University Hospitals Bristol NHS
NHS Foundation Trust

PUBLIC BOARD MEETING

Date:	Monday 30 June 2014	
Time:	10.30 am – 13.00	
Venue:	Conference Room, Trust Headquarters	
Distribution		
Chair:	John Savage	Trust Chairman
Committee Members:	David Armstrong	Non-executive Director
	Kelvin Blake	Non-executive Director
	Julian Dennis	Non-executive Director
	Lisa Gardner	Non-executive Director
	John Moore	Non-executive Director
	Guy Orpen	Non-executive Director
	Alison Ryan	Non-executive Director
	Emma Woollett	Non-executive Director
	Jill Youds	Non-executive Director
	Robert Woolley	Chief Executive
	Sue Donaldson	Director of Workforce and Organisational Development
	Deborah Lee	Director of Strategic Development and Deputy Chief Executive
	Paul Mapson	Director of Finance and Information
	Carolyn Mills	Chief Nurse
	Sean O'Kelly	Medical Director
	James Rimmer	Chief Operating Officer
In attendance:	Julie Dawes	Interim Trust Secretary
	Pauline Holt	Management Assistant to Trust Secretary (Minutes)
Apologies:	David Armstrong	Non-executive Director
	John Moore	Non-executive Director
	Members of	Council of Governors
Copy for Information:	Heather Ancient*	PwC – External Auditor
	Aidan Fowler	NHS Fast Track Executive Director
	Penny Hilton	NHS Fast Track Executive Director
	Jenny McCall*	Audit South West – Internal Auditor

*Agenda and Minutes only

Contact for apologies or any enquiries concerning this meeting should be made to:

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University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

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1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	5
3. Minutes from Previous Meetings To consider the Minutes of a Public Meeting of the Trust Board of Directors dated 28 May 2014 for **approval.**	Chairman	6
4. Matters Arising To review the status of actions agreed for **assurance.**	Chairman	17
5. Chief Executive's Report To receive this report from the Chief Executive to **note.**	Chief Executive	19
Delivering Best Care		
6. Patient Experience Story To receive the Patient Experience Story for **review.**	Chief Nurse	21
7. Quality and Performance Report To receive the Quality and Performance Report for **assurance.** a. Performance Overview – Director of Strategic Development b. Quality & Outcomes Committee Chair's Report c. Board Review – Quality, Workforce, Access.	Director of Strategic Development and Deputy Chief Executive	23
8. Francis Report – Implementation of Action Plan To receive this report from the Medical Director for **assurance**.	Medical Director	103
9. Patient Experience Quarterly Report To receive this report from the Medical Director for **assurance.**	Chief Nurse	109

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18. Strategic Objectives 2014-15 To receive this report by the Director of Strategic Development and Deputy Chief Executive for **approval.**	Director of Strategic Development and Deputy Chief Executive	288
Corporate Governance		
19. Board Corporate Governance Statement – Board self-certification of Compliance To receive this report by the Chief executive for **approval.**	Chief Executive	294
20. Monitor's Letter regarding University Hospital Bristol's performance in Quarter 4. To receive this report by the Chief Executive to **note.**	Chief Executive	309
21. Audit Committee Chair's Report To receive this verbal report from the Chair of the Audit Committee for **assurance.**	Audit Chair	
22. Standing Financial Instructions and Scheme of Delegation To receive this report by the Director of Finance and Information for **Approval**	Director of Finance and Information	313
23. Governors' Log of Communications To receive this report from the Chairman to **note.**	Chairman	404
24. Register of Seals To receive this report by the Trust Secretary to **note.**	Trust Secretary	410
Information and Other		
25. Any Other Business To note any other relevant matters (not for decision).	Chairman	
26. Date of Next Meeting: Public Trust Board meeting, 30 July 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

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10. Report on Staffing Levels for University Hospitals Bristol To receive this report from the Chief Nurse for **assurance.**	Chief Nurse	123
11. Emergency Preparedness Annual Report 2013/14 To receive this report from the Chief Operating Officer for **approval**.	Chief Operating Officer	133
12. Quarterly Patient Complaints Report To receive this report by the Chief Nurse for **assurance.**	Chief Nurse	153
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13. Finance Report To receive this report by the Director of Finance and Information for **assurance.**	Director of Finance and Information	176
14. Finance Committee Chair's Report To receive this verbal report by the Chair of the Finance Committee for **assurance.**	Director of Finance and Information	
15. Medium Term Capital Programme To receive this report by the Director of Finance and Information for **approval.**	Director of Finance and Information	186
Renewing our Hospitals		
16. Estates Strategy 2020 To receive this report by the Director of Strategic Development and Deputy Chief Executive for **approval.**	Director of Strategic Development and Deputy Chief Executive	195
Leading in Partnership		
17. Monitor Five Year Strategic Plan (2014-19) To receive this report by the Director of Strategic Development and Deputy Chief Executive for **approval.**	Director of Strategic Development and Deputy Chief Executive	225

Name	Title	Interest Role	Interest Organisation	Remunerated	First Declaration Date	Last Update
Armstrong, David	Non-executive Director	Director	Chartered Quality Institute	Y	14/04/2014	
Blake, Kelvin	Non-executive Director	Programme Director	BT	Y	21/04/2011	14/04/2014
Blake, Kelvin	Non-executive Director	Board Member	BT South West	Y	21/04/2011	14/04/2014
Blake, Kelvin	Non-executive Director	Trustee	Spinal Injuries Association	N	21/04/2011	19/04/2012
Blake, Kelvin	Non-executive Director	Trustee	Vassall Centre Trust	N	21/04/2011	17/05/2013
Blake, Kelvin	Non-executive Director	Governor	Knowle West Childrens Centre	N	21/04/2011	20/03/2012
Blake, Kelvin	Non-executive Director	Board Member	Bristol Cultural Development Partnership	N	10/11/2011	17/05/2013
Blake, Kelvin	Non-executive Director	Trustee	Knowle West Media Centre	N	19/04/2012	19/04/2012
Dennis, Julian	Non-executive Director	Visiting Professor	Visiting Professor, University of Bath: Water Science and Engineering	Y	14/04/2014	
Donaldson, Sue		None	Nil		14/04/2014	
Gardner, Lisa	Non-executive Director	Director	Watershed Arts Trust	N	20/03/2012	14/04/2014
Gardner, Lisa	Non-executive Director	Shareholder, Associate	Richard Bunker & Company Limited Chartered Accountants	Y	20/03/2012	17/04/2013
Gardner, Lisa	Non-executive Director	Director	Watershed Trading Limited	N	17/04/2013	17/04/2013
Gardner, Lisa	Non-executive Director	Interim Director of Finance	Above and Beyond (Charitable Trust UH Bristol)	Y	14/04/2014	
Lee, Deborah	Director of Strategic Development	None	None	N	05/04/2011	14/04/2014
Mapson, Paul	Director of Finance	None	None	N	05/04/2011	14/04/2014
Mills, Carolyn	Chief Nurse	None	Nil		14/04/2014	
Moore, John	Non-executive Director	Management Consultant	ReAlignment Limited.	Y	08/04/2011	17/05/2013
Moore, John	Non-executive Director	Director	Carbotech Wheels GmbH, (Salzburg)	Y	08/04/2011	04/09/2012
Moore, John	Non-executive Director	Trustee	Bristol Community Family Trust.	N	08/04/2011	04/09/2012
O'Kelly, Sean	Medical Director	None	None.	N	16/04/2012	14/04/2014
Orpen, Guy	Non-executive Director	None	Employee of the University of Bristol - Member of the Senior Management Team at the University of Bristol as Pro Vice Chancellor for Research and Enterprise.	Y	06/09/2012	14/04/2014
Rimmer, James	Chief Operating Officer	None	None	N	14/07/2011	14/04/2014
Ryan, Alison	Non-executive Director	CEO	CEO - Weldmar Hospicecare Trust Director - Weldmar Hospicecare Enterprises Ltd Director - Weldmar Hospicecare Trading Ltd	Y	15/04/2014	
Savage, John	Chairman	Executive President	GWE Business West	Y	13/04/2011	05/09/2012
Savage, John	Chairman	Board Member	South West Regional Development Agency	Y	13/04/2011	05/09/2012
Savage, John	Chairman	Chairman	South West Regional Skills Forum	N	13/04/2011	18/04/2013
Savage, John	Chairman	Chairman	Destination Bristol	N	13/04/2011	14/04/2014
Savage, John	Chairman	Chairman	The Churches Council for Industrial and Social Responsibility	N	13/04/2011	18/04/2013
Savage, John	Chairman	Financial Director	Bristol Cultural Development Partnership Limited	N	13/04/2011	14/04/2014
Savage, John	Chairman	Board Member	South West Chambers of Commerce Limited	N	13/04/2011	14/04/2014
Savage, John	Chairman	Secretary and Treasurer	Bristol Society	N	13/04/2011	05/09/2012
Savage, John	Chairman	Chairman	The Station (My Place - Youth Centre Development)	N	13/04/2011	18/04/2013
Savage, John	Chairman	Executive Chairman	Bristol Chamber of Commerce and Initiative	Y	05/09/2012	14/04/2014
Savage, John	Chairman	Chairman	Learning Partnership West	N	05/09/2012	14/04/2014
Savage, John	Chairman	Vice Chairman	Wessex Water Customer Scrutiny Group	N	05/09/2012	18/04/2013
Savage, John	Chairman	Vice Chairman	Bristol Water Customer Scrutiny Group	N	05/09/2012	18/04/2013
Savage, John	Chairman	Trustee	The Creative Youth Network	N	05/09/2012	18/04/2013
Savage, John	Chairman	Director	Price Associates Limited	Y	05/09/2012	14/04/2014
Savage, John	Chairman	Chairman	The Bristol Initiative Charitable Trust	N	14/04/2014	
Savage, John	Chairman	Lay Canon	Bristol Cathedral Chapter	N	14/04/2014	
Savage, John	Chairman	Patron	Bristol Refugee Rights	N	14/04/2014	
Woollett, Emma	Non-executive Director (Vice Chair)	Management Consultant	Woollett Consulting	Y	11/04/2011	14/04/2014
Woollett, Emma	Non-executive Director (Vice Chair)	Trustee	Above and Beyond	N	11/04/2011	12/04/2013
Woollett, Emma	Non-executive Director (Vice Chair)	Management Consultant	KPMG for South CSU		22/11/2013	14/04/2014
Woolley, Robert	Chief Executive	Advisory Group Member	Science City Bristol	N	06/04/2011	18/04/2012
Woolley, Robert	Chief Executive	Advisory Group Member	Common Purpose Bristol	N	06/04/2011	24/09/2012
Woolley, Robert	Chief Executive	Board Member	Health Education South West – Board Member of the Governing Body (appointed 1 September 2013 for a period of three years	N	16/09/2013	14/04/2014
Woolley, Robert	Chief Executive	Director	West of England AHSN Ltd	N	14/04/2014	
Youds, Jill	Non-executive Director	Non-Executive Director	Hoople Ltd	Y	01/01/2014	02/06/2014
Youds, Jill	Non-executive Director	Managing Director	Cresco Business Solutions Ltd	Y	10/06/2013	02/06/2014
Youds, Jill	Non-executive Director	Executive Director	Senior HR Leaders EMEA Forum, Executive Networks	Y	05/12/2013	02/06/2014

Unconfirmed MINUTES of a Public Meeting of the Trust Board of Directors held on 28 May 2014 at 10:30 in The Conference Room, Trust Head Quarters, Marlborough Street, BS1 3NU

Board Members Present

- John Savage – Chairman
- Robert Woolley – Chief Executive
- Paul Mapson – Director of Finance & Information
- Carolyn Mills – Chief Nurse
- Sean O'Kelly – Medical Director
- James Rimmer – Chief Operating Officer
- Sue Donaldson – Director of Workforce and Organisational Development
- Lisa Gardner – Non-executive Director
- Kelvin Blake – Non-executive Director
- Guy Orpen – Non-executive Director
- Alison Ryan – Non-executive Director
- Iain Fairbairn – Non-executive Director
- David Armstrong – Non-executive Director
- John Moore – Non-executive Director
- Julian Dennis – Non-executive Observer
- Jill Youds – Non-executive Observer

Others in Attendance

- Julie Dawes – Interim Trust Secretary
- Xanthe Whittaker – Head of Performance Assurance & Business Intelligence/ Deputy Director of Strategic Development
- Sue Silvey – Public governor (Lead governor)
- Mo Schiller – Public governor
- Anne Ford – Public governor
- Clive Hamilton – Public governor
- Brenda Rowe – Public governor
- John Steeds – Patient governor
- Anne Skinner – Patient governor
- Pam Yabsley – Patient governor
- Peter Holt – Patient governor
- Wendy Gregory – Patient governor
- Sue Milestone – Patient governor
- Florene Jordan – Staff governor
- Marc Griffiths – Appointed governor
- Jeanette Jones – Appointed governor
- Kaj Kamalanathan, Locum Consultant
- Alistair Johnstone, Locum Consultant
- Bob Skinner, Foundation Trust member
- Sarah Murch – Membership PA/Administrator (minutes)

Item	*Action*
1. Chairman's Introduction and Apologies The Chairman called the meeting to order. He extended a particular welcome to Julie Dawes, who had this month joined the Trust as Interim Trust Secretary, replacing Charlie Helps. He said farewell to Iain Fairbairn, whose term of office as Non-executive Director would end on 31 May 2014. He recorded the Board's gratitude and thanks for everything Iain had done for the Trust. Apologies had been received from Deborah Lee and Emma Woollett.	

2. Declarations of Interest

In accordance with Trust Standing Orders, all Board members (including observers) present were required to declare any conflicts of interest with items on the Meeting Agenda.

No declarations of interests were received.

3. Minutes and Actions from Previous Meeting

The Board considered the Minutes of the meeting of the Trust Board of Directors dated 28 April 2014 and **approved** them as an accurate record.

Actions:

Action 221: Histopathology Services update. *The Chief Executive reported that work was continuing and that there was no further update to give at this stage.*

Actions 263 and 277: Patient Experience stories. *The Chief Executive reported that the Board had discussed at a recent Board Development Seminar its intentions around hearing from patients about their experiences. It was noted that whist today's Patient Experience Story was in the traditional style, the Executive Team were currently exploring ways providing more direct feedback from patients at future meetings.*

Action 267: Performance recovery plan for patient access standards, and how this should be reported to Monitor*. The Chief Executive reported that the Board had already approved in the Trust's Annual Plan declaration its forward risks in 2014/15 regarding its achievement of the 4-hour A&E target, the 62-day cancer target and the 18-week Referral-to-treatment time target. The performance recovery paper had been in this regard entirely consistent. However, he took on board the point that had been made about expressing the Trust's determination to meet these standards to Monitor. Item closed.*

Action 273, 274 and 278: Organisational learning and recording actions from meetings. *The Chief Executive confirmed that the Board and the Executive had discussed these three actions and he emphasised that they were committed to learning and demonstrating their learning in an effective way. He asked for the assistance of all Board members in being clear about their conclusions and actions at the end of any discussions. These items were closed.*

Action 282: Funding flow for the National Institute of Health Research Clinical Research Network. *The Chief Executive reported that further details would be brought back in due course to the Audit Committee as requested.*

Action 218: National Cancer Survey and Action Plan – recruitment update. *The Chief Nurse reported progress on the recruitment of a melanoma nurse specialist. The post had been approved, and had been advertised three times, but had not been appointed to yet. The post would sit across the Divisions of Medicine (Dermatology) and Specialised Services (Oncology).*

Actions 279 and 281: Infection Control reporting. *The Chief Nurse would report back on these actions to the June Board meeting.*

Action 280: Infection Control: change in cleaning score. *The Chief Nurse reported that a paper had now been approved by the Service Delivery Group and the Infection Control Committee. The Trust would be aligning its cleaning standards against the national*

specifications for cleanliness, and she advised that the aims for the risk categories would have an impact on the RAG Rating. More detail would be provided in the next Infection Control report to the Board. ***Action 158: Report on Staff Engagement.*** *The Director of Workforce and Organisational Development had provided a paper on staff engagement for today's meeting. Item closed.* ***Action 161: Workforce planning.*** *The Director of Workforce and Organisational Development confirmed that strategy and planning would be discussed at the July Board Development Seminar.* **Matters Arising** Referring to Action 263, Jill Youds, Non-executive Observer, reiterated that she would still like to receive a response from the Executive Team about the culture of empathy throughout the organisation. The Chief Executive agreed that a proposal would be presented at a future Board meeting about how the Board could best address patient experience and issues associated with compassionate care. He added that the Trust had agreed to bring in a senior executive from the retail industry who had been placed with the Trust from the NHS Leadership Academy, and who would work specifically on this agenda. *There were no further Matters Arising.*	(Action 263)
4. Chief Executive's Report *The Chief Executive provided the Board with updates on the following matters:* 1. The Chief Executive congratulated North Bristol Trust on the official opening of the Brunel Building at Southmead Hospital this month. He was pleased that UH Bristol had been able to offer support through the very significant changes, particularly through the transfer of Emergency Department services on 19 May. 2. Also during the month, UH Bristol had successfully transferred specialist paediatrics from Frenchay Hospital into new and remodelled facilities in the Bristol Children's Hospital, which was now officially designated as the main paediatric trauma centre for the South West. The helideck had become operational and had been used for emergency transfers of patients. Redevelopment work was continuing, and the Trust could expect handover of Level 5 of the new ward block on Terrell Street at the end of June. The Chief Executive was pleased to report that an Office of Government Commerce Gateway review around the state of readiness on the Trust's capital scheme had been rated 'Green' and that it was therefore proceeding well. 3. With reference to the proposed review of children's congenital heart services in Bristol to be overseen by Sir Ian Kennedy, the Chief Executive reported that draft Terms of Reference had been sent by NHS England to the concerned families. Feedback would be received next week, after which a formal announcement would follow. He would inform staff and governors accordingly. 4. The Trust hosted a visit last week from the New Congenital Heart Disease Review team. This was a national review undertaken by NHS England following the demise of the Safe and Sustainable Review into children's heart surgery, and the new review looked at children's and adults' services together. The team visited the Trust's facilities and discussed services provided with staff, directors, governors, patients and families. They	Action 294 Action 295

would report back in due course, and the Chief Executive would keep the Board updated.

5. The Trust's celebrations for Nurses Day on 7 May had included a very inspiring talk from Dame Claire Bertschinger. The Chief Executive congratulated the award-winners. There had also been successful celebrations for Clinical Trials Day last week featuring talks from leading clinicians and research-themed events. The Trust's pharmacy service was among the finalists for the Health Service Journal award for improving safety in medicines. The Chief Executive also reported that CHKS, which supplied the Trust with clinical benchmarking services, had rated the Trust for another year running as one of their top 40 hospitals.

The Chief Executive invited questions. In reference to the Kennedy review of children's congenital heart services, Guy Orpen, Non-executive Director, asked that those present take note of the Board's commitment to supporting the staff in paediatric cardiac surgery. While the Board would of course co-operate with the review and be frank with the public, it also had an absolute requirement to sustain the quality of the service, and implicit in that was the morale of the staff. The Chief Executive echoed these sentiments.

There being no further questions the Chief Executive concluded his report.

Delivering Best Care

5. Patient Experience Story

The Board received and reviewed this report from the Chief Nurse.

Carolyn Mills, Chief Nurse, directed the Board to the key issues contained in the story. It had been a complimentary story that had been posted on the Trust's website by a member of staff who had been very impressed with the care that her young child had received while attending the Emergency Department at Bristol Children's Hospital and after having been admitted to hospital.

The Chairman welcomed the story, adding that while the Patient Experience Story at the Public Trust Board meeting generally focussed on areas in which there had been problems, it was useful on occasion to be reminded that the Trust actually received much more positive feedback than complaints.

There being no further questions the Chair drew this item to a close.

6. Quality and Performance Report

The Board received and reviewed the Quality and Performance Report.

Quality and Outcomes Committee Chair's Report

Alison Ryan, Chair of the Quality and Outcomes Committee, reported that whilst it was acknowledged that the Committee had sought assurance on whether the Risk Register was sufficiently up-to-date, assurance was provided by the Executive Team that further work in conjunction with the Audit Committee was still required to ensure that the two committees were properly aligned in order to oversee the Trust's risk management assurance process.

The Committee had also enquired about the Trust's processes for identifying serious incidents, and had received assurance that staff knew when and how to report serious

incidents and that the process was audited.

In a discussion about the Quality and Performance Report, the Committee specifically emphasised that its focus on meeting targets for Clostridium difficile and 62-day cancer waits was due to the impact of these on patients, rather than because they were on the Monitor framework. The Committee had welcomed signs of improvement in many areas, such as the fact that progress trajectories were now reported in the Access report.

The Committee had received the National Inpatient Survey and had also received a detailed report on Workforce which had been very useful. The Committee had also looked in some detail at the learning points in a report on Serious Untoward Incidents, though these had appeared to be mainly isolated incidents with little common learning.

Finally, the Committee had reviewed the current cycle of reports received by the committee and had identified a number omissions, in particular for issues regarding external partners. It was noted that the Terms of Reference were in the process of being reviewed by the Committee and would be submitted to the Board in due course for the required approval.

Performance Overview

Xanthe Whittaker, Head of Performance Assurance & Business Intelligence/ Deputy Director of Strategic Development reported that the overall health of the organisation had stayed broadly similar to that reported last month. Following reductions in the level of patient complaints and hospital acquired pressure sores, six of the seven indicators of patient experience, quality of care and clinical effectiveness were now GREEN rated. This reflected the sustained improvements seen across a range of quality indicators in recent months including falls, pressure sores and antibiotic prescribing compliance, for which further details were provided in the exception reports contained in the Quality & Performance Report.

The length of stay of patients discharged in the month increased in April. This was primarily due to more long stay patients being discharged in the period. Importantly though, there were fewer long stay patients in hospital at month-end than reported in the previous three months. Although the improvement in this, and other measures of patient flow, had translated into better performance against the A&E 4-hour maximum waiting time standard, the 95% national standard was narrowly missed in April. It was confirmed that the Referral to Treatment Time (RTT) Non-admitted and 62-day GP cancer standards were currently on track with our recovery trajectory.

Xanthe reported that the Trust had an overall score against Monitor's Risk Assessment Framework of 3.0. This would equate to a GREEN rating, in the absence of the repeat failures of two standards for which Monitor had requested further information. The standards failed for the quarter to date were the A&E 4-hour standard, the RTT Non-admitted standard and the 62-day cancer standards.

The number of Clostridium difficile cases was currently above the internally set target for the month, and was following the seasonal trends seen in previous years. However, at present the number of reported cases was below the centrally set limit of 10 cases for the quarter, and below Monitor's minimum reporting level of 12 cases. Work was continuing, nonetheless, to identify the causes of any cases deemed on further investigation to be avoidable, in order to put preventative measures in place where possible. This included ongoing work with Commissioners and the community to try to reduce the number of

patients coming into hospital with Clostridium difficile.

Board Review

Kelvin Blake, Non-executive Director, noted that the Trust was making good progress regarding care of the elderly and dementia care, but he appealed for greater compassion to be evident in the action plan. Carolyn Mills responded that, while the Exception Report necessarily comprised a very clear set of actions, she did not believe that there was any evidence that staff were not compassionate in this area. Robert Woolley pointed to the Trust Values, adding that perhaps the Board needed to be able to describe how it was seeking to influence the culture of the organisation and set the expectations for the type of care that staff should provide.

John Moore, Non-executive Director, welcomed the news that there were fewer long stay patients in hospital at month-end, and enquired whether this was due to relationships with external bodies being established or whether it was a seasonal effect. James Rimmer responded that there was new structural behaviour, and in particular there were two key factors, the Green to Go list, and the Long Length of Stay list, both of which were showing improvement, but that it was too early to say whether they were fully embedded. In response to an additional question by John Moore, James added that there was an improved relationship with Bristol City Council's Social Care, particularly through the Breaking the Cycle initiative, and that the data showed a significant improvement, but again, he would caution that the improvements were not yet fully embedded.

Jill Youds, Non-executive Observer, welcomed the impressive set of actions around dementia, and also wished to commend the staff on Ward 7 for their very pro-active approach to dealing with falls.

Guy Orpen enquired whether the Quality and Outcomes Committee would also be reviewing performance indicators that were not required by Monitor, but which were very useful, for example, the Green To Go list, and Alison replied that it would.

With reference to the Workforce statistics, Lisa Gardner, Chair of the Finance Committee, reported that the Finance Committee had discussed numbers of staff and overage, particularly in Medicine. She observed that, while nursing staff were being recruited to 120% in order to provide cover for those going off sick, it had come to light that in the event that a member of staff was off sick, cover was still being drafted in from Bank and Agency. Sue Donaldson confirmed that the Executive team were aware of this, and were working with the Divisions to reduce the historical reliance on temporary staff as substantive staff numbers are increased.

Action 296

Clive Hamilton, Public Governor, referred to the Serious Incident Themes report, and particular the two serious drug incidents that had resulted in major and moderate harm. He voiced his concern and asked when the outcome of these inquiries would be known. Sean O'Kelly, Medical Director, confirmed that investigations were underway and, once complete, the investigation reports would be considered by the Patient Safety Group and Clinical Quality Group to make sure that those groups for the appropriate action. Alison Ryan confirmed that the Quality and Outcomes Committee would also receive these reports and seek the necessary assurance. The Chairman assured those present that the Trust was very mindful that they were not just dealing with incidents and signing them off, but that they were concerned with the patient's journey and their final outcome.

Anne Skinner, Patient Governor, wished to pass on some positive feedback from ward interviews on Wards 22-23 that she had taken part in. She had observed excellent care and she praised the nurses and the general atmosphere. She enquired whether all staff training covered dementia issues, and Carolyn Mills confirmed that it was covered in Corporate Induction for all members of staff, with a greater level of detail for those who required it.

There being no further questions the Chair drew this item to a close.

7. National Staff Survey Results and Action Plan

The Board received and noted this report from the Director of Workforce and Organisational Development.

The Director of Workforce and Organisational Development, Sue Donaldson, introduced the item by explaining that the summary paper on the 2013 National Staff Survey Results was an overview of a more detailed discussion that had taken place in the Quality and Outcomes Committee in April. There had also been other discussions in committees across the Trust which were ongoing, including in the Senior Leadership Team, the Transformation Board, and with Staff Side representatives. The paper had been informed by the work of Michael West (Professor of Organisational Psychology at Lancaster University Management School, Visiting Fellow at the King's Fund and author of '*Quality and Safety in the NHS: Evaluating progress, problems and promise'*). The overall programme of work was largely a cultural change programme rather than an immediate fix to a few problems, although as it was recognised that cultural change took time, some early priorities were being established.

She wished to highlight in particular that the Trust recognised that there was a significant link between staff engagement and patient experience. It was intended to explore this link in more depth using additional resources that had been made available through the Fast Track Executive Programme. She asked the Board to support the programme of work.

Jill Youds, Non-executive Observer, welcomed the report's understanding of the clear connection between staff experience and patient experience. She sought clarification from the Chief Executive as to the general level of commitment around the broader Senior Leadership Team to this agenda. The Chief Executive gave assurance that the entire Senior Leadership Team was fully committed to it.

With reference to the report's table setting out the overall trends in the findings relating to UH Bristol and the staff survey over the last five years, John Steeds, Public Governor, observed that staff experience appeared to be declining across the board, and commented that the issues raised appeared the same as they had been a year previously.

Marc Griffiths, Appointed Governor, welcomed the report, particularly in relation to work-related stress and wellbeing. He too, was keen to see that the work would have the commitment and support of the Senior Leadership Team to ensure that it was carried out.

Alison Ryan, Non-executive Director, reminded those present that the line management lower down had the biggest impact on front-line staff. She assured members that the Quality and Outcomes Committee recognised that staff issues were the key to getting patient care right; however, the tension arose in the need to achieve a balance between the immediate unremitting clinical pressures of patient care, and the investment in time that was

required to develop competencies and reduce stress.

Kelvin Blake, Non-executive Director, felt that a sense of urgency was required. It was entirely unsurprising, he commented, that NHS staff felt beleaguered, given the lack of pay increases, the financial constraints that they were working under, the increasingly complex nature of their activity, and the significant changes being made to the health service. However, he cautioned that this should not be used as an excuse not to fix what could be fixed at UH Bristol.

In response to a question from John Moore, Non-executive Director, about increasing the sample size, Sue Donaldson affirmed that this year's annual staff survey would be distributed to all members of staff.

There being no further questions the Chair drew this item to a close, adding that the Board fully welcomed and supported this programme of work and looked forward to seeing the results.

8. National Inpatient Survey

The Board received and noted the report from the Chief Nurse.

Carolyn Mills, Chief Nurse, explained that this paper provided a summary of the Trust's performance in the Care Quality Commission's 2013 National Inpatient Survey of patients' views about their care. It was noted that the Trust was rated average in terms of performance around patients, with 59 out of 60 scores classed as being 'about the same as most other Trusts'. However, she explained that the aim was to be ahead of the game, and to this end, the Trust was engaging in benchmarking and learning from other Trusts. She confirmed that no UH Bristol scores had been classed as being 'better than most other trusts', but one score had been classified as being 'worse than most other trusts': whether patients were given sufficient privacy in the Emergency Department. The team in the Emergency Department was currently looking into this.

Carolyn explained that the next step was to pull together the actions linking them with other work. Alison Ryan added that the national survey had been discussed at the Quality and Outcomes Committee meeting on 27 May, and they found it helpful to look at the report in the context of the Trust's own local patient surveys. It had been noted that it did not seem very representative of the demographics of the community served by the Trust.

The Board received and noted the report. There being no further questions the Chair drew this item to a close.

9. Implications of National Quality Board Guidance – Guidance to nurse, midwifery and care staffing – Capacity and Capability.

The Board received and noted this report from the Chief Nurse.

Carolyn Mills, Chief Nurse, explained that this paper had been provided for information. It set out the Trust's response to the National Quality Board Guidance published last October. There were 10 expectations around actions that the Trust needed to take in relation to ensuring robust and safe staffing levels. She highlight three areas in particular which must be delivered by June 2014:

- The Public Trust Board would receive a 6-monthly report detailing and evaluating its

staff capacity and capability. This would come to the June Board meeting. • Displayed on noticeboards outside each ward would be details of planned and actual numbers of staff for each shift and the number of patients on the ward. Pictures of uniforms would also appear on the boards to clarify the different roles. • A committee of the Board would receive on a monthly basis a detailed report around numbers of staff expected to work and numbers actually worked, to be published in the public domain. Guy Orpen, Non-executive Director, asked that the opportunity be taken to update noticeboards to address other issues, such as informing patients how to give feedback on quality of service, or how to raise complaints (both areas in which the Trust scored poorly in the CQC's 2013 National Inpatient Survey). Carolyn agreed to look into this, adding that it would be helpful to have governors' views on the kind of information that could usefully be provided on ward noticeboards. *There being no further questions the Chair noted the report and drew this item to a close.*	Action 297 Action 298
Delivering Best Value	
10. Finance Report *The Board received and reviewed this report from the Director of Finance and Information.* Paul Mapson, Director of Finance and Information, reported that the first month's results showed a deficit of £0.193m (before technical items), representing an adverse variance of £0.7m against plan. It was reported that there has been an underperformance on income and an underperformance on savings. This was largely due to a shortfall in operating plans, and the Trust was therefore working on delivering more savings to improve this. He added that underachievement early in the year was normal, as savings plans were not phased equally, and some of the increase in activity built into the Trust's contracts would not be seen until later in the year. It was noted that there were a few issues in cost control which the Trust was trying to address, particularly the use of temporary staff. He also reported that the Trust was still failing a continuity of service rating as there was very good liquidity, it was slightly behind on its capital programme but there was no scheme slippage, and the Trust was working on clearing some of its older debts. *There being no further questions the Chair drew this item to a close.*	
11. Finance Committee Chair's Report *The Board received and reviewed this report from the Chair of the Finance Committee.* Lisa Gardner, Chair of the Finance Committee, reported that the Committee had registered their concern that the Trust still did not have a balanced Operating Plan. It was noted that the divisions were expected to submit their revised plans to the Executive Team in June 2014, The Committee reviewed in detail the updated Financial Plan, including management of the 2014/15 position and mitigating the known risks. The Committee also considered the changes required to the Capital Investment Policy. They	

could report that there were no significant issues with it, and recommended its approval.

The Committee reviewed the annual accounts and commended the Finance Team for delivering such a clean set of accounts with no significant issues. The Committee had recommended that Annual Accounts to the Audit Committee held on 27 May 2014 and also the Board for approval

It was noted that the Committee had received a report regarding how the reference costs were calculated and had confirmed that they were satisfied with the Trust's costing processes and systems.

The Chair invited questions or comments on the Finance Report.

Marc Griffiths, Appointed Governor, sought assurance that the Board had anticipated that the model of income for students used by HE South West would be changing and Paul Mapson and Lisa Gardner confirmed that they had anticipated this risk.

In response to a question from John Moore, Non-executive Director, about whether Month 1 results were difficult to report accurately, Paul Mapson responded that the processes were far better than they used to be, though the results for Month 2 would be more informative about the direction the Trust was going.

In response to a question from Clive Hamilton, Public Governor, about what special measures had been adopted to deal with poor savings performance in Surgery Head and Neck, Paul Mapson responded that there was a plan. He added that the operating model needed to be seen in context, and that the plan of Patient Flow was key to this.

There being no further questions the Chair drew this item to a close.

12. Capital Investment Policy 2014/15

The Board received this report from the Director of Finance and Information.

Paul Mapson, Director of Finance and Information, introduced this item, adding that he had tabled an extra paper that summarised the changes that were required to the Capital Investment Policy. He explained that the Policy was reviewed on a regular basis and would be followed by a review of the Standing Financial Instructions and Scheme of Delegation In June 2014. The Policy described what schemes would be referred to the Board, and what would be described as high risk investment under Monitor guidance. He explained that the approval thresholds were described, the financial criteria had been changed, and the weightings had been changed to tie in with how the Trust prioritised capital schemes. Monitor had also announced recently a change in the way reportable transactions were made to them in terms of high risk schemes.

*The Board **approved** the revised Capital Investment Policy.*

There being no further questions the Chair drew this item to a close.

Corporate Governance

13. Governor's Log of Communications

A report had been circulated of all recent questions asked by Governors through the

Governors' Log of Communications and responses from Executives that had received. The Chairman commented that Non-executive Directors had been reading the Log and were finding it useful. Wendy Gregory, Patient Governor, informed the Board that she had added two supplementary questions to her Log item since the report was printed, and she described her questions to the Board. She also suggested that each Executive response be circulated to all governors as soon as it was received, rather than just to the governor that originated the enquiry. John Savage reiterated his commitment to ensuring that governors' questions were answered formally through the Log procedure, through which the responses were available as a matter of record in the Log. *There being no further questions the Chair drew this item to a close.*	
14. Annual Review of the Directors' Interests *The Board received and noted this report.* It was noted that amendments were required to this report as several Non-executive Directors (Jill Youds, John Moore and Guy Orpen) had more information to add to their Directors' Interests. The Chairman reminded members that it was necessary to declare all current interests and asked Directors to be clear if one of their interests had a direct link to the Trust's work. *There being no further questions the Chair drew this item to a close.*	Action 299
Information and Other	
15. Any Other Business **Governor Elections:** The Chairman provided an update on the recent election results. On behalf of the Board he expressed his sincere gratitude and farewell to those governors who had ended their terms of office on 31 May 2014, and congratulated those who had been successfully re-elected. *There being no further business the Chair thanked everyone for attending and closed the meeting at 12:02.*	
16. Date of Next Meeting **Public Trust Board meeting:** 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol BS1 3NU.	

Action by	ID	Meeting Date	Public / Private	Minute number & title	Description (minute)	Action to be Taken	Date to Report Back	Action Taken
Chief Executive	221	28/11/2013	Public	10. Partnership Programme Board	The feasibility of options for further integrationof histopathology services, including, location and phasing timescales for physical integration were being discussed. Further information to be provided to the Board meeting in January 2014.	28/05/14 The Chief Executive reported that work was continuing and that there was no further update to give at this stage. 27/03/14 The Chief Executive – Partnership Programme Board. Histopathology Services – the Senior Leadership Team had received in March and supported a proposed model for the future configuration of cellular pathology services in Bristol and agreed what the next steps should be. A detailed financial appraisal and the seeking of clarity regarding the balance between a centralised laboratory and satellite services, would follow with update to the Board in due course 27/02/2014 Further progress not reported. 30/01/14 The Chief Executive advised that options were being considered with partners at North Bristol Trust, in fulfilling the one main outstanding recommendation in the Mishcon Inquiry report of 2010 (re the integration of the two cellular pathology departments in Bristol). He advised that the Joint Clinical Director had been leading that process – further information was expected	**30/06/2014**	
Chief Executive	263	27/03/2014	Public	Patient Experience Story	The Chief Executive concluded that the Board were pinpointing the need for the Executive to consider the application of empathy in a systematic and more visible way, considering the specific features of the organisation and its staff, communicating with families who have serious concerns or who are bereaved or about to be bereaved. He said that the executive would report back to the Board.	28/05/14 Jill Youds, Non-executive Observer, reiterated that she would still like to receive a response from the Executive Team about the culture of empathy throughout the organisation. The Chief Executive agreed that a proposal would be presented at a future Board meeting about how the Board could best address patient experience and issues associated with compassionate care. He added that the Trust had agreed to bring in a senior executive from the retail industry who had been placed with the Trust from the NHS Leadership Academy, and who would work specifically on this agenda. 27/03/14 Report back at future Board meeting	**30/06/2014**	
Chief Executive	282	28/04/2014	Public	10.3 National Institute for Health Research Clinical Research Network, West of	John Moore asked for further details of the flow of funding and asked to see the governance structure for the flow and for that of procurement, for the organisations that managed the funding.	28/05/14 The Chief Executive reported that further details would be brought back in due course to the Audit Committee as requested. The Chief Executive said that there was a case for describing to the Audit Committee at its next meeting how the Trust operated hosting across all the institutions that it was a host for	30/07/2014	
Chief Executive	294	28/05/2014	Public	4. Chief Executive's report	3.3 With reference to the proposed review of children's congenital heart services in Bristol to be overseen by Sir Ian Kennedy, the Chief Executive reported that draft Terms of Reference had been sent by NHS England to the concerned families. Feedback would be received next week, after which a formal announcement would follow. He would inform staff and governors accordingly.	Staff and governors to be informed.	**30/06/2014**	
Chief Executive	295	28/05/2014	Public	4. Chief Executive's Update	4.7 The Trust hosted a visit last week from the New Congenital Heart Disease Review team. This was a national review undertaken by NHS England following the demise of the Safe and Sustainable Review into children's heart surgery, and the new review looked at children's and adults' services together. The team visited the Trust's facilities and discussed services provided with staff, directors, governors, patients and families. They would report back in due course, and the Chief Executive would keep the Board updated.	Chief Executive to update the Board	**30/06/2014**	
Chief Nurse	218	28/11/2013	Public	6. National Cancer Survey & Action Plan	Wendy Gregory stressed the importance of Cancer Nurse Specialists and asked for reassurance that the lack of a nurse specialist for Melanoma would be addressed. Ruth Hendy advised that a strategy was being discussed by divisions for cross-working as people progressed on their pathways and would form part of divisional operating plan.	28/5/14 The Chief Nurse reported progress on the recruitment of a melanoma nurse specialist. The post had been approved, and had been advertised three times, but had not been appointed to yet. The post would sit across the Divisions of Medicine (Dermatology) and Specialised Services (Oncology). 28/11/13 Emma Woollett suggested an update to the Board be provided after six months.	**30/06/2014**	

Chief Nurse	277	28/04/2014 Public	6. Patient Experience Story	Carolyn Mills replied that there was a need to understand in what the format the Board required stories to be presented. She would work with teams to rectify the format of information and report back to the Board.	28/05/14 The Chief Executive reported that the Board had discussed at a recent Board Development Seminar its intentions around hearing from patients about their experiences. It was noted that whist today's Patient Experience Story was in the traditional style, the Executive Team were currently exploring ways providing more direct feedback from patients at future meetings. Carolyn would work with teams to rectify the format of information and report back to the Board.	**30/06/2014**
Chief Nurse	279	28/04/2014 Public	8. Infection Control Quarterly Report	Lisa Gardner asked for clarification regarding some of the targets contained in the Infection Control report. Deborah Lee replied that thought needed to be put as to how to draw the Board's attention to the salient points.	28/05/14 The Chief Nurse would report back on these actions to the June Board meeting. Chief Nurse to discuss the production of future reports.	**30/06/2014**
Chief Nurse	280	28/04/2014 Public	6. Infection Control report	John Moore was pleased to see that the cleaning audit had been put in place and asked when it had been implemented. Carolyn Mills advised that the period had been about 6 weeks and the cleaning score was to be changed to align with national standards.	28/05/14 The Chief Nurse reported that a paper had now been approved by the Service Delivery Group and the Infection Control Committee. The Trust would be aligning its cleaning standards against the national specifications for cleanliness, and she advised that the aims for the risk categories would have an impact on the RAG Rating. More detail would be provided in the next Infection Control report to the Board. Further details to be provided at the next meeting.	**30/06/2014**
Chief Nurse	281	28/04/2014 Public	6. Infection Control Report	Jill Youds asked that the infection control training compliance be RAG rated.	28/05/14 The Chief Nurse would report back on these actions to the June Board meeting. Chief Nurse to discuss and advise	**30/06/2014**
Chief Nurse	297	28/05/2014 Public	Implications of National Quality Board Guidance – Guidance to nurse, midwifery and care staffing – Ca	The Public Trust Board would receive a 6-monthly report detailing and evaluating its staff capacity and capability. This would come to the June Board meeting.	Chief Nurse to advise date of first report	**30/06/2014**
Chief Nurse	298	28/05/2014 Public	Implications of National Quality Board Guidance – Guidance to nurse, midwifery and care staffing – Ca	Guy Orpen, Non-executive Director, asked that the opportunity be taken to update noticeboards to address other issues, such as informing patients how to give feedback on quality of service, or how to raise complaints (both areas in which the Trust scored poorly in the CQC's 2013 National Inpatient Survey). Carolyn agreed to look into this, adding that it would be helpful to have governors' views on the kind of information that could usefully be provided on ward noticeboards.	Carolyn to update to Board	**30/06/2014**
Director of Workforce and Organisational Development	161	27/06/2013 Public	5d - Quality and Performance Report - Board Review	John Moore referred to the Workforce report, requesting a greater understanding of the process by which the Trust planned its staff numbers. He particularly wanted to know how the Trust reconciled its increase in Bank and Agency spend with the focus on providing cost savings and high quality care. Claire Buchanan confirmed that she would provide a detailed summary of workforce planning as part of a future Board Seminar on the topic.	28/05/14 The Director of Workforce and Organisational Development confirmed that strategy and planning would be discussed at the July Board Development Seminar. Detailed summary of workforce planning to be provided at May 2014 Board Seminar.	**30/06/2014**
Director of Workforce and Organisational Development	296	28/05/2014 Public	6. Quality & Performance report	With reference to the Workforce statistics, Lisa Gardner, Chair of the Finance Committee, reported that the Finance Committee had discussed numbers of staff and overage, particularly in Medicine. She observed that, while nursing staff were being recruited to 120% in order to provide cover for those going off sick, it had come to light that in the event that a member of staff was off sick, cover was still being drafted in from Bank and Agency. Sue Donaldson confirmed that the Executive team were aware of this, and were working with the Divisions to reduce the historical reliance on temporary staff as substantive staff numbers are increased.	Sue Donaldson to give an update	**30/06/2014**
Trust Secretary	299	28/05/2014 Public	14.1Annual Review of the Directors' Interests	It was noted that amendments were required to this report as several Non-executive Directors (Jill Youds, John Moore and Guy Orpen) had more information to add to their Directors' Interests.	Trust Secretariat to update register.	**30/06/2014 Amendments made to Interests register**

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JUNE 2014

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in June 2014.

2. COMMUNICATIONS

The Senior Leadership Team **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. There continued to be significant performance issues in respect of accident and emergency 4-hour waits, 18 week Referral to Treatment times for Non-Admitted patients and Cancer standards. The weekly meetings to oversee recovery, chaired by the Chief Executive, continued.

4. STRATEGY AND BUSINESS PLANNING

The group received and **approved** the Monitor Strategic Plan subject to final edits and confirmed their support for the Declaration of Sustainability.

The group **noted** the action plan ahead of the Care Quality Commission inspection in September.

The group received and **approved** the Estates Strategy and specifically the development of two outline business cases, as next step in taking the strategy forward.

The group received and **approved** the service specification for the provision and operation of a catering outlet on Level 9 of the BRI, subject to changes reflecting its aspirations for a wide range of food for staff and visitors.

5. RISK, FINANCE AND GOVERNANCE

The group received and **noted** an update on the financial position.

The group received and **noted** an update on Essential Training compliance.

The group received and **approved** a capital pre-commitment for the BNSSG Connecting Care Stage Two Business Case.

The group received and **approved** the Future Outpatients Administration Model business case, and **supported** option 2 to recruit to new trust wide outpatient manager and deputy posts who will manage administration teams centralised within each clinical division.

The group **approved** the start date of consultation for the transfer of the South West Cleft Service to UH Bristol.

The group received and **noted** an update on Transforming Care, and the intention to run Breaking the Cycle Week Together initiative in the Children's Hospital in September, as well as an additional week in the BRI in August with a focus on quality.

The group **approved** the revised Performance Management Framework.

The group **approved** the Quarterly Patient Experience Report and the Quarterly Complaints Report.

The group **approved** the action plan for the arrangements for managing high-risk clinical environments and equipment, and **approved** a power outage review action plan.

The group **approved** staffing principles for setting nursing establishment in general areas.

The group **supported** the proposal to establish a workforce and organisational development group, and the Terms of Reference subject to a review of the membership.

The group **approved** the Board Assurance Framework report onward submission to the Trust Board.

The group **approved** the Emergency Planning and Resilience Response Annual Report, including the plan for 2014/15 and **approved** the Terms of Reference for the Civil Contingencies Committee, Business Continuity Planning Group and Major Incident Planning Group.

Reports from subsidiary management groups were **noted**.

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

6. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
June 2014

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

5. Patient Story

Purpose

To share with the Board members a patient story to support the triangulation of the Board's quality assurance role.

Abstract

Alison and Sue's Story

Context

Despite the significant reduction in healthcare associated infections they still occur too frequently, crating serious distress and hard for patients and their families as a result. In this short film Alison and Sue discuss their personal experiences of both an MRSA and C-difficile infection and the impressions of the healthcare services that they were left with as a result.

By way of setting a context to the Trust Board meeting the story underlines the importance of sustaining the quality-centred culture we promote at UH Bristol.

This is a third party patient story. With that in mind Trust Board is asked to consider:

- What does this story add to our understanding of the quality of services our patients and their families expect of us?

This film which was made in its original form in partnership with the NHS Institute for Innovation and Improvement, is now being used in a re-edited format by the National Institute for Clinical Excellence (NICE) as part of the Board Development Programme toolkit.

Recommendations

The Board is recommended to receive the report

Report Sponsor

Carolyn Mills – Chief Nurse
Tony Watkin PPI lead

Appendices

- Video

Alison and Sue's Story

Context

Despite the significant reduction in healthcare associated infections they still occur too frequently, creating serious distress and harm for patients and their families as a result. In this short film Alison and Sue discuss their personal experiences of both an MRSA and C-difficile infection and the impressions of healthcare services that they were left with as a result.

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University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

07 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 and actions that are being taken to restore performance.

Recommendations

The Board to receive the report for assurance.

Report Sponsor

'Overview' – Deborah Lee (Deputy Chief Executive/Director of Strategic Development)
'Quality' – Carolyn Mills (Chief Nurse) & Sean O'Kelly (Medical Director)
'Workforce' – Sue Donaldson (Director of Workforce & Organisational Development)
'Access' – James Rimmer (Chief Operating Officer)

Appendices

- Appendix A –

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

June 2014

CONTENTS

CONTENTS

SECTION A – Performance Overview

Summary

There was a slight improvement in the overall 'health' of the organisation relative to last month, with a decrease in RED rated indicators by one. The key changes in indicators this month include the number of hospital acquired pressure sores (grade 3 and 4) returning to RED rating. However, sustained improvements continue to be seen across a range of quality indicators including, overall falls and pressure ulcer incidence, medication errors and both Friends & Family Test coverage and scores. There has also been a further reduction in complaints, despite the continued challenges faced in improving access times against a backdrop of increasing patient complexity and demand for services.

Only one of the three measures of efficiency is now RED rated, with Theatre Productivity having improved to a GREEN rating in the period. The Outpatient Appointment Hospital Cancellation Rate has shown an improvement for the fourth successive month. The overall Length of Stay of patients discharged in the month decreased by 0.45 days relative to the previous month, but remains above the RED threshold. Positively, although the proportion of long stay patients being discharged in the month was slightly lower than previous months, there were still fewer patients in hospital that had stayed over 14 days by month-end, than seen in the previous five months. These improvements in patient flow continue to support improved performance against the A&E 4-hour maximum waiting time standard, although the 95% standard was again narrowly missed in the period.

Three of the four measures of financial performance remained GREEN rated in the period, with all four indicators showing an improvement on last month. The level of Savings achieved against plan remains below the RED threshold, reflecting delays in the divisional plans taking effect at this early stage in the year. The current performance against both measures of Delivering Our Contracts at present represent the potential for year-end achievement based upon current forecasts. This assessment will be reviewed and refined each month as performance to date is confirmed and further work to secure future achievement is undertaken. Staff sickness rates continue to be the focus of significant attention and have reduced again, although remain AMBER rated. The staff turn-over rate, reported for the first time as part of the Barometer, is also amber rated. Both indicators of the Trust's Research activities continue to be GREEN rated.

The Trust currently has a Service Performance score of 3.0 against Monitor's Risk Assessment Framework. This score reflects the failure to achieve the A&E 4-hour standard, Referral to Treatment Time (RTT) Non-admitted standard, and 62-day GP Cancer Standard for the quarter to date. Whilst the number of reported cases of *Clostridium difficile* is above the internally set target for the month and for this reason is presently considered at risk, it remains below the minimum reporting level set by Monitor and is expected to return to within target following an assessment of those which are not attributable to the Trust under new guidance. On the basis of the score alone the Trust would be rated GREEN. However, the failure to achieve the A&E 4-hour standard and RTT Non-admitted standards represent repeated failures which trigger governance concerns under the Risk Assessment Framework. For this reason Monitor has requested and received further information as to the causes of the failures of the standards, including the 62-day GP cancer standard, along with the Trust's

recovery plans and progress against these for the quarter to date. The Trust is expecting confirmation of the quarter 4 rating following Monitor's regional board meeting in July. This assessment will result in Monitor returning the Trust to its GREEN rating or pursuing further formal investigation.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
A01	Patient Experience Tracker Score	89	89	N/A	Green: >= 86 Red: < 85	→	Current month is April 2014. Green and Red thresholds raised gloing into 2014/15.
A02	Patient Complaints as a Proportion of Activity	0.238%	0.226%	0.232%	Green: <0.21% Red: >0.25%	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	0	0	Green: 0 Red> >0	→	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	0	1	1	Green: 0 Red: >= 1	↑	No RAG rating for YTD. Zero tolerance for Grade 3 or 4 Pressure Ulcers, so Red threshold changed from "greater than 1" to "greater than or equal to 1".
B02	Number of Inpatient Falls Per 1,000 Beddays	5.08	5.18	5.13	Green < 5.6 Red: >= 5.6	↑	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
C01	Number of Serious Incidents (SIs)	5	7	12		↑	
C02	Cumulative Number of C.Diff cases	5	9	9	Below Trajectory		

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	91.9%	91.8%	91.8%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	0	1	1	Green: 0 Red: >=2	↑	Previous is confirmed Q3. Current is confirmed Q4. YTD is Q1, Q2, Q3 and Q4.
D03	A&E 4 Hour Standard	94.5%	94.3%	94.4%	Green: >=95% Red: <95%	↓	

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
E01	Summary Hospital Mortality Indicator (SHMI) - In Hospital Deaths	60.9	59.8	59.8	Green: <65 Red: >=75	↓	Previous is March 2014 and Current is April 2014. Data now uses the "2013 Baseline" rather than the "2012 Baseline". Target thresholds have been changed to reflect benchmark performance
E02	30 Day Emergency Readmissions	313	289	289	Below 13/14 Readmission Rate	↓	Previous is March's discharges where there was an emergency Readmission within 30 days. Current is April's discharges. Threshold changed to be based on 2013/14 data.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
F01	Overall Length of Stay (Spell)	4.65	4.20	4.42	Green: <= Quarterly target 3.79 Red: >= Quartrely target 3.79	↓	The target for 2013/14 and 2014/15 for this overall indicator of Length of Stay has been derived from the Trust's bed model.
F03	Theatre Productivity - Percentage of Sessions Used	89.4%	90.6%	90.0%	Green: >= 90% Red: < 90%	↑	
F04	Outpatient appointment hospital cancellation rate	10.7%	9.5%	10.1%	Green: <=6.0% Red: >=10.7%	↓	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Turnover	11.1%	11.2%	11.2%	Green: < target Red: >=10% above target	↑	
G02	Staff Sickness	4.4%	3.8%	3.8%	Green: < target Red: >=0.5 percent pts above target	↓	Arrow indicates change in terms of variance from target.

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
H02	Cumulative Weighted Recruitment	7,273	10,361	10,361	Green: Above 2012 Red: Below 2012		Current (and YTD) is rolling Calendar YTD position. Previous is Jan-Feb 2014 and Current is Jan-Mar 2014
H03	Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment)	42.9%	52.0%	52.0%	Green: >=30% (Upper Quartile) Red: <27.7% (Median)	↑	Current is Q4 2012/13 – Q3 2013-14. Previous is Q3 2012/13 - Q2 2013/14. Updated Quarterly. No change from last month.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
J01	Monitor Governance Risk Rating	5	3	N/A	Green: < 4 Red: > = 4	↓	Previous shows the Q4 poisition. Current shows the current position in quarter 1 to date. Whilst the rating is currently GREEN, Monitor is undertakeing further investigations into the repeated failure against a number of standards.

Delivering Our Contracts

The Previous column represents Month 1. Current (and YTD) represents Month 2 2014/15.

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£9.68	£9.68	£9.68	> 50% Green < 50% Red	→	YTD and Current is Potential year-end rewards. Previous is Month 1. To date in 2014/15 no assessment of performance has been carried out. Assumption in monitoring data has been that plan=actual - to be updated when estimate of actual performance is known. Data is variance above (+) or below (-) plan, with a higher negative value representing better performance.YTD and Current is variance reported for May - The only penalty assessed in May is Readmissions, all others assumed on plan - to be updated when estimate of actual performance is known. Previous is variance reported in Month 1.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	-£0.01	-£0.01	-£0.01	Green: Below Plan Red: Above Plan	→	

Managing Our Finance

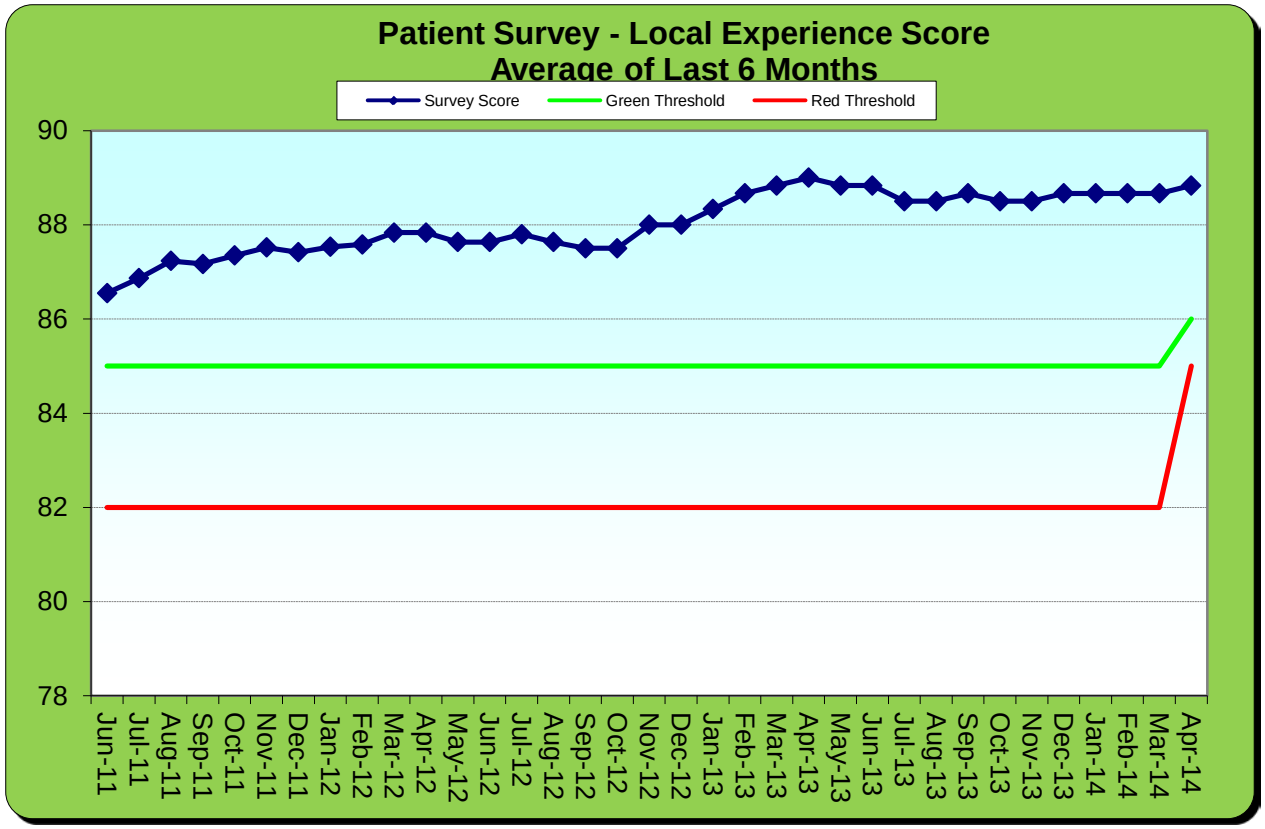
ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
L01	Monitor Continuity of Service	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	For financial measures except CRES, Current and YTD is Current Year To Date. For CRES there is a separate total for latest month and YTD. Previous is previous month's reported data.
L02	Liquidity	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	
L03	Capital Service Capacity	3.0	4.0	4.0	Green: >=3.0 Red: <2.5	↑	
L04	Savings plan achievement	64%	68%	66%	Green: >=90% Red: < 75%	↑	

Notes

Unless otherwise stated, Previous is April 2014 and Current is May 2014

YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2014 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.


Patient Survey - Local Experience Score
Average of Last 6 Months
Survey Score
Green Threshold
Red Threshold
90
88
86
84
82
80
78
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
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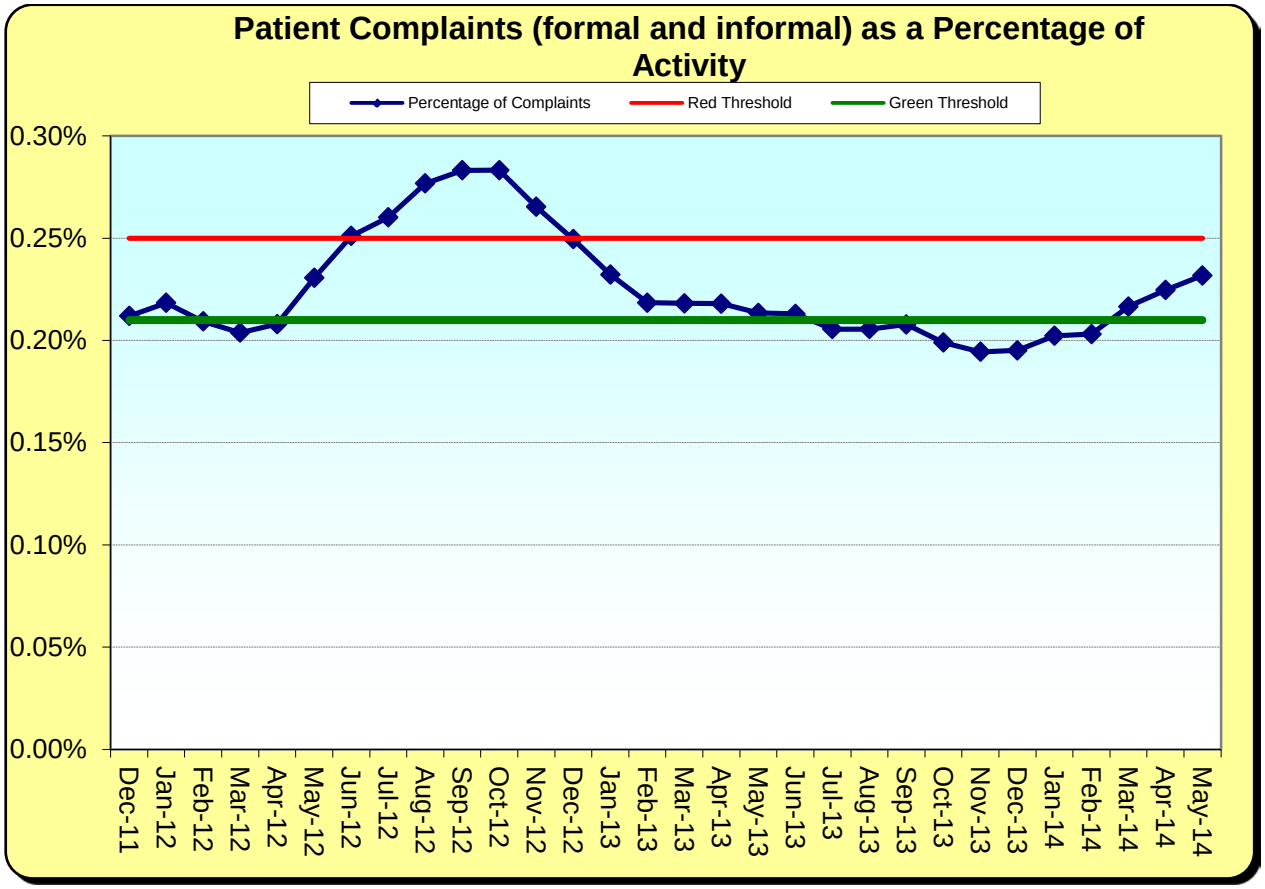
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14


Patient Complaints (formal and informal) as a Percentage of Activity
Percentage of Complaints
Red Threshold
Green Threshold
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
Dec-11
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
Feb-13
Mar-13
Apr-13
May-13
Jun-13
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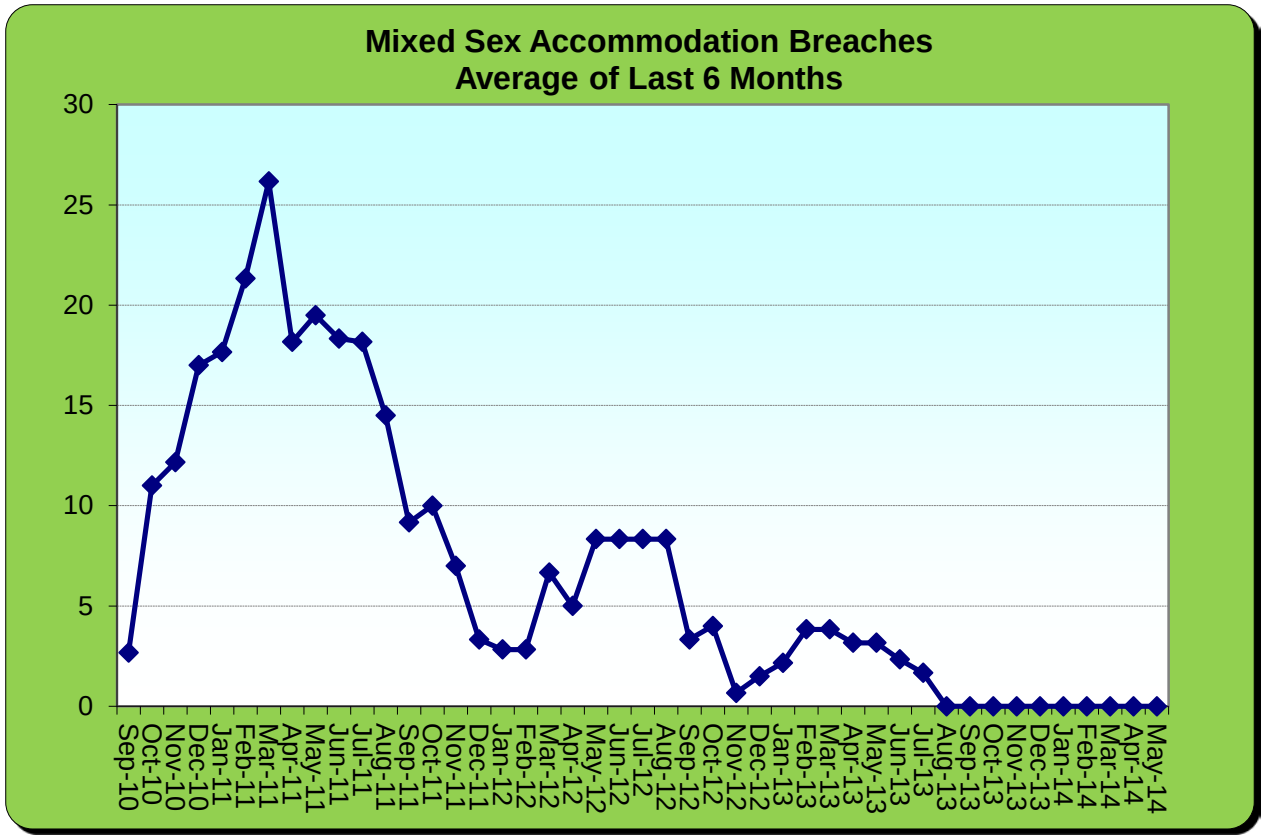
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14


Mixed Sex Accommodation Breaches
Average of Last 6 Months
30
25
20
15
10
5
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
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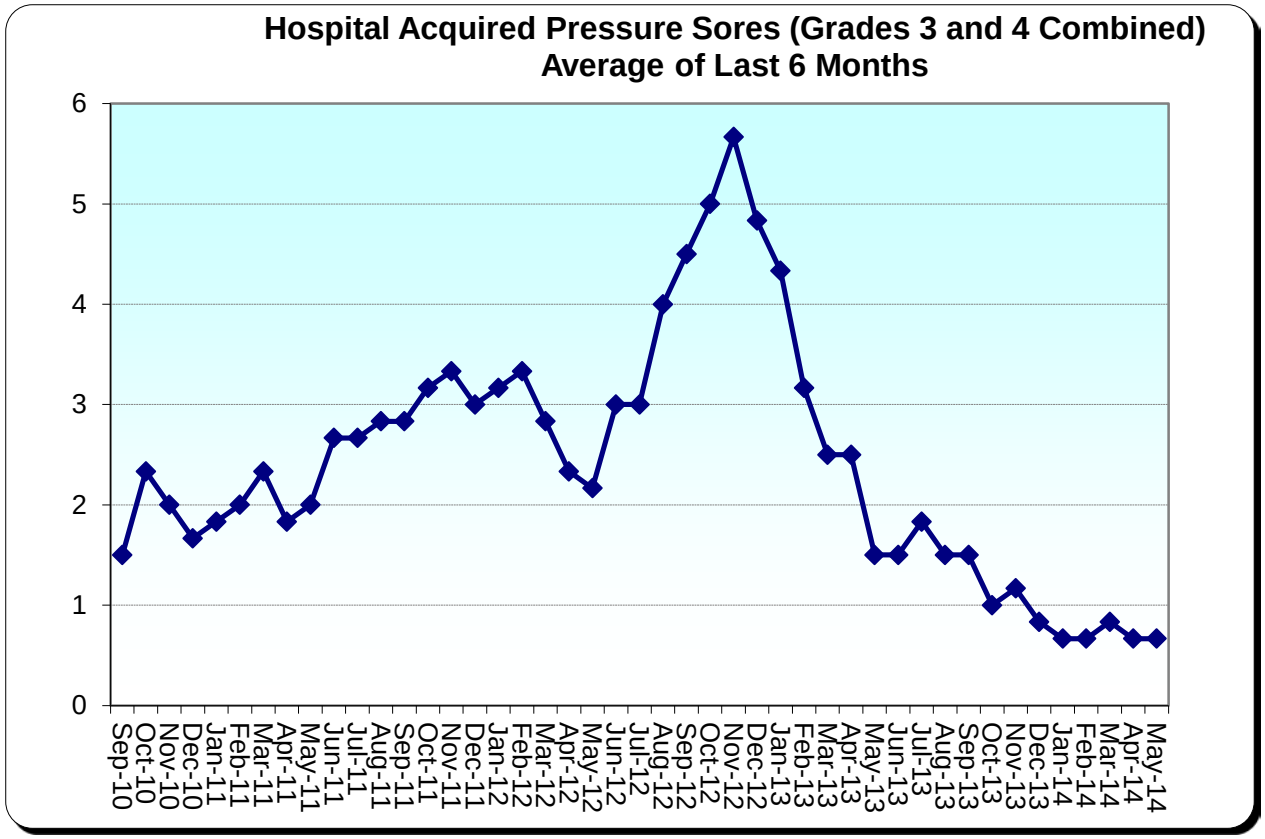
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14


Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Average of Last 6 Months
6
5
4
3
2
1
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
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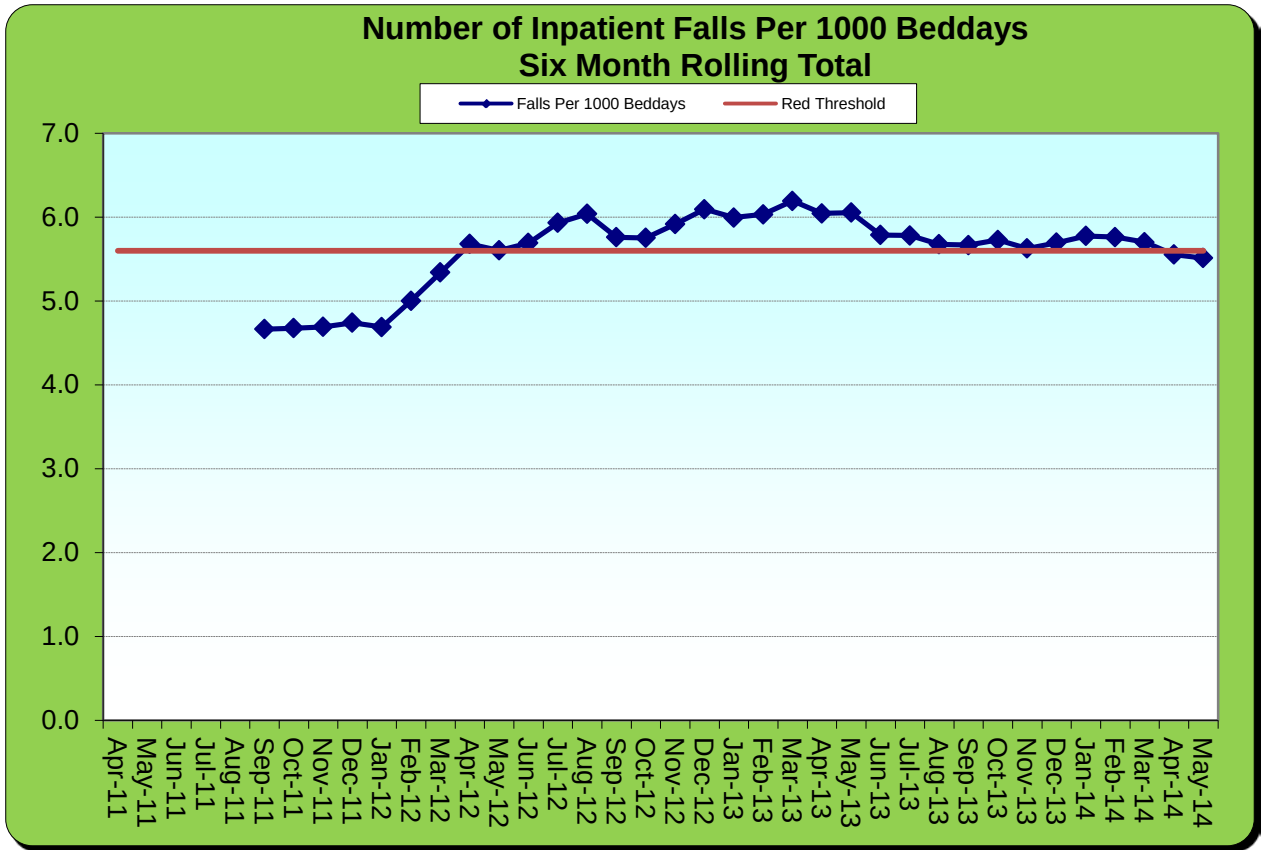
Jan-14
Feb-14
Mar-14
Apr-14
May-14


Number of Inpatient Falls Per 1000 Beddays
Six Month Rolling Total
Falls Per 1000 Beddays
Red Threshold
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
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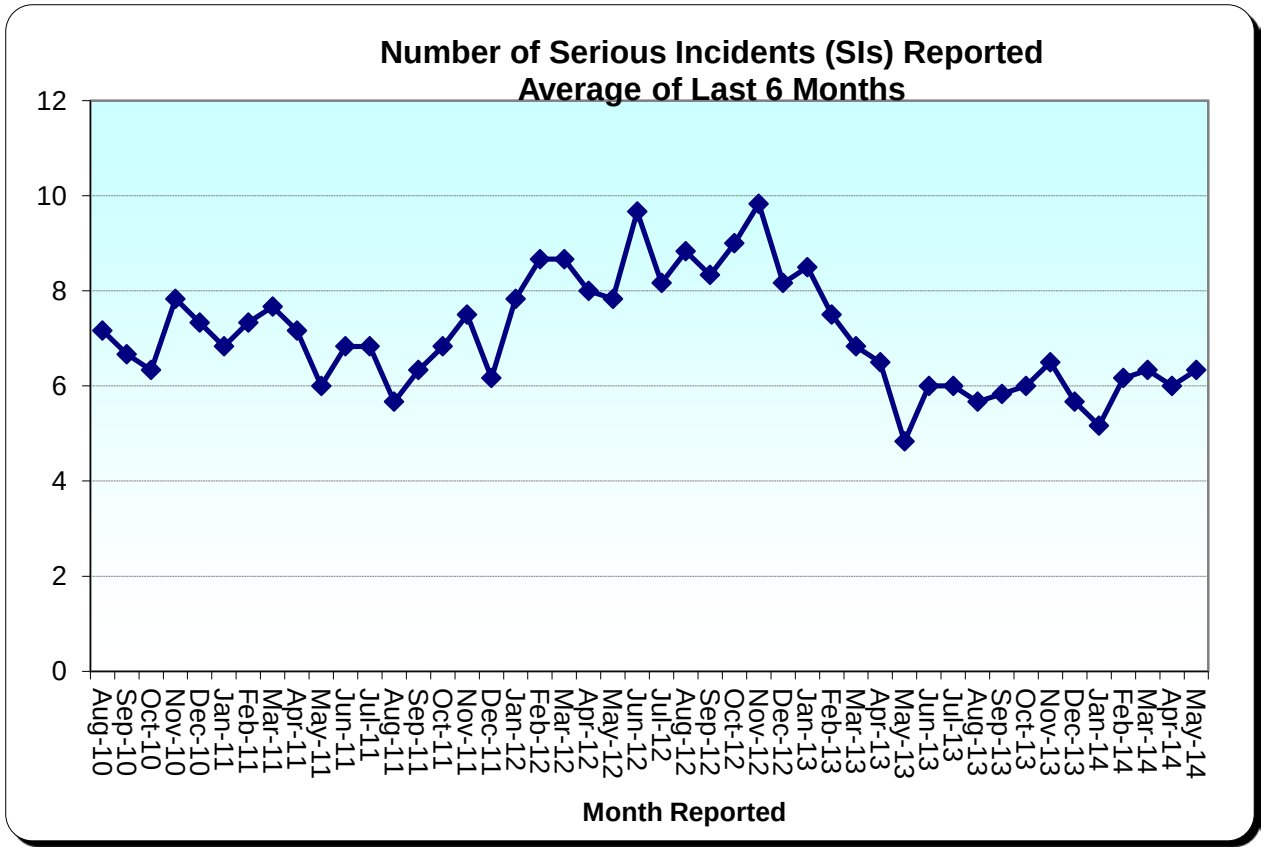
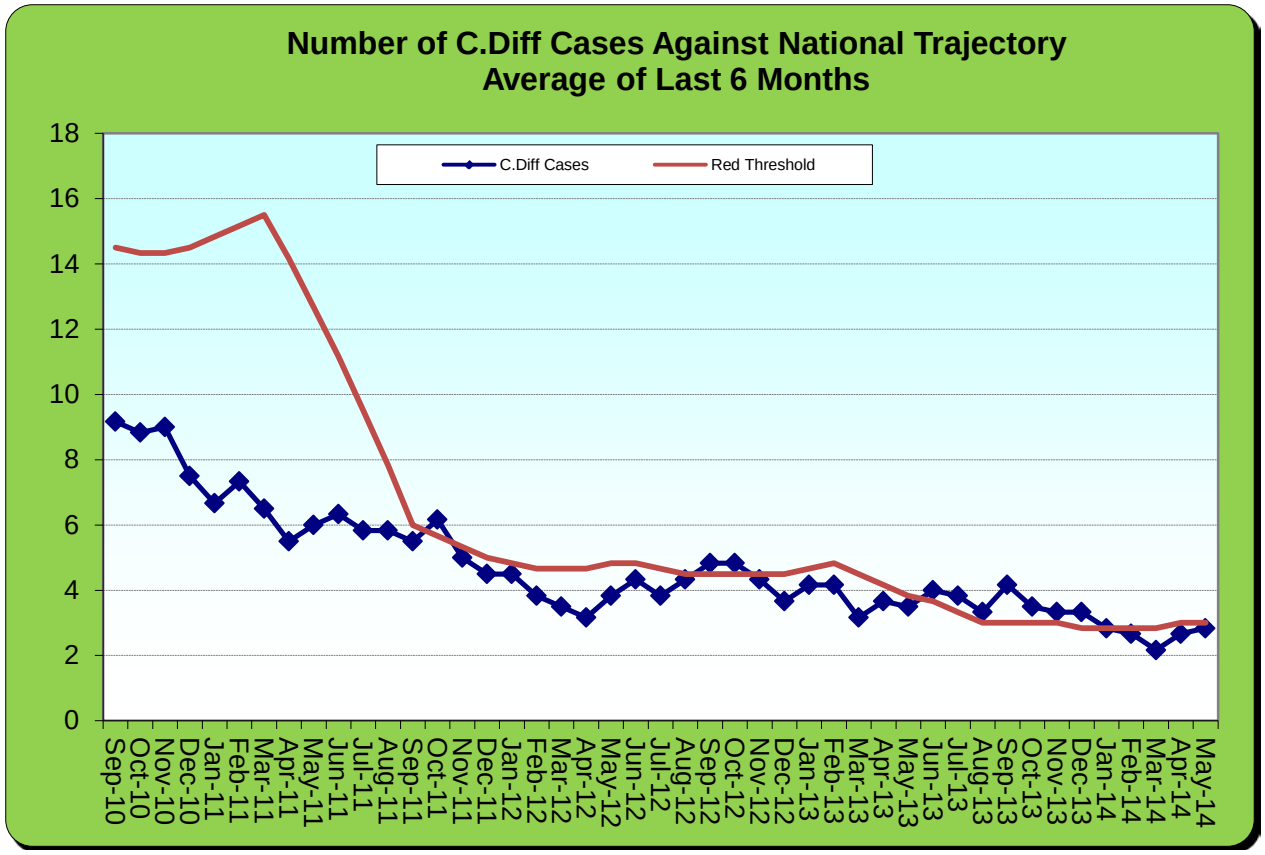
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14


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


Number of C.Diff Cases Against National Trajectory
Average of Last 6 Months
C.Diff Cases
Red Threshold
18
16
14
12
10
8
6
4
2
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
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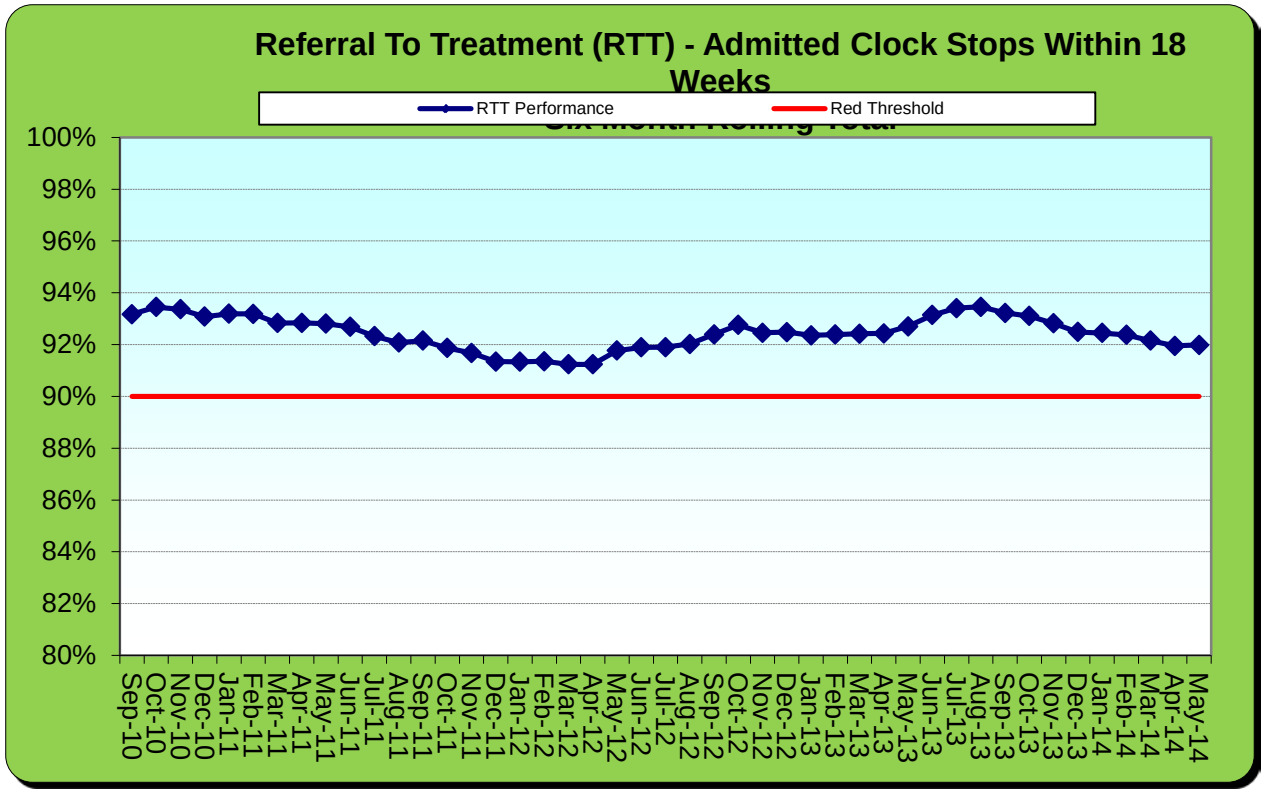
Mar-14
Apr-14
May-14


Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
RTT Performance
Red Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
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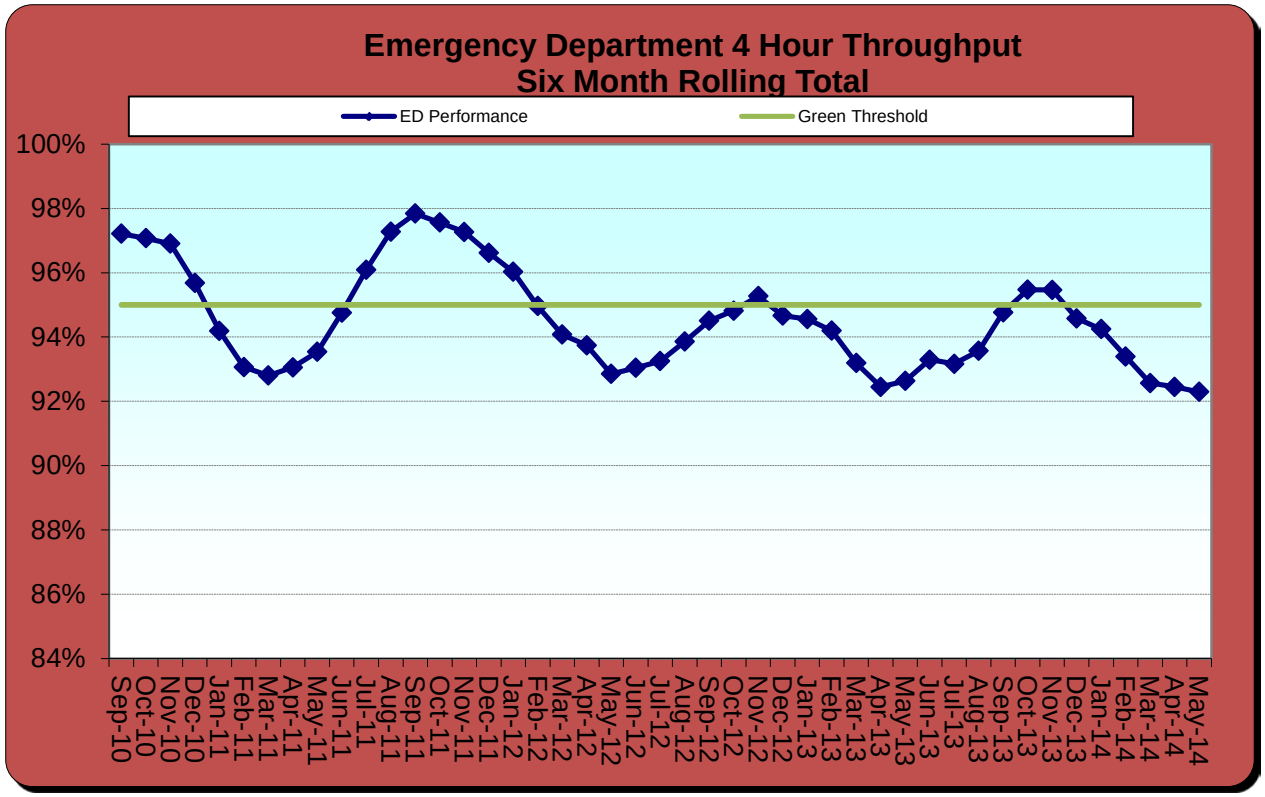
Feb-14
Mar-14
Apr-14
May-14


Emergency Department 4 Hour Throughput
Six Month Rolling Total
ED Performance
Green Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
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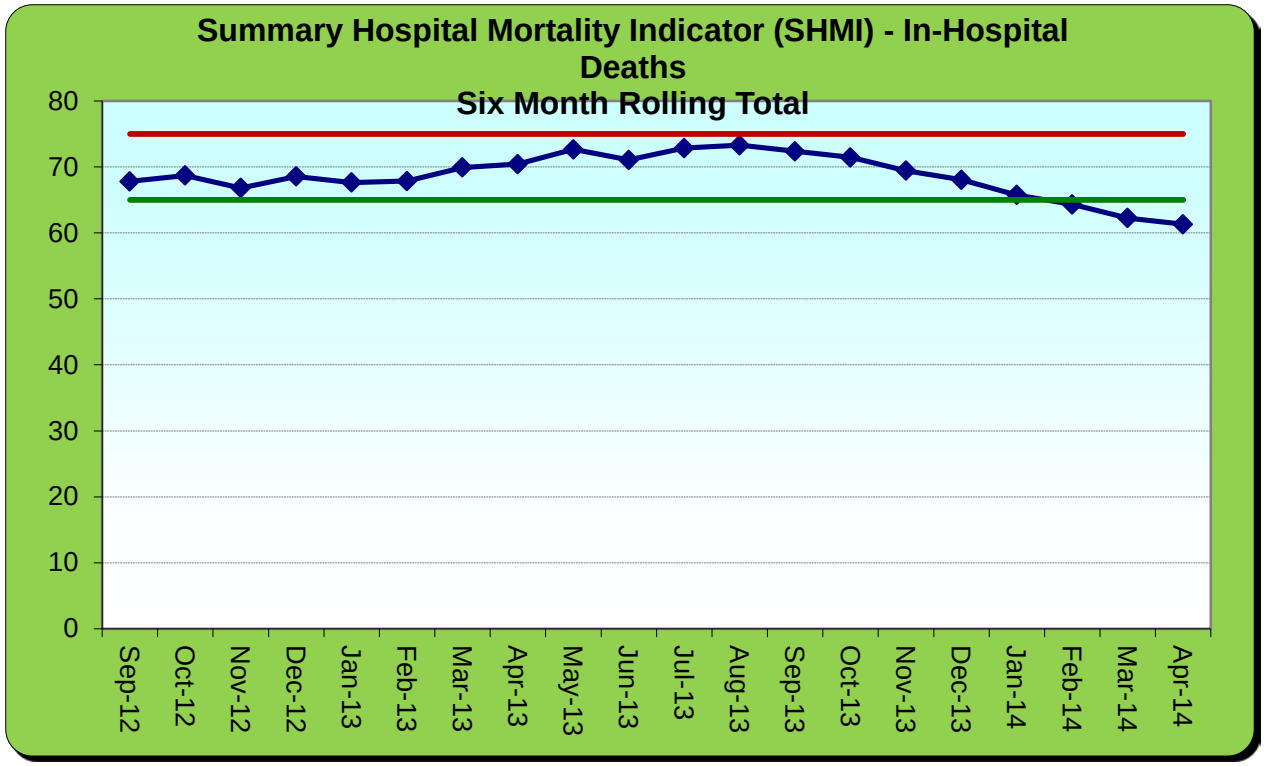
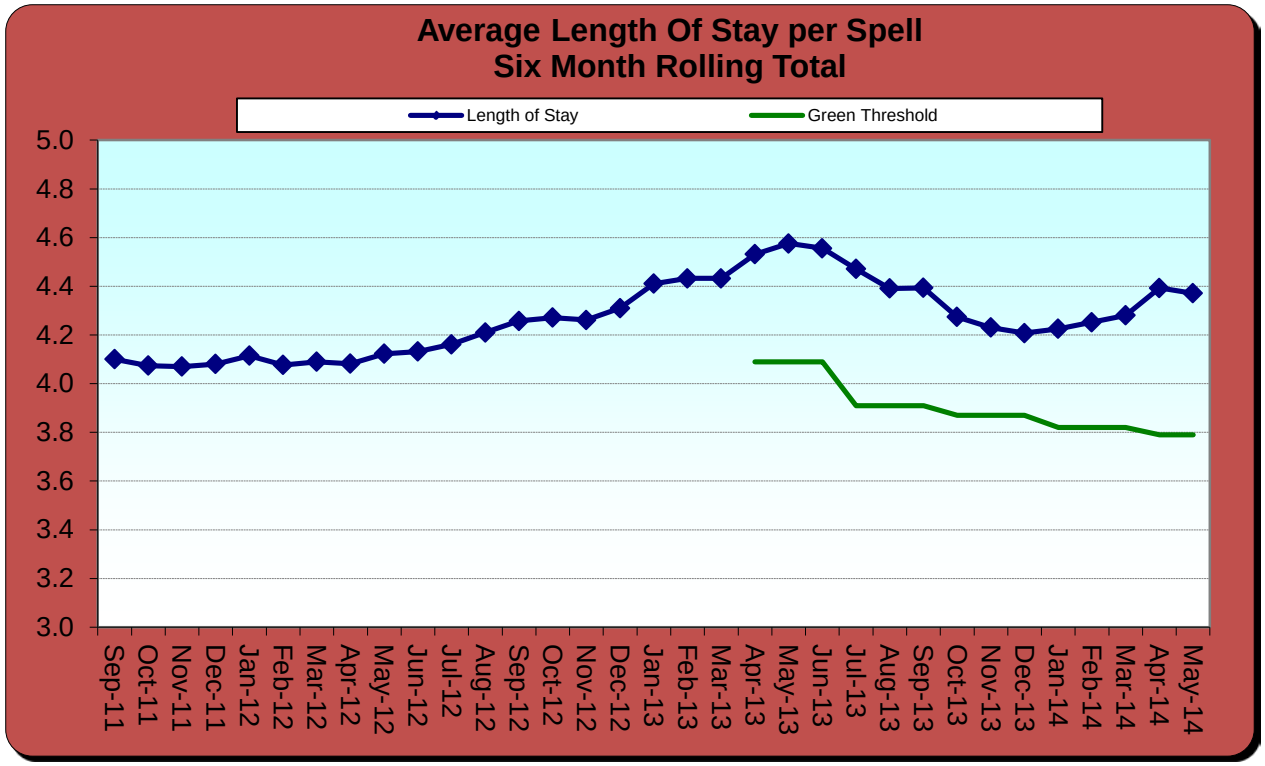
Mar-14
Apr-14
May-14


Summary Hospital Mortality Indicator (SHMI) - In-Hospital Deaths
Six Month Rolling Total
80
70
60
50
40
30
20
10
0
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14


Average Length Of Stay per Spell
Six Month Rolling Total
Length of Stay
Green Threshold
5.0
4.8
4.6
4.4
4.2
4.0
3.8
3.6
3.4
3.2
3.0
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
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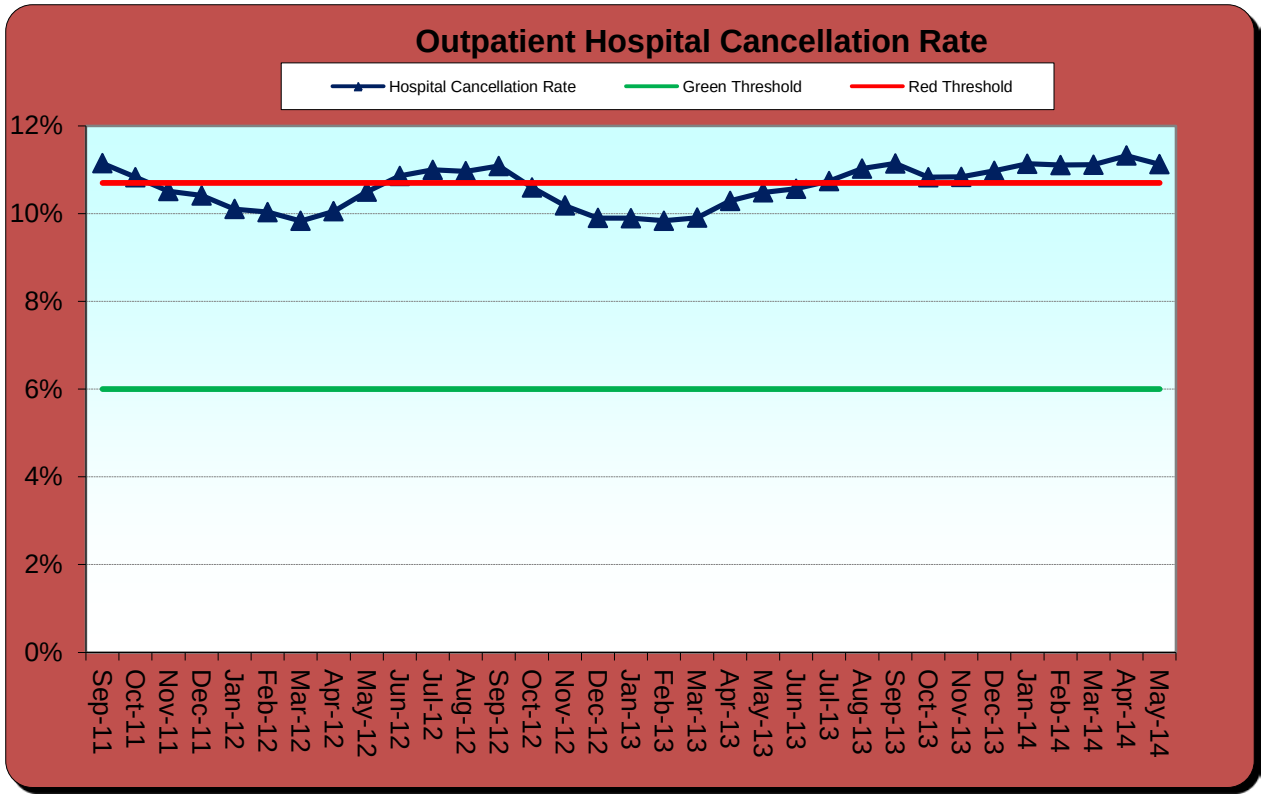
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14


Outpatient Hospital Cancellation Rate
Hospital Cancellation Rate
Green Threshold
Red Threshold
12%
10%
8%
6%
4%
2%
0%
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Incidence of Hospital Acquired Pressure Sores (grade 3 and 4)	In the *Quality* section of this report	
Cumulative number of *C. diff* cases	In the *Quality* section of this report	
A&E 4hour standard	In the *Access* section of this report	
30-day emergency readmission	In the *Quality* section of this report	
Overall Length of Stay	See *Overview section*	
Savings Plan Achievement	See *Overview* section and separate Finance Report.	

SECTION C – Monitor's Compliance Framework

At the end of May the Trust is currently not meeting three of the standards in Monitor's 2014/15 Risk Assessment Framework, for the quarter to date. Exception reports are provided for these three standards, along with *Clostridium difficile* (C. diff) cumulative trajectory, which is above the monthly trajectory set internally and for this reason considered to be at risk, but currently below Monitor's minimum reporting level of twelve cases.

- A&E 4-hour maximum wait (1.0) – *Access section*
- RTT Non-admitted standard (1.0) – *Access section*
- 62-day Referral to Treatment GP Cancer standard (1.0) – *Access section*
- *Clostridium difficile* cumulative trajectory (1.0) – *Quality section*

Overall the Trust currently has a score of 3.0 against the new Risk Assessment Framework, reflecting the three standards not met for the quarter to date. This would equate to a GREEN risk rating in terms of the Service Performance score alone. However, both the RTT Non-admitted and A&E 4-hour maximum wait standards triggered governance concerns in quarter 4, along with C. diff, due to repeated failures. For this reason Monitor has requested and received further information as to the causes of the failures of the standards, including the 62-day GP cancer standard, along with the Trust's recovery plans and progress against these for the quarter to date. The Trust is expecting confirmation of the quarter 4 rating following Monitor's regional board meeting in July.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 1 2014/15.

PERFORMANCE OVERVIEW

Monitor's Risk Assessment Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Compliance Framework Q1 13/14	Compliance Framework Q2 13/14	Risk Assessment Framework Q3 13/14	Risk Assessment Framework Q4 13/14	Risk Assessment Framework Q1 14/15*	Q1 Forecast quarter-end*	Notes	Q1 Forecast Risk rating
Monitor Risk Assessment Framework	1	Infection Control - CDiff Infections Against Trajectory	1.0	< or = trajectory	9	×	×	×	×	9	✓	Cumulative trajectory: Q1 10; Q2 20; Q3 30; Q4 40; de minimis =12	Achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	100.0%	✓	✓	✓	✓	100.0%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	97.9%	✓	✓	✓	✓	95.6%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.9%	✓	✓	✓	✓	98.1%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	75.3%	✓	×	✓	×	77.5%	×	62-day GP standard not forecast to be achieved. The screening standard may be at risk, but only due to the management of pathways at other providers.	Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	89.6%	✓	✓	✓	✓	90.0%	×		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	91.8%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	91.8%	✓		Achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	93.8%	Achieved each month	Not achieved	Not achieved	Not achieved	93.8%	×	Standard failed in April and May so failed for the quarter as a whole.	Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.5%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	92.5%	✓		Achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	97.9%	✓	✓	✓	✓	97.7%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	97.1%	✓	✓	✓	✓	97.1%	✓		Achieved
	8b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
	9	A&E Total time in A&E 4 hours (95th percentile)	1.0	95%	94.4%	×	✓	×	×	94.4%	×	95% standard not met in April or May.	Not achieved
	10	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
		CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Actions implemented	Not applicable	Not applicable	Not applicable		Achieved
					rating	AMBER-RED	AMBER-RED	GREEN	Triggering escalation	Triggering escalation	Triggering escalation		

Please note: If the same indicator is failed in three consecutive quarters, a trust will be put into escalation and Monitor will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur 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. Quarterly figures quoted for the **62-day CANCER STANDARDS** include the impact of breach reallocations for late referrals, which are allowable under Monitor's Compliance Framework. For this reason, the quarterly figures may differ from those quoted in the Access Tracker. For the period shown Q1 and Q3 2013/14 have had corrections applied to the 62-day GP performance figures for breach reallocations.

***Q1 Cancer figures based upon reported figures for April, and draft figures for May. The C diff figures is shown as the cumulative position against the quarter-end target.**

3.0
Escalation for further investigation of issues

1.1 QUALITY TRACKER

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15 YTD	Monthly Totals Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Quarterly Totals 13/14 Q2	13/14 Q3	13/14 Q4	14/15 Q1
Patient Safety																						
Infection Rates	DA01a	MRSA Cumulative Cases Against National Trajectory	0	1	2	1	1	1	1	1	1	1	1	1	2	2	1	1	1	1	2	1
	DA03a	C.Diff Cumulative Cases Against National Trajectory	40	40	38	9	14	17	20	25	27	30	34	34	36	38	5	9	25	34	38	9
	DA02	MSSA Cases Against Trajectory	25	25	27	1	1	2	1	5	3	3	3	1	2	2	1	0	8	9	5	1
MRSA Screenings	DD01	MRSA Pre-Op Elective Screenings	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	DD02	MRSA Emergency Screenings	95%	80%	94.8%	95.7%	95.7%	92.3%	93.9%	94.8%	95.2%	94.9%	95.2%	95%	95.2%	95.3%	96%	95.5%	93.6%	95.1%	95.2%	95.7%
Infection Checklists	DB01	Hand Hygiene Audit Compliance	95%	80%	96.8%	97.2%	97.6%	98.1%	92.4%	97.8%	96.4%	96.1%	96%	98.3%	98.3%	97.2%	97.5%	96.9%	96%	96.2%	97.8%	97.2%
	DB02	Antibiotic Compliance	90%	80%	88%	89.7%	89%	88.3%	85%	86.5%	85.9%	86.5%	86.5%	88.6%	90.1%	90.7%	91.8%	87.4%	86.7%	86.2%	89.9%	89.7%
Cleanliness	DC01	Cleanliness Monitoring - Overall Score	95%	70%	95%	96%	95%	95%	96%	94%	95%	95%	94%	94%	94%	96%	96%	95%	95%	95%	95%	96%
	DC02	Cleanliness Monitoring - Very High Risk Areas	95%	95%	96%	96%	97%	96%	98%	96%	95%	96%	96%	95%	96%	96%	95%	97%	97%	96%	96%	96%
	DC03	Cleanliness Monitoring - High Risk Areas	95%	70%	95%	96%	95%	96%	95%	95%	94%	96%	95%	95%	95%	96%	96%	96%	95%	95%	95%	96%
Serious Incidents	S02	Number of Serious Incidents Reported	-	-	73	12	11	9	3	4	7	5	6	6	9	5	5	7	16	18	20	12
	S02a	Number of Confirmed Serious Incidents	-	-	68	-	10	8	3	4	7	5	6	6	9	2	-	-	15	18	17	-
	S02b	Number of Serious Incidents Still Open	-	-	3	12	-	-	-	-	-	-	-	-	-	3	5	7	-	-	3	12
	S03	Serious Incidents Reported Within 48 Hours	80%	80%	83.6%	66.7%	81.8%	66.7%	100%	25%	85.7%	100%	83.3%	100%	88.9%	100%	80%	57.1%	62.5%	88.9%	95%	66.7%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	80%	80%	92.4%	81.8%	100%	100%	100%	100%	87.5%	100%	100%	87.5%	75%	100%	100%	50%	100%	93.8%	89.5%	81.8%
	S01	Total Never Events	0	1	2	2	1	0	0	0	0	0	1	0	0	0	1	1	0	1	0	2
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	-	-	12090	884	965	1134	914	922	1064	1052	958	1060	954	986	884	-	2970	3074	3000	884
	S06a	Patient Safety Incidents Per 100 Admissions	-	-	9.25	8.25	9.22	10.05	8.38	8.45	9.09	9.57	9.41	9.43	9.28	9	8.25	-	8.97	9.35	9.24	8.25
	S07	Number of Patient Safety Incidents - Severe Harm	-	-	44	4	3	3	1	3	7	3	3	3	7	6	4	-	7	13	16	4
Falls	AB01	Falls Per 1,000 Beddays	5.6	5.6	5.68	5.13	5.16	5.64	5.76	5.8	5.96	5.42	5.59	6.1	5.67	5.46	5.08	5.18	5.73	5.66	5.74	5.13
	AB06a	Total Number of Patient Falls Resulting in Harm	24	25	28	6	0	2	1	3	1	4	2	2	4	3	1	5	6	7	9	6
	tbc	CQUIN Improvement in Falls With Harm																				
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.651	0.651	0.656	0.387	0.66	0.788	0.755	1.078	0.706	0.526	0.555	0.69	0.417	0.417	0.433	0.343	0.871	0.596	0.51	0.387
	DE02	Pressure Ulcers - Grade 2	-	-	184	19	14	18	18	26	17	12	14	17	9	10	11	8	62	43	36	19
	DE03	Pressure Ulcers - Grade 3	0	1	13	1	2	2	1	0	1	1	0	1	1	1	0	1	3	2	3	1
	DE04	Pressure Ulcers - Grade 4	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	96%	95%	98%	98.8%	97%	96.6%	98.1%	97.9%	98%	98.5%	98.2%	98.6%	98.7%	98.5%	98.9%	98.7%	97.5%	98.2%	98.6%	98.8%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	90%	93.4%	95.3%	93.2%	91.6%	92.5%	95.6%	94.6%	95.1%	97.1%	94.9%	96.6%	94.5%	96.4%	94.3%	93.2%	95.6%	95.3%	95.3%
Nutrition	tbc	Nutritional Screening Completed																				
	WB03	Nutrition: Food Chart Review	90%	85%	82.5%	90.4%	77.4%	72.3%	92.4%	80.9%	83.8%	76.9%	84.1%	91.2%	91.8%	78.2%	94.7%	87.4%	81.8%	82.1%	87.7%	90.4%
Safety	Y01	WHO Surgical Checklist Compliance	100%	99.5%	99.6%	99.7%	99.6%	99.7%	99.5%	99.5%	99.6%	99.5%	99.7%	99.9%	99.6%	99.6%	99.7%	99.6%	99.6%	99.6%	99.7%	99.7%
Medicines	WA01	Medication Errors Resulting in Harm	1.61%	2%	0.68%	1.3%	0.66%	0.74%	0%	0.7%	0.61%	0.56%	0%	1%	0.54%	0%	1.3%	-	0.49%	0.41%	0.52%	1.3%
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	95%	95%	97.9%	99.4%	95.7%	99.1%	98.3%	99%	99.1%	100%	100%	99.1%	99%	100%	98.6%	100%	98.8%	99.7%	99.4%	99.4%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	85%	75%	92%	99%	-	93.3%	97.5%	89.1%	89.5%	90.8%	83.3%	85%	100%	100%	98.8%	99.1%	93.6%	88.1%	94.1%	99%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.5%	2%	1.91%	0.85%	1.7%	1.91%	2.1%	1.19%	2.75%	2.32%	2.6%	1.08%	0.91%	1.66%	1.18%	0.55%	1.74%	2.56%	1.23%	0.85%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	95.6%	92.8%	94.1%	96.2%	92%	91.9%	95.2%	94.5%	93.5%	95.8%	95%	95.6%	96.2%	95.2%	95.7%	96.7%	93.9%	94.7%	95.7%	96.2%
	AK04	Safety Thermometer - No New Harms	98.2%	97%	97.2%	98.3%	96.6%	95.9%	97.3%	98.3%	96.7%	97.4%	97.9%	98.5%	97.8%	97.6%	98.2%	98.4%	97.2%	97.3%	98%	98.3%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	95%	90%	85%	85%	98%	79%	85%	80%	85%	82%	76%	91%	86%	88%	89%	83%	82%	81%	89%	85%
	tbc	Resus Team - Crash Calls																				
Discharges	TD04	Out of Hours Discharges	-	-	9%	9.2%	8.1%	9.8%	10%	9.2%	8.7%	8.8%	8.6%	8.1%	10%	9.8%	9.5%	9%	9.7%	8.7%	9.3%	9.2%

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15 YTD	Monthly Totals Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Quarterly Totals 13/14 Q2	13/14 Q3	13/14 Q4	14/15 Q1
Clinical Effectiveness																						
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital Deaths	65	75	67.2	59.8	72.8	70.8	69.9	73.7	65.4	64.3	64.7	57.6	60.8	60.9	59.8	-	71.5	64.8	59.7	59.8
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	100	100	94.7	-	93.7	-	-	95.7	-	-	-	-	-	-	-	-	95.7	-	-	-
Learning Disability	AA03	Learning Disability (Adults) - Percentage Adjustments Made	80%	50%	83.9%	90.5%	93.8%	50%	100%	88.2%	100%	95%	77.8%	95%	90.5%	92.3%	100%	78.9%	73.7%	91.7%	92.6%	90.5%
Readmissions	C01	Emergency Readmissions Percentage	2.7%	2.7%	2.71%	2.71%	2.4%	2.61%	2.49%	2.76%	2.7%	2.69%	2.83%	2.89%	2.93%	2.86%	2.71%	-	2.62%	2.73%	2.89%	2.71%
Maternity	tbc	Measure of Birth Rate - details to be finalised																				
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	95%	90%	77.4%	77.1%	73.5%	75.9%	77.1%	96.6%	90.5%	95.5%	87.8%	55.9%	92.6%	85.7%	88.9%	70%	82.8%	90.5%	76.4%	77.1%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	95%	90%	78.8%	93.8%	64.7%	62.1%	68.6%	75.9%	81%	95.5%	100%	97.1%	100%	100%	94.4%	93.3%	68.8%	94%	98.9%	93.8%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	80%	61.7%	72.9%	47.1%	44.8%	54.3%	69%	71.4%	90.9%	87.8%	52.9%	92.6%	85.7%	83.3%	66.7%	55.9%	84.5%	75.3%	72.9%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	50%	55.1%	52.3%	48.7%	60%	53.7%	62.2%	58%	36.1%	66.7%	62.2%	56.8%	63.9%	52.3%	-	58.5%	55.2%	60.8%	52.3%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90%	80%	84.2%	90.9%	84.6%	91.1%	82.9%	89.2%	86%	83.3%	87.5%	86.7%	79.5%	86.1%	90.9%	-	87.8%	85.8%	84%	90.9%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	60%	55.8%	40%	50%	35.3%	62.5%	71.4%	73.3%	40%	61.1%	50%	45.5%	50%	60%	30%	55.3%	63.2%	48.8%	40%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	90%	80%	67.7%	54.5%	96.3%	80.1%	86.2%	86.6%	83.4%	74.9%	49.7%	46.6%	45.3%	46.9%	57.1%	52.3%	84.5%	68.7%	46.3%	54.5%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	90%	80%	60.6%	74.5%	61.5%	40.4%	52.9%	53.4%	59%	57.7%	66.7%	75.5%	78%	66.7%	71.7%	78.3%	49.2%	60.7%	73%	74.5%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	90%	80%	65.4%	52.3%	85.7%	66.7%	62.5%	62.5%	75%	75.9%	61.5%	57.9%	38.5%	52.4%	47.6%	56.5%	63.6%	70.7%	48.5%	52.3%
	tbc	Dementia Awareness Training on Induction																				
	tbc	Dementia Carers Feeling Supported																				
Outliers	J05	Ward Outliers - Beddays	-	-	10622	1610	637	661	698	517	846	755	1064	1302	1246	960	683	927	1876	2665	3508	1610
Patient Experience																						
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	86	85	-	-	88	88	89	89	88	89	89	88	89	89	89	-	89	89	89	89
	P01g	Patient Survey - Kindness and Understanding	90	88	-	-	92	94	93	94	93	93	93	93	91	94	94	-	93	93	93	94
Friends and Family Test	P03a	Friends and Family Test Inpatient Coverage	25%	25%	29.6%	42.5%	17.5%	17.4%	21.4%	38.2%	42.2%	45.2%	37.4%	37.9%	43.8%	46.7%	45.9%	39.5%	25.1%	41.6%	42.7%	42.5%
	P03b	Friends and Family Test ED Coverage	15%	15%	13.3%	18.5%	8%	10.5%	11.7%	16.2%	19.1%	18.6%	11.6%	13.8%	16.4%	26.4%	15.7%	21.1%	12.7%	16.6%	19.1%	18.5%
	P04a	Friends and Family Test Score - Inpatients	70	64	75.9	75.9	75.7	81.2	75	73.8	76.5	75.7	74.4	75.5	76.5	76.1	78.4	73.3	75.9	75.6	76	75.9
	P04b	Friends and Family Test Score - ED	51	42	70.1	73.2	65.4	70.5	72.3	73.9	71.6	70.8	66.3	70.3	70.1	68.7	75.8	71.4	72.4	70.1	69.5	73.2
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.21%	0.25%	0.212%	0.232%	0.195%	0.162%	0.232%	0.202%	0.192%	0.185%	0.199%	0.214%	0.227%	0.282%	0.238%	0.226%	0.198%	0.192%	0.241%	0.232%
	T03a	Complaints Responded To Within Trust Timeframe	98%	90%	76.4%	87.8%	66.7%	80.3%	77.2%	87.8%	84.9%	82.2%	88.1%	76.1%	92%	88.7%	93.1%	82.5%	81.4%	85%	84.7%	87.8%
	T03b	Complaints Responded To Within Divisional Timeframe	98%	90%	71.1%	84.3%	55.6%	74.6%	93%	83.7%	69.9%	66.7%	57.1%	77.6%	86%	75.5%	82.8%	86%	83.1%	65.6%	79.4%	84.3%
	T04a	Complainants Disatisfied with Response	-	-	62	10	6	6	11	1	7	2	6	6	3	5	6	4	18	15	14	10
Ward Moves	J06	Average Number of Ward Moves	-	-	2.3	2.3	2.1	2.2	2.2	2.3	2.3	2.4	2.3	2.4	2.3	2.4	2.3	2.3	2.2	2.3	2.4	2.3
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	1.5%	1.02%	0.97%	0.82%	1.15%	0.85%	0.72%	0.65%	0.94%	1.02%	1.18%	1.44%	0.92%	0.98%	0.96%	0.91%	0.85%	1.17%	0.97%
	F01a	Number of Last Minute Cancelled Operations	-	-	690	108	45	69	47	40	40	54	47	70	78	52	54	54	156	141	200	108

1.2 SUMMARY

This month the quality report contains a number of changes as a result of our annual review and refresh of our quality dashboard, to reflect our quality objectives for the new financial year and the details of CQUIN (Commissioning for Quality and Innovation) payments being agreed with our commissioners. This results in a somewhat transitional period for the quality dashboard as we finalise our achievements for 2013/14 and start to introduce new measures and thresholds for 2014/15. The majority of changes have been implemented, but some of the new metrics will be reported in the next few months as indicated in the table below. A supporting document outlining the changes made is provided as an addendum to this report.

A number of measures continue to show signs of sustained improvements, such as overall falls and pressure ulcer incidence, medication errors and Friends & Family Test coverage and score in both inpatients wards and the Emergency Departments. Implementation of the Friends & Family Test in outpatient clinics will occur in 2014/15. Challenges remain in achieving the standards for dementia, and the appointment of staff to support our work with patients with dementia and their carers will start to impact on these metrics later in the year. There has been a deterioration in the timescales for reporting and investigating serious incidents, and unfortunately one never event occurred in May, details of which are included in the relevant exception reports.

Achieving set threshold (38)	**Thresholds not met or no change on previous month (8)**
- MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - MRSA (Meticillin Resistant Staphylococcus aureus) screening – elective - MRSA screening – emergency - Hand Hygiene Audit - Cleanliness monitoring: 1) overall Trust score, 2) very high risk areas and 3) high risk areas - Inpatient falls incidence per 1,000 bed days - Total pressure ulcer incidence per 1,000 bed days - Number of grade 4 hospital acquired pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Medicines reconciliation performed within one day of admission (Assessment and cardiac wards) - Medicines reconciliation performed within one day of admission (Oncology and Gynaecology wards)	- Antibiotic prescribing compliance - Percentage adult in-patients who received thrombo-prophylaxis - 72 hour Food Chart review - WHO surgical checklist compliance - Learning disability (adults)-percentage adjustments made - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Patient complaints as a proportion of all activity - Last minute cancelled operations: percentage of admissions

QUALITY

- Non-purposeful omitted doses of listed critical medication - Reduction in medication errors resulting in moderate or severe harm - NHS Safety thermometer- harm free care - NHS Safety thermometer-no new harms - Summary Hospital Mortality Indicator in-hospital deaths (SHMI) - Summary Hospital Mortality Indicator including out of hospital-deaths within 30 days of discharge (SHMI) - Stroke care: percentage receiving brain imaging within 1 hour - Stroke care: percentage spending 90% + time on a stroke unit - Patient experience local patient experience tracker - Monthly patient survey: kindness and understanding - Friends and Family Test (FFT) coverage: Inpatients - Friends and Family Test (FFT) coverage: Emergency Department - FFT Score: Inpatients - FFT Score: Emergency Department - Number of complainants dissatisfied with our response (not responded in full)	
Quality metrics not achieved or requiring attention (17)	**Quality metrics not rated (16)**
- MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory - Clostridium difficile cases against national trajectory - Serious Incidents reported with 48 hours - Serious incident investigations completed within required timescales - Never Events - Falls resulting in harm - Number of grade 3 hospital acquired pressure ulcers - Deteriorating patient- appropriate response to an Early Warning Score of 2 or more. - 30 day emergency re-admissions - Fractured neck of femur patients treated with 36 hours - Fractured neck of femur patients achieving Best Practice Tariff - Dementia admissions-case finding applied - Dementia admissions-assessment completed	**Data not yet available** - Nutritional screening: will report in July - Risk Adjusted Mortality (Hospital Standardised Mortality Ratio equivalent): will be included next month - Number of normal births-will be available next month - Dementia-awareness training on induction will be available next month - Dementia-carers feeling supported: carer surveys will commence in July. - Deteriorating patient- reduction in cardiac arrest calls from adult general ward areas: will be reported a month in arrears **Thresholds to be agreed** - Out of hours discharges - Average number of ward moves

QUALITY

- Dementia admissions-referred on to specialist services - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - Percentage of complaints resolved within agreed timescale - Number of complainants dissatisfied with our response (not responded in full)	- Ward outliers bed-days **Metrics for information** - Number of serious incidents - Confirmed number of serious incidents - Total number of patient safety incidents reported - Total number of patient safety incidents per 100 admissions - Number of patient safety incidents severe harm - Number of grade 2 hospital acquired pressure ulcers - Number of last minute cancelled operations

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

The CQUINs monitored in the quality dashboard for 2014/15 are:

1.3.1 Deteriorating patient:

Rescue of deteriorating patients is one of our quality objectives for 2014/15. It aligns with the Trust's existing proactive adult patient safety improvement programme.

In 2013/14 we focussed on ensuring that observations were being taken and recorded, and early warning scores were being calculated correctly. We also focused on a quantitative measure on the use of use of SBAR (Situation, Background, Assessment, Recommendation) to escalate the sickest of deteriorating patients (with an Early Warning Score of 4 or more) for prompt clinical review. We want to build on this in 2014/15 to improve the appropriate response (according to the escalation protocol) rates to patients with an Early Warning Score (EWS) of 2 or more and to reduce cardiac arrest calls for confirmed cardiac or respiratory arrests. We have proposed a two-part CQUIN with our commissioners:

- Adult patients with an Early Warning Score of 2 or more to have an appropriate response according the escalation protocol. Our improvement target is 95% by Quarter 4.
- Reduction in cardiac arrest calls from general ward areas for confirmed cardiac or respiratory arrests. This has been identified as an outcome measure of identifying and responding to deterioration earlier. The target is a 5% reduction from 2013/14 to be measured at the end of 2014/15.

In May the percentage of documented appropriate responses for adult patients with a EWS of 2 or more was 82.9% against an improvement target of 95%. Reduction in cardiac arrest calls will be reported from next month.

1.3.2 NHS Safety Thermometer improvement goal

This will be reported in future months once agreed with our commissioners.

1.3.3 Friends and Family Test

We will report on two elements of the national Friends & Family Test CQUIN that are suitable for tracking in the quality dashboard: increasing response rates for Inpatients and the Emergency Departments. The targets are 25% in Quarter 1 rising to 30% in Quarter 4 for inpatients, and 15% in Quarter 1 rising to 20% in Quarter 4 for Emergency Departments.

Performance in April was 39.5% against a target of 25% for inpatients, and 21.1% against a target of 15% for Emergency Departments.

1.3.4 Dementia

We will continue to report the dementia case finding metrics as in 2013/14:

- Patients admitted with dementia:

QUALITY

1. Percentage of patients aged over 75 years identified with a clinical diagnosis of delirium or who have been asked the dementia case finding question - performance in May was 53.2% against a target of 90%
2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in May was 78.3% against a target of 90%
3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in May was 56.5% against a target of 90%

In addition we will report compliance with dementia awareness training and the results of our carers survey to identify if they feel adequately supported from July.

1.4 CHANGES IN THE PERIOD

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

- Falls resulting in harm up ↑ from 1 in April to 5 in May;
- High risk Transient Ischaemic Attack (TIA) starting treatment within 24 hours down ↓ from 60% in April to 30% in May;
- Non-purposeful omitted doses of listed critical medication down ↓ from 1.18% in April to 0.55% in May;
- Friends & Family Test coverage in the Emergency Department up ↑ from 15.7% in April to 21.1% in May.

1.5 EXCEPTION REPORTS

Exception reports are provided for sixteen of the RED rated indicators

Please note: an exception report is **not** provided for MRSA cases although it is red on the dashboard. This is because the measure continues to be a cumulative measure throughout 2014/15 rather than number of cases each month. The red threshold of one case was triggered in April 2014 therefore this measure will automatically remain red for the rest of 2014/15.

1. Clostridium difficile cases against national trajectory
2. Serious Incidents reported with 48 hours
3. Serious incident investigations completed within required timescales
4. Never Events
5. Falls resulting in harm
6. Number of grade 3 hospital acquired pressure ulcers
7. Deteriorating patient- appropriate response to an Early Warning Score of 2 or more.
8. 30 day emergency re-admissions
9. Fractured neck of femur patients treated with 36 hours
10. Fractured neck of femur patients achieving Best Practice Tariff
11. Dementia admissions-case finding applied
12. Dementia admissions-assessment completed
13. Dementia admissions-referred on to specialist services
14. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours
15. Percentage of complaints resolved within agreed timescale
16. Number of complainants dissatisfied with our response (not responded in full)

QUALITY

Q1. EXCEPTION REPORT: *Clostridium difficile*	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Patients in hospital for more than 3 days, who have unexplained reasons for diarrhoea and test positive for *Clostridium difficile.*

Monitor measurement: Cumulative year-to-date trajectory, reported quarterly. The national objective set centrally is a limit of 40 cases in the year, with reporting to Monitor against a limit of 10 per quarter (cumulative limits: quarter 1 = 10; quarter 2 = 20; quarter 3 = 30; quarter 4 = 40). Financial penalties are linked to the national objective.

Performance in the period, including reasons for the exception:

There were four Trust apportioned cases of *Clostridium difficile* in May 2014 against an internally set limit of four cases for the month.

Division	Divisional Limit	Number of cases
Medicine	1	0
Surgery, Head & Neck	1	1
Women's & Children's	0	2
Specialised Services	1	1

Recovery plan, including expected date performance will be restored:

- All cases of *Clostridium difficile* infection are visited by the Director of Infection Prevention and Control /Infection Control Doctor/ Microbiologist, Infection Control Nurse and pharmacist within one working day. Each case is assessed to ensure there have been no lapses in care;
- Focused care and management of *Clostridium difficile* positive patients continues on the cohort ward with daily monitoring of patients by the Infection Control Team;
- A process with the Clinical Commissioning Group is being devised, to agree which cases are avoidable and unavoidable. The unavoidable cases will be deducted from the number of reported cases each quarter, for the purposes of the application of fines and reporting to Monitor.

QUALITY

Q2-Q3. EXCEPTION REPORT: **Serious incidents reported within timescale** **Serious incident investigations completed within timescale**	**RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse**

Description of how the standard is measured:

Serious incidents are required to be reported and investigations completed within timescales set-out in the NHS England's Serious Incident Framework (March 2013). Reporting to commissioners and NHS England should take place within 48 working hours of the serious incident being identified

Investigations are required to be completed within 45 working days for a grade 1, and 60 working days for a grade 2 serious incident.

The target in commissioning contracts for both these measures is 80%, measured quarterly.

Performance in the period, including reasons for the exception:

Seven serious incidents were reported in May, four within timescale resulting in performance of 57.1%. Performance for Quarter 1 to date is 66.7%. Reasons for delayed reporting are:

Incident number	Division	Extent of breach	Reason
2014 16972	Surgery Head & Neck	2 days	Reported a safeguarding issue. Extended internal discussion before Patient Safety made aware of a potential serious incident.
2014 17174	Women's and Children's	4 days	Reported internally promptly, did not meet automatic triggers as a potential serious incident so initially managed within the division.
2014 17220	Medicine	3 days	Extent of harm not known at time of initial incident report. Delay in updating incident and informing Patient Safety once diagnosis of major fracture confirmed.

Four serious incident investigations were completed during May, of these two investigations breached the 45 working day timescale resulting in performance of 50%. Both breaches were in the Division of Medicine. Performance for Quarter 4 to date is 81.8%.

- For one incident finalising a Trust-wide action plan, in response to an incident in one particular division, took the investigation over the deadline.

QUALITY

- For the other incident the draft investigation report needed initial then subsequent amendments which took the investigation over the deadline

Recovery plan, including expected date performance will be restored:

Divisions receive feedback on performance in respect of serious incident reporting and investigation timescales, and are reminded of the importance of achieving these wherever possible.

Head of Quality (Patient Safety) to attend Ward Sister's meetings to discuss the importance of high quality and timely investigations.

QUALITY

Q4. EXCEPTION REPORT: Never Event	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

Never Events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. There are currently 25 different categories of Never Events listed by NHS England.

Performance in the period, including reasons for the exception:

One Never Event occurred in May in the category "Wrong site surgery" whereby the wrong procedure was performed on a day-case patient. The patient was correctly identified and the correct hand operated on. However, the surgeon performed a carpel tunnel release instead of a De Quervain's release. The patient was informed of the error as soon as it was identified and an apology was given. The patient elected to have the correct procedure the same day which was performed uneventfully.

A full Root Cause Analysis investigation is underway.

Recovery plan, including expected date performance will be restored:

- A Surgical Never Events Summit took place at the end of April attended by representatives form surgical teams in all divisions to raise awareness of surgical never events and discuss Trust-wide approaches to additional preventative actions;
- Posters to remind staff of the checks required to prevent wrong site surgery have been distributed to all surgical teams and operating theatres;
- Never event awareness and sharing preventative learning is included in all patient safety training;
- As reported last month, a Never Events Working Party has been set-up within the Trust to consider further proactive measures that can be put in place to reduce the risk of systemic Never Events occurring. This will focus on surgical related Never Events in the first instance, which are the most common type of Never Event nationally. NHS England has published provisional data on Never Events for 2013/14, which shows that a total of 312 Never Events occurred in NHS trusts during 2013/14. Of these, 132 Never Events involved a retained foreign object, and 89 Never Events involved wrong site surgery. At least one Never Event was reported by 159 NHS trusts, with the maximum number reported by any single trust being eight.

QUALITY

Q5. EXCEPTION REPORT: Inpatient falls resulting in harm	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Number of falls resulting in moderate or major harm, as defined by Trust's policy which is consistent with the National Patient Safety Agency risk assessment matrix (2008). For 2014/15 we have introduced a red threshold of three or more falls resulting in harm per month, based on a reduction from the number which occurred in 2013/14.

Performance in the period, including reasons for the exception:

Performance in the month for falls incidence was 5.18 per 1,000 bed days against the national benchmark of 5.6. There were 136 inpatient falls in May. This means that overall performance was below the green threshold, for the third month in a row. The degree of harm, based on National Patient Safety Agency guidance, arising from the falls in May was:

Degree of Harm	Jan 14	Feb 14	Mar 14	April 14	May 14
Near Miss	0	0	0	0	0
Negligible	120	114	109	88	98
Minor	37	18	32	40	33
Moderate	0	0	0	0	1
Major	2	4	3	1	4
Unavoidable death	0	0	0	0	0
Total	**159**	**136**	**144**	**129**	**136**

Whilst the overall performance this month is below the green threshold, with a significant improvement seen in Medicine, there were four major harm incidents and one moderate harm incident where patients sustained a fracture.

Two of the patients who fell had a degree of cognitive impairment, one was a patient with a learning disability, and two patients were independent. The falls occurred on wards: 54 (x2), 14, 200 and the Older Persons Assessment Unit (OPAU). Three of the falls were unwitnessed. Root cause analyses are underway to determine what actions if any could have been taken, with any lessons learnt to be shared.

QUALITY

Divisional Data	Jan 14	Feb 14	Mar 14	April 14	May 14
Diagnostics & Therapies	3	3	3	1	2
Medicine	102	93	97	89	64
Specialised Services	22	19	15	19	30
Surgery Head & Neck	27	19	23	19	33
Women's & Children's	4	2	6	1	7
Other	1	0	0	0	0
Total	**159**	**136**	**144**	**129**	**136**

Recovery plan, including expected date performance will be restored:

A modified version of the FallSafe programme is in the planning stage for outpatients. The FallSafe programme is continuing to be reviewed on a monthly basis at the Falls Steering Group with all relevant actions taken:

- Key areas to focus on following a review of themes including: inconsistent documentation and addressing patients' toileting needs at night;
- An area of good practice implemented on Ward 7, which resulted in a significant reduction in falls, is being explored by all divisional falls leads, with feedback at the next meeting planned;
- The use of a red background falling star magnet on the patient status at a glance boards, and a sticker for the nursing documentation, has been implemented to indicate patients at risk of repeat falls; this will be particularly informative if patients are transferred to another ward.

QUALITY

Q6. EXCEPTION REPORT: Number of hospital acquired grade 3 pressure ulcers	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

The rate of hospital acquired pressure ulcers grade 2 and above was 0.343 per 1,000 bed days in May (eight grade 2 and one grade 3) against a target of 0.651.This represents the lowest number of hospital acquired pressure ulcers per 1,000 bed days since robust data capture began in 2010.

Division	May 14	April 14	Mar 14	Feb 14	Jan 14
Medicine	0.312	0.644	0.403	0.431	0.71
Specialised Services	0.442	0.252	0.466	1.05	0.72
Surgery Head &Neck	0.597	0.779	0.607	0.485	1.00
Women & Children's	0.141	0.00	0.278	0.00	0.43
Trust	**0.343**	**0.433**	**0.417**	**0.417**	**0.69**

There was one Grade 3 hospital acquired pressure ulcer reported for the month of May in the Neonatal Intensive Care Unit. The baby, who was very unwell, had been on a Repose mattress since they were just 24 hours old and had been immobilized on their back during oscillation for one week. The pressure ulcer 4-5 mm was on the back of the baby's head. Problems were identified later with the inflation of the mattress. Both MEMO and the manufacturers have been consulted. A Root Cause Analysis is underway

Recovery plan, including expected date performance will be restored:

- Continued implementation of good practice, together with training and education;
- The Tissue Viability Lead Nurse is working with the Trust provider of dynamic mattresses to develop a mattress which is more suitable for Neonates; reviews across the country indicate that there are currently limited mattress options available;

Information and plans for improvements from divisions is provided in the monthly pressure ulcer report which is reviewed at the Tissue Viability Steering Group.

QUALITY

Q7. EXCEPTION REPORT: Deteriorating Adult Patient- appropriate response to an Early Warning Score of 2 or more	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Response to a deteriorating patient is set out in a well established protocol that was implemented alongside the Bristol Observation Chart which identifies the parameters which comprise the Early Warning Score. Compliance is assessed by monthly audits by front line staff (usually the Ward Sister).

The audit consists of reviewing the observations carried-out in the previous 24 hours for all adult patients, identifying those occasions where an early warning score of two or more was triggered and checking the documented response on each occasion to see if it was consistent with protocol. We have set ourselves an improvement target to reach 95% by Quarter 4 and have proposed this to commissioners as part of a CQUIN.

Performance in the period, including reasons for the exception:

Performance in May was 82.9%; 58 out of 70 patients with an Early Warning Score of two or more had documented evidence of a response consistent with the protocol.

The gaps for 12 patients were spread across different wards in the Divisions of Medicine, Surgery Head & Neck and Specialised Services. Each case has been followed-up with the Ward Sister concerned with a full review of the patient's notes. On investigation, in the vast majority of cases the correct response was enacted, but this was not documented on the Bristol Observations Chart.

Recovery plan, including expected date performance will be restored:

- Wards are highlighting the importance of responding and documenting the response to an Early Warning Score of 2 or more in their daily safety briefs, to ensure that all staff, including bank and agency staff, receive the message;
- Local training in wards, particularly where new staff have been appointed, is taking place;
- As reported last month, a deteriorating patient project is underway in 2014/15 which will be used as an opportunity to highlight all aspects of recognising and acting upon deterioration in patients as part of the training and development activities to support the project. A successful pilot has been completed in the Surgical & Trauma Assessment Unit using PDSA (Plan, Do, Study Act) small scale testing with front line staff. This will next be spread to two further wards in different divisions in July before being implemented more widely.

QUALITY

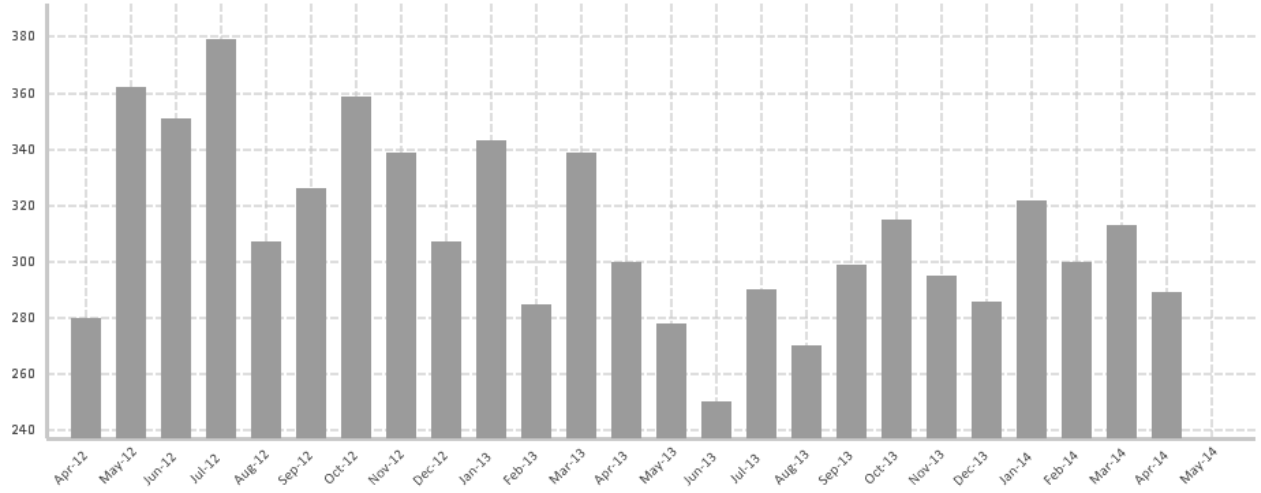
Q8. EXCEPTION REPORT: 30-day emergency readmissions	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

The number of emergency readmissions within 30 days of a previous discharge, rated against a target measured as a percentage of all discharges in the period. The target is an improvement on the previous year's level of emergency readmissions (i.e. 2013/14), which for 2014/15 equates to an emergency readmission rate of 2.70%

Performance in the period, including reasons for the exception:

In April there were 289 emergency readmissions within 30 days of discharge. This 0.01% above the target level of readmissions of no more than 2.70%, but is lower than the number of readmissions in March (313), and for the two months prior to that.



Recovery plan, including expected date performance will be restored:

- Reviews of the causes of any specialties identified as having a high emergency readmission rate, relative to the national average and clinical peer group, to continue to be commissioned by the Quality Intelligence Group. These reviews include the following:
    - Clinical coding review of the readmissions (including an assessment of whether the type of admissions has been correctly classified) that happened during any period for which levels of readmissions were identified as being statistically high;

QUALITY

- Following any amendments to clinical coding, the revised data to be reviewed to assess whether the specialty is still showing as an outlier from the national average and clinical peer group level, with the corrected data;
- Where the clinical coding data changes have not addressed the variance, the initiation of a formal clinical review of the readmission cases, to determine what the causes of readmissions were and whether there are any themes, in terms of avoidable reasons for readmission which need to be addressed.

QUALITY

Q9-10. EXCEPTION REPORT: Fractured neck of femur patients treated with 36 hours Fractured neck of femur patients receiving Best Practice Tariff	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

Best practice tariff for patients with an identified hip fracture requires all of the following standards to be achieved:

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

Performance in the period, including reasons for the exception:

May's Best Practice Tariff performance was 67%. This was under the 90% target due to all the standards not being met for 10 patients out of 30 in total. Performance in May for Time to Theatre was 70%, 21 patients out of 30 went to theatre within 36 hours. The details of the patients are:

- One patient did not receive Orthogeriatric review within 72 hours due to a Bank Holiday;
- Nine patients did not to receive surgery within 36 hours of admission:
  - Six patients were delayed due to lack of available theatre time caused by high levels of trauma admissions;
  - Two patients were delayed due to pre-operative scans and work-up required;
  - One patient was delayed due to a lack of a post-operative High Dependency Unit bed.

Recovery plan, including expected date performance will be restored:

- Continued daily monitoring of trauma waiting times and escalation within the Division to identify additional theatre capacity when required;
- A month-long audit of the 'Golden Case' protocol, aimed at improving times to theatres, commenced on 12th May to identify further opportunity for improvement in time to theatre;
- The Division is reviewing the theatre timetable post-October 2014 when vascular surgery is planned to transfer to North Bristol Trust. This may

provide opportunities to improve the scheduling of trauma operating sessions and increase total operating hours.

QUALITY

Q11. EXCEPTION REPORT: High Risk Transient Ischaemic Attack (TIA) starting treatment in 24 Hours	RESPONSIBLE DIRECTOR: Medical Director

Description of how the target is measured:

High Risk patients are those with an ABCD (Age, Blood, Clinical features, Duration of symptoms) score of 4 or above. Treatments (Aspirin, statin, control of blood pressure, referral for carotid intervention) should be commenced and relevant investigations (e.g. blood tests, electrocardiogram, brain scan) completed within the 24-hour window. The 24-hour window starts at first contact with any health professional. The denominator comprises patients who attend as outpatients, not those who are admitted to hospital.

Performance during the period, including reasons for exception:

Performance against the 60% standard was 30% in May, with seven out of 10 high risk patients failing to be treated within the 24-hour target. These are identified high risk patients and are part of a larger volume of other lower risk patients who need to be seen within 7 days. The reason for not being able to treat these high risk patients within 24-hours is as follows:

- One patient was not identified as high risk from the referral, due to an oversight
- For two patients there was no earlier outpatient appointments
- One patient declined an earlier appointment
- One patient was not seen at North Bristol Trust at the weekend, and was then referred to the Trust
- One patient was seen in the Emergency Department at Weston General Hospital and there was a delay in the GP referring to the TIA clinic
- One patient presented late to GP, having previously been identified as at risk, and there was no clinic on the day they were referred

Recovery plan, including expected date performance will be restored:

- Current review of Stroke pathway underway to map current and future state;
- TIA not currently part of the pathway review, but will be added as a sub-group to the Stroke pathway work. First meeting arranged to include representatives from Diagnostics & Therapies for input in respect of MRI (Magnetic Resonance Imaging) issues;
- Potential for telephone triage by TIA clinic post referral to ensure appropriate patients prioritised;
- Review of clinic capacity underway as late referrals cannot have appropriate investigations completed later in the day – the current cut off point is approximately 3:30 p.m.

QUALITY

Q12-14. EXCEPTION REPORT: Dementia Stage 1 - Find Stage 2 – Assess & Investigate Stage 3 – Referral on to GP	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Green rating 90% or above / Amber rating 80% - 89% / Red rating below 80%

The National Dementia CQUIN, "Find, Assess and Investigate, Refer (FAIR)" occurs in three parts:

1. **Find**
   The case finding of at least 90% of all patients aged 75 years and over following emergency admission to hospital, using the dementia case finding question and identification of all those with delirium and dementia. This has to be completed within 72 hours of admission
2. **Assess and Investigate**
   The diagnostic assessment and investigation of at least 90% of those patients who have been assessed as at-risk of dementia from the case finding question and/or presence of delirium.
3. **Refer**
   The referral of at least 90% of clinically appropriate cases to General Practitioner to alert that an assessment has raised the possibility of the presence of dementia

The CQUIN payment for 2014/15 has identified milestones for achievement for each quarter. As a provider we need to achieve 90% or more for each element of the indicator for each quarter taken as a whole with a weighting of 25% for each quarter.

Performance in the period, including reasons for the exception:

Stage 1- Find – status RED

Performance in May for stage 1 was 52.3%, compared with 57.1 % in April.

Divisional performance

Medicine 55.5%; Surgery Head & Neck 53.8%; Specialised Services 31.6%

Stage 2 – Assessment and Investigation – status RED

Performance in May for stage 2 was 78.3% against a target of 90%. This demonstrates a marginal improvement from April (71.7%)

QUALITY

Divisional performance

Medicine 76.6%; Surgery Head & Neck 100%; Specialised Services 100%

Stage 3 – Referral on to GP – status RED

Performance in April for stage 3 was 56.5% compared with 47.6% in April.

Divisional performance

Medicine 52.4%; Surgery Head & Neck 100%; Specialised Services 100%

During March and April 2014 the Trust team focused improving compliance for stage 1 (asking the dementia case finding question) within the admission areas, which resulted in a 12% increase. This improvement was not sustained in May, despite a continued focus. This is in part due a change at junior doctor level covering the Medical Assessment Unit during this time.

Recovery plan, including expected date performance will be restored:

The following steps have been taken, or are in progress, to improve compliance of all three stages on the CQUIN FAIR process:

- Recruitment process commenced for Lead Dementia role, which will be vacant from June 23rd;
- Development of an Information Management & Technology (IM&T) solution to flag, record and monitor all stages of the FAIR process. This system is expected to be in place by the autumn 2014;
- Successful bid to the CCG for two dementia project posts (150K):
    i. Band 7 WTE two year secondment / fixed term project post to focus on the admission areas (Medical, Older Persons and Surgical & Trauma Assessment Units) to ensure the timely screening, assessment and referral on where appropriate. This post will ensure that this process is embedded into daily clinical practice. Interviews taking place 19th June 2014;
    ii. Band 3 WTE two year secondment / fixed term clinical support post to support lead nurse for Dementia and related project posts in the achievement of the National Dementia CQUIN and best practice. Interviews taking place 16th June 2014;
- It is anticipated that the successful applicants will commence in their new posts by August 2014.The new revised admission documentation (for nursing and Allied Health Professional staff) includes the Dementia case finding question, which will be launched from August 1st (as part of the Trust wide documentation review);
- A sticker has been developed to place in the medical records to prompt medical staff on next steps following a 'yes' answer to the dementia case finding question. This will be implemented by the Band 7 project post across the admission areas.

A care plan ('caring for people with cognitive impairment') has been developed and disseminated and will be implemented Trust-wide by the end of June 2014 and audited from July 2014. The care plan will prompt completion of the FAIR process and guide staff on delivering best practice (identified

action from CQC inspection in January 2014).

QUALITY

Q15-16. EXCEPTION REPORT: Number and percentage of complaints resolved within Local Resolution Plan timescale-Trust timescale and divisional timescale	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

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

Divisional timescale: The percentage of final responses to complaints that were provided by the division for executive sign off within the internally agreed timescale.

Performance in the period, including reasons for the exception:

In May 2014, 47 responses out of the 57 which had been due in that month were posted to the complainant by the date agreed (82.5%). This represents deterioration in performance compared with 93.1% in April.

10 breaches were recorded in total for May (compared with four in April). Of these 10 breaches, 2 were attributable to the Division of Women's & Children's Services. The remaining 8 cases breached due to delays during the Executive sign-off process.

The Divisions of Medicine, Surgery, Head & Neck, Specialised Services, Diagnostics & Therapies and Facilities & Estates recorded zero breached deadlines in May.

(It should be noted that if a response breaches a deadline because significant amendments are necessary, this is attributed as a divisional breach, even if the Division met the initial response deadline.)

Recovery plan, including expected date performance will be restored:

- Each breached deadline is validated by the Patient Support & Complaints Team and the relevant Divisional Complaints Co-ordinator: as well as being a validation of the breach (data quality check), this also ensures that the Division can look at how the delay could have been avoided and therefore how they will learn from this for the future;
- Performance is discussed and monitored at the Patient Experience Group, chaired by the Chief Nurse;
- All written responses must be received by the Patient Support & Complaints Team four working days before the response is due with the complainant: this is to allow time for the response to be checked prior to Executive sign-off.

1.6 SUPPORTING INFORMATION

1.6.1 QUALITY ACHIEVEMENTS

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

- There have been sustained improvements in the key quality outcomes across the Division and in April all quality outcomes were green. The sustained improvement in reduction of pressure ulcers in 2013/14 compared to 2012/13 is shown below.

Year	2012/13	2013/14
Grade 2	67	27
Grade 3	9	4

- The Division continues to see a successful implementation of the Friends & Family Test, with both high return rates in Quarter 4 of 41% and excellent patient feedback with a score of 84;
- The Division has focused on improving medication safety over the past quarter, which has included sharing audits and policies with all members of the multidisciplinary team including Medical staff, Nursing and Pharmacy. This engagement has demonstrated an ongoing reduction in omitted doses of medicines, and a sustained improvement of achieving antibiotic compliance at 93% against a target of 90%. Further work underway includes a Medication Study Day for nurses and full review of four months data of all medication incidents to ensure learning;
- Listening to staff events across the Division have taken the format of specific listening events by the Divisional Director and the Head of Nursing visiting wards/ departments to be available to talk to staff and ' Back to the floor ' working by the Senior Nurses. The Human Resources Business Partners have been undertaking focus groups with several groups of staff which have been well received. These enable staff to talk freely and provide feedback in an anonymous way and the themes identified are then shared with the head of department / ward to generate an action plan. The information gained has been particularly useful in planning the induction packages for new nursing staff. All of these methods of staff engagement are being extended to include most areas over the next year.

Successes for individual staff

- The Division had several nominations for our Trust Nurses Day Awards and winners on the day included:
    - The Adult Congenital Heart Disease Nurse Specialists who won the Team Award in recognition and appreciation of their outstanding work and Ward 62 were highly commended in the Team Award;
    - Suzanne Monaghan, Senior Staff Nurse on Ward 51 was highly commended in the Rising Star Award;
    - Lisa Mace, our Cardiac Wound care Nurse Specialist won the Nursing & Midwifery Scholarship and will be travelling to a hospital in America to view and learn from their management of surgical site infections.

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- Rachel Bohin, Sister in the Cardiac Catheter labs at the Bristol Heart Institute won the best clinical case presented by a nurse or technician at EURO PCR. This is a large European interventional cardiology conference which took place in Paris in May.

1.6.2 SERIOUS INCIDENT THEMES

The quality dashboard shows that seven serious incidents were reported in May 2014, with the following themes:

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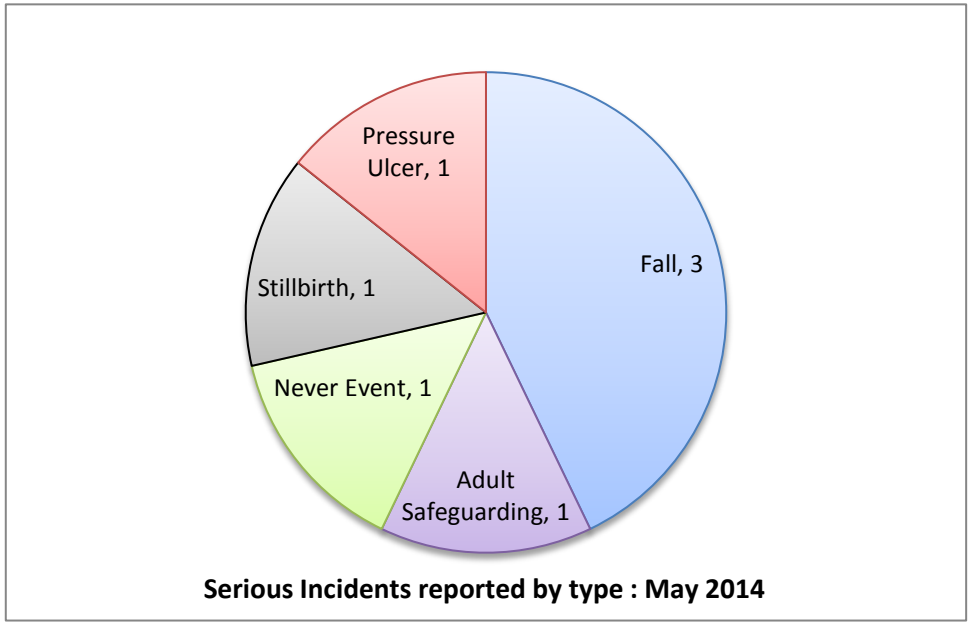

Serious Incidents reported by type : May 2014

Date of Incident	SI Number	Division	Reported within 48 hours	Status	Incident Details	Initial assessment of harm	Investigation
04/05/2014	2014 14663	Surgery, Head & Neck	Yes	Open	Patient fall resulting in fractured hip.	Major	Investigation underway
12/05/2014	2014 15258	Women and Children	Yes	Open	Grade 3 Pressure Ulcer.	Moderate	Investigation underway

QUALITY							
17/05/2014	2014 16431	Medicine	Yes	Open	Patient fall resulting in fractured hip.	Major	Investigation underway
21/05/2014	2014 16799	Surgery, Head & Neck	Yes	Open	Never Event: Carpel Tunnel release performed instead of a De Quervain's release.	Moderate	Investigation underway
19/05/2014	2014 16972	Surgery, Head & Neck	No	Open	Adult Safeguarding.	Minor	Investigation underway
16/05/2014	2014 17174	Women's & Children's	No	Open	Unexpected stillbirth following delivery on the Midwifery Led Unit.	Unavoidable death	Investigation underway
20/05/2014	2014 17220	Medicine	No	Open	Patient fall resulting in fracture.	Major	Investigation underway

WORKFORCE

2.1 SUMMARY

The six indicators included in the monthly performance review are summarised in the dashboard below.

 **Achieving (0)**	 **Underachieving (3)**	 **Failing (2)**
	- Workforce expenditure - compared with budget - Workforce numbers - compared with budgeted establishment - Turnover - compared with target - *Sickness absence (April figures) – compared with target	- Bank and agency usage - compared with target - Vacancies - compared with target

Key Performance Indicators in the quarterly report will include appraisal, essential training, health and safety measures and junior doctor new deal compliance, in addition to those which form part of the monthly performance report. Targets for sickness absence, turnover and bank and agency are agreed with divisions as part of the Operating Plan process. For those targets which are failing, exception reports are provided which detail performance against target, and against the previous month. Graphs in the Supporting Information section are continuous with the previous year to provide a rolling perspective on performance.

*Sickness absence data for May is not yet available due to the timing of the Payroll closure. It is important that Payroll closes sufficiently late to avoid the risk of staff being paid incorrectly, and this month this was not in time to provide the latest sickness absence reporting.

2.2 EXCEPTION REPORTS

An exception report is provided for the RED-rated indicators, which in May 2014 was as follows:

- Bank and agency usage – red rated against target
- Vacancies– red rated against target

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W1. EXCEPTION REPORT: Bank and Agency compliance	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

Bank and agency usage in Full Time Equivalents (FTE) compared with targets set by Divisions for 2014/15.

Performance in the period, including reasons for the exception:

The variance in pay and staff in post compared with budget improved this month, with both being within the agreed threshold for this metric. However, the use of bank and agency exceeded the locally agreed targets in all Divisions, except Diagnostics & Therapies and Trust Services.

During May, bank usage generally increased by 25.6%, compared to the previous month, and agency reduced by 11.1%. Use of bank and agency staff increased from 394 FTE in April to 467 FTE in May. Nursing agency reduced by 37.3% (14.4 FTE), and nursing bank increased by 22.5% (45.9 FTE).

Bank and Agency (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Actual May 2013	413.8	13.6	162.2	37.2	81.4	54.7	34.5	30.3
Actual May 2014	466.8	13.2	133.3	62.5	89.1	72.6	37.5	58.7
Target May 2014	282.3	13.7	99.0	11.9	56.6	30.5	51.4	19.3

Reasons for the exception include:

- Trust-wide, there was no change in bank and agency usage due to workload and clinical needs, extra capacity and administrative workload, which comprised 35.4% of usage;
- Usage to cover vacancies increased to 27%, compared with 24.1% last month;
- 14.1% of usage was due to sickness absence compared with 13.7% last month;
- Nursing assistant one to one care increased this month, from 6.9% up to 7.6%.

Recovery plan, including progress and expected date performance will be restored:

Divisions have detailed action plans which are reviewed in Divisional Performance Reviews. Trajectories will be produced to show how these actions will result in reduced usage. Action plans are generally focussed on the themes below:

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- Improving the way Rosterpro is utilised in ward areas, to ensure that peaks of demand are avoided;
- Review of staffing requirements associated with fluctuations in the acuity and dependency of patients;
- Improving the framework for the assessment of nursing assistant one to ones, through the development of an Enhanced Observation Policy;
- Reviewing the way maternity cover is represented in budgets;
- Ensuring vacancies are filled promptly;
- Managing sickness absence appropriately.

WORKFORCE

W2. EXCEPTION REPORT: Vacancy Levels	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

The vacancy Key Performance Indicator (KPI) is the difference between the full time equivalent budgeted establishment and the full time equivalent substantively employed, represented as a percentage. The Trust-wide vacancy KPI threshold is 5%.

Performance in the period, including reasons for the exception:

There is an overall increase in vacancy levels from 2.2% to 5.5% this month. Women`s & Children`s, Trust Services and Facilities & Estates were over target.

Vacancy	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
	5.5%	3.2%	4.9%	3.1%	4.7%	5.9%	10.8%	8.2%

The increase in vacancy levels in the three divisions was largely as a result of the following:

- The transfer of Specialist Paediatrics, which is associated with vacancies in theatres and the Paediatric Intensive Care Unit;
- Trust Services have increased the budgeted establishment for Medical Records by 10.8 FTE, pending changes in the Electronic Discharge Management System;
- The budgeted establishment and vacancy levels for ancillary staff in Facilities & Estates has also increased, due mainly to the transfer of Specialist Paediatrics and new developments in oncology.

Recovery plan, including progress and expected date performance will be restored:

- Vacancies in Women`s & Children`s associated with the transfer of Specialist Paediatrics are being actively recruited to;
- Medical Records vacancies are being covered with bank staff until the Trust is ready to recruit substantively, pending the implementation of the new staffing models associated with the Electronic Discharge Management System;
- Ancillary recruitment to fill vacancies associated with the new developments, as well as ongoing issues associated with high turnover, are described as part of the overall recruitment plans below.

<u>Ancillary Recruitment</u>

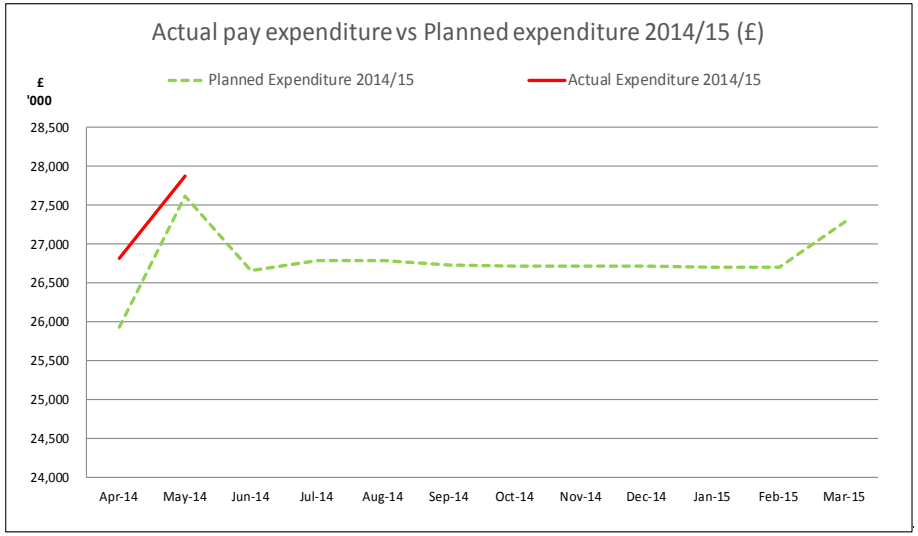
There were 9 starters in May, although 10 left the Trust in the same period. A total of 49 ancillary vacancies were being recruited to at the end of May,

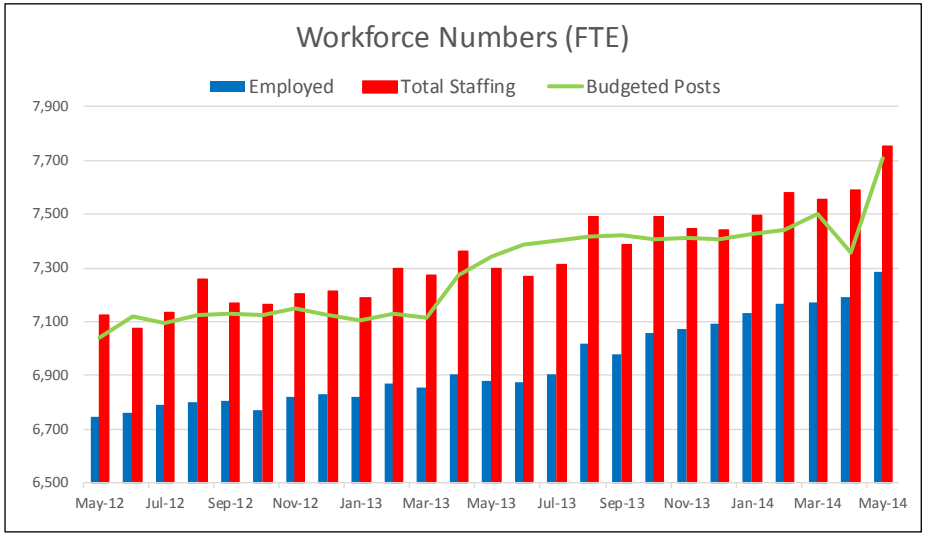
covering Domestic Assistants, Porters and Catering, 23 of which have offers against them. There is a robust recruitment plan to support the Bristol Royal Infirmary redevelopment so that recruitment campaigns link to each phase. 29 Domestic Assistants are required for the expansion to the Children's Hospital. To date, 26 have taken up post, with a further 3 pending start dates. 15 Domestic Assistant posts are currently going through the recruitment process for the Bank, which is anticipated to have a positive impact on agency usage.

2.3 SUPPORTING INFORMATION

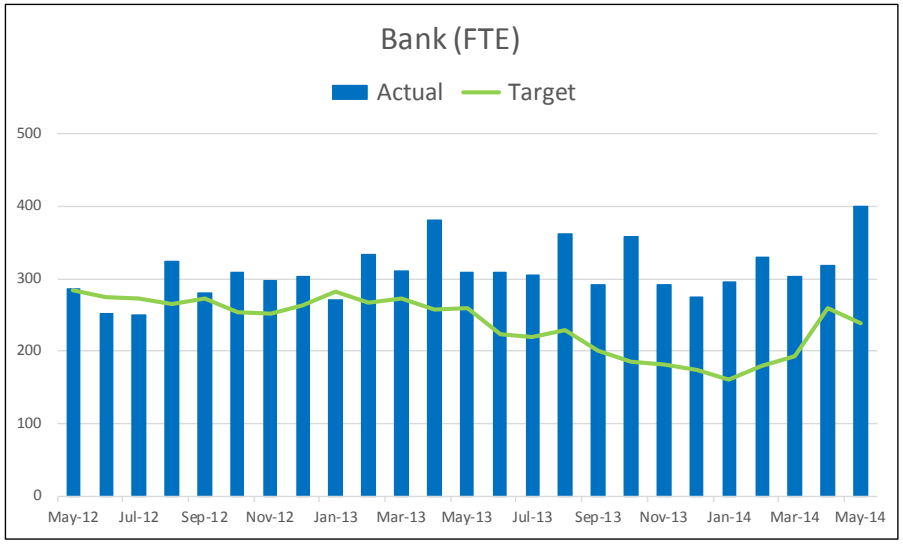
2.3.1 Performance against key workforce standards

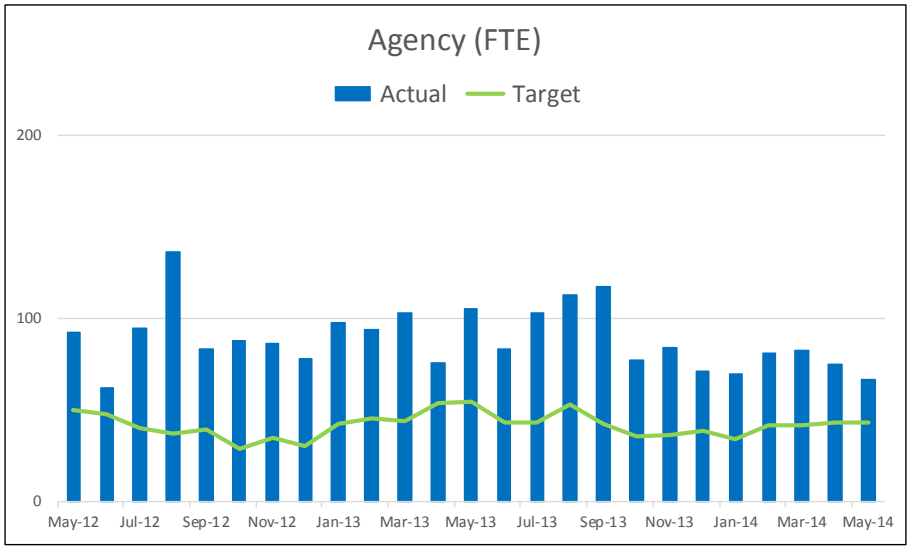
This section provides an outline of the Trust's performance against workforce indicators for workforce expenditure, workforce numbers, and bank and agency usage, with an additional chart to show how the variance against target for agency usage has reduced. There are also graphs to show nursing agency and vacancy rates, sickness rates, and the top five causes of sickness.

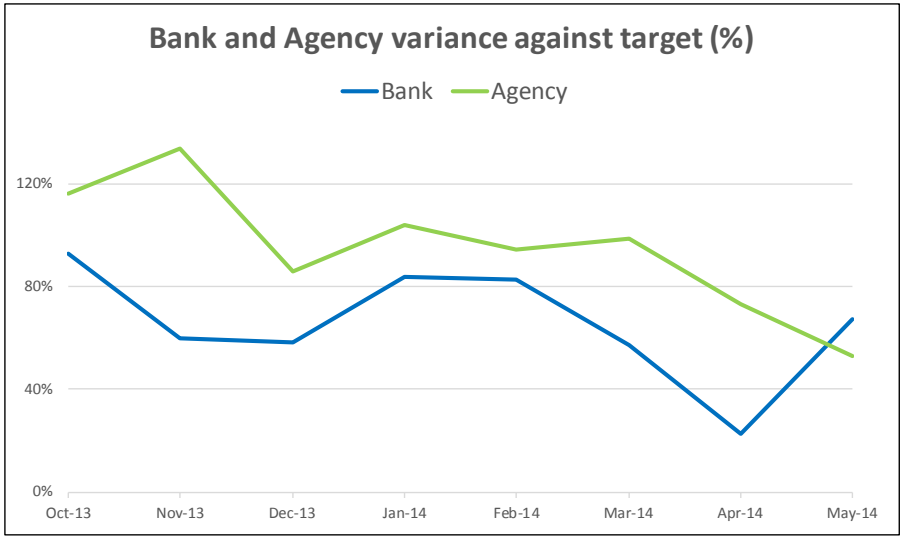


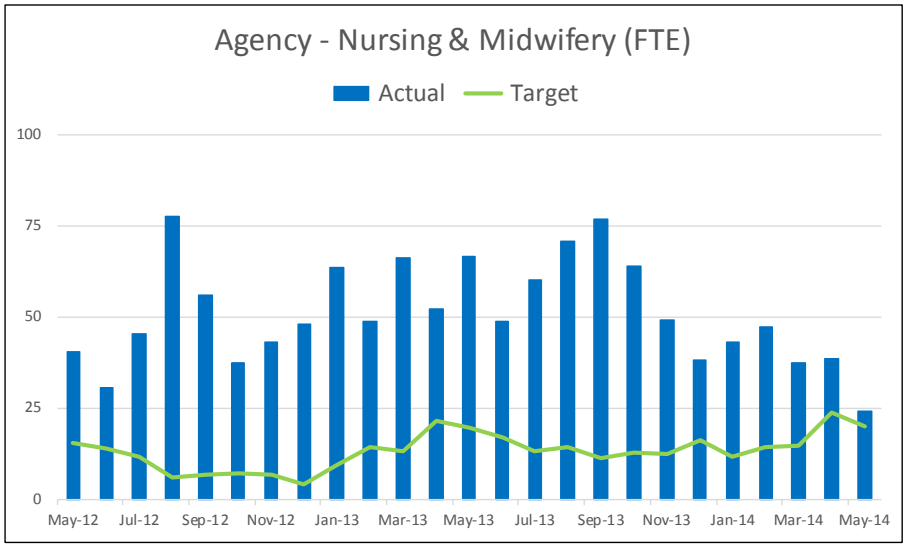


WORKFORCE

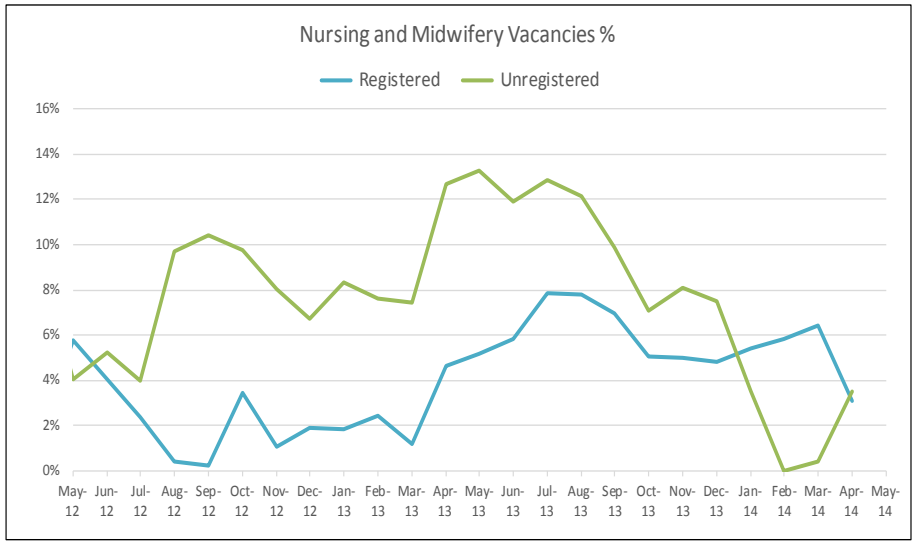

Bank (FTE)
Actual
Target
500
400
300
200
100
0
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14

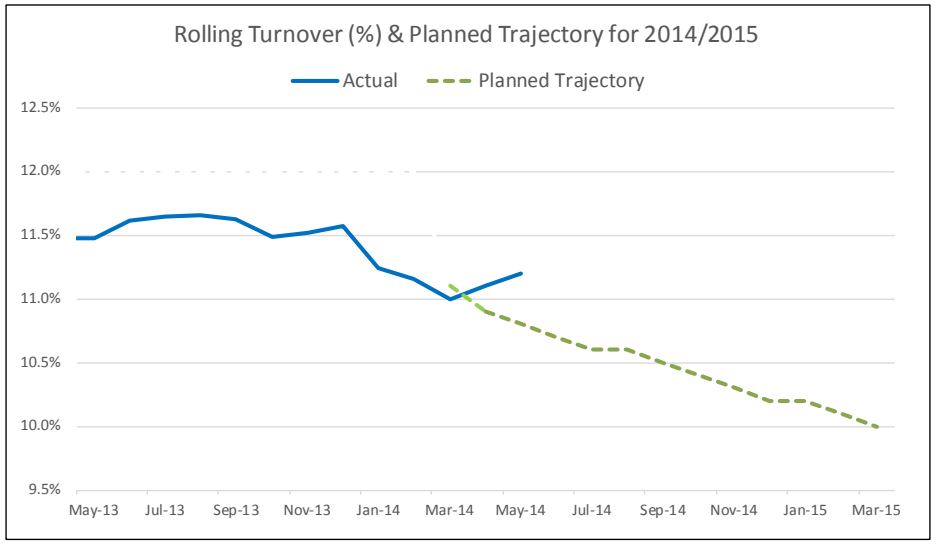

Agency (FTE)
Actual
Target
200
100
0
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14


Bank and Agency variance against target (%)
Bank
Agency
120%
80%
40%
0%
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14


Agency - Nursing & Midwifery (FTE)
Actual
Target
100
75
50
25
0
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14

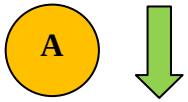
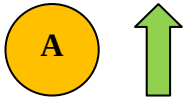
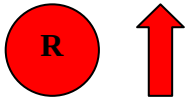
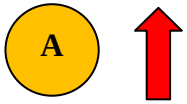
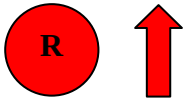
WORKFORCE


Nursing and Midwifery Vacancies %
Registered
Unregistered
16%
14%
12%
10%
8%
6%
4%
2%
0%
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14


Rolling Turnover (%) & Planned Trajectory for 2014/2015
Actual
Planned Trajectory
12.5%
12.0%
11.5%
11.0%
10.5%
10.0%
9.5%
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15

2.3.3 Changes in the period

Performance is monitored for workforce expenditure, workforce numbers, bank and agency usage, sickness and turnover. The following dashboard shows key workforce information indicators RAG (Red, Amber, Green) rated for the month of May. Red rated indicators are outside tolerance limits and exception reports are provided for these.

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Expenditure (£)		Workforce expenditure adverse variance from budget reduced from 3.4% to 0.9% compared with April 2014.	See summary and supporting information.
Workforce Numbers (FTE)		Workforce numbers increased by 2.2% compared with April 2014. This month, workforce numbers were 0.6% above budgeted FTE. This compares with April 2014, which was 3.1% above budgeted establishment.	See summary and supporting information.
Bank/ Agency (FTE)		Agency reduced by 11.1% (8.3 FTE) and bank increased by 25.6% (81.4 FTE) in May 2014 compared with the previous month.	See summary, supporting information and exception report.
Sickness absence		Sickness absence in April was 3.8% compared with a target of 3.6%.	Note: this is April data due to May data not being available
Turnover (%)		Rolling turnover (with exclusions) increased to 11.2% compared a target of 10.8%. 3.7% above the turnover target trajectory for May.	See summary and supporting information.
Vacancy (%)		The vacancy target is 5% or less. Vacancies increased from 2.2% last month to 5.5%	See summary, supporting information and exception report.

Note: RAG (Red, Amber, Green) rating reflects whether the indicator has achieved the target. The direction of the arrow shows the change from last month. The colour of the arrow reflects whether actual this month is better in relation to the target (green) or further from the target than last month (red). Sickness and bank and agency targets are set by Divisions, and appraisal is a Trust wide target.

2.3.4 Monthly forecast and overview

Measure	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	May 14 Target
Budgeted Posts (FTE)	7340.6	7387.6	7399.9	7415.6	7420.3	7408.3	7411.1	7406.4	7424.8	7442.0	7499.3	7355.2	7709.5	7622.1
Total Staffing (FTE)	6882.4	6872.9	6905.5	7017.4	6979.7	7056.7	7071.7	7093.7	7130.2	7167.3	7170.6	7193.7	7285.6	7460.2
Bank (FTE) Admin & Clerical	65.8	71.7	75.1	95.3	67.1	80.0	63.9	58.4	59.0	67.4	64.9	71.3	89.2	64.8
Bank (FTE) Ancillary Staff	21.6	27.3	29.8	37.6	27.4	36.7	27.0	25.6	30.7	35.2	34.6	38.0	54.6	18.9
Bank (FTE) Nursing & Midwifery	209.0	200.2	189.6	217.1	188.6	232.2	194.5	184.2	197.0	220.2	197.4	203.6	249.5	147.2
Agency (FTE) Admin & Clerical	17.8	11.3	18.2	19.9	27.3	12.2	14.8	17.4	13.5	27.1	25.7	23.4	22.4	13.9
Agency (FTE) Ancillary Staff	17.2	13.7	12.2	10.5	-0.5	-10.0	10.7	10.5	3.7	0.0	8.3	0.0	6.8	2.3
Agency (FTE) Nursing & Midwifery	66.8	48.7	60.3	70.9	76.9	64.1	49.4	38.1	43.1	47.2	37.5	38.5	24.1	20.0
Overtime	57.0	59.3	62.1	71.1	96.1	67.7	55.8	58.2	60.1	54.7	83.7	76.4	48.2	46.3
Sickness absence[1] Rate (%)	3.9%	3.5%	3.7%	3.9%	3.8%	3.9%	4.2%	4.2%	4.2%	4.5%	4.2%	4.3%		3.3%
Appraisal (%)	87.6%	87.4%	87.5%	87.4%	87.1%	87.2%	88.6%	89.4%	89.7%	89.6%	88.1%	87.1%	86.3%	85.0%
Consultant Appraisal[5] (%)	93.1%	90.2%	90.3%	90.4%	89.7%	88.3%	87.8%	87.9%	88.2%	88.6%	89.4%	89.1%	89.2%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	18.6%	18.7%	15.9%	18.7%	18.5%	18.4%	18.3%	18.3%	17.9%	18.0%	17.8%	17.8%	18.0%	
Rolling Average Turnover[3] (with exclusions) (%)	11.5%	11.6%	11.7%	11.7%	11.6%	11.5%	11.5%	11.6%	11.2%	11.2%	11.0%	11.1%	11.2%	10.8
Vacancy[4] Rate (%)	6.2%	7.0%	6.7%	5.4%	5.9%	4.7%	4.6%	4.2%	4.0%	3.7%	4.4%	2.2%	5.5%	≤5%

1. Sickness absence is expressed as a percentage of total whole time equivalent staff in post.
2. Turnover measures the number of leavers expressed as a percentage of the average number of staff in post in the period. Turnover (all reasons) excludes bank, locum and honorary staff.
3. Turnover (with exclusions) excludes bank, locum, honorary and fixed term staff together with junior doctors.
4. Vacancy measures the number of vacant posts as a percentage of the budgeted establishment.
5. Consultant appraisal process allows 14 months before counting as non-compliant

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 May 2014**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 1)***, and/or the ***month***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS operating framework and NHS Constitution.

Achieving (15)	**Underachieving (1)**
- 31-day diagnosis to treatment cancer standard - *first treatment* - 31-day diagnosis to treatment cancer standard - *subsequent drug* - 31-day diagnosis to treatment cancer standard – *subsequent radiotherapy* - 31-day diagnosis to treatment cancer standard - *subsequent surgery* - 62-day referral to treatment cancer standard – *screening referred* - 2-week wait urgent GP referral cancer standard - Referral to Treatment Time for 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 Initial Assessment + A&E Time to Treatment - A&E Unplanned re-attendance - Ambulance hand-over delays over 30 minutes (year-on-year reduction) - Reperfusion times (door to balloon time of 90 minutes)	- Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved*
Failing (7)	**Not reported/scored (0)**
- A&E Maximum waiting time (4-hours) - Delayed Discharges - Referral to Treatment Time for non-admitted patients - 62-day referral to treatment cancer standard – *GP referred* - Last-minute cancelled (LMC) operations + 28-day readmission following LMC - 6-week wait for key diagnostic tests	

*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 May. 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

	Target	Thresholds Green	Thresholds Red	Previous YTD	Year to date (YTD)	Month Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Quarter Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	97.6%	97.1%	97.1%	96.6%	95.7%	97.2%	95.0%	96.3%	98.0%	95.4%	98.0%	98.4%	97.1%	Cancer standards report two months in arrears	96.5%	96.4%	97.4%	97.1%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	98.1%	97.9%	97.6%	99.4%	96.5%	94.3%	96.9%	99.5%	97.6%	96.2%	94.0%	97.8%	97.9%		96.7%	98.0%	96.0%	97.9%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%	100.0%	100.0%	100.0%		100.0%	99.7%	99.7%	100.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	83.8%	97.9%	97.2%	96.1%	95.2%	89.3%	100.0%	93.5%	95.0%	93.5%	97.6%	91.8%	97.9%		94.2%	96.9%	94.1%	97.9%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	98.9%	97.9%	98.2%	97.8%	98.1%	97.1%	97.1%	97.6%	99.0%	92.3%	99.5%	95.6%	97.9%		97.7%	97.8%	95.7%	97.9%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	82.7%	75.3%	85.7%	76.6%	77.9%	82.7%	85.6%	83.1%	85.2%	72.9%	77.4%	74.8%	75.3%		78.9%	84.6%	75.1%	75.3%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	96.3%	89.6%	91.2%	95.3%	100.0%	93.9%	91.8%	84.2%	97.6%	98.0%	94.9%	88.9%	89.6%		96.6%	90.5%	94.4%	89.6%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	100.0%	97.5%	100.0%	94.3%	88.2%	100.0%	86.7%	84.2%	93.1%	79.3%	75.6%	97.0%	97.5%		94.2%	88.3%	85.3%	97.5%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	93.3%	91.8%	94.4%	93.0%	92.8%	92.2%	92.9%	91.6%	92.1%	92.8%	92.4%	90.5%	91.9%	91.8%	92.7%	92.3%	92.0%	91.8%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	95.7%	93.8%	95.7%	92.5%	91.5%	91.3%	92.4%	91.3%	94.0%	92.0%	92.7%	93.1%	93.6%	94.0%	91.8%	92.5%	92.6%	93.8%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.3%	92.5%	92.8%	92.2%	92.3%	92.6%	92.9%	93.1%	92.2%	92.6%	92.4%	93.1%	92.7%	92.5%	92.4%	92.7%	92.7%	92.5%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	93.2%	94.4%	96.0%	93.8%	95.6%	97.1%	95.1%	95.4%	90.8%	91.6%	90.1%	92.1%	94.5%	94.3%	95.4%	93.7%	91.3%	94.4%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	47	13	14	14	13	12	13	13	14	12	24	15	14	12	13	13	14	13
	A&E Time to treatment decision (median) - in minutes	60	60	54	55	51	54	47	49	53	53	53	46	55	54	53	57	50	53	51	55
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	2.7%	2.4%	0.7%	0.6%	0.7%	0.6%	2.3%	2.2%	3.0%	2.8%	2.5%	2.4%	2.7%	2.2%	0.6%	2.5%	2.5%	2.4%
	A&E Left without being seen	5%	5%	1.7%	1.7%	1.4%	1.8%	1.7%	1.8%	2.2%	2.1%	2.1%	2.0%	1.8%	1.7%	1.5%	1.9%	1.7%	2.1%	1.8%	1.7%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.28%	0.97%	0.82%	1.15%	0.85%	0.72%	0.65%	0.96%	1.02%	1.18%	1.44%	0.92%	0.98%	0.96%	0.91%	0.85%	1.17%	0.97%
	28 Day Readmissions	95%	85%	84.8%	89.6%	89.5%	88.9%	88.4%	93.6%	95.0%	95.0%	92.6%	93.6%	88.6%	89.7%	94.2%	85.2%	90.1%	94.0%	90.3%	89.6%
	6-week wait for key diagnostics	99%	99%	98.0%	97.4%	98.4%	97.7%	98.2%	98.5%	98.9%	99.5%	98.8%	98.0%	99.2%	99.2%	98.3%	96.6%	98.1%	99.1%	98.8%	97.4%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	72.1%	78.6%	87.8%	89.7%	84.4%	65.0%	86.2%	91.2%	81.6%	77.5%	82.9%	77.1%	78.6%		81.5%	86.1%	78.9%	78.6%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	95.3%	96.4%	95.1%	96.6%	90.6%	95.0%	96.6%	97.1%	89.5%	90.0%	91.4%	91.7%	96.4%		93.8%	94.1%	91.1%	96.4%
	Delayed discharges (Green to Go List)	30	41	Not applicable	53.5	52	58	60	65	57	50	52	60	73	58	56	51	61.0	53.0	63.7	53.5
	Ambulance hand-over delays (over 30 minutes) - *year-on-year reduction*	20%	10%	155.0	98.0	88	123	52	44	63	70	120	94	137	105	96	100	73.0	84.3	112.0	98.0

Please note:
Where the threshold for achieving the standard has changed between years, the latest threshold for 2014/15 has been applied in the Red, Amber, Green ratings.
The thresholds for Ambulance hand-over delays are a percentage reduction on the same period last year, in order to take account of seaonal changes in demand.
The standard for Primary PCI 150 Call to Balloon Time only applies to direct admissions - the local target is shown as the GREEN threshold and the national target as the RED.
All **CANCER STANDARDS** are reported nationally two months in arrears. Monthly figures are indicative, until they are finalised at the end of the quarter. The figures shown are those reported as part of the National Cancer Waiting Times data-set. They do not reflect any breach reallocation for late referrals, which is only allowable under Monitor's Compliance Framework.

3.3 CHANGES IN THE PERIOD

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

- 31-day diagnosis to treatment cancer standard *– subsequent surgery* ↑ (up from 91.8% in March to 97.9% in April)
- 28-day readmission following a last-minute cancellation ↓ (down from 94.2% in April to 85.2% in May)
- 6-week diagnostic wait ↓ (down from 98.3% in April to 96.6% in May)
- Reperfusion times (door to balloon time of 90 minutes) ↑ (up from 91.7% in March to 96.4% in April)

Please note the above performance figures only show the final reported position and do not show the draft May performance against the cancer standards, although additional information is noted where the draft figures have been validated.

3.4 EXCEPTION REPORTS

Exception reports are provided for six of the RED rated performance indicators.

Please note that the number of Delayed Discharge patients in hospital at month-end is now reported as one of the access key performance indicators, along with Ambulance hand-over delays over 30 minutes. As a key measure of patient flow, performance against the Delayed Discharges operational target will be reported as part of the A&E 4-hour Exception Report, in months where the 95% standard isn't achieved.

1) Last-minute cancellations
2) 28-day readmission following a last-minute cancellation
3) 62-day referral to treatment cancer standard – GP referred
4) Referral to Treatment Time (RTT) Non-admitted pathways standard
5) A&E 4-hour maximum wait
6) Six week wait for diagnostic tests

ACCESS STANDARDS

A1–A2. EXCEPTION REPORT: Last-minute cancellation + 28-day readmission following a last-minute cancellation	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.

This standard remains part of the NHS Constitution.

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

There were 54 last-minute cancellations (LMCs) of surgery in May (0.96% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in May were as follows:

- 19% (10 cancellations) were due to no ward bed being available to admit a patient to
- 17% (9 cancellations) were due to an emergency patient being prioritised on the day
- 17% (9 cancellations) were due to no Intensive Therapy Unit (ITU)/ High Dependency Unit (HDU) beds being available to admit patients to
- 13% (7 cancellations) were due to another patient in theatre being more clinically complicated than expected
- 35% (19 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging

Of the 54 cancellations, 23 were day-cases and 31 were inpatients (43% day-cases). On average, seventy percent of the Trust's admissions in a month are day-cases. The higher rate of inpatient cancellations reflects the high cancellation rate due to emergency patients needing to take priority and the lack of a critical care bed, which is more likely to impact inpatient than day-case procedures.

Like last month, ward bed availability was the single highest cause of cancellations this month. If there had been no cancellations due to the lack of a ward bed, performance would have been 0.78% against the 0.8% national standard. The lack of a critical care bed was one of the top three causes of cancellations in the month, which is a change from the previous month, where a clear reduction in cancellations for this reason had been observed. This increase in cancellations due to the lack of a critical care bed appears to be due to a short-term increase in demand and not a return to the pattern of causes of cancellations experienced in 2013/14.

In May, 85.2% of patients cancelled in the previous month were readmitted within 28 days of the cancellation. There were 9 breaches of standard in the month. Eight of these patients were due for readmission to the Bristol Children's Hospital; 2 could not be re-admitted within 28-days due to lack of Paediatric Intensive Care Unit capacity or other bed capacity, the remaining patients were not re-admitted within the target 28 days due to the clinical requirements of patients already booked (a mix of urgency and planned rehabilitation). The one patient due for surgery within the Bristol Royal Infirmary was not re-admitted within 28-days due to more urgent patients taking priority.

ACCESS STANDARDS

Recovery plan, including expected date performance will be restored:

The following actions continue to be taken to reduce last-minute cancellations and support 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 (see A&E 4-hour Exception Report – A6);
- Escalation of all LMCs not re-booked within 7 days of cancellation (ongoing); patient list now also being reviewed at the weekly or fortnightly Referral to Treatment Time (RTT) meetings with Divisions;
- 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 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 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 (ongoing);
- Daily e-mails circulated of all on-the-day cancellations within the Bristol Royal Infirmary by the nominated Patient Flow Co-ordinator, to help ensure patients are re-booked within target (ongoing);
- In addition to the opening of the twentieth ITU bed, a further review of critical care capacity is being undertaken, as part of the 2014/15 Operating Model, which is being led by the Senior Leadership Team.

Progress against the recovery plan:

The 0.8% national last-minute cancelled operations standard was not achieved in May. This was primarily due to emergency pressures on beds and theatres. In contrast to previous months, where a consistent improvement had been seen relative to the same period last year, performance in May was the same as in May 2013.

Performance against the 28-day readmission standard was 85.2%, which represents a significant deterioration on April's performance of 94.2%. The ability to re-admit patients following their cancellation was primarily affected by a combination of emergency pressures and other more urgent patients needing to be prioritised. Reducing the level of ward-bed related cancellations remains critical to the achievement of both the last-minute cancelled operations and the 28-day readmission standards. Delivery of the objectives of the 2014/15 Operating Model should reduce levels of last-minute cancelled operations and improve performance against the 28-day readmission standard.

ACCESS STANDARDS

A3. EXCEPTION REPORT: 62-day referral to treatment for 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, although Monitor treats this as a combined standards for the purposes of scoring

Monitor measurement period: All cancer standards are measured Quarterly (weighted 1.0 in the Risk Assessment framework)

Performance during the period, including reasons for exceptions:

62-day GP referred

Draft performance for May is 80.9% against the 85% standard. However, further validation is still required before national reporting is undertaken in early July. It is expected that the recovery trajectory target of 80.5% will be achieved for the month. The recovery target for the quarter of 75.3% is on track to be met, with the expected impact of validation taken into account.

Performance in April was confirmed as 75.3% against the 85% standard. Breach analysis has shown the reasons for the breaches to be as follows:

Breach reasons	April breaches	Percentage of breaches
Late referral	6.0	31%
Medical deferral/Clinical complexity	4.5	23%
Outpatient delay	1.5	8%
Delayed radiology diagnostic	1.0	5%
Admin delay/pathway planning issue	1.5	8%
Delayed pathway other provider	1.5	8%
Elective capacity	2.5	13%
Other reasons	1.0	5%
	19.5	

Sixty-two percent (62%) of breaches were due to primarily unavoidable reasons, including late referral, medical deferral, clinical complexity and delayed pathways at other providers.

There were 7 breaches (36%) relating to internally managed pathways and 12.5 breaches (24 pathways x 0.5 accountability) relating to shared pathways.

The transfer of breast and urology services to North Bristol Trust has left the Trust with a challenging group of pathways to meet the 62-day GP standard. This is because breast cancers are relatively easy to treat within 62-day of referral because the diagnostic pathways are simple and patients are usually fit enough to proceed to treatment without further intervention. In quarter 4 2013/14, the 85% standard was only achieved for breast and

skin cancers at a national level, and national average performance overall for all tumour sites was 84.6%. The Trust is now the only acute provider in the country that provides neither breast nor urology cancer outpatients or surgical services.

An improvement working group was established in October 2013, focusing primarily on the 62-day cancer pathways. Improvements in performance at a tumour-site level have been realised between quarter 2 and quarter 3, This is especially evident when comparing the Trust's performance against the national average reported for the same quarter. However, the volume and proportion of unavoidable breaches has increased since then, meaning that further improvements now have to be made to offset these additional breaches that are largely outside of the Trust's control.

The improvement work on the high volume tumour sites is ongoing. The focus of this work is informed by monthly breach reviews, and also structured telephone-based interviews which have been carried-out with better performing equivalent providers, to identify good practice from elsewhere. Whilst the telephone interviews provided assurance that there were no obvious differences in the diagnostic or treatment pathways that other providers had in place to treat cancer patients, disappointingly few pathway improvement opportunities were identified through these discussions.

Recovery plan, including expected date performance will be restored:

A fortnightly cancer steering group has been established, to take forward the further improvement priorities which have identified from the most recent breach analysis and learning from other providers. The key actions are as follows:

62-day GP referred actions:

- Implement new management for tertiary thoracic surgery peripheral clinics to reduce delays to referrals from other providers (impact from Q4 onwards); following agreements with North Bristol Trust (NBT), surgical review of patients to be conducted on the same day as the Multi-Disciplinary Team discussion of the patient's case, from June, which should reduce the thoracic pathway by 9 days; meetings scheduled with Yeovil District Hospital, Gloucester Hospitals and Taunton & Somerset trusts, to agree the adoption of a similar approach;
- Reduce maximum wait for 2-week wait step to 7 days (excluding skin and paediatrics, for which the wait to first appointment will not have a material impact on breach volumes) for 90% of patients (end July onwards); demand modelling undertaken for each tumour site; additional clinic capacity established in head & neck, lung and gynaecology, and being planned in other specialties; monitoring report to be available by the end of June;
- Further improvements in histology turn-around times to be expected with recruitment later in 2014/15;
- Establish 2.5 additional ENT theatre sessions per week from October 2014 onwards, to reduce the majority of panendoscopy delays; additional capacity currently being sought to bring forward this action (ongoing);
- Implement new approach to critical care cancellations and booking of cases to minimise impact of residual cancellations; action completed; critical care cancellations continue to be tightly managed, with pro-active cancellations taking place as necessary and back-fill of sessions with cases that do not require a critical care bed, to ensure theatre and surgeon capacity is not wasted;
- Establish additional thoracic and hepato-billiary theatre sessions from October 2014, when Vascular service moves to North Bristol

Trust; review being undertaken as to whether additional short-term capacity can be established before October;

- Revise the pre-operative assessment management process in order to ensure potential issues for patients on cancer pathways can be identified quickly and tests expedited; new protocol-based process established and being monitored;
- Schedule additional elective cancer surgery slots in December 2014, when activity levels are low and breaches can result in quarter 4

Progress against the recovery plan:

62-day GP

The following improvement trajectory has been agreed, on the basis of the actions identified and expected impact of these actions. Performance for May is currently marginally above trajectory, as is performance for the quarter as a whole.

	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	Dec-14	Q3	Jan-15	Feb-15	Mar-15	Q4
Trajectory	75.7%	80.5%	65.0%	75.3%	79.9%	82.1%	81.8%	81.3%	86.4%	85.1%	84.1%	85.3%	84.8%	85.4%	87.0%	85.8%
Actual	75.3%	80.9%														

31-day first definitive

The 31-day first definitive treatment standard was achieved in quarter 4. But due to the narrow margin of achievement against the 96% standard in quarter 4 2013/14, the following trajectory has been agreed and progress with achieving this trajectory will be reported to the Board on a monthly basis. Please note that May's figures are still subject to final validation and reporting.

	Apr-14	May-14	Jun -14	Q1	Jul -14	Aug -14	Sep -14	Q2	Oct -14	Nov-14	Dec -14	Q3	Jan -15	Feb -15	Mar-15	Q4
Trajectory	95.9%	96.4%	96.7%	96.3%	96.8%	96.7%	96.8%	96.7%	97.2%	97.2%	96.7%	97.0%	97.2%	96.9%	97.2%	97.1%
Actual	97.9%	97.9%														

ACCESS STANDARDS

A4. EXCEPTION REPORT: Referral to Treatment Time (RTT) non-admitted pathways standard	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients treated or discharged within 18 weeks of referral, as a percentage of all patients treated or discharged in the month. The Non-admitted target of 95% relates to those patients not requiring an admission as part of their treatment.

Performance is assessed by Monitor at an aggregated Trust level.

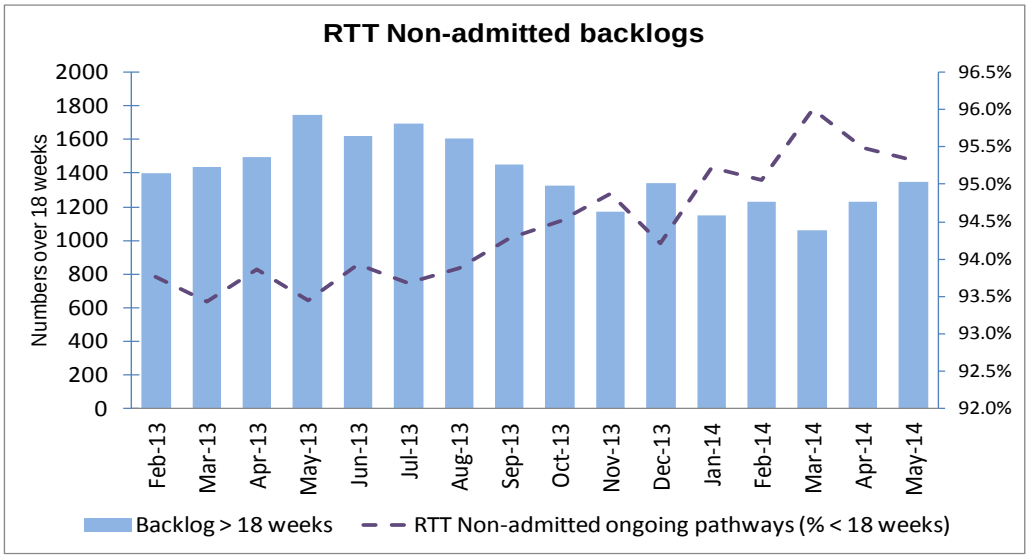
Monitor measurement period: Monthly achievement required but quarterly monitoring

Performance during the period, including reasons for exceptions:

Performance in May was 94.0% against the Non-admitted standard, which is an improvement on the April position of 93.6%, but 1.0% below the 95% national standard.

The failure to achieve the RTT Non-Admitted standard was forecast following the Head & Neck service transfer from North Bristol Trust, due to the number of patients already waiting over 18-week for their first outpatient appointment, at the point of transfer. The forecast failure was flagged to Monitor in the Annual Plan, and re-stated as part of the quarter 2 declaration of compliance. In combination with increases in referrals from GPs, which has resulted in waits for first outpatient appointments lengthening, this led to a failure of the standard in quarter 4, and the Trust flagging to Monitor the potential failure of the standard in quarters 1 and 2 of 2014/15, as part of the quarter 4 declaration and the 2014/15 Annual Plan.

Graph 1 – RTT Non-admitted backlogs versus the percentage of patients on ongoing pathways waiting under 18 weeks.



The percentage of patients on a non-admitted ongoing pathway that are waiting under 18 weeks at each month-end was above 95% for the whole of quarter 4, and remains so in quarter 1 2014/15 to date, despite a small rise in the number of dental specialties waiting over 18 weeks. This rise is due to a bulge in the waiting list, and is being addressed by additional outpatient slots to match demand.

ACCESS STANDARDS

The analysis of the breaches confirms that the main reasons for the failure to achieve the 95% standard in May were:

- Additional patients that had waited over 18 weeks from referral being seen for first outpatient appointments within the adult Ear, Nose & Throat and Oral Surgery services following transfer of the waiting list from North Bristol Trust; this is now mainly due to increases in referral volumes beyond that expected as part of the transfer
- Additional patients being seen for their first outpatient appointment to reduce the waiting times in other dental specialties (included in the RTT speciality 'Other') where waiting times have increased
- Lengthening outpatient waiting times for first appointments in a range of specialties, following increasing volumes of referrals, especially from GPs

Table 1: Performance against the RTT Non-admitted standard at a national RTT specialty level in May.

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
CARDIOLOGY	111	11	122	**91.0%**
CARDIOTHORACIC SURGERY	23	0	23	**100.0%**
DERMATOLOGY	470	10	480	**97.9%**
E.N.T.	621	84	705	**88.1%**
GASTROENTEROLOGY	31	2	33	**93.9%**
GENERAL MEDICINE	229	5	234	**97.9%**
GERIATIRC MEDICINE	56	0	56	**100.0%**
GYNAECOLOGY	403	8	411	**98.1%**
NEUROLOGY	73	0	73	**100.0%**
OPHTHALMOLOGY	929	8	937	**99.1%**
ORAL SURGERY	326	16	342	**95.3%**
OTHER	2614	233	2847	**91.8%**
RHEUMATOLOGY	94	4	98	**95.9%**
THORACIC MEDICINE	213	5	218	**97.7%**
TRAUMA & ORTHOPAEDICS	92	15	107	**86.0%**
TOTAL	**6285**	**401**	**6686**	**94.0%**

In April and May, ten of fifteen specialties achieved the 95% standard.

Recovery plan, including expected date performance will be restored:

- To improve performance for non-admitted Referral to Treatment (RTT) pathways, a three phase project plan has been developed that focuses

on immediate actions required to bring performance back in line as well as more medium / longer term sustainability improvements;

- A working group was established in February, and has developed the recovery plan for reducing waiting times for first outpatient appointments. This group has been meeting weekly and has developed the activity and waiting list trajectories for reducing outpatient waiting times throughout 2014/15. Weekly monitoring of activity against the plan is now taking place and any deviations from plan are being identified so that mitigating actions can be taken;
- A monthly RTT Steering Group has also been set-up to oversee the progress of the working group as well as to provide a more strategic oversight of RTT performance. This group is responsible for ensuring all the milestones of the project are met as well as overseeing risks, reviewing benchmarking information, providing cross divisional oversight and recognising / promoting best practice;
- To provide external assurance that our recovery plan is 'fit for purpose', the national Elective Care Intensive Support Team (IST) was asked to undertake a review of our action plan, to ensure it is robust as well as to share best practice from other organisations. This was scheduled for the week commencing the 21st April (visit complete, a further review is being undertaken in specific areas and the draft report is in the process of being finalised).

Progress against the recovery plan:

Weekly activity plans are being implemented, to further reduce the number of patients waiting over 18 weeks. The modelling which has been undertaken of the impact of shortening first outpatient waits forecasts achievement of the 95% standard from October 2014, as shown in the trajectory below. May's reported position confirms achievement of the improvement trajectory in the month.

Non-admitted Trajectory	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Patients above target outpatient wait	2,940	2,483	1,998	1,454	844	505	364	207	98	98	0	0	0
Forecast performance against RTT Non-admitted standard	93.1%	93.4%	93.7%	94.1%	94.5%	94.7%	94.8%	95.0%	95.0%	95.0%	95.1%	95.1%	95.1%
Actual performance against the RTT Non-admitted standard	93.1%	93.6%	94.0%										

ACCESS STANDARDS

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

Description of how the target is measured:

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

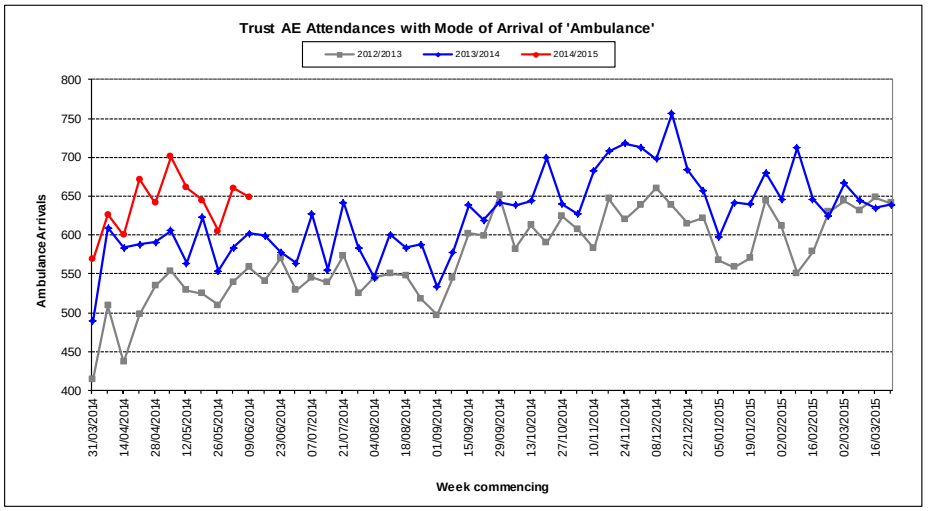
Monitor measurement period: Quarterly

Performance during the period, including reasons for exceptions:

Trust-level performance against the 4-hour standard stayed similar to that of April, at 94.3%, but remained marginally below the 95% standard. Performance against the 4-hour standard at the Bristol Children's Hospital was above the 95% standard and improved by 1.0% over April, at 96.6%. Performance within the BRI remained below the 95% standard and reduced by 1% relative to April, to 91.4%. The Bristol Eye Hospital achieved 99.7% against the 95% national standard.

Graph 1 – Number of ambulance arrivals into the Trust by month over the last three years.

Ambulance arrivals into the Trust remain high and for the BRI were 8.5% higher in May than the same period last year. In quarters 2 and 3 2013/14 emergency admissions stayed at similar levels to previous years despite an increase in ambulance arrivals. This was attributed to the work of the Ambulatory Care Unit. However, in May, as in April, the rise in ambulance arrivals was associated with an equivalent rise (8%) in emergency admissions via the Emergency Department (ED). Three percent of the increase in emergency admissions is attributable to the closure of the Frenchay ED. It is unclear whether the change in the conversion rate from ambulance arrival to emergency admission reflects a change in the acuity of patients seen in the period.



The Bristol Children's Hospital experienced a 23% increase in ambulance arrivals in May, relative to the same period last year. In contrast to previous months there was a 27% increase in the level of emergency admissions. Five percent of the 27% increase in emergency admissions is attributable to the closure of the Frenchay ED.

There was a decrease in length of stay for patients discharged in the month. Although the proportion of long stay patients discharged in the period was

slightly lower than in previous month, there were also fewer long-stay patients in hospital at month-end than the previous five months. This followed the work undertaken during the Breaking the Cycle Together initiative, with reduced levels of delayed discharges being maintained throughout April and May.

Table 1 – Number of Delayed Discharges on the Green to Go list at the end of May compared with the previous six month-ends

Month	Total number of Green to Go (Delayed Discharge) patients at month-end
November 2013	50
December 2013	52
January 2014	60
February 2014	73
March 2014	58
April 2014	56
May 2014	51

Recovery plan, including expected date performance will be restored:

The Senior Leadership Team is overseeing the delivery of the 2014/15 Operating Model. This covers a programme of seven projects which are targeting improvements in patient flow. Progress updates for the projects are provided in the table below.

Project	**Project Aims**	**Progress on delivery**
Breaking the Cycle Together	During week commencing Monday 31st March the Trust ran an initiate a "Breaking the Cycle Together" (BTCT) week with our partner organisations; Bristol Community Health, Clinical Commissioning Group, Commissioning Support Unit and Social Services, to focus on: • To reaffirm and consolidate our standards of patient care; • Using a Major Incident approach to rapidly address barriers to adherence with these standards; • Align our whole organisation's attention from the very top down, to focus and fix issues which get in the way	Learning from the successes of the week has been identified and pilot projects are being undertaken at Divisional level to test out ways to move the learning into business as usual. Learning from the pilots to date will audited before the end of June and the working routines further revised as a result. Changes will be implemented before the end of July. The SAFER bundles have been updated and re-issued as the basis for the revised checklist routines being developed based on the pilot learning.

	of the quality of care we aim to deliver; • This initiative will be run over a full 7 days, and will include all inpatient activity.	
Integrated discharge hub and supporting discharge processes	To co-locate staff from the three key Organisations responsible for managing patients with complex care needs; Bristol City Council, Bristol Community Health and University Hospitals Bristol; to improve efficiency of discharge processes; improve communication, reduce duplication and create an integrated discharge policy and process.	• Training for Discharge champions was carried out in early June • Planning is underway for a joint discharge workshop with Bristol City Council and Bristol Community Health which will develop integrated ways of working. This workshop is scheduled for July
Out of hospital solution	To commission further out of hospital transitional care beds to reduce the number of bed days consumed by 'Green to Go' (delayed discharge) patients, thereby reducing Length of Stay (LOS) and bed occupancy to improve patient flow.	• Potential beds identified. Proposal prepared for the Better Care Fund programme board to agree funding arrangements (**completed**). • Scoping and feasibility assessment is underway for a second wave of capacity. Plans to be firmed up by July
Early Supported Discharge	Effective early supported discharge pathways in place for patients which are provided by either a community partner or UH Bristol, or a combination of both which leads to better patient outcomes, better patient experience and a reduced Length of Stay.	• Currently assessing the available existing capacity and capability in the community to support additional patient groups. (June) • Target patient groups will then be developed and agreed (July)
Trust wide review of Critical Care	The project is still being scoped, but will address issues of flow and capacity in adult critical care facilities.	• Long term capacity review planned alongside short term interventions to improve flow between critical care and other areas (is in planning stage).
Weekend discharge – diagnostic and solution	To understand the issues needed to even out patient flow across the seven days of the week and increase the number of discharges that take place at the weekend.	• Engage with Junior Doctor team to support diagnostics and potential solutions (**Completed**) • Development of fit for purpose Information Technology tool to identify patients for discharge action over weekend (On track for implementation June 2014)

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Protected Beds	To develop an operating model that will support elective and urgent tertiary activity to proceed unhindered by periods of high demand for acute medical care through the Emergency Department. This will ensure that all our patient flows are supported, both planned and unplanned care.	• Agree new Operating models including protected bed model (drafted, to be signed off) • Review Trust-wide escalation policy to support pilot in one area (drafted, to be signed off) • Implementation details now being developed. Target remains to launch in July

The system-wide review of urgent care by the Emergency Care Intensive Support Team (ECIST) took place in the week commencing 19th May 2014 for one week. The review included all partner organisations including the Clinical Commissioning Group, Bristol Community Health and Health & Social Care. A draft report has been circulated for stakeholder input. Feedback following the review will be fed into the Urgent Care Forum who will oversee the system wide action plan based on recommendations from ECIST.

Progress against the recovery plan:

Performance against the 4-hour standard improved significantly following Breaking the Cycle Together initiative at the end of March. Performance in April and May was 94.5% and 94.3% respectively, which although just short of the 95% national standard represents a significant improvement on the performance in March. Key milestones for the achievement of the aims of the Operating Model programme of work have been defined and are now being used to inform an improvement trajectory for sustainable achievement of the 95% national standard in quarters 2 to 4. At present, achievement of the national standard is considered at risk in quarter 1 and quarter 4 of 2014/15, with the new patterns of emergency admissions following the Frenchay Emergency Department closure still emerging and the ongoing pressures of increasing numbers of ambulance arrivals in conjunction with the increasing ago-profile of patients admitted to the Trust each winter. At the time of this report it still remains possible to achieve the 95% standard for quarter 1 as a whole, but this is considered at risk.

ACCESS STANDARDS

A6. EXCEPTION REPORT: 6-week wait for key diagnostic tests	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients waiting over 6 weeks for one of the top 15 key diagnostic tests at each month-end, shown as a percentage of all patients waiting for these tests. The figures include patients that are more than 6 weeks overdue a planned diagnostic follow-up test, such as a surveillance scan or scoping procedures. The national standard is 99%.

Monitor measurement period: Not applicable; the monitoring period nationally is monthly.

Performance during the period, including reasons for exceptions:

Performance in May was 96.6% against the 99% national standard for 6-week diagnostic waits. There were 234 breaches of the 6-week standard at month-end, of which 116 were for MRI scans, 61 were for gastrointestinal endoscopies and 51 were for Cardiac Stress Echocardiograms. The remaining 10 breaches of standard were across a range of diagnostic tests.

The increase in long waiters for MRI scans in May was a combination of heightened demand in the period, but also a loss of capacity in some areas, such as the paediatric MRI service, with a number of sessions being lost due to bank holidays and the lack of anaesthetic cover.

The original dip in performance against the 6-week wait standard in 2013/14 resulted from demand for the gastrointestinal endoscopies outstripping available service capacity. This was due to a significant rise in demand for the procedures, which is a pattern that has been seen both regionally and nationally. The rise in demand could not be responded to quickly due to delays in the opening of additional facilities at South Bristol Community Hospital. However, a remedial action plan was developed which addressed this and the backlog of adult endoscopy cases was cleared at the end of May 2013. Of the 61 gastrointestinal endoscopies breaching the 6-week wait standard in May 2014, 38 were for adult endoscopies, the remainder for paediatric endoscopies.

Demand for Cardiac Stress Echocardiograms also remains high due to changes in NICE guidance for patients with cardiac problems. Capacity is also restricted due to the limited number of staff able to undertake these diagnostic tests.

Recovery plan, including expected date performance will be restored:

The following actions are being taken to improve performance against the 6-week wait standard in quarter 1. *Please note: actions completed in previous months have been removed from the following list*:

- Future paediatric MRI scanning capacity is being reviewed and plans for additional sessions are being taken forward;
- All appropriate adult patients continue to be offered MRI scans at another local provider (however, under waiting times rules, where patients

decline to be seen elsewhere their waiting times cannot be adjusted); the Trust's own MRI scanners continue to be run at weekends, to increase capacity;

- A mobile MRI scanner will be based at South Bristol Community Hospital from mid July to provide further routine capacity and to reduce the likelihood of a backlog building-up again;
- The recruitment of an Echo Cardiographer Radiographer/Technician has been approved, and a locum is being sought from an agency until the post can be recruited to substantively; additional sessions with current staff are also being run in July and August;
- A plan has been developed to clear the backlog of adult endoscopy long waiters, and to ensure maximum waiting times are maintained thereafter;
- A long-term solution is being put in place to support sustainable waiting times for paediatric endoscopies (by the end of quarter 3);

Progress against the recovery plan:

The 99% standard wasn't achieved in May, following achievement of the standard in February and March. Plans are in place to reduce the number of long waiters for a number of different types of diagnostic test, with the current forecast of achievement of the standard again at the end of July.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

08 Francis Report Recommendations

Purpose

This paper is to update the Board on progress since the presentation of the Trust's Francis Response paper in November 2013.

Abstract

The Trust set out its initial response to the Francis report in a paper presented to Board in November 2013. The Francis Response paper described how the Trust had undertaken a process of self-assessment in light of the key domains described in the Francis report and how the Trust had subsequently set out a number of high-level themes to support further work designed to align with these domains and enhance quality. The paper also set out the results of an initial assessment of the 290 specific recommendations contained in the Francis report.

This paper will describe how the key themes arising from the Trust's self-assessment have been incorporated into key strategic and operational Trust documents, as well as describing how the Francis report's specific recommendations have now been reviewed and addressed.

Recommendations

The Board to receive the report for assurance

Report Sponsor

- Sponsor – Medical Director
- Author – Medical Director

Appendices

- Appendix A – Francis Report Update

Update on the Trust's response to the Francis Report.

June 2014.

1. Introduction

1.1 The Trust set out its initial response to the Francis report in a paper presented to Board in November 2013. The Francis Response paper described how the Trust had undertaken a process of self-assessment in light of the key domains described in the Francis report and how the Trust had subsequently set out a number of high-level themes to support further work designed to align with these domains and enhance quality. The paper also set out the results of an initial assessment of the 290 specific recommendations contained in the Francis report.

1.2 This paper will describe how the key themes arising from the Trust's self-assessment have been incorporated into key strategic and operational Trust documents, as well as describing how the Francis report's specific recommendations have now been reviewed and addressed.

2. Francis response Key Themes.

2.1 The Trust's Francis Response paper identified a number of areas where it was considered that the quality of care patients receive could be further enhanced by ensuring progress with a number of specific programmes of work. Some of these programmes predated the Francis report, such as Medical Revalidation, but others needed to be designed and initiated following the Trust's post-Francis self-assessment.

2.2 In respect of this, the Trust presented its Operational Plan for 2014 – 2016 to Monitor in April 2014. This document detailed how the Trust will address its priorities and challenges over the next two years, and includes a section which describes projects identified through the Trust's Francis response work. These projects will be progressed through Trust Divisional and Corporate operational routes, as well as through the Trust's Transforming Care programme and a number have been initiated in the last few months. Work on the implementation of Schwartz rounds for example, multi-professional and multidisciplinary meetings to review cases and episodes where staff have felt especially challenged by some aspect of delivering high quality care, has begun in collaboration with the Macmillan Trust and the Kings Fund. A Trust-wide regular review of mortality has also been initiated following work to allow reviews to be completed by front-line staff through the Trust's electronic patient administration system. Additionally, the Trust's Quality Report 2014/15 describes specific objectives for focused quality improvement work and these objectives are directly consistent with the themes expressed in the Trust's Francis response as well as the Francis report itself.

3. Francis report Specific Recommendations

3.1 As well as setting out a number of broad themes to direct programmes of work, the Trust's Francis Response paper described how an initial assessment by Trust Executives of the 290 recommendations contained in the Francis report had concluded that of these, 83 were applicable to the Trust. This section describes how these 83 Francis recommendations have been further considered, what action may be required to produce compliance with the recommendations and how this action will be completed and governed.

3.2 The Trust's Francis response paper of November 2013 outlined to which broad area of responsibility each of the 83 applicable recommendations corresponded. This was detailed in Appendix 1 of the paper. Further work has described responsibility for each applicable recommendation to the level of Executive Director, apart from a small number considered to be non-specific and already addressed (6). The table below describes the distribution of the 83 recommendations amongst Executive Directors.

Executive Director	**Francis report recommendation number**	**No. of recommendations/ Director**
Chief Nurse	268, 208, 113, 114, 115, 118, 110, 111, 112 , 116, 109, 185, 256, 238, 122, 239, 199, 198, 242, 195, 89, 246, 197, 186, 187, 194, 202, 37, 143, 100, 255, 252, 119, 248, 243, 263, 98, 249.	38
Director of Workforce and Organisational Development	191, 237, 175, 179, 173, 176, 182, 177, 181, 3, 5, 7, 12, 79, 4, 8.	16
Medical Director	236, 279, 180, 160, 174, 280, 11, 76.	8
Director of Finance	36, 245, 244, 262, 252,	5
Director of Strategic Development	120, 269	2
Trust Secretary	80, 84, 178, 273, 75, 45, 86, 204	8
Non-specific	240, 241, 40, 117, 205, 247	6
		Total = 83

Table 1. Distribution of applicable recommendations amongst Executives.

3.3 Following this exercise, Executive Directors were tasked to review the specifics of each recommendation for which they had responsibility and describe whether, in their professional judgement, the Trust was required to initiate any further action in order to achieve compliance with the recommendation, or whether no further action was indicated.

3.4 Table 2 below indicates those recommendations considered by the appropriate Executive Director to be in effect already within the Trust and where the only action required would be that current practice is maintained.

Executive Director	**Francis report recommendation number**	**No. of recommendations/ Director**
Chief Nurse	268, 113, 114, 115, 118, 110, 111, 112 , 116, 109, 185, 238, 122, 239, 198, 242, 195, 89, 246, 197, 186, 187, 194, 202, 37, 143, 100, 255, 248, 243, 263, 98, 249.	33
Director of Workforce and Organisational Development	191, 237, 179	3
Medical Director	180, 160, 174, 76	4
Director of Finance	36, 245, 244, 262, 252,	5
Director of Strategic Development	120, 269	2
Trust Secretary	80, 84, 178, 273, 75, 45, 86, 204	8
Non-specific	240, 241, 40, 117, 205, 247	6
		Total = 61

Table 2. Recommendations for which no further action is required.

3.5 It is evident from the tables above that, for a number of Directors, there are residual recommendations from the Francis report that require further action to be considered, defined and completed before full compliance with the specific recommendations described in the Francis report can be achieved. These residual recommendations will be outlined below.

4. Chief Nurse

4.1 Residual recommendations requiring some further action are detailed below. All other actions have been completed.

- Review uniform design and policy (208): the uniform policy has been reviewed. A cost benefit review of uniform design to support easier differentiation of registered nurses and nursing assistants has not yet taken place. It is planned to be undertaken in 2014. A decision has been made for Clinical Nurse Specialists to have a specific uniform that differentiates them from ward based nurses. Implementation planned

- Electronic patient follow up post discharge (256). Work continues on this as part of the Trust's digital communications strategy.

- Learning from complaints (252/119): ensure anonymised complaint data is available. Quarterly complaints report in public board. Work is ongoing to publish key learning on the Trust's public website.

- Key nurses (199): all patients have a key nurse allocated per shift to co-ordinate care needs for each allocated patient. Re-audit due July 2014.

5. Medical Director

5.1 Residual recommendations requiring some further action include recommendations designed to ensure that each patient always has a named Consultant responsible for their care; that the process of issuing a death certificate mandates the involvement of a senior clinician and that clinicians have a reliable process to resolve any differences of opinion around the relative merits of alternative clinical procedures.

- Named Consultant (236). The Trust has a process whereby the name of the responsible Consultant is entered into the Patient Administration System (PAS) at the time of admission. Currently however, it is evident that the PAS is not always kept up to date when patients transfer from one clinician to another as a consequence of their diagnosis, Consultant shift patterns or Consultant team working arrangements within some acute specialities. Dr Luker, Deputy Medical Director and Chair of the Trust's Clinical Record Group has been tasked with examining how the PAS can be operated in such a way that it is up to date with the details of the Consultant currently in charge of patients' care. This work will be monitored through the Clinical Record Group and reported to the Clinical Quality Group.

- Death certification (279). The Trust's process for the completion of a death certificate is currently being reviewed by the Deputy Medical Director and the outcome will be reported in to the rust's Clinical Record Keeping Group. The recent instigation of a clinician case note review following every adult mortality is expected to assist with the achievement of this objective.

- Clinical Procedures (11). The Trust has a Clinical Effectiveness Group whose terms of reference include the responsibility for ensuring the appropriate implementation of national guidance from NICE technology appraisals and clinical guidance. This group also scrutinises applications from clinicians for the adoption of new procedures. The Chair of this group has recently been appointed and has been tasked with reviewing the group's terms of reference with respect to this recommendation.

6. Director of Workforce and Organisational Development

6.1 The remaining workforce recommendations centre around the requirement to have a consistent message ensuring that organisational values (12, 79), the duty of candour (175, 173, 176, 182, 177, 181) and the principles contained within the NHS Constitution (3, 5, 7, 4, 8) are clearly set out within job descriptions and contracts of employment at all levels of recruitment, as well as being evident within induction and appraisal processes.

- To enable new staff to understand their obligations with respect to the duty of candour, the relevance of the NHS constitution and the organisation's values, the Trust's recruitment process, contracts of employment and induction programme have all been updated to include statements that explain the importance and relevance of these principles during their day to day work.

- For existing staff, the appraisal process and values training has been amended to ensure that these messages concerning these principles are disseminated across teams in the Trust's values training and through individuals at appraisal.

6.2 This work has been approved by the Trust's Human Resources Board, where the wording to ensure that the messages are clear throughout the documentation was developed. These actions are included here as the work necessary to implement the actions has only recently been completed and post-dated the work to describe the state of implementation of specific recommendations.

7. Conclusion

7.1 This paper has described how the broad themes that emerged following the Trust's post-Francis self-assessment have been incorporated into programmes of work that have been described in those high-level Trust documents that direct strategic and operational effort and focus. It has additionally described how the specific recommendations contained in the Francis report have been considered by their Executive owners and how this has identified a small number of areas for further work.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

09 Patient Experience Report

Purpose

To provide an overview of patient-reported experience at UH Bristol

Abstract

This quarterly report presents key quality assurance data and themes arising from the UH Bristol patient experience survey programme, principally: the Friends and Family Test, our monthly inpatient/parent and maternity surveys, and the national patient surveys.

The report provides an analysis of patient experience at Trust, hospital, Division and ward level.

Trust-level data in this report indicates sustained levels of patient-reported experience above the target thresholds agreed by the Board.

Division-level data shows that the highest reported levels of patient satisfaction are consistently in Specialised Services, whilst the inpatient tracker and Friends and Family Test scores in Medicine are consistently lower than for the other bed-holding Divisions.

Hospital-level data indicates that the best patient experiences are provided at the Bristol Eye Hospital (BEH – ward 41), the Bristol Royal Hospital for Children and the Bristol Haematology and Oncology Centre. South Bristol Community Hospital tends to achieve slightly lower scores.

Ward-level data reveals patient experience ratings are lower in postnatal wards (71, 74, 76), wards in the Bristol Royal Infirmary Old Building (21, 22, 23, 26) and Ward 7. The report includes further analysis including possible explanations for these scores and actions being taken in response.

Recommendations

The Board is asked receive the report for assurance

Report Sponsor

- Sponsor – Carolyn Mills, Chief Nurse

  Author – Paul Lewis, Patient Experience Lead (surveys and evaluation)

Appendices

- Patient Experience Report

Patient Experience at University Hospitals Bristol NHS Foundation Trust (June 2014 update)

1. Purpose of this report

This quarterly report presents the key quality assurance data and themes arising from the UH Bristol patient experience survey programme, principally: the Friends and Family Test, the monthly inpatient/parent and maternity surveys, and the national patient surveys. The narrative in the report provides analysis and draws on discussions held at the Trust's Patient Experience Group, where this data is reviewed every month.

2. Trust-level data

Charts 1 to 3 (over) show the three headline measures that are used to monitor the overall quality of patient-reported experience at UH Bristol. The kindness and understanding and patient experience tracker [1] scores (charts 1 and 2), are designed to turn "amber" or "red" if they fall significantly[2]. The Friends and Family Test survey score combines inpatient and Emergency Department ratings (chart 3) [3]. This turns "amber" if it falls below the national average, and "red" if it falls into the lowest 20% of scores nationally. If any of these three headline measures are rated amber or red, then the Trust Board is alerted via the monthly Quality Dashboard[4]. In 2013/14 none of the scores fell to these levels.

In addition to these inpatient and Emergency Department surveys, UH Bristol also carries out an annual survey of outpatients. The latest data from this survey is currently being analysed, but chart 4 presents the headline satisfaction rates and shows that 98% of outpatients (who attended in March 2014) rated their care as excellent, very good, or good. This is in line with previous years and is slightly higher than the national benchmark (based on the last national outpatient survey, carried out in 2011). It should be noted that the Friends and Family Test is scheduled to be extended to outpatient and day-case settings in October 2014, and so more regular data will be available from that point.

Further information about the surveys used in this report, including the scoring mechanisms used and a description of the wider UH Bristol patient feedback programme, can be found in Appendices C and D. Surveys work most effectively at a population (or "system") level, and tend to offer less insight on the unique experience of each individual patient. Overall the data shows that a positive experience is provided to the majority of patients at the Trust, and that UH Bristol performs broadly in line with the national average in this respect. Nevertheless, clear service improvement themes emerge (see Section 6 of this report) and some areas of the Trust achieve relatively low satisfaction scores (Section 7). This data should be used in conjunction with other sources of information to provide a coherent and reliable view of "quality".

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[1] The "patient experience tracker" is made up of four key questions from the UH Bristol monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, and staff-patient communication. These were identified as key drivers of patient satisfaction via statistical analysis of survey data by the Trust's Patient Experience and Involvement Team.

[2] Specifically: if they fall to three (amber) and four (red) standard deviations below the UH Bristol annual mean score. This is known as a "statistical control chart" and is widely by organisations as a quality control tool.

[3] Note: the Friends and Family Test data is available around one month before the postal survey data.

[4] This approach reflects the findings of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust, where consistently-below national average scores in patient surveys should have been used as an early-warning of deeper care failings.

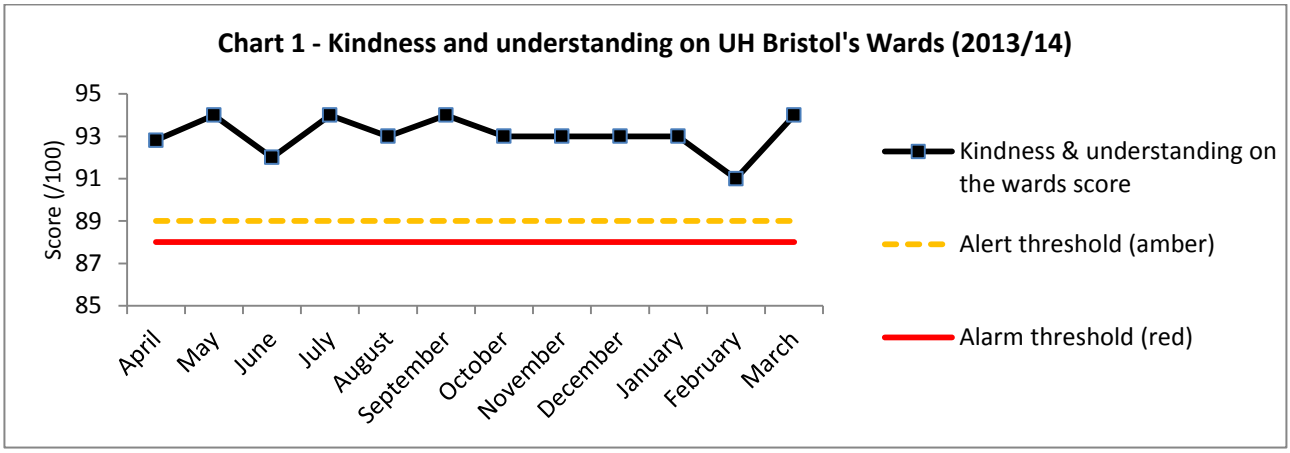


Chart 1 - Kindness and understanding on UH Bristol's Wards (2013/14)
Score (/100)
95
93
91
89
87
85
April
May
June
July
August
September
October
November
December
January
February
March
Kindness & understanding on the wards score
Alert threshold (amber)
Alarm threshold (red)

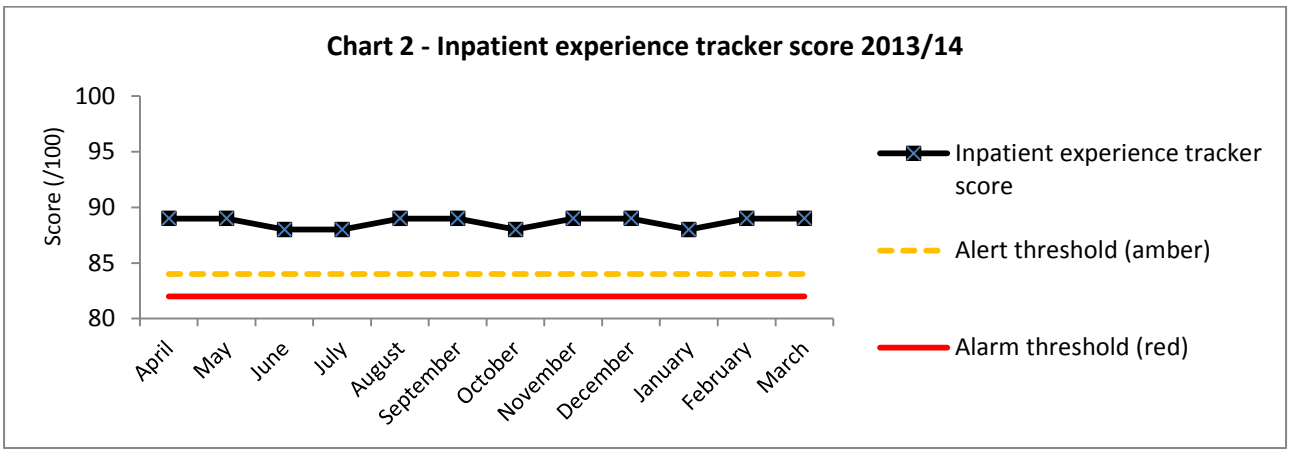


Chart 2 - Inpatient experience tracker score 2013/14
Score (/100)
100
95
90
85
80
April
May
June
July
August
September
October
November
December
January
February
March
Inpatient experience tracker score
Alert threshold (amber)
Alarm threshold (red)

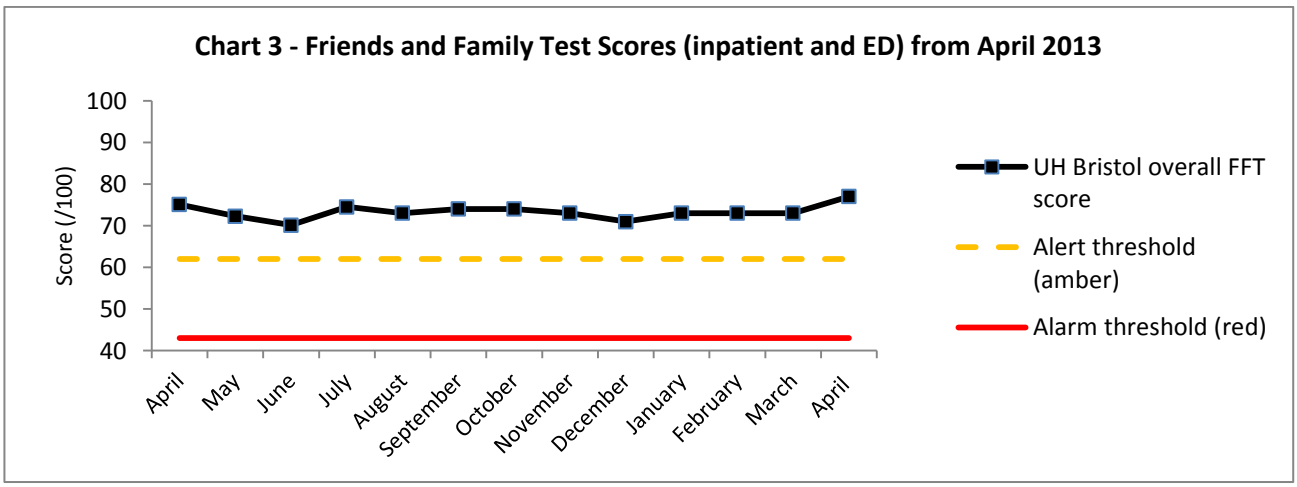


Chart 3 - Friends and Family Test Scores (inpatient and ED) from April 2013
Score (/100)
100
90
80
70
60
50
40
April
May
June
July
August
September
October
November
December
January
February
March
April
UH Bristol overall FFT score
Alert threshold (amber)
Alarm threshold (red)

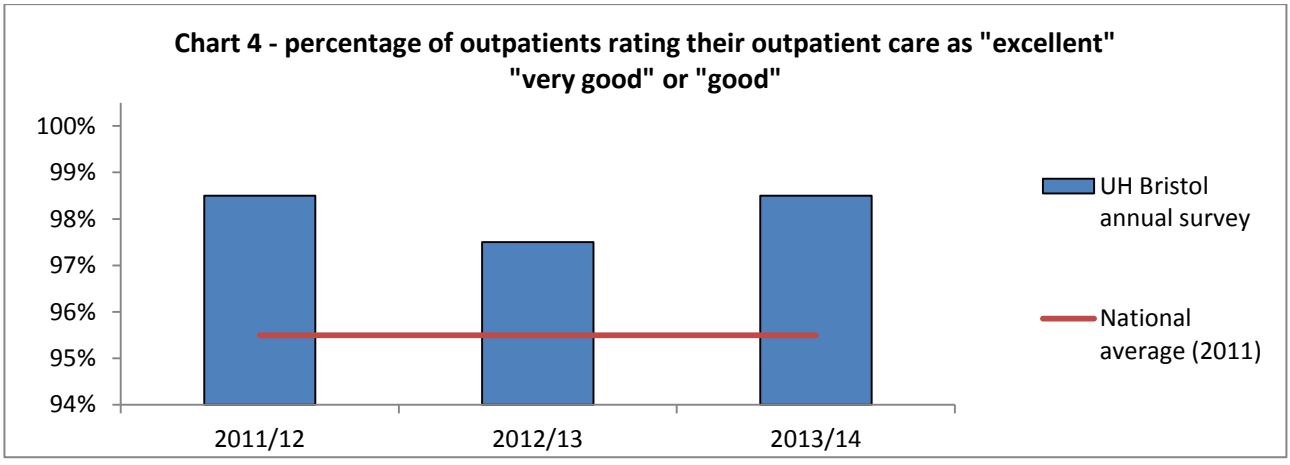


Chart 4 - percentage of outpatients rating their outpatient care as "excellent" "very good" or "good"
100%
99%
98%
97%
96%
95%
94%
2011/12
2012/13
2013/14
UH Bristol annual survey
National average (2011)

3. Divisional-level data

Charts 5 to 7 show the three headline inpatient quality assurance metrics by UH Bristol Division[5]. Overall, none of the Divisions were "red-rated" on these measures. However, the maternity scores (i.e. postnatal wards), and some of the scores for the Division of Medicine, are relatively low. These results are examined in more detail in Section 5, where a ward-level view of the data is provided. The full Divisional data for Quarter 4 (January to March 2014) is provided in Appendix A.

Chart 5 - Kindness and understanding - by Division (2013/14)

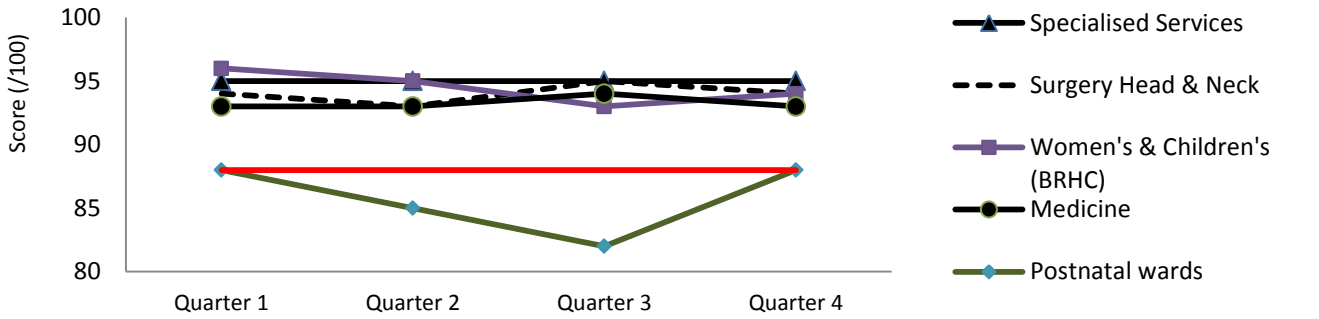


Chart 6 - Inpatient experience tracker score by Division (2013/14)

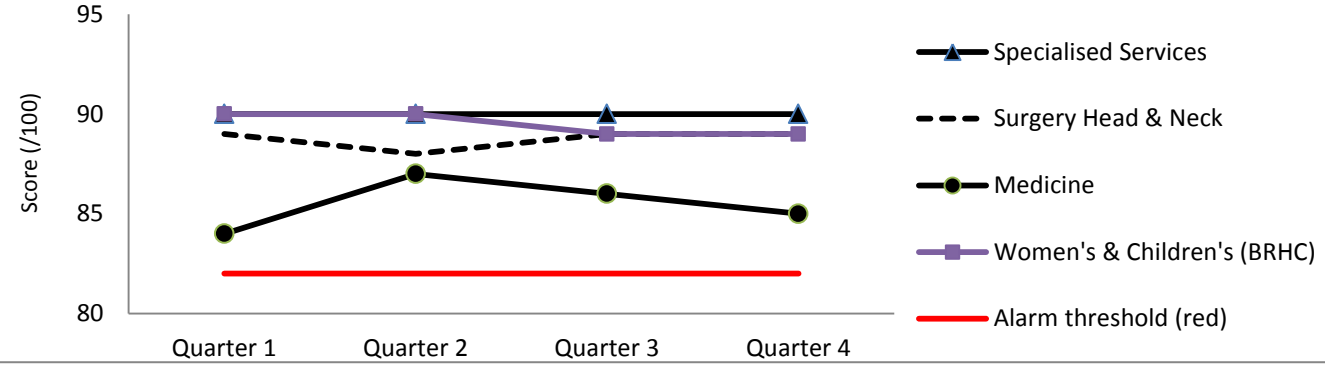
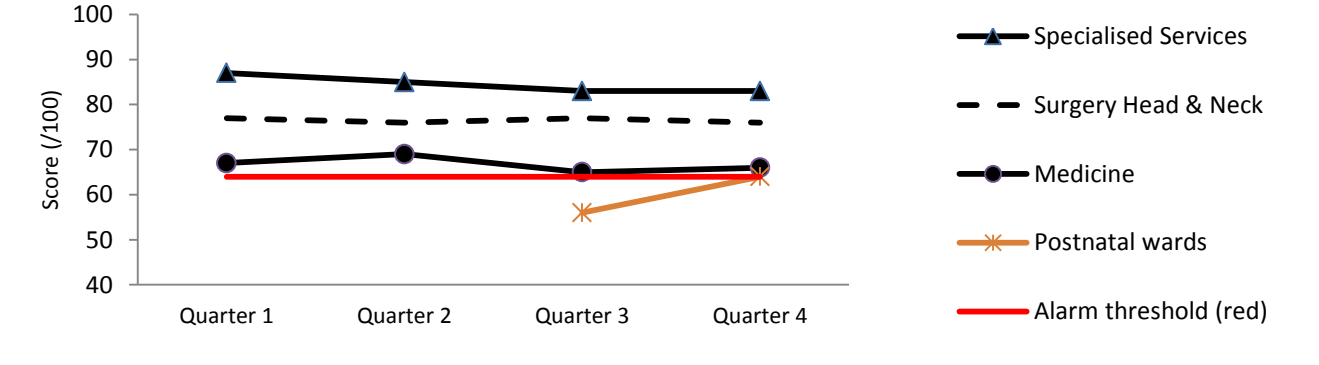


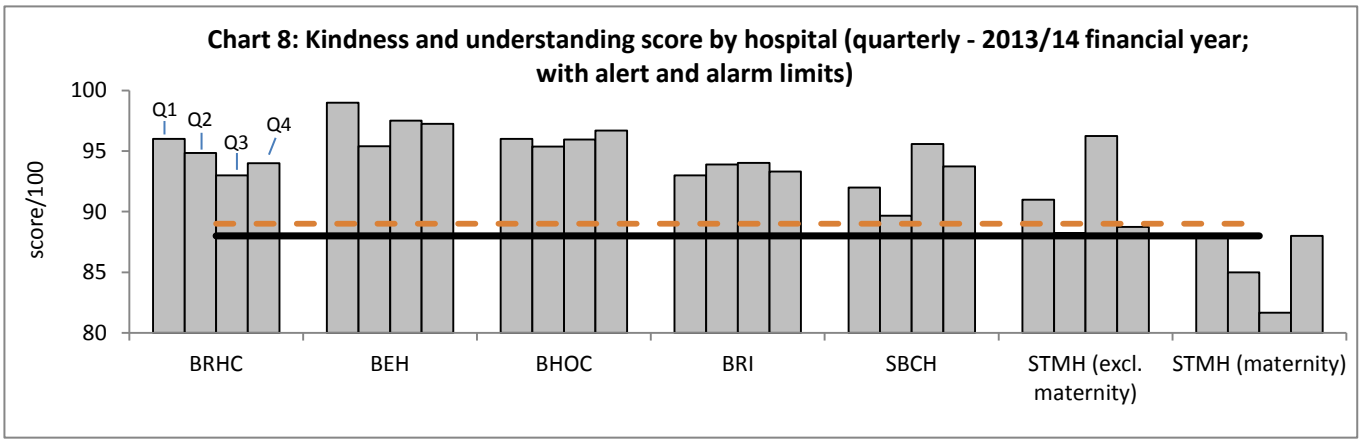
Chart 7 - Friends and Family Test score - inpatient by Division 2013/14

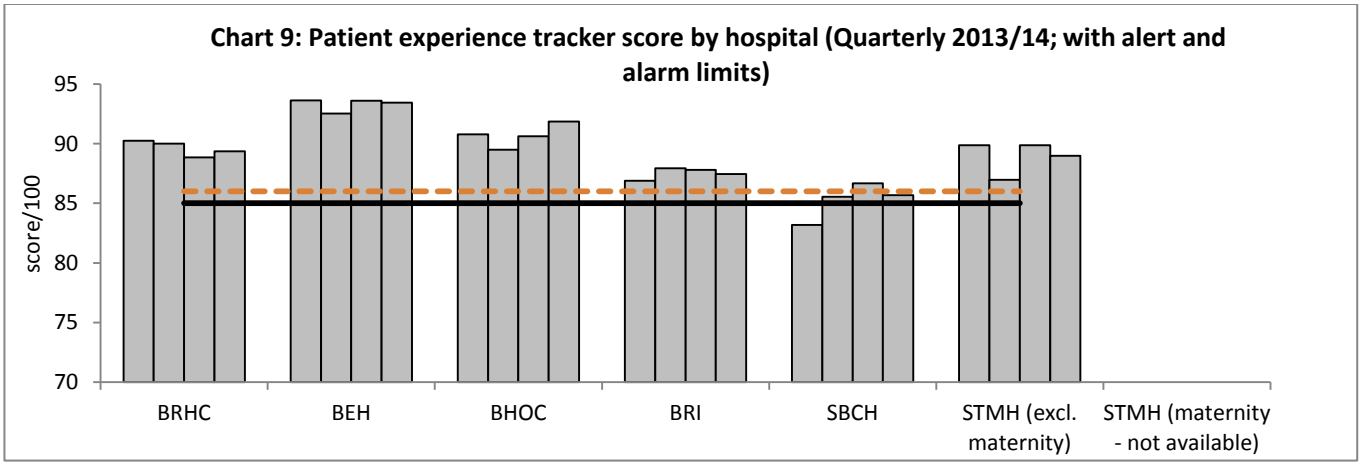


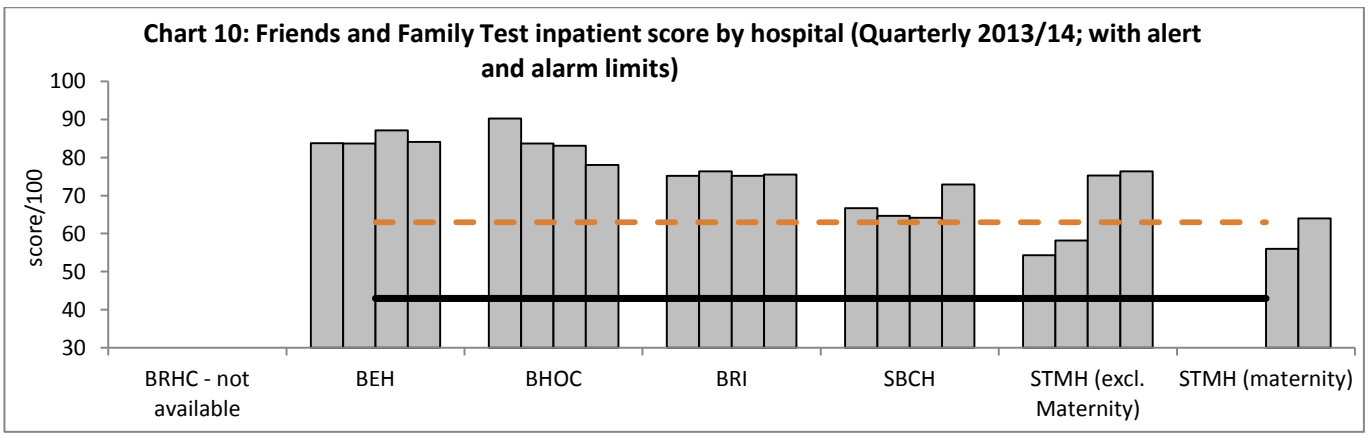
[5] Note: the Women's and Children's Divisional data is split into maternity wards and the Bristol Royal Hospital for Children. The maternity survey does not currently capture all of the data needed to derive the "patient experience tracker" score, but will do so from May 2014 and so this data will be added to the next edition of this report. The Friends and Family Test has not been implemented in children's services, but NHS England are currently exploring the extension of the survey to this setting.

4. Hospital-level data

The hospital-level data suggests that the best patient experiences are provided at the Bristol Eye Hospital (BEH – ward 41), the Bristol Royal Hospital for Children (BRHC) and the Bristol Haematology and Oncology Centre (BHOC). South Bristol Community Hospital (SBCH) tends to achieve slightly lower scores. Further analysis of the data concluded that this is likely to be a reflection of the patient group (i.e. long-stay, complex health and social care needs - which research has shown is correlated with lower patient experience ratings), and not an indication of systemic failures in care. Whilst this demographic effect *may* mean that it is not possible to raise the SBCH scores to the levels achieved by the best performing areas of the Trust, clearly patient experience can still be improved. Therefore, an action plan was put in place by the SBCH management team and this has had a positive impact on the survey scores for the hospital.







5. Ward-level data

The ward-level inpatient data is presented in charts 11 to 13 (over). As the sample sizes are relatively low at this level, it is important to look for consistency across the surveys, and to aggregate the data to a six-month overview. This identifies the following areas of the Trust that receive relatively low ratings from patients:

Postnatal wards (Wards 71, 74 and 76)
It should be noted that experience scores on UH Bristol's postnatal wards are at least in line with, and in some cases better than their national benchmarks (see Section 7). The majority of women state that they have a positive experience of postnatal wards at UH Bristol, with 91% rating their care as excellent, very good, and good[6]. Nevertheless, on average the postnatal ward satisfaction scores are still lower than other inpatient areas of the Trust. Feedback from maternity service users often focusses on the lower number of midwives available on the postnatal wards compared to during birth (where one-to-one care is the norm). This is particularly apparent for women with higher support needs, such as first-time mothers and/or women who have had a caesarean section. In addition, improving the quality/availability of food and the cleanliness of the postnatal wards are common suggestions received via the surveys.

Since 2011/12 there has been an ongoing focus on improving women's experiences of maternity services, and postnatal wards in particular, including:

- Reconfiguration of the postnatal wards, based on service-user feedback
- Recruitment to additional midwifery and midwifery support worker posts
- Running workshops for doctors, midwives and midwifery support workers, focussing on how their role impacts on patient experience
- Identifying a consultant-level patient experience champion who leads patient experience and involvement initiatives in postnatal care
- A focus by the Facilities Department on improving food and cleanliness on the postnatal wards

These activities resulted in a decline in the number of complaints received by the maternity department, and a "kindness and understanding" score that was rated better than the national average by the Care Quality Commission in the 2013 national maternity survey. There have also been improvements in satisfaction with food quality and availability. Through the national maternity survey action plan (see Section 7) and Divisional quality objectives, there will be a continued focus on improving experiences of maternity care in 2014/15.

The Bristol Royal Infirmary Old Building (Wards 21, 22, 23 and 26)
The wards in the Bristol Royal Infirmary Old Building tend to achieve lower patient experience scores than other areas of the Trust. However, the vast majority of comments received from patients about these wards contain praise for the staff. The most common improvement theme emerging from the comments is about the need to improve the ward "environment" i.e. issues associated with the wards being in a very old building. This will be directly addressed when the wards are moved out of the Old Building during 2014. In the meantime, the Head of Nursing for the Division of Medicine is reviewing this patient feedback, and triangulating it with other quality data, in order to identify any immediate actions that can be put in place to improve patient experience in these areas. This action plan will be reported to/monitored by the Patient Experience Group, and further details will be provided in the September edition of this Quarterly Patient Experience Report.

[6] UH Bristol maternity survey - January to March 2014.

Ward 7

Virtually all of the patient comments contain praise for the staff on Ward 7. Again, it is the ward environment that seems to pull down the scores, but in this case it tends to be related to other patients (e.g. noise/disruption, feelings of safety). In addition, several comments have suggested that communication with patients could be improved. All of these factors are likely to be linked to the high proportion of patients with dementia on Ward 7. As part of the review described above, the Head of Nursing is generating an action plan for this ward - details of which will be provided in the next quarterly report.

Chart 11: Kindness and understanding ratings by ward (October 2013 to March 2014, with alert and alarm thresholds)

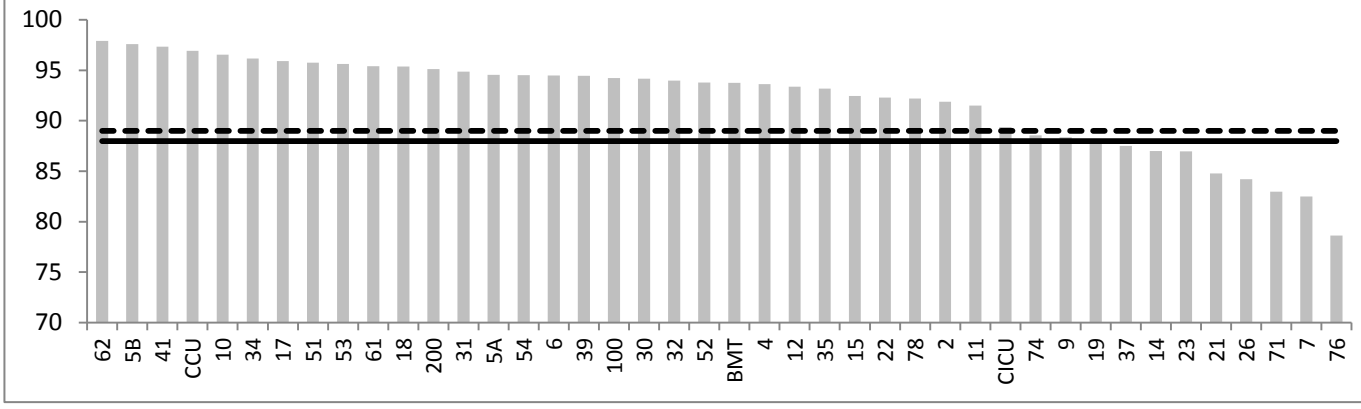


Chart 12: Patient experience tracker score by ward (October 2013 to March 2014, with alert and alarm thresholds; data does not currently include maternity wards)

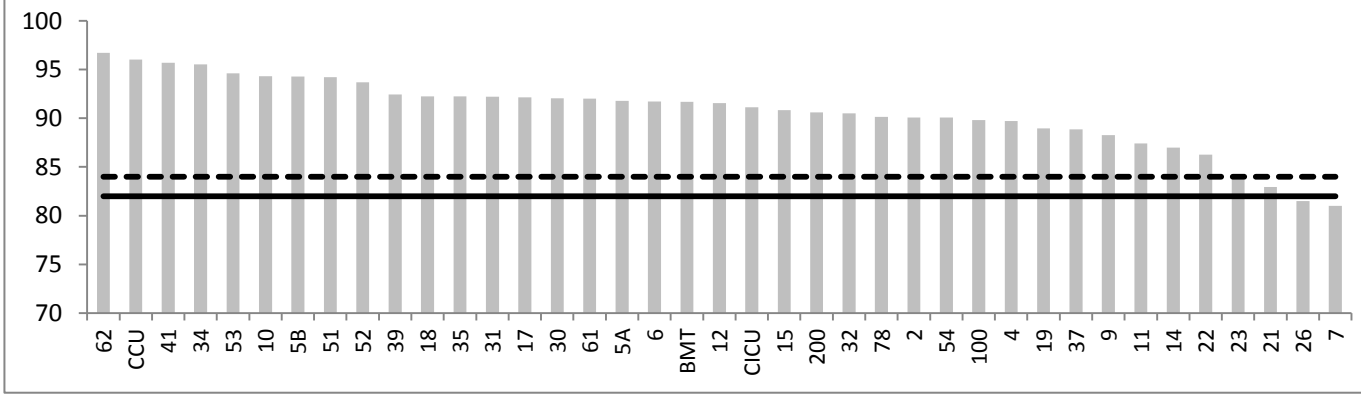
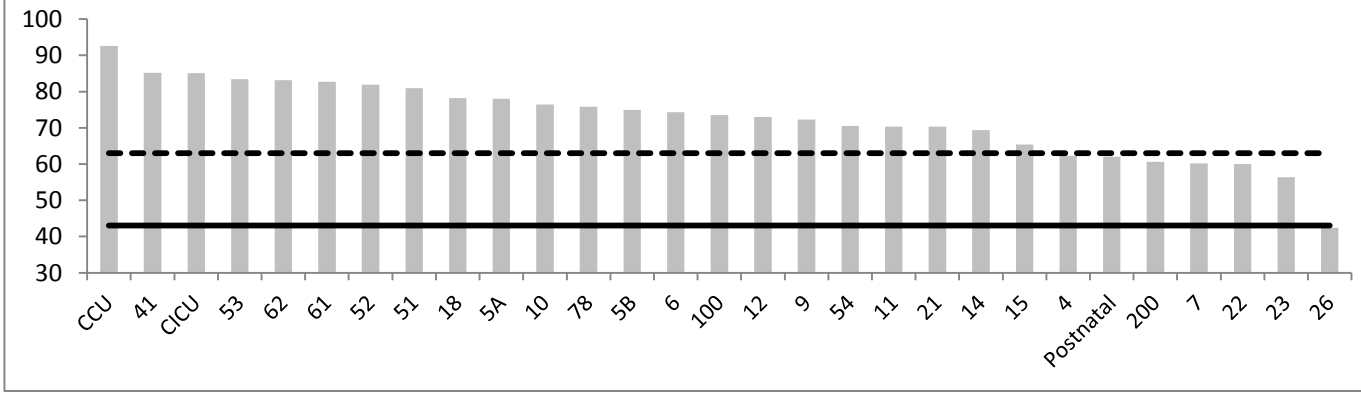


Chart 13: Friends and Family Test score by ward (October 2013 -March 2014; with alert and alarm thresholds)



6. Themes from inpatient free-text comments in the monthly postal surveys (2013/14 financial year)

At the end of our postal survey questionnaires, patients are invited to comment on any aspect of their stay – in particular anything that was worthy or praise or that could have been improved. All comments are reviewed by the relevant Heads of Nursing and shared with ward staff for wider learning. In total we received just over 5,000 comments via these surveys during 2013/14, and the over-arching themes are provided below. Please note that "**valence**" is a technical term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed).

All inpatients/parent comments (excluding maternity)

Theme	Valence	% of comments
Staff	Positive	34%
Waiting/Delays	Negative	6%
Staff	Negative	6%
Communication	Negative	5%
Food/catering	Negative	5%

34% of the comments received contained praise for UH Bristol staff, making this the most common theme. Improvement themes centre on "staff" (particularly "communication"), waiting/delays before and in hospital (especially at discharge), and food.

Division of Medicine

Theme	Valence	% of comments
Staff	Positive	34%
Staff	Negative	7%
Discharge	Negative	6%

The Trust-level themes are largely mirrored across all Divisions. Improving patient flow (including delays at discharge) is a key priority for the Trust, and a number of major projects will be undertaken in relation to this in 2014/15.

Division of Specialised Services

Theme	Valence	% of comments
Staff	Positive	33%
Waiting/delays	Negative	6%
Staff	Negative	5%

In addition to the top three themes shown here, improvement of "information provision" was also a common request (5% of comments). This is being addressed via the action plan for the national cancer survey (see section 7).

Division of Surgery, Head and Neck

Theme	Valence	% of comments
Staff	Positive	36%
Waiting / Delays	Negative	7%
Staff	Negative	6%

Negative comments about staff often relate to a one-off experience with a single member of staff. This demonstrates that "staff behaviour" is usually the main determinant of patient experience.

Women's & Children's Division (excl. maternity)

Theme	Valence	% of comments
Staff	Positive	34%
Staff	Negative	6%
Waiting/delays	Positive	6%

This data includes feedback from parents of 0-11 year olds who stayed in the Bristol Royal Hospital for Children. Again the themes are similar to other areas of the Trust.

Maternity comments

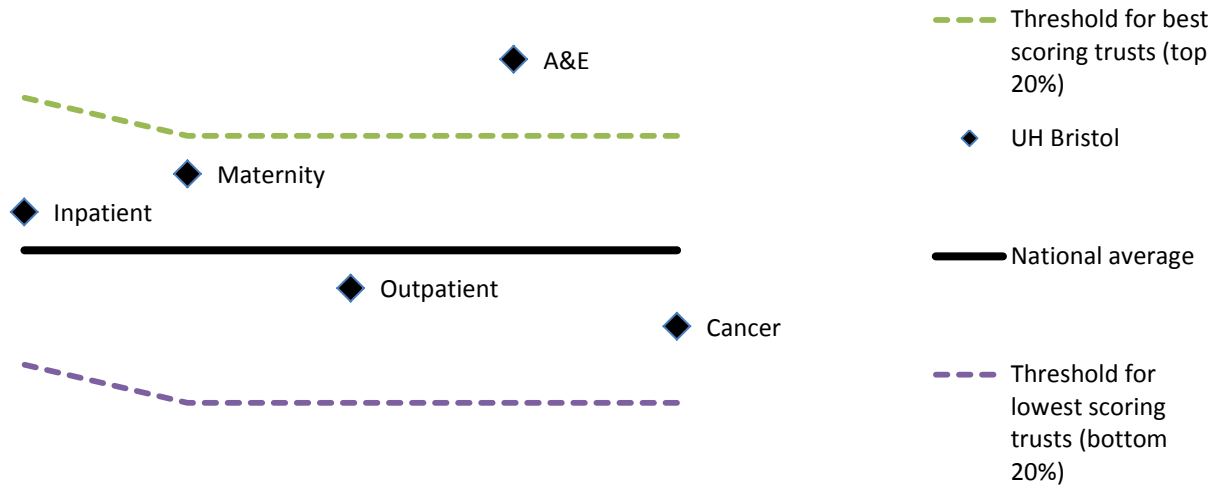
Theme	Valence	% of comments
Staff	Positive	23%
Care during birth	Positive	13%
Information/advice	Negative	=6%
Staff	Negative	=6%

For maternity services, the two most positive themes are around staff and care on the Central Delivery Suite and Midwifery-led birth unit. This contrasts with experiences on postnatal wards, which receive lower experience ratings.

7. National patient survey programme

Along with other English NHS trusts, UH Bristol participates in the Care Quality Commission (CQC) national survey programme. This provides useful benchmarking data, a summary of which is provided in chart 14 below. Although this is a rather blunt analysis[7], it is useful for illustrative purposes and shows that UH Bristol broadly performs among the mid-performing trusts nationally. The main exception here is the 2012 national Accident and Emergency survey, where UH Bristol was among the very best performers in England. The national cancer survey on the other hand tends to produce scores that are slightly lower than is typical for UH Bristol. As with all national survey results received by the Trust, a detailed analysis was carried out of the national cancer survey and an action plan put in place. These reports and action plans are signed-off by the Trust Board, and subsequently monitored by the Patient Experience Group. In terms of patients with cancer, the action plan has mainly focussed on increasing access to Clinical Nurse Specialists and improving information provision. A list of the national patient surveys, along with key issues and actions arising from them, is provided in Appendix A.

Chart 14: UH Bristol National Survey Results (indexed to national mean score = 100)



It is interesting to ask: how good is the national average? This is a difficult question to answer as it depends on exactly which aspect of patient experience is being measured. However, the national inpatient survey asks people to rate their overall experience on a scale of 1-10, and the table below shows that around a quarter give UH Bristol the very highest marks (presumably reflecting an excellent experience), with around half giving a "good" rating of eight or nine.

Rating (0-10, with 10 being the best)	UH Bristol	Nationally
0 (I had a very poor experience)	0%	1%
1 to 4	5%	6%
5 to 7	23%	21%
8 and 9	47%	44%
10	26%	27%

[7] This analysis takes mean scores across all questions and trusts in each survey. The national mean score across all trusts is then set to 100, with upper and lower quintiles and the UH Bristol mean scores indexed to this.

Appendix A: Summary of national patient survey results and key actions arising for UH Bristol

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan progress reviewed by Patient Experience Group*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2013 National Inpatient Survey	59/60 scores were in line with the national average. One score was below the national average (privacy in the Emergency Department)	May 2014	Quarterly	• Privacy in the Emergency Department • Awareness of the complaints process • Delays at discharge • Explaining potential medication side effects to patients at discharge	March 2015
2013 National Maternity Survey	14 scores were in line with the national average; 3 were better than the national average	January 2014	Six-monthly	• Continuity of antenatal care • Communication during labour and birth • Care on postnatal wards	January 2016
2012/13 National Cancer Survey	45/60 scores were in line with the national average, with 15 scores were below the national average	November 2013	Six-monthly	• Patient access to Clinical Nurse Specialists • Information provision • Linking with community healthcare providers	July 2014
2012 National Accident and Emergency surveys	21/37 scores in line with the national average; 16 scores were better than the national average	January 2013	Six-monthly	• Awareness of the complaints process • Waiting times in the Emergency Dept. and being kept informed of any delays • Patients feeling safe in the Department • Explaining potential medication side effects to patients at discharge	December 2014
2011 National Outpatient Survey	All UH Bristol scores in line with the national average	March 2012	Six monthly	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments • Copy patients in to hospital letters to GPs	Unknown

Appendix B: Full quarterly Divisional-level inpatient/parent survey dataset (Quarter 4 2013/14)

The following table contains a full update of the inpatient and parent data for January-March 2014. Where equivalent data is also collected in the maternity survey, this is presented also. All scores are out of 100 (see Appendix E), with 100 being the best. Cells are shaded amber if they are more than five points below the Trust-wide score, and red if they are ten points or more below this benchmark. See page 12 for the key to the column headings.

	MED	SHN	SPS	WAC (Excl. Maternity)	Maternity	Trust
Privacy and Dignity						
When you / your child were first admitted to a bed on a ward, did you / they share a sleeping area with patients of the opposite sex?	87	93	92	70	n/a	86
When you / your child moved wards, did you / they share a sleeping area with patients of the opposite sex?	92	96	88	78	n/a	90
Did you/your child share a bathroom/shower area with patients of the opposite sex?	82	74	84	68	n/a	78
Were you / your child given enough privacy when discussing your condition/treatment?	89	90	91	91	n/a	90
On the ward						
How would you rate the hospital food you / your child received?	62	59	59	63	59	60
Did you / your child get enough help from staff to eat meals?	77	83	87	73	n/a	80
In your opinion, how clean was the hospital room or ward?	91	92	95	92	89	92
How clean were the toilets and bathrooms that you / your child used on the ward?	90	87	91	89	43	89
Were you / your child ever bothered by noise at night from hospital staff?	82	83	79	80	n/a	81
Do you feel you / your child was treated with respect and dignity on the ward?	93	94	96	95	92	95
Were you / your child treated with kindness and understanding on the ward?	93	94	95	93	87	94
How would you rate the care you / your child received on the ward?	83	86	88	87	79	86
Communication and involvement						
When you had important questions to ask a doctor or nurse, did you get answers you could understand?	81	87	89	88	n/a	86
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	70	69	76	71	n/a	71
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	76	82	81	83	n/a	81

Communication and involvement (continued)	**MDC**	**SHN**	**SPS**	**WAC (Excl. Maternity)**	**Maternity**	**Trust**
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	81	88	89	86	n/a	86
Did you / your child find someone to talk to about your worries and fears?	64	72	73	78	78	71
Staff explained why you needed these test(s) in a way you could understand?	78	83	86	88	n/a	84
Staff tell you when you would find out the results of your test(s)?	66	70	73	77	n/a	71
Staff explain the results of the test(s) in a way you could understand?	72	76	80	82	n/a	77
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	75	92	92	92	n/a	90
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	64	77	78	81	n/a	77
Staff were respectful any decisions you made about your / your child's care and treatment	87	91	93	91	94	90
Discharge						
Do you feel you were kept well informed about your / your child's expected date of discharge?	76	84	80	86	74	82
On the day you / your child left hospital, was your / their discharge delayed for any reason?	59	63	63	65	69	62
% of patients delayed for more than four hours at discharge	20	19	17	29	35	21
Did a member of staff tell you what medication side effects to watch for when you went home?	50	64	60	61	n/a	59
Did a member of staff tell you who to contact if you were worried about your / your child's condition or treatment after you had left hospital?	70	81	82	88	n/a	80
Would you recommend our hospitals to a friend or family if they needed similar care or treatment?	37	49	64	57	47	51
Total responses	*441*	*547*	*372*	*372*	*304*	*2036*

Key: MDC (Division of Medicine); SHN (Division of Surgery, Head and Neck); SPS (Specialised Services Division); WAC (Women's and Children's Division, excludes maternity survey data); Maternity (maternity survey data); Trust (UH Bristol overall score from inpatient and parent surveys)

Appendix C – UH Bristol corporate patient experience programme

The Patient Experience and Involvement Team at UH Bristol manage a comprehensive programme of patient feedback and engage activities. If you would like further information about this programme, or if you would like to volunteer to participate in it, please contact Paul Lewis (paul.lewis@uhbristol.nhs.uk) or Tony Watkin (tony.watkin@uhbristol.nhs.uk). The following table provides a description of the core patient experience programme, but the team also supports a large number of local (i.e. staff-led) activities across the Trust.

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	At discharge from hospital, all adult inpatients, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity surveys, annual outpatient and day case surveys)	These surveys, which each month are sent to a random sample of approximately 1500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view.
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

Appendix D: survey scoring methodologies

Postal surveys

For survey questions with two response options, the score is calculated in the same was as a percentage (i.e. the percentage of respondents ticking the most favourable response option). However, most of the survey questions have three or more response options. Based on the approach taken by the Care Quality Commission, each one of these response options contributes to the calculation of the score (note the CQC divide the result by ten, to give a score out of ten rather than 100).

As an example: Were you treated with respect and dignity on the ward?

	Weighting	**Responses**	**Score**
Yes, definitely	1	81%	81*100 = 81
Yes, probably	0.5	18%	18*50= 9
No	0	1%	1*0 = 0
Score			*90*

Friends and Family Test Score

The FFT score is calculated as follows:

The percentage of respondents ticking the “extremely likely to recommend the care” option

Minus

The percentage of respondents ticking the “neither likely nor unlikely”, “unlikely”, and “extremely unlikely” response options

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

10 Report on Staffing Levels for University Hospitals Bristol

Purpose

To provide the Board of Directors with an overview of key issues relating to nursing, midwifery and care staffing capacity and capability in line with CQC & NHS England guidance, making clear recommendations to the Board of any changes proposed to the nursing and midwifery skill mix and establishment.

Abstract

Specifically this paper details:

1. How nursing and midwifery establishments are set.
2. How concerns re staffing levels are identified, escalated and mitigated (strategically and day to day).
3. How does the Trust know the wards are safe?

As this is the first report to the Board some of the detail contained within it is setting context for Board members. Subsequent reports will focus on any changes to the skill mix and establishments within the reporting period.

Recommendations

The Board is asked to review the report and the assurances contained within it in regard to the setting of nursing and midwifery establishments, noting how concerns re staffing levels are identified, escalated and mitigated and how the Trust knows the wards are safe.

Report Sponsor

- Sponsor – Carolyn Mills, Chief Nurse

Appendices

- Report on Staffing Levels for University Hospitals Bristol

Report on staffing levels for UHB adult inpatient wards, including Midwifery and Bristol Children's Hospital - June 2014

1.0 Introduction

There is a requirement, post the publication of the Francis Report 2013 and the new nursing vision: Compassion in Practice that all NHS organisations will take a 6 monthly report to their public Board on the nurse and midwifery staffing levels and whether they are adequate to meet the acuity and dependency of their patient population.

This is not the first time that the Board of Directors has received a report from the Chief Nurse related to nursing and midwifery staffing. In May 2011 University Hospitals Bristol NHS Trust (UHB) undertook a comprehensive nurse establishment and skill mix review of general inpatient areas which was presented to the Board. There has also been a subsequent comprehensive external review of the staffing of children's services presented to the Board in 2012. A nursing skill mix and establishment review was also as part of the business cases for the reconfiguration of services in the Bristol Royal Infirmary (BRI) redevelopment, centralization of specialist paediatrics and the transfer of Adult Bone Marrow Transplantation to the Bristol Haematology and Oncology Hospital (BHOC). A Birth rate Plus review was undertaken in December 2012 and demonstrated that the service required a workforce of 200.51 wte midwives and support workers, a further 3.44 wte midwives were funded.

This report focuses on ward based staffing levels in the Trust, midwifery and ward based staffing levels in the Bristol Royal Hospital for Children (BRHC). The report specifically addresses three key questions:

a) How are nursing and midwifery establishments set
b) How are concerns re staffing levels identified, escalated and mitigated (day to day)
c) How does the Trust know the wards are safe

2.0 Background

There is a greater focus now on ensuring that Trusts have the right size and shape of its nursing & midwifery workforce to meet the needs and expectations of its patients. Evidence can attribute failings in care and increased mortality rates to poorly staffed wards. Evidence also suggests that poorly staffed wards increase staff sickness, burnout and reduce staff wellbeing, all of which have a direct consequence on the process and outcomes of care, including patient experience. An other factor which evidence indicates has an impact on the delivery of safe, clinically effective and compassionate care is strong leadership at ward level.

3. 0 How are nursing and midwifery establishments set?

3.1 As far back as 2001 the Audit Commission recommended that establishment setting, regardless of the method must be simple, transparent, integrated, benchmarked and linked to ward outcomes. There is no one recommended single method. At UHB an evidence based approach to staffing has been used for a number of years.

3.2 Nursing and midwifery establishments are set on a number of sources of evidence. Within UHB four key methods are used:

a) Workload measurement tools
b) Benchmarking against national standards/guidance
c) Review of quality
d) Professional Judgment

3.3 The Trust Policy for setting Safe Nurse Establishments, which is in the final stages of sign off via Trust governance processes, sets out when and how staffing levels should be reviewed. The policy identifies triggers for when a review may be required as follows:

- As a minimum a staffing and skill mix ratio review will be undertaken annually for each clinical area.

OR when there is:

- A significant change in the service e.g. changes of specialty, ward reconfiguration, service transfer
- A planned significant change in the dependency profile or acuity of patients within a defined clinical area e.g. demonstrated by sustained high acuity/dependency scores or an increased specialling requirement.
- A change in profile and number of beds within defined clinical area.
- A change in staffing profile due to long term sickness, maternity leave, other leave or high staff turnover
- If quality indicators in the key performance indicators a failure to safeguard quality and/or patient safety.
- A Serious Incident (SI) where staffing levels was identified as a significant contributing factor
- If concerns are raised about staffing levels by patients or staff.
- Evidence from benchmark group that UHBristol is an outlier in staffing levels for specific services.

The policy also sets out some key principles that will be followed within UHB when planning or reviewing nurse and midwifery staffing, regardless of the specific tools used. These principles are:

- **systematic:** use a systematic approach and apply it consistently
- **staff involvement:** involve staff in both the process and outcomes of a review
- **triangulate:** for example patient dependency based workload tools should be complemented with professional judgment and benchmark data from matched comparators
- **adequate uplift:** having identified the nursing staff needed, the establishment itself must be calculated to allow for service delivery times (ie shift patterns) and staff time away from the service (ie an 'uplift'). UHB has an uplift of 21 percent applied to all its twenty four hour/seven day a week services.
- **evaluation:** the only way we can judge whether the staffing level for a service is optimal, is by looking at indicators of its sufficiency. This relies on good quality HR data and patient outcomes/quality data being collected, and used to review to inform services (at the unit and board level)
- **regular review:** NHS/CQC guidance recommends an annual review.

3.4 Workload measurement tools Current Position:

There are a number of dependency and acuity tools in use in clinical areas already that provide support to determining skill mix and establishment. These are detailed below.

Area	**Tool**
All adult areas not detailed below	Safer Care Nursing Tool – manual data collection (periodic not daily)
Paediatric Intensive Care Unit (PICU)	PICU Dependency Levels 1-4
Adult Intensive Therapy Unit (ITU) and Cardiac Intensive Care Unit (CICU)	British Association of Critical Care Nurses (BACCN) Dependency Levels 1 -4
Neonatal ITU	British Association of Peri-natal Medicine (BAPM) Level ICU – High Dependency Unit (HDU) - Special Care.
Emergency Department	Triage Scoring
Theatres	National Association of Theatre Nurses (NATN) Standard
Maternity	Birthrate Plus
Paediatrics	Peadiatric Early Warning Score

Future position:

The trust is in the process of procuring an IT system to interface with our current e-rostering system which will support the point prevalence measuring of patient acuity and dependency twice a day. This electronic system will enable us to have an overview of any ward whose acuity exceeds 10% of the staffing establishment. Notification triggers will be sent to the senior nursing teams and a review of the dependency and available staffing will take place. This data will form part of the Board's monthly reports on nursing and midwifery staffing once available.

The Trust does not just use the acuity tool in isolation as experience tells us that acuity can be higher than the staffing levels, but adjustments don't need to take place as both the seniority and experience of staff on duty enables them to manage safely.

Therefore when reviewing establishments it is important to take into account the skill mix, and strength in ward leadership. A ward leader must have an adequate number of deputies who can ensure safe, effective care throughout the 24 hour period.

3.5 Benchmarking against national standards/guidance

Different methodologies and guidelines are available to support the setting of skill mix and establishments in a range of specialties. The following table outlines those relevant to, and used by the Trust to support setting safe staffing levels

Methodologies and guidelines for different specialties:

Clinical Area	**Professional guidance**
General medical and surgical areas	Safer Care Nursing Tool (NICE guidance 2014) Professional Judgement, Hurst Nursing Workforce Planning Tool (2012)

	Mandatory Nurse Staffing Levels RCN (2012) Setting safe nurse staffing levels RCN (2010)
Stroke	UK Stroke Forum Education and Training Staffing Calculator
Paediatrics	RCN (2003 updated 2012/13) (SCAMPS, a validated paediatric acuity/dependency tool is tool is being developed in Scotland and should be launched later this year)
Paediatric Intensive Care	Paediatric Intensive Care Society (PICS) (2001 and 2010)
Neonates	British Association of Perinatal Nursing(2010) and DH (2009)
Adult Intensive Care Unit and Cardiac intensive Care Unit	British Association of Critical Care Nurses (BACCN) (2010)
Theatres	Staffing for patients in the perioperative setting Association for Perioperative Practice 2007
Day Surgery	British Association of Day Surgery (BADS) (2003)
Accident & Emergency	There are no current agreed nationally recommended guidelines for minimum staffing levels College of Emergency Medicine, Foundation Trust Network
Catheter Laboratory	British Cardiovascular Society (2007) Non-medical catheter laboratory staffing working group report
Endoscopy	Royal College of Physicians Joint Advisory Group on gastrointestinal endoscopy (2007)
Radiology	The Royal College of Radiologists and the RCN (2006) Benchmarked against peer organisations
Haemato - oncology	British Committee for Standards in Haematology (BCSH); Haemato-Oncology Task Force (2009); FACTJACIE (The Joint Accreditation Committee-ISCT (Europe) & EBMT) (2011); National Cancer Peer Review Programme (2012)
Renal Dialysis	National Renal Workforce Planning Group (2002)

Paediatric/Adult Bone Marrow Transplant	There are no current agreed nationally recommended guidelines for minimum staffing levels for stem cell transplant/ haematology wards. However, there are general agreed principles outlined in the quality measures of regulatory bodies and peer review processes that apply to nurse staffing levels in specialist haemato-oncology centres JACIE applied Standards.
Care of the Elderly	Safe Staffing for older peoples wards RCN (2012)
Midwifery	Birth Rate Plus

Benchmarking is also undertaken with other like organisations of similar size and patient population and is restricted to hospitals within the NHS South. Benchmarking extends beyond workforce data to determine the quality of care and experience in comparator hospitals.

3.6 Ratio of registered to unregistered staff

Determining the skill mix between qualified and unqualified staff is not an exact science and requires a very good understanding of the patient population, number of beds and nursing requirements to determine how many registered versus unregistered staff can be safely deployed per shift. There is evidence that a higher ratio of healthcare support staff to registered nurses in acute settings leads to a "failure to rescue" deteriorating patients.

Within UHB adult inpatient areas the Trust has set staffing levels based on a principle of 60:40 ratio, registered nurse to nursing assistant in general inpatient areas. This will be higher in some specialist ward areas due to the increasing complexity of care, for example medication regimes and the number of intravenous drugs now given and increased dependency and complexity of elderly patients being admitted. As of April 2014 the ratio of registered to unregistered staff for UHB for adult inpatient areas ranged between 50:50 and 90:10. Where the ratio of registered nurses is less than 60% this is based on the professional judgment of the senior nurses and supported by patient acuity and dependency scoring.

3.7 Ratio of number of patients per nurse

It is difficult to provide an accurate picture of the nurse to patient ratios on a day to day basis as this is influenced by how the shift co-coordinator organizes their ward and how patients are allocated. In setting wards establishment and skill mix UHB has used the principles of one registered nurse per 6 patients on a day shift and one registered nurse to 8 patients on a night shift. UHB's funded establishment provides a ratio of the number of patients per RN between 2.3 - 8 on a day shift and 2.3 - 8 on a night shift. In adult critical care areas the ratio is one nurse per patient adult intensive care (level 3 patient) day and night and one nurse per two patients in adult high dependency (level 2 patients) day and night.

3.8 Professional judgment

Professional judgement is a part of setting staffing skill mix and establishment. Evidence shows that professional judgement provides a sound basis for decisions about nurse staffing and skill mix, as long as it is applied systematically and underpinned by the appropriate knowledge and skills. Within UHB professional judgement is informed by specialty specific professional

guidance about staffing (as detailed above) and supported by good-quality management data. This provides a systematic way of checking the soundness of professional judgements. Professional judgements are informed by a number of key issues, such as quality outcome indicators, working environment, support posts/structures in place, and other local contextual factors.

3.9 Additional staffing

Although the establishments are set based on average acuity and occupancy there are times when additional staffing levels are required to 'special' patients and provide 1:1 enhanced observation. For example, this would be to prevent a high risk patient from falling, patients sectioned under the mental health act, patients at risk of wandering or the acutely unwell patient who is unable to step up into an HDU bed. Additional staff requested and deployed for these reasons are recorded within the Trust's e-rostering system, which will guided by the Trust's enhanced observations policy so an organisational standard is applied.

3.9.1 Ward Supervision

In addition to ensuring that we have the right number of staff on duty it is also essential to ensure the ward leader is able to manage and supervise. The role is impossible if he or she is always included in the patient allocation per shift. The Francis report recommendations make it clear that some supervisory time for ward leaders is essential if you want to ensure the delivery of safe high-quality care. In UHB the majority of ward sisters and charge nurses are 100% supervisory.

The supervisory role is about having the time to lead, support the staff, act as a role model and be visible to patients and staff. It is not a role which is to be based in the office.

3.9.2 Unregistered workforce

Supporting our un-registered workforce is absolutely essential so that they are fully supported, supervised, trained and feel part of the nursing team. UHB has a framework in place to support the development of Nursing and Senior Nursing Assistants to reflect their contribution to the whole nursing team. We have a set of competencies nursing assistants need to achieve and access to Diploma level 2 & 3 training. The Trust has a central register of the training completed by this part of our workforce.

4.0 Our approach to ensuring safe staffing levels within the Bristol Royal Hospital for Children Hospital (BRHC)

4.1 The workforce requirements for the Bristol Children's Hospital (BCH) are calculated using 2 tools. The RCN guidance "Defining Staffing Levels for Children's & Young People's Services" (RCN; 2003); which defines staffing levels for Neonatal and Paediatric Intensive Care services as well as specialist children's wards. This document is used by all the Specialist Children's Hospitals and is currently being reviewed. The updated guidance will be published in spring 2015.

The Trust also uses Paediatric Early Warning Tool (PEWS) to score patients.

Within BRCH the majority of our patients are managed using 1 nurse: 3 patient's ratio or a 1 Nurse: 2 patient ratio if they require high dependency care. Within our Paediatric Intensive Care unit our ratio is 1:1. All of which are in line with RCN national guidance as discussed above. Within our Neonatal Unit, on Neonatal Intensive Care (NIC), we do meet the BAPM (British

Association of Perinatal Medicine) standard of 1 nurse : 1 baby for all our NICU cots.

Over the past two years we have reviewed our nursing establishment and skill mix to ensure that it is safe and in line with other specialist children's hospitals across the UK

4.2 Within BRHC, we have a team of paediatric nurses who provide the site management and an outreach specialist paediatric advice within the hospital over a 24 hour period, working very closely with Accident & Emergency to provide the specialist support required. This team is crucial to the operational functioning of BRHC and the safety of patients throughout the 24hr period.

5.0 Our approach to ensuring safe midwifery levels

5.1 The workforce requirements for the maternity unit have been calculated using a mix of 2 models, Birth-rate plus, supported by professional judgement. Birth-rate plus is based upon the principle of providing one to one care during labour and delivery to all women, with additional hours being identified for the more complex deliveries. Birth-rate plus require the unit to record data for a period of 4 months, covering all aspects of midwifery care. In addition it also adds an additional 10% to the workforce requirements, which cover senior and expert midwifery roles. April data showed that the Trust had a ratio of 1:33 by funded establishment, 1:34 in post.

5.2 Over the past 2 years the Unit has successfully introduced the Maternity Support Worker; the post holders undertake a comprehensive training programme and are fully supported and supervised by their Midwives.

6.0 How does the Trust know that wards are safe - review of quality outcomes

6.1 A number of qualitative and quantative metrics are utilized to assure divisional teams, divisional boards, the executive team, trust board members and the Chief Nurse that the care being delivered in inpatient areas is good quality (safety/clinically effectiveness/patient experience). These are reviewed from ward level to Board level. The purpose of the reviews is early identification and intervention in any areas that fall below the stated standards in the domains that affect care quality.

The key metrics reviewed are:

Workforce: temporary staff usage, establishment vacancy & turnover, incidences of lower than expected staffing.
Care Processes: quality in care tool audit, safety thermometer, and hand hygiene
Clinical outcomes: Falls with harm, pressure ulcers, infection, medication errors
Patient experience: UHB face to face patient experience data, friends and family test, complaints/compliments.
Staff experience: staff survey results, staff FFT test,
This data is formally reviewed and challenged in divisional boards, divisional performance reviews, clinical quality committee, quality and outcomes committee and at trust board (all meet monthly). Informal intelligence is gathered through back to the floor clinical programme, patient safety walkabouts and local discussion with staff.

In times of escalation additional review of the above metrics takes place as per Trust escalation policy.

7.0 How are concerns re staffing levels identified, escalated and mitigated (day to day)?

7.1 A robust system for escalation is in place within UHB in all Divisions.

Operationally the approach to assuring adequate staffing levels to meet day to day care lies with divisions who are responsible for on-going management of staffing and ensuring resources are deployed where needed. Divisional Heads of Nursing and their Matrons assess daily staffing levels. These are proactively managed through a daily divisional meeting where the Matrons and Heads of Nursing assess current staffing, addressing shortfalls through redeployment of staff and work with our temporary staffing supplier to escalate where short falls in staffing cannot be rectified. Specifically;

- The Ward sister/charge nurse responds to unplanned changes to staffing eg sickness will respond to changes in acuity and dependency of patients. Escalating to Matron where any inadequate staffing levels to meet patient needs still exist.
- Matrons/Senior Midwife reallocates staff across the area of responsibility to ensure safe staffing levels. Escalate to Head of Nursing for the Division was unable to resolve issues and ensure safe staffing levels.
- Head of Nursing and Head of Midwifery escalate to agency where bank unable to fill shifts. Review situation and risk assess situation across whole Trust. Reallocate staff as per risk assessment. Consider review of clinical activity in ward.

7.2 Roster management is essential to managing staff. Establishments are agreed into operational rosters; in turn this is managed through the eRostering system which has agreed KPIs to ensure effective use, including ensuring competencies for the nurse in charge, under and over hours used and even distribution of annual leave.

7.3 In addition to this, incidents related to staffing levels from the Trust Safeguard (incident reporting) identify where staffing levels have potentially contributed to incidents and the impact this has on care delivery. This is managed at divisional level and reporting through existence governance arrangements.

8.0 Escalation beds

Safe levels of nurse staffing and skill mix for escalation beds are determined as part of capacity planning and the same principles used to set and approve safe nurse staffing and skill mix levels are applied when planning and opening escalation beds, taking into account the location, case mix of patients and number of escalation beds. There should never be more than a 50% split of Trust and temporary staff, to ensure continuity of care there must be a Trust employed band 6 or above who takes supervisory control of the area for the duration the beds are open.

Escalation will be managed in accordance with the Divisional variation of the Trust Patient Flow Escalation Plan. The opening of escalation beds requires agreement and sign-off by the Divisional Head of Nursing or the On Call manager if out of hours. As a minimum, weekly quality assurance audits of the escalation beds will be undertaken by a senior member of the Divisional nursing team.

Furthermore, beds (either escalation or beds in an existing bed base) may be closed where staffing has been deemed, by the Divisional Heads of Nursing after discussion with Divisional Clinical Chair and Divisional Director, as insufficient to maintain patient safety.

Conclusion

For Nurse & Midwifery Staffing levels for UHB's adult acute wards, Midwifery and the BRCH the Trust has undertaken a comprehensive ward by ward review of staffing levels to ensure they are staffed safely. These will be reviewed at a minimum of every 6 months. This paper can assure the Board of Directors that it has establishments and skill mix set that support safe staffing levels and robust processes in place manage, based on risk assessment, any variations to set staffing levels on a day to day basis. There is however there is no element of complacency and there is a recognised need to stabilise the workforce with an effective recruitment campaign and to ensure if the bed numbers increase that staffing is adjusted accordingly.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

11 Emergency Preparedness

Purpose

This paper provides the annual report detailing the Emergency Preparedness, Resilience and Response (EPRR) activities undertaken by the trust during 2013/14 and describes the workplan for 2014/15 that will be used to ensure the Trust is compliant with EPRR core standards.

Abstract

The Annual Report sets out the key activities undertaken for Emergency Preparedness, Resilience and Response (EPRR) activities during 2013/14.

The Trust met its obligations as set out in the Civil Contingencies Act 2004 and associated Emergency planning Guidance.

The Trust has received assurance by means of internal and external audit that it is compliant with Emergency Planning Resilience and Response Core Standards and Business Continuity Planning Standards and that it has developed a comprehensive program of work to ensure continued compliance.

The exception is the delayed rewrite of the Trust Major Incident Plan. The revised plan will be released to coincide with the relocation into the new BRI ward block. The present Major Incident plan remains fit for purpose.

In the future, the annual report for Emergency Preparedness, Resilience and Response (EPRR) will move from financial year to calendar year. Therefore, the Annual Report for 2014 will be presented to the Trust Board in February 2015 as part of the standard board cycle.

Recommendations

Trust Board is recommended to approve this annual report.

Report Sponsor

James Rimmer, Chief Operating Officer

Appendices

- None

University Hospitals Bristol NHS
NHS Foundation Trust

Emergency Preparedness

Annual Report 2013/2014

Prepared by: **Cass Sandmann,** Resilience Manager

Presented by: **James Rimmer,** Chief Operating Officer

Executive Summary

The Civil Contingencies Act 2004 (CCA) places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 Responders.

As a Category 1 Responder (see *paragraph 1.2*) University Hospitals Bristol NHS Foundation Trust is required to prepare for emergencies in line with its responsibilities under the Civil Contingencies Act 2004 and NHS Commissioning Board Emergency Planning Framework (2013).

This report outlines the position of the Trust in relation to emergency preparedness and how the trust will meet the duties set out in legislation and associated statutory guidelines, as well as any other issues identified by way of risk assessments and identified capabilities.

Glossary of Key Terms

Acronym	Definition
A&S	Avon & Somerset
BCM	Business Continuity Management
BCP	Business Continuity Plan
BCPG	Business Continuity Planning Group
BS-25999	British Standard: Business Continuity Management
CBRNe	Chemical, Biological, Radiological, Nuclear, explosion
CCA	Civil Contingencies Act 2004
CCC	Civil Contingencies Committee
CCG	Clinical Commissioning Group
CRR	Community Risk Register
DH	Department of Health
EPLOF	Emergency Planning Liaison Officer's Forum
EPRR	Emergency Planning Resilience and Response
FOI	Freedom of Information Act 2000
ISO 22301	International Standardization Organisation Business Continuity management
LA	Local Authority
LRF	Local Resilience Forum
MIPG	Major Incident Planning Group
NHS	National Health Service
RASG	Risk Assessment Sub-Group
RM	Resilience Manager
SOP	Standard Operating Procedure
SWAS	South Western Ambulance Service NHS Trust
TOR	Terms of Reference

Contents

1 Introduction

1.1 Purpose

This report outlines the Trust's activities during 2013/2014 that relate to the requirements of the Civil Contingencies Act 2004, its associated regulations, statutory and non-statutory guidance.

The report is presented to the University Hospitals Bristol NHS Foundation Trust Board in line with the requirements of the NHS Emergency Planning Guidance 2013 which states that:

> "*The Chief Executive will ensure that the Quality and Outcomes Committee receives regular reports, at least annually, regarding emergency preparedness, including reports on exercises; training and testing undertaken by the organisation and that adequate resource is made available to allow the discharge of these responsibilities."*
>
> (NHS Emergency Planning Guidance 2013)

1.2 Background

The Health and Social Care Act (and the changes it makes to other legislation) makes significant changes to the health system in England from April 2013. Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013 published in April 2012, set out the intended arrangements for delivering safe and consistent Emergency Preparedness, Resilience and Response (EPRR) in the health sector in England from April 2013.

The Civil Contingencies Act 2004 (CCA) sets out a single framework for civil protection in the United Kingdom. The Civil Contingencies Act provides a statutory framework for civil protection at a local level and divides local responders into two categories depending on the extent of their involvement in civil protection work, and places a set of duties on each.

Category 1 responders are those organisations at the core of emergency response. Foundation Status Trusts (FSTs) are identified as Category 1 responders and are subject to the full set of civil protection duties.

Foundation Status Trusts are therefore required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place Business Continuity Management Strategies and arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency; and
- Provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only).

1.3 Context

2013/14 has been a demanding year for emergency planning with continual changing requirements from both Governmental, national and other healthcare community sources.

Given the gravity of ensuring that the trust is well positioned to meet all the requirements of the Civil Contingencies Act 2004, and to continuously revise and test out plans and provide relevant training in a large inner city NHS trust, the position of Resilience Manager has been maintained.

The emphasis of Emergency Preparedness in 2013/2014 has been guided by the following themes:

- The Trust has experienced several critical incidents and business continuity challenges that have tested plans, highlighted the need for additional plans and informed local plan review and revision.

- Following a number of internal and external audits, a number of emergency planning gaps have been identified and plans developed to resolve gaps in planning.

- Further challenges were experienced with new arrangements for Health Emergency Preparedness, Resilience and Response (EPRR***)*** from April 2013 (published April 2012) which set out the arrangements for delivering safe and consistent EPRR following the changes in organisations from April 2013.

The Trust has continued to train, test and exercise plans to the fullest with new training strategies being developed to facilitate learning.

The Trust now has in place comprehensive plans for many different scenarios however it is envisaged that all its plans will require periodic review, training, testing and exercising if the trust is to be able to respond to periods of potential disruption due to perhaps unforeseen causes.

2 Risk Assessment

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

2.1 Community Risk Register

University Hospitals Bristol NHS Foundation Trust contributes to the development and maintenance of the Community Risk Register (CRR) through the Resilience Manager who attends the Avon & Somerset Local Resilience Forum (LRF) Risk Assessment Sub-Group (RASG).

Evidence: Avon and Somerset Community Risk register

2.2 Local Authority Risk Register

Bristol City Council has reviewed and applied the Community Risk Register to the Local Authority area.

2.3 Trust Risk Register

The Trust also maintains a register of risks which may impact on service provision and this is regularly updated and then reviewed by the Governance and Risk Management Committee and Trust Board.

The Trust Maintains an Emergency Planning Risk Register that correlates to the risks identified on the CCR.

The Emergency Planning Risk Register is overseen by the Civil Contingencies Committee.

Risk number	Category	Description	Risk Rating
2368	Adverse weather	Avon Tidal Surge	4
2383	Adverse weather	Ice and snow	6
2478	Adverse weather	Heat-wave	9
2480	Communicable disease	Pandemic Influenza	12
2481	Massed gatherings	St Pauls festival, Ashton Park Music Festival	2
2675	Environmental	UPS provision	12
2676	Environmental	CBRN Incident	4

Evidence: Corporate Risk Register, Emergency Planning Risk register

3 Emergency Planning

This section details the activities undertaken to develop and maintain arrangements for responding to an emergency.

3.1 Generic Emergency Plan

The Trusts Major Incident Plan was last reviewed in February 2012 and coincided with the relocation of the Trust Command and Control Room to Trust Head Quarters. The plan was due to be reviewed in February 2014 however the Senior Leadership Team (SLT) approved an extension to the review date of six months to allow for the required changes instigated by centralisation of paediatric services and move to the new BRI ward block to be incorporated.

The current plan remains compliant with good practice, and will continue to be reviewed by the trust Major Incident Planning Group (MIPG) who report to the Civil Contingencies Committee (CCC), chaired by the Chief Operating Officer. This is in line with Emergency Planning Guidance (2005, 2013) and Health Emergency Preparedness, Resilience and Response from April 2013.

The current plan will be reviewed, rewritten, tested and exercised in 2014.

Evidence: Emergency Planning Pages, Emergency Planning Work Plan

3.2 Communicable Disease Planning

The emphasis has currently moved away from specific pandemic influenza planning and supports a more generic plan for all communicable diseases.

The Trust Resilience Manager is a member of the Avon, Gloucestershire and Wiltshire Local Health Resilience Partnership Communicable Disease Task and Finish Group. The Trust will develop its pandemic influenza plan utilising the recommendations from the communicable disease plan when completed

3.3 Specific Emergency Plans

The following new emergency plans and policy documents have been developed during 2013/2014 and have been presented to the Service Delivery Group (SDG), via the Trust Civil Contingencies Committee for ratification:

Title	Date	Accepting Group
Severe Weather Plan 2013	20/11/13	BCPG
Significant Incident Plan 2013	16/08/13	SDG
Paediatric Significant Incident Burns Operating procedure	06/05/14	CCC
Paediatric Significant Incident major Trauma Operating Procedure	06/05/14	SDG
Heat wave Plan 2014	06/05/14	CCC
Helideck Operating Procedure	09/04/14	BRI Project Board

The following emergency plans and policy documents are being developed during 2014/2015 and will be presented to the relevant group via the Trust Civil Contingencies Committee (CCC) for ratification:

Title	Monitoring group	Accepting Group
Hospital Evacuation Plan	Major Incident planning group	SLT
Trust Massed Casualty Plan	Major Incident planning group	SLT
Communicable Disease Plan	Communicable Disease Planning Group	SDG

The Trust has adopted the concept of Standard Operating Procedure (SOP) for providing a framework that enables staff to effectively manage unforeseen incidents.

Latest SOP's include but are not limited to;

Title	Date	Additional Dates	Accepting Group
Site Wide Generator Testing	First used 17/01/13	Multiple enactments	SDG
Medway and IM&T Updates	First used 18/04/12	24/04/13	SDG
Industrial Action	First used November 2013		SDG
Ambulance 30 minute Turnaround Standard	First released 01/05/13	Multiple enactments	SDG

4 Business Continuity Planning

This section details the Trust's activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.

In previous years the NHS recognised that the British Standard BS-25999 provided definitive guidance on business continuity management and the Trust purchased BS-25999 self- assessment tools and licences that enabled the trust to align itself with the standard during 2011/2012. The licence was extended to 2012. This standard has now been superseded by ISO 22301and whilst there are no significant differences between the two standards, the Trust will align itself to the latest standard.

The Trust's Business Continuity Group is currently undertaking a business continuity plan audit which will aid the transition to alignment with the ISO 22301 standard. The audit is due for completion 30/03/2014.

The Trust is currently fully compliant with Core Quality Commission standards with respect to Business Continuity Planning however it recognises that this important aspect of Resilience Planning will be an on-going process.

4.1 Business Continuity Policy

A Trust Business Continuity Planning Group (BCPG) has been established under the direction of the Chief Operating Officer and acts as the coordinating body of all business continuity policies, procedures and management of processes. This group reports to the Civil Contingencies Committee.

4.2 Business Continuity Strategy

The Business Continuity Planning Group has devised a Business Continuity Management Strategy for 2014/2015 and is in the process of reviewing the effectiveness of overarching and individual area Business Continuity Plans.

The strategy has been developed to take into account issues identified through both internal and external audit.

A revised over-arching Business Continuity Policy document has been ratified by the Business Continuity Planning Group and has been presented and accepted, via the Civil Contingencies Committee to the Service Delivery Group. The policy was reviewed in 2013.

4.3 Business Continuity Plans

The Trusts Business Continuity Plans are currently under review as part of the internal review audit process. A list of business continuity plans are held by the Resilience Manager and are available to view on the Trust Intranet. Hard copies of the plans are held by the Resilience Manager.

Evidence: Emergency Planning Pages

5 Information Sharing

This section details how the Trust has responded to formal or informal requests for information under the provisions of the Civil Contingencies Act 2004.

5.1 Formal Requests for Information

With regard to Emergency Preparedness the Trust, no formal request for information were received from April 2013 to May 2014

5.2 Informal Requests for Information

The Trust deals with routine informal requests for information as part of the normal activities of the Resilience Manager.

Informal requests for information generally come from Resilience Managers or their representatives from other NHS and non-NHS organisations relating to issues surrounding emergency preparedness.

6 Cooperation

This section deals with how the Trust cooperates with other emergency responders.

6.1 Emergency Planning Resilience and Response (EPRR)

The Trust is represented at the Local Health Resilience Partnership by the Accountable Officer for Emergency Preparedness at North Bristol Trust who is invited to attend the Trust's Civil Contingencies Committee.

6.2 Avon & Somerset Local Resilience Forum (LRF)

The Trust is represented at the Local Resilience Forum by the Head of Emergency Planning, Resilience and Response Area Team supported by the Trust Resilience Manager.

Evidence: Minutes of the Local Resilience Forum meetings are available on request to the Resilience Manager.

6.3 NHS South West Emergency Planning Leads Forum

The Trust's Resilience Manager participates in the above forum.

6.4 Local Resilience Forum and Other Working Groups

During 2013/2014 the Trust was represented on the following Local Resilience Forum and other working groups:

- Chemical, Biological, Radiological, Nuclear Working Group
- Local Resilience Forum Site Specific Group (Bristol)
- Avon and Somerset Local Resilience Forum
- Regional Resilience Forum for Massed Casualty Planning
- Local Resilience Forum Massed Casualty Planning
- Local Resilience Forum Training and Exercise Group
- Avon, Gloucestershire and Wiltshire Local Health Resilience Partnership Communicable Disease Task and Finish Group
- Bath, North Somerset, Somerset, South Gloucestershire Local Health Resilience Partnership Tactical planning Group.
- Paediatric Burns Network South West
- Paediatric Major Trauma Network South West

7 Warning & Informing

This section details how the Trust has undertaken activities to communicate with the public with regard to emergency preparedness and health protection.

As a Category One responder under the Civil Contingencies Act 2004 the Trust has a "duty, in partnership with others to warn and inform the public". (Civil Contingencies Act 2004).

7.1 Warning and Informing

In the financial year 2013/2014 the Trust's communications team continued to work in partnership with CCG to warn and inform the public.

Health protection messages were issued to the public either directly by the Trust or jointly with the Clinical Commissioning Group (CCG) and included;

Winter preparedness - Joint press releases with CCG were sent out to the local media to inform the public about alternative services to A&E especially over the Christmas and New Year Period.

Adverse weather - messages were cascaded to the public through the local media and the Trust's website about heavy snow, alternative services to A&E and what patients should do if it was not safe for them to come into the hospital.

Norovirus - Health messages concerning the presence of norovirus in the community and within the Trust were communicated to the public via the local media. This was supported by messaging on the homepage of the Trust's website, hold messages when calling the Trust, posters, leaflets and banners aimed at patients and visitors within the Trust.

8 Training and Exercising

This section details the training and exercising activities undertaken during 2013/2014.

8.1 Training Courses

The following training courses were run within the Trust during 2013/2014 Additional training records are available from the trust Resilience Manager on request.

Title	Date (s)	Additional Dates Planned
Emergency Department response to Chemical, Biological, Radiological, Nuclear incidents	15/05/13, 12/09/13, 11/12/13, 26/03/14	Rolling program Next planned 09/14
Strategic Management in a Crisis Training	05/05/13	Training provided by NHS England, dates to be announced
Major Incident Awareness Training		Delivered quarterly to on call managers next 08/14
Loggist Training	07, 21, 28/04/14	September 2014

The Trust participated in the following training/exercise sessions during 2013/2014

Title	Date
Exercise "Thornbury II" Nuclear establishment multi-agency excise	15/07/13
Exercise "Exodus" Hospital Evacuation Exercise NBT	22/05/13
Paediatric Burns Exercise (South West UK Burns Network)	03/05/13
EMERGO Live Major Incident Exercise	October 2013
Argon series of exercises	Final Exercise report 2013

8.2 Live Exercises

The NHS Emergency Planning Guidance (2005, 2013) states that the Trust must undertake a minimum of one live exercise every three years. The Trust participated in Emergo in October 2013 with the next exercise planned for 2016. Therefore, the Trust is compliant with its requirements for live exercise training.

8.3 Table-top Exercises

The NHS Emergency Planning Guidance (2005, 2013) states that the Trust must undertake a minimum of one table top exercise every year.

The planned Emergo exercise fulfilled this obligation for 2013.

A table top exercise is planned to coincide with the revision of the Trust Major Incident plan and opening of the new BRI ward block during 2014.

9 Communications Cascade Tests

The NHS Emergency Planning Guidance (2005, 2013) requires that the Trust must test its communications arrangements every six months as a minimum; however the trust completes this exercise monthly.

Feedback following these exercises identified gaps within the call-out process. Following this a revised call out system has been developed and put into practice.

Date	Full/Partial Trust Internal Cascade	CCG Initiated Cascade	Ambulance Initiated Cascade
17/06/13			X
15/07/13		X	
13/08/13	X		
14/08/13		X	
10/09/13		X	
01/10/13			X
11/11/13		X	
16/12/13		X	
26/03/14			X
14/04/14		X	
14/05/14	X		
23/05/14	X		

10 Debriefing

It is good practice to debrief staff participating in exercises to identify lessons learnt.

Following an incident, an initial ‘hot debrief’ is held.

Following the hot debrief and usually within a two to three week period, a ‘Cold Debrief ‘ is facilitated by the Trust Resilience Manager.

The Trust has adopted the concept of ‘Structured Debriefing’ and wherever possible the structured debrief will be facilitated by a Resilience Manager from a neighbour acute trust.

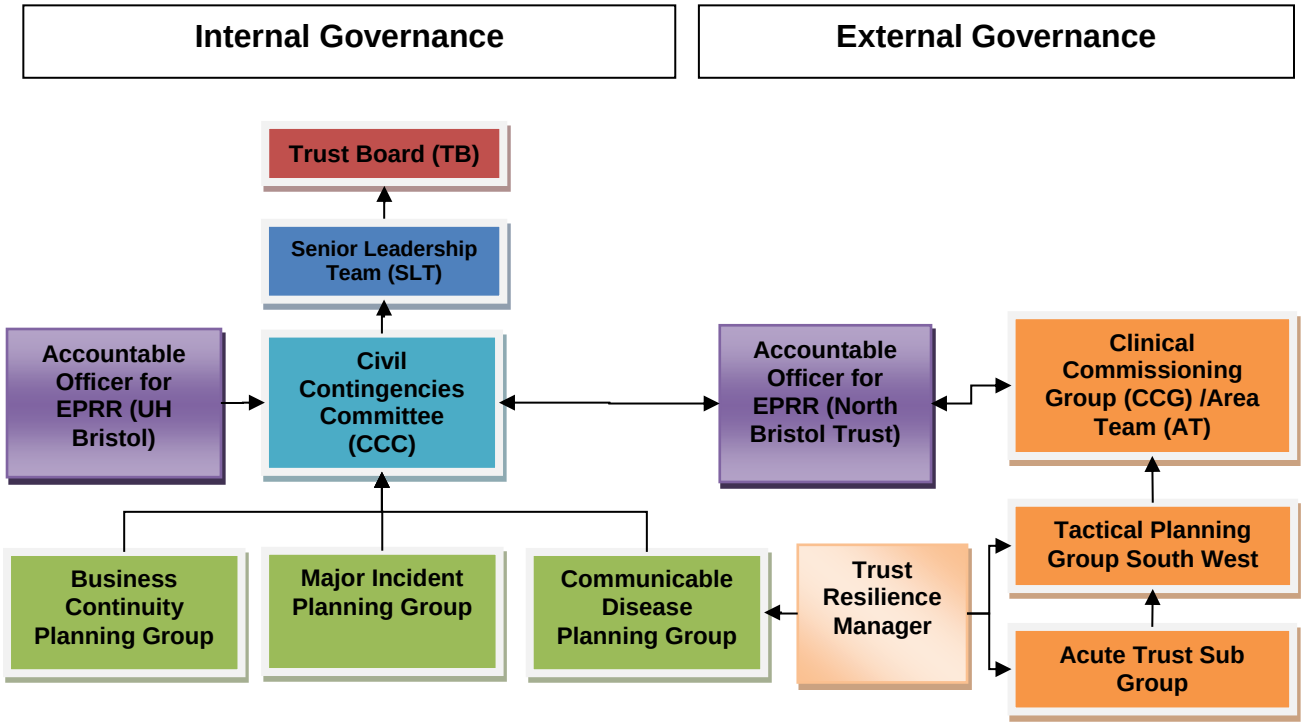
During 2013/2014 debriefing sessions were held following 100% of the exercises held and for 100% of incidents responded to.

Key lessons learnt, and actions taken as a result, have been incorporated into revised plans and processes, as applicable.

There were eight EPRR related incidents recorded in 2013 to date. Debriefs were completed for all.

11 Governance

The following diagram represents the Emergency Planning, Resilience and Response (EPRR) Governance Structure:



12 Audit & Assurance

This section of the report details the internal and external assurance activities undertaken for University Hospitals Bristol during 2013/2014.

Title	Date audit completed	Actions required	Date completed
Chemical, Biological, Radiological, Nuclear	13/04/2014	New Structure purchased	30/4/14
Internal Audit	November 2013	Delivery of the action plan is being overseen by the Civil Contingencies Committee and all actions are on track to be completed by the advised date	2014-2015
External Audit EPRR by CCG	06/02/14	Included on 2014/15 work plan	2014-2015

13 Work Programme 2014/2015

The work programme for the Trust's Emergency Planning Group for 2014/2015 has been developed in consultation with the Civil Contingencies Committee, the Trust Executive Lead for Emergency Preparedness and the Resilience Manager.

It should be noted that the work programme may fluctuate in line with emerging Department of Health guidance.

Evidence: Emergency Planning Work Plan 2014/15

14 Significant Events during 2013/2014

The Trust has experienced the following untoward events during 2013/2014. Where indicated the incidents are closed from an EPRR perspective

Title	Date	Debrief /RCA Held? Y/N	Action Plan produced Y/N	Completed
Migration to the Medway system	18/04/12	Yes	Yes	Closed
Migration to the Medway system	24/04/13	Yes	Yes	Closed
Installation of new power generators and associated commissioning	17/01/13	Yes	Yes	Closed
Power Failure	18/11/13	Yes	yes	Ongoing
Power Failure	18/12/13	Yes	Yes	Closed
Hospital Fire	13/08/13	Yes	Yes	Closed
IT Upgrade	10/05/14	Yes	No	Closed
Telecoms Upgrade		Yes	No	Closed

Lessons learned from debriefs following these events have been incorporated, where appropriate, into Trust plans.

14.1 Uninterrupted Power Supply

Following the power failures (*see above table*), a review of the UPS trust-wide has been undertaken.

A working group has been set up examine the types of UPS, suitability, provision and to further identify the interdependencies between UPS supplied and owned by the Estates Department and those supplied and owned by Medical Engineering Department.

On completion of the review, a gap analysis will be produced and recommendations presented to Senior Leadership Team.

15 Conclusions

The Trust met its obligations as set out in the Civil Contingencies Act 2004 and associated Emergency planning Guidance.

The Trust has received assurance by means of internal and external audit that it is compliant with Emergency Planning Resilience and Response Core Standards and Business Continuity Planning Standards.

The Trust has developed a comprehensive program of work to ensure continued compliance.

The exception is the delayed rewrite of the Trust Major Incident Plan. The revised plan will be released to coincide with the relocation into the new BRI ward block but the present Major Incident plan remains fit for purpose.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

12. Quarterly Patients Complaints Report

Purpose

This report provides a summary of:

- complaints received by the Trust during Quarter 4 of 2013/14
- the Trust's performance in responding to those complaints in a timely and effective manner
- themes and patterns arising from the complaints
- action taken by the Trust and its Divisions to address these concerns

Abstract

The Trust received 415 complaints in Quarter 4 (Q4), which equates to 0.24% of patient activity, against a target of 0.21%. In the previous quarter, the Trust had received 333 complaints, representing 0.19% of patient activity.

The Trust's performance in responding to complaints within the timescales agreed with complainants in Q4 was 84.7% compared to 85% in Q3.

In Q4, slightly fewer complainants told us that they were unhappy with our investigation of their concerns: 14 compared with 15 in Q3.

Recommendations

The Board to receive the report for assurance

Report Sponsor

- Sponsor – Carolyn Mills, Chief Nurse
- Authors – Tanya Tofts, Patient Support and Complaints Manager
  Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)

Appendices

Complaints Report, Quarter 4

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 4, 2013/2014

(1st January - 31st March 2014)

Authors: **Tanya Tofts, Patient Support and Complaints Manager**
Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)

1. Executive summary

The Trust received 415 complaints in Quarter 4 (Q4), which equates to 0.24% of patient activity, against a target of 0.21%. In the previous quarter, the Trust had received 333 complaints, representing 0.19% of patient activity.

The Trust's performance in responding to complaints within the timescales agreed with complainants was 84.7% compared to 85% in Q3.

In Q4, slightly fewer complainants told us that they were unhappy with our investigation of their concerns: 14 compared to 15 in Q3.

This report includes an analysis of the themes arising from complaints received in Q4, possible causes, and details of how the Trust is responding.

2. Complaints performance – Trust overview

The Board currently monitors three indicators of how well the Trust is doing in respect of complaints performance:

- Total complaints received, as a proportion of activity
- Proportion of complaints responded to within timescale
- Numbers of complainants who are dissatisfied with our response

The table on page 3 of this report provides a comprehensive 12 month overview of complaints performance including these three key indicators.

2.1 Total complaints received

The Trust's preferred way of expressing the volume of complaints it receives is as a proportion of patient activity, i.e. inpatient admissions and outpatient attendances in a given month.

We received 415 complaints in Q4, which equates to 0.24% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]; the figures do not include concerns which may be raised by patients and dealt with immediately by front line staff. The volume of complaints received in Q4 represented an increase of 24.6% compared to Q3 (333) and Q2 (334) and was approximately 20% more than in the corresponding period a year ago.

The Trust's current target is to achieve a complaints rate of less than 0.21% of patient activity, i.e. broadly-speaking, for no more than 1 in every 500 patients to complain about our services (although every complaint we receive is one too many).

[1] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.

Table 1 – Complaints performance

Items in italics are reportable to the Trust Board.
Other data items are for internal monitoring / reporting to Patient Experience Group where appropriate.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Total complaints received (inc. TS and F&E from April 2013)	135	120	105	96	123	115	120	109	104	127	124	164
Formal/Informal split	72/63	62/58	73/32	49/47	68/55	60/55	54/66	63/46	55/49	55/72	62/62	89/75
Number & % of complaints per patient attendance in the month	*0.24% 135 of 55066*	*0.21% 120 of 56584*	*0.19% 105 of 53853*	*0.16% 96 of 59079*	*0.23% 123 of 53002*	*0.20% 115 of 56869*	*0.19% 120 of 62480*	*0.19% 109 of 58783*	*0.20% 104 of 52194*	*0.21% 127 of 59288*	*0.23% 124 of 54507*	*0.28% 164 of 58180*
% responded to within the agreed timescale (i.e. response posted to complainant)	*47.37% (27 of 57)*	*54.68% (35 of 64)*	*66.67% (42 of 63)*	*80.28% (57 of 71)*	*77.20% (44 of 57)*	*87.8% (43 of 49)*	*84.9% (62 of 73)*	*82.2% (37 of 45)*	*88.1% (37 of 42)*	*76.1% (51 of 67)*	*92.0% (46 of 50)*	*88.7% (47 of 53)*
% responded to by Division within required timescale for executive review	49.12% (28 of 57)	64.06% (41 of 64)	55.55% (35 of 63)	74.65% (53 of 71)	92.98% (53 of 57)	83.7% (41 of 49)	69.9% (51 of 73)	66.7% (30 of 45)	57.1% (24 of 42)	77.6% (52 of 67)	86.0% (43 of 50)	71.7% (38 of 53)
Number of breached cases where the breached deadline is attributable to the Division [2]				4 of 14	1 of 13	4 of 6	10 of 11	5 of 8	3 of 5	7 of 16	2 of 4	3 of 6
Number of extensions to originally agreed timescale (formal investigation process only)	11	14	5	10	9	7	14	14	9	16	13	11
Number of Complainants Dissatisfied with Response	*1* 1***	*8* 1***	*6**	*6* 2***	*11* 1***	*1* 4***	*7* 8***	*2* 3***	*6* 6***	*6* 3***	*3* 5***	*5* 2***

* Dissatisfied – original investigation incomplete / inaccurate ** Dissatisfied – original investigation complete / further questions asked

[2] The total number of cases where the complainant did not receive their response on time was 7. Of these, 5 delays were attributable to the Divisions. The remaining 2 cases were delayed at Exec level during the sign-off procedure.

Figures 1 and 2 show a fairly consistent pattern of complaints received during 2013/14, but with indications of an upturn at the end of the financial year.

Figure 1: Number of complaints received

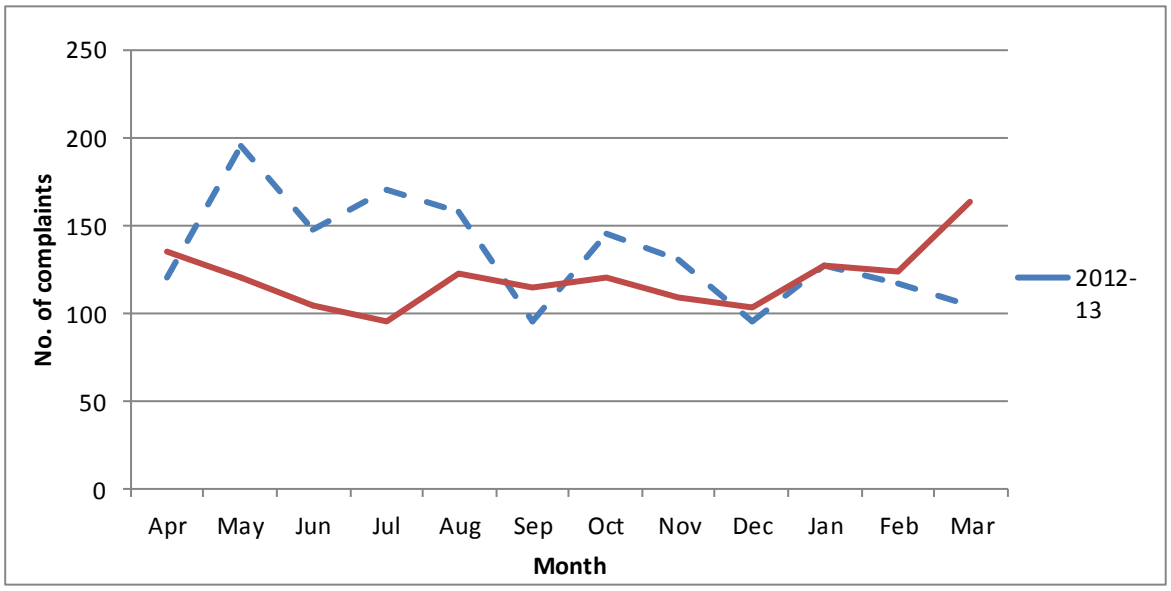
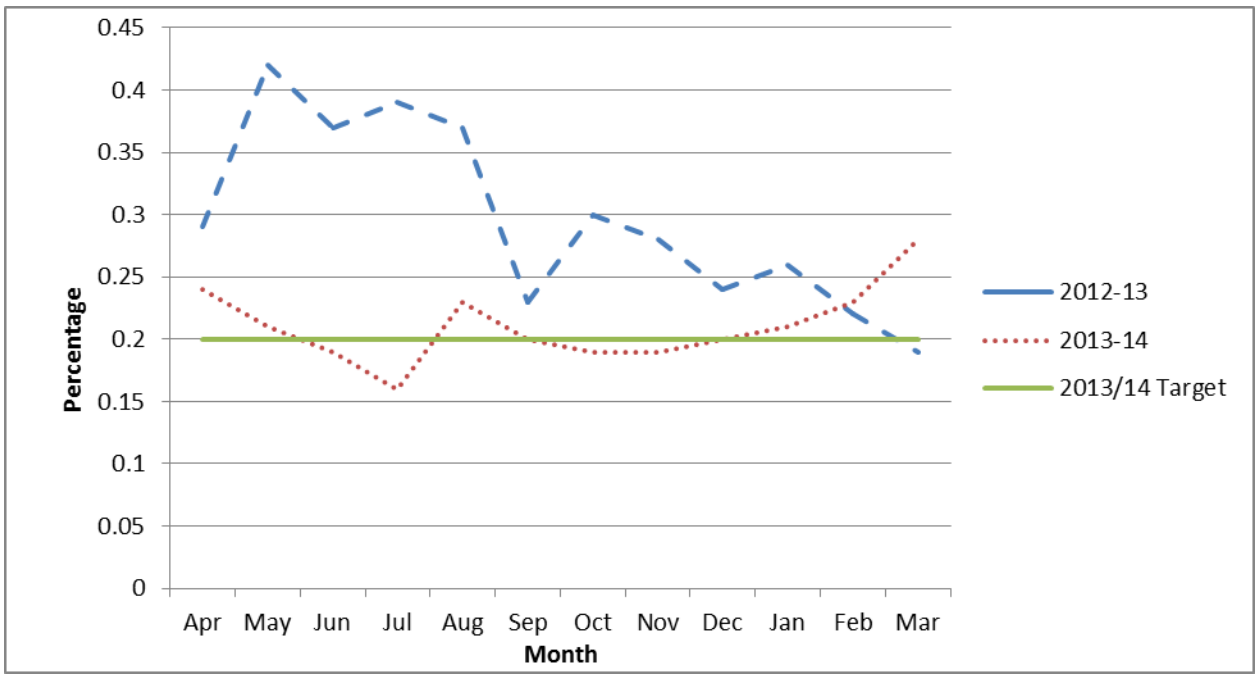


Figure 2: Complaints received, as a percentage of patient activity



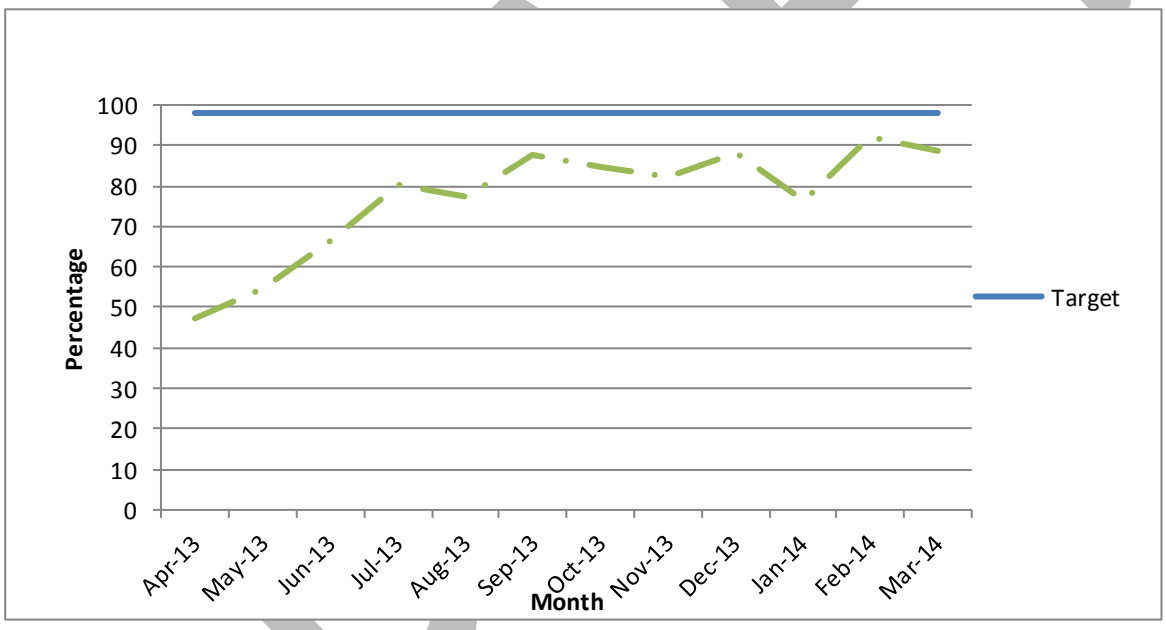
2.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days in Medicine and Surgery Head and Neck[3] and 25 working days in other areas[4].

Our target is to respond to at least 98% of complainants within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q4, 84.7% of responses were made within the agreed timescale, compared to 85% in Q3. This represents 26[5] breaches out of 170 formal complaints which were due to receive a response during Q4[6]. Divisional management teams remain focussed on improving the quality and timeliness of complaints responses.

Figure 3 shows the Trust's performance in responding to complaints in the last 12 months. In May 2013, the Trust identified an error in the way that response times were being calculated[7]: this revealed that performance was significantly worse than had previously been reported. Improvement actions were therefore initiated in May, leading to improvements in the months since then. Data for January-May 2013 has been recalculated so that the information in Figure 3 is an accurate representation of the Trust's performance during that period.

Figure 3. Percentage of complaints responded to within agreed timescale



[3] Based on experience, due to relative complexity
[4] 25 working days used to be an NHS standard
[5] Total includes one breach accredited to Division of Facilities and Estates.
[6] Note that this will be a slightly different figure to the number of complainants who *made* a complaint in that quarter.
[7] Calculations had been made using an endpoint of the date when the draft response was received from the Division: it should have been the date when the final response was posted to the complainant.

2.3 Number of dissatisfied complainants

We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are dissatisfied with the quality of our investigation of their concerns. For every complaint we receive, our aim is to identify whether and where we have made mistakes, to put things right if we can, and to learn as an organisation so that we don't make the same mistake again. Our target is that nobody should be dissatisfied with the quality of our response to their complaint. Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response.

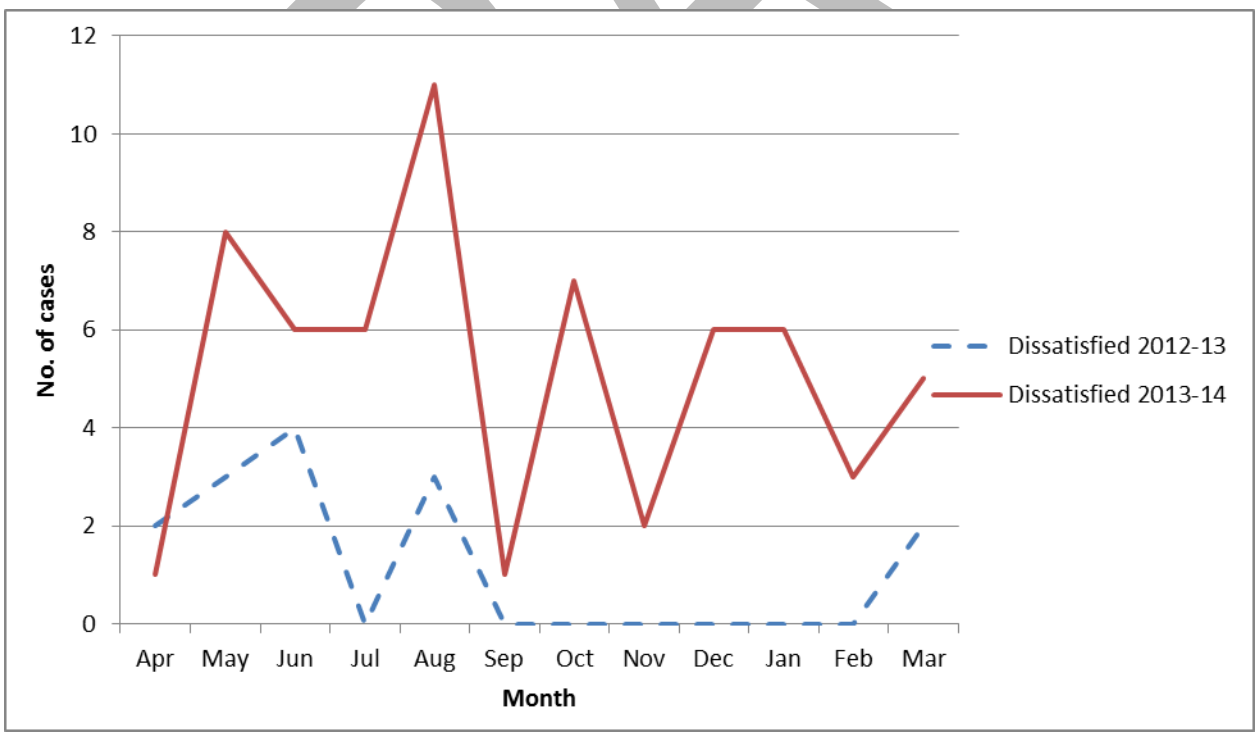
In Q4, there were 14 cases where the complainant felt that the investigation was incomplete or inaccurate. This represents a marginal decrease on Q3 (15 cases). There were a further 10 other cases where new questions were raised; a significant decrease compared to Q3 (17 cases).

The 14 cases where the complainant was dissatisfied were associated with the following lead Divisions:

- 5 cases for the Division of Surgery, Head & Neck (compared to 8 in Q3);
- 4 cases for the Division of Medicine (compared to 4 cases in Q3);
- 3 cases for the Division of Women & Children (compared to 0 in Q3);
- 1 case for the Division of Specialised Services (compared to 3 case in Q3);
- 1 case for the Division of Diagnostics & Therapies (compared to 0 in Q3); and
- 0 cases for the Division of Facilities & Estates (compared to 0 in Q3).

A validation report is sent to the lead Division for each case where an investigation is considered to be incomplete or inaccurate. This allows the Division to confirm their agreement that a reinvestigation is necessary or to advise why they do not feel the original investigation was inadequate.

Figure 4. Number of complainants who were dissatisfied with aspects of our complaints response



The number of dissatisfied complainants has increased overall in 2013/14 compared to 2012/13 (62 compared to 20). No discernible reason has been identified for this increase and there is no particular trend identified within any of the Divisions or in particular departments. However, actions agreed to address this increase are detailed in section 3.6 of this report.

Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of six major themes. The table below provides a breakdown of complaints received in Q4 compared to Q3. This shows that the number of complaints for each theme increased in Q4 and that these increases were broadly consistent across the themes, i.e. there was not a dramatic rise in any one theme in particular.

Category Type	**Number of complaints received – Q4 2013/14**	**Number of complaints received – Q3 2013/14**
Appointments & Admissions	133 (32% of total complaints) ↑	114 (34.3%)
Attitude & Communication	119 (28.7%) ↑	99 (29.7%)
Clinical Care	115 (27.7%) ↑	86 (25.8%)
Facilities & Environment	30 (7.2%) ↑	21 (6.3%)
Access	10 (2.4%) ↑	9 (2.7%)
Information & Support	8 (2%) ↑	4 (1.2%)
Total	**415**	**333**

Each complaint is then assigned to a more specific category (of which there are 121 in total). The table below lists the six most common sub-categories, which in total account for 64% of the complaints received in Q4 (264/415). These top themes are broadly consistent from one quarter to the next.

Sub-category	**Number of complaints received – Q4 2013/14**	**Q3**	**Q2**	**Q1**
Cancelled or delayed appointments and operations	111 ↑ **(29% increase *compared to Q3*)**	86	95	85
Clinical Care (Medical/Surgical)	47 ↑ **(4% increase)**	45	30	35
Communication with patient/relative	32 ↑ **(129% increase)**	14	15	19
Attitude of Medical Staff	30 ↑ **(131% increase)**	13	18	18
Clinical Care (Nursing/Midwifery)	26 ↑ **(12% increase)**	23	32	15
Failure to answer telephones	18 ↑ **(13% increase)**	16	19	21

This data reveals large percentage increases in complaints about communication and the attitude of medical staff, and an upturn in complaints about cancelled or delayed appointments and operations.

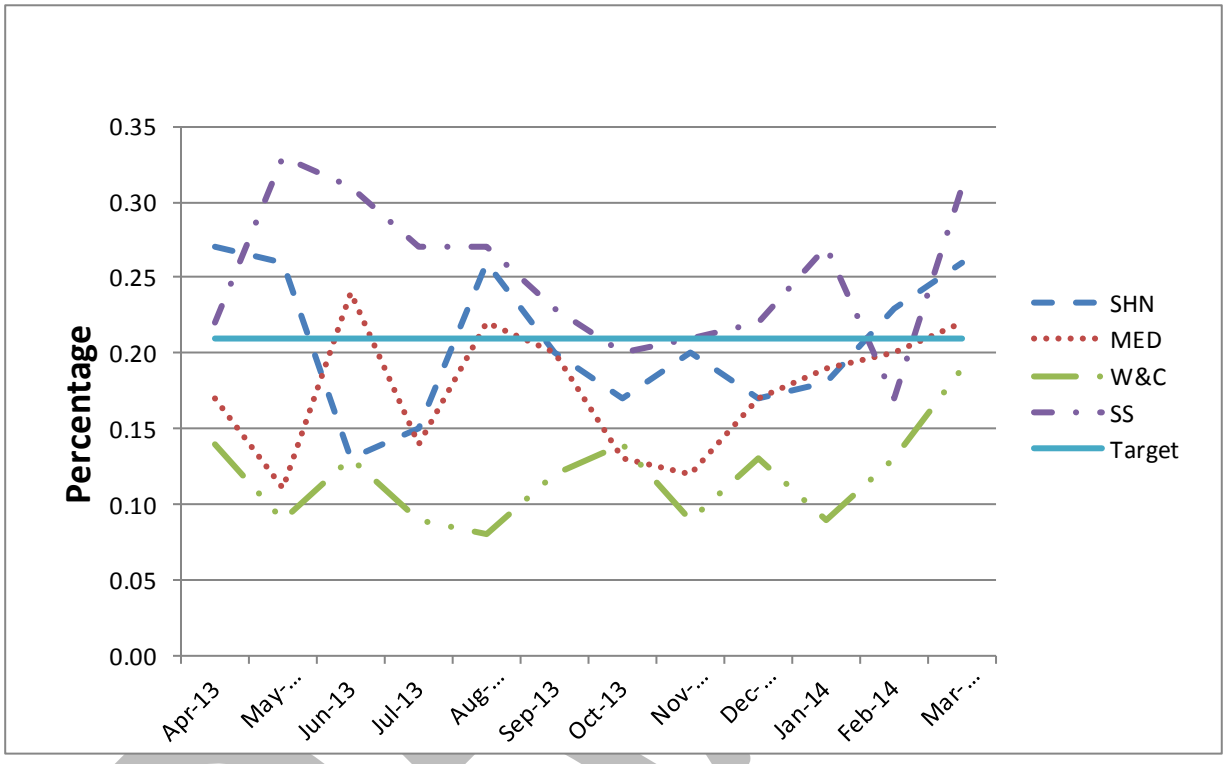
Concern	**Action**
Increase in complaints about cancelled or delayed appointments.	These issues are being addressed through the Trust's Transformation programme, and in the case of outpatients, through improvement activities which originated from the Productive Ward project.
Increase in complaints regarding communication with patients and relatives and about the attitude of medical staff.	Poorer patient experience is often reported where there has been significant use of bank, locum and agency staff. The Trust has implemented a recruitment strategy to keep pace with anticipated staff turnover. The Deputy Medical Director oversees a system to monitor complaints where individual medical staff are cited. Medical staff are interviewed by the DMD or Medical Director if patterns of repeated behaviour are identified which give cause for concern. *Face to Face* surveys and the 15 Steps Challenge are also being used proactively where complaints have been received about staff attitude and communication coupled with lower patient feedback ratings.

3. Divisional performance

3.1 Total complaints received

A divisional breakdown of percentage of complaints per patient attendance is provided in Figure 5. This shows an upturn in the volume of complaints received in all bed-holding Divisions at the end of Q4.

Figure 5. Complaints by Division as a percentage of patient attendance – 2013/2014



It should be noted that data for the Division of Diagnostics and Therapies has been excluded from Figure 5. This is because this Division's performance is calculated from a very small volume of outpatient and inpatient activity. Complaints are more likely to occur as elements of complaints within bed-holding Divisions. Overall reported Trust-level data includes Diagnostic and Therapy complaints, but it is not appropriate to draw comparisons with other Divisions. For reference, numbers of reported complaints for the Division of Diagnostics and Therapies in 2013/2014 have been as follows:

Table 2. Complaints received by Diagnostics and Therapies Division in 2013/14 to date

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of complaints received	9	8	3	3	6	4	12	9	11	14	11	7

3.2 Divisional analysis of complaints received

Table 3 provides an analysis of Q4 complaints performance by Division. The table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 3.

	Surgery Head and Neck	Medicine	Specialised Services	Women and Children	Diagnostics and Therapies
Total number of complaints received	169 (139) ↑	77 (53) ↑	56 (44) ↑	48 (44) ↑	32 (32) =
Total complaints received as a proportion of patient activity	0.22% (0.18%) ↑	0.21% (0.14%) ↑	0.25% (0.21%) ↑	0.14% (0.12%) ↑	N/A
Number of complaints about appointments and admissions	83 (45) ↑	23 (17) ↑	23 (19) ↑	8 (14) ↓	10 (4) ↑
Number of complaints about staff attitude and communication	47 (45) ↑	20 (12) ↑	13 (19) ↓	20 (13) ↑	16 (7) ↑
Number of complaints about clinical care	39 (37) ↑	34 (22) ↑	20 (9) ↑	20 (17) ↑	6 (2) ↑
Areas where the most complaints have been received in Q3	Ear Nose and Throat – 20 (34) ↓ Bristol Eye Hospital – 62 (34) ↑ Trauma & Orthopaedics – 30 (17) ↑ Upper Gastro-Intestinal – 14 (18) ↓ Bristol Dental Hospital – 19 (20) ↓	A&E – 15 (14) ↑ Diabetes/Endocrinology Clinic – 3 (8) ↓ Ward 15 – 5 (6) ↓ Ward 26 – 5 (0) ↑ Respiratory Department (including Sleep Unit) – 8 (4) ↑ Dermatology – 7 (3) ↑	Chemotherapy Day Unit and Outpatients – 11 (14) ↓ Bristol Heart Institute Outpatients – 11 (13) ↓ Cardiology GUCH Services – 6 (2) ↑ Ward 52 – 5 (5) = Ward 53 – 8 (2) ↑ Ward 61 – 5 (5) = Ward 62 – 4 (2) ↑	Outpatient clinics – 16 (21) ↓ Ward 78 – 4 (5) ↓ Ward 30 – 7 (5) ↑ Children's ED & Ward 39 – 6 (2) ↑	Audiology – 12 (7) ↑ Physiotherapy (Adult) – 5 (6) ↓ Radiology – 7 (9) ↓
Notable deteriorations compared to Q3	Bristol Eye Hospital	Ward 26 Respiratory Dermatology	Cardiology GUCH Services Ward 53	Children's ED & Ward 39	Audiology
Notable improvements compared to Q3	Ear Nose and Throat	Diabetes/Endocrinology	-	-	-

3.3 Areas where the most complaints were received in Q4 – additional analysis

3.3.1 Division of Surgery, Head & Neck

Complaints by category type

Category Type	Number and % of complaints received – Q4 2013/14	Number and % of complaints received – Q3 2013/14
Access	3 (1.8% of total complaints) =	3 (2.2%)
Appointments & Admissions	79 (46.7%) ↑	56 (40.3%)
Attitude & Communication	45 (26.6%) ↑	42 (30.2%)
Clinical Care	38 (22.5%) ↑	34 (24.4%)
Facilities & Environment	3 (1.8%) ↑	1 (0.7%)
Information & Support	1 (0.6%) ↓	3 (2.2%)
Total	**169**	**139**

Top six sub-categories

Sub-category	Number of complaints received – Q4 2013/14	Number of complaints received – Q3 2013/14
Cancelled or delayed appointments and operations	71 ↑ (58% increase compared to Q3)	45
Clinical Care (Medical/Surgical)	19 ↓ (24% decrease)	25
Communication with patient/relative	16 ↑ (300% increase)	4
Attitude of Medical Staff	11 ↑ (38% increase)	8
Clinical Care (Nursing/Midwifery)	7 ↑	3
Failure to answer telephones	7 ↑	3

Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Bristol Eye Hospital received 62 complaints in Q4, a significant increase on the 34 received in Q3. Only six cases were in respect of clinical care; 29 (46%) were attributed to staff attitude and communication; and 19 (30%) were in respect cancelled or delayed appointments and operations.	A small proportion of these complaints will have been received in Q3 but actioned in Q4 due to the backlog of enquiries to the corporate Patient Support and Complaints Team. <u>Communication</u> Some of the communication complaints have arisen because we have not explained processes to patients and therefore have not managed their expectations. For example, a patient who attended A&E to rule out anything sinister before referral for cataract	<u>Communication</u> • Each complaint is discussed with the clinicians or staff members concerned (if a junior clinician, this is done in conjunction with their supervisor – this accounts for the majority of complaints); they are asked to provide a statement and reflect upon what went wrong with their consultation, what they could have done differently and how they will change their practice in the future. Recently we have requested that some of the members of staff who have caused offence actually write to the patient directly in order to apologise and inform the patient how their practice has amended. • We are exploring the possibility of

	surgery felt that we should be able to refer them directly to the cataract service once other things had been ruled out, however this is a decision for their GP. <u>Cancelled/delayed appointments</u> Our system for managing patients referral-to-treatment times has not been working effectively due to staff sickness in the bookings team. There has also been a significant increase in delayed medical retinal and diabetic retinopathy outpatient appointments.	creating a secure internal log of communication/staff attitude complaints to enable repeat complaints about individual members of staff to be quickly identified. • Additional complaint training to be arranged for staff to help manage situations without them escalating. <u>Cancelled/delayed appointments</u> • A permanent member of staff has been moved into the bookings team to provide support. • Sustain management support for the admissions department in order to manage the flow of patients appropriately • Advertise the peripheral clinics (e.g. SBCH) in order to encourage patients to want to go there. • We are recruiting fully into the OPD and Technician teams in order to maximise flexibility of services and maintain flow of patients through clinics on the day. • Medical retinal and diabetic retinopathy outpatient appointments are being outsourced to SBCH and Weston. Whilst we finalise these peripheral clinics, we are setting up additional Saturday clinics to help reduce the backlog.
Trauma & Orthopaedics received 30 complaints in Q4, of which 11 were in respect of cancelled or delayed appointments and operations and six were attributed to clinical care. The department received 17 complaints in Q3.	There has been a backlog of operations at North Bristol NHS Trust who manage the waiting list for T&O surgery. *Note:* *T&O inpatient care is provided on wards 9 and 14. Analysis in the latest quarterly patient experience report indicates that for the period October 2013 to March 2014, these wards were among the ten lowest rated wards in the Trust.*	<u>Appointments</u> Project currently being implemented to reduce waiting time for appointments and for cancelled appointments by weekly review of all patients on 18 week wait. Working with D&T to address waiting times for scans/image guided injections. <u>Clinical care</u> The Clinical Director is meeting monthly with consultant and managers to review any complaints received.
The Upper Gastro-Intestinal Department received 14 complaints, the majority of which (12) related to cancelled or delayed	Due to cancer performance pressure, the waiting list for patients with benign disease has increased causing an increase in complaints.	From October 2014, the Division is planning to increase operating capacity in UGI. In short term the option of outsourcing some of this work is being explored.

operations.	*Note:* *UGI inpatient care is provided on ward 5a. Analysis in the latest quarterly patient experience report indicates that for the period October 2013 to March 2014, ward 5a achieved better than average patient-reported ratings, including the Friends and Family Test.*	

3.3.2 Division of Medicine

Complaints by category type

Category Type	Number and % of complaints received – Q4 2013/14	Number and % of complaints received – Q3 2013/14
Access	1 (1.3% of total complaints) ↓	2 (3.8%)
Appointments & Admissions	19 (24.7%) ↑	16 (30.2%)
Attitude & Communication	18 (23.4%) ↑	11 (20.7%)
Clinical Care	32 (41.5%) ↑	21 (39.6%)
Facilities & Environment	6 (7.8%) ↑	3 (5.7%)
Information & Support	1 (1.3%) ↑	0 (0%)
Total	**77**	**53**

Top six sub-categories

Category	Number of complaints received – Q4 2013/14	Number of complaints received – Q3 2013/14
Cancelled or delayed appointments and operations	15 ↑ (36% increase compared to Q3)	11
Clinical Care (Medical/Surgical)	11 ↑ (83% increase)	6
Communication with patient/relative	4 ↓	6
Attitude of Medical Staff	5 ↑	1
Clinical Care (Nursing/Midwifery)	9 ↓	12
Failure to answer telephones	3 ↑	0

Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
A significant number of complaints were received about Ward 26 (five cases compared to none the previous quarter), with	We are reviewing ward 26 in the context of Friends and Family Test scores as well as these complaints *(ward 26 is the lowest ranked ward in the Trust by FFT scores and also has*	An improvement plan has been developed. Feedback, clinical incidents and complaints have been reviewed to identify

three being in respect of clinical care provided by nursing staff.	*the second lowest patient experience tracker score[8]).* Two of the five complaints relate to the same issue, about a discharge funding decision that is outside of the Trust's control. One of the other complaints related to questions about a death where the family wanted additional information – we acknowledge that this could and should have been addressed quickly and outside of the complaints process.	common themes. A Face to Face survey and 15 Step Challenge have already been undertaken and the results of this are due to be presented to the Trust's Patient Experience Group on 19/6/14. The issue emerging from this work is the poor environment.
The number of complaints received by the Respiratory Department (including the Sleep Unit) more than doubled to 11 cases. These complaints were spread evenly across appointments and admissions, attitude and communication, and clinical care.	These complaints mostly reflect administrative issues about answering phones and dealing with enquiries. One complaint was about an appropriate referral to another specialty which the complainant had been unhappy about.	The specialty manager and Matron will work with the department including their administration team to develop an action plan to review the learning and make any changes based on this.
The number of complaints received by Dermatology increased from three in Q3 to seven, with five of these being attributed to cancelled or delayed appointments and procedures.	All but one of these complaints was dealt with swiftly and informally by the specialty manager. Two complaints related to delayed GP referral into the service. The others complaints included appointment changes, confusion about a biopsy appointment and communication of biopsy results.	The specialty manager and Matron will work with the department to develop an action plan to review the learning and make any changes based on this.

3.3.3 Division of Specialised Services

Complaints by category type

Category Type	Number and % of complaints received – Q4 2013/14	Number and % of complaints received – Q3 2013/14
Access	1 (1.8% of total complaints)	1 (2.3%)
Appointments & Admissions	21 (37.5%)	16 (36.3%)
Attitude & Communication	12 (21.4%)	17 (38.6%)
Clinical Care	19 (33.9%)	8 (18.2%)
Facilities & Environment	3 (5.4%)	1 (2.3%)
Information & Support	0 (0%)	1 (2.3%)
Total	**56**	**44**

[8] An aggregate measure of ward cleanliness, respect and dignity, involvement in care decisions and staff-patient communication, which is reported to the Trust Board (as a trust-wide score) each month

Top six sub-categories

Category	Number of complaints received – Q4 2013/14	Number of complaints received – Q3 2013/14
Cancelled or delayed appointments and operations	17 ↑ (42% increase compared to Q3)	12
Clinical Care (Medical/Surgical)	7 ↑	4
Communication with patient/relative	5 ↑	2
Attitude of Medical Staff	2 ↑	0
Clinical Care (Nursing/Midwifery)	3 ↑	2
Failure to answer telephones	1 ↓	6

Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
11 complaints were received by the Chemotherapy & Outpatients Department at Bristol Haematology and Oncology Centre - these were split between cancelled or delayed appointments (five cases) and clinical care (six cases).	A number of issues relate to cross-organisational issues between BHOC and North Bristol NHS Trust and incorrect information in the referral from NBT (or in one case, referral not received). Issues are tracked through the cancer PTL meetings and issues with NBT are escalated to the Trust Cancer Manager. The increase is most likely to due to pathway change (i.e. breast/ urology patients previously split between UH Bristol/ NBT now all referrals are coming via NBT). The root cause of other issues related to communication regarding bookings appears to be that patients were unclear who to contact and they therefore contacted PALS. Once contact was made with BHOC, issues were resolved with patient. One informal complaint related to no bed being available for planned chemotherapy treatment (ward 61).	When referrals are received from NBT, we check the patient details on the Spine (national NHS database based on GP practice records) in order to ensure that correct address and GP practice are updated on Medway. Continue to work to improve accessibility of bookings numbers and ensure that phones are answered when patients make contact. Stickers printed with key numbers on to be put onto appointment sheets and letters, plus changed layout of BHOC welcome guide and website so that contact numbers are clearer. As part of changes to the BHOC welcome guide, we have separated out the inpatient information and included an explanation of why patients need to call and the reasons why beds might not be available, in order to manage expectations appropriately.
There was a notable increase in the	Complaints were related to administration issues:	The following actions have been taken/agreed:

number of complaints received about Cardiology GUCH Services – six complaints compared to just two in Q3. Four of these complaints were in respect of cancelled or delayed appointments.	• Long wait in clinic • Patient not added to waiting list • Letters addressed to a consultant had not arrived • Telephone manner of secretaries	• Introduced electronic message board above reception area to notify patients of waiting times. • Plan to change all clinic letters to advise patients they may be up to four hours in the department due to the various tests required • Disciplinary action taken with one member of staff • Additional resource allocated to the waiting list office • A listing error due to human error has been reviewed with the member of staff responsible for future learning.
Complaints received by Ward 53 increased to eight from just two in Q3. These were split evenly between attitude and communication and clinical care.	The complaints included a message missed on the answerphone of a member of staff who had been off sick, resulting in delayed treatment. There were no common themes. *Note:* *Analysis in the latest quarterly patient experience report indicates that for the period October 2013 to March 2014, ward 53 achieved better than average patient-reported ratings, including the Friends and Family Test (fourth best).*	Arrangements have been put in place for the whole team to pick up answerphone messages in a team members absence. Appropriate action has been taken in response to each complaint including new staff guidance where relevant (e.g. about how to complete an assessment of a patient's skin prior to the application and removal of adhesive electrodes).
11 complaints were received by Bristol Heart Institute Outpatients Department. Seven of these were about cancelled and delayed appointments and four were about staff attitude and communication.	Complaints were related to the following issues: • Shortage of nursing assistants and administrative staff - lack of bank staff made covering the recruitment turnaround times difficult • A 'bug' in the Medway system means that letters are not always being sent to patients when clinics are cancelled	The following actions have been taken/agreed: • All administrative vacancies have now been recruited to • Restructure consultation starting w/c 19/5/14 to improve reception and coordinator cover • Plan to even out flow into department over week to create less stressful working environment • Assurance that correct cancellation protocols and procedures are being followed • Medway issue has been logged with IT and is awaiting solution; the in meantime, the team is able to double check and manually send letters when required

3.3.4 Division of Women & Children

Complaints by category type

Category Type	Number and % of complaints received – Q4 2013/14	Number and % of complaints received – Q3 2013/14
Access	2 (4.2% of total complaints) ↑	0 (0%)
Appointments & Admissions	6 (12.4%) ↑	14 (31.7%)
Attitude & Communication	19 (39.6%) ↓	12 (27.3%)
Clinical Care	19 (39.6%) ↑	16 (36.4%)
Facilities & Environment	1 (2.1%) =	1 (2.3%)
Information & Support	1 (2.1%) =	1 (2.3%)
Total	**48**	**44**

Top six sub-categories

Category	Number of complaints received – Q4 2013/14	Number of complaints received – Q3 2013/14
Cancelled or delayed appointments and operations	10 ↓ (29% decrease compared to Q3)	14
Clinical Care (Medical/Surgical)	9 ↑	7
Communication with patient/relative	5 ↑	0
Attitude of Medical Staff	8 ↑	6
Clinical Care (Nursing/Midwifery)	6 =	6
Failure to answer telephones	1 =	1

Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
The number of complaints received by Ward 30 has continued to rise, with seven cases recorded in Q4, compared to four complaints in Q3 and two in Q2. Four of these complaints were attributed to attitude and communication issues and three to clinical care.	There had been a high level of long term staff sickness on ward 30, leading to an increase in the use of non-substantive staff (Bank/Agency). *Note:* *Analysis in the latest quarterly patient experience report indicates that for the period October 2013 to March 2014, ward 30 achieved patient-reported ratings which were slightly better than the Trust average.*	Concerns about staff attitude and communication have been addressed with the staff concerned and disseminated to the whole team. Substantive staff have returned from long term sick leave leading to a reduction in the use of non-substantive staff.
There was an increase in the number of complaints received by Children's ED/Ward 39. There was no discernible trend, with the complaints being spread across the various categories of complaint.	*Note:* *Analysis in the latest quarterly patient experience report indicates that for the period October 2013 to March 2014, ward 39 achieved patient-reported ratings which were better than the Trust average.*	All lessons learned from complaints are disseminated to the nursing and medical teams. Completed comments cards are now displayed on the ward's 'You said we did' board.

3.3.5 Division of Diagnostics & Therapies

Complaints by category type

Category Type	Number and % of complaints received – Q4 2013/14	Number and % of complaints received – Q3 2013/14
Access	2 (6.2% of total complaints) =	2 (6.2%)
Appointments & Admissions	7 (21.9%) ↑	8 (25%)
Attitude & Communication	14 (43.8%) ↑	13 (40.7%)
Clinical Care	4 (12.5%) ↓	7 (21.9%)
Facilities & Environment	3 (9.4%) ↑	2 (6.2%)
Information & Support	2 (6.2%) ↑	0
Total	**32**	**32**

Top six sub-categories

Category	Number of complaints received – Q4 2013/14	Number of complaints received – Q3 2013/14
Cancelled or delayed appointments and operations	5 ↓	6
Clinical Care (Medical/Surgical)	0 ↓	2
Communication with patient/relative	0 ↓	1
Attitude of Medical Staff	4 ↑	2
Clinical Care (Nursing/Midwifery)	0 =	0
Failure to answer telephones	5 ↑	4

Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
There was a 58% rise in complaints received by the Audiology Department. Seven of the 12 complaints received were in respect of attitude and communication, the majority of which were about failure to answer telephones so patients were unable to get through to the department.	Following the centralisation of the Audiology Services across Bristol on 25th March 2013 the service experienced an increase in the number of phone calls across both sites. The increase in phone calls at St Michael's Hospital was primarily due to the service moving all new bookings onto that site. The volume of calls also continued to be an issue on the Southmead site.	• The service has converted a vacant Band 2 Assistant Practitioner Post to a fixed term Band 2 Clerical post to work across both sites on a 1 year fixed term basis, thus introducing more resource to answer the telephone. The fixed term post will provide the opportunity to assess what resources are required going forward. • On Tues 6th May the service introduced a call waiting system at St Michael's Hospital and this has improved the situation greatly. Monitoring has shown 100% of calls are answered. • Next steps are to move the repair booking for the Southmead sites to the Trust's central booking office and extend the call waiting system to include the clerical team based at Southmead. This will ensure an improvement in the volume of calls answered at both sites, St Michael's Hospital and Southmead. Before these actions can be undertaken, the audiology databases in the two sites need to be merged. This is anticipated to take place in

		August and the service subsequently expects to see a reduction in the number of complaints received relating to telephones not being answered.

3.4 Complaints by hospital site

Of those complaints with an identifiable site, the breakdown by hospital is as follows:

Hospital/Site	Number and % of complaints received – Q4 2013/14	Number and % of complaints received – Q3 2013/14
Bristol Royal Infirmary	193 (46.5% of total complaints) ↑	137 (41.1%)
Bristol Eye Hospital	60 (14.5%) ↑	32 (9.6%)
Bristol Dental Hospital	19 (4.6%) ↓	20 (6%)
St Michael's Hospital	46 (11%) ↓	54 (16.2%)
Bristol Heart Institute	33 (8%) ↑	30 (9%)
Bristol Haematology & Oncology Centre	20 (4.8%) ↓	21 (6.3%)
Bristol Royal Hospital for Children	36 (8.7%) ↑	29 (8.8%)
South Bristol Community Hospital	8 (1.9%) ↓	10 (3%)
Total	**415**	**333**

3.5 Complaints responded to within agreed timescale

The Trust's aim is to respond to complaints within the timescale we have agreed with the complainant. All five clinical Divisions reported breaches in Quarter 4, totalling 25 breaches plus there was one additional breach from the Division of Facilities & Estates.

	Q4 2013/14	Q3 2013/14	Q2 2013/14	Q1 2013/14
Surgery Head and Neck	**8 (11%)**	6 (10%)	9 (12%)	45 (49%)
Medicine	**7 (21.2%)**	11 (25%)	9 (25%)	22 (56%)
Specialised Services	**0**	2 (11%)	4 (12.5%)	2 (15%)
Women and Children	**9 (36%)**	4 (17%)	7 (28%)	10 (34%)
Diagnostics & Therapies	**1 (8.3%)**	0	0	0
All	**25 breaches**	23 breaches	29 breaches	79 breaches

(So, as an example, there were six breaches of timescale in the Division of Surgery Head and Neck in Q3, which constituted 11% *of the complaints responses that had been due in Q4*.)

Breaches of timescale were caused either by late receipt of final draft responses from Divisions which did not allow adequate time for Executive review and sign-off, delays in processing by the Patient Support and Complaints team, or by delays in during the sign-off process itself. Sources of delay are shown in the table below.

	Source of delays (Q4, 2013/14)		
	Division	**Patient Support and Complaints Team**	**Executive sign-off**
Surgery Head and Neck	2	0	6
Medicine	3	0	4
Specialised Services	0	0	0
Women and Children	7	2	0
Diagnostics & Therapies	0	0	1
All	12 breaches	2 breaches	11 breaches

Actions agreed via Patient Experience Group:

- Divisions have been reminded of the importance of providing the Patient Support and Complaints Team with draft final response letters at least four working days prior to the date they are due with the complainant.
- The Patient Support and Complaints Team continues to actively follow up Divisions if responses are not received on time; Divisional staff are also reminded of the need to contact the complainant to agree an extension to the deadline if necessary.
- Longer deadlines are agreed with Divisions if the complainant requests a meeting rather than a written response. This allows for the additional time needed to co-ordinate the diaries of clinical staff required to attend these meetings. (Note that deadlines agreed with Surgery, Head and Neck and Medicine are longer than for the other Divisions, to reflect the larger patient numbers and subsequent complaints received by these Divisions).
- Ongoing vigilance to avoid any delays by Patient Support and Complaints Team.

3.6 Number of dissatisfied complainants

As reported in section 1.3, there were 14 cases in Q4 where complainants were dissatisfied with the quality of our response (in addition to the figures shown in the table below, one case was attributable to the Division of Diagnostics & Therapies).

	Q4 2013/14	**Q3 2013/14**	**Q2 2013/14**	**Q1 2013/14**
Surgery Head and Neck	**5**	8	10	8
Medicine	**4**	4	3	2
Specialised Services	**1**	3	1	1
Women and Children	**3**	0	2	3
Diagnostics & Therapies	**1**	0	1	1
All	**14**	15	17	15

Actions agreed via Patient Experience Group:

- Divisions are notified of any case where the complainant is dissatisfied. The 14 cases recorded in Q4 have now either been responded to in full, or have had revised response deadlines agreed with the complainants.
- The Patient Support and Complaints Team continues to monitor response letters to ensure that all aspects of each complaint have been fully addressed – there has recently been an increase in the number of draft responses which the Patient Support and Complaints Team has queried with the Division prior to submitting for sign-off.
- Trust-level complaints data is now replicated at divisional level to enable Divisions to monitor progress and identify areas where improvements are needed. This data will also be used for quarterly Divisional performance reviews.

- Response letter cover sheets are now sent to Executive Directors with each letter to be signed off. This includes details of who investigated the complaint, who drafted the letter and who at senior divisional letter signed it off as ready to be sent. The Executive signing the responses can then make direct contact with these members of staff should they need to query any of the content of the response.
- Training in complaints investigation and letter writing was delivered to the new Band 7 Supervisory Sisters in October 2013.
- Training on writing response letters has being delivered to key staff across all Divisions with input from the Patients Association. This training was well received and further training on this subject matter is being planned for the coming year.

4. Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team is also responsible for providing patients, relatives and carers with the help and support including:

- Non-clinical information and advice;
- A contact point for patients who wish to feedback a compliment or general information about the Trust's services;
- Support for patients with additional support needs and their families/carers; and
- Signposting to other services and organisations.

In Q4, the team dealt with 161 such enquiries, compared to 173 in Q3. These enquiries can be categorised as:

- 83 requests for advice and information (67 in Q3)
- 70 compliments (95 in Q3)
- 8 requests for support (11 in Q3)

5. PHSO cases

During Q4, the Trust has been advised of new Parliamentary & Health Service Ombudsman (PHSO) interest in seven complaints. Three of these cases were subsequently not upheld and one was partially upheld; we are currently awaiting a decision from the PHSO for the three remaining cases.

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
13887	SC		12/08/2013	BEH	Ophthalmology	Surgery, Head And Neck
Not upheld: The PHSO has advised the Trust that a draft report has been prepared (which we are currently waiting for) but also that the complaint has not been upheld.						
11634	PG	KGG	03/09/2012	BRI	A&E [BRI]	Medicine
Not upheld: Final report received, complaint not upheld and no failings identified.						
13173	MD	JS	08/05/2013	BRI	A&E [BRI]	Medicine
Not upheld: The PHSO agreed that there had been some failings in the care of the patient but has not upheld the complaint as the Trust had already acknowledged these failings and apologised and had dealt with the issue in a fair and proportionate manner.						

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
13261	SL	JS	22/05/2013	BRI	Ward 04	Medicine
Open: The Trust has sent copies of all requested documentation to the PHSO - currently waiting to hear whether they intend to investigate.						
13946	RB		09/09/2013	BRI	Ward 19 (Observation Ward)	Medicine
Open: The Trust has sent the PHSO a copy of our complaint response letter - currently waiting to hear whether they require further information or intend to investigate.						
14588	DG	HJG	13/12/2013	BDH	Adult Restorative Dentistry (B	DIV Surgery, Head And Neck
Open: The Trust has sent the requested documentation to the PHSO - currently waiting to hear whether they intend to investigate or not.						
13223	CP		16/05/2013	BEH	Outpatients Ground Floor (BEH)	DIV Surgery, Head And Neck
Partially upheld: PHSO partially upheld this complaint about a patient's experience of receiving an eye injection. The PHSO made recommendations for improvement and asked us to send a letter of apology to the patient, which has now been done. The complaint was shared with the appropriate staff in order that they understand the implications of their actions, when injecting patients. Staff have also been advised that they are able to use the counselling room for patients who may take a little longer to recover from the procedure and the senior nurse in charge will be available to help non-nursing staff to care for these patients.						

Since 1st April 2013, the PHSO has notified the Trust of a total of 16 cases in which they are taking an interest. Of the nine cases received prior to Q4, three are currently ongoing, five were not upheld and one was upheld. In the case that was upheld, the PHSO recommended that the Trust write a letter of apology to the patient together with a compensation payment of £750: this was done, and an action plan was implemented by the Division. The increase in PHSO interest in Q4 reflects a change in policy: the PHSO has significantly increased the number of complaints it accepts for investigation.

6. Corporate developments in Q4

At the end of Q3, the Patient Support and Complaints Team moved from its temporary office in the Bristol Dental Hospital to a new location in the front of the Bristol Royal Infirmary Welcome Centre. This means that for the first time, the Trust has been able to co-locate its previous complaints and 'PALS' functions in a single location. The move has also enabled the re-opening of the 'PALS' drop-in service.

During Q4, a backlog of enquiries to the Patient Support and Complaints Team developed. Causal factors included the re-opening of the drop-in service, staff sickness and an observed increase in the complexity of complaints received. Whilst all enquiries were acknowledged in a timely manner, it was taking up to four weeks for a caseworker to contact the complainant to discuss their concerns and to agree how and when these would

be investigated. The Trust has appointed two temporary caseworkers to enable the team to address the backlog and proposals have been drafted for increasing permanent support to the team.

In January 2014, the Trust Board received the Trust's internal self-assessment against recommendations contained in Ann Clwyd and Tricia Hart's review of NHS complaints management. Various actions have subsequently been incorporated into the Patient Support and Complaints Team's work plan, the progress of which will be monitored by the Trust's Patient Experience Group.

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

13. Finance Report

Purpose

To report to the Board on the Trust's financial position and related financial matters which require the Board's **review.**

Abstract

The summary income and expenditure statement shows a surplus of £0.655m (before technical items) for the first two months of 2014/15. This represents an adverse variance of £0.330m against plan.

In summary the position to 31 May (month 2) can be described as follows:

- Clinical Divisions – adverse variance of £1.9m due to shortfalls on the Trust's Operating Plan, savings programme slippage and activity under performance;
- Corporate share of income plan increases less the share of under-performance on SLA to date – a net favourable variance of £0.6m;
- Some estimated slippage on reserves of £0.4m due to increments, scheme slippage and provisions;
- An expected favourable variance on financing costs (depreciation and PDC Dividend) of £0.6m due to phasing of capital schemes and the District Valuer 5 year revaluation impact.

The key actions which will enable the financial plan to be delivered include:

- The delivery of planned activity – particularly elective and out-patients;
- Phased savings plans coming on stream;
- Progressing as near as possible to a balanced Operating Plan;
- Improvements in control especially in nursing staff rostering;
- Careful husbandry of overall resources including corporate reserves.

Recommendations

The Trust Board is recommended to receive this report by the Director of Finance and Information.

Report Sponsor

- Sponsor – Director of Finance and Information
- Other Author – Head of Finance

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 – Summary of Divisional Variances and RAG Ratings
- Appendix 6 – Financial Risk Ratings
- Appendix 7 – Release of Reserves

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report May 2014 – Summary Income & Expenditure Statement

Approved Budget / Plan 2014/15	Heading	Position as at 31st May			Actual to 30th April
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
483,451	From Activities	78,487	78,038	(449)	37,384
90,273	Other Operating Income	15,062	15,065	3	7,331
573,724	**Sub totals income**	**93,549**	**93,103**	**(446)**	**44,715**
	Expenditure				
(321,350)	Staffing	(53,541)	(54,687)	(1,146)	(26,810)
(195,462)	Supplies and Services	(33,343)	(33,083)	260	(15,684)
(516,811)	**Sub totals expenditure**	**(86,884)**	**(87,770)**	**(886)**	**(42,494)**
(19,185)	Reserves	(414)	–	414	–
37,727	**EBITDA**	**6,251**	**5,333**	**(918)**	**2,221**
	Financing				
2,220	Reserves		–	–	–
0	Profit/(Loss) on Sale of Asset	0	0	–	0
(21,811)	Depreciation & Amortisation – Owned	(3,254)	(2,822)	432	(1,500)
150	Interest Receivable	25	35	10	14
(338)	Interest Payable on Leases	(57)	(58)	(1)	(29)
(3,117)	Interest Payable on Loans	(475)	(475)	–	(220)
(9,031)	PDC Dividend	(1,505)	(1,358)	147	(679)
5,800	**NET SURPLUS / (DEFICIT) before Technical Items**	**985**	**655**	**(330)**	**(193)**
	Technical Items				
8,588	Donations & Grants (PPE/Intangible Assets)	1,500	1,500	–	–
(24,204)	Impairments	–	–	–	–
1,232	Reversal of Impairments	–	–	–	–
(1,216)	Depreciation & Amortisation – Donated	(317)	(317)	–	(68)
(9,800)	**SURPLUS / (DEFICIT) after Technical Items**	**2,168**	**1,838**	**(330)**	**(261)**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report May 2014- Divisional Income & Expenditure Statement

Approved Budget / Plan 2014/15	Division	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 30th April
			Pay	Non Pay	Operating Income	Income from Activities	CRES		
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements								
480,608	Service Agreements	78,154	-	-	3	(6)	-	(3)	-
(4,719)	Overheads	(219)	-	-	-	567	-	567	-
39,170	NHSE Income	6,809	-	-	-	-	-	-	-
515,059	**Sub Total Service Agreements**	**84,744**	**-**	**-**	**3**	**561**	**-**	**564**	**-**
	Clinical Divisions								
(47,773)	Diagnostic & Therapies	(7,967)	10	39	102	(96)	(46)	9	5
(66,103)	Medicine	(11,056)	(394)	218	28	200	(350)	(298)	(190)
(79,898)	Specialised Services	(12,809)	(109)	306	(7)	(114)	(204)	(128)	(87)
(94,955)	Surgery Head & Neck	(16,877)	(439)	590	17	(375)	(634)	(841)	(457)
(107,599)	Women's & Children's	(17,848)	(115)	357	(35)	(496)	(331)	(620)	(335)
(396,328)	**Sub Total - Clinical Divisions**	**(66,557)**	**(1,047)**	**1,510**	**105**	**(881)**	**(1,565)**	**(1,878)**	**(1,064)**
	Corporate Services								
(33,929)	Facilities And Estates	(5,508)	(14)	63	(32)	0	(10)	7	2
(23,156)	Trust Services	(3,837)	121	(97)	(55)	-	2	(29)	(23)
(4,735)	Other	(3,509)	(23)	(23)	29	(38)	59	4	92
(61,820)	**Sub Totals - Corporate Services**	**(12,854)**	**84**	**(57)**	**(58)**	**(38)**	**51**	**(18)**	**71**
(458,148)	**Sub Total (Clinical Divisions & Corporate Services)**	**(79,411)**	**(963)**	**1,453**	**47**	**(919)**	**(1,514)**	**(1,896)**	**(993)**
(19,184)	Reserves	-	-	414	-	-	-	414	100
(19,184)	**Sub Total Reserves**	**-**	**-**	**414**	**-**	**-**	**-**	**414**	**100**
37,727	**Trust Totals Unprofiled**	**5,334**	**(963)**	**1,867**	**50**	**(358)**	**(1,514)**	**(918)**	**(893)**
	Financing								
2,220	Reserves/Profiling	-	-	-	-	-	-	-	(31)
0	(Profit)/Loss on Sale of Asset	-	-	-	-	-	-	-	-
(21,811)	Depreciation & Amortisation - Owned	(2,822)	-	432	-	-	-	432	241
150	Interest Receivable	35	-	10	-	-	-	10	8
(338)	Interest Payable on Leases	(58)	-	(1)	-	-	-	(1)	(1)
(3,117)	Interest Payable on Loans	(475)	-	-	-	-	-	-	-
(9,031)	PDC Dividend	(1,358)	-	147	-	-	-	147	-
(34,147)	**Sub Total Financing**	**(4,678)**	**-**	**588**	**-**	**-**	**-**	**588**	**217**
5,800	**NET SURPLUS / (DEFICIT) before Technical Items**	**656**	**(963)**	**2,455**	**50**	**(358)**	**(1,514)**	**(330)**	**(676)**
	Technical Items								
8,588	Donations & Grants (PPE/Intangible Assets)	1,500	-	-	-	-	-	-	-
(24,204)	Impairments	-	-	-	-	-	-	-	-
1,232	Reversal of Impairments	-	-	-	-	-	-	-	-
(1,216)	Depreciation & Amortisation - Donated	(317)	-	-	-	-	-	-	34
-	Profiling Adjustment	-	-	-	-	-	-	-	-
(15,600)	**Sub Total Technical Items**	**1,183**	**-**	**-**	**-**	**-**	**-**	**-**	**34**
(9,800)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**1,839**	**(963)**	**2,455**	**50**	**(358)**	**(1,514)**	**(330)**	**(642)**

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14					2014/15			2011/12	2012/13	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Apr £'000	May £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000
Women's and Children's	Pay budget	18,004	18,254	18,456	18,764	73,478	6,188	7,195	6,691	5,651	5,896	6,123
	Bank	446	514	448	406	1,813	172	195	184	171	170	151
	Agency	323	534	254	287	1,398	88	178	133	66	123	117
	Waiting List initiative	53	109	122	81	365	18	51	35	13	14	30
	Overtime	18	47	73	88	226	27	25	26	4	5	19
	Other pay	17,093	17,209	17,690	18,119	70,112	6,021	6,750	6,386	5,464	5,635	5,843
	Total Pay expenditure	17,933	18,413	18,587	18,981	73,913	6,326	7,199	6,763	5,717	5,947	6,159
	Variance Fav / (Adverse)	71	(159)	(131)	(216)	(435)	(139)	(4)	(72)	(66)	(50)	(36)
Medicine	Pay budget	11,063	11,044	11,066	10,978	44,151	3,747	3,932	3,840	3,684	3,689	3,679
	Bank	938	817	771	779	3,305	253	319	286	256	286	275
	Agency	758	681	424	491	2,354	116	133	124	60	115	196
	Waiting List initiative	68	45	21	17	151	21	3	12	9	12	13
	Overtime	22	57	57	61	197	11	6	9	6	6	16
	Other pay	10,195	10,301	10,616	10,631	41,743	3,638	3,615	3,626	3,385	3,424	3,479
	Total Pay expenditure	11,982	11,901	11,889	11,979	47,751	4,040	4,075	4,057	3,715	3,842	3,979
	Variance Fav / (Adverse)	(919)	(856)	(823)	(1,002)	(3,600)	(292)	(144)	(218)	(30)	(154)	(300)
Surgery Head and Neck	Pay budget	17,682	17,750	17,767	17,728	70,927	5,902	6,011	5,956	5,676	5,774	5,911
	Bank	562	520	447	330	1,859	140	190	165	164	187	155
	Agency	186	369	156	97	808	60	91	76	48	82	67
	Waiting List initiative	223	550	372	249	1,394	121	112	117	60	91	116
	Overtime	29	108	186	162	485	37	47	42	12	12	40
	Other pay	17,068	17,276	17,399	17,451	69,195	5,798	5,806	5,802	5,374	5,623	5,766
	Total Pay expenditure	18,068	18,823	18,560	18,290	73,741	6,156	6,245	6,201	5,657	5,996	6,145
	Variance Fav / (Adverse)	(386)	(1,074)	(793)	(562)	(2,814)	(254)	(234)	(244)	19	(222)	(235)
Specialised Services	Pay budget	9,091	9,206	9,186	9,234	36,718	3,138	3,184	3,161	2,945	2,991	3,060
	Bank	263	314	311	296	1,184	89	122	106	79	89	99
	Agency	342	479	542	518	1,882	116	170	143	97	99	157
	Waiting List initiative	98	53	133	95	379	21	47	34	35	24	32
	Overtime	25	38	60	59	182	10	13	12	2	6	15
	Other pay	8,440	8,510	8,492	8,638	34,079	2,947	2,931	2,939	2,840	2,870	2,840
	Total Pay expenditure	9,167	9,394	9,538	9,606	37,705	3,184	3,284	3,234	3,053	3,089	3,142
	Variance Fav / (Adverse)	(76)	(189)	(352)	(371)	(988)	(45)	(100)	(72)	(108)	(98)	(82)

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14					2014/15			2011/12	2012/13	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Apr £'000	May £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000
Diagnostic & Therapies	Pay budget	9,894	9,992	9,881	9,759	39,526	3,300	3,438	3,369	3,105	3,186	3,294
	Bank	96	91	65	54	306	16	27	21	43	33	26
	Agency	5	101	102	132	340	22	40	31	24	30	28
	Waiting List initiative	41	52	52	80	225	7	21	14	11	15	19
	Overtime	86	77	83	69	314	34	29	32	23	23	26
	Other pay	9,564	9,582	9,659	9,347	38,153	3,247	3,297	3,272	2,989	3,124	3,179
	Total Pay expenditure	9,792	9,904	9,961	9,682	39,339	3,326	3,414	3,370	3,089	3,225	3,278
	Variance Fav / (Adverse)	102	89	(80)	77	187	(26)	24	(1)	16	(40)	16
Facilities & Estates	Pay budget	4,706	4,531	4,611	4,586	18,435	1,535	1,594	1,565	1,583	1,553	1,536
	Bank	105	140	144	165	555	60	93	77	27	24	46
	Agency	109	75	74	88	346	21	18	20	117	98	29
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0
	Overtime	253	254	205	183	895	93	70	82	95	94	75
	Other pay	4,161	4,136	4,079	4,021	16,397	1,393	1,407	1,400	1,319	1,329	1,366
	Total Pay expenditure	4,628	4,606	4,503	4,457	18,193	1,568	1,589	1,579	1,558	1,545	1,516
	Variance Fav / (Adverse)	78	(75)	108	129	242	(32)	5	(14)	24	8	20
Trust Services (Including R&I and Support Services)	Pay budget	6,480	6,717	8,160	8,135	29,492	2,118	2,261	2,189	2,240	2,204	2,458
	Bank	170	179	156	176	680	52	65	59	23	44	57
	Agency	80	86	108	102	375	64	30	47	20	11	31
	Waiting List initiative	0	0	0	0	0	0	0	0	(0)	0	0
	Overtime	30	19	20	45	114	11	9	10	12	15	9
	Other pay	6,029	6,221	7,472	7,703	27,425	2,083	1,967	2,025	2,156	2,030	2,285
	Total Pay expenditure	6,309	6,504	7,756	8,026	28,595	2,211	2,070	2,141	2,210	2,101	2,383
	Variance Fav / (Adverse)	171	213	404	109	897	(94)	190	48	30	103	75
Trust Total	Pay budget	76,920	77,494	79,127	79,184	312,726	25,928	27,613	26,770	24,885	25,292	26,060
	Bank	2,579	2,575	2,343	2,206	9,702	783	1,010	896	762	833	809
	Agency	1,805	2,325	1,660	1,715	7,506	488	659	574	432	558	625
	Waiting List initiative	483	809	700	522	2,514	188	234	211	128	156	210
	Overtime	463	599	684	667	2,413	224	200	212	153	162	201
	Other pay	72,549	73,235	75,409	75,911	297,103	25,127	25,774	25,449	23,525	24,035	24,759
	Total Pay expenditure	77,879	79,545	80,796	81,020	319,238	26,810	27,876	27,342	25,000	25,745	26,603
	Variance Fav / (Adverse)	(959)	(2,051)	(1,668)	(1,836)	(6,514)	(883)	(263)	(573)	(115)	(452)	(543)

NOTE: Other Pay includes all employer's oncosts.

<table>
<tr><th>Key Issue</th><th>RAG</th><th>Executive Summary</th><th>Table</th></tr>
<tr><td>Financial Risk Rating</td><td>G</td><td>The Trust's overall Continuity of Services financial risk rating for the two months ending 31st May is 4 (actual score 4.0, April 3.5). The liquidity metric shows the expected improvement in May following the draw down of the £20m loan from the Independent Trust Financing Facility.</td><td>Agenda Item 5.1 App 6</td></tr>
<tr><td>Service Level Agreement Income and Activity</td><td>A</td><td>Contract income is £1.59m lower than plan for the 2 month period to 31st May. Activity based contract performance at £65.26m is £1.19m less than plan. Contract rewards / penalties at a net income of £1.53m is marginally greater than plan. Income of £9.78m for ‘Pass through’ payments is £0.41m lower than Plan.
<table>
<tr><th rowspan="2">Clinical Service</th><th rowspan="2">Activity to 31 May</th><th colspan="2">Higher than Plan</th><th colspan="2">Lower than Plan</th></tr>
<tr><th>Number</th><th>%</th><th>Number</th><th>%</th></tr>
<tr><td>A&E Attendances</td><td>19,731</td><td></td><td></td><td>46</td><td>0.2</td></tr>
<tr><td>Emergency</td><td>6,315</td><td>154</td><td>2.5</td><td></td><td></td></tr>
<tr><td>Non Elective</td><td>455</td><td></td><td></td><td>7</td><td>1.6</td></tr>
<tr><td>Elective</td><td>2,330</td><td></td><td></td><td>9</td><td>0.4</td></tr>
<tr><td>Day Cases</td><td>8,581</td><td>102</td><td>1.2</td><td></td><td></td></tr>
<tr><td>Outpatient Procedures</td><td>8,437</td><td></td><td></td><td>269</td><td>3.1</td></tr>
<tr><td>New Outpatients</td><td>23,256</td><td></td><td></td><td>2,365</td><td>9.2</td></tr>
<tr><td>Follow up Outpatients</td><td>45,875</td><td></td><td></td><td>3,353</td><td>6.8</td></tr>
</table>
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.</td><td>Agenda Item 5.2 INC 1</td></tr>
<tr><td>Savings Programme</td><td>R</td><td>The 2014/15 Savings Programme totals £20.771m. Actual savings achieved for April and May total £1.948m (66% of Plan before the 1/12ths phasing adjustment), a shortfall of £0.997m against divisional plans.</td><td>Agenda Item 5.4</td></tr>
</table>

Key Issue	RAG	Executive Summary	Table
Income and Expenditure	A	The surplus before technical items for the first two months of 2014/15 is £0.655m. This represents an under performance of £0.330m when compared with the planned surplus to date of £0.985m. Total income of £92.937m is £0.446m lower than Plan. Expenditure at £87.604m is greater than Plan by £0.472m. Financing costs are £0.588m lower than Plan.	Agenda Item 5.3
D&T	G	£9k underspending to date. Shortfall on share of income from activities offset by underspendings on pay, non pay and operating income.	
Med	R	Overspending in May brings cumulative position to £0.298m adverse – this is in line with current operating plan shortfall. Pay budget overspending of £0.94m includes £0.252m on nursing staff. Income £0.228m ahead of plan.	
Spec Serv	G	Overspending of £41k in May and £128k to date as a result of non achieved savings (£204k) and underperformance on cardiac surgery (patient acuity and reduced theatre capacity) and cardiology (temporary capacity reductions).	
SH&N	R	Overspending to date @ £0.841m is £140k higher than proportion of Operating Plan shortfall. Causal factors are historical non achievement of savings programme and under performance on income from activities. Significant progress made in recent weeks on savings programme and capacity planning to increase volume of services provided.	
W&C	R	Overspending to date at £0.620m is £0.385m higher than the proportion of Operating Plan shortfall. The main reasons are the impact of the Centralisation of Specialist Paediatrics transfer (£137k) , a net under-performance on other income from activities together with higher than planned nursing staff numbers and agency junior doctors.	
F&E	G	Underspending of £7k reported for 2 months to 31st May.	
THQ	AG	Overspending of £4k in May and £19k to date. Operating Plan anticipates funding for three posts which will bring the Division back into financial balance.	
Capital	A	Expenditure for April and May totals £11.053m. This equates to 94.5% of the planned expenditure for the period.	Agenda Item 6
Statement of Financial Position and Treasury Management	G	The cash balance on 31st May was £66.897m. The balance on Invoiced Debtors has increased by £0.738m in the month to £13.787m. The invoiced debtor balance equates to 9.2 debtor days. Creditors and accrual account balances total £72.550m with £2.341m relating to deferred income. Invoiced Creditors - payment performance for the month for Non NHS invoices and NHS invoices within 30 days was 91% and 58% respectively. Payment performance by invoice value is 83% for Non NHS and 71% for NHS invoices.	Agenda Item 7 SFP 1 SFP 2 SFP 3

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report May 2014 - 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	Savings Programme	High	10.0	Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed.	JR	High	6.0	Savings achieved of £1.948m = 56% of Plan to 31st May.
962	Delivery of Trust's Financial Strategy in changing national economic climate.	High	-	Long term financial model and in year monitoring of financial performance by Finance Committee and Trust Board.	PM	High	-	2014/15 Plans are very challenging
2116	Non delivery of contracted activity	High	10.0		JR	Medium	5.0	
1240	SLA Performance Fines	High	3.0	Regular review of performance.	DL	Medium	2.0	
	Commissioner Income challenges	Medium	3.0	Maintain reviews of data, minmise risk of bad debts	PM	Medium	2.0	
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	Medium	1.0	
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	-	

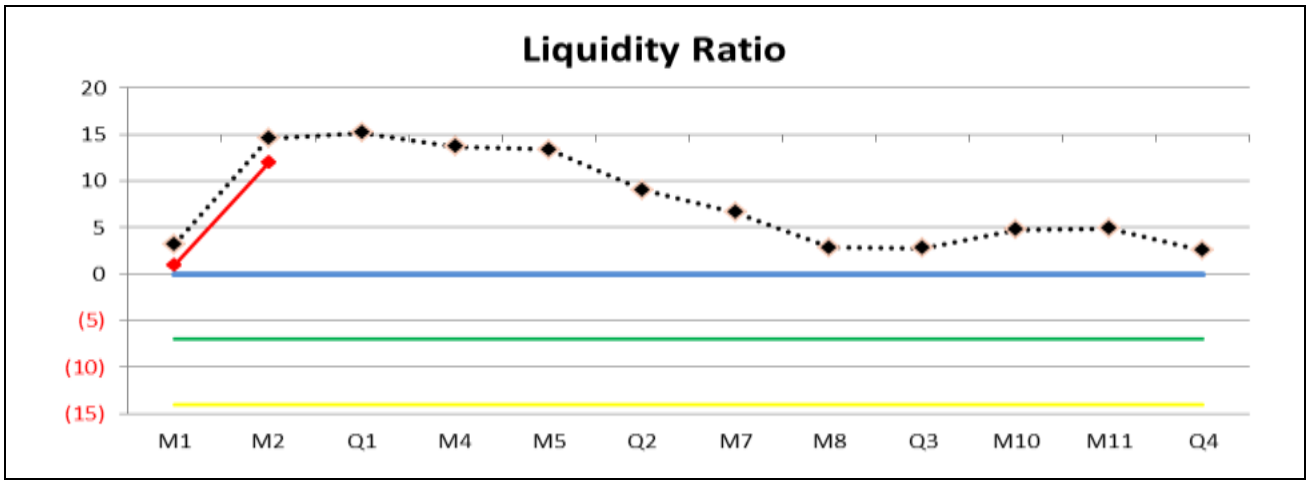
University Hospitals Bristol NHS
NHS Foundation Trust

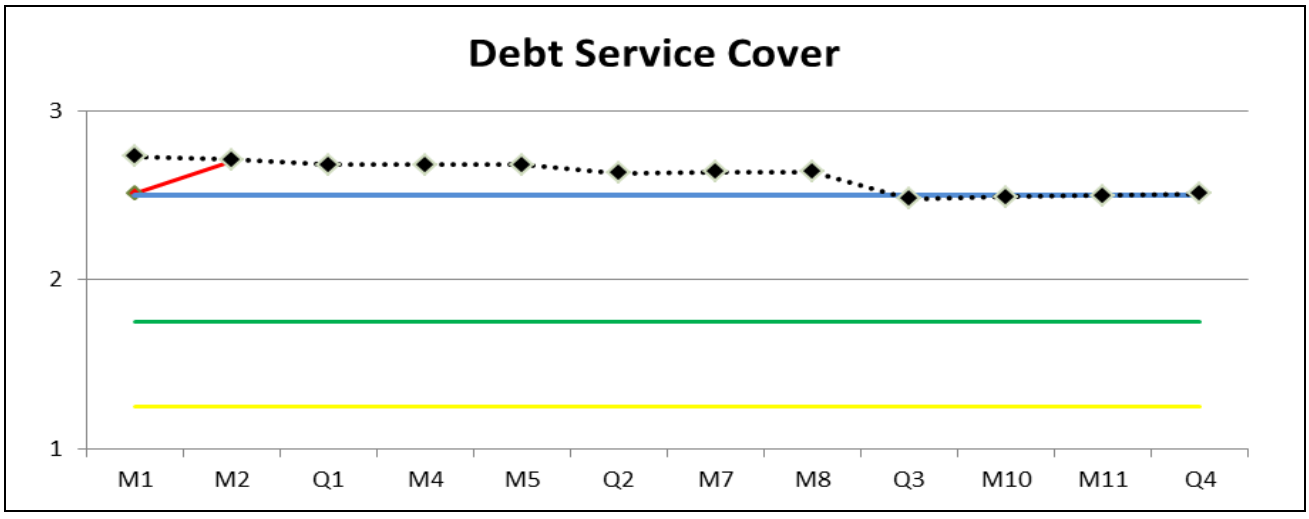
Appendix 6

Continuity of Service Risk Rating – May 2014 Performance

The following graphs show performance against the 2 Financial Risk Rating metrics which came into use from 1st October under the new Risk Assessment Framework. The 2014/15 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 4 (blue line)**; **FRR 3 (green line)** and **FRR 2 (yellow line)**.

	March 2014	Annual Plan 2014/15	April 2014	May 2014
Liquidity				
Metric Performance	2.71	2.53	0.26	12.23
Rating	4	4	4	4
Debt Service Cover				
Metric Performance	3.04	2.51	2.36	2.78
Rating	4	4	3	4
Overall Rating	**4**	**4**	**4**	**4**





Release of Reserves 2014/15 **Appendix 7**

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve £'000	Inflation Reserve £'000	Operating Plan £'000	Savings Programme £'000	Other Reserves £'000	Non Recurring £'000	Totals £'000	Diagnostic & Therapies £'000	Medicine £'000	Specialised Services £'000	Surgery, Head & Neck £'000	Women's & Children's £'000	Estates & Facilities £'000	Trust Services £'000	Other £'000	Totals £'000
Provision as per Resources Book	2,000	4,468	59,894	(108)	12,885	3,750	82,889									
Fund technical items			(8,588)				(8,588)									
Adjustments to V7		(98)	5,339				5,241									
Revised provision	2,000	4,370	56,645	(108)	12,885	3,750	79,542									
April Movements	(199)	161	(29,944)	595	(7,954)	(1,052)	(38,393)	1,342	5,986	9,901	9,368	7,467	752	6,158	(2,581)	38,393
Month 1 balance	1,801	4,531	26,701	487	4,931	2,698	41,149	1,342	5,986	9,901	9,368	7,467	752	6,158	(2,581)	38,393
May Movements																
Centralisation of specialist paediatrics			(13,562)				(13,562)	825				11,765	931	41		13,562
Pay award		(932)					(932)	147	120	110	182	186	87	90	10	932
Spend to save projects						(58)	(58)							58		58
BRI redevelopment						56	56						(56)			(56)
Levy Income Changes					(381)		(381)	641	15		961			30	(1,266)	381
Clinical Excellence Award funding					233		233			104	150	147			(634)	(233)
Paediatric epilepsy			(189)				(189)					189				189
Capital charges			(1,791)				(1,791)								1,791	1,791
Corporate share of 2014/15 SLA increases			(4,719)				(4,719)								4,719	4,719
2013/14 provisional overperformance			1,170				1,170								(1,170)	(1,170)
Other	(36)	(30)	(42)		(385)	(6)	(499)	9	19	(9)	33	296	27	126	(2)	499
							-									
Month 2 balance	1,765	3,569	7,568	487	4,398	2,690	20,477	2,964	6,140	10,106	10,694	20,050	1,741	6,503	867	59,065

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

15 Medium Term Capital Programme

Purpose

To report to the Board the updated Medium Term Capital Programme 2014/15-2018/19

Abstract

This report informs the Board of proposed changes to the Medium Term Capital Programme which include the 2013/14 outturn position, the planned disposal of the Grange, the re-phasing of the BRI Redevelopment Phase IV schemes and technology fund schemes.

The MTCP has been considered by the Finance Committee in their meeting on the 27th June 2014 and for ratification by the Trust Board.

The overall impact of the proposed changes is described in the attached report.

Recommendations

The Board is recommended to approve the changes as set out in the report.

Report Sponsor

- Paul Mapson, Director of Finance

Appendices

- 14.1 – Medium Term Capital Programme Report
- 14.2 – Medium Term Capital Programme Tables

University Hospitals Bristol NHS
NHS Foundation Trust

Item 15.1

Medium Term Capital Programme
2014/15 to 2018/19

1. Introduction

The Capital Programme Steering Group (CPSG) received an update of Medium Term Capital Programme (MTCP) in March 2014. This paper updates the MTCP for the 2013/14 outturn position, the planned disposal of The Grange, the updated phasing of the BRI Redevelopment Phase IV schemes and the technology fund schemes.

This update will inform the final Monitor Strategic Plan which covers the 2014/15 to 2018/19 financial years. The paper is structured so that it is read in conjunction with Appendix 1.

2. Overall impact of the proposed changes

The 2014/15 plan has been updated for the 2013/14 actual slippage of £17.648m and a net underspend of £253k. The total committed schemes for 2014/15 including the 2013/14 carry forwards now totals £65.048.

The 2014/15 planned slippage of £7.467m assumes slippage of 15% on all non P21 schemes with an additional 100% slippage on the replacement MRI scanner which is due in April 2015 and the contingency balance of £2m held for potential future changes to the VAT regime in the NHS. The 2014/15 capital expenditure plan net of slippage is £57.581m.

The MTCP also contains indicative capital expenditure plans for the period 2015/16 to 2018/19. Including prior years' expenditure the MTCP totals £291.416m, a net decrease of £10.961m compared with the MTCP approved by CPSG in March 2014. A summary of the impact is provided below:

Capital Programme	Prior Yrs £'m	2013/14 consolidated into Prior Years	2014/15 £'m	2015/16 £'m	2016/17 £'m	2017/18 £'m	2018/19 £'m	**Total £'m**
March '14	86.160	67.913	57.621	24.653	22.927	22.241	20.862	**302.377**
June '14	74.281	64.986	57.581	28,197	23.268	22.241	20.862	**291.416**
Inc / (Dec)	(11.879)	(2.927)	(0.040)	3.544	341	-	-	**(10.961)**

The decrease of £10.961m is primarily due to the exclusion of prior year figures for schemes which are complete and no longer included in the MTCP:

	£m
Exclusion of prior year expenditure for completed schemes	(11.879)
Increase in 13/14 MTCP from March '14	0.877
Net underspend not carried forward at March '14	0.041
Total decrease	(10.961)

The 2013/14 outturn reduced by £2.927m due to the following changes:

	2013/14 £m	
Increase in 13/14 programme	0.202	revenue to capital funding transfers
Decrease in forecast outturn	(2.918)	
Increase in net underspend	(0.211)	
Total decrease	(2.927)	

The 2014/15 plan has reduced by £0.040m due to the following changes:

	2013/14 £m	
Net increase in 13/14 slippage	2.918	
Net underspend carried forward	0.253	
Updated phasing on Phase IV	(2.276)	see below
Technology fund schemes	0.657	
Divisional donated scheme	0.017	
Planned slippage	(1.609)	£2m VAT contingency £2m & updated Phase IV
Total decrease	(0.040)	

The Director of Facilities & Estates has updated the 2014/15 phasing in the Phase IV programme as follows:

Ref	Description	Phasing in March '14 £m	Updated phasing £m	Movement
1415-04/1415-05 1415-06/1516-01 1516-02/1516-03	Wards 7,9 ,11,12 & 15	2.888	0.497	(2.391)
1415-13 / 1415-14	Orthotics & Offices at CHC	0.438	0.017	(0.421)
1415-15	Medical Equipment library	0.150	0.067	(0.083)
1415-02/ 1415-03/ 1415-17	Wards 2,3,4,6,18,14,17,99,54 & 10	2.656	2.611	(0.045)
1415-19	Resourcing front office	0.345	0.015	(0.330)
1516-04	HPA space level 8	-	0.047	0.047
1516-05	Medical physics	-	0.022	0.022
1516-06	Offices HPA	-	0.003	0.003
1516-07	BRI Restaurant	-	0.518	0.518
1516-09	Discharge Lounge – phase 2	-	0.404	0.404
	Total	**6.477**	**4.201**	**(2.276)**

The reduction in 2014/15 is re-phased in full into 2015/16.

The increase of £3.544m in 2015/16 is due to:

	2014/15 £m	
Updated phasing on Phase IV	2.276	as advised by Director of Facilities & Estates
Planned slippage from 2014/15	1.609	£2m VAT contingency £2m & updated Phase IV
Planned slippage 2015/16	(0.341)	
Total decrease	3.544	

The increase of £0.341m in 2015/16 is due to:

	2015/16 £m
Planned slippage	0.341

The main changes in the Medium Term Capital Programme sources of funding are as follows:

	£m
Increase in 13/14 final depreciation	0.169
Decrease in depreciation due to planned disposal	(0.086)
Increase in depreciation due to application changes	0.276
Increase in donations for divisional scheme	0.017
Increase in disposal proceeds – The Grange	0.670
Net decrease in cash requirement due to sale of The Grange	(0.584)
Decrease in cash requirements due to increase in depreciation	(0.276)
Increase in cash requirement for technology fund schemes	0.657
Exclusion of prior year donations for completed schemes	(0.408)
Exclusion of prior year disposal proceeds for completed schemes	(8.028)
Exclusion of prior year capital grants for completed schemes	(0.080)
Exclusion of prior year cash for completed schemes	(3.288)
Total funding changes	(10.961)

3. Sources of Capital

Sources of capital total £291.416m for the period to 2018/19. These are as follows:

3.1 Public Dividend Capital

The Trust has been awarded Public Dividend Capital for 2014/15 of £2.625m in relation to Technology Funds.

3.2 Retained Depreciation

The retained depreciation is generated from the capital charges forecast exercise which incorporates the District Valuer's five year revaluation of buildings at 31st March 2014. The extension of asset lives of key building (BHOC, BRHC & Queens building) has reduced retained depreciation from 2014/15 onwards.

3.3 Prudential Borrowing

The MTCP includes the prudential borrowing from the Independent Trust Financing Facility (ITFF) of the £20m approved in December 2013 which was drawdown in full in May 2014.

3.4 Donations

Donations for 2014/15 has increased by £17k to £8.605m following the approval of a minor divisional scheme for the Bristol Haematology and Oncology Centre with 2015/16 remaining at £3.000m.

3.5 Disposals

Total disposal proceeds over the period have increased by £0.670m which is a prudent assessment of The Grange sale proceeds. The sale is expected in May 2015 on the expiry of the current lease agreements.

3.6 Capital Grant

There are no capital grants forecast for the period 2014/15 to 2018/19

3.7 Cash Balances

The use of cash for capital purposes impacts upon the Trust's ability to meet its ongoing revenue obligations arising from the Trust's day to day operating activities which underline the importance of delivering balanced Divisional Operating Plans and savings programme in each year over the period. If these are not achieved, then the cash available as a source of funding is reduced and capital programme expenditure must be scaled back.

4. Application of Funds

The applications of capital funding total £291.416m for the period to 2018/19. These are as follows:

4.1 Major Strategic Schemes

These schemes are the principal application of capital funding at £189.682m over the period of the programme.

The BRI Redevelopment scheme capital expenditure, including Phase 4, has reduced by £0.520m to £115.233m following the transfer of £674k from the BRI Redevelopment scheme to the Trust wide critical care monitors scheme, £375k transfer into the BRI Redevelopment scheme from IM&T funding within the Centralisation of Specialist Paediatric (CSP) scheme, £1m allocation of additional loan funds from operational capital to the façade scheme together with a further £328k transfer from contingencies and the transfer of £1.549m from Phase IV balance of funds to the contingency fund for potential future changes to the VAT regime in the NHS.

The Centralisation of Specialist Paediatrics (CSP) scheme has decreased to £31.216m to reflect the £375k transfer of funds for IM&T costs to the BRI Redevelopment scheme.

The gross capital expenditure for the Welcome Centre is scheme unchanged at £6.154m.

The BHOC Redevelopment scheme is unchanged at £16.046m.

4.2 Medical Equipment

A total of £32.167m is allocated over the period of the MTCP. Pre-commitments against these sums have been approved for the replacement of two Linear Accelerators in 2016/17 and 2017/18 each costing £2.580m.

4.3 Information Technology

The Clinical Systems Implementation Programme (CSIP) totals £11.585m for the period. In addition, £1.320m is provided over the period for general IM&T investment, £285k for non-radiological imaging, £951k for critical care CIS and £0.5m per year for the on-going replacement of personal computers.

4.4 Roll Over Schemes

The principal call on these schemes totalling £16.978m is the Works Replacement programme of £14.690m for the period.

4.5 Operational Capital

Operational capital totals £37.570m for the period and includes a number of specific schemes: Decontamination Compliance of £3.780m, the Cleft refurbishment scheme of £1.293m, Dental Capital Programme of £0.45m per year, Divisional capital of £600k per year in 2014/15 and 2015/16 rising to £1m thereafter, Radiopharmacy works of £0.5m and the Cook/freeze project of £250k.

General Operational Capital funding for 2014/15 is fully committed with funding of £12.0m available for the four years from 2015/16 through the Trust's capital prioritisation process.

4.6 Scheme Slippage

The 2014/15 planned slippage of £7.467m assumes slippage of 15% on all non P21 schemes with an additional 100% slippage on the replacement MRI scanner which is due in April 2015 and the contingency balance of £2m held for potential future changes to the VAT regime in the NHS. The 2014/15 capital expenditure plan net of slippage is £57.581m.

Slippage is carried forward into the following year and is regarded as a prudent assumption.

5. Implications

The programme outlined in this paper is dependent on several core assumptions, including:

- Capital sources – these include but are not limited to the ITFF loan, public dividend capital, significant donations from charitable sources, depreciation and cash. The attainment of each source is essential to the programme. The most significant risk is charitable donations particularly in the case of TGA in terms of timing and the planned value of donation. The Director Strategic Development continues to work closely with the charities.

- Operating Plans and savings programme – delivery of plans for income, expenditure and cost savings in line with the Trust's LTFP will have an impact on the Trust's liquidity and therefore the availability of cash for the MTCP. This is an essential link between the Trust's Capital Programme and its annual financial performance;

- Scheme costs – changes or further slippage may result in revisions to the capital programme aligning applications of funding with sources;

- Prioritisation of capital – annual processes are established and continue to be developed for the allocation of Major Medical and Operational Capital, and a separate process for identifying priorities for Strategic Refurbishment capital. Changes to the overall amounts required for these schemes will impact on other parts of the programme.

6. Conclusion

This paper summarises the latest position in respect of capital schemes in the period to 2018/19. The relationship between the MTCP and the Trust's annual Operating Plans and savings programme achievement is such that, should the net surplus of the Trust in any year fall below the planned surplus, an equal and opposite reduction will be applied to the MTCP in order to maintain the Trust's liquidity position.

The Finance Committee is asked to approve the Medium Term Capital Programme.

Catherine Cookson
Head of Capital Accounting

Medium Term Capital Programme
SOURCES

Subjective Head	Prior Years	Slippage B/Fwd	2014/15	Total 2014/15	2015/16	2016/17	2017/18	2018/19	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Public Dividend Capital	490	-	2,625	2,625	-	-	-	-	3,115
Retained Depreciation	35,498	-	19,211	19,211	22,302	23,021	23,932	24,638	148,601
Prudential Borrowing	74,950	-	20,000	20,000	-	-	-	-	94,950
Donations	1,100	-	8,605	8,605	3,000	-	-	-	12,705
Disposals	-	700	-	700	670	-	2,000	-	3,370
Capital Grants	-	-	-	-	-	-	-	-	-
VAT Recovery	-	-	954	954	-	-	-	-	954
Cash Requirements	27,229	17,201	(11,715)	5,486	2,226	247	(3,691)	(3,776)	27,721
Total Source of funds	**139,267**	**17,901**	**39,680**	**57,581**	**28,197**	**23,268**	**22,241**	**20,862**	**291,416**

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APPLICATIONS

Subjective Head	Prior Years	Slippage B/Fwd	2014/15	Total 2014/15	2015/16	2016/17	2017/18	2018/19	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Major Strategic Schemes	122,835	5,072	27,590	32,662	11,952	6,099	8,874	7,260	189,682
Medical Equipment	3,089	4,078	4,000	8,078	2,520	7,880	5,300	5,300	32,167
Information Technology	4,159	1,491	7,584	9,075	1,261	1,461	826	1,400	18,182
Roll Over Schemes	3,496	532	2,425	2,957	2,400	2,725	2,725	2,675	16,978
Operational Capital	5,688	6,728	5,548	12,276	6,256	4,450	4,450	4,450	37,570
Total Committed Schemes	**139,267**	**17,901**	**47,147**	**65,048**	**24,389**	**22,615**	**22,175**	**21,085**	**294,579**
Net slippage for the year		-	(7,467)	(7,467)	3,808	653	66	(224)	(3,163)
Total Application of funds	**139,267**	**17,901**	**39,680**	**57,581**	**28,197**	**23,268**	**22,241**	**20,862**	**291,416**

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SOURCES

Source of Funds	Prior Years	Slippage B/Fwd	2014/15	Total 2014/15	2015/16	2016/17	2017/18	2018/19	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Public Dividend Capital									
2013/14	490	-	-	-	-	-	-	-	490
Safer hospitals safer care technology fund	-	-	2,625	2,625	-	-	-	-	2,625
Sub total Public Dividend Capital	490	-	2,625	2,625	-	-	-	-	3,115
Retained Depreciation									
Depreciation from long term plan (@24/02/14)	35,498	-	19,224	19,224	22,289	22,927	23,883	24,589	148,410
Adjustments to V7	-	-	(14)	(14)	(63)	27	(18)	(18)	(86)
Adjustments to V8	-	-	-	-	76	67	67	67	276
Sub Total Retained Depreciation	35,498	-	19,211	19,211	22,302	23,021	23,932	24,638	148,601
Prudential Borrowing									
Prudential Borrowing	74,950	-	-	-	-	-	-	-	74,950
Prudential Borrowing - additional funds	-	-	20,000	20,000	-	-	-	-	20,000
Sub Total Prudential Borrowing	74,950	-	20,000	20,000	-	-	-	-	94,950
Donations				-					-
Area 61 - Divisional Scheme (A&B & TCT)	-	-	17	17	-	-	-	-	17
HELP appeal - Air Ambulance	250	-	250	250	-	-	-	-	500
BHOC upgrade - Above & Beyond	-	-	2,000	2,000	-	-	-	-	2,000
BHOC upgrade - Friends of BHOC	-	-	2,000	2,000	-	-	-	-	2,000
BHOC upgrade - Teenage Cancer Trust	850	-	1,500	1,500	-	-	-	-	2,350
BRI Redevelopment - Above & Beyond	-	-	-	-	2,000	-	-	-	2,000
CSP - The Grand Appeal	-	-	3,838	3,838	2,000	-	-	-	5,838
Risk re charitable donations	-	-	(1,000)	(1,000)	(1,000)	-	-	-	(2,000)
Sub Total New system funding	1,100	-	8,605	8,605	3,000	-	-	-	12,705
Disposals									
Sale of Kingsdown	-	700	-	700	-	-	-	-	700
Sale of The Grange (NBV waiting on BP)	-	-	-	-	670	-	-	-	670
Sale of BRI Old Building	-	-	-	-	-	-	2,000	-	2,000
Sub Total Disposals	-	700	-	700	670	-	2,000	-	3,370
VAT Recovery									-
Welcome Centre	-	-	954	954	-	-	-	-	954
Sub Total VAT Recovery	-	-	954	954	-	-	-	-	954
Cash Requirements									
Planned cash contribution	27,229	17,201	(11,715)	5,486	2,226	247	(3,691)	(3,776)	27,721
									-
Total Source of funds	**139,267**	**17,901**	**39,680**	**57,581**	**28,197**	**23,268**	**22,241**	**20,862**	**291,416**
									-

SUMMARY OF MAIN ALLOCATIONS

Main allocation	Prior Years £000's	Slippage B/Fwd £000's	2014/15 £000's	Total 2014/15 £000's	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	Total £000's
MAJOR STRATEGIC SCHEMES									
BRI Redevelopment - Phase 3	75,283	1,191	12,147	13,338	-	-	-	-	88,621
BRI Façade Project	324	85	3,136	3,221	-	-	-	-	3,545
BRI Redevelopment - Phase 4	895	2,131	6,889	9,020	11,952	1,200	-	-	23,067
Specialist Paediatrics	26,212	1,586	3,418	5,004	-	-	-	-	31,216
BHOC Strategy	14,403	(357)	2,000	1,643	-	-	-	-	16,046
Strategic Capital	-	-	-	-	-	4,899	8,874	7,260	21,033
BRI Welcome Centre	5,718	436	-	436	-	-	-	-	6,154
TOTAL MAJOR STRATEGIC SCHEMES	122,835	5,072	27,590	32,662	11,952	6,099	8,874	7,260	189,682
MEDICAL EQUIPMENT									
Emergency Medical Equipment	202	71	-	71	300	300	300	300	1,473
Major medical programme - pre 2013/14	303	262	-	262	-	-	-	-	565
Major medical programme - 2013/14	562	2,993	-	2,993	-	-	-	-	3,555
Major medical programme - 2014/15	-	-	2,500	2,500	-	-	-	-	2,500
Major medical programme - futre years	-	-	-	-	2,220	5,000	2,420	5,000	14,640
Linear Accelerator	2,022	78	-	78	-	2,580	2,580	-	7,260
Replacement MRI scanner	-	-	1,500	1,500	-	-	-	-	1,500
ITU Monitors	-	674	-	674	-	-	-	-	674
TOTAL MEDICAL EQUIPMENT	3,089	4,078	4,000	8,078	2,520	7,880	5,300	5,300	32,167
IM&T & ROLL OVER									
Information Management & Technology	4,159	1,491	7,584	9,075	1,261	1,461	826	1,400	18,182
Roll Over Schemes	3,496	532	2,425	2,957	2,400	2,725	2,725	2,675	16,978
OPERATIONAL CAPITAL									
Contingency	135	205	203	408	-	-	-	-	543
Operational Capital - pre 2013/14	2,367	447	-	447	-	-	-	-	2,814
Operational Capital - 2013/14	1,228	3,388	(983)	2,405	-	-	-	-	3,633
Operational Capital - 2014/15	-	-	2,315	2,315	-	-	-	-	2,315
Operational Capital - future years	-	-	-	-	3,000	3,000	3,000	3,000	12,000
Additional schemes	-	-	-	-	450	-	-	-	450
Cook /Freeze	-	-	250	250	-	-	-	-	250
Sterile Services	1,163	204	657	861	1,756	-	-	-	3,780
Dental Capital	64	433	950	1,383	450	450	450	450	3,247
Divisional Capital	594	572	600	1,172	600	1,000	1,000	1,000	5,366
PEAT/PLACE	97	130	-	130	-	-	-	-	227
Radiopharmacy	-	500	-	500	-	-	-	-	500
VAT contingency	-	444	1,556	2,000	-	-	-	-	2,000
Spend to Save	40	405	-	405	-	-	-	-	445
TOTAL OPERATIONAL CAPITAL	5,688	6,728	5,548	12,276	6,256	4,450	4,450	4,450	37,570
TOTAL COMMITTED SCHEMES	**139,267**	**17,901**	**47,147**	**65,048**	**24,389**	**22,615**	**22,175**	**21,085**	**294,579**
Slippage from prior year					7,467	3,658	3,005	2,939	17,070
In year slippage			(7,467)	(7,467)	(3,658)	(3,005)	(2,939)	(3,163)	(20,232)
Net slippage for the year	-	-	(7,467)	(7,467)	3,808	653	66	(224)	(3,163)
	139,267	**17,901**	**39,680**	**57,581**	**28,197**	**23,268**	**22,241**	**20,862**	**291,416**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Meeting of the Trust Board of Directors, to be held on 30 June 2014 at 09.30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 16 – Estates Strategy

Purpose

The purpose of this paper is to present the 2015 to 2020 Estates Strategy to the Board for its approval.

Abstract

The Trust is in a 15 to 20 year strategic asset management cycle which commenced in 2005. This document outlines the forward estates strategy for the Trust in light of the imminent delivery of the prevailing 2005-2015 strategy which is set to be concluded in March 2016 upon completion of Phase lV of the BRI development programme.

In approving the strategy, the Board should note the following proposals that it would be supporting:

- An evaluation of the merits of seeking to acquire Myrtle Road property
- A proposal to declare the property known as the Grange, surplus to requirements
- Retention of the Central Health Clinic pending further evaluation once the outcome of the tender for sexual health services
- Declining the offer to acquire (from the Above & Beyond charity) the Abbots House and Honey Pot properties, for the development of parent's accommodation.
- Incorporation of the Tyndall's Park accommodation within the Marlborough Hill site development and the subsequent evaluation of the on-going requirements to retain the site.
- An assessment of the strategic estates refurbishment priorities, to inform the deployment of the £21m of strategic estates capital in the forward capital programme.

Recommendations

The Board is recommended to **approve** the Estates Strategy reflecting the final stage of the current 20 year asset management cycle. Specifically the Board is recommended to **approve** the development of two Outline Business Cases:

- To evaluate the options for the future use of the Old Building Site as set out in the strategy
- For the redevelopment of land at Marlborough Hill

The Board is also asked to note the endorsement of the six points above which are inherent within the strategy and request it be kept informed on their progress.

Report Sponsor
The Director of Strategic Development, Deborah Lee.
Report Author
The Director of Strategic Development, Deborah Lee.
Appendices
• Appendix 1 – Estates Strategy

University Hospitals Bristol NHS
NHS Foundation Trust

in partnership with CAPITA

Estate Strategy 2015-2020

University Hospitals Bristol NHS Foundation Trust

June 2014

Contents

Executive Summary

Where are we now?

The Trust is in a 15 to 20 year strategic asset management cycle which commenced in 2005. This document outlines the forward estates strategy for the Trust in light of the imminent delivery of the prevailing 2005-2015 strategy which is set to be concluded in March 2016 following completion of Phase lV of the BRI development programme

To date, implementation has focussed on the development and optimisation of core clinical facilities to significantly improve adjacencies and co-locations of key services and retire estate that is no longer fit for purpose. This approach has resulted in the expansion of core clinical accommodation, elimination of poor quality accommodation including nightingale ward environments, and improvements in the built environment of more than 50 services.

Notably, the current strategy has realised £200m of estate investment to improve facilities for our patients, visitors and staff, supporting the Trust in delivering its mission '*to provide exceptional care, teaching and research every day'.*

The 2015-2020 estate strategy now concentrates primarily on ancillary and non-clinical estate provision - which is the final element of the asset management cycle - whilst ensuring the estate is 'future proof' for known or predicted clinical requirements.

The strategy has been conceived in the context of the Trust's previously agreed strategic estates objectives and the known estates priorities to 2020 and beyond. It also sets out the strategic framework for further estates decisions, including the future use of the Old Building and other land considered surplus to future requirements.

Recognising that any strategy must be tested for deliverability, a master site planning exercise and financial impact assessment has been completed as part of the development work to enable us to demonstrate the feasibility of the strategy proposed.

Where do we want to be?

The recent redevelopment and rationalisation of the estate has provided an opportunity to create surplus land for future strategic development or disposal. This strategy sets out the ways in which the Trust's strategic objectives and estates priorities will be delivered over the next five years, making best use of these opportunities

Strategic Estate Objectives

The Board has resolved that in relation to our estate its strategic objectives are:

- To address all known estate priorities
- Rationalise the estate whilst promoting operational and clinical efficiency
- Minimise current and future backlog maintenance
- Develop maximum flexibility within the estate to address future priorities – known and unknown
- Develop strategies that deliver a contribution to the Trust's financial health

- Align any proposed commercial development of surplus land to schemes which maximise both strategic and financial benefit for the Trust;
- Develop estate solutions which help diversify risk and promote strategic partnering opportunities, notably in areas that support the Trust's core mission of care delivery, teaching and research.

Estate Priorities

Work has been done to scope the Trust's known and predicted estates priorities and these have been previously agreed as

- Improved patient access through on-site, multi-storey parking provision, alongside associated rationalisation of existing provision and enhanced drop off and site circulation.
- Replacement of Trust Head Quarters (THQ) and Estates & Facilities accommodation arising from rationalisation of land on Marlborough Hill to accommodate multi-storey parking.
- Re-provision of
  - Soon to be obsolete parent accommodation and further expansion to accommodate the impact of recent service and future service growth, notably the specialist paediatric transfer from Frenchay.
  - Accommodation for services displaced by any future service changes e.g. requirement for neonatal intensive care expansion
- Retained space for
  - An additional 24 bed ward or other clinical accommodation such as care home.
  - Further expansion of Trust research and teaching offer, including enhanced medical school provision
  - Displaced services in a scenario where disposal of Central Health Clinic and/or Tyndalls' Park is deemed desirable.

How do we get there?

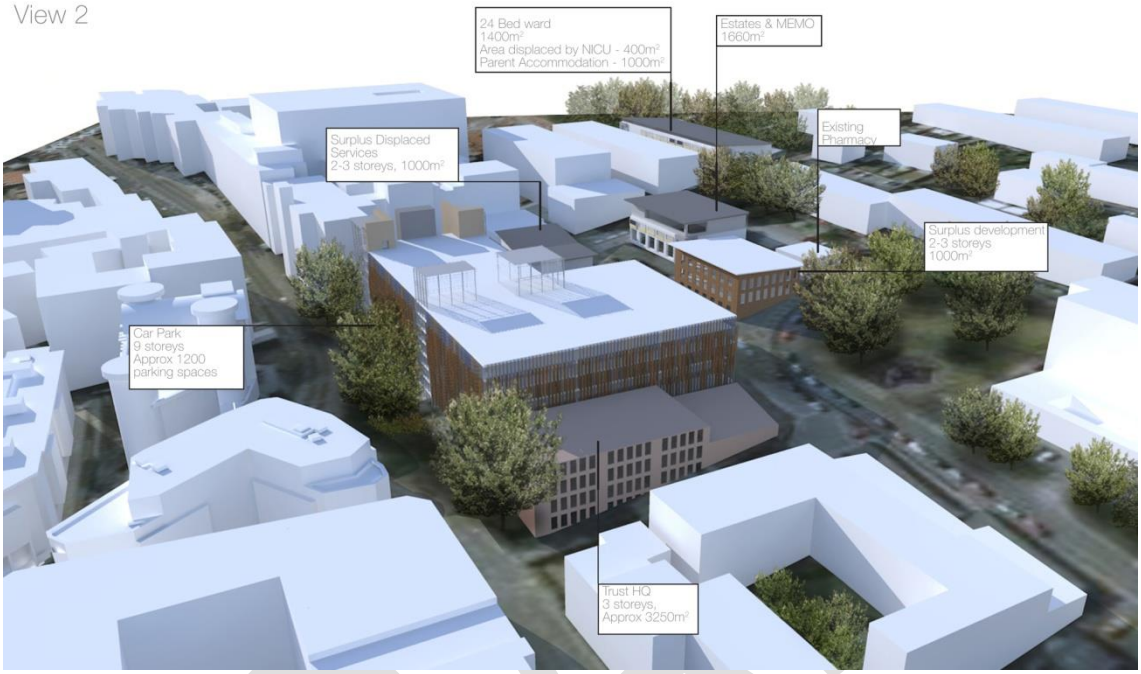
Realisation of the current estate strategy affords two significant opportunities for further development or asset disposal, created through the realisation of surplus estate; these are to redevelop or dispose of the land at Marlborough Hill and/or the Old Building site.

Economic appraisal of the available land has determined that, of the two sites, Marlborough Hill would more appropriately accommodate the Trust's estate priorities due to its location, likely planning restrictions and lower commercial value, along with its greater potential for flexibility to meet future needs and demands, through a phased approach to redevelopment.

The Old Building site is considered to lend itself to disposal or redevelopment due to its attractiveness to commercial developers, opportunities for more diverse uses and the opportunity to realise beneficial strategic partnerships through innovative development vehicles.

A site master plan was completed in April 2014 to ensure that the strategic estates priorities set out above were broadly deliverable and provided the most optimum solution for use of the Trust estate. The master plan considered the use of the land on Marlborough Hill to accommodate the estate priorities and achieve estate objectives.

Below is an illustration of the site master plan for the Marlborough Hill site – showing the potential for development over the next 5 years.



The 2011 BRI Development Full Business Case referenced the potential to dispose of the Old Building and obtain a capital receipt. This option, alongside others, will be evaluated through the development and presentation of an Outline Business Case to the Board.

Conclusion.

This Estate Strategy sets the Trust's strategic direction for estates development over the five years from 2015-2020 and describes the opportunities open to us to extract maximum value from our estate to support our mission to provide exceptional care, teaching and research for the benefit of the people we serve.

It describes two significant development opportunities and proposes the development of two Outline Business Cases (OBCs) for the Old Building and Marlborough Hill sites.

1 | Overview

1.1 Introduction – Where are we now?

The Trust is in the final stages of realising our current estates strategy culminating in the renewal and optimisation of significant parts of the core clinical estate. The key objective of the strategy was to align the Trust's clinical accommodation to the prevailing service and strategic objectives.

Execution of the strategy will result in the development and rationalisation of core clinical facilities, including the decommissioning of the Trust's older estate, significantly improved adjacencies and co-locations of key services, expansion of core clinical accommodation, the elimination of nightingale ward environments and improvement in the built environment of more than 50 services.

Notably, the current 10 year strategy, culminating in 2016, will have driven investment of c£200m into the development of the estate and notable impacts will include

- Expansion and refurbishment of the dental service and school
- Expansion of the Bristol Haematology and Oncology Centre
- Refurbishment of large parts of the BRI and King Edward's Building (KEB)
- A Welcome Centre and new façade to the Bristol Royal Infirmary (BRI)
- Disposal of the Bristol General Hospital and transfer of services to South Bristol Community Hospital
- Modern clinical accommodation through the creation of the Terrell Street Ward Block
- Expansion of Bristol Royal Hospital for Children
- Decommissioning of the Old Building
- Development of the Bristol Heart Institute
- Development of the Clinical Research Imaging Centre (CRIC)

A key consequence of this estate rationalisation is an opportunity to realise future strategic priorities (including delivery of the strategic objectives that are known or anticipated, in the next 5 years and beyond) by decommissioning of the Old Building, creating land surplus to the Trust's immediate requirements which would be available for development or disposal.

This document outlines the strategic direction for the Trust regarding the future of the estate and acts as a framework to inform the future estate decisions over the next 5 years.

A number of key changes have taken place within the NHS and the wider economy which affect the current and proposed estate strategy. The key contextual changes of particular relevance include:

- Major restructure of the NHS in 2012 which has changed the way services are commissioned and provided.
- Financial challenges in the public sector and the need to contribute to savings, NHS Improving Quality and efficiencies targets

- Increased demand for higher quality service provision from regulators, our customers and the general public.
- Our Foundation Trust (FT) status, secured in June 2008, allowing us to assert greater autonomy over our financial affairs, including capital investment decisions with access to long term loan finance and the ability to pursue joint ventures with commercial partners.
- Changes introduced through the Health and Social Care Act 2012, for Foundation Trusts (FT) have increased the cap on income that FTs can generate from non-core services from 2% to 49% of the total Trust income, opening up the scale of commercial diversification now possible

Work to date has positively transformed many aspects of the Trust's estate and, most importantly, the services we offer to patients and staff. The culmination of this strategy now affords the Trust an opportunity to take stock of our emerging future priorities and consider the next steps in the asset management cycle.

2 | Strategic Estate Opportunities – Where do we want to be?

Aims and Objectives of the Estate Strategy

The estate strategy aims to set the framework for the future development of the estate that is aligned to our strategic goals and objectives.

Whilst long term service planning represents a challenge in a health landscape renowned for change, the Trust already has a number of strategic priorities that it must address, whilst understanding that any future plan for the estate must retain sufficient flexibility to enable us to respond to changes in service demands that are presently unknown

Strategic Estate Objectives

The following forward-looking estates objectives have been agreed by the Board:

- To address all known estate priorities
- Rationalise the estate whilst promoting operational and clinical efficiency
- Minimise current and future backlog maintenance
- Develop maximum flexibility within the estate to address future priorities – known and unknown
- Develop strategies that deliver a contribution to the Trust's financial health
- Align any proposed commercial development of surplus land to schemes which maximise both strategic and financial benefit for the Trust;
- Develop estate solutions which help diversify risk and promote strategic partnering opportunities, notably in areas that support the Trust's core mission of care delivery, teaching and research.

Estate Priorities

The above aims have been considered alongside the known and predicted estates accommodation requirements and opportunities and the following priorities have been agreed:

- Improved patient access through on-site, multi-storey parking provision, alongside associated rationalisation of existing provision and enhanced drop off and site circulation.
- Replacement of Trust Head Quarters (THQ) and Estates & Facilities accommodation arising from rationalisation of land on Marlborough Hill to accommodate multi-storey parking.
- Re-provision of
    - Soon to be obsolete parent accommodation and further expansion to accommodate the impact of recent service and future service growth, notably the specialist paediatric transfer from Frenchay.
    - Accommodation for services displaced by any future service changes e.g. requirement for neonatal intensive care expansion

- Retained space for
  - An additional 24 bed ward or other clinical accommodation such as care home.
  - Further expansion of Trust research and teaching offer, including enhanced medical school provision
  - Displaced services in a scenario where disposal of Central Health Clinic and/or Tyndalls' Park is deemed desirable.

The Trust operates from its main hospital precinct at the Bristol Royal Infirmary with the majority of adjacent administrative and clinical buildings all within walking distance. The Trust also has some smaller freehold and leasehold buildings within the City of Bristol. A plan outlining the main hospital precinct is held in appendix A of this report.

The main Hospital clinical campus has undergone major redevelopment in previous years primarily concentrating on improvements to clinical facilities. Anticipated service changes and key estate priorities have been included in the future master plan for the Trust estate, in order to ensure that future flexibility is provided for. It is not envisaged that any significant changes will be made to the core clinical estate in the next five years.

As part of the asset strategy cycle, the estate strategy will also address those ancillary or support buildings which are in need of investment, alongside an opportunity to maximise the use of our land through the most optimum solutions.

The diagram below illustrates the asset management cycle.

Adapted from "The basic business process for effective property asset management"
RICS Public Sector Property Asset Management Guidelines, 2nd Edition

The existing backlog maintenance cost of the estate is estimated to be in the region of £25.3m. It is anticipated that the backlog maintenance figure will reduce further over the period of this strategy, once all the new core clinical buildings are commissioned in 2016, enabling older, unfit estate to be retired.

3 | How do we get there?

3.1 Estate Opportunities

A significant benefit from the BRI redevelopment is the realisation of redevelopment land within the hospital precinct. Two main sites have been identified that can be utilised to meet the strategic estates objectives and priorities set out in this strategy:

- The Old Building
- Marlborough Hill site

3.2 Old Building

As identified in the 2005-2015 Estates Strategy, the **Old Building** site and structures are potentially surplus to requirements once existing services have been relocated in the remainder of the estate.

The 0.7 hectare site includes a number of buildings and services including; BRI Old Building, Milne Centre, Rheumatology, offices, the Mortuary, Chapel, Heart Valve Bank and Patient Catering Department; none of the structures are listed as of significant architectural or historical note.

Located on Marlborough Street, the site has good visibility with easy access to the central bus station, the main shopping area, the city's bars and entertainments, and both existing and planned student residential developments. It is, however, outside the commercial office core area and is separated from the residential areas of Cotham and Kingsdown.

In the period since production of the 2005-2015 Estate Strategy, land values have fallen considerably. Any valuation where the Trust is not retaining a presence on the Old Building site will have to take in to account the estimated £1.2m enabling works required to separate the Old Building from the remainder of the estate.

The value the site can achieve will vary subject to the potential uses along with appropriate planning consents, which will be considered in any business case approval.

3.3 Land at Marlborough Hill

This land mainly accommodates the ancillary and support buildings such as Trust HQ, staff, multi-storey car park, (MSCP) Marlborough St. staff accommodation, Estates & Facilities, Trust Medical Equipment Management Organisation (MEMO) and a number of surface level parking areas as well as an access road.

These buildings no longer provide functionally suitable, sustainable or efficient accommodation for their respective uses and as such form the culmination of our asset strategy cycle.

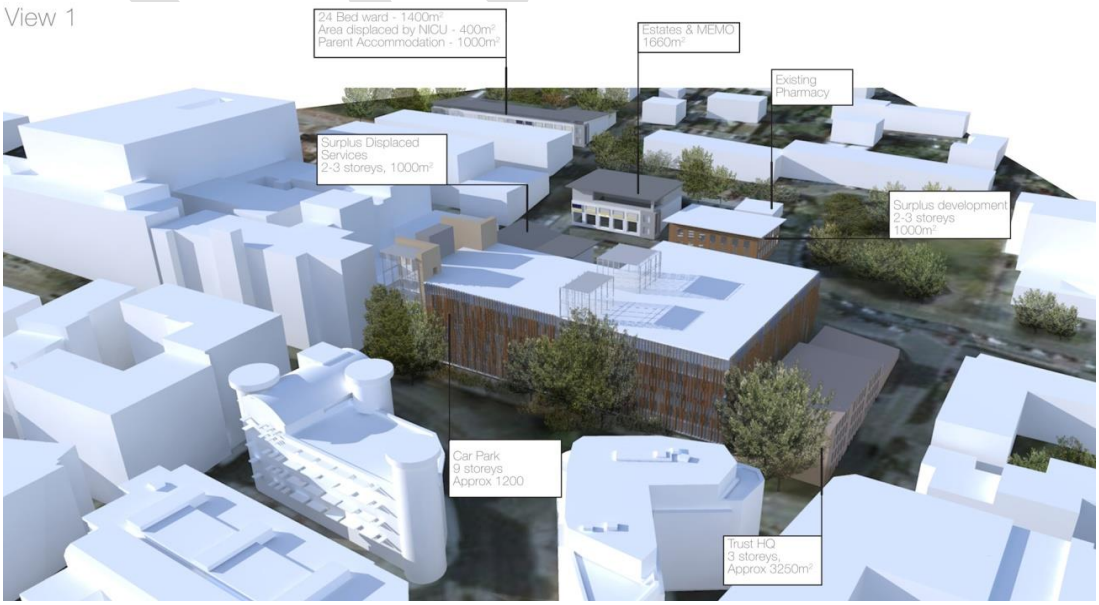
The initial economic, commercial and financial analysis carried out indicates that this site is large enough to facilitate the Trust's estate objectives and priorities. It is also adjacent to the existing main hospital buildings which would further complement the campus and enhance overall patient and visitor experiences, as it is not dissected by the busy road network, unlike the Old Building. A copy of the appraisal is included in Appendix B.

3.4 Site Feasibility Plan

Overview

The site feasibility plan was carried out as a high level test to ensure that all estate priorities could be accommodated on Marlborough Hill and that land was still released for disposal, aligning to our strategic estate objectives.

The high level conceptual feasibility plan was carried out during March and completed in April 2014. It considered the feasibility for the Marlborough Hill site to accommodate the estate priorities (subject to planning).



The image demonstrates how all the Trust's estates priorities (set out in section 1.2 of this document) can be accommodated on the land at Marlborough Hill. The consequence of this exercise is that options for evaluation of the plans for the Old Building site will be broadened in scope and explored through the production of an OBC.

The master plan indicates that the land at Marlborough Hill can accommodate:

- a new multi-storey car park
- trust HQ in a newly constructed building
- parent accommodation
- estates and facilities, including MEMO;

With future flexibility and surplus space to accommodate:

- a 24 bed ward or equivalent clinical accommodation
- displaced accommodation arising from the potential expansion of NICU
- any services displaced as a result of future disposals, such as the Central Health Clinic and Tyndalls' Park

One impact of this strategy will be the displacement of staff residences however the Senior Leadership Team (SLT) have accepted that any future accommodation strategy is not be dependent on these properties. It should be noted that one of the residences is occupied under a protected tenancy and another owned on a leasehold basis - the impact of finding a solution to these two residences would need to be fully assessed and analysed as part of any Outline Business Case.

The master plan also assumes that closure of Eugene Street would be permitted in order to maximise land use and accommodate the total number of car parking spaces required. The whole master plan will be subject to consultations, full planning and financial analysis.

Generally the hospital is located in a busy, high density city centre location where access and egress from the buildings is challenging and further complicated by the natural topography of the site, including the steep slope from the top of Marlborough Hill down to Upper Mauldin Street.

Site A | Old Building

Site B | Marlborough Hill

Car Parking

Car parking is an emotive subject and a challenge faced by NHS Trusts all around the country, and we know that our patients, their families and visitors find it increasingly difficult to park in appropriate locations when visiting the main hospital site. The disparate location of our car parks has increased road congestion and we receive numerous complaints from the public about parking every year. Appendix 1 sets out the context of our current parking offer and has informed this proposal to create c 1300 additional parking spaces.

As a result, we are exhausting every alternative option to a multi-storey car park (MSCP), including:

- provision of bus services, patient transport and/or shuttle buses,
- utilisation of existing city car parking including Cabot Circus,
- promoting green travel,
- exploring options for joint working with the City Council's transport departments.

Linkage and access to main hospital site will form part of the overall car parking strategy and we will continue to explore any potential opportunity to improve access and transport to the site, including any new rapid links. Expansion of drop off zones and the shuttle bus service will also be considered alongside improving transportation throughout the site for those with mobility difficulties.

Benchmarking the Trust against 16 similar NHS organisations in the country, UH Bristol has the lowest amount of car parking spaces per bed. Taking the city centre location into account and green travel planning, we could reasonably set a target in the lowest quartile of 1.9 spaces per bed. After consolidation of some existing car parking this would indicate a requirement for circa 1,300 spaces – this would be subject to full analysis, consultations and statutory approvals - but demonstrates the current under provision of car parking at the main hospital site which needs to be addressed.

Trust Head Quarters

Due to a focus on investment in core clinical services, our Trust Head Quarters (THQ) has not had any significant improvement in recent years and does not conform to modern methods of working and is not functionally suitable in some areas. The current THQ

location is in the proposed development zone of the intended MSCP and an opportunity is presented to relocate and rationalise our THQ, vacate some off-site leased accommodation and re-provide a modern and fit-for-purpose facility.

Parent Accommodation

Providing accommodation for parents is a vital part of our commitment to support families of children with serious illness, and we currently benefit from fantastic support of charities and fundraisers. There is an ongoing requirement to provide parent accommodation and it is predicted that 36 units will be required by 2020. This requirement is, as a result of the ageing current accommodation that needs to be replaced, repatriation of existing parent accommodation from other sites and planning for additional parent accommodation requirements.

A new parent accommodation facility could potentially be provided on Marlborough Hill or at Myrtle Road (if the Trust made a strategic acquisition of the Public Health England building adjacent to the main hospital precinct).

The options surrounding the delivery of this facility will be explored in detail through a separate Outline Business Case.

3.5 Other potential strategic Acquisitions and Disposals

Myrtle Road

Public Health England will relocate to a new facility 2016/17 and the current Myrtle Road site will become vacant. Given the adjacency of the site to the hospital campus this is considered to be a strategic estate opportunity and it is proposed that further work will be done to evaluate the strategic, service and economic benefits of acquiring this property.

Abbotts House and Honey Pot

The Trust was formally offered both of these buildings for use as parent / overnight accommodation. A commercial appraisal has been carried out considering both the capital investment cost required for adaptation of the buildings, the operating costs and the standard of accommodation that could be achieved after completion of the works. The conclusion is that acquiring these buildings would not be as viable (economically or operationally) as other opportunities to provide a long term solution for parent accommodation.

The Grange

The Trust owns The Grange, on Woodlands Road, and leases it to the University of Bristol and Archfield Nursery. A process has been agreed with the District Valuation office for the disposal of this site to one or other of the current tenants, as part of a strategic disposal programme subject to the Board declaring it surplus to Trust requirements.

Central Health Clinic

The Sexual Health Service, located within the Central Health Clinic is subject to a strategic review, pending a competitive tender for re-provision of all sexual health services in Bristol by the City Council. The site is located adjacent to the Great Western Ambulance Station, (which the Homes & Communities Agency is currently in the process of purchasing).

The procurement outcome may change the longer term future of this site and could potentially result in its disposal if the service were not retained by UH Bristol in full or in part.

Tyndalls' Park

Currently occupied by MEMO and training services, the Tyndalls' building is outside the Trust's core estate area and the future strategy for the site will be aligned to the overall strategic development to take place on Marlborough Hill.

Appendix C details the future estate requirements and the service drivers of our property portfolio; it summarises our current strategy for each property, area by area, considering factors such as condition, service objectives and estate optimisation.

3.6 Financial Resourcing

The Trust's approved Medium Term Capital Programme (MTCP) outlines the sources and application of capital funding for the period from 2014/15 through to 2018/19. For the period 2016/17 to 2018/19, we have earmarked strategic capital funding of £21million in support of our future capital priorities, including the Estates Strategy. These resources, alongside further capital receipts, are the internal resources available to support implementation of the Estate Strategy.

In addition, the Trust could obtain further long term loan finance from the Independent Trust Financing Facility (ITFF) or we could consider a joint venture initiative with a commercial partner depending on the outcome of our recurring revenue assessment and affordability analysis.

OBC's will be developed for each component of the strategy and will confirm the affordability and value for money of the options described., However, high level assessment of our internal resources, the potential for further external financing and the attractiveness of the proposals to third party investors, all indicate that the strategy set out is affordable and could be financed.

4 | Strategy Implementation

4.1 Next Steps

The estate strategy will be delivered through developing key assets, increasing income from commercial and clinical activities, acquiring strategically and disposing of estate that becomes surplus to requirements.

Affordability and delivery will be achieved using the most appropriate financial mechanism to leverage the optimum level of financial and non-financial benefits to the Trust.

Each proposed change to the physical assets will be appraised against the identified options and presented for approval in the context of the framework set out by this overarching estate strategy.

Options for Old Building site

A range of options for alternative uses of the Old Building site will be developed to Outline Business Case (OBC) stage and aiming to be presented for consideration by the Board in September 2014. The options to be evaluated at OBC are:

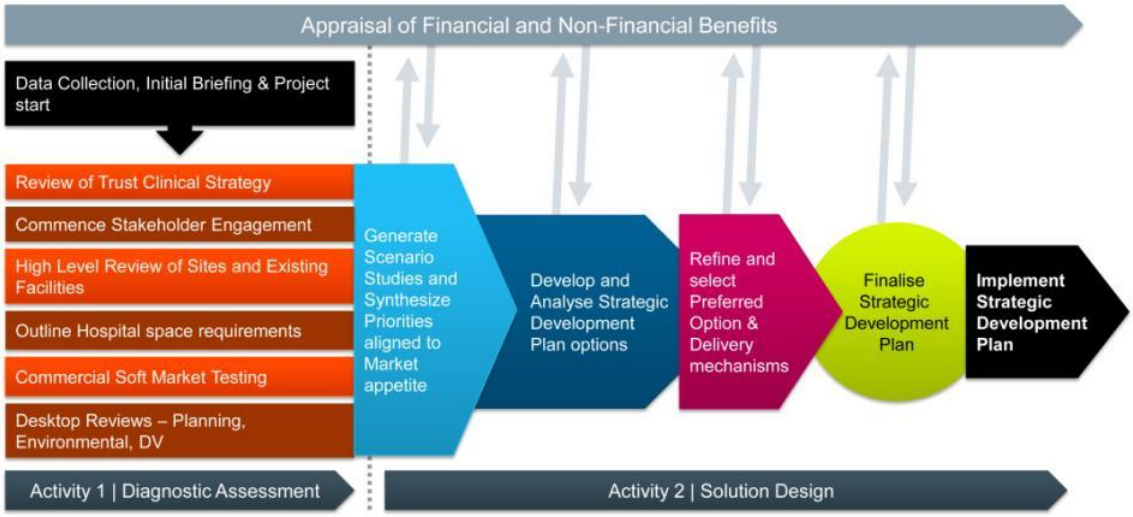
1) Secure Old Building and retain for future, undetermined use
2) Demolish and retain site for future, undetermined use
3) Dispose
4) Lease and develop, alone or in partnership

To minimise ongoing liabilities (including capital charges and running costs) associated with this site from April 2016, the site must be declared surplus to requirements by **March 2015**, if it is not deemed suitable for future use and any business case option appraisal must consider this timescale for delivery.

The OBC will describe the best option to maximise the return from the Trust estate in line with the objectives and priorities set out in this strategy. This approach to revenue cost reduction is a key planning assumption within the Trust's current Long Term Financial Plan (LTFP).

Alongside the work to develop the OBC for the Old Building, a separate OBC will be developed for the Marlborough Hill site.

4.2 Delivery Models



The diagram above details the process that we are currently undergoing as part of our asset management cycle - the next stage will be to refine and select the preferred options as outlined in this estate strategy.

A number of delivery models would be considered for redevelopment of the sites if this direction is concluded through the OBC evaluation and could include a Local Asset Backed Vehicle or facilitation through a Strategic Estates Partnership/ Corporate Joint Venture.

Our approach would be to test the viability and potential of each proposed delivery mechanism against the net social, economic and financial benefits of the more traditional capital procurement routes to realise the most appropriate option.

As a Trust, we will always strive to invest our capital in the core estate that is used for the delivery of clinical services, or those assets with the potential to generate a return and contribution to the Trust's financial well being.

4.3 Financial Affordability

The Estate Strategy recognises the Trust's current Medium Term Capital Programme (MTCP) and the funding currently available. The capital funding is based upon our current Long Term Financial Plan (LTFP) and the delivery of financial surpluses of approximately 1% of turnover and the delivery of savings plans at 4% over the period to 2018/19.

The sustainability of these planning assumptions is currently under review as part of our strategic plan response due, with Monitor, in June 2014. For our current LTFP, it is estimated that the Old Building will deliver £2 million of recurrent revenue savings from April 2016 and provide a capital receipt of £2 million. Options for redevelopment of the Marlborough Hill site will require a recurring revenue assessment and an assessment of capital affordability in the OBCs, the output of which will feature in our LTFP going forward.

5 | Recommendations

The Trust Board is asked to approve this Estate Strategy reflecting the final stage of the current 20 year asset management cycle.

Specifically, it is asked to approve the development of two Outline Business Cases

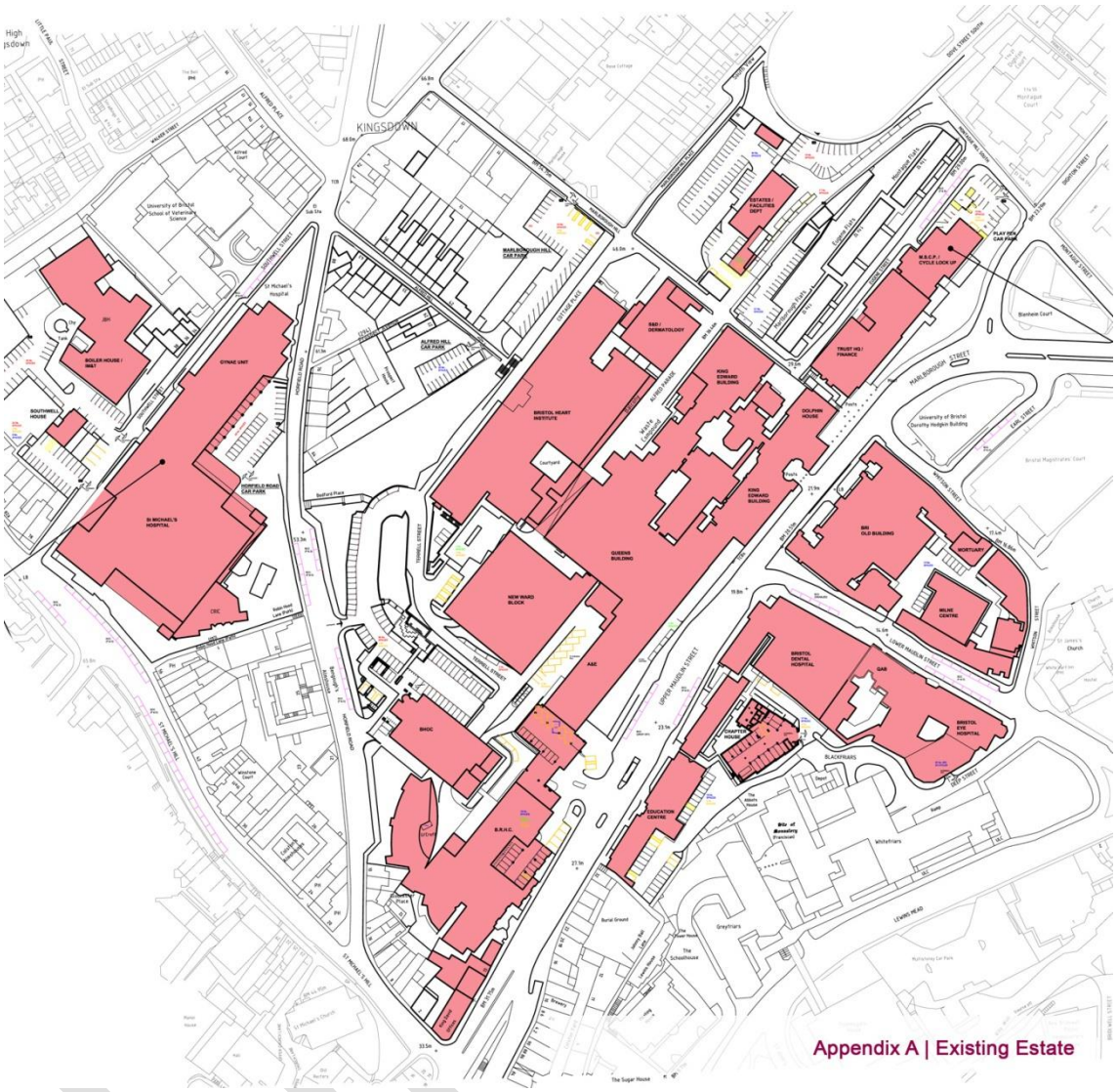
- to evaluate the options for the future use of the Old Building Site as set out in the strategy
- for the redevelopment of land at Marlborough Hill

In addition, in approving the strategy, the Board is endorsing

- An evaluation of the merits of seeking to acquire Myrtle Road property, currently owned by Public Health England
- A proposal to declare the property known as the Grange, surplus to requirements
- Retention of the Central Health Clinic subject to further evaluation, pending the outcome of the tender for sexual health services
- Declining the offer to acquire (from the Above & Beyond charity) the Abbots House and Honey Pot properties for the development of parent's accommodation.
- Incorporation of the Tyndall's Park accommodation within the Marlborough Hill site development and the subsequent evaluation of the on-going requirements to retain the site
- An assessment of the strategic estates refurbishment priorities, to inform the deployment of the £21m of strategic estates capital in the forward capital programme.

Appendices

Appendix A | Existing Estate


KINGSDOWN
ST MICHAEL'S HOSPITAL
BRISTOL HEART INSTITUTE
QUEENS BUILDING
NEW WARD BLOCK
A&E
BHDC
B.R.H.C.
KING EDWARD BUILDING
DOLPHIN HOUSE
BRI OLD BUILDING
MORTUARY
MILNE CENTRE
BRISTOL DENTAL HOSPITAL
BRISTOL EYE HOSPITAL
EDUCATION CENTRE
GYNAE UNIT
BOILER HOUSE / MALT
ESTATES / FACILITIES DEPT
TRUST HQ / FINANCE
PEARL BUILDING STREET
Whitefriars
Greyfriars
Appendix A | Existing Estate

Appendix B | Land Appraisal

Economic

The Marlborough Hill land (**Site B**) is considerably more suitable to meet the Trust's accommodation requirements than the Old Building (**A**) site. **Site B** has the capacity for the anticipated accommodation demands and is divided into distinct levels, due to the natural topography, better suited to phased development.

It is more economically and financially viable to develop to meet the Trust accommodation requirements over a 5 year + timeframe than **site A**, which consists of a smaller land footprint requiring a non-phased development approach to provide future capacity.

This would require the provision of speculative 'shell' space to meet, the yet to be defined future provision, which would be both costly and high risk.

The discreet phasing of land parcels on **Site B** will enable the provision of all the identified estate priorities, namely a new MSCP, THQ, parent accommodation, Estates and Facilities accommodation, in addition to flexibility for the anticipated future provision of a 24 bed ward, space for NICU expansion and to accommodate displaced services on surplus land.

The consolidation of core clinical accommodation on **Site B** is considered to be economically advantageous and has been accepted as a key requirement; this would ensure patient and staff access would not have to cross the busy main road.

Site A has greater potential for optimum alternative uses such as student accommodation, due to its anticipated density and massing levels, supported by the adjacent buildings, the standalone nature of the site and its situation being on the south side of Maudlin Street across from the main hospital site.

Facilities on this site will be decommissioned when existing services are relocated to the new accommodation, which further lends itself to redevelopment subject to planning.

Planning guidance has indicated a preference for car parking on **Site B** and it is planned to absorb the existing Eugene Street access into the layout to optimise the multi storey car parking requirement for **Site A**.

Commercial

Soft Market testing resulted in the preference for **Site A** for development of the most valuable alternative use, maximising returns from the amount of available land.

Site A could achieve higher anticipated density and massing due to the precedent of adjacent building optimising the use of land.

Site B could be phased for development to align to Trust financial resource and deliverability.

Phasing would assist with timing for any future requirements

Financial

The revenue savings arising from decommissioning **Site A** can be made available in line with the assumptions of the LTFP.

Site A has more potential to contribute to the financial performance of the Trust.

The valuation for **Site A** with secured planning for student accommodation would be maximised.

Site B would accommodate a similar value for the same use but would require more land availability due to massing and density restrictions.

Based on the above assessment which is aligned to the Trust's estate strategy objectives **Site B** (Marlborough Hill) should be retained by the Trust to address known estate priorities and facilitate future flexibility to accommodate the unknown requirements.

Decommissioning **Site A** (the Old Building) would be assist in contributing to the Trust's financial performance whilst also rationalising existing estate and reducing backlog maintenance costs.

This use of land in this proposed format would yield the maximum benefit for the Trust.

Appendix C | Estate Strategy - Portfolio

1 | Hospitals

Current facility	Future strategy	Action
Bristol Royal Infirmary	No Change	No Action
Bristol Royal Hospital for Children	No Change	No Action
Bristol Haematology and Oncology Centre	No Change	No Action
Bristol Eye Hospital	No Change	No Action
Bristol Dental Hospital	No Change	No Action
St Michael's Hospital	No Change	No Action
South Bristol Community Hospital	Retain/ Dispose	Subject to Lease/ Service Contract

2 | Treatment Centres: Non Hospital-Patient Facilities

Current facility	Future strategy	Action
Central Health Clinic	Retain/ Dispose	Subject to Service Contract
36 & 38 Southwell Street	No Change	No Action
Parents' Hostel: Ronald McDonald House	Replace Accommodation	Subject to Business Case
Parents' Hostel: Sam's House	Replace Accommodation	Subject to Business Case

3 | Support Facilities: Non Hospital-Non Patient

Within the central hospitals precinct:

Current facility	Future strategy	Action
Southwell House and Boiler House	No Change	No Action
Tyndalls' Park former Children's Centre	Retain/ Dispose	Subject to Business Case
Education Centre (Leased from Above and Beyond)	No Change	No Action
Trust Headquarters	Replace	Subject to Business Case
Multi Storey Car Park & Cycle Store	Retain / Replace	Subject to Business Case
Facilities & Estates Building	Replace	Subject to Business Case
Radiopharmacy	No Change	No Action
King David Hotel Complex	No Change	No Action

Off the precinct:

Current facility	Future strategy	Action
The Grange (leased to University and Archfield Nursery)	Dispose	Subject to Approval
Whitefriars (leased from others)	No Change	No Action
Brislington House Playing Fields	No Change	No Action
Kingsdown former Fire/Health & Safety Office (sold subject to contract)	Dispose	Subject to Contract
2 St Michael's Hill	No Change	No Action
Colston Fort (3 flats leased from AWP)	No Change	No Action

4 | Residential Properties

Current facility	Future strategy	Action
Alfred Hill [27, 29, 33, 35, 37, 41, 42, 43 and 44]	No Change	No Action
St. Michael's Hill [78, 80, 82, 84, 86, 88, 90, 92, 94, 96, 98 and 100] (Leased from Above and Beyond and sub-leased to West End Properties)	No Change	No Action
10 & 10a Marlborough Hill Place	No Change	No Action
Eugene Street Flats	Redevelop for Alternative Use	Subject to Business Case

University Hospitals Bristol NHS
NHS Foundation Trust

CAPITA

Bath office
Pinesgate (West Building) | Lower Bristol Road | Bath | BA2 3DP
01225 476 340

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Meeting of the Trust Board of Directors, to be held on 30 June 2014 at ρπ.30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 17 – Monitor Strategic Plan

Purpose

The purpose of this paper is to present the Five Year Strategic Plan to the Board for approval, prior to submission to the Trust's regulator, Monitor.

Abstract

The Trust is required to submit a 5 year strategic plan to Monitor as part of the strategic planning cycle; the plan is to be submitted to Monitor on the 30th of June. This development of this plan is part of the wider re-fresh of the Trust's strategy and it builds upon the Trust Operational Plan 2014-16 approved by the Board in March 2014.

The plan sets out our analysis of the challenges we, and others in our health economy, face and describes how we plan to respond to these issues. In summary the challenge ahead is simply described as *the challenge of maintaining and improving quality, within fewer resources.*

A key requirement of the Board's approval is the confirmation (or not) that the Trust will be sustainable in one, three and five year time horizons. This plan confirms the broadly sustainable nature of the Trust's services having considered financial, clinical, operational and workforce sustainability. It also notes the key assumptions which underpin this declaration – notably that national efficiency, conveyed through tariff deflation, will not exceed 2% from years 2 to 5 of the plan.

The plan describes a number of risks to this declaration which include the impact of the Better Care Fund, unplanned changes to activity flows and workforce availability in relation to junior doctors and specialist staff most notably.

The plan has widely 'socialised' within the Trust and feedback incorporated. The plan has been developed having regard for the views of Governors through the Annual Plan Focus Group and a successful stakeholder meeting has been held engaging partners from across the health system including patient representatives. Specific commissioner views have been sought but feedback has been limited at this time and further focus on alignment of plans across the system is in hand.

A number of the key strategic initiatives described in this plan are captured in the Trust's strategic objectives represented through the Board Assurance Framework (BAF). However, given most failures in strategy are a failure of execution, rather than planning, development of a strategic implementation plan is in hand, which will be overseen by the Trust's Clinical Strategy Group and reported to the Senior Leadership Team.

Recommendations

The Board is recommended to **approve** the Strategic Plan 2014-2019 for submission to Monitor and in doing so support the **declarations of sustainability** in respect of the one, three and five year period covered by this plan set out in section 1.3 of the plan.

Report Sponsor
The Director of Strategic Development, Deborah Lee.
Report Author
The Director of Strategic Development, Deborah Lee.
Appendices
Appendix 1 – Monitor Strategic Plan (Appendices to the plan have not been provided, due to their size, but are available on request by emailing Amy. Rich@UHBristol.nhs.uk)

University Hospitals Bristol NHS
NHS Foundation Trust

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

STRATEGIC PLAN 2014-19

Version 11 dated 23rd June 2014

Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

Name	**Deborah Lee**
Job Title	**Deputy Chief Executive and Director of Strategic Development**
e-mail address	**deborah.lee@uhbristol.nhs.uk**
Tel. no. for contact	**0117 342 3606**
Date	**30 June 2014**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	

Signature

CONTENTS PAGE

EXECUTIVE SUMMARY

This five year strategic plan, for the period 2014-2019, sets out the Trust's forward challenges and the strategic direction and initiatives it intends to pursue, to ensure a sustainable organisation for the future. The plan builds upon the Operational Plan 2014-2016, published in March of this year, and as such should be read in conjunction with that plan.

The plan has been informed by the strategic analysis undertaken to understand the current and likely future context within which the Trust will be operating and to which any strategy must respond. This work has included both market analysis including an assessment of the threats and opportunities in the external environment alongside consideration of the Trust's current strengths and weaknesses. The response to these findings has been developed through a nine month review and refresh of the Trust's strategies for clinical, teaching and research activities and has involved Board, staff and stakeholders from across the local health economy. The Trust has informed its approach to this work by utilising Monitor's framework for assessing the robustness of strategic planning within foundation trusts.

Positively, the Trust enters the period with financial headroom to support transition towards the challenges ahead, taking forward a recurrent surplus of £14m into 2014/15. The plan describes a broadly sustainable outlook predicated upon a number of key planning assumptions, notably the assumption that the future requirement for nationally efficiency will not exceed 2% per annum for years two to five of the plan and that tariff uplifts in this period reflect the inflationary pressures facing this sector. This includes the pressures arising from changes to pension and national insurance contributions and the costs associated with responding to the quality requirements driven by the recommendations arising from the Francis Report and similar.

The Trust has developed a methodology for assessing the sustainability of the organisation, considering the clinical, operational, workforce and financial sustainability of services and has set out the strategic and tactical responses to the issues identified that represent a risk to sustainable services within the plan; these are described both thematically in areas such as workforce but also specifically in service lines where there are specific risks to sustainable services such as specialist neonatal intensive care services.

Throughout the plan, it is noted that a sustainable future is not only predicated upon realistic funding levels and mitigation of specific service risks but it is wholly dependent upon the system, and the system partners, re-designing care pathways and services that reduce reliance on hospital based care, which in turn is expected to lead to a reduction in overall demand for services and an ability to return patients to primary and community settings as soon as their acute needs have been met. The Better Care Fund is noted to be a critical element of the system architecture if this change is to be planned, co-ordinated and implemented successfully. However, in summary the plan confirms a broadly sustainable future, noting the immediate risks to sustained operational performance in the first year of the plan which the Trust is actively managing, and which Monitor is currently reviewing.

Finally, given most failures in strategy are a failure of execution, rather than planning, development of a strategic implementation plan is in hand, which will be overseen by the Trust's Clinical Strategy Group and reported to the Trust's Senior Leadership Team.

SECTION 1 – SUMMARY AND DECLARATION OF SUSTAINABILITY

1.1 Introduction

The Trust has spent the last 6 months refreshing its strategy in the context of the challenges ahead. This approach has been led by the Board but has been supported by significant "bottom-up" input from clinical teams.

Consultation with stakeholders has been sought with mixed levels of engagement, however those that have formally responded have confirmed broad support for the direction set out i.e. to consolidate and grow our specialist offer, improve the quality of our local, non-specialist services whilst only providing in hospital that which cannot be provided outside – by us or our partners.

We have also run a number of public events to help us develop our Strategic Plans. These have focussed on helping us to understand what it is about our organisation and our services that our patients and public value, what it is that we should preserve and what it is that we should change –including specific consideration of what it is that we mean by 'hospital' and how we might need to think differently about the settings in which we deliver our care, support or advice.

We have also sought the public views via an online survey seeking their comments on a draft version of this document.

As part of the work on our 2020 strategy, we have identified what we have described as the 'future challenge'. This is relevant to both the broader 2020 strategy and the production of the Monitor Strategic Plan and it remains:

*Responding to the challenge of maintaining and developing the quality of our offer, whilst managing with fewer resources***.**

Addressing this demands three key approaches:

- Optimising the productivity and operational efficiency of our systems, processes and staff;
- Transforming the way in which we deliver care through service and workforce redesign;
- Making strategic choices that directly address the challenge.

As part of this third approach around strategic choices, we have attempted to:

- Signal new business opportunities that we might pursue;
- Identify opportunities for the development and expansion of existing services;
- Direct our discussion to the disinvestment and redesign of financially, or clinically unviable services;

- Enable cost avoidance through the strategies we execute.

Our Monitor Strategic Plan sets out the challenges we face as an organisation and as members of a community of people and organisations (the Local Health Economy (LHE)) over the next 5 years.

We have set out our position on some key strategic questions, our specific plans for the next two years, and those areas where we plan to develop – with others – longer term strategic responses to these challenges.

1.2. Declaration of sustainability

The Board declares that, on the basis of the plans and caveats as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years' time.	*Confirmed*

One Year Sustainability

The Trust's Operational Plan 2014-16 describes a sustainable Trust in the context of financial and clinical parameters. The key risks to sustainability set out in this period are those pertaining to operational sustainability (and associated quality impacts) and include risks to the delivery of A&E, cancer and referral to treatment time (RTT) standards and are the focus of our Operational Plan 2014-16.

Three Year Sustainability

The Board has considered its assessment of *sustainability* in the context of four domains – financial, workforce, clinical and operational sustainability. In broad terms, the Board and Senior Leadership Team assess that the Trust and its services are sustainable over the next three years.

However, in making this statement there are a number of key underpinning assumptions - set out below:

- The national efficiency requirement, delivered through tariff deflation, does not exceed 2% per annum for the remainder of the planning period;
- The impact of the Better Care Fund does not exceed that assumed within this plan;
- There are no significant changes to activity flows in the period;
- Workforce availability remains within parameters assumed;
- The current unsustainable position on the achievement of access standards is addressed.

In addition to the above key assumptions, there are a number of known risks that we have

assumed we will eliminate or significantly mitigate as a means of ensuring the sustainability of our services and wider organisation. These are set out in the body of this plan and in summary below.

Operational Sustainability – Key Risks and Issues

The current unsustainable position on delivery of key access standards including A&E, cancer and RTT is a threat to the Trust's forward declaration and must be addressed. There are a number of strategic issues that have the potential to support or undermine this position and these include:

- The future catchment for urgent and emergency care across the wider Bristol area has the potential to be impacted by the acquisition of Weston Area Health NHS Trust - given that Weston is generally considered to have an unsustainable model of urgent care. This risk will need to be managed alongside determining the sustainable catchment area of the new Southmead Hospital, operated by North Bristol NHS Trust (NBT);

- The ongoing delivery of minor injuries services across the area; ownership of these services by UH Bristol has the potential to significantly improve the sustainability of A&E performance standards through a changed case mix reflecting a greater stream of minors as many Trusts experience;

- The Trust's cancer case mix now means the Trust has to perform in the upper quartile of trusts for all cancer pathways which given the clinically complex nature of its services, as a tertiary provider, is a challenge. Any future changes to service case mix will need to be carefully considered for their impact on cancer standards;

- Right sizing critical care capacity to reflect the volume, speciality and case mix of services operated across the Trust is key to sustainable operational and quality performance;

- Successful implementation of the revised Trust Operating Model, as set out in the Trust's Operational Plan 2014-2016 and notably a reduction in the number of patients whose discharge is delayed, to support lower levels of bed occupancy which we know to be directly related to good flow and delivery of access standards.

Workforce Sustainability

The Trust currently has a broadly sustainable position in respect of workforce however there are a number of on-going issues and risks that will need to be addressed to ensure sustainability in the medium term. These include;

- Recruitment to hard to fill specialist roles including the resolution of hard to fill consultant posts notably in the areas of paediatric radiology, cellular pathology, oncology and acute physicians;

- Minimising the adverse impact of national changes to junior doctor numbers from 2016;

- Minimising the local impact of predicted national shortages in qualified nurses over the next three years.

Clinical Sustainability

The size of the Trust means that in broad terms, clinical sustainability is achievable. However there are a number of local issues and risks that will need to be actively managed to ensure this position is maintained and these include;

- Addressing non-compliance with national service specifications where commissioner derogations have not been secured;
- Restoring trust and confidence in paediatric cardiac services and delivering those services in line with the proposed standards for care;
- Ensuring the long term viability of pathology services through resolution of the strategic options work looking at the alternative models for delivery;
- Development of sustainable models for the retrieval of children and neonates from across the region, including agreement and implementation of a sustainable model for level 3 neonatal intensive care services;
- Address the service model and associated workforce implications for dental services including the way in which teaching and care delivery are aligned, working closely with university partners.

Financial Sustainability

Positively, the Trust retains financial headroom to support transition towards the challenges of 2015 and beyond, taking forward an underlying surplus of £14m into 2014/15 and from this platform, the Trust is forecasting a balanced plan for the five year period in its *base scenario* where the national efficiency requirement does not exceed 2%.

In addressing the requirement for on-going cost reductions of this scale, the following are pre-requisites to a balanced financial plan over the next five years:

- The small number of significantly loss making savings are re-designed (or divested) and losses largely eliminated;
- A sustainable service and financial model is developed for South Bristol Community Hospital;
- Tariff uplifts that reflect acute sector inflation.

Five Year Sustainability

Assuming that tariff deflation continues at the 2% net impact assumed, there are no significant additional challenges to sustainability identified at this point, beyond those set out in the three year forward look. However, not surprisingly, statements of assurance for a period five years hence are notably difficult to make, not least given the potential for a

change in Government during this time.

The most significant risks to on-going sustainability of services beyond the three year point are considered to be:

- The extent to which tariff funding reflects the developments in practice and quality standards expected – notably the extent to which they reflect the rising expectations with regard to staffing levels;
- The impact of predicted demographic change, and community service development, on the acuity and complexity of the acute sector case mix;
- The success of the Better Care Fund (or successor approaches) to managing demand for acute sector services to levels affordable by the commissioning sector;
- Tariff uplift which reflects acute sector inflation.

SECTION 2 – OUR PURPOSE, MISSION AND VISION

The Trust has spent the last nine months working closely with the Board and its staff to re-fresh its strategy to address the challenges ahead and ensure the viability and sustainability of its services. This strategy has been developed in the context of commissioners' strategic plans and their expressed commissioning intentions. The following section sets out the refreshed mission and vision for the organisation.

University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of hospitals in the heart of Bristol, a vibrant and culturally diverse city.

We have over 8,000 staff who deliver over 100 different clinical services across nine individual sites. With services from the neonatal intensive care unit to older peoples care, we offer care to the people of Bristol and the South West from the very beginning of life to its later stages. We are one of the country's largest acute NHS Trusts with an annual income of £575m.

Our **Mission** as a Trust is *to improve the health of the people we serve by delivering exceptional care, teaching and research, every day*.

Our **Vision** is *for Bristol, and our hospitals, to be among the best and safest places in the country to receive care.*

We want to be characterised by:

- *High quality individual care, delivered with compassion;*
- *A safe, friendly and modern environment;*
- *Employing the best and helping all our staff fulfil their potential;*
- *Pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation;*
- *Our commitment to partnership and the provision of leadership to the networks we are part of, for the benefit of the region and people we serve.*

The Trust's strategic objectives for this five year period have been developed to ensure the Trust's principal activities are focussed upon the five key elements on the vision. Appendix 1 sets out the Trust's strategic objectives and the milestones for the forthcoming year.

SECTION 3 - THE CONTEXT IN WHICH WE AND OTHERS MUST OPERATE AND THE CHALLENGES WE FACE

3.0. The Context

As described, the work to produce this plan has been part of, and connected to, a broader review of our Trust strategy. The summary below sets out our thinking in terms of the challenges and choices we face not just as an organisation, but as a health system.

This section includes:

- The general challenges that we and others face in our Local Health Economy;
- A summary of our market analysis (full detail available on request);
- A summary of how we have analysed the sustainability of our services.

3.1. The General Challenges we and others face

As an organisation. We have described our forward challenge as *responding to the challenge of maintaining and developing the quality of our services, whilst managing with fewer available resources.* The simplicity and clarity of message within this statement is critical to our approach to engagement of staff around a common and shared purpose.

We have recognised the need to make strategic choices that directly address this challenge.

These choices include:

- To what extent should what we do contribute to the wellness of the populations we serve as well as helping those who suffer illness? What is our contribution to making the city healthier?
- Do we still want to focus - and deepen in some key areas - our specialist services? If so, how do we decide which ones?
- What should our approach to working with other providers be to ensure resilience and diversity within our services. Leadership – both within our own organisation and across the local health economy. What is our role in the Local and Regional Health Economy? What is our role in the Local and Regional Economy?
- Do we have the right model of partnership with our patients and the wider public?

Our response to these challenges and choices has been to develop a strategic framework that sets out our position as a Trust with regard to the key choices we face. This framework is included in Section 4.2 of this plan and is already being used to assess strategic choices we are considering now.

3.1.2 As part of a wider health system. We have also considered challenges faced by our Local Health Economy (LHE). We believe these to be:

- Changing the way in which the whole health and care system works, not just the individual organisations that comprise it. We are clear that we will need to think in new ways about the way in which resources are allocated across the health and care system, to align incentives that drive the right services and outcomes for patients and use this discussion as a way to drive changes to the structure of the system both in terms of how we collectively plan and how we organise the provision of care delivered by multiple providers;

- More specifically, we need to work together even more effectively to reduce the requirement for hospital services, by eliminating unnecessary admissions to hospital and also working better together to ensure that people do not stay longer in hospital than is necessary – and in particular that they can leave hospital when they no longer require hospital based care;

- We accept and embrace the need for change, but need to find ways to be bolder in the changes we seek and notably in our effectiveness to execute our whole system strategies and plans. Our current approach is incremental and based on marginal improvements to the current operating model at system level. This is likely to require us and our partners to be less risk averse in the way we work together and the changes we seek;

- Finally, we must avoid becoming fixed by physical location. What we refer to now as a hospital is one component of a broader network – physical and virtual –that makes up the health and care system. We need to find ways to build capability across all the different aspects of this system, including physical locations but also the networks of information and influence which also help us promote health or treat illness. Technology will have a huge part to play in supporting new ways of working, connecting providers involved in single pathways and supporting the vision of a single electronic patient record, accessible by all health and social care providers.

3.1.3 Some specific challenges in the next two years (a summary of analysis in our Operational Plan)

As well as the (medium term) issues above, we must also deal with a number of specific and pressing challenges in the short term (over the next two years). The way in which we deal with these is the subject of our Operational Plan 2014-2016, published in March of this year. Short term challenges include:

- Retaining our focus on quality as the underpinning requirement for the delivery of all our services and the key component of our reputation – and ensuring that we are compliant with the newly developed range of specifications for the provision of specialised services;

- Rising to the considerable operational challenges in the next two years across the acute sector of Bristol, we are opening two major new facilities, which together have the potential to improve significantly the services available to our local and regional populations - but we face a collective challenge in terms of ensuring that the transition to new operational models across the city is achieved smoothly;

- Accordingly, it is crucial that we find ways to take greater control of the urgent care pathway (Emergency Care) – including developing appropriate and sufficient capacity in social and community provision across our Local Health Economy;

- With regard to the Better Care Fund, there is the challenge of releasing approximately £30m of savings from within the acute sector across Bristol, North Somerset and South Gloucestershire, which are currently assumed. And second, there is the related challenge of avoiding double costing in the short term – a potential situation where costs continue to be incurred within the acute sector at the same time as the new costs of a service designed to either replace acute provision or reduce the requirement for acute services is also being borne.

In summary, the challenges of the next five financial years demand that we work more effectively across the Local Health Economy to address operational and financial challenges. We are already well focused on working with commissioners at both local and regional level as their understanding of their own objectives is developing – but we are also working to broaden the scope of our collaboration in the next two years in particular, including with local authorities and others via the Better Care Fund initiative.

3.2 Market Analysis

As well as the general analysis shown above, we have also conducted market analysis as part of the work to produce this strategic plan. The key points are summarised below.

3.2.1 Population - key messages:

- University Hospitals Bristol provides regional and tertiary services to a population of circa £5.3m across the geographically and economically diverse South West region of England;
- Whilst the region has some of the best life expectancy in England, there is also a mixed picture of health in Bristol and the wider region, where the health of the population in deprived areas is poor;
- Bristol has one of the fastest growing populations of the English Core Cities, including a higher than average rate of growth in the child population;
- Neighbouring areas are seeing a high growth in elderly population. Bristol will see a 9% growth in the elderly population to 2020, but this is lower than the national projection of 23% whilst North Somerset is predicting growth in excess of 20% relating to expected housing expansion;
- Life expectancy is increasing, and it is projected that there will be a relatively large increase in people aged over 90 years in Bristol; health and social care requirements, especially in relation to people living with dementia and long term conditions, will therefore increase;
- Death rates in Bristol show that cancer, stroke and heart disease remain the highest causes of early deaths; early death rates from cancer remain significantly higher in Bristol than the national average. Smoking, alcohol and drug abuse account for a larg***e***r proportion of deaths/long hospital stays in Bristol than the national average.

Summary of Implications – The demand pressure for local services provided by the Trust will continue to grow, if external factors do not change. Despite a lower than average growth in older population, demand for services across Bristol will still grow. Further pressure will be felt by the faster than average growth in the younger population, which will put pressure on the growing portfolio of children's services. It is also concluded that demand for the Trust's specialised services such as Cancer and Cardiology services will grow relating to the ageing population.

3.2.2 Commissioning – key messages

- Affordability for acute sector activity and required developments continues to challenge commissioners. Regionally, NHS England is significantly over-committed on its expenditure for specialist services and locally, two of our three commissioning groups are in deficit and one significantly funded below its target resource level;
- In 2013/14 the highest proportion (47%) of income was derived from activity commissioned by BNSSG Clinical Commissioning Groups, with 40% being commissioned by NHS England Specialised Services commissioning;
- Commissioners continue to introduce efficiency measures, including net reduction in PbR and non-PbR tariff, whilst maintaining a focus on improved quality arising from reviews such as Francis and Winterbourne View;
- There will be fewer, bigger CQUINs at a local level. At a national level, in 2014/15 the pot of money available from CQUINs attributable to NHS England has reduced as PbR Excluded Drugs and Devices are not included in the contract value to which CQUIN applies;
- There will be a focus from commissioners on 7-day working and improving the city wide urgent care system, including Ambulatory Care, GP support unit and full utilisation of South Bristol Community Hospital;
- NHS England will focus on compliance with national service specifications, and whilst some investment has followed, non-compliance in many areas rests with the Trust to address;
- Contractual standards, with penalties for non-achievement will be an increasing feature of the commissioning landscape.

In Summary, commissioners are facing increasing financial challenges, and their expectation is that trusts will need to share the burden of efficiency whilst aiming to drive up quality. This presents a significant challenge to the Trust in terms of viability of services and sustainability in terms of workforce and clinical quality. There will be both financial and non-financial impact from any ongoing non-compliance with national service specifications, which needs to be accounted for when considering the sustainability of certain specialties.

3.2.3 Activity trends – key messages

- The highest increase in admissions, in the last five years, has been from North Somerset, arising from an increase in population, most notably Portishead area.

- Admissions for patients aged over 75 have increased significantly in the last year from North Somerset and South Gloucestershire, showing the growth in elderly population playing out in the demand for our services. This is matched by the increase in Emergency Department attendances from those areas;
- Outpatient attendances see a similar trend, with a reduction in the proportion of attendances from Bristol CCGs and an increase from North Somerset and South Gloucestershire CCGs.

Summary - Evaluating the risks to sustainability of services needs to take account of the shift in activity trends but also the local priorities for North Somerset and South Gloucestershire. A shift in focus from those areas towards other services and/or service providers will impact on market share and potentially sustainability.

3.2.4 Market share – key messages

- There have been significant changes in market share but overall the Trust maintains a strong position locally and regionally. The greatest changes are attributable to recent service transfers including Head and Neck, Breast and Urology services;
- Gains in BNSSG commissioned work include Gastroenterology, Cardiology and Obstetrics;
- Losses in BNSSG commissioned work include Midwifery episodes, General Medicine, Upper GI surgery, A&E, Clinical Haematology and Ophthalmology. Gains across the South West include A&E, Obstetrics, Paediatrics (excluding transfer), and Thoracic surgery.
- Losses across the South West include Midwifery episodes, Clinical Haematology and Cardiology (although on the last two points the Trust remains in a strong market position);
- Across the South West, UH Bristol remains the main provider of Cardiac surgery (58.7%), Paediatric Surgery (98.4%) and Thoracic Surgery. Plymouth Hospitals NHS Trust is also a major provider in Cardiac and Thoracic Surgery and remain the main competitor for specialist service provision in the Peninsula.

Summary -. UH Bristol remains strong on a number of fronts and should build on this strength in the face of competition from other providers. Ophthalmology presents a key risk, in light of local competition from both Bath and the independent sector but the Bristol Eye Hospital brand remains strong.

3.3 Assessing the Sustainability of our services

3.3.1 Our Understanding of Sustainability

To support this assessment of the current resilience and future sustainability of the Trust and our services, we have developed a framework to analyse the current and future position. This framework is included at Appendix 3 for reference. The framework is based on three

components of sustainability, listed and described in brief below.

Component 1 - Market and Demand Sustainability

This component of sustainability of services relates to the rationale for continued provision of the service – the current demand, how the need for care is going to change and develop, the existence and intentions of competitors, and the views and plans of commissioners.

Component 2 – Clinical and Quality Sustainability

This component of sustainability of services relates to the key clinical and quality elements of a service. The key elements of analysis in this section will include compliance with standards and service specifications, our ability and preparedness to response to recommendations arising from national reports such as Francis, alongside current performance against key measures of quality.

Component 3 – Operational Sustainability

This component of sustainability relates to those things required for the day to day delivery of services to performance standards and clinical requirements and includes finance, workforce and estate issues.

Component 3a –Financial Sustainability

This is a sub-set of component three and utilises insights from both service line reporting (an assessment of profitability) alongside reference cost indices (an assessment of cost efficiency) to assess the current viability and on-going sustainability of individual services.

3.3.2 Identifying our Key Service Lines

Having developed an approach to sustainability, we have categorised our Key Service Lines at Trust Level. These key service areas are:

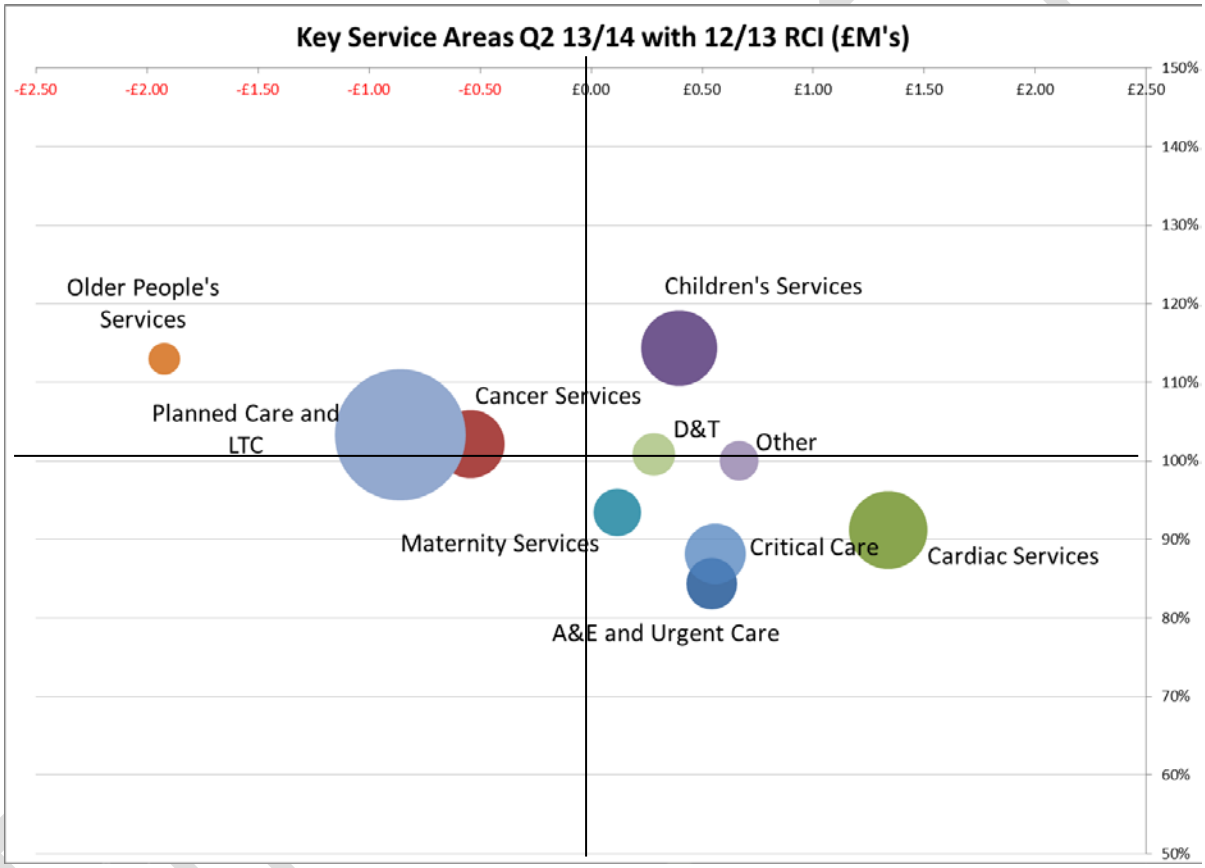
- Children's Services;
- Accident and Emergency (and Urgent Care);
- Older Peoples Care;
- Cancer Services;
- Cardiac Services;
- Maternity Services;
- Planned Care and Long Term Conditions;
- Diagnostics and Therapies (Radiology and Cellular Pathology in particular);
- Critical Care.

The starting point for our analysis has been to construct a top level summary of the risks to the sustainability of these key service areas using the sustainability framework developed and included here at Appendix 3. A summary of this analysis is at Appendix 4.

3.3.3 Working through our Sustainability Framework - Financial risk as a starting point

Using the framework we have developed, the work commenced with a more detailed analysis of risk with financial risk because this is one of the most obvious ways in which the potential unviability of a service can be understood. The overall financial position with regard to each of the key service areas described above is shown below.

The x axis shows deficit or surplus in £millions. The y axis shows Reference Cost Index (RCI). The size of the bubble is determined by income, used as a proxy for the financial importance of a service. Please note this chart is based on Quarter 2 2013/14 income and SLR information and 2012/13 RCI.



In order to generate this chart we have mapped the SLR reporting onto these service areas using a structure shown at Appendix 5. This presentation shows how each of our specific service lines maps onto the nine key service areas that we have identified.

The approach uses RCI alone as the best indicator of medium term financial sustainability of a service due to the impact of tariff changes over time, on SLR. Appendix 5 shows the RCI of each service line with services listed in descending order of RCI. Please note that this table is based on 2012/13 RCI data.

Further categorisation and our analysis of service lines on the basis of RCI has occurred and is described below:

- Less than 95 – These are services that we provide more efficiently than our peers

and might consider expanding as part of our Strategic Plan;

- 95 to 105 – These are services we provide at similar levels of efficiency to others;
- 105 and above – These are services which may be unsustainable from a financial perspective in their current configuration - and we must develop a strategic response to this challenge, and describe it in our strategic plan.

The group of services with RCIs of 105 and above (as at the end of FY 2012/13) have been highlighted in red at Appendix 5.

3.3.4 Initial Analysis of Clinical Risk –Service Specifications and Derogation.

We also conducted some general analysis of clinical risk with regard to specialised services compliance. This is summarised below.

Background

As at April 2014, NHS England listed 85 specialised or highly specialised services being commissioned by University Hospitals Bristol NHS Foundation Trust[1]. At this time, UH Bristol had declared that it was not fully compliant with the key requirements in 17 specifications (this equates to 20% of the specialised services which UH Bristol provides, which is in line with the national picture of compliance, confirmed by NHS England in February 2014).

Reasons for non-compliance include not meeting specific workforce requirements, not having appropriate facilities (particularly for children), process and systems not in line with specifications etc. In some cases, internal and external investment proposals were required to move towards full compliance with the key requirements. Service transfers and redevelopment of the Trust's estate, notably the Children's Hospital and Oncology Centre, will resolve some of the areas of non-compliance, particularly for Teenage and Young Adults (TYA) cancer services and paediatric neurosurgical services. Confirmation has also subsequently been given by NHS England that paediatric haematology rotas meet, subsequently revised, key workforce requirements.

There is ongoing derogation in respect of adult respiratory specifications which are currently under review nationally. An assessment of compliance with the revised specifications will be undertaken when published.

Of the 13 remaining service specifications where compliance has been derogated (accounting for 19 key requirements), three have been accepted by commissioners fully as derogations for which they are responsible (this includes vascular services which is pending its transfer to North Bristol NHS Trust). A further two services, paediatric and neonatal retrieval have received additional investment from commissioners which will address compliance in part, though there is recognition that further investment is needed to ensure full compliance, and commissioners have accepted responsibility for the derogations for these services also. There are therefore five commissioner derogations in total and the Trust is actively working on remedial plans to address all other areas of non-compliance.

[1] Position prior to transfer of specialist paediatric services from North Bristol NHS Trust

Risk

If the Trust does not achieve compliance there is a risk of remedial action through contract mechanisms and potentially financial penalties in the short term. In the longer term, depending on the scale of non-compliance and where the Trust is clearly an outlier, there is a risk that commissioners may choose to decommission services.

Mitigation

The services which remain non-compliant need to achieve compliance through additional internal or external funding (service development or activity funded – some of which has already been agreed for 2014/15), service reconfiguration or completion of existing action plans.

Chemotherapy ePrescribing for children remains an outstanding issue. Whilst this is being taken up nationally through the relevant specialised commissioning routes, this remains provider derogation and work is in hand to develop an action plan to take us towards compliance.

3.3.5 Identification of Specific Service Lines carrying major sustainability risk.

Having considered the sustainability risk to broad service areas, we then identified specific service lines which in our judgement are carrying sustainability risks across a number of different components of our sustainability framework. These specific services are set out at Appendix 4.

SECTION 4 – RESPONDING TO THE CHALLENGES WE HAVE IDENTIFIED

Having considered the context within which we operate, the challenges that we and others face, we conducted market analysis and considered the future sustainability of our services, and have chosen to respond in two broad ways.

The first has been to consider the choices we face and to set out our position in a way that creates clarity for people both within our own organisation and also people and organisations with whom we work across the Local Health Economy.

These statements, which together comprise our **strategic framework**, are set out in the first part of this section – along with a declaration of our **strategic intent**.

The second set of responses describe **what we plan to do** – and is the subject of the second part of this section (4.3 onwards). Here, we describe our plans in terms of:

- Our general approach to the key components of our mission and vision;
- A summary of our priorities in the short term and key elements of our operational plan for the next two years, and;
- The strategic initiatives that will address the challenges we, and others, face over the next five years (to 2020).

4.1 Our Strategic Intent

Our Strategic Intent

Our strategic intent is to provide excellent local, regional and tertiary services, and maximising the mutual benefit to our patients that comes from providing this range of services.

Our focus for development remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare.

As a University teaching hospital, delivering the benefits that flow from combining teaching, research and care delivery will remain our key advantage. In order to retain this advantage, it is essential that we recruit, develop and retain exceptionally talented and engaged people.

We will do whatever it takes, within the resources available to us, to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or out sourcing services that others are better placed to provide and delivering new services where patients will be better served.

The Trust's role in community service provision will be focused upon supporting our partners to meet the needs of our patients in a timely way; however, where our patients' needs are not being met, the Trust will provide or directly commission such services.

Our patients – past, present and future - their families, and their representatives, will be

central to the way we design, deliver and evaluate our services. The success of our vision to provide "high quality individual care, delivered with compassion" will be judged by them.

4.2 Our Strategic Framework – Our Position on the key choices we face

The purpose of this framework is to provide clarity on our position to those with whom we work, and to provide our own staff with guidance to shape the individual choices that they face in developing their own plans. It reflects the broad strategic intent of the Trust Board, and is set out in summary in the statements below.

To what extent should what we do contribute to the wellness of the populations we serve as well as helping those who suffer illness? What is our contribution to making the city and region healthier?

Our Position: In the course of delivering our "core" business, there are many opportunities to influence the health of the patients we treat, and importantly their families; any future service strategy should embrace these opportunities in more systematic ways. In particular, we want to work with others on those areas where we have a direct impact on people's requirements for the services we provide.

Do we still want to focus - and deepen in some key areas - our tertiary (specialist) services? If so, how do we decide which ones?

Our Position: Delivery of specialist services is a key part of the Trust's strategic intent. We are uniquely placed to be the provider of choice in the South West region for many specialist services. Our decision to expand our existing services or develop new should be based upon our ability to deliver services to the right standard and within the resources commissioners are willing to pay. UH Bristol should not proceed to diversify into specialist service areas already provided in the City other than in the case of an agreed service reconfiguration.

Out of hospital care – should we influence, commission or provide?

Our Position: We have no plans for the wholesale diversification into general community services provision. However, where existing community providers cannot meet the Trust's needs (and the needs of our patients for timely discharge) for community services that support our in-hospital services, there is a strong case for the Trust delivering or directly sub-contracting these services and we will do so if necessary.

Are there geographical limitations to our "DGH" offer – how would we describe the catchment area for this element of our service?

Our Position: The strategic rationale for expansion of our DGH catchment beyond BNSSG[2] is weak and as such we plan that this will remain our defined catchment. Any proposal to expand DGH services within this catchment will only be considered because of a well evidenced, positive contribution to the Trust and/or Divisions strategy or operational plan and

[2] Bristol, North Somerset and South Gloucestershire.

where safety, quality, operational and financial impact, are all acceptable.

Should we drive the development of our services under the UH Bristol@ model outside of our current catchment?

Our Position: Given the operational complexity associated with remote delivery of services, the UH Bristol@ model will be considered where the following key "qualifying conditions" have been met – the development is strategically aligned, it delivers a significant financial contribution to the service and safety, quality and operational impacts are all manageable.

What should our approach be to 'outsourcing' what we have always regarded as core business? In principle, is the Trust supportive of outsourcing (core) clinical services?

Our Position: In principle where there is a financial and operational benefit to outsourcing a clinical service it should be considered – however the "burden of proof" that this will not impact detrimentally on the service being outsourced or those retained in-house, which rely upon an outsourced service, will be necessarily rigorous.

Does the Trust support divesting in services it currently provides?

Our Position: Central to our decisions about service configuration should be the interests of patients. Services should not be divested simply because they operate at a loss. If the service in question is strategically aligned to the Trust's portfolio or is interdependent to other services then the priority should be to re-design the service to eliminate or reduce losses. However, where patients would be better served by a service being run by another organisation, divestment will be actively considered.

What is the Trust's approach to partnership working? Compete or collaborate?

Our Position: Despite the national policy context, there is limited local evidence that competition in the local health system has driven up quality or lowered cost. Where our aims and objectives can be achieved through working collaboratively with other organisations – NHS, independent, third sector - then this should be our default way of working.

The Trust recognises the value of working in partnership but also recognises the complexity and loss of agility and pace often associated with partnership working. Not all the work we do will be in partnership, but we will always seek this approach where there is evidence that patients will be better served – and the Trust's objectives will be better met (or only met) - by working in partnership.

Do we have the right model of partnership with our patients and the wider public?

Our Position: The "modus operandi" for working with our patients, with members and with the wider public is ill-defined and does not currently constitute a major Trust activity. However, recent events have served to highlight the importance of putting patients, their representatives and families at the heart of our approach to planning, delivering and evaluating services.

4.3 Our general approach - how we will deliver our mission and achieve our vision?

4.3.1 Our approach to delivering exceptional care

Our quality objectives for the next two years will focus upon:

- Working with people, to ensure that through their insights, we are well placed to provide a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm;
- Achieving clinical outcomes for our patients that are consistently in the upper quartile of comparable Trust performance.

We are committed to addressing the aspects of care that matter most to our patients which they describe as:

- Keeping them safe;
- Minimising how long they wait for hospital appointments;
- Being treated as individuals by all who care for them;
- Being fully involved in decisions about their care;
- Being cared for in a clean and calm environment;
- Receiving appetising and nutritional food;
- Achieving the very best clinical outcomes possible for them.

Like all NHS organisations the events and subsequent learning from Mid-Staffordshire, the Berwick Report and Keogh Reviews have shaped our approach to quality and more specifically how we listen and engage with our staff and our patients. We have published our response to the Francis and other reports, and in the process of working on this we identified a number of further issues that we also plan to address, including: perceived variation in attitudes to openness and sharing across the Trust, listening and learning more effectively throughout the Trust following incidents and near misses and making the process of change easier, and more rapid, across the Trust.

4.3.2 Our approach to delivering exceptional research

Our vision for research is to improve patient health through our excellence in world-class translational and applied health services research and embedding a culture of innovation.

Our approach has been shaped by recent national changes in funding that have encouraged and facilitated academics and NHS researchers to work closely together in larger and integrated multi-disciplinary teams. This integration and the focus on translational and

applied health services research has attracted additional infrastructural and programme grant funding and has also highlighted the need to promote the clinical research skill base in professions other than medicine.

The response by the Bristol healthcare research community over the last four years to the above changes in the national applied health services and biomedical research agenda has been transformational. We have worked with partner universities and NHS trusts in the region to form Bristol Health Partners (BHP), which was formally launched in May 2012. The aims of BHP are to generate significant health gain and improvements in service delivery by integrating, promoting and developing Bristol's strengths in health services, research, innovation and education. The way BHP is delivering these aims is to form Health Integration Teams (HITs). HITs include commissioners, public health and NHS specialists working with world-class applied health scientists and members of the public to develop NHS-relevant research programmes and drive service developments to improve health, well-being and healthcare delivery.

The strengths of BHP and its HITs have directly led onto to the recent award of an NIHR Collaboration for Leadership in Applied Health Research and Care for the West of England (CLAHRCwest) that is focused on research that is targeted at chronic diseases and public health interventions.

The research and implementation themes of BHP and CLAHRCwest dovetail with the stated aims and objectives of the West of England AHSN (WEAHSN) of the need for robust research to inform and accelerate the adoption and diffusion of evidence of best care. All three organisations are committed to active dialogue and reciprocal communication, seeing research and implementation as symbiotic. The above research and implementations workstreams will be facilitated and further strengthened by the new NIHR west of England clinical research network (CRN) hosted by UH Bristol.

Our Research and Innovation strategic objectives are to:

- Focus on and foster our priority areas of high quality translational and applied health services research and innovation where we are, or have the potential to be, world-leading;
- Train, mentor and support research-active staff to deliver high quality translational and applied health services research of direct patient benefit in our priority areas of research;
- Develop a culture in which research and innovation are embedded in routine clinical services leading to improvements in patient care;
- Work with our regional partners to strategically and operationally align our research and clinical strengths and support the delivery aims of our Health Integration Teams.

4.3.3 Our approach to delivering exceptional teaching

Our vision is to develop a culture of lifelong learning across all staff groups; ensuring

teaching is aligned with the values, synonymous with quality, cost, performance and the delivery of high quality individual care delivered with compassion. We wish to position ourselves as the premier provider of multi-professional student and staff education, teaching and learning to deliver the best clinical care. We work closely with our academic partners, University of Bristol, University of the West of England and other Higher Education institutions to achieve this.

With the changing nature of healthcare, competition in the market place and financial pressures, we have seen significant changes in placement capacity across the region in recent years. To address some of these fluctuations, UH Bristol has implemented changes within the undergraduate medical education provision with the development of clinical teaching fellows to improve the student experience.

UH Bristol is responding to the Health Education England funding review by working closely with our academic partners and local stakeholders to identify the best and most effective model for education provision for the future NHS workforce.

Our primary aim is to focus on creating and supporting the capabilities needed to provide high quality individual care, delivered with compassion.

The Trust acknowledges that with the increased technology, equipment and therapies, together with the development of new clinical specialities there is an increased knowledge and expertise required by health professionals within the Trust. Our main priority is to build the capability of all our staff, ensuring we design and commission appropriate teaching and education to enable staff to fulfil their potential.

We are modernising and investing in the education and teaching structure to ensure the entire workforce is equipped with the requisite skills and knowledge required to:

- Work as a team across professional and organisational boundaries, enhance the delivery of high quality, cost effective care to patients and their families under the care of UH Bristol;
- Maximise the contribution of all health staff to care for patients and their families, breaking down the historical barriers associated with role definition, ensuring that the individual practitioner best suited to deliver care is able to do at the time it is required;
- Support new ways of working and expanding the training and development of all practitioners.

Our Teaching and Learning strategic objectives are:

- To expand and develop our multi-professional education and training strategy to ensure we integrate teaching fully with research and clinical care;
- Develop a culture in which education and training are embedded in clinical practice to ensure optimal quality patient care;
- Through teaching, generating a workforce that is able to deliver services to the

broader health community outside of the Trust;

- Work with our local and regional hospitals, higher education and other educational institutions to provide and deliver robust, evidence-based training and education for all health care professionals;
- To develop innovative and creative strategies to generating new income to re-invest into UH Bristol NHS Foundation Trust Teaching and Learning services.

4.4 Our Priorities in the short term

The Trust Board maintains oversight of the Trust's core business activities and strategic objectives through the Board Assurance Framework (BAF) which also sets out detailed responsibilities for delivery and accountability at Executive level. The BAF is included at Appendix 1. Our Board level objectives in the medium term form the first part of our five year strategy and are listed below. They are structured according to the elements of our Trust Vision, and are as follows:

We will consistently deliver high quality individual care, delivered with compassion.

- To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model;
- To ensure patients receive evidence based care by achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners;
- Deliver a programme designed to enhance compassion in clinical staff;
- To establish an effective and sustainable complaints function to ensure patients receive timely and comprehensive responses to the concerns they raise and that learning from complaints inform service planning and day to day practice;
- To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well;
- To achieve upper quartile performance in process and outcome measures for the Friends and Family Test (FFT);
- To ensure the Trust's reputation reflects the quality of the services it provides;
- To achieve upper quartile performance standards for all nationally benchmarked patient safety measures.

We will ensure a safe, friendly and modern environment for our patients and our staff

- To successfully deliver phase 3 and 4 of the BRI Redevelopment;

- Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audits have been implemented;
- Set out the future direction for the Trust's Estate;
- Deliver against the National Quality Board 10 safe staffing expectations for Trust Boards.

We will strive to employ the best and help all our staff fulfil their individual potential.

- We will ensure that the workforce feel highly engaged and empowered by implementing a range of agreed actions to develop staff in their place of work and demonstrate a year on year improvement in the annual staff survey engagement score;
- We will take appropriate action to reduce the incidences of work related stress by introducing a number of measures that support all staff to undertake their role safely;
- We will equip our leaders with the requisite skills, behaviours and tools to develop high performing teams, so staff have objectives with a clear line of sight to the Trust's vision;
- We will revise the Teaching and Learning strategy to ensure the strategic priorities support an attractive and viable learning environment whilst continuing to provide exceptional care to our patients.

We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.

- Implement modern clinical information systems in the Trust;
- We will maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR and maintain our performance in initiating research) and remaining the top recruiting Trust within the West of England Clinical Research Network and within the top 10% of trusts nationally (published annually by NIHR);
- We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR);
- We will demonstrate the value of research to decision makers within and outside the Trust.

We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.

- Ensure organisation support for developments under the Better Care Fund;

- We will effectively host the Operational Delivery Networks that we are responsible for;
- We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care;
- We will be an effective host to the networks we are responsible for including the CLARHC and Clinical Research Network.

We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal

- Deliver minimum normalised surplus;
- Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas;
- Deliver minimum cash balance;
- Deliver the annual savings programme in line with the Long Term Financial Plan (LTFP) requirements;
- Refresh the Trust's Strategy including its direction for research & innovation and teaching & learning;
- Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decisions as they arise;
- Continue to develop the private patient offer for the Trust.

We will ensure we are soundly governed and are compliant with the requirements of our regulators

- Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above;
- Establish an effective Trust Secretariat to ensure all principles of good governance are embedded in policy and practice;
- Robustly prepare for the planned Care Quality Commission inspection;
- Prepare for and achieve a successful outcome from the proposed Monitor investigation into performance concerns with the aim of reverting to a GREEN rating by Quarter 2 2014/15;
- Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways;
- Improve cancer performance to ensure delivery of all key cancer targets.

4.5 Key Elements of our Operational Plan

As well as the Trust objectives listed in Section 4.4, we also maintain a specific focus on the key delivery elements of our Operating Plan and associated Operating Model that are necessary to address the short term challenges we face, through oversight in both the transformation work stream and the Senior Leadership Team.

Our Operational Plan has already been submitted (and published) and for ease of reference the key elements are included at Appendix 6. Again, these activities form a significant part of the first 18-24 months of our Strategic Plan.

SECTION 5 – OUR STRATEGIC PLANS

Our strategic plan focus on the medium term and are organised around five key strategic initiatives, which are outlined below. These initiatives will provide the shape of planning activity for the Trust in the next few years as we firm up plans beyond the next two financial years. They represent the key areas of work for the Trust in strategic terms and describe where it is that we want to drive change and how.

5.1 Strategic Initiative 1 - Driving Engagement and Collaboration across the Local Health Economy

The Aim of this initiative is to:

Deal with the challenges that we and others have identified at system – and not organisational - level.

Our Strategic Plans in this area are:

- **Collaborating more ambitiously in operational terms in order to plan and operate the acute (hospital based) system – and Urgent Care in particular – in a collaborative way.** Specifically, we need to work together to ensure that new facilities in the region (Southmead and the redeveloped BRI) are utilised in a way that is focused on creating system, and not organisational, benefit and that the development of services in community and primary care is focused upon reducing the current reliance on hospital based care;

- We will set up a cross system **forum for the promotion of cross system strategic planning** and the deliberation and sharing of organisational plans. This forum will meet for the first time on the 13th of July;

- We plan to use this forum to explore a series **of 'Bristol scenarios'** that we will develop jointly with commissioners and local authorities and which will be the basis for joint strategic planning and the 'stress-testing' of organisational plans;

- **To focus on the greatest opportunities for improving the quality of local care** in the context of declining resources by the pursuit of more integrated services between acute, community and social care sectors;

- **To consider specific findings of the Acute Services Review** (summarised at Appendix 7). We remain committed to working with our acute hospital partner, North Bristol NHS Trust, and local commissioners, towards the consideration of which of the findings in the review merit implementation and how we should prioritise those we decide to take forward;

- **Continue to work together more effectively to reduce the requirement for hospital services**, by eliminating unnecessary admissions to hospital and also working better together to ensure that people do not stay longer in hospital than is necessary – and in particular that they can leave hospital when they no longer require hospital based care. Our focus for this work is the Better Care Fund. A

summary of the current plans in the Bristol Better Care Fund is given below.

We assess that the impact of these plans will be:

- **Greater coherence and consistency in the strategic planning** being done by major partners across the health economy (in particular other Trusts and CCGs) and a filling of the perceived vacuum in system wide planning which has materialised since revisions to the commissioning landscape two years ago;
- **A system wide response to the current challenges being felt across the local urgent care system** and a new integration of the provision of services, to older people and children in particular;
- We have **yet to confirm the potential benefits of the Better Care Fund** in terms of reducing hospital admissions but whatever benefit is accrued will also be balanced by a reduction in income. Our general mitigation of that impact however will be to increase income from our specialist provision – consistent with our stated strategic intent and recent trends. As a specific issue, there is also no current provision for potential 'double running' of costs as the out of hospital capability that will drive down hospital admissions is developed. This risk is considered to primarily be a risk for funders of care.

In Bristol, the Better Care Fund provides £3.8bn in 2015/16 for local health and social care within a newly created pooled budget to drive integration at scale and pace, providing a significant catalyst for change. The Better Care Fund Programme assumes a disinvestment of £15m from the acute sector across Bristol local authority area for future investment in community services and support. The fund has been developed to;

- Drive integration, partnership working and service transformation;
- Improve quality of care and outcomes for patients, service users and carers, by ensuring the right care, in the right place, at the right time;
- Give people greater control, place them at the centre of their own care and support, and provide them with a better service and quality of life;
- Help us manage pressures and improve long term sustainability;
- Enable a significant shift of care closer to home.

An increasing demand for quality services requires UH Bristol and other local partner organisations to work differently with a focus on providing (in particular):

- Single point of contact to access services from all agencies;
- Increased use of key workers who can operate across all agencies;
- Seamless transition from one service to another for users.

As a system, the vision is that by 2018, there will be better outcomes for users, which may include; personal health budgets, online appointments for patients, greater use of assistive technology and tele-health, and integrated care packages with lead accountable person.

This will be achieved through shared working to integrate information, staff, funding and

risk. Areas that have been identified include joint forecasting and modelling, shared data (CCG, Acute Trusts, and Council), 7 day working, joint rehabilitation and reablement teams, generic job roles, and joint discharge co-ordination centres in UH Bristol and NBT.

This work should help us as a Local Health Economy to:

- Shift Settings of Care closer to home;
- Reduce length of stay in hospital;
- Help users manage their care more effectively and;
- Provide more effective use of staffing and resources at a neighbourhood level.

The first draft of the action plan was submitted on 14th February 2014 and was supported by all partner organisations. The first phase of this work will focus on the integration of services for people with long term conditions and older people but the aspiration is that this will broaden over time to include other areas in adult, children and family services.

There is recognition that as services are transformed and move from one model to another, there is likely to be an increase in existing costs initially to support double running of services as it will not be possible to stop one model and implement a new one instantaneously. We are assuming that any implications for acute trusts resulting from the Better Care Fund Programme will be incorporated into future contract discussions**.**

5.2 Strategic Initiative 2 - Identifying and dealing with issues of sustainability

The Aim of this initiative is to:

Address the risks we have identified to the sustainability of our key service areas and to specific service lines. We also aim to use this opportunity to consider changes to our workforce model in the medium term.

Our Strategic Plans in this area are to:

- **Continue to focus on 'right-sizing' capacity of service lines** to match demand more closely and address Reference Cost Index (RCI) where it is high (see Section 3.3.3);

- **Re-examine the service mix which we deliver at South Bristol Community Hospital**, specifically recognising the longer term unsustainability of the current financial model for that group of our services. This work will be conducted over the autumn of 2014;

- **Address identified risk to the sustainability of key service areas or specific service lines**. Specifically we plan to redesign those services where sustainability risks are identified and notably to develop plans to address those services that out lie in respect of their financial sustainability highlighted by either their high cost base, as highlighted by their Reference Cost Index or their profitability, as indicated by their financial contribution demonstrated by Service Line Reporting analysis. A narrative

description of our strategic plans by key service area – and where appropriate by specific service line - is below;

We assess that the impact of these plans will be:

- **Addressing high RCI**. We are committed to reducing the RCI to 100 or less for all those services shown in red at Appendix 5. If delivered, this will result in approximately £29m of savings between 2016/17 and 2018/19;

- **Addressing broader sustainability.** We are confident that we have identified the issues that present a risk to the sustainability of our services. We have a number of current plans in place to address these issues but we also recognise that there are a number of further plans that need to be developed across all of our service areas in order to address sustainability in the medium term. We undertake to produce these plans by the summer of 2015, primarily as part of the next round of our business planning. That said, the speed at which we can work to develop these plans will depend on the speed at which we can work with others across the health economy – and in some cases this will take more than the next 12 months.

THE SUSTAINABILITY OF KEY SERVICE AREAS

Children's Services

Key issues in terms of the future sustainability of these services are linked to the growth in child population and the impact that will have on all services in the city. Alongside this is a growing sense that those presenting to our hospitals are more sick and their conditions more complex. Workforce issues, such as recruitment and retention of middle grade doctors, nursing and consultants in critical care, interventional radiology and paediatric pathology alongside continued efficiency requirements in the NHS will therefore make it harder for the Trust to achieve its objectives for sustainable, safe and excellent Children's Services.

Currently, our plans in place to address these issues include:

- Efficiency and savings programmes to address high cost services;
- Workforce and role redesign to fill skills gaps in "hard to recruit" services and roles;
- Considering our role in community paediatric services as a means of creating greater economies of scale and driving more integrated care provision to improve flow through specialist services;
- Focussed investment in key service requirements.

We will develop further plans (by summer 2015) to improve the sustainability outlook in years 3-5. We will particularly focus on:

- Improving links both in secondary care and across the health and social care system to stem the flow of patients into acute care;
- Improve our approach to the use of technology and innovative solutions;
- Recruitment and retention strategy, taking account of alternative workforce models;

- Building upon the opportunities, that the recently transferred services provide for further growth in both NHS and private work.

By 2020 we aim to have a reduction in reference costs where this is appropriate, a stable and effective workforce and system wide relationships that ensure the appropriate use of the Bristol Royal Hospital for Children.

Finally, the Trust recognises the loss of trust and confidence in its paediatric cardiac services and the impact this has had on the wider reputation of the Bristol Royal Hospital for Children– addressing this is a key strategic theme for the future.

Accident & Emergency (A&E) and Urgent Care

Key issues in terms of the future sustainability of these services are around our ability to meet access standards in the context of an ageing population with more complex health and social care needs. Our ability to perform will depend on how we are able to organise the capacity within the redeveloped BRI through new models of care to meet both demographic changes and city wide changes (such as the new A&E at Southmead and its role as the adult major trauma centre). There are also workforce issues including turnover of nursing staff, potential shortage of junior doctors and difficulty in recruiting acute physicians that must be addressed.

Currently, our plans in place to address these issues are closely linked to the re-development of the BRI and implementing the right model of care to ensure patient flow is optimised alongside work to conclude the implementation of changes to the Trust Operating Model. This is are intended to significantly improve flow, through initiatives to reduce length of stay and thus drive down occupancy and plans to protect elements of the Trust's bed base to support the efficient and consistent delivery of elective care.

In addition to operational sustainability, the greatest threat to the Trust's long term sustainability is the excess costs evident in the medical specialities (notably older people's care) and urgent care pathways.

We will develop further plans (by summer 2015) to address issues directly within A&E but also across the health and social care system in Bristol to improve the sustainability outlook in years 3-5. We will particularly focus on:

- Taking a lead role in working with partners to build system wide resilience;
- Understanding barriers to patient flow and ensuring the models in the BRI match capacity with demand through a flexible workforce;
- Working with other acute trust and community partners to review workforce requirements across the city, enhancing the role of Enhanced Nurse Practitioners (ENP), designing innovative working models and providing incentives through training for medical staff;
- Ensuring services outside of hospital are of the right capacity and specification to support reduced reliance on hospital based care;

- Plans to address the significant excess costs, evident in our general medical service portfolio.

By 2020 we aim to have normalised the cost base of acute medical services, delivered a stable but flexible workforce that can meet the demands of demographic change and developed more effective integration with our community partners.

Older People's Care

Like A&E, the key issues in terms of the future sustainability of these services are in our ability to meet the needs of an ageing population with more complex health and social care needs, whose expectations of services are high. Continued need for system wide efficiency will impact on the resources to help move patients through the system in the safest and most effective way. There are currently high nursing costs which, if transferred to the re-developed BRI, will impact on our ability to implement new models of care. Lack of trainees and shortage of consultant geriatricians will also impact on the specialist input into the needs of older people, potentially impacting on our ability to improve patient outcomes quickly.

Currently, our plans in place to address these issues are closely linked to the re-development of the BRI and implementing the right model of care to ensure patient flow is optimised. This includes admission avoidance schemes and ensuring the patient pathways are enhanced, with consultant led, multi-disciplinary approach to care and appropriate skill mix across the department. There is significant interdependency with the transformation aspects of this plan.

However, the challenge of Older People's Care is one that, like A&E, requires a system response. We are committed to working with others on this work, with a particular focus on:

- Operational integration of the delivery of Older Peoples Care across the Acute and community settings in particular;
- Review and understand the causes of staff shortages to plan for longer term workforce requirements;
- Ensure the model of care, working environment, training and incentives enhance the staff experience of UH Bristol creating a happy and stable workforce.

By 2020 we aim to have achieved operational integration of the delivery of Older People's Care across the Local Health Economy and the redesign of the financial model that underpins the service at system level.

Cancer Services

Key issues in terms of the future sustainability of these services are in our ability to meet national access standards for cancer, which will be further exacerbated if we are unable to address workforce risks such as inability to recruit consultant oncologists and adequately staff Bone Marrow Transplant (BMT) services, potentially limiting growth. There is increased competition from NHS and non-NHS providers and if we fail to invest in research and

innovation, or recognise the key benefits of teaching and learning, then we risk the competitive edge to maintain sustainable services.

Currently, our plans in place to address these issues are:

- Continued presence and potential expansion of community chemotherapy services;
- Securing funding for research, especially paediatric cancer research;
- Focusing our specialist offering e.g. Children, Teenagers and Young Adults (TYA), Gamma Knife and BMT;
- Promoting the Bristol Haematology and Oncology Centre as a centre of excellence – a "re-branding" of our offer in this regard is underway following a major redevelopment and expansion of the centre.

We will develop – by summer 2015 - further plans to address sustainability in the medium term, with particular focus on:

- Reviewing staffing needs and alternative, flexible working models to address workforce risk;
- Investment in technology and IM&T where required;
- Expansion into new service areas and catchments, alongside the repatriation of regional work from providers outside of the South West and most notably London.

By 2020 we aim to have in place not only a sustainable service built on the foundations of a strong flexible workforce, but a service which provides cutting edge care and research in Bristol and for the South West.

Cardiac Services

Key issues in terms of the future sustainability of these services are linked to the impact of other trust acute services on the ability of the Bristol Heart Institute (BHI) to deliver specialist services and increased competition as services become more routine and delivered at district hospital level and in the private sector. This increased competition has the potential to pull activity and consultants away from the service, impacting on the ability of the service to run an efficient and effective 24/7 service. Investment in imaging equipment, will also be a key initiative to ensure we maintain our competitiveness.

Currently, our plans in place to address these issues are:

- Working with other providers to secure tertiary referrals;
- Expand our interventional cardiology offering;
- Increase ring fenced cardiac critical care and surgical facilities;
- Improve productivity and reduce length of stay;
- Support acute services elsewhere in the Trust, but prioritise the Bristol Heart Institute for cardiac and specialist cardiology services.

We will develop – by summer 2015 - further plans to address sustainability in the medium

term, with particular focus on:

- Developing newer cardiac surgery techniques e.g. minimally invasive surgery;
- Development of clinical pathways to reduce emergency admissions, linking with ambulatory care;
- Reviewing the suitability and capability of imaging equipment to feed into forward looking capital investment plans;
- Continuing to support - and develop - academic leadership in clinical roles.

By 2020 we aim to have continued productive and competitive cardiac services, with appropriate technology to support the BHI in delivering cutting edge surgical and cardiology techniques.

Maternity Services

Key issues in terms of the future sustainability of these services are linked to the plateauing of birth rates across the city, but with increasing complexity resulting from an increase in maternal age at birth. In addition, midwifery recruitment difficulties are compounded by a lack of availability of midwives and services are already running with a high number of vacancies.

Services delivered to mothers living in North Somerset make up an important portion (c25%) of the UH Bristol activity and the long term sustainability of the service is inextricably linked to the future of Weston Area Health NHS Trust and its maternity service and the continued flow of patients from North Somerset.

Neither of the providers of level 3 neonatal care in the City is fully compliant with national service standards, notably in relation to workforce availability with both consultant and specialist nursing skills being scarce. The long term sustainability of this service is a key risk for the Trust and plans to address this are a key focus for action working closely with partners at North Bristol NHS Trust.

We will develop – by summer 2015 - further plans to address sustainability in the medium term, with particular focus on:

- Workforce planning to address shortages and fill vacancies where necessary;
- The future model for specialist neonatal services across the City;
- Our ongoing role in the provision of services and support to maternity services in North Somerset.

By 2020 we aim to have a sustainable model for level 3 neonatal services and a maternity service, appropriately configured for the population we serve.

Planned Care and Long Term Conditions

Key issues in terms of the future sustainability of these services are related to our ability to protect sufficient capacity to consistently deliver planned care, to the desired standards and to "right size" our services (workforce and infrastructure) to reflect the changes in demand for this portfolio which includes growth from demographic impacts and reductions from the redesign of pathways shifting the focus of care towards community settings. Notably, successful implementation of the proposed Operating Model is critical to ensuring we can deliver operationally and financially sustainable services.

Alongside this are high cost bases in some surgical specialties, difficulty recruiting to specialist areas such as dentistry and anaesthesia and difficulty accessing nurse specialists across all surgical specialties which we must address.

Currently, our plans in place to address these issues are:

- Maximising the use of existing facilities and increased productivity measures in theatres and outpatients;
- Better use of peripheral sites, such as South Bristol Community Hospital;
- Clearly differentiating elective and emergency flow;
- Integrated working with primary and community care to assist early discharge;
- Implementing plans to reduce costs;
- Right sizing capacity in areas where we have excesses or deficits;
- Redesigning pathways, notably for the management of long term conditions, in partnership with primary and community providers.

We will develop – by summer 2015 - further plans to address sustainability in the medium term, with particular focus on:

- Growth in market share and development of specialist and tertiary services;
- Working collaboratively across divisions, with other trusts and with primary care and community partners.

By 2020 we aim to be able to support the acute emergency services of the Trust, but be able to deliver productive, efficient outpatient and surgical services to elective patients and people with long term conditions.

Diagnostics and Therapies

The key issues in terms of the future sustainability of these services are increased desirability of community, as opposed to hospital delivered diagnostic and therapy services, against the backdrop of competition from any qualified/willing providers. If the Trust does not embrace technology and innovation in these areas, it could fall behind innovative competitors. This sits alongside specific issues of viability of services in the short term, such as cellular pathology and paediatric radiology and the longer term challenges of determining the future model for pathology services and how to respond to the challenge of seven day working within available resources, both workforce and financial.

Currently, our plans in place to address these issues are:

- Implementation of local pathology action plans;
- Integration of cellular pathology;
- Developing a clear sense of how the Acute Services Review findings could be implemented in D&T;
- Developing policies and processes, underpinned by the Trust Strategy, to determine which new business opportunities to bid for, or where to disinvest;
- Establish a rolling programme of capital investment in equipment and technology innovation.

We will develop – by summer 2015 - further plans to address sustainability in the medium term, with particular focus on:

- Engagement and investment in future technology and innovation;
- Working with partners to determine which services could move to the community;
- Agreeing the future model for pathology services i.e. to retain in house or outsource.

By 2020 we aim to be continuing to deliver general diagnostic services in such a way as to support the Trust as a whole, but with much greater focus on the delivery of therapies and diagnostics in the most appropriate place for patients. We also aim to have concluded any reorganisation of pathology services across the city.

Critical Care

Key issues in terms of the future sustainability of these services are mainly linked to the competing demands across the Trust for critical care facilities.

Currently, our plans in place to address these issues are:

- Developing ring fenced cardiac critical care within the Bristol Heart Institute;
- Right sizing of critical care capacity across the Trust and improved flow out of critical care to ward based settings;
- Protected pathway redesign to improve operational resilience and reduce cancellations of planned care.

By 2020 we aim to have the right level of capacity in critical care which can support the acute activity within the Trust, and ensure that the specialist, tertiary services can also be delivered effectively.

THE SUSTAINABILITY OF SPECIFIC SERVICE LINES

Appendix 4 describes the risks to specific lines and the key actions to address.

5.3 Strategic Initiative 3 - Broader programmes of change

This initiative sets out a series of 'hooks' for the development of broad change programmes to address the thematic challenges we have identified during our review. The details of this initiative set out our commitment to develop plans in these areas and will provide us with a strategic framework for our major change programmes. As they are developed, these plans will be incorporated into our Transforming Care programme (Strategic Initiative 5) and/or strategic objectives, flowing from the yet to be developed Strategic Implementation Plan which will be developed over the remainder of 2014/15.

The Aim of this initiative is to:

Take a thematic approach to dealing with broad areas of challenge that we have identified as a result of our strategic review.

Our Strategic Plans in this area are:

- **To review and refresh our approach to public engagement and patient and public involvement** in the development and delivery of our services;
- **Where necessary, review workforce models to ensure capacity is aligned with workforce.** In the medium term, this may include developing new models for our workforce to ensure that the most appropriate staff deliver services to ensure that they are cost effective and sustainable with a particular focus on the utilisation of our non-medical workforce;
- **To drive system level changes to the shape of our health and care systems on the basis of a new 'patient centred' understanding of value in health and care systems**;
- **Developing a much more active approach to data and the way we use and share it.** We must accept the underpinning role of information technology in getting better at this, but at the same time realise that better IT will not in itself be the answer. We must make data social (open and not proprietary) in a way that we have not done before;
- **To re-examine the way we use technology and how we understand its benefits** – specifically to consider how technology facilitates access to our services and advice as well as how it allows us to deliver those services more effectively and efficiently;
- Working **on technology and innovation from a system or regional perspective** – through organisations such as the Academic Health Science Network. Our organisations typically lack the expertise or economies of scale to develop and utilise new technology on an individual basis, but there is much to be gained if we can work with and for each other to utilise the potential of advances, such as 3-D printing.

We assess that the impact of these plans will be:

To transform our organisation by delivering major changes in the areas outlined above. In particular, we aim to:

- Be innovative in the way we think about how our application of resources actually creates value for patients and to redesign services on that basis;
- Use technology to facilitate access as well as improve service efficiency and quality;
- Focus in particular on the greater utilisation of our non-medical workforce as we implement our new organisational strategy.

5.4 Strategic Initiative 4 – Our Estate Strategy

The Trust Estates' Strategy builds on our current 2005-2015 strategy which is set to be concluded in March 2016 following completion of Phase IV of the BRI development programme.

To date, strategy implementation has focussed on the development and optimisation of core clinical facilities to significantly improve adjacencies and co-locations of key services and retire estate that is no longer fit for purpose. This approach has resulted in the expansion of core clinical accommodation, elimination of poor quality accommodation including nightingale ward environments, and improvements in the built environment of more than 50 services.

Notably, the current strategy has realised £200m of estate investment to improve facilities for our patients, visitors and staff, supporting the Trust in delivering its mission.

The Aim of this initiative is to:

- Complete the current 15 to 20 year strategic asset management cycle which commenced in 2005.

The 2015-2020 estate strategy now concentrates primarily on ancillary and non-clinical estate provision - which is the final element of the asset management cycle - whilst ensuring the estate is 'future proof' for known or predicted clinical requirements.

Our Strategic Plans in this area include two major initiatives :

- To evaluate the options for the future use of the Old Building Site as set out in the strategy;
- Develop an outline business case for the redevelopment of land at Marlborough Hill (including the provision of approximately 1200 new parking spaces).

We assess that the impact of these plans will be:

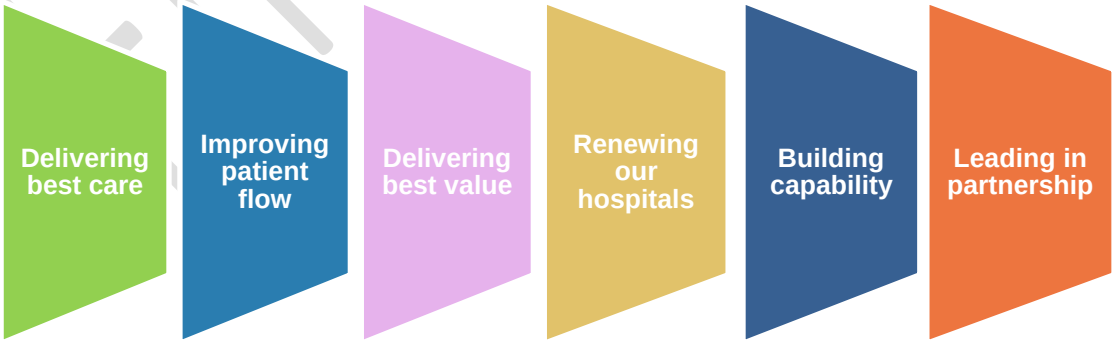
- Improved patient access through on-site, multi-storey parking provision, alongside

associated rationalisation of existing provision and enhanced drop off and site circulation;

- Replacement of Trust Headquarters (THQ) and Estates and Facilities accommodation arising from rationalisation of land on Marlborough Hill to accommodate multi-storey parking.
- Re-provision of:
    - Soon to be obsolete parent accommodation and further expansion to accommodate the impact of recent service and future service growth, notably the specialist paediatric transfer from Frenchay;
    - Accommodation for services displaced by any future service changes e.g. requirement for neonatal intensive care expansion.
- Retained space for:
    - An additional 24 bed ward or other clinical accommodation such as a care home;
    - Further expansion of Trust research and teaching offer, including enhanced medical school provision;
    - Displaced services in a scenario where disposal of Central Health Clinic and/or Tyndalls Park is deemed desirable.

5.5 Strategic Initiative 5 – Transforming Care

Transforming Care is the Trust's unifying strategy for improvement. It is the overarching programme of transformational change designed to drive us towards our vision for the Trust. Transforming Care is both a set of projects and a structured approach to support the organisation in making change happen and to enable all our staff to improve the services which our patients receive.



The programme is structured under the 6 "pillars" above, which provide focus on the areas we need to address in order to achieve our vision.

Transforming Care is already well established in the Trust and is the key mechanism by which we plan to execute our Operational Plan. It will remain a key component of our longer term strategic plan, and an outline of the way in which the key elements of the programme will develop is set out below.

The Aim of this initiative is to:

Build on the current work of Transforming Care by developing programmes to support the strategic objectives below and the priorities set for the coming year and beyond.

Our Strategic Plans in this area are:

Delivering Best Care

- We need to maintain our good position in care quality and outcomes and react when necessary to ensure consistency of high standards;
- We must promote innovation more strongly – for example by a greater focus on collaborative work and connection to the work of larger partnerships such as Bristol Health Partners.

Improving Patient Flow

- There is more to do – we need to be increasingly robust in both planned and unscheduled care;
- There is a twofold challenge - to become better at making and sustaining improvements and to convert those improvements into measurable performance improvement and efficiency savings;
- We need to align our efforts with health economy wide initiatives (e.g. Better Care Fund).

Delivering Best Value

- We must be more forensic about understanding and dealing with our cost base, using available intelligence such as reference costs and benchmarks to deliver increasing value for money.

Renewing Our Hospitals

- We must continue to implement our Estates Strategy;
- We must implement our clinical systems strategy moving to Paper Light and then onto Paper Free;
- We must continue to support clinical teams in adopting technologies that enable better access to and use of data to improve patient care;
- We must fully realise the transformational potential of our investment in information systems.

Developing Capability

- We must deliver a step change in staff engagement and staff experience through a cultural change programme, knowing this will bring further benefits in patient experience;
- We must deliver our workforce strategy across staff groups to develop our workforce aligned to the future needs of our patients.

Leading in Partnership

- We will address the unscheduled care pathway and complex discharge with our partners at system level;
- We need to develop greater agility in the way we work with others – so we can move to action more quickly without any loss of governance and assurance.

5.6 Strategic Implementation

The Trust is acutely aware that the success of any strategy lies in its successful execution. A detailed Strategic Implementation Plan, which will be overseen by the Trust's Senior Leadership Team is being developed and will conclude for the 2015/16 planning round.

Our mechanisms to drive strategic implementation are as follows:

Our Business Planning and Operating Plans

The first two years of this strategic plan are already in place and have been set out in detail in our Operational Plan. We will begin business planning again in October 2014 and will then look at the first of years 3-5 in our strategic plan in more detail. Successive years of the strategic plan set out in outline here will then be picked up and clarified as part of our annual Business Planning process.

Our model for planning and implementation will continue to reflect the balance of corporate and divisional initiatives within our overall business model of devolved autonomy to our five clinical divisions.

Medium Term Capital Plan

This plan is set out in our Financial Plan (Section 7) and contains the provisions for the major investments that we anticipate in our Estates Strategy in particular. The provision for spending on medical equipment, minor estates works and other infrastructure spending also includes the outline provisions for the estimated costs of addressing the sustainability challenges described in this Plan.

Transforming Care

Although it is itself one of our key strategic initiatives, Transforming Care is itself the

overarching programme of change through which we drive delivery across the Trust. In simple terms, as specific strategic plans in each of our strategic initiatives are confirmed, they will be fed into and become part of the Transforming Care programme where they are intended to deliver a step change in performance or outcomes, and will be governed and managed via the auspices of that broader programme.

SECTION 6 – OUR STRATEGIC WORKFORCE PLAN

6.1 Introduction

This section sets out our current position, including our strengths, weaknesses, opportunities and threats in relation to our workforce agenda and describes the plans and programmes which will enable us to achieve our objectives over the next five years.

Our plans and programmes include delivering our services in different ways, optimising productivity and efficiency, and redesigning our workforce, ensuring that it aligns with the resources available and the needs of our services and patients.

6.2 Our Workforce in 2014

Our strengths, which we need to maintain and build on, are: our highly skilled, dedicated workforce; traditionally good partnerships with our trade union representatives, redevelopments which provide a better working environment for staff and a number of positive ratings in our staff attitude survey, including proportions of staff recommending the Trust as a place to work or receive treatment.

However, our analysis also shows that we have a number of weaknesses, for example turnover and sickness absence rates, which are higher than those of similar trusts, and financial challenges associated with the need to align staffing levels with activity and capacity, and to reduce bank and agency usage. We also have some key threats in the future: recruitment to key staff groups in a tight labour market, and the financial challenge of maintaining and developing the quality of our services with fewer available resources. These threats will bring opportunities, making it more important to work in partnership with local organisations and our own staff side, and providing staff with the chance to work in new ways and train for new roles.

SWOT Analysis May 2014

Strengths	Weaknesses

• Staff who are committed to delivering excellent patient care
• A developing culture of lifelong learning and personal development
• Highly regarded teaching trust – attractive to potential recruits
• Specialist tertiary service with highly skilled and expert workforce
• Traditionally good partnerships with our trade union representatives
• High appraisal rates, relative to sector
• Clear KPIs and action plans
• Areas of potential strength indicated by the staff attitude survey:
  o Numbers receiving job-relevant training, learning or development
  o Staff recommendation of the trust as a place to work or be treated
  o Not feeling pressured to attend work when unwell
• A modern and pleasant environment
	• Turnover above benchmarking peer Trusts
	• Sickness absence levels above benchmarking peer Trusts
	• Bank and agency levels above KPIs
	• Workforce costs higher than budget
	• Issues indicated in the staff attitude survey:
	  o Work related stress
	  o Health and safety training
	  o Well-structured appraisals
	  o Harassment and bullying from other staff
	  o Communication between senior management
	  o Equality and diversity training
	  o Discrimination at work
	  o Satisfaction with work quality

Opportunities	Threats
• Further opportunities to develop our workforce – new roles, different ways of working – providing staff with new opportunities and new skills • We can do more to optimise the productivity and operational efficiency of our systems, processes and staff • The need to change and adapt will drive change and provide scope to transform the way in which we deliver care through service and workforce redesign • We will need to engage even more closely with our staff and Trade Union representatives to support future changes • Academic partnerships can be developed which would produce benefits in shared expertise and skills, and workforce development. • We can do more to market potential employees the benefits of working at UH Bristol, including our status as a major teaching trust and being centre of expertise for specialist services • Partnerships with other providers could be further developed to learn from best practice, benchmark and work collaboratively in developing our workforce and delivering services	• National shortage of qualified nurses due to retirements likely to impact during 2015-17 • Difficulties in recruiting to certain areas, such as consultant radiologists, pathologists, oncologists and acute physicians • Changes to junior doctor numbers mean potential shortages 2016 onwards • Financial challenges due to reduced funding • Scale of change may be demanding for staff to accommodate • Funding and infrastructure to develop and train for new roles and new ways of working may be difficult to identify and secure • Potential national agreements regarding pay which may impact on our ability to deliver 7 day working • The age profile of some consultants and some specific areas of the service could result in cohorts of retirements, resulting in the loss of key skills

6.3 Our Workforce Vision

Our workforce vision is:

We will be an employer of choice, attracting, nurturing and developing a workforce that is skilled, committed, compassionate and empowered, so that we can deliver excellent care to our patients.

Our vision is underpinned by a number of strategic themes which are as follows:

- Supporting our leaders to deliver transformational change, creating a culture of high performance, continuous improvement and organisational transformation;
- Engaging our workforce, so staff feel valued, empowered and are committed to delivering excellent care;
- Recruiting and retaining the best staff to ensure that we can meet future demand to provide the exceptional quality of healthcare to our patients;
- Ensuring that staff are rewarded and recognised for high performance and that teams and individuals have clear accountability for their actions.;
- Developing a culture of lifelong learning across all staff groups within the Trust where Teaching and Learning supports the Trust values and strategies;

- Ensuring that we have a sustainable workforce which aligns capacity and staffing within the financial envelope, with safe and appropriate numbers of staff and skill mix, and minimal agency usage.

The work streams to deliver these priorities will be supported by partnership working, both across the Trust, with our trade union representatives, and with external partners, impacting on all staff groups. Progress against the work programmes which underpin these themes will be reported to the relevant workforce governance group on a quarterly basis.

6.4 Workforce Risks to Sustainability

Our key workforce risks – along with our mitigation plans – are considered below.

6.4.1 Workforce affordability

Risk: We recognise the future risk of delivering services within a reduced resource, particularly given the increasingly complex health needs of patients, and the requirement to provide services within extended hours.

Mitigation: There are a range of solutions which are being implemented to address the key issue of workforce costs, which include the following:

- We have reviewed our nursing levels, using the national Safer Care Nursing Tool, combined with an external review, benchmarks and review of risks. This has resulted in agreed general ratios which are already being met, even taking account of acuity and dependency requirements, providing the assurance that there are not significant increases in nursing levels required to achieve national benchmarks;

- Our consultant job planning database enables an assessment of capacity against service requirements. In addition, we have a rigorous approach to ensuring that new consultant posts are not established without a clear justification and business case. We have a specific workstream which will focus on securing further efficiencies from our medical workforce. We are also collaborating with NHS Employers to support their modelling of the implications of changes to the consultant contract, with the objective of reducing the financial impact of 7 day services;

- We are leading on a programme to develop workforce models as part of the Better Care Fund in the Bristol Health community. This work is in recognition of the increasing proportion of elderly who are admitted to our hospitals and the specific workforce and service redesign across health and social care which is required to ensure that patients are cared for in the most appropriate place by staff with the best possible skills;

- UH Bristol will also continue to develop the expectation that staff work across sites in the Bristol community, whether this is in a community setting, or for a different acute provider, in order that services continue to be sustainable and cost effective.

6.4.2 Changes to junior doctor training

Risk: By 2015, 80% of Foundation posts will be required to contain a 4 month Community

post, rising to 100% by 2017. These changes will result in significant reductions in junior doctor numbers working in the Trust. This will exacerbate the existing shortages in some areas of juniors and middle grade doctors.

Mitigation:

- Develop and implement an action plan, based on a cost benefit analysis, in partnership with Divisions, which will be focussed on the following solutions:
    - Instigate Academic F2 posts where available, which are funded by Health Education South West (HESW) with out of hours and on costs funded by UH Bristol;
    - Review and extend the Clinical Site Management Team;
    - Develop a "Teams at Night" programme, to ensure the cover at night is provided using cross-team approaches;
    - Review of roles to ensure that doctors are only undertaking tasks which specifically require medical input and ensure that processes are efficient in supporting junior doctors to increase efficiency;
    - Implement the Advanced Nurse Practitioner and Extended Practice Physiotherapist/Health Care Scientist roles which we already have in place in several areas such as the Emergency Department, Rehabilitation, Paediatrics and Cardiac, to cover other specialties as necessary;
    - Continue to work with Health Education South West to ensure there is appropriate training available to support the development of the new roles, and in particular, ensure that there is increased provision for non-medical prescribing training;
    - Ensuring we continue to collaborate with Health Education South West Severn Post Graduate Medical Education Deanery to understand as early as possible the potential impact in years beyond 2017.

<u>6.4.3 Temporary Staffing Usage</u>

Risk: Some use of temporary staffing is positive and providing the flexibility to supply additional staff during peaks and troughs of demand and to cover for maternity, sickness absence, and vacancies. However, temporary staffing usage currently exceeds budgeted establishment, and this would be a risk if not reduced in the future.

Mitigation:

- We have a range of actions which are being implemented to support and maintain reduced bank and agency usage through the reduction of the drivers, including vacancies and sickness absence and to further improve control mechanisms;
- We are also improving the way we use our rostering system, to ensure shifts are booked six weeks ahead, that rosters are signed off at an appropriate level, and that

staffing levels comply with agreed Chief Nurse staffing guidelines;

- There is enhanced reporting at Quality and Outcomes Committee and at Divisional Reviews to ensure that the agreed trajectory for reducing bank and agency usage is achieved.

6.4.5 Recruitment and Retention

Risk: Where there is a limited supply of a specific professional group and recruitment is challenging, this can result in difficulties in recruitment. National projections for the forecast future supply of registered nurses shows a likely reduction of between 6 and 11 per cent between 2013 and 2016, and baseline projections for supply and demand show a shortfall of nurses by 2016 (The Centre for Workforce Intelligence CfWI 2013). In addition, there are specialist areas which are difficult to recruit to, and given our age profile, service sustainability could be impacted when key staff with specialist expertise retire.

Mitigation:

- We have a range of recruitment activities which are focussed on attracting both newly qualified and experienced nurses, including participating in recruitment fairs, holding open days, and utilising the Trust Microsite;

- We have aligned workforce plans with recruitment to anticipate demand resulting from turnover and service developments;

- We are developing appropriate attraction packages, both to market the benefits of working in a specialist, tertiary teaching Trust, and in offering specific terms where appropriate, focussing on difficult to recruit areas, which include histopathology, pathology, radiology and oncology;

- We have taken the opportunity to transform our recruitment processes, implementing an assessment centre approach which will be extended to all staff groups, to ensure that we recruit for compassion as well as skills.

6.4.6 Sickness Absence

Risk: Our long term ambition is to achieve a sickness absence level of no more than 3%, with an interim target for 2014/15 of 3.5%. High levels of sickness absence are linked with reduced productivity and increased usage of temporary staffing, but these are challenging targets and there is a risk that they will not be achieved.

Mitigation:

- Our early priorities as part of our Staff Experience and Engagement programme include providing support for staff, in terms of wellbeing and tackling work-related stress in addition to the existing services for employees through our Physio-direct service, allowing direct access to physiotherapy at the earliest sign of musculo skeletal injury, a staff counselling service and a programme to address stress related absence;

- We will also be scoping and piloting an Employee Assistance Programme, and will extend this subject to positive outcomes.

SECTION 7 - FINANCE STRATEGY

7.1 Introduction

The Financial Strategy commentary describes the Trust's assessment of the Strategic Plan for the period until 2018/19 and builds upon the Operating Plan submitted to Monitor in early April 2014. The commentary details the key assumptions, transactions and projections in support of the financial template for the "Base" scenario and "Downside" scenario.

7.2 Financial Sustainability

The Trust undertakes regular reviews of its Long Term Financial Plan and formally updates the Long Term Financial Plan on an annual basis in line with Monitor's annual planning cycle. The Trust has always adopted a prudent approach to financial planning and refers to the following criteria in assessing the affordability and sustainability of its plans:

- A recurrent or normalised surplus achieved in every year of the plan;
- An in year surplus of 1% of turnover excluding technical items to meet the Trust's loan principal repayments;
- A minimum cash balance of £20 million;
- A Continuity of Services Risk Rating of at least 3; and
- A maximum Reference Cost Index of 100.

7.3 The Base Scenario

7.3.1 Savings Plans

The Trust has delivered savings of £84.2 million since it became a Foundation Trust in June 2008. Going forward, the Trust believes the continued delivery savings at a rate of 4% is unsustainable having assessed the opportunity to transform its own services at c2%. For the purposes of the Strategic Plan submission, the Trust has set a strategic direction at 2% as the Trust's "Base" scenario. The Trust savings plan going forward is summarised below:

Base Scenario	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Savings requirement @ 2%	8.0	8.4	8.5	8.7

It should be noted that, at this stage of the Strategic Plan, detailed plans are not in place to deliver the 2% saving which the Trust believes is sustainable; these will

need to be worked up in due course as the strategic direction of travel is translated into savings plans.

7.3.2 Income

The income assumptions over the period of the Strategic Plan are as follows:

- Net nil activity growth pending a review of activity volumes and the impact of the Better Care Fund;
- An assessment of National Tariff gross uplift at 2.67% in 2015/16, 3.67% in 2016/17, 3.77% in 2017/18 and 3.87% in 2018/19 offset by a National Tariff gross efficiency requirement of 2% in each year. The net inflator of 0.67% in 2015/16 is necessary to cover increases in employer costs arising from NHS pension contributions. The net inflator of 1.67% in 2016/17 is due to an increase in National Insurance employer contributions. Smaller changes in later years is due to further increases in NHS pension contributions due to automatic enrolment of staff into the NHS pension scheme from 1st October 2017.
- MPET rebasing impact of £1.0 million in 2015/16 and £0.5million in 2016/17; and
- The receipt of charitable donations in 2015/16 of £3 million in support of the Trust's Medium Term Capital Programme.

7.3.3 Costs

The 2015/16 – 2018/19 cost outlook for the Trust should be considered in the context of an increasingly challenging environment. Pressures on spending, savings plans and transformation initiatives are intensifying and firm control will be required to avoid the Trust's medium terms plans being undermined. The main assumptions and considerations included in the Trust's cost projections are:

- Pay inflation 1.25% in 2015/16, rising to 2.73%, 2.88% and 3.04% by 2018/19 which includes a 1% pay ward and the impact of NHS pension and National Insurance contribution changes, drugs at 5%, clinical supplies 2% and capital charges at 2%;
- Recurrent savings delivery at 2% per year;
- Payment of loan interest at £3.1 million in 2015/16 falling to £2.5 million in 2018/19;
- Loan principal repayment of £5.8 million each year; and
- A recurring risk reserve of £0.5 million in each year from 2015/16.

The following non-recurring costs are provided for:

- £1.0 million change / invest to save costs each year in recognition of the transformation requirement;

- £0.5 million transitional costs in support of the Trust's strategic capital schemes;
- £0.8 million technology implementation costs in 2015/16 and £1.0m each year from 2016/17;
- £0.5 million risk reserve in each year;
- £0.5 million contingency in 2016/17 rising to £1.25m in 2018/19; and
- £9.4 million impairment in 2015/16 arising from the writing down of capital cost to depreciated replacement cost of the BRI Redevelopment Phase 4.

7.3.4 Strategic Developments

Bristol Royal Infirmary Redevelopment

Commissioning of Phase 3 begins in June 2014 and will be completed in January 2015 providing up to date and modern estate. Phase 3 will enable the delivery of new models of care through the Acute Medical Assessment Unit which will improve service efficiency, patient flow and quality of care. The full year effect net recurring revenue cost of Phase 3 in 2014/15 is £6.9 million, the part year effect is £4.6 million. A key risk is the delivery of the planned length of stay reductions before the opening of Phase 3, and the delivery of length of stay savings post 2014/15. The bed closures are necessary to deliver the decant of patient services from the Trust's King Edward Building and the subsequent closure of the BRI Old Building in March 2016. The closure of the BRI Old Building delivers recurrent savings of £2.0 million from 2016/17 meaning the net recurring revenue cost of the scheme from 2016/17 is £4.9 million.

7.3.5 Other Service Developments

There are no further developments planned for the period 2015/16 to 2018/19.

7.3.6 Transactions

Breast Screening Transfer

The transfer of the Avon Breast Screening Service from UH Bristol to North Bristol NHS Trust is planned to take place from 1st August 2014. The transfer will reduce the Trust's income by £1.5 million and reduce the Trust's expenditure by £1.36 million resulting in a net loss to the Trust of £0.14 million.

Centralisation of Specialist Paediatrics

The project meets the long-term vision and strategy to centralise paediatric services

delivering integrated paediatric services within the existing Bristol Royal Hospital for Children. The recurring revenue impact is financially neutral with increases in both income and expenditure of £16.1 million in 2014/15. The new service commenced in May 2014.

Vascular Transfer

The transfer of Vascular services from UH Bristol to form a Major Arterial Centre at North Bristol NHS Trust is now scheduled for October 2014. The recent full year effect assessment shows the transfer will reduce UH Bristol's income by £3.3 million and costs by £2.5 million resulting in a net loss to the Trust of £0.8 million.

Other Transactions

There are no further transactions planned for the period 2015/16 to 2018/19.

7.3.7 Capital expenditure

The Trust has a significant Medium Term Capital Programme investing £94.6 million from April 2015. This is summarised in the table below:

	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m	Total Plan £m
Strategic schemes	12.0	6.1	8.9	7.3	34.3
Backlog works	2.4	2.7	2.7	2.7	10.5
IM&T	1.3	1.5	0.8	1.4	5.0
Operational capital	6.3	4.5	4.5	4.5	19.8
Medical equipment	2.5	7.9	5.3	5.3	21.0
Slippage	3.7	0.6	0.0	(0.3)	4.0
Totals	**28.2**	**23.3**	**22.2**	**20.9**	**94.6**

The Trust's major strategic schemes in this period are:

BRI Redevelopment Phase 4 £13.0 million

Phase 4 involves the refurbishment and conversion of the Trust's King Edward Building and the BRI Queen's Building upon opening of Phase 3 in January 2015. Phase 4 will complete by March 2016 and will ultimately allow for the decommissioning and disposal of the BRI Old Building in 2016/17 and 2017/18 respectively.

Strategic Capital £21.3 million

The Trust's Medium Term Capital Programme has set aside uncommitted strategic capital moneys of £21.3 million over the period 2016/17 to 2018/19.

7.3.8 Liquidity

The Trust's liquidity is fundamental to ensuring the Trust can meet its financial obligations arising from its revenue expenditure and capital investment as they fall due. The 2015/16 projected year end cash balance is £46.5 million, rising to £53.8 million in 2018/19. The Statement of Financial Position forecasts net current assets of £12.8 million at the 31st March 2016 rising to £18.7 million as at the 31st March 2019. This increase reflects the Trust's decreasing Medium Term Capital Programme over the period and includes assumed disposal proceeds of £2 million in 2017/18 relating to the BRI Old Building.

	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Current Assets – Cash	46.5	46.7	50.2	53.8
Current Assets – Other	30.2	30.1	30.5	30.8
Current Liabilities	(63.9)	(64.8)	(65.3)	(65.9)
Net Current Assets	**12.8**	**12.0**	**15.4**	**18.7**

7.3.9 Continuity of Services Risk Rating

The Trust's forecast Continuity of Services Risk Rating performance is 3.5, rounded up to 4 over the period to 2018/19. The Trust's forecast liquidity days exceeds zero days for each of the financial years giving a liquidity metric rating of 4. The Debt Service Cover metric performance exceeds 1.75 times over the planning period giving a metric rating of 3. The components are summarised below:

	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
Liquidity - days	2.4	1.8	3.9	6.0
Liquidity metric	**4**	**4**	**4**	**4**
Debt service cover –	2.2	2.2	2.3	2.3
Debt service metric	**3**	**3**	**3**	**3**
Overall Rating (rounded up)	**4**	**4**	**4**	**4**

Rating 4	Rating 3
0 days	-7 days
2.5 times	1.75 times

7.3.10 Summary Financial Results – Base scenario

The financial outlook for the Trust over the planning period remains one of strength relative to the Foundation Trust sector with a forecast Continuity of Services Risk Rating of 4 in each year of the Strategic Plan.

The Base scenario outlook continues the past decade of delivering net surpluses and forecasts:

- A normalised surplus in every year of the plan;
- A net surplus margin of 1%;
- A minimum Continuity of Services Risk Rating of 3; and
- A minimum cash balance of £20 million.

The financial results are summarised in the table below:

7.3.11 Summary Financial Projections – Base scenario

	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Income	572.2	576.4	584.6	593.4
Operating expenditure	(529.0)	(535.3)	(542.7)	(550.8)
EBITDA*	43.2	41.1	41.9	42.6
Non-operating expenditure	(45.2)	(38.5)	(39.1)	(40.2)
Net surplus / (deficit)	**(2.0)**	**2.6**	**2.8**	**2.4**
Net surplus / (deficit) (excluding exceptional items)	**5.4**	**5.8**	**5.8**	**5.8**
Year-end cash	46.5	46.7	50.2	53.8
Continuity of Services Risk Rating	4	4	4	4

*Earnings Before Interest, Taxation, Depreciation and Amortisation

7.4 The Downside Scenario

The Trust has undertaken a simple "Downside" scenario as an illustration taking into account a national savings requirement set at 4% from 2015/16 onwards. All other assumptions and transactions are unchanged from the "Base" scenario. The savings requirement at 4% is summarised in the table below:

Downside Scenario	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Savings requirement @ 4%	15.9	16.4	16.4	16.4

The impact of the savings requirement at 4% and delivery at 2% are summarised in the table below:

7.4.1 Summary Financial Projections – Downside scenario

	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Income	564.3	560.1	558.8	559.0
Operating expenditure	(529.0)	(535.5)	(542.2)	(550.9)
EBITDA*	35.3	24.6	16.6	8.1
Non-operating expenditure	(45.3)	(38.4)	(39.1)	(40.2)
Net surplus / (deficit)	**(10.0)**	**(13.8)**	**(22.5)**	**(32.1)**
Net surplus / (deficit) (excluding exceptional items)	**(2.6)**	**(10.6)**	**(19.5)**	**(28.7)**
Year-end cash	38.6	22.4	1.1	(29.5)
Continuity of Services Risk Rating	3	2	1	1

*Earnings Before Interest, Taxation, Depreciation and Amortisation

The impact of the recurring saving requirement at c£16 million per year compared with recurring sustainable delivery at £8 million per year has a major compound effect of c£80 million over the planning period. The result is a Continuity of Services Risk Rating of 3 in 2015/16, 2 in 2016/17 and 1 in later years.

Clearly, the scale of mitigation required would need to be significant in order to first restore the Trust's cash balance and weak liquidity position. The only material mitigation available to the Trust would be an equivalent reduction of the Trust's Medium Term Capital Programme. This scenario would have a significant adverse impact upon the Trust's ability to provide high quality care and is, in relation to the Trust's criteria of financial sustainability, an unsustainable scenario.

7.5 Changes to the 2015/16 Financial Plan

7.5.1 Introduction

Monitor received the Trust's 2014/15 – 2015/16 Operating Plan submission on 2nd April 2014. Having reviewed the Operating Plans of the Foundation Trust sector, Monitor has written to all Foundation Trusts asking them to consider their 2015/16 plans in light of the financial challenge.

7.5.2 Rationale for the changes

The 2015/16 plan was based on information and intelligence available to the Trust in March 2014. In the context of the Trust's savings delivery of £84.2 million since 2008 and a further savings requirement of £20.9million in 2014/15, it has become increasingly apparent that savings delivery in 2015/16 at 4% is not sustainable having assessed the opportunity to transform its own services at c2%.

7.5.3 Changes made

The following key changes have been made to the 2015/16 plan compared with the April submission:

1. The National Tariff uplift is assessed at 2.67% compared with 2.5% taking to consideration an initial assessment of the increasing cost of employer pension contributions;
2. The National Tariff deflation or saving requirement re-stated at -2% from -4% having assessed the opportunity to transform the Trust's services. In absolute terms, a 2% saving requirement equates to £8.0 million;
3. A re-assessment of pay inflation at 1.25% , up from 1% including the initial assessment of additional employer pension costs; and
4. An increase in capital expenditure of £3.5 million from £24.7 million to £28.2 million due to timing changes arising from an update of the BRI Redevelopment Phase 4 programme.

SECTION 8 - APPENDICES: COMMERCIAL OR OTHER CONFIDENTIAL MATTERS

Appendix 1 – Trust Strategic Objectives (Board Assurance Framework)

Appendix 2 – Market Analysis

Appendix 3 – Methodology for Analysis of Sustainability Risk

Appendix 4 – Summary of Sustainability Risks and Mitigation Options

Appendix 5 – Mapping of Service Lines to Key Service Areas and RCI Analysis by service line

Appendix 6 – Key Elements of Our Operational Plan

Appendix 7 - Summary of the Acute Services Review

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Meeting of the Trust Board of Directors, to be held on 30 June 2014 at 09.30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 18 – Board Assurance Framework

Purpose

The purpose of this paper is to present the proposed Board Assurance Framework to the Board for its approval.

Abstract

The purpose of the Board Assurance Framework is to track progress against the Trust's stated medium term objectives and specifically tracks progress against the annual milestones which were derived as part of the 2014/15 Annual Planning programme. It is a major source of assurance to the Board, that the Trust is on track to meet its strategic objectives.

Importantly, the framework describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

Following a re-fresh of the Trust's Strategy, the Strategic Objectives have been revised to reflect the agreed vision for the Trust and the objectives that underpin its delivery. The annual milestones reflect the progress required in the current year to ensure delivery of the strategic objective.

The BAF has been reviewed by the Senior Leadership Team who have supported its recommendation to the Board.

Recommendations

The Board is asked to **approve** the Board Assurance Framework and the objectives set out for 2014/15 and request quarterly updates on progress, commencing July 2014.

Report Sponsor

The Director of Strategic Development, Deborah Lee.

Report Author

The Director of Strategic Development, Deborah Lee.

Appendices

- Appendix 1 – Board Assurance Framework 2014/15

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	We will consistently deliver high quality individual care, delivered with compassion.	To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model	Develop integrated discharge processes, team and hub			Risk of lack of momentum through diverse leadership causing a delay in implementation.	Risk mitigated through bringing the individual projects together in coordinated themes.	Regular progress and exception reports to Transformation Board			COO	Senior Leadership Team
			Undertake a review of the need for, and nature of, further additional out of hospital capacity									
			Establish early supported discharge for priority pathways									
			Develop plans for weekend discharge based on findings from diagnostic and Breaking the Cycle									
			Implement a protected beds model covering key planned care pathways									
			Review adult critical care provision across the organisation with the aim of eliminating cancelled operations due to access to critical care									
			Ensure a robust operating model for BCH before next winter to prevent repeat of last year's dip in performance									
			Plan and co-ordination of the Breaking the Cycle week and mobilise follow up plan									
		To ensure patients receive evidence based care by achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners	Reach final agreement with specialised commissioners on standards that they will derogate			Commissioners decline to derogate standards in areas where compliance cannot be readily secured resulting in financial penalties and the need for Trust investment to achieve compliance	Working proactively with commissioners to understand rationale for derogation and providing appropriate evidence in support of request.	Compliance position reported to Clinical Strategy Group and SLT. Non-compliance recorded on Divisional Risk Registers.			D of SD	Clinical Strategy Group
			Develop action plan to achieve compliance with all areas where derogation has not been agreed, in line with timescales set by commissioners.									
		Deliver a programme designed to enhance compassion in clinical staff	Review values training to incl. evaluation of impact on behaviours			Stress in staff in the workplace (personal and work related) & vacancy rates, staff feeling unsupported impacts on people's ability to deliver compassionate care Weak leadership at team/dept level so team feel unsupported and uninformed	Development and implementation of a health and well being strategy, specific action plans to address any hotspots identified via staff FFT and "pulse checks", develop and implement a trust wide work related stress programme Leadership development of these in key leadership positions to be effective leaders	Delivery of transformational project plan, deliver against UH Bristol staff experience and engagement action plan			CN	Transformation Board
			Implement values based recruitment for RN's Midwives, NA's , domestic assistants, medical staff									
			Develop Compassionate care programme for UH Bristol nurses and midwives - following focus work to identify understanding/barriers to deliver of compassionate care									
		To establish an effective and sustainable complaints function to ensure patients receive timely and comprehensive responses to the concerns they raise and that learning from complaints inform service planning and day to day practice	To strengthen the Patient Support and Complaints Team resources to address the current lack of resilience.			Non appointment to key posts, high levels of sickness in team	External advertisement of positions/positive marketing, Occupational Health involvement	Delivery of complaints KPIs as per monthly complaints reporting		ref 2647	CN	Executive Directors
			Deliver the complaints annual work plan, which includes learning from Francis/Clywd Hart									
		To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.	Deliver the stretch and quality improvements as per 14/15 CQUIN schedule			Delayed sign off with commissioners and/or, lack of clear senior leadership ownership of delivery..	Nominated SLT leads to oversee delivery of individual CQUIN's, robust governance of delivery of CQUIN monitored via SLT, robust monitoring of annual quality objectives, delivery of flow projects.	delivery against annual quality objectives reviewed monthly via Flow Group, CQC and Trust Board.			CN	Clinical Quality Group
			Deliver all annual quality objectives described in the Trust's quality report									
		To achieve upper quartile performance in process and outcome measures for the Friends and Family Test (FFT)	Implement FFT in outpatient and day case settings			Data collection is currently only via a small no. of sources Internal patient facing coms around FFT is limited and not very visible FFT performance is difficult to predict and is affected by service pressures.	Implementation of alternative methods of collecting data/delivery of planned publicity drive/constant reinforcement and vigilance of requirement	Patient Experience Group monitors family and friends test monthly.			CN	Clinical Quality Group
			Explore options for increasing monthly response rate to meet increased national targets									
		To ensure the Trust's reputation reflects the quality of the services it provides	To ensure services are compliant with national quality standards including compliance with the draft standards for paediatric cardiac services			Workforce or other resource constraints prevent compliance.	Audit of compliance to assess gaps and risks to compliance. Close working with service and commissioners to ensure appropriate developments are supported to address non-compliance.	W&C quality and governance committee			MD	Clinical Strategy Group
			Fully engage with Sir Ian Kennedy Review of children's heart services with the aim of restoring trust and confidence in the service and addressing any shortcomings in care quality identified through the Review			Risk that the media does not accurately reflect the quality of the Trust's service offer and/or risk that areas of service quality fall below that expected	Proactive engagement with local media through Trust Communications Team. Programme approach to Kennedy review established to ensure effective engagement. Robust systems of clinical governance and assurance to ensure services are compliant with all necessary standards and specifications.	weekly media summaries and monthly communications report to Senior Leadership Team			D of SD	Senior Leadership Team
			Work proactively with media and other key stakeholders to actively promote positive coverage of the Trust's activities									
		To achieve upper quartile performance standards for all nationally benchmarked patient safety measures	Monitor performance and take corrective action when appropriate.			Risk that action plans and recovery actions are not progressed	Frequent and regular monitoring of safety performance parameters with regular Patient Safety updates through the Trust's Patient Safety Group				MD	Senior Leadership Team
			Review Patient Safety Group function within Trust governance apparatus.									
2		To successfully deliver phase 3 and 4	Helideck operational May 2014			Risk that acute medical model of care will	1. Division of Medicine asked to re-submit	Office of Governance and		2476 & 759	COO	Senior Leadership

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
		of the BRI Redevelopment	ITU relocated (Aug), new surgical wards restructured (Aug), new assessment units (Oct), closure of Old Building to inpatient wards (Oct) and completion of inpatient provision in the new ward block (Jan)			not be in place in time for October 2014.	operating plan by end of June 2014 to deliver affordability of model. 2. ECIST to review acute medical model in June 2014 to understand model and to offer suggestions/support/alternatives.	Commerce (Green rating received in May 2014).				Team
			Complete and handover level 5 of new ward block to Children's Hospital (June)									
			Completion of refurbished wards and ward move plan implemented by Q4 Queen's Lecture Theatre conversion completed and levels 9 & 10 remodelled by end of Q3 Surgical Assessment Unit completed and operational in Q3 Integrated Discharge Hub established. Q3. Staff Restaurant opened Q4.								
			Successfully deliver Queen's Building Façade Project									
	We will ensure a safe, friendly and modern environment for our patients and our staff	Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audit have been implemented	Interim Major Incident plan and Business Continuity plans in place to reflect changes to operational physical estate during BRI redevelopment and service moves by end Q2			One individual responsible for Emergency Planning therefore, limited resource to enable full commitment to the process and a single point of failure for Resilience within the Trust.	Risk mitigated through changing the staff mix in the COO office.	Internal and External Audits			COO	Senior Leadership Team
			Six month review following EPRR audit completed									
			Major Incident Plan revised to reflect new BRI build by end of Q4									
		Set out the future direction for the Trust's Estate	Estates and Asset Management Strategy agreed by Board June 2014			Workforce capacity prevents timelines for strategy and Business Cases (BC) being met	Risk mitigated through externally sourced capacity	Strategy and BCs delivered to Board			D of SD	Senior Leadership Team
			Business Case for future use of Old Building Site and developed and agreed by Board by end of September									
			Scope future priorities for refurbishment of remaining estate post BRI Phase IV and incorporate into forward strategic capital programme									
		Deliver against the National Quality Board 10 safe staffing expectations for Trust Boards	Deliver expectations 1,3,7,8 (June 2014)			Delay in the procurement of an IT solution for measuring patient acuity and dependency/delay in Boards for displaying staff info (due to supplier)	Clear project plan/close working with IT/procurement and supplier (for IT element once identified)				CN	Senior Leadership Team
			Deliver remaining expectations									
3	We will strive to employ the best and help all our staff fulfil their individual potential.	We will ensure that the workforce feel highly engaged and empowered by implementing a range of agreed actions to develop staff in their place of work and demonstrate a year on year improvement in the annual staff survey engagement score.	Structured programme of listening events to follow up Breaking the Cycle Together - consideration of Listening into Action methodology to equip managers			Slippage of projects due to absence of key project leads / resources. Slippage of one project impacting adversely on another objective/action due to interdependencies.	Continuous monitoring of resources and project plans to identify and rectify resourcing gaps as early as possible. Closely manage interdependent projects to timescale, with frequent updates.	Review by Transformation Board			DWOD	Senior Leadership Team
			To create a cohesive performance management framework for all staff groups, enabling staff to delivery high quality patient care									
			Development and implementation of a Staff Recognition and Suggestion Scheme									
			Build the capability of our leaders to embed a culture of behaviour and style of management which supports staff in fulfilling their duty of candour									
			Ensure managers build their skills to enable high quality appraisals and objective setting									
		We will take appropriate action to reduce the incidences of work related stress by introducing a number of measures that support all staff to undertake their role safely	Develop a Trust-Wide Work-Related Stress Action plan - using existing Divisional Stress plans to run in parallel with the development of a Trust Health and Well Being Strategy			Failure to implement Health and Wellbeing/Stress action plan due to lack of funding and resource.	Appropriate investment in HWB with identified resource and funding. Continuous monitoring of resources and project plans to address resourcing and funding gaps.	Review by Health and Safety Risk Manager Group			DWOD	Senior Leadership Team
			Health & Safety - evaluate policy and practice to focus high quality patient care to support the reporting learning from incidents including physical violence									
			Discrimination - review and scope opportunities for revised e-learning package to support managers									
		We will equip our leaders with the requisite skills, behaviours and tools to develop high performing teams, so staff have objectives with a clear line of sight to the Trust's vision.	Identify and agree who are our leaders and managers , clearly articulating and agreeing what it means to be a leader, with clear competencies and standards of behaviour.			Failure to comprehensively identify all staff with leadership roles due to limited definition of "leaders".	Agree definition of leaders e.g. those who are responsible for the development, performance and wellbeing of a number of staff and identify all those who fall within the definition, rather than relying on grade to indicate leadership.	Review by Transformation Board			DWOD	Senior Leadership Team
			Introduce comprehensive programme of quarterly leadership forums, annual leadership conference and access to learning sets - to ensure leaders understand the opportunities and challenges									
			Revise appraisals to include feedback on leadership competencies and behaviours - to include 360 or staff feedback.									
			Develop and agree a 1 - 3 year Organisational Development plan to provide continuous and systematic leadership development and the need to understand what leadership means as a cultural proposition.									
		We will revise the Teaching and Learning strategy to ensure the strategic priorities support an	To review the existing strategic priorities with the Teaching & Learning Steering Group			Misalignment of priorities with Trust strategic risk. Failure to work in partnership with providers and HEE.	Comprehensive review of education, teaching and learning.	Review by Teaching and Learning Group.			DWOD	Senior Leadership Team

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
		attractive and viable learning environment whilst continuing to provide exceptional care to our patients.	Revise the priorities in line with the draft strategic vision for UH Bristol									
			To provide a revised Teaching & Learning Strategy in March 2015									
4		Implement modern clinical information systems in the Trust	Phase 2 Implementation			IT implementations are inherently high risk generally.	Proper programme monitoring and management processes will manage the generic risks.	IM&T Committee and CSIP Committee			DoF	Information Management and Technology Committee
			Phase 3 Design									
		We will maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR)maintain our performance in initiating research) and remaining the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR)	(a) Monitor our performance and analyse reasons for failure to meet the benchmark (performance initiating research), putting in place measures to address those reasons			(a) failure to engage with services which can influence our performance in meeting the benchmark. (b) multiple stakeholders have different agendas and priorities (c) resistance of workforce to taking on more flexible (cross specialty) roles; true flexibility and mobility of research funding is required. (d) focus on clinical pressures consumes clinical divisions making it difficult to focus on research. (e) 'one size fits all' approach may not be suitable	(a) identify areas where there are blocks and work with them to streamline processes and help them understand their part and impact in delivering research. (b) clear communication, defined work plan and accountabilities agreed between R&I and division of W&C (c) standardised core JDs for research delivery staff; engagement by research matron with B7 research staff to understand need for flexibility (d) increased engagement and regular meetings with divisional staff at all levels. (e) work with each division to reach suitable solution.	Progress reports to Trust Research Group			MD	Trust Research Group
			(b) Develop and implement, in collaboration with the division of W&C, a sustainable staffing model to deliver paediatric research by the end of 2014/15									
			(c) Work towards developing a more flexible and agile mechanism to deploy the research delivery workforce across the trust in line with the R&I 'Workforce' work plan.									
			(d) Provide clinical divisions with the information they need to oversee and manage research performance, increasing visibility within divisional boards.									
			(e) Achieve common agreed processes across clinical divisions for job planning and recommendation of research SPA allocation.									
	We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR)	(a) Oversee and performance manage small grants which have been pump-primed by UH Bristol/Above and Beyond funding to deliver their objectives, increasing the conversion rate to NIHR grants over 2013/14 levels.			(a) and (b) capacity to manage process effectively may impact on performance (c) focus solely on UH Bristol opportunities may detract from allocating time to collaborative work	(a) and (b) new post (in development) to support research grants manager will release capacity (c) use cross-organisational networks currently in existence to maintain awareness of opportunities	Progress reports to Trust Research Group			MD	Trust Research Group
			(b(Identify opportunities for new submissions for NIHR grant funding within existing external and pump-priming grant holders									
			(c) identify collaborative opportunities for grant applications with our local and regional partners.									
		We will demonstrate the value of research to decision makers within and outside the trust	(a) Routinely identify recently completed grants and collate information about the outputs and potential impact			(a) clinical impact difficult to identify/quantify until some time after research has taken place (b) recognition of impact can be difficult to quantify (c) failure to identify appropriate stakeholders within the organisation	(a) maintain rolling programme of review; include impact on clinical care of the research practice during conduct. (b) engagement with clinical and research staff both directly and through the network of research staff (c) engagement with clinical division	Progress reports to Trust Research Group			MD	Trust Research Group
			(b) Identify clinical areas where the conduct of research has had a defined impact on the service delivery									
			(c) Disseminate information to relevant stakeholders (internal and external)									
		Transformation Priorities	Refresh our Transforming care programme, renewing the priority projects to achieve the aims of each pillar and mobilising focussed, benefits driven, rapid delivery project teams			Do not identify the right actions to address underlying issues We allow progress to drift	Scope sign off and monthly progress review by Transformation Board	Progress updates to Trust Board			COO	Transformation Board
			Establish structured progress monitoring by PMO reporting monthly to Transformation Board			Do not intervene to keep progress on track	Structured review by Transformation Board	Progress updates to Trust Board			COO	Transformation Board
			Mobilise delivery at pace; Communicate intentions to build organisation engagement and buy in			Do not act with pace	Transformation Board to hold to account for delivery	Progress updates to Trust Board			COO	Transformation Board
5		Ensure organisation support for developments under the Better Care Fund	UH Bristol to be represented at BFC meetings and provide steer on changes to the services we provide			Risk that the plans do not fully consider the existing savings plans required by the Trust (4%) and other partners.	Risk mitigated by highlighting this risk in the Bristol BCF submissions and ongoing attendance at meetings.	Better Care Fund external reviews.			COO	Senior Leadership Team
			Model any impact on UH Bristol services from proposed changes to models of care developed through the BCF Programme									
		We will effectively host the Operational Delivery Networks that we are responsible for.	Establish governance arrangements for both Critical Care Networks.			Clinical Directors for ODNs do not lead on agenda.	Hold assurance meetings with ODN Clinical Leads.	Evidence of delivery against objectives			MD	Senior Leadership Team
	We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care.	Fully engage with BHP agenda and governance.			Trust does not contribute to AHSc and BHP research agendas	Attendance at key AHSN and BHP Board and Executive meetings	Minutes evidencing attendance			MD	Senior Leadership Team
			Fully engage with AHSC governance and assist with strategic planning.									
		We will be an effective host to the networks we are responsible for including the CLARHC and Clinical Research Network	Establish robust internal governance including Board reporting for the CRN and CLARHC			Risk that CRN leads fail to lead on research agenda.	Monthly governance meetings with CRN Clinical Lead and Chief Operating Officer.	Minutes from governance meeting and feedback to Executive Team via work programme			MD	Senior Leadership Team

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
6	We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal	Deliver minimum normalised surplus	Achieve full delivery of annual CRES programme (detail provide below) and positive contract settlement with CCG and NHSE commissioners			LA sign off and North Somerset CCG to re-admissions	On-going discussions	Oversight by operational planning core group			DoF	Finance Committee
		Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas.	SLR development Use of result in informing Business Planning			Risks include non-adoption of efficiency opportunities by the Clinical Directors.	Risks not yet mitigated particularly re Medicine Division.	Updated Operating Plan at end of June will describe how the efficiency opportunities have been adopted in the Business Plans.			DoF	Finance Committee
		Deliver minimum cash balance	Maintain ratio of at least 15 days and cash balance of no less than £15m			No risk at present.	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.			DoF	Finance Committee
		Deliver the annual Cash Releasing Efficiency Savings (CRES) programme in line with the LTFP requirements	Ensure robust in year oversight of Divisional CRES plans through monthly Finance & Operations Review. Develop recurrent CRES plans to ensure all non-recurrent CRES is secured recurrently by Q3 2014 and delivery 14/15 CRES requirement on a normalised basis			It is considered that there is minimum risk to the plans currently identified. The real risk to delivering the target is a lack of new schemes coming through the pipeline process. There is a risk that there is a lack of knowledge and skill set amongst Trust staff in order to identify new savings schemes as well as a potential shortage of capacity in terms of time available for existing staff to focus on savings programme delivery.	Savings Programme plans are regularly reviewed each month at Divisional and Work stream accountability meetings . This helps to ensure that the current forecast delivery is robust. Work streams have been refreshed and are identifying additional savings through productivity. The Trust has engaged and experienced CIP Director who is working with Divisions in order to identify new savings and ensure delivery of existing schemes.	Divisions are held to account for this both at Monthly Divisional Savings Programme Reviews and more importantly the monthly Operational and Financial reviews chaired by the COO and attended by the DOF and other Directors. Monthly reports on progress are presented to the Finance Committee Internal Audit Report.		741	DoF	Finance Committee
		Refresh the Trust's Strategy including its direction for research & innovation and teaching & learning	Complete sustainability review of Trust key service areas and incorporate findings and response into Trust strategy and Monitor Five Year Strategic Plan concluded and approved by Board in June 2014			Workforce constraints prevent strategic plan from being completed.	Prioritisation of tasks within SD and Finance Teams	Programme Update to Clinical Strategy Group and Board on regular basis			D of SD	Senior Leadership Team
		Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decision as they arise.	Appraise the risks and benefits associated with forthcoming major, strategic choices e.g. SBCH, Community Child Health, Weston Area Health Trust and ensure the Board is adequately briefed and supported to make choices.			Workforce constraints prevent strategic plan from being completed and/or access to information to adequately evaluate strategic choices is not accessible	Prioritisation of tasks within SD and Finance Teams. Working closely with procurement leads in tendering organisations to ensure access to information.	Programme Update to Clinical Strategy Group and Board on regular basis			D of SD	Senior Leadership Team
		Continue to develop private patient offer for the Trust	Private patient 'front door' up and running and Private Medical Insurance contracts signed by end of Q1 Private Patient Strategy for 2015-2020 developed and presented to the Board by end of Q4 Monthly income and expenditure reports in place by end of Q2			Development of PP marketing approach is taking longer than anticipated which is impacting on agreement of the colour scheme for the 'front door' Private Patients Manager vacancy resulting in gap in resources for 3 month period.	Work underway between private services and communications to develop proposal for marketing approach. New Deputy Chief Operating Officer commences role in August 2014.	Private Patients Steering Group			COO	Senior Leadership Team
7		Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above.	Achieve EBITDA, Return on Assets, Net Surplus Margin and Liquidity ratio in line with plan			Delivery of CRES plans and reduction of premium cost services. Increase in volume of clinical activity to secure income from activities income in line with SLA and Trust Plan	Monthly Operational and Financial Reviews chaired by COO with Exec Director support.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.			DoF	Finance Committee
		Establish an effective Trust Secretariat to ensure all principles of good governance are embedded in practice and policy	Review, develop, consult and establish a new structure for the Trust Secretariat and recruit to all vacant post by end of December 2014.			Failure to secure staff support for proposed structure and/or recruitment to vacant posts is not achieved in a timely fashion.	Engage staff and their representatives in development of future structure and formally consult staff. Ensure roles, responsibilities and salaries are such that roles are attractive in market place.	Regular updates to Executive team through work programme oversight			Deputy CEO	Risk Management Group
			To review effectiveness of Board sub-committees including approach to workforce governance			Delayed appointment to Trust Secretary vacancy.	Establish satisfactory interim arrangements and commence recruitment as soon as practical with aim of new TS starting in October 2014.	Regular updates to Executive team through work programme oversight			Deputy CEO	Risk Management Group
			To scope and develop Terms of Reference for work programme to address current shortcomings in approach to Procedural Document Management.			Workforce constraints prevent project from being scoped and progressed.	Interim Trust Risk Manager appointed and PDM an early priority.	Regular updates to Executive team through work programme oversight			Deputy CEO	Risk Management Group
			Develop and deliver actions arsing from on-going external governance reviews e.g. Lawson Review, W&C Governance Review			Workforce constraints during interim period of TS vacancy delay implementation.	Establish satisfactory interim arrangements and commence recruitment as soon as practical with aim of new TS starting in October 2014. Establish action priorities and ensure focus on implementation of those.	Regular reports to Risk Management Group			Deputy CEO	Risk Management Group

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
	We will ensure we are soundly governed and are compliant with the requirements of our regulators	Robustly prepare for the planned Care Quality Commission inspection.	Develop and coordinate delivery of an action plan to coordinate preparation for CQC visit.			Vacancy for CQC project manager.	Out to advert. Contingency temporary staff if do not recruit.	Regular reports to CQC steering group and SLT/Execs			CN	Senior Leadership Team
			To develop a clear communicational support plan for staff.								CN	Senior Leadership Team
		Prepare for and achieve successful outcome from proposed Monitor investigation into performance concerns with the aim of reverting to a GREEN rating by Q2	To provide all necessary information, in a comprehensive and robust fashion, in advance of visit			Workforce capacity constraints	Prioritisation of this work, above lower priorities	Regular updates to Executive team through work programme oversight			Director of SD	Executive Directors
			Ensure team are adequately prepared for Monitor visit and key messages are appropriately develop and clearly communicated throughout the process.			Lack of preparation and availability of key personnel.	Adequate preparation	Regular updates to Executive team through work programme oversight			Chief Executive	Executive Directors
		Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways	To review findings of IST following their visit and agree actions to address recommendations and any resulting impact on RTT performance			Activity is on track against plan but the backlog numbers of patients waiting over Stage of Treatment (SOT) first outpatient waits is not reducing as per trajectory. Increases in demand over and above planned trajectory. Ability to recruit to vacancies / new consultant posts to support increased demand in system.	Weekly tracking of delivery against the first outpatient wait recovery plan. Improvements in the first outpatient wait PTL process, supported by validation to ensure PAS holds accurate data. Discussions with Emerson's Green to assess options for outsourcing where capacity issues exist.	RTT Steering Group RTT Operational Group Divisional PTL Meetings Elective Care (ECIST) external review Service Delivery Group		1967	COO	Senior Leadership Team
			Recovery plan for non-admitted monitored weekly and RTT non-admitted delivered by end of Q2									
			To be consistently achieving agreed waiting time standards - No patient waiting over 13 weeks for outpatients, no elective patient cancelled due to lack of beds and no patient waiting >40 weeks on a RTT pathway									
		Improve cancer performance to ensure delivery of all key cancer targets	Establishment of monthly Cancer Performance Steering Group			Ability to increase capacity for Thoracic pathways ahead of the vascular transfer. Vascular transfer not occurring in October 2014. ITU / HDU capacity and acuity. Where delays occur due to late referral, risk they will not accept responsibility for the breach.	Assessing options for putting on non-recurrent additional capacity to tackle the short term capacity pressures. Recruiting to Cancer Network posts who will take forward improvements in timeliness of inter-provider referrals. Vascular service transfer being overseen by the BRI Redevelopment Board. Operating Model 2014/15 - Planned Care / Protected Pathways project.	Cancer Steering Group Cancer Operational Group Cancer PTL Meeting Service Delivery Group		1412	COO	Senior Leadership Team
			Achievement of 62 day cancer standard from Q3 onwards									
			Transfer of breast screening patients on the cancer register to have been completed accurately by end of Q2									

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 19 – Corporate Governance Statement - Board Self Certification

Purpose

To provide the necessary assurance for the Board to be able approve the proposed Corporate Governance Statement

Abstract

Under the governance condition of the Provider Licence regime, the Board is required to submit the following self-certifications as part of its Annual Plan submission to Monitor on 30 June 2014:

- Corporate Governance Statement
- Joint Ventures and Academic Health Science Centre; and
- Training of Governors

The governance statement specifically requires the Board to confirm:

- Compliance with the governance condition at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, identifying (i) any risks to compliance; and (ii) any actions proposed to manage those risks.

This paper outlines the proposed response for each question and the assurance in place to support the Board's self-certification process.

Recommendations

The Board is recommended to:

a) Approve, in light of the assurances described in the attached paper (Appendix A), the Corporate Governance Statement for submission to Monitor on 30 June 2014, noting the potential risks to on-going compliance described in the paper alongside their specific mitigations.

b) Consider how the work of the Committees at both board and executive level, might better support assurances concerning this annual self-certification process for the future and ensure the agendas and work programmes of the Committees are driven accordingly.

Report Sponsor

Robert Woolley - Chief Executive

Appendices

Appendix A: Corporate Governance Statement 2013/14 – Sources of Assurance

Corporate Governance Statement - Board Self Certification

30 June 2014

1. Background

The Risk Assessment Framework (RAF) requires Foundation Trusts to submit both a 2-year Operational Plan and a 5-year Strategic Plan to Monitor, as part of the annual planning process. Monitor uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. Monitor will also assess the quality of the underlying planning processes.

Part of this annual planning process is the Board Statements, which for 2014/15 have been changed to reflect both Monitor's new licencing regime and the two-part planning submissions.

The Board Statements have now been replaced by a number of different statements and certifications relating to sections of the Risk Assessment Framework, provider licence and the Health and Social Care Act 2012, and are contained in the two submissions to Monitor, as follows:

31 May 2014 Submission (which was considered and approved at the May 2014 Board meeting)

- Availability of Resources Statement – as required by condition CoS 7 of the provider picence; and
- Certification regarding systems for compliance with the licence – as required by condition G6 of the provider licence.

30 June 2014 Submission

- Corporate Governance Statement – confirming compliance with condition FT (4) of the provider licence;
- Certification for Academic Health Science Centres (AHSC) – as required by Appendix E of the Risk Assessment Framework (only required for Trusts that are part of a joint venture or AHSC); and
- Training of governors statement – as required by section151(5) of the 2012 Act. (relates to the requirement for Foundation Trusts to ensure that Governors are equipped with the skills and knowledge they require to undertake their role).

The format for each of the above statements/certifications was issued by Monitor and the first series of statements were submitted for the Board's consideration and certification, prior to the 31 May 2014 submission deadline. The second submission is presented for consideration to the Board meeting on 30 June 2014 in conjunction with the Trust's Five Year Strategic Plan.

2. Introduction

Monitor uses a set of national measures to assess the quality of governance at NHS Foundation Trusts. Monitor assesses performance against these indicators as a component of the service performance score used to calculate governance risk ratings.

In accordance with Monitor's Risk Assessment Framework, to comply with the governance conditions of their licence, NHS Foundation Trusts are required to provide a statement (the **Corporate Governance Statement**) setting out:

- any risks to compliance with the governance condition; and
- actions taken or being taken to maintain future compliance.

The statement replaces the board statements that NHS foundation trusts were previously required to submit with their annual plans under the *Compliance Framework*. Where facts come to light that could call into question information in the corporate governance statement, or indicate that a Foundation Trust may not have carried out planned actions, Monitor is likely to seek additional information from the Foundation Trust to understand the underlying situation. Depending on the Trust's response, Monitor may decide to investigate further to establish whether there is a material governance concern that merits further action. The Trust is expected to submit its declarations to Monitor on 30 June 2014 immediately after the conclusion of the Board meeting.

3. Self-certification process

The Board declarations are made through the Corporate Governance Statements which are provided in the Risk Assessment Framework. A table top exercise has been undertaken with the aim of providing evidence relating to each of the component parts of the Corporate Governance Statement to support the Board's assessment of its compliance with each of the key questions, the identification of any risks sand mitigation and completion of the overall Statement. The proposed sources of evidence to substantiate thee statements in the Board's declaration is included as Appendix **A** to this paper.

Board members will need to reflect on their own sources of assurance, assess the adequacy and sufficiency of the evidence used to support each corporate governance statement included in this report and determine the adequacy and appropriateness of assurances necessary to self-certify.

In the event that the Trust is unable to fully self-certify, it must provide Monitor with commentary explaining the reasons for the absence of a full self-certification and the action it proposed to take to address the issues. Where the corporate governance statement indicates risks to compliance with the governance condition, Monitor will consider whether any actions or other assurance is required at the time of the statement or whether it is more appropriate to maintain a watching brief.

4. Recommendations

The Board is invited to:

a) Consider and, in light of the assurances described in the attached paper (Appendix A), certify each Statement and if unable to do so, agree what supporting commentary the Board wishes to submit;

b) Approve (including any amendments agreed) the Corporate Governance Statement for submission to Monitor on 30 June 2014; and

c) Consider how the work of the Committees at both board and executive level might better support assurances concerning this annual self-certification process for the future and ensure the agendas and work programmes of the Committees are driven accordingly.

Appendix A

CORPORATE GOVERNANCE STATEMENT 2013/14 – SOURCES OF ASSURANCE

	Corporate Governance Statement	Suggested evidence as assurance for Self-certification *(for internal reference only)*	Risks and mitigating actions	Proposed Board Response
1.	The Board is satisfied that University Hospitals Bristol NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Corporate Governance section of Annual Report outlining Code of Governance compliance • Constitutional review undertaken during 2014 • Audit and Board approved Annual Governance Statement provides assurance on the strength of Internal Control regarding risk management processes, review and effectiveness; • ISA 260/External Audit Opinion 2013/14 on Annual Report and Quality Accounts from PwC; • Head of Internal Audit Opinion and audit of quality indicators; • Approved Internal Audit Plan which demonstrates focus across the year; • Individual internal and external audits with action plans that have been approved by Senior Leadership Team; • Follow-up internal audit to check compliance with internal audit recommendations; • Trust Board Governance Structure; • Board Effectiveness Review; • Monitor Operational Plan 2014/15 -2015/16; • Quarterly progress reports against Corporate Objectives; • Quarterly submissions to Monitor on the Board's self-declaration on its anticipated financial and governance ratings; • Monthly quality and performance reports (including aggregated balanced scorecard) to	**1.1 Any risk(s) to compliance going forward** 1.1.1 Lack of capacity and resources to further embed Monitor's requirements of implementing good and effective corporate governance at all organisational levels. 1.1.2 Corporate and clinical governance not fully integrated **1.2 Mitigating actions** • Board cycle of business to include quarterly review of Corporate Governance Statement to ensure it remains an accurate assessment of the Trust's position; • Introduction of Board Assurance Statement twice per annum to support the Annual Governance Statement • Alignment of Clinical Audit Plan with Trust's agreed quality priorities (Quality Accounts); Further work required to embed process and to fully understand how audit has supported improvement in clinical outcomes of care • External Agency Recommendations Policy developed for implementation to ensure the full Board is sighted. • Strengthening of the Secretariat function to include a dedicated role with specific	**CONFIRMED**

		Quality and Outcomes Committee and Board; • Programme of regular quality reports and reporting to the Board in respect of patient safety, workforce issues and patient; experience including incidents, complaints and infection control; • Response to Francis • Monthly finance reports to the Board; • Quarterly review of Board assurance framework and annual assessment of strategic risks; • CQC Essential Standards of Care compliance reports/CQC Intelligent Monitoring Tool • Risk Management Strategy; • Corporate and Divisional Risk Registers; • IG Toolkit self-certification and implementation work • Mandatory training compliance – monitored by Board • Review of Code of Conduct for both Board and Council of Governors • SFIs, Scheme of Delegation and Standing Orders annual review to ensure all governing suite accords with the Trust's Constitution and the Act. • Board walk rounds • Staff appraisal performance monitored by Board	responsibility for Compliance and Business Assurance • Increased risk management focus, development and roll-out of a comprehensive risk training and awareness programme; review of risk management strategy.	
2.	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time.	• Monitor guidance generally implemented on an ongoing basis, e.g. Risk Assessment Framework board seminar session • Current review by the Executive Team of the recent the guidance on external governance reviews published by Monitor in May 2014 with a view to scheduling a Trust governance review;	**2.1 Any risk(s) to compliance going forward** 2.1.1 Lack of capacity and resources to fully embrace and adopt improved corporate governance processes, procedures and systems, leading to a potential degradation in the Trust's corporate governance effectiveness.	**CONFIRMED**

		• Self-assessment on Monitor's guidance in Dec 2013 on strategic planning undertaken • Annual review of compliance with Monitor's Code of Compliance • PwC technical updates to the Audit Committee advise on forthcoming changes to regulation • Circulation of Monitor's monthly FT Bulletin to board members	**2.2 Mitigating actions** • The proposed new lead for Compliance and Business Assurance will be responsible for reviewing guidance(s) from Monitor and producing briefing reports for the Executive Team, Trust Board (and Council of Governors (where relevant) on the implications of any new guidance and draw up plans for adoption and implementation plans where appropriate; • The Trust Secretary in conjunction with the Head of Workforce and OD to develop and roll-out an improved training and development programme in Q2 2014/15 for Board and Council of Governor members	
3.	The Board is satisfied that University Hospitals Bristol NHS Foundation Trust implements:		**3.1 Any risk(s) to compliance going forward** 3.1.1 Immaturity of existing committee and governance structures/lagging behind pace of external requirements leading to a loss of effective Trust Board oversight; 3.1.2 Committees become overburdened, thereby reducing effectiveness; 3.1.3 The Board committees become mired in operational detail and lose strategic focus; 3.1.4 The governance structure becomes cumbersome, increasing bureaucracy and resulting in loss of clear reporting lines. **3.2 Mitigating actions** • All Board Committees and Executive Assurance Committees review their terms of reference and carry out an annual	**CONFIRMED**
	a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those Committees; c) Clear reporting lines and accountabilities throughout its organisation;	• Board approved committee and governance structure structures, including review of committee membership; • Reports and minutes from Committees to the Board • Review of the effectiveness of the Board and its committees and an increase in the number of strategic board development/seminar sessions • Terms of reference in place for all governance committees and working groups • Annual reports from committees and review of terms of reference/ annual forward planners etc;		

		• Internal Audit reports on corporate governance related issues (Risk management, Integrated Governance, BAF, Data Quality, CQC compliance etc) • Board approved Annual Governance Statements for 2012/13 and 2013/14. • Annual self-assessment of compliance with Monitor Code of Governance • Review of the Trust Constitution (including Standing Orders), SFIs and Scheme of Delegation • Cross Board Committee NED Membership and reporting lines • Individual board members agree their objectives on annual basis • Board member appraisal and development plans • Board member training records • Performance Management Framework • Risk management strategy outlines flow of information through the organisation regarding risks and the management of corporate and local risks and how these are escalated and de-escalated Statutory disclosure of Director' responsibilities in Annual Report • Code of Conduct of Board Members (reviewed April 14) • Current Organisational Structure	effectiveness review /'fit for purpose' test on an annual basis; Alignment of meeting dates/terms of reference/forward planners etc for all committees • All Board sub-committees produce post meeting key issue reports to the Board to highlight areas of concern and good practice; any matters escalated for board approval. • Development in Q2 2014/15 of an *Assurance and Escalation Framework*, the aim of which will be to ensure that through the articulation of the assurance vision and explanation of key aspects within the relevant system and processes there is a common understanding throughout the Trust of what is meant by assurance and its importance in a well-functioning organisation • Development and roll-out an improved training and development programme in Q2 2014/15 for Board and Council of Governor members • Roll-out and embedding of the Performance Management Framework (approved by the Senior Leadership Team in June 14) • Development and roll-out of a Decision Rights Framework/Accountability Matrix in Q2 2014/15 • Development of a BAF Policy in Q2 2014/15 • External governance review commissioned in Q2 2014/15	

4.	The Board is satisfied that the Trust effectively implements systems and/or processes	• The Board has access on an ongoing basis to inform its assessment of the risks to compliance with its licence : – Monthly performance data is reported to the Board and reviewed in respect of targets and standards, under the risk assessment framework. In addition, the Board receives a programme of regular quality reports and monitoring information in respect of workforce, patient safety, patient experience including incidents, complaints and infection control; – Monthly Board finance reports track the overall financial position/performance against efficiency savings and key financial risks; – Quarterly consideration of Financial Risk Rating (FRR), Continuity of Service Risk Rating (CoSRR) through approval of submission to Monitor on the Trust's self-declaration on its anticipated financial and governance ratings; • Quarterly self-certification to Monitor and supporting narrative in reporting to Board • Monthly Chief Executive report to the Board • Annual Plan and business planning process/scrutiny /challenge	**4.1 Any risk(s) to compliance going forward** 4.1.1 Lack of capability, capacity and resources to effectively manage regulatory requirement of the Licence and to ensure adaption of systems and processes to meet such needs 4.1.2 Assurance of the accuracy, timeliness and consistency of data and reporting/performance tools with the potential to compromise decision-making 4.1.3 Financial sustainability/Delivery of Efficiency Programme 4.1.4 Lack of Board planning means gaps around compliance assurance reporting 4.1.5 Inconsistent, untimely data does not give the Board adequate insight of compliance and performance issues 4.1.6 Board does not have sufficient insight/awareness of risk to compliance **4.2 Mitigating actions** • The proposed new lead for Compliance and Business Assurance will provide day to day specialist advice, monitoring,	**CONFIRMED**
	a) To ensure compliance with the Licence's duty to operate efficiently, economically and effectively;			
	b) For timely and effective scrutiny and oversight by the Board of Licensee's operations;			
	c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professionals;			
	d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);			

	e) To obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.	• KPIs/Board metrics • Monitoring of complaints, survey results, incidents, claims and effective reporting mechanisms that provide intelligence triangulation • The Board's Finance Committee and the Quality and Outcomes Committee provide ongoing review, scrutiny and monitoring of required development actions throughout the year – ensuring the Board has appropriate mechanisms to respond should any concerns develop in year; • Annual internal audit programme confirmed by annual accounts audit opinion and ISA 260 report to Audit Committee • Divisional performance review meetings /service line meetings • Quarterly Board report on progress with key elements of the organisation's strategy and corporate objectives • Regular reporting to Quality and Outcomes Committee and Board on compliance with CQC Essential Standards • Information Governance Toolkit submitted annually • Cleanliness audits/PLACE inspections/Clinical Audit & Effectiveness programme /Infection Control Standards	supporting and carrying out investigations to ensure the development of effective compliance and assurance across the Trust. • Quarterly monitoring of Licence compliance reporting factored into the Audit Committee cycle of business (forward planner) • Risk to compliance identified via the Board Assurance Framework and assurance reported on a quarterly basis to Audit Committee and Board • NED confirm and challenge ongoing programme an priority focus • Roll-out of Performance Management Framework and tools such as • Further development of Service Line management, monitoring and reporting to enhance decision-making and timely action • Development of stakeholder mapping and engagement strategy/ implementation plan in order to inform, influence and enhance relationships across the health system (Commissioning, provision, scrutiny) • Robust challenge of going concern assumptions	

		• CCG Contract review meetings • Monthly Board finance reports presented to Finance Committee and Trust Board, including progress on delivery of efficiency savings programme • Internal audit reports on financial systems and controls • External audit report (ISA 260) on the 2013/14 annual report and accounts; an d • Approval of the financial plan as part of the 2014/15-2015/16 Operational Plan to Monitor • Annual cycle of business (forward planner) for Board and Board committees ensures appropriate scheduling of reports • Trust corporate risk register and Board Assurance Framework reports key risks for finance and performance • Board assessment of strategic risks • Risks and mitigations identified in Monitor's Operational Plan/ Annual Report and Long Term Financial Model (LTFM) • The Corporate Risk Register (CRR) is monitored by the Risk Management Group, Senior Leadership Team, Quality and Outcomes Committee and Board and mitigating action is recorded on the CRR.	• Board self-assessment of strategic planning process using Monitor's self-assessment tool published in Dec 13.	

		• Trust's going concern review • Cost Improvement Plans • Governance arrangements (Constitution, Standing Orders, SFIs, Scheme of Delegation) • Budget setting process • Annual Clinical Audit Plan • Board walk rounds • Staff and Patient Surveys • Review of SIs, RCAs link to learning, adherence, improvement		
5.	The Board is satisfied that the systems and/or processes referred to in paragraph [section] 5 should include but not be restricted to systems and/or processes to ensure:		**5.1 Any risk(s) to compliance going forward** 5.1.1 The Board has insufficient representation or focus on Quality 5.1.2 Insufficient time at meetings is dedicated to quality of care and the impact a decision made may have on quality 5.1.3 The Board does not receive adequate information to enable it to identify a deterioration in the quality of services or care delivery.	**CONFIRMED**
	a) That there is sufficient capacity at Board level to provide effective organisational leadership on the quality of care provided;	• Self-Declarations - Monitor • Outcome of appraisals • Board approved Nomination and Remuneration Committees Terms of reference • Details of training undertaken by NEDs and EDs • Induction programme • Board skills audit and a succession plan • Register of interests and standards of business conduct • Pre-employment checks; contractual conditions regarding other employment		

		• Constitution - Board composition and work of Remuneration Committee	**5.2 Mitigating actions** • Agendas are developed with appropriate regard for discussions relating to the quality of care • The Board's sub-committee responsible for quality, provides the Board with adequate assurance that the Board's decisions take timely and appropriate account of quality considerations • Quality Impact Assessments (QIA) are carried out as part of the risk assessment for Board decisions • The Board and its quality sub-committee, regularly review the insights into the quality of services provided through the dashboards and associated metrics for signs of any pending or actual deterioration in quality of care and takes robust and timely remedial action.	
	b) That the Board's planning and decision-making processes take timely and appropriate account of quality and care considerations;	• Approved Quality Strategy • Quality Accounts – priority development process and monitoring • Patient Story and follow up to every Board meeting • Board line of sight – walk rounds, • Confirm and challenge focussing specifically on complaints process – complaints trends and themes to Board • External assurance (re Quality Account) • CQC Intelligent Monitoring Tool • CQC Compliance assessment - Quality report • Annual Plan • Head of Internal Audit Opinion • Quality impact assessments • Monthly and Quarterly Quality reports – complaints/surveys themes and trends • Board dashboard – further work progressing regarding triangulation of e.g. claims/complaints/incidents • Clinical Audit plan improvements – time required to understand progress and link to improvements in outcomes of care		
	c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	• External assurance (re Quality Account) • CQC Intelligent Monitoring Tool • Annual Plan • Director of Internal Audit Opinion • IPR • IG toolkit compliance reporting • Clinical audit plan improvements in process • CQUIN performance reports • Committee meeting minutes focusing on quality improvement		
	d) That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;			

		• Complaints, claims and incidents report • SUI reporting to Board each month and through QOC committee, robust RCA process with further work commencing to improve learning loop and dissemination of learning • Board monthly quality dashboard • Survey outcomes to Board with remedial actions • Data quality focus increasing – validation, internal audit focus, business analysts, coding, Buddying arrangements etc		
	e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	• Annual Plan – bottom up – divisions, governors, CCG, Council • Friends & family test • Patient Survey • Staff Survey • CQC Intelligent Monitoring Tool • Board walk rounds • CoG Project Focus Groups – independent, influencing agenda CoG and committees • Governor feedback – PLACE audits etc		
	f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to Board where appropriate.	• Quality Strategy driving analysis of Trust's performance on key quality metrics • Direct link to quality improvement through quality accounts and quality strategy • Nurse staffing reporting mechanisms to Board (Berwick) • Board walk rounds • Board approved Committee ToRs – clear responsibilities • Head of Internal Audit opinion • Patient surveys • Staff surveys • Incidents, complaints and claims report • Serious Incident process and reporting		

		• SUI reporting to Board • Executive job descriptions • CQC standards reporting – Outcome Guardian work/focus • Ward dashboards • Service improvement focus • Transformation Strategy • Risk registers are supported and fed by quality issues captured in Divisional registers – more work to gain confidence of effectiveness of this at service line down to ward level • SLT escalation protocols re off plan performance/quality • Performance management framework		
6.	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are suitably qualified to ensure compliance with the conditions of its NHS provider licence.	• A formal, rigorous and transparent procedure is followed for the appointment of new directors to the Board • Board approval of composition/ Constitution Review • Board contains appropriately qualified DoF, MD and DoN/Chief Nurse • re-employment checks • Annual skills and competencies audits • Annual appraisal process • Minutes of Nomination and Appointments Committee (EDs)/Council of Governors' Nomination and Appointments Committee (NEDs) • Nursing staffing review/monitoring of nursing numbers • Revalidation process for doctors has been implemented • Outcomes from appraisals and revalidation • HR policies and procedures	**6.1 Any risk(s) to compliance going forward** 6.1.1 The inability to recruit Board members with the right skill mix and/or appropriate qualifications 6.1.2 Supply and availability of suitably qualified clinical staff **6.2 Mitigating actions** • Processes for recruitment of Board members reviewed periodically for compliance with best practice • The Board annually reviews its skill mix and ensure alignment with strategic plans to ensure capability to deliver • Regular nursing recruitment drives	**CONFIRMED**

		• Induction Programme in place for board members • Board seminar programme in place		
7.	TRAINING OF GOVERNORS The Board is satisfied that during the financial year, most recently ended the Trust has provided the necessary training to its Governors as required by in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role	In consultation with the Council of Governors, a development programme for Governors has been in place during 2013/14 and is being strengthened for 2014/15. The programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively and to discharge their responsibilities with enhanced levels of insight. The programme reflects Monitor's guidance for governors and was co-created with governors using self-assessment and short-life task and finish groups. Attendance at these development seminars is mandatory for governors. There is also range of other opportunities for training and development provided to governors in the course of their attendance at various project focus groups and other meetings and activities throughout the year.	7.	**CONFIRMED**
8.	**CERTIFICATIONS ON ACADEMIC HEALTH SCIENCE CENTRE (AHSCS) AND GOVERNANC**E For NHS Foundation Trusts: • That are part of a major Joint Venture or AHSCS; or • Whose Boards are considering entering into either a major Joint Venture or an AHSC.	Not applicable for the current financial year.	8.	**NOT APPLICABLE**

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

20 – Monitor's Letter regarding University Hospital Bristol's performance in Quarter 4.

Purpose

To brief the Board on the results of the Quarter 4 Compliance Framework Monitoring Exercise.

Abstract

Monitor's analysis of Q4 is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 4
- Governance risk rating – Considering Investigation

The Trust has failed to meet the 62day (GP referral) cancer, the A&E 4 hour wait, the Referral to treatment (non-admitted) and C.difficile targets which has triggered consideration for further regulatory action. For this reason the Trust's governance risk rating is Under Review.

Recommendations

The Board is recommended to note the report.

Report Sponsor

- Chief Executive

Appendices

- Appendix A – BRISTOL 1314 Q4 executive summary

6 June 2014

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

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Making the health sector work for patients

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Dear Robert

Q4 2013/14 monitoring and 2014/15 annual plan review of NHS foundation trusts

I am writing to you in respect of our review of the two year operational plan phase of the 2014/15 annual plan review (APR) as well as the Q4 2013/14 monitoring cycle.

The purpose of Monitor's review of operational plans is to assess whether foundation trusts (FTs) are effectively planning for the future while maintaining and improving quality. This enables Monitor to make a more informed judgement about future risks to the Trust's compliance with its licence conditions.

Under the APR process all FTs are subject to high-level review of two-year operational plans. Following this, and alongside our Q4 monitoring, Monitor determines if a change in regulatory approach is required on a trust by trust basis. This may include specific planning focused actions[1] or Monitor could consider whether to take any regulatory action under the 2012 Act, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[2] and the Risk Assessment Framework[3].

As set out in our letter dated 16 May 2014[4], at an aggregate level, Monitor's review has highlighted significant concerns about the quality of the sector's planning, particularly that year two of the plans may, on aggregate, be overly optimistic. We ask that you bear this in mind when completing your strategic plan.

In addition, where Monitor has identified specific weakness in individual plans we may ask individual FTs to resubmit their plans as part of the strategic plan submission.

[1] Please see section 2.5 of Monitor's Annual plan review 2014/15 guidance
[2] www.monitor-nhsft.gov.uk/node/2622
[3] www.monitor.gov.uk/raf
[4] APR update letter 16 May 2014

Risk ratings

Monitor has now completed the review of your two-year operational plans[5] and Q4 submissions.

Based on this work, the current and forecast risk ratings are:

	Q4 13/14 (actual)	Q1 14/15 (plan)	Q2 14/15 (plan)	Q3 14/15 (plan)	Q4 14/15 (plan)
Continuity of service risk rating	4	4	4	4	4

Governance risk rating	Considering Investigation

The governance rating represents Monitor's current view of governance at the Trust. The Trust therefore has a single rating.

These ratings will be published on Monitor's website in June. We would emphasise that the forecast continuity of service risk ratings are the FT's own risk ratings as submitted in the operational plan and as such are never adjusted by Monitor.

The Trust has failed to meet the 62day (GP referral) cancer, the A&E 4 hour wait, the Referral to treatment (non-admitted) and C.difficile targets which has triggered consideration for further regulatory action. For this reason the Trust's governance risk rating is Under Review.

Monitor uses the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it, could indicate that the trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the 2012 Act, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[6] and the Risk Assessment Framework[7].

As discussed at our meeting on 2 June 2014, the Trust's governance risk rating will remain Under Review whilst we gather further information with regards to the targets breached by the Trust at Q4. We have scheduled a meeting with the Trust on 16 June 2014 to allow the Trust to present on its plans to return to compliance and to further discuss our concerns. Following this meeting we will determine what, if any, further regulatory action is required.

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[5] Please note that these findings are interim as we consider both the operational and strategic plans part of the same process. As previously communicated in our guidance, final APR findings will be provided to FTs in October 2014 following review of the five-year strategic plan submissions.

[8] www.monitor-nhsft.gov.uk/node/2622

[9] www.monitor.gov.uk/raf

Other than the above there are currently no further changes to our regulatory approach as a result of our review of the Trust's operational plan.

Next steps

A report on the FT sector aggregate performance from Q4 2013/14 will shortly be available on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we will shortly be issuing a press release setting out a summary of the key findings across the FT sector from the Q4 and APR monitoring cycle.

We will also publish on our website, under your entry in the Public Register of NHS foundation trusts, the commentary/summary document of the operational plan excluding any appendices in a similar format to previous years.

Please note that as previously communicated in April's FT bulletin[8] we are not attaching an executive summary of our quarterly review as we have done previously.

If you have any queries relating to the above, please contact me by telephone on 02037470485 or by email (Amanda.Lyons@Monitor.gov.uk).

Yours sincerely

Amanda Lyons
Senior Regional Manager

cc: Dr John Savage, Chairman
Mr Paul Mapson, Finance Director

[8] FT Bulletin April 2014

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

22 – Standing Financial Instructions and Scheme of Delegation

Purpose

To report to the Board on proposed changes to the Trust's Standing Financial Instructions and Scheme of Delegation.

Abstract

The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) were last reviewed and amendments considered and approved at meetings of the Finance Committee and Trust Board in March 2013.
This report informs the Trust Board of changes proposed to the SFIs and SoD following the annual review. These have been considered by the Finance Committee in their meeting on the 27th June 2014 for ratification by the Trust Board.
The changes are described in the attached report.

Recommendations

The Board is recommended to approve the changes as set out in the report.

Report Sponsor

- Paul Mapson, Director of Finance

Appendices

- Appendix A – Standing Financial Instructions Report
- Appendix B – Standing Financial Instructions and schedule of matters reserved to the Board
- Appendix C – Scheme of Delegation, original and revised.

Standing Financial Instructions and Scheme of Delegation

1. Introduction

The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) are required to be reviewed on an annual basis. Any changes must be considered by the Finance Committee before being recommended for approval at the Trust Board. This was last done at the Trust Board meeting in March 2013.

The purpose of this report is to inform the Trust Board of proposed changes to the SFIs and SoD following the annual review process. These changes have been considered by the Finance Committee at their meeting on the 27th June 2014.

The revised SFIs and schedule of matters reserved to the Board are attached at appendix B. To enable the committee to review the changes, additions are highlighted in yellow and words being removed are crossed through. The changes are summarised below.

2. Proposed Changes

The changes can be considered under the following categories:

- Changes to titles of people/groups
- Changes following national financial changes
- Changes reflecting revised operational practice
- Other

This report does not detail where paragraphs have been moved within a section or words have been changed to aid understanding without changing the meaning of the SFIs.

2.1 Changes to titles of people and groups

The following changes have been made throughout the document:

Trust Management Executive to Senior Leadership Team
Divisional Director to Clinical Chair or Divisional Director as appropriate
Cost improvements to savings programmes
Capital Plan to Medium Term Capital Programme

2.2 Changes following national changes

The Trust no longer has a prudential borrowing limit and therefore all references to the need for the Trust to comply with it have been removed, (2.2.3(c), 2.4.2(a), 6.2).

The Trust no longer has a working capital facility requirement or limit and this has been removed (6.2.6, 6.2.10, 6.2.11).

The NHS Capital Investment Manual has been scrapped and reference has been removed (14.3.3).

Protected assets have been redefined as Commissioner Requested Services (CRS) assets and references have been changed (6.2.1, 6.2.9).

2.3 Changes reflecting operational practice

The Trust's electronic requisitioning and ordering system (EROS) has systems controls, including a requirement that every requisition is authorised by a second person (vetting by a third person is optional and depends on the order value). The goods can be receipted by the requisitioner, authoriser or third person, thereby achieving separation of duties. The original paragraph wording caused ambiguity and has been made clearer.

Reference is now made to the need for fund advisors to comply with written procedures issued by the Trustees (16.2.5).

Reference is now made for the need to ensure any charitable donations for capital investment requires the approval of the Capital Programme Steering Group (19.2.10)

The schedule of matters reserved for the Board has been revised to reflect the Capital Investment Policy, whereby capital expenditure/investment is recognised as the same thing and Board approval is required for high risk and schemes over 1% of turnover.

2.4 Other

Overdraft has been replaced by the term working capital facility.

References to Private Finance Initiative have been changed to commercial/private finance (19.3) to reflect the Trust's wider options.

2.5 Scheme of Delegation

The Scheme of Delegation is attached at appendix C. The previous and revised formats are given to enable the changes to be reviewed. The changes are as follows:

- 1b and 3d have been added as per the SFIs
- 3b now reflects the Capital Investment Policy that was approved by the Finance Committee in May 2014.
- 3c has been added to reflect the authorised signatory list in place.
- Section 4 has been updated to reflect the Capital Investment Policy and elements have been moved under section 3, reflecting that there is in effect no difference between capital expenditure and capital investment authorisation limits.
- 16v has been added to incorporate research network hosting responsibilities.
- Changes are made as per section 2.1 above

3. Recommendation:

The Trust Board is asked to consider and approve the changes set out above.

University Hospitals Bristol NHS
NHS Foundation Trust

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

JUNE 2014

Approved at Finance Committee:
Approved at Trust Board:

Contents

1. Introduction

1.1 Purpose and Content

1.1.1 These Standing Financial Instructions (SFIs) regulate the conduct of the Trust, its Directors and Officers in relation to all financial matters. ~~They shall have effect as if incorporated in the Trust's Standing Orders (SOs).~~

1.1.2 These Standing Financial Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law, the requirements of the Independent Regulator and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way the Trust manages public resources. They should be used in conjunction with the Standing Orders, Schedule of Matters Reserved to the Trust Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice and should be read in conjunction with the relevant departmental guidance and the financial procedure notes (available on the intranet or via the Finance Department). All detailed financial procedures must be approved by the Director of Finance.

1.1.4 These Standing Financial Instructions do not include applicable Regulator's guidance, the current version of all relevant guidance should be consulted. They also do not contain every legal obligation applicable to the Trust.

1.1.5 Each section in the Standing Financial Instructions clearly sets out its objectives and the financial responsibilities, policies and procedures relevant to it which must be complied with. When situations arise which are not specifically covered by this document, staff and Trust Board members are required to act in accordance with the spirit of the instructions as set out in the objectives.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.7 These Standing Financial Instructions have been reviewed by the Trust's Finance Committee and approved by the Trust Board. It is expected that all staff employed by the Trust will comply with these instructions at all times. **The failure to comply with the Trust's standing financial instructions and standing orders could result in disciplinary action up to and including dismissal**. Should any other guidance or departmental policies appear to conflict with these instructions, these Standing Financial Instructions will prevail. Any apparent conflict should be brought to the attention of the Director of Finance.

1.1.8 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.1.9 These Standing Financial Instructions and associated scheme of delegation should be reviewed annually.

1.2 Responsibilities and Delegation

1.2.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Matters Reserved to the Trust Board at Appendix 1. Those aside, all executive powers are invested in the Chief Executive, who in turn will delegate powers to appropriate Officers or Committees.

1.2.2 The Scheme of Delegation, at Appendix 2, contains all delegated powers. Should responsible officers delegate any of these powers to other individuals within their organisational control, a full record should be maintained with evidence of authorisation.

1.2.3 The Trust Board

~~The Trust Board has resolved that certain powers and decisions may only be exercised by the Board in formal session, as set out in the Schedule of Matters Reserved to the Trust Board. All other powers have been delegated to such other committees as the Trust has established.~~

The Trust Board exercises financial supervision and control by:

(a) formulating the Trust's financial strategy,

(b) approving the Trust's budgets, ensuring they are within approved allocation/income limits;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) approving specific responsibilities placed on members of the Board and employees as set out in the Scheme of Delegation.

1.2.4 The Chief Executive and Director of Finance

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

The Chief Executive

The Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State and Independent Regulator, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is a duty of the Chief Executive to ensure that members of the Board and employees, including ~~and~~ all new appointees, are notified of and ~~put in a position to~~ are required to understand their responsibilities within these instructions.

The Director of Finance

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies, and ~~for~~ coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(i) the provision of financial advice to other members of the Board and employees;

(ii) the design, implementation and supervision of systems of internal financial control;

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.5 **All Trust Employees**

All Trust Employees have a responsibility for ensuring probity and accountability in all of their work for the Trust. In particular they are severally and collectively responsible for:

(a) the security of the property of the Trust.

(b) avoiding loss.

(c) exercising economy and efficiency in the use of public resources.

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation, Constitution and NHS Provider Licence.

For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must ~~be to the satisfaction~~ meet the requirements of the Director of Finance.

1.2.6 **Contractors and their Employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2. Business Plans, Budgets and Budgetary Control

2.1 Objective

2.1.1 **To ensure the Trust Board is provided ~~provide the Trust Board~~ with the ~~sufficient~~ information required regarding ~~on~~ the development of the Trust's activities and finances to enable the Trust's Directors to fulfil their responsibilities. To ~~give~~ provide assurance that the Trust exercises proper control of income and expenditure throughout the year. To ~~provide~~ inform budget managers with their delegated responsibilities**

2.2 Preparation and Approval of Annual Plans and Budgets

2.2.1 The Chief Executive will, with the assistance of the Director of Finance, compile and submit to the Trust Board an annual financial plan, taking into account financial targets and forecast income and service developments. The annual plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan.

2.2.2 The Chief Executive will, with the assistance of the Director of Finance, compile and submit to the Independent Regulator of Foundation Trusts (Monitor) ~~Board~~ all strategic and operational plans required by them in accordance with their guidance and submission dates. This information will be prepared by the Trust's Officers who must have regard to the views of the Council of Governors.

2.2.3 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit an annual revenue budget for approval by the Board. This will:

(a) be in accordance with the aims and objectives set out in the Trust's annual business plan

(b) accord with ~~workload~~ capacity and workforce plans

(c) be produced in accordance with principles agreed with the Senior Leadership Team as advised by the Director of Finance ~~following discussion with appropriate budget holders~~

(d) be prepared within the limits of available resources ~~funds with regard to the Prudential Borrowing Limit~~

(e) identify potential risks

2.2.4 The Director of Finance is responsible for the co-ordination and preparation of the overall Trust budget within the total income receivable by the Trust, and in accordance with its agreed strategies and policies. Operational budgets shall be set at the beginning of each financial year by financial and operational managers in line with the Trust's approved budget.

2.2.5 Operational plans shall be compiled for each Division by the Clinical Chairs and Divisional Directors ~~Head of Division~~ and for each corporate service area by the Head of Service. These plans should reflect the Trust's annual business plan and budget and will be approved by the Chief Executive

2.2.6 Officers must provide financial, statistical and any other relevant information as required by the Director of Finance for the compilation of business plans and budgets.

2.3 Budgetary Delegation

2.3.1 The Chief Executive may delegate the management of budgets for defined services to the Clinical Chairs/Divisional Directors or Heads of ~~Division/~~Corporate Services responsible for the management of those services. Delegation and associated responsibilities must be clearly communicated. Control of budgets shall be exercised in accordance with these Standing Financial Instructions and supplementary guidance issued by the Director of Finance.

2.3.2 Clinical Chairs, Divisional Directors and Heads of ~~Division/~~Corporate Service with budgetary responsibility must ensure that their budgets are structured appropriately to ensure effective budgetary control. Whilst accountable for the overall budget management, Clinical Chairs, Divisional Directors and Heads of ~~Division/~~Corporate Service are authorised to delegate the management of specific budgets to named budget managers. Delegation and associated responsibilities must be clearly communicated to these budget managers. It is the responsibility of the Head of Division/Corporate Service to ensure the budget structure and delegation to budget managers is maintained in line with organisational and staff changes

2.3.3 The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Trust Board, except as specified below:

(a) The Chief Executive may vary the budgetary limit of a Division or Service within the Trust's total budgetary limit.

(b) Clinical Chairs, Divisional Directors and Heads of ~~Division/~~Corporate Service are permitted to authorise expenditure over the budget on individual budgets within their delegated areas provided this does not cause their delegated budget area to overspend or to exceed the financial limit set by (a) above.

2.3.4 Budgets shall only be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement.

2.3.5 Non-recurring budgets must not be used to finance recurring expenditure unless authorised by the Director of Finance.

2.3.6 Expenditure for which there is no provision in an approved budget and is not subject to funding under the delegated powers of virement, or approved procedures for new funding obtained during the year, may only be incurred if authorised by the Chief Executive.

2.3.7 Budget limits, individual and group responsibilities for the control of expenditure, exercise of virement, and achievement of planned levels of income and expenditure, shall be set out annually in a Resources Book approved by the Trust Board.

2.4 Budgetary Control and Reporting

2.4.1 The Chief Executive shall require the Director of Finance to ensure effective systems of budgetary control. All Trust staff responsible for the management of a budget or for incurring expenditure or collecting or generating income on behalf of the Trust must comply with these controls.

2.4.2 The Director of Finance is responsible for providing budgetary information and advice to enable the Board, Chief Executive and other officers to carry out their budgetary responsibilities. This includes:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date against plan and forecast year-end position,

(ii) the statement of financial position, changes in working capital and other material balances,

(iii) monthly cash flow monitoring of actual against plan and forecast year-end position,

(iv) capital expenditure against plan and forecast year-end position,

(v) explanations of any material variances from plan,

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation,

(vii) performance against the Independent Regulator's Risk Assessment Framework. ~~and Prudential Borrowing Limit.~~

(b) The issue of timely, accurate and comprehensible advice and financial information to all budget holders, covering the areas for which they are responsible,

(c) The provision of clear financial processes and procedures,

(d) Training and support to budget holders to allow them to undertake their financial responsibilities,

(e) Investigation and reporting of variances from financial, activity and workforce budgets,

(f) Monitoring of management action to correct variances,

(g) Arrangements for the authorisation of budget transfers.

2.4.3 The Director of Finance shall keep the Chief Executive and Board informed of the financial consequences to the Trust of changes in government policy, pay, terms and conditions, accounting standards and any other events affecting the current or future financial plans of the Trust.

2.4.4 All delegated budget managers are responsible for ensuring that:

(a) they check and validate all monthly budget statements,

(b) they fully understand their financial responsibilities and have received the required training and support to understand the financial information presented to them to fulfil these responsibilities,

(c) any likely overspending or reduction of income, which cannot be met by virement, is not incurred without the prior consent of the Head of Division/Service as per 2.3.3 (b) above,

(d) their delegated budget is only used in whole or in part for the purpose it was provided for, subject to the rules of virements,

(e) no permanent employees are appointed without the required approval as set out in section 7.3.2 and are provided for within the available resources and workforce establishment as approved by the Board,

(f) ~~cost improvements, cost~~ savings programmes and income generation initiatives are implemented to achieve a balanced budget,

(g) all expenditure is approved and authorised in advance of commitment in line with financial processes and procedures issued by the Director of Finance.

2.4.5 The Chief Executive is responsible for authorising the implementation of cost improvements, cost savings and income generation initiatives in accordance with the requirements of the Annual Business Plan to secure a balanced budget.

2.5 Capital Expenditure

2.5.1 The Director of Finance is responsible for compiling and submitting to the Board for approval an annual capital programme, ensuring that the planned expenditure is in line with available resources. Performance against the capital programme, forecast out-turn, and changes in capital allocation must be reported to the Board monthly.

2.5.2 The Director of Finance is responsible for submitting to the Independent Regulator (Monitor) all capital programme information required by them in line with their requirements and timescales.

2.5.3 The general rules applying to delegation, control and reporting above shall also apply to capital expenditure, (see section 19 for details relating to capital investment).

2.6 Research and Innovation

2.6.1 All applications for research and innovation funding require approval from the Director of Finance or a designated deputy. This applies to applications to NHS institutions such as grant requests to the National Institute for Health Research, and to applications to non-NHS organisations, such as charitable bodies and research councils.

2.6.2 All other documents (including commercial research and innovation contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments) relating to research & innovation, require approval from the Director of Research & Innovation or a designated deputy, ensuring all the necessary checks have been carried out, including finance checks where applicable.

2.6.3 The general rules applying to delegation, control and reporting above shall also apply to research and innovation projects.

3. Service Agreements for the Provision of Healthcare Services

3.1 Objective

3.1.1 **To ensure that the Trust's service agreements for the provision of healthcare services are properly planned and controlled and that all income relating to these agreements is properly accounted for.**

3.2 Service Agreements

3.2.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable legally binding contracts with service commissioners for the provision of NHS services. Appropriate legal advice identifying the Trust's liabilities within the terms of the contract should be considered. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services; and
- any model contracts issued by the Department of Health.

Where the Trust makes arrangements for the provision of services by non-NHS providers, the Chief Executive is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided.

3.2.2 In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

(a) costing and pricing of services, including contract currencies;
(b) payment terms and conditions;
(c) amendments to contracts and extra-contractual arrangements;
(d) payment by results.

3.2.3 Agreements should be devised as to minimise risk whilst maximising the Trust's opportunity to generate income. The Trust will use the National Tariff where appropriate and, for services not covered by the National Tariff, a local tariff agreed with the Commissioners.

3.2.4 All agreements should aim to implement the agreed priorities contained within the Annual Plan. National guidance on arrangements for contracting should be taken into account.

3.2.5 The Chief Executive is responsible for ensuring the Trust has the required internal processes in place to support the production of the proposed agreements and negotiation with NHS Commissioners. All Trust staff involved with these processes must ensure that they comply with these processes and provide information in support of these processes as required.

3.3 Service Agreement Monitoring and Reporting

3.3.1 The Director of Finance is responsible for ensuring that systems and processes are in place to record patient activity, invoice and collect monies due under the agreements for the provision of healthcare services.

3.3.2 The Director of Finance is responsible for reporting to the Board the Trust's actual contract activity and income due against the agreed contracts with an assessment of the financial impact of any contract under/over achievement.

3.3.3 The Director of Finance is responsible for providing information to Clinical Chairs, Divisional Directors and Heads of ~~Division/~~Corporate Service for the actual contract activity and income due against the agreed contracts and the associated financial consequences for their service areas to facilitate financial management.

3.3.4 The Director of Finance is responsible for ensuring training and support to the Clinical Chairs, Divisional Directors and Heads of ~~Division/~~Corporate Service to be able to understand the contracts for their service areas and the information relating to activity and financial performance.

3.3.5 All Clinical Chairs, Divisional Directors and Heads of ~~Division/~~Corporate Service responsible for the management of service agreement income must ensure they understand and use the contract monitoring information for the financial management of their service areas.

4. Annual Accounts and Reports

4.1 Objective

4.1.1 **To ensure the production of the Trust's Annual Accounts and Report in accordance with statutory requirements**

4.2 General

4.2.1 The Director of Finance, on behalf of the Trust, is responsible for the preparation and submission of financial reports and returns as required by the Independent Regulator (Monitor) and other Government Departments in such form as they require and in accordance with their timetable.

4.2.2 The Director of Finance, on behalf of the Trust, is responsible for the preparation and submission of the Trust's annual accounts as required by the Independent Regulator (Monitor) in such form as they require and in accordance with their timetable.

4.2.3 The Trust's financial returns and annual accounts will be prepared in accordance with the accounting policies and guidance issued by the Independent Regulator (Monitor), with the approval of HM Treasury, the Trust's accounting policies, International Financial Reporting Standards and other accounting standards applicable at the time. The Director of Finance is responsible for ensuring the Trust's accounting policies are reviewed annually, updated as required and approved by the Audit Committee.

4.2.4 The Trust's annual accounts must be audited and certified by an independent external auditor (see section 17) and the Director of Finance is responsible for ensuring this happens in accordance with the Independent Regulator's timetable.

4.2.5 The Trust's Company Secretary, on behalf of the Trust, is responsible for the preparation and submission of the Trust's Annual Report to the Independent Regulator (Monitor) in such form as they require and in accordance with their timetable.

4.2.6 The Trust's annual report (including the quality report) must be audited and certified by an independent external auditor (see section 17) and the Company Secretary is responsible for ensuring this happens in accordance with the Independent Regulator's timetable.

4.2.7 The Trust's annual report and statutory accounts must be presented to the Trust Board for approval. They must be laid before Parliament, after which they cannot be changed. They must be made available for inspection by the public. The annual report and accounts and the auditor's report must be presented at a meeting of the Council of Governors in accordance with the Independent Regulator's timetable. ~~once they have been laid before Parliament.~~

5. Banking, Cash and the Investment of Cash Surpluses

5.1 Objective:

5.1.1 **To ensure the effective management of the Trust's cash and to ensure it is properly controlled and safeguarded from loss and fraud.**

5.2 General

5.2.1 The Director of Finance is responsible for producing a Treasury Management Policy, in accordance with any relevant guidance from the Independent Regulator, for Trust Board approval.

5.2.2 The Director of Finance is responsible for the operation of the commercial bank and Citi Bank accounts and for the management of accounts receivable, cash flow forecasting and investment of surplus funds. The Director of Finance will ensure that these functions are properly managed and that information is provided to the Trust Board to support this.

5.3 Banking Arrangements

5.3.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued by the Regulator.

5.3.2 The Director of Finance shall prepare procedural instructions on the operation of all commercial bank accounts, investment accounts and Citi Bank for the approval by the Finance Committee.

5.3.3 The Finance Committee shall ensure proper safeguards are in place for security of the Trust's funds by:

(a) approving the Trust's commercial bankers, selected by competitive tender.
(b) approving a list of permitted 'relationship' banks and investment institutions.
(c) setting investment limits for each permitted investment institution.
(d) approving permitted types of investments /instruments.
(e) approving the establishment of new/ changes to existing bank accounts.

5.3.4 The Director of Finance is responsible for ensuring approved bank mandates are in place for all accounts and that these are updated regularly for any changes in signatories and authorised limits.

5.3.5 The Director of Finance is solely authorised to open, operate and control any bank account where Trust funds are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any officer of the Trust outside of the organisational control of the Director of Finance to operate such an account.

5.3.6 Any Trust Officer wishing to manage non Trust funds such as ward funds or funds from donations are required to do so through the Charitable Trustees who will operate the accounts on their behalf. It is not permissible for such an account to be held in the name of a Trust Officer as it can create a lack of transparency and allow the officer's integrity to be questioned.

5.3.7 The Trust's Commercial Bankers shall be selected by competitive tenders and formally approved by the Finance Committee**.** Competitive tenders shall be sought at least every 5 years.

5.3.8 The Director of Finance, on behalf of the Finance Committee**,** shall advise the Trust's commercial and relationship bankers in writing of the conditions under which each account shall be operated, the limits to be applied to any overdraft, the limitation on single signatory payments and the officers authorised to release money from and draw cheques or other payable orders on each account. This must contain

the Chief Executive and Director of Finance. The cancellation of any such authorisation shall be notified promptly to the bank.

5.3.9 Where a new banking relationship is suggested this must be pre-approved by the Director of Finance before a proposal is made to the Finance Committee. The Finance Committee will consider the need for and potential benefit of the new relationship and sanction or reject the proposal. The Trust's bankers shall be notified by the Director of Finance**,** on behalf of the Finance Committee of any alterations in the conditions of operation of the Trust's accounts that may be required by the Finance Committee**.**

5.3.10 The Director of Finance may enter into a formal agreement with the Trust's bankers or other agents, as appropriate, for payments to be made directly from the Trust's bank accounts on behalf of the University Hospitals Bristol NHS Foundation Trust by electronic funds transfer (e.g. The Bankers Automated Clearing Services or Direct Debit). Where such an agreement is entered into, the Director of Finance shall ensure that appropriate security procedures are observed in relation to the Trust's bank accounts.

5.3.11 The Director of Finance may operate a credit card on behalf of the Trust. This credit card must be used in accordance with a written policy approved by the Finance Committee.

5.4 Cash Management

5.4.1 The Director of Finance is responsible for managing and monitoring the cash flow of the Trust and ensuring that it has enough cash balances to meet all its commitments.

5.4.2 Any member of Trust staff aware of significant and unexpected delays in the receipt of cash or of significant unexpected or early payments that will have an effect on the Trust's cashflow position must inform the Director of Finance or other Senior Finance Manager.

5.4.3 The Director of Finance is responsible for providing assurance to the Trust Board and Finance Committee on the management of the Trust's cash position through monthly reporting.

5.5 Investment of Temporary Cash Surpluses

5.5.1 Temporary cash surpluses shall be invested in line with the Treasury Management Policy, subject to the overall cash flow position and in line with any relevant guidance from the Independent Regulator.

5.5.2 The Director of Finance is responsible for advising the Finance Committee on investments and shall report monthly to the Finance Committee concerning the performance of investments held.

5.5.3 The operation of investment accounts and the records maintained must be in accordance with detailed procedural instructions issued by the Director of Finance and approved by the Finance Committee.

5.5.4 The Finance Committee shall:

(a) approve a list of permitted investments institutions.
(b) set investment limits for permitted investment institutions.
(c) approve a schedule of permitted types of investments and financial instruments

5.5.5 Investments for purely speculative purposes are strictly prohibited.

6. External Borrowing and Public Dividend Capital

6.1 Objective:

6.1.1 To ensure that borrowings are properly authorised and controlled and that interest and principal is repaid in accordance with agreed timescales

6.2 General:

6.2.1 As a foundation trust, the Trust has the freedom to borrow externally subject to the following ~~three~~ constraints:-
~~a prudential borrowing limit agreed with the Regulator and reviewed annually;~~
a) prohibition on the use of ~~protected~~ Commissioner Requested Services (CRS) relevant assets as security for borrowing; and,
b) any additional financial and non-financial covenants with financial institutions.

~~6.2.2 The Trust's prudential borrowing limit, as approved by the Regulator under the terms of the Prudential Code, applies to the Trust's total debt liability. The Prudential Code requires external debt to be kept within designated limits, taking account of affordability in terms of capacity to generate revenue to service debt.~~

6.2.2 The Trust can obtain a ~~access~~ working capital facility~~ies~~ from the commercial banking sector ~~subject to an overall limit agreed with the Regulator.~~ All such borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position.

6.2.3 The Director of Finance shall be responsible for advising the Trust Board concerning the Trust's ability to repay public dividend capital (PDC) and long-term loan principal together with the payment of dividends and interest on such borrowings. ~~pay interest on, and repay the public dividend capital within the Trust's borrowing limit set by the NHS Provider Licence and reviewed annually by the Independent Regulator (the Prudential Borrowing Code).~~ The Director of Finance shall also be responsible for reporting periodically to the Trust Board concerning the PDC debt and all loans or working capital facility. ~~overdrafts~~.

6.2.4 Any application for a loan~~, overdraft~~ or working capital facility will only be made by the Director of Finance or an officer designated for this purpose following approval by the Finance Committee, and in accordance with the Scheme of Delegation as appropriate.

6.2.5 The Director of Finance shall maintain a schedule of employees (including specimens of their signatories) approved by the Finance Committee who are authorised to make short term borrowings (within the limits specified in the current Annual Plan) on behalf of the Finance Committee. This must include the Chief Executive and Director of Finance.

~~6.2.6 The Director of Finance shall ensure that the Trust operates within the working capital facility limit set by the Independent Regulator~~.

6.2.6 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowing at the next meeting.

6.2.7 All long term borrowing in respect of Strategic Capital Schemes must be consistent with the plans outlined in the current Medium Term Capital Programme ~~Financial Plan~~ approved by the Finance Committee.

6.2.8 The Director of Finance must prepare detailed procedural instructions concerning applications for new borrowing and on the form of records to be maintained, which comply with the instructions issued by the Independent Regulator from time to time.

6.2.9 Assets defined as Commissioner Requested Services (CRS) relevant assets ~~protected under the NHS Provider Licence~~ shall not be used or allocated for borrowing; non-CRS relevant ~~protected~~ assets will be eligible as security for loans.

~~6.2.10 The Finance Committee shall approve the Trust's Working Capital Facility provider.~~

6.2.10 All short term borrowings must be kept to the minimum period of time consistent with the overall cash flow position, represent good value for money, comply with the Trust's Treasury Management Policy and all guidance issued by the Independent Regulator.

~~6.2.11 The Trust's Working Capital Facility may only be used with the pre-approval of the Director of Finance and approval of the Finance Committee.~~

6.2.11 Long term borrowings will only be used to finance longer term capital or investment programmes.

7. Payment of Trust Employees and Contractors

7.1 Objective

7.1.1 **To ensure proper control over the appointment and payment of Trust employees and contractors.**

7.2 Remuneration and Terms of Service of Directors

7.2.1 In accordance with Standing Orders and the 2006 Act, the Board shall establish a Remuneration and Terms of Service Committee consisting of Non-Executive Directors to decide the remuneration and allowances and other terms of office of the Executive Directors, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

7.2.2 The Committee will:

(a) Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust and other senior employees including:

(i) All aspects of salary (including any performance-related elements/bonuses);

(ii) Provisions for other benefits, including pensions and cars;

(iii) Arrangements for termination of employment and other contractual terms;

(b) Make such recommendations to the Board on the remuneration and terms of service of Executive Directors of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) Monitor and evaluate the performance of individual Executive Directors (and other senior employees);

(d) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

7.2.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

7.2.4 The Council of Governors will decide the remuneration and allowances and other terms of office of the Chair and Non-Executive Directors.

7.2.5 The Trust will pay allowances to the Chairman and Non-Executive Directors in accordance with all relevant guidance.

7.3 Other Staff Remuneration and Appointments

7.3.1 The implementation of national pay directives relating to the remuneration of staff will be approved by the Chief Executive. Any variation from these or implementation requiring local interpretation or negotiation will be approved by the Chief Executive.

7.3.2 All Trust officers responsible for the engagement, re-engagement and regrading of employees, either on a permanent or temporary contract, or for hiring agency staff or contractors, or agreeing to changes in any aspect of remuneration must comply with the scheme of delegation and act in accordance with the processes designated by the Director of Workforce and Organisational Development. In particular such actions must be within the limit of their approved budget and funded establishment.

7.3.2 The Board shall delegate responsibility to the Director of Workforce and Organisational Development for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) ensuring processes are in place for dealing with variations to, or termination of, contracts of employment.

7.4 Notification of Information to Payroll

7.4.1 All Trust Officers responsible for the engagement and management of staff must inform the Director of Finance's Payroll Department promptly and in the agreed form of full details in respect of:-

(a) Commencement of employment ~~or office~~.

(b) Change to terms and conditions of employment or circumstance.

(c) Termination of employment ~~or office~~.

7.4.2 On appointment, a properly authorised appointment form for Direct Hires or an e-Starter form for all staff recruited through ESR and such documents as required by the Director of Finance and/or Director of Workforce and Organisational Development shall be submitted to the Payroll Department immediately.

7.4.3 A properly authorised change of conditions e-form shall be submitted to the Payroll Department immediately a change in status of employment or personal circumstances of an employee ~~or office holder~~ is known.

7.4.4 A properly authorised termination of employment e-form and other relevant information shall be submitted to the Payroll Department immediately the effective date of an employee's ~~or office holder's~~ resignation, retirement or termination is known. Where an employee fails to report for duty in circumstances which suggest that they have left without notice, the Payroll Department shall be informed immediately.

7.4.5 All absence due to sickness and other reasons as required shall be notified to the Payroll Department on a weekly basis in the required form and timescales.

7.4.6 All documents used for payroll purposes such as time sheets and payment sheets must be in a form approved by the Director of Finance and must be properly authorised.

7.5 Processing Of Staff Payments

7.5.1 The Director of Finance is responsible for:

(a) specifying timetables for the submission to the Payroll Department of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

7.5.2 The Director of Finance will issue instructions regarding:

(a) Verification and documentation of data.

(b) The timetable for receipt of data, preparation of payroll and the payment of staff.

(c) Maintenance of subsidiary records for superannuation, income tax, national insurance, social security and other authorised deductions from pay.

(d) Security and confidentiality of payroll information.

(e) Checks to be applied to completed payroll before and after payment.

(f) Authority to release payroll data under the provisions of the Data Protection Act.

(g) Methods of payment for ALL staff by BACS.

(h) Procedures for payment of BACS and in an emergency cheques, or cash to staff.

(i) Procedures for recall of BACS.

(j) Pay advances and their recovery.

(k) Separation of the duties of initiating and making payments.

(l) A system to ensure the recovery from leavers of sums due by them to the Trust.

(m) Maintenance and regular reconciliation of adequate control accounts with appropriate internal check procedures.

7.5.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting properly authorised time records, and other notifications to the Payroll Department in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's ~~or officer's~~ resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

7.5.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.5.5 The Director of Finance shall pay salaries and wages on the currently agreed dates but may vary these when necessary due to special circumstances (e.g. Christmas and other bank holidays). Payments shall not normally be made in advance of the authorised normal pay date.

7.6 Use of Management Consultants and Other Contractors

7.6.1 The engagement of management consultants and other contractors, including retired NHS officers, to provide services to the Trust, gives rise to tax, national insurance and pension implications. It is the responsibility of ~~Officers of the~~ Trust managers engaging the provision of such services to ensure that the arrangements comply with the requirements of HM Revenue and Customs.

7.6.2 The Director of Finance is responsible for ensuring there are detailed procedures in place for ensuring that employing managers are able to assess and select the correct form of contractual relationship required (payable gross on invoice or subject to statutory deductions through PAYE) to comply with HM Revenue and Custom requirements.

7.6.3 The Trust must ensure that arrangements for using management consultants or other contractors do not contravene IR 35. The aim of this legislation being to eliminate the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, in circumstances where an individual worker would otherwise:

- for tax purposes, be regarded as an employee of the client; and
- for national insurance contribution purposes, be regarded as employed ~~in employed earner's employment~~ by the client.

7.6.4 All Trust officers responsible for procuring the provision of services by individuals not directly employed by the Trust must ensure that they comply with relevant Trust procedures and should seek guidance if required.

7.7 Travel and Subsistence

7.7.1 Payment of travel and subsistence costs to officers, shall be made by the Payroll Department in accordance with the current regulations, subject to verification of claim details, upon receipt of the prescribed form, properly completed and authorised by an officer with delegated authorisation for this purpose.

8. Payment for Goods and Services Received

8.1 Objective

8.1.1 To ensure that:

(a) Payments are only made for goods and services which have been ordered and received in accordance with these instructions, and are of the appropriate quality and quantity.

(b) Contract invoices are paid in accordance with contract terms or otherwise in accordance with National Guidance.

(c) Invoices and other valid claims are paid promptly.

8.2 General

8.2.1 The Director of Finance is responsible for the payment of all properly authorised invoices and claims.

8.2.2 The Director of Finance is responsible for establishing procedures regarding the prompt notification of all monies payable by the Trust arising from transactions initiated by Trust officers. All Trust employees are responsible for complying with these procedures.

8.2.3 The Director of Finance shall ensure there are procedures covering the provision of professional advice regarding the supply of goods and services, including the tendering of goods and services.

8.3 Requisitioning

8.3.1 The Director of Finance is responsible for establishing procedures regarding the requisitioning of goods and services on behalf of the Trust. This will include a list of managers authorised to requisition goods and services, including levels of authorisation. See also section 13.

8.3.2 Requisitioners should ensure that they comply with the Trust's procedures in the procurement of goods and services. They should always seek to obtain best value for money for the Trust and ensure that there are no conflicts of interest. In doing this the advice of the procurement department should be sought.

8.3.2 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

8.4 Verification and Payment

8.4.1 The Director of Finance is responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by the Trust.

This system shall provide by certification or by compliance with an authorised computer system that:-

(a) Goods and services have been ordered in accordance with Section 13.

(b) Goods have been duly received, are in accordance with specification and order and that prices are correct;

(c) Services have been satisfactorily executed in accordance with the order and that the charges are correct;

(d) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time records, that the rates of labour are in accordance with the appropriate rates, that the materials have been checked as regards quantity, quality and price, and that the charges for the use of vehicles, plant and machinery and other expenses have been examined and are reasonable;

(e) The invoice is arithmetically correct;

(f) The account has not been previously passed for payment or paid;

(g) The account is in order for payment.

8.4.2 A list will be maintained of Trust employees (including specimens of their signatures) who are authorised to certify invoices. All changes to this list must be notified to the Director of Finance.

8.4.3 The Director of Finance shall ensure that all invoices and accounts are paid promptly having regard to:

(a) The Trust's cash flow

(b) The possibility of receiving a discount for early payment.

(c) Current Department of Health guidance on prompt payment.

8.4.4 Where an employee certifying accounts relies upon other employees to do preliminary checking they shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

8.4.5 In the case of contracts for building or engineering works which require payment to be made on account during the progress of the work, the Director of Finance shall make payment on receipt of a certificate from the appropriate technical consultant or officer. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subjected to financial and general examination by the person responsible to the Trust as Project Manager before the final certificate is issued.

8.5 Prepayments

8.5.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages ~~(i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).~~

(b) The appropriate employee must provide, in ~~the form of a written report~~ writing, ~~a~~ the case for a prepayment, setting out all relevant circumstances of the purchase. This ~~e-report~~ must include ~~set out~~ the effect on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered.

8.6 Duties of Managers and Officers

8.6.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive branded seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 7 and the principles outlined in the national guidance contained in HSG 93(5) and Register of Interests Policy (2006) “Standards of Business Conduct for NHS Staff”);

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

8.6.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice and guidance issued by the Department of Health and Monitor. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.

8.7 Imprests

8.7.1 The Director of Finance may authorise advances on the imprest system for petty cash and other purposes as required. Individual payments from such imprests must not exceed an amount authorised by the Director of Finance and must be properly reconciled to petty cash sheets, which are supported by vouchers showing details of the transaction (see Section 9).

8.8 Negotiation with Suppliers

8.8.1 Where there are ongoing disputes with suppliers that require compromise arrangements to resolve, these will be considered and approved as follows:

- £0 - £1,000 – the Head of Finance
- £1,001 - £25,000 – the Director of Finance
- Over £25,000 – the Finance Committee

9. Security of Cash, Cheques and Other Negotiable Instruments

9.1 Objective

9.1.1 (a) To ensure that cash, cheques, payable orders and similar documents of value are kept securely and properly controlled.

(b) To design and securely control all controlled stationery e.g. receipt books, agreement forms, income books.

9.2 Cash

9.2.1 Cash handling represents an area of high risk, therefore it should be kept to a minimum with banking facilities used whenever possible. All staff responsible for cash handling must ensure that they comply with these standing financial instructions and all detailed procedures applicable to their work, in order to protect themselves and prevent their integrity from being called into question.

9.2.2 The Director of Finance is responsible for establishing systems and procedures for the handling of cash within the Trust.

9.2.3 The Senior Manager responsible for an area where cash is handled must:-

(a) Obtain written confirmation from all members of staff involved with the handling of cash that they are aware of their duty to comply with Standing Financial Instructions and with any supplementary procedures issued by the Director of Finance.

(b) Be satisfied by inspection or otherwise, that the provisions of this section of the Standing Financial Instructions and any supplementary procedures are strictly observed. Procedures for ward staff shall incorporate the requirements of this section as well as sections 10, 11 and 16.

9.2.4 On every occasion when cash is transferred from the custody of one person to another it shall be the duty of the recipient to check it and of the other to obtain a written acknowledgement. Where this is not possible due to the cash being in sealed packets, the packets shall be counted and acknowledged unopened.

9.3 Cash Expenditure

9.3.1 If a Manager considers it necessary for a member of staff to use cash to purchase goods or services on behalf of the Trust, where cheque payment or bank transfer is impractical, they must comply with the conditions and procedures established by the Director of Finance.

9.3.2 The Trust's money shall not, under any circumstances, be used for the encashment of private cheques or be used for private purposes.

9.3.3 Every payment must be recorded and authorised in accordance with procedures established by the Director of Finance with evidence supporting the transaction.

9.3.4 It is the responsibility of all staff authorised to hold cash to reconcile, at least once a week, the record of transactions with the amount actually in hand, in line with Trust procedures. It is the responsibility of their manager to review and make appropriate checks in line with Trust procedures. Any discrepancy or concerns must be reported to senior management and the Director of Finance without delay.

9.4 Cash Income

9.4.1 Income received shall be handled and accounted for in accordance with the requirements of Section 10.

9.5 Security of Cash

9.5.1 Staff involved in the handling of cash and their managers are responsible for ensuring that cash is kept securely and in accordance with instructions issued by the Director of Finance.

9.5.2 Safes and/or lockable cash boxes shall be provided for the custody of cash in all places where it is necessary for cash to be held. Coin-operated machines shall wherever possible be fitted with separately lockable compartments for cash.

9.5.3 Cash boxes holding cash shall not be left unattended at any time and shall be kept in a safe when not in use.

9.5.3 Cash held in a safe overnight shall be limited to the amount as approved by the Director of Finance.

9.5.4 The inspection of the cashier's safe shall be included in security patrol duties.

9.5.5 Only the Trust employee responsible for the custody of the contents of a safe or cash box or for collection from a coin-operated machine shall hold its key. The key shall be carried on the person. The loss of any key shall be reported to the Director of Finance by the responsible officer immediately its loss is discovered.

9.5.6 Duplicate keys shall be kept in accordance with the arrangements which the Director of Finance shall prescribe.

9.6 Unofficial Funds

9.6.1 The Trust shall not be liable in any circumstances for the loss of unofficial funds. The holder of the key of a safe provided for the custody of official cash shall not accept unofficial funds for safe keeping except in identifiable sealed packages or locked containers. When such deposits are made, a written indemnity shall be obtained from the person or organisation concerned absolving the Trust from responsibility for any loss.

9.7 Controlled Stationery

9.7.1 The Director of Finance is responsible for approving the design of, and ordering, all controlled stationery such as receipt books, agreement forms, invoices or other means of recording monies received or receivable

9.7.2 All controlled stationery shall be issued and kept securely in accordance with procedures established by the Director of Finance. Any loss of controlled stationery must be reported to the Director of Finance immediately.

9.8 Cheques

9.8.1 All blank cheques or other orders for payment shall be ordered only on the authority of the Director of Finance, who shall make proper arrangements for their safe custody. They shall be subject to the same security precautions as are applied to cash. Any loss of cheques shall be reported to the Director of Finance immediately.

9.8.2 Cheques will only be drawn to "cash" with the specific, written authority of the Director of Finance. All cheques drawn to "cash" must have a second authorised signature.

9.9 Movement of Cash

9.9.1 The Director of Finance shall prescribe the system for the transporting of cash and shall be responsible for making all arrangements with any security company operating under a contract with

the Trust. Cash in transit (including cash moved from one office or building to another on Trust premises) and the making up paying out of cash payments shall be suitably safeguarded. When substantial amounts have to be moved, special security arrangements shall be made.

9.9.2 Any employee who has any indication that the safe custody of cash on the Trust's premises or in transit to or between premises may be at risk shall immediately notify the Director of Finance and the Security Officer confidentially of the circumstances.

9.10 Transfer of Responsibilities for Cash, Cheques and Controlled Stationery

9.10.1 When an employee, whose duties include the holding of cash, cheques or controlled stationery hands over responsibility prior to leave or termination of appointment, both the outgoing and the incoming officer shall sign a handing over certificate stating:-

(a) The composition of the cash;

(b) The consecutive numbers of the cheques or controlled stationery;

(c) Particulars of keys handed over;

(d) Particulars of anything else being held for safekeeping.

9.10.2 In the unavoidable absence of the outgoing employee, one or more other employee shall be appointed to carry out the hand-over to the incoming officer.

9.10.3 Where the responsibility for an imprest changes permanently, this fact shall be notified to the Director of Finance. Hand-over certificates evidencing the change in responsibility should be retained within the area for future reference.

9.10.4 During any absence of the substantive holder of the key to a safe or cash box, the officer or officers appointed to act temporarily shall be fully accountable for the performance of such duties and shall be subject to these Standing Financial Instructions as though they were the substantive key holder.

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10. Income

10.1 Objective

10.1.1 **To ensure that:**

(a) Income due is promptly assessed and collected; and

(b) Income received is promptly banked and fully accounted for.

10.2 Income Due

10.2.1 The Director of Finance is responsible for designing and maintaining systems for the proper recording, invoicing and collection of all monies due, including income due under contracts or extra-contractual arrangements for the provision of healthcare services, together with systems for financial coding.

10.2.2 The Director of Finance is also responsible for the prompt banking of all monies received.

10.2.3 The Director of Finance is responsible for the design and ordering of all receipt books, tickets, agreement forms, or other means of officially acknowledging or recording amounts received or receivable. They will be issued and controlled according to procedures established by the Director of Finance and will be subject to the same precautions as are applied to cash (Section 9).

10.2.4 Cash payment for charges made by the Trust, for the provision of any goods or services, must not normally be accepted where the value of any single transaction is in excess of €15,000 (£10k). In the unlikely event of this occurring, the transaction must be notified by Finance to HM Revenue and Customs.

10.2.5 All Trust employees shall promptly inform the Director of Finance of money due to the Trust arising from transactions which they initiate including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

10.2.6 The notification of income due shall be as prescribed by procedures established by the Director of Finance, ensuring sufficient details are included to enable the prompt payment by the debtor.

10.2.7 The Director of Finance shall ensure that debtors are invoiced promptly on receipt of the advice of income due.

10.2.8 There must be clear separation of duties so that officers responsible for raising invoices or accounting for amounts due to the Trust shall not handle cash or cheques received by the Trust.

10.2.9 Employees responsible for agreeing the prices of goods and services provided by the Trust should ensure that they cover all costs, including overheads. Support should be sought from the finance department as required. Appropriate, independent professional advice shall be taken on matters of valuation. Prices and charges shall be reviewed at least annually. This paragraph applies equally to:

- tenders for the sale of goods and services;
- quotations for support to commercial research trials and projects; and
- pricing of service agreements with other NHS bodies.

10.2.10 The Trust's price tariff for private patient treatment is set by the Director of Finance. The pricing structure ensures that prices are at least equal to those charged to NHS Commissioners and ensures that Public funds are not used to subsidise private patient activity. Any proposed variations to the Private Patient Tariff prices must be approved by the Director of Finance before patients are advised of the cost of their treatment

10.2.11 The Director of Finance shall take appropriate recovery action on all outstanding debts and no claims shall be abandoned except as in accordance with Section 15 - Losses and Special Payments.

10.2.12 Disposal of assets, scrap material and items surplus to requirements shall be dealt with in accordance with Section 20 of these Instructions.

10.3 Income Received

10.3.1 All income received into the Trust must be collected, receipted and accounted for in accordance with the procedures established by the Director of Finance. It is the responsibility of all Trust employees responsible for these duties to ensure they comply with these procedures. It is the responsibility of the Senior Managers responsible for areas where income is received to ensure that their staff are complying with these procedures.

10.3.2 All cheques, postal orders, cash, etc shall be banked intact promptly in accordance with the Director of Finance's instructions. Disbursements shall not be made from cash received. Payment by debit or credit card may only be accepted by staff designated by the Director of Finance. All transactions must be processed in accordance with the instructions approved by the Director of Finance.

10.3.3 The opening of incoming post must be undertaken by officers working in pairs and all cash, cheques, postal orders and other forms of payment shall be entered immediately in an approved form of register and certified by both officers.

10.3.4 Every employee authorised to receive remittances in cash or other forms must keep up to date a record of the amounts received in accordance with procedures approved by the Director of Finance. This record must be reconciled with the amount held in accordance with these instructions. Any discrepancy shall be reported immediately to their senior manager and the Director of Finance.

10.3.5 Official receipts shall be issued in all cases involving cash and only where especially requested by the payer for cheques, debit card etc.

10.3.6 All cash received, if not paid directly into the bank, shall be locked as soon as possible in the safe or cash box provided for the purpose, which shall be safeguarded as specified in Section 9.

10.3.7 Collections from cash tills, telephone and other coin boxes and from night safes shall be made at such intervals as shall be prescribed by or with the approval of the Director of Finance. The opening of each such box or safe and the counting and recording of the contents shall be undertaken by two employees together. Both shall sign the record and the keys shall, at other times, be separately held by a senior officer.

10.3.8 The Director of Finance shall ensure that all income received into the Trust's bank accounts is accounted for promptly – as per section 5.

11. Patients' Property

11.1 Objective

11.1.1 **To ensure that property of patients is properly safeguarded and fully accounted for.**

11.2 Responsibilities

11.2.1 The Trust has a responsibility to provide safe custody for money or other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital, or dead on arrival.

11.2.2 Staff shall be informed, on appointment, by the appropriate departmental head or senior officers of their responsibilities and duties for the administration of the property of patients.

11.2.3 The Chief Executive shall be responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' monies and personal property brought into the Trust's premises, unless it is handed in for safe custody and a copy of the patients' property record is obtained as the official receipt.

11.2.4 Where possible patients should be advised to make their own arrangements for the safe custody of their property - outside of the hospital.

These matters shall be drawn to patients' attention by means of:-

(a) Notices and information booklets;

(b) Hospital admission documents and property records; and

(c) The verbal advice of administrative and nursing staff responsible for admissions.

11.2.5 The Director of Finance must provide detailed written instructions on the collection, custody, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises) for all staff whose duty it is to administer in any way the property of patients.

11.2.6 Every employee of the Trust into whose personal custody any money or other property of a patient is received must comply with the requirements of these instructions. Valuable items shall be dealt with in the same way as cash and therefore instructions in sections 9 and 10 will apply.

11.2.7 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements specified by the Director of Finance. Monies deposited in excess of the patients' needs shall be invested in accordance with guidance from the Secretary of State and in accordance with arrangements specified by the Director of Finance.

11.2.8 Except as provided below in Section 11.3, refunds of property handed in for safe custody shall be returned to the patient, as required, by the employee who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate, and witnessed.

11.3 Deceased Patients

11.3.1 In all cases where property, including cash and valuables of a deceased patient is of a total value of more than £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments Act 1965), the production of a Grant of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be obtained.

11.3.2 In respect of a deceased patient's property, if there is no will and no lawful kin, the property vests with the Crown, and particulars shall, therefore, be notified to the Treasury Solicitor, or to the Duchies of Lancaster and Cornwall, as appropriate.

11.3.3 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any cash of the estate held by the Trust shall be appropriated towards funeral expenses. No other expenses or debts shall be discharged out of the estate of a deceased patient.

12. Stores and Receipt of Goods

12.1 Objective

12.1.1 To ensure that all stockholdings of significant value are properly safeguarded and accounted for.

12.2 Control of Stores

12.2.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

12.2.2 Subject to the responsibility of the Director of Finance for the systems of control, the overall control of stores shall be the responsibility of the relevant Divisional Manager/Head of Trust Services function. The day to day responsibility may be further delegated to a Trust employee such as a departmental manager or storekeeper provided this is clearly documented.

12.2.3 The Director of Pharmacy is responsible for the control of pharmaceutical stocks.

12.2.4 The Director of Estates is responsible for the control of fuel stocks (oil and coal).

12.2.5 The Director of Finance shall establish procedures and systems regarding the control of stores including receipting, issues, returns and losses. All staff responsible for the control of stores must comply with these procedures.

12.2.6 The responsibility for security arrangements and the custody of keys for all stores locations shall be clearly defined in writing by the designated employees and agreed with the Director of Finance. Wherever practicable, stocks shall be marked as Trust property.

12.2.7 The Director of Finance shall be informed of any variations in policy that are likely to result in any significant variation in overall stock levels.

12.3 Stocktaking

12.3.1 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the designated responsible officer. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check.

12.3.2 Any surpluses or deficiencies revealed on stocktaking shall be reported to the responsible officer for investigation. Evidence of such investigation shall be recorded and all confirmed surpluses or deficiencies shall be reported immediately to the Director of Finance.

12.3.3 All responsible employees shall comply with the arrangements made by the Director of Finance to certify stock values at the 31st March each year.

12.4 Losses and Slow-Moving Items

12.4.1 The responsible employee shall maintain a system approved by the Director of Finance for reviewing slow moving and obsolete items at least annually and for the condemnation, disposal and replacement of all unserviceable items. They shall formally report to the Director of Finance any evidence of significant overstocking and of negligence or malpractice.

12.4.2 Breakages, deteriorations due to overstocking and other losses of goods in stores shall be recorded as they occur, and a summary should be presented to the Director of Finance at quarterly intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, such as certain foodstuffs and natural deterioration of certain goods.

12.4.3 It is a duty of employees responsible for the custody and control of stores to notify all losses including those due to theft, fraud and arson, in accordance with Section 15 and 20 of these instructions.

13. Procurement of Goods and Services

13.1 Objective

13.1.1 To ensure that proper control is exercised and value for money is obtained in the procurement of goods and services.

13.2 General

13.2.1 The Trust Board may enter into contracts on behalf of the Trust within the statutory powers delegated to it. The procedure for making all contracts shall comply with these powers and Standing Financial Instructions. Delegated powers of authorisation are granted to Trust officers according to the Scheme of Delegation.

13.2.2 All contracts made shall endeavour to obtain best value for money by using the Trust's procurement department and processes established by the Director of Finance. The Chief Executive shall nominate an employee who shall oversee and manage each contract on behalf of the Trust.

13.2.3 Goods, services and works shall only be ordered in line with the controls and systems established and approved by the Director of Finance, which must comply with the financial limits and other principles set out in this section.

13.3 EU Directives, Legislation and Guidance

13.3.1 The Trust shall comply with all European Union and Government Directives regarding public sector purchasing and prescribed procedures for awarding all forms of contracts.

13.3.2 The Trust shall comply as far as is practicable with all guidance and advice issued by the Department of Health and the independent regulator in respect of procurement, capital investment, estate and property transactions and management consultancy contracts.

13.3.3 No order shall be issued to any firm which has made an offer of gifts or rewards to Directors or employees. The Trust Standing Orders set out the Standards of Business Conduct which apply at all times.

13.4 Financial Limits

13.4.1 A minimum of four competitive tenders shall be invited in accordance with the requirements of Section 14 for any purchase of goods or services over £25,000 (excluding VAT) including:

(a) a specification for equipment, goods, service contract, construction contract or other project;

(b) a period standing order, call-off contract or other purchase of goods or services where the aggregate value exceeds £25,000 in any year.

13.4.2 Where such purchases exceed £5,000 but are less than £25,000 a minimum of three competitive quotations in writing shall be obtained.

13.4.3 Where such purchases do not exceed £5,000, non-competitive quotations in writing may be obtained. Best practice should be a minimum of three such quotations.

13.4.4 Before placing an order for goods or services, potential suppliers and the cost should be adequately investigated and evaluated. This should include consultation with the Procurement Department.

13.4.5 Orders shall not be placed in a manner devised to avoid the financial thresholds specified by the Trust Board.

13.4.6 If the Procurement Department is asked to issue orders outside these thresholds, they will refer the ~~requisition~~ request back to the budget holder or to the Director of Finance. The ordering of goods or services above £25,000 without competitive tendering will not be allowed but if the budget holder believes there is an exceptional case for doing so, that case must be submitted to the Director of Finance for consideration of approval as a Single Tender Action. When orders between £5,000 and £25,000 are not supported by competitive quotations, the case for proceeding must be submitted to the Divisional Manager to decide whether to approve as a Single Tender Action ~~Quotation~~.

13.4.7 For any none standard procurement the processes referred to in 13.2.2 should be followed and the limits in 13.4.6 shall apply.

13.5 Other

13.5.1 No requisition or order shall be placed for items for which there is no provision in an authorised budget.

13.5.2 Access to the requisitioning/ordering system shall only be granted to budget holders and officers delegated by them.

13.5.3 Information regarding every order shall be notified to the Director of Finance in an agreed form immediately the order is issued.

13.5.4 Official orders shall be consecutively numbered, in a form approved by the Director of Finance, and shall include such information concerning prices, discounts, and other conditions of trade as they may require. The order shall incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations, etc.

13.5.5 Orders requisitioned through the Trust's electronic requisitioning and ordering system EROS are required to be independently authorised by a second person. The receipt of the goods can therefore be carried out by one of these officers. All orders requisitioned outside of EROS must be certified by a separate person. ~~The ordering of supplies and certification of the receipt of those supplies shall be carried out by separate persons. When EROS is used, a second person must perform at least one of the three stages of Requisitioning, Authorising and Receipting~~.

13.5.6 All contracts, leases, tenancy agreements and other commitments, which may result in a long-term liability, must be notified to the Director of Finance in advance of any commitment being made.

13.5.7 Where consultancy advice is being obtained, the procurement of such skills must be in accordance with the latest guidance issued by the NHS Executive.

14. Tendering Procedure

14.1 Objective

14.1.1 To ensure that major purchases are tendered in a manner which can be demonstrated to ensure fair competition and value for money and to comply with legislation. The Trust shall ensure that competitive tenders are invited for:

- **the supply of goods, materials and manufactured articles;**
- **the tendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);**
- **For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.**

14.2 Requirement to Tender

14.2.1 The following instructions shall apply to any purchase over £25,000 as required by Section 13.4. The principles in this instruction apply equally to the separate tendering procedures operated by the Estates Department (for capital contracts) and the Procurement Department. Formal tendering procedures may be waived by the Chief Executive, where the supply is proposed under special arrangements negotiated by the DH, in which event the said special arrangements must be complied with.

14.2.2 Formal tendering procedures **may** be waived by the Chief Executive in the following circumstances:

(a) in very exceptional circumstances where it is decided that formal tendering procedures would not be practicable and the circumstances are detailed in an appropriate Trust record
(b) where the requirement is covered by an existing contract
(c) where national NHS agreements are in place
(d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) where specialist expertise is required and is available from only one source;
(f) when the task is essential to complete a project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(g) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

14.2.3 Where the tendering procedures are waived under (a) above this must be reported and approved by the Trust Board before being actioned.

14.3 EU Directives, Legislation and Guidance

14.3.1 EU procurement directives and UK procurement legislation governing procedures for awarding contracts by an NHS body shall have effect as if incorporated in these Standing Financial Instructions.

14.3.2 Contracts above specified thresholds must be advertised and awarded in accordance with EU and other directives and Government legislation. The Procurement Department will advise on these requirements.

~~14.3.3 Any capital project must be managed in accordance with the NHS Capital Investment Manual.~~

14.3.3 The Trust should never enter into a contract which involves a contractor assessing and carrying out work on behalf of the Trust.

14.4 Selection of Suitable Firms to Invite to Tender

14.4.1 The Procurement Department shall ensure that they maintain information on suppliers suitable to be invited to provide tenders or quotations for the supply of goods or services to the Trust. Suitability will include the technical and financial competence of the supplier.

14.4.2 The Estates Department will refer to the Government Register of Contractors in considering suppliers suitable to be invited to provide tenders or quotations for their requirements.

14.4.3 All suppliers deemed suitable to be invited to submit quotations or tenders should comply with the Equality Act 2010, the Health and Safety at Work Act, procurement sustainability, fair and equitable trade policy and all other legislation concerning employment and the health, safety and welfare of workers and other persons. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

14.4.4 The Director of Finance may make or institute any enquiries deemed appropriate concerning the financial standing and financial suitability of approved contractors. The Directors with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

14.5 Health Care Services

14.5.1 Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

14.6 Pre-Qualification Questionnaire

14.6.1 Expressions of interest from potential suppliers are subject to a process of pre-qualification. Potential suppliers must demonstrate their financial, commercial and technical capabilities to fully meet the contractual requirements under tender by completing a Prequalification Questionnaire (PQQ). It takes account of a company's past performance and experience with reference to contracts of a similar nature, both with the Trust and other organisations. It seeks clear demonstration of their commitment to corporate social responsibility, equal opportunities, environmental issues, ethical trading and health and safety where appropriate.

14.7.2 The decision to use a Pre-Qualification Questionnaire as part of the tendering process depends on the complexity and value of the requirement and the market conditions. Pre-Qualification

Questionnaires should be used for all procurements that are above the EU threshold and procurements below the EU Threshold that are subject to sealed bid tendering.

14.8 Invitation to Tender

14.8.1 The Trust shall ensure that:

(a) invitations to tender are sent to a sufficient number of firms to provide fair and adequate competition and that a minimum of four firms shall be invited to tender in all cases

(b) (the firms invited to tender are deemed suitable as described above, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

(c) the firms invited to tender area subject to the pre-qualification questionnaire described above

(d) invitations to tender shall clearly state the date and time as being the latest time for the receipt of tenders.

(e) invitations to tender shall state that no tender will be accepted unless it meets the submission requirements of the Trust's e-tendering process or for manual tendering unless:

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) by the latest date and time for the receipt of such tender and addressed to the Chief Executive or nominated manager

(ii) the tender envelopes/ packages are free from any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

14.8.2 Before inviting tenders the appropriate officers shall compile a formal estimate of the probable expense of meeting the specification. Such estimates must quote the value of the relative item in the capital and/or revenue budget for the year approved by the Trust Board.

14.8.3 Every tender for goods, services or disposals shall include such of the NHS Standard Contract Conditions as are applicable.

14.8.4 Every tender for building, engineering works, land and property transactions shall comply with the industry standards for such contracts .

14.8.5 In the case of IT procurements the requirements of relevant industry standards shall be followed.

14.9 Receipt and Safe Custody of Tenders and Records

14.9.1 Tenders received via the e-tendering system will be subject to the controls regarding the build into the system regarding the receipt and safe keeping of all tenders and records.

14.9.2 The date and time of receipt of each manual tender shall be endorsed on each unopened tender envelope/package.

14.9.3 The nominated employee shall be responsible for the receipt, endorsement and safe custody of manual tenders received until the time appointed for their opening, and of records maintained in accordance with Section 14.10.

14.10 Opening Tenders

14.10.1 Manual Tenders

(a) Within three working days after the date and time stated as being the latest time for the receipt of tenders, they shall be opened in the presence of persons specified in the separate procedures for Capital and Procurement. In the case of J C T tenders, for capital projects, they shall be opened by:

- Executive members of the Trust Board
- Head of Finance
- Deputy Director of Operations
- Head of Human Resources

(b) Every tender received shall be stamped with the date of opening and initialled by the persons in Section 13.18(a) above, who witnessed the opening.

Every envelope shall be referenced to the tenderer and shall be retained with the tender documents.

(c) All pages of the tender documents containing the tender prices or making specific reference to terms and conditions stipulated by the tenderer shall be stamped in the presence of the persons witnessing the opening, with a uniquely identifiable stamp, which shall be held securely in the charge of a nominated officer.

(d) A record shall be maintained by the Nominated employee for each set of competitive tender invitations despatched, which shall be initialled by the witnesses to the opening of tenders. The register shall contain the following information:-

(i) The names of all the firms invited;

(ii) In the case of building and engineering contracts, the estimate of the probable cost in accordance with Section 13.13

(iii) The names and the number of firms from which tenders have been received and the amount of each tender where applicable;

(iv) The date the tenders were opened;

(v) The persons present at the opening and their signatures;

(vi) Particulars of any anomalies in accordance with Section 13.19(a), 13.19(d) and 13.19(f).

(e) Every price alteration appearing on the tender shall be initialled by two of those present at the opening.

(f) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

14.10.2 E-Tenders

Within three working days after the date and time stated as being the latest time for the receipt of tenders, they shall be unlocked and opened in the e-tendering system by two officers within the Procurement Department. The system shall ensure that the controls and recording described in 14.10.1 above are adhered to.

14.11 Admissibility and Acceptance of Tenders within Prescribed Limits in Section 14.10

14.11.1 (a) If for any reason it appears that tenders received are not strictly competitive; no contract shall be awarded without the approval of the Chief Executive.

(b) Tenders received after the due date, but prior to the opening date may be considered. Tenders received after the opening may not be considered unless it is agreed by the Chief Executive that there is adequate reason for the late arrival and that it is in the interest of the Trust so to do and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

If none of the tenders that were received in time is economically or in other ways acceptable, re-tendering to a new date shall be invited.

While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

(c) Necessary discussion and consultation with a tenderer to clarify the tender before the award of a contract need not disqualify. However, if such discussions result in clarifications of the specification, which result in a tender price being reduced below what were previously lower prices of other tenderers, a contract shall not be awarded unless all the other tenderers have been given the benefit of any clarification to the specification that has resulted from the discussions, and an opportunity to re-tender if they wish.

(d) The lowest tender if payment is to be made, or the highest if payment is to be received, shall be accepted unless, for good and sufficient reasons which must be formally recorded, the Chief Executive decides otherwise.

(e) No tender shall be accepted until the professional officer concerned has formally agreed that it is technically satisfactory.

(f) No tender for building works which is in excess of the budget sum under 14.8.2 by more than 10% or £5,000, whichever is the greater, should be accepted without the approval of the Chief Executive.

(g) All tenders shall be treated as confidential and should be retained for inspection.

14.12 Form of Contract

14.12.1 (a) Every contract including those for building and engineering works shall embody or be in the same terms and conditions of contract as those on the basis of which tenders were invited.

(b) Every contract for building and engineering works, which exceeds the sum of £150,000, shall be executed under the common seal of the Trust (except those executed under the JCT form of contract for minor works). The use of the common seal of the Trust shall be in accordance with Section 16p of the Scheme of Delegation.

14.13 Payments to Contractors by Instalments

14.13.1 (a) Where contractors provide for payment to be made by instalments, the Director of Finance shall keep a contract register to show the state of account on each contract, between the Trust and the contractor, together with any other payments and the related professional fees.

(b) Payment to contractors on account shall be made only on a certificate issued by the appropriate Works Officer, Private Architect or other consultant nominated as Contract Administrator.

14.14 Variations

14.14.1 (a) Subject to the provision of the contract in each case, no extra or variation shall be authorised except in writing by the appropriate employees as in Section 14.13.1(b) above. Such variation or instruction orders must be issued prior to the commencement of the work in question, excepting in the case of emergency when it must be issued on the next working day. All such orders must be priced within one month ~~at the most~~ from the date of issue.

(b) A report to the Chief Executive must be made when 66% of the contingency sum has been expended and a further report if the contingency sum is 90% expended.

(c) Any extensions to contracts should be made in writing in accordance with the Trust's scheme of delegation.

14.15 Final Certificates and Accounts

14.15.1 (a) The final payment certificate of any contract shall not be issued until the appropriate Contract Administrator, as in Section 14.12.1(b), has certified the accuracy and completeness of the value of the final account submitted by the contractor.

Any final account that is agreed at a figure in excess of the approved sum in the contract shall be reported to:-

(i) The Chief Executive if in excess of 5%;
(ii) The Trust Board if in excess of 10%.

(b) The Director of Finance may examine final accounts for contracts and may make all such enquiries and receive such information and explanations as may be required in order to be satisfied of the accuracy of the accounts.

14.16 Competitive Tendering of Support Services

14.16.1 The costs of support services may be tested by competitive tendering in accordance with appropriate legislation.

14.16.2 For each tendering exercise the following groups shall be set up:-

(a) Specification group, comprising a nominee of the Chief Executive and a specialist technical officer who will obtain such support from Management Services as is required.

(b) In-house tender group, comprising a nominee of the Chief Executive with technical support as necessary.

(c) Evaluation team, comprising specialist support from the Purchasing Department and a Director of Finance's representative.

14.16.3 All groups should work independently of each other. Individual officers may be members of more than one group, although no member of the in-house tender group may participate in evaluation of tenders.

14.16.4 The evaluation team shall make recommendations on the award of contracts to the Trust Board.

14.16.5 The price at which a tender is accepted becomes the new budget for the service and shall not be varied except for:-

(a) Subsequent changes in specification authorised by the Chief Executive (being a different person to the in-house contract manager) at prices to be negotiated by the Divisional Director of the NHS Supplies Authority.

(b) Price variations allowed for in the contract.

14.16.6 Monitoring of performance against the contract shall be the responsibility of the in-line senior manager utilising such advice as is appropriate.

14.16.7 The provisions of this section relating to tendering and contracting shall also be observed in competitive tendering for support services.

15. Losses and Special Payments

15.1 Objective

15.1.1 To ensure that losses and special payments are properly controlled and fully accounted for.

15.2 General

15.2.1 The Director of Finance is responsible for establishing procedures for the recording of and accounting for losses and special payments.

15.3 Losses

15.3.1 Any employee discovering or suspecting a loss of any kind must immediately inform their Head of Department, who must ensure that their Divisional Manager (or Head of Service in the case of Trust Services) is informed.

The Divisional Manager or Head of Service must appropriately inform the Chief Executive, Director of Finance or Chief Internal Auditor. Employees may also report suspicions directly to the Chief Internal Auditor.

Where a criminal offence (i.e. theft or arson) is suspected, the Chief Executive, Director of Finance or Chief Internal Auditor shall notify the police immediately.

15.3.2 For initial suspicions of fraud, the Director of Finance will discuss the particular circumstances with the NHS Local Counter Fraud Unit. If the case involves suspicion of fraud, and it is suspected that a criminal offence has been committed the Director of Finance will discuss the particular circumstances of the case with the NHS Regional Counter Fraud Operational Service in deciding how to proceed.

15.3.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance shall notify:

(a) The Trust Board and

(b) The Statutory Auditor.

15.3.4 The Director of Finance must also prepare a 'Counter Fraud Plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

15.4 Write-Offs and Special Payments

15.4.1 The Trust Board shall approve a scheme of delegation for the approval and authorisation of the write-off of losses and making of special payments within the limits of delegation granted to the Trust by the Independent Regulator. In this context the "write-off of loss" means also:-

(a) the abandonment of claims;

(b) the charging of fruitless payments; and

(c) the making of compensation and ex-gratia payments.

15.4.2 For any loss the Director of Finance shall consider whether any claim can be made against insurers and ensure this is pursued if appropriate.

15.4.3 The Director of Finance shall maintain a losses and special payments register in which all losses shall be recorded without delay. Appropriate officers must undertake a review of systems and processes to reduce the risk of similar losses arising in the future and seek advice where they believe a particular case raises a point of principle.

15.4.4 The Director of Finance shall report to the Audit Committee a summary of losses each quarter with details of all cases for which the Trust Board's specific approval is required.

15.5 Ex-Gratia Payments

15.5.1 The authority to make ex-gratia payments and the process for doing so is included in the procedures referred to in section 15.2.1. In summary, the powers to make ex-gratia payments including payments to patients and staff for the loss of personal effects are as follows:

(a) Rules for ex-gratia payments

Ex-gratia payments for loss or damage to employees' or patients' personal effects should only be paid if there has been negligence on the part of the Trust or of any of its employees. Divisional Managers/Heads of Service must confirm that the loss occurred on Trust property and that there was negligence on the Trust's part which contributed to the loss. Accidental damage to an employee's clothes, etc., where no other person is involved does not qualify for compensation unless caused by defects in equipment or conditions which are the responsibility of the Trust and which could not reasonably have been foreseen or avoided by the employee. Accidental damage to staff's personal effects caused by a patient should be dealt with on the merits of the case.

All ex-gratia payments over the value of £50 must be supported by a receipt for the replacement items which are actually subject to the loss. Such payments may be approved in accordance with the delegated limits as shown below.

(b) Delegated Limits (excluding Personal Injury and Clinical Negligence Cases)

Up to £1,000	- Approval by an Executive Director
£1,001 - £50,000	- Approval by the Chief Executive
Over £50,000	- Approval by the Trust Board.

(c) Recommendations for ex-gratia payments should be made to the Director of Finance in accordance with Trust procedures. Only the Director of Finance or delegated deputy can authorise such payments.

(d) Personal Injury and Public Liability Cases

Personal Injury cases will be dealt with in the following manner:

Over £10,000 – decided in conjunction with the NHS Litigation Authority.
Up to £10,000 – may be settled without legal advice with the approval of the Chief Executive or Director of Finance or the Director of Workforce and Organisational Development

Public Liability cases will be dealt with in the following manner:

Over £3,000 – decided in conjunction with the NHS Litigation Authority.
Up to £3,000 – may be settled without legal advice with the approval of the Appropriate Divisional/Corporate Services Manager or the Chief Executive or Director of Finance.

(e) Clinical Negligence Cases

All clinical negligence cases are handled and decided by the NHS Litigation Authority (NHSLA) on behalf of the Trust. Whilst the NHSLA are administratively and financially responsible for all clinical negligence cases the legal liability remains with the Trust.

15.6 Insurance

15.6.1 There is a scheme available, administered by the NHS Litigation Authority, through which the Trust insures. A small number of specified risks are not insurable through the NHS scheme and these may be insured commercially. See section 22. The Director of Finance shall establish procedures so that claims are made for all insured losses that are reported.

15.7 Severance Payments

15.7.1 All proposals for individual severance payments or voluntary severance schemes require a supporting business case for submission to the Trust's relationship manager at Monitor. Subject to the quality of the business case Monitor will then forward to HM Treasury for approval.

15.7.2 Special severance payments to staff outside contractual or statutory entitlements (including settlement of employment tribunal claims) in order to terminate employment need to be approved by HM Treasury before settlement is offered. There are no delegated limits for special severance payments, and all cases need to go to HM Treasury.

15.7.2 All applications for severance payments must be submitted by the Director of Finance according to Trust procedures and in the appropriate form required by HM Treasury.

15.7.3 The Trust is required to obtain approval for time limited voluntary severance schemes, which obviates the need to make a submission for each individual non contractual or non-statutory payment made under the scheme.

15.8 Maladministration and Distress Payments

15.8.1 All proposals for payment for maladministration and distress shall be dealt with in accordance with the Trust's 'Guidelines for Managers on receipt of a request for financial remedy relating to the local resolution of a complaint'. Divisional Managers shall sign off all payment requests for approval.

15.8.2 The delegated limits for approving such cases are as follows:

Up to £1,000	Director of Finance or Head of Finance,
£1,001 - £50,000	Chief Executive,
Over £50,000	Trust Board.

15.9 Bankruptcy and Liquidation

15.9.1 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16. Funds Held in Trust

16.1 Objective

16.1.1 To ensure that funds held in trust are properly safeguarded and used for the benefit intended.

16.2 General

16.2.1 'Funds held in trust" are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the NHS, the objects of which are for the benefit of the NHS in England.

16.2.2 The charitable trusts for the University Hospitals Bristol NHS Foundation Trust are administered by the Trustees of Above & Beyond (hereafter called the Trustees). The Trustees have their own systems of accounting and financial control and operate separate bank accounts to the Trust. Charitable funds should not be confused with those operated by the Trust for its exchequer funds.

16.2.3 All gifts, donations and proceeds of fund-raising activities which are intended for the Trust's benefit shall be handed immediately to either the Trustees or to the Trust's cashier who will bank the money and transfer to the Trustees. Any charitable funds paid in through the Trust's cashier must be clearly identified as such to ensure it is separated from the Trust's exchequer funds. However the funds are passed to the Trustees, there must be clear instruction regarding the donor's intentions or the area to benefit.

16.2.4 The Director of Finance shall be required to advise the Trust Board on the financial implications of any proposal for fund-raising activities which the Trust may initiate, sponsor or approve.

16.2.5 The Trustees will designate a fund advisor for each fund held who must comply with the written procedures issued by the Trustees regarding the use of these funds.

16.2.6 Expenditure of any funds held in trust shall be conditional upon:-

(a) the expenditure being within the terms of the appropriate fund

(b) meeting the delegated limits which are:

<£1,000 approved by the designated fund advisor
>£1,000 approved by the Trustees
equipment >£5,000 approved in the first instance by the Trust's Capital Programme Steering Group and then the Trustees

Expenditure can only be as prescribed by the approval given and can't exceed the value approved.

(c) the prior approval of the Trust's Capital Programme Steering Group being obtained for items falling within the capital definition;

(d) being authorised by the fund advisor in writing, or by a person to whom the fund advisor has delegated authority having advised the Trustees in writing.

17. Audit and Counter Fraud

17.1 Objective

17.1 **To ensure a systematic and effective review of the Trust's financial and management controls to give assurance that resources are used efficiently and safeguarded against misuse or fraud.**

17.2 Audit Committee

17.2.1 In accordance with Standing Orders, the NHS Act 2006 and the NHS Foundation Trust Code of Governance as developed by Monitor, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and membership consistent with relevant guidance issued by Regulators or the Department of Health, including the NHS Audit Committee Handbook.

17.2.2 The role of the Audit Committee is to provide assurance to the Board on the suitability and efficacy of the Trust's governance, risk management and internal control by obtaining an independent and objective view of the Trust's financial systems, financial information, management controls and compliance with relevant laws and guidance. This will be achieved by:

(a) Monitoring and reviewing the effectiveness of the Trust's Internal and External Audit function, including involvement in the selection process when there is a proposal to review the provision of their services;

(b) Monitoring the integrity of the Trust's financial statements, reviewing significant financial reporting judgements contained in them;

(c) Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) Monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) Reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly;

(g) Reporting to the Council of Governors.

17.2.3 Where the Audit Committee considers there is evidence of ultra-vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Independent Regulator via the Director of Finance in the first instance.

17.3 Responsibilities of the Director of Finance

17.3.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function.

(b) ensuring that the Internal Audit is effective and meets the NHS mandatory audit standards and any directions given by the Independent Regulator.

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover*:*

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

17.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employees of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and

(d) explanations concerning any matter under investigation.

17.4 Internal Audit

17.4.1 Internal Audit primarily provides an independent and objective opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's objectives. Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability and reliability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
  (i) fraud and other offences;
  (ii) waste, extravagance, inefficient administration;
  (iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and/or the Independent Regulator.

17.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property of the Trust or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

17.4.3 The Chief Internal Auditor will normally attend the Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

17.4.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

17.4.5 The Chief Internal Auditor is responsible for developing and maintaining an Internal Audit Strategy to provide an objective evaluation of, and opinion on, the effectiveness of the organisation's risk management, control and governance arrangements. The Chief Internal Auditor's opinion is a key element of the framework of assurance the Chief Executive needs to inform the completion of the Annual Statement on Internal Control. The delivery of this strategy will be realised through the delivery of considered and approved annual plans which will systematically review and evaluate risk management, control and governance of all the Trust's operations, resources, services and responsibilities for other bodies.

17.4.6 The Chief Internal Auditor will co-ordinate Internal Audit Plans and activities with line managers, external audit and other review agencies to ensure effective audit coverage is achieved and duplication of effort is minimised.

17.4.7 Internal Audit have the right to access all records, assets, personnel and premises of the Trust in the pursuit of information necessary to fulfil its responsibilities. In any instances of conflict this will be referred for resolution to the Director of Finance, Chief Executive or Chair of Audit Committee as appropriate.

17.4.8 If the Chief Internal Auditor, Chief Executive, Director of Finance or the Audit Committee consider that the level of Internal Audit resources or the terms of reference in any way limit the scope of Internal Audit, or prejudice the ability of Internal Audit to deliver a service consistent with the definition of internal auditing, they should advise the Board accordingly.

17.4.9 Internal Audit provides an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance. The service applies the professional skills of Internal Audit through a systematic and disciplined evaluation of the policies, procedures and operations that management put in place to ensure the achievement of the

organisation's objectives, and through recommendations for improvement. Such consultancy work contributes to the opinion, which Internal Audit provides on risk management, control and governance.

17.4.10 Internal Audit must be sufficiently independent of the activities which it audits to enable auditors to perform their duties in a manner, which facilitates impartial and effective professional judgements and recommendations. Internal Audit will have no Executive responsibilities.

17.4.11 Internal Auditors must have an impartial, unbiased attitude, characterised by integrity and an objective approach to work, and should avoid conflicts of interest. Internal Auditors must declare any conflicts of interest to the Chief Internal Auditor. Any conflicts of interest encountered by the Chief Internal Auditor must be declared to the Director of Finance.

17.4.12 The Director of Finance is responsible for ensuring the Chief Internal Auditor is of sufficient status to facilitate the effective discussion and negotiations of the results of Internal Audit work with senior management.

17.4.13 Appointment at all levels within the Internal Audit team must endeavour to fulfil the four main principles of the code of ethics for Internal Auditor's Audit, integrity, objectivity, competency (ie professional qualifications, skills and experience) and confidentiality.

17.4.14 Within the parameters of the contract for the Internal Audit Service, the Chief Internal Auditor is responsible for ensuring the team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience to deliver the Internal Audit Plan in line with the NHS Internal Audit Standards. The team will undertake regular assessments of professional competence through an on-going appraisal and development programme (Personal Development Plans and Continuing Professional Development) with training provided where necessary.

17.5 External Audit

17.5.1 The External Auditor is appointed by the Council of Governors Representative at a general meeting of the Council of Member Representatives and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and reported to the Audit Committee and Council of Governors Representatives.

17.5.2 The Trust will ensure that the external auditor complies with the Audit Code for NHS Foundation Trusts at the date of appointment and on and on-going basis throughout the term of appointments.

17.5.3 The Council of Governors shall determine the terms of the contract for the provision of the External Audit.

17.5.4 The Audit Committee will receive and agree the External Auditor's annual plan.

17.6 Fraud and Corruption

17.6.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with relevant directions and guidance on countering fraud and corruption within the NHS.

17.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud and Corruption Manual and relevant directions and guidance.

17.6.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in the NHS Counter Fraud and Security Management Services (CFSMS) in accordance with the NHS Fraud and Corruption Manual.

17.6.4 The Local Counter Fraud Specialist will provide a written report to the Audit Committee, at least annually, on counter fraud work within the Trust.

17.7 Security Management

17.7.1 The Chief Executive is responsible for ensuring compliance with directions issued by the Department of Health relating to NHS security management.

17.7.2 The Trust shall nominate a director at Board level who will have delegated responsibility for security management as required by the Department of Health guidance on NHS security management.

17.7.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

18. Information Management and Technology

18.1 Objective

18.1.1 To define responsibilities for the management of the Trust's Information Management and Technology Systems.

18.2 Responsibilities and Duties of the Director of Finance

18.2.1 The Director of Finance is responsible for the accuracy and security of the computerised financial data of the Trust.

18.2.2 In terms of the Trust's financial systems, the Director of Finance is responsible for:

(a) devising and implementing any necessary procedures to ensure appropriate protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensuring that appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensuring that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensuring that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are carried out.

(e) ensuring procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

18.2.3 The Director of Finance is responsible for ensuring that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

18.2.4 Where computer systems have an impact on corporate financial systems, the Director of Finance shall seek assurance that

(a) systems acquisition, development and maintenance are in line with corporate policies including the Clinical Systems Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that there is an audit trail;

(c) Director of Finance staff has access to such data;

(d) appropriate computer audit reviews are undertaken.

18.3 Responsibilities and Duties of Other Directors in Relation to Computer Systems of a General Application

18.3.1 The Legal Services Department (with support from the Head of Information Management and Technology) shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. This describes the information regarding the Trust that is made publicly available.

18.3.2 For the implementation, upgrade or changes to computer systems used generally within the Trust, the responsible manager for the system will present a business case to the Information Management and Technology Committee for approval.

18.4 Contracts for Computer Services with NHS Bodies or Outside Agencies

18.4.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another NHS body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

18.4.2 Where another NHS body or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

18.5 Risk Assessment

18.5.1 The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

19. Capital Investment and Private Financing

19.1 Objective

19.1.1 To ensure that capital investments are properly planned, approved and controlled.

19.2 Capital Investment

19.2.1 The Trust Board shall approve the funding ~~financial limits~~ contained within ~~of~~ the Trust's ~~annual~~ Medium Term Capital Programme ~~capital investment programme~~ as part of the annual budget approval process and any subsequent updates.

19.2.2 The Director of Finance shall ensure that the Trust produces a Capital Investment Policy and this is reviewed annually and approved by the Trust Board.

19.2.3 The Chief Executive

(a) shall ensure that there is an adequate appraisal and approval process in place in line with the Trust's Capital Investment Policy**,** for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the ensuring the effective management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges and potential impairment losses.

19.2.4 For every capital expenditure proposal the Chief Executive shall ensure;

(a) that a business case is produced in line with guidance issued by the DoH or Independent Regulator and the Trust's Capital Investment Policy which sets out:

i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to cost

ii) the involvement of appropriate Trust personnel and external agencies

iii) appropriate project management and ~~control~~ governance arrangements.

(b) that the Director of Finance has validated the capital costs and revenue consequences detailed in the business case.

(c) approval of each business case prior to ~~accept a successful~~ tender

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with appropriate guidance and the Trust's Standing Orders.

19.2.5 For capital schemes requiring stage payments, the Director of Finance shall issue procedures on their management.

19.2.6 The Director of Finance shall ~~assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme~~ ensure that all capital schemes are accounted for in accordance with HM Revenue and Custom guidance.

19.2.7 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitments against the Trust's approved Medium Term Capital Programme.

19.2.8 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall ensure that there are procedures in place identifying managers responsible for each scheme, specifying:

(a) levels of authority to commit expenditure;

(b) authority to proceed to tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Trust's Standing Orders.

19.2.9 Schemes must be tendered and managed in accordance with the requirements of Section 14.

19.2.10 Donations received from charitable parties for the purposes of capital investment will require the approval of the Capital Programme Steering Group. Any associated legal agreement containing obligations on the part of the Trust requires signature by the Director of Finance or Director of Strategic Development.

19.2.11 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

19.3 Commercial/Private Finance

19.3.1 The Trust should give consideration to private finance ~~normally test for PFI~~ when considering material capital procurement**.** When the Trust proposes to use private finance ~~under the Private Finance Initiative~~ the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of commercial/private finance represents value for money and genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Trust Board.

19.3.2 The Director of Strategic Development is responsible for ensuring that:

(a) a programme of service delivery inspections is in place to ensure contract terms are monitored;

(b) payments to the ~~PFI~~ commercial partners are authorised in accordance with the contracted availability and performance factors;

(c) clearly established dispute resolution procedures are in operation;

(d) effective procedures for agreement of changes to service delivery; and

(e) the service is market tested in line with the contract.

19.4 Leases

19.4.1 All proposals for finance or operating leases must be submitted to the Director of Finance for advice and approval. Leasing proposals must demonstrate value for money. The Director of Finance must sign all leases.

20. Fixed Asset Register and Security of Assets, Disposal and Accounting of Assets

20.1 Objective

20.1.1 To ensure that assets are properly safeguarded and accounted for.

20.2 Asset Register

20.2.1 The Director of Finance is responsible for the maintenance of the Trust's register of assets and for arranging for a physical check of assets against the asset register to be conducted once every two years.

20.2.2 The Director of Finance must ensure the Trust maintains an asset register recording all fixed assets in accordance with the requirements of the Independent Regulator.

20.2.3 Additions to the fixed asset register must be clearly identified to an appropriate officer and be validated by reference to

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

The Trust shall maintain a publicly available property asset register recording protected property in accordance with the guidance issued by the Independent Regulator.

20.2.4 The Trust may not dispose of any protected property assets without the approval of the Independent Regulator. This includes the disposal of part of the property or granting an interest in it.

20.2.5 Where capital assets are sold, scrapped, lost or otherwise disposed of, the responsible officer must notify the Director of Finance, who will ensure that their value is removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

20.2.6 Assets that are leased by the Trust must not be disposed of.

20.2.7 The Director of Finance shall approve procedures for reconciling the fixed asset balances in the financial ledger with the balances on the fixed asset register.

20.2.8 The value of each asset shall be re-valued at least annually to fair values in accordance the Trust's agreed accounting policies.

20.2.9 The value of each asset shall be depreciated over its expected asset life in accordance with the appropriate accounting standards and any guidance issued by the Independent Regulator.

20.3 Security of Fixed Assets

20.3.1 The Chief Executive is responsible for the overall control of the Trust's fixed assets.

20.3.2 Asset control procedures (including fixed assets, including donated assets, cash, cheques and negotiable instruments) must be approved by the Director of Finance. These procedures shall make provision for

(a) recording the managerial responsibility for each asset;

(b) the identification of additions and disposals;
(c) the identification of all repairs and maintenance expenses;
(d) the physical security of assets;
(e) the periodic verification of the existence of, condition of and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset; and
(g) reporting, recording and safekeeping of cash, cheques and negotiable instruments.

20.3.3 All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Director of Finance.

20.3.4 Each employee has a responsibility for the security of the Trust's property and should ensure that equipment and property is secured when not attended and should report suspicious incidents and losses to their appropriate manager. It is the responsibility of Directors and senior managers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported to the Chief Executive.

20.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported in accordance with the procedure for reporting losses in section 15.

20.3.6 Where practical, purchased or donated assets should be marked as Trust property.

20.3.7 Where assets are loaned or leased to the Trust, responsible officers should ensure these are notified to the Director of Finance in accordance with prescribed procedures. These assets must be clearly identified and must not be scrapped or otherwise disposed of. An inventory of such assets will be maintained but will not form part of the fixed asset register.

20.4 Protected Property

20.4.1 A register of Protected Property is required to be maintained in accordance with requirements issued by the Independent Regulator. The property referred to in the NHS Provider Licence which is to be protected is limited to land and buildings owned or leased by the Foundation Trust.

20.4.2 No Protected Property may be disposed of (including disposing of part of it or granting and interest in it) without the approval of the Independent Regulator.

20.4.3 The Annual Plan will include proposed changes in the treatment, disposal and acquisitions of protected assets.

20.4.4 The Trust is required to notify relevant bodies of the publication date of such plans in 20.4.3 to allow objection to be lodged. Twenty one days is allowed before the plans are then approved.

20.4.5 The Asset Register must be updated for any such changes. The relevant bodies should then be notified that an updated Asset Register is available.

20.5 Disposal of Assets

20.5.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to Managers.

20.5.2 When a Department decides to dispose of a Trust asset, the Head of Department, or authorised deputy must comply with the Trust's procedures. In particular by:

(a) establishing whether it is needed elsewhere in the Trust; and if not

(b) determining and advising the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

20.5.3 In the event of a private sale (e.g. to a member of staff) the Head of Department should first follow the procedure in Section 20.5.2. If the private sale is more beneficial the Divisional Manager should be notified of the course of action. Advice should be sought from the Finance Department regarding the VAT liability of the proposed sale.

20.6 Condemnations

20.6.1 All unserviceable articles can only be condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance and in accordance with Trust procedures. In particular the condemnation must be appropriately recorded in line with these procedures identifying whether the articles are to be converted, destroyed or otherwise disposed of. All records shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

20.6.2 The officer condemning the item shall establish whether or not there is evidence of negligence in use and shall report such evidence to the Director of Finance who will take appropriate action.

21. Retention of Documents

21.1 Objective

21.1.1 To ensure the Trust has appropriate arrangements for retaining documents to comply with legal responsibilities and to enable the effective operation of the Trust.

21.2 General

21.2.1 The Chief Executive shall be responsible for maintaining archives for all records, including electronic records, required to be retained in accordance with Department of Health guidelines.

21.2.2 The documents held in archives shall be capable of retrieval by authorised persons.

21.2.3 Documents held in accordance with Department of Health guidelines shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

22. Risk Management and Insurance

22.1 Objective

22.1.1 To define the Trust's requirements for risk management and insurance.

22.2 Risk Management

22.2.1 The Chief Executive shall ensure that the Trust has robust risk management arrangements, in accordance with any requirements of the Independent Regulator which must be approved and monitored by the Board.

22.2.2 The programme of risk management arrangements shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(a) a clear indication of which risks shall be insured;

(g) regular review of the Trust's risk management arrangements..

22.2.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by the Independent Regulator.

22.3 Insurance

22.3.1 The Chief Executive, in conjunction with the Director of Finance, is responsible for ensuring that adequate insurance cover is held in line with the Trust's risk management policy approved by the Board. This will include insuring through the risk pooling schemes administered by the NHS Litigation Authority, self-insuring for some or all of the risks covered by the risk pooling schemes and purchasing insurance from commercial insurers. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

22.3.2 Trust Officers are required to notify the Director of Finance of all new risks or property which may require to be insured and of any changes that may affect risk or existing insurance.

22.3.3 All insurance policies must be approved by the Director of Finance

22.3.4 The Trust may purchase commercial insurance policies for risks not provided for under the Property Expenses Scheme (PES) and Liabilities to Third Parties Scheme (LTPS). This includes:

- Additional cover over and above the Trust's delegated limit under PES i.e. property (to the full reinstatement value of the property), contract works, fidelity, and business interruptions.

- Providing cover for specific activities outside the LTPS i.e. non-clinical professional indemnity, charitable trustees' liability, and Directors and Officers liability.

- All such insurance policies must be approved by the Director of Finance.

22.3.5 Arrangements to be followed in agreeing insurance cover

a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

c) All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

23. Acceptance of Gifts by Staff and Other Standards of Business Conduct

23.1 Objective

To ensure that Trust staff comply with required standards of behaviour when using public funds.

23.2 General

23.2.1 The Chief Executive is responsible for ensuring that the Trust has policies in respect of conflicts of interest and the acceptance of gifts or other benefits in kind conferring an advantage to a member of staff. These policies should be consistent with the Standards of Business Conduct for NHS Staff.

23.2.2 The Chief Executive shall ensure that all Trust employees are aware of these Trust policies and the restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage that could be considered to be bribes under the Bribery Act 2010.

23.3.3 The Trust shall maintain a Register of Interests and Hospitality and it is the responsibility of all Trust employees to comply with the procedures regarding the disclosure of such interests and hospitality as well as the policies referred to in 23.2.2.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST - SCHEME OF DELEGATION

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
1. BUDGETS			
1a	Management of Budgets, Responsibility of Keeping Expenditure within Budget – overall financial control	Chief Executive and Director of Finance	SFIs Section 1.2.4
	Financial Policies and internal systems	Director of Finance	SFIs Section 1.2.4
	Maintenance and update of Trust's financial procedures	Director of Finance	
1b	Budget responsibility levels ▪ at individual cost centre level ▪ at department level ▪ divisional level ▪ at corporate director level	Budget holder or nominated deputy Departmental Manager or nominated deputy Head of Division / members of the Divisional Management Team as authorised by the Head of Division. The Divisional Management Team may consist of: a. Divisional Manager b. Assistant Divisional Manager c. Head of Nursing d. Divisional Financial Manager Director of Facilities and Estates Director of Information Management Technology Corporate Director or delegated deputy	SFIs Section 2.3-2.6
1c	Approval of virements A virement is described as a transfer of budget between budget lines whether within or between departments. All virements require consultation with and the approval of the Divisional Financial Manager ▪ Between pay budget lines within a department. Virement not to exceed overall department pay budget value. ▪ Between non-pay budget lines within a department: Virement not to exceed overall department non-pay budget value	Budget holder with one of the following: Head of Nursing/modern matron Divisional Manager or Assistant Departmental Head Director of Facilities and Estates Director of Information Management Technology Budget Holder	SFIs Section 2.3

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ Between Divisional/Department Up to £5,000 Over £5,000 Virements must be supported by appropriate paperwork maintained by the Finance department • Between Divisions	 Budget Holder for both Departments / Divisions Budget Holder and Divisional Manager/Director of Facilities and Estates/Director of Information Management Technology or appropriate Deputy of both Departments/Divisionals Heads of Division / Director of Facilities and Estates / Director of Information Management Technology by joint agreement	
1d	All virements from reserves Virements must be supported by appropriate paperwork maintained by the Finance department	Director of Finance or nominated Deputy	

2. BANK ACCOUNTS AND INVESTMENTS			
2a	Maintenance and Operation of Bank Accounts Overall control of Trust Bank Accounts	Director of Finance Director of Finance	SFIs Section 5 SFIs Sections 5.2.2 & 5.3.1
2b	Maintenance of Operating Procedures and Instructions	Director of Finance	SFIs Sections 5.2.1 & 5.3.2
2c	Opening of Bank Accounts	Director of Finance	SFIs Section 5.3.5
2d	Approved Cheque (and other payable order) Signatories encompassing Approval requirements • Cheque payments over single signatory limits • Cheque drawn to cash	 Chief Executive or Director of Finance or nominated Senior Finance Manager Director of Finance	 Treasury Management Policy SFIs Section 9.8.2
2e	Approved Bank transfer signatories	Chief Executive or Director of Finance or nominated Senior Finance Manager	
2f	Investment of Surplus Cash	Director of Finance or Head of Finance	SFIs Section 5.5
2g	Application Loan or overdraft	Director of Finance or nominated Deputy	SFIs Section 6.2.5

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
3	**Non-pay revenue and capital expenditure\requisitioning\ordering\payment of goods and services.** Financial thresholds in this section mirror the procurement limits and as such exclude VAT Where there is an order/contract for more than one financial year, the total cost must be included not just the 12 months element.		SFIs Section 19 SFIs Section 13 SFIs Section 13
3a	All Orders ▪ up to £5,000 ▪ £5,000 to £25,000 ▪ £25,000 to EU Threshold ▪ EU Threshold to £1m ▪ Over £1m	 Requisitioner as specifically designated by budget holder Budget holder or authorised deputy Divisional Manager / Director of Facilities and Estates / Director of Information Management Technology / relevant Corporate Director or authorised deputy Director of Estates and Facilities to authorise all Estates and Facilities services orders, Relevant Corporate Director or authorised deputy for all other services Chief Executive, after approval by Trust Board	
3b	Capital Expenditure Subject to the above tendering and quotation limits. In addition the following will apply. • Under £100,000 a statement of case must be prepared to justify the expenditure, plus value for money, and identify revenue consequences. • £100,000 to £500,000 – A detailed business case prepared. • Over £500,000 – A detailed business case prepared. Capital Expenditure – variations to approved sum. • Up to £250,000 • Over £250,000 to £500,000 • Over £500,000	 Capital Programme Steering Group Capital Programme Steering Group Approved by Trust Board Capital Programme Steering Group Trust Management Executive Group Trust Board	
3c	Approving expenditure greater than tendered or quoted price by the lesser of 10% or £100: ▪ Up to £5,000 ▪ £5,000 to £25,000 ▪ Over £25,000	 Budget Holder or nominated deputy Divisional Manager / Head of Division/Director of Facilities and Estates / Director of Information Management Technology Director of Finance	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
4	**Capital Investment**		SFIs Section 19
4a	Selection of architects, quantity surveyors, consultant engineers and other professional advisors within European Union regulations.	Director of Facilities and Estates and/or Strategic Development Programme Director	
4b	Financial Monitoring and reporting on all capital scheme expenditure	Director of Finance or nominated Deputy	
4c	Approval of Capital Investments/Major Strategic Schemes		
	1. Management of Strategic Schemes	Capital Steering Group	SFIs Section 19
	Defining the Scope of Work	Director of Strategic Development and Director of Facilities and Estates	
	Approval of Project Budgets	Director of Strategic Development and Director of Finance	
	Approval of a comprehensive business cases valued between 0.25% (£1.250m) and 1% (£5m based on a turnover of £500m.	Finance Committee	
	Approval of high risk and major investments (OBC and FBC) and greater than 1% (£5m) of the Trust's turnover.	Trust Board	
	Approval of investments below 0.25% (£1.250m) of the Trust's turnover which do not qualify as high risk.	Trust Management Executive Group. The Trust Management Executive Group may delegate approval of capital investments below a certain value to the Capital Programme Steering Group.	
	Approval of the Trust's Capital Investment Policy annually.	Trust Board	
	Approval of procurement strategy	Director of Strategic Development and Director of Finance	
	Selection of Advisors	Director of Strategic Development and/or Strategic Development Programme Director	
	Signing of contracts	Chief Executive	
	Changes to project management infrastructure	Director of Strategic Development	
	Sign off of projects	Director of Strategic Development	
	Financial Monitoring of Major Capital Scheme Expenditure	Director of Finance and Director of Facilities and Estates and / or Strategic Development Programme Director	
	Authorise payments of invoices	Up to a delegated limit of £3m - Strategic Development Programme Director. Invoices higher than £3m – Director of Strategic Development	
	2. Other Schemes • Approval of Business Case and Financing	Capital Programme Steering Group	Capital Programme Steering Group / Terms of Reference
4d	Private Finance • Approval of Business Case	Trust Board	
4.e	Leasing • Approval of Lease Proposals	Director of Finance	SFIs Section 19.3.3

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
5	**Quotation, Tendering and Contract Procedures** **Value of supplies or services defined as the total cost over the period of the contact. All thresholds in this section exclude VAT**		SFIs Section 14
5a	Supplies and Services ▪ Up to £5,000 – best value to be demonstrated non competitive quotations in writing may be obtained ▪ £5,000 to £25,000 Minimum of 3 competitive quotations shall be obtained in writing ▪ £25,000 and over Minimum 4 competitive quotations shall be obtained in writing ▪ Over £1,000,000 minimum of 4 competitive quotations shall be obtained in writing	 Requisitioner Budget holder Divisional Manager / Director of Facilities and Estates / Director of Information Management Technology / Corporate Director Trust Board	 SFIs Section 13.4.3 SFIs Section 13.4.2 SFIs Section 13.4.1 NHS Capital Investment Manual.
5b	Wavering or variations of tendering or quotation requirements ▪ £5,000 to £25,000 ▪ £25,001 and above All breaches of these provisions shall be reported to the Audit Committee through the Chief Executive	 Divisional Manager, may approve single tender quotation Director of Finance may approve single tender quotation	 SFIs Section 13.4.6 SFIs Section 13.4.6

6	**Setting of Fees and Charges**		
6a	Private Patients, overseas visitors, income generation and other patient related services	Director of Finance or nominated deputy	SFIs Section 10.2.11
6b	Service Agreements ▪ Under £1m ▪ Over £1m	 Director of Finance or nominated deputy in consultation with Director of Strategic Development Chief Executive and Director of Finance in consultation with the with Director of Strategic Development	

7	**Expenditure of Charitable Funds**	Managed by the Charitable Trust of the University Hospitals Bristol NHS Foundation Trust	SFIs Section 16

8	**Condemning & Disposal**		SFIs Section 20
8a	Items obsolete, redundant, irreparable or cannot be repaired cost effectively. ▪ with a current or estimated purchase price up to £1,000. ▪ with a current purchase price of £1,000 - £25,000 ▪ with a current purchase price over £25,000.	 Divisional Manager or nominated deputy Director of Finance	
8b	Disposal of x-ray films	Radiology Departmental Manager / Head of Division / Divisional Manager	
8c	Disposal of mechanical engineering plant.	Director of Facilities and Estates	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
9	**Losses, write off and compensation payments.**	**These should be reported to the Audit Committee on a quarterly basis.**	SFIs Section 15
9a	All losses in any of the categories below up to £1,000 (subject to reporting the loss) All losses over £1,000 up to £50,000 All losses over £50,000	Executive Director Chief Executive or Director of Finance Trust Board	
9b	Losses of cash due to theft, fraud, overpayment of salaries and others.	Chief Executive, Director of Finance (or nominated Deputy re overpayment of salaries)	
9c	Fruitless payments including abandoned capital schemes.	Chief Executive and Director of Finance	
9d	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors and Others	Chief Executive and Director of Finance or nominated Deputy	
9e	Damage to buildings, fittings, furniture and equipment and property in stores and in use due to culpable cause (fraud, theft, arson).	Chief Executive and Director of Finance	
9f	Compensation (no limit) payments made under legal obligation	Chief Executive and Director of Finance	
9g	Extra contractual payments to contractors up to £50,000	Chief Executive and Director of Finance	
9h	Personal Injury Claims • Up to £10,000 • Over £10,000	Director of Workforce and Organisational Development or Chief Executive or Director of Finance – without legal advisor Director of Workforce and Organisational Development or Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	
9i	Public Liability Claims • Up to £3,000 • Over £3,000	Divisional General Manager or Chief Executive or Director of Finance – without legal advice Divisional General Manager or Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	
9j	Other, except cases of, maladministration where there was no financial loss by the claimant. • Remedy up to £1,000; • Remedy between the value of £1,001 and £50,000; • Remedy over the value of £50,000.	Director of Finance or Head of Finance Chief Executive Trust Board	
9k	Ex-gratia payments patients and staff for loss of personal effects ▪ Up to £1,000 ▪ between £1,001 and £50,000 ▪ Over £50,000	Director of Finance or nominated deputy Chief Executive Trust Board	SFIs Section 15.5.1b SFIs Section 15.5.1b SFIs Section 15.5.1b

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
9l	Cancellation of NHS debts • Up to £5,000 • Over £5,000	 Head of Finance or Divisional Financial Manager Director of Finance or nominated deputy	
9m	Maladministration and distress payments • Remedy up to £1,000; • Remedy between the value of £1,001 and £50,000; • Remedy over the value of £50,000.	 Director of Finance or Head of Finance Chief Executive Trust Board	
10	**Petty Cash Disbursements**		SFIs Section 6
	▪ expenditure up to £50 per item with the exception of wage advances ▪ expenditure over £50 per item	Budget holder or nominated deputy Divisional Manager	
11	**Hospitality**		
11a	Receiving hospitality for individual and collective hospitality receipt items in excess of £25 per item received	Receiving member of staff required to declare hospitality has been received.	Section 7 Standing Orders/ Policy on Register of Interests and Hospitality – September 2010
11b	The keeping of the Hospitality Register and Register of Interests	For Corporate Divisions – Corporate Directors All other Divisionals – held by Divisional Manager / Head of Division	
12	**Implementation of internal and external audit recommendations.**	Divisional Managers and Corporate Directors	SFIs Section 17
13	**Contracts and SLAs**	Chief Executive or Director of Finance in consultation with the Director of Strategic Development	SFIs Section 3
13a	Agreements\Licences Preparation and signature of all tenancy agreements\licences for all staff subject toTrust policy on accommodation ▪ form of tenancy agreements ▪ signature of individual tenancy agreements Extensions to existing agreements Letting of premises to outside organisations Approval of Rent based on professional assessment	 Director of Estates and Facilities or nominated deputy Director of Estates and Facilities or nominated deputy Residences Manager Residences Manager Director of Estates and Facilities or nominated deputy Director of Finance	
13b	SLA monitoring and reporting	Director of Finance or nominated deputy in conjunction with the Chief Operating Officer and relevant Corporate Directors	SFIs Section 3
13c	SLA management	Director of Finance or nominated deputy in conjunction with the Director of Strategic Development and relevant Corporate Directors and Divisional Managers	SFI Section 3

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
13d	Monitor Proposals for Contractual Arrangements between the Trust and Outside Bodies.	Delegated lead as defined in the framework document	SFIs Section 3
13e	Review of the Trusts Compliance Code of Practice for handling confidential information in the contracting environment.	Medical Director	
14	**Legal**		
14a	Reporting of Incidents to the Police	Chief Executive, Director of Finance, Chief Internal Auditor	SFIs Section 15.3.2 & 17.3.1b
	▪ general ▪ where a fraud is involved	Appropriate departmental manager – need to inform Divisional Manager or relevant Corporate Director as soon as possible. Also inform Local Security Management Specialist Director of Finance or Local Counter Fraud Specialist	 Counter Fraud Policy
14b	Compliance with Freedom of Information Act	Trust Solicitor	Freedom of Information Policy – December 2009
15	**Personnel and Pay**		SFIs Section 7
15a	Authority to fill funded post on the establishment with permanent staff	Budget holder or nominated deputy (subject to any vacancy review policy in place)	Vacancy panel review procedure and terms of reference
15b	Authority to appoint staff to post not on the formal establishment	Head of Division or Executive Director with Head of Human Resources and Director of Finance	
15c	The granting of additional increments to staff within the defined payscale for the post held	Within terms & conditions - Divisional Human Resources Manager	
15d	Upgrading and re-grading	Head of Division for Divisions Corporate Directors for corporate teams Director of Estates and Facilities for Estates and Facilities Director of Information Management Technology for Information Management Technology	
15e	Establishments ▪ additional staff to the agreed establishment within specifically allocated finance ▪ additional staff to the agreed establishment without specifically allocated finance	 Divisional Manager with appropriate Human Resource advice Head of Division or Executive Director with Head of Human Resources and Director of Finance	 Vacancy panel review procedure and terms of reference Vacancy panel review procedure and terms of reference
15f	Pay Authority to complete standing data forms effecting pay, new starters, variations and leavers Authority to complete and authorise positive reporting forms Authority to authorise overtime Authority to authorise travel and subsistence expenses Approval of performance related pay	 Budget holder or nominated deputy Budget holder or nominated deputy Budget holder or nominated deputy Budget holder or nominated deputy Remuneration Committee	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
15g	Leave Approval of annual leave	 Line manager	Annual Leave Policy
	Annual leave carried forward up to Whitley agreed limit	Line manager	
	Annual leave carried forward in excess of Whitley agreed limit	Divisional Manager or Corporate Director	
	Any special leave Medical staff leave of absence Time off in lieu Maternity leave paid and unpaid Sick Leave Extension of sick leave after half pay completed Return to work part time on full pay to assist recovery Extension of sick leave on full pay	Line manager, in accordance with agreed Human Resource policies Head of Division\Medical Director Line Manager Line Manager but seek guidance from Human Resource Department Line Manager Divisional Managers and senior corporate managers after discussion with Head of Human Resources Divisional Manager or Corporate Director in conjunction with Head of Human Resources Head of Division or Corporate Director in conjunction with Head of Human Resources	Special Leave Policy Maternity Leave Policy Absence Management Policy
15h	Removal Expenses ▪ up to £8,000 • above £8,000	 Divisional Human Resource Manager in conjunction with Payroll Manager Head of Human Resources and Director of Finance	Removal Expenses Policy South West Training grade doctors relocation policy
15i	Grievance Procedure\appeals board procedures	Director of Workforce and Organisational Development	Disciplinary Policy Poor Performance Policy Grievance Policy
15j	Authorised Car Users ▪ requests for new post to be authorised as car users ▪ authorised car users – request for extension	 Divisional Manager or Corporate Director Divisional Manager or Corporate Director	
15k	Authorised mobile phone users - requests for new phones to be authorised within Trust policy	Divisional Manager or Corporate Director	
15l	A renewal of fixed term contracts	Budget holder or nominated deputy	
15m	Staff retirement policy extension of contract beyond normal retirement age in exceptional circumstances Early Retirement in furtherance of efficiency	Divisional Manager Director of Workforce and OD and Director of Finance	Retirement Policy
15n	Redundancy	If payment is up to the value of the annual salary – Director of Workforce and Organisational Development If payment is beyond annual salary – Director of Workforce and Organisational Development and Director of Finance. If employee over minimum early retirement age – Director of Workforce and Organisational Development and Director of Finance	Redundancy Policy
15o	Dismissal	See Matrix	Disciplinary Policy and Procedure

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
15p	Engagement of Staff Not on the Establishment		
	Non Medical Consultancy Staff		
	• Where the aggregate commitment is up to £100,000	Divisional Manager or relevant Corporate Director – in line with tendering procedures	
	• £100,000 to £500,000	Director of Finance	
	• Over £500,000	Chief Executive	
	Engagement of Trust Solicitors	For specific Human Resource related issues: Head of Human Resources For property issues – Director of Estates and Facilities All other matters – Director of Finance or Chief Executive	
	Booking of Bank\Locum\Agency Staff		
	▪ Nursing	Budget holder or nominated deputy	
	▪ Clerical/support services	Budget holder or nominated deputy	
	▪ Medical	Head of Division/some or all of the Divisional Management Team as authorised by the Head of Division. Divisional Management Team may consist of: a. Divisional Manager b. Assistant Divisional Manager c. Head of Nursing	
	Consultancy Services (outside major strategic capital projects)		
	Up to £1,000	Divisional Manager or Corporate Director	
	Over £1,000 - £5,000	Corporate Director or Head of Division	
	Over £5,000	Chief Executive	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
16. GENERAL			
16a	Authorisation of new drugs or significant change of use of existing drugs	Medicines Advisory Group-- see specific guidelines and terms of reference of this committee	
	▪ Request for new drugs require authorisation before purchase	Senior Pharmacy Manager	
	▪ Orders placed to suppliers over £5,000 to be signed	Director of Pharmacy or Pharmacy Purchasing Manager	
	▪ Pharmacy Payment Lists to be authorised ▪ Copy invoices over £10,000 and invoices from NHS bodies to be sent with the Payments Lists to Creditor Payments	Director of Pharmacy or Pharmacy Purchasing Manager or Senior Pharmacy Clerical Officer	
	▪ Pricing agreements and quotations should be authorised	Director of Pharmacy and Pharmacy Purchasing Manager	
	▪ Authorisation of coding slips for invoices and credits requirement payment to be carried out	Senior Clerical Officer	
16b	Authorisation of sponsorship deals		
	▪ all deals to be vetted for potential legal and other conflicts plus:	Trust Solicitor	
	▪ up to £15,000	Divisional Manager	
	▪ £15,000 to £50,000	Director of Finance	
	▪ over £50,000	Chief Executive	
16c	Authorisation of commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.	Director of Finance or designated deputy for funding applications Director of Research & Innovation or designated deputy for all other Research & Innovation documents	SFIs Section 2.6
16d	Insurance Policies	Director of Finance	SFIs Section 22
16e	Patients' & Relatives' Complaints :		
	▪ Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Nurse	
	▪ Responsibility for ensuring complaints relating to a divisional are investigated thoroughly	Divisional Manager and Head of Nursing / Midwifery	
	▪ Legal Complaints - Co-ordination of their management	Trust Solicitor	
16f	Relationship with the Media	Head of Communications who reports to the Chief Executive	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
16g	Infection Control and Prevention • Corporate Policy • Divisional and Clinical Delivery	Director of Infection Control and Prevention / Chief Nurse /Heads of Division	Standing Orders section 2.10
16h	Governance and Assurance Systems Corporate Risk Register Divisional Risk Registers Quarterly review of Risk Registers Reports on the Risk Registers quarterly Maintenance of the Assurance Framework Quarterly review of Assurance Framework Exception Reports on the Assurance Framework (1/4ly)	 Relevant Executive Directors Heads of Division and Divisional Managers Risk Management Group Trust Management Executive Trust Secretary Trust Management Executive Audit Committee	SFIs Section 22
16i	All proposed changes in bed allocation	Chief Operating Officer	
16j	Review of Fire Precautions	Fire Safety Manager	Fire Safety Policy and Fire Standards Procedures and Guidelines
	Review of all statutory compliance: legislation and Health and Safety requirements including control of substances hazardous to health regulations	Director of Estates and Facilities / Health and Safety Advisor	Control of Substances Hazardous to Health (COSHH) Policy
16k	Review of compliance with environmental regulations for example those relating to clean air and waste disposal	Director of Estates and Facilities	Operational Policy for Handling Disposal of Waste – August 2005
16l	Review of Trust's compliance with Data Protection Act	Director of Information Management and Technology	Health Records Policy
16m	Review the Trust's compliance with the Access to Records Act	Director of Information Management and Technology	Health Records Policy
16n	Allocation of sealing in accordance with standing orders	Trust Secretary on behalf of the Chief Executive	
16o	The keeping of a Register of Sealing	Trust Secretary on behalf of the Chief Executive	Section 8 Standing Orders
16p	Affixing the Seal	Chief Executive (or, should the Chief Executive not be available, another Executive Director not from the contract's originating department) and Director of Finance or Head of Finance	
16q	Retention of Records	Relevant Corporate Directors	SFIs Section 21
16r	Clinical Audit	Medical Director	
16s	Human Rights Act Compliance	Trust Solicitor	
16t	Equality and Diversity Schemes	Director of Workforce and Organisational Development	
16u	Child Protection	Chief Nurse	Section 2.10 Standing Orders

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST - SCHEME OF DELEGATION

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
1. BUDGETS			
1a	Financial control, budgetary management	Chief Executive and Director of Finance	SFIs section 1.2.4
	Financial policies and internal financial control systems	Director of Finance	SFIs section 1.2.4
	Maintenance and review of Trust's financial procedures	Director of Finance	SFIs section 1.2.4
1b	Annual planning and budgets	Chief Executive and Director of Finance	SFIs section 2.2
	Divisional/Corporate Service operational plans	Clinical Chairs/Divisional Directors/Corporate Service Director	SFIs section 2.2.5
1c	Budget delegation ▪ individual cost centre level ▪ department level ▪ divisional level	 Budget holder or nominated deputy Departmental manager or nominated deputy Clinical Chair / members of the Divisional Board as authorised by the Clinical Chair. The Divisional Board may consist of: a. Divisional Director b. Divisional Manager c. Head of Nursing d. Divisional Financial Manager e. HR Business Partner	SFIs sections 2.3-2.7 and 2.4.4
	▪ corporate service level	Director of Facilities and Estates Director of Information Management Technology Corporate Director or delegated deputy	
1d	Virements A virement is described as a transfer of funding between budget lines whether within or between departments. All virements require consultation with and the approval of the Divisional Financial Manager		SFIs section 2.3
	▪ Between pay budget lines within a department. Virement not to exceed overall department pay budget value.	Budget holder with one of the following: Head of nursing/modern matron Divisional Director/Manager or Assistant Departmental Head Director of Facilities and Estates Director of Information Management Technology	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ Between non-pay budget lines within a department: Virement not to exceed overall department non-pay budget value	Budget holder	
	▪ Between Divisional/Department Up to £5,000 Over £5,000 Virements must be supported by appropriate paperwork maintained by the Finance department • Between Divisions	 Budget holder for both Departments / Divisions Budget holder and Divisional Manager/Director of Facilities and Estates/Director of Information Management Technology or appropriate Deputy of both Departments/Divisionals Divisional Director / Director of Facilities and Estates / Director of Information Management Technology by joint agreement	
	All virements from reserves Virements must be supported by appropriate paperwork maintained by the Finance department	Director of Finance or nominated Deputy	

2. BANK ACCOUNTS AND INVESTMENTS			
2a	Maintenance and operation of bank accounts Overall control of Trust bank accounts	Director of Finance Director of Finance	SFIs section 5 SFIs sections 5.2.2 & 5.3.1
2b	Maintenance of operating procedures and instructions	Director of Finance	SFIs sections 5.2.1 & 5.3.2
2c	Opening of bank accounts	Director of Finance	SFIs section 5.3.5
2d	Approved cheque (and other payable order) signatories encompassing approval requirements • Cheque payments over single signatory limits • Cheque drawn to cash	 Chief Executive or Director of Finance or nominated Senior Finance Manager Director of Finance	 Treasury Management Policy SFIs section 9.8.2
2e	Approved bank transfer signatories	Chief Executive or Director of Finance or nominated Senior Finance Manager	
2f	Investment of surplus cash	Director of Finance or nominated Senior Finance Manager	SFIs section 5.5
2g	Application for loan or working capital facility	Director of Finance	SFIs section 6.2.4

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
3	**Non-pay revenue and capital expenditure\requisitioning\ordering\payment of goods and services.** Financial thresholds in this section mirror the procurement limits and as such exclude VAT Where there is an order/contract for more than one financial year, the total cost must be included not just the 12 months element.		SFIs Section 19 SFIs Section 13 SFIs Section 13
3a	Ordering ▪ up to £5,000 ▪ £5,000 to £25,000 ▪ £25,000 to EU Threshold ▪ EU Threshold to £1m ▪ Over £1m	 Requisitioner as specifically designated by budget holder Budget holder or authorised deputy Divisional Director / Director of Facilities and Estates / Director of Information Management Technology / relevant Corporate Director or authorised deputy Director of Estates and Facilities to authorise all Estates and Facilities services orders, Relevant Corporate Director or authorised deputy for all other services Chief Executive, after approval by Trust Board	
3b	Capital expenditure and investment Subject to the above tendering and quotation limits and in accordance with the Capital Investment Policy, the following will apply. • Equal to or less 0.25% of turnover including VAT, a short form business case is required for approval. It must justify the investment, demonstrate value for money and identify the recurring revenue consequences. • Greater than 0.25% of turnover and less than or equal to 0.5% of turnover – a comprehensive business case is required for approval. • Greater than 0.5% of turnover and less than or equal to 1.0% of turnover a comprehensive business case is required for approval. • Greater than 1.0% of turnover, an Outline Business Case is required for approval followed by a Full Business Case for approval.	 Capital Programme Steering Group Senior Leadership Team Finance Committee Trust Board	Capital Investment Policy SFIs section 19

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	Capital Expenditure – variations to approved business case. • Up to £250,000 • Over £250,000 to £500,000 • Over £500,000	 Capital Programme Steering Group Senior Leadership Team Trust Board	
	Selection of architects, quantity surveyors, consultant engineers and other professional advisors within European Union regulations.	Director of Facilities and Estates and/or Strategic Development Programme Director	
	Financial Monitoring and reporting on all capital scheme expenditure	Director of Finance or nominated Deputy	
3c	Payment for goods and services • Certified invoices • Pre-payments	 Budget holder or authorised signatory for cost centre Director of Finance	 SFIs section 8.4.2 SFIs section 8.5
3d	Negotiations with suppliers • Up to £1,000 • Over £1,000 to £25,000 • Over £25,000	 Head of Finance Director of Finance Finance Committee	SFIs section 8.8
3e	Approving expenditure greater than tendered or quoted price by the lesser of 10% or £100: ▪ Up to £5,000 ▪ £5,000 to £25,000 ▪ Over £25,000	 Budget Holder or nominated deputy Divisional Director / Director of Facilities and Estates / Director of Information Management Technology Director of Finance	

4	**Capital Investment**		SFIs Section 19
4a	Approval of the Trust's Capital Investment Policy annually.	Trust Board	
4b	Approval of procurement strategy	Director of Strategic Development and Director of Finance	
4c	Selection of advisors	Director of Strategic Development and/or Strategic Development Programme Director	
4e	Signing of contracts	Chief Executive	
4f	Changes to project management infrastructure	Director of Strategic Development	
4g	Sign off of projects	Director of Strategic Development	
4h	Financial monitoring of major capital scheme expenditure	Director of Finance and Director of Facilities and Estates and / or Strategic Development Programme Director	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
4i	Private Finance • Approval of Business Case	Trust Board	
4.j	Leasing • Approval of Lease Proposals	Director of Finance	SFIs Section 19.3.3
5	**Quotation, Tendering and Contract Procedures** **Value of supplies or services are defined as the total cost over the period of the contact. All thresholds in this section exclude VAT**		SFIs Section 14
5a	Supplies and Services ▪ Up to £5,000 – best value to be demonstrated non competitive quotations in writing may be obtained ▪ £5,000 to £25,000 Minimum of 3 competitive quotations shall be obtained in writing ▪ £25,000 and over Minimum 4 competitive quotations shall be obtained in writing ▪ Over £1,000,000 minimum of 4 competitive quotations shall be obtained in writing	Requisitioner Budget holder Divisional Director / Director of Facilities and Estates / Director of Information Management Technology / Corporate Director Trust Board	SFIs Section 13.4.3 SFIs Section 13.4.2 SFIs Section 13.4.1 NHS Capital Investment Manual.
5b	Wavering or variations of tendering or quotation requirements ▪ £5,000 to £25,000 ▪ £25,001 and above All breaches of these provisions shall be reported to the Audit Committee through the Chief Executive	Divisional Director may approve single tender quotation, with Head of Procurement sign off Director of Finance may approve single tender quotation, with Head of Procurement sign off	SFIs Section 13.4.6 SFIs Section 13.4.6
6	**Setting of Fees and Charges**		
6a	Private Patients, overseas visitors, income generation and other patient related services	Director of Finance or nominated deputy	SFIs Section 10.2.10
6b	Service Agreements ▪ Under £1m ▪ Over £1m	Director of Finance or nominated deputy in consultation with Director of Strategic Development Chief Executive and Director of Finance in consultation with the with Director of Strategic Development	
7	**Expenditure of Charitable Funds**	Managed by the Charitable Trust of the University Hospitals Bristol NHS Foundation Trust	SFIs Section 16
8	**Condemning & Disposal**		SFIs Section 20
8a	Items obsolete, redundant, irreparable or cannot be repaired cost effectively. ▪ with a current or estimated purchase price up to £1,000. ▪ with a current purchase price of £1,000 - £25,000	Divisional Manager Divisional Director or nominated deputy	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ with a current purchase price over £25,000.	Director of Finance	
8b	Disposal of x-ray films	Radiology Departmental Manager / Divisional Director / Divisional Manager	
8c	Disposal of mechanical engineering plant.	Director of Facilities and Estates	
9	**Losses, write off and compensation payments.**	**These should be reported to the Audit Committee on a quarterly basis.**	SFIs Section 15
9a	All losses in any of the categories below up to £1,000 (subject to reporting the loss) All losses over £1,000 up to £50,000 All losses over £50,000	 Executive Director Chief Executive or Director of Finance Trust Board	
9b	Losses of cash due to theft, fraud, overpayment of salaries and others.	Chief Executive, Director of Finance (or nominated Deputy re overpayment of salaries)	
9c	Fruitless payments including abandoned capital schemes.	Chief Executive and Director of Finance	
9d	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors and Others	Chief Executive and Director of Finance or nominated Deputy	
9e	Damage to buildings, fittings, furniture and equipment and property in stores and in use due to culpable cause (fraud, theft, arson).	Chief Executive and Director of Finance	
9f	Compensation (no limit) payments made under legal obligation	Chief Executive and Director of Finance	
9g	Extra contractual payments to contractors up to £50,000	Chief Executive and Director of Finance	
9h	Personal Injury Claims • Up to £10,000 • Over £10,000	 Director of Workforce and Organisational Development or Chief Executive or Director of Finance – without legal advisor Director of Workforce and Organisational Development or Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	
9i	Public Liability Claims • Up to £3,000 • Over £3,000	 Divisional Director or Chief Executive or Director of Finance – without legal advice Divisional Director or Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	
9j	Other, except cases of, maladministration where there was no financial loss by the claimant. • Remedy up to £1,000; • Remedy between the value of £1,001 and £50,000; • Remedy over the value of £50,000.	 Director of Finance or Head of Finance Chief Executive Trust Board	
9k	Ex-gratia payments patients and staff for loss of personal effects ▪ Up to £1,000	 Director of Finance or nominated deputy	 SFIs Section 15.5.1b

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ between £1,001 and £50,000 ▪ Over £50,000	Chief Executive Trust Board	SFIs Section 15.5.1b SFIs Section 15.5.1b
9l	Cancellation of NHS debts • Up to £5,000 • Over £5,000	 Head of Finance or Divisional Financial Manager Director of Finance or nominated deputy	
9m	Maladministration and distress payments • Remedy up to £1,000; • Remedy between the value of £1,001 and £50,000; • Remedy over the value of £50,000.	 Director of Finance or Head of Finance Chief Executive Trust Board	
10	**Petty Cash Disbursements**		SFIs Section 6
	▪ expenditure up to £50 per item with the exception of wage advances ▪ expenditure over £50 per item	Budget holder or nominated deputy Divisional Manager	
11	**Hospitality**		
11a	Receiving hospitality for individual and collective hospitality receipt items in excess of £25 per item received	Receiving member of staff required to declare hospitality has been received.	Section 7 Standing Orders/ Policy on Register of Interests and Hospitality – September 2010
11b	The keeping of the Hospitality Register and Register of Interests	For Corporate Divisions – Corporate Directors All other Divisions – held by Divisional Director	
12	**Implementation of internal and external audit recommendations.**	Divisional Directors and Corporate Directors	SFIs Section 17
13	**Contracts and SLAs**	Chief Executive or Director of Finance in consultation with the Director of Strategic Development	SFIs Section 3
13a	Agreements/Licences Preparation and signature of all tenancy agreements/licences for all staff subject to Trust policy on accommodation ▪ form of tenancy agreements ▪ signature of individual tenancy agreements Extensions to existing agreements Letting of premises to outside organisations Approval of rent based on professional assessment	 Director of Estates and Facilities or nominated deputy Director of Estates and Facilities or nominated deputy Residences Manager Residences Manager Director of Estates and Facilities or nominated deputy Director of Finance	
13b	SLA monitoring and reporting	Director of Finance or nominated deputy in conjunction with the Chief Operating Officer and relevant Corporate Directors	SFIs Section 3

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
13c	SLA management	Director of Finance or nominated deputy in conjunction with the Director of Strategic Development and relevant Corporate Directors and Divisional Directors	SFI Section 3
13d	Monitor proposals for contractual arrangements between the Trust and outside bodies.	Delegated lead as defined in the framework document	SFIs Section 3
13e	Review of the Trusts Compliance Code of Practice for handling confidential information in the contracting environment.	Medical Director	
14	**Legal**		
14a	Reporting of incidents to the police	Chief Executive, Director of Finance, Chief Internal Auditor	SFIs Section 15.3.2 & 17.3.1c
	▪ general ▪ where a fraud is involved	Appropriate departmental manager – need to inform Divisional Director or relevant Corporate Director as soon as possible. Also inform Local Security Management Specialist Director of Finance or Local Counter Fraud Specialist	 Counter Fraud Policy
14b	Compliance with Freedom of Information Act	Trust Solicitor	Freedom of Information Policy – December 2009
15	**Personnel and Pay**		SFIs Section 7
15a	Authority to fill funded post on the establishment with permanent staff	Budget holder or nominated deputy (subject to any vacancy review policy in place)	Vacancy panel review procedure and HR policies
15b	Authority to appoint staff to post not on the formal establishment	Head of Division or Executive Director with Head of Human Resources and Director of Finance	
15c	The granting of additional increments to staff within the defined payscale for the post held	Within terms & conditions Human Resources Business Partner	
15d	Upgrading and re-grading	Head of Division for Divisions Corporate Directors for corporate teams Director of Estates and Facilities for Estates and Facilities Director of Information Management Technology for Information Management Technology	
15e	Establishments ▪ additional staff to the agreed establishment within specifically allocated finance ▪ additional staff to the agreed establishment without specifically allocated finance	 Divisional Manager with appropriate Human Resource advice Head of Division or Executive Director with Head of Human Resources and Director of Finance	 Vacancy panel review procedure and HR policies Vacancy panel review procedure and HR policies
15f	Pay Authority to complete standing data forms effecting pay, new starters, variations and leavers Authority to complete and authorise positive reporting forms Authority to authorise overtime Authority to authorise travel and subsistence expenses Approval of performance related pay	 Budget holder or nominated deputy Budget holder or nominated deputy Budget holder or nominated deputy Budget holder or nominated deputy Remuneration Committee	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
15g	Leave Approval of annual leave	 Line manager	Annual leave policy
	Annual leave carried forward up to Trust agreed limit	Line manager	
	Annual leave carried forward in excess of Trust agreed limit	Divisional Director or Corporate Director	
	Any special leave Medical staff leave of absence Time off in lieu Maternity leave paid and unpaid Sick Leave Extension of sick leave after half pay completed Return to work part time on full pay to assist recovery Extension of sick leave on full pay	Line manager, in accordance with agreed Human Resource policies Clinical Chair/Medical Director Line manager Line manager Line manager Divisional Managers and senior corporate managers after discussion with Head of Human Resources Divisional Managers or Corporate Director in conjunction with Head of Human Resources Divisional Director or Corporate Director in conjunction with Head of Human Resources	Special leave policy Maternity leave policy Supporting attendance policy
15h	Removal Expenses ▪ up to £8,000 • above £8,000	 Divisional Human Resource Business Partner in conjunction with Payroll Manager Head of Human Resources and Director of Finance	Removal expenses policy South West Training grade doctors relocation policy
15i	Grievance procedure/appeals board procedures	Director of Workforce and Organisational Development	Disciplinary Policy Managing Performance Policy Grievance Policy
15j	Authorised car users ▪ requests for new post to be authorised as car users ▪ authorised car users – request for extension	 Divisional Manager or Corporate Director Divisional Manager or Corporate Director	
15k	Authorised mobile phone users - requests for new phones to be authorised within Trust policy	Divisional Manager or Corporate Director	
15l	A renewal of fixed term contracts	Budget holder or nominated deputy	
15m	Staff retirement policy extension of contract beyond normal retirement age in exceptional circumstances Early retirement in furtherance of efficiency	Divisional Director Director of Workforce and OD and Director of Finance	Retirement Policy
15n	Redundancy	If payment is up to the value of the annual salary – Director of Workforce and Organisational Development If payment is beyond annual salary – Director of Workforce and Organisational Development and Director of Finance. If employee over minimum early retirement age – Director of Workforce and Organisational Development and Director of Finance	Redundancy Policy
15o	Dismissal	See Matrix	Disciplinary Policy and Procedure

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
15p	Engagement of staff not on the establishment Non Medical consultancy staff • Where the aggregate commitment is up to £100,000 • £100,000 to £500,000 • Over £500,000 Engagement of Trust Solicitors Booking of Bank\Locum\Agency Staff ▪ Nursing ▪ Clerical/support services ▪ Medical Consultancy Services (outside major strategic capital projects) Up to £1,000 Over £1,000 - £5,000 Over £5,000	 Divisional Director or relevant Corporate Director – in line with tendering procedures Director of Finance Chief Executive For specific Human Resource related issues: Head of Human Resources For property issues – Director of Estates and Facilities All other matters – Director of Finance or Chief Executive Budget holder or nominated deputy Budget holder or nominated deputy Clinical Chair/some or all of the Divisional Board as authorised by the Clinical Chair. Divisional Board may consist of: a. Divisional Director b. Divisional Managers c. Head of Nursing d. Divisional HR Business Partner Divisional Manager or Corporate Director Corporate Director or Divisional Director Chief Executive	

	16. GENERAL		
16a	Authorisation of new drugs or significant change of use of existing drugs ▪ Request for new drugs require authorisation before purchase ▪ Orders placed to suppliers over £5,000 to be signed	Medicines Advisory Group– see specific guidelines and terms of reference of this committee Senior Pharmacy Manager Director of Pharmacy or Pharmacy Purchasing Manager	
	▪ Pharmacy Payment Lists to be authorised ▪ Copy invoices over £10,000 and invoices from NHS bodies to be sent with the Payments Lists to Creditor Payments	Director of Pharmacy or Pharmacy Purchasing Manager or Senior Pharmacy Clerical Officer	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ Pricing agreements and quotations should be authorised	Director of Pharmacy and Pharmacy Purchasing Manager	
	▪ Authorisation of coding slips for invoices and credits requirement payment to be carried out	Senior Clerical Officer	
16b	Authorisation of sponsorship deals ▪ all deals to be vetted for potential legal and other conflicts plus: ▪ up to £15,000 ▪ £15,000 to £50,000 ▪ over £50,000	 Trust Solicitor Divisional Director Director of Finance Chief Executive	
16c	Authorisation of commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.	Director of Finance or designated deputy for funding applications Director of Research & Innovation or designated deputy for all other Research & Innovation documents	SFIs Section 2.6
16d	Insurance Policies	Director of Finance	SFIs Section 22
16e	Patients' & Relatives' Complaints :		
	▪ Overall responsibility for ensuring that all complaints are dealt with effectively ▪ Responsibility for ensuring complaints relating to a division are investigated thoroughly ▪ Legal Complaints - Co-ordination of their management	Chief Nurse Divisional Director and Head of Nursing / Midwifery Trust Solicitor	
16f	Relationship with the media	Head of Communications who reports to the Chief Executive	
16g	Infection Control and Prevention • Corporate Policy • Divisional and Clinical Delivery	Director of Infection Control and Prevention / Chief Nurse /Clinical Chairs	Standing Orders section 2.10
16h	Governance and Assurance Systems Corporate Risk Register Divisional Risk Registers Quarterly review of Risk Registers Reports on the Risk Registers quarterly Maintenance of the Assurance Framework Quarterly review of Assurance Framework Exception Reports on the Assurance Framework (1/4ly)	 Relevant Executive Directors Divisional Directors and Divisional Managers Risk Management Group Senior Leadership Team Trust Company Secretary Senior Leadership Team Audit Committee	SFIs Section 22
16i	All proposed changes in bed allocation	Chief Operating Officer	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
16j	Review of Fire Precautions	Fire Safety Manager	Fire Safety Policy and Fire Standards Procedures and Guidelines
	Review of all statutory compliance: legislation and Health and Safety requirements including control of substances hazardous to health regulations	Director of Estates and Facilities / Health and Safety Advisor	Control of Substances Hazardous to Health (COSHH) Policy
16k	Review of compliance with environmental regulations for example those relating to clean air and waste disposal	Director of Estates and Facilities	Operational Policy for Handling Disposal of Waste – August 2005
16l	Review of Trust's compliance with Data Protection Act	Director of Information Management and Technology	Health Records Policy
16m	Review the Trust's compliance with the Access to Records Act	Director of Information Management and Technology	Health Records Policy
16n	Allocation of sealing in accordance with standing orders	Trust Company Secretary on behalf of the Chief Executive	
16o	The keeping of a Register of Sealing	Trust Company Secretary on behalf of the Chief Executive	Section 8 Standing Orders
16p	Affixing the Seal	Chief Executive (or, should the Chief Executive not be available, another Executive Director not from the contract's originating department) and Director of Finance or Head of Finance	
16q	Retention of Records	Relevant Corporate Directors	SFIs Section 21
16r	Clinical Audit	Medical Director	
16s	Human Rights Act Compliance	Trust Solicitor	
16t	Equality and Diversity Schemes	Director of Workforce and Organisational Development	
16u	Child Protection	Chief Nurse	Section 2.10 Standing Orders
16v	The West of England Clinical Research Network (CRN:WoE) Decision to provide additional funding to an NHS partner of the CRN:WoE following a request for financial support; Of £50,000 or below In excess of £50,000	 West of England Clinical Research Network Executive Group West of England Clinical Research Network Partnership Group	

University Hospitals Bristol NHS
NHS Foundation Trust

**Cover Sheet for a Report for a Public Trust Board Meeting,
to be held on 30 June 2014 at 10:30am
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

13. Governor's Log of Communications

Purpose

The purpose of this report is to provide the Trust Board of Directors with an update on the most recent questions on the Governors' Log of Communications.

Abstract

The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.

Those items on the Governors' Log of Communications that have been added to or amended since the last Public Board meeting can be seen at Appendix A.

Recommendations

The Trust Board is recommended to note this report by the Chairman

Executive Report Sponsor or Other Author

- Sponsor – Chairman

Appendices

- Appendix A – Governor Log – Items altered since the previous meeting.

ID Governor Name

94 Wendy Gregory **Title:** **Self-medication - supplementary question to Item ID88**

Query **21/05/2014**

I have just one supplementary if possible and that is:-
To conclude , what proportion of the total bed stock have the facility to self medicate trust-wide by the end of May and are we happy that 90 minutes delay to administer patients own medication on the ward, if one adds the potential delay of an A&E stay, is satisfactory? I still have an element of concern for those patients who have the capacity to self-administer and may well suffer severe breakthrough of pain during that 90 minute window.

Response **13/06/2014**

Response from Deputy Chief Executive & Director of Strategic Development:

1.Self administration of medicines
'what proportion of the total bed stock have the facility to self medicate trust-wide?'

It is of important note that a proportion of the hospital beds would be very unlikely to adopt self-administration of medicines as a process; such areas include the intensive care unit, high dependency unit, cardiac intensive care and HDU beds, coronary care unit and the majority of wards in the Bristol Childrens' Hospital. Secondly there are some wards that have a small number of 'self-administration' lockers and they can place these at the bedside for the selected patients for whom medicines self-administration would be helpful. For example, the 60 beds at South Bristol Community Hospital have a small number of lockers that are available to be used in this way.

It is calculated that 375 beds have self-administration lockers. Bearing in mind the second point above, the facility is therefore available for more than 375 patients, but it is difficult to calculate the proportion of the total relevant bed stock but it is the vast majority of beds where it is appropriate to have such arrangements.

The key focus currently is to enable better uptake through supporting nursing staff with the process, therefore making best use of the available cabinets. A number of short training sessions are being scheduled in July, run jointly by Pharmacy and Nursing staff who are regularly involved in the self-administration process.

2.Delays in administration of medicines
'are we happy that 90 minutes delay to administer patients own medication on the ward, if one adds the potential delay of an A&E stay, is satisfactory?'

This is an important point and reflects the recommendation concerning medicines that is raised in the Francis report:
242 Medicines administration
In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.

The 90 minute 'window' is not the expected delay but an estimation of the realistic time for nursing staff to safely administer medicines to patients on their wards. Clearly medicines should be administered in a timely fashion, and it would be unacceptable for patients to wait for analgesia when in pain. Patients in pain on A&E would receive analgesia. I do not envisage such delays in practice, and am aware that nursing staff rightly prioritise the administration of analgesia and complaints about lack of appropriate analgesia is not a theme.

93 Mani Chauhan **Title:** **Feasibility study for potential new car park**

Query **14/05/2014**

There was mention of a potential new car park. I appreciate this is sensitive however is there a report or feasibility study on the proposal we can look at?

Will any future car park charges be capped and will they be set by a private operator?

Response **21/05/2014**

Response from Deputy Chief Executive & Director of Strategic Development:
The Trust Board will receive the Estates Strategy at its June Board which will confirm the intention to provide enhanced car parking provision on the campus. This strategy will seek Board support for an Outline Business Case to be developed by the end of September 2014 when further detail on the car park provision will be available.

Work to confirm the model of operation and charges has yet to be undertaken.

92 Clive Hamilton **Title:** **Guidance on nurse staffing levels**

Query **17/05/2014**

Directors will be aware the The National Institute for Health and Care Excellence have recently issued guidance on nurse staffing levels. The recommended minimum level recommended is 1 nurse for every 8 patients. Are the Non-Executive Directors assured that this minimum level is met throughout the Trust and that nurse staffing is at a safe level in intensive care environments such as High Dependency? Do Non-Executive directors subscribe to the recommendation that the level of safe nursing cover in each ward should be displayed for visiting public and patient reference?

Response **13/06/2014**

Response from Chief Nurse: I can confirm that the Trust has done a risk assessment against delivery of the 10 expectations of the NQB which was presented in the public board in May, which includes displaying staffing information outside all inpatient areas by end of June 2014. The Trust is signed up to some principles for setting staffing levels in adult and children's services for day and night shifts these are within the recommended minimum level of 1 nurse per 8 patients.

ID	Governor Name		
91	**Clive Hamilton**	**Title:**	**Targets for 18-week wait time for non-admitted patients - Opthalmology and Paediatric Cardiology**

Query **07/05/2014**

The action plans outlined in the Extraordinary board meeting on the 14th April contain an undertaking to bring the 18 week wait time for non-admitted patients back to 95% target by October 2014. There were 2 notable outliers - Ophthalmology and Paediatric Cardiology carried over to target achievement as late as January 2015. Have the Non-Executive Directors received assurance that this is the earliest date possible and if so, why is this?

Response **20/06/2014**

Response from Chief Operating Officer: The plans detailed in the Board pack describe the improvement plan to reduce the waiting time for first outpatient appointments. This will support both the delivery of the non-admitted and admitted performance by shortening the time patients wait on the first part of their pathways. This then allows more time along the 18 weeks pathway for diagnostics, further follow ups and admission, if required.

In the case of Ophthalmology, this is a high volume specialty and there are capacity constraints both in terms of physical location and resources to increase capacity. There are also some specific capacity constraints at sub-specialty level. Recruitment in underway to increase resources to support reductions in waiting times but this will take until the end of the calendar year to deliver the improvements.

For Paediatric Cardiology, the reduction in waiting times for first outpatient appointment is reliant on the recruitment of two additional consultants. This will increase capacity in the service to match demand. It is expected that these two posts will be recruited to by October 2014. Once these posts are in place, it will take time for the increased capacity to result in the required improvements in waiting times for the service.

All plans have been critically reviewed to ensure they are challenging yet robust. Delivery against the plans is monitored weekly and divisions continue to look for opportunities to accelerate the recovery plans where possible.

The plans for delivery of improved waiting times in Ophthalmology and Paediatric Cardiology do not present a risk to the improvement in overall Trust's performance, as assessed by Monitor.

90	**Clive Hamilton**	**Title:**	**Progress of programme to rationalise and standardise in-house documentation**

Query **07/05/2014**

When Alison Moon was Chief Nurse, there was a proposed programme to rationalise and standardise in house documentation to reduce confusion and the burden of document entry. Has this programme been completed and do the Non-Executive Directors have assurance that all administrative entry systems are standardised and necessary?

Response **16/05/2014**

Response from Chief Nurse: Some of this work has progressed – the programme is yet to be completed.

Actions taken to date: Development and implementation of an e-handover document. Nursing Admission documentation has been reviewed/developed and is being implemented. A Care Log has been developed and is in Trust-wide use which evidences interventions for patients at specific risk of falling, developing pressure ulcers, having poor nutritional intake or of infection. A risk assessment booklet has been developed for assessing all patients on admission and is in use.

89	**Clive Hamilton**	**Title:**	**Paediatric Intravenous Phlebitis Assessment controls**

Query **22/05/2014**

Controls for Paediatric Intravenous Phlebitis Assessment include information which is supposed to accompany a patient with an imbedded cannula on ward transfer. Is there assurance that this is being done consistently. Has this process been audited and if so, what information is available about the effectiveness of controls.

Response **08/05/2014**

Assigned to Executive Lead

ID Governor Name

88 Wendy Gregory **Title: Self-medication**

Query 25/04/2014

[These are supplementary questions following Wendy Gregory's query about self-medication at the January Council of Governors meeting and the response from Stephen Brown, Head of Pharmacy, on 22/04/14.]

Thank you for this response. I am encouraged by the following points.
a) that self-medication, where appropriate is to be encouraged- How widespread is this practice at this stage -a question to note?
b) that patients' own medication can stay with them locked away for medical staffs administration if appropriate
c) there should not be a substantial time delay for new medication to be administered.
I would like to ask how one would define "substantial" as with certain drugs such as Amatrypcyline, Baclofen, Tramadol etc a delay can cause breakthrough of pain which is very difficult to get on top of and can cause a set-back to patients recovery and well being.

Response 16/05/2014

Response from Deputy Chief Executive & Director of Strategic Development:
Self-medication:

We recognised in 2012 that the self-medication (or self-administration) process was not being suitably utilised as the Trust's stock of bedside medicines cabinets in many areas had deteriorated and so could not be used for this purpose. Pharmacy therefore led an operational capital proposal for 2013/14 to replace many of the bedside lockers in order to provide suitable cabinets that are fit for purpose, for safe storage of, and appropriate access to, patients medicines. Initially there were suitable cabinets available in some areas such as the Bristol Heart Institute, and so the other ward areas were prioritised and installation of the new cabinets has been progressed in three batches. The first two batches are installed, with good feedback from nursing staff and patients, and the third batch is being installed before the end of May. The wards were prioritised depending on the condition of their current storage for patients' own medicines. In phase 1 cabinets were provided to wards 10, 2, 61, and 15; phase 2 covered wards 5B, 6, 7, 9 and 11; phase 3 will cover wards 78, 11 and 4. Small numbers cabinets have also been provided to wards 100, 200 and 35. There has therefore been an important focus on enabling patient self-administration of medicines through provision of suitably designed hospital bedside medicines cabinets.
Some areas of the Trust that have suitable bedside medicines cabinets are routinely enabling patient self-administration of medicines, such as adult haematology on ward 62 and for Cystic Fibrosis patients on ward 54. All of the wards with new cabinets (detailed above) are using the process for some patients, but it has been recognised that this is still limited. Refresher sessions are therefore currently being scheduled in the coming weeks (being led by Pharmacy and the nursing staff who regularly enable self-administration) to ensure nursing staff are confident when applying the Trust policy and procedures. These sessions are focussing on the self-administration process and the nursing staff assessment of the capacity of patients to safely administer their own medicines.

Time delays:

We have a target that all medicines should be administered within 90 minutes of the specified prescribed time, apart from medicines for Parkinsons disease which should be administered at the actual time specified on the prescription.

87 Mani Chauhan **Title: Cancer treatment targets**

Query 15/04/2014

These questions refer to the matters discussed at the Extraordinary Board Meeting on Monday 14 April 2014.

Question 1: With regards to Cancer 62-day GP analysis. The opening statement reads "85% of patients referred by their GP with a suspected cancer to be treated within 62 days."
Where does this 62 day period come from - is it an overall NHS strategy?

Question 2: How do you define treated - actual treatment or do you mean "an appointment"?

Question 3: If it is actual treatment - how long does it take on average for a patient to be seen for an initial appointment to the hospital after that first GP referral where cancer is suspected? I'm concerned with how many sleepless nights a patient has to suffer before they know they have cancer or not.

Response 08/05/2014

Response from Chief Operating Officer:
Question 1: The 62 day target is nationally defined, and all NHS providers are expected to meet the target. The target (along with the other cancer waiting times targets) is laid out in the NHS Operating Framework and its importance is reinforced in the Department of Health policy 'Improving Outcomes: A Strategy for Cancer'

Question 2: The 62 day standard measures time from referral to start of treatment, not simply an appointment. There is extensive guidance from the Department of Health on how to apply the Cancer Waiting Times standards, including how to define a treatment. Usually a treatment is the start of an active treatment (surgery, chemotherapy or radiotherapy most commonly) or of palliative care/active monitoring if that is the only course of management being pursued.

Question 3: There is a separate standard for first appointments: a maximum of two weeks to first appointment after a suspected cancer 'fast track' referral from a GP is received. The national target is for this to be met for 93% patients. We consistently achieve this standard at UH Bristol and any 'breaches' are usually due to patients electing to wait longer than the two week period (which we cannot adjust for). In quarter 4 2013/14 the average (mean) waiting time from referral to first appointment for GP fast track referrals was 9.8 calendar days. We are currently working towards reducing the waiting time for first appointment down to one week (7 calendar days) for appropriate specialities, to further reduce the time for diagnosis and treatment, as well as improve patient experience. There will be some areas where this isn't appropriate, for example where patients attend 'one-stop' clinics that enable multiple tests on the same day, which is more convenient for the patient and usually results in a faster overall time to diagnosis.

ID	Governor Name		
86	**Ken Booth**	**Title:**	**On-street drop-off parking for volunteer drivers**

Query **14/04/2014**

Response from Chief Operating Officer:
The Board will be aware that lengthy discussions with City Council officials lead by Bob Pepper, Director of Facilities and Estates, with a view to the provision of on-street patient drop-off spaces have been un-successful. With the full support of governors Lorna Watson and I have been pressing for spaces to be set aside on both Upper and Lower Maudlin streets, particularly adjacent to the BRI entrance (where there would be no obstruction to traffic) and opposite the Eye hospital entrance (where there are currently pay & display spaces).

This issue poses a serious problem for volunteer drivers in car schemes who bring the elderly and/or infirm to out-patient appointments, as well as to those of us who offer this facility to friends or neighbours on an informal basis. Parking tickets are frequently issued by over-zealous attendants, outside the BRI, which makes volunteer drivers reluctant to provide this service. Short-term (15 minute, parking ticket-free) drop-offs outside the Eye hospital are practically impossible.

Providing easy access to our hospitals should be a priority if we truly believe in our values. This must not be obstructed by red-tape and excuses put forward of council officials. I now ask our Non-Executive Directors to support a direct approach by Robert Woolley to the Mayor, with a view to solving this problem once and for all.

Response **13/05/2014**

It is agreed by everyone that the dropping off provision for our city centre hospitals is less than ideal. The hospital sites are very constrained as they are largely covered with buildings, so we sought to discuss with Bristol City Council how the parking spaces on the public highway in and around the precinct could be better used. In addition, representatives of the various volunteer driver organisations sought to have these spaces identified for their exclusive use.

Discussions have taken place with the city council department responsible for the highway and who operate the statutory controls over parking across the city. This included site visits with their manager to look at each of the locations in Lower and Upper Maudlin Street as well as Horfield Road. Among other things we discussed the desirability of reducing the maximum period of stay, to increase turnover and in effect permit more people to make short duration stops outside the hospitals.

The outcome of the discussion and site visits was then considered internally within the Transport Department and fed back to the Trust at a meeting with their manager.

What was then advised to us was that the Council would not be minded to make changes to these areas at this time as they fell into the current city centre CPZ area. The process for making a change is formal and protracted, as we understood it, and would require a consultation process and at this time the council did not wish to pursue that course of action as the previous consultation was lengthy and contentious.

They did not reject the idea of our request when the area comes up for routine review which might be in a couple of years' time.

Bearing in mind that these car parking spaces are on public highway, and are therefore theoretically available for any tax or rate payer, we got the impression that reserving them for purely one interest group i.e. for volunteer drivers, was unlikely to obtain council support. However that view was not formally confirmed as such.

The Executive team will consider how best to re-open these issues with the Council and how to win the support of the Mayor.

85	**Mo Schiller**	**Title:**	**Trust support for staff training**

Query **09/04/2014**

What can the trust do to support care assistants/nursing/midwifery assistants financially to allow them to undertake further training to become qualified registered nurses/.midwives/operating department assistants.

Response **16/05/2014**

Response by Head of Human Resources:
UH Bristol does not provide any direct financial support to fund staff for 3 years to undertake their training.

The training programme at the University of the West of England (UWE) provides all pre-registered nursing places that Health Education South West pay tuition fees for, students depending on their personal circumstances can apply for bursaries but this is unlikely to be able to support them in replacing a salary. Student hardship funds are available from UWE however this is not much and is for a short term crisis and would no way cover salary costs.

Students are able to work on the bank as Health Care Assistants during their training to support them financially, however at present there is no funding available to cover salary costs either from UH Bristol or other bodies.

84	**Mo Schiller**	**Title:**	**Process for cancelling appointments**

Query **09/04/2014**

What is the purpose of sending out 1st class letters confirming a cancellation due to black alert 3 days after the booked session is cancelled.Surely speaking with the patient verbally is adequate.

Response **19/06/2014**

Response from Chief Operating Officer:
The Access Policy and Outpatient Standards currently set out timeframes for sending letters when booking appointments:

'All patients will be sent a confirmation letter for any agreed appointment or admission date, unless the appointment is within 3 working days and any such letter cannot be guaranteed to arrive ahead of the appointment date.'

No equivalent guidance exists for when appointments are cancelled so the Outpatient Standards & the Access Policy will be updated to reflect this omission.

ID	Governor Name		
83	**Mo Schiller**	**Title:**	**Productive Outpatient initiative**

Query **09/04/2014**

The Productive Out patient initiative was meant to alleviate some of the problems with appointment booking.Why is it that the telephone lines meant to be manned Monday to Friday,9-5pm do not respond to messages when staff are away from their desks.A minimum 36 hours should be adequate for a telephone response.

Response **19/06/2014**

Response from Chief Operating Officer:
The Trust is still in the process of centralising appointment booking – mainly to the Appointment Centre with separate smaller booking centres for the Eye and Dental Hospitals currently. This problem should not happen once appointment booking is through the three appointment centres as patients are placed in a queue if no-one is available to take their call, rather than going to voicemail. Where booking calls take place outside of these centres, patients may end up leaving voicemail messages.

A recent review of the Outpatient Standards across the Trust also identified the issue of slow responses to voicemail messages. The standards are in the process of being revised and reissued with updated guidance to all booking teams. The Transformation Team is also offering additional training to Divisions on these standards. However, the existing standard is a response within one working day and this will be re-emphasised.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 June 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

24 Register of Seals

Purpose

To report applications of the Trust Seal as required by the Foundation Trust Constitution.

Abstract

Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.

The attached report includes all new applications of the Trust Seal to 12 June 2014 since the previous report on 27 March 2014.

Recommendations

The Board is recommended to receive this report to note

Report Sponsor

- Sponsor – Chief Executive
- Author – Trust Secretary

Appendices

- Appendix A – Trust Seal Register 2014-06-30

Register of Seals Jan - June 2014

Ref:	Date Signed	Document Sealed	1st Sig.	2nd Sig.	Witness	Date Rec'd
738	12/06/2014	Disposal(sale) 6 Kingsdown Parade & Garages. UH Bristol & Kingsdown Arcadia Ltd.	R Woolley	P Mapson	P Holt	11/06/2014 11:00
739	12/06/2014	Agreement sale) 6 Kingsdown Parade. UH Bristol & Arcadia Ltd.	R Woolley	P Mapson	P Holt	11/06/2014 11:00
736	25/04/2014	Licence between UH Bristol and the University of Bristol for aviation light on University buldings (Helipad)	R Woolley	Not required	C Helps	10/04/2014 09:00
737	25/04/2014	Power Purchase Agreement between Bristol City Council and UHB Foundation Trust. Equipment at St Michael's Hospital.	Paul Mapson	Robert Woolley	Charlie Helps	16/04/2014 09:00
735	09/04/2014	Lease between UHBristol and The City Council of Bristol relating to apparatus at part of St Michael's Hospital (Bristol). Photovoltaic Panels.	Deborah Lee	Paul Mapson	P Holt	08/04/2014 11:30
734	26/03/2014	Lease of the Bristol Haematology & Oncology Centre. UH Bristol NHS Foundation Trust and the Secretary for Health.	R Woolley	P Tanner	P Holt	20/03/2014 00:00