University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors, to be held on 28 February 2013 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	
3. Minutes and Actions from Previous Meetings To consider the Minutes of a Public Meeting of the Trust Board of Directors dated Thursday 28 January 2013 for **approval,** and the status of Actions agreed.	Chairman	01
4. Chief Executive's Report To receive this report to **note**.	Chief Executive	17
Quality, Performance and Compliance		
5. Process for Responding to the Mid Staffordshire NHS Foundation Trust Public Inquiry Report (the "Francis Report") To receive this report by the Chief Executive to **note**.	Chief Executive	20
6. Quality and Performance Report To receive the Quality and Performance Report for **review**. a. Patient Experience – Chief Nurse b. Overview – Director of Strategic Development c. Quality & Outcomes Committee Chair's Report d. Board Review	Director of Strategic Development	22
Finance		
7. Finance Report To receive this report for **review**. a. Overview – Director of Finance b. Finance Committee Chair's Report c. Board Review	Director of Finance and Finance Committee Chair	103
Risk		
8. Annual Review of Board Risk Management Strategy To receive this report and consider the recommendations for **approval**.	Chief Executive	121
Information and Other		
9. Any Other Business	Chairman	

Item	*Sponsor*	*Page*
To consider any other relevant matters not on the Agenda.		
10. Date of Next Meeting **Public Trust Board meeting**, Thursday 28 March 2013 from 10:30 – 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of a Public Meeting of the Trust Board of Directors held on 28 January 2013 at 10:30 in the Liberty Suite, Holiday Inn City Academy, Bond Street, Bristol, BS1 3LE

Board Members Present	
• John Savage – Chairman • John Moore – Non-executive Director • Lisa Gardner – Non-executive Director • Paul May – 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 • Lee Mercer – Trust Risk Manager • Sarah Murch – Membership Administrator • Garry Williams – Patient Governor • Anne Skinner – Patient Governor • Peter Holt – Patient Governor • Wendy Gregory – Patient & Carer Governor • Pam Yabsley – Patient Governor • John Steeds – Patient Governor – Local • Joan Bayliss – Community Governor • Jeanette Jones – Partnership Governor, Joint Union Committee • Belinda Cox – Staff Governor • Florene Jordan – Staff Governor	• Jan Dykes – Staff Governor • Clive Hamilton – Public Governor • Heather England – Public Governor • Anne Ford – Public Governor • Dr Richard Brindle – Director of Infection Prevention & Control • Karen Forbes – Consultant in Palliative Medicine *(for Item 06 – End of Life Care)* • Paul Lewis – Patient Experience Lead *(for Item 08 – 2012 National Accident & Emergency Survey Results and Action Plan)* • Anne Frampton – Consultant in Emergency Medicine *(for Item 08 – 2012 National Accident & Emergency Survey Results and Action Plan)* • Bob Skinner – Foundation Trust Member • Matthew Roy – Specialist Registrar, Rheumatology • Gayle Johnson – BT Health • David Jones – Health Care Assistant

Item	*Action*
1. Chairman's Introduction and Apologies Apologies were noted from Emma Woollett, Iain Fairbairn and Kelvin Blake.	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Board Meeting Agenda. No declarations of interest were made.	

3. Minutes and Matters Arising from Previous Meetings

The Board considered the Minutes of the Public meeting of the Trust Board of Directors dated Friday 21 December 2012 and **approved** them as an accurate record.

Referring to the sixth bullet point on page 9 of the previous minutes, James Rimmer updated the Board that an external partner had been agreed on to assist in supporting the Trust's 4-hour process.

4. Chief Executive's Report

The Board received a report by the Chief Executive, which included the activities of the Trust Management Executive to **note**.

Robert Woolley highlighted the following items:

- The Bristol Acute Services project was in a position to commence a review of the Clinical Services Strategy of Bristol, North Somerset, South Gloucestershire (BNSSG). The review was being designed by external partners, and would communicate how to take this forward in the next few weeks. The Strategic Health Authority (SHA) funded the support process to allow development of an outline business case, potentially for May 2013, and regular updates on progress would be provided to the Trust Board.
- The Mid Staffordshire NHS Foundation Trust Public Inquiry conducted by Robert Francis QC, had announced that its final report would be delivered to the Secretary of State on Tuesday 05 February. On publication, the Trust planned to assess its own services and governance against the recommendations. There was an expectation of strong emphasis on staffing and the management of staffing risks, but UH Bristol had taken steps in recent years to heighten awareness in the Executive team and divisionally, regarding these issues.
- The NHS Commissioning Board had announced it would sponsor a review of urgent and emergency care services across England. This was followed by open letter by the NHS Confederation and leaders of the Royal Colleges, giving support to a review and the inevitable service reconfiguration in the NHS, and calling on politicians to put local party political interests aside and support the health service as it undertook difficult evaluation of what change was needed to sustain future services.
- Dr Mike Nevin had resigned as Head of Division of Surgery, Head and Neck and planned to leave his post at the end of March 2013. Robert Woolley proposed to wait until the internal review of divisional leadership arrangements had been concluded before commencing the formal process of appointing to the vacancy.
- In the light of lessons learnt related to compliance with the Abortion Act (1967), the Board had requested a review of compliance with other Acts of Parliament. Robert confirmed that the review had shown that, bar one or two areas where further information was being sought, the Trust was fully compliant, and had highlighted this in a recent report to the Trust Management Executive.
- In response to the 'best practice' recommendations provided by Monitor for Board declarations of compliance with the Monitor Compliance

Framework, the Trust assessed its own practices and established that it was fully compliant on twenty of the twenty-three recommendations. The remaining three would reflect the same level of compliance on completion of an on-going review of the Divisional accountability framework, governance and management arrangements. Comments: • Responding to Paul May's question regarding the Mid Staffordshire Inquiry report, Robert Woolley confirmed that the Trust would undertake an essential review of the Francis Report and its implications.	
Quality, Performance and Compliance	
5. Quality and Performance Report The Board received and **reviewed** this report by members of the Trust Executive. It was noted that the Quality and Outcomes Committee continued to consider the performance report in detail prior to the meeting of the Trust Board. **a. Patient Experience** The Chief Nurse, Alison Moon, presented the Patient Experience report which came from the Division of Medicine. The report highlighted: • The importance of smooth discharge processes, communication with the family of patients, and patient transport. • The Division had addressed the matters related to the patient, and matters related to discharge from the organisation were being addressed. This was in addition to a number of other local learning points which were identified and documented in the report. Points of discussion included: • Guy Orpen said it was heartening to see a "real-life" example of how improvements in the quality of a service also reduced costs. • Following a request for John Moore regarding future management arrangements for discharge, James Rimmer planned to bring a paper to the Quality and Outcomes Committee. **b. Overview** The Director of Strategic Development, Deborah Lee, introduced the item and explained that, when focussing on in-month performance, it was a mixed picture. Deborah highlighted that: • Mixed-Sex Accommodation Breaches had returned to a red rating, which reflected difficulties with bed pressures during the Christmas period; • Trial Recruitment had returned to a red rating, but there was confidence that this position would be remedied; • Patient Falls and Pressure Ulcers remained red-rated, and consequently Trust Board concerns remained regarding the quality of care delivered. Of positive note, Alison Moon reported signs of recovery in January; • Performance related to the processing of patient complaints had been a challenging in 2012, but had now returned to a green rating in the last month; • Three main indicators on the Compliance Framework continued to	Chief Operating Officer

challenge the Trust in this and the future quarter, which included: 62-Day Cancer Screening target and 4-Hour Accident & Emergency standards. The tolerance had been breached regarding Methicillin-Resistant Staphylococcus Aureus (MRSA) cases, which would play-through until year end as the annual target had been breached;

- Regarding finance, a slight reduction had been seen in the amount of Cash Releasing Efficiency Savings (CRES) achieved in-month, which was largely attributed to deferral in schemes, rather than wholesale loss of impact. Consequently, the year-end projection was more positive than first assumed.

Comments:

- Guy Orpen declared an interest through his University work and its partnership with the Trust, regarding the currently Red-rated National Institute for Health Research (NIHR) and notable fluctuations of Clinical Trials. He requested additional focus regarding these elements of activity at a future Board meeting, which John Savage and Robert Woolley agreed was "suitable and wholly appropriate". — Chief Executive

c. Quality and Outcomes Committee Chair's Report

Emma Woollett had chaired the Committee in Paul May's absence but she was unable to attend the Board meeting. John Moore presented the report, explaining that:

1. The meeting did not achieve a quorum of members, but the Chairman had attended and positive and detailed discussion of the key issues was undertaken.
2. Key points regarding the Quality Report:
   a. The Committee received reassurance that robust plans were in place to recover the MRSA performance. There have been eight cases in the year to date, compared to four in the previous year. A key area of focus was regarding intravenous line insertion, as this emerged from Root Cause Analyses (RCAs) as a common underlying theme. The Trust's target for the next year would be zero cases;
   b. The Deputy Chief Nurse presented a detailed report on Patient Falls and Hospital Acquired Pressure Ulcers, both of which, it was said, "remained stubbornly difficult to reduce, although the incidence of Grade 2 and Grade 3 ulcers had been lower in December and performance to date looked encouraging". A visit was scheduled to Guy's and St Thomas' NHS Foundation Trust to see if there was anything to be learned, as they had a low incidence of pressure ulcers. The Committee was pleased to learn that consultants would now automatically be involved in RCA meetings for Grade 3 or 4 pressure ulcers. It was stressed that there was both strong commitment to the action plan and a strong belief that it would deliver, provided focus was maintained. This was an area that the Committee would continue to monitor closely;
   c. The Medical Director reaffirmed his focus to improve Antibiotic Compliance, an important factor in maintaining prevention of Clostridium Difficile (C.Diff).
3. Under the Workforce Section, the Committee noted the significant and

detailed work underway to reduce Sickness levels, although the overall rates had remained static at 4.6%. Concern was also raised regarding Training compliance, but the process for Essential Training was being overhauled and the plan to achieve this was currently under consideration.

4. Under the Access Section, discussion focused on 2 key indicators:

   a. For 4-Hour performance to improve required improved flow within the Trust and improved cooperation with the wider system to limit the number of "red list" patients (i.e., patients medically ready for discharge but awaiting input from external agencies.) A more dynamic system leadership now appeared to be in place, which gave hope that there might be scope for significant improvement in this regard. In terms of the flow of patients within the Trust, much work was being undertaken internally, and there was also the possibility that external help would be sought to make the necessary step-change in this area;

   b. Regarding 62-Day Cancer Referral to Treatment from Screening, the Committee was reassured that the underlying problems for both screening and colonoscopy delays had been fully addressed, so no delays would be seen going forward. However, there were still patients who were already delayed in their pathway, and required continued treatment in Quarter 4, with the result that this target was unlikely to be met in the current quarter. A "green" forecast was expected in Quarter 1.

5. Good progress regarding the outstanding items on the Histopathology Action Plan was noted, which included Job Planning and Recruitment. Two other important points were made:

   a. The Committee was pleased to hear examples from both Dr Robert Pitcher and Alison Moon of collaborative working between pathologists from UH Bristol and their colleagues in North Bristol NHS Trust. Dr Pitcher felt that these examples reflected a more positive culture in the service;

   b. Dr Pitcher impressed on the Committee the importance of the work being undertaken by Severn Pathology to develop a single service across Bristol, which was a key recommendation arising from the Independent Inquiry into Histopathology Services. Recognising concerns regarding the support for Specialised Services under such a model, Dr Pitcher advised that Severn Pathology was committed to taking an evolutionary approach to changing practices, in-line with the fact that there was no consensus on the best model.

6. The Committee reviewed the progress report on Annual Corporate Quality Objectives, which showed mixed progress. In relation to the NHS Patient Safety Thermometer, which measured the percentage of patients receiving "harm-free care", the Committee expressed a desire to understand how this was benchmarked, and also to see a target for reduction in the 3% of patients that were exposed to potential harm through hospital acquired pressure ulcers, falls, urinary tract infections or venous thromboembolism.

7. The Committee reviewed the quarterly Board declaration of compliance and agreed with the recommendation from the Chief Executive that the Board should approve a Governance Risk Rating of Amber-Red.

8. The Committee reviewed the Corporate Risk Register and discussed, in particular, the risk regarding Maternity Staffing, where they received reassurances that long-term solutions were being sought. 9. The Committee noted the Francis Report publication date of 05 February 2013. • John Savage assured the Board that the term "sought reassurance" indicated the robust nature of the scrutiny provided by the Committee. **d. Board Review** Alison Moon said that the focus on Pressure Ulcers, Patient Falls and C.Diff was expected to yield positive results for the full year, assisted by the 'basket' of four Safety Thermometer measures for Falls, Pressure Ulcers, catheter acquired infections and Venous Thromboembolism. Action plans focused on "harm" acquired within the Trust and questioned how to reduce these. As of Quarter 4, all trusts had to benchmark nationally, which was an objective set by the Chief Nurse for the Head of Quality (Patient Safety). James Rimmer raised three additional points: 1. Robust discussion had taken place at the meeting regarding queuing risks in Accident & Emergency; 2. The 4-Hour recovery plan for Quarter 4 remained on track and emphasised the role that the new local area team director had played in bringing all partners together; 3. Regarding the Finance risk regarding Referral to Treatment Time (RTT). A risk had arisen since the meeting, which would be mitigated, but James flagged this for Board awareness and planned to give a full update at the February Quality and Outcomes Committee meeting. Discussion: • Paul May asked if the downward trend of the Hospital Standardised Mortality Ratio could be continued with ambitious planning. Sean O'Kelly was in favour of further reductions, but he was unsure to what extent the level of the 'green line' was within the Trust's control. Robert Woolley questioned this wisdom from a statistical point of view, and added that it would be reviewed, but cautioned that it might seem "artificial" when presented back to the public. • Responding to Lisa Gardner's question regarding improvement of performance on fractured neck of femur, Sean O'Kelly explained that the issue was regarding theatre access, which would be addressed with the introduction of a dedicated trauma list to secure theatre time and be less susceptible to other emergencies. Deborah Lee added that this was embedded in plans for March and April as part of Head and Neck surgery transfers. • James Rimmer explained to John Moore that additional theatre hours would be introduced with the reconfiguration and Deborah Lee expected that this might address the current bottle-necks of theatre access and 'patient flow'. • Responding to a request by Lisa Gardner regarding the possible timescale to reach Green compliance, Deborah Lee said that there was an expectation that once the nine additional sessions were implemented in April,	Medical Director

following the tri-service move, that the Trust would achieve full compliance with the standard.

- Alison Moon highlighted the quality achievements of the Division of Medicine in January, as provided on page 73 of the pack.

e. Infection Control Report

The Director of Infection Prevention & Control, Richard Brindle, gave an update to the Board regarding Clostridium difficile (C.Diff), and MRSA and methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemias:

- Although C.Diff rates were low at present, these levels may not be maintained as most cases were in previously colonised patients. Focus continued on a daily basis;
- Solid action plans were in place, and there had been no recent MRSA bacteraemias. An issue regarding screening had been reported with action not always being taken on positive results, but there were plans to collect data in 'real-time' to ensure patients were effectively screened. As part of the recovery plan, an Audit Review of care had commenced in December, which highlighted areas for improvement and focused intervention;
- MSSA was also on downward trajectory, and there was confidence that intravenous line care would improve;
- Antibiotic Prescribing Compliance had seen a slow improvement; prescribers were being reviewed once again, and would receive feedback of their results. There was an increasingly large cohort of effective prescribers, who would bring improvement over time.

Comments:

- In response to a question by Robert Woolley seeking an explanation of the 'blip' seen in MRSA performance, and avoidance of future increases, Richard Brindle stated that statistics in recent years revealed small numbers and no significant increase, and the 'blip' had been useful in focussing the Trust on intravenous line care. He added that it could be possible for the Trust to achieve a zero MRSA rate and that the MSSA rate was a better indicator of line care and surgical site infection.
- Alison Moon reiterated Richard's comment that UH Bristol focussed on all possible reasons for blood infections and the 'blip' had brought line management care to the fore and the audit in February should highlight further improvement, if the action plan continued to be implemented fully.
- Deborah Lee was reassured that the Trust planned to visit other exemplar sites to share practices in intravenous line care.

There being no further questions or discussions, the Chair concluded this review of the Quality and Performance Report.

6. End of Life Care

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

Alison Moon felt it was timely for the Board to hear how the Trust approached End of Life (EOL) care. She introduced Karen Forbes, a Consultant in Palliative Medicine who outlined key points of the report:

- Three years ago the Trust had audited deaths which might have been

predicted, in addition to areas of end of life care which might be improved. During this time, the Department of Health's End of Life Care Strategy was published. This recommended that trusts had 'care of dying' pathways in place, which included the Liverpool Care Pathway, which she said "had recently received adverse media coverage". The Trust decided not to use this pathway and instead, the Palliative Care Team established a research project to develop its own End of Life care tool, which was noted to be simple and had been positively received by nursing staff;

- Karen explained that "in tandem with poor media attention regarding the Liverpool Care Pathway", a simple Standard Operating Procedure was added. All developments in relation to the EOL tool were overseen by the Trust's End of Life Steering Group;
- To introduce and maintain the Trust's own EOL care tool, all relevant ward staff had been educated with short ward-based sessions. Additionally, the culture of the Trust required a change in thinking, to view that death was not failure, and that earlier acceptance could improve patient care;
- Trust infrastructure was also challenging, as there was only the limited resource of a fixed-term project nurse to deliver education and gather date regarding end of life care;
- Most complaints received by Trusts about EOL care relate to the distress of relatives, as well as things that might have gone wrong. There was an emphasis on improving communication between staff and families;

The Board was assured that significant work was underway to provide effective quality of care for patients at the end of life.

Comments:

- Paul May requested clarification regarding the end of life pathways for children. Karen explained that children were represented at the Trust-wide End of Life Steering Group, which the Children's End of Life Group reported to. Regarding work to identify children who might die of their disease, a Child and Family Wishes document had existed for some years.
- Responding to a question from Wendy Gregory, a Patient Carer for Bristol, regarding the communication at discharge of a patient at end of life, Karen explained that although it was challenging, there was an in-reach consultant from the hospice for one session a week, who assisted the Trust and visited its patients. Communication between the agencies was noted to be effective, but a more significant issue was the availability of beds.
- Gary Williams, a Patient governor, who was present, asked if the Trust had connections to specialist paediatric end of life facilities, and what the perception was regarding the Trust's end of life pathways, in considering individual patient factors. Karen confirmed that UH Bristol worked with a senior clinician from Children's Hospice South West, who undertook in-reach sessions at the Children's Hospital. Responding to Garry's second question, Karen explained that a patient was only put on the pathway following a full assessment and diagnosis by the whole Multi-Disciplinary Team that the patient was dying, prior to further consultation with the patient, or carers of a child, or with the child if this was possible. In each case, attempts were made to hasten diagnosis so the patient could be involved with

their care whilst they maintained capacity. As such, Karen emphasised that it was fundamental that the pathway considered human factors, and was certainly not a 'tick-box' exercise. • The Chairman took a number of questions from Governors about the detail of the end of life approach. • Deborah Lee emphasised the Quality Incentive Scheme to the Trust Board, and added that the Commissioning for Quality and Innovation (CQUIN) proposals included the promotion of end of life care, and might restore some funding. *There being no further questions or discussion, the Board resolved to **note** the End of Life Care Report.*	
7. Histopathology Action Plan Update The Board received this report by the Chief Executive to **note**. The Medical Director, Sean O'Kelly, reiterated that the Quality & Outcomes Committee reviewed the action plan in detail. Action 2.1 still awaited progress, but a number of others had been progressed since the last report, which included Action 6.3 – Job Plans for Pathologists, which had been completed on the UH Bristol site. *There being no further questions or discussion, the Board resolved to **note** the Histopathology Action Plan Update.*	
8. 2012 National Accident & Emergency Survey Results and Action Plan The Board received this report by the Chief Nurse to **note**. Alison Moon introduced the report, saying that the Adult Emergency Department, Outpatients and Maternity were on a three-year cycle. She introduced Anne Frampton, Accident and Emergency Consultant, to the meeting. Anne said that results were positive, and key headlines were: • The survey was commenced across 147 trusts in the UK, which were then benchmarked against each other; • None of the scores for UH Bristol were lower than average; 16 scores were above national average, and 8 of the 16 achieved the top score. The Trust was in the top-five trusts on aggregate scores. Anne focused on the scores where the Trust had underachieved and completed an action plan as a consequence: • Taking a patient's home situation into account on discharge; • The length of time patients waited for handover from ambulance staff. The majority of the action plan was in progress, some had been completed, and completion of the full plan was expected by year-end. Comments: • John Savage congratulated Anne Frampton on the performance of the Emergency Department demonstrated in the report. • Referring to John's point, James Rimmer added that work towards improved flow as a known issue was on-going, so he was delighted that it was emphasised at Trust Board. He assured the attendees that the survey	

confirmed that patients were not affected, but despite being in the top five performers in the country, improvement could still be made.

- In response to a question by Garry Williams regarding Children's Accident & Emergency, Anne Frampton clarified that children were treated in a separate emergency department. Anne explained the process of when patients queued in these departments and the balances in place.
- Responding to further questions from Garry, James Rimmer clarified that from a clinical perspective the department was seen as the "Emergency Department", but legally it must be advertised as the "Accident & Emergency Department".

John Savage concluded that the clarity of the information from this survey revealed that the Trust might previously have underestimated the high quality of patient experience in the Emergency Department.

There being no further questions or discussion, the Board resolved to ***note*** *the 2012 National Accident & Emergency Survey Results and Action Plan.*

Finance

9. Finance Report

The Board received and considered this report on the activity of the Finance Committee for **review.** The most recent meeting was held on Friday 25 January 2013.

a. Overview – Director of Finance

Paul Mapson highlighted the following main headlines from the report:

- A slight improvement had been seen on the November position, as activity in December (month nine) was relatively high;
- The year-to-date position had seen a slight deterioration regarding divisional issues, but some areas had improved the position, such as Her Majesty's Revenue and Customs (HMRC) and telecoms;
- The importance of demonstrating to Monitor, at Month 9 of the Quarter 3 projection, that the Trust was moving towards a forecast outturn of £5.7m;
- CRES delivery was at about 78%, but problems existed regarding undertaking activity. However, the Trust was still in a better position than previously, and continued to project an achievement of £5.7m surplus at year-end;
- The capital loan had not been drawn-down, to avoid the need to pay interest. Capital slippage had been used to finance the cash position that consequently, was lower than planned. A £5m loan was taken recently, and an additional sum of £20m would be taken in February or March, as the cash balance would reduce to a level where it was required;
- Some divisional trends were still of concern to Paul, but he planned a presentation at the February Board Development Seminar to address these, followed by a proposed budget at the Public Board Meeting in March.

b. Finance Committee Chair's Report

The Chair of the Committee, Lisa Gardner, presented a verbal report on the meeting of the Finance Committee of 25 January 2013.

- The Executive team had selected a tender for commencement in March, to review certain areas of flow and discharge.
- Paul had provided an update on commissioning and contracting, which was also due to begin;
- Lisa reiterated Paul's comment that December had seen some improvement, but there was still a worrying underlying trend position; however, it was still on-target to meet the year end of £5.7m turn-out;
- Amounts of nursing and agency staff was discussed in the meeting, and Robert Woolley confirmed that the Executives were aware of this and continued to review and question usage;
- If CRES overspend in the Division of Surgery, Head and Neck was side-lined, other divisions would be seen to be doing well and should therefore be congratulated on their achievements;
- Capital spend was still marginally under 75%, to ensure Monitor that the Trust was not spending capital money to fund its revenue position; this was attributed to the timing of the capital project and by year-end should be in the region of 75% –78%;
- Successful work had been undertaken to claim some outstanding debts;
- The Finance Committee anticipated a Finance Risk Rating of 3 for the next twelve months.

c. Board Review

- In response to John Moore's question regarding the cause of an increase in pay this year in the Division of Surgery, Head and Neck, Paul Mapson explained that it was attributed to a number of factors, including an increase in agency staff. Other factors were the costs associated with opening South Bristol Community Hospital, and other control issues not reflected in overspend, such as medical staffing.
- John Moore asked a further question regarding what was driving increases in non-pay spend versus CRES. Paul Mapson said that a number of factors were involved, such as the high level of inflationary costs associated with drugs, increases in National Institute for Health and Clinical Excellence (NICE) funded clinical attendances and general inflation. Each division reviewed these increases, as they each had different cost considerations and complexities.
- John Savage invited John Moore to attend the Finance Committee if he required further assurance.

There being no further questions or discussions, the Chair concluded this review of the Finance Report.

Strategy and Business Planning

10. Partnership Programme Board Report

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

Robert Woolley explained that the two Bristol trusts had met and a brief report was taken describing the future of Weston General Hospital, which was still playing out, in addition to a number of other areas for collaboration

that would continue, regardless of the outcome of the broader agenda of whether the management of the two trusts should be integrated. Questions: • Paul May welcomed the minutes of the Partnership Programme Board and enquired whether North Bristol NHS Trust received the minutes in their Board meeting. Deborah Lee explained that both trusts had agreed to take it into their Board meetings. • Robert Woolley responded to a further question by Paul May, and gave an update on progress of the Central Steam Sterilising Department (CSSD) review; his latest understanding was that the planned Sterile Services unit at North Bristol NHS Trust could not be expanded to accommodate UH Bristol, so the organisation would have to create its own plan for a sustainable future of sterile services support. Paul Mapson added that a full report would be brought to a future Partnership Programme Board in this regard. *There being no further questions or discussion, the Board resolved to **note** the Partnership Programme Board report.*	
11. Transformation Programme Board Update Report The Board received this report by the Chief Executive to **note**. Robert Woolley highlighted that there was a great deal of focus on leadership development, as part of the wider Transforming Care agenda and in that context, the Executive had enjoyed a facilitated session with Helen Bevan (Chief of Service Transformation at NHS Institute for Innovation). NHS Change Day on 13 March 2013 would be utilised to re-energise the Transformation Programme and a Transformation Director for the Programme would be recruited at the beginning of March. *There being no further questions or discussion, the Board resolved to **note** the Transformation Programme Board Update report.*	
12. Quarterly Capital Projects Status Report The Board received this report by the Director of Strategic Development to **note**. Deborah Lee said this was an opportunity to review the Trust's significant capital programme, which captured the four different elements of the single programme. Deborah reported that: • The programme was on-budget and on-time; • There was a significant milestone regarding the new site-wide generator test, which was led by James Rimmer, and noted to be a success; • Significant progress was being made in relation to the developments, such as the steel frames for the Welcome Centre and Bristol Haematology and Oncology Centre, which gave a sense of the developing 'footprint'; • Programme architecture (governance) had been reviewed and changes made to include senior personnel from North Bristol NHS Trust joining the Board of Centralisation of Specialist Paediatrics (CSP) project; • A commissioning manager had recently been appointed to lead on the operational elements of the Bristol Royal Infirmary project.	

Two key risks:

1. Within the CSP Scheme, work was underway to refresh the original planning assumptions made at Full Business Case. Early signs were that future income would be lower than originally assumed, reflecting changes in commissioning intentions from Welsh and South West Commissioners in the areas of neurosurgery and scoliosis surgery, respectively. The key mitigation would be a re-sizing of required capacity and commensurate reduction in proposed expenditure, but the net impact of these changes remained unknown. Current assessment was that this would cause a degree of financial revenue pressure. The Trust had signed a Memorandum of Agreement with specialised commissioners for further external funding, in such a scenario and this would be the primary route of redress in a scenario where income did not cover costs.

Within the BRI scheme, ambitious assumptions had been made at the time of the business case regarding length-of-stay improvements in the Bristol Royal Infirmary. Work had been completed to review the national picture, and the Trust's own performance, and it was seen that length-of-stay had extended nationally, particularly for patients on urgent care pathways, and not made the gains anticipated. This had prompted a review of the planned bed-base, which pointed to a requirement for more beds than originally assumed. Work was now in-train to re-model the future bed base, reflecting these contemporary findings and to assess the impact on the Trust's long-term Financial Plan.

2. John Savage noted that on Monday 14 January, work on the construction of the new ward block behind the Bristol Royal Infirmary reached its highest point. The milestone was marked with a 'topping-out' ceremony, where the Head of Division of Surgery, Head and Neck, Mike Nevin, tightened the last 'golden bolt' at the top of the new structure.

*There being no further questions or discussion, the Board resolved to **note** the Quarterly Capital Projects Status Report.*

Risk

13. Board Assurance Framework Report

The Board received and **reviewed** the report by the Chief Executive.

Robert Woolley explained that the Trust was coming to end of a 3-year plan and that there would be discussion re how the Board Assurance Framework would be re-cast for the future.

This progress report read-across into the Corporate Risk Register. Two objectives had an inherent and residual Red risk rating, which were:

1. Compliance with Care Quality Commission (CQC) registration;
2. Notwithstanding the positive comments regarding CRES said in this meeting, it was clear that the Trust would not achieve the set target.

There being no further questions or discussions, the Chair concluded this review of the Board Assurance Framework Report.

14. Corporate Risk Register

The Board received and **reviewed** the report by the Chief Executive.

Robert Woolley said that the register included high inherent risks as assessed across the Trust and its Divisions. Since the report was last taken: • The High Dependency Care for children risk had been downgraded following the CQC outcome; • 62-day Cancer was under re-assessment given the Quarter 4 situation; • There was concern regarding the delivery of the Clinical Negligence Scheme for Trusts (CNST) Level 3 accreditation, in relation to staff training compliance across Trust. Comments: • Robert Woolley explained to Paul May that Radio-Pharmacy was a production unit that managed radioactive isotopes used in care of cancer patients, which had significant health & safety implications regarding management of materials. The Trust had a dedicated facility with temporary planning permission, and a decision had been made to leave this in-situ, whilst working with planners for a solution to accommodation requirements. A planning conclusion was expected shortly for report back to the Board. • Lisa Gardner requested a progress report regarding the high Endoscopy Service risk. James Rimmer explained that this had been an omission from the paper, but an external review had commenced, and extensive plans were in place, following review at the Quality and Outcomes Committee. • Robert Woolley responded to a query by John Moore regarding mitigating actions for the 'high residual' risk of failure to achieve Level 3 NHSLA Risk Management Standards. Although significant work was underway, it had taken longer to revise systems for training compliance than anticipated. • Wendy Gregory commented on the format of the Register, as it had been virtually unreadable due to small text. Robert Woolley stated that the Trust's new Risk Manager would commit to addressing the legibility of reports. *There being no further questions or discussions, the Chair concluded this review of the Corporate Risk Register.*	Trust Secretary
15. Quarter 3 Compliance Framework Monitoring & Declaration Report The Board received and considered this report by the Chief Executive for **approval**. Robert Woolley sought the Board's agreement to the proposed declaration of a Trust Finance Risk Rating of 3 and Governance Risk Rating of amber-red. James Rimmer flagged a further risk regarding Referral to Treatment Times, which was under investigation, but should not affect the Board's declaration. Monitor had the ability to apply a red override based on any further factors, and they also had the power to escalate their intervention. However, the Trust had assured Monitor of the actions underway to address these issues. Comments: • Referring to the 4-Hour Accident & Emergency review, Paul May expressed his concern that there was a risk of "cutting corners" in a drive for improvement. Robert Woolley responded that the timeliness of care was as	

much a quality issue, as other elements of care in the department, and the Trust wanted to ensure that the department was as effective as possible, in terms of its flow and discharge agenda. *There being no further questions or discussions, the Board resolved to **approve** the Results of Quarter 2 Compliance Framework Monitoring Exercise.*	
Information and Other	
16. Any Other Business **AOB 1** Robert Woolley said that since April 2012, UH Bristol had considered the terms of a Novation of Contract from Medirest, regarding the Trust's role as lead provider for South Bristol Community Hospital. Trust Standing Orders required the Board's approval to affix the Trust Seal, which the Board agreed was appropriate.	
17. Date of Next Meeting **Public Meeting of the Trust Board of Directors**, Thursday 28 February 2013 from 10:30 – 12:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	

ID	Entity	Meeting Date	Minute number	Description	Action by	Date to Report Back	Comments
58	Public Trust Board	29/11/2012	12	**Corporate Risk Register** - A themed report would be brought to the Board or Quality and Outcomes Committee regarding annual reviews of staffing (this followed the recent Conroy Review of ward staffing)	Chief Nurse	21/12/2012	Chief Nurse will link this action with recommendations from the Francis Report on Staffing.
65	Public Trust Board	28/01/2013	5	**Quality & Performance Report (Board Review)** - Paul May asked if the downward trend of the Hospital Standardised Mortality Ratio could be continued with ambitious planning. Robert Woolley questioned this wisdom from a statistical point of view, and added that it would be reviewed.	Medical Director	28/02/2013	Opinion of Medical Director sought.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 28 February 2013 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 – FEBRUARY 2013

1. INTRODUCTION

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

2. COMMUNICATIONS

The Trust Management Executive **noted** the monthly report on the activities of the Communications Department.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the Trust's performance against Monitor's Compliance Framework. The Trust experienced very high pressures due to high levels of emergency patients attending the Trust, delays in discharging patients back to the community and a number of wards closed due to norovirus. The Trust had been in black escalation for a period of 8 days and maintaining patient safety had been the focus for the period. The resulting reduction in the number of available beds had led to a significant reduction in planned surgery and had significantly impacted on performance in the period. Key risks arising from the impacts of the last week, for Quarter 4 2012/2013, were Cancer 62-day screening standard and 4-hours accident and emergency waiting times.

The immediate priority was to re-book all cancelled care, eliminate escalation bed capacity from the bed base and develop performance recovery plans.

The group **received** results of the Annual Health and Safety divisional audit and noted significant improvement across all Divisions with no Division now being RED rated on any domain.

4. STRATEGY AND BUSINESS PLANNING

The group **received** an update on progress in respect of the 2013/2014 Operating Plan and discussions with commissioners and noted that progress towards contract settlement was slower than in previous years reflecting the significant changes in commissioning structures and responsibilities.

The group welcomed and **approved** the proposed local CQUINs (Quality Incentive Scheme) for 2013/2014 on the basis that they reflected the priorities of the Trust.

The group **approved** a proposal to reduce the opening hours of the Bistro following a review of usage of the facility, whilst noting that a catering strategy was being prepared which would seek to address the future catering needs of, both patients, visitors and staff.

5. RISK, FINANCE AND GOVERNANCE

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

- An update on the Trust's weighted recruitment into National Institute for Health Research portfolio studies, which had been confirmed at 3.7% above plan and was 34% improved on the previous year
- An update on the Macmillan 1:1 support pilot project
- An update on consultation with Divisions on the 2013/2014 clinical audit programme
- An update on the proposal to resubmit a bid for Intestinal Failure and Nutrition Services designation on the basis of a single site option
- An update on the Trust's response in respect of Neonatal Intensive Care Unit designation
- Progress on the work to refocus the Teaching and Learning Group and the development of a work programme for 2013
- An update on the recovery plan for essential training
- Progress in respect of the Medway Phase 1b software release
- Progress in respect of the Head and Neck, Urology and Breast Service Reconfigurations

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

6. RECOMMENDATIONS

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

Deborah Lee (TME Chair February)
Deputy Chief Executive/Director of Strategic Development

University Hospitals Bristol NHS
NHS Foundation Trust

Report for the Public Trust Board Meeting, to be held on 28 February 2013 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 05 – Process for Responding to the Mid Staffordshire NHS Foundation Trust Public Inquiry Report (the "Francis Report")

Purpose

To set out the Trust's process for responding to the Francis Report.

Abstract

On 9 June 2010 the Secretary of State for Health, Andrew Lansley MP, announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust.

The final report of the Inquiry was published on Wednesday 6 February 2013 by its Chair, Robert Francis QC. The report, setting out 290 recommendations for the government and the NHS, was immediately distributed to the Trust Board of Directors and the Trust Management Executive.

As an immediate response, the Executive has conducted an assessment of the recommendations to establish which require immediate action by the Trust. These recommendations will be addressed and managed by the Trust Management Executive.

It is further recommended that the Trust Board of Directors conduct a review of the recommendations with a view to identifying any elements of its own corporate governance which might require revision so as to ensure the Board can evidence that it:

- fully understands the content and implications of the Francis Report;
- accurately understand the quality of the care the Trust provides;
- is able to effectively assess and mitigate risks to quality;
- understands that quality is the responsibility of the entire Board (not only the medical and nursing directors); and,
- it is committed to continuous quality improvement, and has put in place the tools to address performance issues.

As part of this review, the Quality and Outcomes Committee has recommended that its own Terms of Reference should be revised as part of the Board's wider consideration of the Francis Report. The Committee recommends that this review should include consideration of the Committee's self-assessed performance and any proposed changes to the constitution of the Committee.

The Board will receive an update report in April 2013.

Recommendations

It is recommended that the Board undertake the review set out above, and seeks on-going evidence of compliance with relevant recommendations of the Francis Report.

Executive Report Sponsor or Other Author

- Sponsor: Chief Executive
- Author: Trust Secretary

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
11 February 2013, 18 February 2013, 21 February 2013		26 February 2013			

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 28 February 2013 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 06 – 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 (Head of Quality (Patient Safety)) Heather Toyne (Assistant Director of Workforce Planning)

Division of Women & Children – Patient Story for January 2013 PEG/February 2013 Board

The Patient Story from the Division of Women & Children is an example of excellent care experienced by a patient and her family during and after the birth of their daughter at St Michael's Hospital. This was expressed as a written compliment from the new parents.

The mother-to-be and her husband arrived at the Central Delivery Suite in the early hours of the morning, ready to begin the process of having their first baby. After 14 hours in Central Delivery Suite, under the skilful direction of the midwife, a healthy baby girl was born.

In their letter the parents described how, from the moment they arrived, they were made to feel relaxed, comfortable and safe. They wrote that all of the staff in the Central Delivery Suite were thoroughly professional but informal enough to put them at their ease. They explained that they had met quite a few of the midwifery team and were impressed with the level of dedication, friendliness and good humour shown by them all.

The parents felt that they received exceptional treatment from a team who really cared about how they were feeling, whilst delivering a very high standard of clinical expertise. They both felt that the staff they met really went the extra mile to help them through an exhausting and emotional experience, and also to make sure it was special for them. They explained that throughout the labour, the midwife who delivered the baby managed all aspects of their care with calm supportiveness.

Through the whole experience, both parents felt that the team were always in control and keeping them safe, acting in their best interests and involving them fully in any decision making. They say that the staff made meeting their daughter for the first time a joyous experience, one they will never forget and they could not thank the staff enough for delivering her safely and with such care.

Following the birth of their daughter, the parents went on to say how they continued to receive the same excellent and thoughtful care they had received during the labour. The new mother particularly appreciated the small kindnesses shown to her after the delivery: the reassurance and humour whilst she was having stitches, a member of the team kindly washing her hair and helping her to dress, and the midwife who initially looked after her during labour coming to see how she had got on after she had finished her night shift.

The parents found that this ethos and level of care continued on the ward, with the staff there living up to the high standards set by their colleagues in the Central Delivery Suite. They had to return to the ward after their initial discharge as the baby had lost weight and needed a tongue tie repair. They described how the assistance they received establishing feeding and support during their return to St Michael's was again expert, constant and reassuring.

Good Practice

- Providing reassurance and support to these first time parents from the moment they arrived; making them feel involved, special and safe.
- Communication throughout was to a very high standard.

- Care and treatment was to a clinically high standard and was delivered in a professional but friendly manner.
- All the staff involved, both during and after the birth, treated the parents with warmth and kindness, resulting in a very special experience that they will remember forever.

Organisational Learning

- The importance of a calm, supportive and professional approach to care and of involving patients in decisions about their care
- The importance of excellent communication skills and individualised care being provided by skilled staff
- Staff make a difference to their patients' experience by treating them with compassion, care, dignity and professionalism.

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

February 2013

CONTENTS

CONTENTS

SECTION A – Performance Overview

Summary

There has been a improvement in the overall 'health' of the organisation relative to last month, with an increase in GREEN rated indicators by two, and a decrease in RED rated indicators by one. The net changes include Hospital Acquired Pressure Scores moving from a RED to a GREEN rating. Although the number of Inpatient Falls remains just above the GREEN threshold there has been a significant reduction in the rate of falls in the period, reflecting the overall improving picture for quality of care.

The Trust's Hospital Standardised Mortality Ratio (HSMR) remains well within the GREEN threshold reflecting a lower level of deaths than would be expected for a Trust of this scale and complexity, as does the level of 30-day emergency readmissions. Whilst elective length of stay has reduced and is now GREEN rated again, emergency length of stay increased in the period. However, the emergency length of stay figure for January is known to have been skewed by the discharge of a small number of very long stay emergency patients in the period.

Staff sickness remains RED rated and deteriorated slightly in the period and remains a significant focus for attention. There remains significant variation between individual Divisions and learning from high performing divisions is being disseminated across the Trust.

Three of the four measures of financial performance have retained an AMBER rating. Although the level of Cash Releasing Efficiency Savings (CRES) achieved in the month has remained RED rated, there was a slight improvement in the month. However, the forecast for year-end achievement has reduced by 1.1% to 79.8%. Our Liquidity improved by 1.2 days in the period, as a consequence of us drawing down the first tranche of the long-term loan, which accounted for 3.8 Liquidity days. Although there has been a deterioration in EBIDTA (Earnings Before Interest, Taxes, Depreciation and Amortization) and Income & Expenditure our overall Financial Risk Rating (FRR) remains at 3 (rounded), and we continue to be GREEN rated for both financial measures of Contract Delivery.

The Trust currently has an AMBER-RED Governance Risk Rating (GRR) against Monitor's Compliance Framework at this stage in Quarter 4; this reflects the forecast failure to meet the 62 Day Cancer GP/Screening standard and the Trust having exceeded both its annual objective and the minimum reporting level for MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemias. Whilst the A&E 4-hour standard was not achieved in January, the forecast remains that the 95% standard will be achieved for the quarter as a whole following a rapid return to strong performance following the recent operational pressures.

However, the Board should note that Monitor has the right to apply a RED rating over-ride to the Q4 rating for the failure to achieve our annual MRSA objective and/or a failure to achieve the A&E 4-hour standard for a third quarter in a 12-month period.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
A01	Patient Climate Survey (Overall CQUIN Score)	78	74	N/A	Green: >= 73.9 Red: <71.9	↓	Current month is December 2012.
A02	Number of Patient Complaints	96	118	1378	Green: <120 Red: >=135	↑	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	5	4	33	Green: 0 Red> >0	↓	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	2	0	39	Green: 0 Red: > 1	↓	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	6.78	5.67	6.02	Green < 5.6 Red: >= 5.6	↓	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
C01	Number of Serious Incidents (SIs)	4	9	84		↑	
C02	Number of C.Diff cases	1	4	42	Below Trajectory	↑	

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
D01	18 Weeks Admitted Pathways	91.7%	91.1%	92.3%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	2	1	1	Green: 0 Red: >=2	↓	Previous is confirmed Oct and Nov 2012. Current is confirmed Quarter 3. YTD is confirmed Quarters 1-3
D03	A&E 4 Hour Standard	92.05%	94.63%	94.34%	Green: >=97.5% Red: <95%	↑	

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
E01	Hospital Standardised Mortality Ratio (HSMR)	70.9	66.0		Green: <80 Red: >=90	↓	Previous is September 2012 and Current is October 2012.
E02	30 Day Emergency Readmissions	335	304	2981	Below 11/12 Readmission Rate (3.4%)	↓	Previous is November's discharges where there was an emergency Readmission within 30 days. Current is December's discharges.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
F01	Elective Length of Stay Reduction	4.0	3.6	3.8	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	6.3	5.1	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	85.1%	87.0%	86.9%	Green: >= 90% Red: < 90%	↑	Data now includes South Bristol Community Hospital and the Eye Hospital
F04	Outpatient appointment hopsital cancellation rate	9.7%	10.6%	10.4%	Green: <=6.0% Red: >=10.7%	↑	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
G01	Appraisal Compliance	87.8%	87.9%	N/A	Green: above target Red: below target	↑	
G02	Staff Sickness	4.5%	4.7%	4.3%	Green: above target Red: below target	↑	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
H01	NIHR Income (£000s)	£2,196	£2,777	£2,777	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-December and Current (and YTD) is April-January
H02	Number of Patients Recruited Into NIHR Trials	3,713	4,264	4,264	Green: Above 10/11 Red: Below 10/11		Current (and YTD) is rolling YTD position to end of December. Previous is to end of November.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
J01	Monitor Governance Risk Rating	3	2	N/A	Green: < 1 Red: > = 4	↓	Previous shows the confirmed Q3 confirmed position. Current shows the forecast for Q4, with the potential RED rating over-ride.

Delivering Our Contracts

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
K01	Financial Performance Against CQUINs (£millions)	£6.46	£6.36	£6.36	> 50% Green < 50% Red	↓	YTD and Current is Forecast year-end rewards, assuming BNSSG all payable. Previous is month 9 (Dec) performance, Current is month 9 assessment based on Month 10 performance.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	-£2.67	-£2.17	-£2.17	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 Jan Previous is YTD for Dec.

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)	95%	94%	94%	Green: 100% Red: <85%	↓	
L03	CRES Achievement	74%	74.6%	78%	Green: >=90% Red: <75%	↑	
L04	Liquidity (in Days)	15.0	16.2	16.2	Green: 25+ days Red: <=14 days	↑	

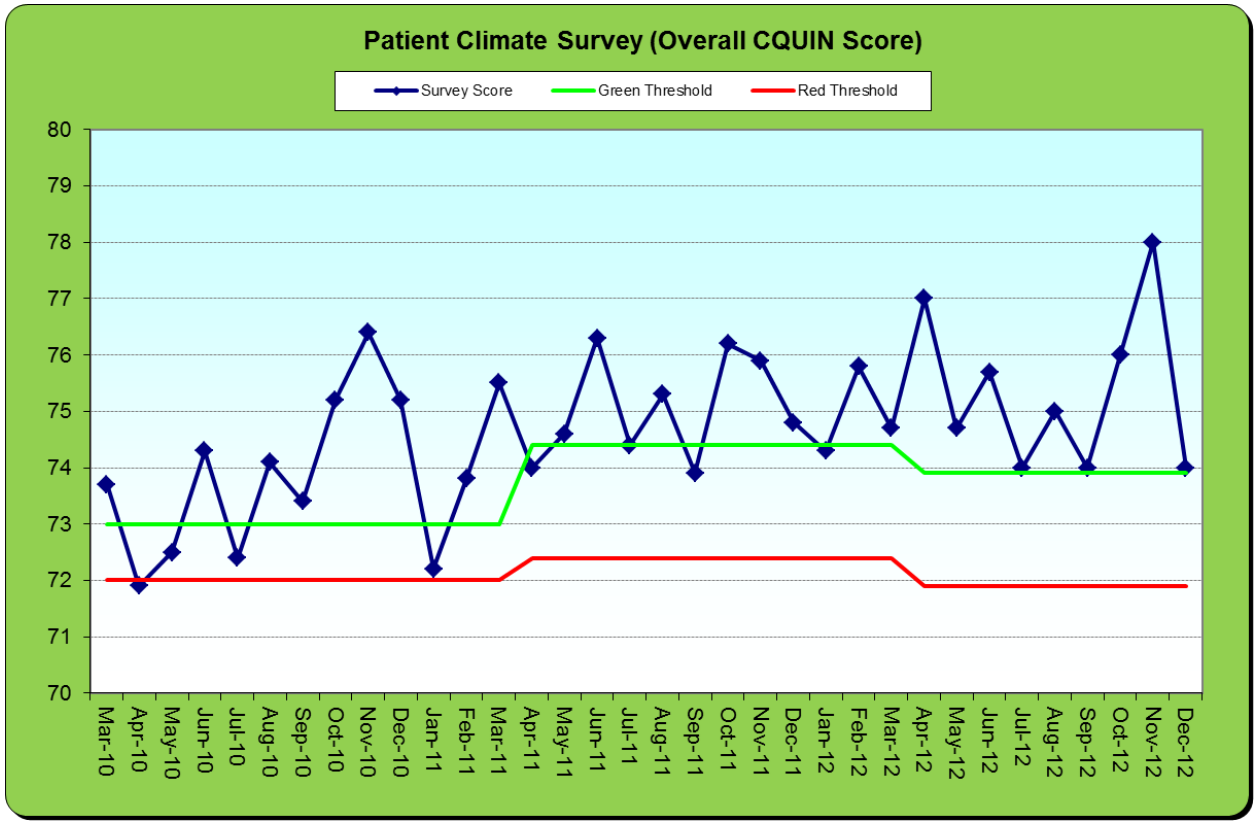
Notes

Unless otherwise stated, Previous is November 2012 and Current is December 2012

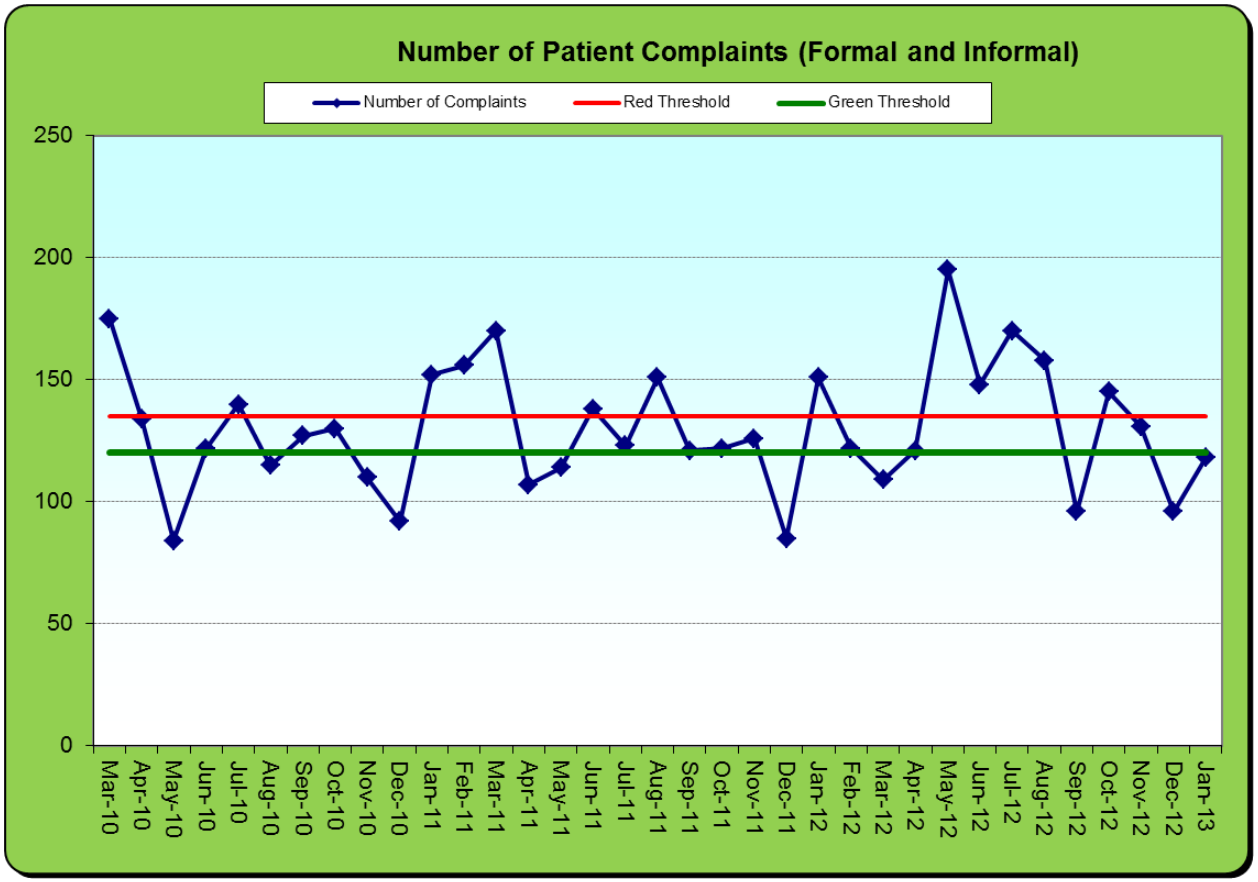
YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2012 up to and including the current month

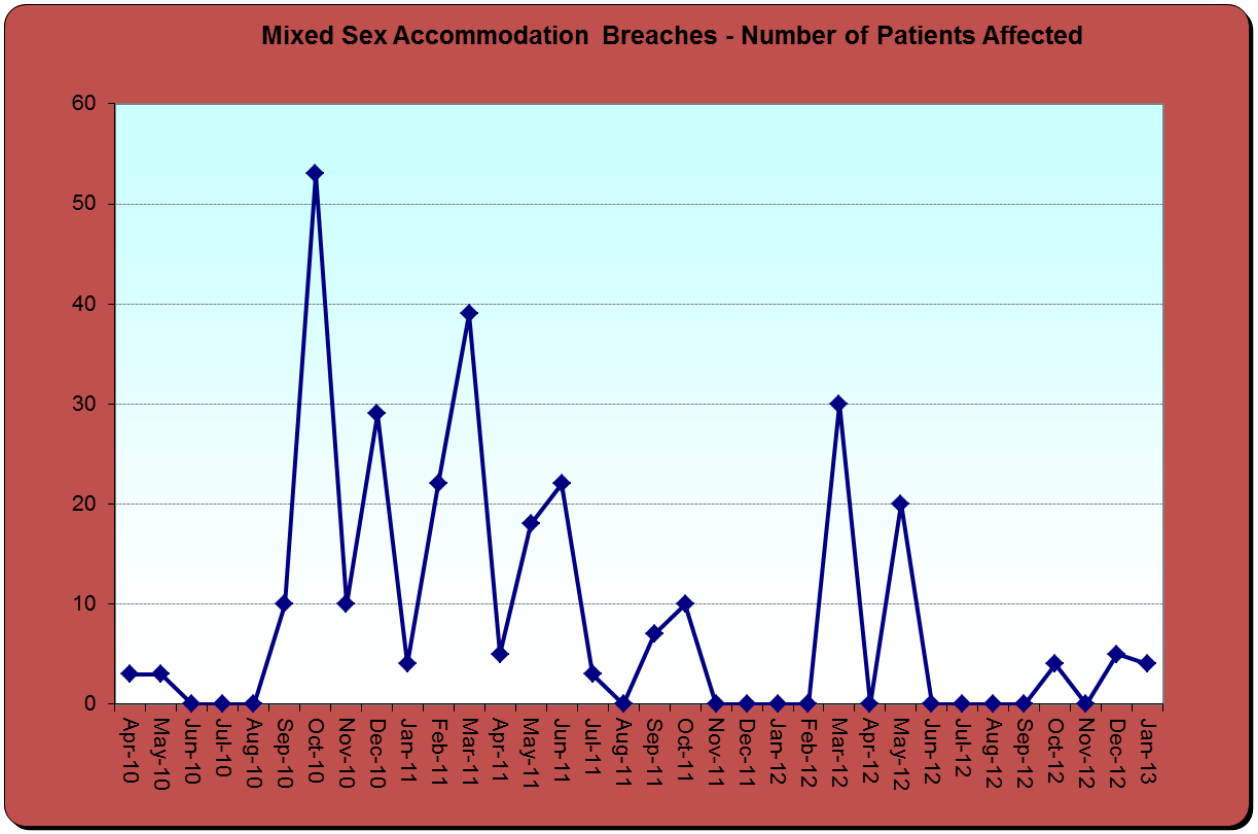
RAG (Red/Amber/Green) rating only applied to YTD where an agreed target number of cases/score exists for the year.

PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW




Mixed Sex Accommodation Breaches - Number of Patients Affected
60
50
40
30
20
10
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
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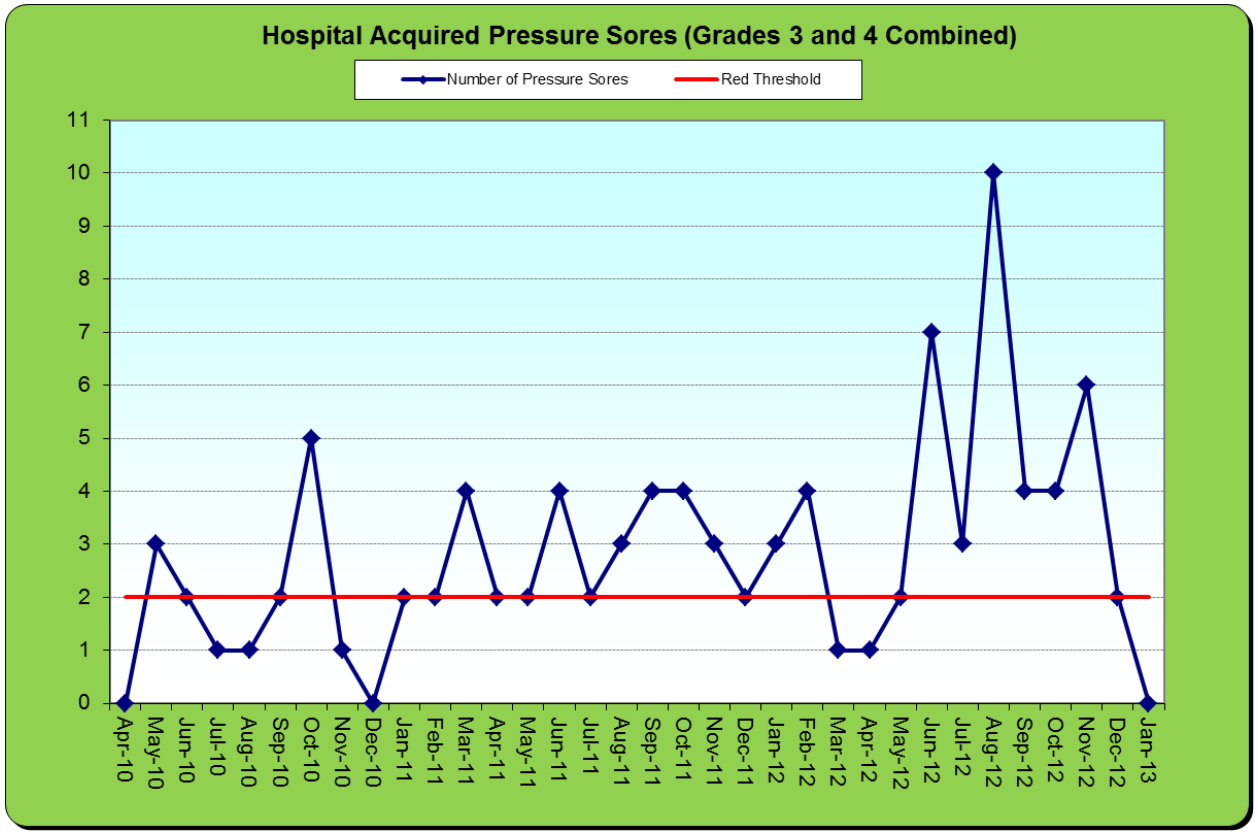
Jan-13


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
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May-11
Jun-11
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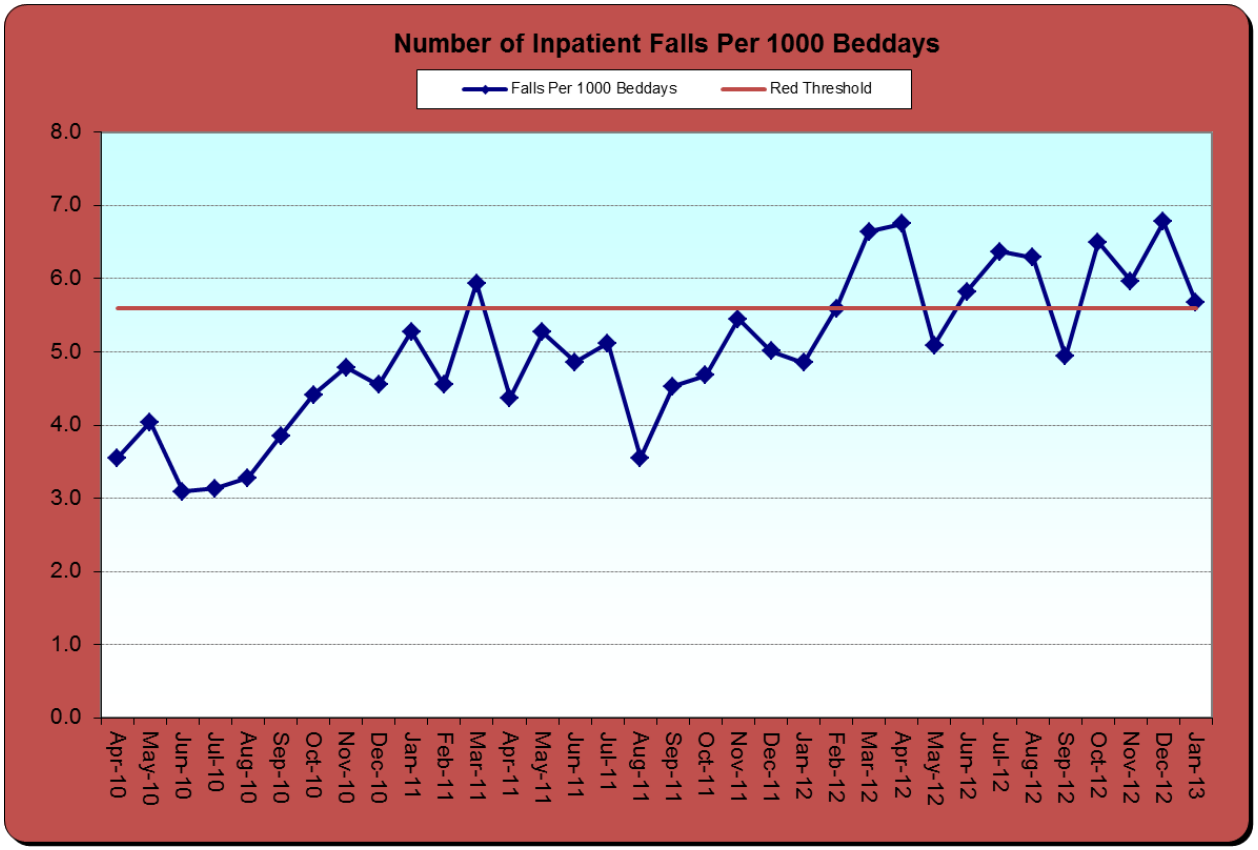
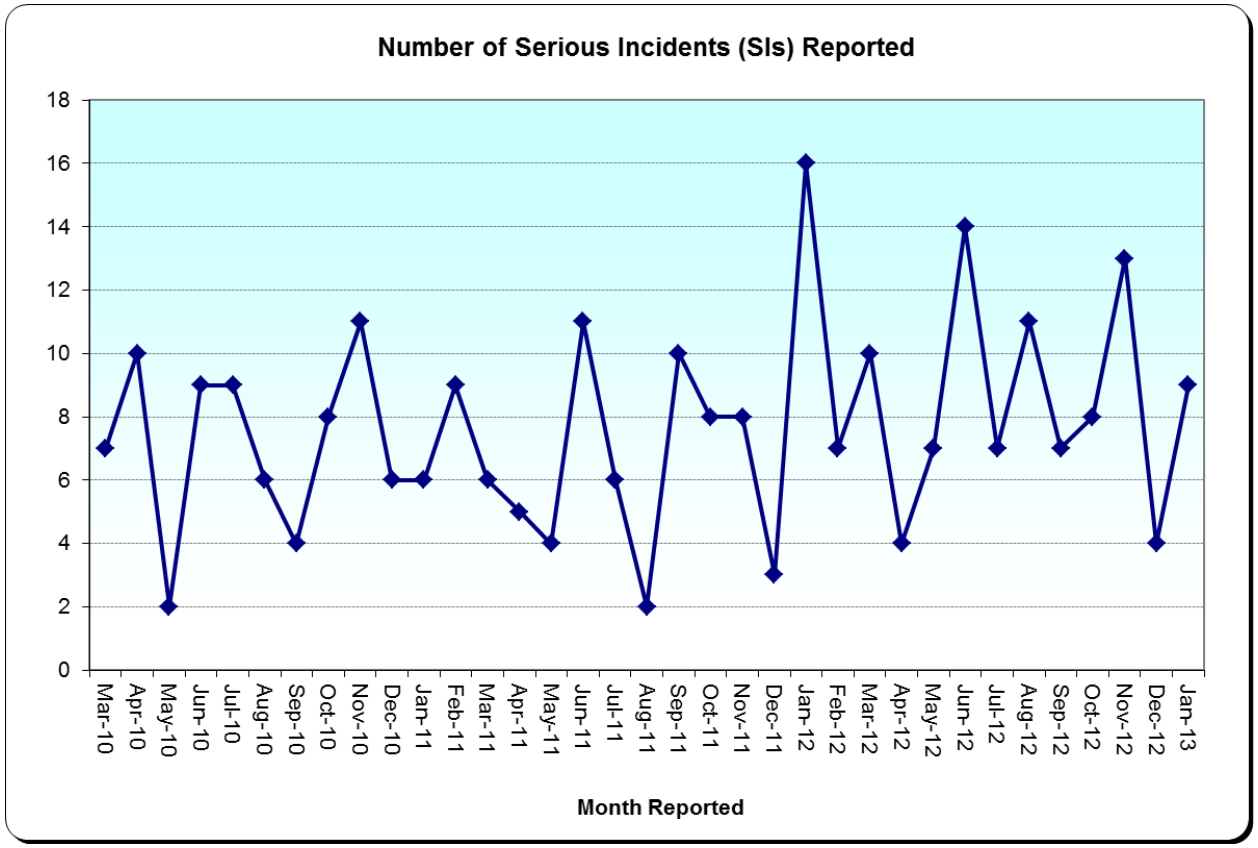
Jan-13

PERFORMANCE OVERVIEW




Number of Serious Incidents (SIs) Reported
18
16
14
12
10
8
6
4
2
0
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
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Jan-12
Feb-12
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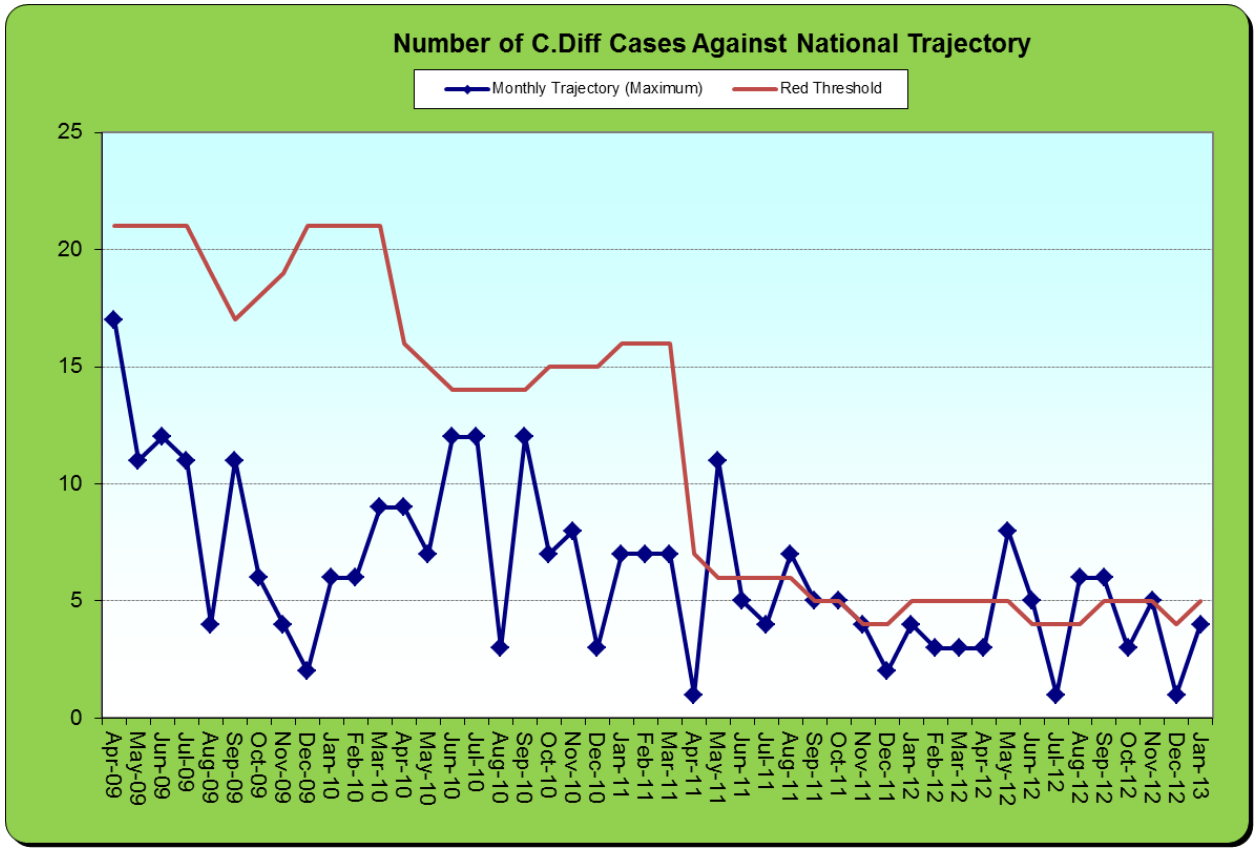
Dec-12
Jan-13
Month Reported


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
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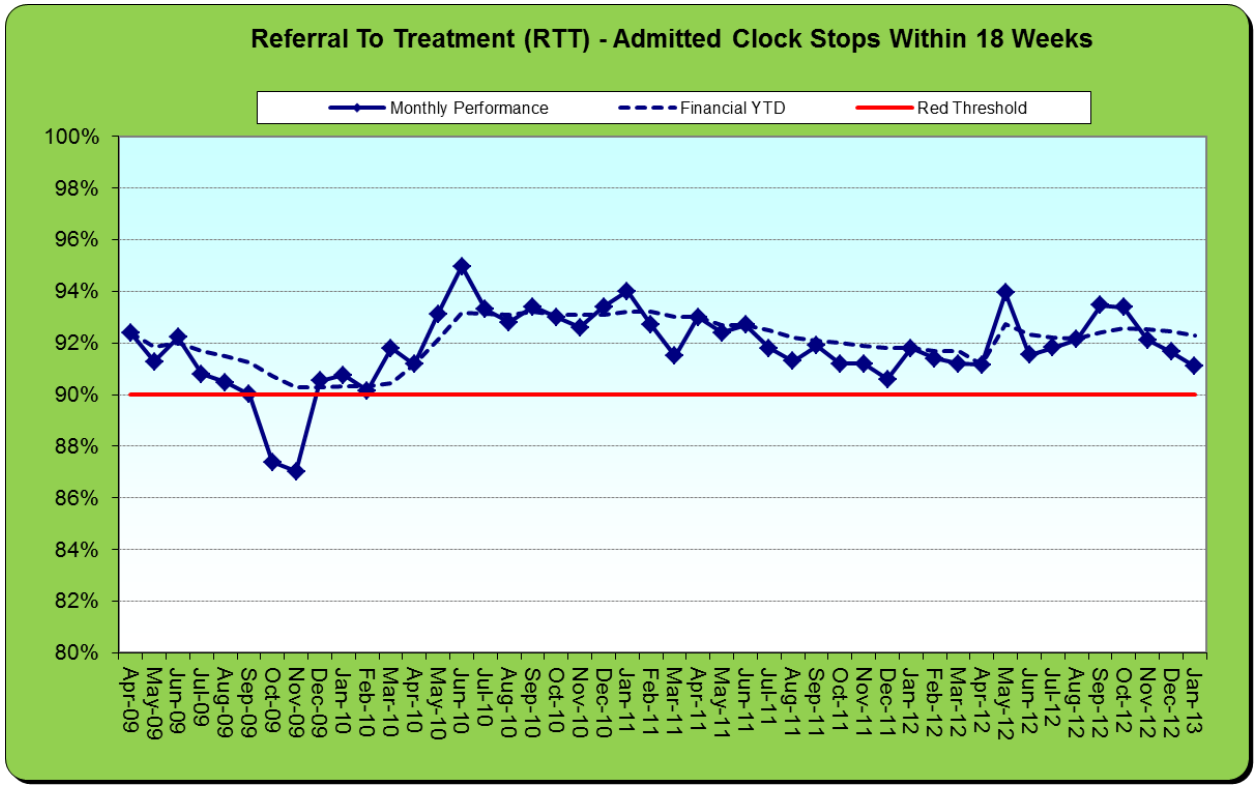
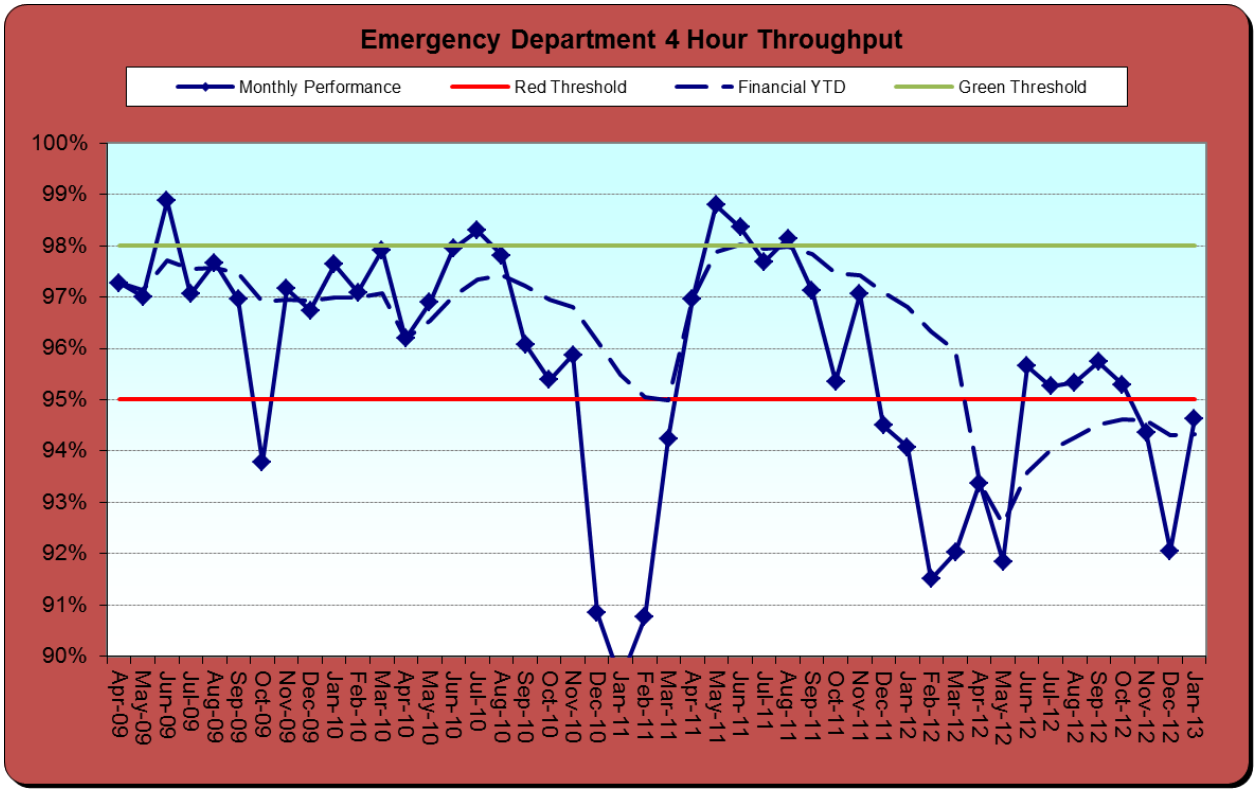
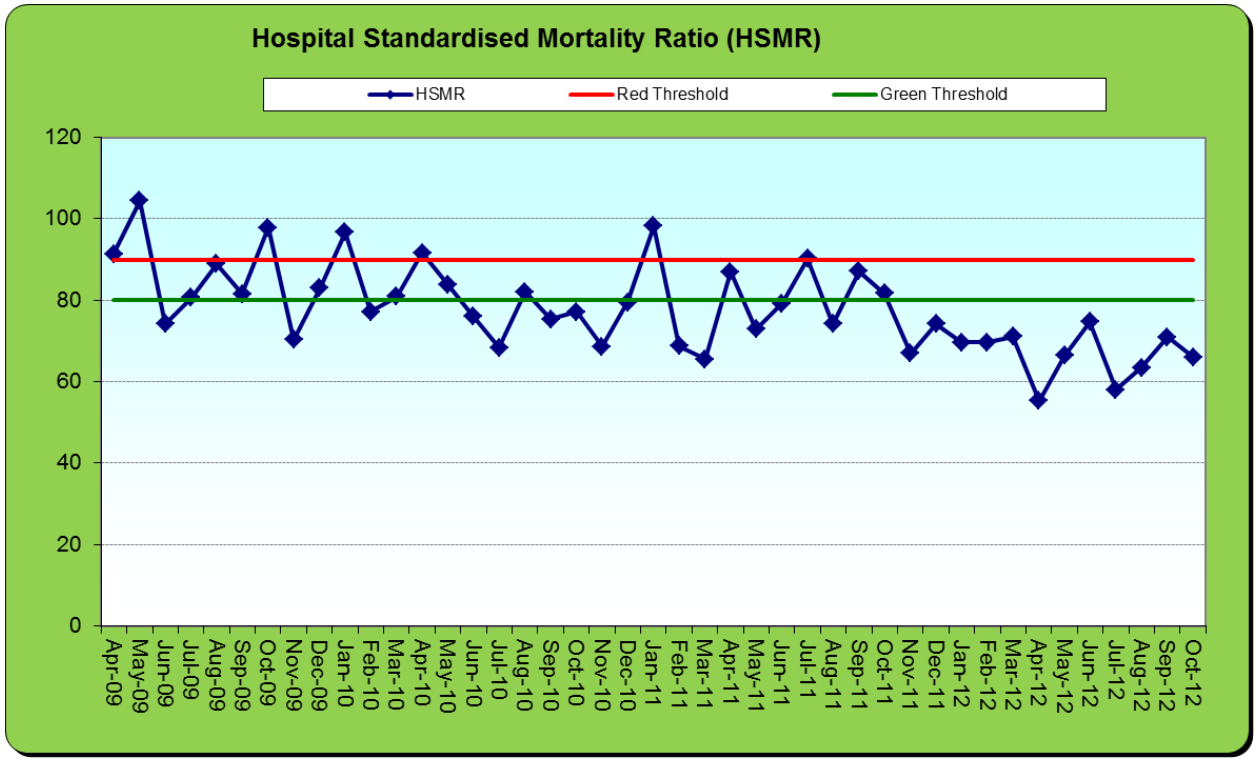
PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW



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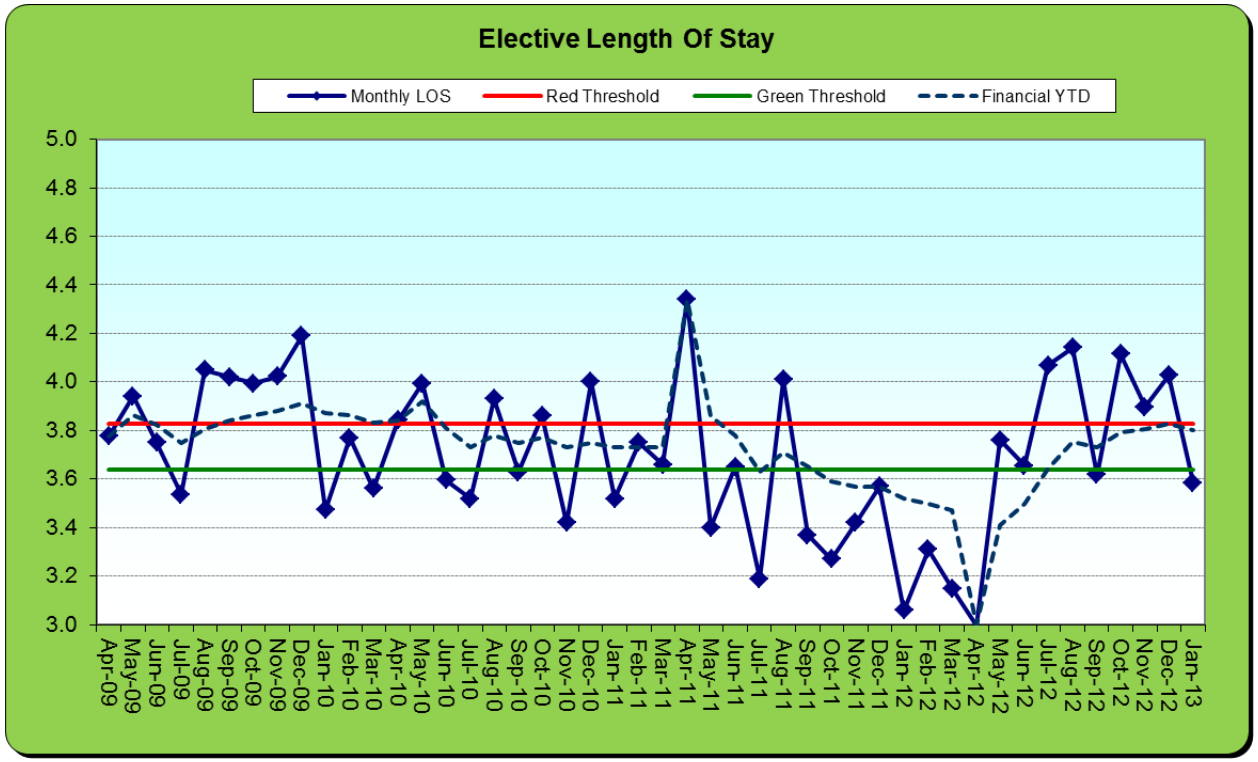
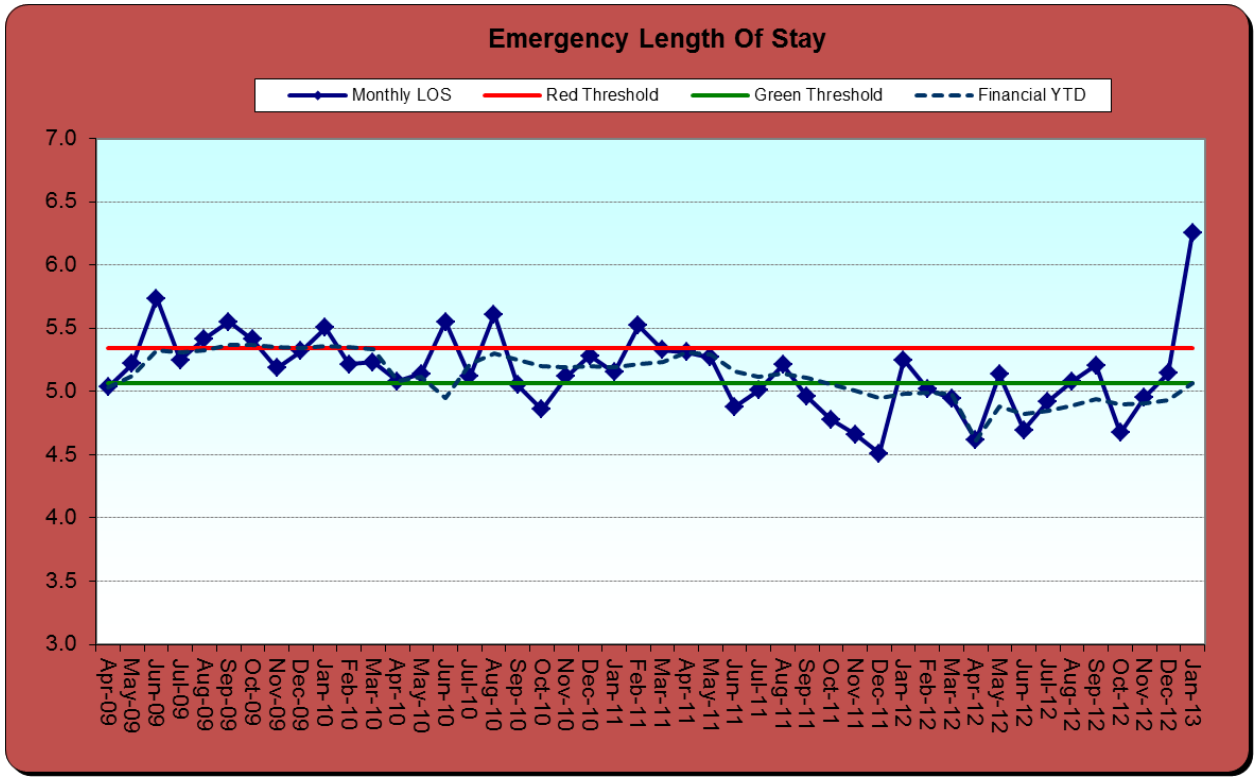
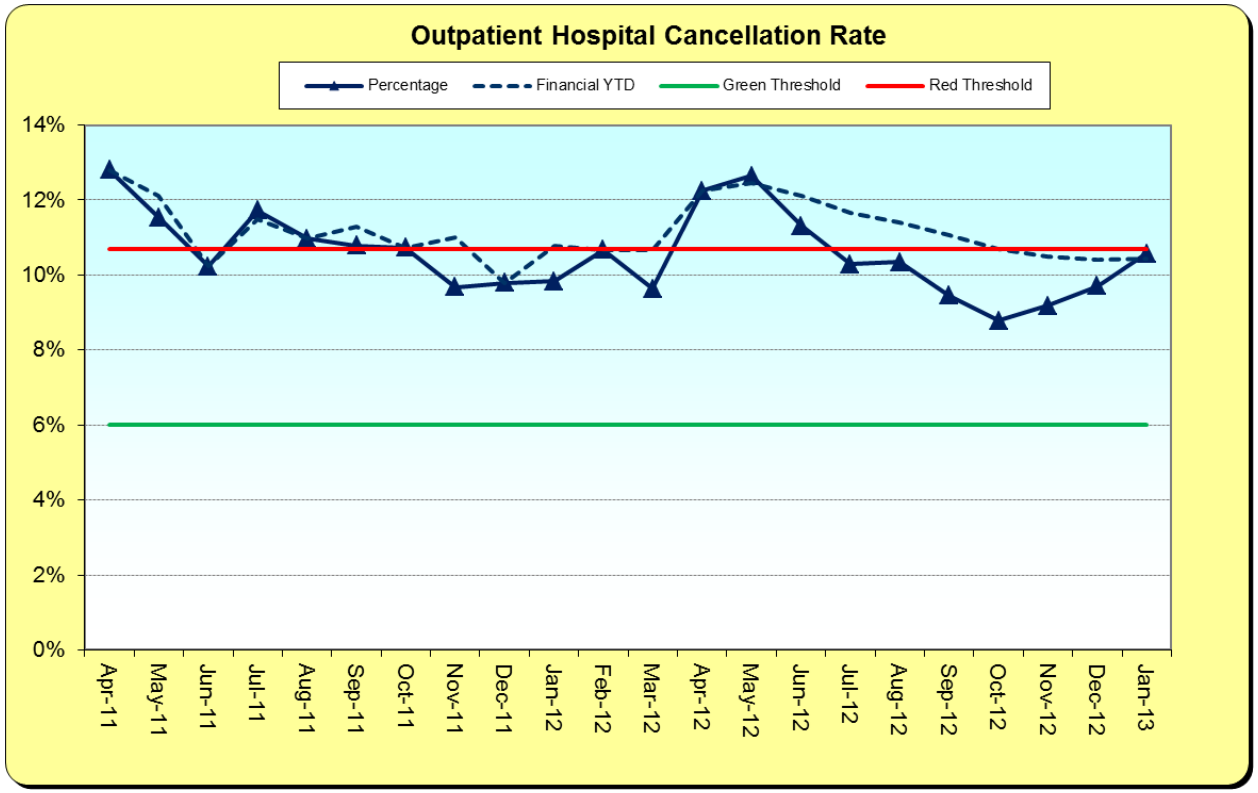


PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Same Sex Accommodation Breaches	In the *Quality* section of this report	
Number of Inpatient Falls per 1,000 bed-days	In the *Quality* section of this report	
Cancer Standards	In the *Access* section of this report	
A&E 4-hour standard	In the *Access* section of this report	
Emergency Length of Stay	See Additional Information	January's emergency length of stay figures are known to have been skewed by the discharge of a small number of very long stay patients in the period.
Theatre Productivity	See Additional Information	This indicator remains RED rated following the inclusion of South Bristol Community Hospital sessions. This reflects the poorer levels of theatre utilisation at the SBCH, which remain an ongoing focus. However, performance did improve in the period.
Staff sickness	In the *Workforce* section of this report	
NIHR Income	See Additional Information	The level of NIHR (National Institute for Health Research) income remains below the target level for the year, although this is thought to reflect the lag in reporting year to date and the highly variable nature of monthly income levels, rather than income reducing over time. The number of patients recruited into NIHR trials also remains RED rated for the same reasons.
Number of patients recruited into NIHR trials	See Additional Information	There was a dip in recording of recruitment over the Christmas period which has impacted the year-to-date figures.
Cash Releasing Efficiency Savings (CRES) achievement	See Finance Report	

SECTION C – Monitor's Compliance Framework

At the end of January 2013 the Trust has achieved all of the targets in Monitor's 2012/13 Compliance Framework, with the exception of the Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias cumulative trajectory, the A&E 4-hour standard, and the 62-day referral to treatment cancer standard for screening and GP referred patients.

The following Exception Reports are therefore provided for the standards not currently being achieved in quarter 4 to date:

- MRSA bacteraemias (1.0 weighting) – *Quality section*
- 62-day referral to treatment (screening/GP) cancer standard (1.0) – *Access section*
- A&E 4-hour standard (1.0) – *Access section*

Although the A&E 4-hour 95% standard was not met in January, it is still forecast to be achieved for the quarter as a whole. Our draft score against the Compliance Framework is therefore 2.0, which equates to an AMBER-RED rating. However, Monitor's Compliance Framework makes provision for a RED rating over-ride in the event of both the MRSA national year-end target, and the *de minimis* reporting level of 6, being exceeded at any point in the year. The Trust exceeded both at the end of last quarter, so will continue to report failure of the MRSA bacteraemia standard in Q4. A failure to achieve the A&E 4-hour target, following failures in quarters 1 and 3, would also permit Monitor to consider applying a RED rating over-ride.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 4 2012/13.

PERFORMANCE OVERVIEW

Monitor's Compliance Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Quarter: Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13*	Q4 Forecast	Notes	Forecast Q4 Governance rating
Monitor Compliance Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	42	✓	✖	✖	✓	42	✓	Cumulative trajectory: Q1 14; Q2 27; Q3 41; Q4 54	Achieved
	2	Infection Control - MRSA Bloodstream Cases Against Trajectory	1.0	< or = trajectory	8	✓	✓	✓	✖	8	✖	Target for the year = 2	Not achieved
	3a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	100.0%	✓	✓	✓	✓	100.0%	✓		Achieved
	3b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	94.7%	✓	✓	✓	✓	97.6%	✓		
	3c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	98.9%	✓	✓	✓	✓	95.4%	✓		
	4a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	86.7%	✓	✓	✓	✓	75.5%	✖	Achievement of both 62-day standards is at risk	Not achieved
	4b	Cancer 62 Day Referral To Treatment (Screenings)		90%	89.7%	✓	✓	✓	✖	80.0%	✖		
	5	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	92.3%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	91.1%	✓		
	6	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	95.6%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	95.1%	✓		Achieved
	7	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.1%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	92.1%	✓		Achieved
	8	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	0.5	96%	97.2%	✓	✓	✓	✓	96.2%	✓		Achieved
	9a	Cancer - Urgent Referrals Seen In Under 2 Weeks	0.5	93%	94.6%	✓	✓	✓	✓	95.9%	✓		Achieved
	9b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	96.6%	✓	✓	✓	✓	94.6%	✓		
	10	A&E Total time in A&E 4 hours (95th percentile)	1.0	95%	94.3%	✖	✖	✓	✖	94.6%	✓	Achievement of 95% standard still possible.	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	Not applicable	Not applicable	Not applicable	To be confimed	To be confimed	Not applicable		Achieved
					rating	AMBER-GREEN	AMBER-RED	AMBER-RED	AMBER-RED	AMBER-RED	AMBER-RED		2.0
													AMBER-RED

Please note: If the same 1.0 weighted indicator is failed in three successive quarters, Monitor may apply a RED rating over-ride. For A&E 4-hours, a RED rating over-ride may be 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.

***Q4 Cancer figures based upon draft figures for January. The C diff and MRSA figures are shown as the cumulative positions against the quarter-end target.**

Monitor may apply a RED RATING over-ride if the A&E standard is failed in Q4 or for the MRSA year-end target (above the reporting level) being exceeded.

QUALITY

1.1 QUALITY TRACKER

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Q1	Q2	Q3	Q4
Patient Safety	Infection Rates	PS-A1	MRSA Bloodstream Cases Against Trajectory - Monthly Totals	<Traj.	8	0	2	1	1	0	1	1	1	0	2	1	0	2	3	3	0
		PS-A2	C.Diff Infections Against National Trajectory - Monthly Totals	<Traj.	42	3	3	3	8	5	1	6	6	3	5	1	4	16	13	9	4
		PS-A3	MSSA Cases Against Trajectory	<Traj.	27	3	2	3	4	4	3	0	2	4	5	2	0	11	5	11	0
		PS-A4	Number of GRE Bacteraemias	<3 mth	13	3	0	2	2	1	4	0	1	0	1	2		5	5	3	
		PS-A5	E. Coli Bloodstream Infections		200	12	20	23	24	16	21	18	19	14	27	21	17	63	58	62	17
	Infection Control	PS-A6	MRSA Pre-Op Elective Screenings	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%
		PS-A7	MRSA Emergency Screenings	95%	94.0%	94.4%	92.0%	92.2%	93.8%	92.3%	93.9%	93.5%	95.3%	94.5%	94.1%	94.8%	95.4%	92.8%	94.2%	94.5%	95.4%
		PS-A8	Hand Hygiene Audit Compliance	95%	96.7%	98.2%	98.3%	98.0%	98.2%	97.1%	97.8%	95.7%	96.6%	95.6%	95.7%	95.5%	97.1%	97.8%	96.7%	95.6%	97.1%
		PS-A9	Antibiotic Compliance	90%	84.1%	84.2%	83.7%	80.6%	84.7%	84.2%	85.1%	85.9%	82.3%	83.0%	85.1%	84.6%	86.1%	83.0%	84.5%	84.1%	86.1%
		PS-A10	Matron's Checklist	95%	94.3%	96.4%	98.8%	97.3%	95.6%	93.4%	91.5%	94.0%	92.8%	94.5%	94.4%	95.4%	95.2%	94.9%	93.3%	94.8%	95.2%
	Cleanliness	PS-A11	Cleanliness Monitoring - Overall Score	95%		95%	96%	96%	95%	95%	94%	94%	95%	95%	95%	95%	95%				
		PS-A12	Cleanliness Monitoring - Very High Risk Areas	95%		96%	96%	96%	97%	96%	96%	97%	96%	97%	97%	96%	96%				
		PS-A13	Cleanliness Monitoring - High Risk Areas	95%		96%	96%	96%	95%	95%	95%	96%	95%	95%	95%	95%	95%				
	Incidents	PS-B1	Number of Serious Incidents (SIs) Reported		84	7	10	4	7	14	7	11	7	8	13	4	9	25	25	25	9
		PS-B2	Number of Serious Incidents (SIs) as a Proportion of Activity																		
		PS-B3	Serious Incidents Reported Within 48 Hours	80% (Q3)	86%	86%	80%	75%	86%	93%	100%	82%	71%	100%	85%	100%	67%	88%	84%	92%	67%
		PS-B4	Percentage of Serious Incident (SI) Investigations Completed Within Timescale	80% (Q3)	88%	86%	92%	88%	100%	100%	88%	77%	57%	100%	100%	88%	91%	95%	75%	95%	91%
		PS-B5	Total Never Events	0	1	0	1	0	0	0	0	1	0	0	0	0	0	0	1	0	0
		PS-B6	Total Number of Patient Safety Incidents Reported		10321	807	892	803	850	955	1141	1087	941	1090	1215	1088	1151	2608	3169	3393	1151
		PS-B7	Patient Safety Incidents Reported per 100 Admissions		9.9	7.8	8.0	8.2	7.9	9.3	10.3	10.4	9.5	9.8	11.3	11.1	11.3	8.4	10.1	10.7	11.3
	Falls	PS-C1	Number of Inpatient Falls Per 1,000 Beddays	<5.6	6.02	5.59	6.64	6.75	5.09	5.82	6.37	6.29	4.94	6.50	5.97	6.78	5.67	5.86	5.88	6.42	5.67
		PS-C2	Repeat Inpatient Falls		23.2%	13.4%	19.6%	12.9%	28.7%	30.9%	18.4%	26.9%	24.7%	17.0%	22.0%	24.3%	25.0%	24.7%	23.5%	21.0%	25.0%
		PS-C3	Number of Inpatient Falls - Patients Aged 65 And Over		1170	93	124	118	101	101	125	134	98	127	117	137	112	320	357	381	112
		PS-C4	Number of Inpatient Falls - Patients With Cognitive Impairment		635	42	62	62	57	62	67	74	49	64	59	79	62	181	190	202	62
	Pressure Ulcers Developed in the Trust	PS-D1	Total Pressure Ulcer Incidence per 1,000 Bed Days	<0.651	1.32	1.57	1.66	1.32	1.34	1.57	1.38	1.71	1.10	1.29	1.48	1.04	0.96	1.41	1.40	1.27	0.96
		PS-D3	Number of Hospital Acquired Grade 2 Pressure Ulcers	<83 yr	297	33	41	31	33	32	32	33	23	30	32	25	26	96	88	87	26
		PS-D4	Number of Hospital Acquired Grade 3 Pressure Ulcers	0	36	3	1	1	1	7	3	9	4	4	6	1	0	9	16	11	0
		PS-D5	Number of Hospital Acquired Grade 4 Pressure Ulcers	0	3	1	0	0	1	0	0	1	0	0	0	1	0	1	1	1	0
	Pressure Ulcers Present On Admission	PS-D6	Number of Grade 2 Pressure Ulcers Present On Admission		627	47	43	41	53	61	70	66	48	63	67	76	82	155	184	206	82
		PS-D7	Number of Grade 3 Pressure Ulcers Present On Admission		153	9	7	7	6	16	19	26	11	16	19	15	18	29	56	50	18
		PS-D8	Number of Grade 4 Pressure Ulcers Present On Admission		45	1	4	4	3	5	7	5	8	3	2	2	6	12	20	7	6
	Venous Thrombo-embolism (VTE)	PS-E1	Adult Inpatients who Received a VTE Risk Assessment	90%	96.4%	98.4%	98.9%	98.7%	93.3%	95.3%	96.5%	95.1%	93.1%	94.6%	95.9%	91.8%	93.2%	97.8%	94.9%	94.0%	93.2%
		PS-E2	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	90%	96.4%	92.5%	97.4%		97.8%	98.4%	98.9%	98.4%	99.1%	99.5%	98.4%		79.1%	98.1%	98.8%	99.2%	79.1%
	Nutrition	PS-F1	Fully Completed Nutritional Screening Within 24 Hours	90%	90.3%	85.0%	87.2%	85.6%	86.4%	87.3%	89.0%	90.9%	91.9%	94.0%	92.6%	94.3%	91.6%	86.5%	90.6%	93.6%	91.6%
		PS-F4	Protected Mealtimes Observed (Adult Inpatients)	95%	92.9%	93.8%	89.7%	80.0%	93.3%	96.7%	100.0%	96.6%	86.2%	92.9%	89.7%	95.7%	96.7%	90.0%	94.2%	93.2%	96.7%
		PS-F2	Malnutrition Risk Identified in Adults	90%	84.4%	84.5%	82.0%	69.5%	82.8%	83.6%	83.7%	84.2%	89.2%	86.3%	87.3%	89.8%	84.6%	78.9%	85.6%	87.9%	84.6%
		PS-F3	Malnutrition Risk Identified in Children	90%	85.7%					85.8%			84.3%			87.2%		85.8%	84.3%	87.2%	
	Safety	PS-G1	WHO Surgical Checklist Compliance	98%	98.8%	98.4%	99.0%	95.4%	98.7%	99.4%	98.4%	98.1%	98.5%	99.8%	99.6%	99.8%	99.6%	97.8%	98.3%	99.7%	99.6%
	Medicines Reconcilliation	PS-H1	Medication Reconciliation Within 1 Day (Assessment Wards)	95%	90%						74%	80%	90%	93%	98%	93%	98%		81%	95%	98%
		PS-H2	Medication Reconciliation Within 1 Day (Cardiac/Cardiology Wards)	90%	88%								68%	82%	96%	89%	91%		68%	89%	91%
		PS-H3	Non-Purposeful Omitted Doses of the Listed Critical Medication	<3.75%	3.24%						4.61%	4.62%	3.83%	2.83%	3.03%	2.29%	2.91%		4.33%	2.76%	2.91%
	NHS Safety Thermometer	PS-J1	NHS Safety Thermometer - Coverage		100%				99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		PS-J2	NHS Safety Thermometer - Harm Free Care		91.2%				90.3%	91.4%	92.6%	91.5%	92.2%	91.1%	91.6%	89.5%	91.0%	90.9%	92.1%	90.7%	91.0%
		PS-J3	NHS Safety Thermometer - No New Harms		95.7%				94.2%	95.8%	96.8%	96.9%	94.3%	95.8%	96.8%	95.8%	94.9%	95.0%	96.0%	96.1%	94.9%

QUALITY

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Q1	Q2	Q3	Q4
Clinical Effectiveness	Mortality	CE-A1	Hospital Standardised Mortality Ratio (HSMR)	<=80		70	72.4	66.1	65.6	74.8	58	63.5	70.9	66							
		CE-A2	Summary Hospital Mortality Indicator (SHMI)	<=80	64.0	68.9	64.2	59.2	69.4	69.8	62.5	63.2	63.8	64.4	59.4			66.2	63.1	61.9	
	Learning Disability	CE-D1	Risk Assessment of Patients with Known Learning Disability within 48 Hours	85%	79.9%	100.0%	88.9%	92.9%	63.6%	68.4%	90.5%	82.4%	100.0%	78.9%	67.7%	88.2%	80.0%	75.0%	89.6%	76.1%	80.0%
		CE-D2	Risk Assessment of Paediatric Patients with Learning Disability within 48 Hours	85%	68.8%			7.7%	36.4%	50.0%	60.0%	18.2%	35.7%	82.5%	95.1%	64.5%	86.7%	23.1%	37.1%	82.1%	86.7%
	Readmissions	CE-E1	Emergency Readmissions Within 30 Days	<3.36%	3.0%	2.9%	2.9%	2.7%	3.2%	3.2%	3.2%	2.8%	3.1%	3.0%	3.0%	3.0%		3.1%	3.0%	3.0%	
	Maternity	CE-G1	Percentage of Spontaneous Deliveries Compared to All Births	64.3%	65.10%	62.63%	66.67%	68.16%	63.96%	65.22%	68.42%	66.60%	62.38%	66.61%	60.25%	64.40%	64.33%	65.78%	65.84%	63.89%	64.33%
	Fracture Neck of Femur	CE-H1	Fracture Neck of Femur Patients Treated Within 36 Hours	95%	58.7%	58.8%	92.3%	80.0%	61.3%	62.5%	64.5%	58.1%	43.5%	48.3%	68.2%	48.3%	54.5%	67.0%	56.5%	53.8%	54.5%
		CE-H2	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72hours	95%	65.2%	76.5%	79.5%	80.0%	93.5%	71.9%	56.2%	45.2%	56.5%	62.1%	59.1%	69.0%	57.6%	81.8%	52.3%	63.7%	57.6%
		CE-H3	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	37.3%	44.1%	53.8%	64.0%	54.8%	37.5%	34.4%	22.6%	21.7%	34.5%	50.0%	31.0%	27.3%	51.1%	26.7%	37.5%	27.3%
	Stroke Care	CE-J1	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	49.9%	46.4%	50.0%	52.8%	44.4%	60.6%	54.3%	51.1%	37.1%	44.4%	57.1%	48.8%	51.1%	51.8%	47.9%	49.6%	51.1%
		CE-J2	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	80%	78.9%	68.3%	64.3%	87.2%	72.0%	68.6%	72.2%	63.8%	80.6%	91.7%	88.9%	81.8%	82.6%	75.8%	71.4%	87.5%	82.6%
		CE-J3	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	58.49%	59.09%	71.43%	83.33%	57.14%	53.85%	52.38%	53.33%	58.33%	37.50%	61.29%	62.50%	58.82%	64.10%	54.17%	58.18%	58.82%
Patient Experience	Single Sex Accom.	PE-A1	Same Sex Accommodation Breaches - Number of Patients	0	33	0	30	0	20	0	0	0	0	4	0	5	4	20	0	9	4
	Patient Survey Responses	PE-B1	Patient Survey - National CQUIN Score	73.9		75.8	74.7	77	74.7	75.7	74.1	75.1	74	75.8	77.9	73.9		75.4	74.4	75.8	
		PE-B2	Patient Survey - Noise At Night	84-86		80.8	79	83	81	82	82.3	82.9	82.3	82.7	82.4	82.9		82	82	82.5	
		PE-B3	Patient Survey - Explaining Medication Side Effects	61-64		61.1	59.5	59	61	64	58.4	61.3	60.2	61	59.8	56.5		61	60	58.2	
		PE-B4	Patient Survey - Maternity Services	85			86			85	85	83	85	83	87	85		85	84	85	
		PE-B5	Patient Survey - Patients Who Would Recommend The Trust	92%		97%	96%	96%	95%	96%	95%	96%	98%	96%	96%	95%		96%	96%	96%	
		PE-B6	Patient Survey - Local Patient Experience Score	83		88	87.8	88	87	88	88	87	87	88	90	88		88	87.3	89	
	Patient Complaints	PE-C2	Patient Complaints as a Proportion of all Activity	<0.25%	0.317%	0.249%	0.207%	0.287%	0.416%	0.372%	0.391%	0.375%	0.229%	0.301%	0.288%	0.244%	0.261%	0.361%	0.333%	0.280%	0.261%
		PE-C3	Percentage of Complaints Responded To Within Timeframe (Formal Complaints)	98%	94.7%	95.2%	94.3%	96.7%	94.5%	94.7%	94.2%	94.8%	97.3%	95.8%	85.5%	92.5%	98.4%	95.2%	95.4%	91.6%	98.4%
		PE-C6	Complainants Disatisfied with Response (Not Responded In Full)	<4/mth	22	0	2	2	3	4	0	3	0	0	3	2	5	9	3	5	5

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

Please note: The pressure ulcer data has been refreshed and is now presented as "in the month reported" rather than "in the month identified". This change has been made to ensure we don't miss some pressure ulcers which are identified in one month but reported in a subsequent month.

1.2 SUMMARY

In January there have further improvements in the right direction in some of the quality areas which have been challenging the Trust such as pressure ulcer incidence, falls incidence, MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemias and antibiotic prescribing. It is disappointing, but not unexpected, that Venous Thrombo-Embolism (VTE) thrombo-prophylaxis compliance has slipped below the green threshold in January, in the absence of a VTE Project Nurse. Divisions have been asked to refocus on this to restore performance. There were some gaps in the timeliness of updating reported incidents when major harm was identified subsequent to the original incident report which meant they now met criteria for reporting as serious incidents. Further detail is provided in the exception report.

The CQUIN section of the report also provides information as to where we have and have not improved sufficiently to achieve CQUINS being measured in Quarter 3.

Achieving set threshold (34)	**Thresholds not met or no change on previous month (4)**
- MRSA (Meticillin Resistant Staphylococcus aureus) bloodstream cases against trajectory - *Clostridium difficile* cases against national trajectory - MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - GRE (Glycopeptide Resistant Enterococci) Bacteraemias - MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – elective - MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – emergency - Hand Hygiene Audit - Matrons checklist (C. difficile dashboard) - Cleanliness monitoring overall Trust score - Cleanliness monitoring very high risk areas - Cleanliness monitoring high risk areas - Serious incident investigations completed within required timescales - Never Events - Number of hospital acquired grade 3 pressure ulcers - Number of hospital acquired grade 4 pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism	- Antibiotic prescribing compliance - Percentage adult in-patients who received thrombo-prophylaxis - Malnutrition risk identified in adults - Patient complaints as a proportion of all activity

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(VTE) risk assessment - Fully completed nutritional screening within 24 hours - Protected mealtimes observed (adult inpatients) - WHO surgical checklist compliance - Medicines reconciliation performed within one day of admission (Assessment Wards) - Medicines reconciliation performed within one day of admission (Cardiac Wards) - Non-purposeful omitted doses of listed critical medication - NHS Safety Thermometer-coverage - Hospital Standardised Mortality Ratio (HSMR) - Summary Hospital Mortality Indicator (SHMI) - Risk assessment of paediatric patients with known learning disability within 48 hours - 30 day emergency re-admissions - Percentage of spontaneous deliveries compared to all births - Stroke care: percentage spending 90% + time on a stroke unit - Stroke care: percentage receiving brain imaging within 1 hour - Patient experience overall CQUIN score - Monthly patient survey: maternity services - Monthly patient survey: patients who would recommend the Trust - Percentage of complaints resolved within formal timescale	
Quality metrics not achieved or requiring attention (13)	**Quality metrics not rated (15)**
- Serious Incidents reported with 48 hours - In-patient falls incidence per 1,000 bed days - Total pressure ulcer incidence per 1,000 bed days - Number of hospital acquired grade 2 pressure ulcers - Risk assessment of patients with known learning disability within 48 hours - 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	**Data not available** - Escalation of the deteriorating patient using a structured communication tool **Quarterly metric** - Malnutrition risk identified in children **Thresholds not yet applicable** - E coli *(Escherichia coli*) blood stream infections (surveillance only) - NHS Safety thermometer-harm free care (threshold to be set in Q4)

QUALITY

- High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - Number of breaches of the same sex accommodation standard - Monthly patient survey: noise at night - Monthly patient survey: explain medication side effects - Number of complainants dissatisfied with the response (not responded in full)	- NHS Safety thermometer-no new harms (threshold to be set in Q4) **Metrics for information** - Number of serious incidents - Detection of the deteriorating patient: early warning scores - Total number of patient safety incidents reported - Total number of patient safety incidents per 100 admissions - 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 January was 93.2% against a target of 90%.
- Patients receiving appropriate thrombo-prophylaxis to be achieved each month. Percentage for January was 79.1% 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 December was 73.9 against a target of 73.9.
- Patient Experience: reducing noise at night. Score for December was 82.9 against the new 2012/13 target of 82 to be achieved for Q3. We have not improved enough to achieve this CQUIN for 2012/13.
- Patient Experience: explaining medication side effects. Score for December was 56.5 against a target of 64 to be achieved for Q3. We have not improved enough to achieve this CQUIN for 2012/13.
- Patient Experience: kindness and understanding (Maternity Services). Score for December was 85 against a target of 85 to be achieved for Q3. We have improved enough to achieve this CQUIN.
- Patient Experience: patients who would recommend the Trust. This is a new CQUIN for 2012/13. Score for December was 95% against a target of 92% to be achieved for Q3. We have improved enough to achieve this CQUIN.
- 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 January was 100%.
- MUST (Malnutrition Screening Tool) nutritional assessments for adults to be achieved in Q4. Performance for January was 91.6% against a target of 90%.
- Protected mealtimes observed to be measured in Q4. Performance for January was 96.7% against a target of 95%.
- Malnutrition risk identified in adults to be achieved in Q4. Performance for January was 84.6% against a target of 90%.
- Malnutrition risk identified in children to be achieved in Q4. This is a quarterly metric next to be reported at the end of Q4.
- Risk assessment of paediatric patients with learning disability within 48 hours to be achieved in February 2013. Performance for January was 86.7% against a target of 85%.

QUALITY

- Spontaneous vaginal deliveries as a percentage of all births to be achieved in Q4. Performance for January was 64.33% against a target of 64.3%.
- Detection of the deteriorating patient: Early Warning Scores completed correctly as measured by the Quality in Care Tool to be achieved in Q4. Target is 95%. No further data yet available since the report to the January Board.
- Escalation of the deteriorating patient for senior review. Improvement in the use of a structured communication tool - SBAR (Situation, Background, Assessment, and Recommendation) - for clear communication of clinical need for a deteriorating patient to be reviewed. CQUIN to be achieved in Q4. Target is 95%. Pilot implementations of the tool have been successfully completed in most Divisions with plans to spread to other areas.
- Patients with medicines reconciliation performed within 1 working day to be measured at the end of Q4 using the 6 months preceding data. This is split into two metrics, one for assessment wards and one for cardiac wards. In assessment wards, performance of 98% in January against a target of 95%. In cardiac wards, performance of 91% in January against a target of 90%.
- Non-purposeful missed omitted doses of the listed critical medication to be measured in Q4. Performance of 2.91% in January against a target of < 3.75%.

1.3 CHANGES IN THE PERIOD

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

- Percentage of serious incidents reported with 48 hours, down ↓ from 100% in December to 67% in January
- Overall pressure ulcer incidence moving in the right direction, down ↓ from 1.04 per 1,000 bed days in December to 0.96 per 1,000 bed days in January
- Percentage of adult in-patients receiving thrombo-prophylaxis down ↓ from 98.4% in November to 79.1% in January
- Risk assessment of paediatric patients with a known learning disability up ↑ from 64.5% in December to 86.7% in January
- Number of complainants dissatisfied with response (not responded to in full) up ↑ from 2 in December to 5 in January

1.4 EXCEPTION REPORTS

Exception reports are provided for thirteen RED rated indicators and one further indicator* which is amber rated, fourteen indicators in total.

1. Antibiotic prescribing compliance*
2. Serious Incidents reported with 48 hours
3. In-patient falls incidence per 1,000 bed days
4. Total pressure ulcer incidence per 1,000 bed days
5. Number of hospital acquired grade 2 pressure ulcers
6. Risk assessment of patients with known learning disability within 48 hours
7. Fractured neck of femur patients treated with 36 hours
8. Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours
9. Fractured neck of femur patients achieving best practice tariff
10. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours
11. Number of breaches of the same sex accommodation standard
12. Monthly patient survey: noise at night
13. Monthly patient survey: explain medication side effects
14. Number of complainants dissatisfied with the response (not responded in full)

QUALITY

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

Description of how the standard is measured:

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

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

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

Performance in the period, including reasons for the exception:

The overall percentage compliance rose in January to 86.1%. This is the highest performance to date during 2012/13. There was a rise in compliance in three divisions:

- Medicine (88%, a rise from 86%)
- Surgery head and neck (84%, a rise from 82%)
- Women's and Children's (82%, a rise from 79%)

There was a slight full in compliance in one division:

- Specialised services (87%, a fall from 91%)

Reasons for the exception:

- The number of reviews undertaken increased in January to 671. Of these 70 (10.4%) did not include a valid stop or review date. This continues to be the main cause of failure to reach the 90% target.

Recovery plan, including expected date performance will be restored:

- Continue with joint microbiology / pharmacy review rounds.
- Continue to monitor through divisional boards.
- The anti-infective intranet page is being redesigned (within the limitations of Connect) to aid the selection of guidelines when prescribing.
- The paediatric drug chart has been updated and released; this now has a separate anti-infective page which prompts for a stop or review date

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and indication to be stated in a similar way to the adult chart.

- More information is being sent to ward pharmacists on antibiotic prescribing and the results from the reviews to further engage them in the process.

QUALITY

Q2. EXCEPTION REPORT: Serious Incidents reported within 48 hours	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

Nine incidents were reported in January; of these three breached the 48 hour timescale = 67%. All of the incidents which breached were inpatient falls.

Serious Incident number	Ulysses number	Division	Ward	Reason for breach
2013/1032	117931	Surgery, Head & Neck	Ward 9	Fall reported promptly by ward nurse at 02:00. From the incident report it is not clear if the major fracture was identified at this time. The Root Cause Analysis (RCA) investigation has been commissioned to include reasons for the delay in notification of harm.
2013/1035	118299	Surgery, Head & Neck	Ward 14	Fall reported promptly by ward nurse. However, x-ray subsequently identified a major fracture, but the incident was not updated with the new level of harm, nor was this communicated outside of the ward in a timely manner. The RCA investigation has been commissioned to include further detail of the delay in notification of harm.
2013/1469	117046	Medicine	Ward 23	Fall reported promptly by ward nurse. However, x-ray subsequently identified a major fracture, but the incident was not updated with the new level of harm, nor was this communicated outside of the ward in a timely manner. The RCA investigation has been commissioned to include further detail of the delay in notification of harm.

Recovery plan, including expected date performance will be restored:

- Ward Managers have been asked to ensure that when there is subsequent identification of major harm arising from an incident, staff contact a senior manager, e.g. Matron, Head of Nursing, Patient Safety Lead, to update and to inform them so that the high risk incident process is triggered at this point.

QUALITY

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

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

Performance in the month was 5.67 falls per 1,000 bed days against the national benchmark of 5.60, a significant improvement from December's figure of 6.82 falls per 1,000 bed days. There were 153 inpatient falls in January.

The degree of harm, based on National Patient Safety Agency guidance, arising from the falls in January were:

Degree of Harm	June 2012	July 2012	August 2012	September 2012	October 2012	November 2012	December 2012	January 2013
Near Miss	6	5	0	1	1	4	12	5
Negligible	93	91	73	57	89	72	90	77
Minor	47	61	85	62	78	72	73	68
Moderate	0	0	1	2	1	1	1	0
Major	2	3	0	0	1	2	1	3

There were 3 major incidents reported in January. Two patients fell resulting in hip fractures, one in the Division of Surgery Head & Neck and one in the Division of Medicine. One medical patient fell and after investigation was found to have a subdural haematoma and suffered a stroke. It is not known at this stage whether the patient fell as a result of the stroke or if the fall caused the subsequent injury.

Breakdown of Falls by Division

Division	June 2012	July 2012	August 2012	September 2012	October 2012	November 2012	December 2012	January 2013
Diagnostics & Therapies	1	1	1	1	1	0	2	0

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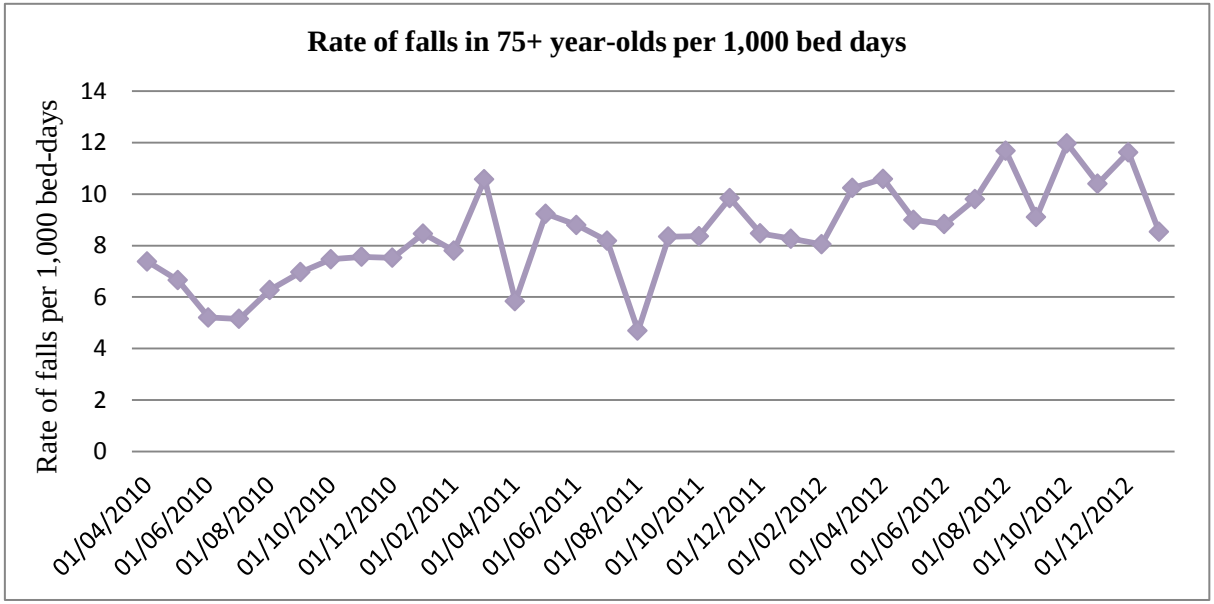
Medicine	97	104	102	81	108	89	111	88
Specialised Services	20	21	25	14	24	21	28	23
Surgery Head & Neck	27	32	28	20	32	33	32	34
Women's & Children's	3	2	3	7	5	8	4	6

It is encouraging to see improvement in the Divisions of Medicine and Specialised Services in January 2013. All Divisions remain focussed on reducing the incidence of avoidable falls.

To understand the potential impact of an increasingly elderly population of patients, the rate of falls (per 1,000 bed-days) for patients 75 years and over has been plotted, over a three year period:



During 2010/11, reporting of falls was not as good as it now is. So the rate of falls in the 75+ age group is likely to have been under-reported. January's falls rate in 75+ year olds was 8.53, which is the lowest it's been since February 2012. The rate of falls in this group of patients will continue to be monitored against this three-year picture, to understand if sustained improvements in falls reduction are being made.

Recovery plan, including expected date performance will be restored

1. A review and update of the Falls Policy – ratified by the Falls Group in December. Amendments made to ensure suitable for paediatrics and

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now due at Patient Safety Group in February 2013 for approval.

2. Falling Star magnets ordered to identify patients at risk of falling on 'patient at a glance' boards, to alert all staff to patients at risk and generate multi-disciplinary discussion on Board Rounds. Magnets are now available in all inpatient areas.
3. Agreement to review the categories of falls which result from episodes such as cardiac or other medical events, which are not predictable due to be finalised at February Falls meeting.
4. An evaluation report of the Fallsafe pilot project is underway will be available at the end of February.
5. A review of all patient falls which led to a fracture is underway, to identify any cross-divisional themes.

QUALITY

Q4-Q5 EXCEPTION REPORT:	**RESPONSIBLE DIRECTOR: Chief Nurse**
• **Pressure ulcer incidence per 1,000 bed days** • **Number of hospital acquired grade 3 and 4 pressure ulcers**	

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

The rate of hospital acquired pressure ulcers grade 2 and above was 0.96 per 1,000 bed days in January 2013, a decrease from December's figure.

Division	Jan 13	Dec 12	Nov 12	Oct 12	Sept 12	Aug12	July 12	June 12	May 12	April 12
Medicine	0.94	0.50	1.17	1.76	1.13	1.50	1.98	2.05	1.95	1.24
Specialised Services	1.35	2.49	1.39	1.35	1.23	1.45	0.71	2.37	0.64	1.65
Surgery Head & Neck	1.43	2.08	2.70	1.31	2.22	3.79	2.18	2.06	2.08	3.00
Women's & Children's	0.44	0.00	0.89	0.73	0.30	0.60	0.29	0.15	0.29	0.30
Trust	**0.96**	**1.00**	**1.44**	**1.33**	**1.14**	**1.71**	**1.34**	**1.61**	**1.30**	**1.37**

Of particular note is the overall improvement across the Trust, with no reported grade 3 or 4 pressure ulcers in January. It is encouraging to see the actions identified within the pressure ulcer plan are impacting on clinical practice.

The core themes emerging from the Root Cause Analyses remain consistent:

- Incorrect categorisation/grading during admission, indicating the need for further education and training.
- Inconsistent practice with regard to care rounding and documentation.
- Further analysis undertaken by the Divisions of Medicine and Specialised Services shows a close link to poor nutrition and sepsis.
- An emerging link is the time spent on the floor/bed bound pre-admission, or on a trolley and the development of a pressure ulcer within 24-48 hours, which is being explored

The graphs below indicates a reducing number of grade 2 pressure ulcers in the Trust during 2012/2013, with zero grade 3 pressure ulcers seen in Jan 2013.

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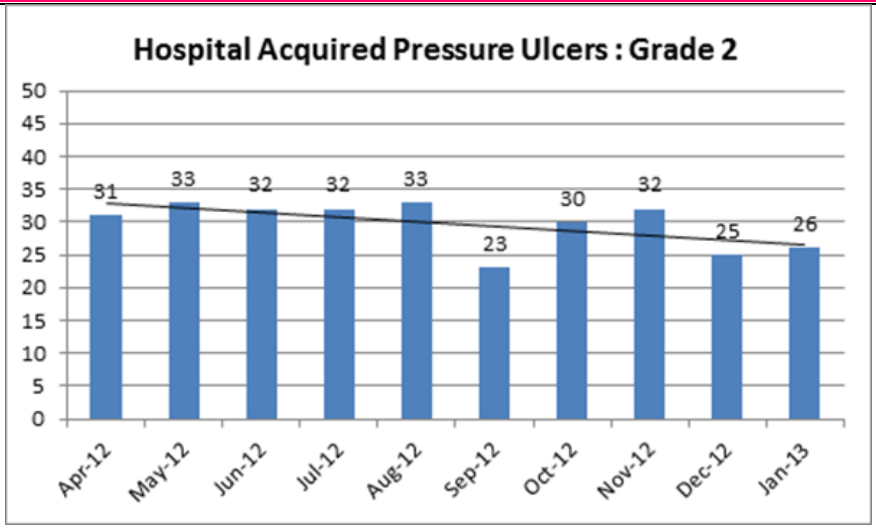

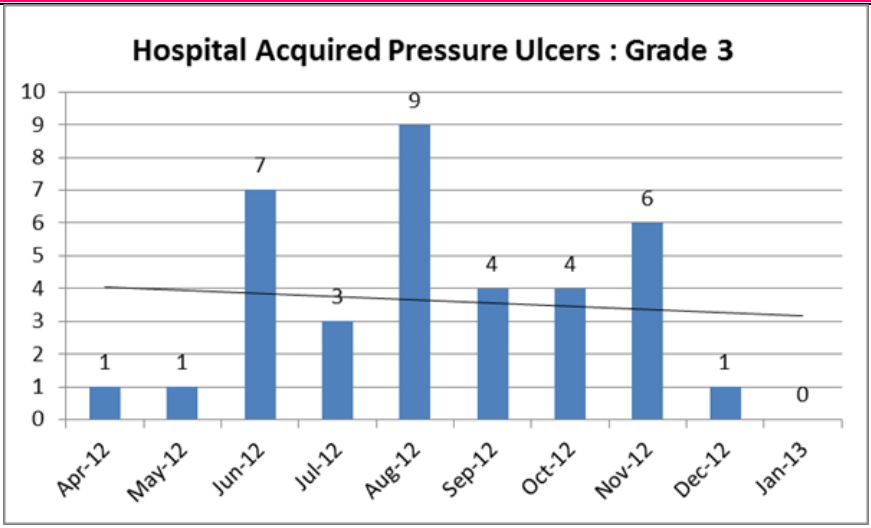

Recovery plan, including expected date performance will be restored:

- Specialised Services have Matron-led daily ward rounds in place on the Cardiac Intensive Care Unit, where a high number of their incidents have occurred. This has proved successful with a marked decrease in incidence within the Division.
- A workshop held on February 18th to progress the Trusts approach to Care Rounding was greatly supported from a cross section of nursing staff. An approach developed by the Division of Medicine was supported, with a first version available for all Divisions to use from April, with plans for ongoing reviews to ensure the approach is fully implemented
- A business case for an efficient and cost effective medical equipment library within the Trust is underway, led by Diane Crawford from the Division of Diagnostics & Therapies.
- Meeting held with the Primary Care Trust to discuss partnership working to address the increasing numbers of patients admitted with a pressure ulcer to the Trust. A Bristol-wide group to be established
- The existing bed store is now open, with bespoke storage for the mattresses in place.
- A temporary band 2 role was agreed to support the function of the bed mattress store. Interviews were held and the post appointed to. Unfortunately the candidate has since pulled out. An internal secondment opportunity will be advertised w/c 25th February.
- The testing of the interactive "virtual patient" training programme to support the competency package has begun with a demonstration planned at the February Steering Group. Areas to pilot the tool have been selected.

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- A visit to Guys & St Thomas' in January to review their practice, systems and processes was delayed due to sickness but has been re-scheduled.
- All Divisions continue to be required to complete and submit detailed recovery plans to the Divisional 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.

QUALITY

Q6. EXCEPTION REPORT: Risk assessment of patients with known Learning Disability within 48 hours	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Patients with a known learning disability will receive an assessment within 48 hours of admission to an inpatient bed. The CQUIN target set last year was for 85% to be achieved by Quarter 4 2011/12. A CQUIN has not been set for 2012/2013. However the improvement achieved last year aimed to be maintained.

Performance in the period, including reasons for the exception:

Performance in January was 80%, following December's performance of 88.2%. Quarter 3 performance as a whole was 76.1%, which was below the internally set target of 85%. Performance in the last two months has however been a significant improvement on October and November. There remains a strong focus on achieving and maintaining the CQUIN standard achieved last year.

Recovery plan, including expected date performance will be restored:

- In last month's report the aim to achieve the CQUIN was to identify the clinical areas which need additional support. Training has now been secured for the Medical Admissions Unit and will roll-out further training throughout other areas in the Division of Medicine. Meanwhile the aim is to continue to maintain standards throughout the Trust.
- The Adult LD Nurse will cascade the Learning Disabilities/Autism care pathway to all senior leads and links. Discussion is taking place with senior management to look at the role of the LD Nurse and ways in which to support the role itself and creating an additional role within the current budget in the form of a Healthcare Assistant or administrator.
- The LD Nurse is requesting additional support from Divisions, to act as senior LD links, to act as representatives on the LD Steering Group, and to disseminate LD awareness. The senior LD links will also manage Clinical Alerts of patients' admissions and activities currently received solely by the LD Nurse.

QUALITY

Q7-Q9. EXCEPTION REPORT:	**RESPONSIBLE DIRECTOR: Medical Director**
• **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**	

Description of how the standard is measured:

The Fragility Hip Fracture Best Practice Tariff (BPT) was introduced in 2010/11 with the aim of promoting best practice in the care and secondary prevention of hip fractures in line with the clinical guidelines and quality standards from NICE (CG124 and QS16). The Best Practice Tariff (BPT) for hip fractures requires the following 8 indicators to be achieved:

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

Performance in the period, including reasons for the exception:

There remain two main constraints in improving Best Practice Tariff performance which are, access to theatre within 36 hours of admission, and Ortho-geriatrician review within 72 hours.

Fracture Neck of Femur	**Q1**	**Q2**	**Q3**	**Q4**
Best Practice Tariff achievement	51.1%	26.7%	37.5%	27.3%
Surgery within 36 hours	67.0%	55.8%	53.8%	54.5%
Ortho-geriatrician review within 72hours	81.8%	52.3%	63.7%	57.6%

1. Surgery within 36 hours

Daily trauma operating lists will commence from 26th March 2013 following centralisation of Head and Neck services at University Hospitals Bristol. This is expected to improve access to theatre within 36 hours of admission for 90% of patients.

2. Ortho-geriatrician Review

QUALITY

The Trust has approved the recruitment of 1 full-time Orthogeriatric Clinical Fellow and additional Consultant Orthogeriatrician sessions to enable 100% of patients to be reviewed within 72 hours of admission. Discussions are in progress with the Division of Medicine to appoint joint Orthogeriatric and Care of the Elderly Physicians using this identified funding.

Recovery plan, including expected date performance will be restored:

Performance against Best Practice Standards for theatre access and Orthogeriatric review will remain static until the new trauma timetable and additional Orthogeriatric input is in place. This is anticipated to be in place by Quarter 1 2013/14. Once recruitment plans are in place a phased achievement of the BPT will be agreed for Quarter 1 2013/14, with 90% achievement expected by the start of Quarter 2.

QUALITY

Q10. EXCEPTION REPORT: Stroke care • **High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours**	**RESPONSIBLE DIRECTOR: Medical Director**

Description of how the target is measured:

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:

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

Performance in January was 58.8%, marginally below the 60% standard. Performance for the year to date is also just below the 60% national target (58.5% against the 60% standard), but continuing to improve month on month. 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

In January there were 7 breaches. The reasons were:

- Patient choice to defer appointment/treatment x 2
- Patients referred late by their GP x 4
- Patient had to see a vascular surgeon, for which there was a short delay x 1

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*:

- Incidents of GPs referring late or via the wrong route are being feedback to individual GPs via the Primary Care Trust (ongoing)
- The stroke team is developing an electronic referral solution to reduce the potential delays and risks associated with fax and paper-based

referrals (Ongoing – work is continuing with the Primary Care Trust and our own Information Management & Technology (IM&T) department; an NHS.net account is being set-up to receive electronic referrals)

Progress against the recovery plan:

Performance against the 24 hour TIA treatment standard is just below the 60% national standard year-to-date (58.5%) but continues to improve. The implementation of a system for receiving electronic referrals is expected to improve performance where the incorrect referral route, or the use of paper-based referrals, has been the source of the delay. However, this still requires the referral to be made by the GP or other healthcare professional, at the time of the decision to refer. The impact of patient choice is more difficult to mitigate.

QUALITY

Q11. EXCEPTION REPORT: Mixed Sex Accommodation	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The data is submitted as total occurrences of unjustified mixing in relation to sleeping accommodation only. If a patient is placed in mixed sex accommodation more than once during their stay each occurrence is counted separately. 'Sleeping accommodation' includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight (i.e. it includes admissions and assessment units plus day surgery and endoscopy units). It does not include accident and emergency cubicles.

Performance in the period, including reasons for the exception:

In January 2013 there were 5 incidents of a Mixed Sex Accommodation breach. The breaches occurred on one day only when the whole health community was at black escalation status due to very high levels of emergency patients attending the Trust and delays in discharging patients back to the community.

The decision to allow a mixed gender bay on the Surgical & Trauma Assessment Unit was made by the Chief Operating Officer in liaison with the Medical Director in the interests of patient safety in the Emergency Department. The breaches lasted for a maximum of 3 hours and 30 minutes. All the patients involved had the rationale explained to them at the time and were given written information to read on the Trust's policy regarding this issue

Recovery plan, including expected date performance will be restored:

All non-urgent adult operations for the day were cancelled. In addition, and where appropriate, outpatient clinics were cancelled for the afternoon session to free-up clinical staff to support ward areas and focus on patient discharge.

The position was recovered at 17:00 the same day when the volume of patients in the Emergency Department decreased to more reasonable levels.

QUALITY

Q12. EXCEPTION REPORT: Monthly patient survey - noise at night	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The Noise at Night CQUIN was selected by the Trust because this was one of the top five issues raised by patients in our monthly survey. The Trust achieved the CQUIN target in 2011/12 and decided to keep the CQUIN in 2012/13 as a commitment to sustained improvement. This CQUIN is specifically about noise at night from hospital staff (i.e. not from other patients). But it is worth noting that this is a subjective experience and it can sometimes be difficult to disentangle noise from staff from general noise, or noise from other patients.

Analysis of patient feedback shows that patients are pragmatic about their expectations of noise on wards: they expect a certain amount of noise in a busy city centre hospital; however they understandably get annoyed by what might be termed "inconsiderate" noise from staff.

This metric is measured via the Trust's monthly postal survey. The survey is sent out at the end of each month to a random sample of inpatients, parent / guardians (of 0-11 year olds), and women who have given birth at St Michael's Hospital during that month. The CQUIN is expressed as a statistically calculated score rather than a percentage.

Performance in the period, including reasons for the exception:

The score in December was 82.9 points. This is marginally higher than the previous month (82.4). The score for Quarter 3 was 82.5 points. The threshold for achieving 50% of the related CQUIN value for 2012/13 was 84.0 points. Disappointingly, therefore we have not met our own improvement target. It should be noted however that the same survey question appears in the National Inpatient Survey and that provisional data for the 2012 national survey indicates that the Trust's performance is better than the national norm.

Recovery plan, including expected date performance will be restored:

- Heads of Nursing, Matrons and Ward Sisters have reminded staff of the importance of controlling staff-related noise at night, and all staff are requested to raise awareness with colleagues at the time should there be instances of unnecessary noise.
- 'Sound Ear' noise monitors and data recorders have been purchased for use in each bed-holding Division – the Sound Ears provide a visual prompt to staff when noise levels exceed a pre-determined level. The data recorder allows wards to understand whether there are times during the night when noise is particularly an issue
- Soft-closing black bins have been purchased and delivered to wards to help reduce patient-reported noise

QUALITY

Q13. EXCEPTION REPORT: Monthly patient survey – explaining side effects of medication	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

The CQUIN for explaining side effects of medication was selected because this is an area where local and national survey data suggests that the Trust tends to perform poorly in absolute score terms: for example, this was one of the Trust's five worst scores in the 2011 National Inpatient Survey. It should be noted, however, that our performance historically mirrors the national norm, i.e. this is a perennially low scoring indicator across the NHS (specialist cancer trusts tend to score highest).

UH Bristol patient-reported performance over the past 12 months has been very consistent: no deterioration, but we have not seen the level of reported improvement that would have been hoped for. Explaining side effects of medication to patients supports on-going compliance with Care Quality Commission Outcome 9 (Management of medicines).

This metric is measured via the Trust's monthly postal survey. The CQUIN is expressed as a statistically calculated score rather than a percentage.

Performance in the period, including reasons for the exception:

The score in December was 56.5 points. The score for Q3 was 58.2 points. The threshold for achieving 50% of the related CQUIN value for 2012/13 was 61 points. Disappointingly, therefore we have not met our own improvement target. It should be noted however that the same survey question appears in the National Inpatient Survey and that provisional data for the 2012 national survey indicates that the Trust's performance is better than the national norm.

Recovery plan, including expected date performance will be restored:

- Discussion at Patient Experience Group – reminder to Heads of Nursing to ensure that Patient Experience Action Plans state clearly how each division is seeking to improve performance against this measure
- The new adult discharge checklist (part of the updated discharge policy) will help to address this issue. There is a section of the checklist - developed with pharmacy - where staff can record their discussions about discharge medications and side effects (we currently have no auditable evidence that these conversations take place, as the existing record of the conversation is given to the patients on discharge). The new checklist has a tear-off portion for the patient and a separate record that will be filed with the medical notes and can potentially be included in the new admission nursing documentation as a complete record of admission, inpatient stay and discharge. The checklist is currently at final draft review stage prior to printing. The checklist will also support the Trust's compliance with CQC Outcome 6, relating to discharge arrangements and how we work collaboratively with other providers.

QUALITY

- Proposal that a local CQUIN is repeated in 2013/14, ensuring continued organisational focus on this measure.

QUALITY

Q14. EXCEPTION REPORT: Number of complainants dissatisfied with response	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

The number of complainants who are dissatisfied with the response provided to their complaint due to the original investigation being incomplete or inaccurate. The target set for this indicator is nil.

Performance in the period, including reasons for the exception:

January 2013 performance was 5 complainants in total dissatisfied with their response, which is an increase from the previous month. This was broken down into the following Divisions:

- 4 x Division of Surgery, Head & Neck
- 1 x Division of Women's & Children's

All of the 5 complaints are currently with the respective Divisions for further investigation and response.

Recovery plan, including expected date performance will be restored:

- Support is being provided to the relevant Divisions in situations where a complaint response requires further improvement prior to being sent. This has been provided through discussion with the appropriate caseworker within the Patient Support & Complaints Team when the response is initially received.
- The Divisions involved have been notified of each case and reinvestigations, further responses and/or meetings with complainants have been requested where appropriate.
- The corporate Patient Support & Complaints Team continues to closely monitor response letters to ensure that all aspects of a complaint have been fully addressed and requesting amendments before sending the response letter if this has not happened.
- An action plan has been agreed with Divisional Complaints Leads, which includes actions to improve performance in relation to this standard to build upon the work carried out already in 2011/2012. This will be taken forward as an ongoing improvement with the Divisions concerned.

The Board is also asked to note that the newly appointed Patient Support and Complaints Manager has reviewed complaints data previously presented to the Board in Q3 and has identified the following errors:

In respect of the proportion of complaints responded to within agreed timescale, the reported and corrected data for October to December 2012 is

shown in the table below.

	October	November	December
Reported performance	97.9%	93.9%	96.9%
Corrected data	95.8%	85.5%	92.5%

The cause was an error in the final calculation used to determine the percentage (incorrect denominator selected).

Action taken in respect of identified data errors:

Starting from the March Board report:

- Responsibility for calculating complaints data reported to the board will be transferred from the Patient Support and Complaints Team to an analyst supporting the work of the Deputy Head of Business Intelligence
- A complaints validation template will be introduced for any reported breaches, i.e. cases where the complainant was dissatisfied or where we have not responded to the complaint within the agreed timeframe

1.5 SUPPORTING INFORMATION

1.5.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the Division of Specialised Services

- The acute oncology service at Bristol Haematology and Oncology Centre (BHOC) celebrated its 1st birthday this month; this is an assessment area which is a 4 bedded bay on Ward 61, and is a run by a nurse practitioner who has set up a dedicated triage hotline so that patients with cancer can phone and receive advice 24 hours a day, 7 days a week. They may need to attend the area to be seen, but can be treated and discharged the same day if required. This service has enhanced patients' experiences and receives regular patient compliments.
- The Bristol Testicular Cancer Service at the BHOC won Cancer Charity Initiative of the Year award in December at the 2012 Quality in Care Excellence in Oncology awards. The award was collected by Sue Brand, Germ Cell Clinical Nurse Specialist and Dr Jeremy Braybrooke, Consultant Oncologist.
- The Division has worked hard to increase the knowledge and practice in all the quality metrics. The prevention of pressure ulcers on all wards and departments focus is high. No patient in the Division acquired a grade 3 or 4 pressure ulcer in January 2013, which was the first month since July 2012.
- The nutritional care quality metrics have all scored green in the Division in the past month for the first time since February 2012; this is due to the commitment of the ward sisters in working to embed this within their teams.
- The Division made multiple nominations for the Recognising Success Awards and winners from the Division included: The BHOC Porters for the Non–Clinical Team of the Year and the Specialist Palliative Care Team in the Best Service Improvement category.
- The Adult Congenital Heart Disease service in the Bristol Heart Institute (BHI) were the first nationally to set up a nurse led follow up clinic for patients in August 2012. This has been instrumental in reducing the waiting times for patients to be seen in clinic.
- The enhanced recovery programme for patients requiring cardiac surgery was launched in October 2012 and to date the percentage of patients enrolled on this programme when seen at the Pre-Operative Assessment Clinic has been over 70%. There has been really good engagement from all the health professionals involved throughout the patient pathway, and the outcomes of the enhanced recovery programme are currently being analysed.

1.5.2 EXAMPLE OF LEARNING FORM COMPLAINTS

Summary of Complaint

A patient's wife wrote to complain that her husband's insulin, blood monitoring equipment and district nursing notes were lost during his admission, and his insulin was not prescribed on his drug chart and administered. Her husband suffered from mild dementia.

The investigation found that

- The patient's property was listed on the Medical Assessment Unit and his wife signed the property form with the Nursing Assistant. There was no documentation on the arrival of the patient's District Nursing notes and medications onto the ward.
- It was documented in the patient's notes that he had type 2 diabetes and required insulin. The patient's blood glucose level was monitored and performed at correct times during his stay.
- It was documented in the patient's notes that he had dementia, but it was not recorded if the "This is me" leaflet was used.
- The patient's drug history was taken and documented in the medical clerking. Insulin was recorded, however which insulin and dose was unknown at the time of clerking by the Medical Doctor. This accounted for the drug not being prescribed on the drug chart at the time of clerking. The ward pharmacist confirmed the insulin and the dose on the day following his admission via a fax from the General Practitioner. There was no evidence on the drug chart this was communicated to a Doctor to prescribe, and was not initially prescribed.
- The patient's diabetic medications for the day following his admission were crossed through by a doctor and not given as he was fasting prior to a procedure. It was correct to omit the insulin in this instance, but the prescription should not have been crossed through. The correct procedure would be to write the number 1 (patient fasting) or number 8 (clinical reason- and document this in the notes).
- The transfer checklist was not used when transferring the patient out of the unit.

Local and Organisational earning

- The clerking doctor could have entered 'insulin' only on the prescription as a reminder to staff.
- The patient should have received a smaller dose of insulin on the day after his admission following his procedure if he was eating and drinking.
- The patient's drug box and notes were located on the unit after much searching and had not been stored in the correct place, due to the size and shape of the box.

QUALITY

Action taken to reduce the risk of a recurrence

- A stamp labelled ‘Patient’s own drugs’ has been ordered which will be stamped at the top of the nursing notes and will be ticked if present. This will be easily visible and alert staff when patient’s own drugs are present on the ward and also to remind staff to transfer these medications with the patient.
- Staff have been reminded of the importance of using the transfer checklist as a prompt to ask if the patient has any of their own medications.
- Staff have been reminded of the importance of looking after patient’s belongings and consequences of not doing so by using this complaint to feed back to staff.

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, and bank and agency usage.

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

2.2 EXCEPTION REPORTS

An exception report is provided for the RED-rated indicator, which in January 2013 was as follows:

- Sickness absence – 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 4.7% in January compared with 4.5% in the previous month, continuing to exceed the target, which in January increased to 3.9%. For the health sector, the average days lost per full time employee is 9.3 and the annual sickness percentage is 4.1%, (CIPD Annual Absence Survey 2012). This compares with 10.5 days lost at UH Bristol in January 2013 and 4.3% cumulative absence April 2012 to January 2013. NHS Employers issued data in January 2013 which showed that between July and September 2012, the average sickness absence rate for acute Trusts in the South West was 4.3%, which was exactly the UH Bristol reported sickness level during that period. Reasons for absence are included in the supporting information, see section 2.3.

	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates & Facilities)	Estates & Facilities
Absence January 2012	4.6%	2.6%	5.8%	3.9%	4.8%	4.4%	4.4%	6.4%
Target January 2013	3.9%	2.5%	4.4%	3.4%	4.0%	3.8%	3.6%	5.7%
Absence January 2013	4.7%	2.6%	5.1%	4.9%	4.5%	5.2%	3.6%	7.2%
Cumulative absence January 2013	4.3%	2.5%	4.7%	4.4%	4.4%	4.1%	3.5%	6.6%
	0.8%	0.1%	0.7%	1.5%	0.5%	1.4%	0.1%	1.5%

Women's and Children's

- Sickness absence in Women's and Children's increased to 5.2% in January 2013. Whilst still above target, the cumulative percentage is 4.1%, compared with 4.2% for the same period last year. January was only the third month since April 2012 when the monthly sickness rate was higher than the same period last year – in all other months the rate was lower.
- The top two reasons for absence were Anxiety/Stress/depression/other psychiatric illness (477 days in month) and colds, coughs and flu, (474

days in month) - other musculoskeletal problems were also high (348 days in month).

- The Human Resources Business Partner (HRBP) 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 Human Resources Consultant who supports the Division is reviewing sickness again in all the wards/departments where there are high levels of sickness.
- Staff who are on long-term sick and approaching a no pay situation, with no clear date of return, are being dismissed for incapability due to ill health. One member of staff has been dismissed, and four more dismissals are due to take place shortly. There are a further four who are likely to be dismissed pending information from Occupational Health.

Medicine

- Absence in Medicine increased to 5.1%. This compares with 5.8% in January 2011, and 5.7% in January 2010.
- Gastrointestinal-related absence reduced significantly from 391 calendar days to 182, a reduction of 53%. In January, there were bays closed on ward 12 and ward 4 for infection control reasons, and incidents reported in Emergency Department and ward 4.
- The other principal reasons for absence were: other musculo-skeletal (352 days lost); stress and anxiety, (376 days), up by 25%, and absence related to cough, colds and flu, (368 days) which increased by 50%. Nursing Assistant absence increased significantly by 24%.
- There was an increase of 14% in long-term sickness to 934 lost days, and a small decrease in short term sickness.
- Areas with high sickness continue to be reported at the Division's Management Team meeting, and Employee Services has been tasked with extending their support to accountable matrons and speciality managers. Absence in Ward 11 has reduced from 19% to 9% since the agreed increase in skill mix. Ward 23 has received additional support from Human Resources, but absence remains high and the matron will be attending future sickness review meetings. Rheumatology, Ward 54, Ward 26, Ward 15 and 12 and 4 will also receive further support.
- Sickness across the Christmas bank holiday period has been identified and sent out to managers to ensure leave is appropriately recalculated and to identify any members of staff that require an individual warning about their absence over these dates.
- The Ward to Board reports, containing a range of indicators including sickness, continue to be used as a performance management tool.
- The Division has a 'Stress Action plan' to support managers as they deal with stress in workplace to maximise the use of Trust processes. This involves all managers attending the "Health and Safety Executive Managing Stress in the Workplace" workshop, and the completion of risk assessments for all departments.

Specialised Services

- Specialised Services absence remained at 4.9% for January 2013. For the last six months, musculo-skeletal related absence has been the highest cause of sickness. But this month, colds and flu were the top reason, increasing from 173 days in December 2012 to 260 in March 2013. There

was a reduction in registered nursing absence, but an increase in unregistered nursing absence.

- The Divisional Employee Services representative continues to hold regular meetings with key managers to review all workforce metrics, with a particular recent focus on sickness absence. These meetings have been expanded to include non-nursing areas. Important feedback has already been received from this process, and 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 Human Resources Business Partner and Employee Services Representative have held two sickness absence workshops in October 2012 and February 2013 for all managers in the Division, where these themes were specifically addressed. This received extremely good feedback, and further sessions will be held throughout 2013.
- The Division has produced 'league tables' of the highest areas of sickness in Specialised Services to ensure an on-going focus on the key areas of concern.
- The highest areas for sickness absence include Wards 51 and 52 in the Bristol Heart Institute, and Outpatients and Administrative staff in the Bristol Haematology and Oncology Centre. The Division is now holding fortnightly 'sickness panels' with managers of areas with the highest sickness, involving the Human Resources Business Partner, the Divisional Manager and the Head of Nursing. The purpose of these meetings is to hold managers to account for their sickness, and actions being taken to address this, whilst also ensuring that appropriate support is given.
- The Human Resources Business Partner continues to remind all managers of dates for training on managing sickness absence and strongly encourages those who are non-compliant with this training to attend.

Estates & Facilities

- Absence reduced from 7.6% in December to 7.2% in January. Within the top 5 reasons for sickness, all reasons except back and musculoskeletal problems reduced significantly. Long-term sickness reduced by approximately 25%. Whilst the number of episodes of short term sickness reduced slightly, the average length of each episode increased. In particular, absence of between 11-20 days increased by 50%.
- The agreed action plan results from the stress audit carried out at the end of last year will be presented to Divisional Board in week commencing 18th February.
- Following an initial meeting with the Occupational Health Business Manager on 31st January to discuss Divisional feedback, key members of the Occupational Health team will be invited to the next management team meeting, with a view to improving communication in this key working relationship. It is expected that improvements in long-term sickness will be achieved in April 2013. **Review – March 2013.**
- Plans are underway for a focussed skills training session for managers and supervisors, to develop key skills to support absence management in the Division. Combined with training in and use of the QlikView information system, it is hoped this will result in more proactive and effective

WORKFORCE

absence management. **Review – end March 2013.**

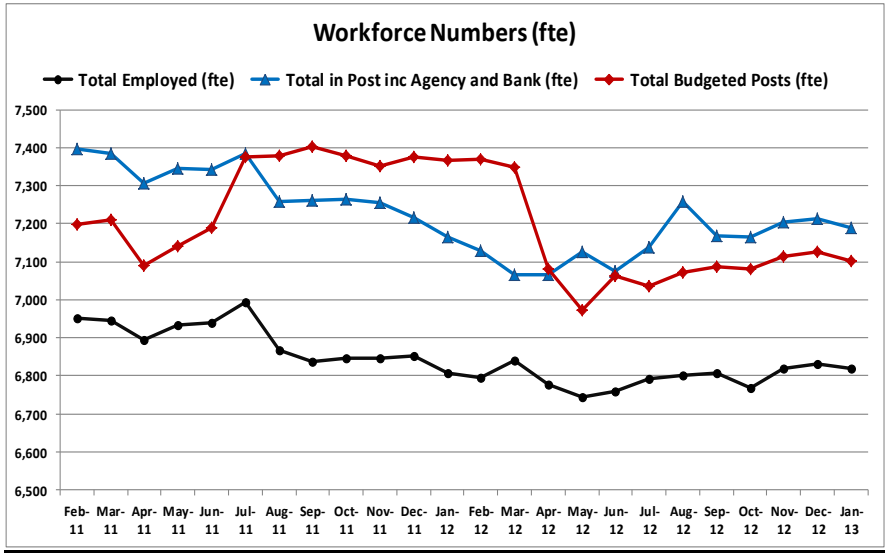
- Guidance to support managers considering percentage attendance as a way of managing sickness absence has been agreed and will be put on HR Web.
- The Human Resources Business Partner has scheduled meetings with the Assistant General Managers in both Facilities and Estates to review sickness in all areas and a recommendation has been made to require action plans from each area with sickness absence over the Trust target. The Division is also reviewing a proposal for a league table type initiative, recognising areas for innovative ways of reducing sickness and reductions in monthly sickness rates.
- A final meeting to agree actions arising from feedback from the programme of "Meet the Team" sessions is scheduled for 27th February. Some of the changes should result in improvements in environment, communication and support/training for managers. **Review – March 2013.**

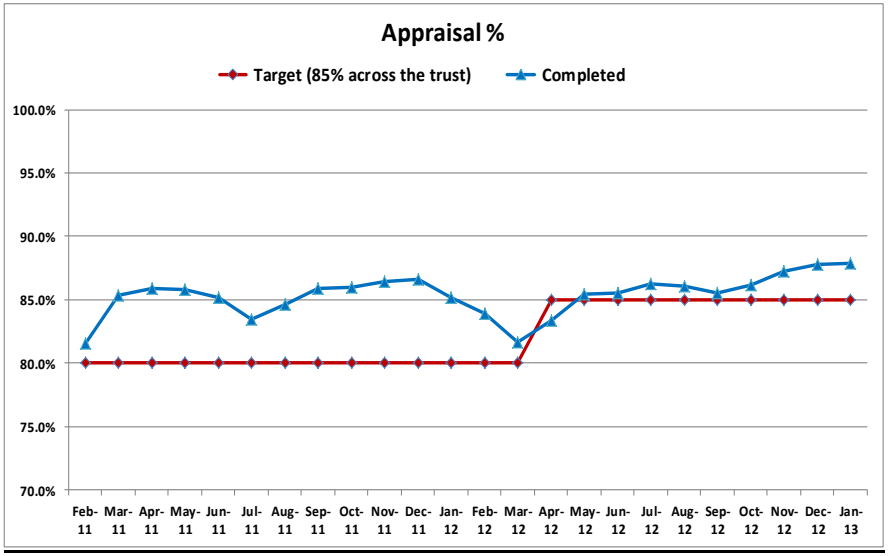
Progress against recovery plan: See above.

2.3 SUPPORTING INFORMATION

2.3.1 Performance against key workforce standards

This report provides an outline of the Trust's position against key workforce standards for the month of January 2013, 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.





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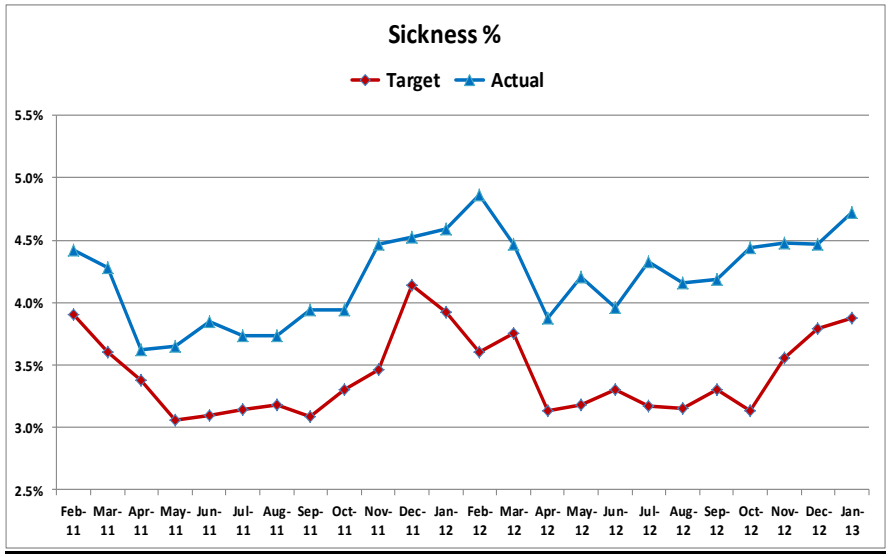
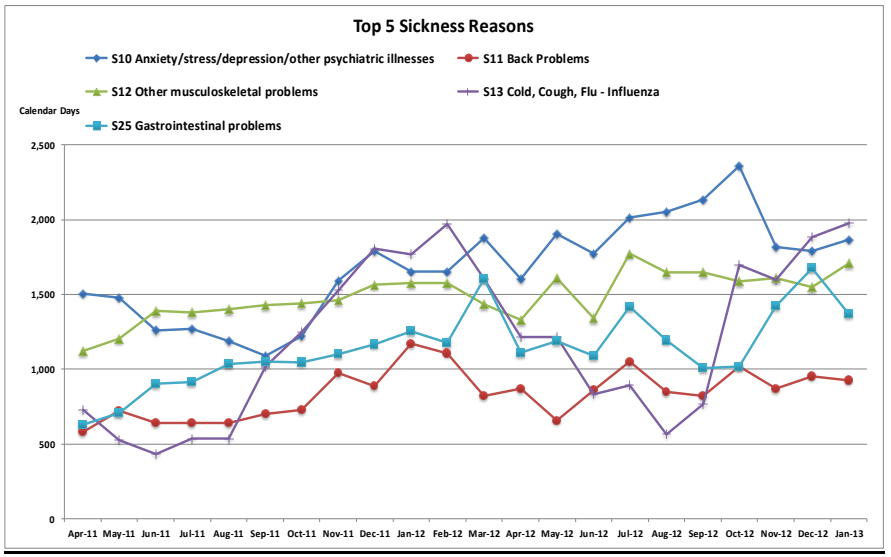
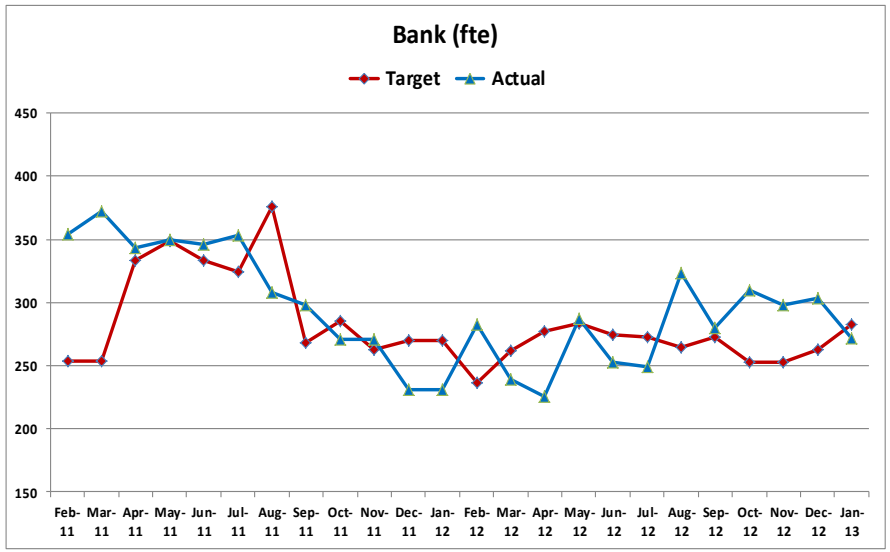
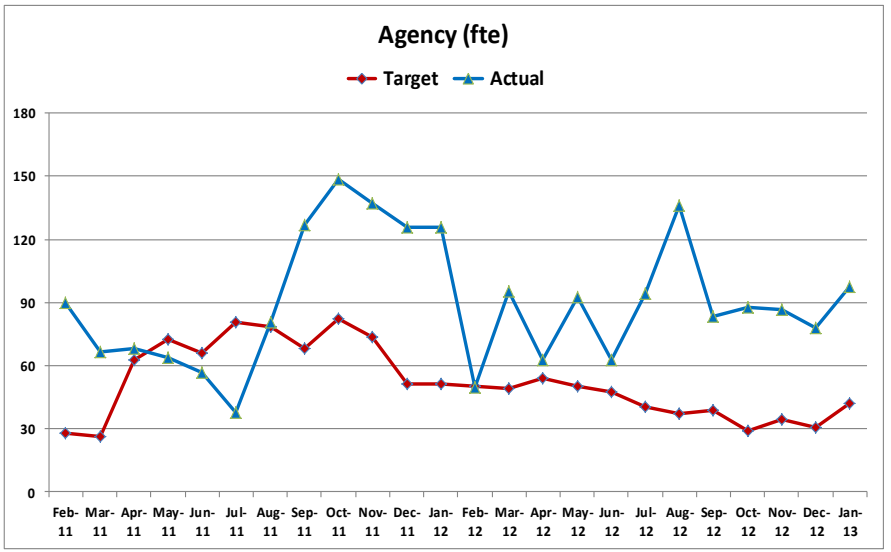








Agency usage in January 2013 includes a one-off accrual to bring the reporting period in line with the monthly usage.

2.3.2 Further information on European Working Time Directive

This report reflects the new, robust RAG (Red, Amber, Green) rated reporting of compliance with New Deal regulations, and will be provided to the Human Resources Governance Board on a quarterly basis.

- **Green status** - monitoring yielded valid return rate set and showed New Deal compliance in the current contracted pay band.
- **Amber status** - monitoring yielded invalid return rate in accordance with New Deal regulations, or as agreed by the Trust and rota group.
- **Red status** - monitoring exercise indicated potential non-compliance/band 3 (or pay band higher than contracted), or concern has been raised about rota compliance and is under investigation.

The abbreviations used in the sections below (e.g. F1 and ST1) are the grades of doctors.

Rotas rated Red are as follows:

Specialised Services: Cardiothoracic Surgical Trainees (ST) year 3+ - returned at band 3, discussion on-going; Haematology flexis ST3+ - returned at Band 3 due to breaches, discussion on-going.
Women's & Children's: Paediatric Cardiology ST4+ - banding appeal; Obstetrics and Gynaecology third on call - monitored at Band 3; Neonatal Intensive Care Unit (NICU) ST1-3 - returned at Band 3 due to breaches - to re-monitor; Paediatric Cardiac Surgery ST4+ - meeting with British Medical Association (BMA) to discuss banding.
Surgery Head & Neck: Anaesthesia ST3+ - invalid exercise; Anaesthesia Paediatric ST3+ - to be re-monitored;
Diagnostic & Therapies: Radiology ST3+ - monitored at Band 3 due to breaches at last exercise. To be re-monitored following discussion.
Medicine: None.

Rotas rated Amber are as follows:

Specialised Services: Haematology/ Oncology ST1-2; Oncology ST3+; Haematology ST3+; Cardiothoracic ST1-2; Cardiology flexi ST3+ - all invalid returns from last exercise, need to re-monitor.
Women`s & Children`s: Obstetrics and Gynaecology second on call ST3-5 - invalid return from last exercise; Paediatric Emergency Department ST4+ - invalid returns from last exercise - to be re-monitored.
Surgery Head & Neck : General Surgery ST1-2 - valid at 1A not 2B - proposed new rota from Feb 2013; Trauma and Orthopaedic ST3+ - rota issues ; Urology ST3+; Ophthalmology first on call and second on call ST3+; Maxillofacial Surgery Senior House Office and Specialist Registrar (SPR) - all invalid returns from last exercise. To be re-monitored.
Diagnostic & Therapies: Histopathology ST1-2 & ST3+; Chemical Pathology ST3+ - all invalid returns, to be re-monitored.
Medicine: Adult Emergency Department ST1-2 & ST3+; General Medicine ST3+; Rheumatology ST3+; Genito Urinary Medicine ST3+ - all to be monitored shortly - invalid returns from last exercise - to be re-monitored.

Rotas rated Green are as follows:

Specialised Services: Cardiology ST3+.
Women's & Children's: Paediatric Oncology ST4+; NICU ST4+; Obstetrics & Gynaecology first on call Foundation Year (F) 2/ ST1; Clinical Genetics ST3+; Paediatric Medicine F2/ General Physician Surgical Trainee (GPST); Paediatric Medicine ST2-3; Paediatric Medicine flexi ST2-3;

WORKFORCE

Paediatric Medicine ST4+; Paediatric Medicine Flexi ST4+; Paediatric Specialty Flexi ST4+.
Surgery Head & Neck: Anaesthesia General Flexi ST3+; Anaesthesia Intensive Care Unit ST3+; Ear Nose and Throat (ENT) ST3+; General Surgery F1 Flexi; General Surgery SpR Flexi ST3+;
Diagnostic & Therapies: None.
Medicine: General Medicine ST1-2; Dermatology ST3+**.**

Rotas currently monitoring:

Specialised Services: None.
Women`s & Children's Paediatric Surgery ST1-2 & ST4+; Paediatric Intensive Care Unit ST2+.
Surgery Head & Neck: Anaesthesia Cardiac ST3+; Anaesthesia Obstetrics and Gynaecology ST3+; Critical Care HDU F2; ENT ST1-2; General Surgery F1; General Surgery ST3+; Trauma and Orthopaedics ST1-2;
Diagnostic & Therapies: None.
Medicine: General Medicine F1; Dermatology Flexi ST3+; Dermatology Flexi Supernumerary ST3+;

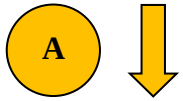
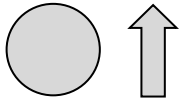
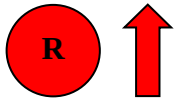
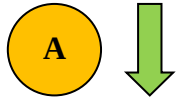
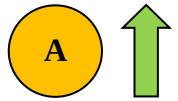
Key Issues

The following areas have outstanding issues:

- Maxillo-Facial Surgery has a city-wide rota which includes Royal United Hospital Bath, and has monitored non-compliant. North Bristol Trust counterparts function on a non-compliant rota, awaiting a copy of the rota and ongoing meetings to discuss.
- Cardiology is going through a Banding Appeal; the results will be communicated.
- Paediatric Cardiology and Cardiac Surgery are both going through Banding Appeals – on-going discussions with Consultants and other parties.
- Paediatric Anaesthesia remain on a 2A banding, monitoring results due shortly to see if banding can be reduced.

2.3.3 Changes in the period

Performance is monitored for workforce costs, workforce numbers, bank and agency usage, turnover, sickness and appraisal percentage. Indicators on a rolling reporting programme are: European Working Time Directive (EWTD) (February 2012), and Essential training (April 2013). The following dashboard shows key workforce information indicators RAG (Red, Amber, Green) rated for the month of January. Red rated indicators are outside tolerance limits and exception reports are provided for these.

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Numbers		Workforce numbers reduced by 0.3% compared with December 2012. As last month, this is1.2% above budgeted workforce numbers.	See summary and supporting information
Turnover		Rolling turnover (with exclusions) increased to 11.3%.	See summary
Sickness		Sickness increased by 0.2 percentage points compared with December 2012 across the Trust, 0.8 percentage points above the monthly target for 2012/13.	See summary, supporting information and exception report.
Bank/ Agency		Bank reduced by 32.3 FTE and agency reduced by 6.6 FTE in January 2013 (excluding accrual for agency usage in previous months), compared to December 2012.	See summary and supporting information
Appraisal		Trust wide appraisal rates for all staff were 87.9%. All Divisions achieved the stretch target of 85% which was introduced in April 2012.	See summary and supporting information
European Working Time Directive		64 rotas were monitored in this period. Out of 64, 8 were rated red, 22 amber and 18 green.	See supporting information

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.

2.3.4 Monthly forecast and overview

Measure	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Jan 13 Planned
Budgeted Posts (FTE)	7365.3	7368.1	7347.4	7081.2	6973.2	7063.9	7036.2	7072.1	7085.7	7080.7	7114.9	7126.2	7102.7	7221.7
Total Employed (FTE)	6806.7	6795.7	6841.0	6776.8	6745.7	6760.1	6793.3	6800.0	6806.3	6767.1	6819.8	6831.1	6818.7	6693.5
Sickness Rate (%)	4.6%	4.9%	4.5%	3.9%	4.2%	4.0%	4.3%	4.2%	4.2%	4.4%	4.5%	4.5%	4.7%	3.9%
Bank (FTE) Admin & Clerical	60.8	70.1	61.4	54.1	68.3	55.3	65.3	81.8	63.5	63.8	68.4	76.9	63.2	60.1
Bank (FTE) Ancillary Staff	15.0	15.5	12.9	12.8	14.9	12.9	11.8	14.4	15.2	11.0	15.2	16.1	14.5	6.3
Bank (FTE) Nursing & Midwifery	152.1	197.3	164.7	158.2	203.6	184.3	171.1	227.4	201.2	231.6	214.5	210.6	181.7	193.0
Agency (FTE) Admin & Clerical	13.5	4.5	5.2	6.4	11.8	5.4	8.7	16.9	10.7	27.3	24.3	10.9	13.1	1.3
Agency (FTE) Ancillary Staff	63.4	36.3	34.6	30.0	20.0	22.9	25.3	17.5	14.8	11.9	11.6	12.9	15.9	21.1
Agency (FTE) Nursing & Midwifery	26.7	0.0	37.6	32.4	40.3	30.8	45.5	77.8	56.1	37.3	43.2	47.9	37.0*	9.5
Overtime	72.2	76.6	89.1	83.8	70.0	70.9	67.8	74.4	64.5	76.4	64.6	61.1	66.5	49.8
Appraisal (%)	85.2%	83.9%	81.7%	83.4%	85.5%	85.6%	86.2%	86.1%	85.5%	86.1%	87.2%	87.8%	87.9%	85.0%
Rolling Average Turnover (all reasons) (%)	16.5%	16.2%	16.8%	17.0%	17.0%	17.2%	20.0%	17.8%	18.0%	18.0%	18.0%	18.2%	17.6%	
Rolling Average Turnover (with exclusions) (%)	9.5%	9.8%	10.3%	10.4%	10.4%	10.5%	10.5%	10.9%	11.1%	11.0%	11.0%	11.2%	11.3%	
Vacancy Rate (%)	7.6%	7.8%	4.3%	4.3%	3.3%	4.3%	3.5%	3.8%	3.9%	4.4%	4.1%	4.1%	4.0%	

*agency FTE excludes 26.6 FTE accrual for agency used in previous months

- 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.
- Sickness Rate is expressed as a percentage of total whole time equivalent 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 January 2013**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 4)***, 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 (17)	**Underachieving (1)**
- 31-day diagnosis to treatment cancer standard - *first treatment* - 31-day diagnosis to treatment cancer standard - *subsequent surgery, drug + radiotherapy* - 2-week wait urgent GP referral cancer standard - Symptomatic breast patients (cancer not initially suspected) 2-week wait - Referral to Treatment Time for admitted patients - Referral to Treatment Time for non-admitted patients - Referral to Treatment Time for incomplete pathways - Genito-Urinary Medicine (GUM) 48-hour access - A&E Left without being seen rate - A&E Time to Treatment - A&E Unplanned re-attendance - A&E Time to Initial Assessment (ambulance arrivals) (95th percentile) - Access to healthcare for patients with learning disabilities - Reperfusion times (door to balloon time of 90 minutes) - Infant health – breastfeeding rate	- Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved*
Failing (5)	**Not reported/scored (0)**
- A&E Maximum waiting time (4-hours) – *national standard not being met* - Last-minute cancelled operations - 28-day readmission – *following a cancellation at last-minute* - 62-day referral to treatment cancer standard – *Screening referred* - 62-day referral to treatment cancer standard – *GP referred*	

*Please note: Performance for the cancer standards is reported by all trusts in the country two months in arrears. The current cancer performance figures shown include the draft figures for January. 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.*

3.2 ACCESS DASHBOARD

Access Standards - dashboard

		Thresholds		Previous	Year to	Month												Quarter			
	Target	Green	Red	YTD	date (YTD)	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Q1 12/13	Q2 12/12	Q3 12/13	Q4 12/13
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	88%	95.8%	94.6%	96.6%	97.1%	96.7%	96.5%	94.6%	95.3%	94.7%	93.9%	93.8%	93.9%	92.0%	Cancer standards report two months in arrears	95.9%	94.7%	93.2%	
	Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks	93%	88%	98.0%	96.6%	98.4%	95.7%	96.1%	97.3%	95.7%	94.0%	98.4%	96.6%	98.5%	97.2%	93.6%		96.5%	96.5%	96.8%	
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	93%	97.8%	97.2%	98.4%	99.2%	99.5%	98.4%	92.1%	95.5%	98.0%	95.3%	98.7%	98.6%	98.3%		96.7%	96.3%	98.5%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	93%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	89%	97.0%	94.7%	96.4%	98.2%	100.0%	98.2%	85.4%	98.1%	93.1%	93.2%	89.9%	96.8%	100.0%		94.7%	94.7%	94.8%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	89%	99.6%	98.9%	96.9%	99.1%	99.5%	99.4%	99.4%	100.0%	97.8%	97.1%	99.0%	98.2%	99.4%		99.4%	98.3%	98.9%	
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	80%	86.6%	86.7%	87.7%	87.4%	92.8%	90.8%	83.1%	84.5%	87.4%	84.7%	85.5%	88.6%	81.6%		89.1%	85.6%	85.6%	
	Cancer 62 Day Referral To Treatment (Screenings)	90%	85%	93.8%	89.7%	100.0%	92.9%	100.0%	100.0%	87.5%	89.5%	93.5%	89.4%	83.7%	84.2%	83.3%		95.9%	90.5%	83.8%	
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	94.5%	93.6%	93.6%	93.8%	100.0%	100.0%	88.6%	100.0%	87.5%	90.3%	91.2%	97.1%	83.3%		96.7%	93.4%	90.5%	
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	85%	91.8%	92.3%	91.4%	91.2%	91.2%	93.2%	91.5%	91.8%	92.1%	93.5%	93.4%	92.1%	91.7%	91.1%	92.3%	92.5%	92.5%	91.1%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	90%	97.9%	95.6%	97.6%	98.0%	97.9%	96.8%	95.9%	95.8%	95.3%	95.1%	95.1%	95.1%	95.0%	95.1%	96.8%	95.4%	95.1%	95.1%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	87%	Target not in effect	92.1%	Target not in effect		92.2%	92.2%	92.1%	92.4%	92.2%	92.1%	92.0%	92.0%	92.1%	92.1%	92.1%	92.2%	92.0%	92.1%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	96.8%	94.3%	91.5%	92.0%	93.4%	91.9%	95.7%	95.3%	95.3%	95.7%	95.3%	94.4%	92.1%	94.6%	93.6%	95.4%	93.9%	94.6%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	13	70	48	30	120	196	15	13	13	13	12	13	12	12	151	13	13	12
	A&E Time to treatment decision (median) - in minutes	60	60	18	53	24	26	30	69	62	61	50	54	52	53	56	45	53	56	53	45
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	1.8%	2.6%	1.5%	1.6%	1.1%	2.1%	2.6%	2.4%	2.3%	2.5%	3.4%	3.2%	3.2%	2.8%	2.0%	2.4%	3.3%	2.8%
	A&E Left without being seen	5%	5%	0.9%	1.9%	1.1%	1.3%	2.2%	5.0%	2.4%	1.5%	1.7%	1.2%	1.5%	1.1%	1.3%	1.1%	3.3%	1.5%	1.3%	1.1%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	0.87%	1.08%	0.96%	0.76%	1.08%	1.59%	0.94%	0.77%	0.96%	0.70%	0.91%	1.22%	0.97%	1.61%	1.21%	0.81%	1.04%	1.61%
	28 Day Readmissions	95%	85%	94.0%	91.3%	92.0%	86.8%	84.4%	88.2%	88.0%	87.8%	93.0%	96.3%	91.9%	96.5%	93.2%	93.9%	87.2%	92.5%	94.0%	93.9%
	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%	84.6%	82.6%	90.4%	81.1%	89.7%	81.8%	88.2%	83.3%	71.4%	87.9%	84.2%	77.3%	82.6%		86.5%	80.9%	80.5%	
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	90.9%	92.5%	94.2%	91.9%	96.6%	84.8%	97.1%	95.2%	88.6%	97.0%	89.5%	86.4%	97.8%		92.7%	93.6%	91.4%	
	Infant Health - Mothers Initiating Breastfeeding	76.3%	74.5%	76.3%	80.3%	74.7%	76.0%	74.2%	82.3%	82.3%	80.9%	80.1%	81.0%	81.6%	81.2%	80.0%	79.2%	78.8%	80.7%	81.0%	79.2%

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:

- A&E Total Time in A&E 4-hours ↑ (up from 92.1% in December to 94.6% in January)
- Last-minute cancelled operations ↑ (up from 0.97% in December to 1.61% in January)
- 62-day referral to treatment (GP referral) ↓ (down from 88.6% in November to 81.6% in December)
- Cancer 2-week wait urgent GP referral ↓ (down from 93.9% in November to 92.0% in December) – *achieved for the quarter and on track to achieve in January*
- Primary PCI - 90 Minutes Door To Balloon Time ↑ (up from 86.4% in November to 97.8% in December) – *achieved for the quarter*

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

3.4 EXCEPTION REPORTS

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

1) Last-minute cancelled operations
2) 28-day readmission
3) 62-day referral to treatment cancer standard – *Screening referred*
4) 62-day referral to treatment cancer standard – *GP referred*
5) A&E 4-hour maximum wait

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 92 last-minute cancellations (LMCs) of surgery in **January** (1.61% of operations) which is significantly above the national standard of 0.8%. The main reasons for cancellations in January were as follows:

- 29% (27 cancellations) were due to no ward beds being available
- 13% (12 cancellations) were due to an emergency patient being prioritised on the day
- 13% (12 cancellations) were due to no critical care bed being available
- 11% (10 cancellations) were due to equipment failure
- 8% (7 cancellations) were due to a lack of theatre time due to another clinically complicated case taking longer than planned

Of the 92 cancellations, 26 were day-cases and 66 were inpatients (28% 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 no critical care bed being available, which is more likely to impact inpatient than day-case procedures.

Of the 27 cancellations in the month due to a ward bed not being available, 25 were for patients due to be treated in the Bristol Royal Infirmary (BRI) and the Bristol Heart Institute (BHI). Following a steep rise in emergency admissions across the community significant pressure on beds grow during the 30th January. Black escalation was declared and all non-emergency operations were cancelled. Twelve patients were cancelled across the 30th and 31st January for this reason.

Six of the 10 patients cancelled due to equipment failure were due to have ophthalmology procedures (three patients on each of two surgical lists). A further three patients were cancelled in Cardiology on the same day due to a problem with a piece of equipment in the Catheter Laboratory.

In January, 93.9% of patients cancelled in the previous month were readmitted within 28 days of the cancellation. This is just outside the national standard of 95%, but a slight improvement on the previous month's performance. All three failures to re-admit patients within 28 days were paediatric cardiology/cardiac cases. The reduction in paediatric cardiac surgery beds to create additional high dependency beds has impacted on the hospital's ability to re-admit patients over the past few months.

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*):

- Ongoing implementation of 4-hour plans, the actions from which should reduce cancellations related to bed availability
- Escalation of all LMCs not re-booked within 7 days of cancellation (ongoing)
- An integrated programme of work to support patient flow is being implemented, which includes the following:
    - A review of current bed occupancy and bed requirements for the BRI and BHI (divisional and specialty level), to try to understand how the number of medical outliers can be reduced, thereby reducing the impact on the elective bed-base;
    - KPMG will be starting a programme of work to reduce length of stay;
    - The recent refresh of the bed capacity model, which forecasts future bed requirements based upon age-related population growth and improvements in length of stay (achievement of upper quartile length of stay in 50% of specialties by 2016/17), is being used to develop the new ward configuration to come into effect following opening of the new BRI ward block
- 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 are being 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)
- Daily e-mails circulated of all on the day cancellations within the Bristol Royal Infirmary by the Patient Flow Co-ordinator, to help ensure patients are re-booked within target (ongoing)
- A review of demand for high care/intensive therapy unit beds is being undertaken as part of the refresh of the bed capacity model (end January – initial modelling completed and to be reviewed by the clinical team in February)

Progress against the recovery plan:

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. It is not expected that the 0.8% national last-minute cancelled operations standard will be achieved in

ACCESS STANDARDS

February due to the second period of black escalation being declared as a result of the norovirus outbreak.

ACCESS STANDARDS

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

Description of how the target is measured:

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

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

Performance during the period, including reasons for exceptions:

62-day screening referred

In December (the last reported month) 83.3% of patients were treated within 62 days of referral from one of the three national screening programmes against the 90% national target. Four bowel screening patients were not treated within the standard in the month, the reasons for which were:

- Delay to initial specialist bowel screening practitioner appointment, due to service capacity, followed by a delay for colonoscopy due to patient choice;
- Delay to initial specialist bowel screening practitioner appointment, due to service capacity, followed by a delay for colonoscopy due to patient choice;
- Delay to initial specialist bowel screening practitioner appointment, due to service capacity; patient then refused a colonoscopy and required a medical review, which further delayed the diagnosis;
- Delay to initial specialist bowel screening practitioner appointment, followed by a delay for the colonoscopy at North Bristol Trust, both due to service capacity

Three key causal factors of breaches of the 62-day standard have been highlighted from the review of Quarter 3 breaches. These are:

1. Delays to initial bowel Specialist Screening Practitioner (SSP) appointment
2. Delays to colonoscopy
3. High levels of patient choice to defer appointments and diagnostic tests.

There were vacancies in the SSP team which have now been recruited to. Overall demand for endoscopies is significantly above last year and has outstripped available capacity. The delayed opening of South Bristol Community Hospital's endoscopy suite has limited the Trust's ability to flex physical capacity to meet demand for colonoscopies. High levels of patient choice to delay diagnostic tests and outpatient appointments also had a significant impact on pathways in the period. The impact of patient choice is most pronounced for screening pathways, where patients are not exhibiting symptoms and therefore are more likely to elect to delay invasive diagnostics. Medical deferrals, but also delays at other providers due to

patient choice and capacity, also contributed to breaches in quarter 3.

The delays to SSP appointment and colonoscopy were addressed in Quarter 3, but have also impacted in Quarter 4 – see final section of this exception report.

62-day GP referred

In December (the last reported month) 81.6% of patients were treated within 62 days of referral by a GP against the 85% national target. Twenty patients were not treated within the standard in the month. In order of magnitude, the breach reasons were as follows:

- Late referral from another provider (mainly affecting lung pathways)
- Complex case requiring multiple diagnostic tests and/or more than one potential tumour site
- Patient choice to delay their pathway
- Issue at another provider (e.g. delay to treatment or administrative error)
- Other (including elective cancellations, no high care bed being available, medical deferral or delayed diagnostics)

Of the 20 patients not treated within target, 9 were on lung cancer pathways, which is a significant increase on previous months. However, the breaches were multi-factorial. Seventy percent of the breaches during the period were outside of the control of the Trust (i.e. late referral, patient choice, complex case, or resulting from a medical deferral).

Recovery plan, including expected date performance will be restored:

The following actions are being taken to reduce the risks to achievement of the 62-day standard for screening referred patients in Quarter 4. *Please note: actions completed in previous months have been removed from the following list*:

- Additional thoracic and upper GI operating lists have been established, to help to reduce the delays to patients cancelled as a consequence of black escalation (Immediate)
- From April, routine an additional1.5 theatre lists per week will be made available to the thoracic and upper gastro-intestinal hepatobiliary teams to increase capacity and reduce the impact of elective cancellations (End March).
- More in-depth analysis will be undertaken of the thoracic pathway and what improvements can be made to reduce the risk of breaches; this will include a review of the amount of operating capacity available to meet total demand for thoracic surgery, as the number of cases being operating on appears to have increased (end March)
- Weekly monitoring of colonoscopy and Specialist Screening Practitioner appointment waiting times, with corrective action being taken as

necessary (Ongoing)

- All patients with delay starts to their screening pathway continue to be tracked, with their diagnostic tests and treatment being expedited wherever possible (Ongoing)
- Plans are being enacted to help manage the potential increase in demand due to the planned breast cancer awareness campaign (**Action complete**)
- Review of administrative support to cancer services will be finalised (**Action complete**; funding options being discussed; for implementation in Q1 2013/14)
- Letters continue to be sent to referring trusts when a referral is received after day 46 in the pathway (Ongoing)
- Please also see the actions detailed in the A&E 4-hour exception report

Progress against the recovery plan:

62-day screening

The actions taken in November and December were to achieve the following Key Performance Indicators:

- Maximum 14 day wait to Specialist Screening Practitioner appointment:
    - Since the week ending 23rd November, all patients have been offered a date for their SSP appointment within 14 days of referral from the national hub (typical waits remain well below 14 days)
- Maximum 14 day wait to Colonoscopy diagnostic procedure:
    - Since the week ending 28th December, all patients choosing to having their diagnostics at University Hospitals Bristol have been offered a date for their colonoscopy within 14 days of SSP review (typical waits remain well below 14 days)

Overall, the list of patients being managed on 62-day screening pathways has reduced from 183 at the start of November to 113 at the start of February. This 38% reduction is a result of recently referred patients now having shorter pathways.

Although the impact of the delayed practitioner appointments and colonoscopies primarily impacted in quarter 3 some patients with delayed starts to their pathways are being treated in quarter 4. Draft performance for January is below the 90% standard at 80%. However, performance is expected to improve during the second half of this quarter, so it is possible that the standard may be met for the quarter as a whole (although this isn't currently forecast). The delays reported last month for patients choosing to have their colonoscopies at North Bristol Trust have now been addressed.

62-day GP

There have been two periods in the quarter to date during which there was significant pressure on beds, with black escalation being declared as a

result. This represents the highest status of escalation, with the priority being maintaining patient safety and freeing-up as many beds as possible to improve flow. The first period, at the end of January, lasted a day and was a result of high levels of emergency admissions and pressures across the community. The second period of nine days resulted from an outbreak of norovirus with 10 affected wards being closed at its peak. During these periods the availability of beds was so limited that most non emergency operations had to be cancelled. The lack of ward beds also affected high care bed availability, as patients could not be promptly transferred from the Intensive Therapy Unit into a ward bed. This, in combination with high levels of patient choice, delayed referrals and capacity constraints within the thoracic (lung cancer) service in particular, has impacted heavily on performance in the quarter. As a result achievement of the 62-day GP standard in Quarter 4 is high risk.

ACCESS STANDARDS

A5. EXCEPTION REPORT: A&E maximum wait 4 hours	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

A&E maximum wait 4 hours

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

Monitor measurement period: Quarterly

Performance during the period, including reasons for exceptions:

Overall performance against the 4-hour standard improved from 92.1% in December to 94.6% in January. Performance at the Bristol Children's Hospital (BCH), which was an issue in Quarter 3, improved by almost 6%, from 93.2% in December to 99.1% in January. Performance at the Bristol Royal Infirmary (BRI) also improved, from 89.2% in December to 91.2% in January.

During January the main contributory factors resulting in the failure to achieve the 95% standard were:

- The significant deterioration in performance in the last week in January in the BRI, which was associated with two consecutive weeks of high levels of admissions, with black escalation being declared across the community due to bed pressures
- An increase in long waiters as a result of the community being unable to accommodate delayed discharge patients quickly enough

The other key risk factors identified at the end of Quarter 3 continue to contribute to the worsening of patient flow through the BRI in late January and early February:

- Significant ward closures due to norovirus at the BRI, with empty beds not being able to be used on closed wards
- Increase in bed occupancy rates resulting in an increase in patients outlying from their specialty wards and an increased in length of stay
- Increase in over 14-day stays and associated 'Red List' of delayed discharges
- Increase in ambulance arrivals and conversion rate, with longer lengths of stay for these patients (all potential indicators of increasing acuity)
- Increase in the numbers of 90 plus year-olds being admitted to the hospital (again an indicator of increasing acuity)

Recovery plan, including expected date performance will be restored: The following key actions are being undertaken as part of the main improvement work-streams (*please note: actions completed in previous months have been removed from the following list*).

- Open two extra beds on the Observation ward at the BCH, to increase capacity (end January) – bed spaces identified

ACCESS STANDARDS

- Agree protocols for covering short-term junior doctor absence at the BCH (**Action complete**)
- Agree expectations for timely specialty doctor review in the BCH ED to provide specialist opinion (end February) – in progress
- Commission second triage room and agree nursing allocation and triggers for utilising the room to prevent a deterioration in Decision to Admit (DTA) times at the BCH (end March) – in progress
- Avoid BRI 4-hour breaches due to peak transfer pressures, with additional resources to support (including portering and input from ED Navigator role) (end January) – in progress
- Sign-off escalation plan which includes additional board rounds during times of escalation to maintain patient flow (**Action complete**); triggers for the agreed escalation bed usage matrix under development
- Provide resilient BRI ED medical staffing required to hit all ED process/flow targets (**Action complete**)
- BRI Medical take consultant to provide in-reach at ED Board rounds (**Action complete**)
- Medicine and Surgery to ensure 10 discharges are identified by 10:00 hours each weekday (mid January); Medicine daily flow meeting in place to deliver against this standard; Surgery and Specialised Services developing their processes
- BRI Hospital Discharge Team to be established with increased resources to support (end February) - in progress
- Professional standards (e.g. time to specialist opinion in the ED) to be implemented by all Divisions (end January) – in progress following agreement at the Trust Management Executive
- Therapist cover for weekends to progress discharges in the BRI over the weekend (ongoing) – in progress
- Bid for funding submitted for extra capacity/outliers team to increase capacity across the health community (**Action complete**) – funding confirmed. Additional bed capacity being established in North Somerset and Bristol. We are working with Bristol City Council for additional staffing resources (**Ongoing**).
- Six to twelve nursing home beds to be identified and used by the Trust to reduce pressure on acute beds; this will be funded by Department of Health winter pressures money (**Ongoing**) - Funding confirmed; community capacity being set-up in North Somerset and Bristol; patients being transferred w/c 4th February as appropriate community capacity becomes available.
- GPs to be contracted to provide medical cover for ward 20 as a delayed discharge ward, to reduce pressure on medical and inpatient teams (end February) – in progress; awaiting completion of contract negotiations with BRISDOC (out of hours GP service provider). Currently ward 20 is covered by Medicine Division Physicians.
- Analyse conversion rate to admission and length of stay (LOS) of ambulance patients, to understand impact of ambulance growth - Early analysis indicates 63% of ambulance patients are admitted and have an above average LOS. Further detailed analysis of historical patterns

and seasonal trends underway.

Progress against the recovery plan:

Since the re-opening of wards closed by norovirus performance in February has averaged 97.7%. The forecast for February as a whole is to achieve 94.1%. Achievement of the 95% standard is still possible for the quarter as a whole, based upon current levels of performance and historical performance for the month of March.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 28 February 2013 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 07 – 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 £4.414m for the ten months to 31st January 2013, a favourable movement of £0.444m in the month. The cumulative position reduces the shortfall against the projected Annual Plan surplus for the year to date to £0.461m. The Trust's Financial Risk Rating is unchanged at 3 (actual 2.90). Expenditure within the Capital Programme is £5m less than forecast to date with slippage of £2.8m in January, mainly on strategic schemes. The revised programme from the contractor for the BRI Redevelopment scheme advises that current slippage will be recovered by June 2013.
Recommendations
The Board is recommended to **review** the financial position for the 10 months to 31st January 2013.
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 February 2013		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £4.414m for the ten months to 31st January 2013, a favourable movement of £0.444m in the month. The overspending on divisional services budgets is offset by the proportion of the operating surplus built into the Trust's financial plan (£5.7m for the year) and the income surplus realised on the sale of assets (£0.367m). The Annual Plan projected surplus to date is £4.875m so the results represent slippage against the Plan of £0.461m, compared with £0.492m adverse to Plan reported last month. The operating surplus (EBITDA[1]) at £27.855m equates to 93.7% of the Annual Plan projection for the 10 month period.

The impact of the results to date is reflected in the Trust's Financial Risk Rating which stands at 3 (actual 2.90), further information on this is given in section 6 below.

The 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 £8.628m. Detailed information and commentary for each Division is to be considered by the Finance Committee (agenda item 5.3 refers).

Divisional Variances	Variance to 31st December	Variance this month	Variance to 31st January	Memorandum CRES Variance
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(4,187)	(605)	(4,792)	(1,968)
Non Pay	(1,381)	(104)	(1,485)	(3,429)
Operating Income	1,056	160	1,216	44
Income from Activities	(3,468)	(99)	(3,567)	(387)
Totals	**(7,980)**	**(648)**	**(8,628)**	**(5,740)**

It can be seen that the non-achievement of savings within the CRES programme is a significant feature on the expenditure lines. CRES accounts for 41% of the £4.8m overspending on the pay heading. The adverse CRES variance shown against the non-pay heading includes the proportion of unidentified savings within divisional plans of £2.512m to date. The cumulative overspending shown against non-pay includes £2.132m being 10/12ths of the non-recurring support issued at the start of the year. The overspending on pay budgets and the underperformance on Income from Activities are the key drivers of the adverse variance to date.

[1] Earnings Before Interest Depreciation Taxation and Amortisation

Pay budgets have a cumulative overspending of £4.792m – an increase of £0.605m in January. The principal areas of overspending have taken place with the Divisions of Medicine (£0.276m), Surgery, Head and Neck (£0.245m) and Diagnostic and Therapies (£0.162m). Actual pay expenditure for January was £110k higher than December with increases shown on directly employed staff costs of £67k and a net increase in expenditure on bank, agency, waiting list initiative and overtime payments of £43k.

Non-pay budgets show a cumulative adverse variance of £1.485m, an adverse movement of £0.104m in the month. A significant overspending in the month has been recorded against Specialised Services (£0.208m). This relates to a high incidence of expenditure on clinical supplies, further information is given within the Specialised Services Division commentary below.

Operating Income budgets show a favourable variance of £1.216m, a favourable movement of £0.160m in the month. Notable favourable variances were recorded in January by Medicine (£81k), Specialised Services (£64k) and Surgery, Head and Neck (£42k).

Income from Activities shows a cumulative under-performance of £3.567m, an adverse movement in the month of £99k. A significant adverse variance has been recorded against the Women's and Children's Services (£0.325m). This is offset by better than planned performance against Service Agreements by Diagnostic and Therapies (£72k), Medicine (£104k) and Surgery, Head and Neck Services (£74k).

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

	£'000
Mutually Agreed Resignation Scheme	271
Inherited Metabolic Disorders Service	156
European Working Time Directive	136
Haemophilia Service	127
Medical and Dental Education Levy	122
Energy Inflation	121
Clinical Systems Implementation Project	94

3. Cash Releasing Efficiency Savings

The achievement of cash releasing efficiency savings headline message is that January has seen delivery of CRES savings of £17.914m to date. This equates to 78% of the Plan for the first ten 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.

The January report reflects an adverse variance of £5.740m year to date on the CRES programme. Actual savings of £17.914m represents slippage of £5.173m when compared with profiled planned savings for the first ten months of £23.087m. The adjustment to bring CRES plans on to a 1/12ths basis adds a further £0.567m to the reported non achieved CRES to date.

4. Income

For the months of April – January contract income is greater than Plan to date. The summary table below shows significant favourable variances against elective inpatients, non-elective inpatients, PbR exclusions / NICE and Contract Penalties / Rewards. This is partially offset by significant under performance on emergency in patients and out-patient services. On a cumulative basis contract income is £2.38m higher than– 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	9.79	9.74	(0.05)
Emergency Inpatients	60.12	57.66	(2.46)
Day Cases	25.48	26.04	0.56
Elective Inpatients	40.03	40.70	0.67
Non-Elective Inpatients	24.92	25.94	1.02
Excess Bed days	6.39	6.70	0.31
Outpatients	55.51	53.51	(2.00)
Bone Marrow Transplants	6.79	6.77	(0.02)
Critical Care Bed days	30.46	29.96	(0.50)
PbR Exclusions / NICE	33.38	35.12	1.74
Contract Penalties / Rewards	0.07	1.72	1.65
Other	44.69	45.08	0.39
Sub-Totals	**337.63**	**338.94**	**1.31**
2011/12 Estimate v Actual	-	1.07	1.07
Totals	**337.63**	**340.01**	**2.38**

The variance of £1.65m on Contract Penalties / Rewards includes Emergency Readmissions (£1.49m), the Emergency Marginal Tariff (£1.17m) and the BNSSG risk share contract assessment (-£0.69m).

Expenditure

In total, Divisions are shown as overspent by £8.628m for the ten months to 31st January. The position for each Division, together with comparable results with CRES accounted for on the Divisional Phased Plan basis, is summarised below:

Division	**CRES on 1/12ths profiling**		**CRES on Phased Plan**	
	Variance to 31st January Favourable / (Adverse)	Memorandum CRES Variance to 31st January	**Variance to 31st January Favourable / (Adverse)**	**Memorandum CRES Variance to 31st January**
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	61	(62)	107	(16)
Medicine	(1,464)	(863)	(1,262)	(661)
Specialised Services	(1,239)	(869)	(1,146)	(776)
Surgery, Head and Neck	(4,767)	(3,328)	(4,667)	(3,228)
Women's and Children's	(2,003)	(305)	(1,944)	(246)
Facilities and Estates	8	(106)	45	(69)
Trust Services	138	-	168	30
Other Services	638	(207)	638	(207)
Totals	**(8,628)**	**(5,740)**	**(8,061)**	**(5,173)**

The table below summarises the changes in financial performance in January 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 December Fav / (Adv)	Variance for January Fav / (Adv)	Cumulative Variance to 31st January Fav / (Adv)
	£'000	£'000	£'000
Diagnostic and Therapies	167	(106)	61
Medicine	(1,309)	(155)	(1,464)
Specialised Services	(1,000)	(239)	(1,239)
Surgery, Head and Neck	(4,552)	(215)	(4,767)
Women's and Children's	(1,886)	(117)	(2,003)
Estates and Facilities	(31)	39	8
Trust HQ	121	17	138
Trust Services	510	128	638
Totals	**(7,980)**	**(648)**	**(8,628)**

This position is after additional support of £2.557m for the year has been issued from Reserves as follows:

	2012/13	Year to date
	£'000	£'000
Diagnostics and Therapies	86	72
Medicine	355	296
Specialised Services	794	662
Surgery, Head & Neck	1,050	875
Women's and Children's	272	227
Totals	**2,557**	**2,132**

Four 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 £4.767m, an overspending of £0.215m in the month when compared with the December position of £4.552m adverse.

Pay budgets have a cumulative overspending of £2.263m. Within the overspending is the impact of CRES slippage of £0.907m, the prior year shortfall of £0.976m relating to non-achieved CRES on pay headings in the Division and overspendings on medical staff budgets of £0.774m.

Non pay budgets are overspent by £0.746m to date, an overspending of £86k in the month. This includes slippage on CRES (£1.778m) offset by a proportion (£0.875m) of the £1.05m non recurring central support. There have been a number of other, mainly minor, changes on non-pay operational budget headings.

Income from Activities shows an adverse variance of £1.992m, a favourable movement in January of £74k. The improvement reflects the Division's share (£30k) of higher income levels obtained to support SLA overperformance by other clinical divisions and the recognition of some arrears (£190k) of SLA income for the ophthalmology service. After adjusting for these favourable gains there is a net under-performance on other clinical activity income budgets. Service managers

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

continue to work closely with lead clinicians to complete activity recovery plans for the final quarter of 2012/13, however experience in recent weeks with restricted access to beds is a significant threat to the delivery of this part of the Division's plan. Operating Income budgets have improved in the month by £42k to give a cumulative favourable variance of £0.234m.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £2.003m, an overspending of £117k in the month.

Pay budgets are overspent by £0.706m – an improvement of £15k in the month. Children's ward nursing staff expenditure is increasing as new staff appointed to support the HDU take up post. Savings were reported as a result of vacancies in Midwifery and for AHP staff.

The overspending on Income from Activities has increased by £0.325m in the month to a cumulative overspending of £1.447m. The overspending is as a result of lower than planned activity e.g. only 4 Bone Marrow Transplants (limited beds availability following high volume of work performed in December and nursing staff vacancies), Maternity services saw a further month of low activity (under investigation and may be linked to under recording of activity), unseasonably low activity at the Children's Hospital ED and subsequent emergency admissions.

The **Division of Medicine** reports an adverse variance of £1.464m for the ten months to 31st January, a deterioration of £155k when compared with the adverse variance to 31st December of £1.309m.

The Division has significant overspendings on pay headings (£1.476m), an increase of £276k in the month. Pay costs are higher than planned as a result of providing unfunded capacity and incurring higher than planned pay costs for nursing and medical staff. The Division reports that significant costs (£0.286m) were incurred in January as a result of the high use of agency nursing staff.

Non-pay budgets are cumulatively overspent by £0.823m, an increase of £64k in the month. The overspending this month is linked to the provision of higher than planned capacity including portering services and additional deep cleaning of clinical areas.

Income from Activities reports a cumulative over achievement of £0.421m to date, £104k in the month. This reflects the additional income receivable to contribute towards the cost of recent over performance against service level agreements.

The underspending on operating income budgets has increased in the month by £81k to a cumulative underspending of £0.414m.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £1.239m, an adverse movement of £0.239m in the month.

Pay budgets show a cumulative overspending of £1.005m, an overspending of £76k in January. The overspending relates mainly to the higher than planned costs on nursing staff, consultant and other medical staff.

Non pay budgets show a net overspending of £0.180m to date – an adverse movement of £0.208m in the month. The January position includes a high incidence of expenditure on clinical supplies, including the late notification of invoices (£100k) from NHS Supply Chain. A further invoice from this supplier is being investigated to establish its origin and to check for receipt of goods.

Operating Income budgets show a favourable variance to date of £0.231m an increase of £64k in the month. Income from Activities shows a cumulative adverse net variance of £0.285m, an

adverse movement of £19k in the month. January has seen a further level of underperformance on cardiac surgery as a consequence of reduced elective activity over the period the Trust was in 'black escalation'. Cardiology services have delivered above contract volumes to reduce the waiting list backlog. Haematology over performance is greater than the under performance to date on BHOC Radiotherapy and Oncology services.

The remaining three divisions are green rated.

The **Diagnostic and Therapies Division** reports a cumulative underspending of £61k, a deterioration of £106k in the month. The principal reason for the overspending this month is the payment of arrears (£134k) relating to the on-call rota for Radiology SpR staff.

The Facilities and Estates Division reports an underspending to date of £8k, a favourable movement of £39k in the month.

Trust Headquarters Services report an in-month underspending of £17k and a cumulative underspending of £0.138m.

5. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 31st January is 3. The actual financial risk rating is 2.90 (December = 3.10) which rounds to 3. The deterioration in the Trust's financial position is because the Income and Expenditure margin has fallen below the 1% minimum required to secure a 3 on this metric. 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.

There has been a small improvement in the liquidity metric this month as the first tranche (£4.95m) of the long term loans was drawn down towards the end of January. The Annual Plan has projected that a further £15m of the loan, equivalent to 11 liquidity days would have been drawn down by 31st January.

	31st January 2013									
Metric	Metric Result	Metric Score	Weighted Average Score	Weighting %	Rating categories 5	4	3	2	1
EBITDA										
Margin	6.33	3	0.75	25	11	9	**5**	1	<1
Plan achieved	93.7	4	0.40	10	100	**85**	70	50	<50
Net Return on Financing	1.46	3	0.60	20	3	2	**-0.5**	-5	<-5
I&E surplus margin	0.92	2	0.40	20	3	2	1	**-2**	<-2
Liquidity ratio (days)	16.2	3	0.75	25	60	25	**15**	10	<10
			2.90						

Overall Financial Risk Rating	**3**

The Trust is operating well within the 4 metrics specified in the Prudential Borrowing Limit.

6. Capital Programme

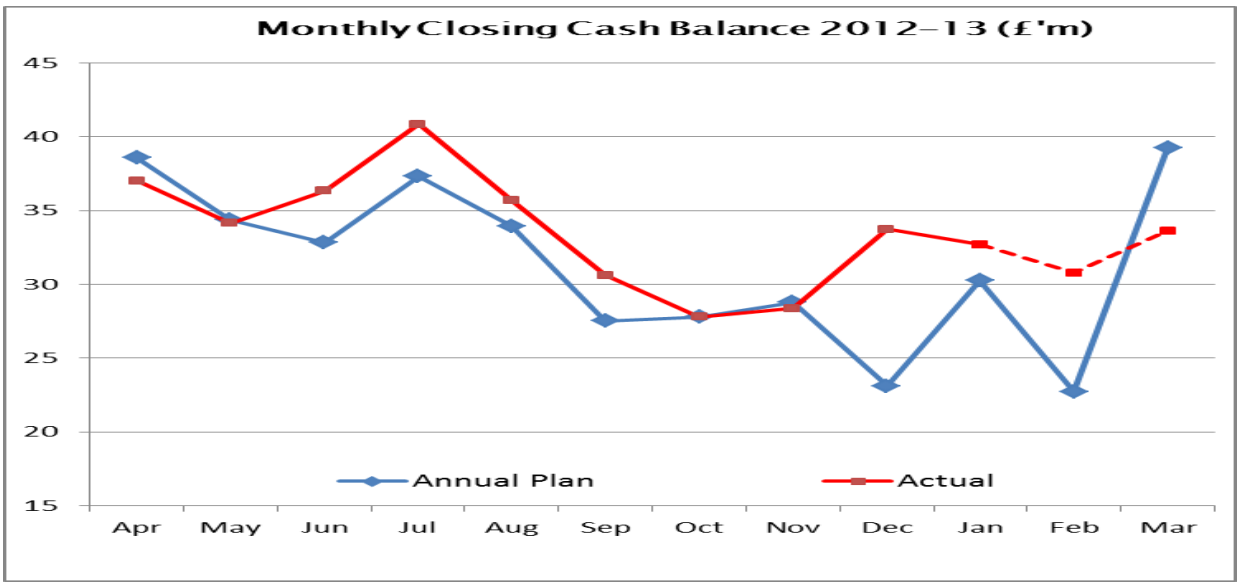
A summary of income and expenditure for the ten months to 31st January is given in the table below. Expenditure for the period of £44.749m is £5.039m less than the current Plan.

Plan for Year		10 Months Ended 31st January 2013		
		Plan	Actual	Variance Favourable / (Adverse)
£'000	**Sources of Funding**	£'000	£'000	£'000
551	Donations	455	387	(68)
17,685	Retained Depreciation	14,705	14,690	(15)
29,950	Prudential Borrowing	4,950	4,950	-
8,395	Sale of Property	7,695	7,720	25
25,468	Cash balances	21,983	17,002	(4,981)
82,049	**Total Funding**	**49,788**	**44,749**	**(5,039)**
	Expenditure			
(54,041)	Strategic Schemes	(37,758)	(33,707)	4,051
(9,145)	Medical Equipment	(3,455)	(3,301)	154
(6,155)	Information Technology	(2,966)	(2,923)	43
(1,876)	Roll Over Schemes	(1,560)	(1,467)	93
(4,190)	Refurbishments	(899)	(792)	107
(9,508)	Operational / Other	(3,150)	(2,559)	591
2,866	Anticipated Slippage	-	-	-
(82,049)	**Total Expenditure**	**(49,788)**	**(44,749)**	**5,039**

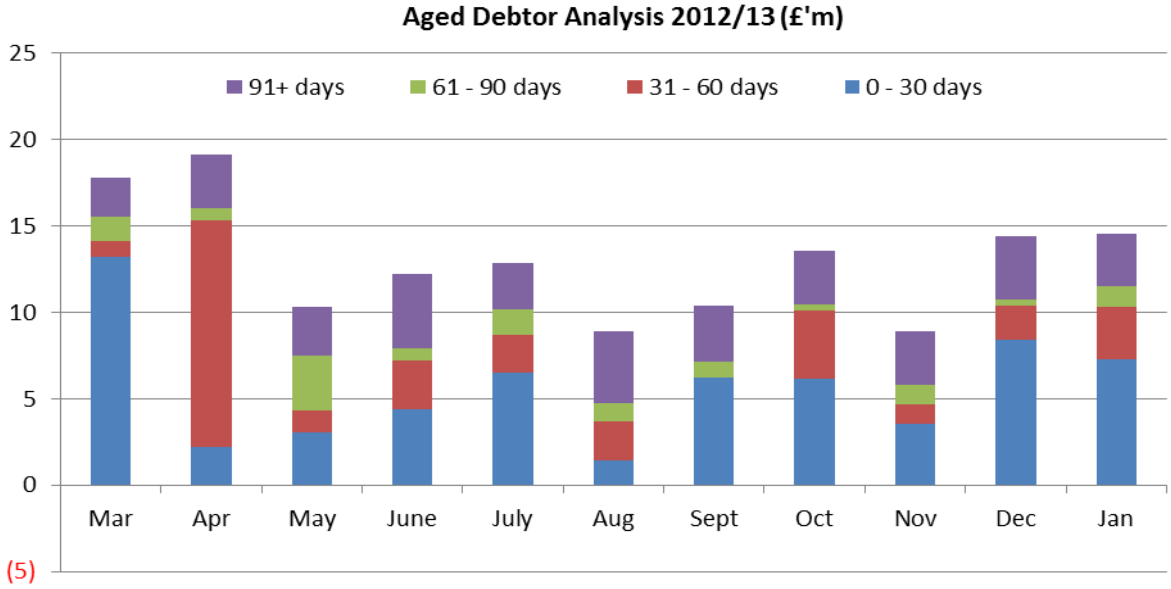
The Finance Committee is provided with further information on this under agenda item 6.

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

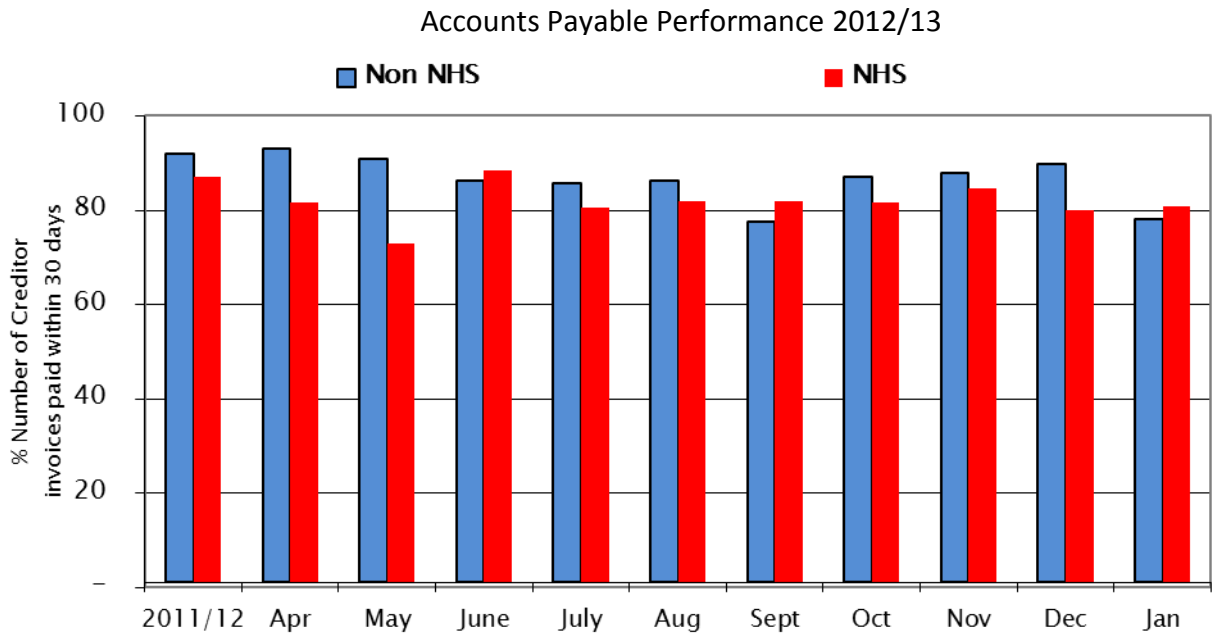
Cash - The Trust held a cash balance of £32.816m as at 31st January. The graph, shown below, sets out the current forecast for month end cash balances to March 2013. The lower cash balance is due primarily to the deliberate slippage in taking up the loans (£50m planned). £4.95m was taken up in January and a further £20m in will be drawn down in February / March.



Debtors - The total value of invoiced debtors has increased by £0.111m during January to a closing balance of £14.543m. The total amount owing is equivalent to 10.3 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In January the Trust achieved 81% and 78% compliance against the Better Payment Practice Code for NHS and Non NHS creditors. Staffing issues and a push to resolve long standing queries has led to disappointing results in recent months. An improvement is expected next month.



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

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report January 2013- Summary Income & Expenditure Statement

Approved Budget / Plan 2012/13	Heading		Position as at 31st January Plan	Actual	Variance Fav / (Adv)	Actual to 31st December	Forecast Outturn
£'000			£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)						
415,150	From Activities		348,518	345,128	(3,390)	308,982	413,552
111,858	Other Operating Income		93,271	94,649	1,378	84,639	113,728
527,008	Sub totals income		**441,789**	**439,777**	**(2,012)**	**393,621**	**527,280**
	Expenditure						
(305,987)	Staffing		(255,096)	(259,935)	(4,839)	(233,357)	(311,658)
(177,699)	Supplies and services		(150,035)	(151,987)	(1,952)	(134,924)	(181,465)
(483,685)	Sub totals expenditure		**(405,131)**	**(411,922)**	**(6,791)**	**(368,281)**	**(493,123)**
(7,914)	**Reserves**	Reserves	(6,933)	-	6,933	-	-
(7,914)		Sub Total Reserves	**(6,933)**	-	**6,933**	**-**	**-**
35,409	**EBITDA**		**29,725**	**27,855**	**(1,870)**	**25,340**	**34,157**
6.72	**EBITDA Margin - %**			**6.33**		**6.44**	**6.48**
(300)	Fixed asset impairments		-	-	-	-	(300)
(521)	Reserves		(896)	-	896	-	-
350	Profit/ loss on sale of asset		350	367	17	(8)	465
(19,451)	Depreciation & Amortisation		(16,209)	(15,652)	557	(14,048)	(18,784)
226	Interest Receivable		188	189	1	177	226
(387)	Interest payable on leases		(322)	(322)	-	(290)	(387)
(75)	Interest payable on loans		(2)	(2)	-	-	(75)
(9,551)	PDC Dividend		(7,959)	(8,021)	(62)	(7,201)	(9,602)
5,700	**NET SURPLUS / (DEFICIT)**		**4,875**	**4,414**	**(461)**	**3,970**	**5,700**

Appendix 2

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report January 2013- Divisional Income & Expenditure Statement

Approved Budget / Plan 2012/13	Division	Total Net Expenditure / Income to Date	Position as at 31st January [Favourable / (Adverse)] Pay	Non Pay	Operating Income	Income from Activities	Total Variance to date	Memorandum CRES Variance to Date	Cumulative Variance to 31st December	Forecast outturn
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
403,354	Service Agreements	337,632	–	–	132	(132)	–	–	–	
1,437	Overheads	1,746	–	–	–	309	309	–	965	
39,708	NHSE Income	33,174	–	–	15	–	15	–	13	
444,499	**Sub Total Service Agreements**	**372,552**	**–**	**–**	**147**	**177**	**324**	**–**	**978**	**–**
	Clinical Divisions									
(42,944)	Diagnostic & Therapies	(35,457)	(275)	262	243	(169)	61	(62)	167	250
(58,283)	Medicine	(50,164)	(1,476)	(823)	414	421	(1,464)	(863)	(1,309)	(1,440)
(65,372)	Specialised Services	(55,795)	(1,005)	(180)	231	(285)	(1,239)	(868)	(1,000)	(1,255)
(87,296)	Surgery Head & Neck	(77,062)	(2,263)	(746)	234	(1,992)	(4,767)	(3,328)	(4,552)	(5,959)
(87,465)	Women's & Children's	(74,754)	(706)	114	36	(1,447)	(2,003)	(305)	(1,886)	(1,891)
(341,360)	**Sub Totals (1)**	**(293,232)**	**(5,725)**	**(1,373)**	**1,158**	**(3,472)**	**(9,412)**	**(5,428)**	**(8,580)**	**(10,295)**
	Corporate Services									
(6,340)	Trust Hq	(5,110)	246	(258)	63	–	51	(13)	40	80
(5,265)	Human Resources	(4,156)	192	(135)	(41)	–	16	(3)	18	15
(7,117)	Imt	(5,875)	275	(213)	(17)	–	45	1	40	50
(5,004)	Finance	(4,168)	80	(14)	(40)	–	26	15	23	30
(33,322)	Facilities And Estates	(28,699)	26	16	(11)	(23)	8	(106)	(31)	20
(44)	Community	(17)	–	20	–	–	20	–	18	24
(7,458)	Misc Support Services	(8,070)	68	(90)	22	(72)	(72)	(207)	(100)	(63)
(29,002)	Capital Charges	(23,673)	–	496	–	–	496	–	502	–
4,921	Research & Innovation	4,846	45	67	82	–	194	–	90	195
(88,631)	**Sub Totals (2)**	**(74,922)**	**932**	**(111)**	**58**	**(95)**	**784**	**(312)**	**600**	**351**
(429,991)	**Sub Totals (1) and (2)**	**(368,154)**	**(4,793)**	**(1,484)**	**1,216**	**(3,567)**	**(8,628)**	**(5,740)**	**(7,980)**	**(9,944)**
0	**Skills for Health**	16	**(46)**	47	15	–	16		8	
(429,991)	**Totals I & E**	**(368,138)**	**(4,839)**	**(1,437)**	**1,231**	**(3,567)**	**(8,612)**	**(5,740)**	**(7,972)**	**(9,944)**
	Reserves									
(8,808)	General	–	–	7,827	–	–	7,827		6,502	9,944
(8,808)	**Sub Total Reserves**	**–**	**–**	**7,827**	**–**	**–**	**7,827**		**6,502**	**9,944**
5,700	**TRUST TOTALS**	**4,414**	**(4,839)**	**6,390**	**1,378**	**(3,390)**	**(461)**	**(5,740)**	**(492)**	**–**

Appendix 3

Analysis of pay spend 2011/12 and 2012/13

Division		2011/12					2012/13									2011/12
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Q1 £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Jan £'000	Total £'000	Mthly Average £'000	Mthly Average £'000
Women's and Children's	Pay budget	16,638	16,716	16,901	17,553	67,808	17,196	17,384	5,915	5,903	5,950	17,768	5,980	58,328	5,833	5,651
	Bank	496	524	521	514	2,055	575	620	147	160	141	448	106	1,749	175	171
	Agency	182	128	162	315	786	322	375	131	103	97	331	219	1,247	125	66
	Waiting List initiative	73	42	16	27	158	25	36	29	8	8	45	11	117	12	13
	Overtime	14	11	7	12	45	13	9	3	4	5	12	5	39	4	4
	Other pay	16,219	16,274	16,333	16,736	65,562	16,630	16,634	5,674	5,606	5,715	16,995	5,624	55,883	5,588	5,464
	Total Pay expenditure	16,984	16,979	17,039	17,604	68,606	17,565	17,674	5,984	5,880	5,967	17,831	5,965	59,035	5,903	5,717
	Variance Fav / (Adverse)	(346)	(263)	(138)	(51)	(798)	(369)	(290)	(69)	22	(16)	(63)	15	(707)	(71)	(66)
Medicine	Pay budget	11,034	10,900	10,938	11,340	44,213	11,154	10,850	3,603	3,662	3,704	10,968	3,731	36,702	3,670	3,684
	Bank	845	758	689	775	3,067	874	939	250	294	281	826	214	2,853	285	256
	Agency	157	141	113	309	720	155	231	97	144	113	354	308	1,048	105	60
	Waiting List initiative	30	4	26	43	103	28	37	13	5	4	22	26	113	11	9
	Overtime	25	15	16	15	70	16	19	9	5	5	19	7	61	6	6
	Other pay	10,318	10,094	10,041	10,162	40,616	10,238	10,194	3,384	3,428	3,407	10,219	3,452	34,103	3,410	3,385
	Total Pay expenditure	11,375	11,012	10,884	11,305	44,576	11,311	11,419	3,754	3,876	3,810	11,441	4,007	38,178	3,818	3,715
	Variance Fav / (Adverse)	(341)	(111)	54	36	(363)	(158)	(570)	(151)	(214)	(107)	(472)	(276)	(1,476)	(148)	(30)
Surgery Head and Neck	Pay budget	16,416	16,947	17,045	17,710	68,118	16,705	17,125	5,839	5,745	5,827	17,411	5,795	57,036	5,704	5,676
	Bank	450	525	497	497	1,969	528	627	186	188	178	553	127	1,836	184	164
	Agency	121	95	175	189	580	183	410	9	35	80	123	22	738	74	48
	Waiting List initiative	304	50	220	140	714	66	286	91	144	81	316	163	831	83	60
	Overtime	22	35	40	46	142	43	40	14	9	9	32	11	127	13	12
	Other pay	15,784	16,096	15,921	16,682	64,482	16,612	16,762	5,513	5,557	5,606	16,675	5,718	55,767	5,577	5,374
	Total Pay expenditure	16,681	16,801	16,853	17,554	67,888	17,432	18,126	5,813	5,934	5,954	17,700	6,041	59,300	5,930	5,657
	Variance Fav / (Adverse)	(265)	146	192	157	230	(727)	(1,001)	26	(188)	(127)	(289)	(246)	(2,263)	(226)	19
Specialised Services	Pay budget	8,635	8,613	8,641	9,456	35,345	8,664	8,816	2,946	2,943	3,219	9,107	3,014	29,602	2,960	2,945
	Bank	230	265	241	208	945	208	293	127	102	84	312	69	882	88	79
	Agency	243	293	245	382	1,163	165	210	67	126	179	372	144	891	89	97
	Waiting List initiative	138	86	127	72	423	93	62	38	10	22	70	27	252	25	35
	Overtime	3	4	6	14	27	9	8	8	10	10	29	9	55	6	2
	Other pay	8,283	8,362	8,219	9,212	34,077	8,417	8,546	2,880	2,803	3,040	8,723	2,841	28,527	2,853	2,840
	Total Pay expenditure	8,897	9,011	8,839	9,888	36,635	8,892	9,120	3,120	3,051	3,334	9,505	3,090	30,607	3,061	3,053
	Variance Fav / (Adverse)	(262)	(398)	(198)	(432)	(1,290)	(228)	(304)	(175)	(108)	(115)	(398)	(76)	(1,005)	(101)	(108)

Appendix 3

Analysis of pay spend 2011/12 and 2012/13

Division		2011/12					2012/13									2011/12
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Q1 £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Jan £'000	Total £'000	Mthly Average £'000	Mthly Average £'000
Diagnostic & Therapies	Pay budget	9,121	9,280	9,371	9,487	37,259	9,538	9,267	3,266	3,252	3,170	9,688	3,178	31,670	3,167	3,105
	Bank	144	108	129	130	510	109	106	22	31	28	82	25	321	32	43
	Agency	73	46	63	101	284	52	105	43	31	16	90	13	260	26	24
	Waiting List initiative	37	27	28	41	133	43	28	34	4	4	42	19	132	13	11
	Overtime	68	49	67	96	280	77	69	21	21	22	64	21	231	23	23
	Other pay	8,915	9,029	8,965	8,954	35,863	9,240	9,174	3,080	3,119	3,125	9,324	3,262	31,001	3,100	2,989
	Total Pay expenditure	9,237	9,258	9,253	9,322	37,070	9,522	9,482	3,201	3,206	3,195	9,602	3,340	31,945	3,195	3,089
	Variance Fav / (Adverse)	(116)	22	119	165	189	16	(215)	65	46	(25)	86	(162)	(275)	(27)	16
Facilities & Estates	Pay budget	4,657	4,807	4,655	4,874	18,993	4,626	4,713	1,569	1,584	1,537	4,691	1,504	15,534	1,553	1,583
	Bank	93	75	72	84	323	86	71	19	22	24	65	18	240	24	27
	Agency	351	380	312	364	1,407	329	322	98	97	85	280	81	1,012	101	117
	Waiting List initiative	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0
	Overtime	286	250	308	294	1,138	292	316	113	105	87	306	73	986	99	95
	Other pay	3,912	4,021	3,906	3,989	15,828	3,942	4,008	1,342	1,309	1,361	4,011	1,308	13,269	1,327	1,319
	Total Pay expenditure	4,644	4,726	4,598	4,730	18,699	4,648	4,717	1,572	1,533	1,557	4,662	1,480	15,507	1,551	1,558
	Variance Fav / (Adverse)	13	80	57	144	294	(22)	(4)	(3)	51	(20)	29	24	27	3	24
Trust Services	Pay budget	6,369	7,248	7,127	6,138	26,882	6,393	6,580	2,024	2,166	2,307	6,498	2,315	21,785	2,179	2,240
	Bank	115	157	(11)	13	275	(16)	(27)	300	51	56	408	44	409	41	23
	Agency	9	53	83	96	240	30	66	14	26	9	49	(87)	58	6	20
	Waiting List initiative	(1)	0	0	0	(1)	0	0	0	0	0	0	0	0	0	(0)
	Overtime	16	17	23	83	139	59	23	7	8	8	23	5	110	11	12
	Other pay	6,532	6,832	6,617	5,890	25,871	6,108	6,176	1,644	2,014	2,123	5,781	2,238	20,303	2,030	2,156
	Total Pay expenditure	6,671	7,059	6,711	6,083	26,524	6,180	6,238	1,966	2,099	2,196	6,261	2,200	20,880	2,088	2,210
	Variance Fav / (Adverse)	(302)	189	416	55	358	212	342	59	67	111	237	114	905	91	30
Trust Total (excl Skills for Health)	Pay budget	72,870	74,510	74,678	76,559	298,617	74,276	74,735	25,161	25,255	25,714	76,130	25,518	250,658	25,066	24,885
	Bank	2,373	2,413	2,137	2,221	9,144	2,364	2,630	1,052	848	794	2,693	603	8,290	829	762
	Agency	1,136	1,136	1,154	1,755	5,181	1,237	1,719	460	562	578	1,600	699	5,255	525	432
	Waiting List initiative	583	209	417	323	1,532	255	449	205	171	119	495	246	1,445	145	128
	Overtime	434	380	466	560	1,841	509	485	177	162	146	485	132	1,610	161	153
	Other pay	69,963	70,708	70,003	71,626	282,299	71,186	71,494	23,517	23,836	24,376	71,728	24,443	238,851	23,885	23,525
	Total Pay expenditure	74,489	74,845	74,177	76,486	299,997	75,551	76,776	25,410	25,579	26,013	77,001	26,123	255,451	25,545	25,000
	Variance Fav / (Adverse)	(1,619)	(335)	502	73	(1,380)	(1,275)	(2,042)	(249)	(324)	(299)	(871)	(605)	(4,793)	(479)	(115)

Key Issue	RAG	Executive Summary	Table
Service Level Agreement Income and Activity	G	Activity was higher than plan in January leading to an over-performance of £0.25m. This is partially offset by a net reduction in the receivable sum for contract rewards of £0.61m. On accumulative basis the under performance on clinical activity of £0.34m is offset by the net gain from SLA Contract Penalties / Rewards (£1.65m) and the balance of the 2011/12 over-performance of £1.07m. A&E Attendances at 93,398 are 2,939 **lower** than planned. The average number of daily attendances is 305. Emergency activity at 30,054 is 4.4% or 1,384 spells **lower** than planned. Non Elective activity at 17,102 is 4% or 656 spells **higher** than planned. Elective activity at 12,781 is 1.3% or 162 spells **higher** than per Plan. Day case activity at 42,106 is 1.6% or 682 spells **higher** than planned. Outpatient Procedure activity at 30,494 is 31.4% or 7,285 attendances **higher** than planned. New Outpatients activity at 118,999 is 0.3% or 368 attendances **higher** than planned. Follow up Outpatient activity at 250,669 is 11.8% or 33,687 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 10 months to 31st January is £4.414m. This is £0.461m adverse to Plan. The EBITDA surplus of £27.855m equates to 93.7% of the Annual Plan target for the period. Total income to date of £439.777m is £2.012m less than Plan. This includes a proportion (10/12ths) of the residual over performance relating to 2012/13 at £1.07m. Expenditure at £411.922m is less than Plan by £0.142m. Financing costs are lower than Plan by £1.409m.	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 ten months to 31st January total £17,914m, a shortfall of £5.173m (December £4.597m) against divisional plans. The 1/12th phasing adjustment adds a further £0.567m to the total cumulative shortfall to date of £5.740m. The forecast outturn is for savings to total £21.969m of which £2.706m is non-recurring.	Agenda Item 5.4
Statement of Financial Position and Treasury Management	G	The cash balance on 31st January was £32.816m. This is £1.05m lower than the figure forecast last month. The principal factor is actual cash being less than forecast is the delay in the receipt of moneys for services provided by Skills for Health – now expected in February and March. The year-end cash balance is forecast to be £33.6m. The balance on Invoiced Debtors has increased by £111k in the month to £14.543m. The invoiced debtor balance equates to 10.3 debtor days. Creditors and accrual account balances total £74.480m although £7.658m relates to deferred income. Invoiced Creditors - payment performance for the year to date for Non NHS invoices and NHS invoices within 30 days was 86% and 81% respectively.	Agenda Item 7 BS 1 BS 2 BS 3 BS 4
Capital	A	Expenditure for the ten months to 31st January totals £44.749m - this is £5.039m less than profiled for the period. The significant variances reflect slippage on Strategic Schemes (£4.051m), Medical Equipment (£0.154m) and Operational Capital (£0.591m). [*Reclassified from Green to Amber rating in light of in month slippage of £2.78m.]*	Agenda Item 6
Financial Risk Rating	A	The Trust's overall financial risk rating using the results for the ten months to 31st January has been calculated to be 3 (actual score 2.90). The Trust's ratings under the Prudential Borrowing Code are satisfactory with all ratios well within the Monitor thresholds. [*Reclassified from Green to Amber rating in light of change in risk rating to 2.9]*	Agenda Item 5.1 App 6

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

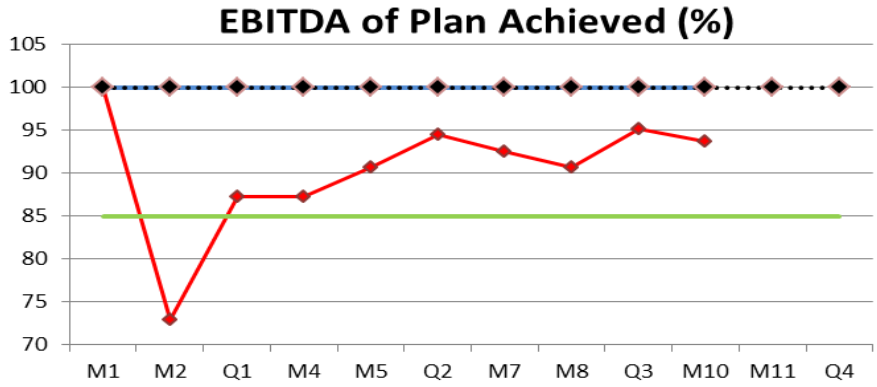
Finance Report January 2013 - Risk Matrix

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	6.0	CRES acheieved to 78% of Plan to 31st January. The forecast outturn CRES is projected to be £21.969m ie £5.653m less than Plan.
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.
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 – January 2013 Performance

1. Financial Risk Rating

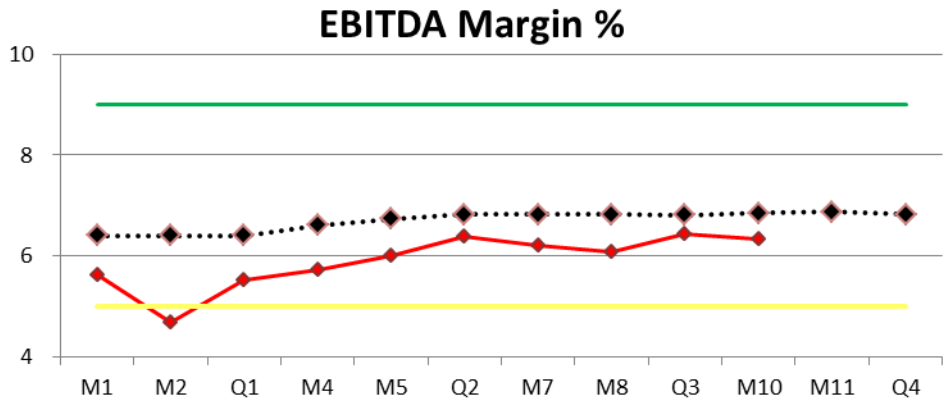
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2012/13 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 5 (blue line)**; **FRR 4 (green line)** and **FRR 3 (yellow line)**.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

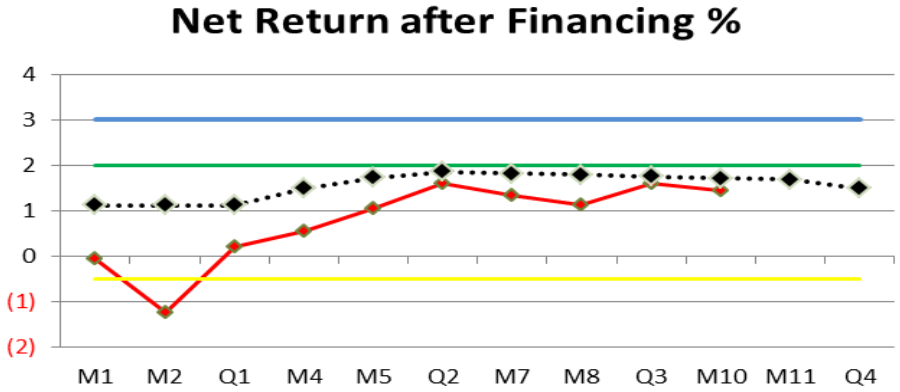


An EBITDA of £27.855m was achieved. This equates to 93.7% of the Annual Plan projection of £29.725m.

EBITDA Achievement of 93.7% of Plan earns a metric score of 4.

The EBITDA Margin of 6.34% for the 10 months to January achieves a metric score of 3. This is less than the Annual Plan forecast of 6.85% to date.



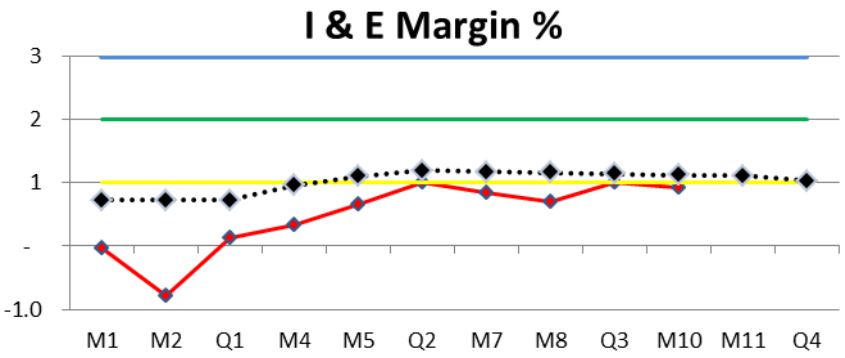


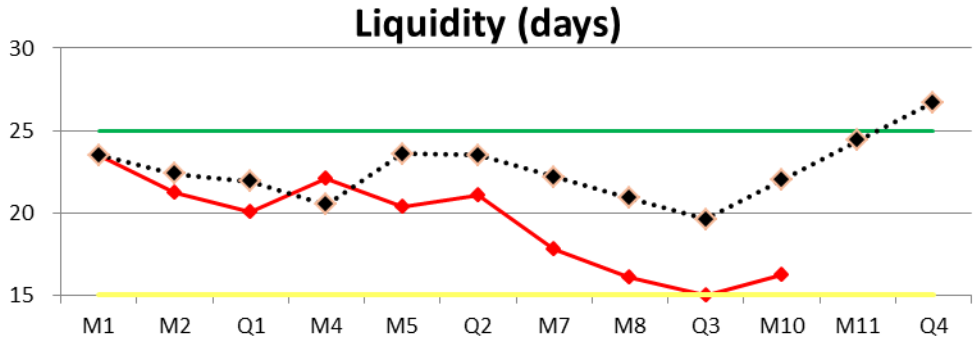
The Net Return on Financing for the 10 months is 1.46%. The result earns a metric score of 3.

Annual Plan = 1.72% to date.

The 2012/13 Annual Plan Income and Expenditure surplus margin is 1.12% to date.

The Income and Expenditure surplus margin for the period is 0.92%, a metric score of 2.





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

The actual liquidity ratio for January is 16.2 days, a metric score of 3.

The Trust's Financial Risk Rating is calculated by using a weighted average score to determine the overall rating. The weighted average score is 2.90. The Trust has therefore achieved a Financial Risk Rating of 3 for the ten months to 31st January.

2. Prudential Borrowing Limit

A summary of the Trust's performance for January 2013 is given in the table below.

Prudential Borrowing Limit Performance	Monitor Ratio Tier 1	31st January 2013	Annual Plan - March 2013	Projection – March 2013
Minimum Dividend Cover	>1x	3.5x	3.6x	3.5x
Minimum Interest Cover	>3x	86x	25x	74x
Minimum Debt Service Cover	>2x	58x	22x	53x
Maximum Debt Service to Revenue	<2.5%	0.11%	0.31%	0.12%

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

University Hospitals Bristol NHS
NHS Foundation Trust

Report for the Public Trust Board Meeting, to be held on 28 February 2013 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08 – Annual Review of Board Risk Management Strategy

Purpose

To brief the Board on the status of the Trust Risk Management Strategy.

Abstract

The Trust Board of Directors approved the Risk Management Strategy on 19 March 2012 following a review by the Board of its risk appetite. Supporting risk management policies and protocols were consequently re-developed in accordance with the Board's revised risk strategy.

As recommended in the Hathaway Action Plan, the Trust has recruited a Risk Manager to advise and support the Board in further developing the Risk Management Strategy and establishing the Board's risk attitude/ appetite/ tolerance and supporting systems of risk management.

The Trust Risk manager was appointed with effect from 02 January 2013, and will be providing recommendations regarding any revisions to risk procedural documents to the Risk Management Group in April 2013.

No changes to the current approved Risk Management Strategy are recommended at this point.

Recommendations

The Board is recommended to **note** the process and timetable for reviewing the Risk Management Strategy, and to **approve** the carrying forward of the current strategy until such time as revisions are recommended by the Risk Management Group.

Executive Report Sponsor & Other Author

- Sponsor: Chief Executive
- Author: Trust Secretary