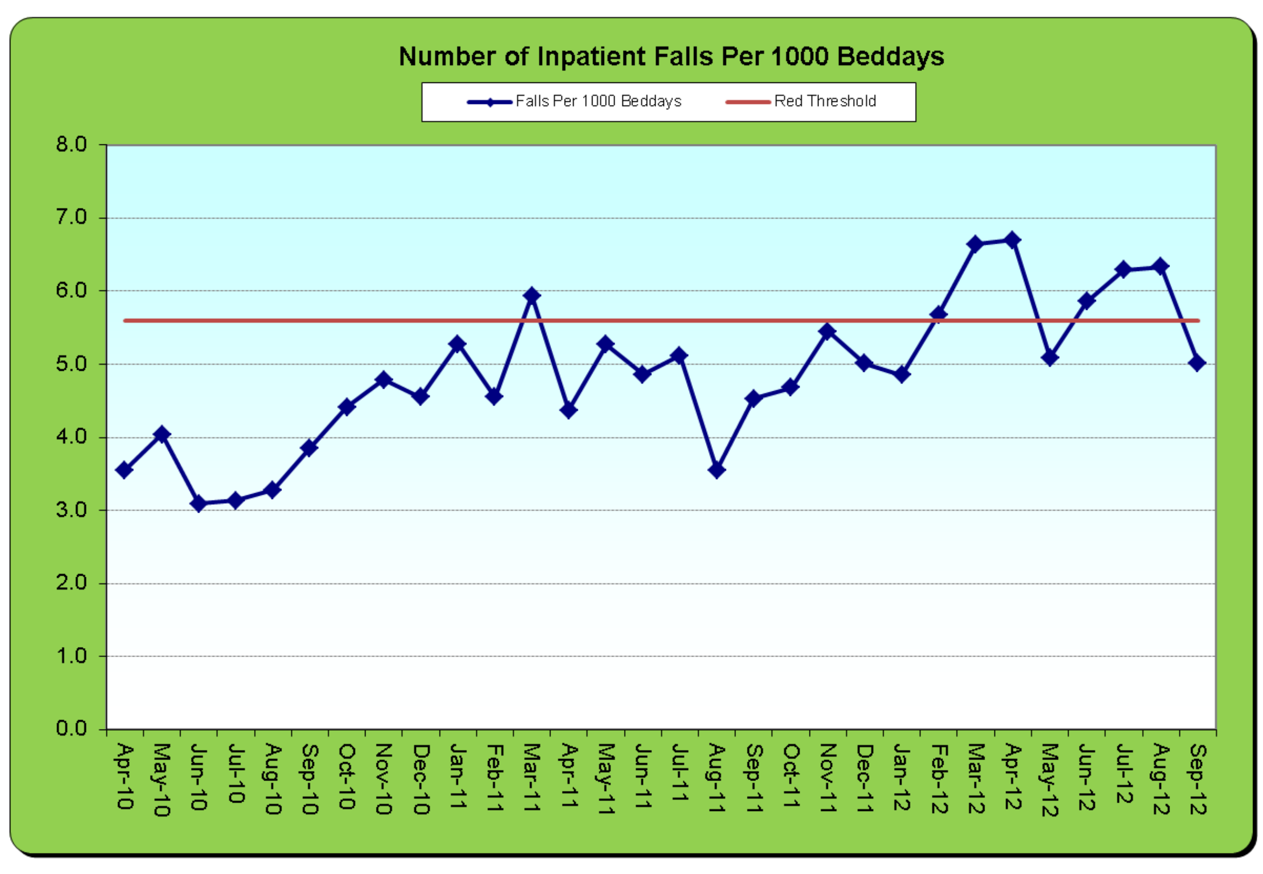
Aug-12
Sep-12


Number of Inpatient Falls Per 1000 Beddays
Falls Per 1000 Beddays
Red Threshold
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
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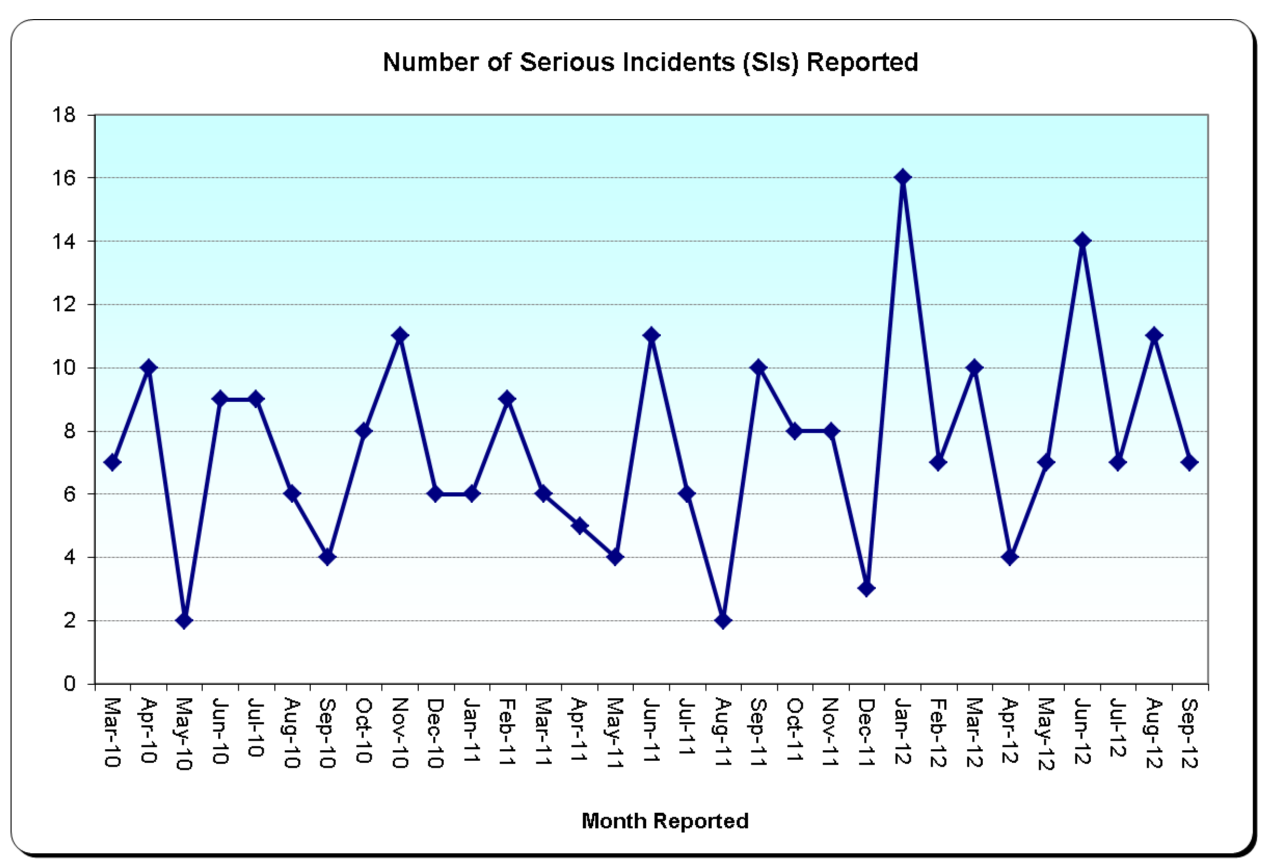
Number of Serious Incidents (SIs) Reported
18
16
14
12
10
8
6
4
2
0
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
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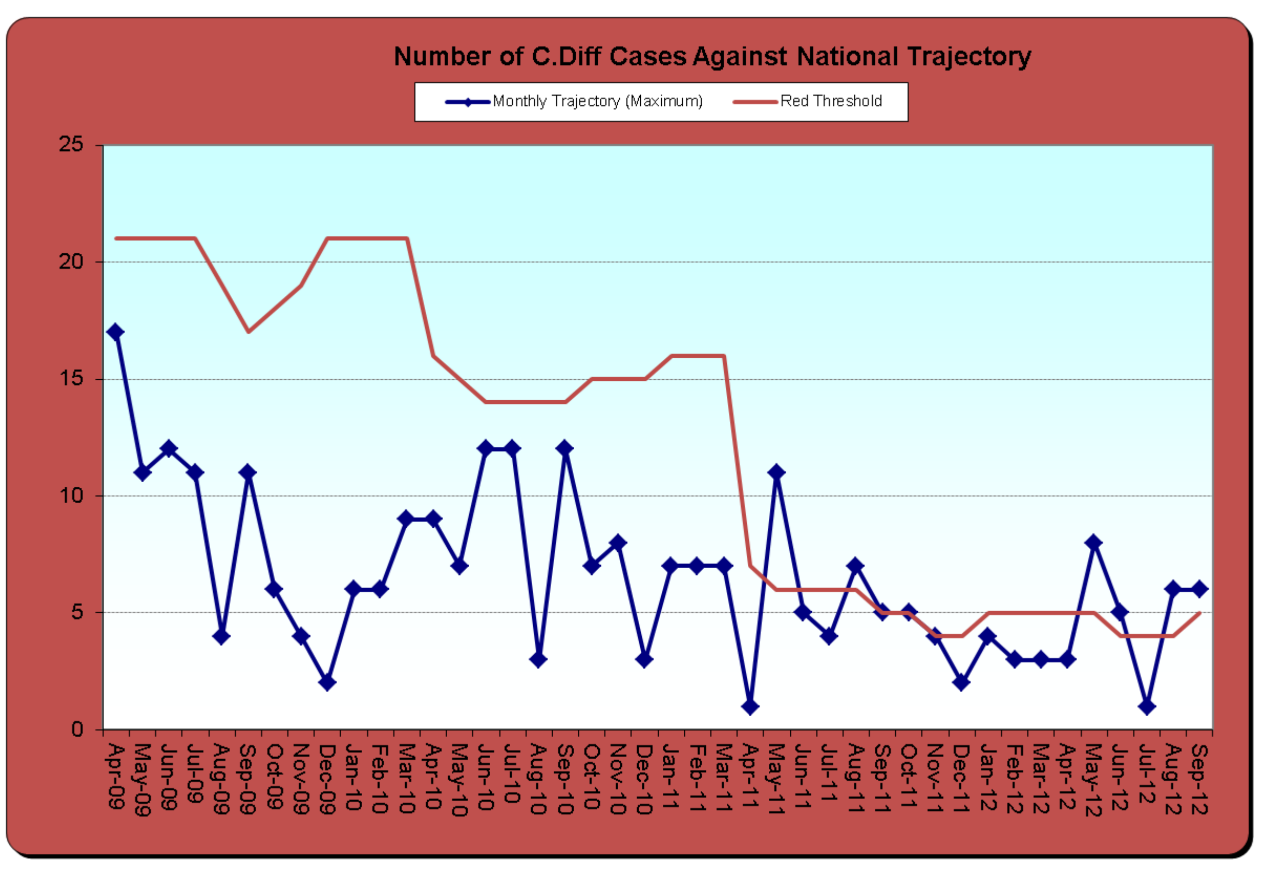
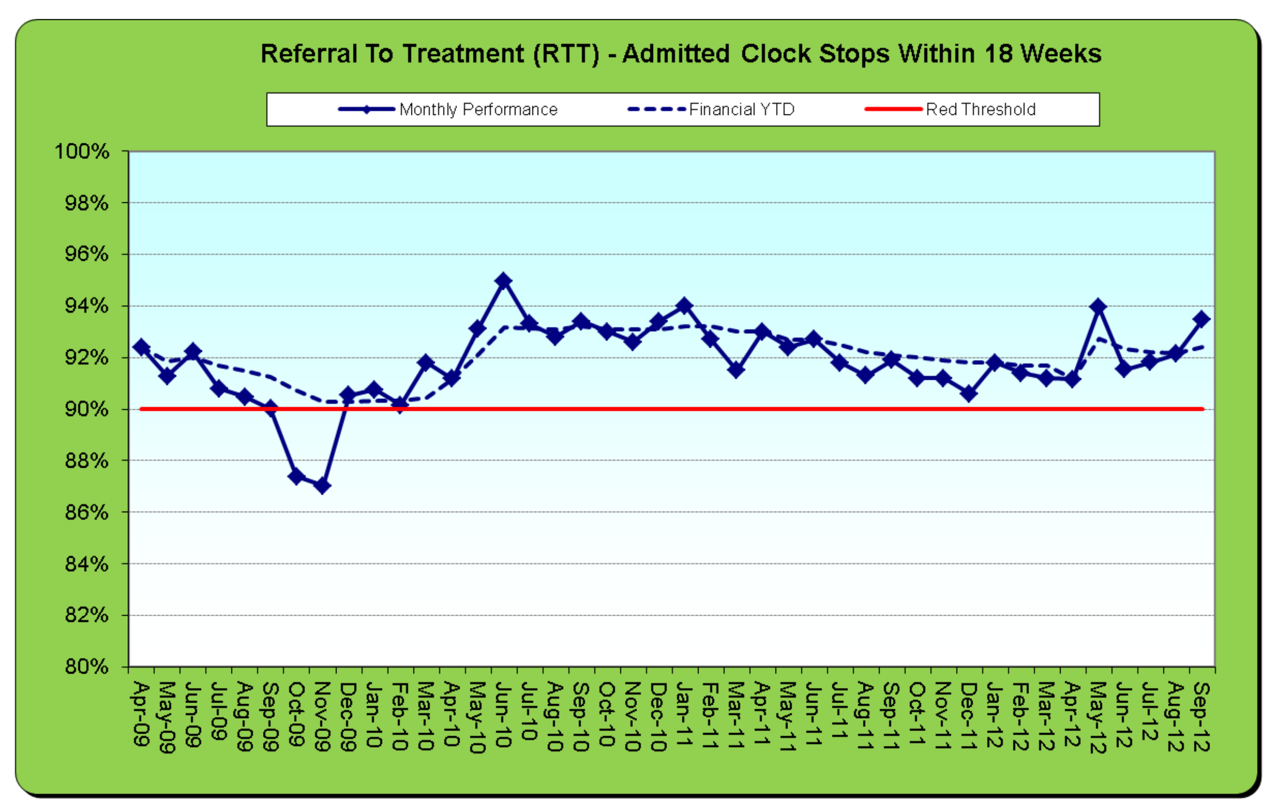
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Month Reported


Number of C.Diff Cases Against National Trajectory
Monthly Trajectory (Maximum)
Red Threshold
25
20
15
10
5
0
Apr-09 May-09 Jun-09 Jul-09 Aug-09 Sep-09 Oct-09 Nov-09 Dec-09 Jan-10 Feb-10 Mar-10 Apr-10 May-10 Jun-10 Jul-10 Aug-10 Sep-10 Oct-10 Nov-10 Dec-10 Jan-11 Feb-11 Mar-11 Apr-11 May-11 Jun-11 Jul-11 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 Sep-12



Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
Monthly Performance
Financial YTD
Red Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
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May-10
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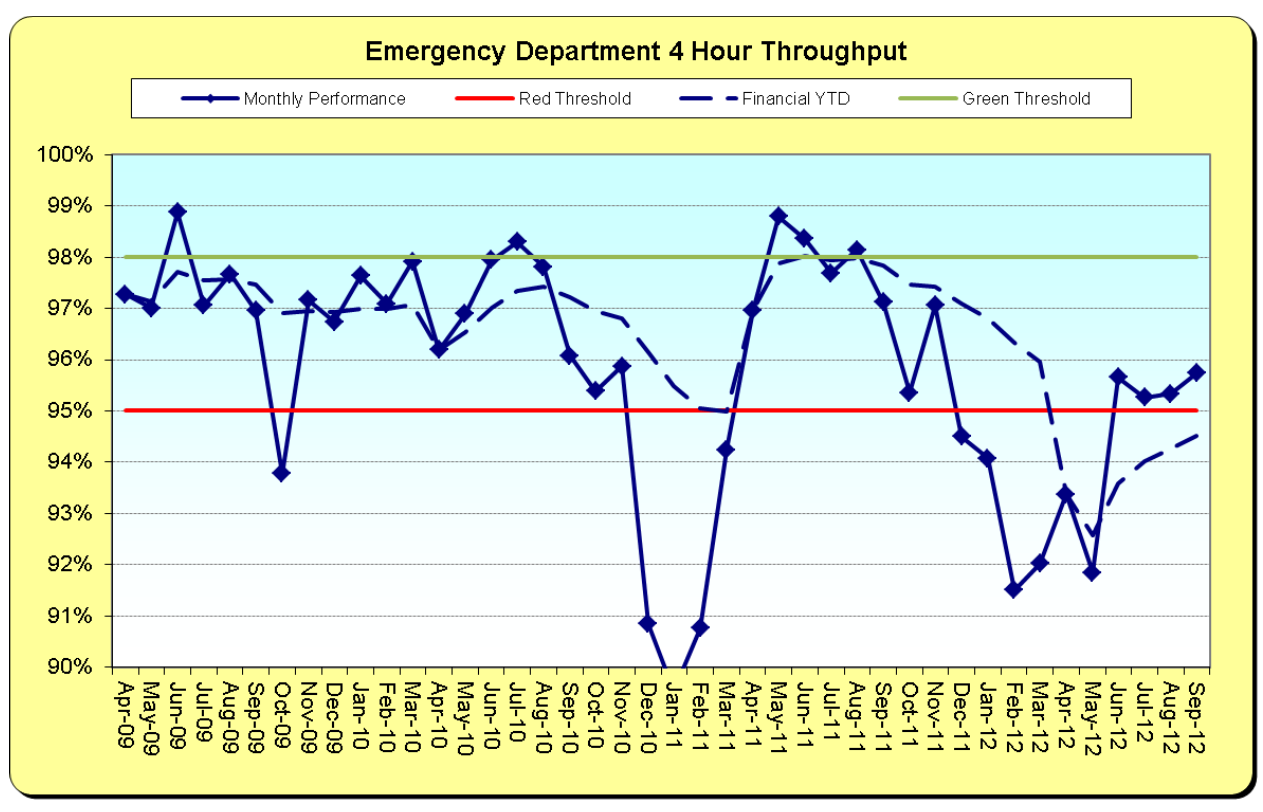
Emergency Department 4 Hour Throughput
Monthly Performance
Red Threshold
Financial YTD
Green Threshold
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
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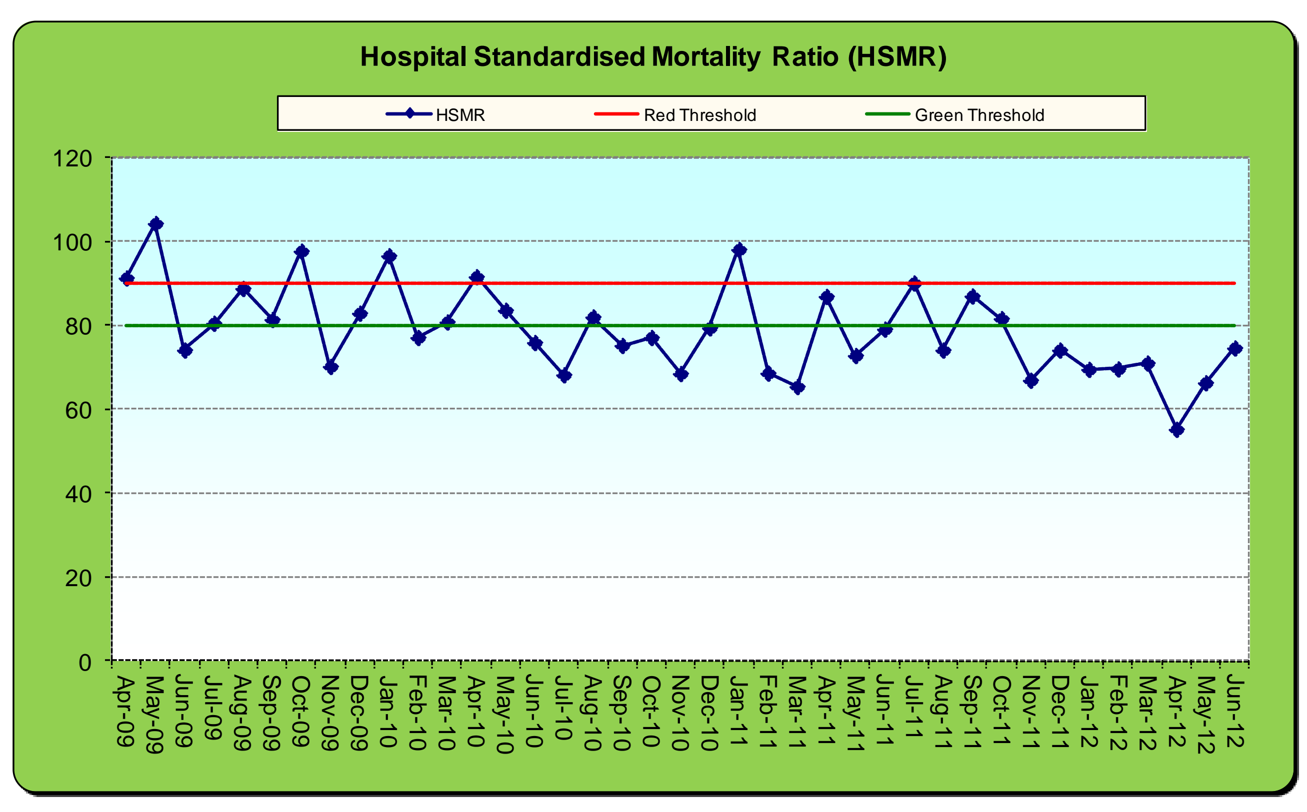
Aug-12
Sep-12



Hospital Standardised Mortality Ratio (HSMR)
HSMR
Red Threshold
Green Threshold
120
100
80
60
40
20
0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
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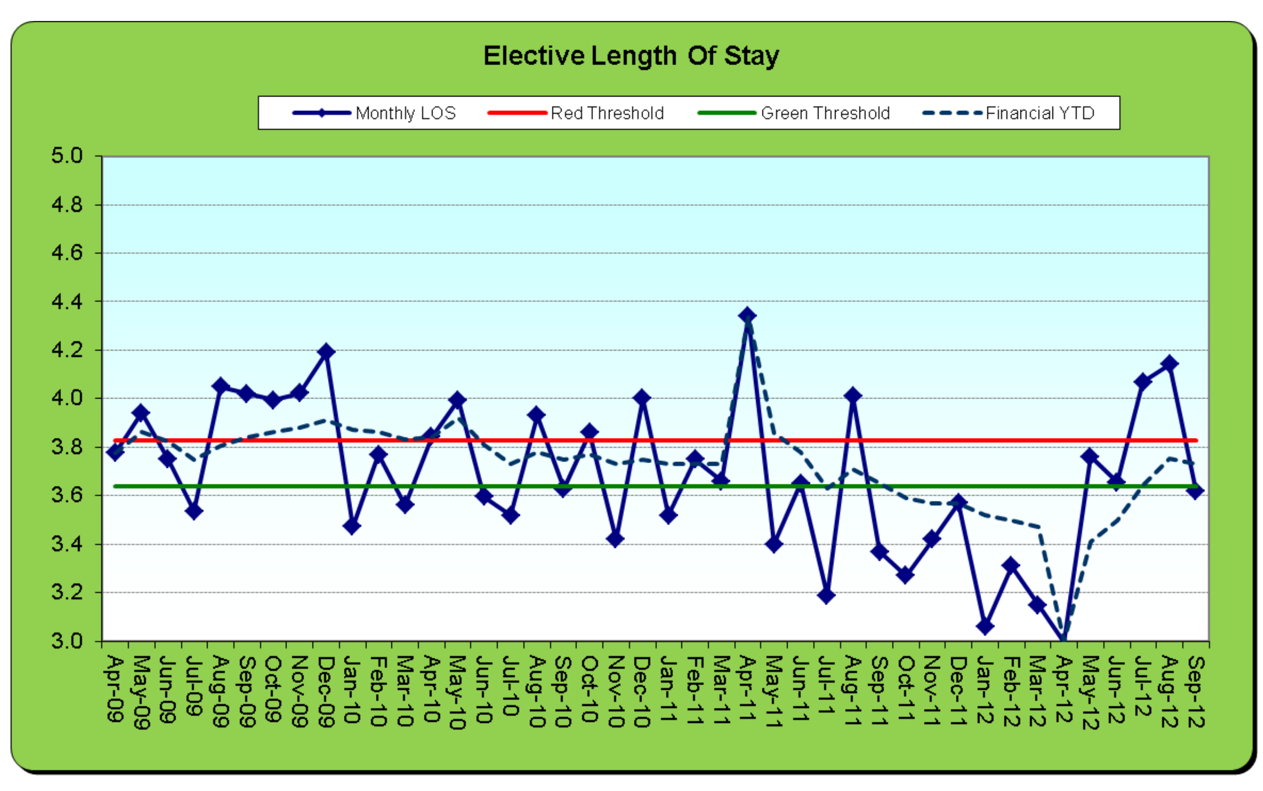
Apr-12
May-12
Jun-12


Elective Length Of Stay
Monthly LOS
Red Threshold
Green Threshold
Financial YTD
5.0
4.8
4.6
4.4
4.2
4.0
3.8
3.6
3.4
3.2
3.0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
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May-10
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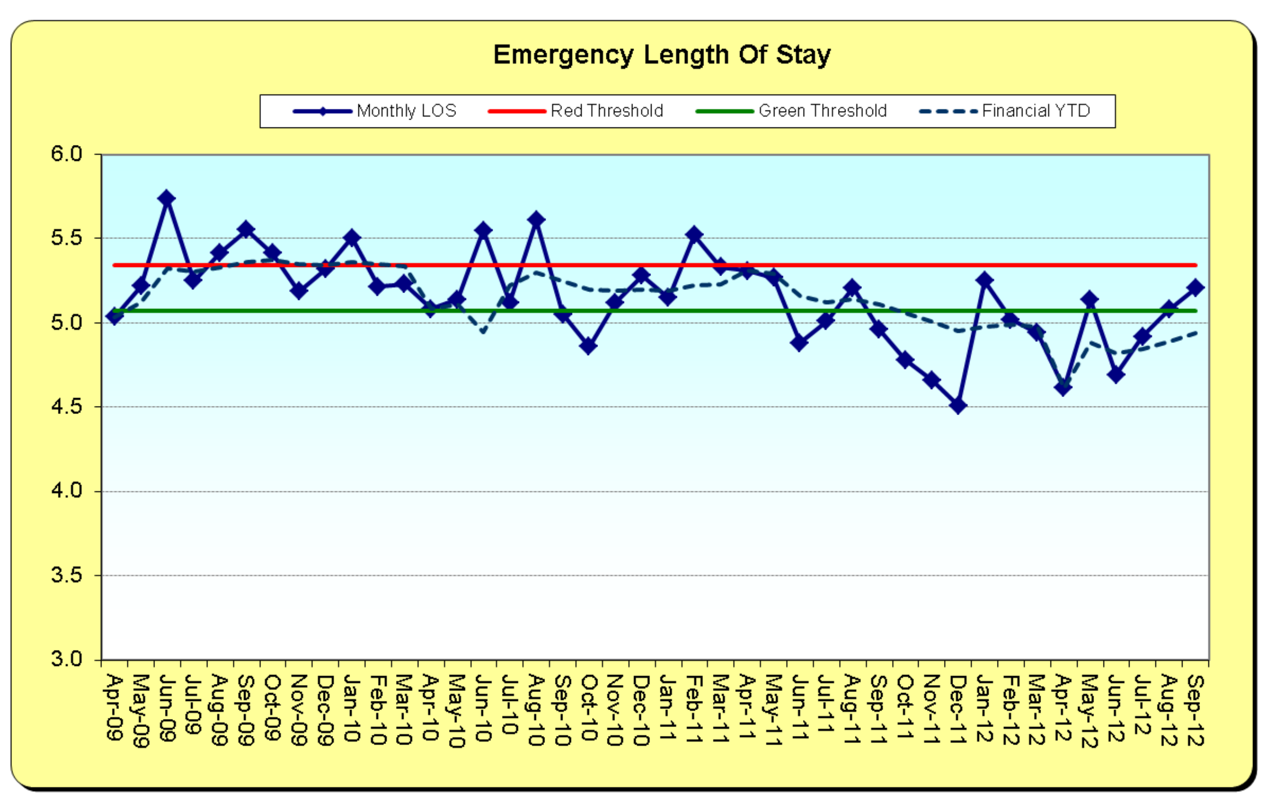
Sep-12



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
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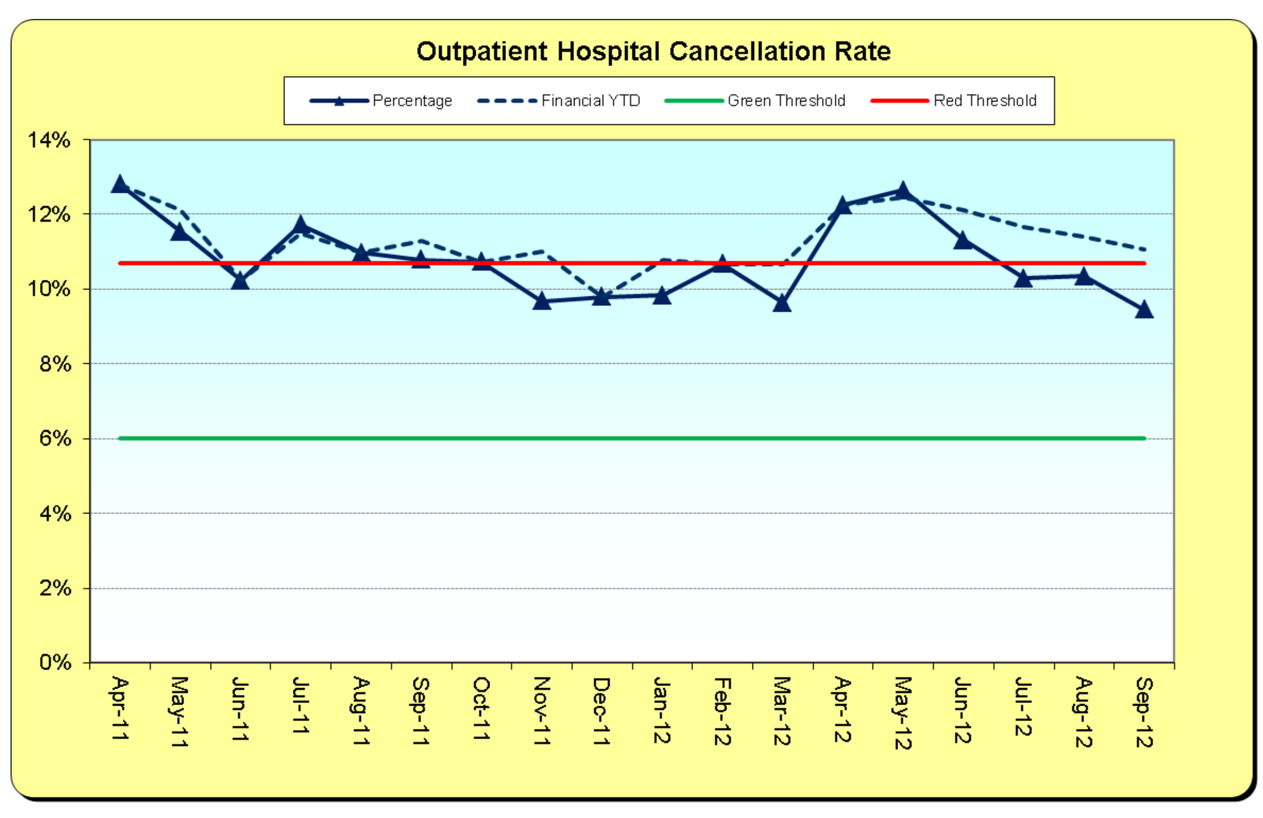


Outpatient Hospital Cancellation Rate
Percentage
Financial YTD
Green Threshold
Red Threshold
14%
12%
10%
8%
6%
4%
2%
0%
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12

PERFORMANCE OVERVIEW

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Incidence of pressure sores (grades 3 and 4)	In the *Quality* section of this report	
Number of C. diff cases	In the *Quality* section of this report	
Staff sickness	In the *Workforce* section of this report	
Number of Patients Recruited into NIHR Trials	See Additional Information	Recruitment into National Institute for Health Research (NIHR) studies is now off target year to date. It is believed the lower September figures are due to incomplete reporting on a new system rather than actual fall in recruitment. Compliance with the reporting of recruitment by researchers is being followed-up.
Cash Releasing Efficiency Savings (CRES) achievement	In the Finance Report	

SECTION C – Monitor's Compliance Framework

At the end of September 2012 the Trust is achieving all of the targets in Monitor's 2012/13 Compliance Framework, with the exception of the *Clostridium difficile* trajectory. Whilst the cumulative, year-to-date, trajectory for *Clostridium difficile* was not met at the end of the quarter, the target was met for the quarter. The number of cases reported to date in October is currently below the target. This puts the Trust in a strong position to recover the year-to-date position by the end of December.

The current reported position against the national cancer standards is based upon the confirmed figures for July and August, together with the draft performance figures held for September. The final reporting for the quarter will take place at the beginning of November, as part of the national return. There is a risk that the performance figures held for the quarter may change, based upon other trusts' submissions. The standard most at risk of changing following quarter-end reporting is the 62-day screening standard.

The following Exception Reports are provided in this report:

- *Clostridium difficile – Quality section*

The *Clostridium difficile* target has a weighting of 1.0 in the Compliance Framework. The Trust therefore has an AMBER-GREEN Governance Risk Rating for 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	Q2 Actual*	Notes	Q2 Governance rating
Monitor Compliance Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	29	✓	✓	✓	×	29	×	Cumulative trajectory: Q1 14; Q2 27; Q3 41; Q4 54	Not achieved
	2	Infection Control - MRSA Bloodstream Cases Against Trajectory	1.0	< or = trajectory	5	✓	✓	✓	2	5	×	Cumulative trajectory: Q1 1; Q2 1; Q3 2; Q4 2; Not scored	Not scored
	3a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)		98%	100%	✓	✓	✓	✓	100.0%	✓		
	3b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	1.0	94%	95.0%	✓	✓	✓	✓	94.7%	✓	All cancer figures are subject to final reporting in November	Achieved
	3c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	99.2%	✓	✓	✓	✓	98.3%	✓		
	4a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	87.3%	✓	✓	✓	✓	85.3%	✓	All cancer figures are subject to final reporting in November	Achieved
	4b	Cancer 62 Day Referral To Treatment (Screenings)		90%	91.8%	×	✓	✓	✓	90.4%	✓		
	5	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	92.4%	Achieved each month	Achieved each month	Achieved each month	Achieved each	92.5%	✓		
	6	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	96.0%	Achieved each month	Achieved each month	Achieved each month	Achieved each	95.4%	✓		Achieved
	7	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.2%	Target not in effect			Achieved each	92.2%	✓		Achieved
	8	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	0.5	96%	96.7%	✓	✓	✓	✓	96.5%	✓		Achieved
	9a	Cancer - Urgent Referrals Seen In Under 2 Weeks	0.5	93%	95.3%	✓	✓	✓	✓	94.6%	✓	All cancer figures are subject to final reporting in November	Achieved
	9b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	96.5%	✓	✓	✓	✓	96.5%	✓		
	10	A&E Total time in A&E 4 hours (95th percentile)	1.0	95%	94.5%	✓	✓	×	×	95.7%	✓		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. The minimum reporting level for MRSA = 6 cases, although our annual target = 2.

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

QUALITY

1.1 QUALITY TRACKER

		ID	Title	Green Threshold	Year To Date	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Q3	Q4	Q1	Q2
						Monthly Totals												Quarterly Totals			
Patient Safety	Infection Rates	PS-A1	MRSA Bloodstream Cases Against Trajectory - Monthly Totals	<Traj.	5	1	0	0	0	0	2	1	1	0	1	1	1	1	2	2	3
		PS-A2	C.Diff Infections Against National Trajectory - Monthly Totals	<Traj.	29	5	4	2	4	3	3	3	8	5	1	6	6	11	10	16	13
		PS-A3	MSSA Cases Against Trajectory	<Traj.	16	5	2	3	3	3	2	3	4	4	3	0	2	10	8	11	5
		PS-A4	Number of GRE Bacteraemias	<3 mth	9	0	0	2	0	3	0	2	2	1	4			2	3	5	4
		PS-A5	E. Coli Bloodstream Infections		121	20	12	16	18	12	20	23	24	16	21	18	19	48	50	63	58
	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%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%
		PS-A7	MRSA Emergency Screenings	95%	93.5%	93.4%	94.1%	93.8%	94.1%	94.4%	92.0%	92.2%	93.8%	92.3%	93.9%	93.5%	95.3%	93.8%	93.4%	92.8%	94.2%
		PS-A8	Hand Hygiene Audit Compliance	95%	97.3%	97.2%	96.2%	98.5%	98.3%	98.2%	98.3%	98.0%	98.2%	97.1%	97.8%	95.7%	96.6%	97.3%	98.3%	97.8%	96.7%
		PS-A9	Antibiotic Compliance	90%	83.8%	81.5%	83.3%	82.9%	86.8%	84.2%	83.7%	80.6%	84.7%	84.2%	85.1%	85.9%	82.3%	82.7%	84.9%	83.0%	84.5%
		PS-A10	Matron's Checklist	95%	93.6%	95.2%	94.9%	95.2%	95.5%	96.4%	98.8%	97.3%	95.6%	93.4%	91.5%	94.0%	92.8%	95.1%	96.3%	94.9%	93.3%
	Cleanliness	PS-A11	Cleanliness Monitoring - Overall Score	95%		95%	96%	94%	96%	95%	96%	96%	95%	95%	94%	94%	95%				
		PS-A12	Cleanliness Monitoring - Very High Risk Areas	95%		97%	96%	95%	96%	96%	96%	96%	97%	96%	96%	97%	96%				
		PS-A13	Cleanliness Monitoring - High Risk Areas	95%		96%	97%	96%	95%	96%	96%	96%	95%	95%	95%	96%	95%				
	Incidents	PS-B1	Number of Serious Incidents (SIs) Reported		50	8	8	3	16	7	10	4	7	14	7	11	7	19	33	25	25
		PS-B2	Number of Serious Incidents (SIs) as a Proportion of Activity																		
		PS-B3	Serious Incidents Reported Within 48 Hours	80% (Q3)	86%	62%	75%	33%	69%	86%	80%	75%	86%	93%	100%	82%	71%	63%	76%	88%	84%
		PS-B4	Percentage of Serious Incident (SI) Investigations Completed Within Timescale	80% (Q3)	83%	100%	100%	57%	71%	86%	92%	88%	100%	100%	88%	77%	57%	79%	85%	95%	75%
		PS-B5	Total Never Events	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0	1	0	1
		PS-B6	Total Number of Patient Safety Incidents Reported		5777	839	782	778	755	807	892	803	850	955	1141	1087	941	2399	2454	2608	3169
		PS-B7	Patient Safety Incidents Reported per 100 Admissions		6.1	8.0	7.5	7.8	7.0	7.8	8.0	8.2	7.9	9.3	10.3	10.4	2.2	7.8	7.6	8.4	5.0
	Falls	PS-C1	Number of Inpatient Falls Per 1,000 Beddays	<5.6	5.88	4.68	5.45	5.01	4.84	5.68	6.64	6.70	5.09	5.86	6.29	6.33	5.02	5.04	5.72	5.86	5.89
		PS-C2	Repeat Inpatient Falls		24.0%	28.6%	17.7%	27.9%	23.3%	13.4%	19.6%	12.9%	28.7%	30.9%	18.4%	26.9%	24.7%	24.7%	18.6%	24.7%	23.5%
		PS-C3	Number of Inpatient Falls - Patients Aged 65 And Over		677	87	96	92	98	94	125	116	101	103	123	135	99	275	317	320	357
		PS-C4	Number of Inpatient Falls - Patients With Cognitive Impairment		372	48	47	51	60	43	61	62	57	63	66	75	49	146	164	182	190
	Pressure Ulcers Developed in the Trust	PS-D1	Total Pressure Ulcer Incidence per 1,000 Bed Days	<0.651	1.41	2.12	1.52	1.41	1.64	1.57	1.58	1.37	1.30	1.61	1.34	1.71	1.14	1.69	1.60	1.42	1.40
		PS-D3	Number of Hospital Acquired Grade 2 Pressure Ulcers	<83 yr	185	49	33	32	33	33	39	32	32	33	31	33	24	114	105	97	88
		PS-D4	Number of Hospital Acquired Grade 3 Pressure Ulcers	<1	25	4	3	1	2	3	1	1	1	7	3	9	4	8	6	9	16
		PS-D5	Number of Hospital Acquired Grade 4 Pressure Ulcers	<1	2	0	0	1	1	1	0	0	1	0	0	1	0	1	2	1	1
	Pressure Ulcers Present On Admission	PS-D6	Number of Grade 2 Pressure Ulcers Present On Admission		338				47	45	44	41	52	61	70	66	48		136	154	184
		PS-D7	Number of Grade 3 Pressure Ulcers Present On Admission		84				7	9	8	6	6	16	19	26	11		24	28	56
		PS-D8	Number of Grade 4 Pressure Ulcers Present On Admission		33				7	0	4	4	3	6	6	6	8		11	13	20
	Venous Thrombo-embolism (VTE)	PS-E1	Adult Inpatients who Received a VTE Risk Assessment	90%	97.1%	97.5%	98.0%	98.4%	98.2%	98.4%	98.9%	98.7%	93.3%	95.3%	96.5%	95.1%	93.1%	98.0%	98.5%	97.8%	94.9%
		PS-E2	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	90%	98.5%	97.5%	89.7%	97.5%	96.0%	92.5%	97.4%		97.8%	98.4%	98.9%	98.4%	99.1%	94.4%	95.3%	98.1%	98.8%
	Nutrition	PS-F1	Fully Completed Nutritional Screening Within 24 Hours	90%	88.7%			83.5%			85.9%			86.5%			90.6%	83.5%	85.9%	86.5%	90.6%
		PS-F4	Protected Mealtimes Observed (Adult Inpatients)	95%	92.0%									90.0%			94.2%			90.0%	94.2%
		PS-F2	Malnutrition Risk Identified in Adults	90%	82.5%									78.9%			85.6%			78.9%	85.6%
		PS-F3	Malnutrition Risk Identified in Children	90%	85.2%									85.8%			84.3%			85.8%	84.3%
	Safety	PS-G1	WHO Surgical Checklist Compliance	98%	98.1%	97.0%	97.3%	97.5%	98.7%	98.4%	99.0%	95.4%	98.7%	99.4%	98.4%	98.1%	98.5%	97.3%	98.7%	97.8%	98.3%
	Medicines Reconcilliation	PS-H1	Medication Reconciliation Performed Within 1 Day of Admission.		77.90%												77.90%				77.90%
		PS-H2	Non-Purposeful Omitted Doses of the Listed Critical Medication		3.88%												3.88%				3.88%
	NHS Safety Thermometer	PS-J1	NHS Safety Thermometer - Coverage		100%								99%	100%	100%	100%	100%			100%	100%
		PS-J2	NHS Safety Thermometer - Harm Free Care		91.6%								90.3%	91.4%	92.6%	91.5%	92.2%			90.9%	92.1%
		PS-J3	NHS Safety Thermometer - No New Harms		95.6%								94.2%	95.8%	96.8%	96.9%	94.3%			95.0%	96.0%

QUALITY

		ID	Title	Green Threshold	Year To Date	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Q3	Q4	Q1	Q2
						Monthly Totals												Quarterly Totals			
Clinical Effectiveness	Mortality	CE-A1	Hospital Standardised Mortality Ratio (HSMR)	<=80		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	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%	82.6%	85.7%	81.8%	83.3%	100.0%	100.0%	88.9%	92.9%	63.6%	68.4%	90.5%	82.4%	100.0%	83.3%	95.5%	75.0%	89.6%
		CE-D2	Risk Assessment of Paediatric Patients with Learning Disability within 48 Hours	85%																	
	Readmissions	CE-E1	Emergency Readmissions Within 30 Days	<3.36%	3.0%	3.7%	3.4%	3.5%	3.2%	2.9%	2.9%	2.7%	3.2%	3.2%	3.1%	2.6%		3.5%	3.0%	3.0%	2.9%
	Maternity	CE-G1	Percentage of Spontaneous Deliveries Compared to All Births	64.3%	63.6%	63.8%	62.0%	62.5%	65.8%	62.6%	66.7%	67.8%	61.3%	62.3%	66.7%	63.5%	59.4%	62.8%	65.1%	63.9%	63.3%
	Fracture Neck of Femur	CE-H1	Fracture Neck of Femur Patients Treated Within 36 Hours	95%	67.0%	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%	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%	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%	46.3%	28.6%	24.3%	25.7%	33.3%	46.4%	50.0%	52.8%	37.8%	54.5%	51.4%	48.9%	34.3%	26.0%	44.1%	47.4%	45.3%
		CE-J2	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	80%	73.7%	85.7%	87.8%	81.4%	65.8%	68.3%	64.3%	87.2%	72.0%	68.6%	72.2%	63.8%	80.6%	84.9%	66.1%	75.8%	71.4%
		CE-J3	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	58.62%	75.00%	64.29%	72.22%	52.63%	59.09%	71.43%	83.33%	57.14%	53.85%	52.38%	53.33%	58.33%	70.45%	60.00%	64.10%	54.17%

		ID	Title	Green Threshold	Year To Date	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Q3	Q4	Q1	Q2
Patient Experience	Single Sex Accom.	PE-A1	Same Sex Accommodation Breaches - Number of Patients	0	20	10	0	0	0	0	30	0	20	0	0	0	0	10	30	20	0
	Patient Survey Responses	PE-B1	Patient Survey - Overall CQUIN Score	73.9		76	76	75	74	76	75	77	75	76	74	75		76	75	75	75
		PE-B2	Monthly Patient Survey - Noise At Night	84-86		83	82	82	80	81	79	83	81	82	82	83		82	80	82	83
		PE-B3	Monthly Patient Survey - Explaining Medication Side Effects	61-64		59	59	56	59	61	60	59	61	64	58	61		58	60	61	60
		PE-B4	Monthly Patient Survey - Maternity Services	85				80			86			85		83		80	86	85	83
		PE-B5	Monthly Patient Survey - Patients Who Would Recommend The Trust	92%		95%	97%	96%	96%	97%	96%	96%	95%	96%	95%	96%		96%	96%	96%	96%
	Patient Complaints	PE-C2	Patient Complaints as a Proportion of all Activity	<0.25%	0.3%	0.3%	0.2%	0.2%	0.3%	0.2%	0.2%	0.3%	0.4%	0.4%	0.4%	0.4%	0.2%	0.2%	0.3%	0.4%	0.3%
		PE-C3	Percentage of Complaints Resolved Within Timeframe (Formal Complaints)	98%	95.3%	90.2%	90.9%	84.2%	81.4%	95.2%	94.3%	96.7%	94.5%	94.7%	94.2%	94.8%	97.3%	88.7%	91.2%	95.2%	95.4%
		PE-C6	Complainants Disatisfied with Response (Not Responded In Full)		12	6	1	0	0	0	2	2	3	4	0	3	0	7	2	9	3

Please note: The April to July Stroke Care figures (indicators CE-J1 and CEJ2) have been revised, following a refresh of the spells data extracted from Medway PAS (Patient Administration System) which identified a small number of additional stroke patients to report. The only material change is the Brain Imaging within 1 hour figure for April, which is now GREEN rated.

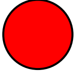
QUALITY

1.2 SUMMARY

The revised Quality dashboard continues to develop to reflect priorities for 2012/13 and more detail is provided on the current position against this year's CQUINs, many of which are due to be achieved by Q4. Of particular note this month are the significant reductions the number of inpatient falls and the number of complaints in September. The reduction in complaints as a proportion of activity from 0.4% to 0.2% represents a reduction in absolute numbers from 158 to 96. It is also worth noting the improvement in stroke patients spending 90% of their time on a stroke unit. Exception reports are provided for metrics which are below the expected performance threshold.

Achieving set threshold (26)	Thresholds not met or no change on previous month (8)
- MRSA (Meticillin Resistant *Staphylococcus aureus*) bloodstream cases against trajectory - MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory - MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – elective - MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – emergency - Cleanliness monitoring overall Trust score - Cleanliness monitoring very high risk areas - Cleanliness monitoring high risk areas - Never Events - In-patient falls incidence per 1,000 bed days - Number of hospital acquired grade 4 pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Percentage adult in-patients who received thrombo-prophylaxis - WHO surgical checklist compliance - Fully completed nutritional screening within 24 hours - NHS Safety Thermometer-coverage - Hospital Standardised Mortality Ratio (HSMR) - Summary Hospital Mortality Indicator (SHMI) - Stroke care: percentage spending 90% + time on a stroke unit - Risk assessment of adult patients with learning disability within 48 hours - 30 day emergency re-admissions - Number of breaches of the same sex accommodation standard	- Antibiotic prescribing compliance - Matrons checklist (*C. difficile* dashboard) - Hand Hygiene Audit - Protected mealtimes observed (adult inpatients) - Malnutrition risk identified in adults - Malnutrition risk identified in children - Monthly patient survey: noise at night - Percentage of complaints resolved within formal timescale

QUALITY

<table>
<tr><td>- Patient experience overall CQUIN score
- Monthly patient survey: explain medication side effects
- Monthly patient survey: patients who would recommend the Trust
- Patient complaints as a proportion of all activity
- Number of complainants dissatisfied with the response (not responded in full)</td><td></td></tr>
<tr><td> Quality metrics not achieved or requiring attention (9)</td><td> Quality metrics not rated (22)</td></tr>
<tr><td>- Clostridium difficile cases against national trajectory
- Serious Incidents reported with 48 hours
- Serious incident investigations completed within required timescales
- 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
- Percentage of spontaneous deliveries compared to all births
- Stroke care: percentage receiving brain imaging within 1 hour
- High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours</td><td>Data not yet available
- Risk assessment of paediatric patients with known learning disability within 48 hours
- GRE (Glycopeptide Resistant Enterococci) Bacteraemias
- Detection of the deteriorating patient: early warning scores
- Escalation of the deteriorating patient using a structured communication tool

Data not available for Q2
- 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

Thresholds not yet applicable
- E coli (Escherichia coli) blood stream infections
- NHS Safety thermometer-harm free care
- NHS Safety thermometer-no new harms
- Medicines reconciliation performed within one day of admission
- Non-purposeful omitted doses of listed critical medication
- Monthly patient survey: maternity services

Metrics for information
- Number of serious incidents
- Total number of patient safety incidents reported
- Total number of patient safety incidents per 100 admissions</td></tr>
</table>

QUALITY

	- 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 the current position against CQUIN targets reported in the Quality dashboard.

- VTE risk assessment to be achieved each month. Percentage for September was 93.1% against a target of 90%.
- Patients receiving appropriate thrombo-prophylaxis to be achieved each month. Percentage for September was 99.1% against a target of 90%.
- 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 August was 75 against a target of 73.9.
- Patient Experience: reducing noise at night. Score for August was 83 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 August was 61 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 August was 96% against a target of 92% to be achieved by Q3.
- Implementation of the NHS Safety Thermometer which measures harm free care in relation to: pressure ulcers, falls, VTE and urinary tract infections. Target is 25% coverage in Q2, 75% coverage in Q3 and 100% coverage in Q4. Coverage for September was 100%.
- MUST (Malnutrition Screening Tool) nutritional assessments for adults to be achieved in Q4. Performance for September is 90.6% against a target of 90%.
- Protected mealtimes observed to be measured in Q4. Performance for September of 94.2% against a target of 95%.
- Malnutrition risk identified in adults to be achieved in Q4. Performance for September of 85.6% against a target of 90%.
- Malnutrition risk identified in children to be achieved in Q4. Performance for September of 84.3% against a target of 90%.
- Risk assessment of paediatric patients with learning disability within 48 hours to be achieved in February 2013. Target is 85%. Data not yet available.
- Spontaneous vaginal deliveries as a percentage of all births to be achieved in Q4. Performance for September was 59.4% against a target of 64.3%.

QUALITY

- Detection of the deteriorating patient. Early warning scores completed correctly to be achieved in Q4. Target is 95%. Data not yet available.

- Escalation of the deteriorating patient for senior review. Improvement in the use of a structured communication tool - SBAR (Situation, Background, Assessment, Recommendation) - for clear communication of clinical need for a deteriorating patient to be reviewed. CQUIN to be achieved in Q4. Target is 95%. Data not yet available.

CQUINS still being finalised:

- Patients with medicines reconciliation performed within 1 working day to be measured in Q4.

- Non-purposeful missed omitted doses of the listed critical medication to be measured in Q4.

1.3 CHANGES IN THE PERIOD

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

- Serious incidents investigations completed within timescale down ↓ from 77% in August to 57% in September
- Falls incidence per 1,000 bed days down ↓ from 6.33 in August to 5.02 in September
- Number of grade 3 pressure ulcers down ↓ from 9 in August to 4 in September
- Fully completed nutritional screening up ↑ from 86.5% in Q1 to 90.6% in Q2
- Number of complaints as a percentage of activity down ↓ from 0.4% in August to 0.2% in September

1.4 EXCEPTION REPORTS

Exception reports are provided for nine RED rated indicators and three further indicators* which are amber rated, twelve indicators in total.

1. *Clostridium difficile* cases against national trajectory
2. Serious incidents reported within 48 hours
3. Serious incident investigations completed within required timescales
4. Total pressure ulcer incidence per 1,000 bed days
5. Number of hospital acquired grade 2 pressure ulcers
6. Number of hospital acquired grade 3 pressure ulcers
7. Protected mealtimes observed (adult inpatients)*
8. Malnutrition risk identified in adults*
9. Percentage of spontaneous deliveries compared to all births
10. Stroke care: Percentage receiving brain imaging within an hour
11. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours
12. Number of complaints responded to within timescale*

QUALITY

Q1. EXCEPTION REPORT: *Clostridium difficile* cases against national 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, on the basis of the cumulative year to date position at the end of the quarter (target for Quarter 2 = 13; cumulative year-to-date target for Quarter 2 = 27).

Performance in the period, including reasons for the exception:

There were six Trust apportioned cases of *Clostridium difficile* in September 2012, taking the total cumulative number of cases for the year to 29 against the target for the end of quarter 2 of 27. The total number of cases for the quarter was 13, against a target of 13.

Division	Target	Number of target cases
Medicine	3	1
Surgery, Head and Neck	1	2
Women's and Children	1	1
Specialised Services	0	2

The Divisions of Specialised Services and Surgery, Head & Neck exceeded their monthly target in September. 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.

- Positive patients are admitted to the cohort ward.
- New national specimen testing and reporting has been introduced to the Trust.
- The Trust is now required to report specific positive results.

QUALITY

- The Trust risk assessment and stool chart reflect the new specimen testing/sending and reporting.
- ICE system reflects new specimen sending and reporting.
- Isolation of patients within 2 hours of suspected *Clostridium difficile* infection. Monitored by clinical site team and reported to Infection Control Group.
- Trust-wide computer screen saver 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

Q2 + Q3. EXCEPTION REPORT: Serious Incidents reported within 48 hours Serious Incident investigations completed within timescale	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

Q2: Percentage of serious incidents reported within 48 working hours as required within commissioning contracts measured quarterly. Target is 80%.

Q3. 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. Target is 80%.

Performance in the period, including reasons for the exception:

Q2. Seven incidents were reported in September; of these two breached the 48 hour timescale = 71%. For one incident there was a delay in reporting by the unit; for the other incident there was a breakdown in communication systems for community services to inform the Trust of incidents which had been detected post discharge, but had possibly occurred within the Trust. The overall figure for Quarter 2 is 84%.

Q3. Seven serious incident investigations were completed in September, and of these three breached their timescale = 57%. Of these three breaches, two were delayed from the same unit which was under new leadership and which had a number of incident reports to complete whilst at the same time introducing corrective actions from learning and reviewing their processes. The third one was an incident involving IT (Information Technology) systems where the investigation was delayed due to staff needing to focus on Medway implementation. The overall figure for Quarter 2 is 75%.

Recovery plan, including expected date performance will be restored:

- Staff have been reminded of the need to report incidents promptly as soon as the care needs of those involved have been met.
- The communication systems for community services to inform the Trust of incidents which had been detected post discharge, but had possibly occurred within the Trust, have been reviewed and an automatic e mail forward from an nhs.net account to relevant Trust e mail accounts has been introduced to ensure notifications of incidents are picked up in a timely manner.

QUALITY

Q4-Q6 EXCEPTION REPORT: **Pressure ulcer incidence per 1,000 bed days** **Number of hospital acquired grade 2 pressure ulcers** **Number of hospital acquired grade 3 pressure ulcers**	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured: Pressure Ulcers identified at nursing/medical assessment are categorised 1-4 (Category 1 being red discolouration, Category 2 being a break or partial loss of skin, Category 3 being tissue damage through the superficial layers, Category 4 involving the most serious tissue damage, eroded through to the bone).

Performance in the period, including reasons for the exception:

The rate of hospital acquired pressure ulcers grade 2 and above was 1.14 per 1,000 bed days in September 2012, a decrease from August's figure.

Division	September 2012	August 2012	July 2012	June 2012	May 2012	April 2012
Medicine	1.13	1.50	1.98	2.05	1.95	1.24
Specialised Services	1.23	1.45	0.71	2.37	0.64	1.65
Surgery Head and Neck	2.22	3.79	2.18	2.06	2.08	3.00
Women and Children's	0.30	0.60	0.29	0.15	0.29	0.30
Trust	**1.14**	**1.71**	**1.34**	**1.61**	**1.30**	**1.37**

Four grade 3 pressure ulcers developed in hospital in September 2012. The core themes emerging from the Root Cause Analyses are:

- Incorrect categorisation/grading on or during admission, indicating the need for further education and training.
- Equipment issues, either access to specialist mattresses in a timely way, or knowledge of staff in using the equipment.
- Inconsistent practice with regard to care rounding and documentation.

These areas are all incorporated within the action plan following the external review report, with identified actions, leads and timeframes

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 was presented to Clinical Quality Group on Oct 4th 2012 and approved at Trust Management Executive 10th October 2012. The Deputy Chief Nurse, Tissue Viability Lead Nurse and Heads of Nursing are monitoring progress against the plan on a weekly basis.
- A planned programme to test all mattresses in the general Intensive Therapy Unit (ITU) has been completed and a report of the findings is being prepared, following a detailed analysis of the test results. ITU have removed any failed beds from use and are currently renting and

evaluating new equipment.

- A core group of staff visited a well-established medical equipment library in Wolverhampton on 12th October. A business case for an efficient and cost effective medical equipment library within University Hospitals Bristol is underway. In the meantime, as a temporary solution, work to upgrade the existing bed store is underway, with a robust system for managing mattresses across the Trust in draft form.
- A Trust-wide programme of teaching has now been completed. The Tissue Viability Lead Nurse and Senior Nurse for Quality are developing a system of competency based training packages. A meeting is planned for October 17th to work with the University of the West of England to develop an interactive "virtual patient" training programme to support the competency package.
- All Divisions continue to be required to complete and submit detailed recovery plans to the Trust Board Quarterly Reviews, where quality indicators are not achieved. The plans are monitored at the monthly performance meeting which either the Chief Nurse or the Deputy Chief Nurse 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.

Q7. EXCEPTION REPORT: Protected mealtimes observed	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Protected mealtimes are an indicator of compliance with Care Quality Commission Outcome 5 and also comprise a CQUIN for 2012/13. This is a monthly observational audit for adult patients against expectations laid out in the Trust's protected mealtimes policy. The target for 100% CQUIN achievement is 95% compliance in Q4 2012/13, with 50% being awarded for 90% compliance.

Performance in the period, including reasons for the exception:

The average figure over the last quarter was 94%. Whilst this is line with 50% achievement of CQUIN, we have seen a drop in compliance with protected mealtimes over the quarter. Protected mealtimes are audited once a month, monthly results went from 100% in July, to 97% in August and down to 85% in September, thus the overall average figure was reduced. There were four non-compliant wards in the September audit. Reasons for non-compliance on three of these wards were due to doctors speaking with patients during their meal.

Recovery plan, including expected date performance will be restored:

- Risk of non-compliance with protected mealtimes continues as the nutrition section on the doctors' induction programme (10mins), which covers nutrition screening awareness and protected mealtimes, has been removed from the programme. A review will take place after three months, and concerned have been logged.
- Wards have been asked to continue to close monitor and ensure compliance
- The nutrition steering group has sent out a message of the importance of compliance via its consultant members.

QUALITY

Q8. EXCEPTION REPORT: Malnutrition risk identified in adults	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Prompt identification of patients at risk of malnutrition is an indicator of compliance with Care Quality Commission Outcome 5 and also comprises a CQUIN for 2012/13. This is a fortnightly case note audit against expectations laid out in the Trust's managing nutritional care policy. The target for 100% CQUIN achievement is 90% compliance in Q4 2012/13, with 50% being awarded for 80% compliance.

Performance in the period, including reasons for the exception:

The average figure over the last quarter was 86%; a small improvement from the results of quarter 1 (79%), target 90%. Data is collected from fortnightly audits. Over the period of quarter 2 results varied from 80-90%. Ward staff must ensure the cutlery sign has been ticked above the patient's bed following nutritional screening. Where patients move beds there is a risk that signage is not immediately altered.

Recovery plan, including expected date performance will be restored:

- Nutrition micro teaches will continue to be provided for each ward and the importance of ticking the cutlery sign raised.
- Audit results are disseminated via the nutrition steering group, where the message of improving cutlery sign usage can be spread.
- Fortnightly audits will continue and will include verbal feedback at the end of each audit, providing an opportunity to feedback to the nurse in charge performance and identify areas for improvement.

QUALITY

Q9. 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 September percentage of spontaneous vaginal births was 59.4% of all births. There were significantly higher numbers of bookings for deliveries in September which we believe have contributed to the reduced percentage in spontaneous vaginal births, although we are currently validating this assertion.

Recovery plan, including expected date performance will be restored:

- The community midwives from Granby team who are experienced in home birth have started working back in the hospital from the beginning of October, and will be able to share expertise.
- We have made positive appointments for Band 5, 6 and 7 midwives, although not all the new appointees are yet in post.
- A bespoke Midwifery led Birthing Unit has been approved as a capital project and work is due to start in November 2012. The anticipated date for completing this is May 2013.
- We are continuing with work via the Normal Birth Working Party and to promote VBAC (Vaginal Birth After Caesarean section) antenatally.
- We are purchasing sonnicaids and telemetry tocographs, which will allow women to be more mobile in labour and increase the chance of a normal birth.

QUALITY

Q10-Q11. EXCEPTION REPORT: Stroke care • Percentage receiving brain imaging within an hour • High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours	RESPONSIBLE DIRECTOR: Medical Director

Description of how the target is measured:

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

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 the decision to refer by the healthcare professional seeing the patient. Only those patients treated in an outpatient setting count as a treatment.

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

Performance during the period, including reasons for exceptions:

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

Performance against this standard was 48.9% in August and 34.3% in September. The national standard is based upon the assumption that 50% of stroke patients have symptoms that suggest brain imaging is required to assess their condition. The Trust's own figures suggest that the percentage of patients with symptoms that would indicate scanning is required, is well below 50%, and all patients receiving thrombolysis are scanned within an hour of arrival.

However, where a scan is required there are two potential areas where delays in the pathway can occur. Firstly a delay in requesting the CT (computerised tomography) scan, and secondly a delay in processing the request and undertaking the scan. At present only doctors can request a scan for acute stroke patient arriving in the Emergency Department, GP Support Unit or Medical Assessment Unit (MAU). In September, five of the six patients that weren't scanned within an hour had not had their scans requested within an hour of arrival. An audit of CT stroke requesting by the Division of Medicine went to the Divisional Mortality & Morbidity review in July 2012. This audit found that there were several reasons for breaches of the one hour standard, the main ones being patients were not being highlighted to Radiology staff and a stroke was not obvious on presentation.

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

Performance in September was 5% better than in August, at 58.3%. Overall performance against this standard is just below the 60% national target

year-to-date (58.6% against the 60% standard). The main reasons why patients are not treated within 24 hours include:

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

Recovery plan, including expected date performance will be restored:

The actions being taken to ensure improved performance are detailed below. *Please note: actions completed in previous months have been removed from the following list*:

- Work is being undertaken by Medicine Division to progress nurse-led (Emergency Department and Thrombosis nurses) CT head requesting under protocol (Action complete – protocol approved); Authorisation required (see below)
- Each individual referrer who will be working to the protocol for CT head requesting needs to complete the form at the end of the protocol – stating name, Registration Number, IRMER (Ionising Radiation Medical Exposure Regulations) training certificate Number. and signed by their leads as indicated on the form. Once received within Radiology department the updates will be made (October 2012)
- Planned Radiology audit of all CT heads requested for stroke during the last 12 months with data to time to scan where requests are made on ICE (Order Communications system) – in progress.
- BRI Emergency Department (ED) professional standards including the CT scan stroke turnaround standard have been published to all Radiographers and are on display in the department (Action complete)
- ED Radiography department is to record when there has been a delay in scanning potential stroke patients. This will enable the department to complete a prospective audit of CT stroke patients (End October - ongoing)
- The Division of Medicine will carry out another audit of ED referral patterns and share the findings with Diagnostics & Therapies Division so action can be taken where necessary (October 2012)
- The stroke 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:

QUALITY

Performance against the 24 hour TIA treatment standard is just below the 60% national standard year to date (58.6%). The implementation of a system for receiving electronic referrals is expected to improve performance, although this still requires the referral to be made by the GP at the time of the decision to refer. Performance against the 1 hour brain imaging standard is also just below the national standard year to date (46.3% against the 50% national standard), but is expected to improve following the implementation of the nurse-led requesting of CT head scans.

QUALITY

Q12. 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:

September 2012 performance was 97.4% which equates to two breaches of timescale for this month. Performance is only just below the Trust standard, and is the highest level of performance over the last 12 months. The reasons for each individual breach are as shown below

Surgery Head & Neck

- One breach of timescale related to the late receipt of the response from the Division.
- The other deadline was breached due to the fact that amendments were required by executive directors; these were made and then further amendments were requested again when the letter was re-sent for signing. The letter was received within timescale from the Division but took 8 working days from originally being received from the Division until it was sent out.

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, and 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 by the end of 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 quarterly basis from December 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.

1.5 SUPPORTING INFORMATION

1.5.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the Division of Women's & Children's.

- **Appointments of four Paediatric Research Nurses have been made funded by West London Cancer Research Network and will be embedded within clinical teams in the Children's Emergency Department and Ward 35.** This will greatly strengthen the support available for patients on trials through staff support and development and, also improve the recruitment of patients into research programmes.

- **Launch of 'Health of the Hospital' dashboard for Children's Hospital.** This gives a quick overview of key operational and quality measures for the Children's Hospital now in its third month. The dashboard will form part of the monthly Divisional reporting once initial data quality issues are resolved.

- **Distinguished Service Award.** Jane Pyman has been awarded DSE Distinguished Service Award from the Chartered Society of Physiotherapists, after nomination by the British Association of Bobath Trained Therapists. This is a rare nationally acclaimed honour which reflects Jane's untiring contribution over the span of her career to the high quality care delivered to children in need of physiotherapy. We are delighted to see this award come to Jane, it is much deserved and we congratulate her.

- **Volunteers on post natal wards**. A further fourteen volunteers have been recruited to work within maternity services and will be used to offer further support on the post natal wards to new mothers.

- **Emergency Gynaecology Room.** This new facility commenced one month ago. The aim is to improve patient experience, reduce length of stay and prevent unnecessary admissions to the ward.

- **Enhanced recovery programme at St Michael's Hospital.** This ensures patients are in optimal condition prior to surgery to maximise the chances of having the best possible outcomes. Pre-operatively patients attend a 'pre-op assessment service' and receive education on the procedure and are made aware of what to expect pre and post-surgery. Post-operative pain relief, nausea and vomiting are actively managed. The enhanced recovery programme includes the introduction of laparoscopic procedures for endometrial cancer and cervical cancer with the aim of achieving a major reduction in length of stay and improved patient satisfaction.

- **Post Natal Clinic at South Bristol Hospital. A**greement has been reached to run a Post Natal Clinic at South Bristol Community Hospital at weekends which started on 15th October 2012. Women will attend the clinic for post natal care and advice rather than the Community Midwives visiting them at home which will allow more efficient use of midwifery time and allow women more choice.

QUALITY

- **Knowledge and Awareness regarding Tissue Viability.** An external review of review of pressure ulcer care showed the Neonatal Intensive Care Unit and Trauma and Orthopaedic teams to be exemplars where children had acquired pressure ulcers. The original pressure ulcers were deemed to have been unavoidable. The Deputy Chief Nurse is sharing learning from these areas with other Divisions.

- **Patient experience newsletter headed 'Luci's News, Patient Views'**. Luci is a young person, previously a patient at the Children's Hospital and now a member of the Trust's Youth Council. Her newsletter presents some of the key feedback messages from the monthly discharged patient surveys, highlighting positive feedback as well as identifying areas for improvement. The aim is to 'share the learning' giving our patients a real voice and the knowledge that their feedback is actively received and acted upon.

- **New builds within Bristol Royal Children's Hospital.** There are three recent developments:
    - Ward 39 – A new space has been opened and a revised model of care developed for the department. It is a light and bright department adding significantly to the patient/parent experience and with a new nurse staffing model the unit will increase to 8 beds this winter.
    - The Children's Emergency Department has moved into the new expanded observation ward (short stay unit) as part of the Centralisation of Specialist Paediatrics (CSP) Project.
    - Adolescent Ward - This ward opened with its first occupants being the Bone Marrow Transplant (BMT) Unit, relocated while the CSP project begins refurbishing the BMT Unit and bedrooms. Feedback from staff and patients using the new facilities has been really positive.

- **Refurbishment of Ward 37 (Renal Ward).** A capital scheme to improve the heating of the ward and replace the reverse osmosis unit (decontamination equipment) has been completed. The ward re-located entirely during this period and moved safely back at the end of September.

- **Official opening of Cots for Tots House.** The Countess of Wessex officially opened Cots for Tots House recently. This is a dedicated 12-bedroom family accommodation facility for parents of sick and premature babies

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.

Achieving (1)	**Underachieving (0)**
- Appraisal compliance - 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 September 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 increased to 4.3% in September compared with 4.2% in the previous month, remaining over the target, which in September increased to 3.3%. All Divisions are red rated except Diagnostic and Therapies. 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 September 2011	3.9%	2.4%	4.7%	3.3%	3.8%	4.2%	4.0%	5.4%
Target September 2012	3.3%	2.4%	3.3%	2.9%	3.2%	3.5%	3.2%	4.9%
Absence September 2012	4.3%	2.0%	4.7%	4.3%	4.7%	4.3%	4.3%	6.0%
Cumulative absence September 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:

Significant work was undertaken to alter the Supporting Attendance Policy to reduce the Bradford Factor triggers which was agreed at Industrial Relations Group on 24th September, and is now on HR Web (intranet page).

Medicine

- The top two reasons for absence were stress and anxiety (271 days in month) and musculo-skeletal and back injuries, (total 349 days lost). Genito-urinary and gynaecological disorders has also been a significant cause of sickness absence, with 213 days lost in the month compared with a previous average of 50 days. Percentage attendance continues to be used as an additional means of managing absence; six members of staff have been assessed through this method this year, and each case has been managed on the basis of attendance.
- Significant work has been undertaken in August to increase referral rates to the staff well-being advisors. Whilst referral rates are just 17% over the full length of the project, referrals increased significantly in Medicine to 50% in August. However, in order to be able to establish the success or otherwise of the intervention, referral rates of 70% need to be achieved. The cause of the low referral appears to be where multiple staff have

responsibility for taking the reporting absence call. Referrals increase when senior staff members co-ordinate, or there is a single point of control. The interim report is being considered by UH Bristol and North Bristol Trust (NBT), and the pilot ends Mid November.

- Following an increased number of reports from Occupational Health requiring clinical staff to return to temporary, non-clinical posts, as part of a phased return, the ward sisters and matrons have agreed a format to find alternative non clinical work for staff to expedite their return to work.
- 22 departments exceeded the agreed Divisional sickness target, and Human Resources (HR) is working on a one-to-one basis in these areas.
- Absence management was tabled at the supervisory ward sister meetings, and implementation discussed to ensure clarity of the new policy.

Specialised Services

- The Divisional Employee Services representative holds regular meetings with key managers to review all workforce metrics, with a particular recent focus on sickness absence due to current below target performance. These meetings have been expanded to include non-nursing areas. Important feedback has already been received from this process, and broadly includes the following:
    - How to ask the right questions and appropriate challenge to enable a practical response from Occupational Health
    - How to deal with underlying health conditions and what allowances should be made in relation to the Disability Discrimination Act
    - How to manage staff who still have sick pay entitlement with no reasonable prospect of return
    - How to manage staff using the provisions in the policy around percentage attendance and patterns of sickness

  The HR Business Partner and Employee Services Representative will be holding a sickness absence workshop in October 2012 for all managers in the Division, with a view to addressing these themes specifically, and this will undoubtedly identify further specific issues which need to be addressed.
- The highest areas for sickness absence include Cardiac Intensive Care Unit (CICU), Medical Secretaries Bristol Heart Institute (BHI), BHI Outpatients, Ward 62 and Medical Records. The Divisional Employee Services representative has reviewed these areas with the HR Business Partner and is developing individual strategies with each area. The Division will be producing ‘league tables’ of the highest areas of sickness in Specialised Services to ensure an on-going focus on the key areas of concern by the end of October 2012.
- Episodes of stress related absence have more than halved over the last two months. This has coincided with specific stress-related work which has been undertaken, including stress audits and reviews of Occupational Health referrals.
- The HR Business Partner has reminded all managers of dates for training on managing sickness absence and encouraged those who are non-compliant with this training to attend within the next 8 weeks.

Surgery, Head & Neck

- A project to review specific areas with high sickness was launched last month and the second round of returns are about to be sent out for completion. This will be reviewed in November 2012, and provided that there are improvements in the 17 high sickness areas, the focus will shift to other high sickness areas to ensure cases are being managed appropriately.
- Levels of sickness absence relating to stress/anxiety/depression have increased for the fourth consecutive month. As well as the support provided by the Safety Team and Employee Services, some analysis has commenced this month to achieve an improved understanding of the reasons for

sickness under this category – this involves managers being asked to specify whether the reason for the individual's absence was work-related stress, bereavement, personal/home circumstances or a mental health condition. This will be reviewed in November 2012, following the results of the audit.

Women`s & Children`s

- The Division is piloting a Staff Wellbeing Project, along with the Medicine Division and NBT, although there is a very poor referral rate from line managers, with 31% of absences being referred from Women`s and Children`s Division in August. Significant work was been undertaken in July and August to increase referral rates.
- The Employee Services representative is communicating with all managers in the Division to go through the changes to the Supporting Attendance Policy, using the lowered Bradford Factors and percentage absence calculations and answering queries.
- The Employee Services representative is meeting with the worst performing areas to ensure the Supporting Attending Policy is being applied correctly and that sickness absence is being manager appropriately, in a timely manner. She is also attending the Matrons' meetings within both Children's and Women's Services to communicate the revised policy.
- The HR Business Partner reviews all long term absence cases with the Employee Services representative on a regular basis, along with any staff who are at formal stages of the Policy.
- The top two reasons for absence were stress and anxiety (369 days in month) and other musculo-skeletal (374 days in month). Infectious diseases was also high (200 days in month) although overall the Division's sickness for these reasons is similar when aggregated over the past year.

Estates & Facilities

- The HR Business Partner has met with operational managers individually to review cases of current sickness absence. The policy is being followed and absences followed up. The HR Business Partner will also meet with staff side to consider any issues that may be affecting morale and stress levels. Other ways that we can decrease absence will be reviewed with HR colleagues.
- The Employee Services representative is holding a surgery with managers to go through the changes to the sickness policy, using the lowered Bradford Factors and percentage absence calculations and answer queries. The managers of the worst performing areas are required to attend the session. Further training will be targeted and delivered as necessary. The HR Business Partner will continue to follow up with the worst performing areas.

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 reduced by 1.2% compared with August 2012, 1.2% above budgeted workforce numbers for September 2012.

	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates & Facilities)	Estates & Facilities
September 2012	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE
Workforce Numbers (including bank & agency)	7169.47	919.22	1092.99	775.75	1611.90	1421.14	633.07	715.40
Budgeted Numbers	7085.67	912.11	972.05	750.42	1625.48	1433.17	673.61	718.83
variance target +/-	-83.80	-7.11	-120.94	-25.33	13.58	12.03	40.54	3.43

Recovery plan, including expected date performance will be restored:

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

Progress against recovery plan:

See bank and agency section below.

WORKFORCE

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 reduced by 43.7 FTE and agency by 52.7 FTE in September 2012 compared to August 2012, 14.2% above target compared with 34.3% above the previous month. Diagnostic & Therapies, Medicine, Specialised Services and Surgery, Head & Neck exceeded their targets.

This increase in bank and agency usage is also the reason for the red rated target for workforce numbers (see table above).

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 September 2011	424.8	16.8	98.6	39.2	77.1	68.2	93.0	31.8
Actual September 2012	363.2	25.5	114.9	46.9	81.5	64.1	2.1	28.3
Target September 2012	311.5	19.3	75.7	29.6	59.8	67.4	27.2	32.4
Variance from target	14.2%	24.1%	34.1%	37.0%	26.6%	-5.2%	-1202.2%	-14.7%

Recovery plan, including expected date performance will be restored:

<u>Diagnostics & Therapies</u>

Bank and agency usage in Diagnostic & Therapies Division is the result of pressures in the following areas:

- Radiology – backlog reporting has required the services of a medical locum
- Laboratory Medicine – there are 11.9 FTE bank staff employed long term on the bank, mainly as Medical Laboratory Assistants, and some

funded research posts. This is due in part to a historical under establishment which is now being adjusted

- MEMO – agency staff employed to fill vacancies in finance and at Weston

An improvement in the bank and agency usage is expected next month as a result of:

- The Radiology Medical locum finishes at the end of September
- Recruitment in Laboratory Medicine, reducing the bank requirement
- An appointment in MEMO finance, ending the need for agency next month.

Medicine

- The unfunded flexible capacity remains open, utilising 13.8 FTE bank staff this month, resulting in ongoing delays in reducing workforce numbers and costs.
- Nursing bank continues to be widely used across the Emergency Department and the Medical Assessment Unit.
- Bank figures are related to the additional resources required to meet the performance targets including 4 hours and other performance targets.
- Unregistered nursing bank usage has been incurred to support one to one and two to one observations. Unregistered nursing to support dementia patients has been mainly on wards 4, 7 and 23, but ward 10 has also utilised additional nursing assistants this month.
- There has been a switch in September from the use of Agency Doctors (in August), to internal locum Doctors at a significantly lower hourly rate. These locum shifts are being used to support pressures in the Emergency Department. These will continue until the additional Emergency Nurse Practitioners start in post (likely to be December 2012).
- The increase in total demand for flexible nurse cover bank/agency has put considerable pressure on the ability of the Bank Office to fill other requests, so the use of Agency nursing remains high.
- There has been significant Registered Mental Health Nurse agency usage.

Specialised Services

There are a number of issues within the Division which are contributing to the unusually high Bank rates. This is broken down into specific nursing areas below; almost all of the bank usage is within nursing.

- CICU (Cardiac Intensive Care Unit): much heavier than predicted workload with all 13 level 3 beds being used 24 hours a day 7 days a week, requiring 1:1 nursing care. In addition there are long term and short term sickness issues, and 3 staff on maternity leave.
- Ward 52: some of the bank usage is to provide cover for maternity leave, and two vacancies which are currently being recruited to. In addition, Nursing Assistants have been required to care for the high number of complex patients leaving CICU with poor medical conditions.
- Bristol Heart Institute (BHI) Outpatients – cover has been used for a vacancy which is now filled. There have also been additional pre assessment and Cardioversion sessions required by the division to deliver activity.
- Ward 62: 5 Bone Marrow Transplant (BMT) patients increased the dependency, resulting in a requirement for each shift for an additional registered nurse as the workload is very high. This is unprecedented and is a cross-Divisional issue which is under review jointly with the

WORKFORCE

Women`s & Children`s Division.

- Ward 61: up until the beginning of October, Ward 61 had 5 registered nurse (RN) vacancies and 4 Nursing Assistant (NA) vacancies which have taken 3 months to get staff into post. Two RNs have already started with two more about to start. Two NAs were on induction last week and a further two to start in November.

Agency usage is due to the following:

- The Nurse Practitioner programme in Cardiac Surgery has more than halved agency usage within Cardiac Surgery juniors, and the Division is currently working on a plan to further expand this programme. Agency usage in Radiotherapy (1.47 WTE) was to cover vacancy due to delayed Graduate programme – graduates have now commenced in post so this will not be continuing. Haematology junior agency is covering a post holder who is currently absent due to an ongoing process. This is likely to be resolved over the next one month.

Target dates for improvement are as follows for Specialised Services:

- It is anticipated that Bank usage will decrease in October 2012, and further decrease in November 2012, as recruited staff are able to start in post and cross-Divisional issues are resolved around BMT
- HR Business Partner will pick up issues around delayed recruitment with Head of Resourcing to understand if there is any additional support that they require from managers within the Division to speed this up
- It is hoped that the situation around ventilated patients in CICU will resolve over the next month; however this is also an unprecedented situation which is being carefully managed by the Deputy Divisional Manager for Cardiac Services and the Matron for CICU
- It is anticipated that the actions taken to address sickness (see separate exception report) will have a positive impact by the end of October, thus reducing the necessity for Bank to cover sickness.

Surgery, Head & Neck

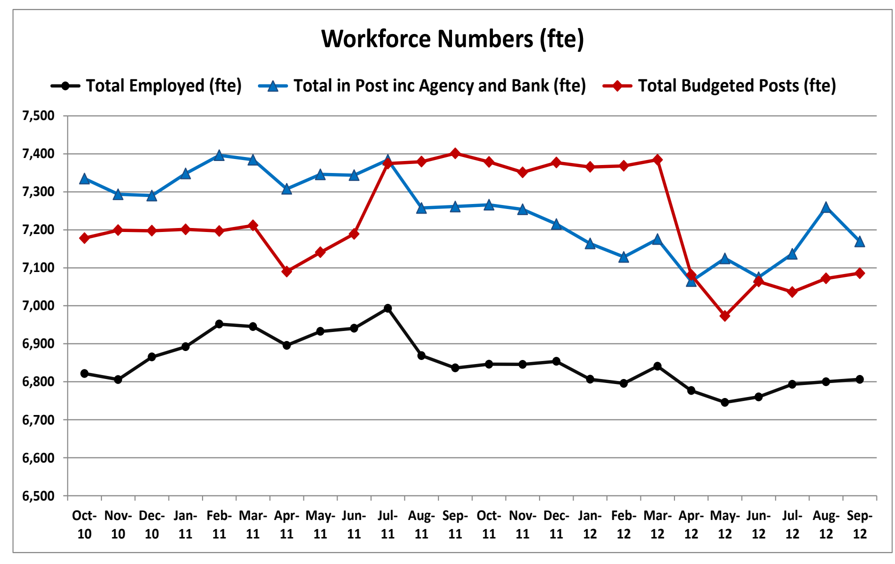
The main reasons for bank use last month were:

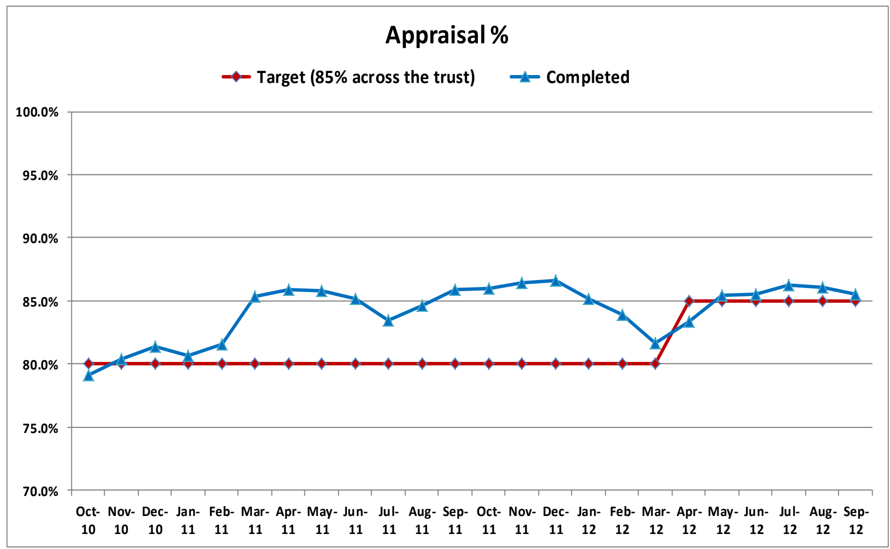
- Cover during the recruitment process. Concerns have been reported about the delays in recruitment in the Division, particularly in the Eye Hospital, and the HR Business Partners are working closely with the Resourcing team to address these issues and ensure there are fewer delays in the processes
- Workload – the current acuity and dependency of patients requires high levels of staffing, particularly due to the needs of psychiatric patients, those suffering with dementia and those at a high risk of falls
- Sickness – sickness rates have increased in the Division again this month, and the sickness figures for St Michael’s Theatres, Wards 2, 5b, 6, 9 and 14 are consistent with the high bank usage in these areas. Actions to address this are covered in the Exception Report W1 above.

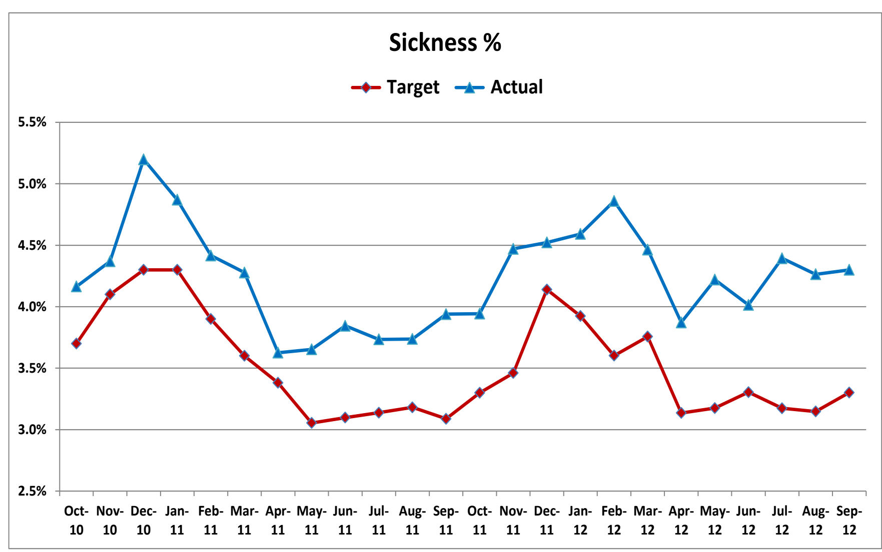
Progress against recovery plan: As above

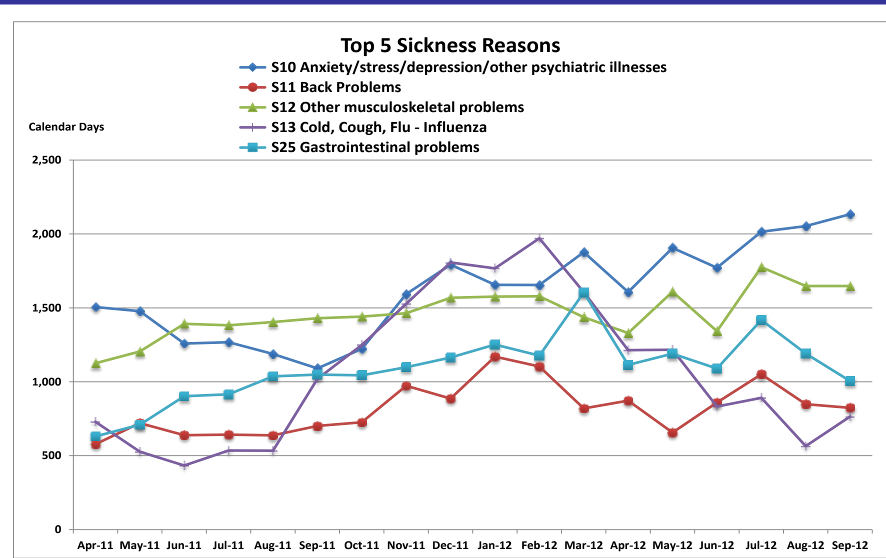
2.3 SUPPORTING INFORMATION

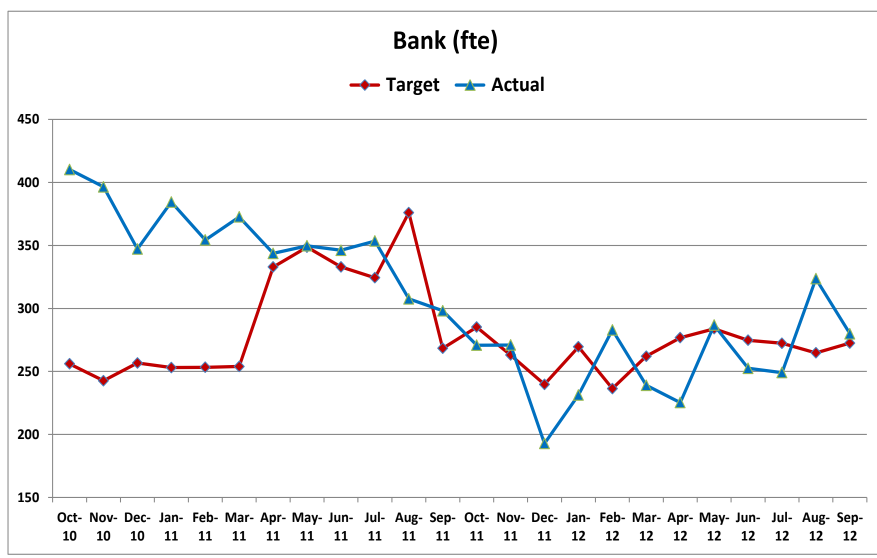
This report provides an outline of the Trust's position against key workforce standards for the month of September 2012, and year to date performance for 2012/13, for workforce numbers, appraisal rates, sickness rates, top five causes of sickness absence, bank and agency usage.

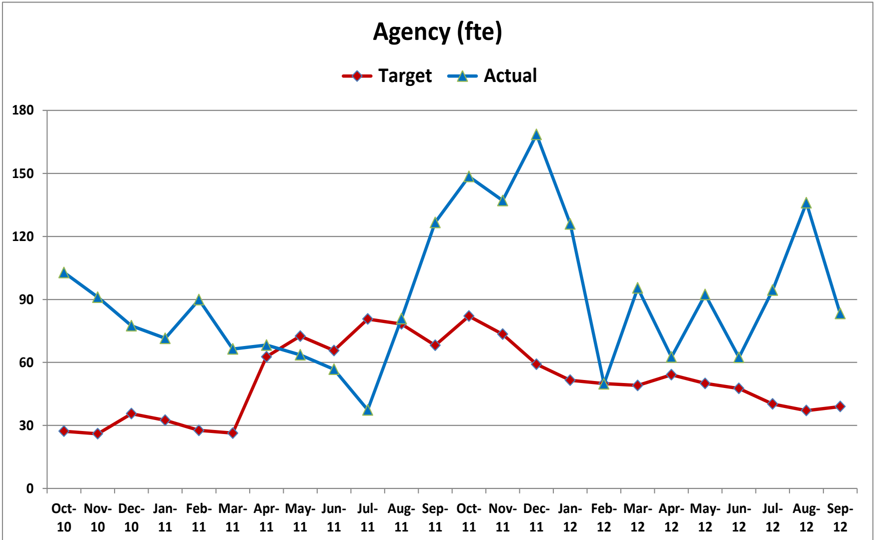





Sickness %
Target
Actual
5.5%
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Oct-10 Nov-10 Dec-10 Jan-11 Feb-11 Mar-11 Apr-11 May-11 Jun-11 Jul-11 Aug-11 Sep-11 Oct-11 Nov-11 Dec-11 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12


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 Sep-12


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


Agency (fte)
Target
Actual
180
150
120
90
60
30
0
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 Sep-12

2.3.1 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: European Working Time Directive (EWTD) (November 2012), Essential training (January 2013). 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	R ↓	Workforce numbers reduced by 1.2% compared with August 2012, 1.2% above budgeted workforce numbers for September 2012. This compares August 2012, when workforce numbers were 2.6% above budget.	See summary and exception report
Turnover	↑	Rolling turnover (with exclusions) increased to 10.9%.	See summary
Sickness	R ↑	Sickness increased by 0.1 percentage points compared with July 2012 across the Trust, 1.0 percentage points above the monthly target for 2012/13.	See summary and exception report
Bank/Agency	R ↓	Bank reduced by 43.7 FTE and agency by 52.7 FTE in September 2012 compared to August 2012, 14.2% above target compared with 34.3% above the previous month.	See summary and exception report
Appraisal	G ↓	Trust wide appraisal rates for all staff were 85.5%, and therefore achieved the stretch target of 85% which was introduced in April 2012. Divisional rates were: Diagnostic & Therapies, 80.2%, Medicine 85.9%, Specialised Services 85.3%, Surgery, Head & Neck 86.1%, Women's & Children's 85.3%, Trust Services 88.2%, and Estates & Facilities 88.9%.	See summary

[1] 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.

2.3.2 Monthly forecast and overview

Measure	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Sep 12 Planned
Budgeted Posts (FTE)	7401.1	7378.4	7351.1	7376.8	7365.3	7368.1	7384.3	7081.2	6973.2	7063.9	7036.2	7072.1	7085.7	7244.3
Total Employed (FTE)	6836.4	6846.4	6845.8	6853.7	6806.7	6795.7	6841.0	6776.8	6745.7	6760.1	6793.3	6800.0	6806.3	6696.3
Sickness Rate (%)	3.9%	3.9%	4.5%	4.5%	4.6%	4.9%	4.5%	3.9%	4.2%	4.0%	4.4%	4.3%	4.3%	3.3%
Bank (FTE) Admin & Clerical	99.3	60.7	71.8	50.6	60.8	70.1	61.4	54.1	68.3	55.3	65.3	81.8	63.5	67.0
Bank (FTE) Ancillary Staff	23.5	81.7	10.2	12.9	15.0	15.5	12.9	12.8	14.9	12.9	11.8	14.4	15.2	10.2
Bank (FTE) Nursing & Midwifery	163.4	118.3	177.6	123.3	152.1	197.3	164.7	158.2	203.6	184.3	171.1	227.4	201.2	179.8
Agency (FTE) Admin & Clerical	6.9	7.4	4.6	5.5	13.5	4.5	5.2	6.4	11.8	5.4	8.7	16.9	10.7	4.6
Agency (FTE) Ancillary Staff	78.6	95.1	84.8	110.2	63.4	36.3	34.6	30.0	20.0	22.9	25.3	17.5	14.8	21.7
Agency (FTE) Nursing & Midwifery	9.7	24.6	22.2	30.0	26.7	0.0	37.6	32.4	40.3	30.8	45.5	77.8	56.1	6.9
Overtime	65.3	62.7	81.1	64.9	72.2	76.6	89.1	83.8	70.0	70.9	67.8	74.4	64.5	61.8
Appraisal (%)	85.9%	86.0%	86.5%	86.6%	85.2%	83.9%	81.7%	83.4%	85.5%	85.6%	86.2%	86.1%	85.5%	85.0%
Rolling Average Turnover (all reasons) (%)	15.2%	15.1%	15.3%	15.7%	16.5%	16.2%	16.8%	17.0%	17.0%	17.2%	20.0%	17.7%	17.9%	
Rolling Average Turnover (with exclusions) (%)	8.8%	8.8%	9.1%	9.3%	9.5%	9.8%	10.3%	10.4%	10.4%	10.5%	10.5%	10.8%	10.9%	
Vacancy Rate (%)	7.6%	7.2%	6.9%	7.1%	7.6%	7.8%	7.4%	4.3%	3.3%	4.3%	3.5%	3.8%	3.9%	

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

ACCESS STANDARDS

3.1 SUMMARY

The following section provides a summary of the Trust's performance against key national access standards at the **end of September 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 (16)	**Underachieving (5)**
- 31-day diagnosis to treatment cancer standard - *first treatment* - 31-day diagnosis to treatment cancer standard - *subsequent drug* - 31-day diagnosis to treatment cancer standard – *subsequent radiotherapy* - 62-day referral to treatment cancer standard – *GP referred* - 2-week wait urgent GP referral cancer standard - Symptomatic breast patients (cancer not initially suspected) 2-week wait - Referral to Treatment Time for admitted patients - 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	- A&E Maximum waiting time (4-hours) – *national standard being achieved, local stretch target of 98% not being met* - 62-day referral to treatment cancer standard – *Screening referred – achieved for the quarter, but not for the month* - 31-day diagnosis to treatment cancer standard - *subsequent surgery – achieved for the quarter, but not for the month* - Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved* - Reperfusion times (door to balloon time of 90 minutes) – *achieved for the quarter, but not for the month*
Failing (2)	**Not reported/scored (0)**
- Last-minute cancelled operations - 28-day readmission – *a date for re-admission within 28 days of cancellation*	

*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 August, and the draft figures for September. 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 current month, but the quarter is currently being achieved, or where a local standard is not being met.*

ACCESS STANDARDS

3.2 ACCESS DASHBOARD

Access Standards - dashboard

	Target	Thresholds Green	Thresholds Red	Previous YTD	Year to date (YTD)	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	88%	95.5%	95.3%	94.2%	96.7%	98.1%	94.0%	96.6%	97.1%	96.7%	96.5%	94.6%	95.3%	93.4%	Cancer standards report two months in arrears	97.0%	96.1%	95.9%	94.4%
	Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks	93%	88%	98.5%	96.5%	93.6%	95.3%	97.7%	100.0%	98.4%	95.7%	96.1%	97.3%	95.7%	94.0%	98.4%		96.8%	97.7%	96.5%	96.4%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	93%	97.5%	96.7%	98.1%	97.5%	98.1%	99.1%	98.4%	99.2%	99.5%	98.4%	92.1%	95.3%	98.0%		97.9%	98.9%	96.7%	96.6%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	93%	99.8%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	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%	97.2%	95.0%	93.6%	94.5%	100.0%	93.3%	96.4%	98.2%	100.0%	98.2%	85.4%	98.0%	93.0%		96.0%	95.9%	94.7%	95.4%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	89%	99.8%	99.2%	99.0%	99.5%	100.0%	99.5%	96.9%	99.1%	99.5%	99.4%	99.4%	100.0%	97.8%		99.5%	98.5%	99.4%	98.9%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	80%	85.2%	87.3%	88.1%	88.2%	89.3%	89.3%	87.7%	87.4%	92.8%	90.8%	83.1%	83.3%	86.9%		88.4%	88.1%	89.1%	85.0%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	85%	92.5%	91.8%	88.1%	100.0%	100.0%	96.2%	100.0%	92.9%	100.0%	100.0%	87.5%	81.8%	88.9%		95.3%	96.2%	95.9%	85.0%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	96.2%	95.9%	94.4%	94.7%	87.0%	91.9%	93.6%	93.8%	100.0%	100.0%	88.6%	100.0%	87.5%		91.7%	93.1%	96.7%	94.5%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	85%	92.2%	92.4%	91.2%	91.2%	90.6%	91.8%	91.4%	91.2%	91.2%	93.2%	91.5%	91.8%	92.1%	93.5%	91.0%	91.4%	92.3%	92.5%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	90%	98.1%	96.0%	97.8%	97.2%	98.0%	97.6%	97.6%	98.0%	97.9%	96.8%	95.9%	95.8%	95.3%	95.1%	97.6%	97.7%	96.8%	95.4%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	87%	Not in effect	92.2%	Target not in effect						92.2%	92.2%	92.1%	92.4%	92.2%	92.1%	Not reported		92.1%	92.2%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	97.8%	94.5%	95.4%	97.1%	94.5%	94.1%	91.5%	92.0%	93.4%	91.9%	95.7%	95.3%	95.3%	95.7%	95.6%	92.5%	93.6%	95.4%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	13	108	14	12	13	12	48	30	120	196	15	13	13	13	13	24	151	13
	A&E Time to treatment decision (median) - in minutes	60	60	16	54	19	17	21	19	24	26	30	69	62	61	50	54	19	23	53	56
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	1.6%	2.2%	2.0%	1.9%	1.8%	1.8%	1.5%	1.6%	1.1%	2.1%	2.6%	2.4%	2.3%	2.5%	1.9%	1.6%	2.0%	2.4%
	A&E Left without being seen	5%	5%	1.1%	2.4%	1.3%	0.6%	0.9%	0.8%	1.1%	1.3%	2.2%	5.0%	2.4%	1.5%	1.7%	1.2%	0.9%	1.1%	3.3%	1.5%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	0.87%	1.01%	0.90%	0.89%	0.85%	0.88%	0.96%	0.76%	1.08%	1.59%	0.94%	0.77%	0.96%	0.72%	0.88%	0.87%	1.21%	0.82%
	28 Day Readmissions	95%	85%	93.9%	89.5%	100.0%	92.0%	93.9%	95.2%	92.0%	86.8%	84.4%	88.2%	88.0%	87.8%	93.0%	96.3%	94.0%	91.0%	87.2%	92.5%
	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%	83.7%	82.7%	85.7%	77.3%	70.4%	86.1%	90.4%	81.1%	89.7%	81.8%	88.2%	83.3%	71.4%		87.8%	86.4%	86.5%	77.9%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	89.0%	92.5%	90.5%	86.4%	100.0%	88.9%	94.2%	91.9%	96.6%	84.8%	97.1%	95.2%	88.6%		91.2%	92.0%	92.7%	92.2%
	Infant Health - Mothers Initiating Breastfeeding	76.3%	74.5%	75.7%	80.1%	78.2%	77.1%	76.5%	77.3%	74.7%	76.0%	74.2%	80.7%	81.7%	80.7%	80.1%	81.0%	77.3%	76.0%	78.8%	80.7%

Please note:
Where the threshold for achieving the standard has changed between years, the latest threshold for 2011/12 has been applied in the Red, Amber, Green ratings
The Rapid Access Chest Pain standard and the Infant Health: mothers not smoking have now been withdrawn from national
Infant Health breast feeding rates have a GREEN threshold of being above last-years performance, and a RED threshold of the
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.

3.3 CHANGES IN THE PERIOD

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

- Last-minute cancelled operations ↓ (down from 0.96 % in August to 0.72% in September)
- 28-day readmission standard ↑ (up from 93.0% in August to 96.3% in September)
- 31-day diagnosis to treatment (first treatment) cancer standard ↑ (up from 95.3% in July to 98.0% in August)
- 31-day diagnosis to treatment (subsequent surgery) cancer standard ↓ (down from 98.0 % in July to 93.0% in August)
- 62-day referral to treatment (screening referred) cancer standard ↑ (up from 81.8 % in July to 88.9% in August)
- 62-day referral to treatment (GP referred) cancer standard ↑ (up from 83.3 % in July to 86.9% in August)
- Door to Balloon times ↓ (down from 95.2 % in July to 88.6% in August)

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

3.4 EXCEPTION REPORTS

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

1) Last-minute cancelled operations
2) 28-day readmission

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 38 last-minute cancellations (LMCs) of surgery in **September** (0.72% of operations) which is within the national standard of 0.8%. The 0.8% standard was not however met for the quarter as a whole (0.82% against the national target of 0.80%). The main reasons for cancellations in September were as follows:

- 24% (9 cancellations) were due to no Critical/High Dependency or Cardiac Intensive Therapy Unit bed being available
- 21% of cancellations (8 cancellations) were due to an emergency patient being prioritised on the day

Of the 38 cancellations, 9 were day-cases and 29 were inpatients (24% day-cases). On average, seventy percent of the Trust admissions in a month are day-cases. The higher rate of inpatient cancellations reflects the high cancellation rate due to emergency patients, and the lack of a high care bed, which are more likely to impact inpatient than day-case procedures.

There were no cancellations in the month due to a ward bed not being available, which mirrors the improvement in patient flow and the achievement of the A&E 4-hour 95% standard.

In September 96.3% of patients cancelled in the previous month were readmitted within 28 days of the cancellation. This is within the national standard of 95%, and a significant improvement on recent months (92.5% for the quarter). The critical success factors in maintaining 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

ACCESS STANDARDS

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)*
- 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
- 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 (on target for completion at the end October)
- 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 and September. But the national standard wasn't achieved in August, although the total number of cancellations in the month was relatively low. The reduction in the levels of cancelled operations overall helped to improve the 28-day readmission rate in September. Maintaining a low level of ward bed-related cancellations remains critical to the achievement of both the 0.8% national standard, but also the readmission of patients within 28 days.

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

Item 06 – Infection Control Quarterly Report

Purpose

To report to the Board on infection prevention and control.

Abstract

- MRSA is above Trust target for the year.
- *Clostridium difficile* remains above the cumulative target for the first two quarters. However is on target for the second quarter.
- New *Clostridium difficile* testing and reporting is now in place.
- Whilst MSSA bacteraemias remain over the target ceiling year to date, the monthly ceiling was achieved in August and September.
- MRSA/MSSA action plan in place.
- The overall Trust cleanliness score has returned to 95% for September.
- In the Very High risk category the overall score is 96%. The BRHC has recorded scores lower than usual as the staff try to overcome the problems of the on-going building works and the movement of Wards and Departments around the site. There are positive signs that the scores are returning to their usual high levels. The Oncology Day unit returned to monthly rather than weekly auditing.
- In the BRI the 3 areas which were in red in August have recovered to amber. The overall BRI score is at an all-time high of 95% for September.
- Improvements in decontamination processes continue and this area continues as compliant within the Care Quality Commission Outcome 8 assessment.
- Training compliance is currently at 86%.
- The Infection Control Group is recommending the continued assessment of compliance against Outcome 8.
- The Infection Control Programme continues to be delivered to schedule.

Recommendations

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

Executive Report Sponsor or Other Author

- Sponsor – The Chief Nurse, Alison Moon
- Author – The Director Infection Prevention and Control, Richard Brindle. Senior Infection Control Nurse/Deputy Director of Infection Prevention and Control, Joanna Hamilton-Davies.

Previous Meetings

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

INFECTION PREVENTION AND CONTROL QUARTERLY REPORT
FOR THE PERIOD JULY TO SEPTEMBER 2012

REPORT PRODUCED BY DIRECTOR INFECTION PREVENTION AND CONTROL AND THE SENIOR INFECTION CONTROL NURSE/ DEPUTY DIPC.

Clostridium difficile:

- The national target ceiling for 2012/13 has been set at 54 cases.
- The number of cases of *C. difficile* associated disease for July to September 2012 was 29 against a target of 27.

Actions for the help the reduction of c diff

- Revised national guidance requires a change in sampling and testing methods for *C. difficile*. The new system of testing/Reporting started on 1 October 2012.
- Bristol stool chart/risk assessment updated. More clarity for staff in the information of sending samples and isolating of patients.
- ICE system has guidance for staff sending specimens.
- On the ward teaching by the infection control team.
- Isolation of the patient by the clinical site team within two hours of request.

GRE/VRE

- During the last three months there has been a small rise in GRE/VRE. The threshold for the Trust is 2 per month. In July there were 4.

Comparative data

- Figure 1 provides comparative regional and national data for Trust-apportioned cases by quarter as published by the Health Protection Agency. These data are published one quarter in arrears. For the reported quarter, the Trust rate was above the regional and national rate.
- Figure 5 shows the number of patients who have died and have C diff on Part 1 or 2 of their death certificate.

(Figures on next page)

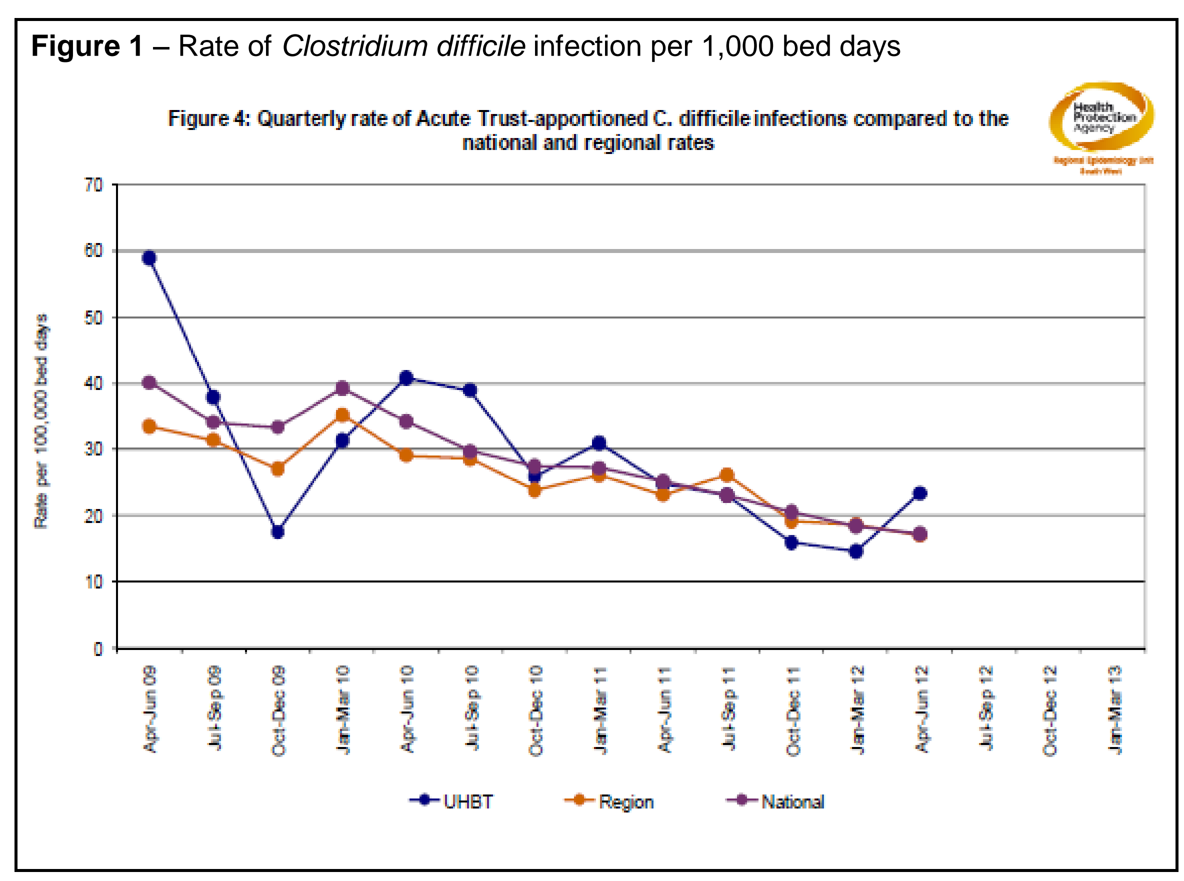


Figure 1 – Rate of *Clostridium difficile* infection per 1,000 bed days

MRSA/MSSA[1] bacteraemias:

- Monitoring of MRSA prevention practice continues through the Saving Lives dashboard (Figure 2). The results of this monitoring and actions to address lower compliance are addressed directly with Divisions.
- The national target for 2012/13 was set at 2 cases. This has been revised to 4.
- The number of MRSA cases from July to September is 5. There are 6 cases recorded on MESS (data capture system), this 1 case in September is being disputed.
- Recovery Action plan for MRSA and MSSA in place and Included in report for infection control group, for information and approval.
- The number of cases of MSSA July to September was 16 (against a target of 14) – MSSA comparative data for Quarter 3 is not available at this time
- Figure 3 provides comparative regional and national data for Trust-apportioned cases of MRSA by quarter as published by the Health Protection Agency. These data are also published a quarter in arrears. For the reported quarter the Trust was over both the national and regional rates, however the increase in rate equates to only one case.
- Figure 4 shows the number of patients who have died and have MRSA on Part 1 or 2 of their death certificate. From July to September 2012 there have been no reported deaths associated with MRSA.

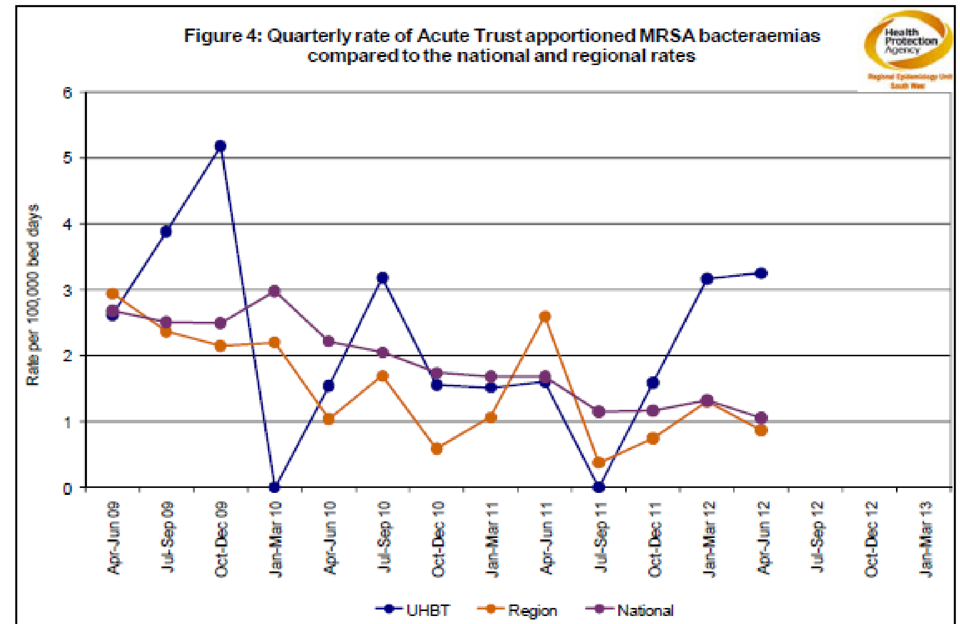
(Figures on next page)

[1] Meticillin sensitive *Staphylococcus aureus*

Figure 2 – Saving Lives Trust-wide compliance

	July 12	Aug 12
Central line insertion	100	99
Central line ongoing care	84	98
Peripheral line insertion	94	96
Peripheral line ongoing care	96	96
Renal ongoing care actions	97	82
Surgical site infection pre-operative	97	82
Surgical site infection peri-operative	85	100
Ventilators observation	85	100
Ventilators ongoing care	100	95
Urinary catheters insertion	99	83
Urinary catheters ongoing care	96	95

Figure 3 – Rate of MRSA bacteraemia per 10,000 bed days



* *HPA data reported a quarter in arrears*

Figure 4 – Death Certificate information (2007 – Sept 2012)

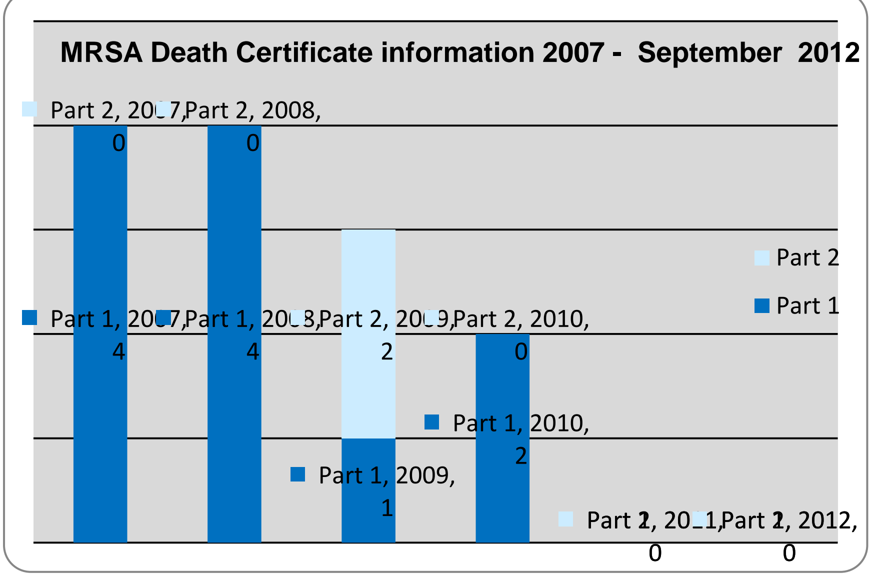
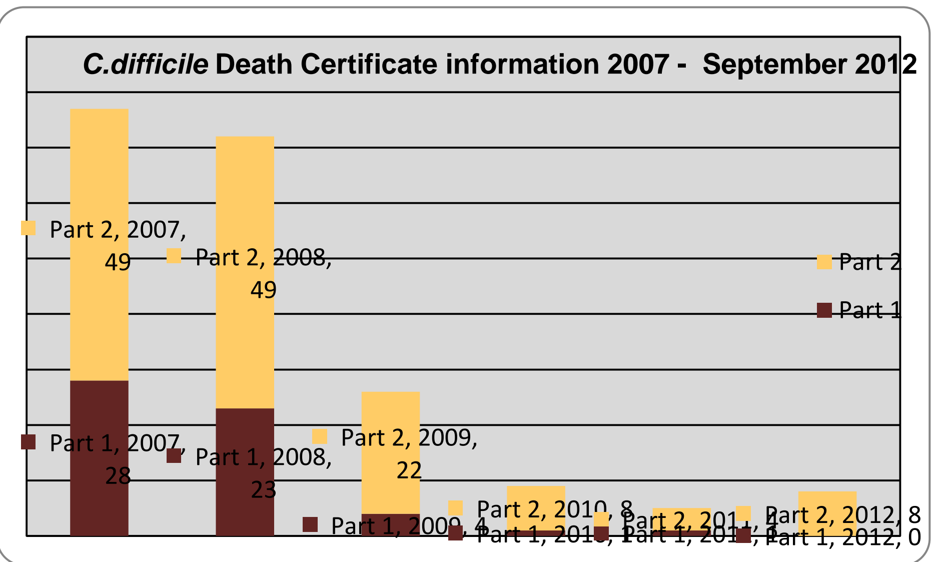


Figure 5 – Death Certificate information (2007 – Sept 2012)



Outbreaks and untoward incidents:

- The NICU Tuberculosis action plan has been updated and is included for the Infection Control Group for information.
- A student nurse has been diagnosed with TB. The nurse was on placement in the Queens Day Unit. This incident has now been closed by Alison Moon, Chief Nurse and Chair of the Infection Control group. RCA included.
- Pulmonary TB Trust update report included.
- Staff members with confirmed and possible Pertussis. Staff and patients traced and letters sent to all concerned. HPA informed and lead on this incident as all patients were out patients.
- Member of Radiology staff with potential chicken pox. Staff and patients contact lists collected. Patients who were still in patients isolated. Result negative no further action.
- Raised incidence reported of pseudomonas in North Bristol Trust NICU. Unit closed to out of Trust admissions. Being investigated by the HPU regarding possible link to cases within UHBT.

Incident investigation themes

- **MRSA**

Screening protocol not followed.

Topical treatment not prescribed or started immediately.

IV line care

- **MSSA**

Peripheral Line management.

- **E. coli**

Aseptic technique practice when manipulating lines/catheters

Outbreak and ward closures.

- 13 areas have closed during July to September. Three of areas closed were complete wards and the rest were bays. Four areas had positive norovirus results.
- Total days of closure was 28 (ward closure). Partial closures were 30 days (Bay closure).

Women's & Children's	1 Ward	4 Bays
Surgery, Head& Neck	1 ward	2 Bays
Specialised Services	1 ward	2 Bays
Medicine		2 Bays

Comments/issues/actions related to outbreaks and ward closures.

- The outbreaks were managed effectively by closing bays.
- In response to the raised incidence of *pseudomonas* in NBT. The Estates department have instigated water testing for *pseudomonas* in the intensive care areas in adults and children. All units are working to the Department of Health guidelines, Water sources and potential *Pseudomonas aeruginosa* contamination of taps and water systems Advice for augmented care units. A Trust risk assessment has been undertaken for all augmented care units and will be added to the Trust corporate risk register. Risk assessment included for ICG approval. For a three month period, babies being admitted from NBT will be screened on admission for *pseudomonas*. The PCT and the Consultant for Communicable Disease Control (CCDC) are aware.
- Due to an increase in c diff during the first quarter of the year an audit was done looking at commode cleaning and condition of the commode. A report is included.

Training compliance:

- Training compliance at the end of September 2012 is at 86%. A breakdown of compliance by Division is shown in the table below.

Division	July 2012	Aug 2012	Sept 2012	↓ / ↔ / ↑
Diagnostics and Therapies	88	87	85	↓
Facilities and Estates	94	94	93	↓
Medicine	89	87	86	↓
Specialised Services	89	87	87	↓
Surgery Head and Neck	89	86	85	↓
Trust Services	87	86	86	↓
Women's and Children's	87	86	84	↓
Grand Total	**89**	**87**	**86**	↓

- Divisions continue to receive details of non-compliant staff to enable follow up.

* *Sept figures do not include maternity leave, this is a trial, so may not be accurate*

Innovation/activity linked to patient improvement

After discussion with microbiologists. MSSA screening will be introduced for Renal patients. Screening on admission of MRSA will be extended to include groin as well as nose for all patients.

The new *C. difficile* guidance for testing and management requires that patients who are at risk of c diff are isolated within two hours of a request for a cubicle. The clinical site team have been monitoring this and have sent the following short report

Since August 2012 there have been 10 requests from the wards to Clinical Site Managers to isolate *C. difficile* positive patients (including suspected cases). 7 patients have been isolated within 2 hours and 3 patients within a 4 hour period. The 3 patients isolated within 2 hours were out of hours requests i.e. past 5pm when the hospital occupancy is increased and further discharges are minimal, so creating a cubicle requires internal movement to acquire the capacity.

Matron Report

Matrons checklist/quality in care tool
Matrons check list is showing signs of reducing c Diff cases, which are now lower that the same time in 2011. This will continue monthly to assure control. Quality in care tool is now more relevant to ward areas and is being tried in high care areas such as the intensive care units. Whilst time consuming the results give rich data to the ward teams on good practice and areas for continued improvement.

Linen and laundry
The monthly linen group meetings continue with the facilities team. The service has been in place for almost a year and the number of problems has been minimal. Service is high and the deliveries on time and of a high quality.

Facilities issues
Facilities are introducing a new hydrogen peroxide machine in October that will drastically reduce turnaround of room cleaning and reducing the need to turn off the fire alarms. New disposable curtains have been tendered and will be fitted across the trust over the next few weeks.

Estates issues
Trial of Electronic helpdesk has started in the BHI. If successful this will be rolled out across the Trust. There is a section for infection control issues to protect both staff and patients.

Patient Environment Operational Group
Summary of key issues/discussions not covered elsewhere.
Nothing to report.

Innovation/activity linked to patient improvement
Division:
Introduction of routine screen for MSSA for both elective and emergency patients in specialised services. This will ensure all patients identified and treated appropriately either before or on admission if found to be positive.
Work from the PEAT money has started in many divisions and is making good improvements.

Ward refurbishment activity
Work at BHOC has started to extend Teenage and young adults unit. Infection control fully aware of progress.

Decontamination Report

Annual Accreditation Audit
Ventilation remains the only major Corrective Action outstanding from this year's audit – estates have undertaken much work to resolves the issue. See below for further information.

Installation of RO water plants across site
RO plants for BHI and HGT are now fully installed and fully functional. The additional RO plant for QDU is on hold whilst the dept. undergoes an assessment of its future needs in terms of both RO plants and AER's following this year's endoscopy audit.
A new RO plant has been successfully installed on level 8 plant room of BRCH – this plant supplies renal (ward 37) only. The existing RO plant on the ground floor continues to supply PICU and BRCH theatres for their AER's.
The Trust now has 9 separate RO plants on site that are cared for daily by the estates decontamination engineers – this will shortly increase to 11 when 2 more come on line at SBCH.

Automatic Endoscopic Reprocessors at SBCH
Solution to the poor water results at SBCH has now been sought and agreed. In order to achieve the best water quality required for endoscope reprocessing 2 RO plants that can be thermally sanitised on a daily basis will be installed into SBCH. These will then provide the AER's with very clean, pure water for the processing of scopes. The project is being funded by both the PCT and the Trust. An anticipated go live date is early February 2013.

Annual and quarterly testing and validation of Trust wide decontamination equipment
Quarterly and Annual validation of all decontamination equipment across the Trust remains on schedule thus meaning that we remain compliant.

CSSD air handling unit and ventilation compliance
9 new Hepa Filters have been installed into CSSD clean room. Air filtration and pressure measurements have been taken and are within recommended parameters. Air balance remains an issue and to assist with this new balance flaps are being manufactured to replace the existing ones that are no longer working effectively. It is hoped these items will be installed before Christmas in order that this piece of work can be completed by end of January 2013.

Age of equipment and risk register
A reasonable amount of decontamination equipment now sits on risk registers across the Trust due their age profile. Divisions will apply for capital monies as part of replacement programmes – it is anticipated that large sums of monies are needed to replace the equipment that is now beyond its useful and cost effective working life.

CSSD services review
A city wide review of sterile services provision for Bristol has been commissioned by the joint trust partnership board. An outlying business case is due to be presented to the board for consideration on 13th December 2012. The proposed solution will include the new CSSD that is being built at Southmead as part of the PFI.

Authorised Engineer for Decontamination
Bob Kingston continues to work closely with the Trust on all topics decontamination related. End users have drawn up action plans in response to recommendations that came out of Bob's annual audit report. Those action plans are beginning to be implemented. Bob has recently been appointed as AED to NBT – this additional appointment sits neatly with the partnership working that is being more widely established across the two trusts.

CSSD Dashboard and Decontamination Incident Reporting
CSSD dashboard continues to display monthly the improvement progress that CSSD continues to make. Appraisal compliance has now been achieved for 8 months in a row.

Tray wrap breach remains the highest incident to be reported and compliance in this measure remains in the red zone. However, once the troublesome sets have been containerised it is anticipated that the number of tray wrap breaches will significantly reduce. To put it into context though of an average of 700 sets processed each month an average of 40 are reported to CSSD with a tray wrap breach = 0.57% breach rate.

Appraisals have now been compliant for 8 months.
Vacancies are at 5.1% = 2.36 wte.
Staff sickness is unfortunately above 8% due to a number of staff off on long-term sick leave – these are all being managed in line with the Trust absence policy.

Containerisation of instrument sets
CSSD has now commenced the roll out of converting instrument sets to containers. Each set has to be managed on an individual basis and therefore we are working with theatre staff re the sets in order to achieve the best solution for all parties.

CFPP's
New guidance has been released with regard to decontamination in the form of CFPP – Choice Framework for Policy and Procedure. No's 0101 apply to sterile services and 0106 applies to endoscopy. These replace the HTM 2030 documents that until now departments have been complying to. The reading and understanding of these documents is well underway and in future the annual decontamination plan for the Trust will encompass any changes necessary as a result of this new best practice guidance.

Clean Steam Installation
Still part of a much longer term-plan with regard to CSSD so on hold.

Cleanliness Scores

RESULTS										
Risk Category	Area	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
VERY HIGH										
	B.R.I	97	96	97	97	97	97	97	97	97
	B.R.C.H	96	97	94	94	97	96	96	95	94
	S.M.H	95	96	96	96	96	96	96	95	96
	B.H.O.C	93	97	97	97	97	97	97	96	98
	B.E.H	99	98	97	97	97	95	98	96	95
	C.H.C		96	97	95	97	97	95	98	97
	S.B.C.H						93	96	99	98
	Total Average	96	96	96	96	97	96	96	97	96
HIGH										
	B.R.I	92	91	92	92	92	92	94	93	94
	B.R.C.H	96	97	96	97	97	96	96	96	92
	S.M.H	95	97	96	98	97	98	97	96	95
	B.H.O.C	97	97	98	97	92	95	95	96	95
	B.D.H	96	94	96	96	96	93	96	95	95
	B.E.H	98	97	97	97	97	97	96	96	97
	B.G.H.	94	94	95						
	C.H.C		98	97	98	97	94	91	97	93
	S.B.C.H						93	94	95	96
	Total Average	95	96	96	96	95	95	95	96	95
SIGNIFICANT										
	B.R.I	94	90	92	89	90	93	92	93	92
	B.R.C.H	96	96	98		94	97	93	98	91
	S.M.H	98	95	99	98	97	97	98	96	96
	B.H.O.C					86		84	84	
	B.D.H				93	92	96	96	95	
	B.E.H	99						95	98	97
	B.G.H.	94	92	90						
	C.H.C							100		96
	S.B.C.H						97	99		97
	Total Average	96	93	95	93	92	96	95	94	95

LOW										
	B.R.I					89		84		
	B.R.C.H									
	S.M.H				100	99	94	96		96
	B.H.O.C								87	
	B.D.H								86	
	B.E.H							84	88	
	B.G.H.									
	C.H.C				95		94	94	95	
	S.B.C.H						97	92		
	Total Average				98	94	95	90	89	96
	TRUST SCORE	**96**	**95**	**96**	**96**	**95**	**95**	**94**	**94**	**95**

KEY	
	>95%<100%
	>80%<94%
	<80%

Average Hospital Scores - Running Totals for the year

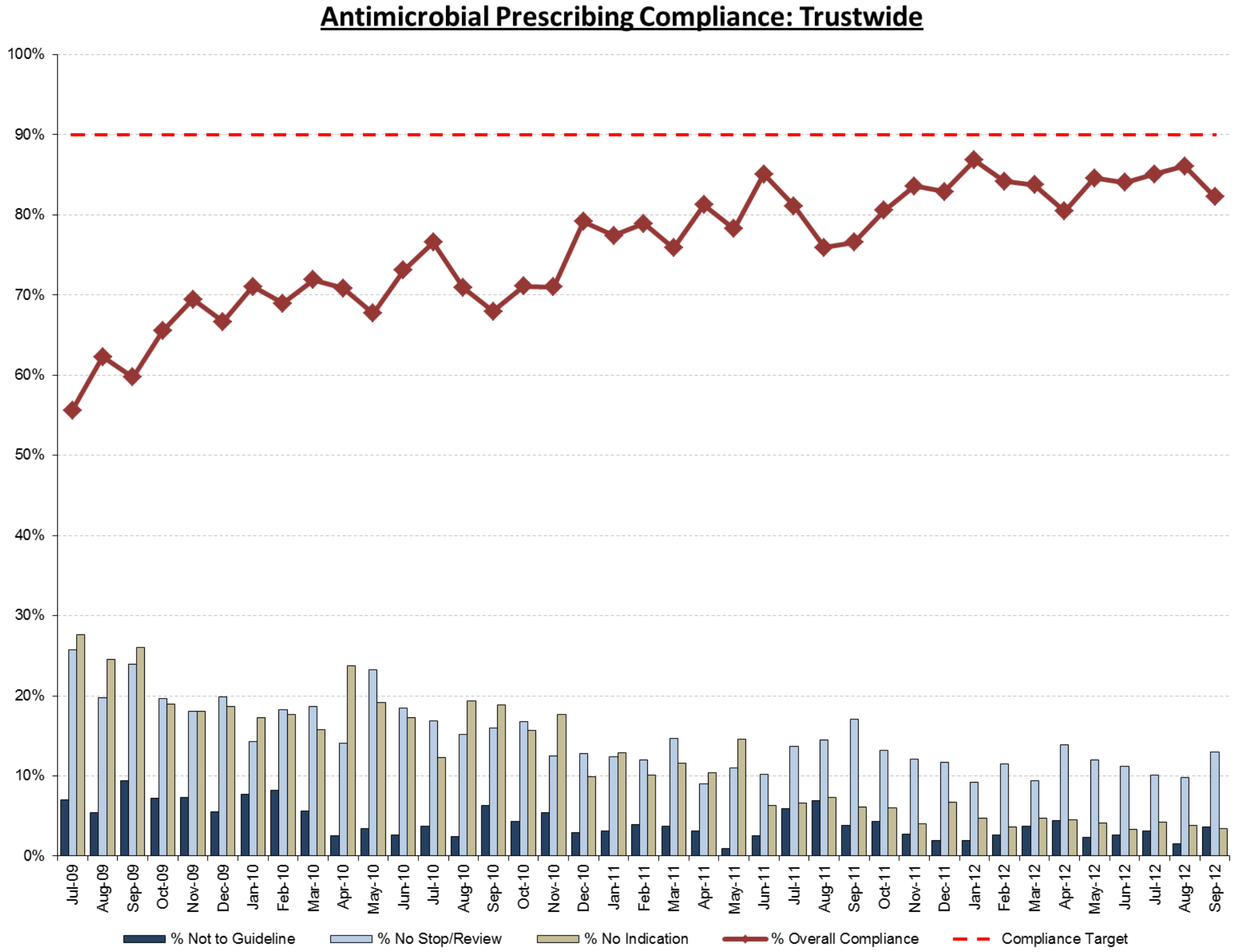
BRI		93	92	93	93	92	93	93	94	95	93.11
BRHC		96	97	95	96	96	96	96	96	93	95.67
SMH		96	96	97	98	97	97	97	96	96	96.67
BHOC		95	97	98	97	92	96	92	92	96	95.00
BEH		98	97	97	97	97	96	94	95	96	96.33
	Trust Total										**95.36**
BGH		94	93	94							93.67
BDH		96	94	96	95	95	94	96	92	95	94.78
CHC			98	97	97	97	95	93	97	94	96.00
SBCH							95	95	96	97	95.75

Antibiotic Prescribing Compliance

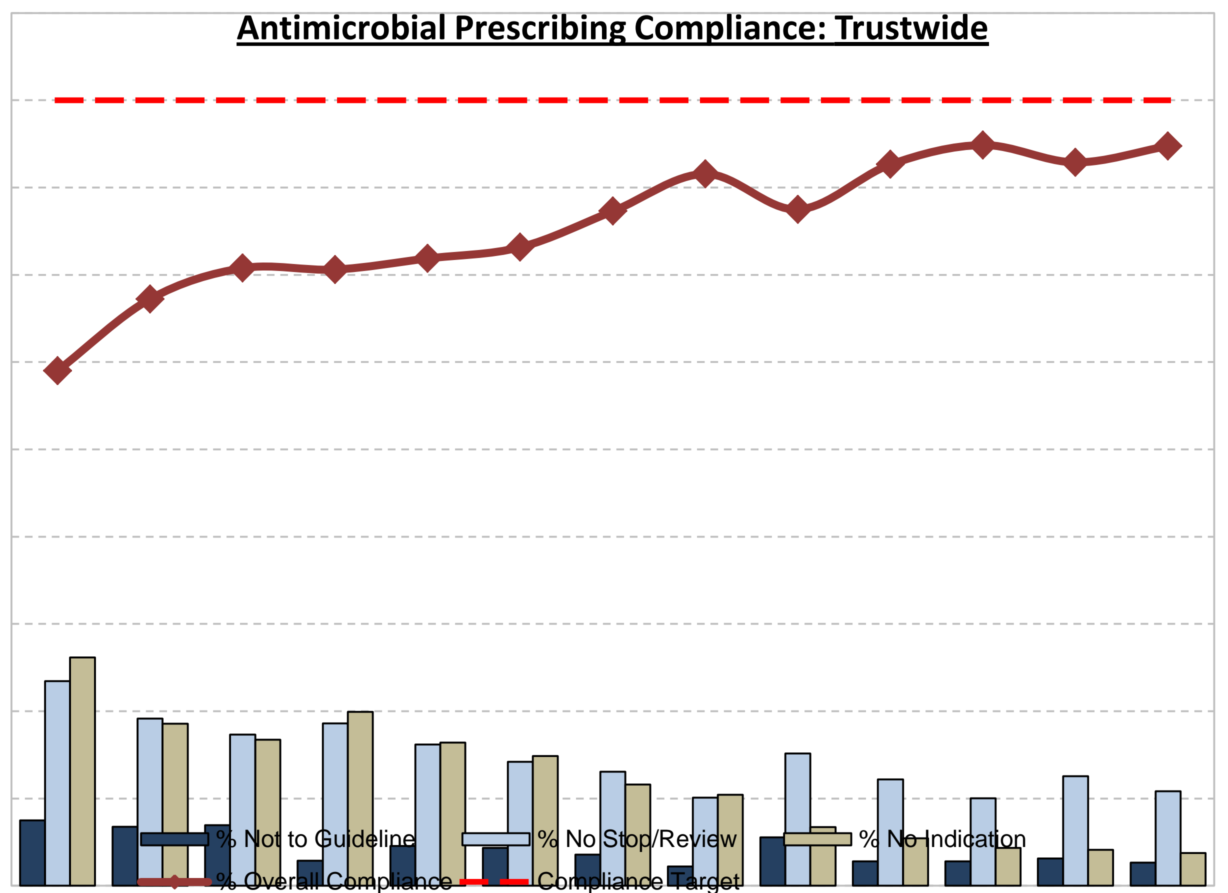
The monitoring of antibiotic prescribing compliance continues. The inclusion of a stop or review date continues to be the main barrier to the achievement of the 90% target. The results for quarter 2 are as follows:

Division	Number of reviews	Percentage compliant	Number compliant	No. Not Compliant	No. not to guideline	No. with no stop or review date	No. with no Indication
Medicine	646	84.1%	543	103	23	75	19
Specialised Services	301	90.0%	271	30	3	26	4
Surgery, Head & Neck	483	81.4%	393	90	19	64	17
Women's & Children's	276	86.6%	239	37	0	20	24
Trustwide Total	**1706**	**84.8%**	**1446**	**260**	**45**	**185**	**64**

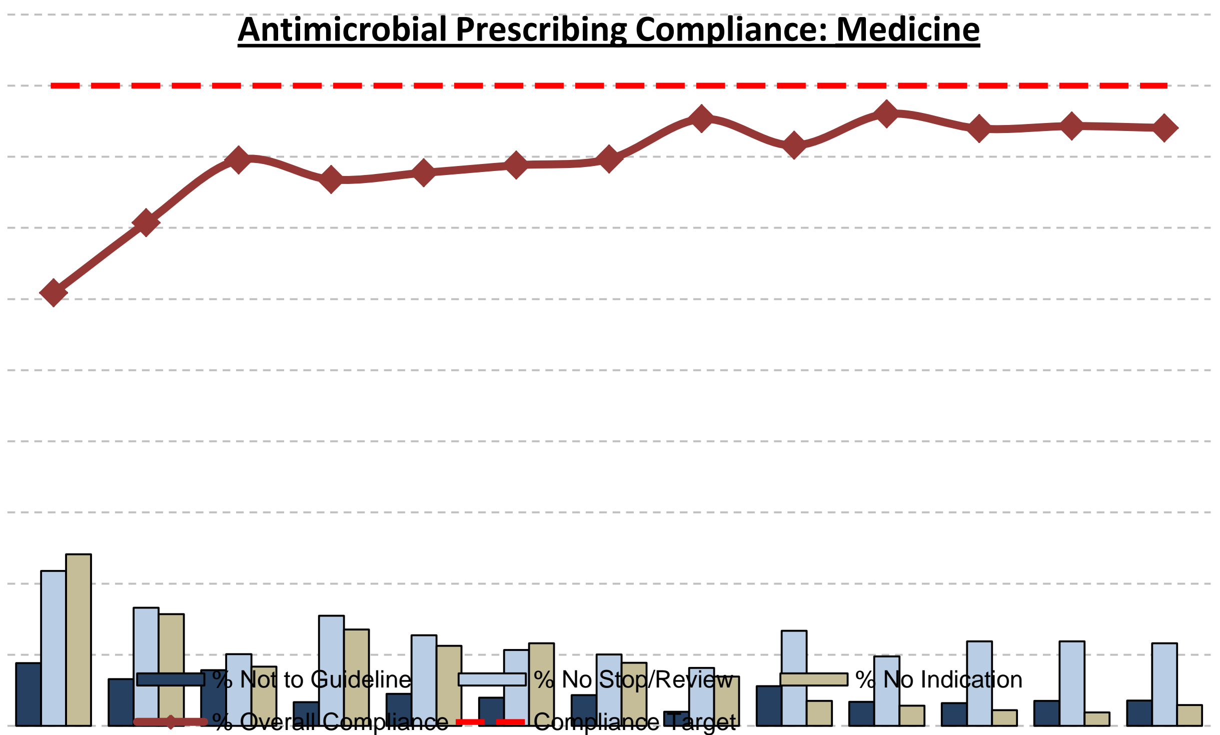
The graphs below show monthly prescribing compliance against the target, the percentage of prescriptions failing the compliance audit and the reasons for the non-compliance.

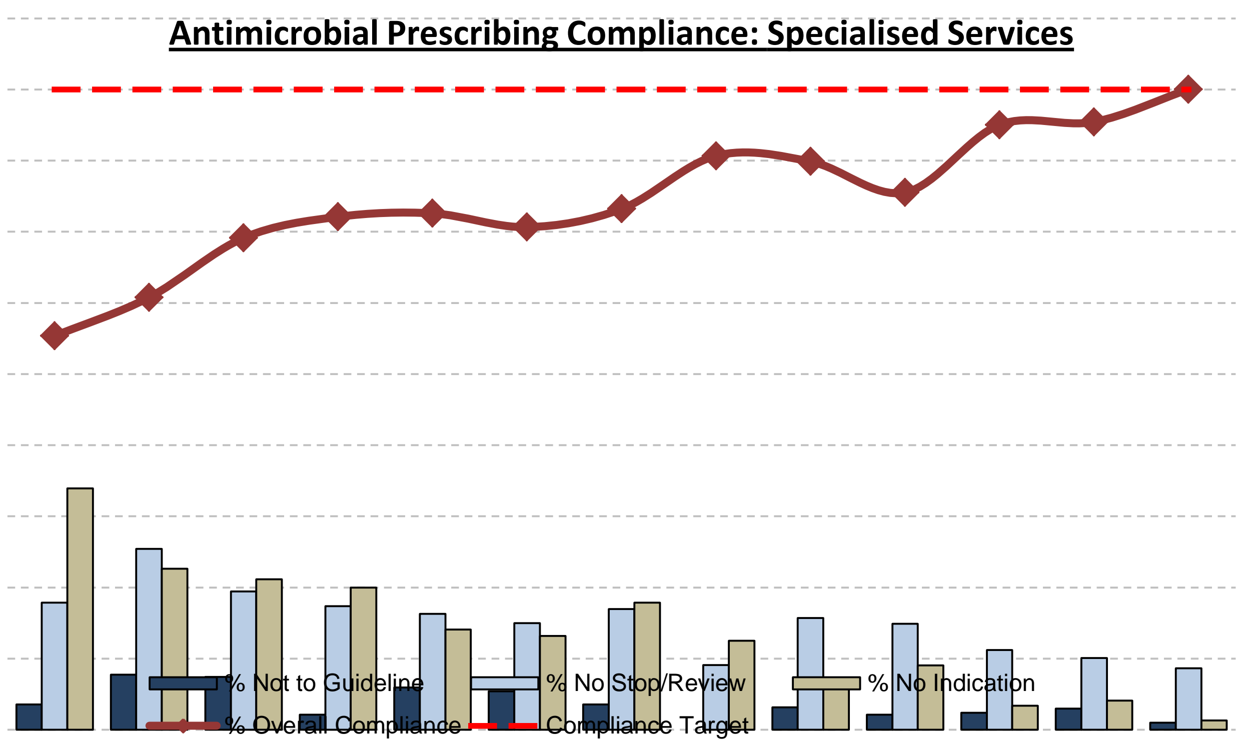


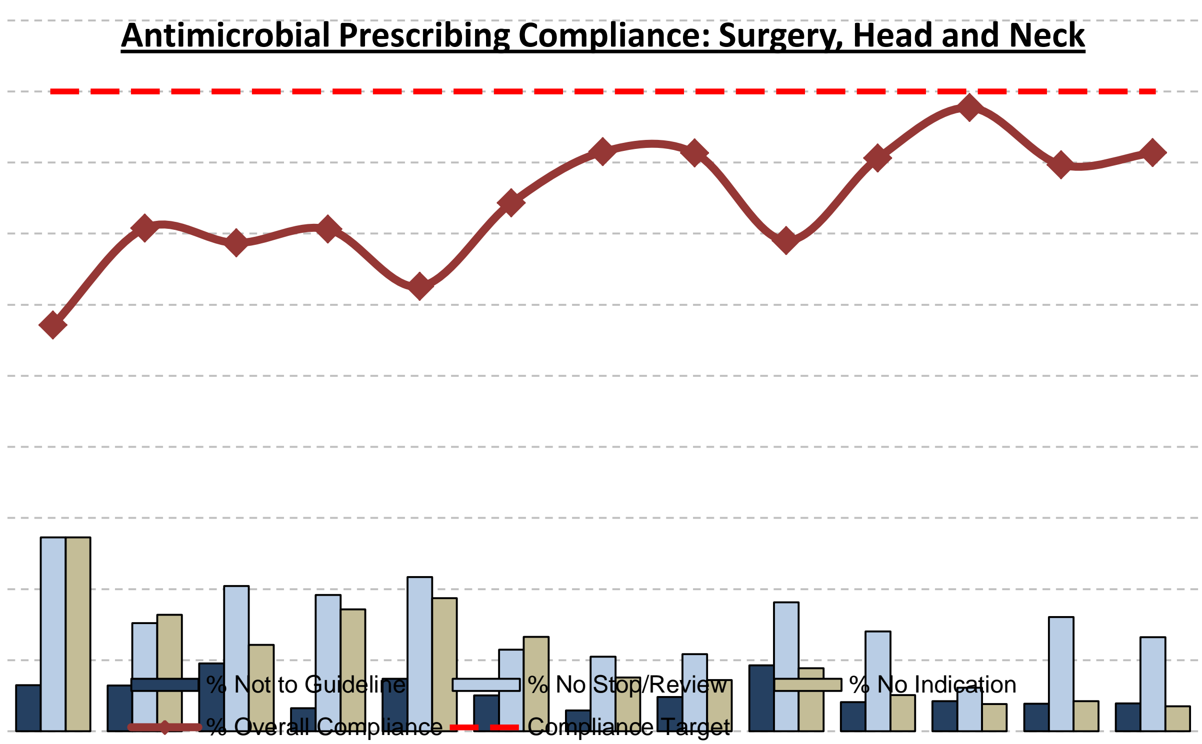
Looking quarterly, the Trustwide results are as follows:

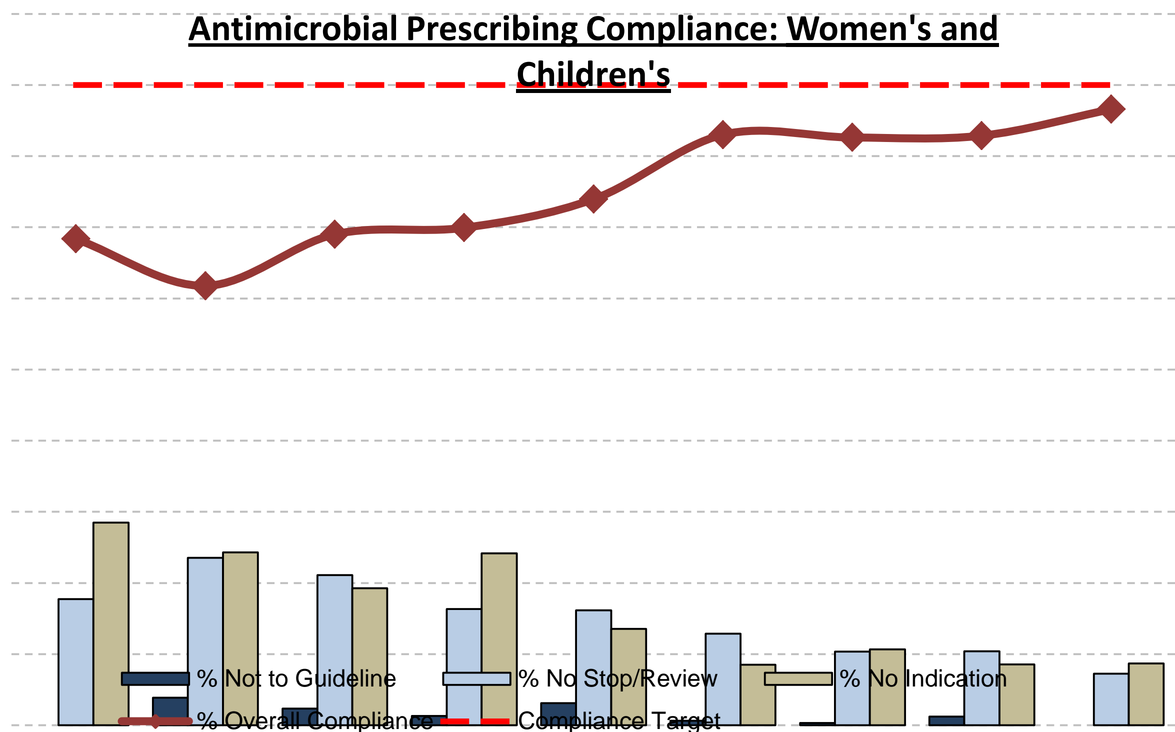


And quarterly graphs for the divisions:




Antimicrobial Prescribing Compliance: Specialised Services
% Not to Guideline
% No Stop/Review
% No Indication
% Overall Compliance
Compliance Target


Antimicrobial Prescribing Compliance: Surgery, Head and Neck
% Not to Guideline
% No Stop/Review
% No Indication
% Overall Compliance
Compliance Target


Antimicrobial Prescribing Compliance: Women's and Children's
% Not to Guideline
% No Stop/Review
% No Indication
% Overall Compliance
Compliance Target

Hygiene code and Care Quality Commission outcome 8 compliance:

The Infection Control Group received evidence against the compliance standards at its meeting on October 2012. The Group confirmed the continued declaration of compliance.

Compliant	Minor concerns	Moderate concerns	Major concerns
49	6	0	0

Infection Control Programme 2012/13

The infection control programme progress continues to be reported to Clinical Quality Group. There are no areas of concern or risk to delivery of the programme at present. The following outlines the

Green – delivery complete or objective expected to be complete within timescale	Amber –delay to delivery of objective	Red – significant delay to delivery of objective
36	7	0

Infection Prevention and Control related risks:

The Infection Control Group reviewed all risk register entries related to infection prevention and control in October 2012. The residual risks are graded as below.

Low	Moderate	High
7	1	0

There are no infection control risks on the corporate risk register.

New Documents/Publications

Department of Health, Seasonal Flu Plan. Winter 2012/13.

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

Item 07 – National Cancer Survey

Purpose

To brief the Board on the National Cancer Patient Experience Survey 2011/12.

Abstract

Paper presented shows the National Cancer Patient Experience Survey 2011/12 results for UH Bristol.

- This was a national inpatient postal survey carried out Sept-Nov 2011 across all UH Bristol cancer patients (not just Bristol Haematology and Oncology Centre).
- Results were released to the Trust in August 2012.
- Paper highlights central and local analysis of results.
- Compared to other Trusts across Cancer Network and nationally, UH Bristol's results are average with 7 scores in the top 20% of Trusts nationally; 7 in the bottom 20% of Trusts nationally and the remaining scores in the middle 60% of Trusts.
- UHBristol is noted this year by Macmillan as being in the top 10 most improved Trusts nationally (out of 160 Trusts). 15 questions showed statistical improvement from the 2010 results. Overall position has moved from poor to average.

This paper details actions already taken since the time of the survey results and an on-going action plan for improvements to practice and service delivery for cancer patients across UH Bristol.

Recommendations

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

Executive Report Sponsor or Other Author

Chief Nurse, Alison Moon.

Authors: Ruth Hendy, Lead Cancer Nurse and Paul Lewis, Patient Involvement Coordinator.

Presented by: Dr Stephen Falk, Lead Cancer Clinician and Susan Ahlquist, Service user / parent representative and member of Cancer Board.

Appendices

- Appendix A – Action plan
- Appendix B – Full set of results

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Trust Cancer Board	Patient Experience Group
	10 Oct 2012			17 Sept 2012	19 Sept 2012

Paper: Trust Board

Subject: National Cancer Patient Experience Survey Results and Action Plan 2011/12

Authors: Ruth Hendy, Lead Cancer Nurse
Paul Lewis, Patient Involvement Coordinator

Presented by:
Dr Stephen Falk, Lead Cancer Clinician and Consultant Oncologist
Susan Ahlquist, Service user / parent representative and member of UHBristol Cancer Board

Date : 30 October 2012

1. Background

This report summarises the key findings of the 2011 National Cancer Patient Experience Survey for University Hospitals Bristol (UH Bristol). In total, 160 acute hospital NHS Trusts took part in this survey. The sample included 1453 UH Bristol patients aged 16 and over, with a primary diagnosis of cancer, admitted as an inpatient or day case and discharged between 1st September 2011 and 30th November 2011. Of these patients, 867 responded to the survey: a response rate of 63% (compared to the national response rate of 67%). A service improvement plan based on the survey results is presented in Appendix A and this will be monitored through the UH Bristol Cancer Care and Delivery Group and Cancer Board in 2012/13.

2. Headline summary of results

Quality Health Ltd, on behalf of the Department of Health, undertook the administration of the survey and carried out a comparative Trust analysis of the results[1]. In the Quality Health report, individual Trust scores are classified as being in the bottom 20%, middle 60% and highest 20% of Trusts nationally[2]. Of the 61questions included in the analysis that relate to care provided by UH Bristol[3], seven were classified in the top (i.e. best) 20% of Trusts nationally:

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[1] Please note that Quality Health's analysis, unlike national surveys managed by the Picker Institute (e.g. the national inpatient survey), does not take into account margins of error in the survey data when categorising scores, and does not weight or standardise the data to correct for differing patient demographic profiles between Trusts.
[2] National cancer survey scores are, unless otherwise stated, based on the percentage of respondents who ticked the best available response option to each question. For example, the question: "were you given enough privacy when discussing your treatment and condition?" has three response options: "yes always", "yes, sometimes", and "no". The question score is the percentage of respondents who ticked "yes, always".
[3] Three further questions relate to how quickly the patient was referred to hospital by their GP (lowest 20%), whether GP practice staff provided adequate support to the patient (middle 60%), and whether the patient felt they got enough care from "health and social care services" after their discharge from

- Hospital staff did everything they did to control the patient's pain (88%)
- The patient was given written information about the potential side effects of treatment (84%)
- Staff clearly explained the purpose of any tests to the patient (85%)
- The patient got understandable answers to their questions from nurses (81%)
- The patient was always treated with respect and dignity as an inpatient (86%)
- The patient was glad to have been asked about taking part in cancer research (98%)
- The patient would have liked to have been asked to take part in cancer research (58%)

Seven UH Bristol scores were in the lowest (i.e. worst) 20% of Trust scores nationally:

- The patient was told that they had cancer in a sensitive way (80%)
- The patient was given written information about the type of cancer they had (64%)
- The patient's views were taken into account when doctors and nurses were discussing which treatment the patient should have (65%)
- The patient was given sufficient privacy when discussing their treatment / condition with staff *(this question relates to inpatient care)* (81%)
- The doctor spent the right amount of time with the patient during outpatient appointments (92%)
- The different people treating and caring for the patient (e.g. GP, hospital staff, community nurses) worked well together (59%)
- The patient was offered a written assessment and care plan (19%)

UH Bristol's remaining scores were in the middle 60% of Trust scores nationally. The spread of results represents an improvement on the 2010 national cancer survey, when UH Bristol had two scores in the top 20% and fifteen scores in the lowest 20% nationally. UH Bristol saw statistically significant improvements on fifteen question scores between the 2010 and 2011 surveys, with one score declining over this period (Table 1 - over).

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hospital (lowest 20%). These have been excluded from this report / analysis as they do not refer to UH Bristol services, but they are included in Quality Health's comparative analysis for the Trust.

Table 1: Statistically significant changes in UH Bristol's national cancer survey results

	2010	2011	Change
Hospital staff told the patient that they could get free prescriptions	60%	73%	+13
The patient received understandable answers to their questions from nurses	71%	81%	+10
The patient was told how their operation had gone in an understandable way	68%	76%	+8
The patient was given written information about their operation	64%	71%	+7
The patient was given written information about potential side effects of their treatment	78%	84%	+6
The patient was given a complete explanation of what would be done during their operation	82%	88%	+6
The patient had confidence and trust in nurses at UH Bristol	66%	72%	+6
The patient was given written information about what they should / shouldn't do after leaving hospital	78%	84%	+6
After referral to hospital, the patient was seen at the hospital as soon as they thought was necessary	79%	84%	+5
The patient finds it easy to contact their clinical nurse specialist	68%	73%	+5
The patient received understandable answers to their questions from doctors	79%	84%	+5
The patient was always treated with respect and dignity in hospital	81%	86%	+5
The patient was given a complete explanation of the purpose of any tests they had	81%	85%	+4
The patient had confidence and trust in the doctors at UH Bristol	82%	86%	+4
The patient felt that their GP got enough information from the hospital about their care and treatment	91%	94%	+3
The patient was given a choice of different types of treatment	88%	81%	-7

3. Detailed Analysis

3.1 Comparison with the best Trusts' nationally

UH Bristol had seven national cancer survey scores among the best 20% of Trusts nationally, and seven scores among the lowest 20%. According to research carried out by Macmillan Cancer Support[4], the best performing Trust nationally was Harrogate and District NHS Foundation Trust, with no scores classified in the lowest 20% and fifty-five in the top 20%. At the other end of the spectrum, Imperial College Healthcare NHS Trust had fifty-six scores in the lowest 20% of Trusts and one in the top 20%. (The same report identified UH Bristol as being among the ten most improved Trusts nationally, in terms of the number of improved scores in the national cancer survey.)

[4] The report can be accessed via the following link: http://www.macmillan.org.uk/Documents/AboutUs/Commissioners/Patientexperiencesurvey2012.pdf

It is also possible to look at the highest (i.e. best) Trust score nationally on each survey question, and compare this to the score achieved by UH Bristol. This analysis is provided in Appendix B. The UH Bristol scores that are furthest away from the best Trust score nationally have been incorporated into the action plan provided in Appendix A.

3.2 Comparison with selected teaching Trusts and geographical neighbouring Trusts

Table 2 shows a comparison of UH Bristol's survey results with selected teaching Trusts, based on the number of scores each Trust had classified in the highest and lowest quintiles[5]. Table 3 (over) provides the same data for UH Bristol's geographical neighbours. The results of this analysis illustrate the improvement in UH Bristol's survey scores between the 2010 survey and 2011 surveys (shown in the last two columns in these tables). The results also highlight the need for continued improvement.

Table 2: 2011 National Cancer Survey: comparison with selected Teaching Trusts

	Number of scores in the highest 20% nationally	Number of scores in the lowest (worst) 20% nationally	2011 Overall score (number of highest minus number of lowest scores)		2010 overall score
Royal Marsden	20	7	+13	↑*	-1
Christie NHS FT	14	2	+12	↓	+18
Oxford UH	9	2	+7	↑	+3
UH Bristol	**7**	**7**	**0**	↑	**-14**
Guy's & St. Thomas's	14	15	-1	↑	-15
UH Southampton	2	9	-7	↓	3
UH Birmingham	7	17	-10	↑	-11

**An upward arrow denotes an improved score on this analysis compared to the 2010 survey, a downward arrow denotes a worse score*

Table 3: 2011 National Cancer Survey: comparison with geographical neighbours

	Number of scores in the highest 20% nationally	Number of scores in the lowest (worst) 20% nationally	2011 Overall score (number of highest minus number of lowest scores)		2010 overall score
Taunton & Somerset FT	21	1	20	↓	23
Weston Area Health	18	7	11	↓	17
RUH Bath	9	5	4	↓	17
Yeovil District Hospital	18	14	4	↓	20
UH Bristol	**7**	**7**	**0**	↑	**-14**
North Bristol Trust	3	12	-9	↓	-7

[5] Please note that the Royal Marsden and Christie Trusts are specialist hospitals treating only cancer, the other four Trusts (including UH Bristol) have a mixed caseload.

3.3 Highest and lowest UH Bristol scores

The analysis provided by Quality Health Ltd is a relative comparison between Trusts, but does not indicate whether a UH Bristol score is in itself high or low. Table 4 shows the UH Bristol scores that had the highest levels of patient satisfaction (i.e. 90% or above), and the five lowest scores. The lowest scores have been incorporated into the service improvement plan available in Appendix A of this report.

Table 4: Highest (best) and lowest UH Bristol scores in the 2011 National Cancer Survey

Highest UH Bristol Survey Scores	
The patient was glad to have been asked to take part in cancer research	98%
The doctor has all of the information they needed to care for the patient	94%
The hospital provided the patient's GP with enough information about their condition and treatment	94%
The patient had enough privacy when being examined or treated as an inpatient	93%
The patient was told who to contact if they were worried about their condition or treatment after leaving hospital	93%
The patient spent the right amount of time with the doctor during their last outpatient appointment	92%
The Clinical Nurse Specialist listened carefully to the patient	91%
The Clinical Nurse Specialist gave the patient understandable answers to their questions	90%
Lowest UH Bristol Survey Scores	
The patient would have liked to have been asked to take part in cancer research	58%
All staff asked the patient what name they preferred to be called by	54%
Hospital staff gave the patient information about financial help / benefits	53%
Taking part in cancer research was discussed with the patient	35%*
The patient was offered a written assessment and care plan	19%

**please note that not all patients are eligible for participation in research projects*

3.4 Team-level scores

The Quality Health report provides a breakdown of the UH Bristol scores by tumour group. These results have been shared with the Trust's specialist cancer teams, along with patient comments received from the survey, in order to develop team-specific action plans in response. These team-specific actions will be in addition to the improvement activities identified in Appendix A of this report. Progress on these team-specific action plans will be monitored through the Cancer Care and Delivery Group.

3.5 Evaluating the UH Bristol 2010 National Cancer Survey Action Plan

Table 4 summarises progress against the UH Bristol action plan that was formulated in response to the previous 2010 national cancer survey results[6]. It can be seen that there were improvements on eleven of these twelve key issues, particularly around information provision and access to a clinical nurse specialist. However, only five of these scores reached the threshold of statistical significance.

Table 5: 2010 National Cancer Survey Action Plan Objectives

Service Improvement Objective	2010	2011	Change
For hospital staff to inform patients that they can get free prescriptions	60%	73%	+13*
Post-operatively, ensure staff explain how the operation went in a way the patient can understand	68%	76%	+8*
To ensure patients are given written information about their operation, pre-operatively	64%	71%	+7*
To ensure patients receive clear written information about what to do after leaving hospital	78%	84%	+6*
To make it easy for patients to contact their clinical nurse specialist	68%	73%	+5*
For hospital staff to inform patients about how they can get financial help or benefits	49%	53%	+4
To ensure patients and their supporters (carers_ get the information they need to continue care at home	55%	59%	+4
To ensure patients are given enough privacy when discussing their condition or treatment	79%	81%	+2
To ensure patients feel they are treated as a whole person, rather than a set of symptoms.	77%	79%	+2
For those close to the patient to feel they had an opportunity to talk to the doctor	60%	62%	+2
To improve the time that patients wait in Outpatients clinics	64%	65%	+1
Enable different professionals to work together more effectively	59	59	0

**denotes a statistically significant change*

[6] The action plan was approved by the Trust Board in April 2011 and signed-off as complete by the Trust's Cancer Board and Patient Experience Group in May 2012. It is not possible to provide a direct comparison on two scores in the action plan, due to a change in the question wording between 2010 and 2011. These questions were: did the patient feel everything was done to control side effects of (1) chemotherapy and (2) radiotherapy. The scores on these questions were in line with the national average in 2011, having been in the lowest 20% in 2010.

4 Identifying service improvement priorities

The UH Bristol service improvement plan in response to the 2011 national cancer survey primarily comprises scores that are of concern for the following reasons:

- Scores that were among the lowest 20% of Trust scores nationally
- The lowest UH Bristol scores (in absolute terms)
- UH Bristol scores that were among the furthest from the best Trust score nationally
- Scores that showed no significant improvement in the 2010 national cancer survey action plan
- Scores that were below the national average (i.e. the score derived from an aggregate of all Trusts' data)
- Scores that declined between 2010 and 2011

The full action plan in response to the 2011 national cancer survey is presented in Appendix A. In addition to scores in the categories identified above, the plan contains an action around access to clinical nurse specialists: this score had in fact shown an improvement since 2010, but it has been highlighted as a vital component of cancer care integral to the ongoing overall improvement of the cancer patient experience.[7] Four survey scores in the action plan do not have specific actions against them, as they have already been identified and incorporated into existing patient experience work-streams (i.e. the Productive Outpatient project).

5. Summary

Improving cancer patient experience at UH Bristol was a priority for the Trust's Cancer Board during 2011/12. The work undertaken in this respect is reflected in the 2011 national cancer survey results, where UH Bristol has been recognised as one of the most improved Trusts nationally by the Department of Health and Macmillan Cancer Care. However, this improvement was from a relatively low base and the 2011 results are not reflective of UH Bristol's ambition to be among the best Trusts nationally. The Trust's own survey data suggests that care at UH Bristol's Haematology and Oncology Centre is comparable with the best Trusts nationally, but the national cancer survey clearly illustrates that care for cancer patients in other UH Bristol hospitals is not currently at these levels. With this in mind, improvement in cancer patient experience will continue to be a priority for the Cancer Board during 2012/13.[8]

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[7] The link to a MacMillan Cancer Support report on this issue can be found here: http://www.macmillan.org.uk/Aboutus/News/Latest_News/Specialistcancernursescanimprovepatientcareandsavemoney.aspx

[8] Please note that a third national cancer survey is planned, with the sample expected to be based on patients attending UH Bristol services between September and November 2012.

Cancer Patient Experience Survey Action Plan (Version 5 –Final)

	Issue	Action	Lead	Comments / Completion date
1. Communication – within teams and community	Patient was told sensitively they had cancer	• To better understand issues and enable more targeted actions, focus groups to be undertaken (with service users) to understand factors leading to perception of insensitivity e.g. timings, venue, content of information, vocabulary, 4 bed bay / open ward, hosp or GP.	Ruth Hendy / Tony Watkin	November 2012
	Patient understood the explanation of what was wrong Patients views were taken into account by doctors and nurses Patient involvement in decisions about care and treatment Staff asked patient what name they preferred to be called by As an outpatient or day case, was patient given enough emotional support by staff Patient did not feel they were treated as a set of cancer symptoms	• Lead Cancer Nurse to present results and action planning to the Patient Experience Group (PEG). Heads of Nursing then to disseminate results and actions to Divisional Matron / Sisters forums (alongside Divisional PEAPs)	Ruth Hendy	Completed 19/09/12
		• Raise awareness and increase uptake onto UHBristol's 'Communication skills workshops / Handling difficult conversations' (all staff groups).	Ruth Hendy	October 2012
		• Raise awareness and increase uptake for all cancer MDT core members to attend 2 day communications skills training.	Ruth Hendy	Completed 17/09/12
		• Monitor training records to ensure increase in uptake.	Ruth Hendy	December 2012
		• Lead Cancer Nurse to discuss with GP Cancer leads and agree plan to disseminate summary of results / raise awareness and identify training needs in Primary care	Ruth Hendy	Completed 14/09/12
		• Attend NHS Bristol GP Forum to disseminate results and discuss. Collaborate with ASWCS Network to present collective results.	Ruth Hendy	November 2012
		• Dissemination of these results / actions required to be incorporated into the implementation of Acute Oncology Service / Cancer Outreach Service training for Trust-wide medical staff	Steve Falk	January 2013
		Trust-wide (non-cancer specific issue). Being addressed through staff attendance at Living the Values and Customer Care training.		
	Were you able to discuss worries or fears with staff during your visit	*Trust wide (non cancer specific issue). Being addressed by Divisional Patient Experience Action Plans.*		
	Patient waited longer than 30 minutes in clinic to see the doctor	*Trust wide (non cancer specific issue). Being addressed by Productive Outpatients Project.*		
	The doctor spent the right amount of time with the patient	*Trust wide (non cancer specific issue). Being addressed by Productive Outpatients Project.*		

	Issue	Action	Lead	Comment / Completion date
2. Information provision – written and verbal	Were patients told they could bring a friend or family member with them, when they came for their diagnosis	• MDTs to review their clinic letters and re-word to advise patients they can bring a friend / family member.	MDT Leads / Ruth Hendy	October 2012
		• Review with Trust Productive Outpatients group. Consider inclusion into all clinic letters (not just diagnosis discussions).	Ruth Hendy	October 2012
	Patient was given written information about the type of cancer they had Patient was given a choice of treatment options Patient was given information about support groups Patient was given information about financial help and benefits Patient was given information of how to get free prescriptions Since diagnosis, has anyone discussed whether you would like to take part in cancer research Written information about operation, given pre-operatively	• Each team to review written information provision (type of cancer, operation, access to financial help and free prescriptions, treatment options, support groups, cancer research) and review how when this is delivered to patients	MDT Leads / Ruth Hendy	October 2012
		• CNSs to educate ward staff about cancer patient access to free prescriptions and financial and benefit information	Ruth Hendy / Cancer Clinical Nurse Specialists	November 2012
		• Each cancer site to produce the following: ○ List of all cancer types covered by MDT, with indication of whether specific written information exists ○ List of all operations performed for cancer, with indication of whether specific written information exists ○ For every gap identified in the exercise above, MDT to produce written information leaflet that can be used ○ List of all site specific cancer research available	Cancer Clinical Nurse Specialists/ Ruth Hendy	November 2012
	Patient offered a written assessment and care plan	• For discussion with ASWCS user group to identify understanding and expectation	Ruth Hendy	14th November 2012
		• Include in Focus Group discussion – to identify understanding and expectation	Ruth Hendy / Tony Watkin	November 2012
		• For wider discussion with MDTs about what is meant by written assessment and care planning and agreement as to how to collectively proceed.	Ruth Hendy / Steve Falk	October 2012
		• Implementation of agreed process (as above) across MDTs	MDT Leads	December 2012

	Issue	Action	Lead	Comment / Completion date
3. Ward care	Patient's family and carers were given enough opportunity to talk to a doctor Patient had confidence and trust in the ward nurses Patient's family and carers were given all the information they needed to care for the patient at home	• Lead Cancer Nurse to present results and action planning to the Patient Experience Group. Heads of Nursing then to disseminate results and actions to Divisional Matron / Sisters forums (alongside Divisional PEAPs) *(linked with action 1. communication)*	Ruth Hendy	Completed 19/09/12
		• CNSs to educate and work with ward staff about the cancer patient experience and ongoing information needs	Ruth Hendy / CNSs	October 2012
	Patient was given enough privacy when discussing treatment/ condition as an inpatient	*Trust wide (non cancer specific issue). Being addressed by Divisional Patient Experience Action Plans.*		
4. Specialist Nurses	Patient contact with a CNS is integral to the ongoing improvement in patient experience, therefore maintain the drive for all cancer patients to be assigned a Clinical Nurse Specialist to improve pathway efficiencies and provide support, information and advice. Patient given the name of the CNS in charge of their care Patient finds it easy to contact their CNS	• Review impact of Macmillan band 4 Cancer Support Worker pilot for participating teams	Ruth Hendy	Pilot posts starting Oct 2012. 2 year evaluation.
		• Link in with Trust CNS Review to identify possible efficiencies and changes in practice, leading to a potential increase in CNS availability to patients	CNS Review Team / Ruth Hendy	December 2012
		• CNS teams to review and consider use of a 'Duty' bleep or mobile that can be answered (so patients are not often met with an answer phone)	Ruth Hendy / CNSs	October 2012
		• Discuss this at PEG with Heads of Nursing, to disseminate and discuss with Matrons (CNS Managers) to support this initiative	Ruth Hendy	Completed 19/09/12

5. Specific MDT action plans	Issue	Action	Lead	Comment / Completion date
	There is significant variation in UHBristol results between some site specific Multidisciplinary Teams (MDTs).	• For those tumour site specific results that are available, MDT leads have reviewed their individual set of results.	MDT Leads	Completed 10th September 2012
		• For those teams where team specific data is not available, raw survey data has been requested from Quality Health for local analysis. (eg skin, TYA, HPB and OG)	Paul Lewis	Completed September 2012
		• Following further analysis, where data is still not available, a site specific local survey will be undertaken	Paul Lewis / MDT Leads	November 2012
		• MDT leads are identifying key relevant actions for their team and producing MDT specific action plans. These action plans will be monitored through Cancer Care and Delivery Group and Cancer Board.	MDT Leads	October 2012
		• The action planning and identification of good practice within teams will be discussed and shared at regular Cancer Care and Delivery Group meetings.	Ruth Hendy /MDT Site specific leads	October 2012

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Ruth Hendy, Lead Cancer Nurse
Dr Stephen Falk, Cancer Lead Clinician
Hannah Marder, Cancer Manager

10th October 2012 (v5 –final, post TME)

Appendix B: Table of results

The following table contains a full list of UH Bristol's survey results and compares these to the national score (i.e. the aggregate of all Trust's data), and the highest score that was attained by any Trust in the country. The data is sorted with the UH Bristol score that was closest to the best Trust score shown first. The result shown is the percentage of respondents ticking the "top-box" (i.e. best available) response category for each question. UH Bristol scores are highlighted in red if they are five points or more below (i.e. worse than) the national average, and green if they are five or more points above this benchmark.

	UH Bristol (%)	National Result (%)	Best Trust Score (%)
Patient glad to have been asked to take part in cancer research	98	95	100
Before you started your treatment, were you given written information about the side effects of treatment(s)?	84	81	89
While you were in hospital did you ever think that the doctors or nurses were deliberately not telling you certain things that you wanted to know?	89	87	94
Do you think the hospital staff did everything they could to help control your pain?	88	84	93
As far as you know, was your GP given enough information about your condition and the treatment you had at the hospital?	94	94	99
Rating care as excellent or very good	89	88	94
The last time you had an appointment with a cancer doctor, did they have the right documents, such as medical notes, x-rays and test results?	94	95	100
Beforehand, did a member of staff explain the purpose of the test(s)?	85	83	92
Beforehand, did a member of staff explain what would be done during the test procedure(s)?	87	86	94
When you have important questions to ask your Clinical Nurse Specialist, how often do you get answers you can understand?	90	91	97
When you had important questions to ask a ward nurse, how often did you get answers you could understand?	81	75	88
Were you given enough privacy when being examined or treated?	93	94	100
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	93	93	100
How do you feel about the length of time you had to wait before your first appointment with a hospital doctor?	84	83	92
The last time you spoke to your Clinical Nurse Specialist, did she/he listen carefully to you?	91	91	99
When you had important questions to ask a doctor, how often did you get answers that you could understand?	84	82	92
The last time you had an outpatients appointment with a cancer doctor, was the time you spent with them too long, too short or about right?	92	94	100
How much information were you given about your condition and treatment?	88	89	96
Before you had your operation, did a member of staff explain what would be done during the operation?	88	87	97
Did you have confidence and trust in the doctors treating you?	86	82	95
Did ward nurses talk in front of you as if you weren't there?	86	84	95
While you were being treated as an outpatient or day case, did hospital staff do everything they could to help control your pain?	83	81	92
Beforehand, were you given written information about your test(s)?	87	86	98

	UH Bristol (%)	National Result (%)	Best Trust Score (%)
Did you understand the explanation of what was wrong with you?	72	73	83
Were the possible side effects of treatment(s) explained in a way you could understand?	76	75	87
Were you involved as much as you wanted to be in decisions about which treatment(s) you would have?	72	72	83
The last time you went into hospital for a cancer operation, was your admission date changed to a later date by the hospital?	89	90	100
Were you given the name of a Clinical Nurse Specialist who would be in charge of your care?	87	87	99
Were you given enough privacy when discussing your condition or treatment?	81	84	93
Were you treated with respect and dignity by the doctors and nurses and other hospital staff?	86	83	98
After the operation, did a member of staff explain how it had gone in a way you could understand?	76	75	89
Did doctors talk in front of you as if you weren't there?	82	83	95
Did you have confidence and trust in the ward nurses treating you?	72	69	85
While you were in hospital, did it ever happen that one doctor or nurse said one thing about your condition or treatment, and another said something different?	80	79	93
Did hospital staff do everything possible to control the side effects of chemotherapy?	83	81	96
Were the results of the test(s) explained in a way you could understand?	76	78	90
How do you feel about the way you were told you had cancer?	80	83	94
Before your cancer treatment started, were you given a choice of different types of treatment?	81	84	95
Patient would like to have been asked to take part in cancer research	58	53	72
Did your health get worse, get better or stay about the same while you were waiting for your first appointment with a hospital doctor?	80	79	95
When you were first told that you had cancer, had you been told you could bring a family member or friend with you?	73	72	88
Patient was able to discuss worries and fears with staff	66	64	81
Were you given clear written information about what you should or should not do after leaving hospital?	84	84	100
Did hospital staff do everything possible to control the side effects of radiotherapy?	77	79	93
Sometimes people with cancer feel they are treated as "a set of cancer symptoms", rather than a whole person. In your NHS care over the last year, did you feel like that?	79	80	95
Did hospital staff tell you that you could get free prescriptions?	73	73	90
Beforehand, were you given written information about your operation?	71	73	88
Patient's views taken into account by doctors and nurses when discussing treatment	65	70	83
Did hospital staff give you information about support or self-help groups for people with cancer?	73	82	91
How easy is it for you to contact your Clinical Nurse Specialist?	73	75	92
Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?	59	62	79

	UH Bristol (%)	National Result (%)	Best Trust Score (%)
When you were told you had cancer, were you given written information about the type of cancer you had?	64	69	86
In your opinion, were there enough nurses on duty to care for you in hospital?	66	61	88
Did hospital staff give you information about how to get financial help or benefits?	53	52	77
If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	62	65	86
While you were being treated as an outpatient or day case, were you given enough emotional support from hospital staff?	69	71	93
The last time you had an outpatients appointment with a cancer doctor at one of the hospitals named in the covering letter, how long after the stated appointment time did the appointment start?	65	70	89
Taking part in cancer research discussed with patient	35	33	62
All staff asked patient what name they preferred to be called by	54	56	82
Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you at home?	59	60	87
Patient offered written assessment and care plan	19	24	49

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 08 – Complaints Annual Report

Purpose

For the Board to receive the Complaints Annual Report 2011/12.

Abstract

The Trust's Annual Complaints Report for 2011/2012 outlines how the complaints process is managed at UH Bristol, the lessons learnt from complaints and our performance during 2011/2012. The report also outlines key objectives for 2012/2013.

Alongside this the Patient Experience Annual Report is provided as a linked report, to set the Complaints Annual Report in the wider context of patient experience at UH Bristol.

During 2012/13 the complaints and patient experience teams are working more closely together and will be producing a comprehensive Patient Experience Annual Report next year which will include a section on complaints in accordance with the requirements of the 2009 NHS Complaints Regulations.

Recommendations

The Board is asked to receive the report and **note** the report and work plan for 2012/13.

Executive Report Sponsor or Other Author

- Executive Sponsor – The Chief Nurse, Alison Moon
- Author – Patient Support and Complaints Manager, Karen Hurley

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	September 2012				Patient Experience Group August 2012

Patient Experience at University Hospitals Bristol NHS Foundation Trust

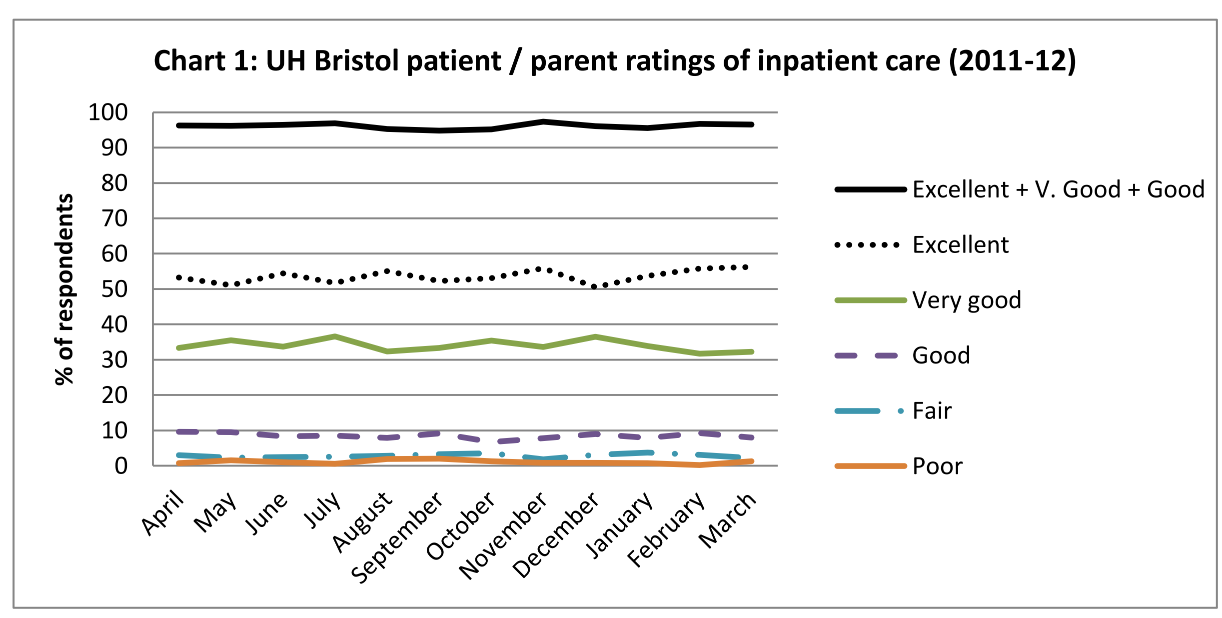
Report to: Trust Management Executive / Trust Board
Author: Paul Lewis, Patient Involvement Coordinator
Date: 30th August 2012

Background and Overview

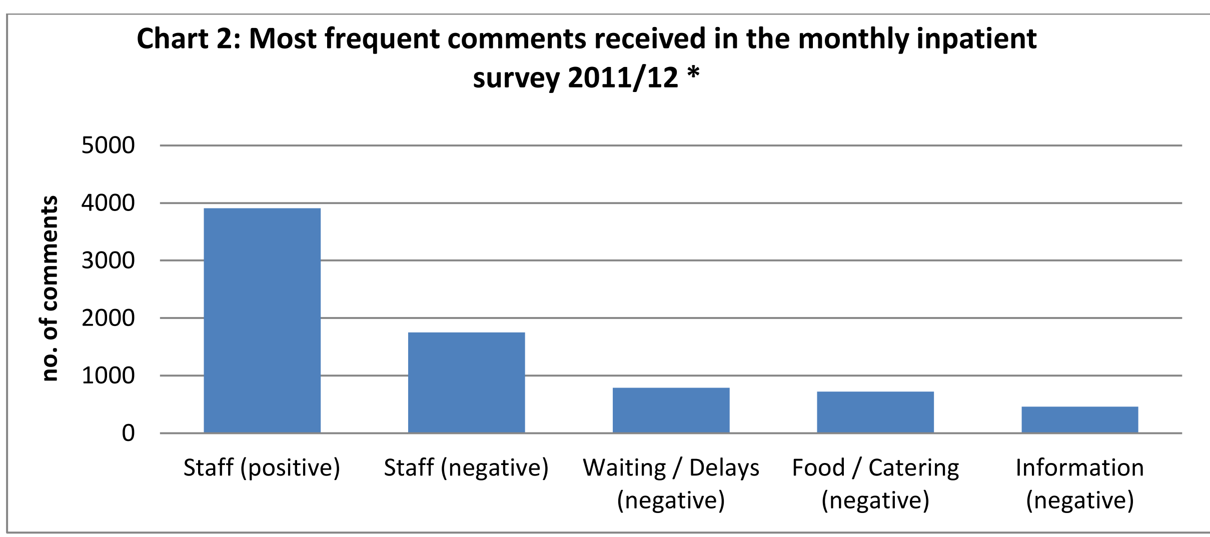
This paper accompanies the 2011/12 Complaints Annual Report in order to set that report in the wider context of overall patient experience at UH Bristol. Complaints are a powerful and important tool for understanding and improving patient experience. On average, however, complaints represent only 0.25% (1 in 400) of patient attendances each month. The Trust's survey data shows that most patients receive a service at UH Bristol which they rate as either good or excellent. Where quality of care falls short of patients', or our own, high standards, the Trust has processes in place to remedy and learn from this, both at an individual level (e.g. complaints resolution process) and at a wider operational level (e.g. via Divisional Patient Experience Action Plans).

Inpatient Experience at UH Bristol

In 2011/12, the Trust's monthly inpatient survey elicited 10,313 responses. Chart 1 shows that in each month during this period, between 95% and 97% of respondents rated the care they received on the ward as 'excellent', 'very good', or 'good' (with just over half of these being in the 'excellent' category). The proportion of respondents rating their care as poor varied between 0.2% and 2%. On average, 96% of survey respondents each month would 'probably' or 'definitely' recommend the Trust to their friends and family, based on their experience as an inpatient (not shown).



Respondents to the Trust's monthly survey are encouraged to provide written comments about the things that went well during their stay and the things that could have been better. It can be seen in Chart 2 that hospital staff are the most frequently cited factor in a positive or negative patient experience at the Trust. The importance of staff in determining patient experience is mirrored in the Complaints Annual Report: "staff attitude and communication" was the third most common category of complaint in 2011/12. However, it is also important to note that by far the most frequent type of comment received in the monthly inpatient survey involves praise for staff.



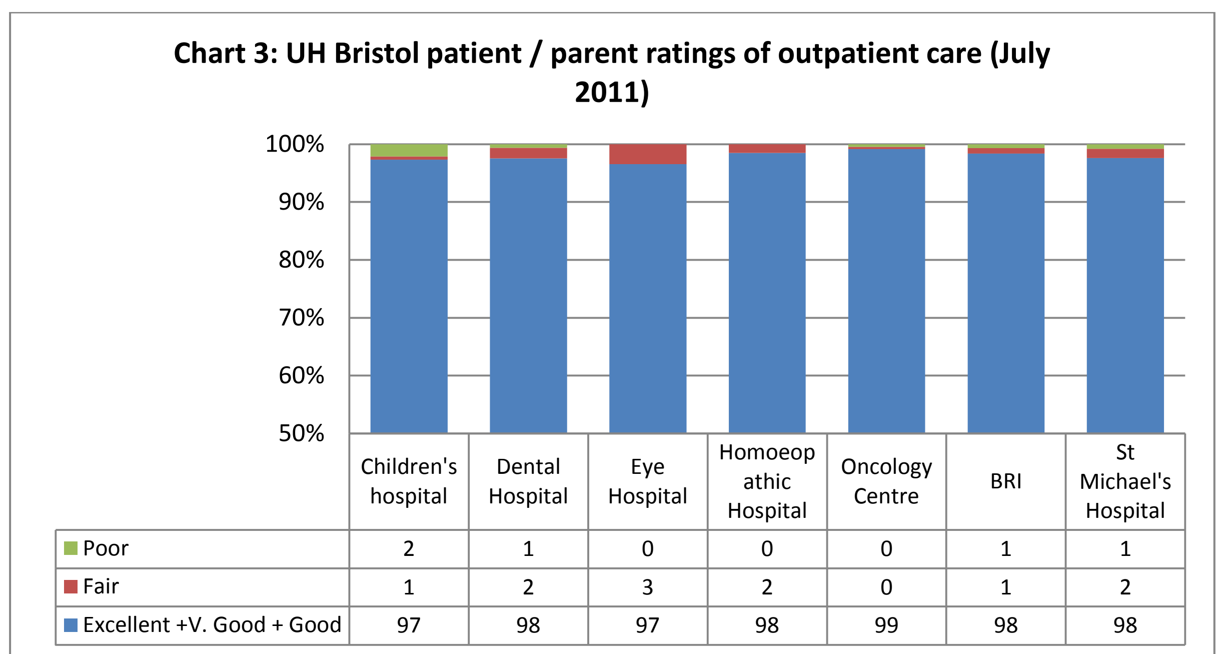
Positive comments involve praise for UH Bristol, negative comments are constructively critical

These headline satisfaction ratings do not provide detailed insight into (and often mask) service improvement needs. The monthly survey also contains more specific questions, which are used to identify areas of the Trust and / or aspects of patient experience that need to be improved. These issues have been incorporated into the Divisional Patient Experience Action Plan programme[1]. However, for the majority of UH Bristol inpatients, these improvements are at the margins of what they already perceive as high quality care.

Outpatient Experience at UH Bristol

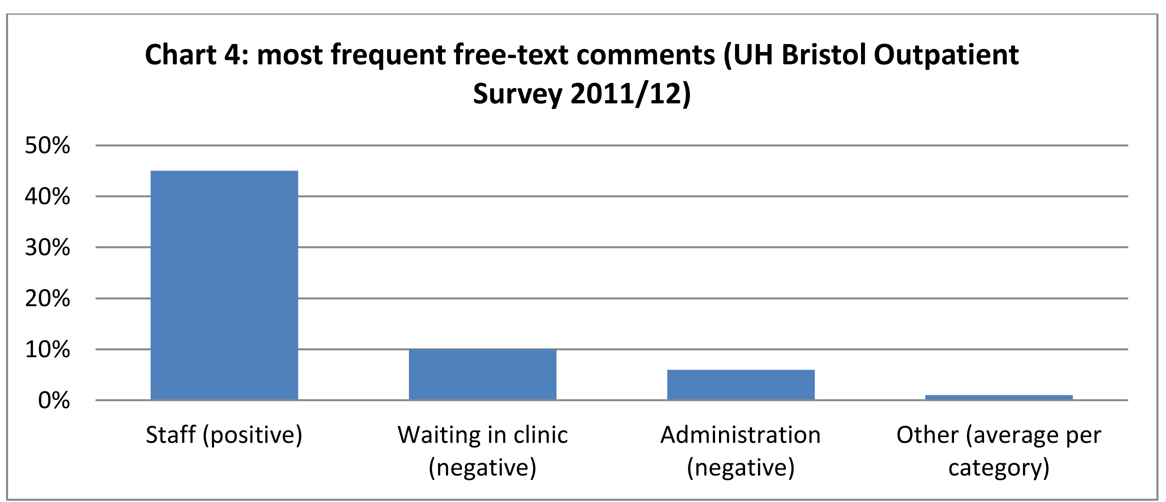
During 2011/12, the Patient and Public Involvement Team carried out a robust and detailed survey of 2,250 outpatients (or parents of 0-11 year olds). This provided the Trust with a Divisional and specialty-level view of outpatient experience, as perceived by outpatients themselves, for the first time. Headline satisfaction was high, with between 97% and 99% of respondents rating the care they received during their outpatient appointment as excellent, very good, or good (Chart 3 – over). In total, 98% of respondents said that they would definitely or probably recommend the department they attended to their family and friends.

[1] The 2012/13 Divisional Patient Experience Objectives and Dashboard have previously been reported to TME and the Trust Board in June 2012, as part of the 2011 National Inpatient Survey report.



	Children's hospital	Dental Hospital	Eye Hospital	Homoeopathic Hospital	Oncology Centre	BRI	St Michael's Hospital
Poor	2	1	0	0	0	1	1
Fair	1	2	3	2	0	1	2
Excellent +V. Good + Good	97	98	97	98	99	98	98

The Trust's outpatient survey again demonstrated the importance of hospital staff in determining a positive patient experience. Respondents also highlighted the need to improve administration systems (particularly delayed and cancelled appointments), waiting times, and responsiveness (e.g. answering telephones). These issues are captured within two of the three most frequent type of complaint received by the Trust during 2011/12 (the "appointments and admissions", and "attitude and communication" categories). The outpatient improvement issues identified via the survey and complaints have been incorporated into the key improvement objectives of the Productive Outpatient project[2]. However, Chart 4 places these issues into context and shows that by far the most frequent type of comment received in the outpatient survey involved positive praise for staff.



[2] The action plan and dashboard relating to this work was reported to TME / Trust Board in March 2012.

Summary

The purpose of this report is to demonstrate that there is a high level of overall patient satisfaction with UH Bristol, and that complaints represent the exception rather than the rule. Some of the most common causes of patient complaints are also reflected in suggestions for improvement which we receive from otherwise satisfied patients. Addressing these issues should have the effect of reducing the number of people who feel that they need to make a formal complaint, but should also move the reported experience of many patients from good to excellent.

Looking forward

In September 2012, line management responsibility for the Trust's Patient Support and Complaints Team will transfer to the Head of Quality (Patient Experience and Clinical Effectiveness). This will enable the Trust to bring together the Patient Support and Complaints Team and the Patient and Public Involvement Team in a more integrated Patient Experience function. Consequently, it is anticipated that in 2012/13 there will be a single Patient Experience Annual Report which will bring together information and analysis about complaints, patient surveys, patient focus groups etc. This 'linked report' to accompany the 2011/12 Complaints Annual Report, is therefore a stepping-stone towards future integrated reporting.

Listening, Responding and Improving : Complaints Annual Report 2011 - 2012

Prepared by:

Karen Hurley
Patient Support & Complaints Manager
(Final – September 2012)

Preface

I am pleased to introduce this Annual Report to you.

In 2011/12 University Hospitals NHS Foundation Trust had 776,545 patient contacts. By far the majority of those contacts were satisfactory for those patients. This report focusses on those who felt the need to complain formally about our services. We take their concerns very seriously and learning from their experiences is a key part of the way we work. We want to 'get it right' for all patients but for those people where we did not get it right we need to say sorry, put it right and truly learn more widely.

Thank you to all our staff, whatever their role, who try to do their best for patients every day.

Alison Moon
Chief Nurse

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1. Introduction

University Hospitals Bristol NHS Foundation Trust aspires to be a learning organisation, which listens to and acts on patient experience, complaints and feedback. Our front line staff are trained and supported to resolve complaints directly with patients whenever possible and we encourage patients to let us know quickly if they are experiencing difficulties, so we can put things right. Patients, their families and carers can raise concerns with us, reassured in the knowledge that they will be treated seriously and their care will not be compromised as a result.

The Patient Support & Complaints Team are responsible for the central co-ordination, reporting and management of complaints. Support is also available in each of our divisions through senior divisional management teams and divisional complaints co-ordinators.

When complaints are of a more complex nature, clear structures are in place to support patients and to assist staff in the overall management and satisfactory resolution of complaints. This helps ensure that learning from complaints is understood and shared at an individual, divisional and organisational level and that actions are implemented across the Trust, to prevent issues recurring and to improve our services for the future. This ethos of complaints management is underpinned by the Trust's Values, which are:-

- Respecting Everyone
- Embracing Change
- Recognising Success
- Working Together

We manage complaints in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Parliamentary & Health Service Ombudsman (PHSO) Principles of Good Complaints Handling 2009, by:-

- **Getting it right**
    - Acting in accordance with the law and relevant guidance.
    - Having senior leadership to support good complaints management and a culture that values complaints.
    - Having clear governance arrangements, with set roles and responsibilities, and ensuring that lessons are learnt from complaints.
    - Ensuring staff are equipped and empowered to act decisively to resolve complaints.

- **Being customer focused**
    - Having clear and simple procedures which are easily accessible, via our website, patient leaflets or asking a member of staff.
    - Advising all complainants how to access advocacy support.
    - Dealing with complaints promptly and respectfully. Our standard is that all telephone calls are acknowledged within 24 hours of receipt and all written correspondence within 72 hours.
    - Listening to complainants to understand their concerns and the outcome they are seeking.

    - Responding flexibly, co-ordinating responses with other health and social care organisations where appropriate.

- **Being open and accountable**
    - Publishing clear, accurate and complete information about how to complain via our website and patient information leaflets.
    - Providing honest, evidence based explanations and providing reasons for decisions.
    - Keeping full and accurate records of all complaints received.

- **Acting fairly and proportionately**
    - Treating the complainant impartially, without discrimination or prejudice.
    - Ensuring that all complaints are investigated thoroughly and fairly.
    - Ensuring that all decisions made are proportionate, appropriate and fair.
    - Ensuring that complaints are investigated by someone independent.
    - Acting fairly towards staff complained about, as well as complainants.

- **Putting things right**
    - Acknowledging mistakes and apologising where appropriate.
    - Providing prompt, appropriate and proportionate remedies.
    - Considering all relevant facts of the case when offering remedy.
    - Taking account of any injustice and hardship that results from pursuing a complaint, as well as from the original complaint.

- **Seeking continuous improvement**
    - Using feedback and lessons learnt from complaints to improve service delivery.
    - Having systems in place to record, analyse and report on learning from complaints.
    - Where appropriate, telling the complainant about the lessons learnt and changes made to services or policy.

Our Complaints Policy has been updated again this year to reflect these principles more clearly and ensure that greater emphasis is placed on the learning from complaints at individual, divisional and organisational level. Financial remedy guidelines have also been written and circulated to staff, to ensure that financial remedy is considered, where appropriate, as part of the local resolution process for complainants.

2. Achievements and learning from complaints in 2011/2012

Our 2011/2012 complaints work plan focused on the improvements identified by the external review of our complaints process in January 2011 and was developed collaboratively with staff in the Patient Support & Complaints Team, divisional managers and complaint staff. We wanted to improve performance, ensuring that people who complained to the Trust were provided with better quality and effective responses.

We also wanted to provide better support for staff to deal with complaints themselves and to embed organisational learning into our complaints process. The objectives were completed by April 2012 and our key achievements were:-

- Using patient stories and examples of complaints within staff training to ensure that training is more customer focused, i.e. within the Trust *Living the Values* training, being rolled out to all staff.
- Providing training to front line staff to help them deal with complaints promptly and for senior staff involved with the investigation and response to written complaints, to improve the quality of responses.
- Improving the time taken to respond to written complaints towards the end of 2011/2012.
- Reducing the number of people who were dissatisfied with the response to their complaint towards the end of 2011/2012, by training staff to undertake more thorough investigations, offering meetings for responding to more complex complaints and reducing internal administration processes.
- Streamlining administration and communication processes between corporate and divisional complaints staff, freeing up time to investigate complaints more thoroughly.

In 2011/2012 partnership working with other health and social care stakeholders has continued, for example:-

- The LIAISE Officer at the Childrens Hospital has continued to attend the National Paediatric PALS Network Meetings and contributed to developments within paediatric services nationally.
- The Patient Support & Complaints Manager has continued to attend the local South West Regional Network meeting of Complaints & PALS Managers in health and social care. Members of the network have worked closely together to support consistent ways of managing complaints across local organisations and to identify key trends and themes from complaints received. The network also allows members to share best practice across organisations in the south west region.

Robust and continuous organisational learning remains our key aim through the management of our complaints activity. This is supported by the use of patient stories and examples of learning at Trust and Divisional Board meetings. Learning which occurs at divisional level but can be applied across the Trust is cascaded through the Trust's Patient Experience Group and is monitored by Divisional Boards. Individuals and teams who are involved in a complaint are asked to reflect honestly and objectively on complaints raised to improve their practice in the future and additional training and support is available from managers and supervisors to develop staff further.

Some examples of learning and service improvements which have occurred during 2011/2012 are:-

- Improvements to the Trust's website, ensuring that we provide clearer communication to patients about the services available at the Trust.
- Improvements in the administration and management of the Early Pregnancy Clinic at St Michael's Hospital, to reduce the waiting time for patients.
- Reducing the time taken to send clinic letters to GPs to 2 days for urgent cases and 5 days for all other correspondence at Bristol Haematology & Oncology Centre.
- Introducing Theatre Care Plans at St Michaels Hospital to ensure that staff record when analgesia is administered in recovery and their care is managed safely.

- Providing Care Direct details to relatives/next of kin when patients are discharged from the Bristol Royal Infirmary, if a package of care is not required or appropriate at that time. This ensures that if needs change quickly after discharge, prompt support can be obtained.
- Following up telephone referrals to District Nurses in writing, at least 48 hours prior to discharge, for patients at Bristol Royal Infirmary and ensuring we communicate this information to relatives/carers.
- Improving processes for the identification of carers upon admission and improving communication with them by Trust staff.
- Improving communication with GPs by ensuring that when patients are admitted to a ward their GP details are checked immediately. This also ensures that follow up care in the community is implemented promptly and addresses concerns raised about delays and the impact this has on patients
- Improving processes for the transmitting and tracking of prescriptions from Bristol Haematology & Oncology Centre to the Pharmacy Department in the Bristol Royal Infirmary, to reduce the waiting time for patients and administration errors identified through complaints.
- Delivering enhanced training and support to front line staff to improve the experience of elderly and frail patients particularly in the Bristol Royal Infirmary, based upon complaints received from elderly care areas.
- Improving patient menus, to ensure that the dietary needs of patients with specific requirements are appropriately met.

Understanding the impact which a poor experience has on someone is fundamental to putting things right when we get things wrong. To illustrate this and also share organisational learning, patient stories are presented to each Trust and Divisional Board meeting. Two examples of these, which are unpinned by our aspirations within the Trust Values, are:-

2.1. Working Together

Patient Z was an 11 year old boy who was admitted to the Bristol Royal Hospital for Children as an emergency patient. He was admitted to Ward 35 (Adolescent Ward) initially and his care needs at this time were of a high dependency level. His diagnosis revealed he needed to have surgery. Following surgery, he was admitted to the Paediatric Intensive Care Unit (PICU) and when his condition was stable he was transferred to Ward 31 (Surgical Ward). On Ward 35 Patient Z received 1:2 nursing care and on PICU Patient Z received 1:1 nursing care. This level was reduced to 1:4 nursing care when he was transferred to Ward 31 in line with his condition, which had stabilised.

Patient Z's mother wrote to the Trust to complain about her son's experience on Ward 31 and about poor nursing care, involving several issues that were below the normal standard expected.

Patient Z was also unable to sleep as staff appeared to do nothing about the noise created by other patients. Also nursing staff failed to deal with large numbers of visitors with a patient in the bed opposite and they were allowed to eat in front of Patient Z who was nil by mouth at the time.

Investigation

The investigation revealed several factors that contributed to the poor experience of Patient Z and his mother, which were:-

- Communication: Patient Z was extremely unwell prior to his surgery and immediately after surgery whilst on PICU. His nursing needs were such that he required a higher than normal nurse to patient ratio. On admission to Ward 31, it was not explained clearly to his mother that these ratios would be reduced as Patient Z was then stable and making a good recovery.
- Practice: The ward has an open visiting policy for family members during the day, although the staff actively encourage parents to restrict the number of visitors. Eating in front of other patients is not tolerated and in this instance staff failed to prevent this from occurring.
- Practice: The Children's Hospital had an issue with noise at night and this was not only applicable to this patient's experience.

Local Learning

- The ward has introduced a buddy system, where nursing staff identify a member of staff to hand over the patients to when at break, rather than handing the patient over to the nurse-in-charge. This practice has been adopted from another ward and has improved communication with patients and families, particularly during handover and at break times.
- There was inconsistency across the wards with numbers of visitors allowed per bed space. Ward 31 and Ward 32 (cardiac ward) are now working more closely to ensure consistent information is given to parents as both wards share the same parents' room. Communication has been improved between wards as a result of all in-patient wards now falling under the remit of one full time Matron, which also makes the learning from such incidents much easier to transpose across more than one area.
- Noise management on the ward has been addressed by (a) the purchase of silent bins; (b) changes to the lighting configuration, to enable nurses to turn lights off or dim them to night setting; (c) a Patient Experience Action Group has been introduced whose members consist of Head of Nursing, Matrons and the Youth Development Worker, to ensure patient feedback is listen to and addressed.
- Parental contracts have been introduced so that there is agreement about what care parents wish to be involved with and which aspects of care will be carried out by the nursing staff. This would have helped alleviate some of the concerns raised by Patient Z's mother and ensured there was clear dialogue with the family, allowing any concerns to be addressed as they occurred.

Organisational Learning

- Noise at night management remedies are being implemented across the Trust, to ensure that noise is reduced as far as possible and to improve the patient environment.
- This case has been discussed at the Patient Experience Group so that learning is taken back into each Division and implemented in other areas, where appropriate.

2.2. Respecting Everyone

Mr A came into the Emergency Department at Bristol Royal Infirmary following complications relating to surgery at another healthcare provider. Mr A needed a British Sign Language (BSL) interpreter as he was profoundly deaf. On admission his sister acted as his interpreter. She was happy in the short term to undertake this role, but it was not appropriate for her to carry on acting in this capacity due to the need for patient confidentiality.

Mr A explained that during his time in the Emergency Department, he had to use the toilet on several occasions and complained that they were not being kept clean. He also mentioned that the receptionist kept saying "I can't hear you" very loudly even though she knew he was deaf. He also stated he was very hot and he needed to go outside for some fresh air and that the security guard was also rude to him.

Mr A explained he had a five hour wait before being admitted to the Medical Assessment Unit at 2.50am and that the staff had been made aware he was deaf and that he would need an interpreter. He was seen by the surgical take team at 8.40am; however it had not been possible to arrange a BSL interpreter by that time.

Mr A recalled how he was then moved to a surgical ward later in the morning. Mr A felt staff had not been communicating well with him. There was also no sign above his bed indicating Mr A was deaf. Mr A explained that, as it was documented in his nursing notes that his sister was happy to interpret for him, the ward staff did not try and book an interpreter until 4 days after his original admission. A BSL interpreter was eventually booked; however the interpreter was not available for a further two days. Mr A said he was seen by a junior doctor whom he felt was embarrassed by his deafness and walked away from him, leaving him feeling 'stupid'. The following day, Mr A was seen by the consultant and his sister again made an exception to interpret for him as the BSL interpreter sourced was not available on this day. Mr A and his sister said they could not understand why an interpreter had not been found for him and were very disappointed with the hospital in this respect.

Six days after Mr A's admission, the interpreter arrived and he was seen by the consultant with an independent interpreter during the ward round. The interpreter was asked to attend the following day, but later confirmed to the ward that he was unable to return and the provider was unable to find another interpreter.

Investigation

The investigation revealed several factors that contributed to the poor experience of Mr A.

- There was an on-going problem in securing an interpreter from an external provider, however ward staff were unaware of the Trust's internal arrangements for obtaining BSL interpreters so did not access this.
- Communication: Staff in the Emergency Department, including reception staff, were not compassionate or helpful in respect of Mr A's needs.
- Communication: Staff on the surgical ward were said to be "grumpy" and a junior doctor seemed embarrassed by the fact that Mr A was deaf. This highlighted a training need in respect of how staff deal with patients who have a sensory impairment.

- Practice: There was no procedure in place for indicating to staff that a patient on their ward suffers a sensory impairment.

Local Learning

- Staff on the surgical ward have been spoken to at length about the lack of care and compassion received by Mr A and his family.
- Staff in the Emergency Department have also been spoken to about how their actions impacted on Mr A's admission.
- Housekeeping staff have been alerted to the shortfall in cleaning in the emergency department.
- Laminated signs explaining that a patient is deaf are now in place on the ward.
- Training was provided to staff about how to book British Sign Language interpreters.
- The case was discussed at a surgical Sisters' meeting to share learning across the division.

Organisational Learning

- This case has been discussed at the Patient Experience Group where there is representation from all divisions to share learning.
- A reminder has been sent out across the Trust of the arrangements in place for booking interpreters and a staff guidance sheet for supporting deaf patients has been reissued through the Patient Experience Group, for disseminating to Trust staff.
- We are currently identifying possible alternatives to our British Sign Language arrangements to increase the support available for deaf patients.
- Translating and Interpreting information on the website has been reviewed and updated.
- The Trust's Translating and Interpreting Policy is being reviewed and updated.
- This complaint has been added to the library of complaints used for staff training in *Living the Values* sessions being implemented across the Trust for all staff.

2.3. Recognising Success & Embracing Change

Usually we use patient stories which contain an example of a patient experience which was not of the standard we expect. The following is an example of a positive patient experience and learning which was shared from best practice.

Miss W wrote to the Chief Executive to share her very positive experience of her treatment at the Bristol Heart Institute. She stated that it has changed not only her life, but the lives of those around her. Miss W has Postural Orthostatic Tachycardia Syndrome (POTS), where her autonomic nervous system does not control her blood pressure or heart rate properly, causing multiple disabling symptoms related to reduced oxygen to her brain.

For most of the last six years, Miss W explained that her life has been extremely difficult. She identified that slurred speech, the inability to think, shaking, loss of co-ordination and altered levels of consciousness were all a normal part of her life. She was medically retired in 2010 at the age of just 28, on grounds of permanent ill health. Miss W reported that the effort

of eating a meal would knock her out for several hours and she was rarely able to hold even a short conversation sitting up. In Miss W's words, she was "surviving but not truly living".

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

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

Organisational Learning

- The importance of clear communication, access to advice and working in partnership with patients to enable them to manage their long term conditions can work extremely well.
- A team approach to patient care, both within the Trust and provision of expert advice to more general community services, has worked well in this particular situation. This example demonstrates the benefit for patients of having specialist expertise contained within a specialist centre but being able to link in with local service provision.
- The use of technology (e mails/blogs) and nurse specialists to provide advice and support patients need without them having to attend Outpatients is better for patients, as they do not need to travel and is more efficient for the Trust as it frees up appointments for others who need to be seen in person.

3. Complaints received in 2011/2012

The total number of complaints we received in 2011/2012 was 1465, averaging 122 per month. This equated to 0.25% of overall patient activity.
The total number of complaints received in 2010/2011 was 1532, averaging 128 per month, which equated to 0.28% of overall patient activity. In 2011/2012 therefore we have had a slight decrease in the total number of complaints received and also the number of complaints per patient attendance. This is attributable in part to a reduction in reported complaints in February and March 2012 due to a temporary reduction in service accessibility. A monthly comparison between complaints received in 2010/2011 and 2011/2012 is shown in Figure 1 below:

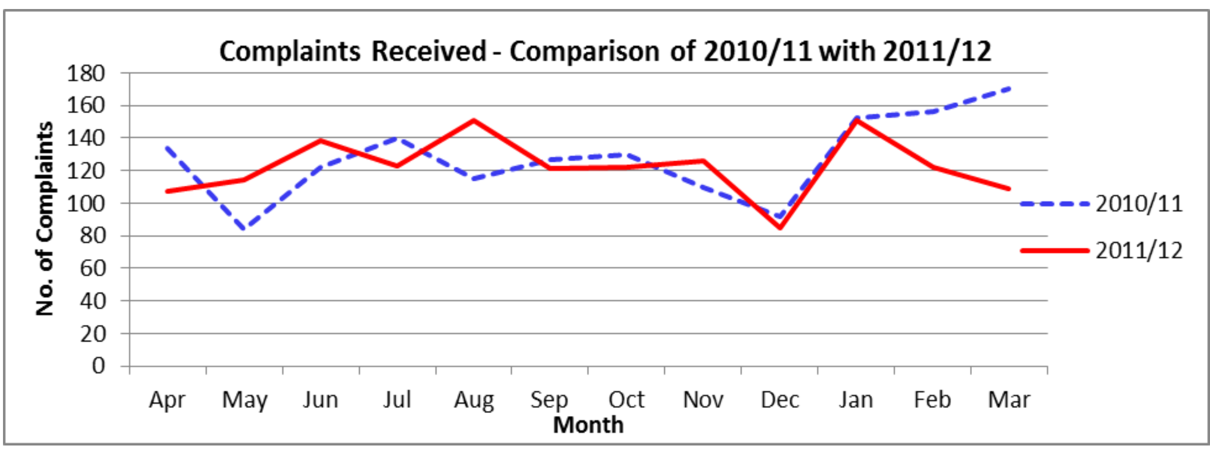

Figure 1 : Comparison of complaints received 2010/2011 and 2011/2012

The total number of complaints received in 2011/2012, broken down by complaint category, is shown below in Figure 2:-

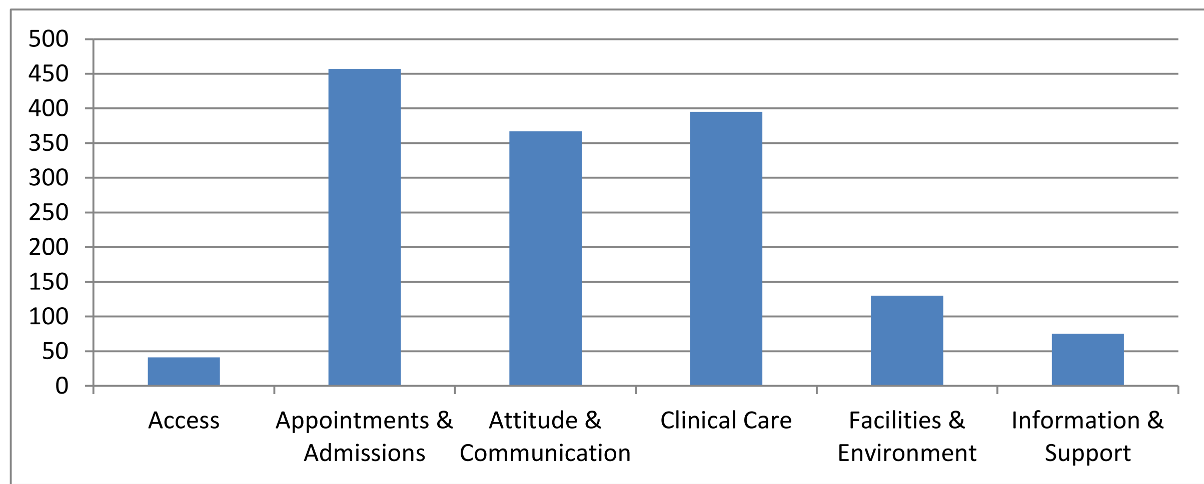

Figure 2 : Total number of complaints received 2011/2012 by complaint category

The highest number of complaints received in 2011/2012 relate to appointment and admission systems, which was the highest cause of complaints for the previous year as well. Bristol Eye Hospital and Bristol Royal Infirmary Trauma & Orthopaedic Department have the highest number of complaints in this category, but also see the highest volume of outpatients. Complaints relating to the cancellation or delay of outpatient appointments at Bristol Eye Hospital remained high at 77, but this has reduced from 97 complaints in 2010/2011. Bristol Royal Infirmary Trauma and Orthopaedic Department has the highest number of complaints regarding outpatient appointment delays or cancellations this year at 109, which is an increase from 85 in 2010/2011.

Complaints regarding the delay or cancellation of surgery continued to be highest in Urology, Lower and Upper GI services at the Bristol Royal Infirmary in 2011/2012. Complaints regarding Upper GI services remained the same as in 2010/2011 at 14 complaints. However complaints about Lower GI rose from 12 in 2010/2011 to 26 in 2011/2012 and in Urology from 23 in 2010/2011 to 49 in 2011/2012.

These issues have been raised with senior managers and are being addressed through the transforming care programmes currently underway at the Trust.

The second highest category of complaints received in 2011/12 relate to the clinical care provided to patients from medical staff. The highest number of complaints received in this category were about the A&E Department at the Bristol Royal Infirmary (27), which was also the department with the highest number of complaints in 2010/2011, but there has been a slight increase of 4 complaints in 2011/2012. However it should be noted the A&E Department do have the highest number of patient attendances in the Division of Medicine, and their ratio of complaints per patient attendance is much lower than other departments across the Trust. No specific trends or themes were identified when the data was analysed. The second highest number of complaints regarding clinical care were received about Trauma & Orthopaedic services who had 23 complaints, a rise from 12 complaints in 2010/2011. Urology services had the third highest number of complaints (14), a rise from 11 complaints in 2010/2011.

Where individual areas of concern have been identified, these have been raised with the staff involved. In 2012/2013 the Medical Director will also be receiving a monthly report of all complaints involving individual Consultant staff, so that any patterns of concern are identified and addressed promptly.

The third highest number of complaints relate to attitude of staff (across all staff groups) and poor communication with patients. Trauma and Orthopaedics at Bristol Royal Infirmary had the highest number of complaints at 19, which is a slight decrease from 21 in 2010/2011. Bristol Eye Hospital outpatients department had the second highest number of complaints at 18, which is the same number as in 2010/2011. The A&E department at the Bristol Royal Infirmary had the third highest number of complaints (16), a rise from 15 in 2010/2011.

Where individual issues of concern have been highlighted about attitude and communication, these have been raised with the appropriate staff and support and training has been identified to improve practice. The Trust has introduced *Living the Values training* which all staff across the Trust will attend during 2012. Actual complaints received by the Trust have been used in this training programme, to illustrate key themes raised by patients, their relatives and carers and the impact this has on their experience of attending the hospital.

Despite being a cause for concern for many visitors and patients, complaints regarding car parking and catering have continued to decrease during the last 12 months. This reflects the improvements which have been made to menu options for patients and better communication provided for patients and visitors for alternative options to parking on site.

4. Our Performance in 2011/2012

4.1. Number of complaints responded to within timescale – Acting fairly and proportionately

When we put things right we try to ensure that we provide prompt, appropriate and proportionate remedies. Response times proportionate to the complexity of the complaint are agreed with complainants before the investigation is started and we are transparent with people in acknowledging when things go wrong and how we will put them right.

We have set an internal target that 98% of all formal complaints received should be responded to within their originally agreed timescale. For the year as a whole, 91.1% of formal complaints were resolved within the timescale agreed with the complainant, which relates to 544 out of 597 complaints received. We recognise that there are improvements which still need to be made but are encouraged by our performance in the last few months of 2011/2012, which we will build upon going forward. Our central and divisional complaints teams improved the way in which they communicate and work together during 2011/2012 and will continue to work collaboratively to identify ways in which this target can be consistently achieved in 2012/2013.

Figure 3 below shows performance against this target on a monthly basis:-

Figure 3 : % of complaints responded to within originally agreed timescale – 2011/2012

4.2. Dissatisfied complainants – Getting it right

Our aim is for everyone who raises a complaint with us to be satisfied with the response we provide, although we recognise that this is sometimes difficult to achieve. In order to 'get it right' and monitor how we are doing, we set an internal target that no more than five complainants each month should be dissatisfied with the response to their complaint. Our performance for the year overall is shown in Figure 4 below. We recognise that we have not consistently achieved this performance target, although during the last six months we have split this target down further to identify whether people were dissatisfied because (a) their response did not address all their original concerns, or (b) whether the response has prompted further questions.
Since November 2011 we consistently achieved the target in relation to (a) and will reduce this performance target to nil for 2012/2013, to ensure our investigation processes and responses are of the highest quality. Training has been and will continue to be provided for senior staff to support them in achieving this target in 2012/2013.

Anyone who contacted us to say they were dissatisfied with the response to their complaint was offered the option of having their complaint reinvestigated. In the majority of cases a re-investigation was required because the complainant raised further questions after receiving our response to their complaint. Whenever appropriate we encourage face-to-face resolution meetings, particularly for more complex complaints or within a bereavement context, to enable further questions to be answered as they arise and for support to be put in place for the person who raised the complaint. These meetings have been supported and facilitated by

clinical/divisional leaders or Executives, demonstrating engagement in the complaints process at all levels across the Trust.

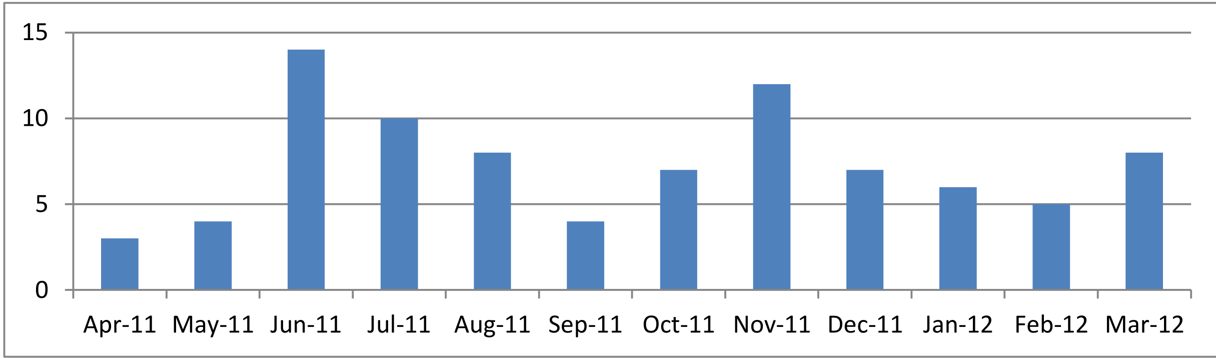

Figure 4 : Number of people dissatisfied with the response to their complaint during 2011/2012

On occasions, despite our best efforts, we are unable to completely resolve a complaint which is raised with us. When this occurs the complainant has the option of contacting the Parliamentary & Health Service Ombudsman (PHSO) for consideration for independent review. All complainants are advised of their right to approach the PHSO and are provided with their contact details when we respond to their complaint.

Some people will contact the PHSO directly without us being aware of this. Many complaints are turned down by the PHSO because their criteria has not been met or we have not yet investigated the complaint ourselves. When this occurs we are not informed about this. The PHSO publish their annual contact figures in October of each year and therefore we currently do have figures available for 2011/2012, although they will be published later in the year.

In January 2012 the PHSO visited us to share learning from the complaints they received regarding the treatment and care we provide. We also discussed the actions we are taking to resolve more complaints locally and ensure that we learn from the complaints raised with us. We were reassured that the PHSO raised no concerns about the way in which we manage complaints but recognise we can still make improvements to the service in the future.

5. Being Customer Focused

We want to make sure that our complaints processes are easily accessible for everyone.
Information is available in other formats and languages upon request and 1:1 support is available via the Patient Support & Complaints Team for anyone needing support to make a complaint. We also let all complainants know how they can contact the Independent Complaints Advocacy Service (ICAS) for independent help and support to make a complaint.

Despite this however, our results in the 2011 National Inpatient Survey found that relatively few people (41%) said they had seen leaflets or posters, explaining how to complain. We recognise that we need to address this issue and ensure that whenever someone is unhappy about their treatment or care, they know who to contact to resolve the problem. New posters have been designed to highlight different methods of feedback, including how to contact the Patient Support & Complaints Team. These posters are in the process of being rolled out across the Trust in circulation, ward and outpatient areas.
One of our objectives for 2012/13 is also to actively promote the services available to support patients to raise concerns, particularly with people from under-represented groups.

Every clinic and ward across the Trust now has comment cards available for patients to provide feedback about their experience. The primary function of the cards is real-time feedback, rather than as a performance measurement tool. By proactively encouraging patients to complete the cards and by regularly reviewing the feedback received, ward and clinical staff can identify "quick-wins" to improve the patient experience, share praise and actions taken and escalate any regularly occurring problems.

5.1. Complaints received by ethnic group of complainant

We have taken steps this year to improve our ethnicity recording, so that we can monitor our service for quality purposes more effectively, although we recognise that we still have work to do. We do not currently obtain ethnicity data in all cases if the complainant is a relative, carer, an MP, another NHS organisation or a member of staff from social services. We also have some complainants who contact us with limited information and then withdraw their complaint, so we are not able to record their ethnicity. This accounted for 407 people in 2011/2012. A further 326 people declined to provide their ethnicity for recording purposes. Figure 5 below shows the breakdown of complainants by ethnic group.

Ethnic Group	Total
African / British African	6
Any other Asian Background	5
Any other Black Background	3
Any other ethnic group	3
Any other mixed background	2
Any other white background	18
Bangladeshi / British Bangladeshi	1
Caribbean / British Caribbean	5
Chinese	1
Indian or British Indian	6
Not known	407
Pakistani / British Pakistani	4
White – British	662
White – Irish	9
White – Asian	1
White and Black Caribbean	6
Not stated / given	326

Figure 5: Breakdown of complainants by ethnic group

It is difficult to draw any analysis from these figures because of the large number of people who have either declined to provide their ethnicity, or because we did not obtain it, for the reasons stated above. We will continue to improve our recording of ethnicity data in 2012/2013, so that we can assure ourselves better that we are providing a customer focused service, which is accessible to everyone.

6. Information, Advice & Support

In addition to managing complaints, the Patient Support & Complaints Team also deal with information, advice and support requests, which were previously dealt with under the remit of the Patient Advice & Liaison Service (PALS), before the two departments merged in May 2010. The total number of enquiries received during 2011/2012 are shown below in Figure 6:-

Type of enquiry	Total Number
Request for information / advice	448
Request for support	90

Figure 6: Total number of enquiries (not complaints) dealt with in 2011/2012

People contact the team for information and advice about their treatment and care, services which the Trust provides, advice about benefits, or if they are seeking support and need signposting to other local or voluntary services. We also provide a point of contact for families who arrive in Bristol with a patient but do not live locally and require local orientation and assistance to find somewhere to stay.

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

Support is provided for patients at outpatient clinic appointments with clinical staff and patients transferring from paediatric to adult services. We also provide a liaison point and support for carers and patients who have additional support needs and complex health problems. We support and communicate with their healthcare teams and work towards both parties being able to work together in the future, without the need for additional support.

7. Training

We have undertaken training for all levels of staff across the organisation in 2011/2012, so that staff can feel confident in dealing with complaints directly and can help to resolve problems quickly for patients. Some examples of training undertaken this year are:-

- Responding to complaints for front line staff – Paediatric and Adult Emergency Department doctors.
- Complaints update training for supervisory and middle management staff – Trust wide
- Complaints update training for Consultant Medical staff – delivered via Consultant Away Days and using learning from complaints and PHSO investigation outcomes.
- Investigating and responding to written complaints - for senior management and senior nursing staff involved with formal complaint investigation. This has improved the quality of responses sent to patients and reduced the number of patients dissatisfied with their response.
- Ulysses training has been provided to all Divisional Co-ordinators, to enable complaints recording to be centralised and undertaken electronically. This enables our recording to be 'real time' and improves the efficiency and effectiveness of the complaints process.

We have also supported the Communications Team in producing *Living the Values* training, which is being rolled out across the Trust for all staff. Examples of patient stories and complaints have been used within the training, to enable staff to understand the impact behaviours and communication have on patient experience.

Training will remain a key objective for 2012/2013, with a particular focus on training for front line and administrative staff, to enable them to feel more confident in dealing with complaints themselves.

8. Key Objectives for 2012/2013

Objective	Action required	By whom	By when
Work collaboratively with divisional staff to ensure that by March 2013 no one is dissatisfied with the response to their complaint because it was not investigated correctly.	Face to face meetings to be offered routinely for complex complaints.	Central & divisional teams	September 2012
	Check written responses thoroughly before letters are sent for signing.	Central & divisional teams	On going
	Roll out training for senior managers and senior nursing staff regarding investigation and responding to written complaints on a quarterly basis.	Central team & divisional management teams	September 2012
Work collaboratively with divisional staff to ensure that 98% of complaints are responded to within originally agreed timescale by March 2013.	Meet with divisions to identify further opportunities for the central team to draft response letters for less complex complaints.	Patient Support & Complaints Manager / divisional teams	October 2012
	Set up quarterly review meetings with divisional complaints staff to discuss issues arising and how to improve processes.	Patient Support & Complaints Manager	October 2012
Provide training and support enabling staff to resolve complaints at local level. To also reduce the number of formal complaints received compared with 2011/2012	Pilot training programme (3 sessions, with 20 staff per session) for front line and administration staff.	Central team	November 2012
	Following evaluation of above, run monthly sessions for 20 staff per session.	Central team	March 2013
	Continue quarterly training programme for senior managers	Central team	October 2012

	and senior nursing staff regarding investigating and responding to written complaints.		
Ensure we have a system in place which maximises learning from complaints and learning from best practice	Cascade learning from complaints to wider trust staff through Connect, Newsbeat and Voices, as per incident processes. Develop processes for the risk assessment of complaints received. Work with the Patient Involvement Team to develop joint reporting and monitoring processes for patient feedback.	Central team Patient Support & Complaints Manager Patient Support & Complaints Manager	September 2012 October 2012 March 2013
Ensure that only the Ulysses database is used for the recording and reporting of all complaints data	Training for divisional and corporate teams in how to complete appropriate sections in Ulysses database.	As above	September 2012
Ensure that we capture complaints resolved locally in divisions	Meet with divisional complaints staff to agree process. Identify with divisions key staff who can be trained to input informal complaints onto Ulysses database. Revise and reissue informal complaints recording documentation.	As above Corporate & divisional teams Patient Support & Complaints Manager	October 2012 October 2012 November 2012
Ensure that everyone who wants to make a complaint is able to	Roll out new posters across UH Bristol precinct, outlining how to complain. Promote the service with under-represented groups, with support of Patient Involvement Project Lead.	Patient Involvement Project Lead Corporate team	August 2012 March 2013

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

Item 09 – Half-Year Update on Corporate Quality Objectives

Purpose

To report to the Board on half year progress towards achievement of the quality objectives set out in the 2011/12 Quality Report (Account).

Abstract

Of a total 21 indicators (covering 17 objectives), the year-end projection is that 12 will be achieved, with potential for the remaining 9 to also be achieved – the year-end projection for a number of these indicators will become clearer in Quarter 3. In terms of progress to date, three objectives are currently red-rated: pressure ulcers; number of complaints received; and time spent on stroke ward. Exception reports for each of these indicators have been received by the Board. It is encouraging to note that the latest Board quality report indicates a sharp fall in the number of complaints received by the Trust.

The year-end target for the South West Patient Quality and Safety Programme requires clarification as the projected target scale-point (3.5) does not correspond with the wording used in the Board Assurance Framework or the 2011/12 Quality Report. Patient Safety Group to discuss and advise.

Recommendations

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

Executive Report Sponsor or Other Author

Sponsor – Chief Nurse, Alison Moon

Author – Head of Quality (Patient Experience and Clinical Effectiveness)

Appendices

- Appendix A – Quarter 2 update on Corporate Quality Objectives

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	10 October 2012				Clinical Quality Group, 04 October 2012

Subject:	**Quarter 2 update on Corporate Quality Objectives**
Report to:	**Trust Board**
Author:	**Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)**
Date:	**18 October 2012**

Introduction

In May 2012, the Board approved the Trust's Quality Report for 2011/12, which included a number of specific quality objectives for 2012/13. These same objectives also form part of the Trust's Annual Plan.

Quarter 2 performance

The Trust's quality objectives for 2012/13 are summarised below with two RAG ratings: one indicating the amount of progress to date; the other indicating the current level of confidence of achieving the objective by the end of March 2013.

Patient Safety:		
We said we would:	**Progress to date**	**Confidence of achieving by year end**
1. Continue to participate in the NHS South West Quality and Patient Safety Improvement Programme. The commitment we made in our Quality Strategy 2011-2014 is that in 2012/13 we will achieve the spread of all key changes relating to the programme in one to three (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas.	Amber	Amber
Through participation in the programme, we will continue to see improvements in key areas including:		
○ Hospital Acquired Thrombosis (VTE)	Green	Amber
○ Medication errors	Green	Green
○ Patient falls	Amber	Green
○ Pressure ulcers	Red	Amber
2. Implement and develop local use of the NHS Patient Safety Thermometer (the Thermometer records data about patient falls, pressure ulcers, hospital acquired thrombosis and catheters with Urinary Tract Infections, as well as other data determined by the Trust), focusing on the core elements, contributing to national benchmarking and learning from best practice.	Green	Green
3. Continue to embed high quality nutritional care across the Trust as part of the follow up to Care Quality Commission inspections in 2011.	Amber	Green

4. Implement a proactive clinical audit programme for histopathology, building upon learning from the Independent Inquiry into the Trust's histopathology services	Green	Green
5. Seek reductions in recorded complications, misadventure and readmissions rates for gynaecological surgery	Amber	Amber

Patient Experience		
We said we would:	**Progress to date**	**Confidence of achieving by year end**
6. Implement the first year of our Patient Experience and Involvement Strategy for 2012-2015. As part of our work plan, this year we will focus on improving the experience of care amongst the following groups in particular: - Children - Frail elderly patients, including patients with dementia and those in end of life care - Patients with Learning Disabilities - Carers - Emergency patients	Amber	Green
7. Reduce patient-reported noise at night	Amber	Amber
8. Ensure patients are treated with kindness and understanding	Green	Green
9. Improve communication with patients: in particular about waiting times in clinic and making sure patients know who to speak to if they have worries or concerns.	Amber	Amber
10. Reduce numbers of reported complaints; and where people do complain, we will provide a full response as quickly as possible	Red	Amber
11. Improve the experience of our staff by reducing the incidence of discrimination at work both from patients / service users and from managers / team leaders / colleagues.	Green	Amber[1]

Clinical Effectiveness/Outcomes		
We said we would:	**Progress to date**	**Confidence of achieving by year end**
12. Ensure that at least 90% of patients are treated for at least 90% of the time on a dedicated stroke ward.	Red	Amber
13. Develop our use of service-specific standardised mortality ratios to monitor clinical outcomes.	Green	Green
14. Ensure that patients with an identified special need, including those with a Learning Disability have a risk assessment and patient-centred care plan in place.	Green	Green
15. Develop the use of enhanced recovery for all surgical areas.	Amber	Green
16. Re-focus on ensuring compliance with published NICE guidance including targeted use of clinical audit.	Amber	Green
17. Continue to implement our Dementia action plan.	Green	Green

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

[1] Amber rated as a key measure of success will be the relevant score in the 2012 National Staff Survey, results of which are reported relative to the performance of other NHS Trusts (which is an unknown variable)

Patient Safety

The Trust is currently on target to achieve **some** of the agreed patient safety objectives for 2012/13.

1. South West Patient Safety and Quality Improvement Programme

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

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

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

The overall score of the programme has moved from 1.5 out of a possible 5 in April 2012 to 2.5 in August 2012. This reflects sustained improvements seen in all work streams although it is clear that within the General Ward and Medicines Management work streams some measures are still only being tested rather than fully implemented.

HSMR – 15% reduction in mortality as measured by HSMR compared with baseline measurement from October 2009.
The 15% reduction target equates to an HSMR of 73.81 by 2014. HSMR is at 74.7 as of June 2012 (latest available data): the Trust remained at target for seven months prior to June and the slight increase for the month of June exhibits the normal statistical variation expected month-on-month with HSMR.

Adverse Event Rate – 30% reduction in adverse events compared with baseline measurement from October 2009.
Monthly audits using the Global Trigger Tool continue. The 30% reduction target equates to an adverse event rate of 31.74 per 1,000 bed days by 2014. The 12 month period August 2011 to July 2012 – when we have had consistency of staff involved in review of case notes to detect adverse events – is showing that we are close to achieving the target with an average adverse event rate of 34.3 per 1,000 bed days. However there is wide variation month on month (0-80). In the first six months of the period (August 2011 to January 2012) the average adverse event rate was 22.5, whereas in the second six months (February to July 2012) it was 46.1. Given that this is a five year target and there has been significant month on month variation in the past 12 months, further data is required before we can be clear if we are having more adverse events: there is a possibility that we are getting better at detecting them. This measure will need close monitoring and triangulation with other data sources

Leadership Work stream – Current individual score 5.0 (highest achievable score)
Data is being collected for all measures and sustained improvement has now been achieved for six consecutive months for the Executive Walk Round Measures.
Already exceeding a score of 3.5 = High confidence

General Ward Work stream – Current individual score 1.5
Data is being collected for all measures (26) with the exception of two. Two meetings chaired by the new lead for the adult part of this work stream have taken place in the last quarter. Representation from all Divisions and relevant specialist services within the Trust has been achieved. The work stream has RAG-rated all its measures in order to focus work on areas currently not collecting data or under achieving. During the next quarter, the work stream will focus on these measures and have access to a dashboard which clearly outlines any achievements. Other work taking place within the Trust aims to streamline the data collected at ward level and ensure all key measures for projects are met. This should help the work stream with its collection of data and see some progress in achieving the target of 3.5 by end of March 2012.
Confidence in achievement of a score of 3.5 by March 2013 = Moderate

Peri-Operative Work stream– Current individual score 5.0 (highest achievable score)
Data is being collected for all measures and achievement has been sustained for over six months. The Group is focusing on further improvement in peri-operative blood glucose control in known diabetics by implementing a new diabetes guideline, and is continuing to work on the surgical site infection bundle, in particular avoidance of peri-operative hypothermia. In addition, the team is also focussing on prevention of pressure ulcers during surgery/anaesthesia which, whilst not directly impacting on peri-operative measures, does impact on the measures for the general ward work stream. Also we have identified a need to focus on the quality of the WHO surgical safety checklist.
Already exceeding a score of 3.5 = High confidence

Critical Care Work stream- Current individual score 2.5
Current data is being collected for all measures and 17 out of 22 are showing sustained improvement for three or more months. Further streamlining of the electronic data collection system continues and the work stream continues to monitor the data currently not showing improvement. The work stream is focused on improving VTE risk assessment and thrombo-prophylaxis compliance, improving peripheral vascular catheter care and reducing infection related events through an infection control programme. This includes the recent acquisition of a light box for staff to check the thoroughness of hand washing.
Confidence in achieving a score of 3.5 by March 2013 = High Confidence

Medicines Management Work stream – Current individual score 2.5
Data is being collected for all four measures with the exception of one and this is optional. Work continues with the reconciliation of medicines on admission and is currently being carried out in three areas of the hospital and work continues to engage medical staff to enable this to be spread to wards 51, 52 and 53. This data also now feeds into a CQUIN for 2012/13, the target for which is for 95% of patients to have their medicines reconciled on admission.

The figures for high INRs[2] above 6 have been revised since July 2011 as there were issued identified with the base data from the anticoagulation laboratory. This has now been resolved and all data corrected. Pharmacy staff are following up inpatient high INRs to try and determine the causes of the high. A significant proportion of the high INRs reported are of community / pre-admission cause.
Confidence in achieving a score of 3.5 by March 2013 = Moderate

[2] INR – International Normalised Ratio – a measure used to determine the clotting tendency of blood

Through participation in the programme, we will continue to see improvements in key areas including:

Hospital acquired thrombosis (VTE)

There are two CQUIN targets for 2012/13:

1. 90% of patients will receive a VTE risk assessment. Performance in Q2 to date (as reported to the Trust Board in September 2012) is 95.1%.

2. 90% of patients will receive appropriate thrombo-prophylaxis. Performance in Q2 to date (as reported to the Trust Board in September 2012) is 98.4%.

It was planned that recording of the VTE risk assessment would be implemented in Medway by the end of Q2, however this has now been further delayed until early November. In addition we are investigating capturing and recording of appropriate thrombo-prophylaxis data through electronic means as part of monthly quality audits in clinical areas. Both of these actions will allowed the VTE Project Nurse to focus on working with front line staff on prevention of hospital acquired VTE, though training and education on the elements of best practice criteria e.g. ensuring doses of prescribed appropriate thrombo-prophylaxis are not non-purposefully omitted. The VTE project Nurse will also focus on ensuring that all hospital acquired VTE's were analysed and themes captured for sharing learning. However there will be a vacancy in the VTE Project Nurse post from October 2012, although there will be very limited bank cover. There is a risk that VTE performance could go off in Q3.

Medication errors

The proportion of high risk medication errors since the April 2012 peak of 3.75% has remained consistently below the 2011/12 threshold of 2.84%. Reporting of medication incidents including those involving missed doses missed doses will continue to be encouraged and learning from these has been shared via two Medicines Safety Bulletins.

The two CQUIN targets to reduce medication errors for 2012/13 are as follows:

- *To reduce the proportion of non-purposeful missed/omitted doses of an agreed list of critical medication.* Data has been collected and it has been agreed with the commissioners that the baseline period is Q2, therefore the threshold is to be confirmed in October 2012.
- *The percentage of patients with medication reconciliation documented as performed within one working day of admission to agreed wards.* Data has been collected and it has been agreed with the commissioners that the baseline period is Q2, therefore the threshold and agreed wards are to be confirmed in October 2012. The target is to be split into two elements, these being maintaining performance on admissions wards and spread to other specified wards. Medicines reconciliation ('getting the medicines right on admission') forms part of the medicines management workstream of the South West Quality and Patient Safety Improvement Programme.

Inpatient falls

Falls incidence per 1,000 bed days was 6.33 in August 2012, which is above (i.e. worse than) the green threshold of 5.6 (NPSA benchmark). The Falls Group is now re-invigorated and focusing on actions to reduce harm caused by patients falling. There is no falls CQUIN for 2012/13, however robust data monitoring and review of falls high risk incident investigations will support risk reduction measures.

Actions to be taken to reduce the incidence of Falls:

- 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.
- A presentation of this work was given at the September Falls Group. Focussing on high risk areas in Medicine, Surgery Head and Neck and Specialised Services, the clinical falls leads will be working closely with three 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 three months with a full report available in January 13

Pressure ulcer prevention and management

The rate of hospital acquired pressure ulcers grade 2 and above in August 2012 was 1.71 per 1,000 bed days. This remains well above (i.e. worse than) the benchmark figure of 0.651. The reporting of pressure ulcers has now changed from numbers per 10,000 bed days to 1,000 bed days. The change was one of the recommendations from an external Pressure Ulcer review undertaken in August 2012 and was approved at Clinical Quality Group. The majority of Trusts report in this way and this will allow for better benchmarking.

Actions being taken to reduce the number of hospital acquired pressure ulcers include:

- 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 4th October 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 is underway and will be completed by 8th October 2012.
- 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 the Trust'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. We are on target for all nurses and healthcare assistants 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 Tissue Viability Steering Group and appropriate actions taken.
- Where pressure sore quality indicators are not achieved, divisions are required to complete and submit detailed recovery plans to Trust Board Quarterly Reviews. The plans are monitored at a monthly performance meeting attended by either the Chief Nurse or the Deputy Chief Nurse. 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 is taken with individual staff where preventative measures could and should have been put in place.

2. NHS Patient Safety Thermometer

The NHS Safety Thermometer has been implemented. The thermometer measures four types of harm - pressure ulcers, falls, urinary tract infections and venous-thromboembolism - by auditing all eligible patients on a specified day each month. Since July 2012, we have audited 100% of eligible patients, against a CQUIN target of 25% in Q2, 75% in Q3 and 100% in Q4.

In August 2012, 91.5% of patients audited were receiving harm-free care; that is they did not have any of the four harms measured by the safety thermometer, either existing or upon admission (old harm) or since (new harm). 96.9% of patients had no new harms; that is, none of the four types of harm had been acquired since admission.

3. Continue to embed high quality nutritional care

The sustainability plan for improving nutritional care is reviewed monthly by the nutrition steering group. Regular audits continue to take place to review our compliance against key indices of good nutritional care across the Trust.

- Nutrition audits have demonstrated that for Q2, nutritional screening on admission has averaged 90%. This figure has been stable throughout the quarter (range 88%-92%).
- Audits have demonstrated that the use of the cutlery sign during Q2 has shown improvement from 79% at the end of the last quarter to 85% at the end of quarter 2 (range 83%-90%). However this still requires further awareness to be confidently sustained at above 90%.
- Compliance with protected mealtimes was repeatedly above 95% for adults at the beginning of the quarter. However, over the past month we have seen four wards fail their protected mealtimes target, which has brought our overall compliance for protected mealtimes down to 94%, just short of the 95% target.
- Children's wards continue to achieve 100% for protected mealtimes on each round of audits.
- Until now, we have presented a short ten minute update at the monthly doctors' induction to raise the profile amongst doctors of the importance of adhering to the principles of protected mealtimes. From September 2012 onwards, this session has been removed from the doctors' induction, leading to a risk of not meeting our 95% CQUIN/CQC target for protected mealtimes. In the last round of audits where four wards failed to adhere to the principles of protected mealtimes, three occurrences were due to doctors seeing patients over mealtimes. The Deputy Chief Nurse will therefore be asking for this decision to be reviewed.
- The use of STAMP nutritional screening for children who are identified as eligible to be screened using this tool, was 100% at the last round of audits for Quarter 2. Monitoring of the completion of STAMP is in the process of changing to Pinet charts and quarter average figures are as yet not available.
- Completion of nutritional care plans was highlighted by the CQC during an inspection in December 2011. Throughout Q2 we have continued to monitor the use of nutrition care plans. Completion of the 72 hour review – a key outstanding issue and one highlighted again by the CQC during their Main Site inspection – has averaged 60% during Q2 (range 54%-66%). Action has been taken to improve this with the introduction of an improved design of food chart, due for launch October 2012, and the introduction of 'micro teaches' to explain the importance of the 72 hour review at ward level (launched 17th September 2012). Thus further improvement should be expected throughout Q3.

- Nutritional care audits will continue on a fortnightly basis to highlight areas where continued improvements are required. Verbal feedback following each audit is an essential aspect of the audit's success as it allows for improvements to be made straight away. Easy to read written reports are also provided for each ward.
- This quarter we have launched the *Nutrition Bites* newsletter: this communicates to staff in a single A4 page key messages about how nutritional care is progressing across the Trust. It also identifies our current progress towards meeting nutrition targets. The newsletter is sent to ward managers and is also circulated with Newsbeat.

On 21st June 2012 the CQC conducted an unannounced inspection of the Main Site which included a further review of Outcome 5. The report from this inspection found us to be compliant with Outcome 5, but noted, as we had ourselves identified, the need to continue to make improvements with 72 hour review of food charts.

4. Implement proactive clinical audit programme for 2012/13 in Histopathology

A programme of clinical audit activity to be undertaken within the current financial year has been agreed by the Histopathology department. Further details of these projects are outlined below.

Title	Sub-Specialty	Lead	Current Status
Audit of supplementary reports issued after multi-disciplinary team meetings to identify discrepancies across all cancer specialties in UH Bristol	All specialties	Joya Pawade	Complete
Correlation of breast tumour grading between core biopsies and resection specimens in a screened population	Breast	Muhammed Sohail	Complete
Audit of The Reporting of Cutaneous Malignant Melanoma at UH Bristol	Dermatopathology	Nidhi Bhatt	Complete
Audit of turnaround time for skin cancers - September 2011 - 2012	Dermatopathology	Nidhi Bhatt	Planning
Reporting of high grade endometrial cancer	Gynaecology	Joya Pawade	In progress
Reporting of vulval carcinomas	Gynaecology	Joya Pawade	In progress
Appropriate indeterminate classification of Inflammatory Bowel Disease	Paediatric	Pramila Ramani	Planning
Audit of microbiology sampling in stillbirth post mortems	Perinatal	Craig Charles Platt	In progress
Quality of perinatal autopsy in South-West of England	Perinatal	Corina Moldovan	In progress
Histological reporting of lung specimen	Pulmonary pathology	Joya Pawade	Complete

Audit on double- reporting of lung pathology cases is in progress	Pulmonary pathology	Golda Shelley-Fraser/Nidhi Bhatt	In progress
Bowel Cancer Screening Program-detected colorectal cancer resection specimens: a comparison of reporting between three Trusts	Upper GI	Newton Wong	In progress
Renal tumour reporting	Uropathology	Muhammed Sohail	Complete

Halfway through the financial year, 11/13 (86%) of projects are therefore in progress or have been completed (which is significantly in advance of the progress we would usually expect to see in an annual audit programme at the mid-year point). Progress against this activity (along with any other histopathology projects initiated within the year) will be monitored by the Trust Clinical Audit Group (CAG) on a quarterly basis. CAG will also review the outcomes and actions from projects as and when they are completed.

5. **Reduce complication, misadventure and readmission rates in gynaecological surgery**

The Q1 update provided assurances that complication and misadventure rates following gynaecological surgery had improved so that the Trust's performance was close to its peers. Readmissions with 28 days of discharge had however increased from to 10.2% for the year 2011/12, which is significantly worse than peer data. Clinical coding continues to be investigated by the division: it appears that some review patients may be returning to the ward and being admitted instead of being recorded as outpatients, thereby skewing the readmission rate. Gynaecology crude mortality data for the period March 2011 – February 2012 also shows the Trust as an outlier compared to peer data: as a first step, coding is being reviewed to exclude the possibility of miscoding of palliative care cases. The Trust's Quality Intelligence Group (QIG) is monitoring the position and receiving regular reports from CHKS. A comprehensive update covering these various aspects of gynaecological surgery data is due to be received by QIG in January 2013.

Patient Experience

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

6. Implement the first year of our Patient Experience and Involvement Strategy for 2012-2015

A review of progress against specific commitments made in the action plan of the Patient Experience and Involvement Strategy is currently being prepared for reporting to Patient Experience Group on 18th October. As part of this action plan, the Trust has committed in 2012/13 to improving the experience of certain identified groups of service users:

Improving the experience of care amongst children

Emergency Department, BRHC

The Young Person's Involvement Worker has supported the department in developing a strategy for listening to the views of children and parents. New individualised comment cards have been introduced which are child-friendly. The team will also be using the National Paediatric Tool to follow up on issues raised through the comments received.

Patient and Public Involvement in service redesign

Due to changes taking place in the Children's Hospital reception, a short project has been undertaken to find out what sort of reception desk is welcoming for children and young people and to establish a preference for the type of artwork that could be placed on a new wall. Patients and siblings were shown examples from other hospitals and asked to express a preference. The report has been forwarded to the relevant project team for them to include in the eventual design of the revised area.

Partnership working with the local community

The Young Person's Involvement Worker has been supporting Jessie May Trust to look at ways of gaining the views of the children and young people they work with as well as the families. This includes patients with significant complex needs. We have been looking at using the National Paediatric Toolkit as well as more simple ways such as using face images to understand whether the patient is enjoying an activity or not.

Involving carers

The Carers Reference Group, consisting of different kinds of carers (including carers of patients with Dementia) has been running successfully since March 2011, and continues to meet. This autumn, the group will be meeting to discuss visiting hours, pressure sores and the new Learning Disabilities passport. In addition, activity continues to deliver the following objectives this year:

- A new 10 point carer questionnaire is being launched this autumn administered by the Community Occupational Therapy team
- A new caseworker has been recruited who will work with carers of patients with Dementia and support them throughout their hospital journey
- The case worker is launching the Carers Badge Scheme on Care of the Elderly wards - this promotes conversation, identification and involvement of carers
- A carer training component has been written on the E-learning platform and the Dementia *An hour to remember* training: a component will also be written for the level 2 and 3 Learning Disabilities training modules
- Carer questions have been added to admission documentation and work will continue with the Emergency Department in promoting the Bristol Carers Emergency Card
- A meeting has been held with Young Carers to gather the group's views on how best to support young carers in the Trust; this will help to inform a project for later in 2013

In addition, this year we will:

- distribute the carer booklet for carers throughout the Trust - this is finalised and awaiting print
- publish and display the Carer's Charter with carers information boards placed around the Trust
- continue to develop specific support and guidance for staff careers
- continue training and supporting staff to be 'carer aware' and to identify carers at information stands around the trust.

Improving the experience of care amongst patients with learning disabilities

The Learning Disabilities Steering Group is committed to ensuring the Trust improves the experience of care amongst patients with learning disabilities and, in doing so, meets its obligations to patients with a learning disability within the current legislative framework, with regard to the Equality Act (2010) and the Mental Capacity Act (2005). For 2012-15, the group has made the commitments listed in Appendix A: in the second quarter of 2012/13 the Group will be refining the specific objectives of its work.

Improving the experience of care amongst patients attending the adult Emergency Department
Activity continues across all areas of Patient Experience in the Department.

Monthly surveys
Provisional data from the National Accident and Emergency patient survey shows is promising, suggesting improvements in scores including cleanliness and communication. The final/official report is anticipated from the Picker Institute in December or January. This will precipitate the inclusion of two performance related questions in the Trust's core feedback survey. The questions will refer to patient experience objectives that are relevant to our Emergency Department service. The objectives will form part of the Division's patient experience plan. In addition, the Emergency Department has begun to develop qualitative patient engagement methods.

Comments boxes for patients
Comments boxes for patient feedback are located in the waiting room end of ED with further boxes in the Major end due to be installed in September 2012. Completed comments cards are owned by the Emergency Department team and are shared with the team. Plans to involve volunteers to help administer the process at the Major end will be considered in September 2012.

Waiting room interviews
A pilot face-to-face Interview process with Emergency Department patients has taken place. The outcomes of the process will inform the further use of such feedback mechanisms with patients.

Bristol and South Gloucestershire Local Involvement Network
Bristol and South Gloucestershire LINk will be undertaking an "enter and view" visit to coincide with the opening of the new Emergency Department accommodation in autumn 2012.

Health and Social Care Overview and Scrutiny Commission (OSC)
Bristol OSC visited the Emergency Department in September 2012 as part of their 2012/13 work plan. Feedback was very positive.

Medicine for Members
A 'Medicine for Members' Foundation Trust event is planned for October 2012.

Focus groups
Focus groups with Emergency Patients will be considered for trial in Q3 – these would expand on themes arising from survey results.

Improving the experience of care amongst frail elderly patients including Dementia and those in end of life care
The trust continues to drive improvements in the care of older people with dementia through the implementation of the eight Southwest Dementia Standards. Standard 6 "Promoting the Contribution of Volunteers" is a focus for 2012/13 and the Trust is establishing a Befriending Scheme which will work with volunteers to offer activities and companionship to frail older adult inpatients and frail older adults with a dementia. The scheme will be launched in October 2012, when the appointed project lead commences in post. A pilot will be undertaken on one care of the elderly ward and one trauma and orthopaedic ward. The pilot will be vigorously evaluated prior to trust wide launch. Also see objective 17.

7. Reduce patient-reported noise at night

Data for July 2012 scores the Trust at 82 points, currently short of the Trust's Q3 CQUIN target (84-86 points). 'SoundEar' monitoring devices have been trialled on a number of wards. The Patient Experience Group has determined that a trust-wide purchase of these devices is not justified, however a small number of additional monitors will be purchased to enable bed-holding divisions to rotate their use. As an alternative use of CQUIN funding associated with this target, Divisions have been asked to calculate the costs of purchasing soft-closing bins (bins being a known cause of patient-reported dissatisfaction with noise at night).

8. Ensure patients are treated with kindness and understanding

The Trust wide bi-monthly 'Deep Dive' surveys continue to offer a snap shot of inpatients' perspectives of being treated with kindness and understanding. The outcomes of these interviews are shared with ward sisters and other staff for local action. In addition, specific workshops with Maternity Services staff have explored the importance of staff behaviours and attitudes on the ward. A question about kindness and understanding is a recent addition to the Trust's core inpatient survey: the patient-reported score for June and July was 85, which is equal to the Q3 CQUIN target.

9. Improve communication with patients: in particular about waiting times in clinic and making sure patients know who to speak to if they have worries or concerns

Status boards are being implemented in each outpatient clinic. These will have a colour coded display to show how delayed the clinic is. An electronic solution is being investigated for the Dental and Eye Hospitals. 'Finding staff to talk to' is included in the Patient Experience Action Plans for Specialised Services and Women's & Children's Services. Confirmed Q1 data shows positive scores for Women's & Children's Services (measured across postnatal wards, Ward 78 and BRHC) and disappointing performance in Specialised Services (score of 72 points against Q1 target of 82). The Divisions will continue to disseminate messages about the importance of a continued focus on this aspect of patient care.

10. Reduce numbers of reported complaints; and where people do complain, we will provide a full response as quickly as possible

The number of complaints received in the Trust during June, July and August 2012 was 148, 170 and 158 respectively. The number of complaints received has remained high for this time of year, although there has been a reduction from the 195 complaints received in May. Performance however started to improve in August and the number of complaints received for that month was consistent with number received in August 2011. This indicates that the measures put in place to address high staffing absence levels and the problems caused by the Medway implementation are starting to have an effect and reduce the number of complaints being raised.

The number of complaints received about the Surgery, Head and Neck Division increased from 79 in June to 93 in July, but reduced to 71 in August. In August 2012, the Division of Surgery Head and Neck recorded the only decrease in the number of complaints received across all Divisions. The highest number of complaints received for Surgery, Head and Neck continues to be the delay or cancellation of appointments at Bristol Eye Hospital and failure to answer telephones. 18 complaints were received in June, rising to 24 in July, although this fell to 12 in August, which again reflects the improvements which are taking place to address the impact of lack of staff and Medway

implementation. The second highest number of complaints relates to delays and cancellations within the Trauma and Orthopaedic Department at Bristol Royal Infirmary. 16 complaints were received in June, rising to 17 in July, although again there was a fall to 9 in August. There was a large increase in the number of complaints regarding cancelled or delayed surgery in Lower GI from 2 in June to 11 in July. This remained high in August but the number of complaints fell slightly to 9.

Complaints regarding delayed appointments at the ENT Department reduced significantly from 12 in June to 4 in July and remained low for August, reflecting the improvements which are being introduced by the department to address staffing issues.

There were no other specific trends or concerns raised regarding other Divisions.

The impact of staffing issues on patients' experiences in relation to appointments has been exacerbated by Medway implementation, although as stated these issues are being addressed and this is reflected in the reduction in the number of complaints which are being raised. We have identified some issues with operational processes that work with the new Medway system which is causing some administrative backlogs and delays in patient appointments.

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 and Orthopaedics

As suggested in the last report, our performance against the target of responding to 98% of complaints within agreed timescale reduced in May, June, July and August due to the large volume of complaints received and staff sickness. Performance against the target was 94.5%, 94.7%, 94.2% and 94.8% respectively. The Patient Support & Complaints Team and Divisions are however continuing to focus on ensuring responses are provided on time. Performance is expected to improve from October 2012.

Performance against our aspirational target for 2012/2013 that there will be no dissatisfied complainants due to the quality of the response provided has fluctuated. 3 complainants were dissatisfied with their response in May, which was an increase from 2 in April. This rose to 4 in June but fell to nil in July. In August we saw an increase to 3. Training on writing quality responses will continue to be rolled out by the corporate team to Divisional key staff during 2012/2013 to improve performance. Training and support is also being provided through a one hour session on the Supervisory Sisters Programmes being run in October 2012. Quarterly meetings with complaints leads in all Divisions will also commence in October, to focus on on-going issues regarding performance and to ensure that appropriate support is provided by the corporate team to ensure that performance improves.

11. Improve the experience of our staff by reducing the incidence of discrimination

In response to Key Finding 38 in the 2011 Staff Attitude Survey (% of staff experiencing discrimination at work in the last 12 months), the following actions are have been agreed and were reported to the Trust Board in May 2012:

- Training in Trust values for all staff, continuing Equality and Diversity training (both E&D training for managers and 'Respecting Everyone' training), use of clear signage to communicate to patients and visitors the expectation to treat staff appropriately and with respect and through strengthened processes, procedures and policy to tackle harassment and bullying in the workplace.
- Local Security Management Specialist has a slot on Induction at which he advises people of sources of support and reminds all new staff of the importance of reporting all incidents of verbal and physical aggression, including racist abuse.
- The Violence & Aggression policy is being revised and simplified to ensure it follows NHS Protect guidance
- A further staff survey is being distributed to staff in UH Bristol during September 2012.

As part of the review and strengthening of the Tackling Harassment & Bullying at Work policy, an assessment tool is being developed for team and self-assessment to understand any issues in more depth in areas where potential problems have been identified.

The Trust's training needs analysis is being strengthened to satisfy NHSLA requirements for Harassment & Bullying training. All new staff receive Harassment & Bullying training at corporate induction.

To date, 1,445 staff have attended *Living the Values* training, including bank and volunteer staff: further sessions are currently booked through until the end of the year.

The Trust Board has supported the principle of more frequent local 'deep dive' staff surveys. A survey exploring the theme of discrimination and harassment/bullying is planned for 2013.

Clinical Effectiveness/Outcomes

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

12. Improve stroke care

The Trust's key stroke target is for at least 90% of patients to be treated for at least 90% of the time on a dedicated stroke ward. The latest data reported to the Board for July shows performance of 73.01% with aggregated performance for the year to-date of 69.4%. Ongoing challenges relate to the need to protect stroke unit beds for stroke admissions. The Trust has struggled with achieving both the 80% national target and implicitly therefore also the 90% local target throughout 2012. The Trust's ability to achieve these targets is closely related to the four hour access target, and the challenge of ensuring that stroke patients are admitted directly to the acute stroke unit. A standard operating procedure has been developed (yet to be ratified by the Board) with the intention of holding a protected stroke bed on ward 12.

13. Develop use of service-specific standardised mortality ratios

As of October 2012, Divisional SHMI (Summary Hospital-level Mortality Indicator) data reported as part of Divisional quality dashboards has been temporarily withdrawn pending further discussion with the Medical Director. In particular, the effect upon the data of case mix needs to be more clearly understood.

14. Ensure patients with an identified special need, including those with a Learning Disability have a risk assessment and patient-centred care plan in place

Problems with data recording via the Quality in Care tool were resolved in Q2, so that data is once again available pertaining to the risk assessment of patients with a known learning disability within 48 hours of admission. Q2 performance (to the end of July 2012) was 86.8% against a target of 85%, although aggregated year-to-date performance is below target at 80.5%.

The Trust's commitments to improving the experience of care amongst patients with learning disabilities are outlined in an appendix to this paper. Also see objective 6.

15. Develop the use of enhanced recovery for all surgical areas

Enhanced Recovery has four founding principles:

1. All patients should be on a pathway to enhance their recovery. This enables patients to recover from surgery, treatment, illness and leave hospital sooner by minimising the physical and psychological stress responses.
2. Patient preparation ensures the patient is in the best possible condition, identifies the risk and commences rehabilitation prior to admission or as soon as possible.
3. Pro-active patient management components of enhanced recovery are embedded across the entire pathway; pre, during and after operation/treatment.
4. Patients have an active role and take responsibility for enhancing their recovery

The overall aim is to improve patients' experience and outcomes by ensuring that patients are in optimal condition for their operation, anaesthesia and postoperative rehabilitation by implementing the Enhanced Recovery programme principles. The objectives of the programme are: no increase on current levels of re-admissions by speciality; reducing length of stay; improving patient experience by education and managing expectations.

The implementation of Enhanced Recovery is closely monitored by the Transformation Board.

Speciality	'Go Live' recruiting patients	Comments
Gynaecology	March 2012	65 Gynae Oncology patients successfully through to date. Of these 65 patients, those who needed a laparoscopic procedure had their length of stay reduced from 4.6 to 2 days
Thoracic	June 2010	Embedded and sustained
Colorectal	August 2012	Restart from pilot in 2010
Oesophagectomy	August 2012	
Vascular	September 2012	
Cardiac	October 2012	Speciality working group formed - currently scoping and scaling opportunities
Maxiofacial Surgery	TBC	Speciality working group to be formed with interim focus to be on identifying scope, scale and opportunity

16. Re-focus on ensuring compliance with published NICE guidance including targeted use of clinical audit

Further to discussion with the Director of Pharmacy, this objective has been broken down into two measures:

1. *Of all NICE TAGs[3] due for implementation in 2012/13, what percentage were implemented within three months of publication?*

The measure will relate to the point in time when implementation was due, as opposed to the point of publication. Implementation is defined as the submission and agreement of a local implementation plan by the BNSSG Commissioning College. The figures for Q1 & Q2 are as follows:

Quarter	Date of Issue	% implemented within timescale
Q1	January	1/2 (50%)
	February	1/2 (50%)
	March	1/1 (100%)
	Total	**3/5 (60%)**
Q2	April	2/3 (66%)
	May	1/1 (100%)
	June	2/2 (100%)
	Total	**5/6 (83%)**

2. *Of those clinical audits agreed with the NICE commissioning college for 2012/13, what percentage have been implemented (in progress or completed)?*

The local NICE commissioning college has identified 25 priorities for inclusion within the Trust's 2012/13 clinical audit programme, as follows:

Specialty	Ref	Title	Current status
Cardiology	TA 95	Arrhythmia - implantable cardioverter defibrillators	In progress
Dermatology	TA180	Ustekinumab - psoriasis	Not yet commenced
Dermatology	TA177	Alitretinoin - hand eczema (chronic)	Complete
Dermatology	TA103	Psoriasis - etanercept	In progress
Dermatology	TA134	Psoriasis - infliximab	Not yet commenced
Dermatology	TA146	Psoriasis - adalimumab	In progress
Endocrinology	TA151	Diabetes - Insulin pump therapy	Not yet commenced
Endocrinology	TA188	Growth failure in children - human growth hormone	Not yet commenced
Endocrinology	TA203	Diabetes (type 2) - liraglutide	In progress
ENT	TA166	Hearing impairment - cochlear implants	Not yet commenced
Gastroenterology	TA187	Crohn's disease - infliximab and adalimumab	In progress
Oncology	TA 34	Breast cancer - trastuzumab	In progress
Oncology	TA 65	Non-Hodgkin's lymphoma - rituximab	In progress
Oncology	TA 70	Leukaemia (chronic myeloid) - imatinib	Complete

[3] Technology Appraisal Guidance

Oncology	TA109	Breast cancer (early) - docetaxel	In progress
Oncology	TA129	Multiple myeloma - bortezomib	In progress
Oncology	TA171	Multiple myeloma - lenalidomide	In progress
Oncology	TA192	Lung cancer (non-small-cell, first line) - gefitinib	Not yet commenced
Oncology	TA193	Leukaemia (chronic lymphocytic, relapsed) -	Not yet commenced
Ophthalmology	TA155	Macular degeneration (age-related) - ranibizumab	Not yet commenced
Rheumatology	TA130	Rheumatoid arthritis - adalimumab, etanercept	In progress
Rheumatology	TA143	Ankylosing spondylitis - adalimumab, etanercept and infliximab	Complete
Rheumatology	TA161	Osteoporosis - secondary prevention including strontium ranelate	Not yet commenced
Rheumatology	TA204	Denosumab - osteoporotic fractures	Not yet commenced
Vascular Surgery	TA167	Abdominal aortic aneurysm - endovascular stent-grafts	Not yet commenced

Currently 14/25 (56%) of projects are in progress or complete, this is an increase from 44% in Q1. The Clinical Effectiveness Group (CEG) will be monitoring progress against the projects outlined above on a quarterly basis.

17. Continue to implement our Dementia action plan

Progress has been made in developing the team to sustain momentum in delivering the plan. This includes:

- Lead Dementia Nurse
- Dementia training post
- Volunteer Dementia Project lead

A dementia volunteer project proposal has been drafted and approved by the implementation group. This will enable us to deliver Standard 6 of the Dementia Standards, a focus for the Trust in 2012/13.

A forget-me-not symbol to identify patients with a dementia is being launched in October 2012. This symbol is used in North Bristol NHS Trust and ensures a consistent approach across both organisations.

An important but challenging national dementia CQUIN has been set for 2012/13. A target of 90% for each part of the CQUIN has been set over three consecutive months. Achievement of the CQUIN is important as it will improve diagnosis, which is currently nationally poor with only 43% of people with dementia having a formal diagnosis (Alzheimer's Society) and means that patients and their carers may not have access to the services and help they require. Achievement of the CQUIN will also bring financial reward to the Trust. The national CQUIN has the following elements:

1. *Finding* people with dementia – all patients admitted as an emergency (or carers if patients are unable to answer) aged 75 and over will be asked within 72 hours "Have you been more forgetful in the past 12 months to the extent that it has significantly affected your daily life?" If patients respond "yes" to the above question, an Abbreviated Mental Test (AMT) will be undertaken. If AMT score is greater than 8/10, move to next stage.

2. *Assessing* people with dementia – this will include more detailed diagnostic assessments and investigations such as scans to determine whether dementia is a possibility.

3. *Referring* people with dementia or likelihood of dementia – this will be made to the patient's General Practitioner and will include information about hospital investigations and possible implications.

Significant work is underway to establish recording processes and briefings for all staff to ensure they understand the rationale and importance for patients behind this CQUIN. The Trust has to achieve 90% compliance over three consecutive months. It is envisaged that data collection will commence in October 2012.

More than 70 Dementia Champions are now in place. These Champions come together twice a year for joint training/education events with NBT. An e-Champion platform is now in place to enable champions from both Trusts to communicate and share ideas.

Approval for dementia to be included as Essential Training has been agreed. Awareness training continues, with target audiences for levels 1, 2 and 3 now established.

Appendix A

NHS South West Quality and Patient Safety Improvement Programme Assessment Scale

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

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

Appendix B

Commitments to improving the experience of care amongst patients with learning disabilities

Parent Carer Participation

- To continue to work closely with user groups such as Health First, People First, Health work group. To attend UH Bristol Governors meetings to present service updates.
- To continue to Implement the University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust and Carers Charter as a Trust commitment and to ensure a greater focus on carers through implementation of the Charter.
- To develop an admission pack including use of staff photographs, information about accommodation, facilities and car parking.

Feedback

- To ensure that patient/carer feedback information is viewed and responded to appropriately, celebrating good practice and care delivery and making recommendations for service adjustments. As part of this work to review the differentiated inpatient comments card.
- Ensure regular reports on progress against the Steering Group work plan are fed into appropriate Trust and Board meetings.

Easy Read

- Within the Trust, there is a varied selection of accessible information leaflets (CQUIN achieved).
- We are currently developing patient and carers' appointment letters in Easy Read formats, these will include: appointment letters, hospital admission letters and change of appointment letters.
- To continue to develop the Hospital Passport across the Trust/to link in with liaisons within the South West Regions with plans to develop ONE document for all - across the South West.
- The Trust is currently developing the learning Disabilities Strategy in an Easy Read format.

Measuring Risk and Ensuring Safety

- Committed to Sign up to the Mencap Charter
- In patients with a learning disability are to risk assessed with 48 hours following admission (CQUIN achieved). To continue to support hospital staff teams in the implementation of this, to continue to deliver this high standard a care.
- A modified version of the learning disabilities risk assessment which incorporates a reasonable adjustments section (which audits can be drawn upon) is currently being drafted and in circulation soon for consultation.
- The Trust is able to identify clinical incidents involving people with learning disabilities via Ulysses. A monthly summary report will be compiled and discussed at the LD steering group to develop current themes, identify additional support needs and shared learning.

Training/Opportunities

- An application/proposal has been submitted to the Trust Essential Training Group for consideration. This training if successful will be delivered at all Trust induction. The aim of the training is to: Rise awareness of the healthcare issues faced by learning disabilities/disabled children and adults when accessing our hospital services
- We are in the early stages of developing a training programme and matrix to support staff caring for people with learning disabilities thought the Trust. Our plan will be to approach NBT inviting a joint approach.

- There are currently 22 Link/Champions within Adult services across the Trust supporting the role of the hospital Liaison Nurse and raising awareness with in there clinical areas, including:
    - Offering health awareness for people with learning disabilities
    - Easy Read leaflets developing in some clinical area
    - Sharing research and good practice
    - Emergency staff team have developed an Transfer list (check list) for people with learning disabilities who are being transferred to an inpatient bed-(pilot stage)
    - The National Autistic Society has planned to roll out Autism awareness training in June.
    - Hospital liaison Nurse to continue to provide training to staff Trust wide as requested/or as in identified need

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

Item 10 – Finance Report
Purpose
To report to the Board on the Trust's financial position and related financial matters which require the Board's **review**. The report has previously been considered by the Finance Committee.
Abstract
The summary income and expenditure statement shows a surplus of £2.650m for the six months to 30th September 2012. This represents an adverse performance of £0.465m (August adverse by £0.929m) when compared with the Annual Plan projected surplus for the period. The Trust's Financial Risk rating is unchanged at 3 (actual 3.10). The Divisional position projected on a straight line basis still shows an £8.8m overspending for the year. The lower activity for BNSSG commissioners results in a reduced provision for 'free' activity – this generates a favourable variance against the Corporate Service Agreement heading. The net projected movement would improve the forecast outturn by c£1.2m and on this basis move the Trust nearer to achieving the planned surplus for the year. This is primarily due to a slowdown in the rate of pay and non-pay expenditure. Cash releasing efficiency savings achieved in September was lower than in previous months and total £11.004m to date (79% of plan for the period). A significant improvement in the rate of savings over the remainder of the year is required to deliver the projected savings of £22.45m, or 81% of the original plan.
Recommendations
The Board is recommended to **review** the financial position for the 6 months to 30 September 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
			22 October 2012		

Trust Board
30th October 2012
Agenda Item 10a

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £2.650m for the six months to 30th September 2012, a favourable movement of £1.19m in the month. The Annual Plan projected surplus for the half year is £3.115m so the results represent slippage against the Plan of £0.465m, compared with £0.929m reported last month. The operating surplus (EBITDA[1]) at £16.813m equates to 95% of the Annual Plan projection for the 6 month period. The impact of the results to date is reflected in the Trust's Financial Risk Rating which stands at 3 (actual 3.10), further information on this is given in section 6 below.

Whilst the Divisional position projected on a straight line basis still shows an £8.8m overspending, the lower activity in August for BNSSG results in a reduced provision for 'free' activity. Therefore, the Corporate Service Agreement line generates a £0.635m favourable variance. The net projected movement would improve by c£1.2m and on this basis move the Trust nearer to achieving the planned surplus for the year. This is due primarily to a slowdown in the rate of pay and non-pay expenditure.

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 £4.408m. Detailed information and commentary for each Division is to be considered by the Finance Committee.

Divisional Variances	Variance to 31st August	Variance this month	Variance to 30th September	Memorandum CRES Variance
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(2,963)	(355)	(3,318)	(1,664)
Non Pay	(885)	655	(230)	(2,525)
Operating Income	640	132	772	49
Income from Activities	(494)	(1,138)	(1,632)	(322)
Totals	**(3,702)**	**(706)**	**(4,408)**	**(4,462)**

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 half of the £3.3m overspending on the pay heading which is the primary driver of the unfavourable variance to date.

Pay budgets have a cumulative overspending of £3.318m – an increase of £0.355m in September. The principal areas of overspending have taken place with the Divisions of Medicine (£0.154m) and Surgery, Head and Neck (£0.150m). Actual pay expenditure for September has reverted to a level marginally above the average observed for the months of April – July and a reduction of £0.6m on the value recorded for August. Clearly continued rigorous management of pay budgets is required

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[1] Earnings Before Interest Depreciation Taxation and Amortisation

over the remainder of the year in support of the aim to deliver the Trust's planned surplus for 2012/13.

Non-pay budgets show a cumulative adverse variance of £0.230m, an improvement of £0.655m in the month. The significant improvements have been recorded against Surgery, Head and Neck (£0.232m) where activity continues below plan but is planned to pick up with a number of initiatives coming on stream early in the third quarter. Specialised Services reports an underspending on its non-pay budgets of £0.195m as the impact of better controls and monitoring come through to the bottom line and a non-recurring gain from moving capital expenditure form the revenue account.

Operating Income budgets show a favourable variance of £0.772m, an improvement of £0.132m in the month. Notable favourable variances were achieved in September by Diagnostic and Therapies (£93k) and Surgery, Head and Neck (£32k).

Income from Activities shows a cumulative under-performance of £1.632m, an adverse movement in the month of £1.138m. The area of greatest concern continues to be within the Surgery, Head and Neck Division which has an under achievement to date of £1.261m. 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 September include the following:-

	£'000
Emergency Tariff Impact Assessment	493
Energy Inflation	121
European Working Time Directive	108

3. Cash Releasing Efficiency Savings

The achievement of cash releasing efficiency savings headline message is that September has seen delivery of CRES savings of £11.004m to date. This equates to 79% of the Plan for the first six 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 September report reflects an adverse variance of £4.462m year to date on the CRES programme. Actual savings of £11.004m represents slippage of £2.952m when compared with profiled planned savings for the first six months of £13.956m. The adjustment to bring CRES plans on to a 1/12ths basis adds a further £1.510m to the reported non achieved CRES to date.

It is of concern that the level of CRES achievement in September was lower than in previous months. A considerable improvement in CRES delivery is required (71% of plan in quarter 2) over the second half of the year in order to secure the total projected savings for the year of £22.45m.

The table shown below summarises divisional CRES performance for the six months to 30th September together with the current projections for the year.

	Diagnostic and Therapies £'000	Medicine £'000	Specialised Services £'000	Surgery, Head and Neck £'000	Women's and Children's £'000	Estates and Facilities £'000	Trust Services £'000	Totals £'000
Plan to 30th September	1,518	2,827	2,311	3,949	2,717	787	1,357	15,466
Actual	1,408	1,829	1,717	1,835	2,431	633	1,151	11,004
Variance – Fav / (Adverse)	(110)	(998)	(594)	(2,114)	(286)	(154)	(206)	(4,462)
Represented by:								
Slippage etc	28	(383)	(448)	(1,831)	(123)	(48)	(147)	(2,952)
/12ths Phasing	(138)	(615)	(146)	(283)	(163)	(106)	(59)	(1,510)
Plan for Year	2,605	4,590	4,588	7,086	4,830	1,377	2,546	27,622
Forecast Outturn								
Recurring	2,189	3,812	3,566	3,654	3,708	1,123	2,103	20,155
Non Recurring	373	90	446	78	871	228	209	2,295
Totals	2,562	3,902	4,012	3,732	4,579	1,351	2,312	22,450
Variance – Fav / (Adverse)	(43)	(688)	(576)	(3,354)	(251)	(26)	(234)	(5,172)
Full Year Effect of Forecast Outturn	2,570	5,678	4,029	4,245	4,194	1,389	2,241	24,346
Recurring shortfall c/fwd into 2013/14	(35)	-	(559)	(2,841)	(636)	-	(305)	(4,376)
Recurring savings for 2013/14 CRES Plan	-	1,088	-	-	-	12	-	1,100

CRES achievement to date at 78.8% of plan results in slippage of £2.952m. The forecast outturn has as its underlying assumption that CRES will be delivered at 83.8% of plan over the remainder of the year to secure savings of £22.45m and slippage for the year of £5.2m. 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 65% of the Trust shortfall on CRES for the year.

4. Income

For the months of April – August contract income is broadly in line with Plan. The under performance on clinical activity is marginally lower than the net gain from SLA Contract Penalties / Rewards. On a cumulative basis (to August 2012) contract income is £1.16m 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	4.87	4.88	0.01
Emergency Inpatients	29.90	29.04	(0.86)
Day Cases	12.73	12.66	(0.07)
Elective Inpatients	19.95	20.27	0.32
Non-Elective Inpatients	12.46	13.40	0.94
Excess Bed days	3.20	3.27	0.07
Outpatients	27.74	25.64	(2.10)
Bone Marrow Transplants	3.51	3.64	0.13
Critical Care Bed days	15.26	15.12	(0.14)
PbR Exclusions / NICE	16.35	17.59	1.24
Contract Penalties / Rewards	1.03	1.57	0.54
Other	21.72	21.73	0.01
Sub-Totals	**168.72**	**168.81**	**0.09**
2011/12 Estimate v Actual	-	1.07	1.07
Totals	**168.72**	**169.88**	**1.16**

5. Expenditure

In total, Divisions are shown as overspent by £4.408m for the six months to 30th September. The position for each Division, together with comparable results with CRES accounted for on the Divisional Phased Plan basis, is summarised below:

Division	**CRES on 1/12ths profiling**		**CRES on Phased Plan**	
	Variance to 30th September Favourable / (Adverse)	Memorandum CRES Variance to 30th September	**Variance to 30th September Favourable / (Adverse)**	**Memorandum CRES Variance to 30th September**
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	179	(110)	317	28
Medicine	(860)	(998)	(245)	(383)
Specialised Services	(234)	(594)	(88)	(448)
Surgery, Head and Neck	(2,745)	(2,114)	(2,462)	(1,831)
Women's and Children's	(684)	(286)	(521)	(123)
Facilities and Estates	(40)	(154)	66	(48)
Trust Services	116	(37)	175	22
Other Services	(140)	(169)	(140)	(169)
Totals	**(4,408)**	**(4,462)**	**(2,898)**	**(2,952)**

The table below summarises the changes in financial performance in September 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 August Fav / (Adv)	Variance for September Fav / (Adv)	Cumulative Variance to 30th September Fav / (Adv)
	£'000	£'000	£'000
Diagnostic and Therapies	229	(50)	179
Medicine	(698)	(162)	(860)
Specialised Services	(260)	26	(234)
Surgery, Head and Neck	(2,228)	(517)	(2,745)
Women's and Children's	(638)	(46)	(684)
Estates and Facilities	(48)	8	(40)
Trust HQ	73	43	116
Trust Services	(132)	(8)	(140)
Totals	**(3,702)**	**(706)**	**(4,408)**

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	43
Medicine	355	177
Specialised Services	794	397
Surgery, Head & Neck	1,050	525
Women's and Children's	272	136
Totals	**2,557**	**1,278**

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 £2.745m, an overspending of £0.517m in the month when compared with the August position of £2.228m 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		(1,122)	705	131	(1,069)	(1,355)
CRES	Slippage	(489)	(1,052)	-	(290)	(1,831)
	/12ths phasing	(118)	(64)	-	(101)	(283)
	Sub Totals	**(1,729)**	**(411)**	**131**	**(1,460)**	**(3,469)**
Adj re	Non Recurring Support	-	525	-	-	525
	March 2012 Income	-	-	-	199	199
Variance to 30th September		**(1,729)**	**114**	**131**	**(1,261)**	**(2,745)**

Pay budgets have a cumulative overspending of £1.729m. Within the overspending is the impact of CRES slippage of £0.489m, the prior year shortfall of £0.722m 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 £0.400m. The management budget overspendings reflect

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

higher than planned expenditure on nursing bank, agency and specialist mental health staff and medical agency staff.

Non pay budgets are underspent by £0.114m to date. The non pay column in the above table shows that this includes management budget underspendings to date of £0.705m offset by an adverse CRES variance and a proportion of the £1.05m non recurring central support. The underspending reported to date is expected 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 £1.261m. 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. A detailed income recovery plan has been prepared in order to secure an improvement in the delivery of the elective activity identified in the 2012/12 SLA. The activity projections, having recently been agreed with service managers, are to be discussed and confirmed by lead doctors shortly. Provision has been made for the cost of having to use third party facilities or premium costs. Operating Income budgets have a favourable variance of £0.131m to date.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £0.684m, an overspending of £46k 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		(635)	142	3	(361)	(851)
CRES	Slippage	(23)	(118)	12	6	(123)
	/12ths phasing	-	(163)	-	-	(163)
	Sub Totals	**(658)**	**(139)**	**15**	**(355)**	**(1,137)**
Adj re	Non Recurring Support	-	136	-	-	136
	March 2012 Income	-	-	-	317	317
Variance to 30th September		**(658)**	**(3)**	**15**	**(38)**	**(684)**

Pay budgets are overspent by £0.658m – an overspending of £23k in the month. The underlying rate of overspend has decreased significantly this month with lower spend recorded on nursing staff costs for Children's services (including the impact of the Summer Ward closure). Junior doctor agency costs are also much lower as the number of junior doctor vacancies decreases.

Non pay budgets show a cumulative overspending of £3k – an improvement of £41k in August. The principal reason for the improvement this month is the marginal costs for lower activity and income such as renal plasma exchanges, ENT Spire usage and Cochlear implants. The non pay heading also includes a significant proportion of the CRES slippage and 1/12th phasing adjustment together with the benefit of the Operating Plan support funding (details shown in the table above).

The Division of Medicine loses its 'amber / green' rating and moves to 'amber / red'.

The **Division of Medicine** reports an adverse variance of £0.860m for the six months to 30th September, a deterioration of £0.162m when compared with the adverse variance to 31st August of £0.698m. The further deterioration in the financial position this month is driven by the inability of the Division to close a ward (as planned at the start of the year) and the on-going cost pressures linked with requirement to avoid a breach of performance targets.

	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	113	(205)	237	(124)	21
CRES Slippage	(326)	(57)	-	-	(383)
/12ths phasing	(515)	(100)	-	-	(615)
Sub Totals	**(728)**	**(362)**	**237**	**(124)**	**(977)**
Adj re Non Recurring Support	-	177	-	-	177
March 2012 Income	-	-	-	(60)	(60)
Variance to 30th September	**(728)**	**(185)**	**237**	**(184)**	**(860)**

The Division has significant overspendings on pay headings (£0.728m), an increase of £0.154m in the month. Costs of medical staffing have been reduced following the switch from agency doctors to internal locum doctors – required to support pressures in the Emergency Department from Thursday evening to Monday morning. Nursing bank staff continue to be widely used across the Emergency Department and the Medical Assessment Unit.

Non-pay budgets are cumulatively overspent by £0.185m after a decrease of £54km in the month. The improvement is as a result of lower than contracted issues of CPAP and BPAP machines (offset by lower income), reduced mattress hire costs, a favourable adjustment for retrospective VAT relief and a correction to charges made by the Health Protection Agency.

Income from Activities reports a cumulative under achievement of £0.184m to date, £73k in the month. The Division has plans, through extended clinics and new staff filling vacant posts, to increase activity over the second half of the year.

A small underspending (£11k) has been recorded operating income budgets in the month.

The Specialised Services Division retains its 'amber / green' rating with a small reduction this month in the cumulative overspending.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £0.234m, a favourable movement of £26k 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	(506)	389	122	(67)	(62)
CRES Slippage	85	(596)	-	63	(448)
/12ths phasing	(110)	(36)	-	-	(146)
Sub Totals	**(531)**	**(243)**	**122**	**(4)**	**(656)**
Adj re Non Recurring Support	-	397	-	-	397
March 2012 Income	-	-	-	25	25
Variance to 30th September	**(531)**	**154**	**122**	**21**	**(234)**

Pay budgets show a cumulative overspending of £0.531m. The overspending relates mainly to the higher than planned costs on nursing staff, a banding increase for junior doctors working in cardiology, payments to consultants for additional sessions and the net additional cost of having to use agency staff to cover junior doctor vacancies.

Non pay budgets show a net underspending of £0.154m to date – an improvement of £0.195m in the month. The improvement is a combination of better controls on non-pay costs, a one-off transfer of £100k as expenditure attributed to the Division's operating budget has been has been moved to the capital programme and the continuing benefit of the non-recurring Trust support funding. Operating Income budgets show a favourable variance to date of £0.122m an increase of £8k in the month. Income from Activities shows a cumulative favourable net variance of £21k, an adverse movement of £0.117m in the month. The underperformance on private patient activity in the BHI @ £0.105m in the month (cumulative £0.595m) is a significant factor in this month's performance on this heading.

The remaining three divisions are green rated.

The **Diagnostic and Therapies Division** reports a cumulative underspending of £0.179m. Pay expenditure is greater than Plan with a £0.199m adverse variance. Non pay budgets are operating within Plan and report a favourable variance of £0.199m to date. Operating Income is £0.245m ahead of Plan with higher charges made this month for chemical pathology testing for services to other providers. Income from Activities is £66k less than Plan.

The Facilities and Estates Division reports an overspending to date of £40k, a favourable movement of £8k in the month. The phasing of the CRES plan contributes £106k to this adverse position.

Trust Headquarters Services report an in-month underspending of £43k and a cumulative underspending of £116k.

6. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 30th September is 3. The actual financial risk rating is 3.10 (August = 2.90) which rounds to 3. The improvement in the Trust's financial position has increased the income and expenditure surplus margin above the 1% threshold which moves performance against that metric to a rating of 3 (previously 2). Performance against the other four metrics has also improved this month but remain unchanged from their August bandings. 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.

Metric	30th September 2012 Metric Result	Metric Score	Weighted Average Score
EBITDA			
Margin	6.4%	3	0.75
Plan achieved	94.5%	4	0.40
Net Return on Financing	1.61%	3	0.60
I&E surplus margin	1.01%	3	0.60
Liquidity ratio (days)	21.1 days	3	0.75
			3.10

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 six months to 30th September is given in the table below. Expenditure for the period of £25.924m is £1.383m less than the current Plan.

Plan for Year		6 Months Ended 30th September 2012		
		Plan	Actual	Variance Favourable / (Adverse)
£'000		£'000	£'000	£'000
	Sources of Funding			
384	Donations	238	184	(54)
18,125	Retained Depreciation	8,722	8,722	-
49,950	Prudential Borrowing	-	-	-
8,395	Sale of Property	5,845	1,000	(4,845)
5,054	Cash balances	12,502	16,018	3,516
81,908	**Total Funding**	**27,307**	**25,924**	**(1,383)**
	Expenditure			
(54,000)	Strategic Schemes	(19,225)	(19,027)	198
(9,000)	Medical Equipment	(1,912)	(1,671)	241
(5,518)	Information Technology	(2,642)	(2,454)	188
(1,879)	Roll Over Schemes	(760)	(765)	(5)
(4,189)	Refurbishments	(816)	(663)	153
(10,188)	Operational / Other	(1,952)	(1,344)	608
2,866	Anticipated Slippage	-	-	-
(81,908)	**Total Expenditure**	**(27,307)**	**(25,924)**	**1,383**

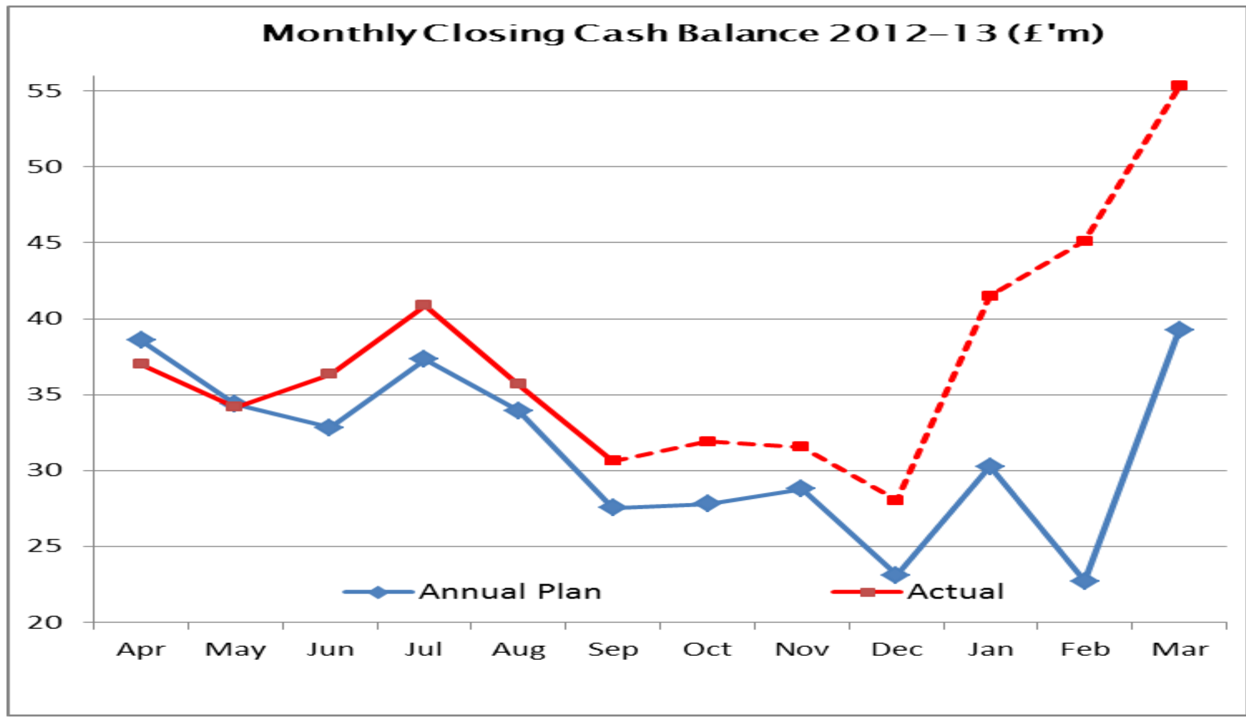
A review of the likely 2012/13 spend on the capital programme has been undertaken. It is now forecast that the likely out-turn will be c£64m compared with the estimate of £75m given last month. This is due primarily to the following significant changes:

	£'000
Major Strategic Schemes	
Phase 3 BRI Redevelopment	2,977
BRI Welcome Centre	922
BHOC Strategy including Adult BMT	1,785
Medical Equipment	1,689
Information Technology	1,718
Operational Capital	2,088

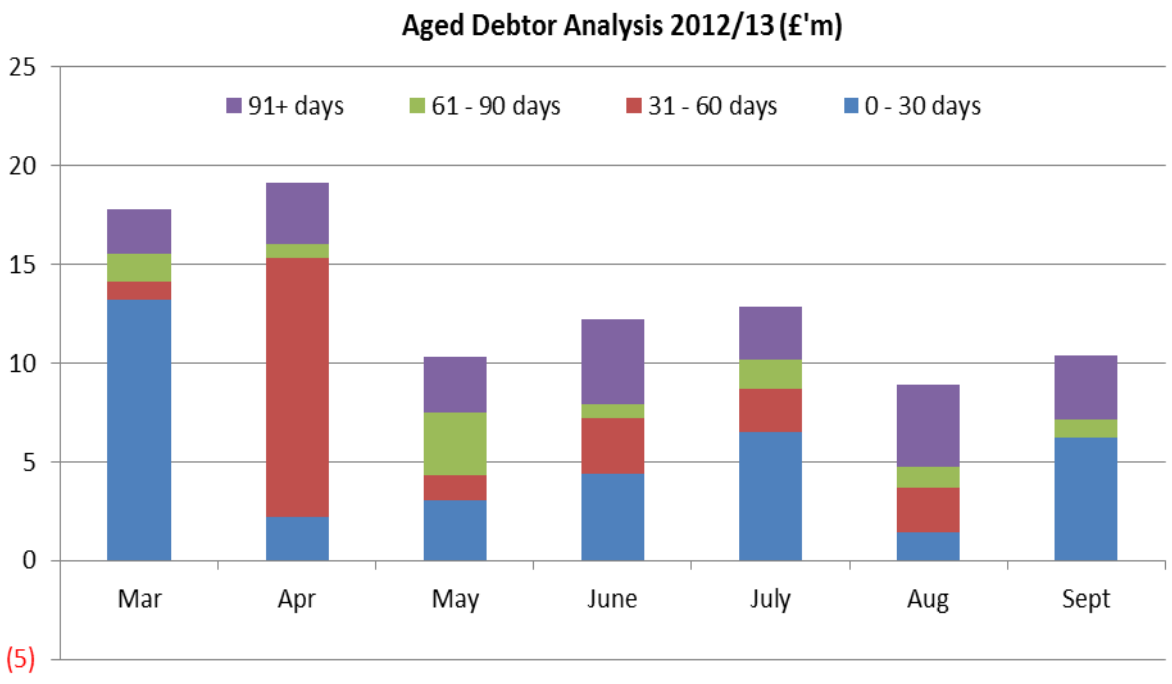
As a consequence the Trust's cash flow forecast has been revised and we will now review the planned draw down of the Long Term loans. It is likely that the original plan to draw down £49.95m will be reduced by c£20m. This will have a positive impact on the income and expenditure position because of lower interest charges.

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

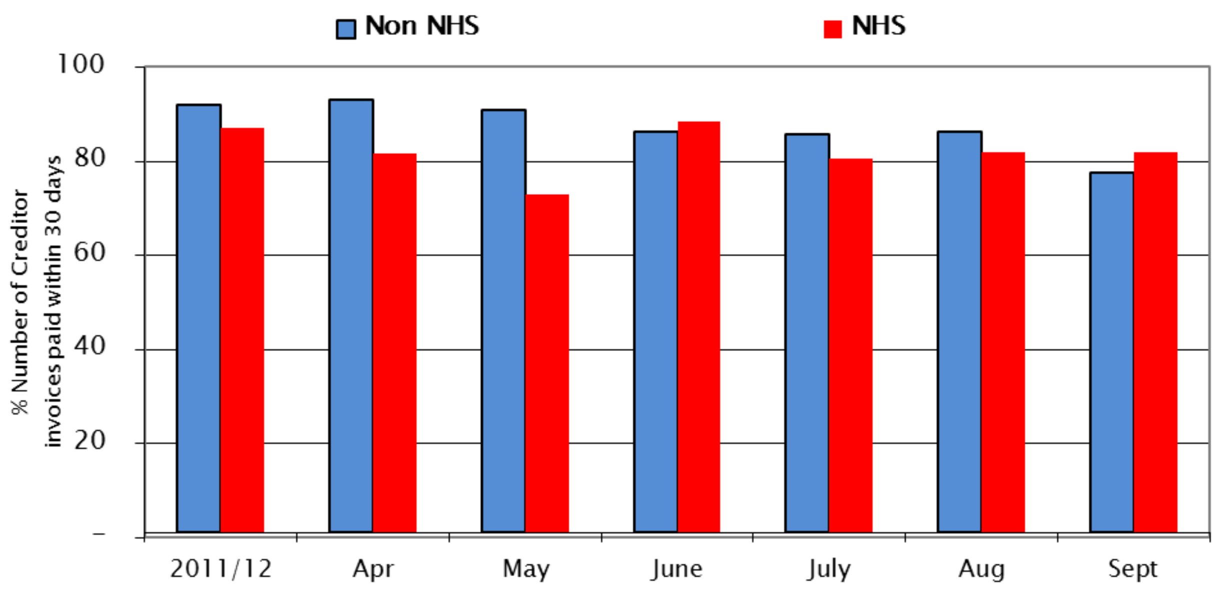
Cash - The Trust held a cash balance of £30.617m as at 30th September. The graph, shown below, sets out the current forecast for month end cash balances to March 2013.



Debtors - The total value of invoiced debtors has increased by £1.398m during September to a closing balance of £10.319m. The total amount owing is equivalent to 7.8 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In September the Trust achieved 77% and 82% compliance against the Better Payment Practice Code for NHS and Non NHS and 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

9. Update on Private Patient Income Cap

Changes to the way the cap on private income of NHS foundation trusts is enforced came into operation from October 1st as a result of the Health and Social Care Act 2012. The 2012 Act obliges foundation trusts to make sure that the income received from providing goods and services for the NHS (their principal purpose) is greater than income from other sources.

The Act requires foundation trusts to publish information on all their non-NHS work and to explain its impact on the delivery of goods and services for the NHS. In addition, any foundation trust wishing to increase the share of its income from non-NHS sources (including private work) by more than five percentage points in any one year must obtain prior approval from the governors.

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report September 2012– Summary Income & Expenditure Statement

Approved Budget / Plan 2012/13	Heading		Position as at 30th September Plan	Actual	Variance Fav / (Adv)	Actual to 31st August	Forecast Outturn
£'000			£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)						
411,351	From Activities		207,989	206,096	(1,893)	172,039	413,759
111,995	Other Operating Income		56,589	57,430	841	47,814	113,755
523,346	Sub totals income		**264,578**	**263,526**	**(1,052)**	**219,853**	**527,514**
	Expenditure						
(301,353)	Staffing		(151,573)	(154,901)	(3,328)	(129,035)	(310,156)
(177,198)	Supplies and services		(92,452)	(91,812)	640	(77,597)	(182,401)
(478,550)	Sub totals expenditure		**(244,025)**	**(246,713)**	**(2,688)**	**(206,632)**	**(492,557)**
(9,752)	**Reserves**	Reserves	(2,771)	–	2,771	–	–
(9,752)		Sub Total Reserves	**(2,771)**	–	**2,771**	–	–
35,043	**EBITDA**		**17,782**	**16,813**	**(969)**	**13,221**	**34,957**
6.70	**EBITDA Margin – %**			**6.38**		**6.01**	**6.63**
350	Fixed asset impairments		–	(1)	(1)	(1)	963
(530)	Reserves		(530)	–	530	–	–
–	Profit/ loss on sale of asset		–	–	–	–	–
(19,451)	Depreciation & Amortisation		(9,282)	(9,282)	–	(7,714)	(19,457)
226	Interest Receivable		113	114	1	95	226
(387)	Interest payable on leases		(193)	(193)	–	(161)	(387)
–	Interest payable on loans		–	–	–	–	(1,000)
(9,551)	PDC Dividend		(4,775)	(4,801)	(26)	(3,980)	(9,602)
5,700	**NET SURPLUS / (DEFICIT)**		**3,115**	**2,650**	**(465)**	**1,460**	**5,700**

Appendix 2

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

Approved Budget / Plan 2012/13	Division	Total Net Expenditure / Income to Date	Position as at 30th September [Favourable / (Adverse)]					Memorandum CRES Variance to Date	Cumulative Variance to 31st August	Forecast Outturn Variance
			Pay	Non Pay	Operating Income	Income from Activities	Total Variance to date			
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
405,114	Service Agreements	201,949	–	–	59	(59)	–	–	(1)	–
827	Overheads	(202)	–	827	–	(202)	625	–	–	
39,494	NHSE Income	19,829	–	–	10	–	10	–	7	–
445,435	**Sub Total Service Agreements**	**221,576**	**–**	**827**	**69**	**(261)**	**635**	**–**	**6**	**–**
	Clinical Divisions									
(42,755)	Diagnostic & Therapies	(20,851)	(199)	199	245	(66)	179	(110)	229	250
(58,002)	Medicine	(29,815)	(728)	(185)	237	(184)	(860)	(997)	(698)	(765)
(65,332)	Specialised Services	(32,784)	(531)	154	122	21	(234)	(594)	(260)	(595)
(87,525)	Surgery Head & Neck	(45,844)	(1,729)	114	131	(1,261)	(2,745)	(2,114)	(2,228)	(5,015)
(86,993)	Women's & Children's	(43,588)	(658)	(3)	15	(38)	(684)	(286)	(638)	(98)
(340,607)	**Sub Totals (1)**	**(172,882)**	**(3,845)**	**279**	**750**	**(1,528)**	**(4,344)**	**(4,102)**	**(3,595)**	**(6,223)**
	Corporate Services									
(6,171)	Trust Hq	(3,090)	146	(152)	61	–	55	7	38	80
(5,210)	Human Resources	(2,475)	79	(77)	10	–	12	(19)	10	–
(6,631)	Imt	(3,582)	190	(145)	(14)	–	31	(4)	17	50
(5,004)	Finance	(2,528)	87	(44)	(25)	–	18	(21)	8	25
(31,654)	Facilities And Estates	(16,248)	(27)	41	(39)	(15)	(40)	(154)	(48)	–
(53)	Community	(13)	–	13	–	–	13	–	11	–
(8,323)	Misc Support Services	(7,101)	40	(114)	7	(89)	(156)	(169)	(148)	(254)
(29,002)	Capital Charges	(14,083)	–	(26)	–	–	(26)		–	–
4,856	Research & Innovation	3,068	12	(5)	22	–	29		5	49
(87,192)	**Sub Totals (2)**	**(46,052)**	**527**	**(509)**	**22**	**(104)**	**(64)**	**(360)**	**(107)**	**(50)**
(427,799)	**Sub Totals (1) and (2)**	**(218,934)**	**(3,318)**	**(230)**	**772**	**(1,632)**	**(4,408)**	**(4,462)**	**(3,702)**	**(6,273)**
–	**Skills for Health**	8	(10)	18	–	–	8	–	6	
(427,799)	**Totals I & E**	**(218,926)**	**(3,328)**	**(212)**	**772**	**(1,632)**	**(4,400)**	**(4,462)**	**(3,696)**	**(6,273)**
	Reserves									
(11,936)	General	–	–	3,300	–	–	3,300	–	2,761	6,273
(11,936)	**Sub Total Reserves**	**–**	**–**	**3,300**	**–**	**–**	**3,300**	**–**	**2,761**	**6,273**
5,700	TRUST TOTALS	2,650	(3,328)	3,915	841	(1,893)	(465)	(4,462)	(929)	0

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	Sep £'000	Q2 £'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	5,847	17,384	34,580	5,763	5,491	5,651
	Bank	2,076	496	524	521	514	2,055	176	209	190	575	183	226	211	620	1,195	199	173	171
	Agency	654	182	128	162	315	786	71	125	126	322	102	171	101	375	697	116	55	66
	Waiting List initiative	304	73	42	16	27	158	18	2	5	25	16	10	10	36	61	10	25	13
	Overtime	91	14	11	7	12	45	6	4	3	13	4	3	2	9	22	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	5,545	16,634	33,264	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	5,870	17,674	35,239	5,873	5,494	5,717
	Variance Fav / (Adverse)	(32)	(346)	(263)	(138)	(51)	(798)	(76)	(200)	(93)	(369)	(71)	(195)	(23)	(290)	(658)	(110)	(3)	(66)
Medicine (inc Central Services for 2011/12)	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	3,638	10,850	22,003	3,667	3,479	3,684
	Bank	3,434	845	758	689	775	3,067	276	305	293	874	297	365	277	939	1,813	302	286	256
	Agency	559	157	141	113	309	720	1	93	61	155	34	100	96	231	386	64	47	60
	Waiting List initiative	315	30	4	26	43	103	2	17	9	28	11	18	8	37	65	11	26	9
	Overtime	69	25	15	16	15	70	5	6	5	16	7	5	6	19	35	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	3,405	10,194	20,431	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	3,792	11,419	22,730	3,788	3,605	3,715
	Variance Fav / (Adverse)	(1,515)	(341)	(111)	54	36	(363)	(34)	(58)	(66)	(158)	(76)	(340)	(153)	(570)	(727)	(121)	(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	5,744	17,125	33,830	5,638	5,512	5,676
	Bank	2,100	450	525	497	497	1,969	158	193	177	528	191	250	187	627	1,156	193	175	164
	Agency	1,206	121	95	175	189	580	39	79	65	183	121	235	54	410	593	99	101	48
	Waiting List initiative	1,209	304	50	220	140	714	30	26	10	66	76	71	139	286	352	59	101	60
	Overtime	152	22	35	40	46	142	10	17	17	43	16	10	14	40	84	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	5,499	16,762	33,374	5,562	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	5,893	18,126	35,558	5,926	5,478	5,657
	Variance Fav / (Adverse)	410	(265)	146	192	157	230	20	(637)	(110)	(727)	(306)	(546)	(150)	(1,001)	(1,729)	(288)	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	2,992	8,816	17,481	2,913	2,816	2,945
	Bank	1,049	230	265	241	208	945	68	73	67	208	71	116	106	293	501	84	87	79
	Agency	654	243	293	245	382	1,163	60	31	74	165	76	48	86	210	376	63	55	97
	Waiting List initiative	537	138	86	127	72	423	42	32	19	93	22	5	35	62	155	26	45	35
	Overtime	20	3	4	6	14	27	3	3	3	9	3	3	2	8	17	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	2,824	8,546	16,963	2,827	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	3,053	9,120	18,012	3,002	2,879	3,053
	Variance Fav / (Adverse)	(760)	(262)	(398)	(198)	(432)	(1,290)	(40)	(120)	(68)	(228)	(93)	(151)	(61)	(304)	(531)	(89)	(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	Sep £'000	Q2 £'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	3,169	9,267	18,805	3,134	3,077	3,105
	Bank	544	144	108	129	130	510	38	38	33	109	31	44	31	106	215	36	45	43
	Agency	389	73	46	63	101	284	(3)	32	23	52	22	59	25	105	157	26	32	24
	Waiting List initiative	156	37	27	28	41	133	0	31	12	43	18	6	4	28	71	12	13	11
	Overtime	264	68	49	67	96	280	20	31	27	77	24	21	23	69	146	24	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	3,105	9,174	18,414	3,069	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	3,189	9,482	19,004	3,167	3,072	3,089
	Variance Fav / (Adverse)	61	(116)	22	119	165	189	(19)	18	17	16	(139)	(56)	(19)	(215)	(199)	(33)	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	1,537	4,713	9,339	1,557	1,559	1,583
	Bank	483	93	75	72	84	323	28	31	27	86	18	27	25	71	157	26	40	27
	Agency	1,300	351	380	312	364	1,407	91	118	119	329	123	111	88	322	651	109	108	117
	Waiting List initiative	7	2	0	0	0	2	0	0	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	96	316	608	101	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	1,322	4,008	7,950	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	1,531	4,717	9,365	1,561	1,545	1,558
	Variance Fav / (Adverse)	165	13	80	57	144	294	(10)	(18)	5	(22)	25	(35)	6	(4)	(26)	(4)	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	2,163	6,580	12,973	2,162	2,230	2,240
	Bank	609	115	157	(11)	13	275	0	(2)	(14)	(16)	(15)	(8)	(4)	(27)	(43)	(7)	51	23
	Agency	209	9	53	83	96	240	7	18	6	30	19	18	28	66	96	16	17	20
	Waiting List initiative	7	(1)	0	0	0	(1)	0	0	0	0	0	0	0	0	0	0	1	(0)
	Overtime	108	16	17	23	83	139	17	29	13	59	11	6	7	23	82	14	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	2,086	6,176	12,284	2,047	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	2,117	6,238	12,419	2,070	2,252	2,210
	Variance Fav / (Adverse)	(257)	(302)	189	416	55	358	43	89	80	212	99	197	46	342	554	92	(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	25,090	74,735	149,011	24,835	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	834	2,630	4,994	832	858	762
	Agency	4,971	1,136	1,136	1,154	1,755	5,181	266	498	473	1,237	498	743	478	1,719	2,956	493	414	432
	Waiting List initiative	2,535	583	209	417	323	1,532	92	108	55	255	143	110	196	449	704	117	211	128
	Overtime	1,864	434	380	466	560	1,841	181	176	152	509	177	157	150	485	993	166	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	23,786	71,494	142,680	23,780	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	25,445	76,776	152,328	25,388	24,325	25,000
	Variance Fav / (Adverse)	(1,928)	(1,619)	(335)	502	73	(1,380)	(116)	(925)	(234)	(1,275)	(560)	(1,126)	(355)	(2,042)	(3,317)	(553)	(161)	(115)

Key Issue	**RAG**	**Executive Summary**	**Table**
Service Level Agreement Income and Activity	G	For the months of April – August contract income is broadly in line with Plan. The under performance on clinical activity is marginally lower than the net gain from SLA Contract Penalties / Rewards. On a cumulative basis (to August 2012) contract income is £1.16m higher than Plan – this includes the balance of the 2011/12 over-performance of £1.07m. A&E Attendances at 47,005 are 1,060 **lower** than planned. The average number of daily attendances is 307. Emergency activity at 15,379 is 0.8% or 126 spells **lower** than planned. Non Elective activity at 8,874 is 7.9% or 651 spells **higher** than planned. Elective activity at 6,372 is 1.4% or 85 spells **higher** than per Plan. Day case activity at 20,531 is 0.8% or 167 spells **lower** than planned. Outpatient Procedure activity at 10,372 is 10.6% or 1,233 spells **lower** than planned. New Outpatients activity at 61,867 is 4.7% or 2,792 attendances **higher** than planned. Follow up Outpatient activity at 131,817 is 6.8% or 9,575 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.	Agenda Item 5.2 INC 1
Income and Expenditure	A	The reported surplus for the 6 months to 30th September is £2.650m. This is £0.465m adverse to Plan. The EBITDA surplus of £16.813m equates to 94.55% of the Annual Plan target for the period. Total income to date of £263.526m is £1.052m less than Plan. This includes a proportion (6/12ths) of the residual over performance relating to 2012/13 at £1.07m. Expenditure at £246.713m is less than Plan by £83k. Financing costs are broadly in line with Plan. *[RAG rating changed in light of improved cumulative financial position]*	Agenda Item 5.3 I&E 1 I&E 2 I&E 3a I&E 3b

Key Issue	RAG	Executive Summary	Table
Cash Releasing Efficiency Savings	R	The 2012/13 CRES programme totals £27.622m. Actual savings achieved for the six months to 30th September total £11,004m, a shortfall of £2.952m (August £2.296m) against divisional plans. The 1/12th phasing adjustment adds a further £1.51m to the total cumulative shortfall to date of £4.462m. The forecast outturn is for savings to total £22.45m of which £2.295m is non-recurring. *[RAG rating changed in light of reported slippage on CRES achievement and reduction in forecast outturn]*	Agenda Item 5.4
Statement of Financial Position & Treasury Management	G	The cash balance on 30th September was £30.617m. This is £5.729m higher than the forecast value. Income was higher than anticipated due to the early receipt of Skills for Health income (£2.262m) and higher than planned SLA income (£1.561m). Payments were lower than forecast by £2.355m. Capital expenditure and payments to traders were lower by £3.643m and £0.650m respectively. NHS payments were £1.796m higher than planned because the payment of the rent for the South Bristol Community Hospital (£1.556m) and work carried out to reduce balances over 90 days. The balance on Invoiced Debtors has decreased by £1.398m in the month to £10.319m. The invoiced debtor balance equates to 7.8 debtor days. Creditors and accrual account balances total £69.738m although £5.933m relates to deferred income. Invoiced Creditors - payment performance for the year to date for Non NHS invoices and NHS invoices within 30 days was 87% and 81% respectively.	Agenda Item 7 BS 1 BS 2 BS 3 BS 4
Capital	G	Expenditure for the six months to 30th September totals £25.924m - this is £1.383m less than profiled for the period. The significant variances reflect slippage on Strategic Schemes (£0.198m), Medical Equipment (£0.241m), Operational Capital (£0.608m) and Information Technology (£0.188m).	Agenda Item 6
Financial Risk Rating	G	The Trust's overall financial risk rating using the results for the six months to 30th September has been calculated to be 3 (actual score 3.10). The Trust's ratings under the Prudential Borrowing Code are satisfactory with all ratios well within the Monitor thresholds. *[RAG rating changed in light of improved cumulative financial position]*	Agenda Item 5.1 App 6
Private Patient Cap	G	Private patient income for the period is £0.575m or 0.28% of total patient related income. This is well below the Trust's Private Patient Cap of 1.1%. It should be noted that	

Item 10a - Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

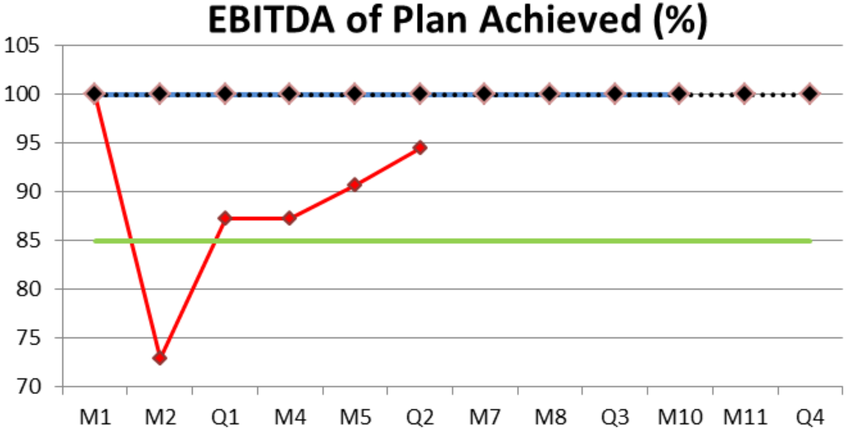
Finance Report September 2012 - Risk Matrix

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 @ 0.28% 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 – September 2012 Performance

1. Financial Risk Rating

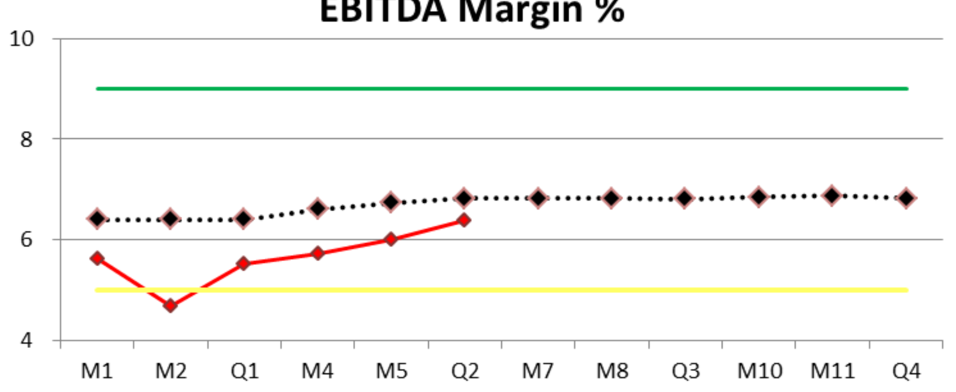
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2012/13 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 5 (blue line)**; **FRR 4 (green line)** and **FRR 3 (yellow line)**.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

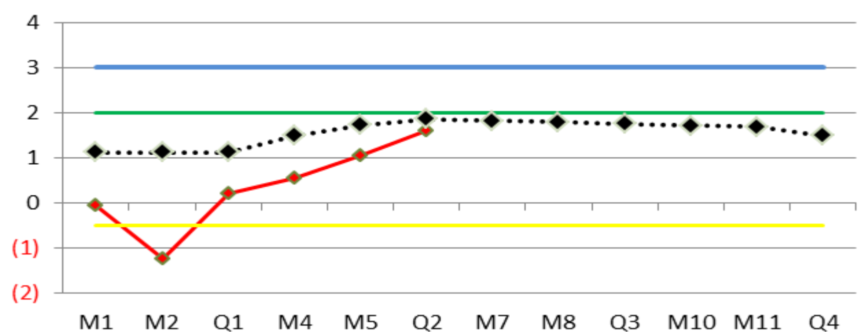


An EBITDA of £16.813m was achieved. This equates to 94.5% of the Annual Plan projection of £17.782m.

EBITDA Achievement of 94.5% of Plan earns a metric score of 4.

The EBITDA Margin of 6.38% for the 6 months to September achieves a metric score of 3. This is less than the Annual Plan forecast of 6.82% to date.



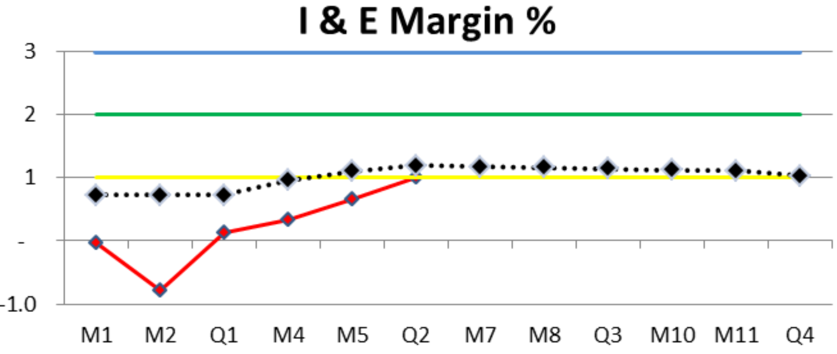


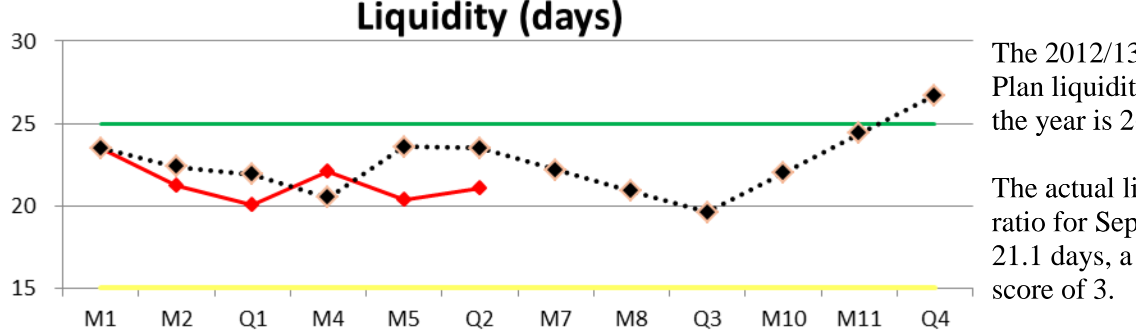
The Net Return on Financing for the 6 months is 1.60%. The result earns a metric score of 3.

Annual Plan = 1.86% to date.

The 2012/13 Annual Plan Income and Expenditure surplus margin is 1.19% to date.

The Income and Expenditure surplus margin for the period is 1.01%, a metric score of 3.





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

The actual liquidity ratio for September is 21.1 days, a metric score of 3.

The Trust's Financial Risk Rating is calculated by using a weighted average score to determine the overall rating. The weighted average score is 3.10. The Trust has therefore achieved a Financial Risk Rating of 3 for the six months to 30th September.

2. Prudential Borrowing Limit

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

Prudential Borrowing Limit Performance	Monitor Ratio Tier 1	30th September 2012	Projection – March 2013
Minimum Dividend Cover	>1x	3.5x	3.6x
Minimum Interest Cover	>3x	88x	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.

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

Item 11 – Board Assurance Framework Report (including Strategic, Corporate and Compliance Objectives Status Report)

Purpose

To provide the Board with the quarterly update on progress against the Trust's objectives at the end of Quarter 2 and to provide assurance of the control of any associated risks to delivery.

Abstract

Context

The purpose of the BAF is to track progress against the Trust's medium term objectives and specifically tracks progress against the 2012/13 milestones which were derived as part of the 2012/13 annual planning process. Importantly, the framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control risks identified with the aim of ensuring delivery is not compromised.

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

Quarter 2 Position

One objective has both an inherent and residual risk rating of RED. This reflects the on-going non-compliance with Outcome 13 within the Trust's maternity service and the risk of non-compliance following the recent Responsive Review of paediatric cardiac services.

There are 45 (46) objectives where delivery is forecast and therefore a residual rating of GREEN and 8 (7) AMBER rated objectives; all AMBER rated objectives have active management plans in place, with the aim of restoring delivery to GREEN status. The milestone which has moved from GREEN to AMBER during the period is 1.9 which reflects higher than planned levels of staff sickness.

NB Figures in brackets reflect Q1 position.

Recommendations

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

Executive Report Sponsor or Other Author

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

Appendices

- Appendix A – Board Assurance Framework

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	10 October 2012				Risk Management Group – 02 October 2012

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2012-2013	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	T&L	1.1	We will develop and implement a teaching and learning Strategy that is fully integrated with all other strategies in order to support the Trust's mission.	Improved Teaching and Learning provision within the Trust. Improved recognition externally of UH Bristol as a Teaching Hospital	Strategy implemented in line with plan. 5% increase in satisfaction with Teaching and Learning provision against 2011 Benchmark	50% to 75%	Currently managing progress against 12 Teaching & Learning strategic objectives at varying stages of progress 2012 Customer Survey completed and feedback being analysed and implemented.	Lack of progress with 12 strategic objectives identified.	Green	Building capability work stream days occur monthly.	Teaching and Learning Group	Green		Dir W&OD	Teaching and Learning Group
1	R&I	1.2	We will focus on and foster our priority areas of high quality translational and applied health services research and innovation where we are, or have the potential to be world leading	Developmental research groups established and productive.	Clear, agreed priorities for each Divisional Unit to be agreed. All researchers to be linked to Divisional Research Units Increase grant income by 5%	25% to 50%	All Divisions now have, or are in the process of planning, dedicated Research Units. These Units will be the delivery vehicle for our research. Each Unit reports to TRG and on to TME and the Board.	Grant income is not increased	Green	Continued support of R&I unit for identified research priority areas to apply for grants		Green		Dir Med	Research Group
1	R&I	1.3	We will develop a culture in which research and innovation are embedded in routine clinical services leading to improvements in clinical care	Transparency within Divisions of research funding achieved. Divisional governance structures for research in place.	The First HITs led from UH Bristol will need support to agree clear, deliverable objectives. Baseline measures to be agreed against which to monitor impact of the HITs	25% to 50%	The first Health Integration Teams (HITs) are currently undergoing assessment for accreditation by Bristol Health Partners. Two HITs from UH Bristol are through to full application stage. Four more will re-apply in the Autumn	Unable to fund research time for staff	Green	Robust job and capacity planning		Green		Dir Med	Research Group
1	R&I	1.4	We will demonstrate our undertaking to improve patient health through our excellence in world-class translational and applied health services research and our culture of innovation by increasing participation in NIHR trials	Increase in the number of patients entering NIHR trials	Systems to be established to support reporting to DH on time taken from receipt of valid application for research trials to recruiting the first patient for the trial (new BRU contracts place contractual obligation on Trust to achieve first patient first visit within 70 days of receipt of application for trial). Systems to be established to support researchers in delivering research to agreed timelines and target recruitment levels	50% to 75%	Recruitment to trials is on track to meet our targets this year, following a disappointing decrease in recruitment last year. However, we need to continue our focus on recruiting patients in to trials to increase our funding from the WCLRN for the delivery of research	Recruitment targets of patients onto clinical trials in not achieved	Green			Green		Dir Med	Research Group
1	CSS	1.5	We will consolidate and expand our specialist services portfolio through designation of target services and repatriation of work from outside the South West	An increase in income from specialised services and a greater proportion of Trust income coming from the specialist portfolio.	Achieve designation status for Paediatric Cardiac Surgery, Paediatric Major Trauma, Paediatric Epilepsy Surgery (in partnership with NBT), Achieve Designation for Adult Intestinal Failure (IF) and Adult Congenital Heart Disease (CHD). Play leading role in Specialised Commissioning Repatriation Project. Develop marketing and implementation plans for repatriation of target services (Bone Marrow Transplant and Cardiac Surgery)	50% to 75%	Paediatric Epilepsy Surgery designation secured. Paediatric Cardiac Surgery Designation achieved (Option B). Implementation launch 19th October Adult CHD, launched 12th June and baseline assessment submitted. IF designation underway. proceeded successfully through 1st Gateway. Bristol Heart Institute (BHI) Strategic Review underway and on track to conclude end of September.	Designation status is not secured through national process.	Green	Strong leadership and support to Divisions for designation processes.	Clinical Strategy Group retains corporate oversight of all designation activity.	Green		Dir SD	Clinical Strategy Group
1	CSS	1.6	We will work with our partners to ensure the optimal configuration for acute services across the City	Single strategy for acute services developed and agreed between NBT and UHB and endorsed by commissioners. Reduction in the number of specialities duplicated across the City, fewer opportunities for competition between acute Trusts.	Develop and agree, with NBT and commissioners, a plan for acute services configuration and agree further priorities for service change Achieve successful transfer of UHB services to SBCH Transfer head & neck, breast and urology services Continue active involvement in Avon Wide Pathology Review with aim of consolidating pathology services under leadership of NBT (subject to successful Business Case) Deliver all BRI and CSP annual milestones to support service transfer in May 2014	25% to 50%	Internal strategy work undertaken and concluded, now being considered in context of City wide work on acute service integration. Terms of Reference for Service Plan to support Integration OBC being developed. SBCH transfer successfully achieved. Tri-service move delayed further, revised transfer date Mar 2013. Vascular Service Review to commence October 2012. Pathology Review delayed due inadequate progress on financial parameters. Business case now deferred to Dec 2012. BRI / CSP programmes on budget and timeline	Failure to reach agreement with NBT and commissioners on future acute service strategy. Tri-service move is further delayed due to inability to resolve financial gap. Pathology Review cannot identify sufficient cost reductions to enable consolidation to proceed. CSP Income re-fresh surfaces revenue pressures in approved FBC	Amber	Acute Services Project established to address question of future service model and organisational form. Robust programme management of all strategic capital programmes in place. Tri-service programme arrangements strengthened including appointment of Senior Programme Manager	All strategic programmes managed through respective Programme Board arrangements including independent chair for Acute Services Project Board. Gateway Review process adopted for Tri-service move. BRI/CSP both subjected to external Gateway	Amber	1660	Dir SD	Clinical Strategy Group
1	CSS	1.7	We will undertake a feasibility study of the opportunities and models for increasing Private Patient Services and Income	Options for private patient services scoped and model for UH Bristol agreed and progressed	Undertake market analysis of business opportunity Undertake option appraisal (if market opportunity is confirmed) for developing private patient provision.	75% to 100%	Review concluded and recommendations supported by TME at September meeting. Case for change and action plan to be developed.	None Identified	Green			Green		Dir SD	Clinical Strategy Group
1	CSS	1.8	Grow the non-clinical income base through exploiting greater commercial opportunities for income generation	Increase in the number of third party providers to whom UH Bristol provides its services. Increase in non-clinical income	Subject to approval of Welcome Centre Comprehensive procure partner to develop Centre and commence construction. Evaluate and decide upon Trust model for commercial development Identify further opportunities for commercial developments / partnerships	75% to 100%	Welcome Centre Business Case approved, retailers selected and construction commenced. Model for Commercial development contingent upon decisions regarding leadership for Private patient development.	No further commercial opportunities identified.	Green	Consideration of creation of Commercial Director Role.	Regular reporting to BRI Redevelopment Board.	Green		Dir SD	BRI Redevelopment Board

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2012-2013	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	CES	1.9	Fully embed the Trust's values in everything we do and say and establish them as the behaviours that drive the way we do things around here.	Improvements in staff survey questions which pertain to morale and positive work place. Reduction in number of staff experiencing bullying and harassment. Achieve place in top 20% of Trusts for UH Bristol being a	Training and guidance on setting behavioural objectives focuses in writing values related objectives. Staff Survey remains in top 20% of Trusts - Improvements in the annual staff survey and Multi Professional Education and Training (MPET), especially relating to bullying and harassment. Staff sickness below 3.75% for the year outcomes Staff sickness below 3.75% for the year	50% to 75%	Rolling out values training to all staff. Values now incorporated into objectives and value based questions being developed for recruitment interviews. Have remained in top 20% of Trusts for Engagement. Overall reduction in staff sickness rate not yet reached. Currently 4.2%	Sickness not reducing as per trajectory	Amber	Continued supporting of managers to manage and reduce absence. Introduction of supervisory ward sisters to support staff. CB is also doing a refresh of health and wellbeing strategy with emphasis on support for staff on sick leave.	Trust Board and HR Board	Amber		Dir W&OD	Trust Management Executive
2	CSS	2.1	We will further refine our strategic intentions and operational role in community service provision	Clear position statement on the provision of community services by UH Bristol. Direction of travel agreed for community services currently provided by UH Bristol.	Develop Partnership Agreement with Bristol Community Health (BCH) as a means of developing opportunities for improved integration of UH Bristol service offer with community services. Confirm future service model and organisational hosting arrangements for Bristol Homeopathic Hospital Services. Scope and identify further opportunities for community service partnerships. Identify test and learn opportunities with community provider partners such as GP Care and others	25% to 50%	Approval by TME for Bristol Homeopathic Service to explore becoming a Social Enterprise under the "Right To Provide" DH initiative. Test and Learn Pilot agreed with GP Care, contract signed with service commencement September 2012 (Consultant Line)	Limited capacity in UH Bristol and BCH Executive Teams to develop joint proposals impacts on pace and scale of achievement.	Green	Clarity regarding priorities for Executive time and appropriate prioritisation of initiatives with greatest potential for positive impact	Executive team oversight	Green		Dir SD	Clinical Strategy Group
2	CSS	2.2	We will confirm our intentions with regard to major strategic opportunities that are likely to arise in the medium term including our role on the provision of services to the Weston community, our role in the running of SBCH and the organisational model through which we will work with North Bristol Trust.	Clarity regarding organisational model for acute services in Bristol. UH Bristol position in relation to SBCH and Weston formulated and agreed by Board.	Continue to work in close partnership with NBT to consider and evaluate options for organisational integration. Actively engage in the "Weston Futures " project to maximise UH Bristol opportunity to work in partnership with WHAT for mutual benefit. Successfully embed Lead provider role for SBCH	25% to 50%	Acute Services Project established and underway. Service Planning (SP)work underway to develop SP upon which OBC will be developed. Good engagement from UH Bristol Executives and lead clinicians in Weston Futures work and developing engagement between respective clinical teams notably in relation to gynaecology and maternity services. Agreement reached with NBT regarding respective roles in supporting Weston. Proposal to provide maternity services submitted to commissioners in July 2012, outcome expected Autumn 2012.	Failure to reach agreement with NBT and commissioners on future acute service strategy. Current Weston model of an Integrated Care Organisation operating as an NHS Foundation Trust cannot be stacked up financially and role of / impact upon UH Bristol becomes uncertain again.	Green	Weston Futures Transition Board established with UH Bristol as active player to ensure UH Bristol has maximum opportunity to both support and influence.	Acute Services Project Board established with independent chair in place. Clinical Strategy Group retains corporate oversight of all Weston Futures work.	Green		Dir SD	Clinical Strategy Group
2	R&I	2.3	Partnership Working – we will work with our Bristol Research and Innovation Group for Health and regional partners to align our research and clinical strengths leading to the establishment of a Bristol Academic Health Sciences	Academic Health Sciences Collaborations operating across health partners with demonstrable increase in research and teaching activity as a result.	Establish successful HITs programme of work and support. Engage with Formal AHSC application process.	50% to 75%	Bristol Health Partners (BHP) formally established in May 2012. Director (Professor Peter Mathieson) appointed. Positioned and ready to apply for formal AHSC accreditation as and when next call from DH released.	Lack of engagement at divisional level	Green	Performance management of HIT delivery	BHP Executive Group and BHP Board	Green		Dir Med	Bristol Research and Innovation Group for Health
3	T&L	3.1	Learning and Development Centre of Excellence - We will create an Academy recognised both within and outside the Trust, that delivers high quality learning and development which is aligned with trust strategies and culture.	The trust will have a Training Academy that delivers quality assured solutions to its staff and the wider community	Academy framework document developed and academy established. Full implementation plan to deliver consistent solutions that are quality assured and appropriately evaluated put in place	50% to 75%	New Teaching & Learning infrastructure implementation to be completed by Q2 (2012) Mapping of cross-divisional training Develop a commissioner-provider model (to meet internal and external demands)	The T&L infrastructure may not support the academy proposal based on current financial model.	Green	Performance management of Academy.	Teaching & Learning Group	Green		Dir W&OD	Teaching and Learning Group
3	T&L	3.2	Skilled and flexible workforce - We will ensure that learning and career pathways are developed based on Trust priorities, are flexible and responsive to changes in service and are supported by effective development solutions	All training is based on Trust requirements, linked to required competencies and provides career development for individuals.	KSF career pathways completed Career planning workshops and support introduced KSFs fully used in performance management	50% to 75%	All 8a and above staff should now have objectives based on divisional operating requirements.	Staff not achieving the objectives set.	Green	Appraisal returns and setting of SMART objectives.	HR Board	Green		Dir W&OD	Teaching and Learning Group

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3	CSS	3.3	To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care	For each of the next three years, we will seek year on year improvements in patient-reported experience of care as measured by our own robust patient surveys and national patient surveys. We will carry out robust patient surveys during 2012/13 to measure progress on these goals. Baseline data will be derived from previous surveys and the targets will be based, as a minimum, on the best Trust score nationally (as determined by the national outpatient survey). We will also seek to improve our scores for 50% of indicators in each successive National Patient Survey.	1. We will reduce patient-reported noise at night. 2. We will ensure that patients are treated with kindness and understanding. 3. We will improve communication with patients: in particular about waiting times in clinic and making sure patients know who to speak to if they have worries or concerns. 4. We want to see fewer complaints being made, but where things go wrong and people have cause to complain about quality of care, we will provide a full response as quickly as possible within agreed timeframes. We will also focus on the quality of responses to complaints and on wider organisational learning from complaints. 98% of complaint responses will be provided within the timescale agreed with the complainant. We will aim for zero dissatisfied complainants due to the quality of response provided.	0% to 25%	1-3. Measurable targets have been agreed with Divisions. Measurement via core surveys. Q1 noise at night score 81 against target of 86; medication side effects score 60 against target of 64; kindness and understanding (postnatal) score 85 against target of 85. CQUIN is formally measured in Q3. 4. 158 complaints received in August (0.4% of activity against a target of 0.25%); 95% of complaints resolved within timeframe against a target of 98%	Risk of complaints reduction not being achieved, based on current trajectory. Risk of patient experience CQUINs not being achieved based on current trajectory.	Amber	1-3. Patient experience CQUINs reviewed by Patient Experience Group 19/9/12. Decisions to be made about purchase of SoundEar noise meters and soft-closing bins. Oncology pilot - patients are receiving additional information about the side effects of medication and are being engaged in conversations about this - potential to transfer learning. 4. Recovery report to September Board, including addressing staffing issues in BEH and T&O OPDs; review of OPD process and Medway interface	Service Delivery Group (for operational risks relating to waiting times, etc.); Patient Experience Group	Amber		Chief Nurse	Patient Experience Group, reporting to the Clinical Quality Group
3	CSS	3.4	We will strive to eliminate all incidents of unintended harm to patients and be recognised nationally for the safety of the services we offer.	To reduce adverse events by 30% and mortality by 15% from the 2009 baseline by the end of 2014.	1. Recover lost ground and achieve a score of 3.5 in the NHS South West Quality and Patient Safety Improvement Programme. This means achieving spread of all key changes in one to three (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas. 2. Implement the NHS Safety Thermometer achieving 50% coverage in Q2, 75% in Q3 and 100% in Q4. 3. Completion of planned histopathology clinical audits in the 2012/13 Clinical Audit Plan. 4. Continue to embed high quality nutritional care across the Trust as part of the follow up to Care Quality Commission inspections in 2011.	0% to 25%	1. The programme overall has been assessed by the Faculty as having reached a score of 2.5. A 15% reduction in mortality since October 2009 achieved. Adverse event rate reduction showing variation. Three of the five work streams on or exceeding target scores. General Ward work stream has reviewed priorities and has identified a need to rationalise data collection in order to demonstrate further progress. Medicines Management is also making progress. 2. NHS Safety Thermometer has achieved 100% coverage in August against a Q2 target of 25%. 3. Histopathology clinical audits agreed in forward plan. We expect all of them to have completed by the end of the financial year. 4. Nutrition screening for adults now consistently over 90%, compliance with protected mealtimes consistently >95% trust wide.	There is a risk that the improvement programme may not progress at a rate sufficient to achieve the target score of 3.5 by the end of 2012/13.	Amber	NHS South West Quality and Patient Safety Improvement Programme: Each work stream has an identified executive lead. Work stream operational leads to produce action plans to demonstrate how they will sustain or on trajectory to achieve the required level of improvement.	Quarterly reports being monitored by the Patient Safety Group	Green		Chief Nurse	Patient Safety Group reporting in to the Clinical Quality Group
3	CSS	3.5	To be recognised for the excellent clinical outcomes we achieve for our patients across all areas of service.	For each of the next three years, we will seek to maintain our 'lower than expected' headline mortality ratings (HSMR and SHMI). We are also committed to developing the use of service-specific standardised mortality ratios to monitor clinical outcomes wherever this data is available to us.	1. We will ensure that at least 90% of patients are treated for at least 90% of the time on a dedicated stroke ward. 2. We will continue to focus on outcomes of care for the frail elderly, including implementation of our extensive Dementia action plan. 3. We will ensure that patients with identified needs (such as a Learning Disability) have a risk assessment and patient-centred care plan in place. 4. We will develop the use of enhanced recovery for all surgical areas. 5. Our aim is to see year on year improvements in one and five year cancer survival, echoing a key priority of the NHS Outcomes Framework. We will work with the South West Public Health Observatory to develop our understanding and practical application of this data. 6. We will re-focus on ensuring compliance with published National Institute for Health and Clinical Excellence (NICE) guidance including targeted use of clinical audit.	0% to 25%	1. For year to date, 69.4% of stroke patients have spent 90% of time on a stroke ward (reported to Board September 2012) - stretch target 90%; 2. Implementation of the Dementia action plan continues to be overseen by the Dementia Strategy Steering Group - good progress; 3. For year to date, 80.5% of patients with a known learning disability have had a risk assessment within 48 hours - target 85%; 4. Trust-wide steering group established to oversee development of enhanced recovery - regular reporting to Transformation Board; 5. Medical Director has received 1 and 5 year survival data from SWPHO - Cancer Board is being asked to own this data; 6. The objective will be measured at year-end in terms of: a) the proportion of NICE TAGs audited as per agreed plan; b) the proportion of NICE TAGs implemented within three months of publication	1. Stroke - the key delivery risk is the operational challenge of protecting dedicated stroke beds at time of high demand for beds. 2. Frail elderly - the key delivery risks are the challenge of enabling all appropriate staff to receive dementia training, and ensuring that the implementation of the standards happens across the whole Trust and is not confined just to Care of the Elderly wards. 3. LDs - the risk is that our targets will not be achieved. 4. Enhanced recovery - the risk of non-delivery is failure to reduce length of stay leading to patients having to spend longer in hospital than required, reducing capacity for other patients. 5. Cancer survival - the risk to achieving our stated goal is that the measures of performance are dependent on the performance of other providers as well as ourselves. 6. NICE - there is a risk that every aspect of a piece of NICE guidance will not be implemented because of local service considerations and	Amber	1. Stroke - comprehensive recovery report to September Board, including Clinical Site Team protocol to keep one bed empty for direct stroke admissions whenever the BRI is on a green escalation status. 2. Dementia - risk is mitigated by leadership/monitoring from the Dementia Implementation Group. 3. LDs - comprehensive recovery report to September Board, including the role of Learning Difficulty Champions. 4. Risk is mitigated by leadership/monitoring from the Bed Optimisation work stream (Improving Patient Flow element of Transformation programme). 5. Risk is mitigated by leadership/monitoring from the Cancer Board. 6. Risk is mitigated by leadership/monitoring from the Clinical Effectiveness Group.	Lead operational and assurance groups for each planned area of action.	Amber		Dir Med	Variously: Quality Intelligence Group, Clinical Effectiveness Group, Clinical Quality Group
3	R&I	3.6	We will achieve compliance as far as is reasonably practicable with all Health & Safety regulations	We will achieve 5 - 10% improvement year on year with audit compliance across the Trust	Each Division/ area drafts and completes resultant action plan to achieve 5% increase in compliance year on year Health & Safety will feature in the Divisional Operating plans as an objective	50% to 75%	We have set compliance against the revised audit process taking place in 2012 this provides Trust compliance of 66%. Annual audits are currently being completed across 6 Divisions (5 clinical and 3 services within Trust Services). This will be completed on 16th October when compliance rates will be calculated and fed back to the Trust executive.	One Division does not comply fully with the standards and requires substantial improvement whereas the remainder do not fully comply with the standards / guidelines and require minor alterations / improvements.	Amber	Health and Safety has become part of the Divisional operating plans and is regularly reviewed regarding progress.	Operating Plans, subject to monitoring and review in Divisions, and via Divisional and Health and Safety Forums.	Green		Dir W&OD	Risk Management Group

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4	CSS / CES	4.1	We will play a greater role in shaping the health system in Bristol and the Southwest through our early and constructive engagement with future influencers. We will improve our reputation with our commissioners by understanding their needs better and rapidly responding to the issues they raise.	Established and productive relationships with PCT Clusters, GP Consortia and National Commissioning Board with evidence of UH Bristol leading, not reacting to, change. GPs will report improved levels of satisfaction with UH Bristol's response to their commissioning intentions and ad hoc issues (evidenced through formal market surveying)	Develop and fully participate in the Healthy Futures Programme and associated sub-groups e.g. BNSSG Clinical Leaders Forum Establish effective working with successor SCG and regional outpost of National Commissioning Board Establish a means of mapping and tracking our reputation with key stakeholders Undertake survey of GP communication needs and satisfaction with services offer	25% to 50%	BNSSG Clinical Leaders Forum now established and meeting monthly with good engagement from UH Bristol clinical leaders and senior management. Continued positive working with developing local National Commissioning Board arrangements GP Survey concluded in May and results fed back to TME and GP Practices; action plan in response to survey findings developed with oversight for delivery via Service Delivery Group (SDG). 360 Survey of partners planned for Q4 to gain greater insights into how UH Bristol is perceived by its key partners locally, regionally and nationally.	No significant risks identified.	Green			Green		Dir SD	Clinical Strategy Group
4	CSS	4.2	We will strengthen our approach to marketing our services to both GPs and consultant referrers with a view to maintaining or growing market share in our target areas	No service losing market share except where as a response to a Trust business decision.	Implement all milestones in GP Engagement Action Plan. Undertake review of purpose and content of GP Newsletter "Stethoscope" in close liaison with GP community and wider Trust. Develop and implement SBCH Marketing Strategy with view to maintaining or increasing market share from SBCH practices.	25% to 50%	GP Engagement planned review by TME at May meeting and good progress against all milestones - on track for delivery. GP Newsletter re-branded and re-launched in April 2012 with positive early feedback from primary care. Opportunities for market share growth being actively pursued in relation to planned care market through review and possible expansion to case mix delivered at SBCH.	Successful marketing by competitors undermines UH Bristol efforts to grow share	Green	Ensuring quality of SBCH offer, understanding priorities of SB GPs and their patients and responding promptly to opportunities for growth.	TME maintains active oversight of GP Engagement and Marketing activities	Green		Dir SD	Trust Management Executive
4	CES	4.3	Agree the nature and form of our future relationships with our major fundraising partners. Agree our priorities for charitable funding and develop cases for support in partnership with charitable leads	Fundraising target for major appeals achieved. Positive working relationships in place with all major charitable partners.	Track delivery of fund raising activities and make changes to strategy / approach as required. Actively engage in A&B Appeal Board	25% to 50%	A&B Appeal Board established, strategy developed. The Grand Appeal making very good progress with strategy and good working relationships developing at both corporate and divisional level.	Financial austerity makes fundraising targets challenging and difficult to achieve. Multiple on-going appeals confuses potential donors with adverse impact on appeal objectives.	Green	Effective appeal strategies and governance arrangements.	All strategic programmes Boards have oversight of fundraising activities of key charitable partners.	Green		Dir SD	Trust Management Executive
4	T&L	4.4	Leaders of the future - We will create leadership and talent pools who are equipped with the skills, knowledge and behaviours required to lead the Trust both now and in the future.	We will have leaders who are fully effective and are able to embrace and deliver change is a safe and sustainable way	Competencies linked to all leadership development activity and integrated into performance management Programmes fully rolled out to target populations based on the Talent Pool	50% to 75%	Leadership Framework agreed. Appraisal process updated. Talent Management Matrix being developed for Bands 7 and above, Bands 5 & 6 and Bands 1 to 4	Refresh of leadership programme underway and taking longer than expected. Resourcing implications for external/internal programmes	Green	Senior agreement on leadership offer.	HR Board and Teaching & Learning Group	Green		Dir W&OD	Teaching and Learning Group
4	CES	4.5	We will continue to work with our media partners locally, regionally and nationally to ensure UH Bristol positions itself as a trustworthy and notable commentator on health issues and is recognised as a successful organisation, through case studies of our staff and patients in relation to Research & Innovation, Teaching & Learning and patient care.	Positive to negative media about UH Bristol increases. All proactive media about UH Bristol is balanced; the Trust is consistently featured aligned to its core values and brand through media coverage. The Trust is known for its commentators	Continuation of improvements, with UH Bristol becoming a commentator as well as a 'reported' story. The Trust seeks to target and maximise exposure through those media accessed by patients and staff.	25% to 50%	The communications strategy is under review including full stakeholder analysis and input. The strategy will include a new way of evaluating media coverage.	Operational issues that have a serious detrimental effect to the Trust's reputation	Green	Through strategic issues & crisis planning		Green		CE	Trust Management Executive
4	CES	4.6	The Trust embraces all appropriate methods of communication, with staff, patients, members and the wider public to involve them in the strategic developments of the Trust.	Staff survey shows improvements in staff perception of communication with respect to capital developments All KPIs being achieved to required standards. Minimal patient complaints about negative impact of construction works	Communications Steering Group is well developed and all communications for the media, patients, staff, members and Governors and stakeholders is consistent, coordinated and cohesive. The emphasis on proactively managing communications enables mitigation of any potential issues The mid project evaluation demonstrates a positive outcome for all affected audiences. The Trust works closely with its key charitable partners to ensure cohesion of messages.	25% to 50%	All projects are supported by a communications strategy and plan; evaluation is under way for the communications activities around key changes to the BRI drop off and pick up. In addition the BHOC development is coming on stream and a coordinated approach is being implemented across all the fundraising partners, incl. Above & Beyond, the Grand Appeal, the Friends of the BHOC, TCT, Help Appeal	Failure to identify relevant stakeholders and implement appropriate communications	Green	Continue to enforce discipline of proactive communications and engagement plans in all change projects and programmes.	Monitoring of media coverage and patient and stakeholder feedback. Full evaluation undertaken of the COMMS activity around drop off/ED access	Green		CE	Capital Programme Steering Group

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5	ES	5.1	An Estates Strategy exists which is agreed by the Board, covering the period up to 2020. Approved Site Development Control Plan exits	Develop a 10 year Estates Strategy and secure Board approval Develop a three year rolling capital planning programme to support Estates Strategy. Develop a Site Development Control Plan	Review plans for the implementation of Phase 4 and align these with the 3 year rolling capital programme. Review year 2 of the 3-year rolling capital programme to reflect progress made and changing operational requirements	25% to 50%	SESG approved scope of works. TME received range of issues requiring inclusion. TME received report on options for private healthcare. Draft report on Old Building disposal in production.	Debate around Trust merger.	Green	The actions in progress column.	Monitored by Strategic Estates Steering Group	Green		COO	Trust Management Executive
5	ES	5.2	Ensure on-going compliance with all annual fire and safety audits.	Avon Fire & Rescue Service issue no Improvement Notices. Health & Safety Executive issue no improvement notices. Care Quality Commission Outcome 10 (Safety and Suitability of Premises) remains compliant. Willis Risk Management Audit shows no major unmitigated risks.	Annual external surveys undertaken for fire, legionella, asbestos, windows, water quality, disabled access, security. Annual Willis Risk Assessment undertaken, reviewed against preceding action plan and updated. Close liaison with Divisions to identify issues. The capital programme to be prioritised and addressed through slippage in 12/13 capital plan; to be reviewed in 13/14 prioritisations. Maintain back up generator testing prior to installation of new HV generators in Autumn 2012.	50% to 75%	Centralised generator project proceeding. Regular review / update of Risks in Risk Register. Progressing capital.	Pause in Fire Safety Improvement Programme due to capital non-availability.	Green	The actions in progress column.	Monitored by Service Delivery Group	Green		COO	Service Delivery Group
5	ES	5.3	To strengthen our approach to business continuity with the aim of ensuring patient safety and minimising operational disruption during times of incident.	UH Bristol viewed as a beacon Trust in the Avon Health Emergency Response Group area. Outcome of test exercises identifies no major shortcomings in Trust arrangements	Implement arrangements and clarify responsibilities for business continuity re-assessing the balance of corporate and divisional responsibility Review of suitability of existing Business Continuity Plans	25% to 50%	Review and feedback / lessons learned with regard to incidents reviewed by SDG.	History shows departmental Business Continuity Plans are often wanting when tested in anger.	Green	The actions in progress column.	Monitored by Civil Contingencies Committee; Internal audit planned.	Green		COO	Civil Contingencies Committee
5	ES	5.4	Improvement trust wide satisfaction with the services provided by the Estates Function Development of KPIs and systems of feedback from Divisions to ensure improvements in responsiveness	User surveys indicate an 80% level of compliance with Service Level Agreement Key Performance Indicators User surveys show 80% return being good or excellent	Set standards for estates and facilities services, including response times. Develop a set of KPIs to monitor achievement of standards and report at divisional level Agree key performance requirements with Divisions annually and introduce an annual Division to Division review of estates performance	25% to 50%	Estates Transformation Project proceeding to programme. Customer survey about to be undertaken. Person appointed to develop an Estates Service Level Agreement.	On programme.	Green	The actions in progress column.	External review; actions being monitored by Audit Committee	Green		COO	Service Delivery Group
5	ES	5.5	Ensure estates practice contributes fully to infection control objectives	Internal and external Assurances / Audits indicate no major shortcomings in key safety related areas. All improvements to process identified through assurances and audits are fully implemented. Compliance with HTMs 1 -7 Assured regularly (at least once every 2 years) Increased percentage of single rooms available year on year.	Review Asset Base and Project Portfolio Management requirement of that base. Implement review of PPM delivery / completion against pre-agreed KPIs. Produce annual report for Infection Control Committee on all aspects of infection risk including Legionella Compliance Implement ward upgrade improvements	25% to 50%	PPM Programme reviewed and updated. Implementation of Estates Transformation Project to programme.	Actions on programme.	Green	The actions in progress column. No plans to increase single rooms before 2014/15.	Monitored by Infection Control Group	Green		COO	Service Delivery Group
5	ES	5.6	Reduce further our carbon footprint	Carbon footprint is reduced by 5% per annum over next 3 years	Achieve annual reduction in energy consumption of 5% per annum over next three years. Relaunch Big Green Scheme to include Green impact award. Implement annual milestones of three year energy strategy and Big Screen Scheme.	50% to 75%	Big Green Scheme reporting to Trust Board July. Green Impact Scheme Awards ceremony. Capital programme / Spend to Save projects being implemented and new projects developed / evaluated.	Actions on programme.	Green	The actions in progress column.	Reported through Big Green Scheme	Green		COO	Service Delivery Group
6	T&L	6.1	Implement revised performance management processes to better align individual performance with trust goals	Performance management will fully support the achievement of Trust goals	Performance management process fully implemented. quality baselines for performance management implementation established Compliance levels at 85%	50% to 75%	Appraisal rates currently at 86%	Maintaining appraisal rates at 85%	Green	Monthly monitoring at corporate and divisional level		Green		Dir W&OD	Teaching and Learning Group

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6	LTFP	6.2	Develop and embed a Trust wide transformation programme to ensure that the Trust maintains and wherever possible improves the quality of its services whilst reducing the cost base of those services in line with funding requirements.	The Trust achieves a balanced plan for the next three years	Embed the programme for Transforming Care across the Trust Ensure appropriate management structures are in place to deliver Transforming Care including Transformation Board, Programme Steering Group and Programme Management office. Ensure Transforming Care Programme is aligned at Executive level and maximizes available resource.	50% to 75%	A transformation programme has been developed with objectives agreed at the transformation board meeting in April. Twelve work streams have been established running across the organisation and supporting Divisional CRES Schemes which has helped achieve a balanced plan. There is clear accountability for delivery for each of the work streams and Divisional CRES schemes. A project management office has already been established to support process, ensure rigour and support clear accountability.	Change in Programme Director could delay progress.	Green	Regular one to ones between Programme Director and Chief Operating Officer.	Review by Monthly Transformation Programme Steering Group.	Green		COO	Programme Steering Group
6	CSS	6.3	Delivery of significant improvement in outpatients by 2014.	The Outpatients function is transformed and is upper quartile nationally on a range of indicators including new to follow-up appointments, Do Not Attends and Cancelled appointments. Clinical Administration is streamlined by using technology, the new Patient Administration System is used to best effect and saved Consultant PAs have been redistributed/eliminated.	Implement the plan for analytical bookings agreed in 2011/12 and review planning of new and follow up appointments. Continue to introduce Digital Dictation and Voice Recognition across the Trust resulting in Clinical Administration savings. Identify consultant PAs that can be reduced by better Outpatient clinic utilisation. Identify further appointments arising from Medway implementations.	25% to 50%	There is a specific work stream for outpatients and is well established under the leadership of the finance director. There is a focus in reducing cancelled appointments. A new information management system has recently been introduced.	Focus on Medway could delay operational benefits	Green	Operational team and Medway working together	Review by Monthly Transformation Programme Steering Group.	Green		COO	Transformation Programme Board
6	CSS	6.4	Delivery of significant improvement in theatre productivity by 2014.	Theatre processes have been fully re-engineered and have released significant savings.	Implement Year 2 of the Productive Theatre Programme. Eliminate the use of Waiting list initiatives through better Theatre scheduling and utilisation. Eliminate last minute cancellations for theatre reasons and deliver re-bookings within 28 days. Maintain the short notice protocol for DNA patients (Eye Hospital) and staggered admissions on the day is introduced.	25% to 50%	There is an established work stream for theatre improvement led by the Divisional Manager for Surgery, Head and Neck. Productive theatre processes have been introduced and well established.	Programme is in its third year and risk that interest could be waning.	Green	work with Transformation teams to refresh programme.	Review by Monthly Transformation Programme Steering Group.	Green		COO	Transformation Programme Board
6	CSS	6.5	Delivery of improvement to upper quartile for Average Length of Stay (ALOS) and associated bed productivity by 2014.	The Trust's Average Length of Stay (ALOS) is Upper quartile for the majority of HRGs.	Improve discharge processes for routine, more complex and highly complex patients. Reduce and sustain the number of non-elective medical patients with a Length of Stay of more than 14 days to 40. These initiatives will enable the permanent closure of beds – in Medicine the current projection is two wards. Move towards upper quartile ALOS for the majority of HRGs. Implement revised urgent care pathways and reduce medical admissions, close flex beds except in times of peak pressure.	25% to 50%	A work stream to improve bed optimisation is well established led by the Divisional Manager for Medicine. Significant focus is being placed on reducing patients with a length of stay of more that 14 days, including escalation processes.	Risk that referrals and emergency admissions do not standardise / decline as planned so benefits of reduced Length of Stay cannot be realised.	Amber	Activity reviewed with commissioners.	Review by Monthly Transformation Programme Steering Group.	Green		COO	Transformation Programme Board
7	CSS	7.1	Develop and implement an engagement programme that ensures staff are fully involved in the work and development of the trust, are able to contribute to its further development and go the extra mile to ensure its success.	Fully engaged workforce evidenced by their participation in and awareness of transformation programme, reflected in staff survey results	Transforming Care fully launched as the vehicle for engagement of staff across the Trust. Full engagement plan in place for each pillar within transforming care, designed to reach all stakeholder groups.	25% to 50%	Transforming Care Programme Workshops in February/March. Workshops being rolled out within divisions. Monthly programme steering group reporting on all themes.	Lack of full engagement with staff.	Green	Senior and clinical management engagement at divisional level	Programme Steering Group and Trust Board	Green		Dir W&OD	Trust Management Executive
7	R&I	7.2	We will train, mentor and support research-active staff to deliver high quality translational and applied health services research of direct patient benefit in our priority areas of research	Increased number of staff participating in research activities with associated increase in number of approved research Pas, patients in trials and grant income.	Research staff within the Divisions will receive input from R&I staff to develop individual development plans to be agreed at appraisal. The development plans will support delivery of new national metrics around the time taken to recruit patients into trials. Return on Investment to research methodology units will be monitored against successful grant applications and income. Commercial income will be monitored against contract value.	25% to 50%	Research Matron appointed to support performance management, training and development of staff. The matron will commence employment in September, funded for first year from WCLRN FSF funding.	None Identified	Green			Green		Dir Med	Research Group
7	CSS	7.3	Ensure continuing GMC licensing of all Medical Staff, and compliance with Responsible Officer legislation, through the development and operation of an effective and efficient Revalidation process	An effective and efficient system of Revalidation supporting the continued licencing of Medical Staff by the GMC	Ensure the development of Trust's Revalidation system and the identification of continuous support to operate Revalidation. Identify a system for remediation.	0% to 25%	Appointment of Associated Medical Director for Revalidation achieved.	Ensuring appropriate levels of Appraisals amongst consultant staff to meet GMC revalidation time line	Green	Increased communication to consultants re appraisal expectations and increased training provided for Trust appraisers.		Green		Dir Med	Trust Management Executive

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7	T&L	7.4	We become an acknowledged regional leader in equality and diversity outcomes both for our patients and staff	All Trust staff (new and existing) undertake basic E&D training dealing with communication and behaviours Selected Trust staff undertake specialist training and updates Patient satisfaction levels are broadly similar across all protected characteristics Patient complaints centred on E&D issues are minimised Staff satisfaction levels are broadly similar for all protected characteristics	Year on year increase in % accessing training. Target 80% by 2014 Year on year development of trained and supported staff, competent in new legislation, new clinical issues such as dementia care etc. Rising patient satisfaction levels and low differentials Reduction by 15% Rising staff satisfaction levels and low differentials	50% to 75%	Values training centering on communications and behaviours being rolled out to all Trust Staff.	Lack of senior management engagement in driving the equality agenda.	Green	Provision of training to Trust staff	Regular reporting of numbers attending	Green		Dir W&OD	Equality and Diversity Steering Group ; Patient Experience Group
7	T&L	7.5	We become a national exemplar for the NHS Equality Delivery System	Implementation of the NHS Equality Delivery System	Implementation enables the Trust to make year on year improvements in reported health outcomes for those in protected groups	25% to 50%	Results of inpatient and staff attitude survey measure progress towards achievement	Lack of senior management engagement in driving the equality agenda.	Green	Monitoring of attendance	Regular reporting of numbers attending	Green		Dir W&OD	Equality and Diversity Steering Group Trust Board
8	IT	8.1	Implement modern clinical information systems in the Trust	Modern clinical information systems are in use in the Trust	Phase 1 Go-Live of replacement core systems and Clinical Desktop Integration. Phase 2 and Phase 3 work commences	0% to 25%	Implemented April 2012	Continuing monitoring of system operation.	Green	Regular monitoring group in place.	IM&T Committee and CSIP Committee	Green		DoF	Information Management and Technology Board
8	IT	8.2	Review and deliver fit for purpose clinical admin support processes	Fit for purpose clinical admin process in place	Agree and implement action plan arising from review. Convert into transformation work streams.	75% to 100%	Now converted into other work streams	None Identified	Green			Green		DoF	Transformation Programme Board
8	IT	8.3	Improve our ability to manage our business through the production of robust and timely business intelligence to both head quarters and divisional staff	20% reduction in analyst time spent on routine report preparation. Improved Divisional satisfaction with information format and flow	Train operational and corporate teams in the use of the QlikView Business Intelligence System. Implement InfoFlow for publishing QlikView reports to a wider audience. Develop and implement the Workforce and 2012/13 Service Level Agreement report modules. Develop relevant Trust & Divisional Board, Committee and Group performance reports which can be automatically updated via QlikView.	50% to 75%	Financial and Performance leads for QlikView Business Intelligence System have received training on the use of InfoFlow. A plan will now be developed and implemented, to use InfoFlow to manage the publication and distribution of all types of reports to staff across the Trust (both QlikView and Excel based reports). Cancer PTL forecasting tool in development and RTT data quality exercise in train. Workforce dashboard developed and in testing phase.	None	Green	Not applicable	Not applicable	Green	Not applicable	Dir SD	Trust Management Executive
8	LTFP	8.4	Develop better understanding of service profitability using Service Line Reporting	Better resource allocation in the Trust	SLR development.	0% to 25%	2011/12 Quarter 3 results published April 2012. Quarter 4 publication planned for August 2012 after completion of the National Reference Cost exercise.	None Identified	Green		Results published and discussed with Divisions.	Green		DoF	Finance Committee
					Inclusion in Medicine Review.		Report to April 2012 meeting of the Finance Committee. Study to be extended in Quarter 2 to the Surgery, Head and Neck Division.	None Identified	Green		Report to Finance Committee	Amber			
							Trust involved in the development of a Patient Cost benchmarking tool with c40 other NHS organisations.	None Identified	Green		Results published and discussed with Divisions.	Green			
9	T&L	9.1	Deliver a full Trust review of structures using the "spans and layers" approach	Structures will have appropriate spans of control and the number of layers between senior leaders and patients will be minimised	Roll out in line with plans Formal establishments and maintenance targets agreed for completed areas.	25% to 50%	A number of departments are using spans & layers methodology	Currently only being used by areas that request supporting methodology. Full Trust review as currently offered as optional consultancy tool	Green	Ensuring spans & layers is included in all service reviews in line with operating plans	HR Board and monthly building capability theme meetings	Green		Dir W&OD	Trust Management Executive
10	LTFP	10.1	Deliver minimum normalised surplus	Deliver minimum normalised surplus	Achieve positive contract settlement with BNSSG and SCG commissioners	75% to 100%	Service Agreement contracts for BNSSG on 30th April. South West, South Central and West Midlands Specialist Commissioning Groups contracts signed on 4th May. Non BNSSG contract signed also signed in May.	None Identified	Green		Signed Service Agreements. SLA performance fines and PCT income challenges risks mitigated in contracts.	Green	962	DoF	Finance Committee
10	LTFP	10.2	Deliver minimum cash balance	Deliver minimum cash balance	Maintain ratio of at least 15 days and cash balance of no less than £15m.	0% to 25%	Trust remains on target to meet objective this year.	None Identified	Green	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	Green	962	DoF	Finance Committee
10	LTFP	10.3	Deliver the annual Cash Releasing Efficiency Savings (CRES) programme in line with the LTFP requirements	Cost reductions commensurate with CRES target achieved	Ensure robust in year oversight of Divisional CRES plans through monthly Finance & Operations Reviews Develop recurrent CRES plans to ensure all non-recurrent CRES is secured recurrently by Q3 2012. Review approach to 2013/14 CRES identification to mitigate risks associated with future CRES requirements	75% to 100%	The Trust is forecasting 85% (£23.720m) delivery of its CRES target of £27.622m. Of this £5.887m is currently identified as non recurring. The performance to date as at month 02 is delivery of £3.924m against a target of £4.718m.	Key risks are that currently £3.902m of CRES remains unidentified. Also whilst all effort is made to ensure current plans are robust, there remains a risk of some CRES schemes slipping due to for example inability to close wards due to operational demands	Amber	Risks are reviewed each month at finance and operational reviews chaired by the COO. Plans are also reviewed each month at Divisional CRES reviews. Divisions are required to deliver their operational plans and so any shortfall on CRES will be picked up and dealt with within each Divisions recovery plan required as part of the Trusts escalation process.	Reports to Finance Committee from each Division on a monthly basis	Amber	741	COO	Finance Committee

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2012-2013	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
11	LTFP	11.1	Maintain Monitor Financial Risk Rating of 3 or above	Maintain Monitor Financial Risk Rating of 3 or above	Achieve EBITDA, Net Return after Financing, Net Surplus Margin and Liquidity ratio in line with plan	0% to 25%	Financial Risk Rating of 3 to Month 4. On track to achieve RR 3.	Delivery of CRES plan. Increase in volume of clinical activity to secure income from activities income in line with SLA and Trust Plan.	Green		Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	Green		DoF	Finance Committee
11	T&L	11.2	Achieve Compliance with EU Working Time Directors for Medical Staff	All staff will be working appropriate hours, ensuring a safe workplace for patients and staff	Remain compliant in audit	25% to 50%	Monitoring of all rotas continues, in close conjunction with Lead Doctors and HR Business Partners. Remonitoring exercises undertaken where required; any risks reported to Director of Workforce.	Trauma & Orthopaedics remains a risk area, rota still functioning as non-compliant whilst a 2A 80% banding is being paid as part of a compromise agreement. Maxillo-Facial Surgery has a city wide rota and has monitored non-compliant, their NBT counterparts function on a non-compliant rota which exacerbates the risk, meeting in place for mid October to discuss. Cardiology are going through a Banding Appeal; the results will be communicated. Paediatric Anaesthesia remain on a 2A banding, monitoring results due shortly to see if banding can be reduced.	Amber	Maintain communication with job holders concerning hours worked.	Monitoring of Junior Doctors hours.	Amber		Dir W&OD	Trust Management Executive
11	CSS	11.3	Maintain registration with CQC including compliance with essential standards of quality and safety	Continued compliance with all relevant CQC standards	Ensure on-going compliance with all CQC registration Outcomes	0% to 25%	1. CQC Abortion Act inspection found Moderate Concerns in relation to Outcome 21 at Central Health Clinic - action plan submitted to CQC - non-compliant activity ceased immediately it was identified 2. CQC Histopathology final report - compliant with all relevant Outcomes of care. 3. CQC Scheduled Inspection 21 June 2012 - non-compliant with Outcome 13 for 'maternity and midwifery services' (regulated activity) at St Michael's Hospital (Main Site registration) - action plan submitted to CQC. 4. CQC DANI inspection SBCH, 15 August 2012 - draft report awaited 5. CQC Responsive Review Ward 32, 5 September 2012 - draft report awaited.	The objective of maintaining continued compliance has, by definition, not been achieved. The specific issue which led to Outcome 21 non-compliance has been addressed - our action plan demonstrating compliance has now been sent to CQC (the Trust should consider self-declaring compliance). The planned unannounced inspection visit concluded non-compliance with Outcome 13 - an action plan for achieving compliance has been sent to CQC.	Red	The specific issue which led to Outcome 21 non-compliance (HSA1 forms) has been addressed and an action plan has been submitted to the CQC. An action plan has also been submitted to the CQC in relation to Outcome 13 maternity staffing. However, by definition, the objective of maintaining continued compliance during 2012/13 has not been achieved.	Regulatory Compliance Group.	Red	402	Chief Nurse	Risk Management Group
11	CSS	11.4	Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.	Continued compliance with all relevant performance standards set as part of Monitor's performance framework (and contractual negotiations), with special reference to those three priorities set out below,	Ensure 4 hour standard is delivered consistently through the year. Maintain grip and focus on cancer standards. Ensure delivery of new RTT standard of 92% of patients on incomplete pathways waiting less than 18 weeks. Highly active management of HCAI agenda in light of revised targets and notably VERY low MRSA target	50% to 75%	Plan developed and being implemented for Q3 and Q4 for 4 hour achievement. 62 day cancer screening target at risk for Q2 cancer. C Diff and MRSA recovery plans in place, noting that 12/13 Cdiff performance is ahead of 11/12 position.	Cdiff: There is a risk that the new C Diff testing regime will increase the number of cases.	Amber	Revised winter escalation plan incorporating feedback from ECIST and NHS South. Co-ordinated 4 hours plan. Recovery plan for C Diff performance.	Emergency Care Intensive Support Team. NHS South.	Amber	743	COO	Trust Management Executive

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

Item 12 – Corporate Risk Register

Purpose

To brief the Board on the content of the Corporate Risk Register.

Abstract

The corporate risk register contains current risks in division risk registers with an inherent risk rating of 15. There is a proviso that any risks identified by exception in the Risk Management Group which require the Board's attention can also be escalated to the corporate risk register. In addition, the corporate risk register presented to the Board will not show a divisional risk which is already reflected in an existing corporate risk.

Three divisions (Surgery Head & Neck, Medicine and Specialised Services) have risks in their risk registers scoring 15 or more which are not shown in the corporate risk register as they are already reflected in corporate risk 741.

Risks escalated to the corporate risk register since last presentation to the Board in July are:

- 1329 Risk of non-provision of radio-pharmacy service beyond 2014.
- 1412 Failure to meet cancer targets
- 1964 Improvements needed in system for provision of pressure relieving equipment (linked to risk 1755 pressure ulcers)
- 1383 Failure to reduce the Incidence of Health Care Acquired Infection, specifically Clostridium Difficile and MRSA.
- 1286 Delays for trauma patients in accessing emergency theatres due to lack of trauma theatre capacity

Risks de-escalated from the corporate risk register since last presentation to TME in July:

- 1316 Radiology plain film backlog: risk reassessed in August 2012 as scoring 10.

The current corporate risk register is provided at Appendix A.

Recommendations

The Board is recommended to **note** the risks contained within the current corporate risk register and that risk 1603 "Compliance with fire safety regulations" will shortly be downgraded as funding had been allocated and a programme of work is being completed to achieve compliance.

Executive Report Sponsor or Other Author

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

Appendices

- Appendix A – Corporate Risk Register

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	10 October 2012				Risk Management Group - 02 October 2012

Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
402	Maternity staffing is below the recommendation of the Safer ChildBirth report (Royal College of Obstetricians/Royal College of Midwives), which could increase the risk of harm to mothers and their babies, lead to the unit being closed to admissions at times and making birth choices for women more difficult to accomodate. This risk is compounded by an increase in overall birth rate in Bristol and fluctuations in activity and complexity of patient which results in increased workload within maternity both within this unit and across the region.	Incidents Or Near Misses	Governance	3.4 Harm Reduction And Safety	21/07/2010	10/10/2012	08/01/2013	Alison Moon	4 Likely	5 Catastrophic	20	4. Extreme	Workforce Management	The staffing of Central Delivery Suite with 8 midwives per shift is prioritised and any short fall is addressed via bank & redeployment of midwives from wards to ensure that mothers receive the appropriate level of care.	Medium	High	Letter sent to the Local Supervising Authority and the Strategic Health Authority highlighting the impact of high workload within the service	Completed.	30/11/2005	07/03/2011	Divisional Board Women's And Childrens
													Workforce Management	The Granby Team midwives (community base) can be called to Central Delivery Suite, and in extreme urgency both the supervisor of midwives and the on-call community midwives can be called to address low staffing levels, ensuring that mothers recieve the appropriate level of care			Repeat Birthrate Plus stafffing assessment tool and bid for funding to meet its recommendations	Completed.	30/11/2005	07/03/2011	
													Workforce Management	Ward clerk cover to support the activity of the Unit is in place for24 hours of each day			Review skill mix and roles - e.g. provision of level 4 maternity worker.	Completed.	30/01/2006	07/12/2011	
													Workforce Management	Appropriately skilled and trained General Nurses employed to support midwives in providing nursing care to mothers on post natal ward			Maternity service review in progress	Completed.	30/01/2006	07/12/2011	
													Planning	Bed management - performed daily to ensure effective use of resources. Escalation plan developed, working with neighbouring Trusts to manage the number of deliveries across the city. Bookings from Mothers outside of Bath North Somerset and South Gloucestershire area managed within a capped limit			Working with Primary Care Trust to reduce admissions of non-labouring women to Central Delivery Suite.	Completed.	07/12/2011	07/12/2011	
													Planning	Guidelines in place for lack of midwives and lack of beds and a procedure for closure of the unit to ensure that mothers and babies can be cared for safely			Expression of interest for additional funding submitted after review of maternity services.	Submission deadline 16th December 2011.	31/03/2012	31/03/2012	
													Planning	Monitoring of deliveries and liaison with Bath and Southmead to re-direct women in labour on an ongoing basis			Working with North Bristol and Weston Trusts to ultilise capacity across the city efficiently	Monthly planning meetings in place. Escalation plans in place for when units are full across Bristol and Weston.	31/10/2012	10/10/2012	
													Workforce Management	Employment of appropriately skilled and trained General Nurses to support the midwives. A General Nurse with recovery room experience is available in Central Delivery Suite. Appropriately trained and skilled staff to provide scrub nurse cover to surgical procedures is available on Central Delivery Suite.			Submitting Expression of interest to capital planning to develop an area alongside the delivery suite where assessment of women can occur alongside delivery suite. Plans for triage area and midwifery led unit and extra 11.4 WTE midwives and plans to transform the model of care under discussion.	Funding for 11.4 WTE midwives and 2 consultants agreed through the Divisional Operating Plan. Plans for investment are being prepared by HoM. Capital agreed for the conversion of Ward 72 into a Midwfiery Led Birthing Unit. Project group in place to take forward development, which is linked to the transfer of ENT services to the BRI and daycase services from QDU to St Michael's. Risks around transfer of ENT across the City and posisble time delay still exist. This is being managed via the project board and the assessment of the risk surrounding delay to scheme and consequent delay in the provision of increased capacity via a midwifery led birthing unit is high.	01/12/2012	Not yet due	
													Funding	Funding required for the service is reviewed on a regular basis to align with delivery numbers Additional funding was provided in 2010/11 and 2011/12. Further 5.6 whole time equivalent staff funded in October 2011. Further expression of interest for further funding submitted.							
													Training	Expediction of mother and baby discharge home through Midwives being trained to undertake clinical examination of newborn babies Introduction of maternity support workers in the community to support mothers and babies following earlier discharges			Risk 402 reviewed and a risk assessment regarding maternity capacity and staffing was accepted by the womens Clinical Governance Committee . The Divisional management team requested in October 2011 that this risk be separated into two risks - physical capacity and staffing. Demand for maternity services is increasing year on year and this will have an impact on the amount of equipment needed, equipment usage (which will include wear and tear on equipment). Bids will be put forward to allow:- 1. A resusuciataire for each labour suite. 2. Replacement of heart rate and contraction monitoring equipment which have exceeded their service agreement period. 3. Increase number of delivery suite beds to meet extended capacity (as identified in risk assessment) and will be suitable for women with a high Body Mass Index	Plan to ensure individual risk assessmenst are presented to the Divisional management team in early 2012. 23rd April 2012 A bid has just been sunmitted for more resuscitarires, beds and CTG's. This bid has been successful.	31/07/2012	01/08/2012	
													Service Redesign	Improved care pathway through improved management of elective caesarean section cases							

Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
741	Cash Releasing Efficiency Savings Plans underachieve and impact on trust annual and planned outturn. This risk is also reflectd as risks scoring 15+ in the risk registers of three divisions (risks 1912, 1420 and 1021) .	Annual Planning Process	Financial	11.3 Maintain Financial Risk Rating	25/06/2012	20/09/2012	19/12/2012	James Rimmer	4 Likely	4 Major	16	3. High	Performance Management	Monthly Divisional CRES reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CRES Programme Steering Group, monthly updated at a glance reports	Medium	Moderate	CRES plans to be monitored at divisional perfomance reviews and recovery actions will be put in place if required. CRES plans monitored at Programme Steering Group chaired by Transformation Director.	Divisional Operating Plans have identified 85% of CRES;plan to close gap by the end of Q2.	31/12/2012	Not yet due	Service Delivery Group
													Performance Management	Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed							
													Performance Management	Divisional control of vacancies and procurement monitored at monthly performance meetings. Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery.							
													Performance Management	Regular Reporting to the Finance Committee and Trust Board							
766	Delays in discharge or transfer due to community services or delays in accessing community services as well as lack of clarity of our own internal discharge planning processes.	Performance Monitoring	Strategic	2.1 Strategic Intentions Community Service Provision	22/06/2012	09/10/2012	07/01/2013	James Rimmer	4 Likely	4 Major	16	3. High	Performance Management	Weekly Trust performance meeting to discuss 'red list'	Medium	Moderate	Hospital DischargeTeam Restructure	Discharge Hub created. Discharge liaison team review. Revised model created with Healthcare @ Home input in MAU and STAU. To be presented to the Execs as a spend to save w/c 15th Oct 2012.	31/03/2013	Not yet due	Divisional Board Medicine
													Local Policy In Force	Weekly community 'red list' meeting takes place and is attended by UH Brsitol Discharge Team Leader.			Social workers to move to 7/7 cover	Discussion with Social Services to review process and structure to work more closely together. Discharge Action Team created - first meeting 9th October 2012 has taken place. Agreed to review processes to identify and agree how best to utilise available resources.	31/03/2013	Not yet due	
													Service Redesign	Restructuring of HDT to incorporate external funtions (e.g. liaison posts, healthcare@home). Draft model proposed. Spend to save to be submitted to the Execs w/c 15th October 2012.			Metrics for 'back door' performance management	Benchmarking undertaken with Southampton NHS Trust. KPIs included in revised discharge team model spend to save proposal w/c 15th October 2012.	31/03/2013	Not yet due	
955	Running of two obstetric theatres out of hours with inadequate theatre personnel. Recruitment of some additional staff, ensuring there are now 3 members of staff available at night, this means that it is possible to open two theatres out of hours and provides some mitigation of this risk. However, there are risks associated with the level of staffing when this occurs and the increased frequency of having to open two theatres, means that this risk remains high. The service is only funded for one theatre and is likely to become increasing problem with increasing maternity workload. This is a shared risk with the Division of Women's and Children (1898).	Incidents Or Near Misses	Governance	3.4 Harm Reduction And Safety	20/04/2012	19/09/2012	18/12/2012	James Rimmer	5 Almost Certain	3 Moderate	15	3. High	Designated Accountability	Out-of hours surgery is co-ordinated by the anaesthetic 'folder holder'. This is the consultant on call. His/her decisions are dependent on accurate information about a patient's condition from the surgeons. The 'folder holder' will prioritise the order of the patients within the Trust.	Medium	Moderate	Review of staffing model, given frequency of use of second theatre to be undertaken by Jane Palmer/Kate Liddington and recommendations to be made regading increased staffing required. Agreement then to be reached with Division of W&C regarding allocation of resource and recruitment to be undertaken accordingly.	Additional recruitment to StMH theatre team has happened	01/04/2012	01/04/2012	Divisional Board Surgery, Head & Neck
													Local Policy In Force	Current 'good will' of the 'day' Anaesthetist to cover after 5pm to undertake emergency surgery or late finishing of elective lists if the on-call Anaesthetist is not able to attend immediately.			Further review of demand for theatre and staffing levels to take place Q1 2012/13		30/10/2012	Not yet due	
													Governance - All Types	Current practice of recovering patient in theatre to ensure adequate anaesthetic and nursing cover prior to commencing surgery on next patient.							

Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1286	Extended length of hospital stay leading to: 1. Additional likelihood of patients outlying on non-specialist wards increasing risk of post-operative complications 2. Increased risk of developing a Hospital Acquired Infection 3. Increased risk of dehydration or acute kidney failure if numerous periods of Nil-by-Mouth pre-operatively 4. Risk of premature death in some instances.	NICE Guidance	Governance	3.3 High Quality Care	05/07/2012	15/10/2012	13/01/2013	James Rimmer	4 Likely	4 Major	15	3. High	Governance - All Types	Daily trauma meeting to review and prioritise patients	Medium	Moderate	Business case for 4 additional weekday trauma lists agreed by Division awaiting Executive sign-off due to Divisional financial position	This proposal has been delayed due to SBCH/QDU timetable allocation.	31/03/2013	Not yet due	Divisional Board Surgery, Head
													Local Policy In Force	7 weekly trauma lists Monday to Friday with additional lists at weekends.			Business case for additional Orthogeriatric input agreed by Division awaiting Executive sign-off as above.	The Division recognises the need for the increase in orthogeriatic input but currently unable to fund extra post. On-going discussions with regards to best practise tariff revenue continues.	31/03/2013	Not yet due	
													Governance - All Types	Process in place for discussion with general surgeons to prioritise trauma patients in CEPOD theatre when appropriate				Planning stages remain - proposal is to allocate 2 beds in ward 14 for direct admissions for patients with fractured neck of femur.	30/10/2013	Not yet due	
													Service Redesign	In times of high trauma demand (>10 patients) elective lists are reviewed and reduced where appropriate							
1329	Planning permission for the current radiopharmacy expires in 2014 (this was extended from the initial expiry of 2010 and we were informed at the time that no further extensions were possible). The strategic decision for the Trust was whether to apply for extension or move the facility. In 2011 a decision was made at executive level to pursue the option to retain radiopharmacy in its existing location and channel effort into achieving this outcome. The risk is that if planning permission is refused the trust would be unable to provide a radiopharmacy service. There is presently no alternative plan for rebuilding the facility on-site, and the timeline for such a build would be approximately 4 years, so if the present facility closes in 2014 the lack of a radiopharmacy service would span a number of years and impact upon many thousand patient procedures. The lack of availability of the service would also reduce Trust income substantially.	Captial And Service Development	Governance	3.3 High Quality Care	03/04/2012	28/08/2012	26/11/2012	Sean O'Kelly	4 Likely	4 Major	16	3. High	Planning	If the radiopharmacy facility is closed, controls would need to be in place with regard to rescheduling patients (numerically thousands) to other trusts for the relevant diagnostic procedures and occasional therapeutic radiopharmacy administration.	Low	High	Escalated to strategic planning discussions	Decision of Trust executives to actively pursue extension of planning permission from 2014.	21/05/2009	14/11/2011	Divisional Board Diagnostics and Therapies
																	Trust considering appeal following receipt of formal response.	Formal response received 2.8.12; appeal being developed. Meeting scheduled 4th September to consider next steps.It was confirmed on behalf of the Trust that, at this point in time, it was not proposed to appeal against the decision of the Council but that the approach would be to work with officers to find an acceptable solution within a reasonable timeframe. Officers confirmed their willingness to enter into a dialogue with a view to resolving matters. The broad timescale discussed was that officers would like to receive (via email) some alternative scheme options for consideration by the end of September. Officers would then provide some feedback during October which could be used to inform the option appraisal document. Interestingly, it was indicated that officers might support a further extension of time for the existing building if matters had not been resolved on a permanent solution but that progress was being made. However, such an approach would be unlikely to provide any more than an additional 12 months.	31/10/2012	Not yet due	
																	CODA architects appointed by estates to design improvements in the appearance of the facility and planning consultants WYG appointed to address the application for extension of planning permission. Pharmacy are engaged in this process to ensure that solutions will satisfy the MHRA.	Planning application submitted		13/06/2012	

Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1383	Failure to reduce the Incidence of Health Care Acquired Infection, specifically Clostridium Difficile and MRSA. Target amended for C diff for 2012/13 . MRSA target exceeded by 2 cases for year 2012/13 as of August 2012. New testing and sample collecting protocol to be introduced. Staff to learn new protocols. Risk of increased numbers due to changes in Trust protocols. MRSA exceeded 3 cases at the end of September. MRSA action plan in place. For approval at October ICG. Risk reviewed in light of performance	Performance Monitoring	Governance	11.4 Maintain Green Rating For	02/10/2012	15/10/2012	13/01/2013	Alison Moon	5. Almost Certain	3 Moderate	9	3. High	Performance Management	Weekly meetings to review actions against outturn. Guidance on priortisation for isolation. Daily review of clostridium difficile numbers and movement of patients. Review of performance against plan at Trust Operational Group meeting, Trust Executive Group Meeting and Trust Board. Action plan delivery monitored and developed at the Trust Infection Control Committee. Trust-wide approach to increasing the number of single rooms. MRSA elective screening in place to meet national expectations. MRSA emergency screening implemented in advance of December 2010.	High	Moderate	Comprehensive action plan in place to prevent and control Healthcare Acquired Infections monitored by Infection Control Committee. Monthly performance monitoring by the Board of a range of infection control metrics. Quarterly comprehensive infection control report to the Board.	August 2011 - progress with action plan presented to infection control group - no outstanding actions December 2011 - awaiting completion of induction period for newly appointed acute pyhsician before progresing some actions related to antibiotic prescribing. No risk to delivery of C diff target as the actions are developmental March 2012 - programme being delivered to timescales	31/03/2013	Not yet due	Clinical Quality Group
													Capital Programme	Increase in single roomas across the Trust as part of the BRI redevelopment from 11% to 33%							
													Audit -Trust Origin	Matron and ward monitoring for C diff dashboard monthly							
													Audit -Trust Origin	Saving lives/High Impact Intervention programme to reduce bacteraemias with audit of practice monthly							
													Documentation -Trust Paperwork	Admission risk assessment form							
													Local Policy In Force	Policies in place for MRSA and C diff prevention and management							
													Monitoring Board/Commitee	Infection control Group monitor progress quartlerly							
													Monitoring Board/Commitee	Trust Board monitor C diff and MRSA performance monthly							
													Training	Infection control induction and update training with compliance over 90%							
													Information Technology	Use of identification by alert on clinical information systems							
													Planning	Infection Control delivery programme developed and implemented annually							
1412	Failure to meet Cancer Targets, specifically 2-week, 31-day and 62-day target.	Performance Monitoring	Operational	11.4.2 Compliance With Cancer Access Targets	20/09/2012	20/09/2012	19/12/2012	James Rimmer	4 Likely	4 Major	16	3. High	Monitoring Board/Commitee	Weekly meetings held with all Divisions to review cancer patient tracking. Performance reviewed every two weeks at the Service Delivery Group and at the Trust Management Executive via SDG. Performance reported to Cancer Board at every meeting.	Low	High	Cancer Action plan in place and reviewed routinely at the weekly meeting. The cancer action team manage every referral that comes into the Trust. Weekly breach analysis to identify cause of breaches.Fortnightly meetings with Surgery, Head and Neck Division to review identified problems with surgical capacity.	Additional theatre sessions in place to meet breaches. Improved communications between services. 2 week, 31 day and 62 day referral to treatment met. 62 day GP screening not met.	31/03/2013	Not yet due	Service Delivery Group
													Service Redesign	Choose and book - implemeted for 14 day breast and seen performance improve to 98%. needs to be sustained at this level or better							
													Service Redesign	Additional ITU capacity - identified as cause of several key 62 day cancellations and addressed through additional capital investment in 2010 on interim basis and 2011 on semi permanent basis							

Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1422	Failure to meet the 5 core ED clinical indicators results in non-compliance with Monitor and this will incur significant financial penalty to the Trust. 1. 95% percentile achievement of 4 hour arrival to disposal standard 2. Initial assessment to be completed within 15 minutes of arrival foe ambulance patients 3. Time to treatment - 60 minute median for al ED patients arrival to start of treatment (start of treatment defined as point of assessment by discharge capable clinician) 4. Number of patients who 'did not wait' to be seen 5. Number of patients who return to ED for the same complaint within 7 days of previous ED attendance	Regulatory Compliance	Governance	11.4.1 Compliance With Emergency Access Targets	22/06/2012	02/10/2012	31/12/2012	James Rimmer	4 Likely	4 Major	16	3. High	Local Policy In Force	Clinical Site Management Team ED electronic tracking board located in ED, MAU, CSM team offices, STAU and on Connect. ED staffing structure to support compliance with the standard, validation processes for all 4 hour breaches, additional portering staff to assist with transfers and admissions, 3 daily patient flow meetings, data analysis and bank holiday planning.	High	Moderate	- Winter planning event for Trust organised for 05/07/2011 to prepare for seasonal winter pressures. - Review of site team remit, structure and responsibilies. - Review of Band 7 non clinical time on wards - KPI for wards. - New internal transfer process	Pilot phase for transfer process out of ED and MAU has finished but will not be continued. New administrative role in Majors is now in the pilot phase and is likely to continue. The staff consultation phase is about to commence. This will assist with flow and administrative duties to release clinical time. Divisional escalation plan has been written led by the DDM of Medicine Ward Sister Supervisory role is in place this will focus on patient flow. New CMS system is in place that will now facilitate automatic hospital diverts. Emergency Access Steering Group is currently being held weekly to monitor the ED clinical indicators	31/03/2013	Not yet due	Divisional Board Medicine
													Performance Management	Daily validation process and review of performance			- Winter planning event for Trust organised for 05/07/2011 to prepare for seasonal winter pressures. - Review of site team remit, structure and responsibilies. - Review of Band 7 non clinical time on wards - KPI for wards. - New internal transfer process out of ED and MAU in pilot phase. - New exec to exec divert agreement process with GWAS - Facilitator role in majors planned to assist with flow and administrative duties to release clinical time - Creation of 'ambulatory care centre' within UH bristol - Review Consultant job planes across Division - Trial ENPs working in majors	Pilot phase for transfer process out of ED and MAU has finished but will not be continued. New administrative role in Majors is now in the pilot phase and is likely to continue. The staff consultation phase is about to commence. This will assist with flow and administrative duties to release clinical time. Divisional escalation plan has been written led by the DDM of Medicine Ward Sister Supervisory role is in place this will focus on patient flow. New CMS system is in place that will now facilitate automatic hospital diverts. Emergency Access Steering Group is currently being held weekly to monitor the ED clinical indicators	31/03/2013	Not yet due	
													Governance - All Types	Feedback to clinical staff each time a breach occurs			The whole ED team need to consider how this can be achieved and maintained with current resources	Unable to validate all 15 minute ambulance arrival times until staffing levels increase. Agreement from DDM Medicine to use short term bank band 2 to complete this work. Regular meetings to take place with GWAS and Bristol PCT to review and monitor performance and to look at more efficient ways of working	31/03/2013	Not yet due	
													Monitoring Board/Commitee	Review of performance on a weekly basis. There was a short term dip in performance due to validation issues in response to the new IT Medway system. This has now been rectified.							
													Equipment	Review of resources and equipment in order to achieve this indicator (medical and nursing). There was a short term dip in performance due to validation issues in response to the new IT Medway system. This has now been rectified.			- Planned process changes for all expected patients to avoid admission through the ED - this needs to be actioned and driven throughout Trust senior management including Cheif Operational officer - Purchase of time stamp machines for use in ED to accurately record in notes when patient treatment from Dr or ENP begins - Review appropriate staffing requirements against demand	Time stamps purchased. 2 extra consultants in place An advert for an additional 4 ENP's is currently advertised.	31/03/2013	Not yet due	

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1603	Compliance Risk Compliance with the Regulatory Reform Order 2005 Act and Firecode Health Technical Memorandom 05-02 The risk stems from the fact that a £4m. programme of works, approved by Capital Prioritisation Group, has not yet been completed. As part of the programme, all hospitals have now been brought up to the L1 fire detection and alarm rated standard (The highest rating for health care premises). This has materially improved the overall risk profile. A programme for other remedial works has still to be completed covering BHOC, BRI Queens and the KEB buildings. Capital funding is awaited to continue the programme. Non compliance, could lead to a further Notice being served upon the Trust and / or prosecution by Avon Fire & Rescue In September 2012 the Director of Facilities and Estates presented a report to the TME inrespect of outstanding fire precautionary works to the BRI Queen`s building, The structure of the report was to identify in priority order the compartmentation works to all floor areas. The report highlghted that we should under take work on levels 5 first follow by level 6, the sum of money to under take this work amounts to £300k The TME gave their approval to this request and we (estates) are presently in the procurement stage of the contract. The Director of Facilities and Estates also confirmed that a sum of money had been ring fenced to complete the remaining floor levels in the new financial year 2012/2013	Regulatory Compliance	Operational	5.2 On-Going Compliance With Fire and Safety Audits	09/08/2010	03/10/2012	01/01/2013	Claire Buchanan	4 Likely	4 Major	16	3. High	Partnership Working	Programme of remedial works to take all hospitals to complete compliance is designed. Schedule of next priority (Queens Building) works will go to Capital Programme Steering Group in August to consider phased release of funding to allow phased implementation of works on a floor by floor basis, risk assessed. Implementation of the new Fire Safety Policy by monitoring Divisional compliance with Departmental Risk Assessments being in place - managed by Service Delivery Group Fire Training - frequency of training has been increased to meet statutory requirements to annual. Compliance being monitored through Servive Delivery Group Ad hoc inspections, visits and specialist training for Risk Assessors continuing on an ongoing basis. Departmental Risk Assessment for has been simplified to encourage its completion Capital funding to the sum of £300k has been approved (September) to commence the fire compartmentation works, we have now	High	Moderate	In addition to other actions, ad hoc visits, inspections and audits undertaken by the fire safety team across the Trust.	Regular and ongoing activity	31/03/2013		Service Delivery Group
													Workforce Management	Competent adviceConsultants + recruitment			Capital Programme Steering Group have oversight of the issue and whilst the risk is above the surveillance level it is reviewed by Risk Management Group and Service Delivery Group.	Capital Programme Steering Group to review availaility of capital to progress remedial programme.	31/03/2013		
																	New fire policy agreed - implementation of Departmental Risk Assessments by the Divisions is being monitored by Service Delivery Group.	Currently running at 57% compliance with Departmental Risk Assessments.	31/03/2013	Not yet due	
																	Fire Training - availability of training courses increased - although take-up is suboptimal.	Progress by divisions towards compliance is slower than required profile	31/03/2013	Not yet due	

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1640	Pharmacy service unable, at weekends and out of hours, to provide the level of clinical support and medicines supply required to meet all patient and Trust demands.	Service Wide Risk Reviews	Governance	3.3 High Quality Care	30/04/2010	26/07/2012	24/10/2012	Sean O'Kelly	4 Likely	4 Major	16	3. High	Workforce Management	Pharmacy project group set up to look at what steps can be taken to improve - see actions for full details of outcome of group.	Medium	Moderate	Raised within division, and a senior review team set up (divisional manager, divisional finance lead, divisional HR lead, pharmacy management team, pharmacy health and safety lead and pharmacy union representative) to review issues and identify solutions. High level outcome - final report presented to Board Transformation Group with plan of funding additional posts to enable dispensary based pharmacy staff contracts to change to 7 days (working 9 day fortnight) to support late evening and weekend service provision. Source of funding investment is the outsourcing of out-patient pharmacy service.	09/01/2012 update - outsourcing of out-patient pharmacy service delayed until April 2013 June 2012 update: Procurement process now completed and final decision to be ratified prior to end June 2012; Welcome Centre Pharmacy implementation reliant upon Welcome Centre timeline; now scheduled to be open by October 2013; implementation planning commencing.	01/10/2013	Not yet due	Divisional Board Diagnostics And Therapies
													Workforce Management	availability of Director of pharmacy to cover weekend work when no volunteers or unforseen circumstance means pharmacist not able to work			Improve pharmacy recruitment prcoess to enable 'recruiting the best', plus infrastructure to ensure staff are retained	Development of pharmacy recruitment microsite Appointment of training and education lead pharmacists (job share) ensures appropriate support and training provided to junior staff thus leading to better retention of junior pharmacists.	30/06/2010	30/06/2010	
													Workforce Management	Availability of emergency duty pharmacist to cover weekend when no volunteers or unforseen circumstance means no pharmacist available			Lean project to review pharmacy processes for dispensing To-take-away (discharge) medicines, with view to getting majority completed within 2 hours of receipt of valid prescription (at BRI)	marked as complete with the implementation of the pharmacy facilitated discharge (carreid out at BRI and BHI wards)	15/01/2011	15/01/2011	
													Planning	Use of Clinical Site Manager to help with workload organisation, ie discharge medicines only accepted in pharmacy after 4pm (Mon - Fri) with CSM approval. This has had positive impact on late finishing times			Increase number of Pharmacy ATOs (basic dispensing functions eg labelling and selection of stock) and accredited checking technicians (able to sign of medicines against a clinically checked (by pharmacist) valid prescription)	Jan 2012 update - issues with PCP process as becoming more difficult to replace staff even at lower grades (ie band 2-5) which impacts such that using higher grade staff (eg 8a or 8b) to carry out as overtime activities that should be done by ATOs/ ACTs (band 2-5) April 2012 update - Ongoing June 2012 update - Staffing skillmix developments have been actioned alongside clarification of budgets and service changes (eg SBCH); progress made but not complete.	01/10/2012		
													Planning	Provision of urgent TTAs only on Sat and Sunday afternoons			Use the professional standards for discharge to help with the planning and presentation of workload to the BRI dispensary for discharge medicines (impact on late evening work)	Pharmacy guidance produced, need trust support with implementation of this June 2012 update - the Pharmacy guidance was produced in May 2011 but has has negligible impact; Carmen Chadwick Cox (ADM from D&T) has been asked to chair a project group reviewing patient flow / medicines discharge, and these are commencing in July. The ToR have been drafted and will address implementation of these standards.	01/10/2012		
													Workforce Management	Increased number of staff working and optimisation of skill mix (use of pharmacy ATOS and accredited checking technicians) during weekday lates and weekends. This means taht the finish times usually are more manageable but does mean that frequency of working has increased.			Engagement with pharmacy around the implications of service provision for the planned 2014 Terrell St development. Pharmacy submitted a staffing template for consideration by the Integarted Admissions Unit planning team, to facilitate a 7 day medicines optimisation service to the Integrated Admissions Unit.	Staffing template submitted, need outcome decision and trsut support for implementation June 2012 update Pharmacy has been asked for a nominee for a 'Clinical Planning Group' for the new build IAU and Kevin Gibbs will represent Pharmacy; we are awaiting the Tor and first meeting of this group to confirm that the detailed action will be within the remit	01/10/2012		
													Workforce Management	Appointed contracted permanent weekend-based hours staff - this means that continuity at weekends, experience if rest of team not dispensary based plus better finish times for overtime based staff.			Liase with HR on staff consultation regarding ensuring able to make voluntary overtime on saturday and sunday extend from 12.30 to 4pm	June 2012 update: Liaison with HR undertaken; consultation drafted and will be addressed alongside on-call consultation in July	01/10/2012		
													Planning	outsource of multidose compliance aids - reduce workload especially late afternoon enabling minised late evening work			manage workload better in week by outsorucing multi compliance aids (MCA/dosettes) as these are very time consuming to dispense	Jan 2012 - process better, action closed Jan 2011 - in place but difficulty in ensuring discharge summaries are written, reviewed and pharmacy screened with the necessary 24 hours notice to enable outsourcine		09/01/2012	
																	reivew overtime payments to identify if able to put business case for permanent substantive posts	HR review complete and 1 substantive post advertised and recruited to		09/01/2012	

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1704	There is a risk that patients on ambulance trolleys may come to harm when queuing in the corridor outside the Emergency Department (ED) due to department at full capacity.	Incidents Or Near Misses	Governance	11.4.1 Compliance With Emergency Access Targets	10/01/2012	25/07/2012	23/10/2012	James Rimmer	4 Likely	5 Catastrophic	20	4. Extreme	Workforce Management	Allocation of emergency department (ED) nurse to corridor patients to triage and priortise admission to ED as space becomes available. We do have an assistant nurse who completes vital signs and a pain score within 15 minutes of all ambulance arrivals however the patient may have a low score but still deteriorate whilst in the corridor.	Medium	High	Improvements in ambulance handover required. Greater partnership working between GWAS & UH Bristol as well as other acute trusts to manage emergency demand in the city. Automatic 999 re-routing will help mitigate some spikes in demand by moving patients on hospital catchment borders to the least busy ED. Ambulance queues are one of the factors that triggers a higher CMS score. 'Downstream' flow improvements required to avoid ED bottlenecks	Routine review meetings with GWAS as part of ambulance handover improvement project is improving processes to support patient safety. Regular senior manager & executive director meetings regarding emergency pathways & ' divert protocol' should improve emergency processes. Agreement about pre-emptive transfer to wards is underway to ensure that pressure is shared across hospital site. Risk routinely reviewed at daily operations meetings, weekly emergency access breach review meeting & through divisional safety meetings. Plan to review & address risk further as part of planning for unscheduled care & winter 2012/13 18-06-2012 Patient Safety Advisor meeting with Margaret Barnaby relating RCA action plan and which ones have been achieved. Minutes of meeting to disseminated to Carole, Claire, Emma and Mark for Divisional meeting with Margaret in the future.	31/10/2012	Not yet due	Divisional Board Medicine
													Local Policy In Force	Formal escalation policy for ED when pressure rises. Try to restrict number of patients queuing to 3 by triggering internal escalation plans. Automatic 999 rerouting, using Great Western Ambulance Service and capacity management system (CMS) is intended to mitigate this risk over time. Go live was 6th December 2011 and effectiveness of this remains uncertain.			Div of medicine to buy x3 ED trollies to transfer queue patients onto. These are wider and more comfortable and the mattress is of high quality specification in relation to pressure relief. Action HON/Chris Davis to agree funding. 1 month		31/03/2013	Not yet due	
													Equipment	Supplementary oxygen from portable cylinders Portable suction from ambulances or from ED resuscitation room			ED require 24 hr band3 patient flow co-ordinators to facilitate clinical and admin flow of patients (assist the patient journey)this will support the management of the 4hr target.	Pilot in place for June 2012	31/03/2013	Not yet due	
													Environment	If possible keep cubicle space free in Ed to use as rolling cubicle for toileting, undressing of patients etc.					01/11/2012	Not yet due	
													Governance - All Types	Ambulance crews to monitor patients vital sign and pain control as per own protocol or if needed on a more regular basis as guided by the ED shift coordinator. All vital signs need to be reported to the ED shift coordinator Prioritise patients and off load when ED capacity available 20-06-2012 GWAS and UH Bristol expect advice from EUST to allow shared care of any queuing patients with a 'rapid assessment and treatment' approach. Joint GWAS - acute trust meeting to discuss and agree approach 12/07/2012.							
													Governance - All Types	Pressure area care by ambulance crews, if this is part of their remit. Can advise patients to change position in some instances							
													Local Policy In Force	ED notes of these patients kept with the ED shift coordinator. Patients in corridor identified in this way on the tracking system. Put queuing patient id no on shift coordinators sheet. Ensure the CSMs are aware of patients queuing							
													Governance - All Types	When capacity becomes available it will be used for the patient of highest priority							
													Local Policy In Force	New RCA process in discussion with James Rimmer 1.All 4 hour Ambulance waits will be designated a SI, reported within 48hours and a full RCA carried out as per usual. It has been argued that such an event may not specifically adhere to the NPSA SI criteria. This point was acknowledged, but in the light of several serious related events occurring recently and the fact that such a delay indicates that the system as a whole is under severe strain, it was felt that using the SI approach was appropriate. 2.All 2 hour waits would continue to be reported to the SHA by Chris 3.Multiple 2 hour waits was the issue that was required further discussion with the Clinical team, with regards to what this term actually meant (relating to circumstances such as static queues or moving queues) and how / if it should be responded to with an SI. This will be discussed at the Emergency Access Steering Group and the conclusions reported via the Patient Safety Group							

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1705	Risk of harm to patients from falling. The total number of reported falls in 2011/12 was 1429 compared to 1345 in 2010/11. In 2011/12, 15 falls were recorded as Serious Incidents resulting in fractures, the same number as in 2010/11.	Incidents Or Near Misses	Governance	3.4 Harm Reduction And Safety	03/05/2012	19/09/2012	18/12/2012	Alison Moon	4 Likely	4 Major	16	3. High	Documentation -Trust Paperwork	Patient Falls are now reported as Patient Safety Incidents. Questionnaire now appears on the online reporting system for alll falls incidents reported. Improved accuracy of report completion and merging process.	Medium	Moderate	Work specifically within the Medicine Division on reducing the number of in patient falls. Specific project identified for Medicine. Falls safe resource pack to inform project at SBCH lead for project Natalie Godfgrey & Scott Allan SOP in progress for assessment & request for extra staffing for 1:1	Matron allocated to lead Being the Best programme in Medicine. Being the Best programme preparation phase complete Being the Best programme implementation phase complete	31/10/2012	Not yet due	Clinical Quality Group
													Documentation -Trust Paperwork	Combined risk assessment incorperating Falls screening tool launched January 2011. All Adult inpatients are assessed for falls risk within 6 hours of admission. Falls prevention care plan assessment of the patients risk of falling and the use of bedrails - launched January 2011			Work on the care plan to further develop good practice for these patients.	Care plan was updated and relaunched Jan 2011	31/03/2012	31/03/2012	
													Benchmarked Best Practice	Increased supervision and intentional rounding implemented on some wards and being tested on other wards. Cardiac Units with side rooms carrying out 1-1 care with patients at risk of falling. Patient Safety briefings, productive ward crosses and Board Rounds now requesting details on the previous evenings falls. Ensuring MDT communication re: falls prevention and risk assessment Template for intentional rounding introduced Trust wide January 2011			Purchase of further ultra low beds via 2011/12 capital bid.	Delay in tender process for beds - purchase will now occur in 2012/13	31/03/2012	03/05/2012	
													Training	'1 hour to prevent a fall' sessions commenced June 2011 Trust wide. Falls discussed during Corporate Patient Safety induction and updates.			National Falls Awareness week June 2012: stand will be in place outside the Trauma and Orthopaedic Clinic and in the Bristol Heart Institute atrium	Plans in place including communication to staff about the event.	30/06/2012	30/06/2012	
													Designated Accountability	Patient Safety Advisor in post in Division of Medicine ensuring falls is standing item for Clinical Governance meetings. This has now been extended to all divisions							
													Monitoring Board/Commitee	Trust Falls Steering Group reviews data on falls and ensures themes and recommendations are communicated to divisions for action. New Chair of Falls group to review Terms of Reference in May 2012. Matrons to meet in between Falls Steering Group to review falls ocurring in divisions identifying key themes and any subsequent actions that need to be taken.							
													Equipment	Rental agreement in place for ultra low beds when required							
													Service Redesign	Being the Best rapid spread improvement progarmme being implemented.Falling star symbol above beds of patients at risk of falling.							
													Documentation -Trust Paperwork	Falls Management Policy in place.							

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1755	Risk of harm to patients due to acquisition of pressure ulcers. Trust pressure ulcer incidence twice that expected in comparison to a nationally populated database in 2010. An external review of pressure ulcers commissioned by the Trust was completed in August 2012 and a comprehensive action plan is being formulated in response to its findings.	External Audit Reports	Governance	3.3 High Quality Care	03/05/2012	20/09/2012	19/12/2012	Alison Moon	5 Almost Certain	3 Moderate	15	3. High	Local Policy In Force	Policy for the prevention and management of pressure ulcers	High	Moderate	Implement a rapid spread programme to embed best practice in preventing pressure ulcers	Project group meeting weekly Launch scheduled for 13th September 2011 Being the best programme in place with next review date of 9th November 2011 Being the best programme has now moved into the embedding phase and will be further reviewed in January 2012 Plan to extend Being the Best into the Care Campaign	31/05/2012	20/09/2012	Clinical Quality Group
													Audit - External To Trust	Audit of pressure ulcers carried out bi-annually by Huntleigh Arjo			Programme of external prevalence audits and internal prevalence audit between external audit	Prevalence audit repeated Feb 2011. Result reported to Board May 2011. Repeat internal audit in August 2011. Internal prevalence completed in July 2011. Prevalence lower than in previous survey. External prevalence survey scheduled for October 2011 Prevalence repeated October 2011 Prevalence survey completed in October. Next survey to be undertaken in Sepetmber 2012.	31/10/2012	Not yet due	
													Equipment	Availabilty of electric profiling beds to prevent pressure ulcers. At present this represents only 50% of bed stock			NHS Patient Safety Thermometer to be introduced into the Trust starting with a pilot in May 2012. 100% coverage achieved in Q2 2012/13. Target is 75% coverage in Q3 and 100% in Q4.	NHS Safety Thermomenter implemented achieving 100% coverage across the Trust in August 2012. This is being monitored via the Trust Quality dashboard.	31/03/2013	Not yet due	
													Equipment	Availabiity of pressure relieving mattresses							
													Local Policy In Force	Pressure ulcer prevention protocols. These protocols include on admission assessment of each patient and ongoing assessment weekly or when patient condition changes. This assessment then guides the appropriate individual patient management to reduce risk of pressure ulcers. In addition there is a comprehensive care plan in place.							
													Audit -Trust Origin	Root cause analysis process in place for grade 2 and above pressure ulcers. Chief Nurse and Lead Tissue Viability Nurse meet with the relevant ward sister for Grade 3 and above to ensure suitable actions are in place. Pressure Ulcer prevalence is discussed at each Divisional Quarterly review with the Trust Board.							
													Benchmarked Best Practice	Re launch of trustwide Being the Best project planned in May, Multi professional intentional rounding on all patients to be implemented.							
1831	Since its inception in August 2009, risk that the department of Inherited Metabolic Disorders (IMDs) cannot meet the minimum standard of care for their patients (as identified by the British Inherited Metabolic Disorders Group (BIMDG) in 2007) due to staffing capacity constraints. In addition, benchmarking information from other regions clearly indicates that the South West is significantly under-resourced.	Individual Or Group Concern	Governance	3.4 Harm Reduction And Safety	12/07/2012	27/07/2012	25/10/2012	James Rimmer	4 Likely	4 Major	16	3. High	Partnership Working	National commissioning have turned down an initial proposal from the British Inherited Metabolic Diseases to commission all metabolic provision nationally, therefore there are no changes to the commissioning arrangements expected. D Lee has been contacted recently regarding adult outreach service from Guy's and St Thomas' in London, but we are waiting for further clarity from the on-going discussions about the paediatric network before pursuing this.	Low	High	Letter sent from D Lee to A Jarvis in September 2011 noting the risks relating to the current provision of this service. Expression of Interest submitted to Trust executives, asked for full proposal to be developed. Submission deadline 16th December 2011 James Palmer, Medical Director of South West Specialist Commissioning Group meeting with Lead Consultant & Divisional Manager 20th December 2011 Funding has now been confirmed for additional consultant, CNS time. Meeting with commissioners in Birmingham on 25th April. Action plan will be worked up with consultant ant DDM.	UHB proposal for increased resources has been funded for the 2012/13 financial year. Steps are now being taken by W&Cs to recruit the necessary personnel required to mitigate the high risk associated with the current IMD provision. Recommended that the risk remains on the risk register until the relevant specialist individuals are in post. Agreement in place for progress on all aspects of funding. Consultant job plan completed and waiting ratification. Recuitment process underway for CNS and Dietetic posts. Agreement reached with Birmingham regarding support to cover the OOH requirement Nurse and dietetic resources in place, working with pharmacy to confirm dedicated pharmacy arrangements. Consultant post in recuitment phase.	31/10/2012	Not yet due	Divisional Board Women's And Childrens
													Workforce Management	Appointed to CNS post, in post from 5th December 2011 Futher posts to be appointed with funding secured in June 2012. Expected to be in post by 1st October 2012			Potential for working with Guy's and St Thomas' in London regarding adult outreach service indentified but we are waiting for further clarity from the on-going discussions about the paediatric network before pursuing this.	New action.	31/12/2012	Not yet due	
													Workforce Management	Number of clinics has been reduced to enable the clinical staff to manage the planned workload, who are working very efficiently. Patients are referred out of region when necessary. Developing networks with Birmingham for on-going support of the service							

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1898	Lack of decicated emergency Theatre sessions, resulting in delays in accessing Theatre and the risk of cancellation of planned cases at St Michael's Hospital. The issue regarding lack of 'in hours' operating list is an on going concern which is on the Risk Register for Surgery Head and Head risk number 955. St.Michael's theatres 1-5 continue to serve gynaecology, ENT and breast surgery patients. The proposed transfer to ENT surgery to the BRI in 2012 will have little impact on the need for an in hours emergency gynaecology list.	National Confidential Enquirie	Governance	3.4 Harm Reduction And Safety	04/02/2012	11/10/2012	09/01/2013	Sean O'Kelly	5 Almost Certain	3 Moderate	15	3. High	Governance - All Types	Priority given to emergency cases when clinically indicated on an individual basis.	Low	High	With the transfer of one list to South Bristol From April 2012 the plan was to close a list here at St Michael's. The Division is re-visiting this with the Division of SH&N with the intention of retaining this Friday morning list for some planned and emergency work. March '12 Limited progress made. Senior level discussions between the two Divisions	Meeting with take place in February March '12 Further meetings to take place DUPLICATE ENTRY	01/05/2012	24/07/2012	Divisional Board Women's And Childrens
																	Reviewing allocation of emergency 'slots' within each planned list, with a view of having identified emergency time at the end of several lists per week. March '12 Discussions on-going. Reviewed at Women's Executive meeting and at Women's Governance meeting.	Revisited at consultant away day and proposal put forward. Job planning required with the consultant gynaecologists. Meetings to take this forward are in place during October.	30/10/2012		
													Planning	Weekly review of Theatre capacity to ensure all available sessions ultilised (Annual leave etc). Discussion with Division of Surgery Head & Neck and multiple other services.			A working party established to take forward changes in the scheduling and improve the organisation of theatre list to better support emergency patients being completed in hours.	First meeting held 28.9.12. Work underway to complete a scheduling policy for adherance to across st Michael's theatres.	01/12/2012	Not yet due	
																	Review of the pathway and service provided to emergency patients. Implementation of a new service model to ensure patients recieve senior assessment and prioritisation for theatre earlier in the day.	New pathway implemented Aug 2012.		30/08/2010	
1901	Risk of a reduction in the quality of care for patients in children's hospital when the number of children with higher dependency needs exceeds the level planned and staffed for.	Strategic Decision Making	Governance	3.3 High Quality Care	02/10/2012	02/10/2012	31/12/2012	James Rimmer	4 Likely	4 Major	16	3. High	Workforce Management	Utilisation of temporary staffing in response to clinical need	Medium	Moderate	Data collection. Senior staff visiting other centres. Close working with North Bristol Trust	Proposed reduction in children's bed base at times when patient acuity requires augmented staffing that cannot be secured effectively. Policy sign off through Children's Executive Committee planned for September	30/09/2012	05/10/2012	Divisional Board Women's And Childrens
													Planning	Frequent and formal processes for managing reources (beds and staff) across the hospital as a whole. Significant team working. Reliance on flexibility in deployment of resources.			(1) Increased nurse staffing by 1 wte per day and night shift to reduce reliance on temporary staff on Ward 32. (2) Identify and request temporary staffing earlier than previously to enhance shift fill rate on all wards where augmented nursing is required. (3) Changes to shift times to deliver more efficient nursing cover. (4) Establish single Matron across PICU and Ward 32 and establish Supervisory Ward Sister model across wards, including Ward 32 . (5) Revise protocol for discharge of children from PICU to wards and monitor compliance.(6) Establish formal, documenetd monitoring of dependency levels of children outside PICU. (7) Submission of formal bid through commissioning and planning process to provide a dedicated High dependent Unit for both children requiring both cardiac and medical HDU.	Actions 1,2,3,5,6 completed. Action 4 - Matron role across PICU / Ward 32 Supervisory Ward Sister on Ward 32 established.Bid to develop HDU rejected by commissioners in 2012/13 planning round. Cardiac HDU proposal to be resubmitted by end of October and PICU / Medical proposal . June 2012 LTV patient funding achieved HDU funding not achieved in this round, however productive dialogue continues with commissioners which has now expanded to include discussions regarding 4 medical HDU beds and 4 cardiac HDU beds. The aim is jointly work up proposal to go into this years commissioning and planning round.	31/03/2013	Not yet due	
													Workforce Management	Daily deployment of practitioners within Outreach team with advanced clinical skills. Team limited to one person per 24/7 to cover hospital as a whole.			Commisioner meetings	Draft policy for LTV patients developed and still under final point discussion with Commissiones. Patient identification and Pathway start notification for LTV patients developed and agreed clinically. Final negotiations regarding wording in progress. Draft HDU operational policy developed by PICU Consultant and working group established	31/03/2013	Not yet due	
1964	Increased risk of patients developing a hospital acquired pressure ulcer due to the factors described below. Current Trust wide system for storage and care of pressure relieving equipment needs improvement to ensure patients are placed one the correct surface in a timely manner. Insufficient assurance that pressure relieving mattresses and beds in ITU are tested to ensure the comply with the minimum pressure defined by the manufacture Processes and current leadership for managing beds and mattresses in the Trust require review.	Service Wide Risk Reviews	Governance	3.4 Harm Reduction And Safety	24/08/2012	20/09/2012	20/10/2012	Alison Moon	5 Almost Certain	3 Moderate	15	3. High	Equipment	Pressure relieving equipment is available in sufficient quantities. Some storage is available but doesn't meet the needs of the organisation. See also controls for risk 1755 for mitigation of risk of pressure sore development.	Low	High	An urgent review is taking place in general ITU to track the pressures in their specialist equipment on the ward.	Tool to enable checking to take place has arrived. Checking has begun with a programme to test all specialist equipment by 8th October. This time is needed to manage the logistics having a bed empty and available for testing.	30/10/2012	Not yet due	Clinical Quality Group
													Audit -Trust Origin	A mattress audit does take place, but current assurance is weak. A full review of the audit programme for pressure relieving equipemnt will take place.			A comprehensive action plan is being developed following an external review of pressure ulcers.	Tool to enable mattress checking in ITU to take place has arrived. Checking has begun with a programme to test all specialist equipment by 8th October. This time is needed to manage the logistics having a bed empty and available for testing. Leadership for beds and matressses has been identified and a working group established. Action plan completed and approved by Trust Management Executive and is now being implemented.	31/03/2013	Not yet due	

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

Item 13 – Annual Business Planning Guidance 2013/14 to 2015/16

Purpose

To seek Board approval for the proposed approach to Annual Business Planning for the three year period commencing April 2013.

Abstract

The annual business planning process is the means through which the Trust identifies it's forward priorities, develops its plans to ensure that it effectively identifies and mitigates risk and sets its annual objectives for the coming year. This process culminates in the production of the Trust's Annual Plan, required for submission to Monitor at the end of May 2013, and the six Divisional Operating Plans through which the Trust plan is mobilised.

This year's approach builds on the major revision introduced last year and as such it remains a risk based approach to planning and prioritisation with transformation as the primary vehicle for driving up quality whilst reducing risk, promoting efficiency and eliminating waste.

The proposed revisions to the approach have arisen following a review of last year's process and feedback gathered through a workshop with divisional staff and the Trust's planning lead. The key changes are summarised as:

- A revised timeline to allow for fuller comment from governors on the annual plan as it develops.
- An established link between the developing of the Trust Medium Term Operating Plan and individual divisional plans to allow for the development of greater detail in years two and three of divisional plans.
- Additional time between second and final cut divisional operating plan submissions to allow divisions more time for iteration following executive team feedback.
- Divisional peer review of plans to ensure best practice is shared across the trust and to maximise the opportunity for identifying cross divisional issues and solutions.
- Earlier publication of the (revised) operating plan template to afford divisions the maximum amount of time to develop their written plan.
- More rigorous testing of the capacity plans described in Divisional Operating Plans in light of evidence this year that the underlying approach was not sufficiently robust, resulting in income and waiting time performance risk in a number of service areas and originating from under performance against contracted activity.
- A formal call for capital bids and unavoidable revenue cost pressures from governance sub-group Chairs to avoid a repeat of the 2012/13 planning round when a small number of "must do" investments were not identified through the planning process and had to be addressed in year.
- Greater scrutiny of the revenue implications of all prioritised capital investments to ensure source of funding is clear and incorporated into Trust or Divisional Plans as appropriate.

Further detail relating to the application of differential Cash Releasing Efficiency Savings (CRES) targets at Divisional level and the value of funds available for capital investments will be confirmed by the end of November 2012 following further consideration of these matters at the Trust Management Executive (TME).

The approach and parameters for Divisional Operating Plan sign off are the subject of discussion at a Trust Management Executive strategy session in October with the aim of ensuring all plans are signed off by the end of quarter 1 2013/14.

Recommendations

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

Executive Report Sponsor or Other Author

- Author – David Relph, Head of Strategy & Business Planning / Deborah Lee, Director of Strategic Development
- Executive Sponsor – Director of Strategic Development, Deborah Lee.

Appendices

- Appendix A – Annual Planning Guidance 2013/14 to 2015/16.

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
04 October 2012	10 October 2012				

1. BUSINESS PLANNING PROGRAMME GUIDANCE FOR 2013-16

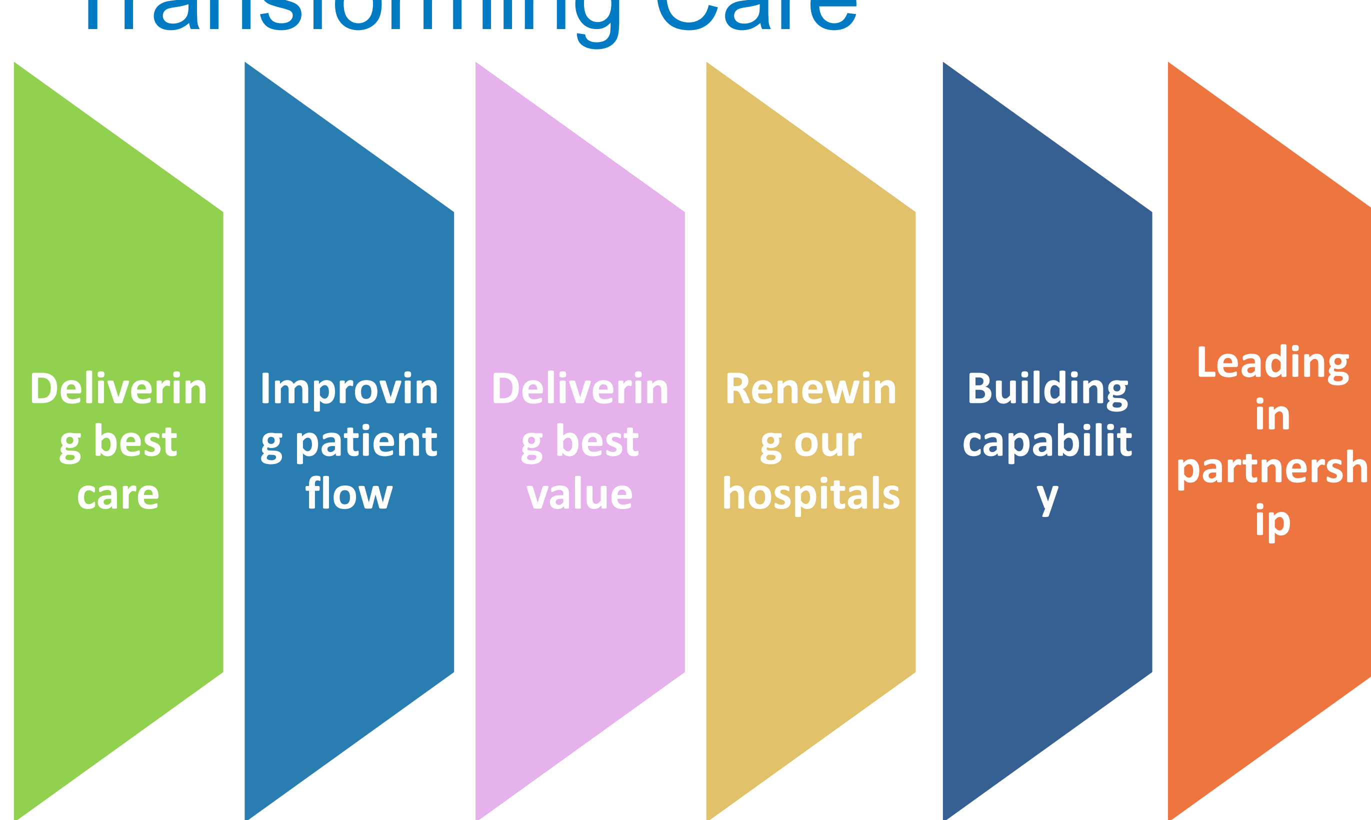
1.1 INTRODUCTION

This paper sets out the high level structure for business planning in the Trust. It will form the wider context within which Divisional Operating Plans should be developed for 2013/14 and set out the outline timelines for all planning processes.

1.2 TRANSFORMATION

Transforming Care provides the primary context for our business planning, it is the approach through which we will drive up quality whilst reducing risk, promoting efficiency and eliminating waste. Whilst our broad strategy as a Trust remains unchanged, our current focus is on embedding the Transforming Care programme, and all of our business planning should be conducted in this context.

The diagram below describes the six programmes that will drive our approach to transforming care and should, therefore, provide the framework for business planning in general and the development of Divisional Operating Plans in particular.



1.3 RISK BASED MANAGEMENT

As with last year's approach, identification and management of risk should be key drivers (inputs) to Operating Plans. This approach results in the identification and prioritisation of risk at the outset of the planning process and operational, financial and workforce plans that are clearly aligned to the management and mitigation of these risks.

Risk should be considered in the context of both the likelihood of occurrence and the impact should the risk arise. The risk categories that Divisions should consider are those set out in the Trust Risk Management Policy.

1.4 WORKFORCE RE-DESIGN

We need to continue to focus on reductions in workforce costs via both reductions in the number of staff and a change in the profile of staff. Notably the focus for work force re-design should be the consideration of non-medical workforce to undertake roles typically fulfilled by medical staff who remain the Trusts most scare and expensive resource.

1.5 SUMMARY

Having moved to a risk based approach to planning in 2012/13, we plan to build on this for 2013/14. The basic structure of the planning process for Divisional Operating Plans will be the same as before, but with the addition of explicit opportunities for peer review (inter divisional sharing and discussion) of developing plans.

2. THE BUSINESS PLANNING PROGRAMME PLAN

2.1 INTRODUCTION

The Business Planning Programme Plan describes the practical arrangements for the annual planning round. The planning process will take place between October 2012 and May 2013 and incorporates aspects of the budget setting process.

As in 2012/13, a core feature of the process is that Divisions will prepare their plans through focusing on risk based management and transformative approaches to service delivery which support a re-modelling and reduction in the workforce.

Plans will also be required to show how they deliver the Trust's primary strategies and align with the NHS Quality, Innovation, Productivity and Prevention and commissioner agendas. The mechanism for demonstrating this will be set out in the Divisional Operating Plan template.

Plans must also incorporate the changes necessary to deliver major service moves and capital re-developments in the period to 2014/15 – and the transformations required to deliver them.

Our Business Planning round will also determine how key risks such as reduced tariff income and cost savings (CRES) can be mitigated to create balanced Operating Plans. The planning period will be 3 years, with a focus on the first (2013/14).

2.2 OBJECTIVES OF THE BUSINESS PLANNING PROGRAMME

The objective of the Business Planning programme is to produce the following business plans:

- Trust Operating Plan 2013-16[1].
- Divisional Operating Plans 2013-16.
- Workforce Plans 2013-16.
- Monitor Annual Plan 2013-16.

2.3 PRINCIPLES OF THE BUSINESS PLANNING PROGRAMME

The principles which guide the Business Planning process are:

- A risk based approach focussed on the identification and prioritisation of risk at the outset of the planning process and Operational, Financial and Workforce plans that are clearly aligned to the management and mitigation of these risks.

[1] At present, the Trust has a high level annual Long Term Financial Model until 2016/17 but does not have an equivalent demand, capacity and workforce long term model. The development of a **three year Trust Operating Plan (TOP)** is an attempt to address this, and to incorporate in this work the planned results of our transformation programme, Transforming Care. This TOP is being developed at Trust level and will set out demand, capacity, workforce, transformation objectives and financial planning at least at Divisional - and potentially Service – level on a quarterly basis over the period of the Plan. An initial version of the TOP is being developed now and will form part of the planning input for Divisions.

- A focus beyond the immediate planning year.
- As much work as possible with commissioners as plans are developed.
- The use of business planning to embed the Transforming Care approach and a clear focus on Operating Plans of how service provision will be transformed.
- The identification of credible savings plans.
- Constant review of the process and iteration as necessary.

2.4 RESPONSIBILITIES

The **Sponsor Group** is the Trust Board, who should advise and support the SRO. This document serves as the Programme Plan.

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

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

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

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

3. BUSINESS PLANNING PROGRAMME OVERVIEW

3.1 STRUCTURE

Figure 1 (below) sets out the 3 Projects that will form the Programme. This structure is basically unchanged from last year's planning round.

Each project will occur in sequence and be given overall direction by a Project Lead. Project Leaders will be confirmed. A detailed timetable and schedule of outputs are contained in the Appendix.

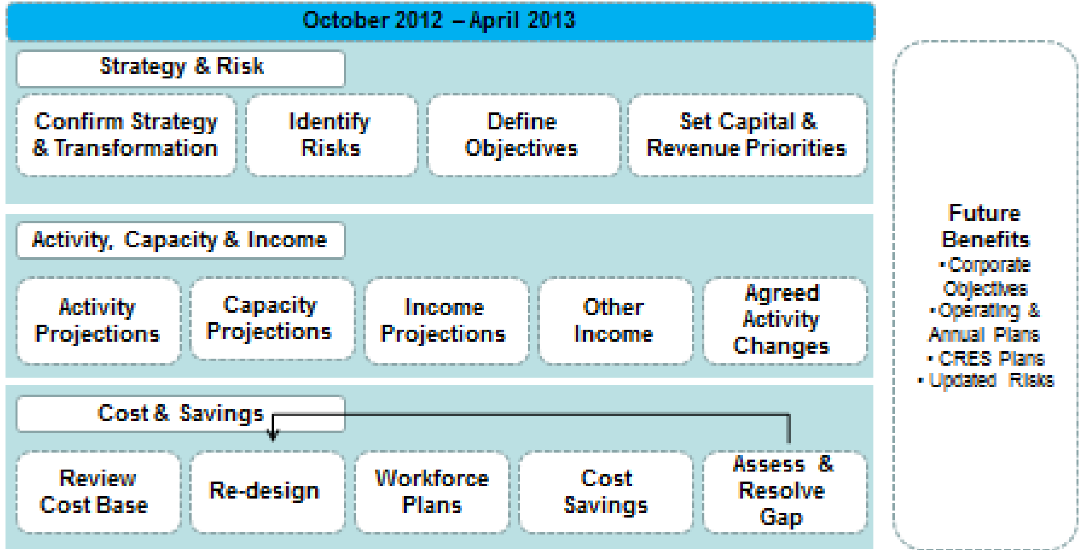


Figure 1: *Annual Planning Projects Overview*

The work of the 3 Projects is at the heart of the Planning process and will lead to the production of Divisional Operating Plans and the Trust's Monitor Annual Plan. Key dependencies include the publication of commissioning priorities, the Department of Health Operating Framework and the national tariff.

3.2 OUTPUTS

At Trust level, the objectives are:

- To develop a three year Trust Operating Plan
- To oversee the production of Divisional Operating Plans.
- To produce and submit a Monitor Annual Plan.

For Divisions, the objective is to compile a financially balanced Operating Plan for the next three years. Final Operating Plans are due for approval by the Trust Management Executive on **11th April 2013**. These will help generate the Trust's Budget and Monitor Annual Plan.

As in 2012/13, three core Projects are at the heart of the planning programme. These will be conducted in parallel and will influence each other through planned iterations of Operating Plans. A schedule of outputs from each Project is listed in Appendix 1.

4. PROJECTS

4.1 PROJECT 1 - STRATEGY & RISK

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

4.1.1 Strategy & Transformation

The Trust's three primary strategies for Clinical Services, Teaching & Learning and Research & Innovation were agreed by the Trust Board in May and June 2011 and are still extant. In addition, the *Transforming Care* programme sets out the Trust's approach to managing change. The Trust's 3-5 year Corporate Objectives remain unchanged but the annual milestones for 2013/14 will be developed as part of the planning process.

Questions that Divisions should ask at this stage include:

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

4.1.2 Identify Risks

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

4.1.3 Planning Assumptions

The results of strategic and risk analyses should be a set of key assumptions on which Divisions should base the development of Operating Plans. These assumptions should cover:

- Transformation priorities;
- Quality improvements;
- Workforce impacts;
- Activity levels and income sources;
- Cost reduction and efficiency priorities;

- Performance standards, including waiting time targets.

4.1.4 Objectives

In developing Operating Plans, Divisions will be required to list key objectives for 2013/14, linking these to:

- Corporate Objectives,
- the management of key risks,
- and Transforming Care.

This will be a key feature of the Operating Plan templates, though it is recommended that work to understand Divisional objectives is undertaken before the templates are released.

4.1.5 Capital priorities

Through objective-setting, a review of risk registers and previous capital plans, Divisions should develop capital investment priorities for 2013/14 – including equipment replacement.

The capital process beginning 2013/14 will have a 3-year focus and link to the BRI and paediatric redevelopment schemes, to avoid capital expenditure that might achieve poor value for money. Timings for the capital prioritisation process are included in the overall timeline at Appendix 2.

4.1.6 Revenue and Spend-to-Save

As in 2012/13, there will be no central revenue prioritisation process this year. Instead, revenue cost pressures and core "Spend-to-Save" proposals will be managed in the first instance through Divisional Operating Plans.

Cost pressures and Spend-to-Save ideas that are deemed critical will receive scrutiny and guidance from Executives during the review of first and second drafts of Operating Plans.

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

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

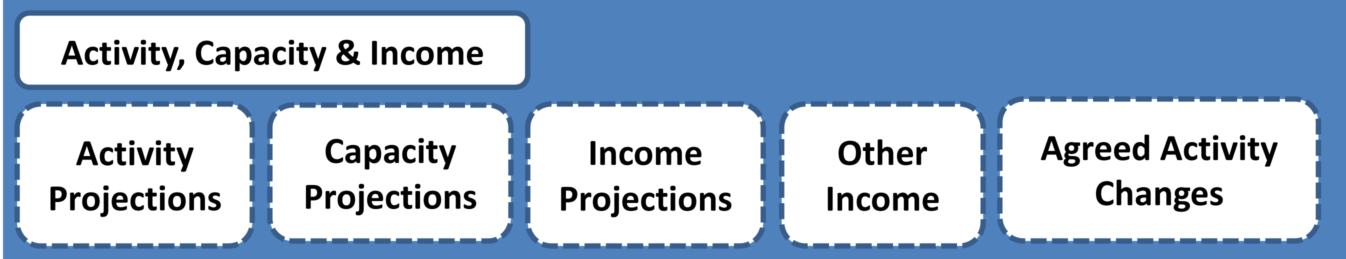
Further specific guidance will follow through the work of the Cost & Savings project.

4.1.7 Project Leadership

The Executive Lead for the Strategy and Risk project will be Deborah Lee, Director of Strategic Development.

4.2 PROJECT 2 - ACTIVITY, CAPACITY & INCOME

The objective of this project is to make an assessment of likely activity, capacity and income levels in 2012/13. This project has key interdependencies with the Costs & Savings Project. This project will also now include the production of the Trust Operating Plan (TOP).



4.2.1 Activity Projections

Activity Projection planning input for Divisions will be developed and issued as part of the process to develop a Trust Operating Plan. The first step will be workshops with Divisions in late October.

4.2.2 Capacity Projections

This will also be dealt with as part of the process to develop a Trust Operating Plan.

4.2.3 Income Projections

Divisional Finance Managers should work with Corporate Finance to identify likely tariff income for 2013/14, based on activity analysis. The additional impact of commissioner-led service design and demand management schemes will impact on the analysis. Divisions will be informed of commissioner plans as part of this process, as soon as they are known.

4.2.4 Other Income

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

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

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

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

4.2.5 Agreed Activity Changes

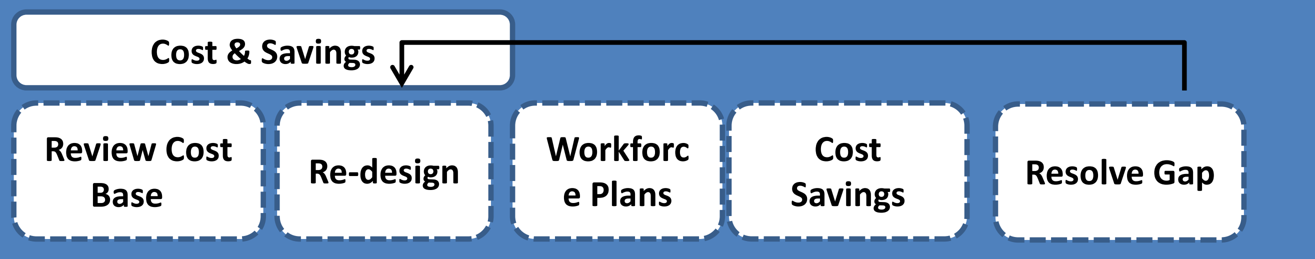
Activity changes as a result of agreed activity or coding / classification changes should be incorporated at this stage, including an assessment of income and capacity impacts.

4.2.6 Project Leadership

The Executive Lead for the Activity, Capacity and Income project will be Paul Mapson, Finance Director.

4.3 PROJECT 3 - COSTS AND SAVINGS

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



4.3.1 Review Cost Base

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

4.3.2 Re-design

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

4.3.3 Workforce Plans

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

4.3.4 Cost Savings

(CRES) targets need to be refined into detailed savings plans as part of this work and will be described in detail in Operating Plan templates.

4.3.5 Project Leadership

The Executive Lead for the Costs and Savings Project will be James Rimmer, Chief Operating Officer.

5. SUPPORTING THEMES

5.1 RESOLVING THE "GAP"

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

At the heart of the business planning process lies the need to assess the gap between planned costs, net of savings and planned income. The effectiveness of each Division's Operating Plan will depend on the realism of this assessment and the measures adopted to turn an income gap into a balanced plan.

The possible responses to an identified gap are:

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

5.2 WORKFORCE PLANNING

An output of the Planning process must be integrated workforce plans that consider:

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

5.3 CONTINGENCIES

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

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

5.4 DIVISIONAL OPERATING AND MONITOR ANNUAL PLANS

Each clinical Division plus Facilities and Estates, Information Management and Technology and Trust Headquarters (incorporating Finance, HR, R&I and core services) will be expected to produce Operating Plans. This process will build on the outputs of the 3 core Projects – the timetable and requirements for Plans is indicated in Appendix 2, including a date for final TME sign-off of **10th April 2013.**

The 3-year Trust Annual Plan for submission to Monitor in May 2013 will take account of and be based on Divisional plans.

5.5 BUDGET-SETTING ASSUMPTIONS FOR 2013/14

5.5.1 Cash-Releasing Efficiency Savings

The expected national tariff CRES is 4.5% for 2013/14. In addition, there are likely to be other unavoidable external cost pressures as well as the risk of MPET and tariff deflation. Notwithstanding the expected resource allocation proposal, Divisions should plan on the basis of a 4.0% CRES requirement for 2013/14 plus any brought forward CRES from 12/13, for first cut operating plans.

5.5.2 Capital Budget[2]

The process for prioritising Capital will have a 3-year focus. Priorities for 2013/14 and an outline programme for subsequent years will be agreed as follows:

5.5.3 Major Medical Equipment

The total budget is *circa £5.0m* for 2013/14 and will be subject to a similar prioritisation system as previous years. Prioritised Expressions of Interest will be reviewed by an expert panel to ensure that Programme is set appropriately, taking into account the need for replacement in 2013/14.

5.5.4 Strategic & Operational Capital

The combined allocation will be *circa £5.0m* for 2013/14. A multi-year programme of Strategic Capital will be agreed first, to ensure that schemes that are in-line with long-term plans attract a high priority. Once this is agreed, the budget for Operational Capital will be set and a prioritisation process will be conducted to ensure that priority capital requirements are funded.

5.5.5 Divisional Capital

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

5.5.6 Revenue Budget

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

[2] Capital allocations are shown in italics as these are indicative figures based on the 2012/13 figures. 2013/14 allocations will be confirmed in November.

Appendix 1 – Summary of Outputs

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

Appendix 2 – Outline Business Planning Timetable 2012-13

Version 1 – TME Draft dated 04 Oct 12

Serial	Month	Date	Description	Governance	Activity Planning	Divisional operating Plans	CRES	Trust Operating Plan (3 Year)	Commissioning	Workforce Plan	Capital Plan	Monitor Annual Plan
1.	September	5 September	Meet Division to get feedback on the 11/12 process									
2.		12 September	Initial Meeting of the Trust Operating Plan (TOP) Group									
3.	October	10 October	Business Planning Programme Plan to **TME**									
4.		17 October	CRES Plans – 1st Cut									
5.		18 October	Commence fortnightly meetings of the business planning working group									
6.		3rd week October	Trust operating Plan Workshops with Divisions – initial Capacity and Planning Workshops (Step 1)									
7.		30 October	Business Planning Programme to **Trust Board**									
8.	November	5 November	Open Commissioner Schemes Database (for EOI)									
9.		8 November	Divisional Operating Plan Templates issued									
10.		8 November	Capital Planning Guidance issued[3]									
11.		12 November	Open Capital database (for EOI)									
12.		21 November	Deadline for submission of Commissioner Schemes EOI									
13.		22 November	**Exec Review** of Commissioner Schemes EOI									
14.		Late November[4]	CRES Plans – 2nd Cut (TBC)									
15.		5 December	**Exec Review** of Commissioner									

[3] This guidance will also be issued to the Chairs of the Trust Governance Sub Groups to ensure that they have full visibility of the process.
[4] This timing is based on last year's programme and is still TBC. This should include a detailed workforce template.

Serial	Month	Date	Description	Governance	Activity Planning	Divisional operating Plans	CRES	Trust Operating Plan (3 Year)	Commissioning	Workforce Plan	Capital Plan	Monitor Annual Plan
			Schemes EOI									
16.		w/c 10 December	Divisions invited to submit selected Commissioner Bid schemes post Exec review									
17.		w/c 10 December	Trust issues outline Trust Operating Plan as confirmation of planning input for Divisional Operating Plans.									
18.	December	14 December	Deadline for submission of Capital EOI									
19.		21 December	Deadline for submission of selected Commissioner Scheme bids prior to collation at Trust level.									
20.		19 December	Capital EOIs to Capital Planners, Estates, MEMO for review[5]									
21.	January	w/c 14 January	Round 2 of Activity and Capacity Planning Workshops (Step 2)									
22.		By 18 January	First draft of Divisional Operating Plans for sharing/review.[6]									
23.		18 January	Estates, MEMO etc Review of Capital EOIs complete									
24.		21 January	**SDG** Peer Prioritisation – Major Medical Capital EOIs									
25.		w/c 21 January	Sharing/Peer Review of emerging Div Operating Plans[7]									
26.		28 January	PCT/Provider Review of Capacity and Activity (TBC)									
27.		End of January	Provider Led Capacity Plan to PCT (TBC)									
28.	February	4 February	**SDG** Peer Prioritisation – Operational Capital EOIs									
29.		5 February	Annual Plan update to									

[5] Finance will also be invited to take a view on the early stage affordability of these Capital EOI.
[6] This serial has been included to allow the sharing and peer review of emerging Divisional Operating Plans prior to the submission of formal 'First Drafts' to the Trust.
[7] This entry is a place marker to accommodate the sharing and peer review of emerging Divisional Operating Plans. The exact timetable for this process will be confirmed but the aspiration is for this sharing and review to take place in late January, prior to the submission of formal 'First Drafts' on 8th February.

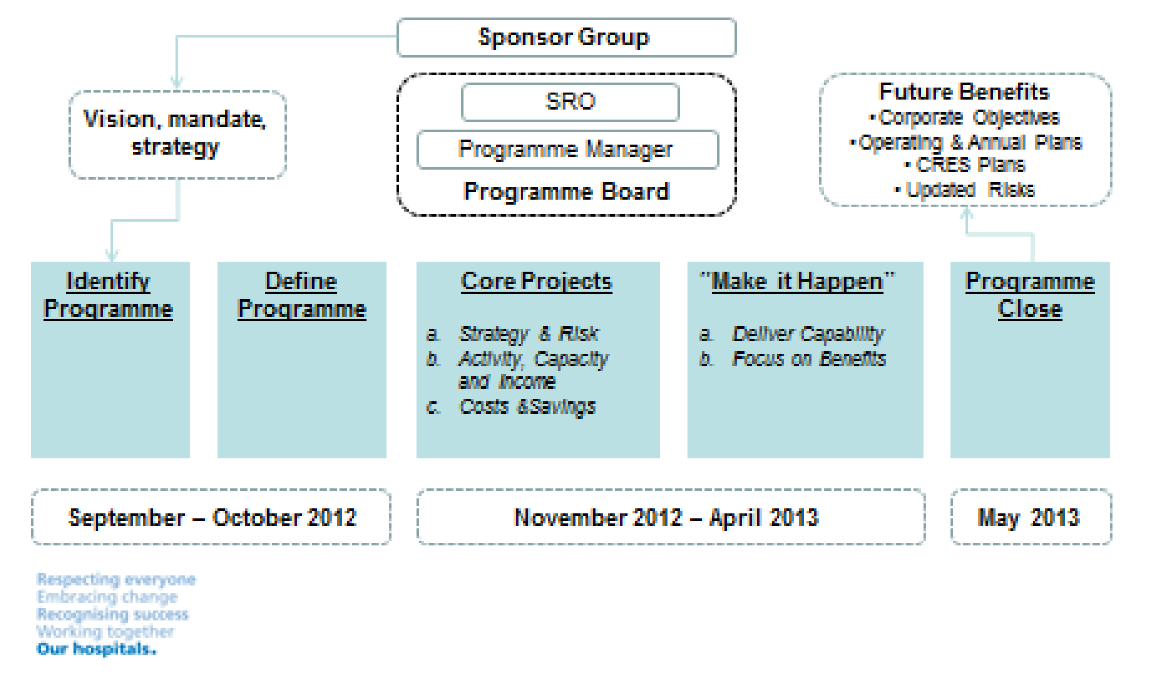
Serial	Month	Date	Description	Governance	Activity Planning	Divisional operating Plans	CRES	Trust Operating Plan (3 Year)	Commissioning	Workforce Plan	Capital Plan	Monitor Annual Plan
			Governors' Strategy Group									
30.		w/c 11 February	Activity & Capacity Planning workshops (Step 3)									
31.		8 February	Divisional Operating Plans - 1st Draft submitted including Workforce Plan									
32.		13 February (TBC)	**Executive feedback** on 1st Draft Operating Plans (tabletop exercise)									
33.		20 February	Issue Monitor Annual Plan responsibilities and template to nominated leads									
34.		18 February	**SDG** Peer Prioritisation - Major Medical Capital EOIs (Date 2)									
35.		By end of February	Provider-led Capacity Plan to PCT (including QIPP)									
36.		w/c 25 February	Assurance testing of Divisional Capacity plans.[8]									
37.	March	TBC	**Board Seminar** – Resources Review									
38.		8 March	Divisional Operating Plans – submission of 2nd Draft including Workforce Plan									
39.		w/c 11 March	**Executive feedback** on 2nd Draft Operating Plans (face-to-face)									
40.		13 March	**TME** Final Prioritisation of Revenue and Capital EOIs									
41.		15 March	Final Capital EOI prioritisation issued to **Capital Programme Steering Group** (next meeting 8 April)									
42.		25 March	Financial Resources Book (inc. Capital) to **Finance Committee**									
43.		22 March	Divisional Operating Plans – Submission of Final Plans including Workforce Plan									

[8] This has been added to the planning process as an opportunity to confirm the robustness of Divisional Capacity planning prior to the submission of the second draft of Divisional Operating Plans.

Serial	Month	Date	Description	Governa nce	Activity Planning	Divisional operating Plans	CRES	Trust Operating Plan (3 Year)	Commiss ioning	Workforc e Plan	Capital Plan	Monitor Annual Plan
44.		27 March	Annual Plan - Draft 1 complete									
45.		28 March	Financial Resources Book to **Trust Board**									
46.		3 April	Annual Plan update / Draft to **Governors' Strategy Group**									
47.		10 April	Final Divisional Operating Plans and Draft Annual Plan to **TME**									
48.		22-30th of April	Quarter 4 Divisional reviews (2012/13 Operating Plans)									
49.		TBC	Annual Plan update to **Trust Board**									
50.	May	TBC	Annual Plan update to Membership Council									
51.		13 May	Final Annual Plan circulated **to Trust Board members**									
52.		24 May	Final Annual Plan **to Finance Committee**									
53.		TBC	Final Annual Plan to **Trust Board**									
54.		31 May	Submit Annual Plan to Monitor									

Appendix 3

Overall Planning Programme Schematic



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

Item 14 – Transforming Care Quarterly Report
Purpose
To brief the Board on the progress of the Transforming Care programme within the Trust.
Abstract
This report is a quarterly progress review reporting latest key performance outputs with added contextual information regarding the programme of work. It includes high level programme objectives for Q3 and an extract from the programme Risk register.
Recommendations
The Board is recommended to **Note** the report.
Executive Report Sponsor or Other Author
Sponsor – Robert Woolley, Chief Executive Officer Author – David Evans, Programme Manager, Transformation Team.

Transforming Care – Update for Trust Board 31st October 2012

Introduction

This paper reports the status of the Transforming Care programme to the Trust Board at the end of Q2 2012/13.

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

Background

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

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

Figure 1 – Transforming Care: programme overview

Delivering best care
- Patient Safety and Quality Improvement Programme
- Improving patient and public involvement
- *Being the Best*
- Clinical outcomes /best practice
- Building our research work

Improving patient flow
- Productive theatres
- Improving outpatients
- Better use of beds
- Booking and waiting list improvements
- Clinical process re-design
  - *Urgent care improvement*
  - *Enhanced recovery*
  - *24 hour hospital*

Delivering best value
- Spend on medicines
- Non-pay spend
- Cost of diagnostics
- Facilities and estates
- Logistics
- Records
- Trust HQ costs
- Workforce productivity

Renewing our hospitals
- Improving access, signage and environment
- Clinical systems
- New buildings and improved facilities:
  - *BHOC*
  - *BRI redevelopment*
  - *BRI reception*
  - *Specialist paediatrics*
  - *S Bristol Community Hospital*

Building capability
- Leadership development
- Rewards and recognition
- Rolling out the values
- Induction and appraisal
- Education and training
- Flexible workforce

Leading in partnership
- Redesigning care pathways
- Primary care engagement
- Clinical networks
- NBT Partnership
- Pathology
- Academic Health Science Centre
- Whole system working
- Charitable partners

Progress Review Q2 – 2012/13

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

- 1453 staff have attended the Living the values sessions (at 30 September).
- A staff recognition scheme has been launched with a celebration event scheduled for 23rd November.
- A staff engagement strategy has been developed – and this in turn will form the basis of a detailed plan targeting interventions at key specific staff group across the trust to help embed a culture shift for 'achieving more with less.'

However, CRES delivery as at the end of H1 is £11m against a 6 month target of £13.8m (shortfall of £2.8m) with a year-end projected shortfall now £5.2 million (81%) against the £27.6m target.

Work streams with a financial target are subject to individual monthly 'accountability' reviews between the respective senior responsible officer, finance and transformation team, where on-going focus will be on mitigating the risk of further slippage, closing the current shortfall and forecasting for 2013/14.

Figure 2 – Progress Review Q2 2012/13 of Corporate Level Activities

Programme Governance

- The programme architecture has been enhanced with a consultancy style service delivered by Communications, Finance, Organisation Development and Transformation team.
- The terms of reference for the Programme Steering Group have been refreshed to develop a more joined up approach to the leadership of all elements of the programme.

Staff Engagement

- Formal engagement strategy approved by the Transformation board.
- Recognising success awards launched.
- On-going delivery of 'Living the values' training workshops.
- Quarterly reviews with each division include a focus on driving engagement and continuous improvement activity.
- A staff guide on how to involve patients and the public in service redesign launched.
- Launch of 'If I could …..' – a staff ideas scheme that offers direction, guidance and resource (if appropriate) to the implementation of service improvement ideas.

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

Theme	Work stream Review
Delivering Best Care	All work streams report progress with clinical outcomes/best practice work focused on the trust Dementia strategy and Stroke pathway. Latest KPI's: Quality and safety programme – performance has improved to 2.5 (Q1) against target of 4.0 by October 2013 Patient falls – 6.04 per 1000 patient bed days (year to date) against target 5.6 Hospital acquired pressure sores – 1.46 sores per 1000 bed days against target of 0.651
Improving Patient Flow	**Theatre efficiency** – an 'enabler work stream' with no direct CRES target. A reorganisation of theatre usage by specialty is underway to make better use of the South Bristol facility and generally improve theatre access to other certain specialities with regular backlogs – to recover lost income estimated at £650K per annum. Additionally, work has commenced in Cardiac theatres to increase case load by 100 procedures per annum - profit £400K. **Productive Outpatients** – 'enabler work stream' with no direct financial target. Implementation of Medway has revealed a large number of operational inefficiencies in Outpatient services across the trust. Current focus is on improving the efficiency of services, whilst undertaking an audit of the reasons for clinic cancellations. This will enable focused productivity reviews to improve clinic and patient slot utilisation. Additionally, a central booking function for Outpatient appointments has been established and a phased approach to migration of all services will see 50% of bookings undertaken within the new function by the end of 2012/13 and full migration by Q3 2013/14. Eventually, this service will move location to the new Welcome centre. **Bed Optimisation –** forecast CRES out turn for the year – 59% - a projected shortfall of £0.6million. The slippage against target is a result of plans to close ward 23 being aborted and the need to extend the use of the 'flexible capacity wards' during the summer months. This has adversely impacted other work streams (notably Estates and Nursing productivity). ECIST (NHS advisory service) have undertaken a review of Emergency Department and Discharge procedures. Their recommendations and other inputs will be considered during a 'patient flow' workshop scheduled for 9th November.
Delivering Best Value	**Medicine spend** – forecast CRES out turn – 100% - £1.4 million. Good progress on a number of schemes – Boots chosen as outsourcing partner with service transfer planned for 2013/14. **Non Pay spend –** forecast CRES out turn 94% - £2.9 million – although work stream lead is confident of 100% achievement. **Estates and Facilities** – forecast CRES out turn – 89% - £ 1.2 million It is possible schemes planned for 2013/14 could be delivered earlier to cover the shortfall. **Medical Staff Costs** – forecast CRES out turn – 49% - £ 1.6 million shortfall. Focus is on evaluation of consultant job plans against required capacity and better engagement of medical staff groups to stimulate 'change' activity. **Nursing Productivity** - forecast CRES out turn – 64% - £ 1.8 million shortfall. New ward rostering arrangements have been implemented, but increased bank and agency costs were incurred to progress these changes. Work stream remains under close monitoring. **AHP/HCSt Productivity** - forecast CRES out turn – 76% - £0.4 million shortfall. Divisional productivity plans are under review, plus a proposal to centralise the management structure for this work force is to be developed for consideration. **Admin and Clerical Staff Productivity** - forecast CRES out turn – 81% - £ 0.2 million shortfall. This work stream will morph into a Technology work stream to focus on quality IT solutions that will help deliver efficiencies and improved customer care within our administration services. **Trust Services costs** - forecast CRES out turn – 102% - £1 million .

Renewing Our Hospitals	Good progress is being made to improve the hospital environment with the building redevelopments on track. A Commissioning board has been established under the chair of Dr Christopher Monk develop and implement plans to transfer services and introduce new a model of patient care in the upgraded facilities.
Building Capability	**Leadership Development** – a framework for developing talent is under development for delivery in Q3. **Rewards and Recognition** – a regional consortium approach to T&C review across south west is due to report during Q3. Agreement has been reached to a trust harmonisation of on-call arrangements, with some variation requests. Formal notice of change issued on 8th October. **Flexible Workforce** – scoping for this initiative is advanced with more detailed planning to be undertaken for some 9 work streams.
Leading in Partnership	**Patient care pathways** – focus on Diabetes, Obstructive jaundice, and Clinical genetics. Other work streams within this theme will be reported to board separately.

Programme Objectives Q3 - 2012/13

Figure 4 – High level Objectives Q3 2012/13

Programme Deliverables

- CRES forecasting 2013/14.
- Operational Intelligence Group to establish Key Performance Indicators for the programme to support development of a 3 year operating plan for the trust and identify/prioritise potential opportunities for performance improvement by benchmarking other suitable trusts.
- Complete an exercise to review clinical risks within each CRES programme to ensure any appropriate mitigating action is in place.

Staff Engagement

- Introduce 'Transforming Care Tuesday afternoons' – protection of diary time for service improvement activity.
- Define an approach for involving patients and the public in the future shaping of the programme.
- Complete and implement a programme engagement plan which targets staff groups, with an initial focus on gaining the influence and involvement of medical staff.
- Recognising Success awards event.
- Feedback on trust communications through the 'Loud and clear' survey.
- Extend the 'If I could …' initiative to encourage wider staff participation.

Programme Governance

- Appoint a Transformation Director to drive forward the transforming care agenda with a focus on benefits realisation.

Key programme risks

An extract from the programme risks and Issues register is provided, including mitigating action.

Figure 5 – Extract from Programme Risks and Issues Register

Description of Risk/Issue	Impact	Mitigating Action
Insufficient engagement with key staff groups – primarily medical staff	Without the support of key influencers the programme is unlikely to be successful – putting achievement of the trusts strategic objectives at risk.	Engagement plan targeting interventions at key staff groups will commence implementation during Q3. Lead Doctors workshop on 5th October
Clinical risks in CRES projects	Focus on driving costs down increases clinical risks to patients	All CRES work streams are focusing on clinical risk performance through the identification of suitable measures and appropriate mitigating actions. Quarterly reviews.
Achievement of financial savings	Annual short falls are rolled into following years targets impacting long term stability of the trust.	Monthly accountability meetings between senior finance leads and work stream leads to review performance and encourage positive action to manage forecast deficits.
Leadership development cohort not engaged fully.	Only a proportion of the original Top 150 is reporting progress in projects to drive improvements in their operational areas.	A refreshed framework for Leadership will be developed and launched during Q3.

Conclusion

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

The board will not underestimate the scale of the challenge to embed a culture of continuous improvement during a period of economic uncertainty and the Transformation board remain committed to successful embedment of the programme principles to achieve the longer term benefits of improved patient care, quality and experience – all within a lower financial budget.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 15 – Quarterly Capital Projects Status Report

Purpose

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

Abstract

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

Progress in the period includes commencing construction on the Welcome Centre, planning approval and subsequent commencement of construction of the Bristol Haematology Oncology Centre (BHOC) and the handover and occupation of level 3 Emergency Department, level 6, and level 7 adolescent's ward of the Centralisation of Specialist Paediatrics (CSP) Project.

Construction continues on programme of the Phase 3 Bristol Royal Infirmary new ward block, which is now up to level 7 floor slab.

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

Recommendations

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

Executive Report Sponsor or Other Author

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

Appendices

- Appendix A – Quarterly Status Report.

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
					Monthly review at CSP Project Board, BHOC Project Board and BRI Redevelopment

					Board

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT

1. Introduction

This status report provides a summary update for Quarter 2 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Trust's Management Executive.

2. Project Updates

CENTRALISATION OF SPECIALIST PAEDIATRICS			
1	**Decisions required**	None.	
2	**Progress**	Tasks completed: - Level 7 BMT temporary relocation to new ward 35 (level 7) complete. - Level 7 BMT toilet upgrades commenced. - Level 5 old Medical Records, dining and school demolition commenced, and burns wards construction commenced. - Level 3 EEG temporary relocation to level 03 complete. - Level 5 CIU temporary relocation to old ward 33. - MRI and CT Scanner evaluation on-going, presentation to November Project Board. - Hybrid Cath Lab design co-ordination meetings on-going.	
3	**Budget**	A capital allocation of £36.9m is in the capital programme including charitable funding support of £5.83m. The scheme remains within budget and the 2012/13 cash flow has been re-projected and incorporated within the Trusts capital programme. Project on budget, with marginal overspend in the month due to profiling. The Grand Appeal has formally launched their fund raising appeal, pledging £3.5m against specific items and scheme elements, with the aim of raising the required funding against additional items yet to be confirmed.	
4	**Programme**	Project on programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Workforce plan cannot be implemented leading to failure to deliver models of care. Theatre and medical staff key risk group.	UH Bristol Human Resources reviewing strategies for training and recruitment of current and future staff to ensure workforce is available, with required skills. Theatre recruitment plan in

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

BRISTOL ROYAL INFIRMARY PROJECT INCLUDING AIR AMBULANCE ACCESS, GENERATORS AND QUEEN'S FAÇADE			
1	**Decisions required**	None. The scheme now incorporates the helipad, the site wide generators and the Queen's Façade.	
2	**Progress**	**BRI Phase 3** - Level 6 ground slab complete and level 7 floor slab under construction. Lift cores and stairwells progressed beyond these levels. Phase 1 of ED Refurbishment complete and occupied. ED Minors Team moved into new Minors Department. Commissioning Board established and role of Clinical Commissioning Manager identified and recruitment underway. **BRI Phase 4** - Space planning progressing with first outputs reviewed. Option appraisal for Old Building underway for future Board consideration. **Air Ambulance Access/Helipad -** Preparation works/crane installation for helipad installation commence late 2012. Fire fighting staffing model review commenced, option appraisal of external agency. HELPS charity has pledged £0.5m. **Generators -** Generators and associated equipment installed and testing commenced. Commissioning process commenced with load bank test in late November. **Queens Façade** – Project launched and Creative Group approved appointment of Willis Newson to manage artist appointment process.	
3	**Budget**	A capital allocation of £86.3m is in the capital programme including assumed charitable funding support of £2m. Allocation of £86.3m includes funding for the Helipad and site wide generators, which is now part of the target price agreement. Budget also includes funding for facade. The scheme remains within budget and the scheme has been reforecast to reflect minor changes in phasing and is now incorporated in Trust capital programme.	
4	**Programme**	Project on programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Delay to construction works and delayed cost certainty.	Constant monitoring and control of scope and cost plan.

		Logistics solution to allow disposal of Old Building not achievable. Services currently located in old Building cannot be re-provided for within future estate and/or available capital.	Detailed enabling works and decant programme developed. Space Allocation Project continuing to mature to ensure all services are mapped to a future location and affordable accommodation plan is being developed to ensure delivery.
		Charitable funding target not achieved.	Above and Beyond have pledged £2m of support. Any residual shortfall will be a call on future years' operational capital.
		Construction and refurbishment stage proves problematic causing additional delays and cost.	Robust monitoring of programme.
		Delay to construction; increased cost and potential health and safety hazards.	Robust monitoring of programme.

WELCOME CENTRE			
1	**Decisions required**	None	
2	**Progress**	Planning permission decision received. Contract negotiations completed with contractor. Retailer selection is near completion with the production of Agreements to Lease with each of the retailers. The Community Pharmacy retailer selection process has also concluded. Rentals have exceeded those assumed at Business Case. Temporary Costa café facility now trading. Temporary Shop provision in BHI to be concluded, WH Smiths proposal received.	
3	**Budget**	£5.2m has been allocated in the Capital programme. Following advice from Ernst & Young the centre will operate under election to tax rules to ensure the maximum benefit of any available VAT recovery to be achieved.	
4	**Programme**	Final programme delivers project completion mid-December 13 for retail units to be operational. This is delay from October 2013 is due to discovery of asbestos on heating system, causing work to be delayed until the end of the heating season. Building hoarding lines being erected, demolition and strip out works commenced August 2012. Ground works for steel superstructure in progress.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Operational disruption to front entrance during construction.	Two phased construction programme to retain current front entrance at all times. Operational policies to support flows through all trust entrances, including specific consideration of patient drop off (including ambulance). Temporary café and shop in place during works.
		On-going adverse publicity in relation to commercial retail offer.	Pro-active media strengthened with clear articulation of benefits secured for patients through commercial model. Continued close working with WRVS senior team.

<table>
<tr><th colspan="4">BRISTOL HAEMATOLOGY & ONCOLOGY CENTRE</th></tr>
<tr><td>1</td><td>Decisions required</td><td colspan="2">None.</td></tr>
<tr><td>2</td><td>Progress</td><td colspan="2">Planning permission decision received.
GMP agreed.
Start on site commenced and canopy removal complete.
Ground works commenced 24th September and piling commenced.
Some impact on radiotherapy operational hours due to ground work operations.</td></tr>
<tr><td>3</td><td>Budget</td><td colspan="2">Allocation of £16.2m (incl. £2m for Linac replacement) supported by £6.5m of charitable funding pledged by Above and Beyond, Teenage Cancer Trust and the Friends of BHOC.</td></tr>
<tr><td>4</td><td>Programme</td><td colspan="2">On programme, construction commenced July 2012 and due to conclude December 2013.</td></tr>
<tr><td rowspan="5">5</td><td rowspan="5">Risks</td><td>Risk</td><td>Mitigation Actions</td></tr>
<tr><td>Business continuity during construction.</td><td>Ensure robust site logistic co-ordination through principle supply chain to provide continuity.</td></tr>
<tr><td>Unable to identify acceptable decant for inpatient ward during construction phase.</td><td>Solution agreed with BRHC, final issue of accommodation for EEG to be resolved.</td></tr>
<tr><td>Adverse operational impact on radiotherapy service during Linac construction phase.</td><td>Robust construction logistic planning in place.
Close working between operational and strategic development teams.</td></tr>
<tr><td>Dust from construction impacting on immunosuppressed patients, possibly leading to a delay if works must be stopped.</td><td>Agree weekly review of works and dust mitigation measures with contractor. Closed window policy agreed with Division. Implement full decant solution for ward 62 patients. Funds to support necessary prescribing prophylaxis included in transitional revenue.</td></tr>
</table>

3. Conclusion

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

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

Item 16 – Private Patient Services Development

Purpose

To brief the Board on the recent review of Private Patients Services and secure its support for the proposed direction of travel.

Abstract

In 2010 the Trust published its five year strategy for Clinical Services *Rising to the Challenge*. The strategic analysis of the Trust's position in relation to comparable organisations revealed a low level of income earned from private patient activity when contrasted to other Trusts in the peer group. Arising from this finding, the Trust incorporated an objective into the 2011/12 corporate objectives to undertake a review of the Trust's strategic options for private patient services.

With the help of external consultants, the Trust undertook a review of the strategic options for private patient services in light of the Trust's current position and the prevailing threats and opportunities. The review was commissioned by the Trust's Management Executive (TME), commenced in March 2012 and was completed and received by the TME in September 2012.

All stakeholders consulted gave their broad support for the Review findings and recommendations noting a small number of important underlying principles which all felt must underpin any future developments.

Recommendations

The Board is asked to note the findings and recommendations of the review and confirm their support for the implementation of Option 3, with the following important principles under pinning the recommended approach:

- Private Patient Services must not be delivered to the detriment of NHS patient care
- There must be clear demarcation between NHS and Private Patient Services in both financial and operational terms
- Private Patient Service income should be used for the benefit of NHS patient care.

Executive Report Sponsor or Other Author

Sponsors – James Rimmer, Chief Operating Officer and Deborah Lee, Director of Strategic Development

Author – Deborah Lee, Director of Strategic Development.

Appendices

- Appendix 1 – Private Patient Services Review Summary

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Commitee	Other
	12 September 2011				Governors' Strategy Working Group - 11 October 2012 Board Seminar - 21 September 2012 TME Leadership Session - 29 August 2012

PRIVATE PATIENT SERVICES REVIEW

1. INTRODUCTION

In 2010 the Trust published its five year strategy for Clinical Services *Rising to the Challenge.* The strategic analysis of the Trust's position in relation to comparable organisations revealed a low level of income earned from private patient activity when contrasted to other Trusts in the peer group. Arising from this finding, the Trust incorporated an objective into the 2011/12 corporate objectives to undertake a review of the Trust's strategic options for private patient services.

2. BACKGROUND

With the help of external consultants the Trust undertook a review of the strategic options for private patient services in light of the Trust's current position and the prevailing threats and opportunities. The review was commissioned by the Trust's Management Executive (TME), commenced in March 2012 and was completed and received by the TME in September 2012; the Board considered the findings and recommendations at a seminar session in September and the Governors' Strategy Working Group considered the review findings and recommendations at their October meeting.

All stakeholders consulted gave their broad support for the Review findings and recommendations noting a small number of important underlying principles which all felt must underpin any future developments.

3. REVIEW FINDINGS

The Review methodology was broad based and included the following scope.

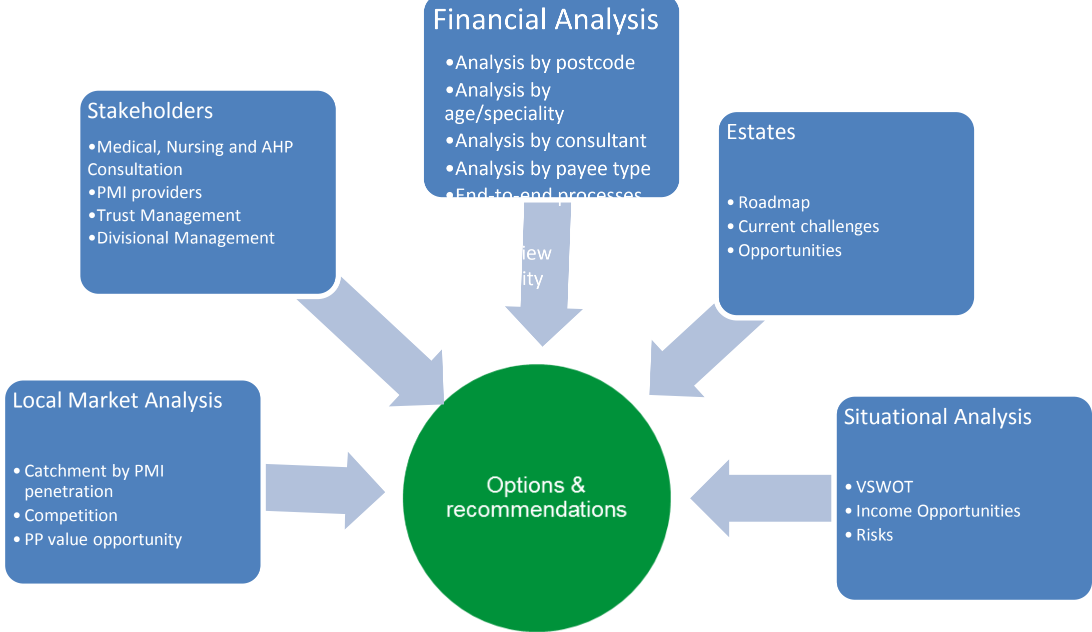


Figure 1 Review Methodology

The key findings upon which the options were developed are summarised as:

- Opportunity to grow private patient income from current £2m towards £10m, key areas of growth identified as cardiac, children's, cancer and other specialist regional services
- Current "offer" falls significantly short of industry standards and would need to be developed if income is to be increased
- Relationship with private insurance sector is under developed and as such represents a barrier to further growth in key areas
- Strong feeling amongst consultant body that the Trust does not support Private Patient Services and that the potential value to NHS patient care is not widely understood
- Significant bed and theatre constraints which limit expansion, quality and profitability of private work
- Strong local independent sector with new entrants exploring prospects including dedicated Private Patients Unit on the Southmead Hospital site
- Low adherence to existing procedures and policies
- Lack of clarity about UH Bristol's offer and associated "USP" (unique selling point) with limited marketing contrasted to sector standard.

4. STRATEGIC OPTIONS

In response to the strategic analysis and considerations of possible options, four options were considered for further evaluation. These were:

- Option 1 – do nothing, continue with current approach
- Option 2 – phase out Private Patient Services
- Option 3 – develop and invigorate the Trust's approach to private patient services through targeted development of essential elements of improved service
- Option 4 – prioritise and invest in a step change in Private Patient Services, including consideration of a dedicated facility and strategic alliance with a private partner

The following consideration of the risks and benefits was made and Option 3 was recommended as the most appropriate way forward on the basis that it has the least risk profile with respect to both financial risk and consultant engagement and has the potential to significantly improve staff and patient experience of Private Patient Services whilst increasing both revenue and income contribution.

Options	Decision	Appraisal
Option I	Do nothing	• Inconsistent with Trust philosophy i.e. if we do something, we should do it well. • Not a feasible option due to risks to consultant relationship, patient experience and governance
Option 2	Phase out private patient activity	• Necessary part of the consultant offer when aiming to attract "the best" • Adverse impact on relationship with consultancy body at a time when consultant engagement is critical
Option 3	Review existing care model to test that it is fit for purpose for PP market and address immediate constraints to practice and patient experience followed by targeted development of key service elements.	• Low risk profile when contrasted to other options • Addresses risks of "do nothing" option, with more limited investment than Option IV • Likely to require some investment (capital and revenue) • Likely to support income and contribution growth
Option 4	Adopt Vision of a Regional PP CoE. Either develop solo or look to external partner to address internal challenges	• High risk profile • Requires clarity regarding direction with NBT in light of their plans • Unlikely to emerge as priority for capital / premium space in medium term

Figure 2 Option Appraisal Summary

5. DEVELOPMENT PRIORITIES

Realisation of the potential benefits associated with Option 3 requires focus and change across the nine key areas listed below

- Statement of Board support for Private Patient Services
- Strengthened leadership, management and governance of Private Patient Services
- Development of the UH Bristol proposition, our unique "offer" and subsequent sector positioning and associated marketing
- Development of the Service's relationship with new and existing private medical insurers

- Consideration of a dedicated private patients outpatient consulting suite to ensure first impressions of the Service match the industry standard – one chance to make a first impression
- Creation of ear-marked bed and theatre capacity as infra-structure
- Review model for nurse remuneration to ensure incentives are appropriately aligned
- End to end review of current systems and processes to ensure offer is, and remains, fit for purpose
- Ensure improved adherence to existing financial and operational policy, procedures and systems.

6. NEXT STEPS

It is proposed to secure some short term project management resource to provide some initial dedicated, focused management time on taking forward some early wins. James Rimmer will be the nominated Executive Lead for Private Patient Services and the Head of Performance Delivery will be the nominated Operational Lead.

7. RECOMMENDATION

The Board is asked to note the findings and recommendations of the review and confirm their support for the implementation of Option 3, with the following important principles under pinning the recommended direction:

- Private Patient Services must not be delivered to the detriment of NHS patient care
- There must be clear demarcation between NHS and Private Patient Services in both financial and operational terms
- Private Patient Service income should be used for the benefit of NHS patient care.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 17 – Quarter 2 Compliance Framework Monitoring & Declaration

Purpose

The Trust Board of Directors is required to make quarterly statements with respect to governance and finance risk ratings in accordance with the Monitor Compliance Framework.

Each quarterly declaration to Monitor must take account of performance in the past quarter, and expected performance risks in the forthcoming quarter.

The purpose of this report is to allow the Board to consider the quarterly governance and finance self-certification to Monitor for Quarter 2 of 2012/13.

Abstract

The Director of Strategic Development had provided an analysis of performance in support of the Governance Statement (Appendix A).

The Director of Finance has provided commentary on financial performance (Appendix B).

Recommendations

The Board is recommended to approve the following declaration:

- A **governance risk** rating of AMBER-GREEN, reflecting performance in the quarter against the C. diff trajectory, but with no significant risks to achievement of standards in quarter 3; and,
- A **financial risk rating** statement of 3, and that the Board expects to maintain a rating of 3 for the forthcoming 12 months.

Report Sponsor

Chief Executive, Robert Woolley

Appendices

- Appendix A – Monitor Quarter 2 Declaration of Governance Compliance 2012/13
- Appendix B –Quarter 2 Financial Performance Commentary for Monitor Return

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	10/10/2012		22/10/2012		

Monitor Quarter 2 Declaration of Governance Compliance 2012/13

1. Context

The Trust is required to make its Quarter 2 declaration of compliance with the 2012/13 Monitor Compliance Framework by 31st October 2012.

The scoring against the Compliance Framework remains the same as last year:

Score less than 1 = GREEN

Score 1 or 1.5 = AMBER-GREEN

Score 2 to 3.5 = AMBER-RED

Score 4 or more = RED

Each quarterly declaration to Monitor must take account of both performance in the quarter, and expected performance risks in the coming quarter.

The context for the declaration is a Monitor Annual Plan Governance Declaration of an AMBER-GREEN rating reflecting inconsistency in performance against the 4-hour achievement. The Trust considered *Clostridium difficile* and the Referral to Treatment Time (RTT) Incompletes standards to be at moderate rather than high risk.

2. Performance in the period

The attached matrix (Table 1) shows the Q2 position against each of the standards in Monitor's Compliance Framework. The cumulative *Clostridium difficile* (*C. diff*) trajectory (score 1) was not achieved for the quarter. However, please note that performance against the cancer standards is still subject to final national reporting. With all the other standards confirmed as achieved this gives the Trust a provisional AMBER-GREEN rating. The matrix also details the known risks as they are currently perceived in relation to Q3 2012/13, which could require us to over-ride this rating.

3. Q2 risk assessment

The risk assessment detailed in Table 1 sets out the performance against each standard in Monitor's Compliance 2012/13 Framework, along with the key risks to target achievement for the coming quarter. The mitigating actions that are being taken are also provided, along with the residual risk.

The standards considered to be at moderate risk for quarter 3 are: *C. diff*, A&E 4-hours, 62-day cancer (screening referred patients), MRSA bacteraemias and the RTT Incomplete pathways standard. There are no high residual risks.

It should be noted that as the 4-hour standard failed to be achieved in Q1 2012/13 and Q4 2011/12, a declared risk of failure to achieve the A&E 4-hour standard for any quarter this year would now constitute a RED rating over-ride. Similarly, we have now failed the C diff target for two successive quarters. Making a declaration of a risk to failure in Q3 would also result in a RED rating over-ride.

4. Recommendation

It is recommended that the Board declares an AMBER-GREEN Governance Risk Rating for quarter 2 2012/13, reflecting performance in the quarter against the *C. diff* trajectory, but with no

significant risks to achievement of standards in quarter 3. The draft declaration for Quarter 2 is shown in Appendix 1.

Table 1. Performance in Q1 against the 2012/13 Compliance Framework, and risks to achievement of these targets in Q2 2012/13

Measure	Threshold for 2012/13	Performance in Q2	Risks for Q3	Risk	Mitigation of risks	Residual risk
Clostridium difficile *(C. diff)*	54 cases per annum (measured as the cumulative number of cases at each quarter-end) Q1 – 14 (14) cases Q2 – 13 (27) cases Q3 – 14 (41) cases Q4 – 13 (54) cases	29 cases against a cumulative quarter-end target of 27. Q1 – 16 cases Q2 – 13 cases The Q2 target was achieved, but the slippage from Q1 resulted in the cumulative trajectory not being achieved at the end of Q2.	The cumulative target trajectory would have been achieved had the sampling protocol been followed (i.e. patients not inappropriately tested) in Q1. Over the last three years between 57 and 67% (average 62%) of the annual C. diff cases were reported in quarters 1 and 2, reflecting improvements in performance over the year, but also the strong seasonal pattern of C. diff cases. If we apply this historical pattern of cases to the Q2 end position of 29, we arrive at a forecast for the year of 47 cases, which is well within the target trajectory. The new testing protocol has come into effect which is more sensitive. However, the particular testing algorithm we will be using has been found to reduce the number of positive cases identified.	High	A number of actions were taken to reduce the likelihood of inappropriate testing. This has had an impact, but has not fully eliminated inappropriate testing, as there was a further incident in Q2. Wards have received a further reminder about this. The new testing algorithm employs a GDH (glutamate dehydrogenase) test followed by Toxin EIA (enzyme immuno-assay). In North Bristol Trust this particular testing algorithm has been shown to result in a 17% reduction in reported cases. To catch-up with the cumulative trajectory the Trust will need to have 12 or fewer cases in Q3, which based upon Q3 and Q4 performance last year is achievable.	Moderate
MRSA bacteraemias	2 cases per annum (measured as the cumulative number of cases at each quarter-end)	5 cases against a target of 1 at the end of Q2 2012/13.	We have exceeded our annual national trajectory. However, we remain within the *de minimis* levels for reporting to Monitor of six cases[1]. If we have two or more	High	Zero tolerance to MRSA bacteraemia cases to continue to be adopted. Continued focus on good clinical	Moderate

- [1] Monitor will score NHS foundation trusts for breaches of the MRSA objectives as follows:

Measure	Threshold for 2012/13	Performance in Q2	Risks for Q3	Risk	Mitigation of risks	Residual risk
	Q1 – 1 (1) case Q2 – 0 (1) case Q3 – 1 (2) cases Q4 – 0 (2) cases		cases in the remainder of the year, we will then be scored against Monitor's Compliance Framework. The guidance makes it unclear whether this would constitute an automatic RED rating. In 2011/12 we reported a total of 4 MRSA bacteraemias. There is monthly variation in levels of MRSA, with no reported cases in some months, and one reported case in other months. With such small numbers it is difficult to predict the likely annual out-turn.		practice, and in particular line care.	
Cancer: 31-day wait for subsequent treatment	Surgery – 94% Drug therapy – 98% Radiotherapy – 94%	Achieved in both Q1 and Q2, and in every quarter in 2010/11 and 2011/12.	Key risks are around cancellations of surgery on the day due to a lack of an adult ITU (Intensive Therapy Unit) bed, and also peaks in demand for Upper GI hepatobiliary surgery. In Q2 there was an increase in breaches resulting from admin error.	Moderate	Prospective planning of subsequent treatments continues, along with tight management of cancer pathways. The impact of last-minute cancellations can be more effectively mitigated by the booking of dates for surgery at least a week prior to the breach	Low

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- Where the number of cases is less than or equal to the *de minimis* limit (i.e. six cases), no formal regulatory action (including scoring in the governance risk rating) will be taken;
- If a trust exceeds the *de minimis* limit (i.e. six cases), but remains within the in-year trajectory for the national objective, no score will be applied;
- If a trust exceeds both the *de minimis* limit (i.e. six cases) and the in-year trajectory for the national objective, a score will apply; and
- If a trust exceeds its national objective above the *de minimis* limit, Monitor will apply a red rating and consider the trust for escalation

Measure	Threshold for 2012/13	Performance in Q2	Risks for Q3	Risk	Mitigation of risks	Residual risk
					date. This is possible with prospective planning of subsequent treatments. Work is underway to model future ITU bed demand, as part of the development of a three-year Trust Operating Plan. A review of the MDT (Multi Disciplinary Team) Co-ordinator and other cancer support functions is under-way, with interim additional support to reduce the likelihood of further administrative errors.	
Cancer: 62-day wait for first treatment	GP referred – 85%	GP referred standard achieved in Q1 and Q2 2012/13, and in every quarter in 2011/12 and 2010/11.	Significant proportion of breaches wholly attributable to late receipt from another provider and/or patient choice to delay; this risk is more difficult to mitigate. Internal risks have increased in the last quarter, relating to elective cancellations, peaks in demand for certain types of surgery and admin errors.	Moderate	Action plan refreshed each quarter, following a review of the reasons for breaches. The action plan is reported to the Service Delivery Group (SDG). Network-wide policy for re-allocation of breaches due to late referral by other providers has been developed and remains under discussion within the network. An audit has been carried-out by each Trust, to determine the reasons for late referral to other providers. However, no actions have at present been agreed. However, we are continuing to send letters to all providers where referrals	Low

Measure	Threshold for 2012/13	Performance in Q2	Risks for Q3	Risk	Mitigation of risks	Residual risk
					are received after day 46 in the pathway. See also mitigating actions relating to 31-day subsequent treatment.	
	Screening referred - 90%	Screening referred standard expecting to be confirmed as achieved in Q2 2012/13; achieved in Q1 2012/13 and in three of the four quarters in 2011/12.	The breaches in Q2 2012/13 were multi-factorial, but a significant proportion were wholly or partly attributable to patient choice to delay outpatients or diagnostics. There were however some other contributory factors for breast screening breaches, including incorrect referral dates from Avon Breast Screening (ABS) and delayed MRI requests resulting in delayed scans (14 days). The nationally prescribed bowel screening pathway is difficult to complete within 62 days. Any delays can result in a breach and these delays are often outside of the control of the Trust (e.g. patient choice; late tertiary referrals)	High	Action plan refreshed each quarter, following a review of the reasons for breaches. The action plan is reported to the Service Delivery Group (SDG). ABS staff made aware of incorrect referral dates, and the pathways we have to report against. Referral dates remain under close scrutiny. Bowel screening pathway continues to be reviewed, and local changes adopted. Patient choice to delay diagnostics, staging and certain types of treatments remains an unmitigated risk. But tight management of pathways has limited the impact.	Moderate
18-week Referral to Treatment Time – admitted patients	90% (Trust aggregated level)	Achieved in every month in Q1 and Q2, and the last two years.	Backlog of over 18 week waiters remains high. Tight management of booking of breached patient remains critical to maximise the number of breach patients we are treating within the constraints of achievement of the 90% standard.	Moderate	Risk to non achievement can be managed by robust monitoring and escalation to optimise the number of long waiters booked each month, within the constraints of the contract. Cross Divisional approach to	Low

Measure	Threshold for 2012/13	Performance in Q2	Risks for Q3	Risk	Mitigation of risks	Residual risk
			Clinical concerns remain about “managing” volumes of breached patients to achieve target.		“breach quota” to support whole Trust achievement.	
18-week Referral to Treatment Time – non-admitted patients	95% (Trust aggregated level)	Achieved in every month of 2012/13 to date, and the last two years.	The risks are higher than in previous quarters, due to longer outpatient waits and some delays in the outcoming of outpatient clinics on Medway.	Low	Robust validation of all non-admitted breaches and ongoing pathways. A non-admitted dashboard or RTT and new outpatient waiting times is being developed for Q3, to help ensure ‘catchable’ patients are booked within target. Weekly monitoring of clinic outcomes to continue until levels of data completeness return to normal.	Low
18-week Referral to Treatment Time – incomplete pathways	92% (Trust aggregated level)	Achieved in every month in Q1 and Q2.	The number of >18 week incomplete pathways is primarily affected by the following factors: 1) Outpatient waiting times 2) Clinic outcomes not being captured in real-time 3) Size of the elective > 18 week backlogs An additional risk factor is that the number of ongoing pathways is also growing for reasons not well understood. Performance at present is only just above the required standard and relies on significant validation efforts.	High	Outpatient waiting times are falling. With the ongoing focus on achievement of a maximum 11 weeks wait in 2012/13 (within the constraints of the contract), this should shorten pathways. Elective backlogs are coming down. There is activity within the 2012/13 contract to focus on reducing elective RTT backlogs. Continued focus on treating patients in the 14-18 week wait category is required, in addition to treating the long-waiters, to	Moderate

Measure	Threshold for 2012/13	Performance in Q2	Risks for Q3	Risk	Mitigation of risks	Residual risk
					help reduce the backlogs quickly. Further mitigation relies upon manual validation of clinic outcomes and pathways. The constraint is the time it takes for this to be undertaken at month-end.	
Cancer: 31-day wait for first treatment	96%	Achieved in Q1, Q2 and in all quarters in 2011/12 and 2010/11.	Lower risk than some of the other cancer standards as not impacted by tertiary referrals. However, more recently, high levels of cancellations has had an adverse impact.	Low	Routine management of cancer pathways/performance to continue, including robust management of the cancer PTL and follow-through on agreed actions.	Low
Cancer: 2-week wait for urgent suspected and symptomatic breast referrals	93%	Urgent suspected and breast symptomatic achieved in Q1 Q2, and in all quarters in 2011/12.	Short-term capacity problems for breast 2-week wait represent the greatest risk, along with patient choice to defer appointments.	Low	Robust escalation process in place to ensure any capacity problems are addressed before they impact on performance. Choose & Book slot polls to be maintained at 11 days or less to allow for re-booking if patients cancel.	Low
A&E maximum wait of 4 hours	95%	Achieved in each month since June.	The deterioration in performance in Q4 and Q1 was attributed to a number of key factors related to rising levels of bed occupancy. These include, discharges happening later in the day, increasing over 14 days stays and an increase in the number of elderly patients needing to be admitted. The age group of patients being admitted is a good	High	The action plan includes the recommendations of the Emergency Care Intensive Support Team (ECIST). Since implementing the most recent plan, the 95% standard has been delivered. The impact has been most evident on the management of BRI non-admitted attendances. Weekly performance now averages	Moderate

Measure	Threshold for 2012/13	Performance in Q2	Risks for Q3	Risk	Mitigation of risks	Residual risk
			indicator of patient acuity/complexity, and therefore expected medical input and length of stay. This along with delayed discharges (i.e. discharges dependent on an external agency) are factors outside of the full control of the Trust. However, performance for non-admitted patients (i.e. category 1 and most category 2 attendances) fell significantly during periods where we failed to achieve the 4-hour standard overall. The throughput of non-admitted patients can be a symptom of bed-related blockages and a very busy Emergency Department. But it is also a significant contributory factor in the deterioration in performance. In the past 30 months, we have only achieved the 95% standard at a Trust level in one month where non-admitted performance has been below 97%. Performance in Q3 2011/12 was above 95% (95.6%), but the same was not true in the previous year (2010/11 = 94.0%). However, this year, performance has not matched historical trends. So this does not provide a strong basis on		above 98%. The Trust has also employed the services of Newton management consultancy team. Their input in Gloucestershire Hospitals NHS Foundation Trust resulted in a significant, rapid improvement in performance against the 4-hour standard.	

Measure	Threshold for 2012/13	Performance in Q2	Risks for Q3	Risk	Mitigation of risks	Residual risk
			which to forecast performance. There have been further dips in performance at the Children's Hospital, and although the 95% standard is still expected to be routinely achieved, it provides no buffer if there is lower achievement at the BRI.			
Access to healthcare for patients with a learning disability	Achievement of standards	Standards were met and continue to be met	None	Low	Monitoring of standards to continue.	Low

APPENDIX 1 – Draft declaration for quarter 2.

Declaration of risks against healthcare targets and indicators for 2012-13 by University Hospitals Bristol

These targets and indicators are set out in the **Compliance Framework**

Definitions can be found in Appendix B of the **Compliance Framework 12/13**

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

Target or Indicator (per Compliance Framework 12/13)	Threshold or target YTD	Scoring	Risk declared at Annual Plan	Score	Quarter 2 Actual Performance	Achieved /Not Met	Any comments or explanations
Clostridium Difficile -meeting the C.Diff objective	27	1.0	No	0	29	Not met	*The Trust had 13 cases in Q2, equalling the quarterly target, but is above YTD.*
MRSA - meeting the MRSA objective	1	1.0	No	0	5	Not relevant	*The Trust is currently below the de minimis level for reporting.*
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No		94.7%	Achieved	*Subject to final national reporting*
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments	98%	1.0	No		100.0%	Achieved	*Subject to final national reporting*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	0	98.3%	Achieved	*Subject to final national reporting*
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	1.0	No		85.3%	Achieved	*Subject to final national reporting*
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	1.0	No	0	90.4%	Achieved	*Subject to final national reporting*
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	90%	1.0	No		92.5%	Achieved	*Target met each month, quarterly totals shown.*
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	95%	1.0	No		95.4%	Achieved	*Target met each month, quarterly totals shown.*
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	92%	1.0	No	0	92.2%	Achieved	*Target met each month, quarterly totals shown.*
Cancer 31 day wait from diagnosis to first treatment	96%	0.5	No	0	96.5%	Achieved	*Subject to final national reporting*
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected)	93%	0.5	No		94.6%	Achieved	*Subject to final national reporting*
Cancer 2 week wait from referral to date first seen, sympomatic breast patients (cancer not initailly suspected)	93%	0.5	No	0	96.5%	Achieved	*Subject to final national reporting*
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	1.0	Yes	1	95.7%	Achieved	*Achieved > 95% each month.*
Failure to comply with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	No	0		No	
Risk of, or actual, failure to deliver mandatory services	N/A	4.0	No	0		No	
CQC compliance action outstanding (as at 30 Sep 2012)	N/A	special	No			No	
CQC enforcement action within last 12 months (up to 30 Sep 2012)	N/A	special	No			No	
CQC enforcement notice currently in effect (as at 30 Sep 2012)	N/A	4.0	No			No	
Minor CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Sep 2012)	N/A	special				No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Sep 2012)	N/A	special	No			No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Sep 2012)	N/A	2.0	No	0		No	
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	N/A	2.0	No	0		No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	special	No			No	
Has the Trust has been inspected by CQC (in the quarter ending 30 Sep 2012)	N/A	special			no of standards	No	
If so, did the CQC inspection find non compliance with 1 or more essential standards	N/A	special			0	No	
		Results left to complete	1			1	
		Total Score	1			0	
		Overide Rating (if any)					Enter the reason for any non-scoring related rating override here
		Indicative Governance risk rating	AMBER-GREEN			AMBER-GREEN	

For consideration and approval by

Finance Committee	22nd October 2012 – Agenda Item 8
Trust Board	30th October 2012 – Agenda Item 17

For consideration by

Membership Council meeting	8th November 2012

QUARTER 2 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURN

Director of Finance
October 2012

1. EXECUTIVE SUMMARY

This commentary covers the results for the 6 months to 30th September 2012.

The Trust reports an EBITDA[1] surplus for the half year of £16.813m. This is £0.969m lower than the Annual Plan projection to date of £17.782m. EBITDA is at 94.5% of Plan. The summary income and expenditure statement shows a cumulative surplus of £2.65m (EBITDA and financing costs). The financial risk rating of 3 is in line with the Annual Plan forecast of 3.

	Weighting	30th September 2012	5	4	3	2	1
EBITDA							
Margin %	25	6.38%	11	9	**5**	1	<1
Achievement of Plan	10	94.55%	100	**85**	70	50	<50
Net Return after Financing	20	1.60%	3	2	**-0.5**	-5	<-5
I&E surplus margin	20	1.01%	3	2	**1**	-2	<-2
Liquid ratio (days)	25	21.1 days	60	25	**15**	10	<-10
Overall rating				**3 (actual weighted score = 3.10)**			

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

Prudential Borrowing Limit Performance	**Monitor Ratio Tier 1**	**30th September 2012**	**Projection – March 2013**
Minimum Dividend Cover	>1x	3.5x	3.6x
Minimum Interest Cover	>3x	88x	25x
Minimum Debt Service Cover	>2x	59x	22x
Maximum Debt Service to Revenue	<2.5%	0.1%	0.3%

The financial plan for the year is a £5.7m income and expenditure surplus.

[1] Earnings Before Interest Taxation Depreciation and Amortisation

2. CLINICAL INCOME

Clinical income is £2.186m higher than the Monitor Annual Plan, standing at £206.096m for the half year. Clinical income includes income from NHS commissioners, territorial bodies, and non-NHS clinical income.

Activity and Income by Worktype

Performance against the Monitor plan for the year to date is summarised below by worktype.

i. Elective Inpatients

Overall Elective Inpatients are £0.275m ahead of the Monitor plan. The over-performance is across a number of specialties particularly Cardiology, Clinical Haematology and Medical Oncology.

ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £0.357m ahead of the Monitor plan for the half year. The key areas of over-performance are Paediatrics, Ophthalmology and Hepatology. A change in the plan relating to non-PbR rebasing also affects the variance, and the key specialties relating to this are Paediatrics and Paediatric Intensive Care. This position excludes the impact of contract penalties which are included in Other NHS activity below.

iii. Day Cases

Day Cases are £0.130m ahead of the Monitor plan for the half year. The key areas of over-performance are Clinical Haematology, Cardiology and Clinical Haematology.

iv. Outpatients

Outpatient activity is ahead of the Monitor plan by £0.290; the key areas of over-performance are AMD with treatment and Respiratory Medicine. The over-performance also relates to changes in the plan around the NICE College contract in particular AMD with and without treatment.

v. Accident and Emergency

A&E has over-performed by £0.007m against the Monitor plan.

vi. Other NHS

Other NHS activity is ahead of the Monitor plan by £1.913m. The key areas of over performance are Avoidable Readmissions and the Emergency Marginal Tariff Adjustment. Other NHS activity includes Direct Access, Radiotherapy, Critical Care, PbR Excluded Drugs & Devices, Contract Penalties and specialised services such as Bone Marrow Transplants.

vii. Private Patient Revenue

Private Patient Revenue has under-performed against the Monitor plan by £0.761m for the half year.

viii. Other Clinical Revenue

Other Clinical Revenue is under-performing by £0.025m against the Monitor plan.

Table 2 – Clinical Income by Worktype

Worktype	Plan £m	Actual £m	Variance £m
Elective Inpatient	23.940	24.215	0.275
Non-Elective Inpatient	50.938	51.295	0.357
Day Case	15.206	15.336	0.130
Outpatient	32.843	33.133	0.290
Accident & Emergency	5.897	5.904	0.007
Other NHS	73.407	75.320	1.913
Private Patient Revenue	1.228	0.467	-0.761
Other Non Mandatory Clinical Revenue	0.451	0.426	-0.025
Grand Total	203.910	206.096	2.186

Over Performance by Commissioner

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

Table 3 Over Performance by Commissioner

Commissioner	Variance £'m	Variance %
NHS Bristol	0.916	1%
NHS North Somerset	-0.196	-1%
NHS South Gloucestershire	-0.354	-2%
NHS Wiltshire	0.090	2%
South West Specialised Commissioning	0.767	2%
NHS Somerset	-0.459	-6%
NHS Gloucestershire	0.062	1%
Prior Year Income	1.071	N/A
Variable Estimates	-0.549	N/A
Other (including Exceptional Funding)	-0.838	N/A
Total	2.186	1%

3. OTHER OPERATING INCOME

Overall other income is £0.645m higher than planned for the quarter. The main reasons are:

- Lower than planned Skills for Health income £1.466m.
- Higher than planned other income for research and development £0.725m
- Lower than planned Education and Training income £0.212m
- Higher than planned other income £1.598m

4. EXPENDITURE

Overall operating costs of £246.713m for the half year are £3.799m higher than plan. Trust pay costs are £1.173m higher than plan and non pay costs are £2.627m higher than plan.

4.1 Pay Costs

Pay costs at £154.901m for the half year were £1.173m, higher than plan.
The main reasons are:

- An underachievement against CRES plans of £0.550m
- Higher than planned spend on Consultants £0.760m
- An underspend on Skills for Health £1.234m
- Higher than planned spend on Nurses £0.485m
- Higher than planned spend on other pay areas £0.612m

4.2 Drugs

Drug costs of £23.764m are £2.715m higher than plan for the half year. This is related to activity and higher than expected costs of drugs funded at cost.

4.3 Clinical supplies and services

Clinical supplies and services costs at £22.630m for the half year were £3.194m lower than plan.

4.4 Miscellaneous Other Operating Expenses

Other costs were £3.323m higher than plan. This is mainly due to lower than planned CRES delivery and a higher than planned spend on premises and fixed plant.

4.5 Depreciation

Depreciation charges at £9.282m were lower than the Annual Plan projection of £9.728m for the half year. Depreciation charges are expected to increase later in the year as expenditure on the capital programme increases.

4.6 Non Operating Expenses

There are no significant variances within this section.

5. CAPITAL

There have been a number of approved changes to the Trust's Capital Programme since the submission of the Annual Plan in May. At that stage expenditure for the year was projected to be £81.514m with expenditure for the half year of £33.967m. Actual expenditure at £25.924m equates to 79% of the Annual Plan projection. The forecast outturn is £64m – this equates to 79% of the Annual Plan projection of £81.514m.

The table provided below shows a comparison of the Trust's current plan with actual expenditure to date.

	6 months ending 30th September 2012		
	Plan for Period £'000	Actual for Period £'000	Variance £'000
Sources of Funding			
Donations	238	184	(54)
Retained Depreciation	8,722	8,722	-
Asset Disposals	5,845	1,000	(4,845)
Prudential Borrowing	-	-	-
Cash balances	12,502	16,018	3,516
Total Funding	**27,307**	**25,924**	**(1,383)**
Expenditure			
Strategic Schemes	(19,225)	(19,027)	198
Medical Equipment	(1,912)	(1,671)	241
Information Technology	(2,642)	(2,454)	188
Roll Over Schemes	(760)	(765)	(5)
Refurbishments	(816)	(663)	153
Operational / Other	(1,952)	(1,344)	608
Total Expenditure	**(27,307)**	**(25,924)**	**1,383**

6. STATEMENT OF FINANCIAL POSITION (Balance Sheet)

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £332.075m at the end of September is £8.120m lower than plan. This mainly reflects lower than planned expenditure for the first two quarters.

6.2 Inventories (formerly referred to as Stock)

At the end of September the value of inventories held totalled £7.046m. This is broadly in line with the Annual Plan projection of £7.054m.

6.3 Current Tax Receivables

The balance of £0.506m at the end of September mainly represents the monthly claim to be made to the HMRC for VAT that is recoverable under legislation.

6.4 Trade and Other Receivables (Including Other Financial Assets)

The balance at the end of September at £11.906m is £10.171m less than plan. However a stricter classification of moneys owed to the Trust, but not yet invoiced is shown as accrued income. This is currently £14.361m which is £13.287m higher than the plan figure. The Trust continues to work to reduce the amount of money owed to the Trust. The invoiced debtor balance at 30th September equates to 7.8 debtor days.

6.5 Prepayment

The prepayment balance at the end of September is £3.466m. This is mainly due to payments for maintenance contracts for servicing of equipment. This is higher than the plan of £2.373m.

6.6 Non Current Assets held for Sale

This item relates to the sale proceeds relating to the disposal of the Kingsdown Garages. The Trust plans to complete disposal of this asset within the next 3 months.

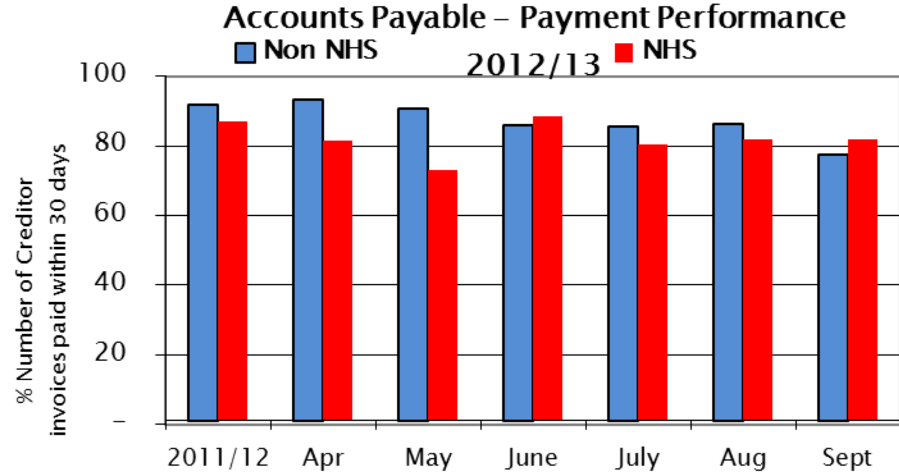
6.7 Deferred Income

Deferred income of £5.704m is £3.195m lower than the plan of £8.899m. The principal balances relate to research and development moneys.

6.8 Trade Creditors / Other Creditors / Capital Creditors

Trade, 'other' and capital creditors total £14.584m at the end of September. This is £3.100m less than the Plan projection of £17.684m.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. For Quarters 1 and 2 of 2012/13 the Trust achieved 81% and 87% compliance against the Better Payment Practice Code for NHS and Non NHS creditors.



6.9 Other Financial Liabilities

The closing balance for Accruals at £30.593m is higher than the Plan projection of £13.941m reflecting the Trust's current estimate of amounts owing for which invoices had not been received at the half year end.

6.10 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 30th September together with comparative information taken from the Trust's Annual Plan.

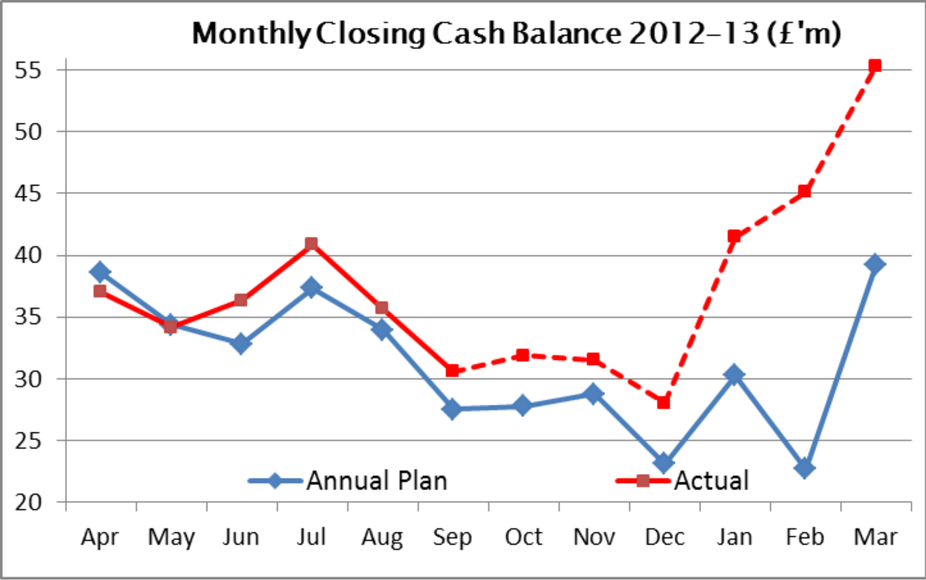
Summary Statement of Financial Position (Balance Sheet)

	Position as at 30th September 2012		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Non Current Assets			
Intangible	4,944	6,247	1,303
Property, Plant and Equipment	335,251	325,828	(9,423)
	340,195	**332,075**	**(8,120)**
Current Assets			
Inventories	7,054	7,046	(8)
Current Tax Receivables	397	506	109
Trade and Other Receivables	22,077	11,906	(10,171)
Other Financial Assets	1,220	14,507	13,287
Prepayments	2,373	3,466	1,093
Cash & Cash Equivalents	27,533	30,768	3,235
Non Current Assets held for sale	-	950	950
Assets Current Totals	**60,654**	**69,149**	**8,495**
ASSETS TOTALS	**400,849**	**401,224**	**375**
Current Liabilities			
Deferred Income	(9,217)	(5,933)	3,284
Provisions	(6,661)	(6,804)	(143)
Current Tax Payables	(6,470)	(6,396)	74
Trade and Other Payables	(17,684)	(14,584)	3,100
Other Financial Liabilities	(13,941)	(30,593)	(16,652)
Other Liabilities	(5,428)	(5,428)	-
Liabilities Current Totals	**(59,401)**	**(69,738)**	**(10,337)**
NET CURRENT ASSETS/(LIABILITIES)	**1,253**	**(589)**	**(1,842)**

	Position as at 30th September 2012		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Liabilities Non Current			
Loans	(9,950)	-	9,950
Provisions	(226)	(236)	(10)
Finance Leases	(5,847)	(5,859)	(12)
Liabilities Non Current Totals	**(16,023)**	**(6,095)**	**9,928**
TOTAL ASSETS EMPLOYED	**325,425**	**325,391**	**(34)**
Taxpayers' and Others' Equity			
Public Dividend Capital	191,011	191,011	-
Retained Earnings	64,556	65,528	972
Revaluation Reserve	69,773	68,767	(1,006)
Other Reserves	85	85	-
TAXPAYERS' EQUITY TOTALS	**325,425**	**325,391**	**(34)**

7. Cash and Cash Flow

The Trust held cash balances at the end of September of £30.768m. This is £3.235m more than the Annual Plan projection of £27.533m. The improvement reflects slippage on the capital programme and lower than expected payments to traders. The graph shown below provides a comparison of actual and projected month-end cash balances for 2012/13.



The Trust has a working capital facility of £37.5m. This was agreed with Barclays Bank for an initial period of 2 years from 1st September 2010. The Finance Committee subsequently agreed that the first of 2 one-year options to extend this arrangement should take effect from September 2012.

As a consequence of the projected slippage on the Capital Programme the Trust's cash flow forecast has been revised and we will now review the planned draw down of the Long Term loans. It is likely that the original plan to draw down £49.95m will be reduced by c£20m. This will have a positive impact on the income and expenditure position because of lower interest charges.

8. Potential Financial Risk Indicators

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

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

UH Bristol = Not applicable. The EBITDA margin for the quarter of 7.2% is in line with the Plan for the quarter. The year to date EBITDA of 6.4% is an improvement of the first quarter's performance of 5.5%.

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

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

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

UH Bristol = Not applicable.

8.4 Working capital facility used in the reporting period.

UH Bristol = Not applicable.

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

UH Bristol = 17% (£1.760m) of the Trust's total debtor balances exceed 90 days. This amount (net of a bad debt provision of £0.226m) relates to the NHS Injury Recovery Unit. The nature of these cases inevitably means that there are delays, sometimes several years, before accounts are settled. The Trust continues to ensure that invoices are raised at the earliest opportunity and that requests for follow up information are dealt with promptly.

UH Bristol is continuing to participate in the NHS South of England initiative to clear all debtor balances over 90 days.

Information on aged debtors is presented to and considered by the Trust's Finance Committee on behalf of the Trust Board each month. The Trust does have and will continue to pursue other aged debts (other than the £1.760m mentioned above). As at 30th September this balance of £3.202m was fully covered by a bad debt provision.

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

UH Bristol =Not applicable.

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

UH Bristol = Not applicable.

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

UH Bristol = Not applicable.

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

UH Bristol = Not applicable.

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

UH Bristol = Not applicable. The Trust's capital expenditure for the half year of £25.9m is equivalent to 76% of the Annual Plan forecast for the period. The forecast outturn capital expenditure is now projected to be £64m – equivalent to 79% of that shown in the Annual Plan. The reduction is expenditure reflects the revised delivery date of a linear accelerator (£2.73m moving to quarter 1 of 2013/14) and the re-profiling of strategic capital expenditure (BRI Redevelopment and Centralisation of Specialist Paediatrics, Welcome Centre and BHOC) of £6.3m into 2013/14 expenditure with no change to project completion dates.

9. Other Information

9.1 Private Patient Income Cap

Private patient income for the 6 months to 30th September is £0.575m or 0.28% of total patient related income. This is well below the Trust's Private Patient Cap of 1.1%.

Changes to the way the cap on private income of NHS foundation trusts is enforced came into operation from October 1st as a result of the Health and Social Care Act 2012. The 2012 Act obliges foundation trusts to make sure that the income received from providing goods and services for the NHS (their principal purpose) is greater than income from other sources.

The Act requires foundation trusts to publish information on all their non-NHS work and to explain its impact on the delivery of goods and services for the NHS. In addition, any foundation trust wishing to increase the share of its income from non-NHS sources (including private work) by more than five percentage points in any one year must obtain prior approval from the governors.