University Hospitals Bristol NHS
NHS Foundation Trust

Meeting of the Trust Board of Directors to be held in Public

Date: Tuesday 30 September 2014

Time: 10.30 am – 13.00

Venue: Conference Room, Trust Headquarters, Marlborough Street, Bristol BS1 3NU

Distribution

Chair:	Emma Woollett	Deputy Chair and Senior Independent Director
Board Members:	David Armstrong	Non-executive Director
	Kelvin Blake	Non-executive Director
	Julian Dennis	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
Observers:	Aiden Fowler	NHS Fast Track Executive
	Penny Hilton	NHS Fast Track Executive
	Council of Governors	Members
In attendance:	Julie Dawes	Interim Trust Secretary
	Brian Courtney	Joint Interim Head of Membership and Governance (Minutes)
Apologies:	John Savage	Trust Chairman
Copy for Information:	Heather Ancient*	PwC – External Auditor
	Jenny McCall*	Audit South West – Internal Auditor
	Debbie Henderson	Trust Secretary Designate

*Agenda and Minutes only

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

Julie Dawes, Interim Trust Secretary, Trust Headquarters.

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University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Meeting of the Trust Board of Directors to be held in Public on 30 September 2014 at 10.30 am 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 pecuniary or non-pecuniary interests relating to any item on the Agenda.	Chairman	
3.	**Minutes from Previous Meetings** To consider the Minutes the Trust Board of Directors held on 30 July 2014 for **approval.**	Chairman	1
4.	**Matters Arising** To review the status of actions agreed for **assurance.**	Chairman	13
5.	**Chief Executive's Report** To receive this report from the Chief Executive to **note.**	Chief Executive	15
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6.	**Patient Experience Story** To receive the Patient Experience Story for **review.**	Chief Nurse	18
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	19
8.	**Patient Complaints and Experience Quarterly Report** To receive this report from the Chief Nurse for **assurance.**	Chief Nurse	109
9.	**Safeguarding Annual Report** To receive this report from the Chief Nurse for **assurance.**	Chief Nurse	130
10.	**Equality and Diversity Annual Report** To receive this report from the Director of Workforce and Organisational Development for **assurance.**	Director of Workforce and Organisational Development	159

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11.	**Quarterly Workforce Report April – June 2014** To receive this report by the Director of Workforce and Organisational Development for **assurance.**	Director of Workforce and Organisational Development	195
12.	**Culture of Compassion (Action 263)** To receive this report by the Director of Workforce and Organisational Development for **assurance.**	Director of Workforce and Organisational Development	227
13.	**Regulatory Changes** To receive a joint report from the Chief Nurse and Trust Secretary for **assurance**. • Duty of Candour Regulations • Fit and Proper Person Requirements	Chief Nurse Trust Secretary	233
	Strategy		
14.	**Workforce and Organisational Development Strategy** To receive this report by the Director of Workforce and Organisational Development for **approval**.	Director of Workforce and Organisational Development	243
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15.	**Finance Report** To receive this report by the Director of Finance and Information for **assurance.**	Director of Finance and Information	267
16.	**Finance Committee Chair's Report** To receive this verbal report by the Chair of the Finance Committee for **assurance.**	Director of Committee Chair	
17.	**Compliance with the Department of Health's new Principles on Patient Parking** **To receive this report from the Chief Operating Officer for assurance.**	Chief Operating Officer	287
	Leading in Partnership		
18.	**Partnership Programme Board Report** To receive this report by the Chief Executive to **note.**	Chief Executive	295
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19.	**Monitor's Letter regarding University Hospital Bristol's**	Chief Executive	298

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	performance in Quarter 1. To receive and note correspondence from Monitor.		
20.	**Audit Committee Chair Report** To receive this verbal report by the Chair of the Audit Committee for **assurance.**	Committee Chair	
21.	**Governors' Log of Communications** To receive this report from the Chairman to **note.**	Chairman	301
22.	**Register of Seals** To receive this report from the Trust Secretary to **note.**	Trust Secretary	305
	Information and Other		
23.	**Communications to the Wider Organisation** To agree any Board decisions requiring communication to the Trust	Chief Executive	
24.	**Any Other Business** *(Should only normally include any matters previously notified to the Chairman at least 48 hours prior to the date of the meeting)*	Chairman	
25.	**Date of Next Meeting:** Trust Board meeting held in public, 30 October 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU	Chairman	

University Hospitals Bristol NHS
NHS Foundation Trust

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

Board Members Present

- Robert Woolley – Chief Executive
- Sue Donaldson – Director of Workforce and Organisational Development
- Paul Mapson – Director of Finance & Information
- Sean O'Kelly – Medical Director
- Carolyn Mills – Chief Nurse
- James Rimmer – Chief Operating Officer
- John Savage (Chair)
- David Armstrong – Non-executive Director
- Julian Dennis – 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

Others in Attendance

- Penny Hilton – Fast Track Executive
- Richard Brindle - Director of Infection Prevention and Control
- Xanthe Whittaker – Head of Performance Assurance & Business Intelligence/ Deputy Director of Strategic Development
- Julie Dawes – Interim Trust Secretary
- Pauline Holt – Management Assistant to Trust Secretary

Observers

- Bob Bennett – Public Governor
- Ian Davies – Staff Governor
- Simon Davies – Press Officer
- Tom Davies – Staff Governor
- Wendy Gregory – Patient Governor
- Mark Griffiths – Appointed Governor
- Clive Hamilton – Public Governor
- Jeanette Jones – JUC Governor
- Florene Jordan – Staff Governor
- Marty McAuley – Trust Secretary, South West Ambulance Trust
- Sue Milestone - Patient Governor
- Bill Payne – Appointed Governor Bristol City Council
- Tony Rance – Tertiary Governor
- Mo Schiller – Public Governor
- Sue Silvey – Patient Governor
- Karen Stevens – Staff Governor
- Mary Watkins –Vice Chair, South West Ambulance Trust
- Peter Wasswa – Staff member
- Pam Yabsley – Patient Governor

Item

1. Chairman's Introduction and Apologies

The Chairman extended a special welcome to Penny Hilton, Fast Track Executive. To Martin McCally the Trust Secretary and Mary Watkins the Vice Chair of South West Ambulance Trust and Bill Payne, newly appointed Governor.

Apologies had been received from Deborah Lee and Lisa Gardner.

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 new 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 held on 30 June 2014 and **approved** them as an accurate record, subject to the following amendments:

Page 3, Patient Experience Story. Add in NHS Innovation Centre before Board Development Toolkit.
Page 5, Para 3. Add the words 'in all areas' to the end of the last sentence.
Page 5, Para 7. Add in the word 'not' to falls and ulcers had **not** been normalised.
Page 7, Report on Staffing Levels, Para 2 first line, and add in 'report' after 'first'.
Page 7, Report on Staffing Levels, Para 3 delete 'basis of 1:6 and 1:8 at night' and add in 'principles of 1 registered nurse to six patients on days.'
Page 7, Report on Staffing Levels, last para add an's' to the word 'establishment' on the second line.
Page 8, report on Staffing levels add in 'staff on duty' after the word total on the last line of para7.

John Moore questioned Page 11 section 8 penultimate paragraph - Trust considering inviting the internal auditor …. and reiterated that the Trust had assessed themselves against the recommendations in the Francis Report and asked if it would be wise to ask the internal auditor to verify that assessment. The Chief Executive expressed hesitation that internal audit were the appropriate body to assess if all 190 recommendations applied to the Trust or not. He said that this was a judgement that the Executive and Trust Secretary had independently made, correlated and played it back at the Executive meeting. He said he was confident that he could defend the selection of relevant recommendations. Having benchmarked with other Trusts the feeling was that UH Bristol had made the assessment as well as others.
The Interim Trust Secretary advised that this could be picked up as part of the Well Led Governance Review and where the external auditors could be given the task of taking a specific look at the Trust's response to Francis.
The Board agreed this resolution.

Action 355: Trust Secretary to arrange for the external auditor to examine the Trust's response to Francis as part of the Well Led Governance Review.

4. Matters Arising

Actions:

Action 263: (Empathy within the organisation) A consolidated draft summary to be produced in August and sent to the Executive and Non-executive and received formally at Board in September.

Action 282: (Governance Structure for hosting arrangements/ clinical research network) To be placed on the Agenda for September Audit Committee.

Action 295: (Visit from the New Congenital Heart Disease Review Team) Draft Service Standards to be produced for a 3 month consultation period. Assessment and response to be advised to the Board in due course.

Action 320: (Medication errors) Further thought to be put to the correct form of response regarding the lessons learned. The Board to be advised.

Action 325: Matter taken to Council of Governors Meeting - Action Closed.

Action 218: Paper to Quality and Outcomes Committee - Action Closed.

Action 298: (Noticeboards) The Chief Nurse advised that a review was being undertaken and to be completed in August/September. Chief Nurse to report back.

Action 317: (Rostering) The Chief Nurse advised that a report had been sent to the Finance Committee regarding rostering. Action closed.

Action 318: (Trajectory for fractured neck of femur). Report to be sent by the Medical Director to the Executive and Non-executive prior to Board in September.

There were no further Matters Arising.

5. Chief Executive's Report

The Chief Executive provided the Board with updates on the following matters:

- A formal letter had been received from Monitor following their review of compliance issues, particularly meeting the A&E waiting times standard, the Referral to Treatment non admitted target, the 62-day urgent GP referral target and the C Difficile target. Monitor had concluded that they would not proceed to the formal investigation stage. As a result, the Trust's compliance rating was to be reverted to green but the view taken was that the Trust should have anticipated some of the problems experienced around cancer waiting times and referral to treatment times. Progress was to be tracked on a monthly basis with monitoring for A&E waiting times, referral to treatment waits, and cancer waits, against the Trust's recovery trajectories. He warned that if the Trust failed to recover Monitor could open a full investigation under the terms of the risk assessment framework. He concluded that 'some comfort' could be taken in that Monitor believed the Board understood the issues and had demonstrated a commitment to recover the position.
- A joint letter had been received from NHS England and Monitor regarding the urgent care system in Bristol and particularly the 4-hour A&E standard. A number of actions had been agreed at a joint meeting with Bristol Clinical Commissioning Group. An Operational Resilience Capacity Plan was to be formed addressing some of the issues the Trust had already flagged around inability to discharge patients and the way jointly (with the Ambulance Foundation Trust) UH Bristol manage the conveyance of emergency patients, particularly adults. Additionally system resilience monies were to be made available to the Trust for delivery of emergency and elective activity. Discussions were in place with the Clinical Commissioning Group regarding this.
- A planned formal inspection from the Care Quality Commission was to take place in the week beginning 8 September. A very substantial data request had been received covering a wide range of areas including a corporate summary of the Trust's strengths and weaknesses.
- The Chief Executive said he was 'delighted to announce' that planning permission from Bristol City Council had been received for the frontage of the Bristol Royal Infirmary. The winning design by a Madrid architect had been approved with the contractor in place to start work in the autumn.
- The Second annual report of the Health Service Journal had declared Deborah Lee (Director of Strategic Development and Deputy Chief Executive) one of their top 50 inspirational women. The Chief Executive offered the Board's congratulations to Deborah.
- The Chief Executive invited Sue Donaldson to give the results of the staff friends and family test :

    - The headline results from the first Staff Friends and Family test were now available. There had been a 19% response from staff (c1600 people). 77% of respondents were likely or extremely likely to recommend UH Bristol as a place to be treated. However, 55% of respondents were likely or extremely likely to recommend UH Bristol as place to work, with 20% neutral. It was therefore clear that much more energy needed to be put into staff engagement and improving staff experience. A further report with results compared to other Trusts across the country was to be brought back to the Board in September as part of the Quarterly Workforce Report.

Robert concluded that there had been no start to the formal procurement of Weston Health Trust. UH Bristol was one of three trusts that had expressed interest in acquiring Weston.

Emma Woollett requested further information regarding the Senior Leadership Team report on the review of risk management at the Children's Hospital. The Chief Executive advised that the Care Quality Commission had visited in November and found non-compliance in terms of managing risks, particularly those associated with building work. They also had concerns around infection control. In view of this an external reviewer, Anne Utley, had been invited to undertake a collaborative review with the division. This had raised a number of issues for the division and the Trust. The division was already reacting and had changed their governance approach. An action plan was being compiled and would be brought back to the Board.

Emma Woollett requested an update on the bid by the Bristol Medical Simulation Centre. Sue Donaldson to ascertain and advise.

Action 333: Sue Donaldson to bring the Staff Survey Results compared to other trusts across the country to Board in September as part of the Quarterly Workforce Report.

Action 334: Chief Executive to bring the resulting Action Plan from the review of risk at the Children's Hospital by the External Reviewer (Anne Utley), to Board when available.

Action 335: Sue Donaldson to give feedback about the bid by the Bristol Medical Simulation Centre.

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

Delivering Best Care

6. Patient Experience Story

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

Carolyn Mills introduced the Patient Experience Story, a lived experience from an individual's point of view. The complainant concerned had volunteered to meet the Chief Nurse and share her experience. The paper provided was her notes for this meeting. She had wanted the Board and clinical teams to gain wider understanding of the impact of poor communication and the feeling of loss of control, and the impact of being treated like you have little knowledge of the case. Carolyn Mills concluded that this was not an experience the Board would want anyone to have and that there was learning to be taken from this experience.

Mo Schiller and Wendy Gregory stated that it was inexcusable to accept that people suffering or dying of cancer should be expected to sit or stand in overheated conditions within Oncology department. They had been raising concerns about overcrowding and overheating since 2010. Advice had been received that air- conditioning was not possible in the Chemo and Clinic areas. (Carolyn Mills to further consider the seating provisions within the waiting areas in Oncology and report back to the Board). James Rimmer agreed to review the area.

These governors also noted that the role of carers was not being recognised and suggested that this be added to the list of learning issues. Alison Ryan endorsed this and asked (regarding the interactions of patients/families and clinicians), if the Trust provided clinical supervision for all clinicians that was rigorously enforced.

Sean O'Kelly advised that he believed clinical supervision was provided for trainees but not consultants. As part of consultant appraisal and revalidation process patient feedback was included. Sue Donaldson and Sean O'Kelly agreed to ascertain and report back to Board the process for clinical supervision for consultants.

John Moore noted that many of the issues highlighted in the story were not new issues. Issues surrounding communication in letters and the effective communication of dropping off points or sending the correct letters to the correct people were easy to solve. Additionally he asked if there was value in the systemisation of management at lower levels so that areas for prioritisation were not forgotten.

The Chief Executive applauded the ambition John had expressed and suggested that the Board should not underestimate the fact that the Trust has been trying for many years to challenge inherent difficulties in running a multi professional organisation and what appeared to be fairly simple nostrums about changing pathways, would have been interrogated many times, over the years. He highlighted the need to focus on the mechanics of how the business runs, the steps of which were complicated by which course of treatment was required. He said that mapping may be a way into addressing the process, system and management issues John had highlighted. He concluded that he was minded to ask the Board if, despite a lot of investment money having made great changes and improved facilities, there was a suggestion that some specific areas had not been dealt with effectively and should the Trust now be looking hard at those areas?

The Chief Executive agreed that the Board should receive an update with a proposal of how to address environmental issues, fundamental to patient experience, recognising that there may be constraints.

David Armstrong wished to highlight that a re-allocation of responsibility was often the way to look for solutions in communication and empathy. Perhaps this role was better suited to the nursing profession and not the medical.

Action 336: James Rimmer to consider the environment in the outpatient waiting areas in Oncology. Report back to Board

Action 337: Sue Donaldson and Sean O'Kelly to report back to Board the process for clinical supervision for consultants.

Action 344: James Rimmer to examine those areas where investment may be needed to address environmental issues fundamental to patient experience (recognising that there may be constraints), to include flow and process.

Action 358: James Rimmer to sample a set of patient letters to ascertain if dropping off points are highlighted. Report back to SDG in September.

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

7. 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 advised the Board that two new non-executive members had joined the Committee, David Armstrong and Jill Youds.

The Committee had received a report on the Review of Serious Incidents which identified some areas for improvement. Quality and Outcomes Committee will be kept updated regarding the process. There had been an in depth report arising from a particular Serious Incident which had identified actions including the importance of notifying protocols and processes for physicians visiting from other organisations. This had prompted a lively discussion on document and policy handling.

The Quality and Performance report had provided excellent data and discussions on the parameters needed to enable a more forward looking report in order for the Committee to assure themselves of the mitigation required for upcoming trends.

They had examined length of stay and received assurance that systems to manage this were in place. They were encouraged by the rates for falls and ulcers and sent congratulations to the nursing teams. Referral to treatment would continue to hold a high spot on the agenda and assurances were required that the data used was correct.

It was discussed that the proximity of the Quality and Outcomes Committee to the Board meeting did not allow for alterations or amendments to reports prior to their inclusion in Board papers.

The Committee had received a verbal report on histopathology and had received assurance that staff were providing an adequate and safe service.

The triangulation of the complaints reports and other indicators of quality had been requested and a mapping was required of the committee structure underneath Board.

David Armstrong wished to note that some requirements placed on the Trust by the Department of Health and regulators could lead to apparently unfavourable outcomes without the ability of capable staff to challenge sometimes inappropriate metrics.

Workforce

Sue Donaldson advised the Board that trajectories around sickness absence and vacancies were off target.

- Absence was mainly stress and musculo-skeletal related and the most prevalent areas for sickness absence were within Estates and Facilities and the Division of Women's and Children's.
- Vacancies within Facilities and Estates (particularly porters, cleaners and caterers) were difficult to fill along with consultant posts (particularly oncology, radiology and pathology) plus perfusionists and theatre staff.

She advised that these issues would present challenges for the rest of the year. However, the new Interim Director of Facilities and Estates, Mark Neil, had some innovative ideas to speed up recruitment in that division.

Sue concluded that maintaining nurse recruitment to avoid bank and agency spend was also a priority.

Board Review

John Moore requested that a cross-check of the pressure ulcers referred to in the Patient Experience Story were part of the numbers seen in the Quality and Performance Report. Carolyn Mills said she would provide the Board with this information.

With reference to the graph regarding bank and agency usage they asked if the Trust had triangulated correctly. With staffing at 120% the recruitment of which was to be financed by a substantial reduction to bank and agency spend, they noted that targets were increasing and not reducing. Paul Mapson explained that recruiting to120% establishment had proved to be inappropriate in some areas. Experience was proving that it was better to staff to 115/6% with some flexibility from a temporary workforce.

They noted that the IT system planned to be in place in the autumn to address recording of the question for dementia was now scheduled for delivery at the end of the year. Carolyn Mills advised that the IT system was only part of the solution with the key step being the engagement of divisions in taking ownership and meeting their own, nationally set targets. A briefing paper had been sent to all divisions highlighting what they needed to deliver, what steps had been taken to date and what the performance by division was. This paper was to be sent to Board members.

Action 347: Chief Nurse to cross check that the pressure ulcers referred to as part of the Patient Experience Story have been recorded in the numbers for the Quality and Performance report.

Action 348: Carolyn Mills to circulate to the Board the briefing paper on the next steps for divisions to meet their own dementia targets.

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

8. Corporate Quality Objectives

The Board received this report from the Chief Nurse for assurance.

Carolyn Mills presented the report and asked the Board to note that the scoping of the baselines was for Quarter 1.

Jill Youds asked if this had been assessed against external benchmarking. Xanthe Whittaker advised that for only a few of the measures had national data available.

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

9. Infection Control Annual Report

The Board received the report for from the Chief Nurse for assurance.

Carolyn Mills introduced the report as a retrospective look back to last year and noted that it was a statutory responsibility under the Health and Social Care Act 2008, specifically the hygiene code. She advised that the report had been brought to Board for assurance. Non-executive Directors had noted in the Quality and Outcomes Committee that legionella was not mentioned within the report.

Dr Richard Brindle advised that Legionella was specifically dealt with in the Water Safety Group and was the management responsibility of the Estates Department.

Alison Ryan noted that the organogram detailed a relationship between the Director of Infection, The Chief Executive and a Non-executive Director. She advised that the latter should read the Chair of Quality and Outcomes Committee.

Clive Hamilton, a Governor asked if the Trust had instigated controls for assurance that bank and agency staff were screened for Tuberculosis.

Sue Donaldson explained that it was usual practice to screen agency staff in the same way as substantive staff but would ascertain the details and advise Clive if it was any different from this.

Emma Woollett asked if the Trust had a contingency plan for the Ebola Virus. Richard Brindle advised that a set

of national guidelines covered this and that any cases would not be nursed within UH Bristol.

Action 349: Sue Donaldson to ascertain the health screening arrangements for agency staff and inform Clive Hamilton if different to those for substantive staff.

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

10. Infection Control Quarterly Report

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

Carolyn Mills presented the Infection Control Quarterly Report advising the Board that it was a look back to the months of April, May and June. She asked the Board to note that the report had been prepared before validation had taken place of the 13 cases of C difficile inspection against a target of 10. This now stood at one case against the limit.

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

11. Quality Strategy 2014-2017

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

Carolyn Mills presented the updated Quality Strategy which she described as an 'umbrella document' under which sat three key sub strategies;

- Patient Experience and Involvement Strategy
- Patient Safety Strategy
- Quality Strategy (on agenda)

Non-executive Directors made the following comments;

- They did not feel that it was a strategy and would have preferred a shorter pithier document. Carolyn Mills confirmed that a simple guide was in production that would be shared with staff.
- There was the expectation for a quality, high level document that was ambitious, tougher and aspirational and backed up the Trust's aspirations to be one of the best. This could then be cascaded into operational plans. Carolyn Mills confirmed that there was a work plan sitting beneath each of the three key sub strategies.

The Chief Executive noted that the Board expected to see a 'crunchy plan' that demonstrated how the ambitions identified in the strategy would be delivered and if the work plans being provided already could be consolidated into a Board level quality improvement plan about quality and standards.

The Trust Secretary advised that as part of the Well Led Governance Review, one of the documents that could be expected would be a quality improvement plan pulling together all the strands of quality improvement. She advised that the Royal Salford Hospitals document was one that was considered to be 'exemplary' and she would share this with the Board.

Sean O'Kelly advised the Board that the Trust Quality Report provided more detail and definition around specific plans and specific quality objectives and the Annual Report also described those in more detail.

Non-executive Directors agreed that there should not be a duplication of reports but rather a streamlining of documents that stated the Trust's aspirations.

The Chairman concluded that the Executive would aspire to pursue the achievement of this aim.

Action 356: The Trust Secretary to share the Royal Salford Quality Improvement Plan with the Board

There being no further questions the Board approved the Quality Strategy.

12. Patient Safety Safety Strategy 2014-2017

The Board received and noted this report from the Medical Director for approval.

Sean O'Kelly advised that the Patient Safety Strategy was closely aligned to the South West Patient Safety Initiative and described a number of safety ambitions and how the Trust will be working with the South West Patient Safety Collaborative to fulfil the criteria and objectives.

The Governors advised that they had examined the report at the Quality and Project Focus Group on 11 July and found it full of the 'right aspirations' and were pleased to recommend it to the Board.

There being no questions the Board approved the Safety Strategy.

Delivering Best Value

13. Annual Complaints Report 2013/14

The Board received and reviewed this report from the Chief Nurse for assurance

Carolyn Mills advised that the report was a retrospective look at the year 2013/14. She wished to draw the attention of the Board to two key areas;

- The inter-relationship between the 17 complaints that had been referred to the Parliamentary Health and Safety Ombudsman. She described the analysis as a good benchmark for the Board on the robustness of the internal processes.
- The number of complaints that had been reopened due to complainants being dissatisfied about factually incorrect replies or incomplete replies had increased to 42 from the position of 20 the previous year. Carolyn said that there was work to be done with the response writers to learn from that feedback and pay attention to the key issues raised, and getting the response to feel sensitive and kind and personalised for recipients.

The Chairman noted the complaints ratio as .21% and falling and declared this to be a significant measure of the Trust's ability and performance.

- Carolyn Mills advised the Board that following a review of equality & diversity data, the proportion of these complainants was not reflected in the total users of the service. She said that work on how to access these groups was to take place with the first step being a new complaints leaflet published in a number of different languages.

Jill Youds advised that she would appreciate some external benchmarking. Xanthe Whittaker advised that the data set was 'fraught with problems' in terms of interpretation. There was a variance amongst Trusts in the inclusion of informal complaints. UH Bristol was reviewing the separating out formal and informal complaints. Carolyn Mills advised that she thought there was national grading, but would check if it was used in the quarterly report.

John Moore noted a potential discrepancy between the report stating complaints as % activity and the graph that formed part of the Quality and Performance Report. Carolyn Mills to check.

Action 350: Carolyn Mills to check for national complaints grading and advise.

Action 351: Carolyn Mills to check the numbers reported in the complaints report against those reported in the patient complaints graph within the Quality & Performance report.

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

14. Transforming Care Report

The Board received and reviewed this report from the Chief Executive for assurance.

The Chief Executive advised the Board that;

- A significant review of the role and content of the Transforming Care Programme had led to an appropriate challenge at the Board around when the review would stop and how to demonstrate the progress in transforming care at UH Bristol, in line with the vision to be the best and safest hospital trust in the country.
- Simon Chamberlain, the programme director, had undertaken a lot of work to bring the programme to the place described in the report. Executive focus had been placed on limiting the priorities to 10 key work streams, which would be acted on for a limited period before the focus of transformational activity moved onto different priorities.
- In response to the challenge that the Board required to see a forward plan and progress, colleagues had developed milestones against objectives. These were subject to constant monthly review at the Programme Board.

Non-executive Directors were pleased to receive the report but Emma Woollett noted that out of the 10 priorities only two were led by clinicians. The Chief Executive explained that each priority had Executive ownership and project leadership that had clinical engagement at its core. Dr Anne Frampton had been appointed as a Clinical Champion for transforming care and was sitting on the Programme Board.

Finally, given the success of the Breaking the Cycle week, a Delivering Best Care week had been planned using similar methodology and principles.

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

15. Report from the Academic Health Science Network

The Board received this report from the Chief Executive for information.

The Chief Executive provided the report and advised that the Academic Health Science Network Board were keen that constituent Boards received their report of activities for information.

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

16. Finance Report

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

Paul Mapson reported a relatively good financial position for the quarter with a small variance on the year to date position of £400 000. He said that he was still projecting reaching the year end plan with a £5.8m surplus. There had been slight variances on divisions around delivery of savings plans and the delivery of activity.

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

17. Finance Committee Chair 's Report

Emma Woollett as acting Chair of the Finance Committee, advised the Board that;

- The Committee had examined an update of profitability and efficiency with the key highlights looking at the reference cost index. The Division of Medicine appeared to still be an outlier with a high cost metric around nursing costs. Surgery Head and Neck showed a loss for surgery at the Bristol Royal Infirmary and surplus on activity at the Dental and Eye hospitals. The Division of Women's and Children's had reduced profitability and risks around speciality tariffs.
- Much discussion had taken place on nursing staffing within the Division of Medicine with a need for greater control in scheduling rosters. KPIs had been put in place to be reviewed after six months.
- The Trust surplus to date was just over £1m with a continuity of service rating of four.
- There had been more cautious optimism on divisional ability to deliver operating plans than there had

been in the past, with Specialised Services giving significant achievement that was worthy of mention as they were 'back on track' after a struggle.

- Savings were £3m to date which, although slightly behind were expected to improve over the period. The income and expenditure and cash positions were satisfactory.
- The Committee had received the proposed report for Monitor and recommended to the Board that they declare a continuity of service rating of 4.

John Moore noted deterioration in June for the Division of Surgery Head and Neck. Paul Mapson explained that signs of improvement could be seen and an operating plan showing improvement through to year end was in place. He said that mechanisms for monitoring were in place and that there was focus in the division surrounding bringing capacity to bear and delivering activity.

The Chairman noted that the Trust consistently managed to keep the finances in order when some Trusts are unable to do so.

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

18. Quarterly Capital Projects Status Report

The Board received this report from the Director of Strategic Development and Deputy Chief Executive for assurance.

Xanthe Whittaker highlighted:

- The successful completion of the Bristol Haematology and Oncology Centre scheme and the Centralisation of Specialist Paediatrics transfer
- Good progress with the completion of ward block levels 5 and 6 at the Bristol Royal Infirmary with levels 7 and 8 to be completed shortly.
- Some delays to some aspects of the ward programme to be dealt with during the condensed commissioning period.
- Two additional capital schemes had commenced. The surgical admission suite at the Bristol Royal Infirmary and the conversion of the Queens Lecture Theatre into office accommodation. These were both on track for completion in Q3.
- Some risks were identified in the report.

Emma Woollett requested feedback from the Gateway Review of the Centralisation of Specialist Paediatrics. The Chief Executive advised that post project evaluation reports would follow in due course.

He wished to acknowledge the phenomenal amount work that operational/clinical teams had undertaken to prepare, commission and relocate to new premises and that the Division of Medicine's proposed model of acute care had been approved following revised operating plan submission. This meant that the division would have the right staffing and service model going into new facilities in September/October.

T*here being no further questions the Chair drew this item to a close.*

Corporate Governance

19. Constitutional Review – Proposed Changes

The Chairman advised that this item had been removed from the agenda and asked the group that had looked at the constitution to reform after the afternoon meeting to examine the implications of a question that would be asked at the meeting of Governors.

20. Risk Assessment Framework Monitoring and Declaration – Quarter 1 2014/15 Report

The Board received this report from the Chief Executive for approval.

The Chief Executive advised the Board that Monitor had asked that they self-certify against their governance rating, against the continuity of service rating and confirm that there were no other issues the Board felt needed to be brought to the attention of regulators. He advised that the statement had proceeded through the internal assessment, preparation and sign off process and recommended the Board to approve the declaration for Q1, where for governance the Board reflected the standards failed as Referral to Treatment times for non- admitted patients, the A&E 4 hour standard and the 62-day GP urgent referral standard for cancer patients and declared a continuity of service risk rating of 3 and no other matters.

The Chair of the Quality and Outcomes Committee confirmed that the Committee had examined the statement and confirmed it.

Xanthe Whittaker advised the Board that the 62-day standard had now been achieved by the validation of other providers' pathways.

There being no further questions the Board approved the Risk Assessment Framework.

21. Board Assurance Framework – Quarter 1 Update

The Board received this report from the Chief Executive for assurance.

The Chief Executive presented the assurance framework against the objectives for the current year in the Board's medium term plan. He advised that there was one red rated objective around delivery of the full savings programme for the year and seven amber rated objectives. He explained to the Board that an amber rating represented a slippage to the objective and not the lack of anticipation regarding recovery.

Emma Woollett requested more external assurance and noted that most of the assurance was provided through internal committees. The Chief Executive advised that the Executive would look at that.

Action 357: Executive Directors to look at providing additional external assurance regarding the Board Assurance Framework.

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

22. Corporate Risk Register

The Board received this report by the Chief Executive for assurance.

The Chief Executive advised that 5 new risks had been added to the register in the quarter risks and assessed against the Corporate Risk criteria

- Corridor queue outside the emergency department
- Risk of reputational damage
- Risk of cancelled operations and consequential risk to cancer standards
- Risk of not resolving complaints in time and resource issues within the Patients Complaints Department
- Risks arising from the review of Children's Services.

Chief Executive apologised to the Board for the use of the term 'de-escalated risks' and advised that the process was not one whereby the Executive decided risks were escalated or not but rather that it involved objective assessment against criteria, with participation from respective divisions. It was this process that determined whether risks were included on the Board's risk register or not.

Emma Woollett questioned the presentation of the report and the lack of clarity between mitigations and the overall plan to address issues.

The Chief Executive said he would wish to consider if the issues raised were presentational or, whether some

risks were ever present. He considered that the ambulance queue, for example, was a constant risk with the Trust running a 24 hour emergency department.

The Trust Secretary advised that the presentation of the register would be examined as part of the Well Led Governance Review.

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

23. Governor's Log of Communications

The Board received this report from the Chairman, to note.

The Chairman reiterated to the Governors that the log must be used. Sean O'Kelly advised that a formal response to Question 89 had been posted.

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

24. Item Removed.

Information and Other

25. Any Other Business

A Governor asked for reassurance as to the evidence available (in terms of data) for the relevance of demand and capacity issues involved in the growing cancer requirements within the region. She said that no evidence had been seen of how people were accessing the Trust's model of care, what the demand was and how it has increased year on year and reflected in the Trust's Strategic Plan. She asked if the Executive or Non-executive had an 'up to date idea' of the position in 2 or 5 years hence.

Chief Executive advised that a full market assessment would have been made as part of the development of the 5 year Plan. Paul Mapson added that single providers would find the analysis hard to make in view of the transfer of services. He explained that the Cancer Network would be a better forum for that analysis and from where the Trust could see what it needed to provide within that framework. The Chairman asked Paul Mapson to ascertain this information.

Action 353: Paul Mapson to ascertain the position regarding cancer activity projections.

There being no further business the Chair thanked everyone for attending and closed the meeting at 13:15.

26. Date of Next Meeting

Meeting of the Trust Board of Directors to be held in Public: 30 September 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol BS1 3NU.

…….. ……*2014*

Chair *Date*

Action by	ID	Meeting Date	Public / Private	Minute number & title	Description (minute)	Action to be Taken	Date to Report Back	Action Taken	Date Completed	Status	Item Type	Path
Chief Executive	221	28/11/2013	Public	10. Partnership Programme Board	The feasibility of options for further integration of 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.	30/06/14 Action 221 – The Chief Executive reported that work, to deliver the boards stated agreed ambition for the delivery of an integrated service of cellular pathology in Bristol was proceeding well with a business case working through a financial appraisal. The Medical Director of North Bristol Trust had reported back at the last Partnership Programme Board that a physical integration should be achievable by Spring 2015. 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 in the next month. Further information to be provided to the Board meeting in January 2014.			Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
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.	30/7/14 A consolidated draft summary to be produced in August and sent to the Executive and Non-executive and received formally at Board in September. 30/06/14 The Chief Executive wished to assure the Board that considerable thought was being put to culture change within the organisation and that work to bring a fuller report was underway for July. 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	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Executive	295	28/05/2014	Public	4. Chief Executive's Update	4.2The 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.	30/07/14 Draft Service Standards to be produced for a 3 month consultation period. Assessment and response to be advised to the Board in due course. 30/06/14 RW to update the Board as and when information available. 28/05/14 Chief Executive to update the Board	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Executive	320	30/06/2014	Public	7. Quality & Performance Report - Board Review	Medication errors – the two incidents under investigation. The governors asked if they could be informed of the root cause analysis, when this had been completed.	30/07/14 Further thought to be put to the correct form of response regarding the lessons learned. The Board to be advised. 30/06/14 The Chief Executive replied that he would consider how best to carry this forward and think how to best advise governors the actions and learning from incidents.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Executive	334	30/07/2014	Public	Chief Executive's Report		30/07/14 Chief Executive to bring the resulting Action Plan from the review of risk at the Children's Hospital by the External Reviewer (Anne Utley), to Board when available.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Executive	357	30/07/2014	Public	Board Assurance Framework	The Chief Executive presented the assurance framework against the objectives for the current year in the Board's medium term plan. He advised that there was 1 red rated objective around delivery of the full savings programme for the year and 7 amber rated objectives. He explained to the Board that an amber rating represented a slippage to the objective and not the lack of anticipation regarding recovery. The Non- executive requested more external assurance and noted that most of the current assurance was provided through internal committees.	30/07/14 Executive Directors to look at providing additional external assurance regarding the Board Assurance Framework.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Nurse	298	28/05/2014	Public	Implications of National Quality Board Guidance – Guidance to nurse, midwifery and care staffing -	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.	24/09/14 New standardised Boards in place from August 2014. 30/07/14 The Chief Nurse advised that a review was being undertaken and to be completed in August/September. Chief Nurse to report back. 28/05/14 Carolyn to update to Board	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Nurse	319	30/06/2014	Public	7. Quality & Perfornce Report - Board Review	John Moore noted that the data for falls and ulcers had been 'normalised' and pointed out that as the population of older people increased then so would the incidents of falls and pressure sores. He asked that analysis of age related data as a percentage of falls and ulcers incurred by the Trust be provided.	30/06/14 The Chief Executive replied that it the context of the Trust's ambition to drive all falls and pressure ulcer incidents down, analysis would be provided to the Board	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Nurse	322	30/06/2014	Public	9. Patient Experience Quarterly Report	Lisa Gardner suggested a list of wards and their location, be placed in the appendices of future reports.	24/09/14 The list will be circulated to board members as a general reference document (rather than adding to the report each time it goes to Board). 30/06/14 Chief Nurse to amend report for the future.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Nurse	324	30/06/2014	Public	10. Report on Staffing Levels for UHB	Clive Hamilton said that he had expected a data set ward by ward, listing safe staffing levels and variations. The Website version was not clear as it was based on hours and he asked why some areas fell below the expected level.	24/09/14 More detail added to website from Sept 2014. 30/06/14 Carolyn Mills accepted that the website information was not as user friendly as it could be and said thought would be put to improvement.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Nurse	347	30/07/2014	Public	Quality & Performance Report		24/09/14 To be closed. Confirmed that divisional reporting of pressure ulcers was robust and was confident that the pressure ulcers referred to in the Patient Experience Story had been reported. 30/07/14 Chief Nurse to cross check that the pressure ulcers referred to as part of the Patient Experience Story have been recorded in the numbers for the Quality and performance report.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Nurse	348	30/07/2014	Public	Quality & Performance Report		24/09/14 Completed - circulated in August 2014. 30/07/14 Carolyn Mills to circulate to the Board the briefing paper on the next steps of engaging divisions to meet their own targets for dementia.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Nurse	350	30/07/2014	Public	Annual Complaints Report		24/09/14 Confirmed there is no national grading for complaints. 30/07/14 Carolyn Mills to check for national complaints grading and advise.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Nurse	351	30/07/2014	Public	Patient Complaints Report		24/09/14 Completed - these were accurate. 30/07/14 Carolyn Mills to check the numbers reported in the complaints report against those reported in the patient complaints graph within the Quality & Performance report.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Operating Officer	336	30/07/2014	Public	Patient Experience Story		30/07/14 James Rimmer to further consider the environment on outpatient waiting areas in Oncology. Report back to Board	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Operating Officer	344	30/07/2014	Public	Patient Experience Story		30/07/14 James Rimmer to examine those areas where investment may be needed to address environmental issues fundamental to patient experience (recognising that there may be constraints), to include flow and process.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Chief Operating Officer	358	30/07/2014	Public	Patient Experience Story	Chief Executive agreed that the Board should receive an update with a proposal of how to address environmental issues, flow and process, fundamental to patient experience yet recognising that there may be constraints.	30/07/14 James Rimmer to sample a set of patient letters to ascertain if dropping off points are highlighted. Report back to SDG in September.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Director of Finance and Information	282	28/04/2014	Public	10. National Institute for Health Research Clinical Research Network, West of	Governance Structure for hosting arrangmeentss for the Clinical Research Network (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).	15/09/14 Item on Audit Agenda. 30/07/14 Item placed on the Forward Planner for Audit Committee in September. 30/06/14 item placed on the Forward Planner for Audit Committee – date to be advised. 28/05/14 The Chief Executive reported that further details would be brought back in due course to the Audit Committee as requested. 28/04/14 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	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Director of Finance and Information	353	30/09/2014	Public	Governors Log of Communications		30/07/14 Paul Mapson to ascertain the position regarding cancer activity projections.	30/09/2014		Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors

Director of Workforce and Organisational Development	321	30/06/2014	Public	8. Francis Report	John Moore asked if the Trust were to consider inviting the internal auditor to advise if they agreed with the Trust's view. Deborah Lee replied that other eyes were on the plan with Commissioners regularly reviewing the action planning progress and the Overview and Scrutiny Committee having sight of the process. Emma Woollett asked if assessments had been made of the impact on staff and its effectiveness.	30/06/14 Sue Donaldson replied that she would consider in the light of the cultural change programme what could be done around cultural not audit assessment. Verbal report to October to describe intentions.	27/10/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Director of Workforce and Organisational Development	323	30/06/2014	Public	10. Report on Staffing levels for UHB	Carolyn concluded that the report was to give the Board assurance that Bristol had establishment and a skill mix that was set to support safe staffing levels. Robust processes were in place for setting that establishment and managing it day to day. With no element of complacency there was recognition of the need to stabilise the workforce with a recruitment campaign and to be constantly attuned to bed numbers with staffing numbers adjusted accordingly.	30/06/14 Sue Donaldson offered to pull together a source document at a high level for all staff groups as a reference point. To be produced at the October QOC meet.	27/10/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Director of Workforce and Organisational Development	333		Public	Chief Executive's Report		19/09/14 High level report provided. More detailed overview of how staff experience compares across NHS Trusts to be included in QOC paper in October 30/07/14 Sue Donaldson to bring the Staff Survey Results compared to other trusts across the country to Board in September as part of the Quarterly Workforce Report.	30/09/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Director of Workforce and Organisational Development	335	30/07/2014	Public	Chief Executive's Report		19/09/14 Verbal report to be given 30/07/14 Sue Donaldson to give feedback about the bid by the Bristol Medical Simulation Centre.	30/09/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Director of Workforce and Organisational Development	337	30/07/2014	Public	Patient Experience Story		23/09/14 All medical and dental trainees within the trust have allocated educational supervisors who oversee their training, and are supervised on a day to day basis by clinical supervisors, usually consultants. Non training grades including consultants work within their professional competencies. If performance issues are highlighted through quality metrics in place for revalidation further training or a period of supervision is arranged as required. 30/07/14 Sue Donaldson and Sean O'Kelly to report back to Board the process for clinical supervision for consultants.	30/09/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Director of Workforce and Organisational Development	349	30/07/2014	Public	Infection Control Annual Report		19/09/14 All agencies are expected to comply with the same level of screening as we provide ourselves and we request this assurance for each worker. 30/07/14 Sue Donaldson to ascertain the health screening arrangements for agency staff and inform Clive Hamilton if different to those for substantive staff.	30/09/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Medical Director	318	30/06/2014	Public	7. Quality & Performance Report - Board Review	Lisa Gardner noted that a review had not been issued for a case of fractured neck femur due to it being a bank holiday. Sean O'Kelly replied that the target was dependent upon the ability of the team to take patients to theatre when trauma patients with clinical priority caused more of a demand. He said that the team were aware of the need to manage peaks in times of demand and were working hard to meet this. He concluded that there was a possible opportunity with the transfer of vascular services to dedicate more capacity to the trauma service. The target had been achieved in June due to specific initiatives.	17/09/14 To form part of the September Q & P Report per J Dawes 30/07/14 Report to be sent by the Medical Officer to the Executive and Non-executive prior to Board in September. 30/06/14 Emma Woollett asked that a trajectory be produced as this target had not been met for some time (with the exception of June).	30/09/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Trust Secretary	355	30/07/2014	Public	Minutes & Actions	The Interim Trust Secretary advised that this could be picked up as part of the Well Led Governance Review and where the external auditors could be given the task of taking a specific look at the Trust's response to Francis. The Board agreed this resolution.	24/09/14 This is still work in progress. 30/07/14 Trust Secretary to arrange for the external auditor to examine the Trust's response to Francis as part of the Well Led Governance Review.	30/10/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors
Trust Secretary	356	30/07/2014	Public	Quality Strategy	The Trust Secretary advised that as part of the Well Led Governance Review one of the documents that will be expected to be seen will be a quality improvement Plan pulling together all the strands. She advised that the Royal Salford document was one that was considered to be 'exemplary' and would share this with the Board.	24/09/14 This will be circulated to Board members outside of the meeting. 30/07/14 The Trust Secretary to share the Royal Salford Quality Improvement Plan with the Board	30/09/2014	Open	Item	sites/Boards/CorporateGovernance/tbod/Lists/Matters Arising Trust Board of Directors

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting to be held on 26 September 2013 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

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

APPENDIX A

SENIOR LEADERSHIP TEAM
REPORT TO TRUST BOARD – SEPTEMBER 2014

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in August and September 2014.

2. COMMUNICATIONS

The Trust Management Executive **noted** the monthly reports on the activities of the Communications Department. In particular, the planning around the Recognising Success Staff Awards 2014.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group noted the current position in respect of performance for Quarter 2 2014/2015 against Monitor's Compliance Framework. The 4-hour emergency target, Referral to Treatment Non-Admitted, Admitted and Ongoing, 6-week diagnostics, last minute cancellations and MRSA standards were not being achieved.

The group **received** updates on the financial position.

The group received and **approved** the corporate and Women's and Children's action plans that had been produced following the review of risk management in the Children's Hospital.

The group **received** an update on the review of the Serious Incident Reporting process.

The group **noted** an update on the latest position with essential training.

The group received and **noted** the IMAS Referral to Treatment Report and Action Plan, **supported** the four principles proposed and the continued work being undertaken.

The group received and **noted** an update on the review of arrangements for responding to major incidents, including the way in which the Trust worked together with local agencies.

The group received to **note** a summary of the Quarter 1 Divisional Reviews that had been undertaken for each of the five clinical divisions and Estates and Facilities.

The group **noted** a report on the Cancer Peer Review Process for 2014.

The group received the Quarter 1 detailed analysis reports of complaints and patient experience and **supported** their onward submission to the Quality and Outcomes Committee and Trust Board.

4. STRATEGY AND BUSINESS PLANNING

The group received an update on the current process and timelines for the potential acquisition of Weston Area Health Trust.

The group **noted** the position in respect of the proposed transfer of the Weston Dermatology service to UH Bristol.

The group **supported** the Division of Women's and Children's Services proceeding with the Clinical Genetics Transfer from Musgrove Park Hospital, Taunton, to UH Bristol, subject to the Referral to Treatment impact being resolved.

The group received and **approved** the Workforce Strategy for onward submission to the Trust Board.

The group **supported** changes to the Trust-wide escalation policy outlining the Planned Care Beds in Bristol Haematology and Oncology Centre, Bristol Heart Institute and Bristol Royal Infirmary, and implementation of the cross-divisional Managed Beds Standard Operating Procedure.

5. RISK, FINANCE AND GOVERNANCE

The group received an update on progress against the corporate quality objectives for Quarter 1 of 2014/2015 to **note**.

The group received and **approved** the Annual Report and action plan for Equality and Diversity and **agreed** that progress be reported back in three months' time.

The group received a report from the West of England Health Science Network Board held in June 2014 to **note**.

The group received an overview of the Trust's performance against the key national access and quality standards relative to national and regional providers for quarter 1 2014/2015 to **note.**

The group received to **note** Internal Audit Reports in relation to CQUINS, Infection Control and MRSA Screening, Learning from Complaints, Financial Planning Efficiency Review, Quality Accounts Review and Emergency Department Performance Indicators. Progress in respect of completed actions and the Internal Audit Plan were also **noted.**

Reports from subsidiary management groups were **noted**, including an update on the work of the Transforming Care programme

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
September 2014

University Hospitals Bristol NHS
NHS Foundation Trust

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

6. Patient Experience Story

Purpose

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

Abstract

This patient story details the experience of a family in the days immediately preceding and the hours following the death in hospital of a family member.

By way of setting a context to the Trust Board meeting the story underlines the importance of End of Life Care, a key priority for University Hospitals Bristol.

This is a third party patient story. With that in mind the 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 in relation to End of Life.
- 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 Excellences (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

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 September 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

7. Quality & 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 is recommended 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)

Authors

- Xanthe Whittaker (Head of Performance Assurance & Business Intelligence / Deputy Director of Strategic Development)
- Anne Reader (Head of Quality (Patient Safety))
- Heather Toyne (Assistant Director of Workforce Planning)

Appendices

-

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other
		25/09/14			

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

September 2014

CONTENTS

CONTENTS

SECTION A – Performance Overview

Summary

The key changes to Organisational Health Barometer indicators between the Previous and Current reported periods are as follows:

Improvements in the period:

Moving from RED to GREEN – 2 indicators

- Incidence of Hospital Acquired Pressure Sores – zero reported in August;
- 30-day emergency readmission – reduction from 328 in June to 290 in July.

Moving from RED to AMBER – 1 indicator

- Staff sickness – reduction from 4.0% to 3.6%.

Deteriorations in the period:

Moving from GREEN to RED – 2 indicators

- Monitor Governance Risk Rating – updated quarterly, so Previous and Current as reported last month;
- Savings Plan Achievement – under-deliver against plan, following a review of the actual delivery of the savings schemes; for further details please see the Finance Report.

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	90	88	N/A	Green: >= 86 Red: < 85	↓	Current month is July 2014.
A02	Patient Complaints as a Proportion of Activity	0.282%	0.321%	0.269%	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)	1	0	2	Green: 0 Red: >= 1	↓	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	4.51	4.59	4.73	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)	10	3	30		↓	
C02	Cumulative Number of C.Diff cases	2	8	8	Below Trajectory	↑	Previous = commissioner agreed avoidable cases Apr to Jul (i.e. 2 cases); Current & YTD = total cases (Apr to Aug), including 6 Aug cases subject to review. Limit for the end of Q2 = 20.

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	87.2%	84.4%	88.9%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	1	1	1	Green: 0 Red: >=2	→	Previous is confirmed Q4. Current and YTD is confirmed Q1.
D03	A&E 4 Hour Standard	92.4%	93.7%	94.0%	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	57.8	55.9	59.5	Green: <65 Red: >=75	↓	Previous is June 2014 and Current is July 2014.
E02	30 Day Emergency Readmissions	328	290	1234	Below 13/14 Readmission Rate	↓	Previous is June's discharges where there was an emergency Readmission within 30 days. Current is July'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)	3.91	4.29	4.25	Green: <= Quarterly target 3.70 Red: >= Quartrely target 3.70	↑	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	85.0%	86.7%	88.3%	Green: >= 90% Red: < 90%	↑	
F04	Outpatient appointment hospital cancellation rate	8.7%	9.3%	9.5%	Green: <=6.0% Red: >=10.7%	↑	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Turnover	12.1%	12.9%	11.9%	Green: < target Red: >=10% above target	↑	
G02	Staff Sickness	4.0%	3.6%	3.8%	Green: < target Red: >=0.5 percent pts above target	↓	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
H02	Cumulative Weighted Recruitment	16,889	20,309	20,309	Green: Above 2012 Red: Below 2012		Current (and YTD) is rolling Calendar YTD position. Previous is Jan-May 2014 and Current is Jan-Jun 2014
H03	Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment)	52.0%	53.6%	53.6%	Green: >=30% (Upper Quartile) Red: <27.7% (Median)	↑	Current is Q1 2013/14 – Q4 2013-14. Previous is Q4 2012/13 - Q3 2013/14. Updated Quarterly. No change from last month's Barometer.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
J01	Monitor Governance Risk Rating	3	4	N/A	Green: < 4 Red: > = 4	↑	Previous shows the Q1 poisition. Current shows the current position for quarter 2.

Delivering Our Contracts

The Previous column represents Month 3. Current (and YTD) represents Month 4 2014/15.

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£6.61	£6.49	£6.49	> 50% Green < 50% Red	↓	This is Potential year-end rewards and reflects assessment of performance as at July 2014 (69%).
K02	Contract Penalties Incurred - Variance From Plan (£millions)	£0.22	£0.29	£0.29	Green: Below Plan Red: Above Plan	↑	Data is variance above (+) or below (-) plan, with a higher negative value representing better performance.YTD and Current is variance reported for August, which reflects assessments available so far for all penalties except EMTA, which is assumed on plan - to be updated when estimate of actual performance is known.

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 Savings 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	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	
L04	Savings plan achievement	91%	68%	72%	Green: >=90% Red: < 75%	↓	

Notes

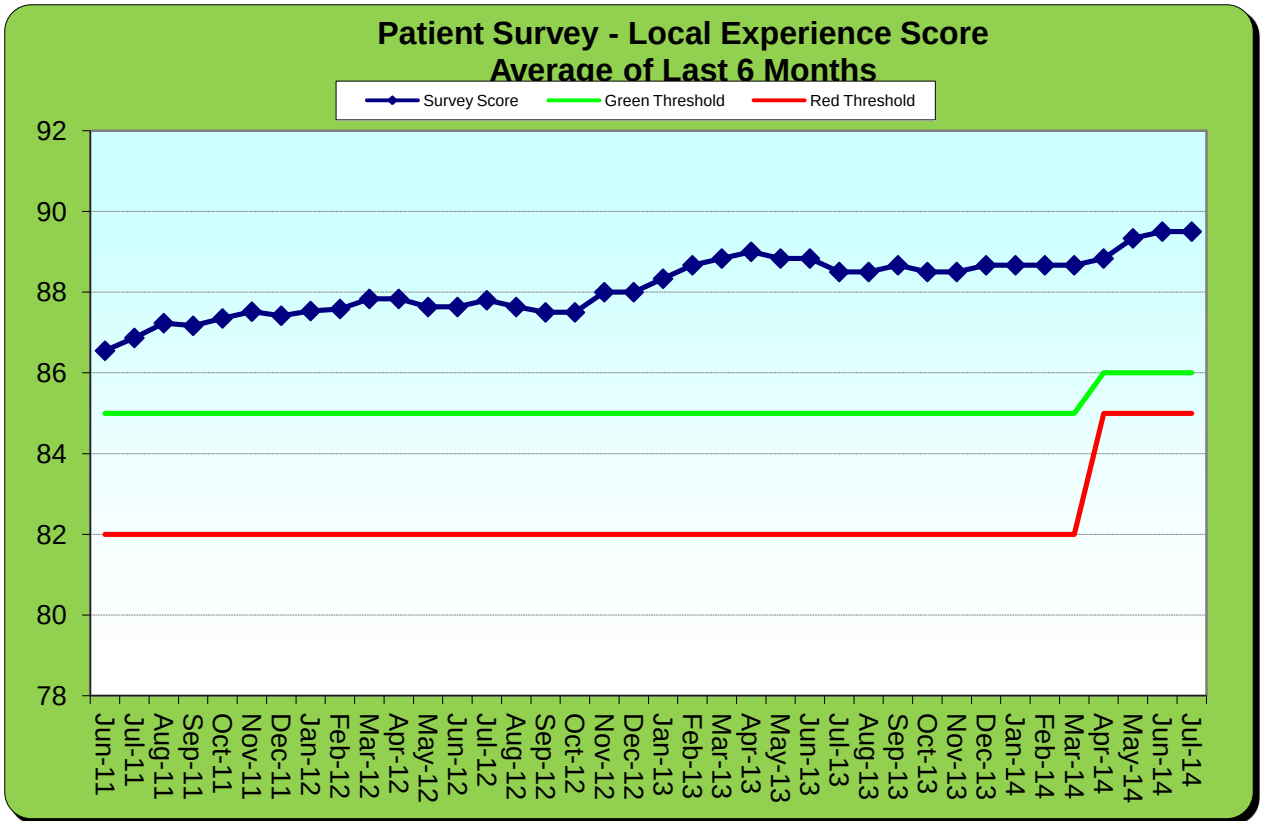
Unless otherwise stated, Previous is July 2014 and Current is August 2014

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.

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Patient complaints as a proportion of activity	In the *Quality* section of this report	
18-week Referral to Treatment Times (RTT) admitted pathways	In *Access section*	
A&E 4-hour standard	In *Access* section	
Overall Length of Stay	See Additional Information	Length of stay increased by 0.38 days and was associated with an increase in the number of long stay patients being discharged in the month. However, the number of long-stay patients in hospital at month-end was again lower than at the previous month-end, reducing from 131 in July to 122 at the end of August.
Theatre productivity	See Additional Information	Overall theatre utilisation is higher in August than in July but remains RED rated. The lower utilisation is a result of the additional theatres at the Children's Hospital coming on line, but not yet being fully utilised.
Turn-over	In the *Workforce* section of this report	
Monitor Governance Risk rating	See Section C - *Monitor Risk Assessment Framework*	
Contract penalties above plan	See separate Finance Report	
Savings Plan achievement	See separate Finance Report	


Patient Survey - Local Experience Score
Average of Last 6 Months
Survey Score
Green Threshold
Red Threshold
92
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
May-13
Jun-13
Jul-13
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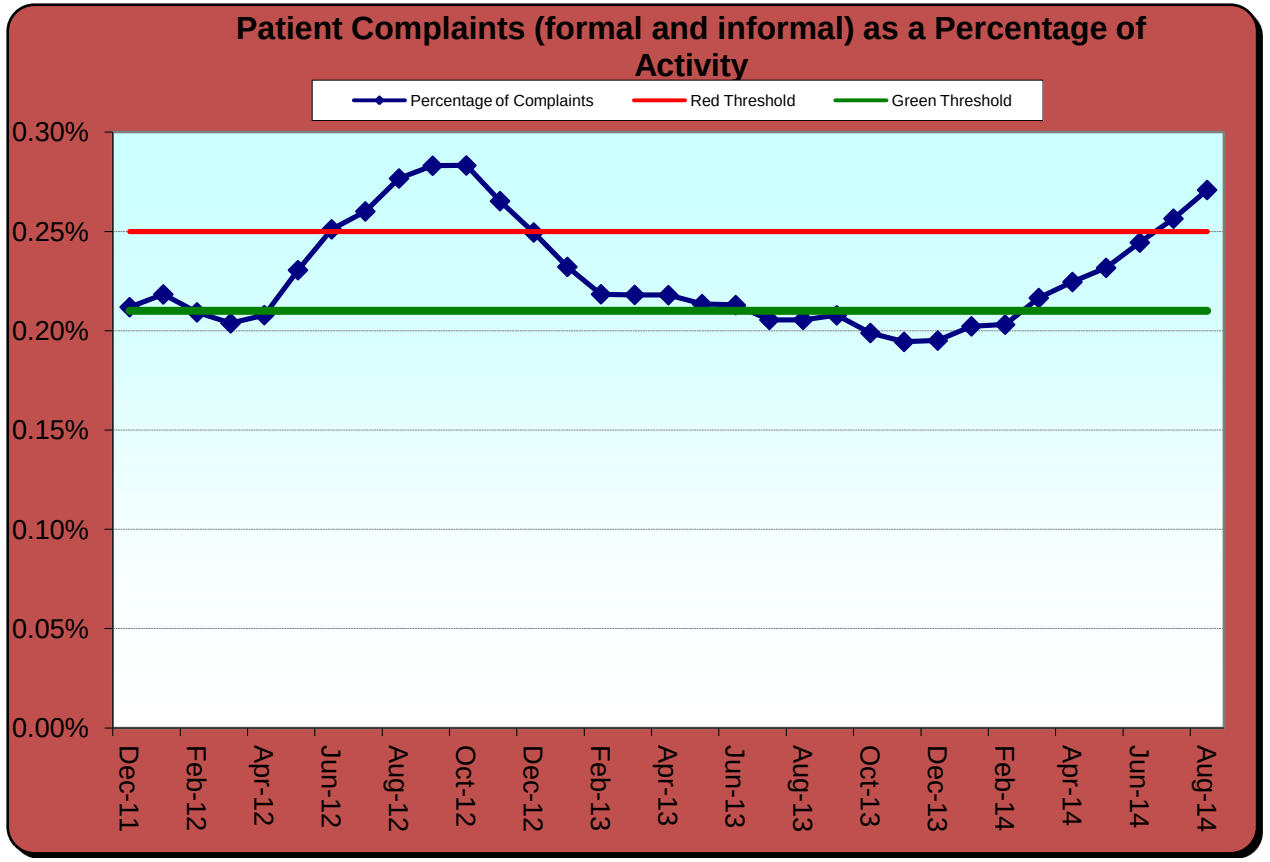
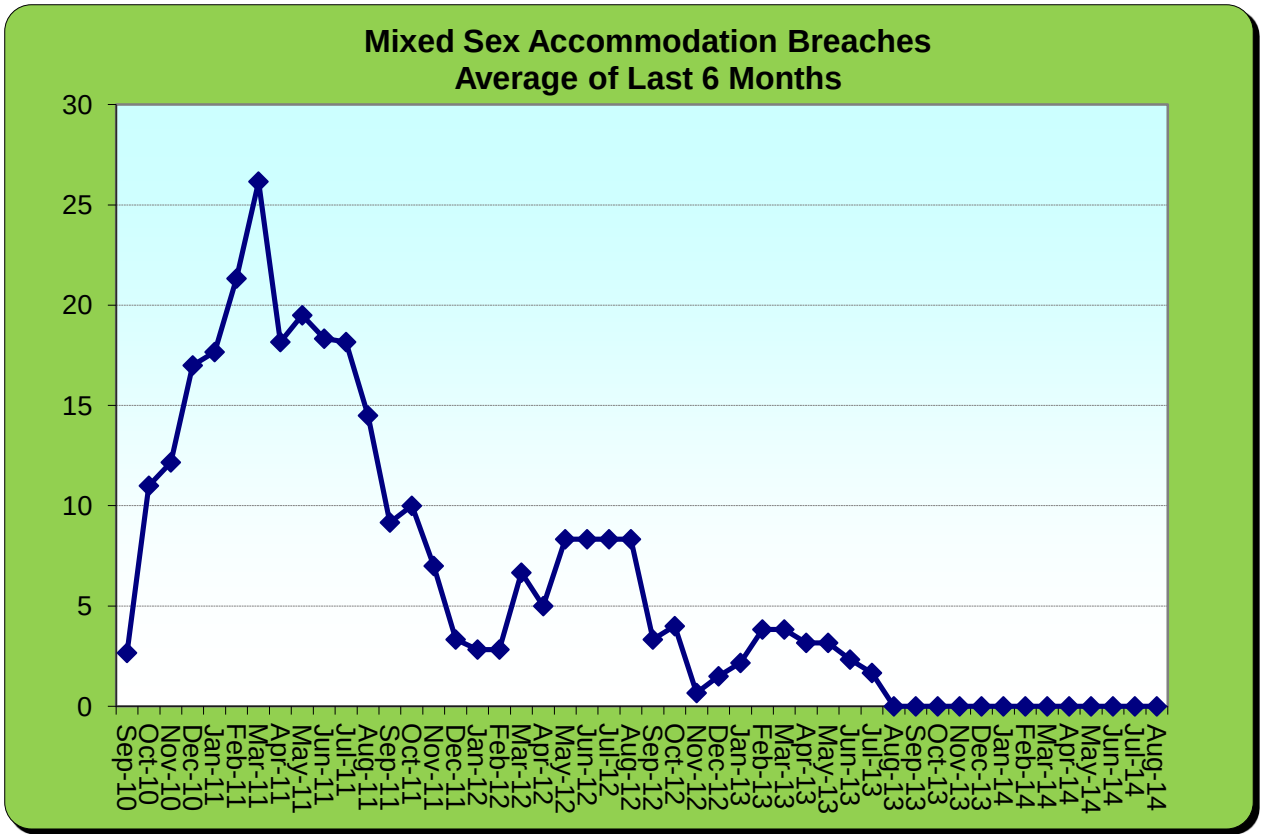
Jun-14
Jul-14


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
Feb-12
Apr-12
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-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
Jun-13
Jul-13
Aug-13
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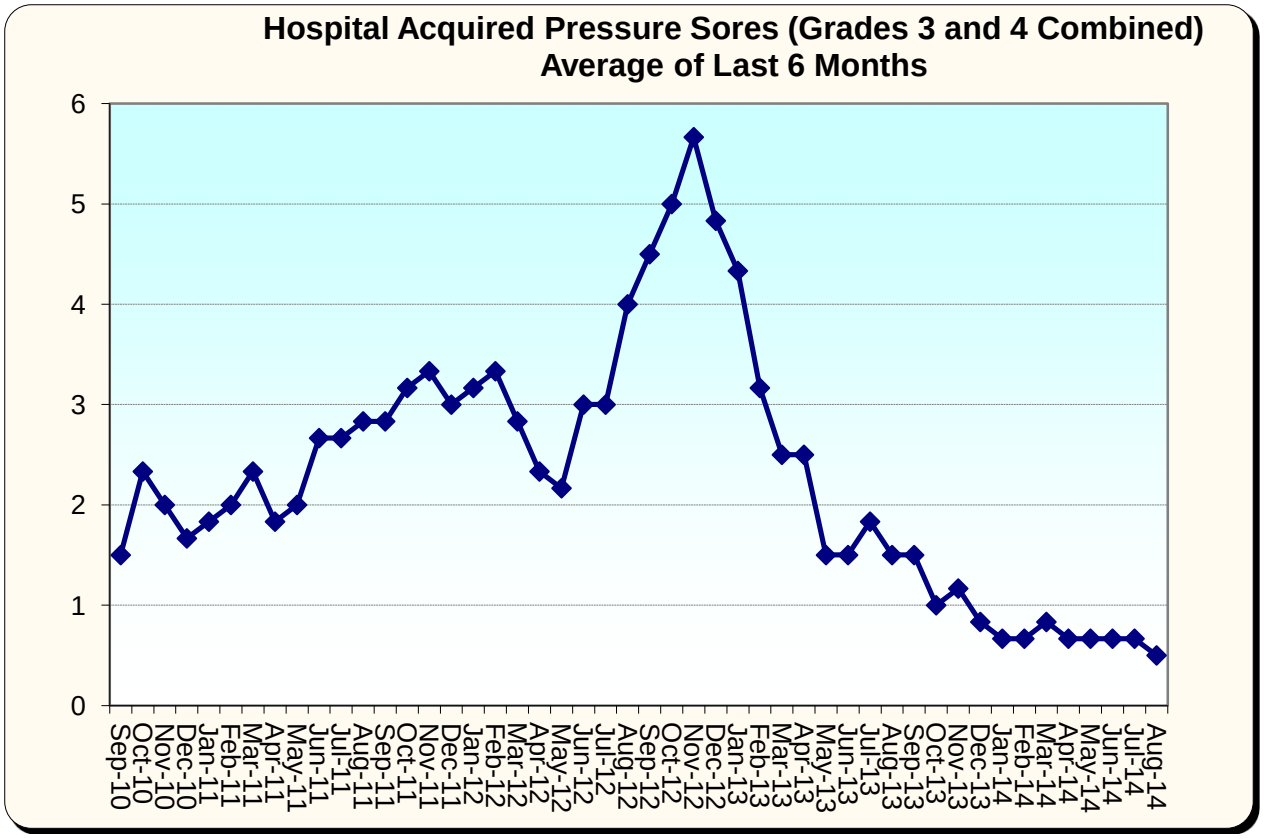
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14


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
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May-13
Jun-13
Jul-13
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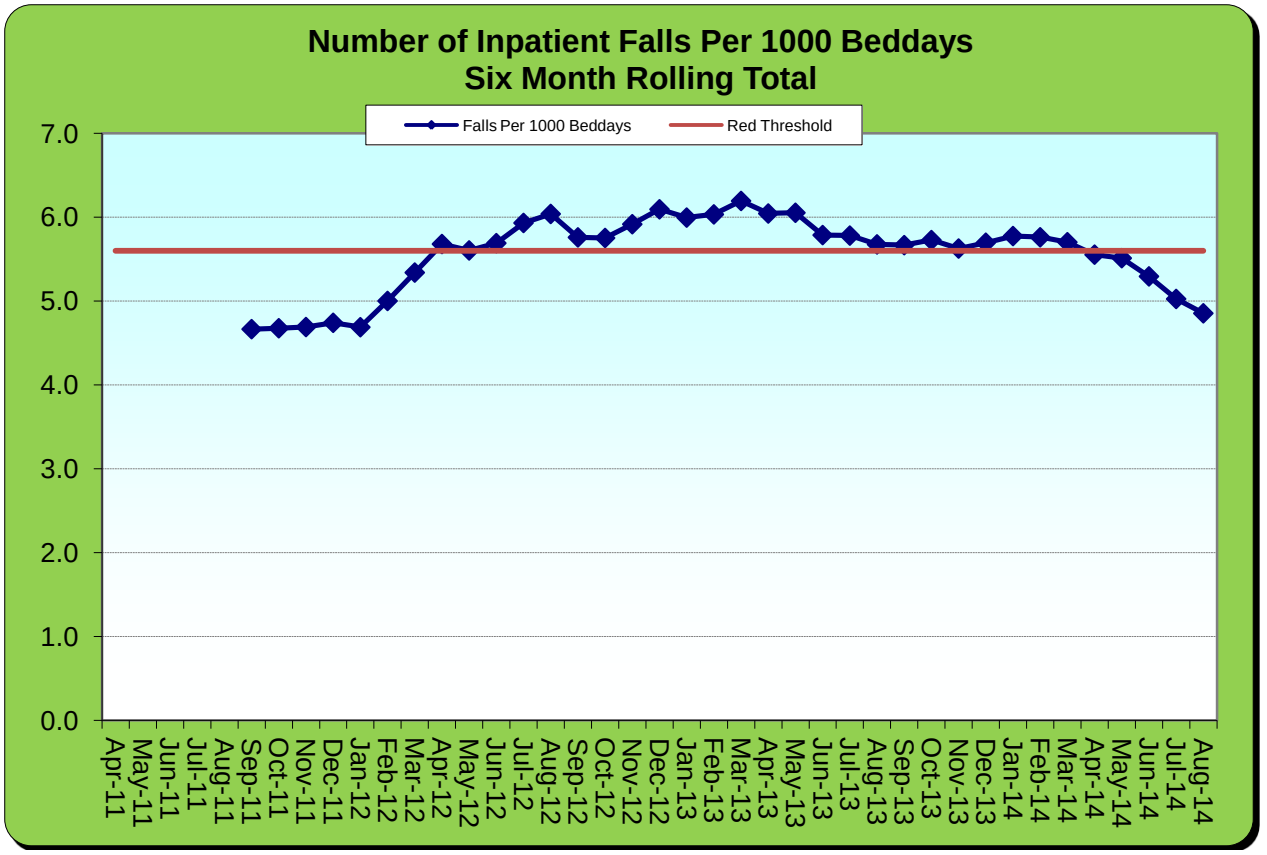
Jun-14
Jul-14
Aug-14


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
Jun-13
Jul-13
Aug-13
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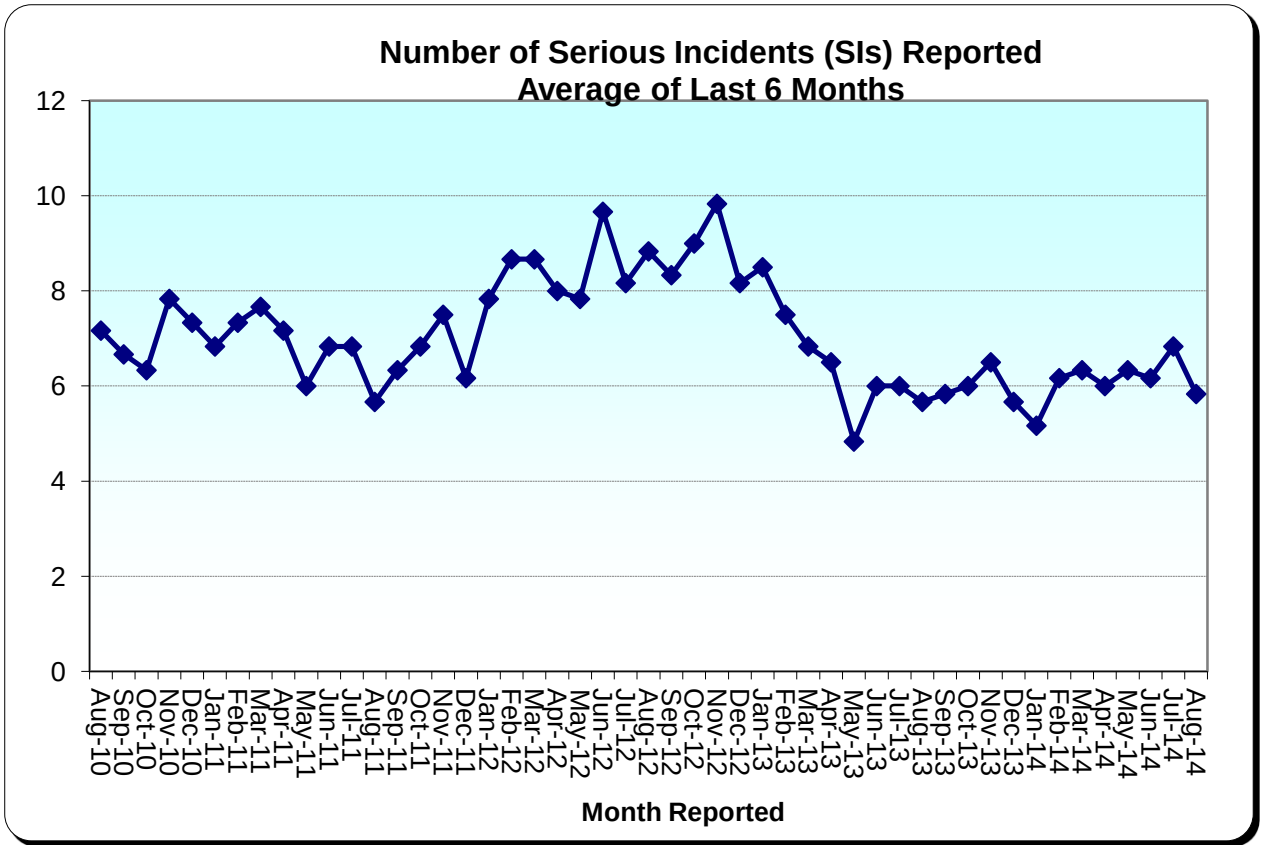
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14


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
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Jan-14
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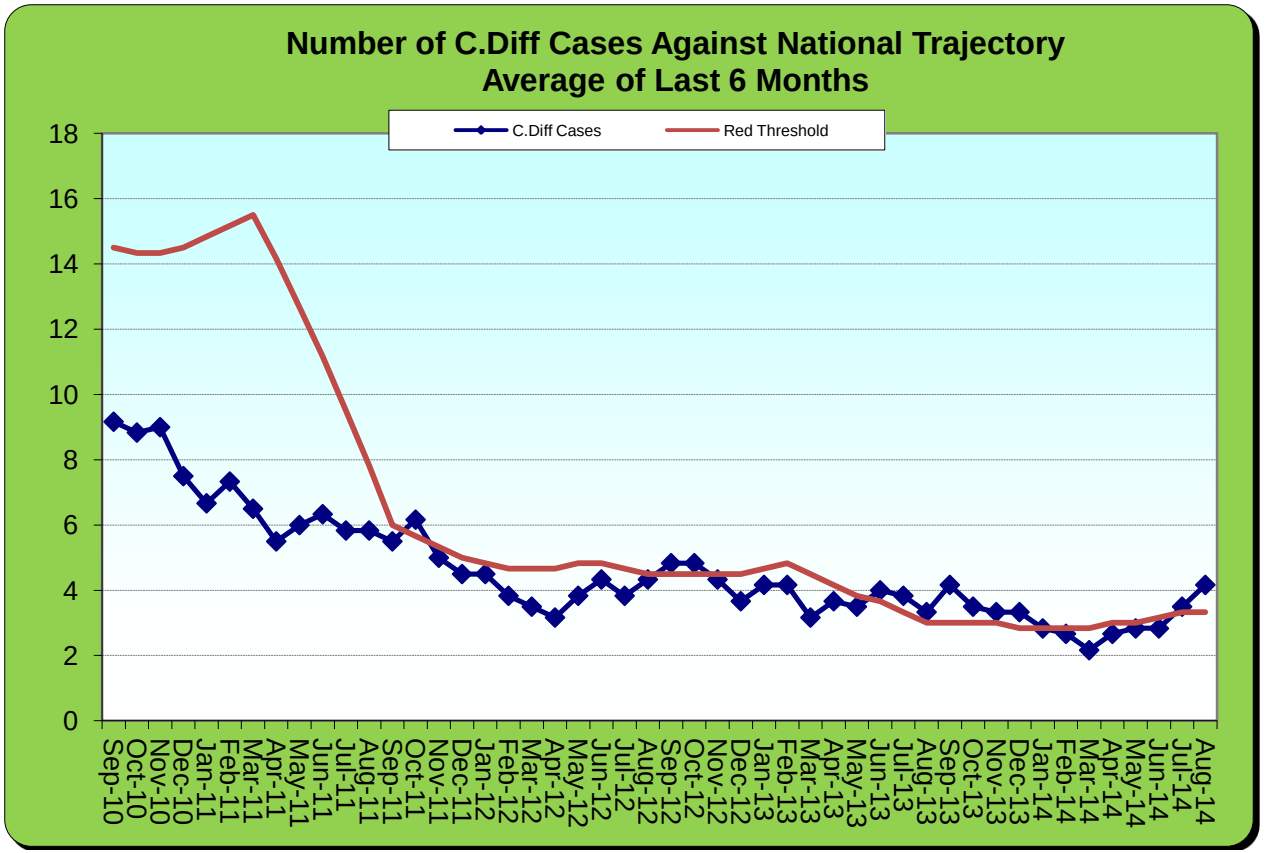
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Month Reported


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
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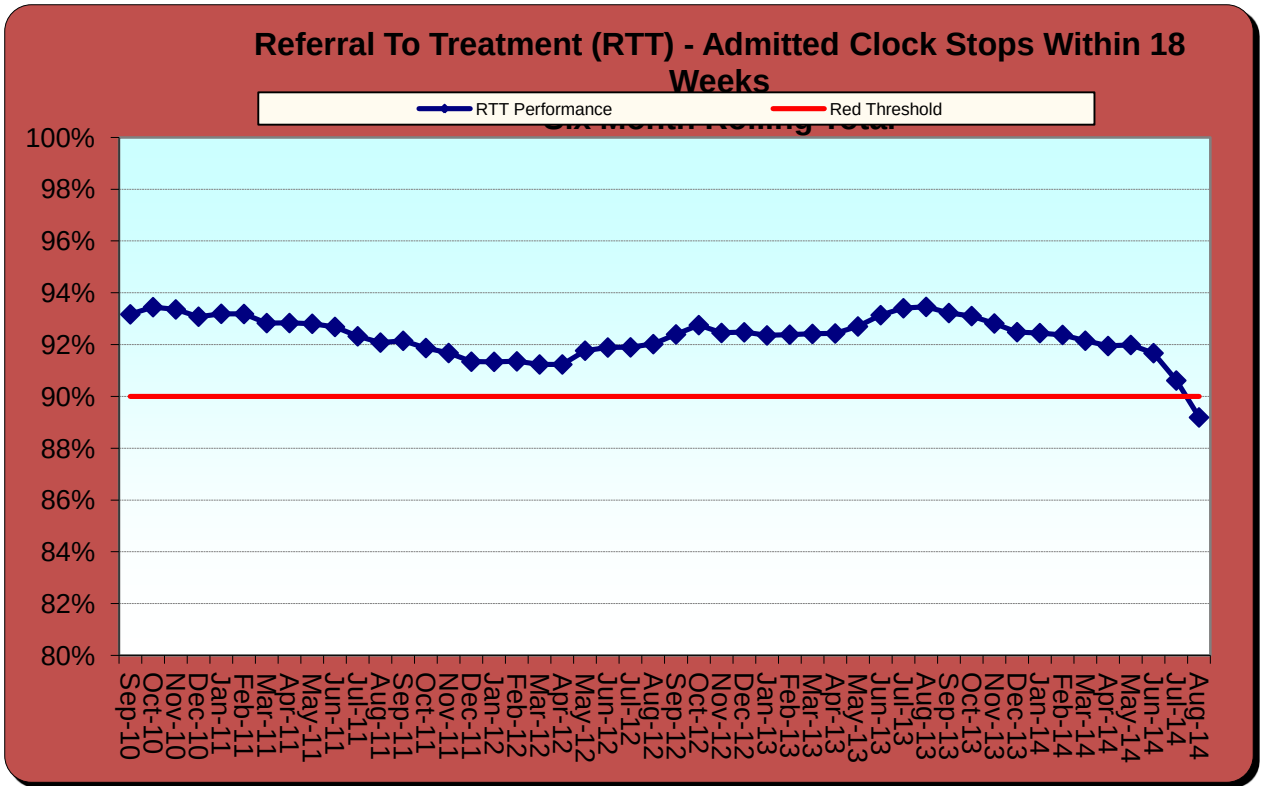
Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
RTT Performance
Red Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
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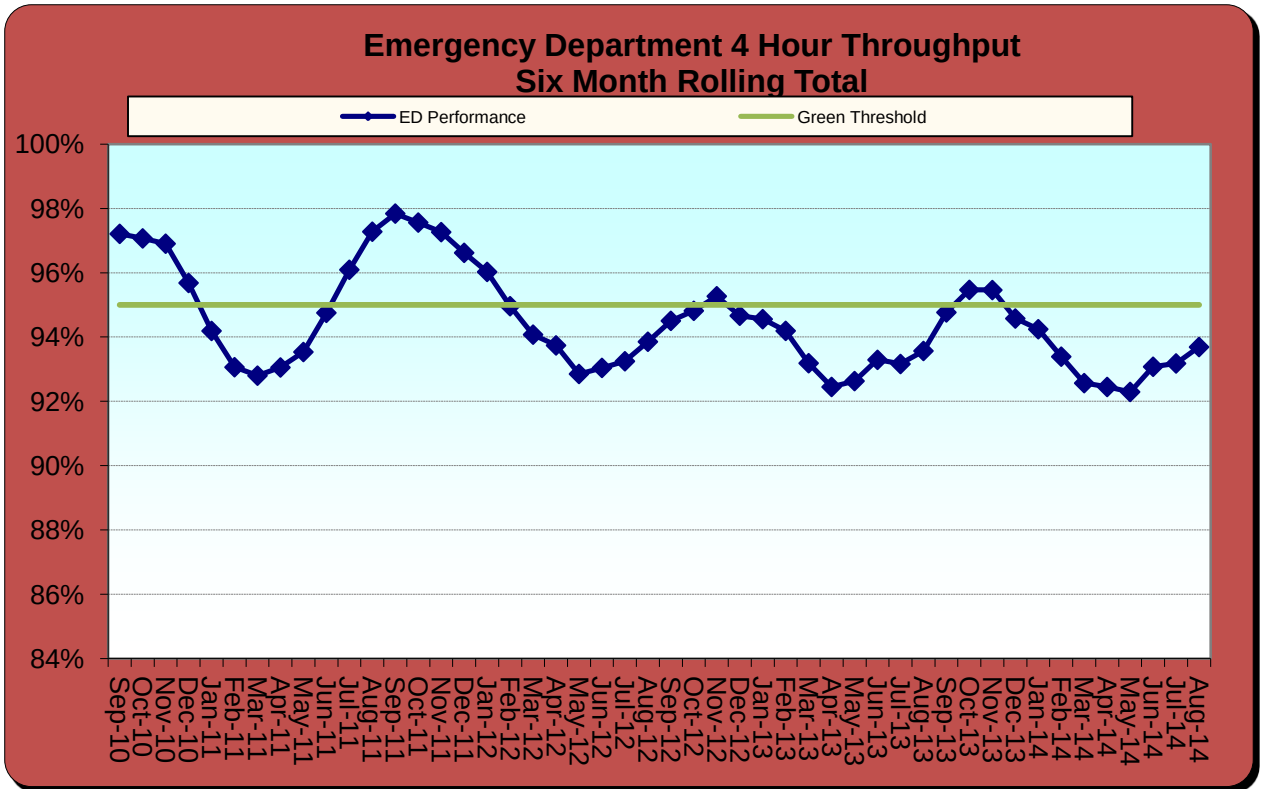
Emergency Department 4 Hour Throughput
Six Month Rolling Total
ED Performance
Green Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
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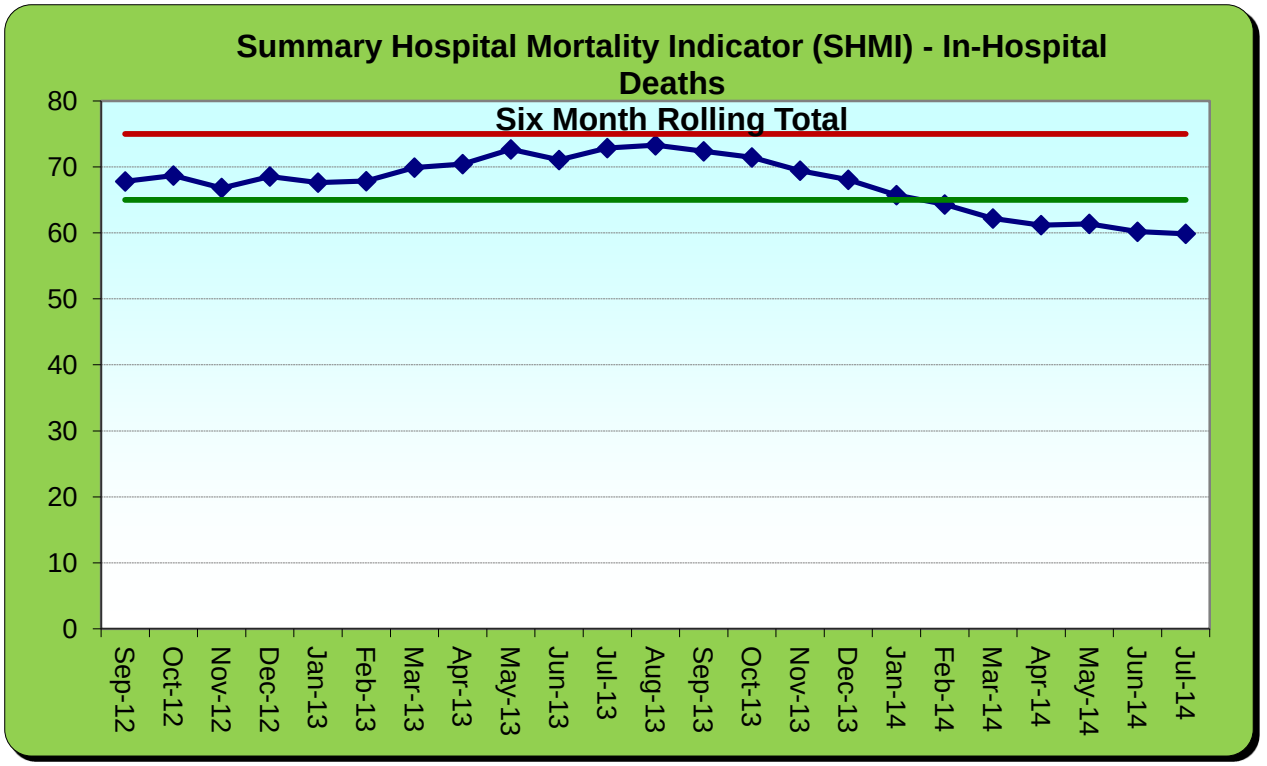
Summary Hospital Mortality Indicator (SHMI) - In-Hospital Deaths
Six Month Rolling Total
80
70
60
50
40
30
20
10
0
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
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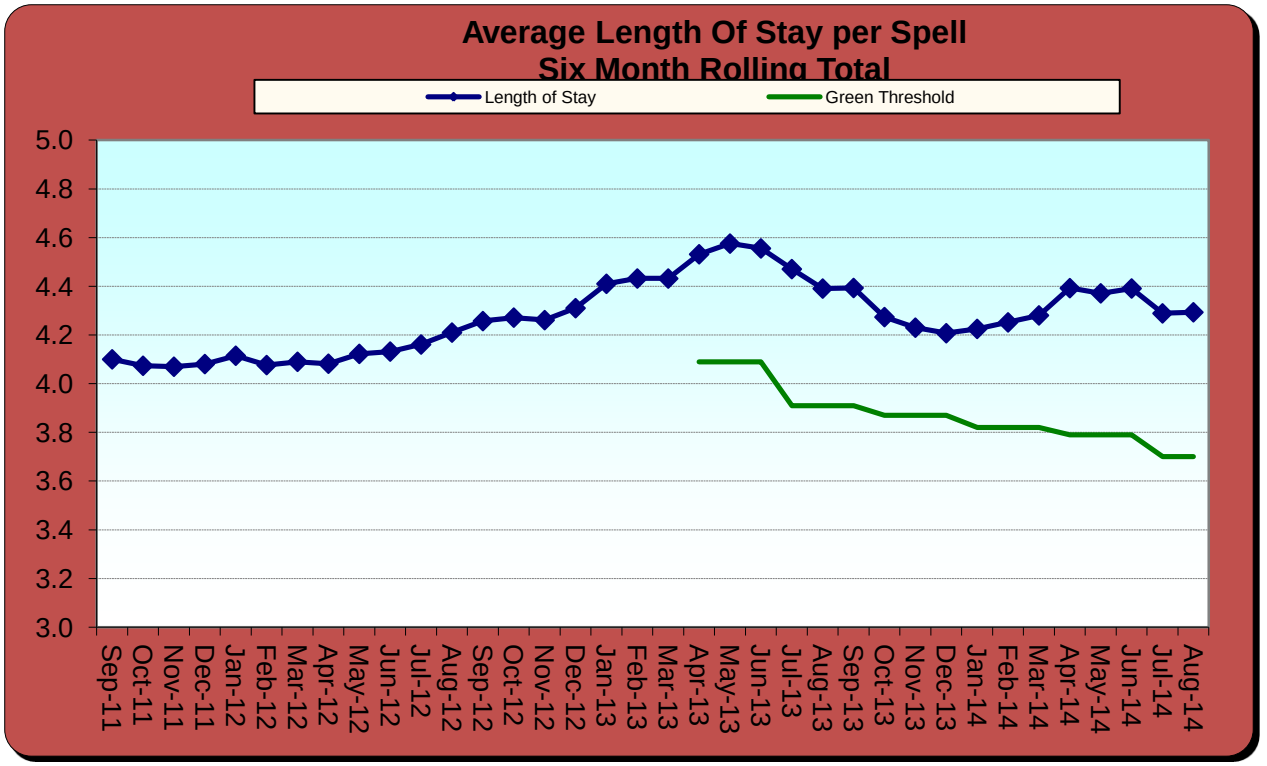
Apr-14
May-14
Jun-14
Jul-14


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
Jun-13
Jul-13
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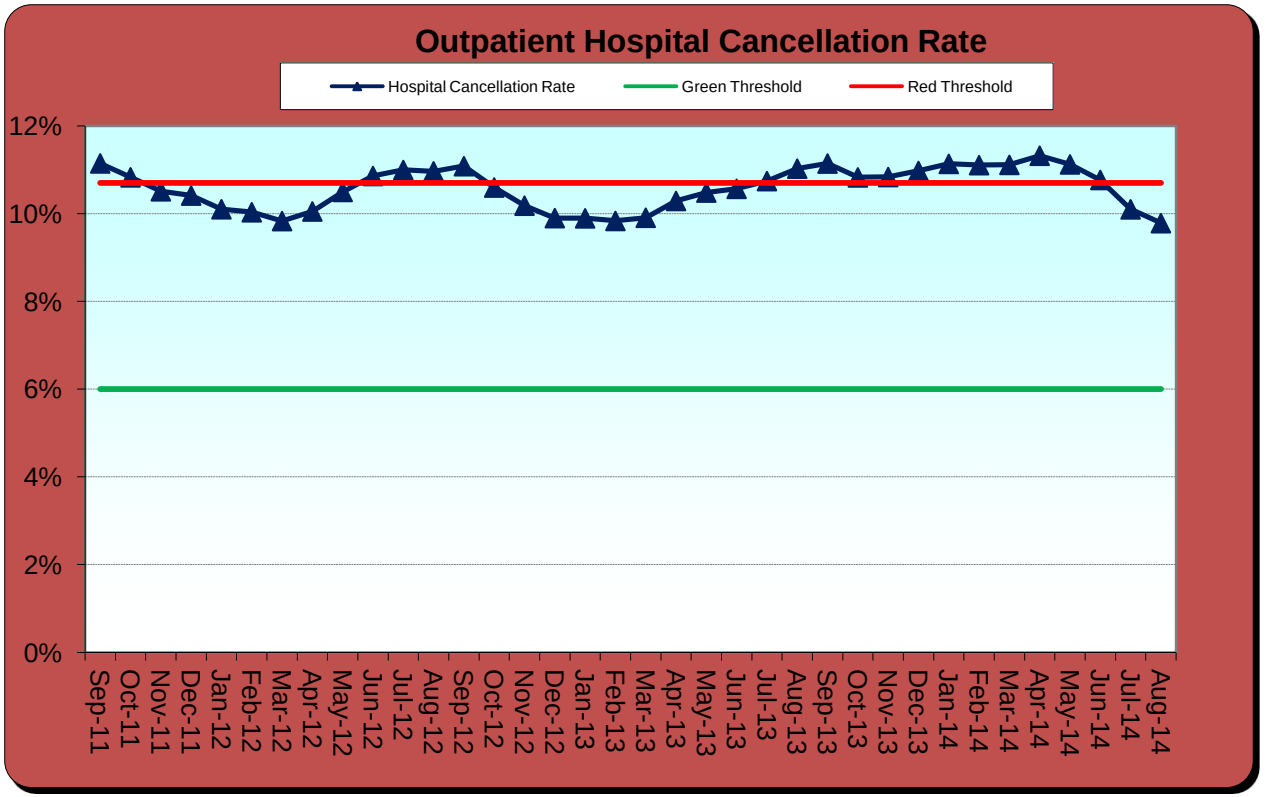
Aug-14


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
Jun-14
Jul-14
Aug-14

SECTION C – Monitor Risk Assessment Framework

In August the Trust failed to meet five of the standards in Monitor's 2014/15 Risk Assessment Framework. Exception reports are provided for four of these five standards, as follows:

- A&E 4-hour maximum wait (1.0) – *Access section*
- RTT Non-admitted standard (1.0) – *Access section*
- RTT Admitted standard (1.0) – Exception report not provided (see note below)
- RTT Ongoing standard (no additional score – see note below) – *Access section*
- 62-day Referral to Treatment GP Cancer standard (1.0) – *Access section*

Please note: An exception report is not provided for the Referral to Treatment Time (RTT) Admitted pathway standard, which was failed in the period in response to a national initiative to reduce the size of the elective waiting list across the country. In Monitor's Risk Assessment Framework failure of all three RTT standards as in the current quarter, is capped at a score of 2.0.

Overall the Trust currently has a forecast Service Performance Score of 4.0 against Monitor's Risk Assessment Framework, reflecting the four standards forecast not to be met for the quarter, taking account of the cap of 2.0 for the failure of the three RTT standards.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 2 2014/15.

PERFORMANCE OVERVIEW

Monitor's Risk Assessment Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Compliance Framework	Risk Assessment Framework				Q2 Forecast quarter-end*	Notes	Q2 Forecast Risk Rating Risk rating
						Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15*	Q2 14/15*			
Monitor Risk Assessment Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	8	✘	✘	✘	✓	8	✓	1potentially unavoidable case in Q1 and 1in July. 6 cases reported in Aug, still subject to review	Achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.8%	✓	✓	✓	✓	100%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	94.7%	✓	✓	✓	✓	95.7%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.3%	✓	✓	✓	✓	97.6%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	80.1%	✘	✓	✘	✘	77.5%	✘	62-day GP standard not achieved for the quarter.	Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	90.4%	✓	✓	✓	✘	90.6%	✓		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	88.9%	Achieved each month	Achieved each month	Achieved each month	✓	85.9%	✘	Planned failure, as requested by NHS England.	Not achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	91.9%	Not achieved	Not achieved	Not achieved	✘	89.8%	✘	Standard failed in July and August so failed for the quarter as a	Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.1%	Achieved each month	Achieved each month	Achieved each month	✓	91.5%	✘	Standard failed in August - but scores for RTT failure capped at 2.0	Not achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	97.1%	✓	✓	✓	✓	96.8%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	96.8%	✓	✓	✓	✓	95.1%	✓		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	1.0	95%	94.0%	✓	✘	✘	✘	92.4%	✘	95.0% standard can no longer be achieved.	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	Actions implemented	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
					rating	AMBER-RED	GREEN	GREEN	GREEN	Triggers further investigation	Triggers further investigation		

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.

***Q2 Cancer figures based upon draft figures for July. The C diff figures is shown as the cumulative position against the quarter-end target with exclusions agreed with commissioners applied for Q1 and July.**

4.0
Meets the criteria for triggering further investigation

The Trust is currently seeking clarity from the regulatory of the impact on Performance Score of the NHS England requested failure of the admitted RTT standard

1.1 QUALITY TRACKER

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Quarterly Totals 13/14	Quarterly Totals 13/14	Quarterly Totals 14/15	Quarterly Totals 14/15
Patient Safety																						
Infections	DA01a	MRSA Cumulative Cases Against National Trajectory	-	-	-	-	1	1	1	1	1	2	2	1	1	2	3	3	-	-	-	-
	DA03a	C.Diff Cumulative Cases Against National Trajectory	-	-	-	-	25	27	30	34	34	36	38	5	9	13	17	23	-	-	-	-
	DA02	MSSA Cases Against Trajectory	25	25	27	12	5	3	3	3	1	2	2	1	0	3	7	1	9	5	4	8
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%	95.2%	94.8%	95.2%	94.9%	95.2%	95%	95.2%	95.3%	96%	95.5%	94.9%	94.3%	95.3%	95.1%	95.2%	95.4%	94.8%
Infection Checklists	DB01	Hand Hygiene Audit Compliance	95%	80%	96.8%	97.2%	97.8%	96.4%	96.1%	96%	98.3%	98.3%	97.2%	97.5%	96.9%	97.8%	96.8%	96.9%	96.2%	97.8%	97.4%	96.8%
	DB02	Antibiotic Compliance	90%	80%	88%	88.9%	86.5%	85.9%	86.5%	86.5%	88.6%	90.1%	90.7%	91.8%	88.2%	87.9%	89.6%	86.2%	86.2%	89.9%	89.4%	88.1%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	87%	79%	95%	94%	94%	95%	95%	94%	94%	94%	96%	96%	95%	96%	90%	91%	95%	95%	96%	91%
	DC02	Cleanliness Monitoring - Very High Risk Areas	98%	89%	96%	95%	96%	95%	96%	96%	95%	96%	96%	95%	97%	95%	94%	95%	96%	96%	96%	95%
	DC03	Cleanliness Monitoring - High Risk Areas	95%	79%	95%	94%	95%	94%	96%	95%	95%	95%	96%	96%	96%	96%	91%	92%	95%	95%	96%	92%
Serious Incidents	S02	Number of Serious Incidents Reported	-	-	73	30	4	7	5	6	6	9	5	5	7	5	10	3	18	20	17	13
	S02a	Number of Confirmed Serious Incidents	-	-	71	18	4	7	5	6	6	9	5	5	7	5	1	-	18	20	17	1
	S02b	Number of Serious Incidents Still Open	-	-	-	10	-	-	-	-	-	-	-	-	-	-	7	3	-	-	-	10
	S03	Serious Incidents Reported Within 48 Hours	80%	80%	83.6%	83.3%	25%	85.7%	100%	83.3%	100%	88.9%	100%	80%	57.1%	80%	100%	100%	88.9%	95%	70.6%	100%
	S04	Percentage of Serious Incident Investigations Completed Within Timescal	80%	80%	92.4%	79.4%	100%	87.5%	100%	100%	87.5%	75%	100%	100%	50%	83.3%	70%	85.7%	93.8%	89.5%	82.4%	76.5%
Never Events	S01	Total Never Events	0	1	2	2	0	0	0	1	0	0	0	1	1	0	0	0	1	0	2	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	-	-	12090	4021	922	1064	1052	958	1060	954	986	939	958	1020	1104	-	3074	3000	2917	1104
	S06a	Patient Safety Incidents Per 100 Admissions	-	-	9.25	8.92	8.45	9.09	9.57	9.41	9.43	9.28	9	8.76	8.6	9.17	9.14	-	9.35	9.24	8.84	9.14
	S07	Number of Patient Safety Incidents - Severe Harm	-	-	44	22	3	7	3	3	3	7	6	4	6	7	5	-	13	16	17	5
Patient Falls	AB01	Falls Per 1,000 Beddays	5.6	5.6	5.68	4.73	5.8	5.96	5.42	5.59	6.1	5.67	5.46	5.08	5.18	4.28	4.51	4.59	5.66	5.74	4.85	4.55
	AB06a	Total Number of Patient Falls Resulting in Harm	24	25	27	11	3	1	4	2	2	4	2	1	5	2	0	3	7	8	8	3
Falls (CQUIN Improvement)	AB07a	Number of Inpatient Falls (CQUIN)	429	429	0	606	0	0	0	0	0	0	0	129	136	109	116	116	0	0	374	232
	AB07b	Inpatient Falls (CQUIN) - Improvement from Baseline	0	0	0	-132	0	0	0	0	0	0	0	-12	-8	-35	-44	-33	0	0	-55	-77
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.651	0.651	0.656	0.382	1.078	0.706	0.526	0.555	0.69	0.417	0.417	0.433	0.343	0.314	0.427	0.396	0.596	0.51	0.363	0.412
	DE02	Pressure Ulcers - Grade 2	-	-	184	47	26	17	12	14	17	9	10	11	8	8	10	10	43	36	27	20
	DE03	Pressure Ulcers - Grade 3	0	1	13	2	0	1	1	0	1	1	1	0	1	0	1	0	2	3	1	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

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Quarterly Totals 13/14	Quarterly Totals 13/14	Quarterly Totals 14/15	Quarterly Totals 14/15
Patient Safety																						
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	96%	95%	98%	98.5%	97.9%	98%	98.5%	98.2%	98.6%	98.7%	98.5%	98.9%	98.7%	98.1%	98.4%	98.6%	98.2%	98.6%	98.6%	98.5%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	90%	93.4%	95.3%	95.6%	94.6%	95.1%	97.1%	94.9%	96.6%	94.5%	96.4%	94.3%	94%	95.3%	96.6%	95.6%	95.3%	94.9%	95.9%
Nutrition	WB05	Nutrition: Screening Tool Completed	90%	90%	-	92.3%	-	-	-	-	-	-	-	-	-	-	92.8%	91.8%	-	-	-	92.3%
	WB03	Nutrition: Food Chart Review	90%	85%	82.5%	89.4%	80.9%	83.8%	76.9%	84.1%	91.2%	91.8%	78.2%	94.7%	87.4%	87.7%	89%	89.3%	82.1%	87.7%	89.5%	89.1%
Safety	Y01	WHO Surgical Checklist Compliance	100%	99.5%	99.6%	99.6%	99.5%	99.6%	99.5%	99.7%	99.9%	99.6%	99.6%	99.7%	99.6%	99.4%	99.4%	99.7%	99.6%	99.7%	99.6%	99.5%
Medicines	WA01	Medication Errors Resulting in Harm	1.61%	2%	0.68%	0.78%	0.7%	0.61%	0.56%	0%	1%	0.54%	0%	1.3%	0%	0.78%	1.09%	-	0.41%	0.52%	0.66%	1.09%
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	95%	95%	97.9%	97.7%	99%	99.1%	100%	100%	99.1%	99%	100%	98.6%	100%	95.6%	95.2%	99%	99.7%	99.4%	98.1%	97.1%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	85%	75%	92%	93.7%	89.1%	89.5%	90.8%	83.3%	85%	100%	100%	98.8%	99.1%	90.9%	86.4%	94.7%	88.1%	94.1%	96.1%	90.2%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.5%	2%	1.91%	1.02%	1.19%	2.75%	2.32%	2.6%	1.08%	0.91%	1.66%	1.18%	0.55%	0.38%	1.41%	1.42%	2.56%	1.23%	0.68%	1.42%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	95.6%	92.8%	94.1%	96.4%	94.5%	93.5%	95.8%	95%	95.6%	96.2%	95.2%	95.7%	96.7%	96%	96.7%	96.9%	94.7%	95.7%	96.1%	96.8%
	AK04	Safety Thermometer - No New Harms	98.2%	97%	97.2%	98.5%	98.3%	96.7%	97.4%	97.9%	98.5%	97.8%	97.6%	98.2%	98.4%	98.5%	98.9%	98.7%	97.3%	98%	98.3%	98.8%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	95%	90%	85%	90%	80%	85%	82%	76%	91%	86%	88%	89%	83%	91%	91%	96%	81%	89%	88%	93%
	CA01	Number of Verified Crash Calls from Adult General Wards	92	108	-	26	-	-	-	-	-	-	-	3	5	5	4	9	-	-	13	13
Discharges	TD04	Out of Hours Discharges			9%	8.6%	9.2%	8.7%	8.8%	8.6%	8.1%	10%	9.8%	9.5%	9%	8.2%	8.6%	7.6%	8.7%	9.3%	8.9%	8.1%
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	90%	80%	-	90%	-	-	-	-	-	-	-	-	-	-	-	90%	-	-	-	90%
	CS03	Number of CAS Alerts Overdue At Month End	0	0	-	0	-	-	-	-	-	-	-	-	-	-	-	0	-	-	-	0
Clinical Effectiveness																						
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital D	65	75	67.2	59.5	73.7	65.4	64.3	64.7	57.5	60.5	60.6	59.3	64.9	57.6	55.9	-	64.8	59.5	60.7	55.9
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	-	-	94.9	-	95.7	-	-	95.1	-	-	-	-	-	-	-	-	95.1	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI)	80	90	75.8	64.5	80.3	69.8	66.8	78.7	66.2	75.2	73.2	67.5	66.3	64.2	59.3	-	72	71.3	66	59.3
Learning Disability	AA03	Learning Disability (Adults) - Percentage Adjustments Made	80%	50%	83.9%	89.4%	88.2%	100%	95%	77.8%	95%	90.5%	92.3%	100%	78.9%	100%	76.2%	-	91.7%	92.6%	93.8%	76.2%
Readmissions	C01	Emergency Readmissions Percentage	2.7%	2.7%	2.71%	2.76%	2.76%	2.7%	2.69%	2.83%	2.89%	2.93%	2.86%	2.71%	2.92%	2.96%	2.44%	-	2.73%	2.89%	2.87%	2.44%
Maternity	G04	Percentage of Normal Births	64%	61%	61.7%	62.3%	61.7%	61.4%	63.9%	62.7%	59.9%	62.6%	61.4%	63.6%	58.9%	62.4%	64.7%	61.4%	62.7%	61.3%	61.7%	63.2%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	90%	90%	77.4%	78%	96.6%	90.5%	95.5%	87.8%	55.9%	92.6%	85.7%	88.9%	70%	82.6%	82.1%	71.4%	90.5%	76.4%	78.9%	76.8%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	90%	90%	78.8%	96.1%	75.9%	81%	95.5%	100%	97.1%	100%	100%	94.4%	93.3%	95.7%	100%	96.4%	94%	98.9%	94.4%	98.2%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	80%	61.7%	74.8%	69%	71.4%	90.9%	87.8%	52.9%	92.6%	85.7%	83.3%	66.7%	78.3%	82.1%	67.9%	84.5%	75.3%	74.6%	75%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	50%	55.1%	47.6%	62.2%	58%	36.1%	66.7%	62.2%	56.8%	63.9%	52.3%	53.6%	36.8%	48.6%	-	55.2%	60.8%	47.3%	48.6%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90%	80%	84.2%	91.2%	89.2%	86%	83.3%	87.5%	86.7%	79.5%	86.1%	90.9%	96.4%	81.6%	97.3%	-	85.8%	84%	89.1%	97.3%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	60%	55.8%	52.7%	71.4%	73.3%	40%	61.1%	50%	45.5%	50%	60%	30%	57.1%	25%	72.2%	63.2%	48.8%	48.3%	57.7%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	90%	80%	67.7%	57.5%	86.6%	83.4%	74.9%	49.7%	46.6%	45.3%	46.9%	57.1%	52.3%	49%	62.1%	67.5%	68.7%	46.3%	52.6%	64.7%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	90%	80%	60.6%	76%	53.4%	59%	57.7%	66.7%	75.5%	78%	66.7%	71.7%	78.3%	59.5%	84.7%	81.7%	60.7%	73%	70.3%	83.2%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	90%	80%	65.4%	47.6%	62.5%	75%	75.9%	61.5%	57.9%	38.5%	52.4%	47.6%	56.5%	22.7%	55.2%	50%	70.7%	48.5%	42.4%	51.9%
	AC04	Percentage of Dementia Carers Feeling Supported			-	64.9%	-	-	-	-	-	-	-	60%	62.5%	90%	-	-	-	-	69.7%	25%
Outliers	J05	Ward Outliers - Beddays	9029	9029	10622	3880	517	846	755	1064	1302	1246	960	683	927	809	685	776	2665	3508	2419	1461

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15	Monthly Totals Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Quarterly Totals 13/14	13/14	14/15	14/15
Patient Experience																						
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	-	-	89	88	89	89	88	89	89	89	92	90	88	-	89	89	90	88
	P01g	Patient Survey - Kindness and Understanding	-	-	-	-	94	93	93	93	93	91	94	94	94	93	92	-	93	93	94	92
Friends and Family Test	P03a	Friends and Family Test Inpatient Coverage	30%	25%	29.6%	38.7%	38.2%	42.2%	45.2%	37.4%	37.9%	43.8%	46.7%	45.9%	39.5%	39.5%	35.5%	32.8%	41.6%	42.7%	41.6%	34.1%
	P03b	Friends and Family Test ED Coverage	20%	15%	13.3%	19%	16.2%	19.1%	18.6%	11.6%	13.8%	16.4%	26.4%	15.7%	21.1%	19.2%	16.1%	22.7%	16.6%	19.1%	18.7%	19.3%
	P04a	Friends and Family Test Score - Inpatients	70	64	75.9	74.7	73.8	76.5	75.7	74.4	75.5	76.5	76.1	78.4	73.3	73.5	72.4	75	75.6	76	75.2	73.7
	P04b	Friends and Family Test Score - ED	51	42	70.1	71.5	73.9	71.6	70.8	66.3	70.3	70.1	68.7	75.8	71.4	69.3	72.4	69.7	70.1	69.5	71.8	70.9
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.21%	0.25%	0.212%	0.269%	0.202%	0.192%	0.185%	0.199%	0.214%	0.227%	0.282%	0.238%	0.226%	0.277%	0.282%	0.321%	0.192%	0.241%	0.248%	0.3%
	T03a	Complaints Responded To Within Trust Timeframe	95%	85%	76.4%	87.9%	87.8%	84.9%	82.2%	88.1%	76.1%	92%	88.7%	93.1%	82.5%	83.3%	91.5%	88.3%	85%	84.7%	86.3%	90.1%
	T03b	Complaints Responded To Within Divisional Timeframe			71.1%	83.3%	83.7%	69.9%	66.7%	57.1%	77.6%	86%	75.5%	82.8%	86%	91.7%	74.6%	83.3%	65.6%	79.4%	86.9%	78.6%
	T04a	Complainants Disatisfied with Response			62	33	1	7	2	6	6	3	5	6	4	11	8	4	15	14	21	12
Ward Moves	J06	Average Number of Ward Moves			2.26	2.34	2.3	2.34	2.36	2.3	2.37	2.31	2.37	2.34	2.3	2.33	2.34	2.38	2.34	2.35	2.32	2.36
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.92%	0.92%	1.02%	1.08%	0.72%	0.65%	0.94%	1.02%	1.18%	1.44%	0.92%	0.98%	0.96%	1.1%	1.35%	0.97%	0.85%	1.17%	1.02%	1.17%
	F01a	Number of Last Minute Cancelled Operations	-	-	690	310	40	40	54	47	70	78	52	54	54	64	84	54	141	200	172	138

1.2 SUMMARY

This month we have introduced two new metrics into the quality dashboard regarding Central Alerting System (CAS) alerts. The CAS is a national system for distributing alerts to NHS organisations about risks to safety, usually derived from national thematic analyses of reported incidents or specific notifications of identified risks. We are required to take the identified action within the timescale specified on each alert. These alerts broadly cover four areas: medicines, medical devices, patient safety and Facilities & Estates. The metrics in the dashboard cover all of the CAS alerts, except those for medicines where we have historically had close to100% compliance and a robust process for their management. The rationale for introducing the CAS alert metrics is as a result of learning from our previous system that was over-reliant on one individual and which resulted in a number of breaches of implementation timescales in their absence. Our lower compliance levels also triggered a risk on the latest Care Quality Commission's Intelligent Monitoring Report. We have reviewed and amended our processes for the management of CAS alerts for medical devices, patient safety and Facilities & Estates, to rectify the weakness in the old process, and have introduced Board level monitoring for assurance of continued improvement. The two new measures are:

1. The alerts closed in the month that were closed within the timescale expressed as a percentage of those closed.
2. The number of alerts overdue at the end of the month.

Of note this month is that we have sustained improvements in all out patient experience survey measures and in overall falls and pressure ulcer incidence. But the challenges in meeting the flow performance measures remain, as demonstrated in the dashboard and associated exception reports.

Achieving set threshold (40)	**Thresholds not met or no change on previous month (9)**
- MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - MRSA (Meticillin Resistant Staphylococcus aureus) screening – elective - MRSA screening – emergency - Hand Hygiene Audit - Cleanliness monitoring: overall Trust score - Serious Incidents reported with 48 hours - Serious incident investigations completed within required timescales - Never Events - Inpatient falls incidence per 1,000 bed days - Falls improvement from baseline	- Antibiotic prescribing compliance - Cleanliness monitoring: high risk areas - Cleanliness monitoring: very high risk areas - 72 hour Food Chart review - WHO surgical checklist compliance - Learning disability (adults)-percentage adjustments made - Percentage of normal births - Dementia admissions-assessment completed - Percentage of complaints resolved within agreed timescale

QUALITY

- Total pressure ulcer incidence per 1,000 bed days - Number of grade 4 hospital acquired pressure ulcers - Number of grade 3 hospital acquired pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Percentage adult in-patients who received thrombo-prophylaxis - Nutritional screening completed - Medicines reconciliation performed within one day of admission (Assessment and cardiac wards) - Medicines reconciliation performed within one day of admission (Oncology and Gynaecology wards) - 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 - Deteriorating patient- appropriate response to an Early Warning Score of 2 or more. - Summary Hospital Mortality Indicator (SHMI) in-hospital deaths - Summary Hospital Mortality Indicator (SHMI) including out of hospital-deaths within 30 days of discharge - Risk Adjusted Mortality (Hospital Standardised Mortality Ratio equivalent) - 30 day emergency re-admissions - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Stroke care: percentage spending 90% + time on a stroke unit - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - CAS alerts completed within timescale - Percentage of CAS alerts overdue at month end. - 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 (12)**	 **Quality metrics not rated (10)**
- Clostridium difficile cases against national trajectory - MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory - Falls resulting in harm - Deteriorating patient- reduction in cardiac arrest calls from adult general ward areas - Fractured neck of femur patients treated with 36 hours - Fractured neck of femur patients achieving Best Practice Tariff - Stroke care: percentage receiving brain imaging within 1 hour - Dementia admissions-case finding applied - Dementia admissions-referred on to specialist services - Ward outliers bed-days - Patient complaints as a proportion of all activity - Average number of ward moves - Last minute cancelled operations: percentage of admissions	**Thresholds to be agreed** - Dementia-carers feeling supported - Out of hours discharges **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 falls - 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:

The 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.

We have agreed a two-part CQUIN with our commissioners relating to this area of quality:

- Adult patients with an Early Warning Score (EWS) of 2 or more to have an appropriate response according the escalation protocol. Our improvement target is 95% by Quarter 4. In August the percentage of documented appropriate responses for adult patients with a EWS of 2 or more was 96% against an improvement target of 95%;
- 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 a baseline of Q4 2013/14, to be measured at the end of 2014/15, which equates to no more than 91 cardiac arrest calls for the whole of 2014/15. In August the number of cardiac arrest calls was 9 against the GREEN threshold target of 7. We are still below our cumulative trajectory of 35 by the end of August with 26 cardiac arrest calls year to date and therefore on track to achieve the CQUIN.

1.3.2 NHS Safety Thermometer improvement goal

We have agreed a two-part CQUIN with our commissioners:

- A reduction in the number of inpatient falls of five fewer per month on average over the whole of 2014/15, against a monthly age-adjusted baseline. In August there were 33 fewer falls against a target of 5 fewer than baseline;

- To implement five actions to enable closer working with our community partners to help reduce harm from pressure ulcers and improve infection prevention and control across the healthcare system. There are no further updates since those reported last month. We are on track to achieve this element of the CQUIN.

1.3.3 Friends and Family Test

We will report on two elements of the national Friends & Family Test CQUIN, achievement of which will be tracked via 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 August was 32.8% against a target of 25% for inpatients, and 22.7% 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:
    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 August was 67.5% against a target of 90%
    2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in August was 81.7% against a target of 90%
    3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in August was 50% against a target of 90%

Our survey of carers looking after people with dementia was conducted in August but only received two responses, which is insufficient for meaningful analysis. Once the Band 3 clinical support to the Dementia Project Nurse is in place we will be able to support carers to complete a survey.

1.4 CHANGES IN THE PERIOD

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

- Meticillin sensitive *staphylococcus aureus* (MSSA) cases against trajectory down ↓ from 7 in July to 1 in August.
- Falls resulting in moderate (or above) harm up ↑ from 0 in July to 3 in August;
- Number of cardiac arrest calls from adult general wards up ↑ from 4 in July to 9 in August
- Friends and family test coverage in the emergency department ↑ from 16.1% in July to 22.7% in August

Exception reports are provided for the twelve RED rated indicators and one* amber rated indicator, thirteen in total.

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.There were no new cases in August 2014.

1. Clostridium difficile cases against national trajectory
2. Falls resulting in harm
3. Deteriorating patient- reduction in cardiac arrest calls from adult general ward areas
4. Fractured neck of femur patients treated with 36 hours
5. Fractured neck of femur patients achieving Best Practice Tariff
6. Stroke care: percentage receiving brain imaging within 1 hour
7. Dementia admissions-case finding applied
8. Dementia admissions-assess and investigate*
9. Dementia admissions-referred on to specialist services
10. Ward outliers bed-days
11. Patient complaints as a proportion of all activity
12. Average number of ward moves
13. Last minute cancelled operations: percentage of admissions**

***For the exception report on last minute cancelled operations please see the Access section of this report*

QUALITY

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

Description of how the standard is measured:

Patients in hospital for more than three days who have unexplained reasons for diarrhoea and test positive for *Clostridium difficile*. The national objective set centrally is 40 cases in the year. Financial penalties are linked to the national objective.

Monitor measurement period: 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 six apportioned cases of *Clostridium difficile* in August 2014 against an objective of three.

Division	Divisional Limit	Number of cases
Medicine	1	1
Surgery, Head & Neck	1	3
Women's & Children's	0	1
Specialised Services	1	1

There were 13 cases in total for the first quarter against a limit of 10. Following a review by Bristol Clinical Commissioning Group (CCG) one case was deemed to be potentially avoidable by the Trust during the first quarter of 2014/15. In July a further case has been deemed potentially avoidable (of the 4 reported), which gives a total for the year to date of potentially avoidable cases of 2 cases. The August reported cases have yet to be assessed by the CCG for 'Avoidable' or 'Non Avoidable' status.

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;

QUALITY

- Focused care and management of *Clostridium difficile* positive patients continues on the cohort ward with daily monitoring of patients by the Infection Control Team;
- Enhanced cleaning is performed in areas where patients are diagnosed with *Clostridium difficile.*

QUALITY

Q2. EXCEPTION REPORT: Inpatient falls	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 4.59 per 1,000 bed days against the national benchmark of 5.6. There were 116 inpatient falls in August. 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 August was:

Degree of Harm	Jan 14	Feb 14	Mar 14	April 14	May 14	June 14	July 14	August 14
Near Miss	0	0	0	0	0	0	0	0
Negligible	120	114	109	88	98	67	80	92
Minor	37	18	32	40	33	40	36	21
Moderate	0	0	0	0	1	1	0	1
Major	2	4	3	1	4		0	2
Catastrophic	0	0	0	0	0	1	0	0
Total	**159**	**136**	**144**	**129**	**136**	**109**	**116**	**116**

Whilst the overall performance this month is below the green threshold, there were two serious incidents where patients sustained a fractured hip and one moderate harm incident where a patient dislocated their hip. One patient stood up, lost balance and fell, one rang for assistance but proceeded to walk back from the bathroom alone and one patient fell whilst in the shower. The falls occurred on Wards: 9, the Older Persons Assessment Unit (OPAU) and 14. Root Cause Analyses (RCAs) are underway to determine what actions, if any, could have been taken with any lessons learned to be shared.

Recovery plan, including expected date performance will be restored:

QUALITY

- The FallSafe programme continues to be reviewed on a monthly basis at the Falls Steering Group with all relevant actions taken. Requests for micro teaching continue with a clear focus and drive in all clinical areas to reduce the number of avoidable patient falls as well as level of harm;
- A technique called SWARM is planned to be tested in three ward areas. This was discussed at a Falls Network day hosted by UHBristol. The technique requires the presence of a Senior Nurse immediately after a patient has fallen to ask a number of specific questions of the team as well as the patient or family if appropriate, in real time. The aim is to identify any immediate themes, learning and to ask was this fall preventable. Feedback from the three Divisions where this is being tested will be monitored at the Trust Falls Group.

QUALITY

Q3. EXCEPTION REPORT: Deteriorating Adult Patient-number of verified crash calls from general ward areas	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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 a baseline of Q4 2013/14, to be measured at the end of 2014/15, which equates to no more than 91 cardiac arrest calls for the whole of 2014/15.

Performance in the period, including reasons for the exception:

In August the number of cardiac arrest calls was 9 against the GREEN threshold target of 7. We are still below our cumulative trajectory of 35 by the end of August, with 26 cardiac arrest calls year to date and are therefore on track to achieve our target.

Recovery plan, including expected date performance will be restored:

As reported previously, a deteriorating patient improvement project is underway in 2014/15 which is being 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. There are five interventions which have been shown to reduce cardiac arrest calls from general ward areas by 30-40%:

1. use of early warning scores;
2. clear escalation;
3. re-skilling nurses to be confident in taking manual observations;
4. appropriate DNACPR (Do not attempt cardio-pulmonary resuscitation);
5. structured ward rounds.

The main focus of the project is re-skilling nurses to be confident in taking manual observations to build on the work already carried out in other areas listed. This has been implemented in four ward areas and is currently being spread to a further four wards with a plan to implement in all adult general ward areas by the end of March 2015.

QUALITY

Q4-5. EXCEPTION REPORT:	**RESPONSIBLE DIRECTOR: Medical Director**
• **Fractured neck of femur patients treated with 36 hours** • **Fractured neck of femur patients achieving best practice tariff**	

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:

August's Best Practice Tariff performance was 68%. This was under the 90% target due to 8 patients failing to meet the 36-hour time to theatre standard (71.4%). The reason for failure of the standard in August was due to lack of trauma theatre capacity.

Of 38 hip fracture admissions in August, there were two days when four patients were admitted within the same day (Friday 18th July and Monday 21st July). Currently there is a total of 8 hours of trauma operating over the weekend period. As a result, only two of the four patients admitted on Friday were treated within 36 hours, and two of the four patients admitted on Monday had surgery within 36 hours due to the backlog of cases from the weekend. A further patient admitted on the Saturday also breached 36 hours due to lack of theatre space.

Recovery plan, including expected date performance will be restored:

The following recovery actions have been identified by the Division of Surgery, Head and Neck to address the current performance concerns, and a trajectory for achievement of 90% by Quarter 4 is currently in progress.

1. <u>Prioritisation of NOF cases</u>

Approximately 20% of patients who breach 36 hours receive treatment in less than 40 hours. There are some instances where a different prioritisation of trauma patients could have avoided a hip fracture patient from breaching 36 hours. The hip fracture clinical lead and theatre team have introduced a

Golden Case system in theatre which aims to prioritise hip fracture cases as first on the list, and with the aim of improving theatre start times and overall list utilisation. This work is ongoing and is reviewed regularly by the hip fracture lead alongside the breach reasons to ensure appropriate prioritisation is taking place. In addition to this, the Division has reviewed the escalation process for identifying risks of breaches to ensure there is appropriate senior input to decision making on a daily basis.

2. Additional all day operating list 1:2 weeks from 6th October

The transfer of vascular services to North Bristol Trust from 6th October 2014 will release 6 inpatient theatre sessions per week at the BRI. Reallocating an all-day list alternate weeks to trauma will increase the overall capacity and increase the number of days when 2 trauma lists run to 3 days per week. This list is proposed to be scheduled on Tuesdays to address the current bottleneck of admissions resulting from minimal weekend operating, and the limited access caused by the dedicated upper limb trauma list.

3. Use of winter pressure funding to pilot increase of weekend operating

The Division plans to increase weekend trauma operating to all day all weekend as part of the 2014/15 winter pressure plan. Recruitment is in progress to have this capacity in place from January 2015.

The detailed trajectory and action plan is below.

Month (of patient discharge)	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Total patients	28	28							
Expected 36 hour breaches	-	-	7	7	6	5	5	3	3
Performance trajectory	**-**	**-**	**77%**	**77%**	**80%**	**83%**	**83%**	**90%**	**90%**
Actual 36 hour breaches	5	8							
Actual performance	**82%**	**71%**							

Assumptions:

- Average of 30 patients discharged per month are eligible for Best Practice Tariff, demand above this average will affect trajectory;
- To achieve minimum 90% of patients having surgery within 36 hours, the Trust can tolerate no more than 3 breach patients per month;
- 2014/15 YTD performance for time to theatre 78% (6.6 breaches):
    - 48% of patients breach due to lack of weekend operating (3 breaches)
    - 37% of patients breach due to lack of in-week operating capacity (2.4 breaches)
    - 10% of patients breach due to lack of Total Hip Replacement kit (0.65 breaches)
    - 5% on average breaches are due to unavoidable clinical reasons (1.5 breaches)

Action plan:

QUALITY

No.	Action	Who	When	Status
1	Golden cases - prioritise hip fracture cases as first on the list, with the aim of improving theatre start times and overall list utilisation.	Sanchit Mehendale (Hip Fracture Lead) Trauma & Theatre Coordinators (HGT)	On-going. To be audited monthly with NOF breach reviews.	Green
2	Escalation – use Divisional management escalation process to highlight when patients at risk of breaching/high trauma demand or golden case process not functioning.	Bronze Command/Patient Flow Managers Trauma & Theatre Coordinators (HGT)	October 2014	Green
3	In week operating - Additional Tuesday operating list 1:2 to be allocated to trauma.	Rhona Galt/James Livingstone	6th October 2014	Planned
4	In week operating – review scheduling of upper limb and planned trauma lists throughout week to reduce variation.	Rhona Galt/James Livingstone	November 2014	Planned
5	Weekend operating – Increase current trauma capacity from afternoon list to all day lists Saturday & Sunday.	Sarah Nadin/Liz Varian Jenny Holly/Mark Scrutton Rhona Galt/James Livingstone	January 2015	Planned
6	General trauma - Review opportunity to transfer ambulatory trauma cases to South Bristol Community Hospital theatres.	Sarah Nadin/Liz Varian Rhona Galt/James Livingstone	December 2014	Planned
7	Total Hip Replacement kit – review breach cases where lack of THR kit was cited as reason. Review options to minimise risk of cancellations, including capital case for additional investment.	Liz Varian/Jennifer Pollock Sanchit Mehendale	December 2014	Planned

QUALITY

Q6. EXCEPTION REPORT: Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	RESPONSIBLE MANAGER: Medical Director

Description of how the target is measured:

The number of valid stroke spells where the patient had a CT Scan within 60 minutes of arrival at the Emergency Department.

Performance during the period, including reasons for exception:

Performance for August was 48.6% against a target of 50%. Nineteen out of 37 patients did not receive brain imaging within 60 minutes.

- The main problem appears to be delay in requesting the scan as radiology responded promptly once the request was made using the appropriate "Acute Stroke CT Head Request" form;
- The Emergency Department (ED) may be missing patients who default to the ED that are GP expected, and should go directly to the Medical Assessment Unit or Older Persons Assessment Unit;
- There appears to be patients past their lysis window who are recognised as having persistent stroke symptoms at triage who aren't escalated to doctor/nurse in charge for 1 hour to CT.

Recovery plan, including expected date performance will be restored:

- We have developed a pathway for patients directly admitted to the stroke unit to stop off in the Emergency Department, be scanned and then go to Ward 15 (stroke unit). This development is part of the pathway review we have been undertaking, but is dependent on the speed the medical take doctor can clerk the patient and request the scan;
- A stroke single point of contact is being developed via a single mobile phone;
- Business case for increasing stroke medical staffing to increase to 7-day model underway;
- Further stroke pathway work being undertaken with GP Support Unit and Division of Diagnostics & Therapies;
- Reception to pick up GP expected patients presenting with stroke symptoms;
- Refresh the message with ED nursing staff via local meetings chaired by the Lead band 7 nurses.

QUALITY

Q7-9. 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 August for stage 1 was 67.5%, compared with 62.1% in July.

Divisional performance

Medicine 74.8%; Surgery Head & Neck 51.1%; Specialised Services 41.1%

Stage 2 – Assessment and Investigation – status RED

Performance in August for stage 2 was 81.7% against a target of 90%, compared with 84.7% in July.

QUALITY

Divisional performance

Medicine 80%; Surgery Head & Neck 83.3%; Specialised Services 100%

Stage 3 – Referral on to GP – status RED

Performance in August for stage 3 was 50% compared with 55.2% in July.

Divisional performance

Medicine 52.5%; Surgery Head & Neck 30%; Specialised Services 50%

It is encouraging to see further improvement in the find element of the CQUIN, especially in the Division of Medicine. The Project Nurse has been focussing on teaching and supporting the new junior Doctors who started in the Trust on August 4th.

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;

- A start date for the Trust Lead for Dementia is still under negotiation as the successful candidate has to give 3 months' notice;
- Development of an electronic system to flag, record and monitor all stages of the FAIR process. This system is expected to be in place by the Autumn 2014 at the latest;
- Band 7 WTE (Whole Time Equivalents) two year secondment / fixed term project post holder is working closely with the admission area teams to ensure the timely screening, assessment and referral on where appropriate;
- 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 took up post on 1st September;
- A care plan ('caring for people with cognitive impairment') has been implemented. The monthly audit, which mainly focuses on the admission/assessment areas ,has been completed for August, with a briefing paper regarding results underway. The care plan prompts completion of the FAIR process and guide staff on delivering best practice (identified action from CQC inspection January 2014);

Following a briefing paper and a request from the Chief Nurse to support this work, there is renewed focus from Divisions on the actions required to improve performance against this standard. Improvements in performance are anticipated in the September.

QUALITY

Q10. EXCEPTION REPORT: Ward Outliers	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

This is one of our quality objectives for 2014/15 and is measured as the total number of bed-days occupied spent by patients outlying on wards, as at the midnight census, that did not meet their specialty group. The specialty-group ward designations are: adult-medicine, adult-surgery, adult-cardiac or adult-oncology. As an example, if one surgery patient spent the whole of August in medicine bed they would attribute 31 outlying bed-days.

The target is set at 9029 bed-days for the whole of 2014/15, which is a 15% reduction on the baseline for 2013/14 (10622 bed-days). The quarterly targets are seasonally adjusted to be: Q1 2444, Q2 1688, Q3 2114 and Q4 2783 bed-days.

Performance in the period, including reasons for the exception:

There were 776 outlier bed-days within the month of August against the seasonally adjusted target of 563 bed-days.

The level of outlier bed-days is known to be over-stated, as a result of poor data entry (i.e. incorrect specialty or consultant, resulting in the patient appearing to be in the incorrect ward). The remainder of the variance from the target level of outlier bed-days relates to issues with capacity and flow within the Bristol Royal Infirmary, which is well understood within the Trust.

Recovery plan, including expected date performance will be restored:

- The real-time data audit reveals inaccuracies in data entry; this plans to be addressed at source so that we have confidence in the figures;
- Reduction in occupancy levels throughout the Trust is being addressed through the widely reported patient flow work (see A&E 4-hour Exception report in the Access section of this report). Lower occupancy gives a greater chance for patients to be placed within the correct ward.

QUALITY

Q11. EXCEPTION REPORT: Percentage of complaints per patient attendance in the month	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of complaints received by the Trust and either managed by a formal or informal resolution process in agreement with the complainant, as a percentage against the number of patient attendances within the month. This excludes concerns raised and immediately dealt with by front-line staff, which are recorded within the Division. A green rating on the dashboard = <0.21%

Performance in the period, including reasons for the exception:

In August 2014, complaints received represented 0.32% of clinical activity (approximately one in every 310 patient episodes of care). This is an increase on the 0.28% reported in July, although the actual number of complaints received in fact decreased slightly: 170 in August compared to 178 in July. Seventy-three of the complaints received in August are being progressed through formal resolution. The divisional breakdown is shown below compared with last month's figures:

Division	Total Complaints Received In August 2014	Percentage Of Patient Activity	Areas With Highest Number Of Complaints In August 2014
Diagnostics & Therapies	6 (17 in July)	Not recorded for this Division	No specific trends noted
Surgery, Head & Neck	70 (60 in July)	0.32%	Bristol Eye Hospital x 18 Ear Nose & Throat x 7 Bristol Dental Hospital x 12 (8 in July) Trauma & Orthopaedics x 8
Medicine	27 (37 in July)	0.22%	Emergency Department x 6 (5 in July)
Women & Children	29 (32 in July) Bristol Children's Hospital – 24 (26 in July) St Michael's Hospital – 5 (6 in July)	0.24%	Children's Hospital Paediatric Orthopaedics x 6
Specialised Services	28 (22 in July) Bristol Heart Institute – 19 (15 in July) Bristol Haematology & Oncology Centre – 8 (7 in July)	0.40%	Bristol Heart Institute Outpatients x 9 Ward 52 x 5 Chemo Day Unit/Outpatients x 4 GUCH Service x 4

There was a notable decrease in the number of complaints received by the Division of Diagnostics & Therapies, with the levels of complaints received

by the remaining Divisions staying approximately the same as in July 2014.

In the Division of Women's & Children's, 11 of the complaints received by the Children's Hospital were about the Paediatric Outpatient Department (compared to 14 in July) and six of these were for Paediatric Orthopaedics. There were no other discernible themes or trends noted, with the complaints shared across various departments within each hospital site.

In the Division of Specialised Services, nine of the complaints received were for the Outpatients Department within the Bristol Heart Institute (BHI), five of the complaints relate to Ward 52 within the BHI, four of the complaints relate to the Chemotherapy Day Unit and four complaints relate to the Grown Up Congenital Heart Disease (GUCH) service.

Recovery plan, including expected date performance will be restored:

August and September complaints data will be discussed in detail by Heads of Nursing at the Trust's next Patient Experience Group meeting on 16th October 2014.

QUALITY

Q12. EXCEPTION REPORT: Average Number of Ward Moves	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

This is one of our quality objectives for 2014/15 and is defined as the average number of ward moves per patient spell. This measure includes only spells where patient has had at least 2 overnight stays and is calculated as total ward moves divided by total spells.

We are aiming to achieve a 15% reduction by quarter 4 2014/15, from a 2013/14 baseline of 2.26. We have calculated seasonally-adjusted quarterly targets of 2.32 (Quarter 1), 2.2 (Quarter 2), 2.09 (Quarter 3) and 1.97 (Quarter 4).

Performance in the period, including reasons for the exception:

In the month of August 2014 there was an average of 2.38 ward moves per patient.

Recovery plan, including expected date performance will be restored:

- The lay-out of the wards and increase in single rooms in the new build should decrease the necessity to move patients to address gender, specialty, acuity and isolation requirements;
- Increased bed numbers in Older Persons Assessment Unit and Medical Assessment Unit will decrease the need for transfers off to down-stream wards. The current timetable for moving to the new wards (the Medical and Older Persons Assessment Units) is February 2015, putting the potential delivery of the improvement at risk for Quarter 4;
- Actions taken to improve patient flow, as detailed in the A&E 4-hour Exception Report in the Access section of this report, should also help to ensure patients get to the right bed, following any assessment period they need, and don't therefore need to move again.

1.6 SUPPORTING INFORMATION

1.6.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the **Trust Services Division:**

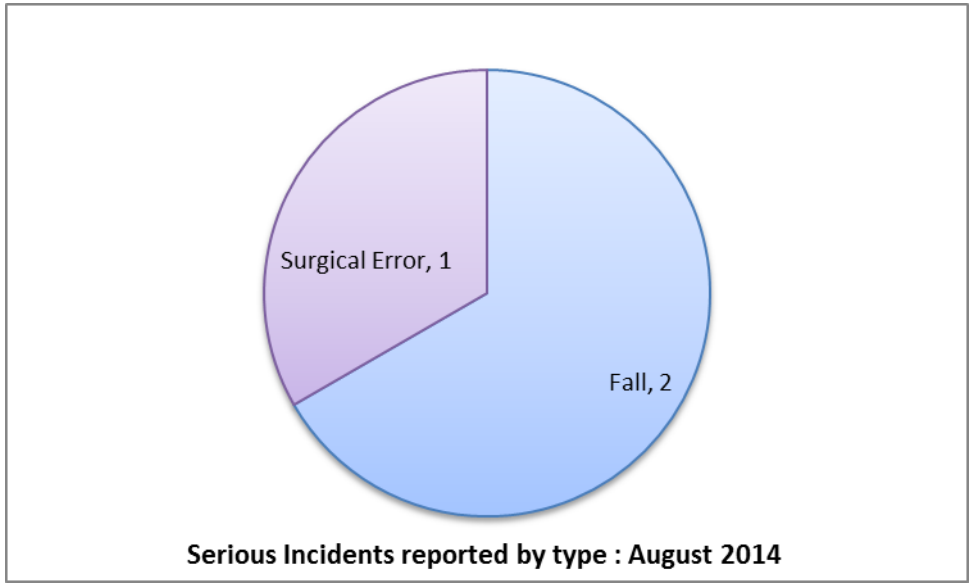
- The Trust was again awarded a CHKS Top 40 Hospital award. These awards are for recognising and rewarding 40 of the best performing CHKS client trusts across the UK. The Top 40 Awards are based on the evaluation of 22 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care;
- We conducted a public consultation event in January which led to the development of a set of quality objectives for 2014/15 based on patient flow;
- We have developed ward-level reporting of patient-reported experience scores, enabling us to begin to triangulate this information with complaints data to identify potential 'hot spots' and follow this up with positive interventions such as the 'Patient experience at heart' initiative, helping staff to reflect upon what great patient experience looks and feels like;
- We have secure funding from The Health Foundation to complete our "Southwest STAR" project to test two innovations designed to improve patient safety in emergency care systems as part of Shine programme. The Shine programme focuses on aspects of health care quality that reflect the key issues facing the UK health service and offers participating organisations the opportunity to demonstrate the feasibility of innovation as the key driver for sustained quality improvements. Our "Southwest STAR project is underway and is focussed in the Emergency Department. It comprises a safety 'checklist' to encompass safety, assessment and triage; and an information technology innovation that helps the clinical site team to place inpatients in the most appropriate bed. The team anticipate that the project will enhance patient safety and outcomes in a cost effective and demonstrable way;
- As part of our transformation programme we have set up workshops with clinical teams, health community partners and voluntary organisations to improve integrated working for patients with complex discharge needs. This has launched a number of joint projects, including the development of an enhanced recovery approach in medicine to accelerate and better prepare patients for discharge;
- In August, we held a Trust wide "Delivering Best Care" week designed and supported by our transformation team which helped us to focus on the Care Quality Commission's Key Lines of Enquiry, and identify both areas of good practice as well as local and trust wide improvement themes;
- We have developed ward level Performance Books which provide a single report for ward based performance data so that managers can access their data in one place and see their ward's contribution to Divisional and Trust performance. These contain relevant ward level metrics as shown in the quality dashboard and also workforce measures such as sickness and bank/agency use. We plan to further develop these to include other data such as budgetary information and electronic discharge summary completion compliance levels;

QUALITY

- The Trust's five year proactive patient safety improvement programme, Safer Care Southwest is coming to an end this year. The programme has an overall aim to reduce mortality by 15% and adverse events by 30% over five years. There are approximately 50 further specific patient safety measures which are monitored and support the overall aims. Progress on these specific areas is measured using an improvement methodology assessment scale from the Institute of Health Improvement, Boston, USA from 0.0 to 5.0:
    - The Trust has achieved its overall 15% reduction in mortality well in advance of the programme's end date and has also reached the 30% reduction in adverse events;
    - Overall progress has moved from 3.5 on the improvement methodology assessment scale in the past 12 months to 4.5. The programme will be fully evaluated at the end of 2014/15 and will be replaced by a new patient safety improvement programme supported by the newly formed West of England Patient Safety Collaborative.
- Finally, we are hosting two members of the Leadership Academy Fast track Executive program each with specific objectives to create continuous sustainable learning cycles to drive up public value. Aidan Fowler is focussed on the strategic implementation plans and specifically the collaborative optimisation of South Bristol Community Hospital whilst Penny Hilton is listening and understanding staff across the organisation to drive a culture of continuous improvement in staff engagement as a means to deliver consistent, compassionate care for patients. The Trust has been open and transparent in granting access and participation to all executive business and has dedicated time in support of learning for their future executive roles.

1.6.2 SERIOUS INCIDENT THEMES

There were three serious incidents reported in August as shown below:



Further details are provided in the table below:

Date of Incident	SI Number	Division	Reported within 48 hours	Status	Incident Details	Initial assessment of harm	Investigation
11/08/2014	2014 26616	Surgery, Head & Neck	Yes	Open	Patient fall resulting in fracture.	Major	Investigation underway

QUALITY

20/08/2014	2014 27747	Surgery, Head & Neck	Yes	Open	Surgical Error*	Minor	Investigation underway
28/08/2014	2014 28068	Medicine	Yes	Open	Fall resulting in fracture	Major	Investigation underway

**There is currently discussion taking place with commissioners as to whether this incident meets the criteria for a never event or not and at the time of writing the decision is to review the position again once the investigation is complete.*

WORKFORCE

2.1 SUMMARY

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

 **Achieving**	 **Underachieving**	 **Failing**
	- Sickness absence – compared with target	- Workforce expenditure - compared with budget - Workforce numbers - compared with budgeted establishment - Bank and agency usage - compared with target - Vacancies - compared with target - Turnover - compared with target

2.2 EXCEPTION REPORTS

Although it is recognised that many of the contributory factors are impacting on more than one workforce KPI, an exception report is provided for each of the RED-rated indicators, which in August 2014 were as follows:

- Workforce expenditure – compared with budget
- Workforce numbers – compared with budgeted establishment
- Bank and agency usage – compared with target
- Vacancies – compared with target
- Turnover - compared with target

Key Performance Indicators (KPIs) in the quarterly workforce report 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 annual Operating Plan process. For those targets which are below plan, exception reports are provided which detail performance against target. Graphs in the Supporting Information section are continuous from the previous year to provide a rolling perspective on performance.

KPIs were determined on the basis of previous years' performance and through benchmarking with other comparable trusts. Some ambition was built into the KPIs to move UH Bristol to the upper quartile in respect of staff experience.

Whilst it is clear from our performance to date and from new benchmarking that some of our KPIs may be over-ambitious, as reported in the quarterly workforce report for April – June 2014, the intense focus on our workforce agenda continues. A Mid-Year review of our KPIs is underway and an update will be provided with the next quarterly workforce report.

WORKFORCE

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

Description of how the standard is measured:

Workforce expenditure in £'000 including substantive, bank and agency staff, waiting list initiative and overtime compared with budget.

Performance in the period, including reasons for the exception:

During August, the pay expenditure to budget variance was 1.3%, compared with 0.4% in July, resulting in a cumulative position at the end of month 5 of 1.3% adverse variance.

	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates and Facilities)	Facilities & Estates
August 2014	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Actual Expenditure	27,752	3,363	3,975	3,214	6,130	7,161	1,813	1,679
Planned Expenditure	28,121	3,319	4,059	3,329	6,364	7,140	1,846	1,698
variance target +/-	(370)	43	(84)	(114)	(234)	22	(33)	(19)
Percentage variance	(1.3%)	1.3%	(2.1%)	(3.4%)	(3.7%)	0.3%	(1.8%)	(1.1%)

The main reasons for the overspend of £370k in August were staffing levels above plan, premium payments and excess use of bank and agency. Reasons by division include:

Medicine Division

There was a 56% increase in the use of agency nursing, including an increase of 85% in Registered Mental Nurses and 290% in nursing assistants providing one to one observation. Despite the sustained closure of wards 20 and 21 the anticipated reductions in nursing cost have not materialised.

Surgery, Head & Neck Division

Adverse variance on nursing costs improved to £20k in month, with expenditure of £73k on nursing bank and £92k on agency, mainly in Intensive Care Unit, offset by vacancies of £185k. Overspends in the Division are largely due to the underlying deficit.

Specialised Services

There is an adverse variance of £247k in nursing budgets, £200k of which (including £116k Agency spend) relates to cost pressures resulting from the

WORKFORCE

Adult Bone Marrow Transfer where staffing levels have been increased following external review. Maternity leave expenditure has exceeded the funded 1% by £59k.

Facilities & Estates

During August substantive Ancillary Staff reported a favourable variance of £130k due to 63.3 FTE (Full Time Equivalent) vacancies. This is offset by an adverse variance of £130k due to the use of Trust Bank Staff (68.7 Whole Time Equivalent - WTE), an increase from £80k in the previous month, and £39k (11.12 WTE) due to the use of Agency Staff.

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

Given that the adverse variance in pay expenditure is attributable to overall staffing levels and the use of temporary staffing, the recovery plan is described in the following two exception reports.

WORKFORCE

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

Description of how the standard is measured:

Workforce numbers in Full Time Equivalent (FTE) including substantive, bank and agency staff, compared with targets set by Divisions for 2014/15.

Performance in the period, including reasons for the exception:

Total workforce numbers (substantive and bank and agency) increased by 0.6% compared with July 2014. This month, total workforce numbers were 1.7% above budgeted FTE.

	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates and Facilities)	Facilities & Estates
August 2014	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE
Actual Employed	7292.5	916.9	998.5	791.6	1613.7	1640.3	642.0	689.5
Bank and Agency	570.8	22.4	165.1	60.7	105.8	92.9	42.2	81.7
Total Workforce Numbers	7863.2	939.3	1163.6	852.3	1719.5	1733.2	684.2	771.1
Budgeted Numbers	7729.1	932.7	1090.3	810.1	1711.5	1731.4	690.3	762.8
variance target +/-	(134.1)	(6.6)	(73.2)	(42.2)	(8.0)	(1.8)	6.0	(8.3)
	1.7%	**0.7%**	**6.7%**	**5.2%**	**0.5%**	**0.1%**	**-0.9%**	**1.1%**

The biggest month on month movement is as follows:

Medicine Division

Workforce numbers were over budget by 6.7% (73.2 FTE) compared with 6.2% last month.

Specialised Services

Workforce numbers were over budget by 5.2% (42.2 FTE) compared with 0.9% last month.

WORKFORCE

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

In the medium to long term the recovery plan to ensure staffing levels align with budgets includes building capability to improve workforce and capacity planning. The short term actions are described in the bank and agency exception report.

WORKFORCE

W3. 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:

As a percentage of total staffing numbers, there is an increase in the proportion of temporary staffing utilised. During August, temporary staffing comprised 7.3% of total staffing numbers (FTE) compared with 6.3% last month, and an average over the last year of 5.6%. Within this figure, agency staffing accounted for 1.4% of total staffing numbers for July, compared to the average for the year of 1.1%.

Usage of bank and agency continues to be for the following reasons:

- Workload and clinical needs, extra capacity and administrative workload – this reduced to 31.0% of overall usage, compared with 30.7% last month, largely due to the closure of extra capacity wards in Medicine, but there was ongoing demand in Specialised Services following the transfer of the Bone Marrow Transplant Service, and increased Administrative and Clerical agency usage in the Bristol Dental Hospital to support waiting list reductions;
- Cover for vacancies – this remained at 27.0%, with usage across nursing in all bed holding divisions and Facilities & Estates, particularly with the opening of the two new wards;
- Cover for sickness absence – this reduced to 14.8% compared with 15.4% last month, which included Facilities & Estates due to absence in the Relief Team, and across a range of ward areas;
- Nursing assistant one-to-one care – this increased this month, from 5.5% to 7.3% of usage, and included wards across Medicine, Surgery Head & Neck and Specialised Services, with high numbers of patients assessed to require enhanced observation.

In addition, there were increased numbers of newly qualified staff this month awaiting registration numbers in Specialised Services, and undergoing orientation in all bed holding Divisions.

An overview by Division is as follows:

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
Bank and Agency August 2013	474.1	17.2	144.4	58.8	99.2	68.9	44.0	41.5

WORKFORCE

Actual August 2014	**570.8**	**22.4**	**165.1**	**60.7**	**105.8**	**92.9**	**42.2**	**81.7**
Target	313.2	18.5	83.1	38.5	60.4	52.4	41.5	18.8

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

General actions to reduce use of bank and agency are the continued focus on recruitment to vacancies (see Vacancy Exception Report W2 for progress) and targeting sickness absence.

Divisional action plans, include more efficient rostering; strengthening controls; and the development and implementation of an Enhanced Observation Policy to reduce the use of Nursing Assistant one to ones.

The Division of Medicine, where bank and agency usage is highest, has a detailed action plan which includes review of all requests by Senior Managers, and advance rostering so staffing needs are well planned and bank requirements assessed appropriately.

As part of the Quarterly Performance Review process planned levels of temporary staff will be re-assessed in light of activity and capacity, in the context of overall pay budgets.

WORKFORCE

W4. EXCEPTION REPORT: Vacancy Levels	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

Vacancy is measured as the difference between the full time equivalent budgeted establishment and the full time equivalent substantively employed, represented as a percentage, compared to a Trust wide target of 5%.

Performance in the period, including reasons for the exception:

There is a slight increase in vacancy levels from 5.4% to 5.6% this month. Vacancies by Division are shown in the table below.

Vacancy Levels by Division	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Vacancy August 2013	5.4%	2.5%	0.6%	3.9%	7.4%	7.8%	7.1%	6.3%
Actual August 2014	**5.6%**	**1.7%**	**8.4%**	**2.3%**	**5.7%**	**5.3%**	**7.0%**	**9.6%**
FTE vacancy August 2014	436.6	15.8	91.9	18.5	97.8	91.1	48.3	73.4

There have been increases in vacancy levels reported for Trust Services, Facilities & Estates, Medicine and Surgery Head & Neck, but reductions within Specialised Services and Women's and Children's. Reasons continue to be the following:

- Vacancies in Facilities & Estates have increased to 9.6% this month compared with 9.5% last month, mainly due to an increase in budgeted establishment;
- Nursing & Midwifery vacancies Trust-wide have increased from 6.7% last month to 8% this month. Rates are highest in the Divisions of Medicine and Surgery, Head & Neck.

UH Bristol compares favourably with benchmarking for nursing vacancies in June 2014 which showed an average rate of 9.3% amongst 8 Association of United Kingdom University Hospitals Trusts, and an overall vacancy rate of 8% across all staff groups.

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

Given the criticality of ensuring vacancies are filled and that there are sustainable recruitment plans in place, particularly going into our winter period, the Senior Leadership Team has commissioned an urgent 'deep dive' into the recruitment process, including our marketing approach, with a view to

considering creative solutions on 1st October 2014.

Progress on the ongoing campaign recruitment to the two staff groups with the highest numbers of vacancies is detailed below:

Ancillary (Cleaning, Catering and Portering) Recruitment

There were 12.7 FTE starters in August, and 6.7 FTE left in the same period. Domestic Assistant vacancies, including for the BRI Redevelopment, currently stand at 63 FTE. Bank, agency and overtime continue to be used over the coming months to ensure effective services are sustained.

Nurse Recruitment

Highlights are as follows:

- Focus on recruitment to include attendance at the Royal College of Nursing recruitment fair in London (September 2014);
- Most of the vacant nursing posts associated with the transfer of Specialist Paediatrics have been appointed to, with start dates between July and October across theatres, renal nursing and the Intensive Care Unit. The reduction in vacancies will not be fully reflected in the Finance Ledger until after October;
- Division of Medicine is working with the recruitment team to launch a specific campaign to target areas of high vacancy in the Division;
- Vacancies are not anticipated to fully recover for at least three months, due to the start dates planned for new recruits.

WORKFORCE

W5. EXCEPTION REPORT: Rolling Turnover	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

Turnover is measured as the total (Full Time Equivalent) permanent employees who have left, as a percentage of the 12 month average total (Full Time Equivalent) permanent staff in post, presented as a cumulative, rolling figure compared with a trust wide trajectory to achieve 10% by the end of 2014/15.

Performance in the period, including reasons for the exception:

Rolling turnover has increased to 12.9% in August, compared with 12.1% in the previous month. We have recently reviewed the trusts we benchmark against to ensure comparability, and UH Bristol rates remain significantly above the average of 9.5%.

Rates by Division are shown in the table below.

Turnover by Division	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Turnover August 2013	11.7%	9.4%	12.8%	10.9%	13.5%	12.5%	10.8%	9.6%
Actual turnover August 2014	12.9%	10.5%	15.5%	16.1%	13.1%	9.5%	12.5%	15.3%
Target	10.6%	8.8%	11.9%	11.6%	10.5%	9.7%	10.9%	11.1%

Specialised Services has had the highest divisional turnover and also highest variance against target this month; the majority of leavers were registered nurses (5.6 FTE), and the biggest reason given for leaving was other/not known. The Division of Medicine also had high turnover particularly among nursing staff. The biggest reason for leavers in Facilities & Estates continued to be dismissal following disciplinary procedures.

Reasons for exceeding target include:

- Nearly a quarter (27.9 FTE) of leavers during August left due to relocation, an increase compared with last month (15.1 FTE, 16.6%); however this is similar to the same period last year, when 26.6% of leavers relocated;
- Major change has previously been associated with turnover, and this was reflected on the BRI Redevelopment project risk register, but despite measures to reduce uncertainty, there appears to have been a general increase in turnover directly before the ward moves;

WORKFORCE

- Turnover of Nursing Assistants generally increase at this time of year, as they leave to go to university for nurse, medical or other health professional training in August;
- Retirements have reduced in August, only comprising 4.8% of leavers FTE, compared with 18.3% last month.

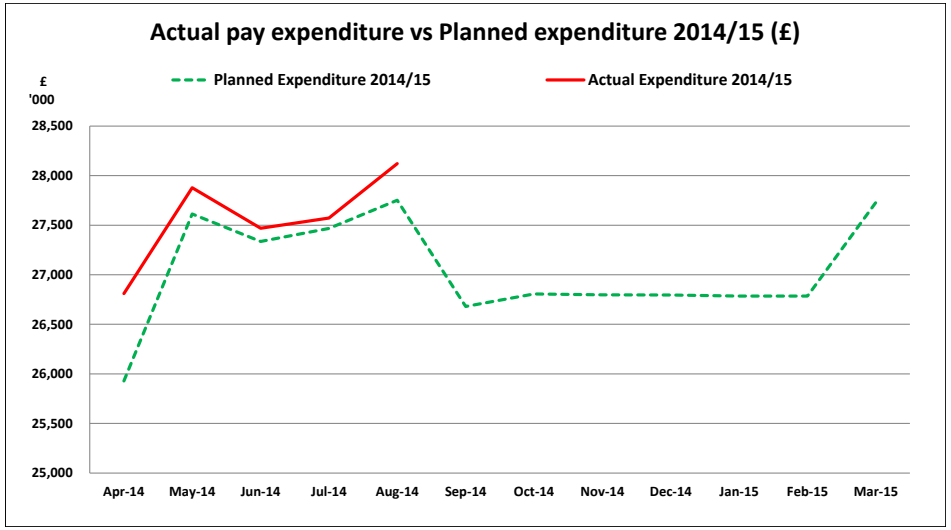
Recovery plan, including progress and expected date performance will be restored:

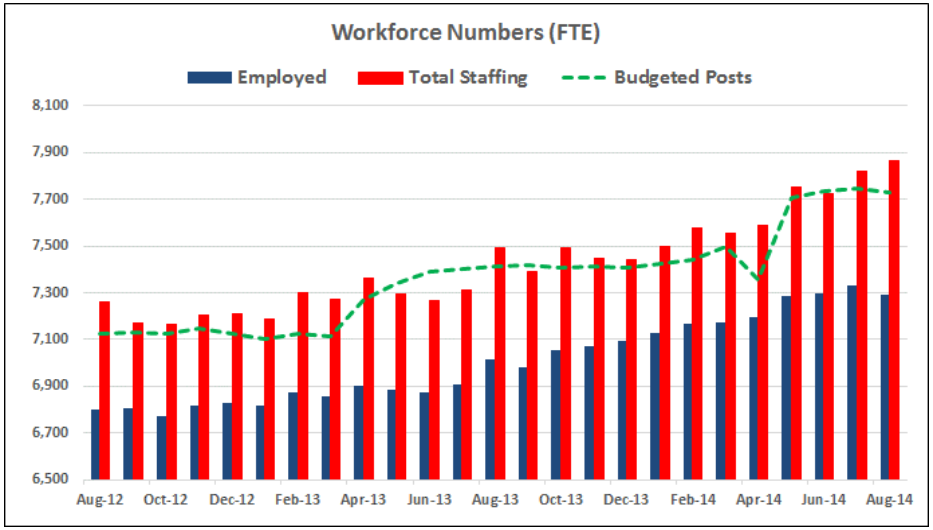
Recovery plans for retention of staff have been previously described in both monthly and quarterly workforce reports. However, these are being re-examined to test impact as part of the development of the Workforce and Organisational Development Strategy and associated work programmes.

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.





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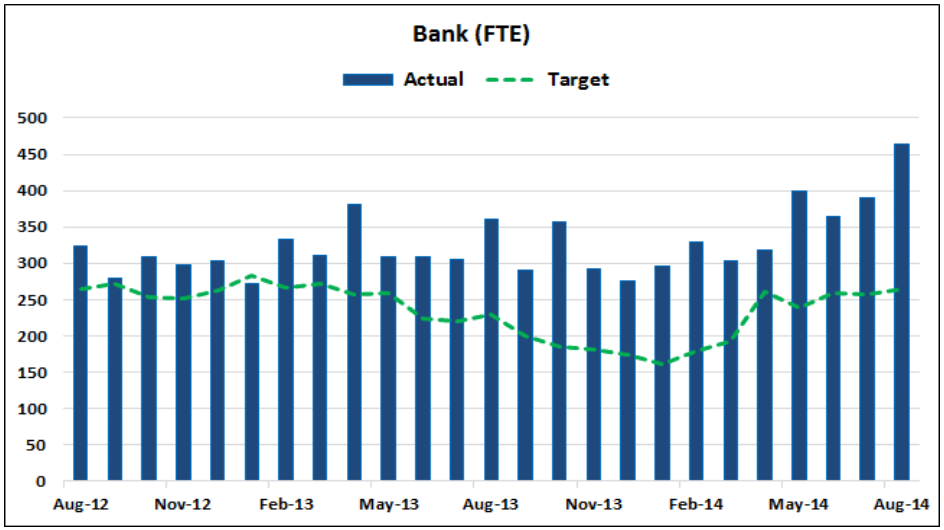
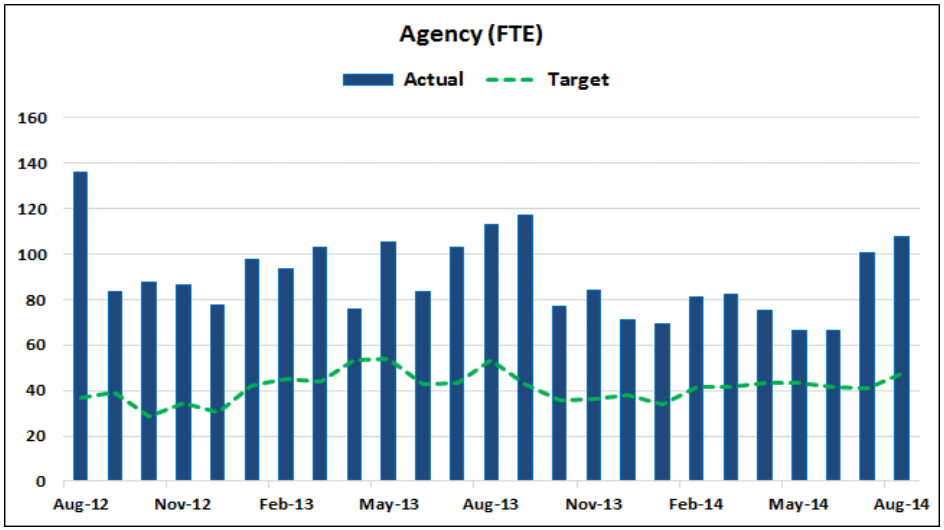
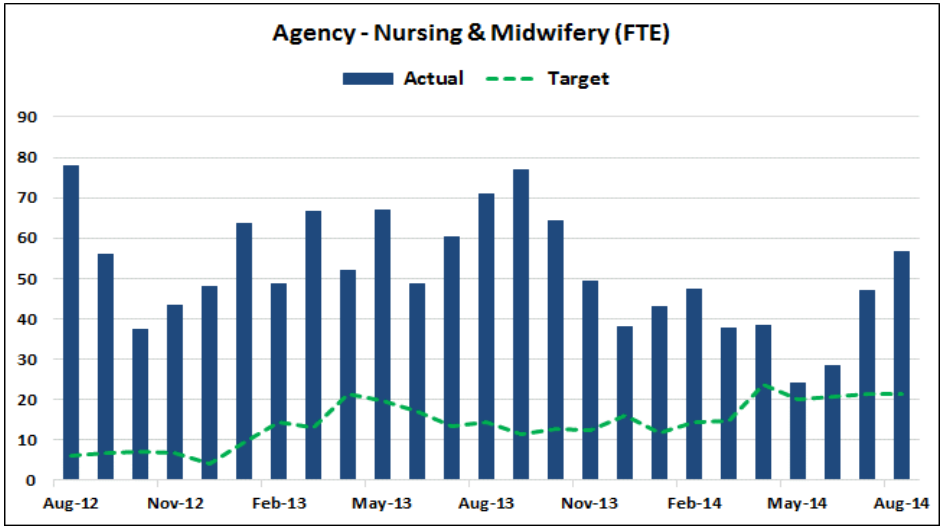
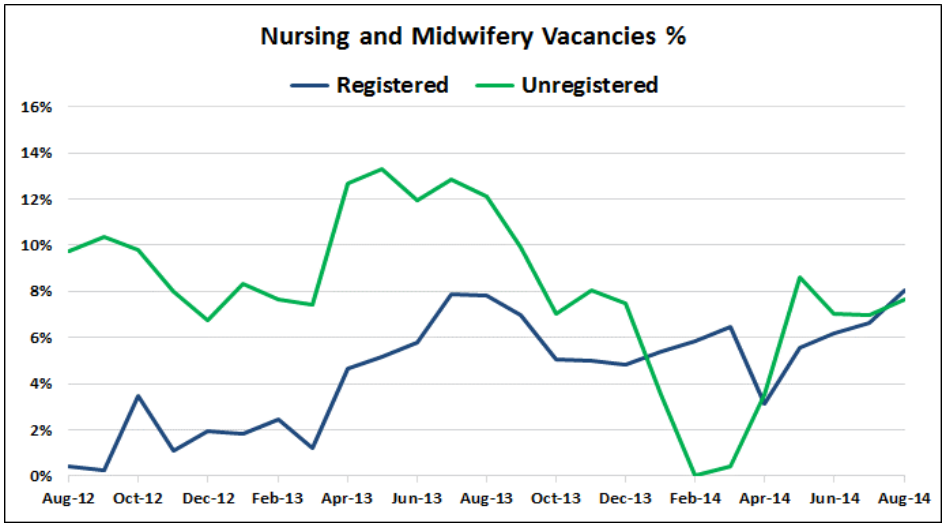
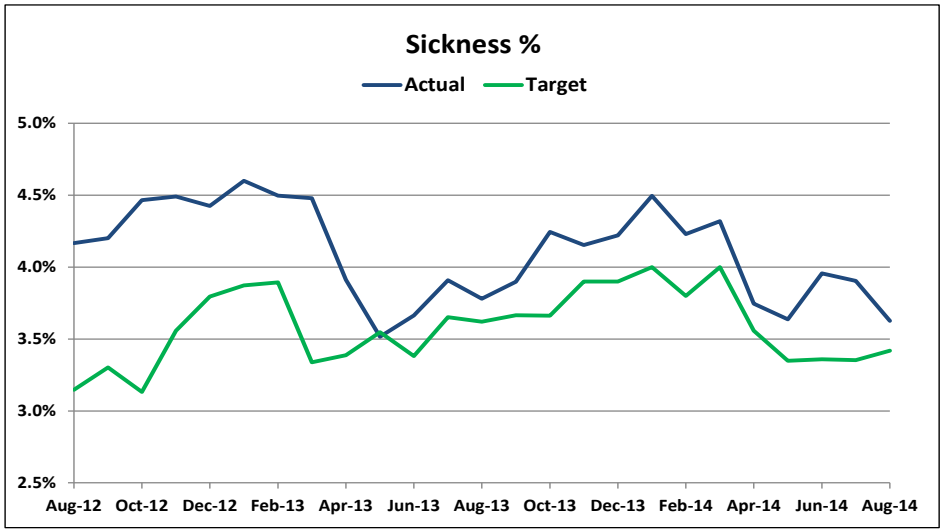

Bank (FTE)
Actual
Target
500
450
400
350
300
250
200
150
100
50
0
Aug-12
Nov-12
Feb-13
May-13
Aug-13
Nov-13
Feb-14
May-14
Aug-14

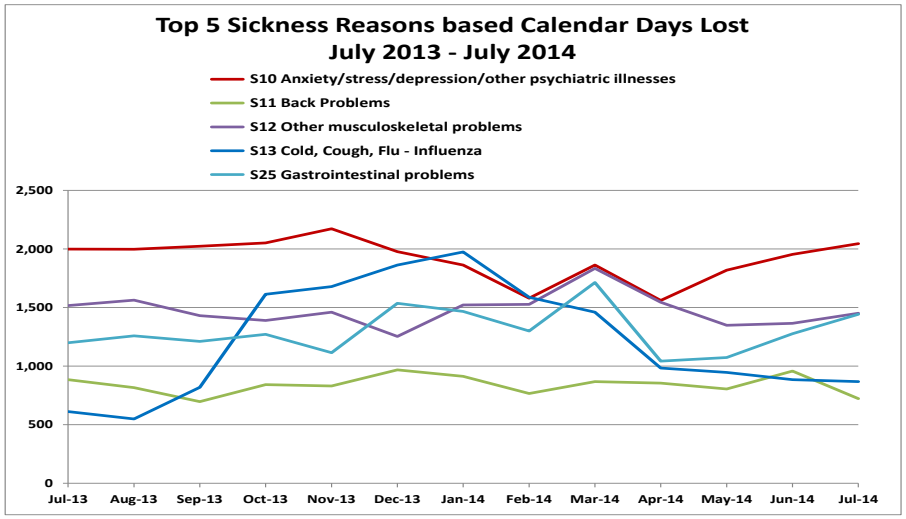

Agency (FTE)
Actual
Target
160
140
120
100
80
60
40
20
0
Aug-12
Nov-12
Feb-13
May-13
Aug-13
Nov-13
Feb-14
May-14
Aug-14

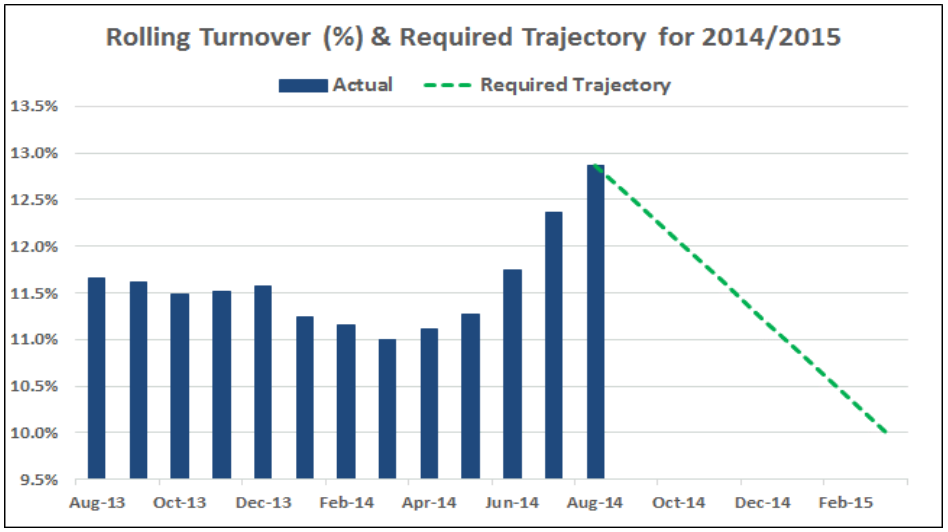

Agency - Nursing & Midwifery (FTE)
Actual
Target
90
80
70
60
50
40
30
20
10
0
Aug-12
Nov-12
Feb-13
May-13
Aug-13
Nov-13
Feb-14
May-14
Aug-14


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

WORKFORCE



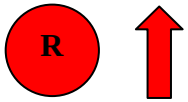
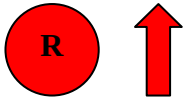
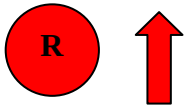
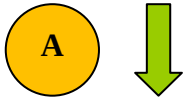
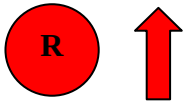
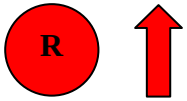




Please note: Sickness absence reasons reflect the position to July 2014 due to August's data not being available at the time of this report.

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 August. 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 increased from 0.38% to 1.33% in month compared with July 2014.	See summary, supporting information and exception report.
Workforce Numbers (FTE)		Total workforce numbers including bank and agency increased by 43.3 FTE compared with the previous month. Workforce numbers were 1.7% above budgeted FTE. This compares with July 2014, when numbers were 1.0% above budgeted establishment.	See summary, supporting information and exception report.
Bank/ Agency (FTE)		Bank increased by 73.9 FTE to 463.2 FTE (compared with a target of 265.5 FTE) and agency increased by 7.0 FTE to 107.6 FTE (compared with a target of 47.8 FTE) in August 2014.	See summary, supporting information and exception report.
Sickness absence (%)		Sickness absence is reported for August when it was 3.6% compared with a target of 3.4%, 0.2 percentage points above target, and compares with 4.0% in July.	See summary, supporting information.
Turnover (%)		Rolling turnover (excluding fixed term contracts, junior doctors, and bank) increased to 12.9% compared a target of 10.6% and up 0.5 percentage points compared with July.	See summary, supporting information and exception report.
Vacancy (%)		Vacancies increased from 5.4% last month to 5.6%, compared with a target of 5%.	See summary, supporting information and exception report.

Note: RAG (Red, Amber, and 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	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	August 14 Target
Budgeted Posts (FTE)	7415.6	7420.3	7408.3	7411.1	7406.4	7424.8	7442.0	7499.3	7355.2	7709.5	7732.9	7744.9	7729.1	7748.9
Total Staffing (FTE)	7017.4	6979.7	7056.7	7071.7	7093.7	7130.2	7167.3	7170.6	7193.7	7285.6	7296.4	7330.0	7292.5	7409.2
Bank (FTE) Admin & Clerical	95.3	67.1	80.0	63.9	58.4	59.0	67.4	64.9	71.3	89.2	83.7	88.8	103.5	70.5
Bank (FTE) Ancillary Staff	37.6	27.4	36.7	27.0	25.6	30.7	35.2	34.6	38.0	54.6	51.8	51.9	73.3	20.2
Bank (FTE) Nursing & Midwifery	217.1	188.6	232.2	194.5	184.2	197.0	220.2	197.4	203.6	249.5	220.8	241.8	274.2	165.5
Agency (FTE) Admin & Clerical	19.9	27.3	12.2	14.8	17.4	13.5	27.1	25.7	23.4	22.4	21.1	19.3	27.7	12.3
Agency (FTE) Ancillary Staff	10.5	-0.5	-10.0	10.7	10.5	3.7	0.0	8.3	0.0	6.8	4.9	15.0	12.1	2.4
Agency (FTE) Nursing & Midwifery	70.9	76.9	64.1	49.4	38.1	43.1	47.2	37.5	38.5	24.1	28.3	47.1	56.7	21.3
Overtime	71.1	96.1	67.7	55.8	58.2	60.1	54.7	83.7	76.4	48.2	62.3	49.6	67.5	48.7
Sickness absence[1] Rate (%)	3.8%	3.9%	4.2%	4.2%	4.2%	4.5%	4.2%	4.3%	3.7%	3.6%	4.0%	4.0%	3.6%	3.4%
Appraisal (%)	86.1%	85.5%	86.1%	87.3%	88.8%	88.5%	87.9%	85.9%	87.1%	86.3%	87.2%	86.3%	86.9%	85.0%
Consultant Appraisal[5] (%)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	89.1%	89.2%	83.0%	85.5%	88.8%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	18.7%	18.5%	18.4%	18.3%	18.3%	17.9%	18.0%	17.8%	17.8%	18.0%	18.6%	19.0%	19.3%	
Rolling Average Turnover[3] (with exclusions) (%)	11.7%	11.6%	11.5%	11.5%	11.6%	11.2%	11.2%	11.0%	11.1%	11.3%	11.7%	12.4%	12.9%	10.6%
Vacancy[4] Rate (%)	5.4%	5.9%	4.7%	4.6%	4.2%	4.0%	3.7%	4.4%	2.2%	5.5%	5.6%	5.4%	5.6%	≤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 15 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 August 2014**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 2)***, and/or the ***month***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS operating framework and NHS Constitution.

Achieving (9)	**Underachieving (1)**
- 62-day referral to treatment cancer standard - *Screening referred* - 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* - 31-day diagnosis to treatment cancer standard - *first treatment* - 2-week wait urgent GP referral cancer standard - A&E Left without being seen rate - A&E Time to Initial Assessment + A&E Time to Treatment - A&E Unplanned re-attendance	- Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved*
Failing (11)	**Not reported/scored (0)**
- A&E Maximum waiting time (4-hours) - Ambulance hand-over delays over 30 minutes (year-on-year reduction) - Delayed Discharges - Referral to Treatment Time for non-admitted patients - Referral to Treatment Time for admitted patients - Referral to Treatment Time for incomplete pathways - 62-day referral to treatment cancer standard – *GP referred* - Last-minute cancelled (LMC) operations + 28-day readmission - Reperfusion times (door to balloon time of 90 minutes) - 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 August. Indicators are shown as being **failed** where the required standard is not achieved for the quarter to date. Indicators are shown as being **underachieved** if there has been a failure to achieve the national target in the current month, but the quarter is currently being achieved, or where a local standard is not being met.*

3.2 ACCESS DASHBOARD

		Thresholds		Previous YTD	Year to date (YTD)	Month												Quarter			
	Target	Green	Red			Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	96.8%	96.8%	95.7%	97.2%	95.0%	96.3%	98.0%	95.4%	98.0%	98.4%	97.1%	97.0%	96.0%	97.0%	Cancer standards report two months in arrears	96.4%	97.4%	96.7%	97.0%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	98.1%	97.1%	96.5%	94.3%	96.9%	99.5%	97.6%	96.2%	94.0%	97.8%	97.5%	97.9%	96.2%	96.8%		98.0%	96.0%	97.2%	96.8%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.8%	99.8%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%		99.7%	99.7%	99.7%	100.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.7%	94.7%	95.2%	89.3%	100.0%	93.5%	95.0%	93.5%	97.6%	91.8%	97.9%	93.2%	93.5%	94.0%		96.9%	94.1%	94.9%	94.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	98.5%	97.3%	98.1%	97.1%	97.1%	97.6%	99.0%	92.3%	99.5%	95.6%	97.9%	98.9%	95.1%	97.6%		97.8%	95.7%	97.2%	97.6%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.3%	80.1%	77.9%	82.7%	85.6%	83.1%	85.2%	72.9%	77.4%	74.8%	75.3%	81.1%	85.1%	79.4%		84.6%	75.1%	80.4%	79.4%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	93.2%	90.4%	100.0%	93.9%	91.8%	84.2%	97.6%	98.0%	94.9%	88.9%	90.3%	90.2%	90.9%	90.2%		90.5%	94.4%	90.4%	90.2%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	98.3%	93.0%	88.2%	100.0%	86.7%	84.2%	93.1%	79.3%	75.6%	97.0%	97.5%	86.1%	100.0%	83.3%		88.3%	85.3%	95.3%	83.3%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	93.3%	88.9%	92.8%	92.2%	92.9%	91.6%	92.1%	92.8%	92.4%	90.5%	91.9%	91.8%	90.1%	87.2%	84.4%	92.3%	92.0%	91.2%	85.9%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	94.1%	91.9%	91.5%	91.3%	92.4%	91.3%	94.0%	92.0%	92.7%	93.1%	93.6%	94.0%	92.8%	89.7%	90.0%	92.5%	92.6%	93.4%	89.8%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.4%	92.1%	92.3%	92.6%	92.9%	93.1%	92.2%	92.6%	92.4%	93.1%	92.7%	92.5%	92.1%	92.0%	91.1%	92.7%	92.7%	92.4%	91.5%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	94.3%	94.0%	95.6%	97.1%	95.1%	95.4%	90.8%	91.6%	90.1%	92.1%	94.5%	94.3%	95.2%	92.4%	93.7%	93.7%	91.3%	94.7%	93.0%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	26	12	13	12	13	13	14	12	24	15	14	12	11	13	12	13	14	12	12
	A&E Time to treatment decision (median) - in minutes	60	60	52	54	47	49	53	53	53	46	55	54	53	57	55	59	47	53	51	55	53
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	1.8%	2.0%	0.7%	0.6%	2.3%	2.2%	3.0%	2.8%	2.5%	2.4%	2.7%	2.2%	2.4%	0.2%	2.5%	2.5%	2.5%	2.4%	1.3%
	A&E Left without being seen	5%	5%	1.7%	1.8%	1.7%	1.8%	2.2%	2.1%	2.1%	2.0%	1.8%	1.7%	1.5%	1.9%	1.4%	2.2%	2.0%	2.1%	1.8%	1.6%	2.1%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.08%	1.08%	0.85%	0.72%	0.65%	0.96%	1.02%	1.18%	1.44%	0.92%	0.98%	0.96%	1.10%	1.35%	0.97%	0.85%	1.17%	1.02%	1.17%
	28 Day Readmissions	95%	85%	86.9%	91.9%	88.4%	93.6%	95.0%	95.0%	92.6%	93.6%	88.6%	89.7%	94.2%	85.2%	94.4%	95.3%	90.5%	94.0%	90.3%	91.3%	92.6%
	6-week wait for key diagnostics	99%	99%	98.1%	97.4%	98.2%	98.5%	98.9%	99.5%	98.8%	98.0%	99.2%	99.2%	98.3%	96.6%	97.3%	97.7%	97.0%	99.1%	98.8%	97.4%	97.3%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	83.1%	79.7%	84.4%	65.0%	86.2%	91.2%	81.6%	77.5%	82.9%	77.1%	78.6%	78.3%	82.1%	80.6%		86.1%	78.9%	79.4%	80.6%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	93.4%	93.5%	90.6%	95.0%	96.6%	97.1%	89.5%	90.0%	91.4%	91.7%	96.4%	93.5%	96.4%	88.9%		94.1%	91.1%	95.1%	88.9%
	Delayed discharges (Green to Go List)	30	41	Not applicable	53.6	60	65	57	50	52	60	73	58	56	51	58	50	53	53.0	63.7	55.0	51.5
	Ambulance hand-over delays (over 30 minutes) - *year-on-year reduction*	0	103.0	114.4	111.6	52	44	63	70	120	94	137	105	96	100	79	139	144	84.3	112.0	91.7	141.5

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 A&E Time to Initial Assessment figures exclude the Bristol Children's Hospital performance, due to problems with reporting accurate figures from Medway Patient Administration System (PAS). Work is ongoing to address the data issues.
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:

- Referral to Treatment Time (RTT) incomplete pathways ↓ (down from 92.0% in July to 91.1% in August)
- Referral to Treatment Time (RTT) admitted pathways ↓ (down from 87.2% in July to 84.4% in August) – this was part of a planned failure against the standard
- 62-day referral to treatment cancer standard – *GP referred* ↓ (down from 85.1% in June to 79.4% in July)
- 28-day readmission following a last minute cancellation ↓ (down from 95.3% in July to 90.5% in August)
- Reperfusion times (door to balloon time of 90 minutes) ↓ (down from 96.4% in June to 88.9% in July)

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

3.4 EXCEPTION REPORTS

Exception reports are provided for eight of the RED rated performance indicators. An exception report isn't provided for the Referral to Treatment Time standard for admitted pathways, which was a planned failure in the month as part of a national initiative to reduce the number of patients awaiting elective treatment.

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 key measures of patient flow, Delayed Discharges and Ambulance Hand-over delay performance 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 (LMC)
2) 28-day readmission following an LMC
3) 62-day referral to treatment cancer standard – GP referred
4) Referral to Treatment Time (RTT) Non-admitted pathways standard
5) Referral to Treatment Time (RTT) Incomplete pathways standard
6) A&E 4-hour maximum wait
7) Six week wait for diagnostic tests
8) Reperfusion times (door to balloon time of 90 minutes)

ACCESS STANDARDS

A1-A2. EXCEPTION REPORT: Last-minute cancellation (LMC) + 28-day readmission following a LMC	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 August (0.97% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in August were as follows:

- 26% (14 cancellations) were due to the surgeon being taken ill or other surgeon unavailability
- 19% (10 cancellations) were due to other emergency patients being prioritised on lists
- 11% (6 cancellations) were due to no ward bed being available to admit a patient to
- 11% (6 cancellations) were due to patients already in theatre proving more complex than expected
- 33% (11 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging

Of the 54 cancellations, 20 were day-cases and 34 were inpatients (37% 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, which is more likely to impact inpatient than day-case procedures. There were, unusually, a total of fourteen cancellations in August due to consultants not being available. This affected a number of different specialties, with six cancellations in Dermatology and four in Paediatric Plastic Surgery.

Similar to July, ward bed availability was not the single highest cause of cancellations this month. This reflects the improvements seen in some aspects of patient flow in the period, mainly around the discharge of long waiters.

In August, 90.5% of patients cancelled in the previous month were readmitted within 28 days of the cancellation. There were 8 breaches of standard in the month. Three of these patients were due for readmission to the Bristol Children's Hospital, two of which could not be re-admitted within 28-days due to more urgent patients taking priority, with the third unable to be readmitted due to a booking error. The remaining five patients were due for surgery within the Bristol Royal Infirmary and were not re-admitted within 28-days due to more clinically urgent patients requiring admission.

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 – A5);
- 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 adult critical care 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.
- Specialty specific plans are shown below:

Specialty	Action
Vascular Surgery	Implement pre-assessment and day case pathway for angioplasty patients to reduce cancellations due to lack of beds.
Thoracic Surgery	Increase operating capacity to reduce cancellations due to lack of time/emergency cases prioritised. (Linked to Vascular service move in October)
Upper GI, Trauma & Orthopaedics & Maxillo-facial Surgery	Implement managed beds for surgical elective admissions to reduce cancellations due to lack of ward beds/lack of High Dependency Unit beds.
Ophthalmology	Working group in place to improve Pre-Operative Assessment processes, reducing clinical cancellation and allowing for

	more accurate time allocation. Lists currently booked assuming lowest level of emergency admissions to maximise time available to clear Referral to Treatment Times backlog, although list space remains allocated for admissions through clinic.
All Paediatric	Through the Winter Planning Project within the Children's Flow Programme, increase medical bed capacity throughout winter to reduce impact on surgical bed capacity and thus last-minute cancellations (LMCs)
All Paediatric	Through the Elective Processes Project in the Children's Flow Programme, improve planning, communication and decision-making to reduce LMCs
Paediatric Cardiac Surgery	Through the Cardiac Transformation Project implement improvements in Operating Model and Communication Processes (includes moving from 4 to 5-day operating model)
Paediatric plastics, maxillo-facial and Trauma & Orthopaedics	Following transfer of Specialist Paediatric services in May this year, there has been a period of settling in to reach optimum operating capacity and efficiency. Work needs to continue to support this.
Dermatology	Majority of recent cancellations were due to clinician availability. Recruitment of additional Consultants (3.6 Whole Time Equivalents) will reduce the overall pressure on the service and improve resilience.
Hepatology	Cancellations were due to bed pressures, move short term the there is a new booking procedure for patients for morning lists which should reduce the bed needs. Long term there are plans for recovery beds for interventional radiology that will help with these patients

Progress against the recovery plan:

The 0.8% national last-minute cancelled operations standard was not achieved in August. This was primarily due to clinician unavailability and emergency pressures on theatres.

Performance against the 28-day readmission standard was 90.5% and so back below the national standard. 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, and more recently developed emergency access plans (see Exception Report A5), 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 August is 76.6%. This figure is subject to further validation and final national reporting, which will take place early in October. However, the recovery trajectory target of 82.1% is not expected to be achieved for the month, for the reasons shown in the final section of this exception report.

Performance in July was reported as 79.4% against the 85% standard. Breach analysis has shown the reasons for the breaches to be as follows:

Breach reasons	July breaches	Percentage of breaches
Late referral	3.0	19%
Medical deferral/Clinical complexity	5.0	31%
Patient choice to delay	2.0	13%
Delayed radiology diagnostic	0.5	3%
Admin delay/pathway planning issue	0.5	3%
Delayed admitted diagnostic	2.0	13%
Elective capacity	0.5	3%
High dependency unit bed availability	1.0	6%
Pathology delay	1.0	6%
Other	0.5	3%
	16.0	**100%**

63% of breaches were due to primarily unavoidable reasons, including late referral, medical deferral and clinical complexity.

There were 8 breaches (50%) relating to internally managed pathways and 8 breaches (16 pathways x 0.5 accountability) relating to shared pathways.

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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 1 2014/15, 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 83.9%. 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 were realised between quarter 2 and quarter 3 2013/14. 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 is taking forward further improvement priorities which have identified from the most recent breach analysis and learning from other providers. The key actions are as follows:

<u>62-day GP referred actions:</u>

- 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 July, which should reduce the thoracic pathway by 9 days; discussions with Yeovil District Hospital, Gloucester Hospitals and Taunton & Somerset trusts ongoing, 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 (planned for end July, but now to be completed by the end of September); demand modelling undertaken for each tumour site; additional clinic capacity established in head & neck, lung and gynaecology, and planned in other specialties; monitoring report being used to review progress against plan;
- 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);

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- 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;
- Cases continue to be moved from Queen's Day Unit to Heygroves theatres to increase the capacity for the more complex cases (Ongoing);
- Additional thoracic surgery lists are being planned where possible, reallocating lists from other specialties where this is an option (Ongoing);
- In September the thoracic surgeons will be piloting running two surgical teams in parallel, to increase operating hours by anaesthetising/operating on two patients in tandem;
- Additional theatre sessions are being established on some Saturdays in September, to bring forward treatment dates for patients requiring thoracic (lung) cancer surgery;
- Establish additional thoracic theatre sessions from October 2014, when Vascular service moves to North Bristol Trust;
- 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. The figures for April to June are now confirmed following the completion of quarter 1 reporting. The figure for August is still subject to final validation and will be confirmed on final national reporting early in October. August's performance is below trajectory, mainly due to the high number of late tertiary referrals and complex cases in the period.

	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	75.5%	81.6%	85.1%	80.4%	79.4%	76.6%										

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.

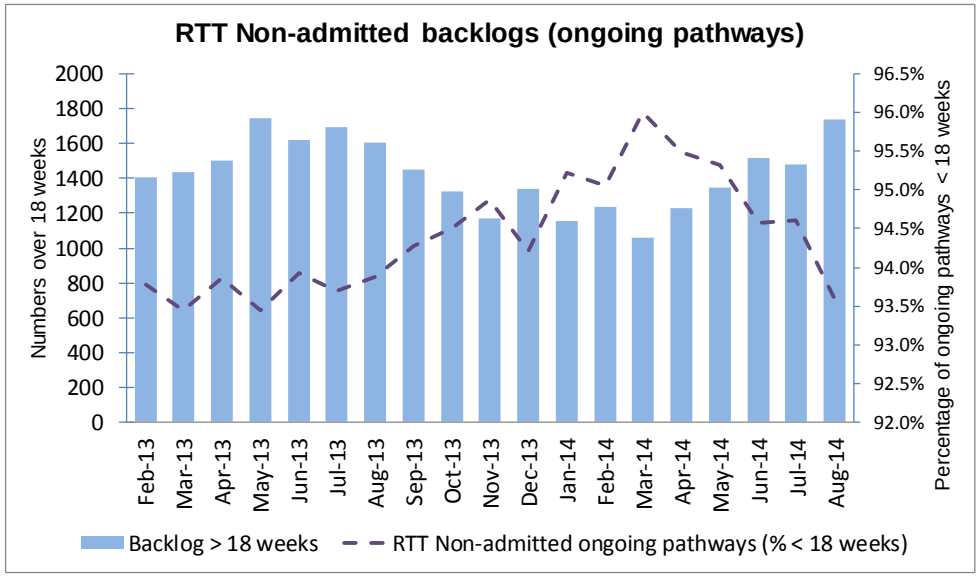
Performance is assessed by Monitor at an aggregated Trust level.

Monitor measurement period: Monthly achievement required but quarterly monitoring

Performance during the period, including reasons for exceptions:

Performance in August was 90.0% against the Non-admitted standard, which is consistent with the revised monthly trajectory (88.0%).

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 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% between January and May, but dipped below 95% in June, July and August. This rise in the backlog is due to a 'bulge' in the number of patients waiting for a dental first outpatient appointment, moving through the waiting list. Action was taken in June to establish 1600 additional dental outpatient appointments during June to September, to address the additional waiters now progressing through the waiting list. Overall non-admitted RTT activity (treatments) in August decreased by 1480

relative to July (18% down on July). With fewer breaches being treated, this has resulted in an increase in the non-admitted backlog.

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

- Forty-six percent of the patients treated in the month who had waited over 18 weeks for treatment were in dental specialties, which reflects the additional activity undertaken to reduce the number of long waiters; an additional 12% were Ear, Nose & Throat (ENT) patients.

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

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
Cardiology	92	27	119	**77.31%**
Cardiothoracic Surgery	15	1	16	**93.75%**
Dermatology	499	10	509	**98.04%**
E.N.T.	508	80	588	**86.39%**
Gastroenterology	40	12	52	**76.92%**
General Medicine	177	0	177	**100.00%**
Geriatric Medicine	72	0	72	**100.00%**
Gynaecology	348	10	358	**97.21%**
Neurology	66	1	67	**98.51%**
Ophthalmology	830	33	863	**96.18%**
Oral Surgery	284	70	354	**80.23%**
OTHER	2707	383	3090	**87.61%**
Rheumatology	75	2	77	**97.40%**
Thoracic Medicine	191	10	201	**95.02%**
Trauma & Orthopaedics	93	28	121	**76.86%**
TOTAL	**5997**	**667**	**6664**	**89.99%**

In August, eight of fifteen specialties achieved the 95% standard, compared with seven in July.

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 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 Interim Management and Support (IMAS) 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. Following the original visit in April and further visits to the Trust in June and July, final reports are now available. The key recommendations of the review are now in the process of being implemented. These include a further review of outpatient capacity using an IMAS developed planning tool, which is now underway.

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 forecasted achievement of the 95% standard from October 2014, as shown in the trajectory below. July and August's revised target was achieved. However, the non-admitted backlogs remain high due to the higher levels of demand than accounted for in the specialty level plans. Encouragingly, there has been a drop in the front-end of the waiting list, which will feed through in the next couple of months and result in an improvement in performance. It is not clear at this stage whether the impact will be seen quickly enough to restore performance to 95% in October as planned. For this reason achievement of the 95% standard in October is considered at risk.

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%	89.5%	88.0%	92.5%	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%	92.8%	89.7%	90.0%							

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A5. EXCEPTION REPORT: Referral to Treatment Time (RTT) incomplete pathways standard	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients, not yet treated or discharged who are waiting less than 18 weeks from referral at month-end, as a percentage of all patients still waiting. The target is 92%.

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 August was 91.1% against the 92% standard. This is the first time the Trust has failed the 92% standard. The failure was a result of the admitted backlog having risen during the early part of the year, and not having reduced as part of the planned failure of the admitted standard, along with the non-admitted backlogs not reducing as planned with the additional first outpatient activity.

The number of patients being added to the elective waiting list has increased significantly during 2014/15, relative to last year. This growth is mainly in specialties such as Dermatology, for which we have seen a significant increase in outpatient referrals. As can be seen from Table 1, Dermatology performed at 95.1% against the 92% standard in August. However, the specialty's backlog has doubled in the last month, and performance has previously averaged 97%. The Cardiology admitted backlog remains high, but the non-admitted backlog has recently worsened, due to increasing volumes of referrals. The main areas with backlogs within the specialty of 'Other' are Paediatric specialties (admitted and non-admitted backlogs), upper GI (primarily admitted backlog) and dental specialties (non-admitted backlogs), due to a combination of capacity constraints and increasing demand.

Table 1: Performance against the RTT incomplete pathways standard at a national RTT specialty level in August.

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Ongoing	Percentage Under 18 Weeks
Cardiology	2127	533	2658	80.0%
Dermatology	1825	97	1920	95.1%
E.N.T.	2410	160	2570	93.8%
Gastroenterology	507	28	535	94.8%
General Medicine	131	1	132	99.2%
Gynaecology	965	39	1004	96.1%
Neurology	230	36	266	86.5%

Ophthalmology	4587	209	4796	95.6%
Oral Surgery	2440	147	2587	94.3%
OTHER	13364	1708	15071	88.7%
Rheumatology	389	12	401	97.0%
Thoracic Medicine	752	7	759	99.1%
Trauma & Orthopaedics	928	66	994	93.4%
Cardiothoracic Surgery	356	15	371	96.0%
Geriatric Medicine	215	2	217	99.1%
TOTAL	**31226**	**3060**	**34281**	**91.09%**

In August, twelve of fifteen specialties achieved the 92% standard, compared with fourteen out of sixteen in July.

Recovery plan, including expected date performance will be restored:

Plans to reduce backlogs of long waiters as quickly as possible include the following:

- Specialty-level capacity plans have been developed for quarter 3, to ensure the Trust can reduce the backlog as quickly as possible during the period of the planned failure of the admitted standard; these plans take into account the level of capacity needed to meet the additional recurrent demand we are seeing, in addition to the capacity needed to clear the backlog; however, in not all cases can the level of capacity required to reduce backlogs be put in place in quarter 3; more detailed monthly plans are going to be developed by mid October, to provide further assurance over the speed with which the admitted backlog can be reduced;
- One of the recommendations of the IMAS review was to use an IMAS developed planning tool, to re-assess the required level of outpatient capacity; the use of this planning tool is now underway;
- A review of 'picking' patterns is being undertaken, to ensure patients are booked according to clinical need, in chronological order;
- The application of the Trust's Patient Access policy is being re-visited, to ensure that appropriate action is being taken when patients delay their outpatient appointments or elective admissions.

Progress against the recovery plan:

Trusts across the country have now been asked to continue to fail the admitted pathways standard until the end of November, in order to reduce backlogs of admitted long waiters. Additional capacity is being put in place to enable more long waiters to be treated during the next two months, in addition to the clinically urgent and other long waiters that would ordinarily have been admitted in the period.

Whilst disappointing that more rapid progress in reducing the non-admitted backlogs has not been made, there are indications that the front-end of the

non-admitted waiting list is starting to drop, which in future months should start to reduce the number of longer waiting patients who need to be seen. In conjunction with actions that continue to be taken to further reduce the length of wait for first outpatient appointments, this will help to reduce the backlog of non-admitted long waiters.

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A6. EXCEPTION REPORT: A&E maximum wait 4 hours	RESPONSIBLE DIRECTOR: Chief Operating Officer

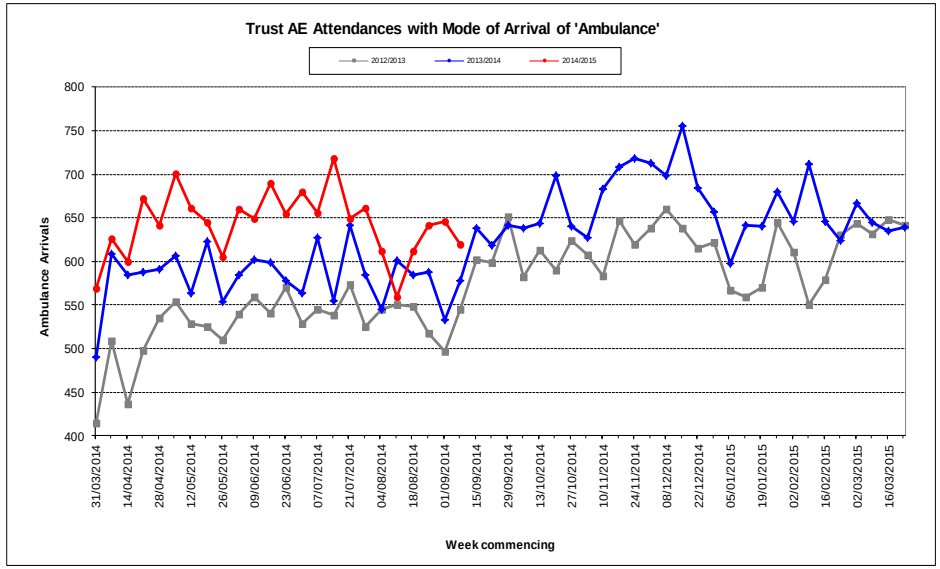
Description of how the target is measured:

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 was 93.7% in August, against the 95% national standard. Performance against the 4-hour standard at the Bristol Children's Hospital was 99.1% in August, compared with 97.6% in July. Performance within the BRI also increased, from 87.6% in July to 89.5% in August. 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 8.8% higher in August than the same period last year. Levels of emergency admissions were 1.6% higher than in August last year. The lower conversion rate may be due to the work of the BRI Ambulatory Care Unit.

In contrast to most previous months, the Bristol Children's Hospital saw a 2.1% decrease in ambulance arrivals in August, relative to the same period last year. However, emergency admissions were still 9.3% higher than last year. Based upon the Trust's planning assumptions, two-thirds of the rise in total Trust emergency admissions since May can be attributed to the closure of the Frenchay Emergency Department (ED).

There was a 0.38 day increase in overall length of stay for patients discharged in the month, reflecting a higher proportion of long stay patients discharged in the period. Consistent with this, the number of long-stay patients in hospital at month-end was again lower than at the previous month-end, reducing from 131 in July to 122 at the end of August. This is the lowest reported level since November 2013. The reduction in over 14 day stays cannot be attributed to a decrease in the number of delayed discharges, with the numbers showing a slight rise between July and August (see

Table 1 below).

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

Month	Total number of Green to Go (Delayed Discharge) patients at month-end
January 2014	60
February 2014	73
March 2014	58
April 2014	56
May 2014	51
June 2014	58
July 2014	50
August 2014	53

The number of ambulance hand-over delays in the period showed a further increase, from 139 in July to 144 in August. This reflects the high level of ambulance conveyances, along with the numbers of patients needing to be managed in the BRI Emergency Department (ED) at certain times, due to the pressure on ward bed availability. However, despite the increased number of ambulance conveyances, greater than 95% of patients arriving by ambulance were assessed within 15 minutes. Other measures of flow reflected the problems with ward bed availability, such as the number of days patients spent on the wrong specialty ward, which increased in the month from 685 in July to 776 in August, and also bed occupancy.

Recovery plan, including expected date performance will be restored:

An emergency access plan has recently been developed with partner organisations, as shown below. Progress against this plan will now be reported to the Trust Board on a monthly basis.

Plan	Timescales (impact from)
Reduction in minors breaches	
Increase Consultant cover in Emergency Department (ED) 7 days/week to support see and treat at peak times.	November onwards
Additional Emergency Nurse Practitioner cover 7 days week 18.00 – 0200hrs to cover minors.	September onwards
Increase numbers of ED slots available in GP Support Unit from 1045-2115. Total 206 ED slots per	September onwards

week.	
7 day liaison Psychiatry service.	September onwards
Reducing ED attendances	
Extension to opening times of South Bristol Urgent Care Centre (BrisDoc).	November onwards
Implementation of ambulance trust to GP Support Unit (GPSU) pathway 5 days/week (BrisDoc).	October onwards
Admission avoidance and/or reduction in length of stay	
Consultant-led Rapid Assessment Team to cover Older Persons Assessment Unit and Emergency Department Team led by Care of the Elderly Consultant supported by Therapists and Nurses (in association with Bristol Community Health).	November onwards
Implementation of a pilot virtual Multi Disciplinary Team and Rapid Assessment Clinic for Older People at South Bristol Community Hospital. This service will support GPs in the management of the frail elderly (in association with Bristol Community Health).	November onwards
Support Nursing and Residential homes to have access to Dietetic and Speech and Language services to support people at high risk of malnutrition/aspiration due to swallowing problems.	November onwards
Extended REACT service supported by Social worker 6 days/week (Bristol Community Health).	August onwards
Advanced Nurse Practitioner support to REACT 5 days /week 08:00-20:00 hours (Bristol Community Health).	August onwards
New pathways from Callington Road (BrisDoc/Avon & Wiltshire Mental Health Partnership).	September onwards
Commencement of Heart Failure service to Medicine.	September onwards
Winter/Interim beds (Bristol City Council).	November onwards
Increased Community rehab beds (Bristol City Council).	November onwards
Increase Echocardiogram capacity in evenings 5 days a week.	November onwards

An additional inpatient catheter laboratory session over the weekend. This will improve weekend discharge rates and further support delivery of elective targets.	November onwards
Safe Haven beds for people with Dementia (Bristol Community Health)	November onwards
Increase weekend discharges	
Increase Therapist cover across the BRI 7 day's week. This scheme will increase Therapy cover over a weekend across all Divisions and will support early discharge.	November onwards
Increase Medical cover to the Division of Medicine over the weekend. This scheme includes a Consultant, Registrar, additional Pharmacy and portering support.	November onwards
Increased weekend ward round cover and theatre capacity in General Surgery and Trauma & Orthopaedics. This will support weekend discharge and deliver improved emergency surgical and trauma flow.	November onwards
Increase ward round cover at weekends within the Bristol Heart Institute (BHI). This scheme includes Consultant, Nursing, Admin and Pharmacy.	November onwards
Decrease weekend admissions	
GP Support Unit (GPSU) weekend cover (BrisDoc)	October onwards
Improve flow	
Introduction of Senior Navigator to ED 10:00-20:00 hrs weekdays.	August to September
Surgical escalation triggers/new roles/additional surgical pathways.	September onwards

Progress against the recovery plan:

The 95% standard wasn't achieved for August as a whole, despite good progress being made in the latter half of month. The expected impact of both the internal and partner organisations actions' in reducing 4-hour breaches of standard has been assessed. This has been used to create an A&E 4-hour performance trajectory using 2013/14 as a baseline, with a best case and realistic scenarios. Using historical performance and activity as a baseline has allowed seasonal pressures to be factored-in. Whilst performance In August was consistent with the trajectory, performance for September to date has been below 95%. Metrics have been established to enable the delivery against the individual elements of the above plan to be monitored, and to enable analysis of which actions are not delivering the expected outcomes to be undertaken.

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The new patterns of emergency admissions following the Frenchay Emergency Department closure are still emerging. In addition, the Trust is continuing to see increasing numbers of ambulance arrivals, which in conjunction with the increasing ago-profile of patients admitted to the Trust, pose risks to achievement of the 95% standard over the winter, which may be difficult to mitigate fully, as reflected in the Realistic scenario.

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014/15 Q2	Q3	Q4
Best case scenario	93.2%	96.2%	95.6%	96.8%	94.0%	95.1%	94.2%	95.9%	93.9%	95.5%	95.1%
Realistic	93.2%	95.1%	95.4%	96.2%	93.5%	93.5%	92.9%	94.4%	93.5%	95.0%	93.6%
Actual performance	93.7%										

ACCESS STANDARDS

A7. 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 August was 97.0% against the 99% national standard for 6-week diagnostic waits. This is a 0.7% deterioration from July's performance of 97.7% There were 210 breaches of the 6-week standard at month-end, of which 68 were for MRI scans (an increase from 56 in July), 29 were for gastrointestinal endoscopies (an increase from 22 in June) and 95 were for Cardiac Stress Echocardiograms (a rise from 67 in July). There was also 1 breach of standard for patients awaiting neurophysiology tests, 5 for CT scans, 2 for sleep studies and 10 non-obstetric ultrasound.

The increase in long waiters for MRI scans in August was expected, with a number of sessions being lost due to bank holidays and the lack of anaesthetic cover for some paediatric MRI lists. However, plans are in place to undertake additional sessions in September, above the routine level of capacity, which will reduce the backlog and result in an overall improvement against the 6-week standard.

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. A small backlog arose again during a three-month period between March and May 2014. However, there were only 4 adult gastrointestinal endoscopy long waiters at month-end (for clinical rather than capacity reasons), with the remaining 25 endoscopy breaches being for routine paediatric patients. The number of paediatric endoscopy long waiters remains similar to that of previous months, with sustainable changes in capacity planned during quarter 4.

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:

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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;
- A consultant paediatric gastroenterologist post is currently out to advert; it is expected the successful applicant will now be in post in January 2015; additional sessions will be run during quarter 3, with the aiming of clearing the backlog by the end of the quarter.

Progress against the recovery plan:

The 99% standard wasn't achieved in August. Additional capacity continues to be put in place to reduce the number of long waiters for a number of different types of diagnostic test. From this an improvement trajectory has been developed, which forecasts achievement of the 99% standard again from October onwards, as shown below. The August recovery target of 96.5% was achieved.

Month	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**
Waiting list size (estimate)	6991	6842	6768	6749	6749
Total > 6 weeks	244	107	61	52	53
Performance trajectory	**96.51%**	**98.44%**	**99.10%**	**99.23%**	**99.21%**
Actual total > 6 weeks	210				
Actual performance	**96.96%**				

ACCESS STANDARDS

A8. EXCEPTION REPORT: Reperfusion times (door to balloon time of 90 minutes)	**RESPONSIBLE DIRECTOR: Chief Operating Officer**

Description of how the target is measured:

The number of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Hearth Institute. This standard applies to direct admissions to hospital.

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

Performance during the period, including reasons for exceptions:

Of the 36 patients treated in the period, four had waits to treatment of over 90 minutes. High level analysis shows no emerging themes. However, the notes of these patients are being pulled in order to conduct pathway reviews.

Recovery plan, including expected date performance will be restored:

- The pathways of the longer waiting cases are now being reviewed, to identify whether anything could have been done to reduce their waiting times and to identify any common causes of the delays.

Progress against the recovery plan:

To date in 2014/15, 93.5% of patients have received reperfusion within 90 minutes, which is above the 90% standard. The 90% standard was consistently achieved in each month of quarter 1.

University Hospitals Bristol NHS
NHS Foundation Trust

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

8. Patient Complaints and Experience Quarterly Report

Purpose

The attached reports describe patient-reported feedback from complaints and surveys during the first quarter of 2014/15. The reports are presented to together to enable and encourage discussion about triangulation of themes, however it should be remembered that the nature of the data presented in the two reports is different. In particular, the 'agenda' for survey data is largely set by the Trust (albeit in response to themes raised by patients previously), i.e. the Trust is seeking feedback about predetermined themes; whereas the complaints agenda is set entirely by the people who use our services. The patient experience report includes an analysis of free-text comments received from service users (see section 7); during the next quarter, we will be looking at whether and how the free-text themes used in this report might be aligned more closely to those used by the Patient Support and Complaints Team (as reflected in the complaints report).

Abstract

The patient experience report shows that when we ask for comments from service users without setting any theme or agenda, the most common feedback is praise for our staff – and overwhelmingly so. Suggestions for improvement are usually about reducing waiting/delays and improving communication; in other words, the same as two of the three high level themes that are regularly identified in our complaints reports (the third complaints theme being clinical care). When we ask service users how they would rate us overall, 98% tell us that our services are either good, very good or excellent, and our Friends and Family Test scores are consistently better than the national average. Our inpatient tracker indicator also provides robust assurance of consistent high levels of reported patient experience. Analysis of key patient experience indicators can now be viewed at ward level: this tends to show consistent patterns of reported experience (e.g. wards who score well on the FFT also tend to score well in our own survey, and so forth), and also enables a degree of triangulation with reported complaints (if a ward is experiencing increased numbers of complaints, we can check whether there has been a similar shift in their patient survey scores to help build a wider picture of patient experience and consider whether any supportive intervention might be required, such as the Patient Experience at Heart programme).

The Q1 complaints report indicates the beginnings of an upward trend in the number of complaints received by the Trust, which we know has continued in Q2. Complaints about appointments and admissions increased in Q1 and emerge as a recurring theme in the Divisional 'hot spot' analysis provided in the report. With regards to our internal management of complaints, Q1 saw an improvement in the proportion of complaints responded to within the timescale agreed with the complainant, but also an increase in the number of complainants telling us that they were unhappy with the Trust's response letter (although these monthly figures fluctuate and remain broadly comparable to benchmark trusts).

Recommendations
To receive the report for assurance.
Report Sponsor
Carolyn Mills, Chief Nurse
Appendices
Q1 Complaints Report Q1 Patient Experience Report

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other
	17/9/14	25/9/14			Patient Experience Group 14/8/14

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 1, 2014/2015

(1st April – 30th June 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 427 complaints in Quarter 1 of 2014/15 (Q1), which equates to 0.25% of patient activity, against a target of 0.21%. In the previous quarter, the Trust had received 415 complaints, representing 0.24% of patient activity.

The Trust's performance in responding to complaints within the timescales agreed with complainants was 86.3% compared to 84.7% in Q4 of 2013/14.

In Q1, there was an increase in complaints relating to appointments and admissions; these accounted for more than a third of complaints received by the Trust. There was also a significant rise in complainants telling us that they were unhappy with our investigation of their concerns: 21 compared to 14 in Q4.

This report includes an analysis of the themes arising from complaints received in Q1, 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 427 complaints in Q1, which equates to 0.25% 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 Q1 represented an increase of approximately 3% compared to Q4 (415), a 28% increase on Q3 (333) and a 19% increase on 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.

	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Total complaints received (inc. TS and F&E from April 2013)	105	96	123	115	120	109	104	127	124	164	131	130	166
Formal/Informal split	73/32	49/47	68/55	60/55	54/66	63/46	55/49	55/72	62/62	89/75	60/71	64/66	64/102
Number & % of complaints per patient attendance in the month	*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*	*0.24% 131 of 54981*	*0.23% 130 of 57463*	*0.28% 166 of 60027*
% responded to within the agreed timescale (i.e. response posted to complainant)	*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)*	*93.1% (54 of 58)*	*82.5% (47 of 57)*	*83.3% (50 of 60)*
% responded to by Division within required timescale for executive review	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)	82.8% (48 of 58)	86.0% (49 of 57)	91.7% (55 of 60)
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	2 of 4	2 of 10	6 of 10
Number of extensions to originally agreed timescale (formal investigation process only)	5	10	9	7	14	14	9	16	13	11	5	21	8
Number of Complainants Dissatisfied with Response	*6**	*6* 2**	*11* 1**	*1* 4**	*7* 8**	*2* 3**	*6* 6**	*6* 3**	*3* 5**	*5* 2**	*6* 10**	*4* 2**	*11* 4**

* 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 the increase in the volume of complaints received towards the end of 2013/14 continuing into the first quarter of 2014/15.

Figure 1: Number of complaints received

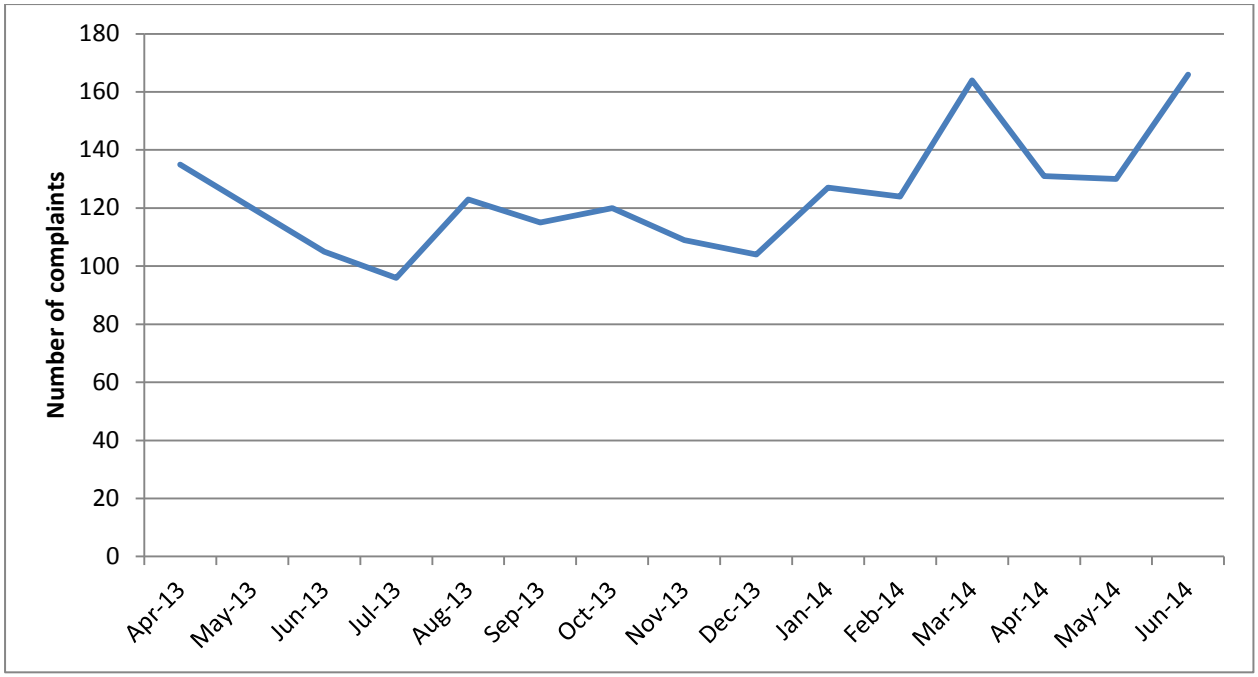
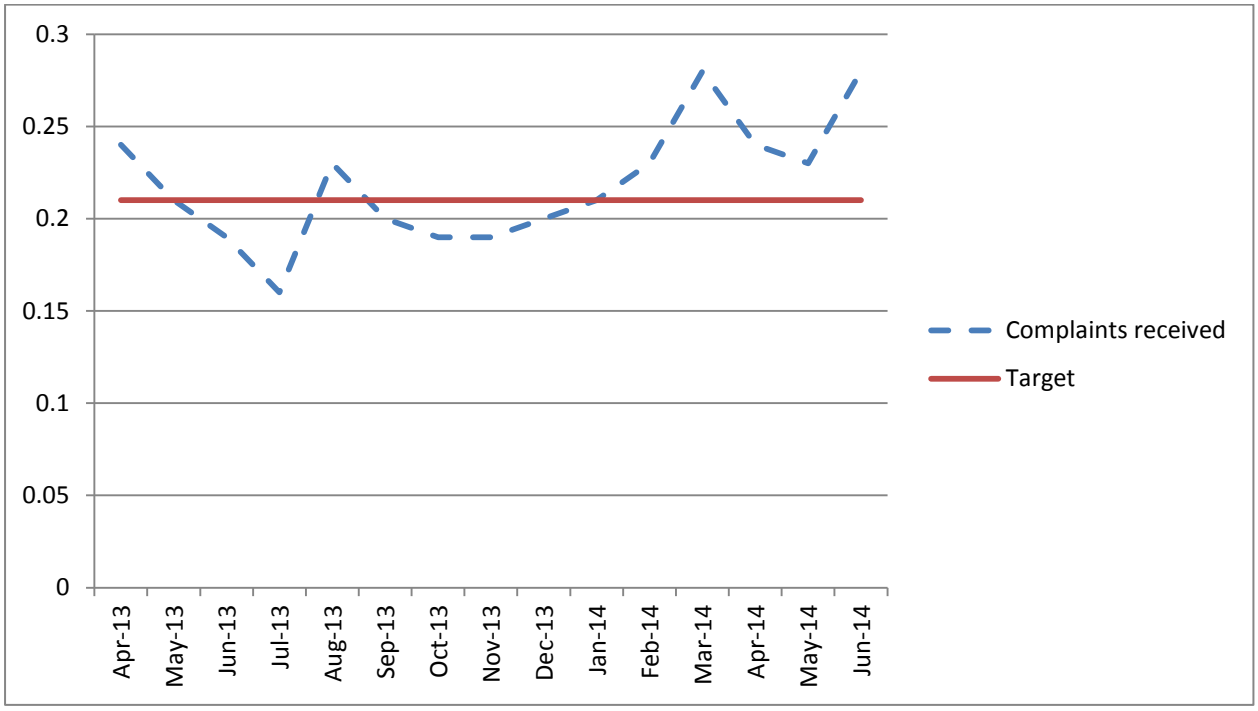


Figure 2: Complaints received, as a percentage of patient activity

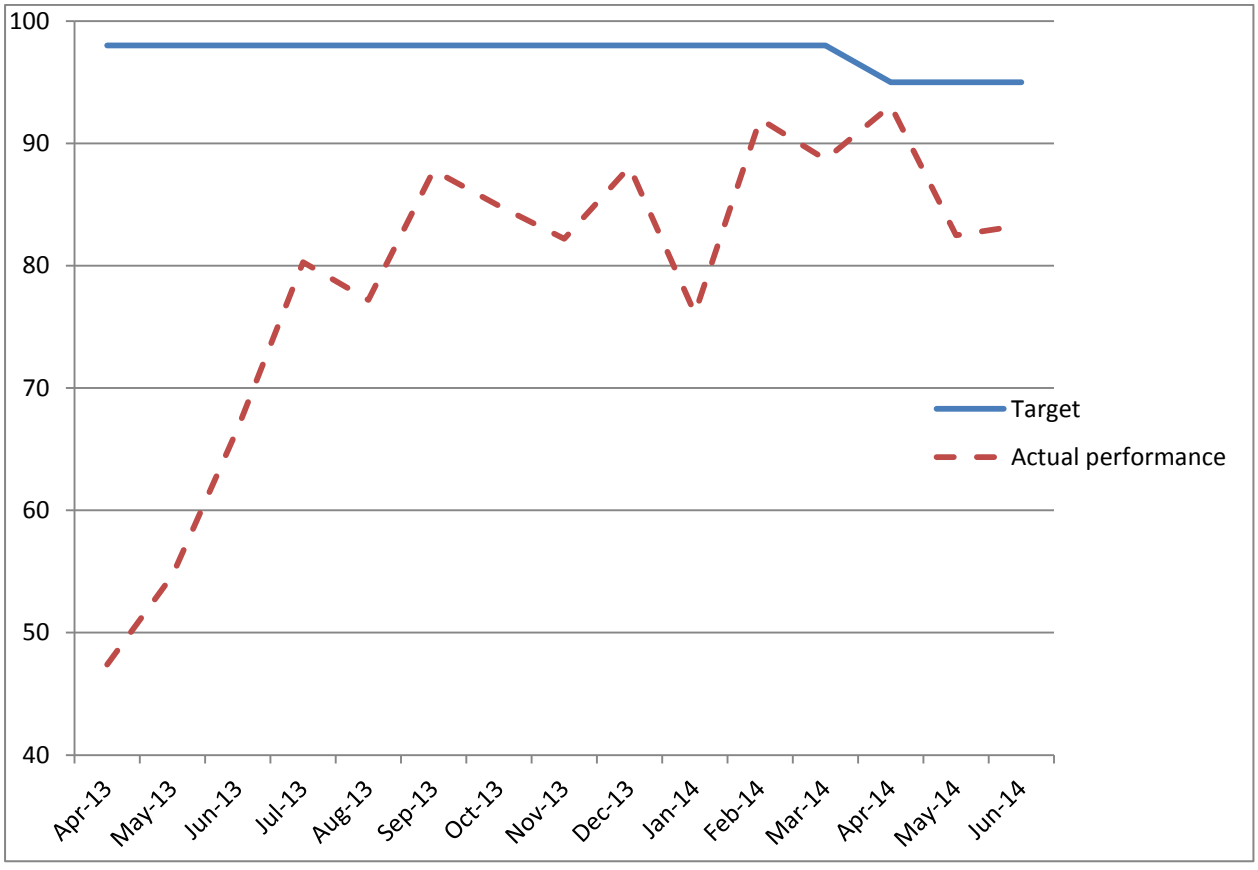


2.2 Complaints responses within agreed timescale

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].

Until Q1 2014/15, our target was to respond to at least 98% of complainants within the agreed timescale. From Q1, this target has been adjusted slightly downwards to 95%. The end point is measured as the date when the Trust's response is posted to the complainant. In Q1 86.3% of responses were made within the agreed timescale, compared to 84.7% in Q4. This represents 24 breaches out of 175 formal complaints which were due to receive a response during Q1[5]. 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 Q1.

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] Note that this will be a slightly different figure to the number of complainants who *made* a complaint in that quarter.

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 Q1, there were 21 cases where the complainant felt that the investigation was incomplete or inaccurate. This represents a significant increase on Q4 (14 cases). There were a further 16 cases where new questions were raised, compared to Q4 (10 cases).

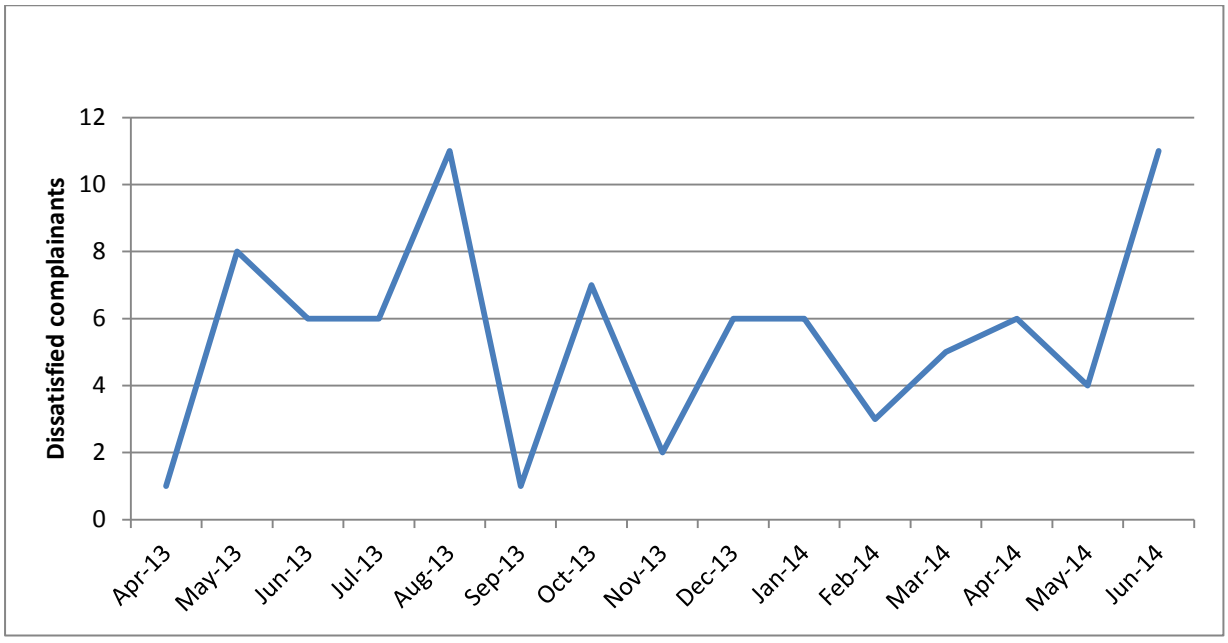
The 21 cases where the complainant was dissatisfied were associated with the following lead Divisions:

- 8 cases for the Division of Surgery, Head & Neck (compared to 5 in Q4);
- 5 cases for the Division of Medicine (compared to 4 cases in Q4);
- 5 cases for the Division of Women & Children (compared to 3 in Q4);
- 2 cases for the Division of Specialised Services (compared to 1 in Q4);
- 1 case for the Division of Diagnostics & Therapies (compared to 1 in Q4); and
- 0 cases for the Division of Facilities & Estates (compared to 0 in Q4).

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.

The number of dissatisfied complainants increased overall in 2013/14 and, despite a decrease in the second month of Q1, has increased again towards the end of the quarter. 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. Although the Division of Surgery, Head & Neck has seen an increase in the number of dissatisfied complainants, this has been in proportion with the increase in the number of complaints received overall by the Division. However, actions agreed to address this increase are detailed in section 3.6 of this report.

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



2.4 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 Q1 compared to Q4. Complaints about 'appointments and admissions' and 'clinical care' increased in Q1, both in real terms and as a proportion of total complaints received. The reverse was true of complaints about 'attitude and communication'.

Category Type	**Number of complaints received – Q1 2014/15**	**Number of complaints received – Q4 2013/14**
Appointments & Admissions	152 (35.6% of total complaints) ↑	133 (32% of total complaints)
Attitude & Communication	91 (21.3%) ↓	119 (28.7%)
Clinical Care	132 (30.9%) ↑	115 (27.7%)
Facilities & Environment	27 (6.3%) ↓	30 (7.2%)
Access	9 (2.2%) ↓	10 (2.4%)
Information & Support	16 (3.7%) ↑	8 (2%)
Total	**427**	**415**

Each complaint is then assigned to a more specific category (of which there are 121 in total). The table below lists the six most consistently reported complaint categories. In total, they account for 78% of the complaints received in Q1 (335/427). Two other complaints categories were notable in Q1: Communication – Administrative (17) and Attitude of Nursing Staff (16). These themes will be included in the next quarterly report if significant numbers of related complaints continue to be reported.

Sub-category	**Number of complaints received – Q1 2014/15**	**Q4 2013/14**	**Q3 2013/14**	**Q2 2013/14**
Cancelled or delayed appointments and operations	132 ↑ **(19 % increase *compared to Q4*)**	111	86	95
Clinical Care (Medical/Surgical)	119 ↑ **(153% increase)**	47	45	30
Communication with patient/relative	29 ↓ **(9% decrease)**	32	14	15
Attitude of Medical Staff	20 ↓ **(33% decrease)**	30	13	18
Clinical Care (Nursing/Midwifery)	30 ↑ **(15% increase)**	26	23	32
Failure to answer telephones	5 ↓ **(72% decrease)**	18	16	19

This data reveals a significant increase in complaints about clinical care (medical/surgical) in Q1 and a notable increase in complaints about cancelled or delayed appointments and operations for the second successive quarter (following a previous 29% increase in Q4).

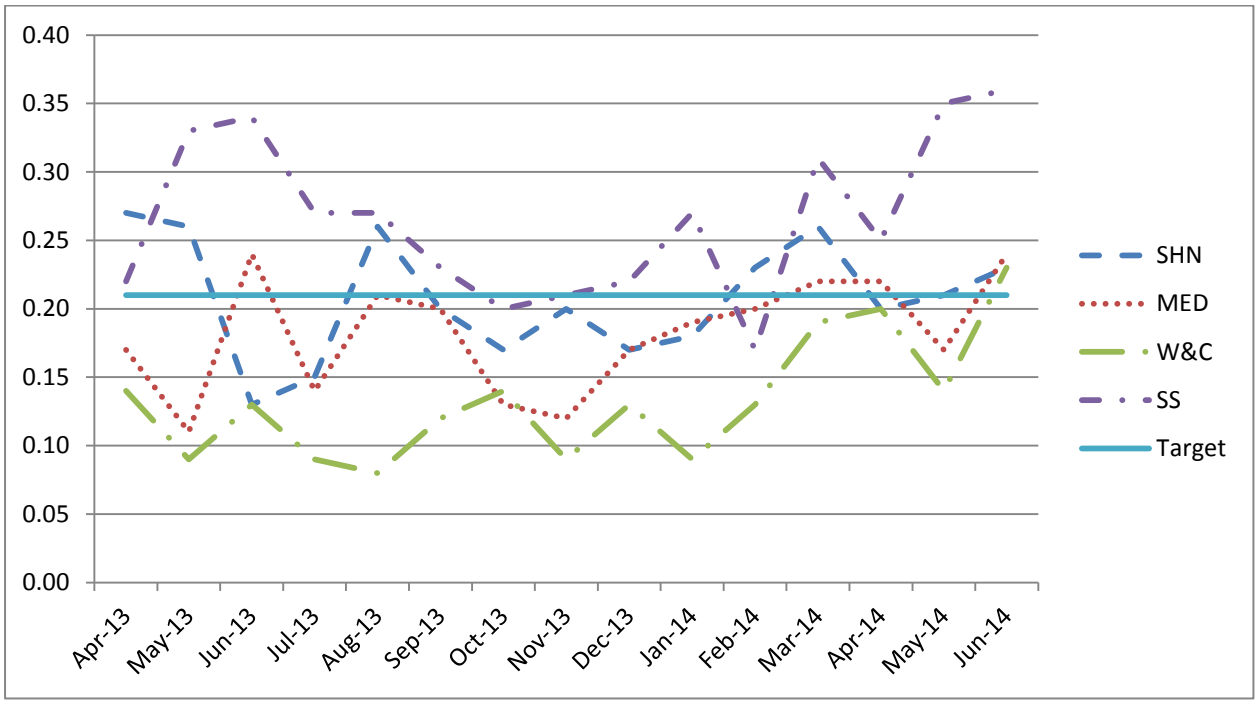
Concern	**Action**
Increase in complaints about cancelled or delayed appointments.	These issues are being addressed through the Trust's Transformation programme, and in the case of outpatients, through improvement activities which originated from the Productive Ward project. Divisions have been asked to comment about the increases in complaints about clinical care later in this report (Section 3.3).
Increase in complaints regarding clinical care (medical/surgical)	The Associate Medical Director (AMD) oversees a system to monitor complaints where individual medical staff are cited. Medical staff are interviewed by the AMD or Medical Director if patterns of repeated behaviour are identified which give cause for concern. Divisions have been asked to comment about the increases in complaints about clinical care later in this report (Section 3.3).

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 Q1.

Figure 5. Complaints by Division as a percentage of patient attendance



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 since July 2013 have been as follows:

Table 2. Complaints received by Diagnostics and Therapies Division since July 2013

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

3.2 Divisional analysis of complaints received

Table 3 provides an analysis of Q1 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	156 (169) ↓	81 (77) ↑	73 (56) ↑	69 (48) ↑	23 (32) ↓
Total complaints received as a proportion of patient activity	0.21% (0.22%) ↓	0.21% (0.21%) =	0.33% (0.25%) ↑	0.19 (0.14%) ↑	N/A
Number of complaints about appointments and admissions	80 (83) ↓	24 (23) ↑	26 (23) ↑	19 (8) ↑	6 (10) ↓
Number of complaints about staff attitude and communication	34 (47) ↓	32 (20) ↑	15 (13) ↑	11 (20) ↓	5 (16) ↓
Number of complaints about clinical care	44 (39) ↑	19 (34) ↓	26 (20) ↑	37 (20) ↑	10 (6) ↑
Areas where the most complaints have been received in Q1	Ear Nose and Throat – 28 (20) ↑ Bristol Eye Hospital – 38 (62) ↓ Trauma & Orthopaedics – 29 (30) ↓ Upper Gastro-Intestinal – 12 (14) ↓ Bristol Dental Hospital – 25 (19) ↑	A&E – 15 (15) = Diabetes/Endocrinology Clinic – 2 (3) ↓ Ward 15 – 2 (5) ↓ Ward 26 – 3 (5) ↓ Respiratory Department (including Sleep Unit) 10 – (8) ↑ Dermatology – 8 (7) ↑ Ward 17 (MAU) – 7 (4) ↑	Chemotherapy Day Unit and Outpatients – 7 (11) ↓ Bristol Heart Institute Outpatients – 16 (11) ↑ Cardiology GUCH Services – 11 (6) ↑ Ward 52 – 5 (5) = Ward 53 – 4 (8) ↓ Ward 61 – 5 (5) = Ward 62 & 62a – 7 (4) ↑	Outpatient clinics – 35 (16) ↑ Ward 78 – 5 (4) ↑ Ward 30 – 0 (7) ↓ Children's ED & Ward 39 – 8 (6) ↑	Audiology – 2 (12) ↓ Physiotherapy (Adult) – 4 (5) ↓ Radiology – 12 (7) ↑
Notable deteriorations compared to Q4	ENT and Bristol Dental Hospital	Ward 17 (MAU)	Cardiology GUCH Services BHI Outpatients	Outpatient clinics	Radiology
Notable improvements compared to Q4	Bristol Eye Hospital	Ward 26	Ward 53	Ward 30	Audiology

3.3 Areas where the most complaints were received in Q1 – additional analysis

3.3.1 Division of Surgery, Head & Neck

Complaints by category type [6]

Category Type	Number and % of complaints received – Q1 2014/15	Number and % of complaints received – Q4 2013/14
Access	3 (1.8% of total complaints) =	3 (1.8% of total complaints) =
Appointments & Admissions	76 (48.5%) ↓	79 (46.7%) ↑
Attitude & Communication	32 (20.6% ↓	45 (26.6%) ↑
Clinical Care	41 (26.7%) ↑	38 (22.5%) ↑
Facilities & Environment	3 (1.8%) =	3 (1.8%) ↑
Information & Support	1 (0.6%) =	1 (0.6%) ↓
Total	**156**	**169**

Top six sub-categories

Sub-category	Number of complaints received – Q1 2014/15	Number of complaints received – Q4 2013/14
Cancelled or delayed appointments and operations	76 ↑ (7% increase compared to Q4)	71 ↑ (58% increase compared to Q3)
Clinical Care (Medical/Surgical)	19 =	19 ↓ (24% decrease)
Communication with patient/relative	10 ↓ (37.5% decrease)	16 ↑ (300% increase)
Attitude of Medical Staff	9 ↓ (18% decrease)	11 ↑ (38% increase)
Clinical Care (Nursing/Midwifery)	8 ↑ (14% increase)	7 ↑
Failure to answer telephones	1 ↓ (85% decrease)	7 ↑

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
The Ear Nose & Throat Service received 28 complaints, an increase of 40% compared to Q4. This follows a previous improvement in Q4 compared to Q3, i.e. data has fluctuated. All complaints received in Q1 related to cancelled or delayed appointments, the majority of which were appointments for the nurse-led ear cleaning /suction clinic.	This is due to a chronic understaffing issue in the nurse led clinics due to long term sickness and difficulty recruiting suitable candidates.	Staff nurse who was on long term sick leave is now back at work on a staged return. The unit is undertaking a capacity diagnostic to understand what extra resources are needed to resolve this problem.
Bristol Dental Hospital received 25 complaints in Q1; an increase of 31% compared to Q4. 13 (52%) of these	Due to difficulty in recruiting to a restorative consultant, there has been a lack of availability of clinic slots and	Recruitment is ongoing – additional clinics have been arranged during the undergraduate holidays to clear the backlog. Complaints are being

[6] Arrows in Q1 column denote increase or decrease compared to Q4. Arrows in Q4 column denote increase or decrease compared to Q3. Increases and decreases refer to actual numbers rather than to proportion of total complaints received.

complaints were for Adult Restorative Dentistry. Of the total complaints received by BDH, 12 were in respect of cancelled or delayed appointments, 10 related to clinical care and three were about attitude of staff.	this has led to a backlog of patients waiting to be seen.	managed on a case by case basis and urgent clinical issues are being addressed immediately.

3.3.2 Division of Medicine

Complaints by category type

Category Type	Number and % of complaints received – Q1 2014/15	Number and % of complaints received – Q4 2013/14
Access	1 (1.2% of total complaints) =	1 (1.3% of total complaints) ↓
Appointments & Admissions	22 (27.2%) ↑	19 (24.7%) ↑
Attitude & Communication	30 (37%) ↑	18 (23.4%) ↑
Clinical Care	17 (21%) ↓	32 (41.5%) ↑
Facilities & Environment	7 (8.6%) ↑	6 (7.8%) ↑
Information & Support	4 (5%) ↑	1 (1.3%) ↑
Total	**81**	**77**

Top six sub-categories

Category	Number of complaints received – Q1 2014/15	Number of complaints received – Q4 2013/14
Cancelled or delayed appointments and operations	9 ↓ (40% decrease compared to Q4)	15 ↑ (36% increase compared to Q3)
Clinical Care (Medical/Surgical)	10 ↓ (9% decrease)	11 ↑ (83% increase)
Communication with patient/relative	7 ↑ (75% increase)	4 ↓
Attitude of Medical Staff	4 ↓ (20% decrease)	5 ↑
Clinical Care (Nursing/Midwifery)	5 ↓ (44% decrease)	9 ↓
Failure to answer telephones	1 ↓ (66% decrease)	3 ↑

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Complaints received by the Respiratory Department (including the Sleep Unit) have continued to increase. There were 10 complaints in Q1 compared to eight in Q4 and four in Q3. Four of the complaints received in Q1 were in respect of clinical care; two were attributed to staff attitude and two to cancelled or delayed	Two complaints were for the Respiratory Department, four for the Sleep Unit and four for Ward 10. In respect of the outpatient complaints, one was closed as a patient misunderstood the information they had been given and four related to appointment issues and Outpatient departments. There were four complaints in respect	A process mapping review is underway in respect of the Sleep Unit and will be completed by the end of 2014/15.

appointments.	of the ward – one of these was a request for information (which was subsequently managed in a meeting); one related to a family requiring support following a bereavement; one was about cigarette usage and one remains under investigation and appears to be a misunderstanding around the provision of a waiting area.	
Ward 17 (MAU) received seven complaints in Q1. These were spread across a number of categories, with four being about staff attitude and communication.	Two of the complaints related to food quality and pathway information, so were not ward specific. Other complaints related to ward noise, the attitude of nursing and medical staff, and communication with a patient involving the need to move them to a side room.	The ward will soon be moving to a new environment with more side room provision. Issues around specific staff involved in complaints have been managed locally.
Note: in the Trust's monthly survey, Ward 17 achieves a high patient-reported score for kindness and understanding and a mid-range aggregate patient experience tracker score.		
The number of complaints received by Dermatology increased slightly again to eight in Q1, compared to seven in Q4 and three in Q3. Five of the complaints received in Q1 were about cancelled or delayed appointments and procedures.	The service is experiencing some pressures at the moment with an increase in activity, some of which is related to the service transfer from Weston General Hospital. Concerns have been raised around new appointment waiting times and difficulties contacting the clinic co-ordinator.	A new locum consultant is starting in the department on 1st September 2014. Issues around nursing vacancies have been addressed. One 1.0WTE clinic coordinator has been appointed. A capacity review of the department is currently being undertaken.

3.3.3 Division of Specialised Services

Complaints by category type

Category Type	Number and % of complaints received – Q1 2014/15	Number and % of complaints received – Q4 2013/14
Access	1 (1.4% of total complaints) =	1 (1.8% of total complaints)
Appointments & Admissions	26 (35.6%) ↑	21 (37.5%)
Attitude & Communication	15 (20.6%) ↑	12 (21.4%)
Clinical Care	26 (35.6%) ↑	19 (33.9%)
Facilities & Environment	3 (4.1%) =	3 (5.4%)
Information & Support	2 (2.7%) ↑	0 (0%)
Total	**73**	**56**

Top six sub-categories

Category	Number of complaints received – Q1 2014/15	Number of complaints received – Q4 2013/14
Cancelled or delayed appointments and operations	24 ↑ (41% increase compared to Q4)	17 ↑ (42% increase compared to Q3)
Clinical Care (Medical/Surgical)	10 ↑ (43% increase)	7 ↑

Communication with patient/relative	7 ↑ (40% increase)	5 ↑
Attitude of Medical Staff	1 ↓ (50% decrease)	2 ↑
Clinical Care (Nursing/Midwifery)	8 ↑ (166% increase)	3 ↑
Failure to answer telephones	2 ↑ (100% increase)	1 ↓

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
The number of complaints received in Cardiology GUCH Services increased again to 11 in Q1 compared to six in Q4 and two in Q3. Five of the complaints received in Q1 were attributed to cancelled or delayed appointments or procedures. A further three were in respect of communication and two were about lost or delayed test results.	The recent growth in the outpatient follow-up backlog has led to patients' routine follow-ups being delayed. This has been compounded by long term secretarial vacancies.	The service has now appointed a fourth ACHD (Adults with Congenital Heart Defects) consultant, who will commence in post on 24th August and will focus on addressing the follow-up backlog. The ACHD service also appointed a replacement support secretary to cover the vacant post. Unfortunately the individual appointed chose not to take up the post and therefore the department will be re-advertising.
Complaints for Bristol Heart Institute increased from 11 to 16 in Q1. Nine of these complaints related to cancelled or delayed appointments or procedures. Two each were attributed to communication and clinical care.	During Q1, the BHI received three formal and 13 informal complaints categorised as "BHI OPD". Of these, three related to the waiting times for complex heart procedures and three related to non-OPD administrative issues. Difficulties with the administration service in Q1 were caused by long term sickness in the secretarial team.	Of the two posts affected by long term sickness, one has been resolved and the member of staff is back in work. The other post is currently being recruited into following the withdrawal of a previously appointed candidate. We anticipate this post being filled substantively by October 2014 and interim arrangements are in place.

3.3.4 Division of Women & Children

Complaints by category type

Category Type	Number and % of complaints received – Q1 2014/15	Number and % of complaints received – Q4 2013/14
Access	0 (0% of total complaints) ↓	2 (4.2% of total complaints) ↑
Appointments & Admissions	19 (27.5%) ↑	6 (12.4%) ↑
Attitude & Communication	11 (16%) ↓	19 (39.6%) ↓
Clinical Care	36 (52.2%) ↑	19 (39.6%) ↑
Facilities & Environment	2 (2.9%) ↑	1 (2.1%) =
Information & Support	1 (1.4%) =	1 (2.1%) =
Total	**69**	**48**

Top six sub-categories

Category	Number of complaints received – Q1 2014/15	Number of complaints received – Q4 2013/14
Cancelled or delayed appointments and operations	15 (50% increase compared to Q4) ↑	10 ↓ (29% decrease compared to Q3)
Clinical Care (Medical/Surgical)	14 (55.5% increase) ↑	9 ↑
Communication with patient/relative	3 (40% decrease) ↓	5 ↑
Attitude of Medical Staff	6 (25% decrease) ↓	8 ↑
Clinical Care (Nursing/Midwifery)	9 (50% increase) ↑	6 =
Failure to answer telephones	0 (100% decrease) ↓	1 =

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
There has been a significant increase in the number of complaints received by outpatient clinics in the Children's Hospital, from 16 in Q4 to 35 in Q1. The majority of these complaints (10) were in respect of cancelled or delayed appointments or procedures, with nine attributed to clinical care.	Children's outpatient activity has grown substantially since the Centralisation of Specialist Paediatrics (CSP) in May this year. T&O pathways have been particularly challenging and a high number of concerns have been raised. Data quality from North Bristol NHS Trust has been inconsistent, contributing to confusion for our staff and patients.	Work taking place to address teething issues and improve new processes. Working with clinical teams to prioritise patients based on clinical need post-CSP. Ongoing work with NBT to sign off data transfer. Transformation project launching in outpatients to improve many aspects, including patient experience.
Complaints received by The Children's Emergency Department (CED) and Ward 39 (observation unit) increased again in Q1 to eight, compared with six in Q4 and two in Q3. Of the complaints received in Q1, 75% (six) were in respect of clinical care. The remaining two cases were attributed to attitude and communication.	CED has seen an increase in activity of around 20% since May 2014 so a proportional increase in complaints, although not desirable, is not unexpected	Lead Clinician sighted on all complaints to ensure systematic review and learning, with aim of avoiding similar events occurring in future.
Note: in the Trust's monthly survey, Ward 39 achieves high patient-reported scores for kindness & understanding and the aggregate patient experience tracker.		

3.3.5 Division of Diagnostics & Therapies

Complaints by category type

Category Type	Number and % of complaints received – Q1 2014/15	Number and % of complaints received – Q4 2013/14
Access	1 (4.4% of total complaints) ↓	2 (6.2% of total complaints) =
Appointments & Admissions	6 (26%) ↓	7 (21.9%) ↑
Attitude & Communication	5 (21.8%) ↓	14 (43.8%) ↑
Clinical Care	9 (39%) ↑	4 (12.5%) ↓
Facilities & Environment	2 (8.8%) ↓	3 (9.4%) ↑
Information & Support	0 (0%) ↓	2 (6.2%) ↑
Total	**23**	**32**

Top six sub-categories

Category	Number of complaints received – Q1 2014/15	Number of complaints received – Q4 2013/14
Cancelled or delayed appointments and operations	5 =	5 ↓
Clinical Care (Medical/Surgical)	1 ↑	0 ↓
Communication with patient/relative	0 =	0 ↓
Attitude of Medical Staff	0 ↓	4 ↑
Clinical Care (Nursing/Midwifery)	0 =	0 =
Failure to answer telephones	0 ↓	5 ↑

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
The number of complaints received by Radiology rose from seven in Q4 to 12 in Q1. These were spread across a number of categories, with three each relating to clinical care, attitude of staff and lost or delayed test results.	Of the 12 complaints in Q1, four were formal and eight were informal. The four formal complaints included an incorrect diagnosis at Avon Breast Screening Unit (now managed by North Bristol NHS Trust), damaged personal property (patient removed hearing aid and it fell under an MRI scanner), failure of a radiographer to follow a scanning protocol correctly, and delay in reporting a test result. The informal complaints were all dealt with at the time and appropriate action was taken.	In the case of the incorrect diagnosis, the service apologised that the potential diagnosis was not delivered clearly and for the distress caused. Part of the learning was to ensure that there is greater diligence in giving patients clear information. The Audiology Department has offered to source a replacement hearing aid for the patient whose hearing aid was lost underneath the MRI scanner in the BRI. The radiographer who failed to follow the correct procedure has been reminded of the protocol, and learning from the event has been disseminated within the department. The delayed report related to a CT scan and was due to a reporting capacity issue at that time. The service has recruited an additional consultant in this area and plans are in place for further capacity to be introduced.

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 – Q1 2014/15	Number and % of complaints received – Q4 2013/14
Bristol Royal Infirmary	170 (39.8% of total complaints) ↓	193 (46.5% of total complaints) ↑
Bristol Eye Hospital	38 (8.9%) ↓	60 (14.5%) ↑
Bristol Dental Hospital	26 (6%) ↑	19 (4.6%) ↓
St Michael's Hospital	57 (13.3%) ↑	46 (11%) ↓
Bristol Heart Institute	50 (11.7%) ↑	33 (8%) ↑
Bristol Haematology & Oncology Centre	25 (5.9%) ↑	20 (4.8%) ↓
Bristol Royal Hospital for Children	50 (11.7%) ↑	36 (8.7%) ↑
South Bristol Community Hospital	11 (2.7%) ↑	8 (1.9%) ↓
Total	**427**	**415**

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. Four of the five clinical Divisions reported breaches in Quarter 1, totalling 24 breaches. The Division of Diagnostics & Therapies did not record any breaches for Q1.

	Q1 2014/15	Q4 2013/14	Q3 2013/14	Q2 2013/14
Surgery Head and Neck	**9 (14.3%)**	8 (11%)	6 (10%)	9 (12%)
Medicine	**7 (21.2%)**	7 (21.2%)	11 (25%)	9 (25%)
Specialised Services	**2 (8.7%)**	0	2 (11%)	4 (12.5%)
Women and Children	**6 (19.4%)**	9 (36%)	4 (17%)	7 (28%)
Diagnostics & Therapies	**0 (0%)**	1 (8.3%)	0	0
All	**24 breaches**	25 breaches	23 breaches	29 breaches

(So, as an example, there were seven breaches of timescale in the Division of Medicine in Q1, which constituted 21.2% *of the complaints responses that had been due in Q1*.)

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	3	0	6
Medicine	2	0	5
Specialised Services	0	1	1
Women and Children	5	0	1
Diagnostics & Therapies	0	0	0
All	10 breaches	1 breach	13 breaches

Actions agreed via Patient Experience Group:

- New KPIs have been agreed in respect of turnaround times for the Patient Support and Complaints Team and for the Executives, in addition to the four working days allowed for the Divisions. The Patient Support and Complaints Team must send the response letter to the Executives for signing within 24 hours of receipt from the Division. The Executives then have up to three working days (maximum) to review, sign and return the response to the Patient Support and Complaints Team.
- 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).

	Q1 2014/15	**Q4 2013/14**	**Q3 2013/14**	**Q2 2013/14**
Surgery Head and Neck	**8**	5	8	10
Medicine	**5**	4	4	3
Specialised Services	**2**	1	3	1
Women and Children	**5**	3	0	2
Diagnostics & Therapies	**1**	1	0	1
All	**21**	14	15	17

Actions agreed via Patient Experience Group:

- Divisions are notified of any case where the complainant is dissatisfied. The 21 cases recorded in Q1 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 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 (training plan to be drafted by end of October 2014).

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 Q1, the team dealt with 174 such enquiries, compared to 161 in Q4. These enquiries can be categorised as:

- 104 requests for advice and information (83 in Q4)
- 60 compliments (70 in Q4)
- 10 requests for support (8 in Q4)

5. PHSO cases

During Q1, the Trust has been advised of new Parliamentary & Health Service Ombudsman (PHSO) interest in five complaints (compared to seven in Q4). Two of these cases were subsequently not upheld and one was partially upheld; we are currently awaiting a decision from the PHSO for the two remaining cases.

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
14650	CF	MS	23/12/2013	BRI	Upper GI	Surgery, Head And Neck
Not upheld: The PHSO allowed the Trust further opportunity to resolve the issues raised. A meeting was subsequently held with the complainant on 8th May 2014. An action plan was generated and sent to the patient at the beginning of June 2014 and the complainant appears to be satisfied.						
13223	CP		16/05/2013	BEH	Outpatients	Surgery, Head & Neck
Not upheld: Final report received, complaint not upheld and no failings identified.						
10805	AJ	MM-L	17/05/2012	BRI	Ward 9	Surgery, Head & Neck
Open: The Trust has sent copies of all requested documentation to the PHSO – currently waiting to hear whether they wish to investigate.						

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
13173	MD	JS	08/05/2013	BRI	A&E (BRI)	Medicine
Partially upheld: Some failings were found, specifically in relation to the lack of food and drink provided to the patient. However, the PHSO are satisfied that the Trust has apologised and that the remedial action taken was appropriate and proportionate.						
13987	AB	DJ	10/09/2013	BRI	QDU (Endoscopy)	Surgery, Head & Neck
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.						

6. Corporate developments in Q4

During Q4 of 2013/14, a backlog of enquiries to the Patient Support and Complaints Team developed. Causal factors included the re-opening of the drop-in service in a prominent location within the Bristol Royal Infirmary Welcome Centre, 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 agreed to the appointment of three new members of staff to strengthen the team: recruitment is due to be completed by mid-October 2014. In the interim, two temporary caseworkers were initially appointed to enable the team to address the backlog. At the end of Q1, the backlog had reduced significantly, although it has since increased (at the time of writing, in mid-September, it is taking approximately two weeks for caseworker follow-up of complaints enquiries, following the Trust's initial acknowledgement). Operational performance indicators have been introduced to ensure that any deterioration in future performance is identified and escalated for appropriate action. Estates works have been carried out during August to facilitate the arrival of new staff members; this includes provision of a new meeting room for drop-in enquiries.

A formal update of the 2014/15 complaints work plan is being reported separately to the Senior Leadership Team in September.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 09. Safeguarding Annual Report 2013/14

Purpose

The purpose of this annual report is to provide both assurance and evidence to the University Bristol NHS Foundation Trust Board that the Trust is fulfilling its statutory responsibilities to safeguarding adults, children and young people.

The annual report details the work over the last year to ensure that UH Bristol has made in fulfilling its statutory responsibilities to safeguarding adults, children and young people, as set out under Section 11 of the Children Act, 2004 and the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs). This report reviews the Trust's progress on meeting national and local priorities.

Abstract

The report sets out the evidence available and measures the effectiveness of safeguarding arrangements for adults, children and young people within the Trust during 2012-2013.

The report illustrates that the Local Safeguarding Boards, continue to facilitate the co-operation of local agencies to safeguard and promote the welfare of adults and children.

The report illustrates that safeguarding activity of Trust staff illustrating that previous increases in activity have been sustained.

The report gives evidence of compliance with CQC Outcome 7.

The report illustrates that governance arrangements are robust, with Board representation and a team of safeguarding professionals in post, including a Named Doctor and Named Nurse for Children.

The report illustrates that a number of policies have been reviewed and updated during the reporting period and an audit programme is in place to analyse their effectiveness.

A number of actions have been identified to drive further improvements in the safeguarding of adults children and young people within the Trust.

There are several risks in relation to safeguarding children on the Trust Risk Register, each are clearly defined with controls and action plans in place to reduce risk.

Risk 2419 – The inability to report safeguarding training compliance is a high level risk. This is being addressed as a matter of urgency within the Trust and its progress is being monitored closely by the Training Department, the Safeguarding Steering Group and Bristol Clinical Commissioning Group.

Recommendations
The Committee to receive the report for assurance.
Report Sponsor
Chief Nurse
Appendices

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other
		25 September 2014			Safeguarding Steering Group September 2014

University Hospitals Bristol NHS
NHS Foundation Trust

Safeguarding Annual Report

April 2013 – March 2014

1. Introduction

This reporting period has seen a continuing high level of public scrutiny of both national and local safeguarding arrangements for all organisations involved in the delivery of health and welfare services to children, young people and adults. The reviews including Winterbourne View Report, the Francis Report and the Jimmy Savile abuse inquiry have kept safeguarding very much in the forefront of public attention. The Government has re- empathised that safeguarding must remain a priority for the NHS and must be integral to NHS reforms both nationally and locally (University Hospitals Bristol National Health Service Foundation Trust (UHBristol) has been and continues to remain fully committed to safeguarding children, young people and adults and continues to view safeguarding as a priority. UHBristol recognises that safeguarding is everybody's business who work in the Trust and also that of everyone working in health care who have a responsibility to help prevent abuse and to act quickly and proportionately to protect children, young people and adults where abuse is suspected.

Safeguarding continues to be addressed nationally under one combined agenda following a 'Think Family' approach. This is reflected in the Trust's internal safeguarding arrangements with both adult's and children's safeguarding retaining specific specialist teams with individual areas of responsibility and work plans.

This annual report reflects the key safeguarding activities for children, young people and adults for the period 1st April 2013 to 31st March 2014, reflecting on the work plans of both safeguarding teams. The safeguarding agenda is robustly supported by all the divisions within the Trust through membership of the Trust Safeguarding Steering Group and Safeguarding Operational Groups. The safeguarding agenda is underpinned by the Trust's values; in particular the strong culture of both multi-agency and multi-disciplinary working reflecting the aims of 'Working Together' and 'Respecting Everyone', being a core value to all aspects of safeguarding.

2. Brief Update of National and Local Safeguarding Drivers.

2013/14 saw a number of national and local changes to the systems and processes in place to safeguarding children. The final report by Professor Eileen Munro, produced as part of the National review of safeguarding children, made a number of recommendations aiming to develop a system which was less bureaucratic and process driven and more focused on protecting the child. This led to a revision of Working Together to Safeguard Children, which came into force in April 2013, which clarifies the responsibilities of organisations and professionals and requires that NHS organisations continue to comply with a number of key requirements including:

- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.
- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services.
- Arrangements which clearly set out the process for sharing information.
- Named professional leads.
- Safe recruitment procedures in place.
- Appropriate supervision and support for staff including undertaking safeguarding training.
- Clear policies for dealing with allegations against people who work with children.

These statutory requirements for safeguarding children are underpinned by Section 11 of the Children Act 2004 and self-assessment audits are completed annually to provide evidence of compliance with the Section 11 requirements to the Bristol Clinical Commissioning Group and Safeguarding Children Boards.

During 2013/14, Bristol's safeguarding children's arrangements have also undergone significant changes during this reporting period as part of a wider Children's Social Care 'Change Programme'. Of particular importance has been the transfer of the Hospital Social Work team, historically located within Trust premises, to an offsite central city location. This has resulted in major changes in the role and responsibilities of the Hospital Social Work Team within the Trust. A city wide restructuring of locality duty teams has been undertaken as part of the 'Change Programme', and following a pilot scheme in the North of the city, 'First Response' a single referral point for all safeguarding referrals for Bristol, went live at the end of this reporting period.

The Trust Executive lead for Safeguarding and the Named Professionals have worked closely with partner agencies including Children's Social Care to ensure that the Trust's safeguarding children's arrangements remain fully aligned with the new Bristol structure. The implications of these changes have been monitored and managed closely by the Child Protection Nursing Team and the Safeguarding Steering Group to ensure that children and young people remain protected whilst in our care.

The Trust safeguarding children referral process and the role of the Child Protection Nursing Team have been adapted in response to these changes. The 'Change Programme' will continue into the next reporting period (2014/15).

This reporting period has also seen significant development in the national guidance, which underpins practice for safeguarding adults. The Department of Health published a 'Statement of Government Policy on Adult Safeguarding' in May 2013 This document focused on new priorities and values for safeguarding and clearly set out 6 safeguarding adults principles of: empowerment, prevention, proportionality, protection, partnership and accountability.

These principles were for local authorities, housing, health, the police and other agencies to use as a guide to the engagement of vulnerable adults and for developing and assessing the effectiveness of their local safeguarding arrangements. The statement also described, in broad terms, the outcomes for adult safeguarding, for both individuals and organisations.

The Care Bill (HL) 2013-14

Members of Parliament completed the debate on the report stage and third reading of the Care Bill in the House of Commons Chamber on Tuesday 11 March 2014. The Bill has now completed all of its Commons stages. The Care Bill sets out the first ever statutory framework for adult safeguarding, which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect.

These provisions require the local authority to: Carry out enquiries into suspected cases of abuse or neglect. Establish Safeguarding Adults Boards in their area The role of these Boards, described in Schedule 1, will be to develop shared strategies for safeguarding and report to their local communities on progress. The Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if certain laid out conditions are met. Safeguarding

Adults Boards can request a person to supply information to it or to some other person specified in the request and the person to whom the request is made must comply if certain laid out conditions are met.

On 19 March 2014, the Supreme Court handed down its judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council".
The judgment is significant in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty. This judgement is likely to significantly impact on the number of DOLS applications that will need to be made by Acute Trusts.

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

The UHBristol Trust Board continues to hold ultimate accountability for ensuring that safeguarding responsibilities for both adults and children are met, led by the chief nurse as Executive Lead for Safeguarding. Day to day safeguarding activities continue to be supported by teams of well-established and experienced professionals.

During this year (2013/14) the Trust has further recognised the importance of the 'Think Family' agenda and the close working relations between children's and adult's safeguarding by amalgamating the Children's and Adult's Safeguarding Steering Groups into a combined Steering Group chaired by the Chief Nurse. The new combined group will be supported through the work of adult's and children's operational groups implementing individual action and work plans.

Monitoring of safeguarding activity forms part of the Trust governance arrangements and is reported quarterly to the Trust Safeguarding Steering Group, and includes data required by the NHS commissioning contracts and the Local Safeguarding Children/Adults Boards. All divisions are represented at the Safeguarding Steering Group and have the responsibility for the dissemination of information through their Divisional Boards. Action plans from local Serious Case and Homicide Reviews are actioned and monitored as part of these arrangements.

The Trust has in place safeguarding children, young people and adult policies and procedures to guide staff through their contractual responsibilities to protect vulnerable patients, which includes, for example, guidance on information sharing, making a referral and how to manage a professional difference of opinion. These policies and procedures are based on current national and local guidance and are available electronically for all staff and are reviewed regularly.

4. Summary of Key Safeguarding Achievements of 2013/14

During this reporting period significant progress has been made in delivering safeguarding adults and children's work plans and key objectives. Key achievements are summarised below:

- Joint working with partner agencies to develop and promote safe systems and practice for both children and adults in a challenging and changing safeguarding landscape.
- Strengthening of the Trust's internal safeguarding arrangements including the formation of a combined adults and children's Safeguarding Steering Group. A review of the Operational Groups supporting the Steering Group is planned in the next reporting period.

- Safeguarding training packages and target audiences are regularly reviewed to reflect national and local changes with the expectation that this will impact positively on practitioner skills and confidence.
- Progress is being made in the development of Transitional Care arrangements, including the formation of a Trust Transition Care Steering Group, supported by both adults and children's safeguarding teams.
- Participation in local Serious Case and Domestic Homicide Reviews and both the North and South Bristol MARAC.
- The establishment of closer working relations between the adult Hospital Social Work Department, the Hospital Discharge and Adult Safeguarding Team has enabled better communications and streamlining of work.
- The Adult Safeguarding Team has started using the Trust wide electronic patient logger on a regular basis resulting in more effective communications with the patient's multi-disciplinary teams.
- Representation at the local Safeguarding Boards and Sub groups for both children and adults with the Trust Adult Safeguarding Lead now acting as chair for the Training Sub Group.
- Liaison with practitioners from North Bristol Trust to ensure that children continue to be protected from harm within the UHB safeguarding systems following the centralisation of Specialist Paediatric Services due to take place at the beginning of the next reporting period.
- Significant progress has been made to mitigate the potential risk to children through the existence of multiple sets of notes within the Trust through the plan to introduce Electronic Patient records and with partner agencies through the 'Connecting Care' project.
- The Safeguarding intranet pages have been significantly updated and improved with the involvement and feedback from practitioners.
- The implementation of an electronic alert on Medway for children and young people who are 'Looked After' by Bristol Local Authority.
- To support safeguarding, caring for people with learning difficulties has remained high on the agenda, and achieved some excellent results with inter-agency working. ***(See Appendix One)***
- The Dementia Standards work has also contributed to safeguarding with the implementation of dementia champions, and the 'This is me' document which focuses on the person behind the medical condition, being fully utilised across the Trust. ***(See Appendix Two)***
- The impact of the Independent Domestic Violence Advisers now evidenced to have made a significant contribution in providing a specialist support to high-risk victims of domestic abuse and their children. ***(See Appendix Three)***

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

5. Safeguarding Training

The provision and delivery of safeguarding training for both children young people and adults remains a key priority for both safeguarding teams, with the requirement that all staff are provided with the appropriate level of training, according to their role and responsibilities. The aim of the safeguarding training is to ensure that every member of staff is aware of their safeguarding

responsibilities, recognise abuse and know what to do about it as the minimum requirement. For safeguarding children this is underpinned by the competencies specified within the revised national Intercollegiate Document, which was finalised during this reporting period.

Safeguarding training has been reviewed as part of the Trust's validation exercise of all mandatory training. As a result Level 1 and 2 training for both children and adults is now incorporated into all clinical and non-clinical induction and update packages. In view of this change there has been a significant increase in the amount of safeguarding training delivered to staff, meaning Trust employees should be better able to recognise signs of abuse and more importantly feel more confident in knowing what action to take if they have a concern.

At the end of this reporting period the Trust procured a new training data reporting system and work has been ongoing to transfer historic records and map learning pathways to allow for accurate reporting of all mandatory training data, including safeguarding adults and children. This work unfortunately has taken longer than anticipated and training compliance data remained unavailable at the end of this reporting period. The situation is being monitored closely both through the Trust's internal governance structures, including the Risk Register, and externally by Bristol Clinical Commissioning Group and the Local Safeguarding Children Board

5.1 Clinical Holding / Restraint Training

The Trust recognises that all patients should receive care, treatment and support from staff who understand the different forms that restraint can take, whilst respecting dignity and protecting human rights. The requirements of CQC Outcome 7 Regulations also include guidance surrounding restraint/clinical holding practice.

In the proceeding twelve months a Clinical Holding/ Restraint Policy has been updated incorporating the most recent Department of Health guidance released following the recommendations of the Winterbourne View Inquiry. The policy will be ratified in the next reporting period

Clinical holding training is available to practitioners in high-risk areas across the Trust, identified from clinical incident reports. The provision of specialist training to support practitioners has been an area of challenge during this reporting period which has been monitored closely by the training department and reviewed regularly by the training department and remains on the Trust risk register.

5.2 Prevent Training

The Government Prevent strategy, which aims to ensure that staff are able to identify violent extremism and make appropriate referrals, has been incorporated into mandatory safeguarding adults induction and update training. Further details are included in ***Appendix Four***.

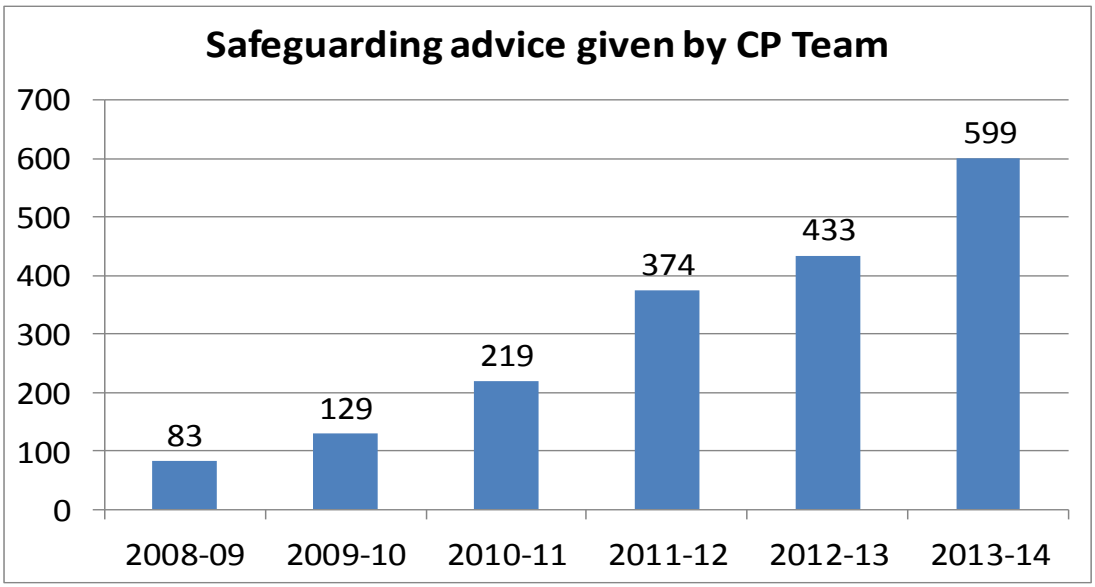
6. Safeguarding Activity Data

A summary of safeguarding activity for both children and adults across the Trust is detailed below.

6.1 Safeguarding Children Activity Data

The ability to recognise safeguarding risks to the unborn baby, children and young person and to know 'what to do' next is an essential component of the Trust's mandatory safeguarding training. Staff are advised during safeguarding training to contact the Child Protection Team if they require advice, support and supervision to manage cases.

Figure 1: Safeguarding Advice given by the Child Protection Team



There continues to be a year on year increase in the number of recorded contacts with the Child Protection Nursing Team from practitioners across the Trust, including increasing numbers of call from those working in adult services. This also correlates with the change in the role and responsibility of the Hospital Social Work Team **(Figure 1).**

6.1.2 Supervision of Safeguarding Children Practice

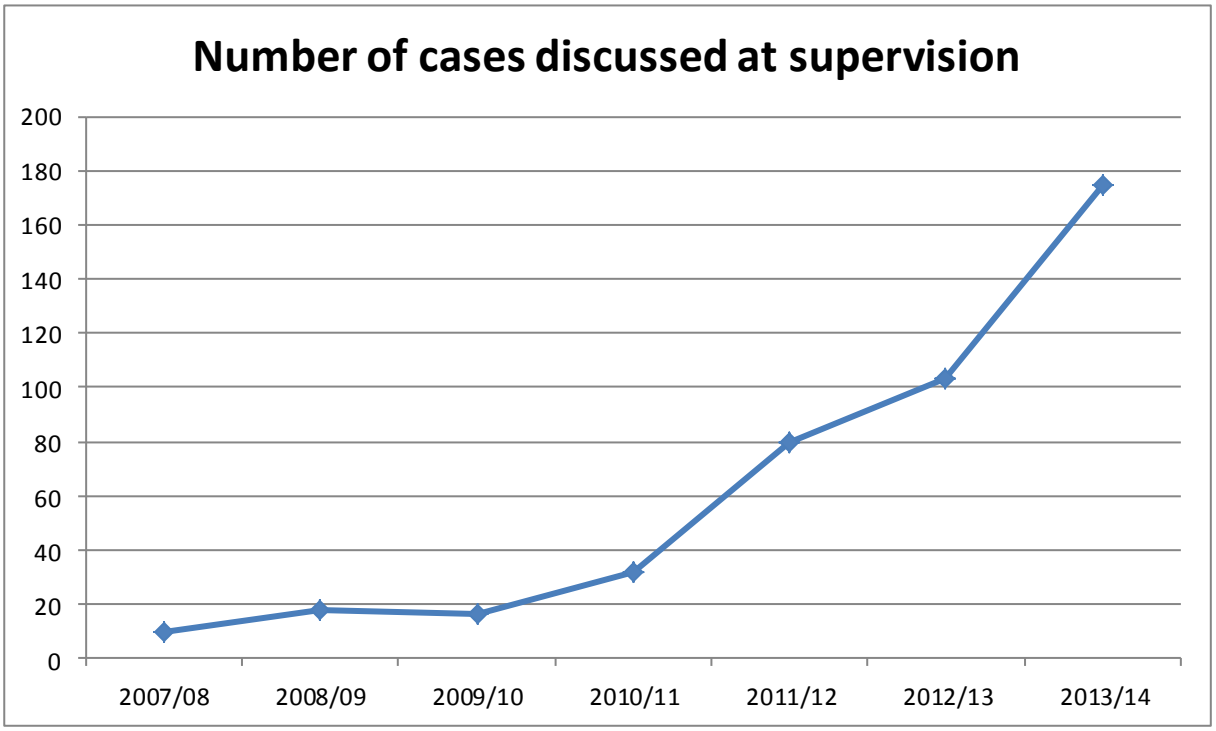
The provision of safeguarding supervision for staff, both on an ad-hoc and regular basis, is frequently noted to be essential to support staff in effectively protecting children from harm, especially when they are managing complex and challenging cases (Sidebotham *et al*., 2010). The revised Working Together to Safeguard Children (2013) reinforces the importance of supervision.

The Child Protection Nursing Team continues to provide safeguarding supervision to a range of practitioners including those who are responsible for managing their own caseloads, such as the Paediatric Clinical Nurse Specialists and Community Midwives. The Named Professionals will

continue to focus on strengthening the supervision practice during the next reporting period; this will include the development of a more formalised system which will allow for a greater degree of monitoring and reporting.

The number of cases discussed at formal supervision sessions continues to rise. This could be a positive reflection of increased awareness by staff both of safeguarding risks within their caseload as well as of the value of the supervision provided by the Safeguarding Team.

Figure 2: Provision of Safeguarding Supervision by the Child Protection Team



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
No of cases	10	18	16	32	80	103	175

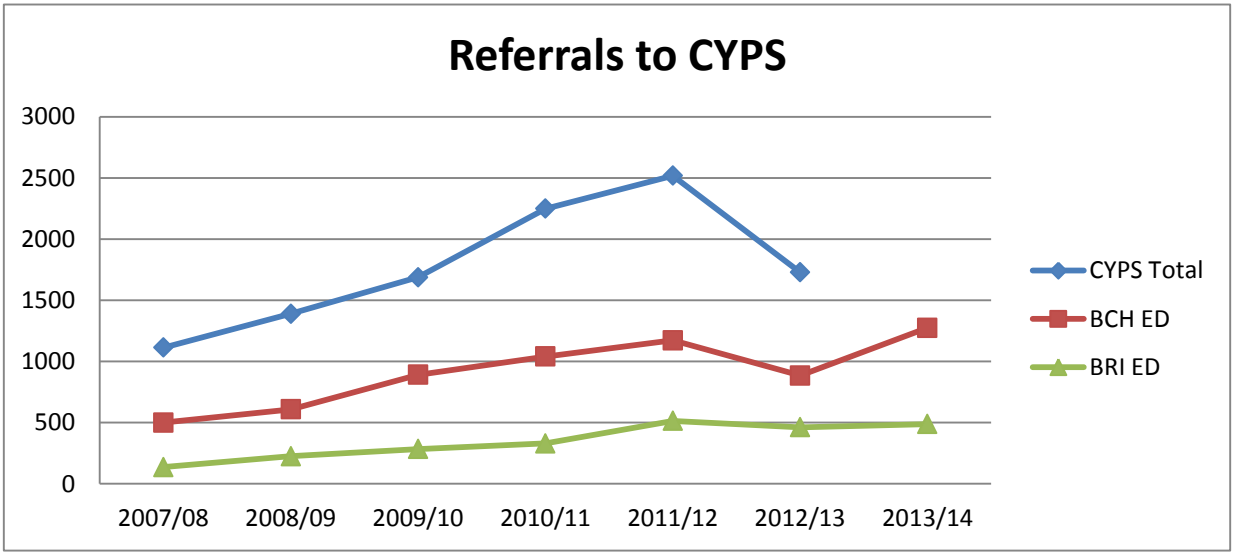
Figure 2 demonstrates a continued increase in the number of cases discussed in formal supervision sessions. This supports staff, for example: Paediatric Clinical Nurse Specialists and Consultants in managing their own caseloads, and ensures as far as possible a high standard of practice.

6.1.3 Safeguarding Children Referrals.

There is currently no robust system in place either across the UHBristol Trust to collect all details of referrals made. The majority of the referrals to CYPS initiate in the emergency department setting (Figure 3). Complex regional and ward cases have not been recorded other than through the advice given by the Child Protection Nursing Team.This was reviewed during this reporting period and a

robust system of data collection developed alongside the introduction of the First Response and the new referral form, will allow for accurate data reporting as well as monitoring for patterns and trends of referrals within the Trust. This data will be included in the annual report for 2014/15.

Figure 3: Referrals to CYPS



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
CYPS Total	1114	1390	1688	2249	2518	1729	N/A
BCH ED	500	609	891	1041	1172	885	1275
BRI ED	137	225	284	330	514	462	488

6.2 Safeguarding Adults Activity Data

The overall number of **referrals (see figure 4**) received this year has increased by a third. This is likely to be as a result of an increased awareness of the Safeguarding agenda which has occurred as a result of improved engagement with training and perhaps the increased profile of Safeguarding nationally.

Figure 4: Safeguarding Adults Referrals

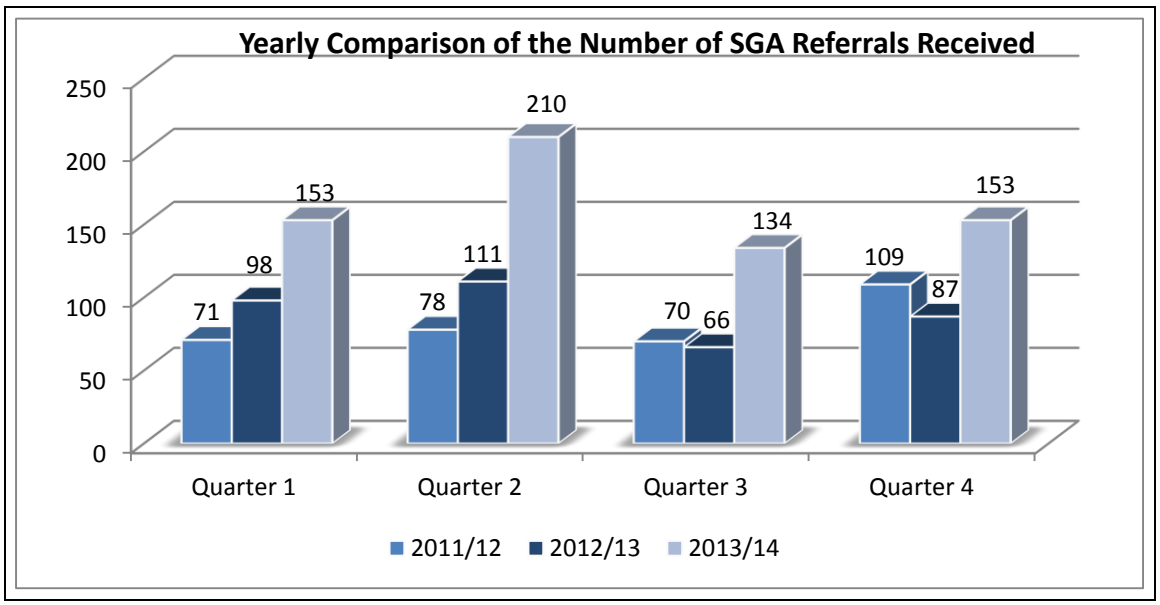


Figure 5: Safeguarding Adults referrals by category

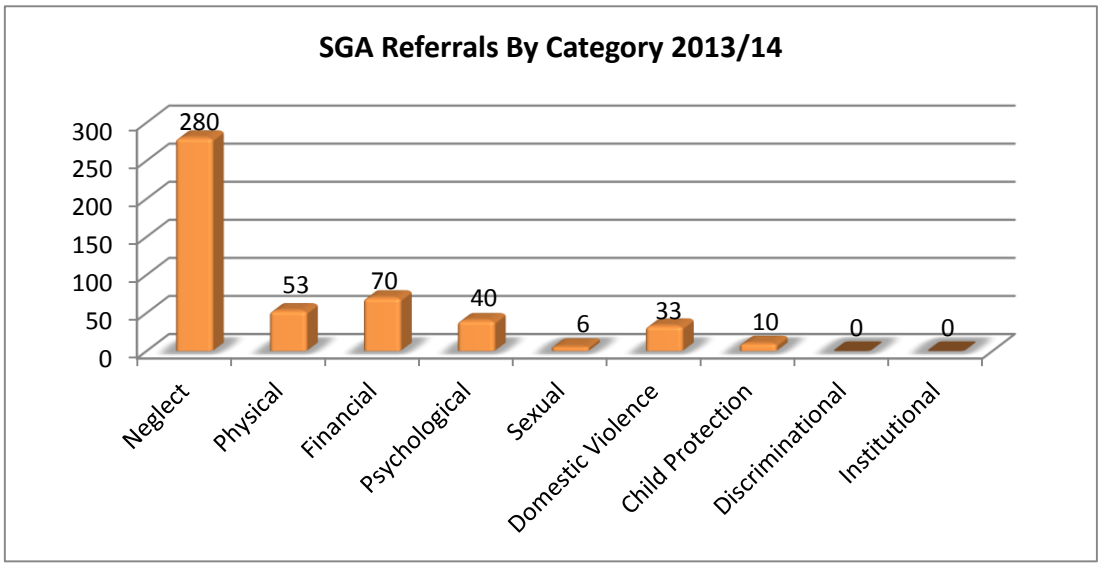


Figure 5 provides data related to the category of abuse alleged to have taken place. The seven categories used are those specified by the Department of Health.

The primary category for referral continues to be under the heading of neglect, the balance of other referrals remains largely unchanged from the previous year.

Figure 6: Safeguarding Adults Incidents by Division

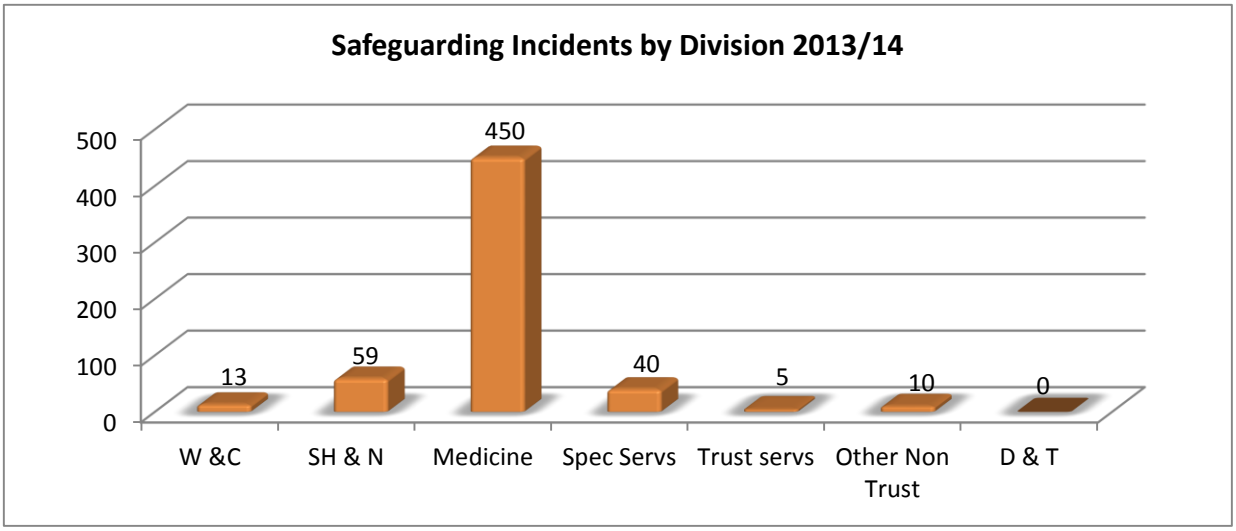


Figure 6 demonstrates the continued, expected prevalence of referrals from the Division of Medicine as it encompasses the ward areas where elderly and vulnerable patients are cared for. Within this division is the Emergency department which contributes a high proportion of the referrals as a result of timely, initial assessments.

6.2.1 Internal Safeguarding Alerts

The following sets of data give a detailed breakdown of those Safeguarding referrals which have been raised as pertaining to internal factors

Figure 7: Internal Safeguarding Alerts Received Per Quarter

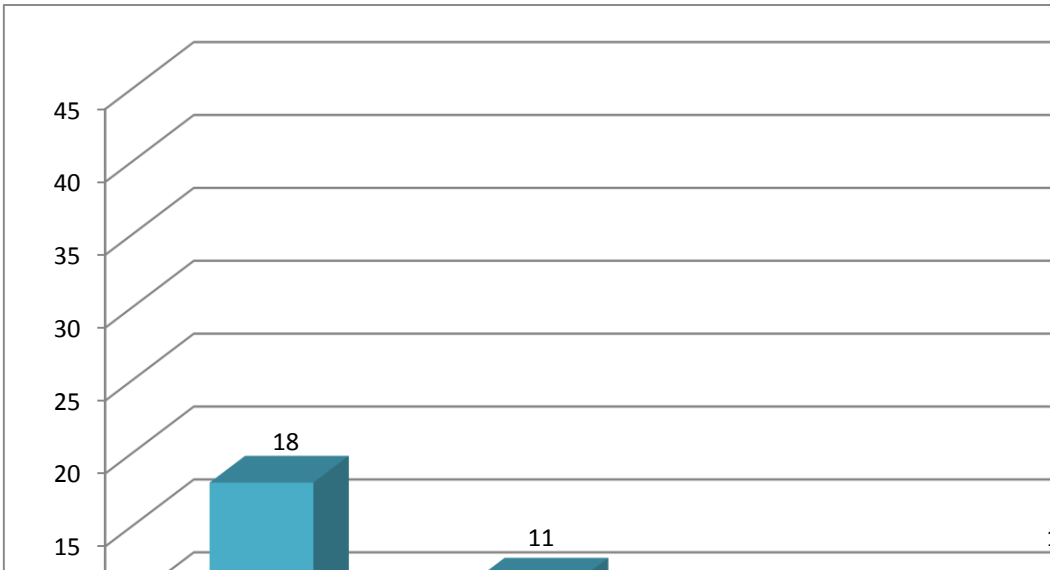


Figure 8: Internal Safeguarding Alerts by category

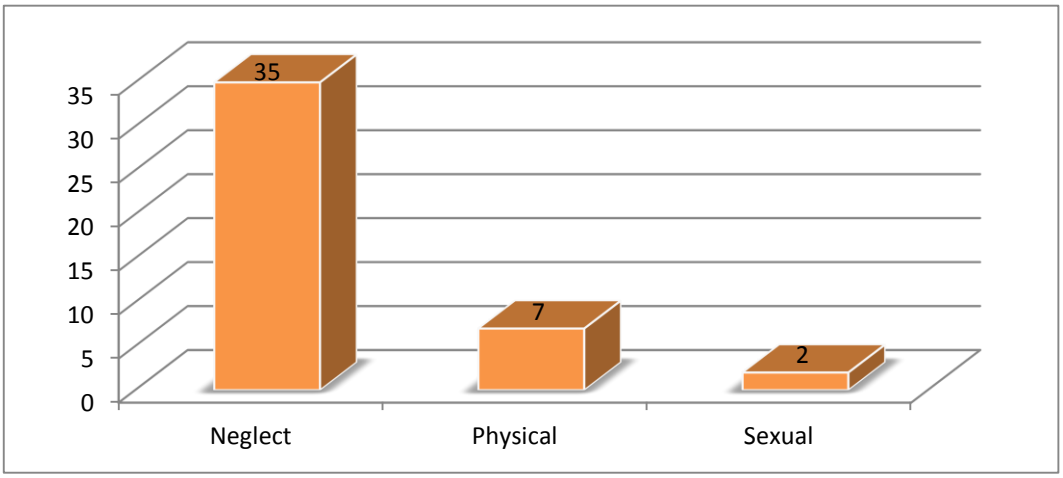


Figure 9: Outcome of internal Safeguarding investigations 1st April 2013- 31st March 2014

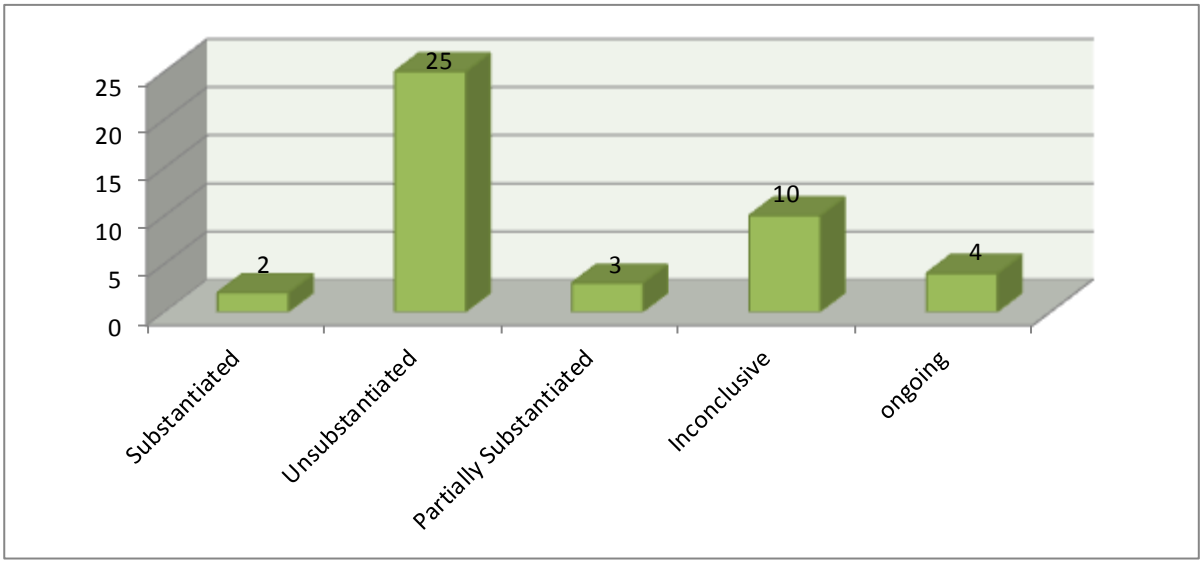


Figure 7, 8 and 9 show there have been 44 internal Safeguarding alerts raised this year, the majority have been concluded as unsubstantiated. The category of the cases referred were mostly under the heading of "neglect" and after review, were either unfounded, misreported or in some circumstances care had been misinterpreted at a time of acute confusion.

The two cases which were found to be substantiated both related to the development of a grade three pressure sore. In both cases UHB staff were fully engaged in the investigation process and the lessons learnt were embraced. Staff continue to be vigilant and are increasingly aware of situations which may have a Safeguarding component.

Lessons have also been learnt during the investigation of those cases which turned out to be unsubstantiated or inconclusive. A common theme in many cases has been noted to relate to the importance of effective communication, both between ward areas/ divisions but more particularly regarding written communication between the hospital and the community. This issue is being addressed in conjunction with the Hospital Discharge team and the community care providers.

6.2. 3 Deprivation of Liberty Safeguards (DOLS)

Figure 10: Number of DOL's Requests

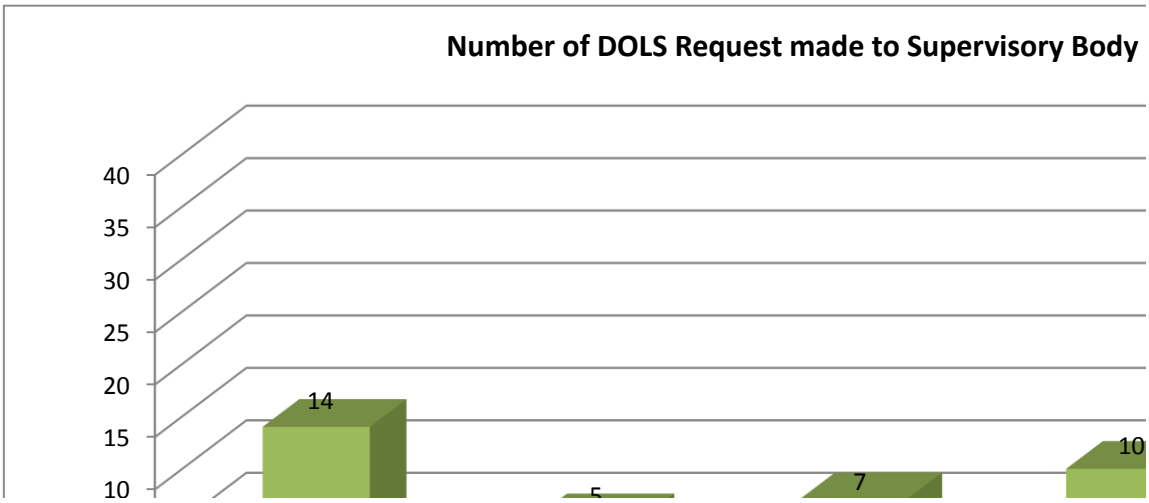
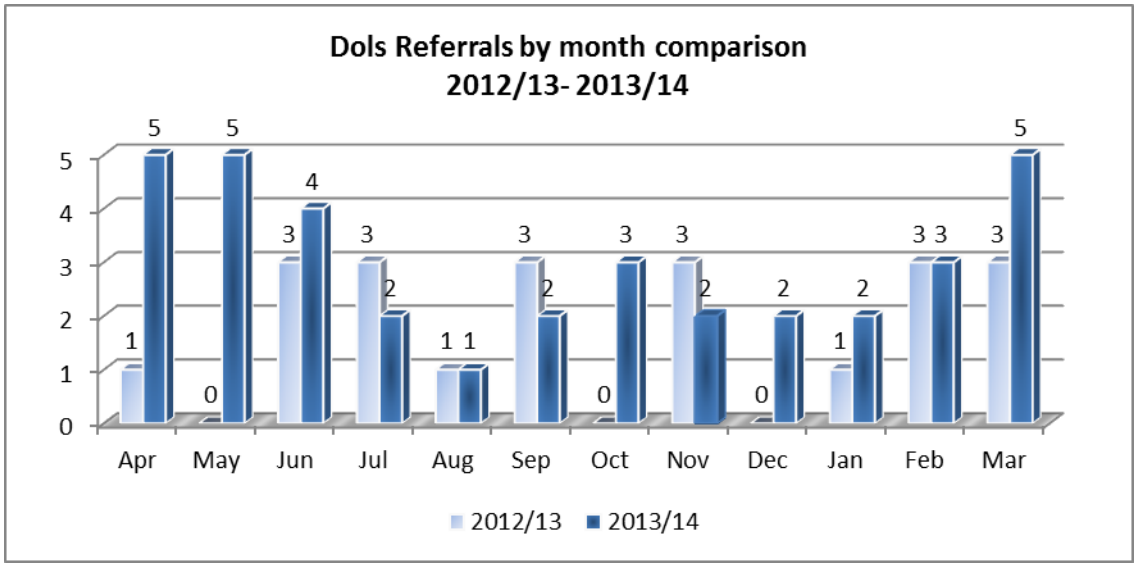


Figure 11: DOL's Requests by month comparison



There has been a 65% increase in DOLS applications this year. This has occurred as a likely result of the continuing training programme which has successfully increased the awareness of the circumstances that amount to a deprivation of liberty.

7. Serious Case Reports, Management Reviews and Domestic Homicide Reviews

Serious Case Reviews are local enquires conducted following the death or serious injury of a child where abuse or neglect is a known or suspected factor. They are commissioned by the Local Safeguarding Children Board under the statutory framework of the Children Act 2004.Follwoing the guidance set out in the revised Working Together to Safeguard Children (2013) Local Safeguarding Boards have moved away from the traditional methodology and are now following a systems methodology.

Health is involved in most case review as a provider of universal services. During this reporting period the Trust were asked to contribute to a number of case reviews, including two Domestic Homicide Reviews (DHR) which became statutory in 2011. In each case the management review and chronologies were completed within the specified time scales, all of the Serious Case Reviews followed the new systems methodology. Approach (detailed below):

- Child C – South Gloucestershire following the death of a 17 week old baby (awaiting publication)
- 'Sarah' – Bristol Serious Case Review following the death of a teenager (awaiting publication)
- Child T - Bristol Serious Case Review following the death of a BABY(awaiting publication)
- 3 complex multi-agency case review requiring the compilation of shared chronology for a child with possible fabricated or induced illness.
- 2 DHR (Bristol & South Gloucestershire)

The resulting action plans from these case review are monitored by the Child Protection Operational Group within the Women's and Children's Division. This process is overseen by the Trust Safeguarding Steering Group. Further work will take place in the next reporting period to strengthen the process of implementing and monitoring action plans from DHR.

8. Safeguarding Performance Monitoring, Quality Assurance and Audit

The Trust continues to have in place has a robust performance management framework through which safeguarding activities are monitored both internally and externally. Examples of this include:

- Quantitative safeguarding children data reported quarterly to Bristol and South Gloucestershire Local Safeguarding Children Boards and NHS Bristol as a part of compliance with the 'Safeguarding Children: Standards for providers of health services' (2013-14).
- Completion of annual 'Children Act 2004, Section 11 Self-Assessment' (South Glos Local Safeguarding Children Board).
- Monitoring of allegations, complaints and clinical incident forms by the safeguarding leads for further actions to be taken. This enables recognition of possible patterns and trends, which in turn informs supervision practice and teaching content. More detailed analysis of the incidents is planned in the next reporting period alongside the strengthening of the role of both the children's and adults Operational Groups. (See Appendix Five).
- The Safeguarding Team have also been involved with the Trust's Auditors in completing an audit about the 'Did Not Attend Policy', the resulting action plan is being implements through the Women's and Children's Division governance structures. A further audit about Consent, Safeguarding and Whistle blowing has also been completed, the results of which will be available in the next reporting period.
- The Bristol Adult Safeguarding Board has also audited adult safeguarding externally. No direct feedback is received from this audit, however what can be seen from the data compiled across all agencies across Bristol is that the Trust has robust policies and

procedures to support the adult safeguarding process and is engaged and committed to adult safeguarding.

- Robust annual audit work plans, for both safeguarding children and adults, are monitored quarterly through the safeguarding steering groups.
- 8.1 Safeguarding Risks:
- The following areas of concern are recorded on the Trust risk register to ensure that they are regularly reviewed and mitigated as far as possible:
- 1483 - The potential risk to a child through the use of multiple sets of notes across Trust hospital sites. A robust long term plan is in place to introduce Electronic Patient Records which will reduce this risk. The Trust is also engaged in working with partner agencies in developing a joint information sharing system between health and social care called Connecting Care.
- 2169 – Concerns about compliance with the regulatory requirement for the provision of clinical holding / restraint training. Training provision has proved to be an area of challenge during this reporting period. Capacity has been reviewed and a plan is in now place for the on- going delivery of training. The clinical holding policy has been reviewed during this reporting period and will be ratified in the next reporting period.
- 2419 – The inability to report safeguarding training compliance. This is being addressed as a matter of urgency within the Trust and is progress is being monitored closely by the training department, the Safeguarding Steering Group and Bristol Clinical Commissioning Group.
- 5052 – The transfer of the Hospital Social Work Team from Trust premises. This is an evolving process as part of the Bristol Change Programme which has had a significant impact on the activity of the Child Protection Nursing Team. This is being monitored by the Safeguarding Steering Group.

9. Midwifery and the Unborn Baby

The midwifery service safeguarding activity for unborn babies continues to increase with more referrals to social services many of which continue to be extremely complex with an increase in the number of removals at birth, for child protection reasons.

The reporting requirements from Bristol and South Gloucestershire Commissioning of midwifery activity data changed at the beginning of this reporting period. New reporting activity is detailed in table 1 and will allow for a more specific activity analysis in future

Table 1: Midwifery Safeguarding Activity

	2011/2012	2012/13	2013/14
Number of unborn babies discussed at case conferences /pre-birth meetings	109	141	
Number of Common Assessment Frameworks completed	39	17	
Number of unborn babies receiving an enhanced midwifery service (not yet Child Protection)	255	333	

Of particular note the number of Common Assessment Frameworks completed by midwives in this reporting period has dropped significantly. This reflects CAF activity across the city and as part of the 'Change Programme' a new assessment process is due to be introduced in the next reporting period. This will be underpinned by the new Thresholds Guidance which was published by the Bristol Safeguarding Children Board in February 2014 and the Signs of Safety training due to be rolled out in Bristol over the next 2 years.

Safeguarding supervision is provided to the Community Midwifery Teams and the Specialist Midwives to support them in managing these complex cases. These figures are incorporated into 6.1.2.

The police continue to inform the midwifery service when they are called to a domestic violence incident involving a pregnant woman.

10. Safeguarding and Domestic Violence / Multi-Agency Risk Assessment Conferences (MARAC)

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

The Trust continue to engage fully with the process of Multi-Agency Risk Assessment Conferences (MARAC) which shares information about the risk of serious harm or homicide to people experiencing domestic abuse and their children. The expansion of the Child Protection Nursing team, facilitated by Bristol Public Health funding has allowed for the introduction of a dedicated MARAC nurse, who now also attends the North Bristol MARAC and delivers MAARC awareness training across the Trust. This has also led to the formation of a Domestic Abuse Steering Group, which will be developed further over the next reporting period to support the Domestic Homicide Review agenda.

Table 2 MARAC Data

Year	MARAC's attended	Cases discussed
2009-2010	12	258
2010-2011	12	249
2011-2012	12	340
2012-2013	12	285
2013-2014	22	544

11. Safeguarding Resourcing Committee

The purpose of the Safeguarding Resourcing Committee is to ensure the Trust's safeguarding duties for both adults and children relating to all resourcing matters are fully considered and in line with current national and local requirements. In this reporting period this has included a review of the Trust process following Government changes to the criminal records checks and barring arrangements.

The Committee also took action following the high profile allegations in the widely reported in the media against the late Jimmy Saville of the historical sexual abuse, including many in NHS premises. A wider investigation entitled Operation Yew Tree followed, culminating in the report ' Giving Voice to Victims'. In November 2012 the Department of Health and NHS England contacted all NHS organisations asking that they provide assurance that robust process were in place aimed at protecting the interests of patients that a similar situation could not happen.

Following which the Committee, supported by the Trust Communications Team, reviewed the current process in place when celebrities visited Trust premises, including the Children's Hospital. This piece of work resulted in the formalisation of the existing process and the introduction of Trust wide guidance. Compliance with this guidance will be monitored during the next reporting period.

Further details of the committee's work for this reporting period are included in Appendix Five.

12. Mental Health Operational Group (Children's)

The Mental Health Operational Group (MHOG) within Bristol Children's Hospital is the planning, identifying and operational forum for mental health issues. The group focuses on the effectiveness of mental health services in the Trust.

Achievements by the group in the past year includes sign off of the mental health care pathway, implementation of the Risk Assessment Matrix (RAM), sign off of tranquilisation guidelines for under 18's, development of training programmes and more robust governance structures.

There is recognition that the current provision for Paediatric Liaison is inadequate and cannot meet the needs of the children and families who present. Evidence from the past year is being collated as evidence of the need for such a service.

12.1 Hospital Child & Adolescent Mental Health Service (CAMHS)

This reporting period has been particularly busy for the Hospital CAMHS team. There has been a significant 52% increase in presentation this is consistent with the national picture.

Alongside this increase in referrals we have also seen a rise in complexity of presentation, which in turn can take more time to assess, plan and deliver appropriate, care packages. This has meant that the assessment process is taking longer and the need to communicate in a timely way even more important. The UHB provision to **adolescent/young people's mental health** service remain on the risk register in regard to out of hours cover to the children's hospital and the BRI for under 18 year olds.

Mental Health Operational Group (Adults)
The Mental Health Operational Group (MHOG) adults Hospital is the planning, identifying and operational forum for mental health issues. The group focuses on improving the effectiveness of mental health services in the Trust,

Achievements by the group in the past year includes work of the **Bristol Health Partners Health Integrated Team** (HIT): the STITCH project, key projects have been around improving care delivery in the Emergency Departments in BRI and Frenchay and working with commissioners, GPs and patients to reduce prescribing of medications lethal in overdose to the patients who have self-harm history, **Older adults liaison psychiatry** has appointed a full time Consultant so there is dedicated consultant psychiatrist input into UHBristol. The lack of a seven day o**ut of hours psychiatric service** remains on the Medical Directorate's risk register.

13. Care Quality Commission (CQC) Outcome Seven

Safeguarding is a key priority for the Care Quality Commission (CQC), which reflects both our focus on human rights and the requirement within the Health and Social Care Act. Whilst the CQC recognises that there are differences in the statutory basis and policy context between safeguarding of children and adults, they state that for both, that there is an overarching objective of enabling people to live their life free from abuse.
The Trust is required to maintain compliance with Care Quality Commission outcome 7, which included the standards of both children and adult safeguarding for the first time. Compliance with this outcome is also required as part of NHS Bristol's Commissioning Standards.

This standard is monitored quarterly within the Trust via the Regulatory Compliance Group. The main area of concern remains:

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

14. Child Death Overview Panel (CDOP)

Since 2008 there has been a statutory responsibility for all Local Safeguarding Children's Boards to be informed of both expected and unexpected deaths of all children and young people up to the age of 18 years, who live in the Local Authority area. This includes the requirement to have a Child Death Overview Panel (CDOP). The process was reviewed as part of the revised Working Together to Safeguard Children (2013) with no major changes being made. The Trust, including the safeguarding teams, continue to be fully engaged with the Child Death Review Process.

The Child Death Overview Panel is an example of effective partnership working across agencies which provide a rigorous overview of all child deaths in or from the West of England, with the overall aim to improve outcomes for children by identifying areas for reducing the risk of preventable deaths.
Full details of the key findings from the Child Death Overview Panel will be published in the West of England Child Death Overview Panel Annual Report for 2013.

15. Summary

Ensuring that the Trust continues to fulfil its duty to safeguard vulnerable people remains a key priority and this report summarises the key safeguarding activities and achievements in this reporting period. Whilst there have been many achievements and examples of successful joint working across the safeguarding teams over the last twelve months, further work is needed to ensure that staff continue to receive the appropriate level of training for their role and responsibilities and that this can be accurately monitored and reported.
It has been essential to maintain the quality of safeguarding practice across the Trust during a challenging period of local change and continuing financial austerity. Multi-agency working in this current environment is difficult as the complexity and numbers of safeguarding cases increases. Supporting staff in day to day practice through the delivery of high quality supervision is essential, underpinned by case management advice and regular supervision, which will be developed further in the next reporting period.

16. Key Objectives for 2014/15

Whilst there are many pieces of legislation, policy and guidance from multi agencies in the area of safeguarding, the principles of empowerment, protection, prevention, proportionality, partnership and accountability remain the same for all. In order to ensure that the Trust continues to demonstrate learning from experience, and improving standards for vulnerable children and adults the following key recommendations are asked to be considered for 2014/2015:

- To continue to follow the training recovery plan as set out, with continued support from all divisions to achieve safeguarding compliance across the Trust.
- To continue to support Transitional Care arrangements for all specialists from Children's to Adult Services with a safeguarding perspective.
- To continue to play our part in Serious Case Reviews and action any specific recommendations identified.
- To review and strengthen the process for implementing action plans resulting from Domestic Homicide Review as part of the Trust Domestic Violence and Abuse (DVA) Agenda.
- To action recommendations made following Bristol and neighbouring Local Authorities, Ofsted /CQC inspections, both announced and unannounced.

- To continue to develop and promote the process of safeguarding children supervision across the Trust, including as an agenda item at Governance meetings to facilitate the involvement of individual clinical areas in demonstrating and maintaining good practice in safeguarding children.
- To work closely with local partner agencies in the promotion of the Single Assessment Framework, Early Help and the continuing 'Change Programme'.
- The formation of a short life-working group to facilitate the process of reporting of Female Genital Mutilation (FGM) data from across the Trust, as required by the Department of Health.
- To strength the process of recording qualitative evidence of practitioners listening to the 'voice of the child' and consideration of what 'A day in the Life of the child' is really like and how this is embedded in practice. This is in line with the first strategic priority of the Bristol Safeguarding Children Board.
- To develop a care-plan for use with patients detained under DOLS.
- Work with multi-agency partners to develop local process and procedures for adult safeguarding.

Full details of the aims and objectives of both safeguarding teams will be detailed in work and audit plans for 2014 -2015.

Appendix One.

Learning Disabilities

The population of the South West is approx. 5,229,346 people of which 2% (104, 835) are people with a learning disability. Only approximately 22% of this population are known to statutory services. There are approximately 10 million disabled people in Great Britain covered by the Disability Discrimination Act, which represents around 18% of the wider population.

Every day, over a hundred thousand people are treated in hospital, visit their GP or are cared for by the NHS and Social Care in the South West.

As an acute Trust, our aim and commitment is to improve the health outcomes of people with a learning disability and/or autism in a person-centred way, by:

- Maintaining momentum in improving care and outcomes for people with a learning disability, in the light of the 'Six Lives' Progress Report; and the 'Confidential Inquiry into the Premature Deaths of People with Learning Disabilities' by delivering awareness training Trust wide to raise the profile and status of people with a learning disability in general hospitals.
- Ensuring staff are trained to make reasonable adjustments, communicate effectively and follow the Mental Capacity Act (2005) Code of Practice to ensure full compliance with the law and implementing the Equality Act (2010). Aiming to identify the needs of patients with learning disabilities and to provide a range of support including 'reasonable adjustments' which is monitored monthly.
- Continually developing effective systems and processes, which include 'flagging systems'.
- Maintaining strong links and working partnerships with user groups and local authority in order to improve patient experience.

Learning Disability Research Studies Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD)

Mencap's report *Death by Indifference* described the circumstances surrounding the deaths of six people with learning disabilities who died while they were in the care of the NHS, exposing *'institutional discrimination'.* An Independent Inquiry chaired by Sir Jonathan Michael followed, which recommended the establishment of the learning disabilities Public Health Observatory, and a time-limited Confidential Inquiry into premature deaths of people with learning disabilities.

The Confidential Inquiry into the Deaths of People with Learning Disabilities (CIPOLD) was tasked with investigating the avoidable or premature deaths of people with learning disabilities through a series of retrospective reviews of deaths. The aim was to review the patterns of care that people received in the period leading up to their deaths, to identify errors or omissions contributing to these deaths, to illustrate evidence of good practice and implement recommendations.

These key recommendations (Appendix One) will be factored into the Learning Disabilities Steering Group for planning and action.

Bristol Autism Strategy 2012-2015

The Bristol Strategy and Action Plan were produced with the help of both autistic people and also family carers. They were produced in response to the requirements of the Autism Act (2009) and are designed to ensure the local implementation of 'Fulfilling and Rewarding Lives: The Strategy for Adults with Autism in England'.

The strategy is deliberately ambitious in that it goes beyond the requirements set out in the Autism Act and the associated policy guidance, which only applies to adults. By including the needs of children in this strategy, they hope to do more to support autistic people in realising their potential at all stages of their lives.
As an acute Trust we ensure that raising awareness is high on our agenda providing awareness training for all our new employees at Trust induction and by providing `pop-up' training to our existing staff. In addition to this, annual training event will continue to incorporate autism awareness training aimed at the link nurses who have expressed an interest within their clinical areas. In order to maintain current levels and progress in the implementation of the strategy quarterly meetings are held in order to action movement and monitor progression. The autism strategy and other useful resources can be found at www.bristol.gov.uk/autism.

Appendix Two:

Dementia Care

Commissioned by the South West Dementia Partnership in 2010, an Expert Reference Group was established. The group developed and agreed a set of eight common standards with the aim of significantly improving services for patients and their carers/families and to provide a level of consistency in care wherever they are cared for.
During 2013/14 a considerable amount of progress has been made across all eight Southwest standards and continued focus to achieve the FAIR CQUIN, which is also incorporated into the Fallsafe programme (Trust wide in September 2013).
Dementia CQUIN

Indicator 3.1 Find Assess, investigate, refer

May performance was;
Stage 1- Find – status RED at 52.3%
Stage 2 – Assessment and Investigation –status RED at 78.3%
Stage 3 – Referral on to GP – status RED at 56.5%
746 patients who were 75 years or over were admitted in the month of May 2014.
The CCG have funded a WTE band 7 project post (2 years) to focus on the admission areas to improve the timely screening and assessment of patients. This post has been recruited into and will commence July 2014. IM&T have developed a system specification that will flag, monitor and record all 3 stages of the CQUIN. The current planned completion date is November 2014.

Indicator 3.2 Clinical Lead & Training Programme

- Dementia awareness training provided on induction will be included on the quality dashboard from June 2014. Compliance rate threshold of 85%.

Indicator 3.3 Carer Support

This indicator requires us to ensure that carers of people with dementia feel supported. This requires a monthly survey of carers of people with dementia and hosting 4 focus groups per year.

The CCG have funded a WTE band 3 support post (2 years) to support the administration of the carers surveys to ensure a minimum of 24 responses are obtained per month. This indicator will also be included on the quality dashboard from June 2014.

A care plan 'Caring for people with cognitive impairment' has been developed and will be implemented across the adult in patient areas by the end of June 2014. The wards will audit aspects of the care plan from July. These actions were identified following the CQC inspection in January 2014.

Appendix Three

Independent Domestic Violence Advisor (IDVA) Service Emergency Department

The Bristol Royal Infirmary (BRI) Emergency Department Independent Domestic Violence Advisor (IDVA) service was set up in April 2011 and continues to provide patients attending the hospital's Emergency Department, who disclose to medical staff that they had been victims of domestic violence and abuse (DVA), the opportunity to receive immediate crisis intervention and support. The service has been running consecutively for the past 3 years – overseen by the Senior IDSVA with 2 additional IDVAs (one substantive member of staff and one bank IDVA), addressing the safety of victims at risk of harm from domestic violence to improve their safety and the safety of any children and reduce their risk.

Between 1st April 2011 and 31st March 2014 the BRI IDVA service has received 816 referrals, of which just over 40% are professionally assessed as high risk (generating 335 MARAC referrals). Education of ED staff has been an important part of this service, and engaging support of staff via training and exercising a co-ordinated team approach has contributed to a 50% increase in IDVA referrals since Year 1.

	Year 1	**Year 2**	**Year 3**
Number of referrals	215	261	340
MARAC referrals	70	112	153

Year 3 data (n= 340) indicates 126 children living in abusive households, generating 69 Cause for Concern forms within ED and 46 referrals to Children & Young People Services/First Response, (EDT out of hours).

"….this hospital [BRI] IDVA service is supporting a large proportion of high risk victims with complex needs, many of whom are slipping through the net of other agencies, for example the police or social services" *('A place of greater Safety'* CAADA policy report, November 2012).

Data continues to show victim's use of alcohol and drugs, mental health issues including self-harm or threatened or attempted suicide, play a significant associative factor and have implications for ED staff education in terms of targeting those patient groups. The IDVAs sustain strong links with Alcohol Liaison Nurses (ALN), drug specialist nurses and the Psychiatry Liaison unit on site, to support and treat victims through collaborative care pathways. Referrals from BME communities are positive being higher (24%) than the local BME population in the city (21%) showing equality of opportunity for victims to access this ED IDVA service, irrespective of their cultural or ethnic background.

Referral Pathways Year 3 (n= 340)

Referral Source	**Count**	**Percentage**

BRI ED Minors/Majors/Resus	191	56
BRI ED Observation Unit	28	8
Adult Safeguard team	22	6
Other Trust	62	18
Self-referral	8	2
Other (including Police/MARAC)	29	9
TOTAL:	**340**	

Staff training

IDVAs location within ED means that all staff have access to extensive training on the subject of DVA (Recommendation 6, NICE Guidelines 2014) including appropriate methods of screening, i.e. in a private one-to-one setting, and how to assess the current risk of the patient. All training delivered is current and relevant to emergency medicine, i.e. training on common injuries as well as recognising emotional signs and symptoms of DVA - depression, anxiety, suicidal thoughts, substance misuse. A total 104 members of Trust staff have been trained over the last 12 months by the IDVAs.

Feedback from clinicians:

"*I found this training very informative and useful and was given resources and information regarding what to do if a case presents itself within the ED department*"
ED staff nurse

"I have found even brief training very informative and well structured. I consider this information very useful and also important in order to notice and highlight issues patients can have when presenting themselves in our Dept."

Feedback from service users:

"I found the advisors to be very understanding & supportive. They were very knowledgeable and offered lots of important and useful information regarding DV and processes/procedures. Overall a very useful service. The lip balm with Tel No. is a very good idea too"

Appendix Four

PREVENT

The Office for Security and Counter Terrorism (OSCT) in the Home Office is responsible for providing strategic direction and governance on CONTEST. As part of CONTEST, the aim of PREVENT is to stop people becoming terrorists or supporting terrorism.

CONTEST is primarily organised around four key principles. Work streams contribute to four programmes, each with a specific objective:

- PURSUE: to stop terrorist attacks
- PREVENT: to stop people becoming terrorists or supporting terrorism
- PROTECT: to strengthen our protection against a terrorist attack
- PREPARE: to mitigate the impact of a terrorist attack.
-

The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.
PREVENT has 3 national objectives:

Objective 1: respond to the ideological challenge of terrorism and the threat we face from those who promote it
Objective 2: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
Objective 3: work with sectors and institutions where there are risks of radicalization, which we need to address

The Health Sector contribution to PREVENT will focus primarily on Objectives 2 and 3. PREVENT training undertaken in line with Objectives 2 and 3 are known as Health WRAP training.
Why Health care staff?

The overall principle of health is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation. PREVENT is also about protecting individuals.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence.

Healthcare staff are well placed to recognise individuals, whether patients or staff, who may be vulnerable and therefore more susceptible to radicalisation by violent extremists or terrorists. It is fundamental to our 'duty of care' and falls within our safeguarding responsibilities.

Every member of staff has a role to play in protecting and supporting vulnerable individual who pass through our care.

Appendix Five

The Safeguarding Resourcing Committee comprises of:
Deborah Tunnell – Head of Resourcing and Chair of the Committee
Helen James – Temporary Staffing Bureau Manager
Joe Bennett - Interim HR Business Partner, Women's & Children's Division
Carol Sawkins – Safeguarding Lead for Children
Linda Davies – Safeguarding Lead for Adults

Summary of Key Activity in last 12 months

- **Adverse disclosures** - the Trust's formal protocol for approving appointments where an individual has an adverse disclosure was reviewed following initial implementation in 2012/13
- The **level of criminal record check** required for the different types of substantive roles within the Trust was reviewed and updated
- The **level of criminal record check** required for the different types of volunteer roles within the Trust was reviewed formally for the first time
- An annual audit cycle was created to monitor **levels of supervision** where staff have been allowed to take up post in the absence of their disclosure being received from the DBS (Disclosure and Barring Service) and to monitor **agency compliance with safeguarding training** both in terms of frequency and the appropriate level for agency workers
- **Volunteer compliance with safeguarding training** continued to be formally reported to the Safeguarding Leads. Bank compliance with safeguarding training remains under review in light of the Trust's new Learning Management System.
- **Section 11 Children Act self-assessment** audit undertaken for South Gloucestershire Safeguarding Children's Board
- A review of the new **Children's Commissioning Standards for Health Providers** was undertaken
- **The Trust's Third Party Protocol** for external contractors on Trust premises was reviewed and disseminated. Reference to this is now made through Health and Safety and the Recruitment Policy
- **The NSPCC paper '**Towards Safer Organisations' was reviewed by the Committee
- **Work Experience Placements** for school and college students within the Women's and Children's Division remains under review
- Review of the **age of volunteering roles** remains ongoing
- The process for GMC restrictions was reviewed and reiterated with the Medical HR team.
- Terms of reference for the group were reviewed in December 2013.
- The Committee contributed to the Trust's new **VIP policy, which** is awaiting ratification.

University Hospitals Bristol NHS
NHS Foundation Trust

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

10. Equality and Diversity Annual Report

Purpose

The Trust is committed to Equality and Diversity and recognises the significance of the Equalities agenda on both patient and staff experience. As such, the Trust's Equality and Diversity Annual Report provides progress in relation to the Trust's objectives in this important area and compliance with the Equality Act 2010.

As part of the Trust's annual cycle of business, the Equality and Diversity Annual Report is now being presented to the Trust Board to provide assurance that the Trust is meeting its equality duties and making progress towards key objectives.

Abstract

This report includes a review of the key achievements and challenges in relation to the Trust's 2012 – 2014 Equality Objectives, together with an action plan for the priority work areas.

Recommendations

The Trust Board is recommended to receive the Report.

Report Sponsor

Sue Donaldson, Director of Workforce and Organisational Development

Appendices

A – Workforce Staff Equality Profile
A1 – Outpatient Attendance and Inpatient Admissions (recorded by Gender; Ethnicity; Religious Belief and Age)
B – Draft Equality and Diversity Action Plan – 2014/15
C – Formal Disciplinary Cases completed in 2013 (recorded by Sex; Disability; Age and Ethnicity
D – Patient Experience Survey Information
E – Patient Complaints (recorded by Ethnicity; Age; Gender)
F – EDS Outcomes Summary 2012/13

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other
	20th August 2014	25th Sept 2014			

Equality and Diversity – Annual Report

2013 - 2014

1. Introduction

1.1 University Hospitals Bristol NHS Foundation Trust (hereafter referred to as 'the Trust') is committed to eliminating discrimination, promoting equality of opportunity and providing an environment which is inclusive for patients, carers, visitors and staff. We aim to provide equality of access to services and to deliver healthcare, teaching and research which are sensitive to the needs of the individual and communities. We are committed to providing equal access to employment opportunities and an excellent employment experience for all.

1.2 As part of our commitment to providing responsive, high quality care and an excellent employment experience, this Annual Report demonstrates the Trust's undertakings relating to equality and diversity including compliance with the Equality Act 2010 and the following general duties:

- to eliminate discrimination, harassment and victimisation;
- advance equality of opportunity between people who share a characteristic and those who do not;
- foster good relations between people who share a characteristic and those who do not.

1.3 The Trust published its Equality Objectives in April 2012. This report sets out progress and activity in relation to these objectives, highlighting areas for improvement as well as noting areas of good practice.

2. Context

2.1 *Workforce Profile*

2.1.1 Bristol serves a socially and ethnically diverse population and this is broadly reflected in the profile of the Trust's workforce. 84% of the Bristol area are classified as White compared with 84.3% of the UH Bristol Workforce. A detailed profile of the Trust's workforce is provided in Appendix A, including a breakdown of the workforce by staff group and a workforce profile comparison with NHS England[1]. Some high level workforce profile points to note are as follows:

- The Trust employs a total of 8,290 staff. Nursing and Midwifery staff are the biggest staff group across the Trust's workforce, representing 38% of the total workforce, followed by Administrative and Clerical staff/Senior Managers with 20% of the workforce.
- 77.5% of staff are female which mirrors the sex (formerly known as gender) split across NHS England.

[1] NHS England – comprises of all NHS organisations in England including all community services

- The Trust has a comparatively younger workforce than NHS England. 27% of the Trust's staff are over 50 years old compared to 32% of NHS England staff. 49% of Trust staff are under 40 years old compared to 40% of NHS England staff.

- 78.2% of staff are recorded as being White British; 15.1% of staff are recorded as Black and Minority Ethnic (BME) staff. In addition, 5.2% of staff are recorded as Any Other White background, which may reflect European Union nationals. Of the BME groups in the Trust, 4.1% of UHBristol staff are Indian; 3.2% African and 1.8% Caribbean. These statistics reflect Bristol's changing diverse population.[2]

- 3.1% of UHBristol staff declared having a disability compared to 2.5% of NHS England staff.

- 37.1% of UHBristol staff chose not to declare any religious belief, but 42% of staff are recorded as Christian compared to 38% of NHS England staff, followed by 11.2% as Atheists compared to 7% of NHS England staff.

- 1.4% of staff are recorded as either gay, lesbian or bi-sexual, which reflects sexual orientation figures for NHS England.

2.2 *Patient Attendances and Admissions Profile*

2.2.1 The points below highlight patient attendances and admission information by protected characteristics where we have the breakdown. Further details are provided at Appendix A1**.**

- In 2013, the Trust undertook a total of 738,997 inpatient admissions and outpatient attendances.
- Of these attendances, 15.4% were for patients under 16 years old and 33% for patients over 65 years.
- 8.1% of these attendances were for patients from a BME background; 83% for white patients, however 9% of episodes were recorded as not stated or unknown.
- The gender split between male and female patient episodes is 55% and 45% respectively.

3. The Trust's Strategic Equality and Diversity Objectives

3.1 The Trust's strategic objectives were developed in 2012 following engagement events in South Gloucestershire and Bristol with patients, carers and local interest groups. The events were organised by a cluster of five local NHS Trusts.[3] The group is known as the 'Diamond Cluster' and is chaired by the Equality Lead from the Commissioning Support Unit.

[2] www.bristol.gov.uk/population

[3] University Hospitals Bristol NHS Foundation Trust, North Bristol Trust (acute Trusts); Avon and Wiltshire Partnership (Mental Health Trust) and NHS Bristol and NHS South Gloucestershire, two of the local clustered primary care trusts, now Clinical Commissioning Groups (CCGs).

3.2 The Trust's strategic objectives 2012 – 14 are:

- We become an acknowledged regional leader in equality and diversity outcomes both for our patients and staff. (This includes specific commitments to staff training, to patient satisfaction levels and to mitigating differential experiences reported in healthcare);

- We become a national exemplar for the NHS Equality Delivery System. (This is a commitment to make the Scheme work for the benefit of all the Trust's patients and staff).

3.3 In order to meet these two strategic objectives, the Trust agreed the progress would be monitored against:

- the number of Trust staff undertaking basic Equality and Diversity training dealing with communication and behaviours; and selected staff undertaking specialist training;
- patient and staff satisfaction levels broadly similar for all protected characteristics and patient complaints relating to Equality and Diversity issues minimised.

4. Progress during 2013/14 against the Trust's Equality Objectives

4.1 This section illustrates the Trust's progress in relation to meeting its Equality and Diversity objectives and highlights further work areas for development.

4.2 Actions relating to areas for development are listed in greater detail in the Trust's Equality and Diversity Action plan in Appendix B.

4.3 *Staff Training*

4.3.1 All Trust staff receive basic Equality and Diversity awareness training as an integral part of the Trust's induction programme. Communication and behaviours are specifically covered as part of the Trust's 'Living the Values' sessions. The Living the Values sessions describe the Trust's culture and values and also outlines the expected behaviours staff should embrace and witness during their employment. The importance and linkages of these behaviours on patient care is also examined and reviewed. 1,414 staff attended specific 'Living the Values' training during January 2013 – July 2014.

4.3.2 Feedback from these sessions, detailed below, demonstrates that staff appreciate the opportunity for reflection and discussion about this subject:

- 'Patients have put their trust in me. I will remember to do the best I possibly can for our patients, regardless of pressures'

- 'Appreciate there are always other things going on in other people's lives. We need to be more patient and value a person's individual differences'.

4.4. ***Examples of Clinical training specifically relating to patients with learning disabilities and dementia***

4.4.1 The Trust also provides a range of training for clinical issues relating directly and indirectly relate to Equality and Diversity. Examples include dementia training - competent level dementia training is achieved by completing the e-learning modules available on the South West Learning4health site. All staff on Medical Assessment Unit, Emergency Department, Short Term Assessment Unit, Wards 4, 7, 11, 12, 14 & 23 and Band 6, Ward Sisters and Matrons are required to meet the competent level.

4.4.2 Learning Disabilities awareness training is embedded in the Trust's Induction programme, with micro teaching identified and provided to staff as required. The Learning Disabilities Team also hold an annual awareness event, which this year was entitled 'Looking Ahead' and included a training presentation from the Bristol Autism Spectrum Service and the Bristol Hate Crime Services.

4.5 ***Further Training Planned***

4.5.1 Clinical training sessions relating to the protected characteristics is on-going. Further targeted training, for example, additional equalities training for managers and leaders on unconscious bias and reasonable adjustments forms part of the Trust's Equality and Diversity Action Plan.

4.6 ***Staff Experience/Engagement***

4.6.1 In order to understand the experience of staff from the protected characteristics, the Trust is using evidence from the annual staff survey[4] and triangulating the data with monitoring information taken from formal employee cases. Together, this information has highlighted some emerging themes such as job satisfaction, career progression, harassment and bullying, discrimination and disciplinary outcomes. This information will be used to populate the Equality and Diversity Action plan.

More detailed information on the themes and the steps the Trust has taken and is planning to take are provided below:

4.6.2 Job Satisfaction and Career Progression

4.6.3 Both male and female staff had similar staff job satisfaction scores but there was a lower score between staff declaring a disability compared with those who were not disabled (3.58 compared with 3.61 respectively). BME staff scored lower in terms of job satisfaction compared to white staff – 3.47 compared to 3.64. Notably, there was a higher motivation at work score amongst BME staff (4.07) compared to white staff and disabled and non-disabled staff.

[4] 439 staff out of 850 at UH Bristol took part in 2012/13 staff survey, a response rate of 52%, which is average for acute Trusts in England. During 2013/14 all staff will be invited to participate in the annual staff survey.

4.6.4 88% of staff survey respondents stated that they believed that the Trust provided equal opportunities for career progression/promotion, but this is a 2% decrease since 2012 and equals the national average for acute Trusts.

4.6.5 The Trust is working with the Staff Black and Minority Ethnic Workers Forum to improve the overall employment experience for BME staff. The Forum has led a Reverse Mentoring pilot. Reverse Mentoring provides BME staff with the opportunity to talk directly, openly and honestly with an individual senior member of staff, about some of the organisational issues and barriers to progression in the Trust. Conversely, senior staff gain a new perspective on the complex diversity issues in the Trust and improve their understanding and knowledge on equality issues. Senior staff involved in the pilot have included the Chief Operating Officer, the Deputy Chief Nurse and a Divisional and Deputy Divisional Director.

4.6.6 The pilot is currently being evaluated and based on positive feedback received to date, it is anticipated that the scheme will become part of the Trust's approach to Leadership development.

4.6.7 Harassment, Bullying and Discrimination

The number of staff experiencing harassment and bullying from other staff, was one of the Trust's bottom ranking scores in the staff survey, scoring 28% (above the national average for acute Trusts scoring a percentage of 24%). Analysis of workforce monitoring data demonstrates there was proportionately a higher percentage of formal harassment and bullying cases from staff with a Black and Minority Ethnic background (BME) than white staff.

4.6.8 14% of staff stated that they had experienced discrimination at work during the previous 12 months. This is an increase of 2% from the 2012 survey, and is above average (11%) for acute Trusts.

The Trust has already been taken steps to address harassment and bullying such as:

- strengthening the Trust's existing policy, including giving clearer definitions and examples of what is and is not bullying behaviour
- identifying sources of support both for people who believe that they have been bullied and for those accused of bullying
- creating a diagnostic toolkit to address concerns in areas where bullying/ harassment/ inappropriate behaviour is known/strongly suspected but no formal complaint has been made
- specifically targeted information for Junior Doctors re: how to raise concerns and sources of support available. promoting a culture of no tolerance for harassment, bullying and discrimination.

4.6.9 The Trust will continue to promote a culture of no tolerance for harassment, bullying and discrimination. The Trust will review actions taken to date and will be formulating

a Trust-wide 'Tackling Harassment, Bullying and Discrimination and Victimisation' plan which will link to existing Organisational Development (OD) strategies and plans.

4.6.10 Disciplinary outcomes

4.6.11 Analysis of the Trust's workforce data also demonstrates that 5.5% of the total number of BME staff were involved in formal disciplinary action compared to 3.5% of white staff. Further details are also available at Appendix C.

4.6.12 Auditing the outcomes of formal disciplinary and grievance cases undertaken by Employee Services, will be a key a priority in order to understand the context and reasons for cases reaching formal stages. The audit will also provide an opportunity to review the equity of policy application.

4.7 *Other actions taken by the Trust to support staff with protected characteristics*

4.7.1 The Trust continues to support staff with protected characteristics in a variety of ways as described below:

- The Trust understands its obligations to ensure that people with disabilities are given equal opportunity to enter into employment and progress wherever possible. Recruitment procedures have been aligned with the Equality Act's requirements for good practice for pre-application health checks permitted in the Equality Act.

- All staff must adhere to the Trust's Equality and Diversity, Human Rights policy and Recruitment policy. The Trust plans to review this policy as part of the planned introduction of a Trust Equality and Diversity Strategy.

- The Trust complies with the "Positive about Disabled People" scheme. This scheme commits the Trust to interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their skills, experience and knowledge.

- The Trust updated its Equality and Diversity policy and used an infographic poster to highlight NHS Equality and Diversity and Human Rights Week across the Trust.

- The Trust takes steps through its Redeployment Policy to enable employees to remain in employment wherever possible. This includes working closely with the Occupational Health Department, Employee Services and external agencies such as Access to Work to ensure reasonable adjustments are made.

- The Trust completes Personal Emergency Evacuation Plans (PEEP) for staff, where a disability/impairment may impede safe evacuation.

- The Trust celebrated Black History Month with a seminar run in conjunction with the Bristol City Council regarding the introduction of Reverse Mentoring.

- The Trust has an established Black and Minority Ethnic Workers Forum. The Trust is going to re-launch forums in September 2014 for staff with disabilities/physical and sensory impairments and Lesbian, Gay, Bi-sexual and Transgender staff, enabling

staff from these groups to raise issues among peers, contribute to Trust policy and develop and support the EDS2 objectives.

- In partnership with the Trust's Royal College of Nursing representative, the Trust has formed a support group for staff with dyslexia which is both highlighting issues for dyslexic staff and working with the Trust to overcome them.

4.7.2. In addition, the Trust has developed work programmes which aim to address some key areas in the staff survey. The programmes include Staff Experience and Engagement, Health and Well Being; Retaining and Recruiting the Best; Building Leadership Capability and Performance and Reward.

4.8 ***Patient Experience** – **supporting information and examples of good practice***

The Trust has undertaken a wide variety of stakeholder engagement and involvement events designed to improve the overall patient experience, examples of which are detailed in section 4.9 below. The Trust has made progress in data collection and feedback received from patient surveys and learning from formal and informal complaints. Areas requiring improvement include increasing overall patient monitoring information to enable the effective objective setting.

Further details of patient experience data are detailed below:

4.8.1 ***Patient Experience Surveys***

4.8.2 Patient surveys provide the Trust with useful data on how service users view the care/service they have received. The diversity information relating to patient experience information is based on two key patient experience surveys – the monthly in-patient survey and annual outpatient survey. The survey responses are linked to the information held on the Trust's Patient Administration System which currently uses the limited demographic data of age, gender and ethnicity. Expanding the data categories to improve monitoring will form part of the Equality and Diversity Action plan. From May 2014, UHBristol has added questions to the monthly in-patient survey in order to pick up additional data on religion, sexuality and disability.

4.8.3 The survey question used was 'overall, how would you rate the care that you/your child received? With the response options: excellent, very good, fair, and poor.

4.8.4 In brief, UHBristol inpatient satisfaction by age shows a pattern that is mirrored at a national level: steadily increasing satisfaction by age, with a slight decline for patients in the oldest age groups. There is no discernable pattern of age effect in the out-patient survey data although 26-44 year olds has the lowest levels of satisfaction.

4.8.5 There were low numbers of respondents in non-white ethnic groupings, with no ethnic group consistently rating UHBristol's care below average. Caution is needed with the out-patient data, as very small numbers of people from non-white groups responded.

4.8.6. In terms of gender, the Trust results mirror national trends in that females rate the care less positively than males (49% and 55% respectively giving an 'excellent' rating for inpatient care; 61% versus 64% for out-patient care).

4.8.7 As data is taken from the Trust's survey programme there is no direct national comparison available. Nevertheless, the Trust consistently performs in line with the national average Care Quality Commission's National Patient Survey Programme.[5] Therefore, it would be a reasonable working assumption that the scores seen in the charts contained in Appendix D are in line with national norms. Furthermore, some of the trends seen in the data are also corroborated with the broad findings of the national surveys[6]:

- Women tend to give less positive ratings of care than men
- Inpatient satisfaction increases with age, except among the oldest age groups

4.8.8. One national trend that we do not find in our data is that of a difference in satisfaction levels between ethnic groups. A large scale analysis of the CQC national inpatient survey data found that Non-white groups tended to report more negative experiences than White patients[7]. There are a number of explanations that may account for the fact we do not see this trend in the UH Bristol survey programme, for example:

- UH Bristol may provide a better than average hospital service to patients from ethnic minorities
- The relatively small number of responses that we have in our survey from non-white people, with its conversant effect on data reliability, may be masking real differences in our data
- There may be a "specialty-level" explanation for the difference in ethnic groups seen at a national level (e.g. patients from certain groups are more prone to certain disease types, and it may be that those specialties are not delivering such a good experience to all of their patients – rather than the fact a patient comes from a Non-white group *per se*).

4.8.9 We cannot tell which of these (if any) is the correct explanation. However, we can say with more certainty that postal surveys are not a feedback channel that tends to

[5] http://www.cqc.org.uk/content/surveys

[6] http://www.pickereurope.org/J%20Health%20Serv%20Res%20Policy-2014-Sizmur-1355819614536887.pdf

[7] http://www.pickereurope.org/assets/content/pdf/Survey_data_analyses/Multilevel_analysis_of_inpatient_experience_March_2011.pdf

engage minority groups. Therefore, it is important that the Trust continues to have a programme of engagement in place that is largely qualitative (face-to-face) in nature.

4.8.10 The Trust will continue direct engagement and involvement events with services users and the local community which forms a significant part of the Trust's Patient Experience and Involvement Action Plan 2014/15.

4.9 ***Patient Complaints***

4.9.1 In 2013/14 the Trust's target was that the volume of complaints received should not exceed 0.21% of patient activity – in other words, that no more than approximately 1 in 500 patients complaining about our service. We achieved 0.21%, compared to 0.29% in 2012/13.

4.9.2 The total number of complaints received during the year was 1,442, a decrease of 10% on the previous year. Compared with 2012/13, there was a decrease of 6% in the number of complaints managed through the formal investigation process and a 13% decrease in the number of complaints managed through the informal investigation process.

4.9.3 Patients' ethnicity, age and gender are recorded on the Trust's patient administration system, Medway. Where available, the data covers patients' age, gender and ethnic group. Information about the age, gender and ethnicity of patients who made a complaint in 2013/14 (or on behalf of whom a complaint was made) can be found at Appendix E. This data shows that:

- There was a broadly even distribution of complaints between men and women
- 31.6% of patients were aged 65 years or above[8]
- The overwhelming majority of people who complained, and whose ethnicity is recorded, were White British.

4.9.4 In 2013/14, there were 488 patients whose ethnicity was unknown. If that group of patients bore the same characteristics as the group whose ethnicity is known, it would be reasonable to conclude that the ethnic origin of people who complain about the Trust's services does not mirror the ethnicity of the population the Trust serves. This may be for cultural reasons, and partly it may reflect UH Bristol's role as a tertiary care centre (i.e. the population of the wider region is less diverse than in Bristol). However it may also raise questions about accessibility.

4.9.5 The Patient Support & Complaints Team has commenced the practice of routinely asking for the patient's ethnic group, age and gender if this data has not been pre-populated. In the meantime, the Trust will be making its Patient Support and Complaints Team *'How can we help?'* leaflet available in several of the ethnic languages most commonly spoken by residents of Bristol.

[8] This includes all inpatient and outpatient complaints. However, as a point of reference, 29.4% of inpatients seen by the Trust in 2013/14 were aged 65 or above, i.e. the pattern of complaints is broadly similar.

5. *Patient Experience – improvements made in the last twelve months*

The following examples are steps undertaken by the Trust, designed to improve the experience and quality of care received by patients from a number of the protected characteristics:

- *STITCH - Services and Trusts Integrated to Transform Care in Self-Harm*. This is a user led experience based co-design project working with patients who self-harm harm presenting in the BRI Emergency Department.

- *SMART Recovery Group*- The SMART Recovery group runs every Wednesday in the BRI. This is a mutual aid group for people who have problems with addictive behaviours such as drugs, alcohol, gambling etc. and promotes abstinence from these types of behaviours. The group is open to in-patients, out-patients, ex-patients and other members of the public. One of the facilitators is a service user.

- *Paediatric Hearing Loss Diagnosis Clinic*. This focus group reviewed the parent/carer experience of this service resulting in a new simple leaflet for parents being designed.

- *End of Life* - Recruitment of lay representatives for end of life steering group for adults and children.

- *Bristol Physical Access Chain* have been involved in discussions pertaining to: the development of the BRI Welcome Centre, a new Trust wide Catering Leaflet, The Trust plans for improved way marking, the Trust plans for new patient letters.

- *Carer Liaison* - Our Carer Liaison Worker started work on 1st April 2014 and works across the Trust now the post has been extended from 3 to 5 days per week. 42 referrals were received during the first month, including new referrals for support for carers of patients within Bristol Haematology and Oncology Centre (Ward 61 - Oncology).

- *Learning Disability* - All Inpatients with a learning disability are risk assessed with 48 hours following admission and reasonable adjustments are identify and made

- *Patients with Dementia* - Discussions have taken place in conjunction with the Alzheimer's Society regarding the new build and refurbishment works to ensure the needs of people with dementia are considered to create a healing environment for people with dementia. The Trust provides a successful ward based volunteer befriending scheme for patients with dementia. The Trust continues to review its systems and procedures, such as electronic patient administrative systems, to ensure patients with dementia who also have other complex diagnoses, receive appropriate holistic care and support.

- *Congenital Services* – the Specialist nurses in this area have been working with young patients to improve their care experience and together have created new leaflets to help young patients understand their medication and to weigh up the options of mechanical versus tissue heart valves.

- Adult patients have been involved in the development of a mobile application for patients with Adult Congenital Heart Disease (ACHD) to record their progress and assess their symptoms.

- The Congenital Specialist nurses has also devised easy read leaflets for patients with learning disabilities for *'Coming to the BHI – Day-Case Procedure''* and *'Coming to the BHI – Overnight Stay'.*

- *Rheumatology Services* – patient and staff feedback was instrumental in the design of the new Rheumatology department.

- *Cleft Services* – the clinical lead for the Cleft Services is working with the patient support group, CLAPPA, to inform the transfer of the Cleft service to UHBristol.

- Rationalisation and improvement to patient letters and the design of a Patient Nutrition information leaflet has been completed with involvement with Health Watch and the Bristol Physical Access Chain.

- The Trust has undertaken Equality Impact Assessment (Equality Analysis) for service developments such as the Cleft Service and BRI Redevelopment Model of Care, and recognises that additional training and support is required to embed the practice and improve the quality of the assessments.

- The Trust has increased the number of Honorary Chaplains including a local Imam Rafiqul Alam, to visit Muslim patients.

- To support patients our patients we provide an interpreting service. Staff interpreters cover 36 languages, although the Bristol City Council report 91 languages spoken in Bristol. In 2013/14, the Trust was able to provide interpreters for 80% of all interpretation requests. The total spend on interpreting services in 2013/14 was £118,050.

6. Assessment against the Equality Delivery System (EDS)

6.1 The Equality Delivery System (EDS) was implemented in the NHS in 2011. A central element of the EDS is engagement with service users. Two dedicated engagement events were organised by a local cluster of NHS organisations – University Hospitals Bristol NHS Foundation Trust, North Bristol Trust (acute Trusts); Avon and Wiltshire Partnership (Mental Health Trust) and NHS Bristol and NHS South Gloucestershire, two of the local primary care trusts as was and now Clinical Commissioning Groups. The Group is led by the Commissioning Support Unit. The group is known as the 'Diamond Cluster' (see section 3.1). The Trust undertook an initial assessment based EDS which contained in Appendix F.

6.2 Following the introduction of the EDS2 – a revised, more streamlined and responsive framework, UHBristol has been working in partnership with the other members of the Diamond Cluster on its planned implementation of EDS2. The Diamond Cluster has

concentrated on recruiting and training an Equality Expert Group consisting of members of the public who may represent the protected characteristics and who have an interest in equalities issues. This expert group will act as a resource for the local NHS organisations to draw upon to assess the goals and outcomes required as part of the EDS2 assessment.

6.3 The Trust will use the EDS2 framework for improving service provision to reflect all the needs of its users and staff. The Trust is in the process of reviewing its approach to EDS2, recognising that it is much better to manage a comprehensive implementation programme over three to five years, using informed selective choices from stakeholders. The Trust is developing an EDS2 implementation plan which will involve an initial self-assessment to support the Expert Group. The implementation plan will be completed by October 2014.

6.4 Recognising the EDS2 framework will form the foundation of the Equality and Diversity agenda across the Trust, an experienced project manager has been recruited on a fixed term basis to develop a full EDS2 action plan. High level points from the EDS action plan include:

- Using the EDS outcomes as statements which align to the Trust's business
- Working with the Public Patient Involvement team to collate evidence in order to set priorities and objectives from staff and patients using a star chart process (see Appendix F)
- Devising a detailed Communications and Engagement plan specifically relating to the EDS for internal and external use
- Further collation of evidence relating to the top three priorities identified from the staff, patients and stakeholder feedback
- Involve members of the Expert Group throughout the process and use this group to agree overall EDS score
- Use the identified priority areas and scores to develop the Trust Equality Objectives for 2015/17
- Publish objectives widely and use to support further engagement with the local community and service improvements.

7.0 Action Plan Priorities for 2014/15

7.1 In order to reinforce the Trust's commitment to Equality and Diversity and to ensure the completion of the Trust's Equality and Diversity Objectives, the Trust recognises there are a number of priorities for 2014/15. These key priorities are:

- Completion of the EDS2 self-assessment and action plan.
- Full implementation of EDS2 action plan leading to revised equality objectives using stakeholder engagement and involvement.
- Develop a Trust-wide 'Tackling Harassment, Bullying and Discrimination and Victimisation' plan – linking to Organisational Development (OD) existing strategies and action plans.
- Develop and implement an integrated Equality and Diversity Strategy for service users and the Trust workforce.

- Implementation of Equality and Diversity e-learning and additional specialist training for managers.
- Review recruitment and retention processes for 'unconscious bias'.
- Ensure equity of access for training and development and improve career development opportunities for staff from the protected characteristics.
- Continue to triangulate workforce and patient data to improve employment and patient experiences.
  As previously indicated, these priorities and other actions described in this report are detailed in the Equality and Diversity Action plan at Appendix B.

8. Governance

8.1 The Trust's Board of Directors are responsible for ensuring the Trust's commitment to Equality and Diversity is implemented at all levels of the organisation and that all business is carried out in accordance with the values of the organisation. The Board monitors the implementation of its equality and diversity work as part of its annual cycle of Board reporting and the Board Assurance Framework.

8.2 The annual report demonstrates commitment to compliance with the Equality Act 2010. The report includes coverage of both workforce and patient services.

8.3 The Director of Workforce and Organisational Development is the nominated lead Director for Equality and Diversity. There is a dedicated Trust Equality and Diversity/Health and Wellbeing Group.

8.4 The Equality and Diversity/Health and Well-Being Group leads on the actions contained in the Action Plan (Appendix B). The membership and role of this Group is being reviewed as part of the Trust's Equality and Diversity Action Plan.

8.5 Progress on the action plan will be reported to the Workforce and OD Group and the Senior Leadership Team. A summary will also be included in the quarterly workforce report to the Trust's Quality Outcomes Committee (QOC) and the Trust Board from September 2014.

8.6 The Trust works in partnership with its Staff Side representatives. Staff side members actively participate in the Equality and Diversity/Health and Well-Being Group. Equality and Diversity issues can be raised at any point but notably the Industrial Relations Group regularly reviews equality data and all Trust employment policies are agreed in partnership and are equality impact-assessed.

9. Conclusion

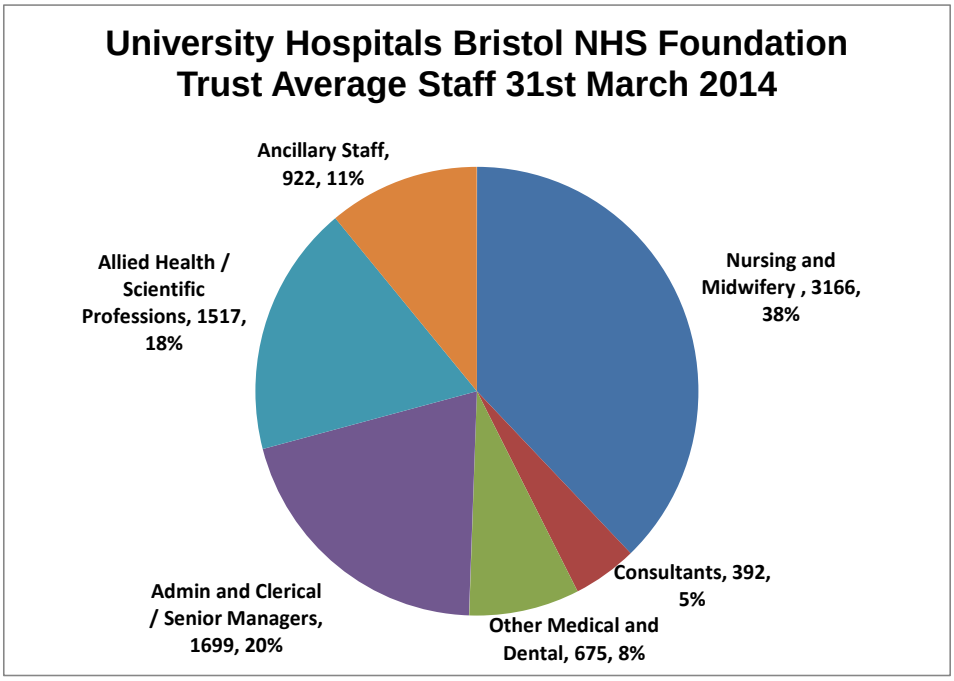
9.1 The Trust has made progress on key objectives and has undertaken a wide range of Equality and Diversity activities during the year. However there is considerable work still required as demonstrated by the action plan which will form the basis of work programmes for the remainder of the financial year.

Rebecca Ridsdale, Head of Reward
July 2014

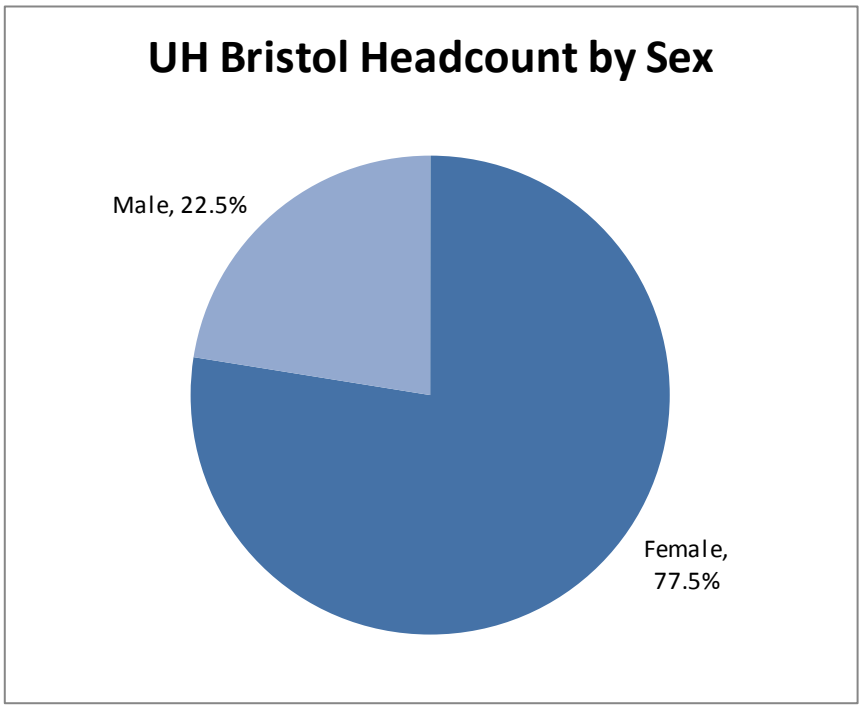
Appendix A

UHBristol Workforce Equality Profile

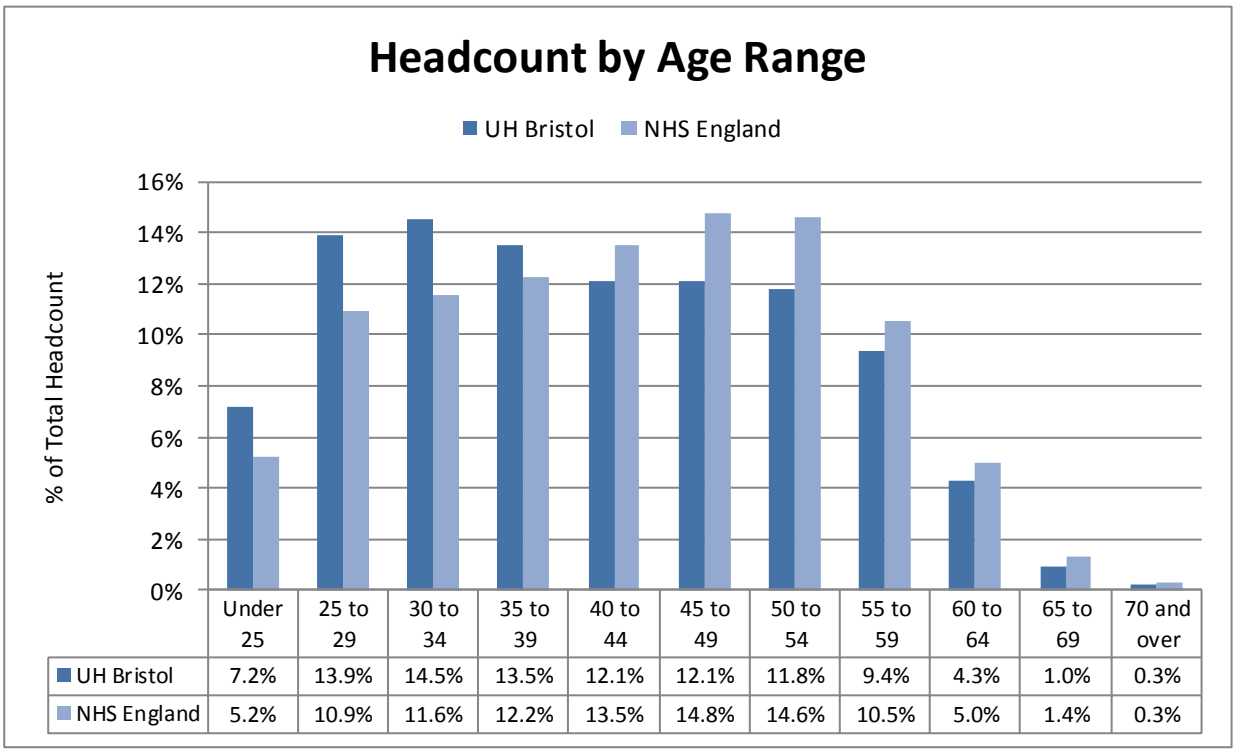
1. Workforce Staff Group Profile



2. Sex – (formerly known as Gender) of UHBristol Workforce

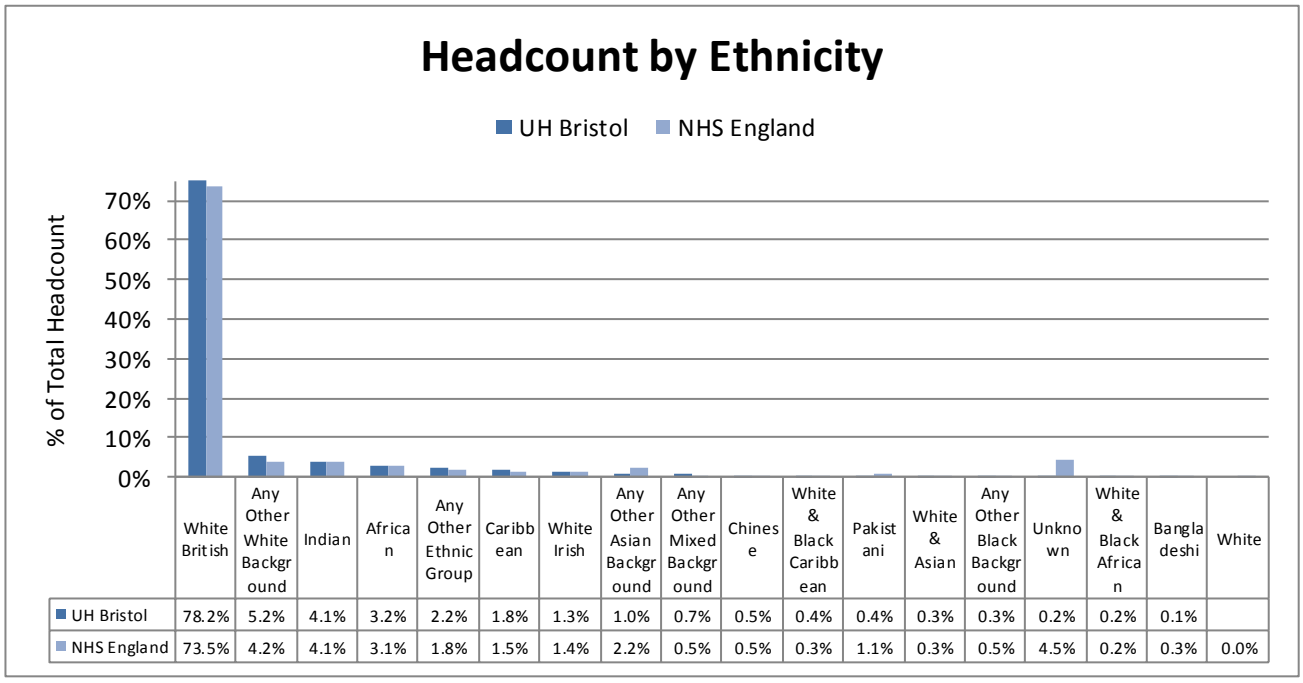


3. Age



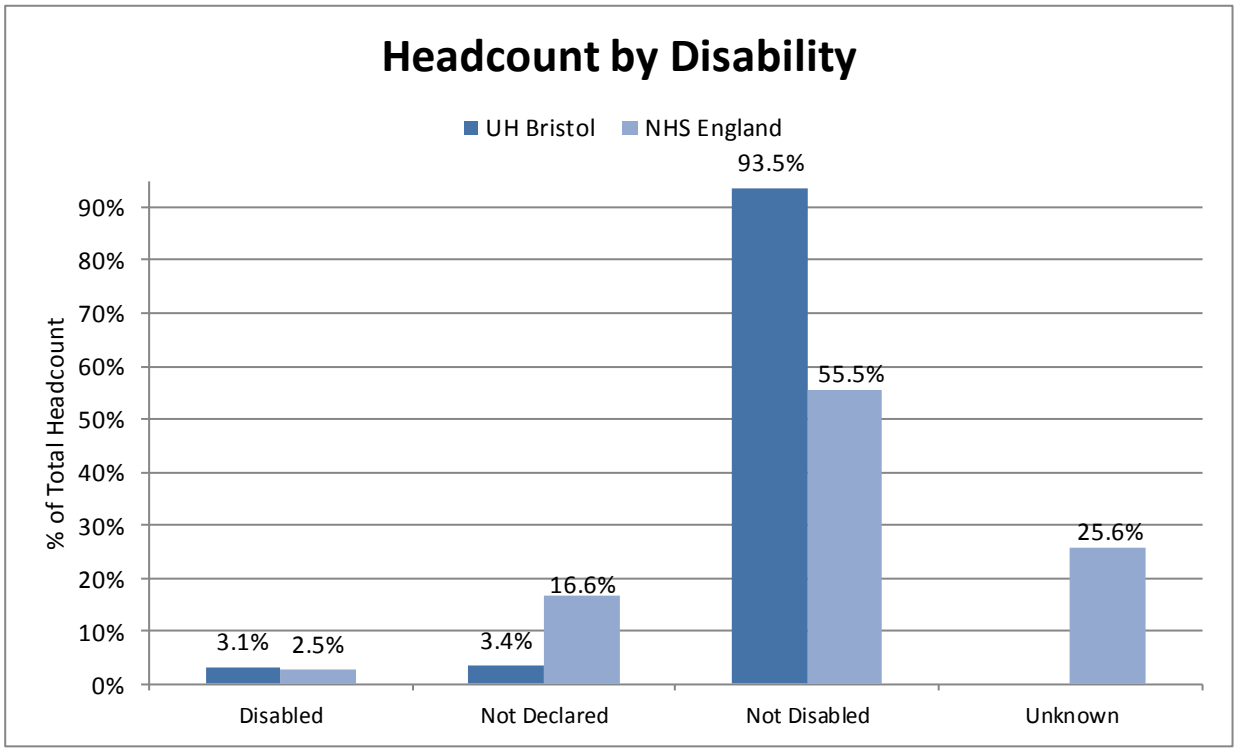
	Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 and over
UH Bristol	7.2%	13.9%	14.5%	13.5%	12.1%	12.1%	11.8%	9.4%	4.3%	1.0%	0.3%
NHS England	5.2%	10.9%	11.6%	12.2%	13.5%	14.8%	14.6%	10.5%	5.0%	1.4%	0.3%

4. Ethnicity of UHBristol Workforce compared with NHS England

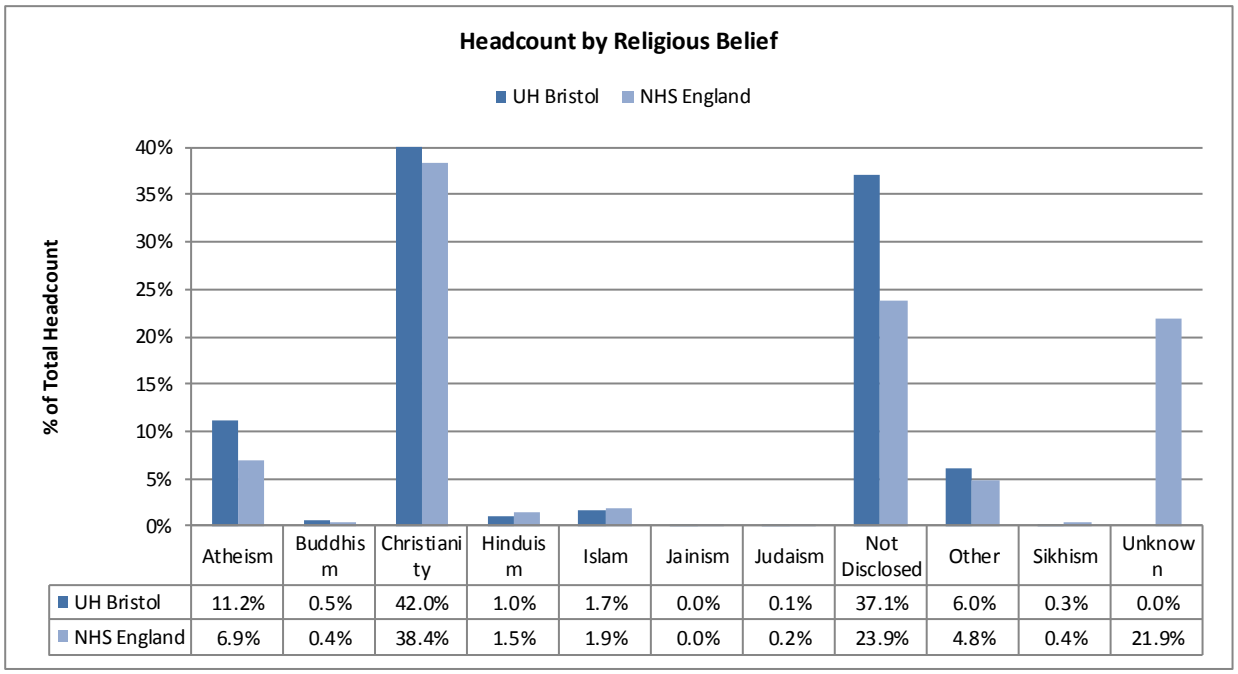


	White British	Any Other White Background	Indian	African	Any Other Ethnic Group	Caribbean	White Irish	Any Other Asian Background	Any Other Mixed Background	Chinese	White & Black Caribbean	Pakistani	White & Asian	Any Other Black Background	Unknown	White & Black African	Bangladeshi	White
UH Bristol	78.2%	5.2%	4.1%	3.2%	2.2%	1.8%	1.3%	1.0%	0.7%	0.5%	0.4%	0.4%	0.3%	0.3%	0.2%	0.2%	0.1%	
NHS England	73.5%	4.2%	4.1%	3.1%	1.8%	1.5%	1.4%	2.2%	0.5%	0.5%	0.3%	1.1%	0.3%	0.5%	4.5%	0.2%	0.3%	0.0%

5. Disability – UHBristol Workforce compared with NHS England

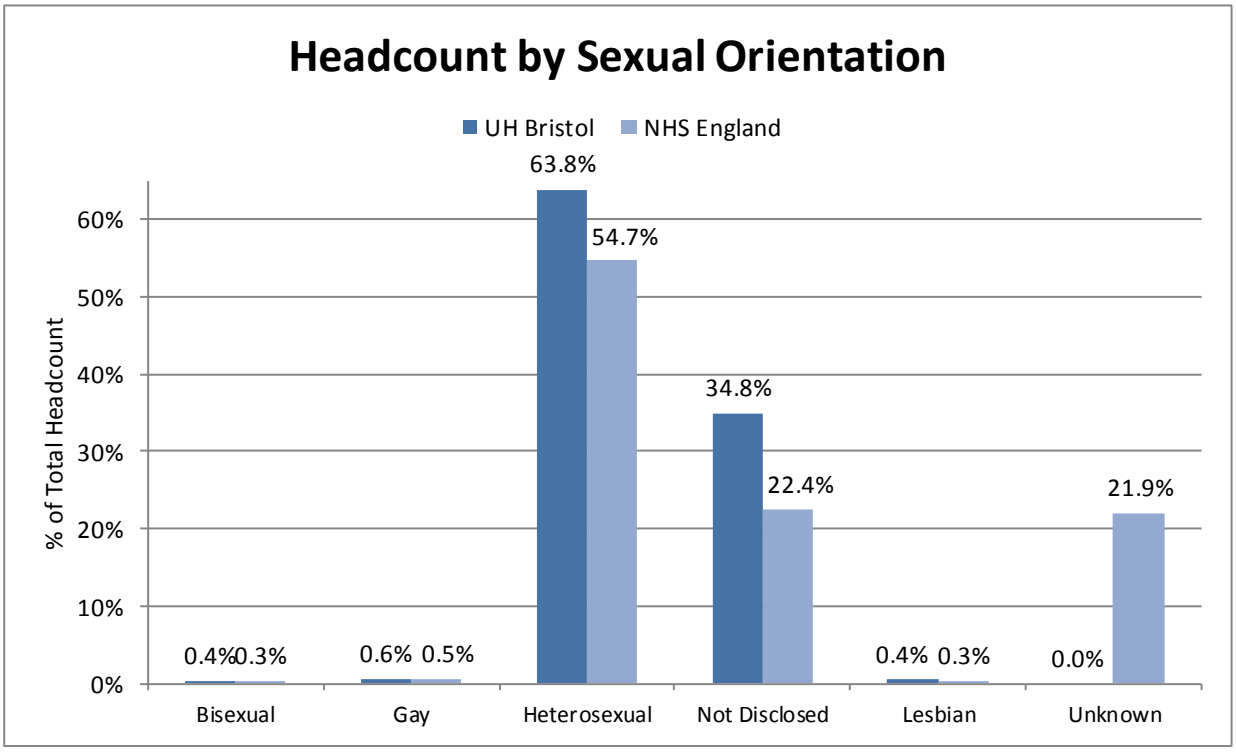


6. Religious Belief



	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism	Judaism	Not Disclosed	Other	Sikhism	Unknown
UH Bristol	11.2%	0.5%	42.0%	1.0%	1.7%	0.0%	0.1%	37.1%	6.0%	0.3%	0.0%
NHS England	6.9%	0.4%	38.4%	1.5%	1.9%	0.0%	0.2%	23.9%	4.8%	0.4%	21.9%

7. Sexual Orientation of Workforce compared to NHS England



Appendix A1

Outpatient Attendances and Inpatient Admissions

Grand total	738,997				
Gender	**Total**	**%**		**Ethnicity**	**Total**	**%**
Male	403952	54.7%		White	610908	82.7%
Female	335042	45.3%		Black & Minority Ethnic Background	59543	8.1%
				Not stated / unknown	68546	9.3%
Religious Belief	**Total**	**%**		**Age Group**	**Total**	**%**
Atheism	2671	0.4%		Age Under 16	113771	15.4%
Buddhism	1424	0.2%		16 - 20	27068	3.7%
Christianity	402237	54.40%		21 - 25	30990	4.2%
Hinduism	2313	0.3%		26 - 30	37979	5.1%
Islam	19123	2.6%		31 - 35	39203	5.3%
Jain	2	0.0%		36 - 40	32508	4.4%
Judaism	781	0.1%		41 - 45	33792	4.6%
Sikhism	2293	0.3%		46 - 50	39986	5.4%
Other	5193	0.70%		51- 55	42772	5.8%
None - Not Religious	147239	19.9%		56 - 60	45477	6.2%
I do not wish to disclose	33	0.00%		61 - 65	52211	7.1%
Not set / Unknown	155688	21.10%		Age Over 65	243240	32.9%

Appendix B

UHBristol Equality and Diversity Action Plan – 2014/15

Planned Actions	Proposed Timescale	Facilitator
TRAINING		
Develop a comprehensive training plan for all staff	October	Head of Reward/Head of Teaching and Learning
Develop training modules for managers and leaders	October – March	Head of Reward/Head of Teaching and Learning
Devise and run training and briefings/seminars for the Senior Leadership Team and Trust Board on 'Unconscious Bias' and other equalities topics	November – March	External Consultant/Director of Workforce and OD
Implement appropriate e-learning for Equality and Diversity as part of essential training review	January	Head of Reward/Head of Teaching and Learning
Develop a resource pack on disability and reasonable adjustments for managers	December	Head of Reward
Develop additional resources for staff and managers to access via HR Web	On-going	Head of Reward
STAFF EXPERIENCE		
Review and make recommendation for the formal implementation of a Trust Reverse Mentoring programme.	October	Chair of the Trust BME Workers Forum/*Head of Reward
Develop a 'Standards of Behaviour' leaflet for managers and staff which supports the Trust's Values and its overall approach to Tackling Harassment and Bullying	December	Head of Reward/Head of Organisational Development
Review the Trust's recruitment processes for potential unconscious bias	January	Head of Resourcing
Audit formal grievance and disciplinary cases and review application of related polices for equity and escalation	January	Head of Resourcing/Head of Reward
Devise strategies and actions to recruit a representative workforce across all Trust staff groups	March	Head of Resourcing
Support and develop the Staff Dyslexia Group to address workplace issues and provide support and advice for staff and managers with dyslexic staff and	On-going	RCN representative/Head of Reward

associated disabilities/impairments		
Refresh and reintroduce the staff equalities groups for LGBT and PSIG (Lesbian, Gay, Bi-Sexual and Transgender and Physical and Sensory Impairment)	September	Head of Reward
PATIENT EXPERIENCE		
Review processes for patient monitoring data seeking to reduce numbers of 'not declared/no known and increase information collected for all protected characteristics	March	Director of IM&T/Deputy Chief Nurse/Head of Reward
Hold further patient and engagement events as detailed in the Patient and Involvement Action Plan	On-going	Assistant Director of Audit and Assurance/Patient and Public Involvement Officer
Produce the 'How can we help' leaflet in several of the ethnic languages spoken in Bristol	March	Assistant Director of Audit and Assurance
Develop electronic flag system for additional reporting of patients with dementia	March	Chief Nurse/IMT Department
Recruit a Band 3 Support post to support the Dementia Project Nurse	December	Dementia Project Nurse
EQUALITY DELIVERY SYSTEM (EDS2)		
Completion of the EDS2 self-assessment and action plan	October	Interim E&D Project Advisor/Head of Reward
Implementation of the EDS2 action plan	October – March	Deputy Director of Workforce and OD/Head of Reward
Develop additional objectives based on the Equality Delivery System (EDS2)	October – March	Head of Reward
Devise a comprehensive Communications plan for the remainder of the financial year for both internal and external communications	December	Head of Communications/Head of Reward
Develop training and additional support for managers on EDS2	December	Head of Reward
Review the Trust's processes for undertaking and completing equality analysis.	October	Head of Reward /Trust Board Secretary
GOVERNANCE		
Review Terms of Reference of the Equality and Diversity/Health and Well- Being Group	July	Head of Reward

Terms of Reference to be ratified by the Workforce and OD Group	~~September~~ November	Director of Workforce and OD
Annual Equality and Diversity Report for Workforce and OD Group and Trust Board	HR Board – July SLT - August QOC – September Trust Board – September	Director of Workforce and OD/Head of Reward
Develop and implement an integrated Equality and Diversity Strategy for service users and the Trust workforce.	October - December	Head of Reward
MONITORING		
In partnership with staff side, further scrutinise workforce monitoring and audit formal employment process outcomes relating to the protected characteristics and develop Key Performance Indicators (KPIs) for 2014/15 and 2015/16.	December	Chairs of the Joint Union Committee/Head of Reward and Head of Resourcing
Review the Trust Equality Impact Assessment forms using best practice and benchmarking from other public sector bodies	November	Head of Reward
Conduct an Equal Pay Audit across all staff groups	March	Head of Reward /Assistant Director of Finance (Payroll Services)

Appendix C

Formal Disciplinary Cases completed in 2013

Disciplinary Cases – recorded by Sex (formerly known as gender)

	April 2011 - March 2012		April 2012 - March 2013		April 2013 – March 2014	
Sex	**Number**	**%**	**Number**	**%**	**Number**	**%**
Male	57	42%	73	36%	131	38%
Female	76	57%	129	64%	214	62%
Group Case	1	1%	0	0%		
Not recorded	0	0%	0	0%	1	0%
TOTAL	**134**	100%	**202**	100%	**346**	100%

Disciplinary Cases – recorded by Disability

	April 2011 - March 2012		April 2012 - March 2013		April 2013 – March 2014	
Disability	**Number**	**%**	**Number**	**%**	**Number**	**%**
Yes	6	5%	11	5%	23	7%
No	105	78%	187	93%	302	87%
Not Declared	8	6%	4	2%	20	6%
Not recorded	14	10%	0	0%	1	0%
Group Case	1	1%	0	0%		
TOTAL	**134**	100%	**202**	100%	**346**	100%

Disciplinary Cases recorded by Age

	April 2011 - March 2012		April 2012 - March 2013		April 2013 – March 2014	
Age Profile	**Number**	**%**	**Number**	**%**	**Number**	**%**
16 - 20	2	2%	3	1%	2	1%
21 - 25	15	11%	21	10%	34	10%
26 - 30	14	10%	22	11%	46	13%
31 - 35	12	9%	25	12%	39	11%
36 - 40	17	13%	28	14%	24	7%
41 - 45	26	19%	28	14%	49	14%
46 - 50	13	10%	33	16%	44	13%
51 - 55	18	13%	17	8%	57	17%
55 - 60	4	3%	21	10%	39	11%
61 - 65	7	5%	3	1%	6	2%
Over 65	1	1%	1	0%	5	1%
Group	1	1%	0	0%		
Not recorded	4	3%	0	0%	1	0%
TOTAL	**134**	100%	**202**	100%	**346**	100%

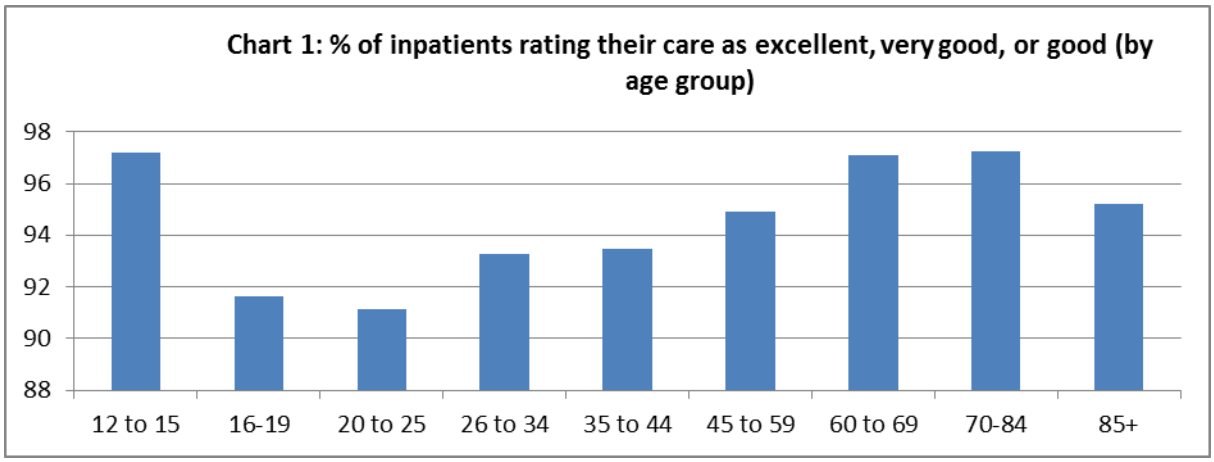
Disciplinary Cases Recorded by Ethnicity

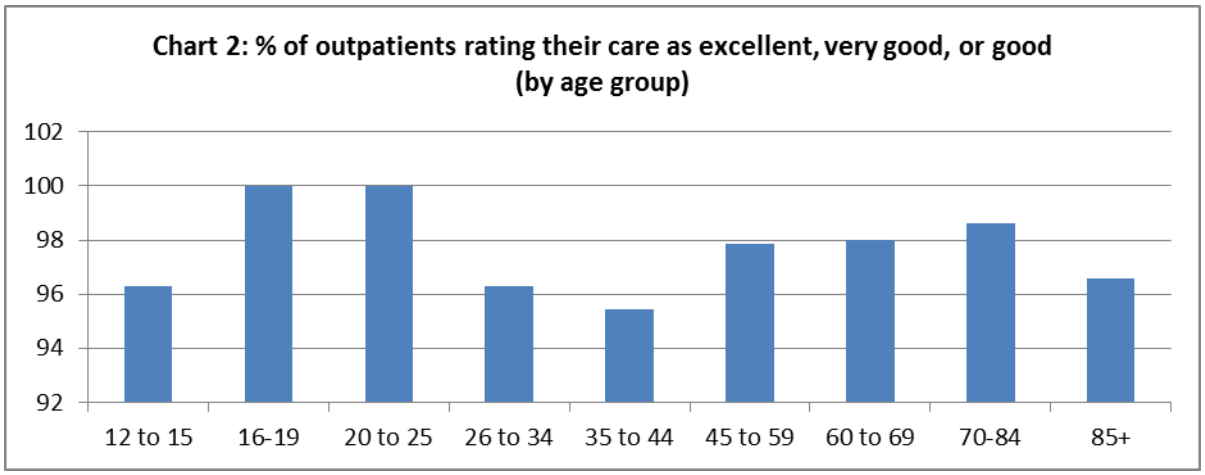
	April 2011 - March 2012		**April 2012 - March 2013**		**April 2013 – March 2014**	
Ethnicity	**Number**	**%**	**Number**	**%**	**Number**	**%**
White British	82	61%	123	61%	213	62%
Black & Minority Ethnic Groups	50	37%	79	39%	132	38%
Group / Not stated / not recorded	2	2%	0	0%	1	0%
TOTAL	**134**	**100%**	202	100%	**346**	100%

Appendix D

Patient Experience Survey Information

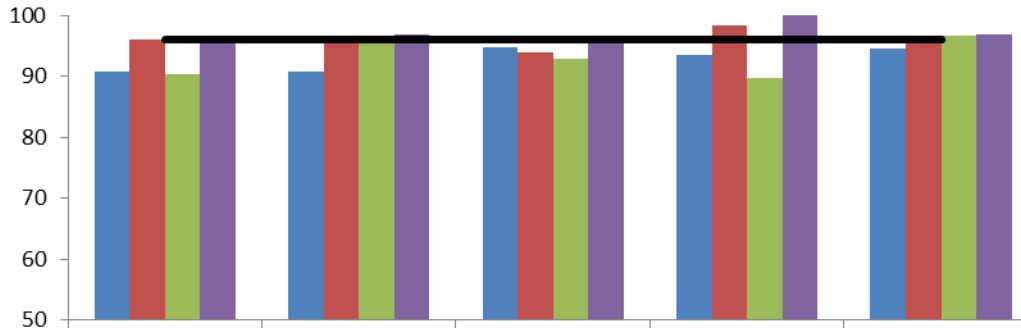
1. In-patient and Out-patient ratings in relation to age





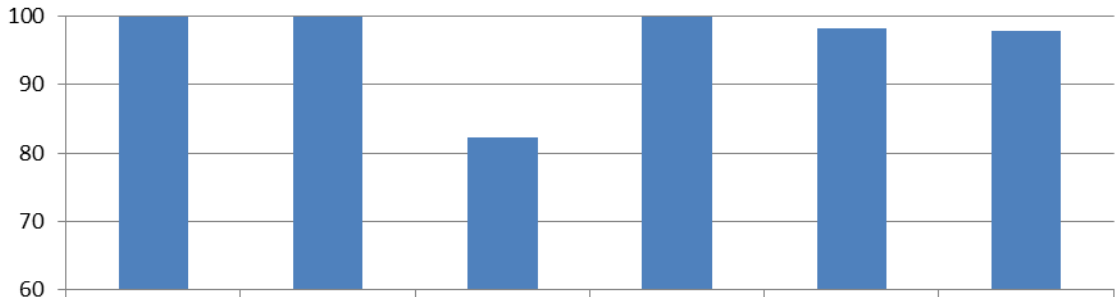
2. In-patient and Out-patient ratings in relation to ethnic group

Chart 3: % of inpatients stating the inpatient care was excellent, very good, or good (by ethnic group)



	Asian	Black	Mixed	Other	White
2010-11	91	91	95	94	95
2011-12	96	95	94	98	96
2012-13	90	97	93	90	97
2013-14	96	97	96	100	97
Average (2010-14)	96	96	96	96	96

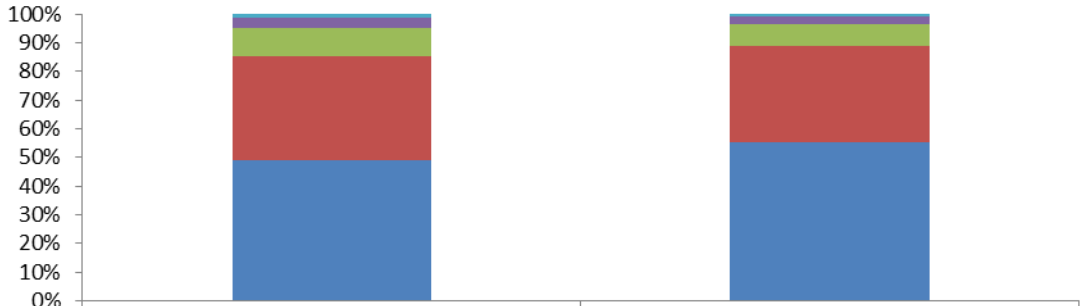
Chart 4: % of outpatients stating the inpatient care was excellent, very good, or good (by ethnic group)



	Asian	Black	Mixed	Other	White	Overall
Series1	100	100	82	100	98	98

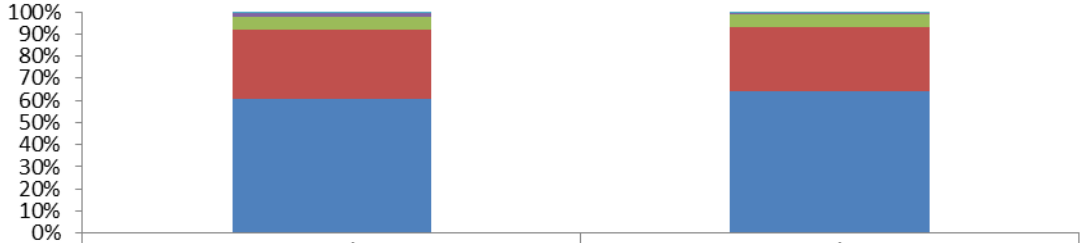
3. In-patient and Out-patient ratings in relation to gender

Chart 5: Overall inpatient care ratings by gender)



	Female	Male
Poor	1	1
Fair	3	3
Good	10	8
Very good	36	34
Excellent	49	55

Chart 6: Overall outpatient care ratings by gender)



	Female	Male
Poor	1	0
Fair	2	1
Good	6	6
Very good	31	29
Excellent	61	64

Appendix E

Information about the protected characteristics of people who complained about Trust services (or on behalf of whom a complaint was made) in 2013/14

Ethnic group of patient	Number
White British	930
Any Other White Background	6
White Irish	4
African or British African	3
Caribbean or British Caribbean	2
White and Black Caribbean	2
Pakistani or British Pakistani	1
Indian or British Indian	1
White and Black African	1
Any Other Asian Background	1
Any Other Ethnic Group	3
Unknown	488
Total	1442
Age Group of Patient	**Number**
0-15	127
16-24	66
25-29	68
30-34	65
35-39	69
40-44	66
45-49	79
50-54	90
55-59	93
60-64	105
65+	455
Prefer not to say or Unknown	159
Total	1442
Gender of Patient	**Number**
Male	657
Female	764
Prefer not to say or Unknown	21
Total	1442

Appendix F

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

EDS OUTCOMES SUMMARY 2012/13

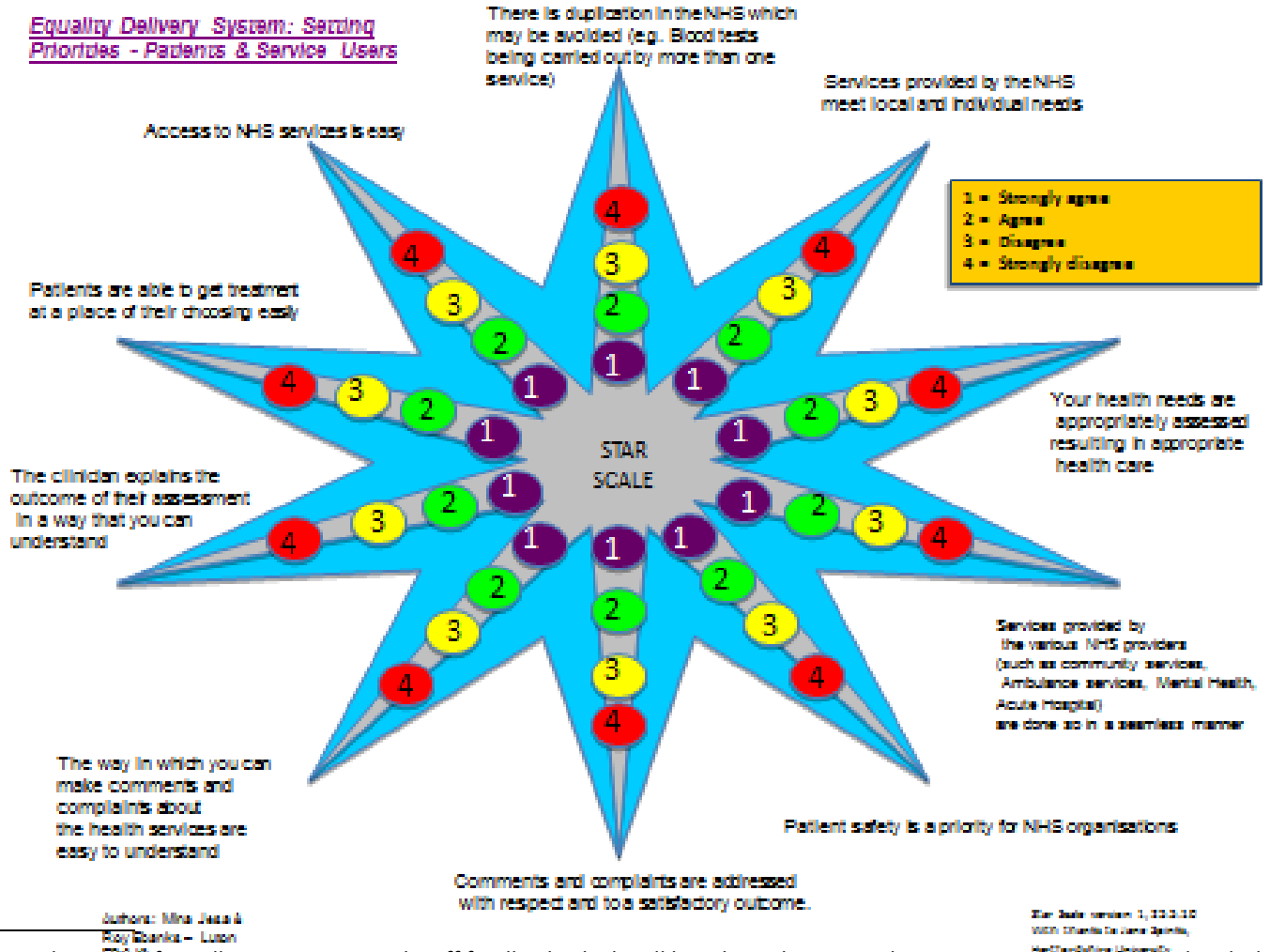
	EDS Outcomes	Grade	Reasons for grading
1.1	Services are commissioned, designed and procured to meet the health needs of the local communities, promote well-being, and reduce inequalities	Developing	The Trust can site examples of work and initiatives which meet the health and well-being of protected groups. Our key challenge is around understanding and quantifying gaps in relation to protected groups
1.2	Individual patients health needs are assessed and resulting services provided, in appropriate and effective ways	Developing	The Trust has developed several Working Groups resulting from specific patient needs which aim to improve patient outcomes through mainstream processes
1.3	Changes across services for individual patients are discussed with them and transitions are made smoothly	Developing	The Trust uses Patient Experiences information and Patient Involvement mechanisms to improve patient care pathways and transitions. Need to focus on more on specific protected groups
1.4	The safety of patients is prioritised and assured	Developing	The Trust can demonstrate that patient safety is prioritised for all patients. Our challenge is to ensure we evidence how we are improving patient safety specifically for patients under the protected groups
1.5	Public health, vaccination and screening programmes reach and benefit all local communities and groups	Not Applicable	
2.1	Patients, carers and communities can readily access services and should not be denied access on unreasonable grounds	Developing	We adopt several mainstream and targeted approaches to meet the service access needs of relevant protected groups. Our key challenge though is to monitor patients from the protected characteristics to enhance our services and access.
2.2	Patients are informed and supported so that they can understand their diagnoses, consent to their treatment and choose their places of treatment	Developing	The Trust can demonstrate that all patients are informed and supported so they can understand their diagnoses, treatment. We have targeted approaches for some of the patients from protected groups but further

			work could be developed in some specific areas
2.3	Patients and carers report positive experiences of the NHS where they are listened to and respected and their privacy and dignity is prioritised	Developing	We can demonstrate that service users are involved in the redesign and commissioning of services. We need to ensure that patients from all the protected characteristics have these opportunities.
2.4	Patients and carers complaints about services and subsequent claims for redress should be handled respectfully and efficiently	Developing	Complaints and PALS queries are handled with respect, efficiency and thoroughness, although further development of monitoring from all the protected characteristics is needed.
3.1	Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades	Achieving	The Trust can demonstrate a clear commitment and evidence that its recruitment processes are fair and equitable.
3.2	Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay	Achieving	UHBristol takes steps to implement NHS pay, terms and conditions (i.e. Agenda for Change). Job evaluation takes place in accordance to the original AfC principles with JE panels having staff side involvement. This rating can be approved if an Equal Pay Audit was conducted across the organisation.
3.3	Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately	Achieving	The Trust's policies such as study leave and appraisal, demonstrate a clear commitment to supporting, training and developing staff.
3.4	Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all	Developing	The Trust can demonstrate a clear commitment to eliminating harassment, bullying and violence towards staff. All staff can and are encouraged to utilise all of the Trust's policies. Our objective is to ensure we understand the experiences of all protected groups and respond effectively to any issues identified.
3.5	Flexible working options are made available to all staff, consistent with the needs of patients and the way that people lead their lives	Achieving	The Trust has a number of policies to support all staff with flexible working options where the service provision allows.
3.6	The workforce is supported to remain healthy with a focus on addressing major health and lifestyle issues	Developing	The Trust is in the process of developing a Health and Well Being strategy and action plan. The trust recognises this is an area of significant

	that affect individual staff and the wider population		important both in terms of staff well-being and the impact on patient care.
4.1	Boards and senior leaders conduct and plan their business so that equality is advanced and good relations fostered within their organisations and beyond	Developing	The Trust can demonstrate that its Board and senior managers are committed to engaging with patients, communities and staff across the protected characteristics through their positive adoption of E&D policies and initiatives.
4.2	Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination	Developing	Middle/line managers are supported through training, policies and procedure to ensure their staff work in an environment free from discrimination.
4.3	The organisation uses the Competency Framework for Equality and Diversity Leadership to recruit develop and support strategic leaders to advance equality outcomes	Undeveloped	The Trust is currently reviewing its entire Leadership programme and the EDS is an opportunity to ensure the competency framework or similar tool is used to support the development of existing and future managers.

Appendix G

Example of a Star Chart



[9] This is example of a Star Chart used for collecting patient and staff feedback which will be adapted to cover the EDS2 outcomes. Published with thanks to Mina Jesa.

9

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 11. Quarterly Workforce Report April – June 2014

Purpose

This report includes a review of the key achievements and challenges in Quarter One in relation to the Key Performance Indicators (KPIs) for workforce, together with an overview of the forthcoming programmes of work.

Abstract

This is the second of a new style 'Quarterly Workforce Report' which is intended to provide a more detailed and wide ranging update on our Workforce and Organisational Development agenda than is currently provided in the monthly performance reports. It details the position against KPIs and shows progress on the strategic workforce priorities identified within the Workforce and Organisational Development Strategy.

The report was presented to the new Workforce and Organisational Group, Strategic Leadership Team, and Quality and Outcomes Committee where it has been debated in detail. The Quality and Outcomes Committee agreed that it should also be presented to Trust Board to provide assurance that comprehensive work is in train to deliver on workforce KPIs and supporting programmes of work.

This report should be read in conjunction with the workforce section of the monthly Quality and Performance Report. It is clear from the August data that the position against KPIs has deteriorated since the end of the first quarter, particularly in respect of staff turnover levels and use of temporary staff. A mid-year review of our KPIs is underway and an update will be provided with the next quarterly report.

Recommendations

Trust Board are asked to receive the Quarterly Workforce for assurance.

Report Sponsor

Sue Donaldson, Director of Workforce and Organisational Development

Appendices

Workforce Dashboard – Appendix One

Breakdown of KPI by Division – Appendix Two

Breakdown of KPI by Staff Group – Appendix Three

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other
	17th September 2014	5th September 2014			Workforce and Organisational Development Group 3rd September 2014

University Hospitals Bristol NHS
NHS Foundation Trust

QUARTERLY WORKFORCE REPORT – APRIL – JUNE 2014

INTRODUCTION

This is the second of a new style 'Quarterly Workforce Report' which is intended to provide a more detailed and wide ranging update on our Workforce and Organisational Development agenda than is currently provided in the monthly performance reports.

Section A provides information about achievement against key performance indicators (KPIs) this quarter, including actions to sustain or improve our position and the impact this should have on future performance against KPIs. **Section B** gives an overview of progress on workforce and organisational development work programmes, aligned to the emerging Workforce Strategy. The Workforce Strategy will shortly be presented to the Strategic Leadership Team (SLT) and Trust Board for final sign off.

The Committee is asked to:

- Note the contents of this report;
- Discuss any issues arising in relation to the areas reported;
- Provide feedback on how the content or presentation could be improved for future quarterly workforce reports.

SECTION A: PERFORMANCE AGAINST KPIs

1. BACKGROUND

The workforce KPIs and the Trust position against these at the end of Quarter One are set out in the following table. As previously described, these KPIs represent a broader set of workforce metrics than in previous years. Also a level of stretch has been built in to the KPIs in an endeavour to move the Trust into upper quartile performance when compared to comparable Trusts. The intention is to undertake a half year review at the end of Quarter Two to assess if the range and level of workforce KPIs are appropriate. This review will take into account the latest benchmarking data which suggests some of our KPIs may be over-ambitious. In particular, vacancy levels have generally deteriorated across the NHS, and very few Trusts have achieved the 3% absence level agreed by trusts in the South as part of the 2011/12 Operating Framework. This data will be thoroughly examined and the conclusions of this review will be included in the next quarterly workforce report.

The Trust workforce KPIs are reviewed with Divisions at monthly and quarterly reviews. A summary dashboard of the KPIs is included in Appendix 1, together with detail of performance at a Divisional level (Appendix 2) and, where available, a breakdown is provided by staff group (Appendix 3).

Overview of performance against workforce KPIs – Quarter One

Domain	Measure	KPI Description	KPI Threshold	Q1 Performance
Workforce costs /FTE	**Workforce expenditure (£)**	Workforce expenditure aligns with budget	Within budget	1.6% above budget
	Workforce numbers (FTE)	Staffing numbers align with budgeted establishment including bank and agency	Within budget	1.2% above budget
	Bank & Agency (FTE)	Target for bank and agency achieved	885 FTE = 3.9% of workforce numbers, average across quarter	5.6%
	Sickness absence rate*(%)	Quarterly target achieved (Annual target 3.5%)	3.4% for Q1	3.8%
Staff Experience	**Vacancies**	Difference between budgeted establishment and in post	Greater than 5%	4.4% (average)
	Turnover	Trajectory to achieve 10% target by March 2014	10.7% for Q1	11.6%
	Friends and Family Test	Percentage returns	20% for Q1	19%
Staff Development	**All staff Appraisal (exc medics)**	Appraisal completed on a rolling 12 month cycle	85% of eligible staff appraised	87.2%
	Medical Staff Appraisal	Appraisal completed on a 15 month cycle – 5 within 5 years	85% of eligible staff appraised	92.9%
	Essential Training	All staff completed relevant essential training topics	90% compliance across all topics	73%
Compliance Requirements	**Manual Handling Risk Assessment**	Risk assessments completed or reviewed within 12 month timeframe	Risk assessment completed or reviewed in last 12 months in +80% of cases	75%
	Stress Risk Assessment	Risk assessments completed or reviewed within 12 month timeframe	Risk assessment completed or reviewed in last 12 months in + 80% of cases	81%
	Junior Doctor New Deal compliance	Junior doctor rotas compliant with New Deal requirements	More than 90% of rotas compliant	81%
	Junior Doctor New Deal Action Plans	Robust action plan to achieve compliance	Actions achieved in line with plan	

2. WORKFORCE COSTS/'FULL TIME EQUIVALENT' (FTE) STAFF

Workforce costs/FTE has three, interlinked components: workforce expenditure; workforce numbers; and temporary staffing (bank and agency) usage. The position for each is set out below. The overall position described shows no material change since the last quarter in terms of the percentage variance of pay expenditure or FTE employed compared to budget. However, there has been an increase in the proportion of total staffing costs and numbers employed attributable to use of bank and agency staff.

a) Workforce Expenditure

The pay expenditure for the quarter was £82.16m against a plan of £80.88m. The cumulative over-spend was £1.28m representing 1.6% more than budget.

Trust-wide, the gap between pay budget and expenditure has narrowed compared with the cumulative positon at the end of 2013/2014, when variance was 2.1% above budget. This can be seen in the pay budget and expenditure graphs in Appendix 1.

During the first quarter, the position between Divisions varies. Diagnostic and Therapies; Facilities and Estates; Trust Services; and Women`s and Children`s; were all amber or green rated. However, Surgery Head and Neck and the Division of Medicine are red rated.

b) Workforce Numbers

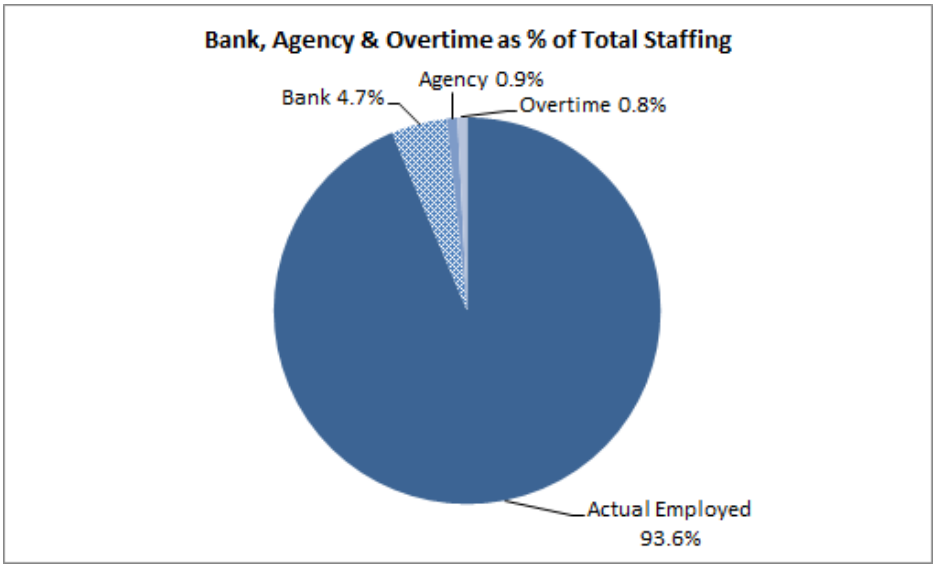
The average FTE employed, including bank and agency staff, over the quarter was 7688.7 and was at the highest at the end of May when it reached 7752.4. The variance remains at 1.2% above budgeted establishment, which is at the same level as last quarter. Of this number at 30 June 2014, 7296.4 staff were substantively employed, c125 FTE more than at 31 March 2014. This increase is attributable to the transfer of specialist paediatric staff from North Bristol Trust.

The variance between workforce numbers and budgeted establishment broadly mirrors the expenditure position described above.

Staffing levels in relation to budgeted establishment are shown graphically in Appendix 1. This indicates that at the end of the quarter there is a closer alignment between workforce numbers and budget than at the beginning.

c) Temporary Workers - Bank and Agency Staff and Overtime Working (FTE)

5.6% of staffing was provided by bank and agency this quarter, as shown in the pie chart below. Percentages vary by staff group, with the highest proportion being for 'nursing and midwifery' and 'administrative and clerical' at 8.2% and 6.6% respectively. The total pay bill for temporary staff was £4.4m, which accounted for 5.4% of the total pay bill for the period. This compares with £3.9m spent in the previous quarter. A further 186.9 FTE or 0.8% of staffing was provided through overtime working. 60% of all overtime was undertaken by staff within our Facilities and Estates Division.

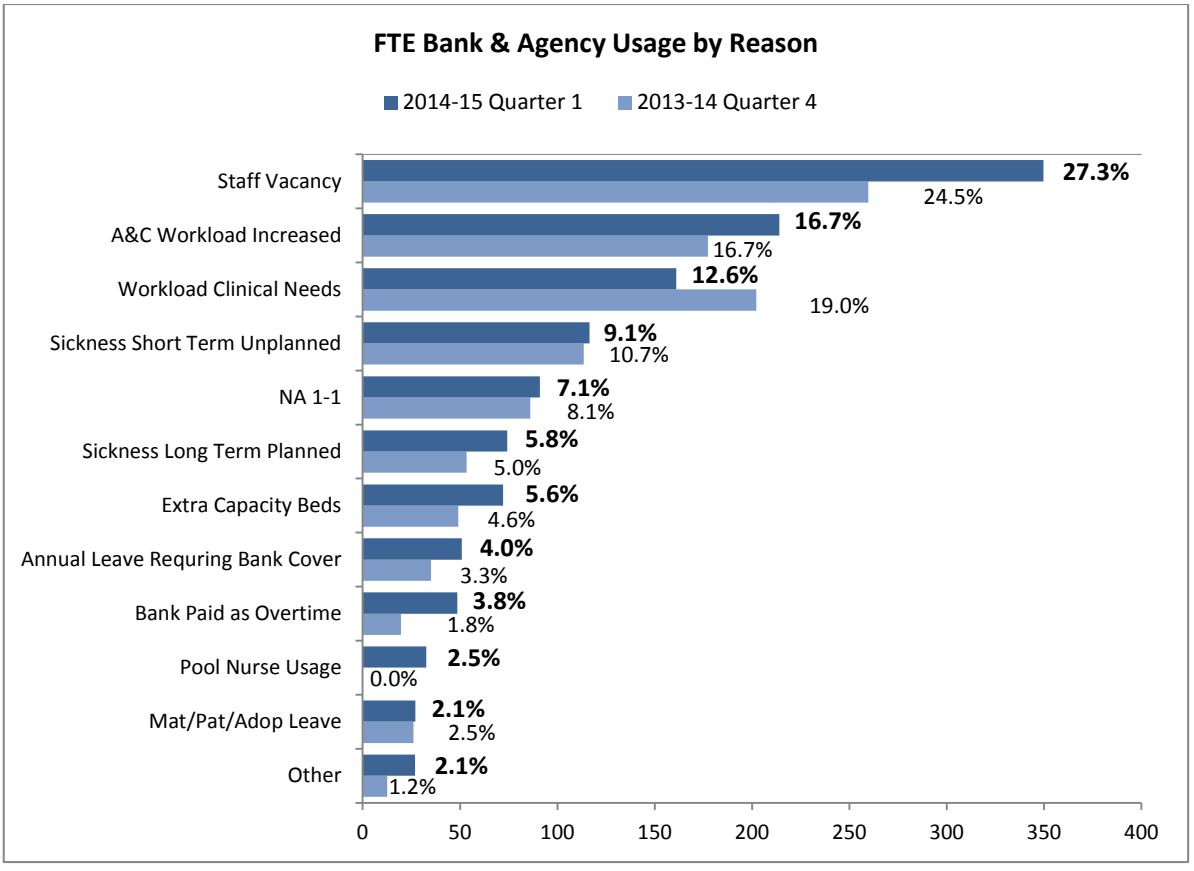


The overall trend for bank is upwards, despite peaks and troughs over the last year, but agency usage shows a very slight downward trend.

Bank usage can be an effective way of providing flexible staffing, with agency being a more expensive option, so it is positive that agency usage reduced in the quarter in every staff group except medical staff, although bank usage did increase between April and May.

Reasons for booking (table below) show that the greatest increase has been in the cover for vacancies, accounting for 27.3% of all usage this quarter.

Reasons for booking bank and agency staff



Given the historical use of temporary staffing and the ongoing use in the first quarter, the Divisional and Trust targets for bank and agency will be critically examined in the half year review of workforce KPIs. Clearly this will need to be within the context of overall pay budgets. The goal remains to achieve an optimum mix of substantive and temporary workers such that we have the flexibility to manage peaks and troughs of activity and cover vacancies/absences without incurring premium payments. Feedback indicates that the plan to recruit to 120% of nursing establishments may not be appropriate in all areas. This will be a key feature of the review.

d) Forward look – Workforce Costs/FTE Employed

Progress with work programmes which will impact on pay costs and staffing numbers next quarter include the following. In addition, tight controls are in place in respect of authorising use of agency staff. These continue to be audited.

- **Rosterpro Project**

The project to implement best practice in the use of the Rosterpro system continues to make progress. The aim is to reduce the use of agency to a minimum, providing cover only when skills cannot be provided by bank or substantive staff, such as Registered Mental Nurses. Recent and planned actions include training and clarifying expectations for ward sisters; improving 'the bank' requesting system; issuing guidance; and establishing KPIs to monitor the impact of the project.

- **Enhanced Observation Policy**

The Enhanced Observation Policy to reduce the use of Nursing Assistant one to ones will be finalised in August 2014, ensuring that there is a robust and consistent process across the whole Trust to assess the requirement and provide assurance that staffing levels are appropriate to patient requirements.

- **Divisional Measures**
  - In **Medicine Division**, extra capacity wards have been staffed using mainly bank and agency on a longstanding basis. In June, Ward 22 closed which is likely to reduce demand for bank and agency staff in the next quarter, until the opening of escalation capacity (Ward 18) in the last quarter of 2014/2015. Work has also been underway to understand why nursing usage has been averaging 135% rather than the agreed 121%, and the Finance Committee will be overseeing work to explore why ward costs in the Division are apparently high compared with benchmarks, which will report back in January 2015.
  - **Women`s and Children`s** usage of bank and agency has exceeded targets, but the pay position remains below the red threshold because the temporary staffing has been used to cover the higher than expected level of vacancies following the transfer of Specialist Paediatrics. Both bank and agency usage and vacancies should reduce as newly recruited staff take up post, but this will not impact fully until quarter three.
  - **Estates and Facilities** will continue to use agency to cover vacancies, but this will be procured as a block contract. Agency for this staff group, whilst more expensive than substantive staff, is far more cost effective than nursing agency usage, and despite the high levels of bank and agency, the pay expenditure for the Division is expected to remain below the red threshold.

3. SICKNESS ABSENCE

Sickness absence has reduced this quarter to 3.8% (target: 3.4%) compared to 4.3% last quarter (target 3.9%). However, sickness absence shows a seasonal pattern, typically lower during Spring and Summer.

The highest levels of Divisional absence during the period were recorded in Facilities and Estates (6.6%), and the lowest in Diagnostics and Therapies (2.1%). Absence rates vary by staff group, the highest incidence is in the categories of 'Nursing and Midwifery

Unregistered' (7.7%) and 'Estates and Ancillary' (6.6%), with the lowest amongst Medical and Dental (1.0%) and Allied Health Professionals (1.2%). Long-term absence (those of 21 days or more) accounted for 59% of the total calendar days lost during the quarter.

The top five reasons are shown in the table below. Although the key reasons remain as previously reported, there has been an increase in sickness absence due to anxiety/stress and depression, which accounted for 18% of days lost, compared with 16% in the previous quarter.

Reason	2014-15 Quarter 1		2013-14 Quarter 4	
	Days Lost	% Total Days Lost	Days Lost	% Total Days Lost
Anxiety/stress/depression/other psychiatric illnesses	5333	18%	5306	16%
Cold, Cough, Flu - Influenza	4258	14%	4480	13%
Other musculoskeletal problems	3392	11%	5022	15%
Gastrointestinal problems	2814	9%	4883	14%
Back Problems	2618	9%	2547	8%

There is an extensive programme of Trust-wide initiatives which are intended to support the achievement of the sickness absence KPI, however many of these have only become established towards the end of the quarter, and are likely to take time to effect staff absence rates. A high level overview of each of these programmes is described below.

Stress, Anxiety and Depression

- "Lighten up" is an accredited health and wellbeing programme comprising workshops and supporting materials, aiming to reduce stress, which started in July as a three month pilot. The programme, delivered by the Avon Partnership NHS Occupational Health Service, provides coping strategies to improve quality of life, both at work and home, thus improving health and wellbeing. There is measurable evidence that these programmes have a positive impact on psychological well-being, and this will be monitored during the programme, together with the impact on stress related absence.
- Avon Occupational Health Service has expanded the provision of one to one counselling by bringing in newly qualified counsellors onto work placements, and has been involving counsellors in team mediation and support across the Trust. 64 staff were provided with one to one counselling in the last three months.
- A 12 month initial contract has been agreed on a pilot basis to provide an Employee Assistance Programme for Women`s and Children`s Division which includes face-to-face, 24-hour telephone and online counselling. There is evidence that such programmes reduce absence and provided positive outcomes are demonstrated, the scheme may be extended to other Divisions.

Flu - Influenza

- The 2014/15 flu vaccination campaign has been initiated, which is designed to be ahead of the flu season to ensure maximum impact on sickness absence. The percentage of patient facing staff vaccinated in 2013 increased to 51% from 33.4% in the previous year. The aim is to increase this to 75% in the current year.

Musculo-skeletal and back problems

- Over the last quarter, Physio-direct has supported an average of 71 members of staff per month by providing a telephone consultation and advice for Minor Musculo-skeletal conditions. The impact on potential causes of absence is evidenced by the fact that 50% require no further intervention. The remaining 50% receive rapid access to treatment by a dedicated OH physiotherapist within the Physiotherapy department.

Pregnancy Related Absence

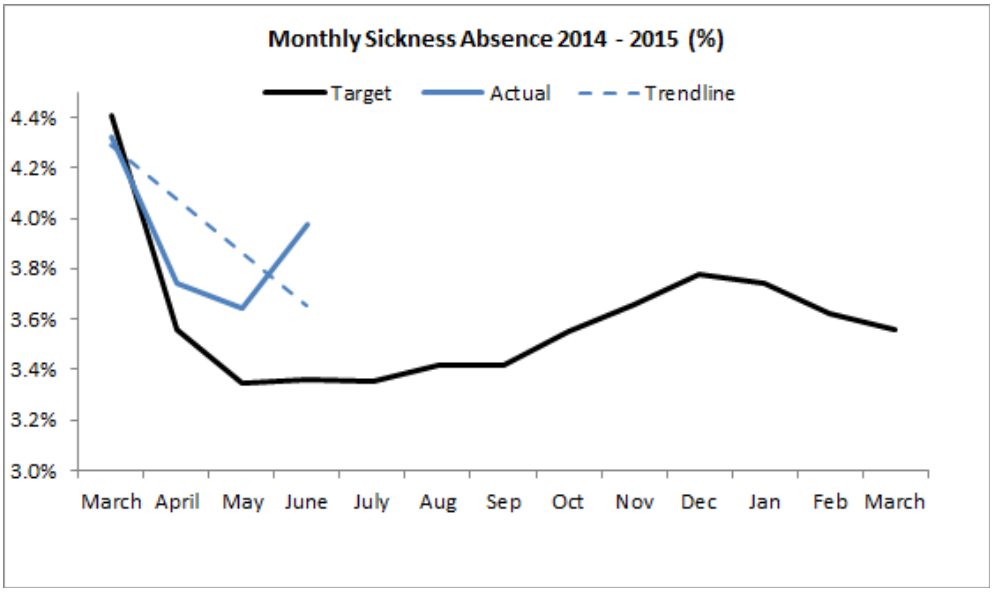
- A new series of 4 monthly 'Working in Pregnancy Workshops' commenced in June. The workshops are intended to generally support health and well-being and are also anticipated to reduce levels of pregnancy-related sickness absence.

Divisional Business Partners and Employee Services continue to support managers in implementing the Supporting Attendance Policy. Division-specific initiatives include the following examples:

- **Medicine Division** introduced a centralised hotline in June as a three month pilot, to target weekend sickness.
- **Specialised Services** have undertaken "return to work" audits combined with focus groups for staff and training for managers.

In addition Work with Occupational Health to reduce delays in providing staff with support has produced positive results, and referral times this quarter were one week for a nurse appointment, and are within the 10 day KPI for doctor appointments. The reconfiguration of Occupational Health which will improve the facilities, access to telephone and face-to-face appointments, improved management information and on line referrals and feedback for managers is also underway.

Targets have been set for each month, and agreed with Divisions to achieve an overall absence over the year of 3.5%. The graph below shows the trend-line for the first quarter, and performance compared with and whilst this shows a downward progression overall, the actual rate is considerably above target, and is also above performance for the same quarter last year.



However, all Divisions except Facilities and Estates are predicting they will achieve the target for the next quarter. During the mid-year review process, there will be an assessment of whether the extensive range of schemes will have a sufficiently significant impact to achieve the KPI by the end of 2014/2015.

The 3.5% KPI for the year overall was derived from the aspiration for all NHS Trusts to achieve levels of 3% sickness absence. This may need to be reviewed in the light of performance in the year to date, and new benchmarking data. Recently publicised comparisons for 2013/2014, show that our comparable benchmark group had an average of 4.1% sickness last year, compared to 4% for UH Bristol for the same period. The average sickness absence rate for all health organisations in Health Education South West (which includes community organisations which traditionally have lower absence rates than acute providers) was 4.4%. Against these benchmarks, 3.5% may be ambitious.

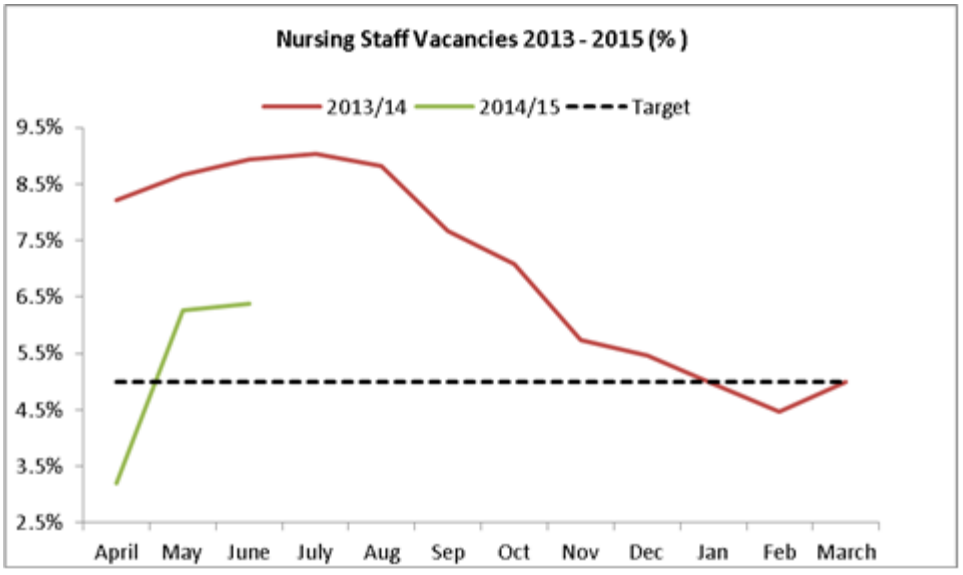
4. STAFF EXPERIENCE

a. Vacancies

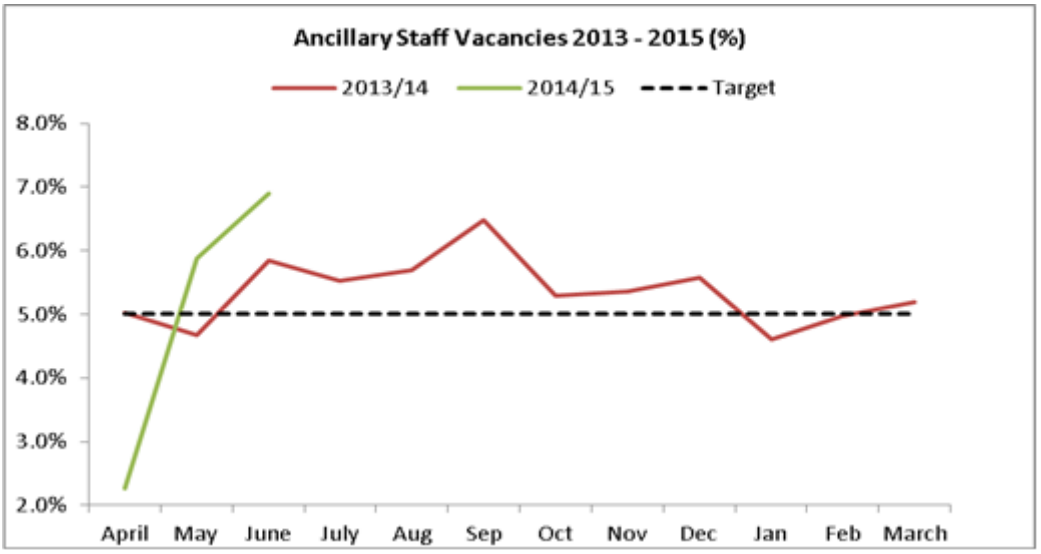
Vacancies this quarter have increased to 4.4% compared to 4% in the previous quarter, but this continues to be below the KPI threshold of 5%.

Successful recruitment to vacancies was highlighted as a risk in the UH Bristol Monitor Strategic plan, with a particular focus on nursing, facilities and estates, and hard to recruit to posts. Posts which are difficult to recruit to may not show in the overall vacancy percentages, as they are generally small numbers, but are highlighted because of their potential impact for the Trust to deliver services in a safe, timely and cost-effective way.

Whilst there have been increases in vacancies in the last two months of the quarter amongst **nursing staff**, the graph below shows that vacancy levels are considerably less than a year ago.



Ancillary vacancies have also risen in the last two months, mainly due to the increased budgeted establishment resulting from the BRI redevelopment changes and the transfer of specialist paediatrics, as the table below shows.



Progress on recruitment and retention plans are described in the 'Recruitment and Retaining the Best' Section in Part B of the paper.

Whilst the vacancy is within KPI of 5% for this quarter, we know from subsequently available data that vacancies at UH Bristol are continuing to rise. Specialised Services, Medicine Division and Estates and Facilities are all predicting that they will exceed the vacancy KPI for the second quarter. New benchmarking undertaken by the Association of UK University Hospital Trusts suggests that vacancies are an even greater issue for many other Trusts. Trusts participating in the survey indicated an average of 8% vacancies and some had nursing vacancies considerably above this level. This will be taken into consideration when achievement of KPIs and projections for the last half of the year are updated in the mid-year review.

b. Turnover

Turnover at the end of Quarter One was 11.5%, against a target of 10.7% for the period. This is aligned to levels in the previous year. However, given our overall turnover rates remain high relative to benchmarks; this KPI remains a key area of focused action for the Trust.

Turnover rates between Divisions continue to vary, as the table in Appendix 2 shows. This is due in part to the staff composition, for example, Medicine at 14.0% has traditionally had higher rates due to the higher proportion of nursing assistants. Turnover of nursing assistants is currently at 18.4%. By contrast, the turnover rate in Diagnostic and Therapies this quarter was 9.6%, and in Women`s and Children`s at 9.1%. As previous reported the attrition rate of Estates and Ancillary Staff remains high at 14.3%.

Data on reasons for leaving is completed by managers as part of the termination of employment process. The table below shows a comparison between this quarter and last year. The table shows that there have been increases in dismissals this quarter, but the biggest

rise appears to be associated with 'Relocation' and 'Work Life Balance'.

Leaving Reason	Q1 2014/15		Q1 2013/14		Headcount change
	Headcount	%	Headcount	%	
Better Reward Package / Promotion	37	17.0%	30	23.6%	7
Death in Service	3	1.4%	1	0.8%	2
Dismissal	16	7.3%	8	6.3%	8
Health	6	2.8%	4	3.1%	2
Lack of Opportunities	6	2.8%	4	3.1%	2
Redundancy / MARS	3	1.4%		0.0%	3
Relocation	63	28.9%	46	36.2%	17
Retirement	27	12.4%	40	31.5%	-13
Work Life Balance / Child Dependants	57	26.1%	41	32.3%	16
Total	**218**	**100.0%**	**127**	**100.0%**	**91**

More extensive information has been sought through exit questionnaires and interviews to better understand reasons for leaving, as this data includes detailed narrative. In the last quarter, 45% of leavers (206) had an exit interview or completed a questionnaire. Further work is also underway to increase the response rate at the point of termination, as the last quarter has seen a reduction in responses.

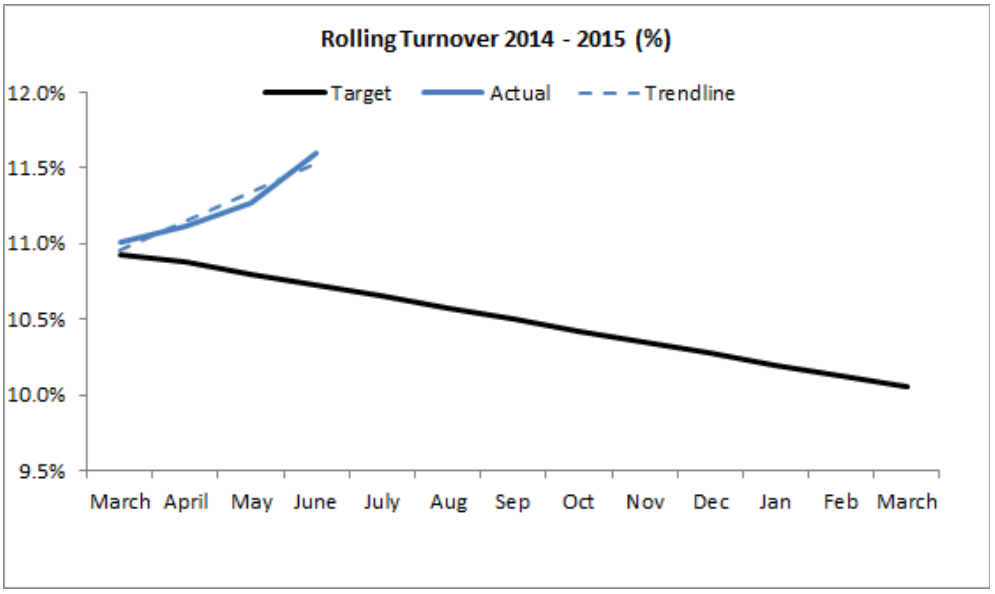
The data from exit interviews and questionnaires has been split by staff group, which has enabled common themes to be identified for groups with high turnover. Nursing assistants, for example, most frequently gave the following reasons for leaving:

- Attend college/university/other training
- Personal Commitments
- Pursue new career path
- Retirement
- Personal Commitments
- Lack of career development

Most of the above themes have been addressed by the new nursing assistant recruitment and training pathway, with internships and improved support and career development pathways. The impact of these will be closely monitored.

The results from exit questionnaires and interviews will continue to be triangulated with the Friends and Family Test and Staff Attitude Survey as part of the Staff Engagement plan.

The graph below shows that the trend line for turnover shows an upward trajectory, and data available for July, which falls outside the quarterly report, indicates that this trend is continuing. Specialised Services, Estates and Facilities and Medicine Divisions are predicting that they will not achieve the turnover target for Quarter Two.



There are a range of programmes to tackle retention, but many of these will take several months to impact in order to reverse the trend. These include:

- New starters interviewed 3,6 and 12 months after appointment to establish (a) whether their experience is that the Trust Values are "real and lived" (b) to assess new starter experience via telephone/face to face interview - including recruitment, orientation, level of support received, instances of harassment and bullying.
- Focus groups in Divisions with particular emphasis on groups where turnover is particularly high, e.g. Nursing Assistants.
- Face to face exit interviews Employee Services Team with leavers, to identify problem areas and address them. Feedback given via HRBPs and relevant managers.

Actions taken to improve staff experience, arising from information gathered in interviews and focus groups described above include:

- Managers attending stress awareness training;
- Review of stress risk assessments;
- Rapid access to Occupational Health support for staff suffering from work-related stress;
- Improved frequency and content of team meetings**;**
- Changes in working practice;
- Improved process for allocating breaks;
- Increased dedicated management time for Band 6 Nurses – particularly when covering the Ward Manager;
- Review of medical support available at weekends;
- Bespoke living the values training in identified areas.

c. Staff Family and Friends Test

From April 2014, NHS England introduced the Staff Friends and Family Test (Staff FFT) in all NHS Trusts providing acute, community, ambulance and mental health services in England. The test is made up of two questions:

- How likely are you to recommend University Hospitals Bristol NHS Foundation Trust to friends and family if they needed care or treatment?
- How likely are you to recommend University Hospitals Bristol NHS Foundation Trust to friends and family as a place to work?

There is a requirement that Staff FFT data be collected and submitted to NHS England quarterly in Q1, Q2 and Q4. The methodology employed by the Trust for the first year was a postcard based survey – freepost retruns, with a distribution to all substantively employed staff in the first quarter. The response rate was 19% (1,604 people). This is broadly in line with expectations set by our supplier. We will work to improve this over time.

Percentage results for the first quarter are summarised in the appendices. The Divisions with the highest rate of responses indicating that its staff would recommend the Trust as a place to work were Diagnostics and Therapies (59.6%), Medicine (59.5%) and Specialised Services (59%). The lowest rate of positive responses came from Facilities and Estates (52.7%) and Women's and Children's (50%).
Responses to the statement: *If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation* also varied by Division, with the highest rates of "extremely likely" or "likely" responses in Surgery, Head and Neck, Medicine (79.5%) and Specialised Services (78.2%). Highest rates of "Extremely unlikely or unlikely" responses came from Women's and Children's (7.4%) and Trust Services Division (6.6%).

FFT results have been shared with the Executive and Senior Leadership Teams and with the HR Board and Workforce and OD Committee. They are currently in the process of being shared more widely. The results and key actions against findings will be published to HR Web. The feedback from the FFT is being used to inform the existing Staff Experience/Staff Engagement Action plan which is summarised in Part B of this paper.

Full comparison against all Trusts nationally will be possible when NHS England publishes the Staff FFT Quarter One results later in September 2014.

5. STAFF DEVELOPMENT

a. Appraisal

Appraisal compliance for staff other than medical staff has remained above target in Quarter One, with a rate of 87.2% at 30 June 2014, compared with 86.1% at the same point in the previous year. As part of the revised 2014/2015 KPIs, monitoring of appraisal compliance for medical staff has been separated, reflecting the different process and context.

All Divisions were compliant with the 85% target for their non-medical staff groups except Estates and Facilities, where a recovery plan is in place.

The figures from the medical revalidation database for medical appraisal for the quarter are as follows:

Consultants		**SAS doctors**		**Clinical fellows**		**Total Compliance (Revalidation)**	
Overdue (heads)	Compliant (%)	Overdue (heads)	Compliant (%)	Overdue (heads)	Compliant (%)	Overdue (heads)	Compliant (%)
19	95.30%	4	89%	9	18%	32	92.9%

Different parameters apply to medical staff, as revalidation requires five appraisals to take place in five years, rather than a strict annual requirement. For this reason, they are not considered overdue until 15 months have elapsed since the last appraisal, in contrast with other staff, for whom an annual appraisal is required.

For all staff, the priority is to improve the quality of appraisals and work is underway within the context of our staff engagement plan.

b. Essential Training (ET)

Overall Trust compliance with Essential Training at the end of June 2014 was 73% against a KPI of 90%. The compliance position by individual topic varies. Given the gap in compliance, this remains a key risk for the Trust and, as such, comprehensive plans are in place to address. Progress is reviewed monthly by the Strategic Leadership Team (SLT).

We have experienced some technical difficulties with the new Learning Management System, introduced earlier this year, and have been working in partnership with the supplier to address the system issues to enable robust real-time reporting of Essential Training compliance. This work will be completed by the end of August when we will be able to verify our compliance position and produce trajectories to illustrate how we will achieve the KPI. The aim will be to achieve compliance for all topics within 2014/2015.

During the last quarter, capacity for Essential training updates has been significantly increased, this has resulted in a total of 2404 training places in the system for the remainder of 2014; this represents more than 25% of the workforce.

Also, the Teaching and Learning Team, in partnership with Information Management and Technology colleagues, have developed 16 in house E-learning modules for Essential Training. This supports the strategic direction of blended learning and will give staff flexibility in terms of access.

Due to work over the last 12 weeks the Trust is positioned well for both reporting and the next phase of the project which is working towards the introduction of E-Learning and self-service in October. The latter will enable all staff to have access to their individual training records and book courses.

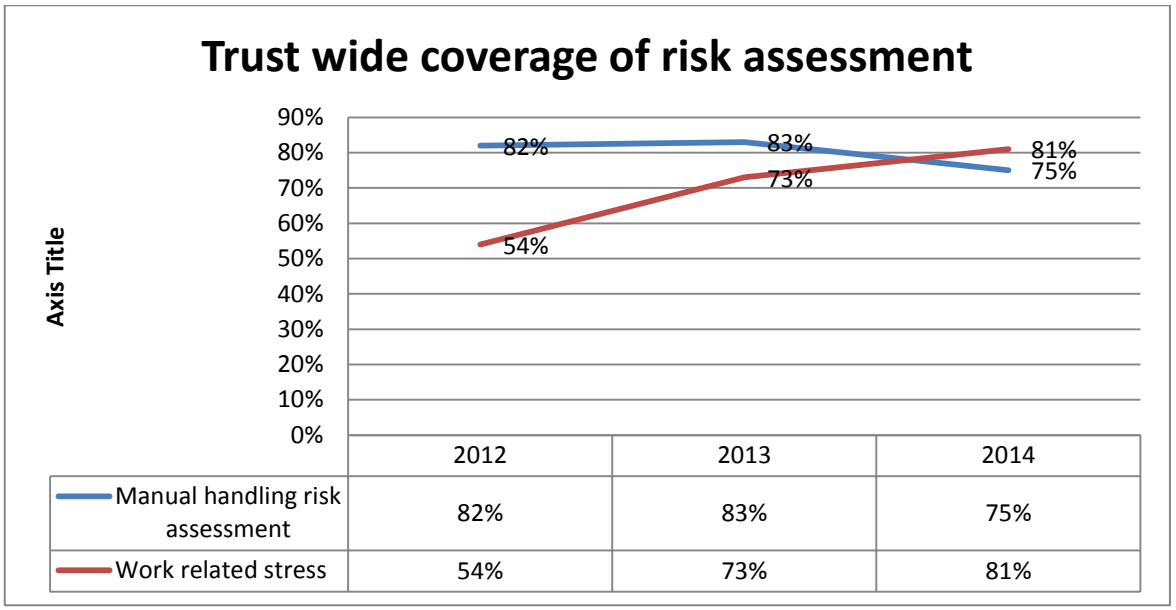
6. COMPLIANCE REQUIREMENTS

a. Health and Safety

During Quarter One annually required Health and Safety audits are completed by all departments trust wide, on the basis which statutory assessment coverage is gauged. Since 2012 a key performance indicator of 80% has been set as an internal target for coverage in risk assessment, whilst working towards the ideal of 100%.

Manual handling risk assessments and work related stress assessments are of particular note due to the linkage with areas such as sickness absence data, staff survey results in the case of stress and health and safety incident reporting in the case of manual handling. Work related stress became a cause for concern trust wide in 2012 reflected in the National staff survey results. Since when, all departments have completed a risk assessment in this category; therefore 54% in 2012 was a starting point for percentage coverage. The chart below shows

the comparison for the last 3 years, whereas the table illustrates the divisional position in Quarter One of 2014/2015.



June 2014	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's	Trust wide
Manual Handling Risk Assessments	90%	100%	72%	87%	86%	68%	68%	75%
Stress Risk Assessments	90%	80%	72%	88%	86%	63%	87%	81%

Further improvement is being achieved in Divisions by the Safety Dept. team working with departmental assessors on site, to complete risk assessments in both topics. Progress will be demonstrated in Quarter 2's report.

a. Junior Doctor New Deal Compliance

The 'New Deal' refers to the Junior Doctors Terms and Conditions of Service. This includes rest and hours targets which must be met in order for a rota to be 'compliant'. At the end of June, there were 56 compliant and 9 non-compliant rotas. The divisional position is provided below:

	Number Non-Compliant	Number Compliant	Compliance	Anticipated Date for 100% Compliance
Diagnostics and Therapies	0	4	100%	
Medicine	0	14	100%	
Specialised Services	4	4	50%	March 2015
Surgery Head and Neck	2	19	90%	October 2014
Women's and Children's	3	15	83%	October 2014

Each Division has a robust action plan, with dates to achieve compliance. Divisions are required to report progress against action plans at their quarterly reviews. All are reporting that they are on track with the anticipated date for 100% compliance.

SECTION B: UPDATE ON WORKFORCE STRATEGY AND WORK PROGRAMMES

1. WORKFORCE STRATEGY

The UH Bristol NHS 'Workforce and Organisational Development Strategy' was initiated during February 2014 and over the last six months, has extensively involved stakeholders including the Trust Board, Senior Leadership Team, Divisional Boards, Trade Union representatives, groups such as the Nursing Workforce Committee and key professional leads. It is intended that the final document will be formally submitted to the Senior Leadership Team and to Trust Board for approval in September.

The Strategy builds on the work undertaken for the UH Bristol Strategic Plan, and a detailed workforce assessment which was undertaken as part of the Health Education South West annual workforce planning cycle. These processes identified some key risks to workforce sustainability which the strategy aims to address. These include the following:

- Recruiting to hard to fill consultant posts, and also recruitment to specialist technical roles;
- Ensuring there are sustainable junior doctor rotas, and minimising the adverse impact of national changes to junior doctor numbers from 2016;
- Managing the local impact of predicted national shortages in qualified nurses over the next three years, and the existing recruitment challenges for nurses in acute medicine, intensive and critical care, and theatres;
- Tackling the relatively high turnover for some staff groups, for example nursing assistants and ancillary staff, ensuring there are approaches focused on those hot spots;
- Planning for an ageing workforce profile which may result in loss of key skills or cohorts of staff retiring at the same time;
- Achieving and maintaining the Workforce Key Performance Indicators (KPIs) which have been discussed in the first section of this report;
- Ensuring the Trust has a representative workforce at all levels of the organisation and across all staff groups.

The strategy then goes on to undertake a comprehensive review of our strengths, weakness, opportunities and threats, and our workforce risks. In this context, a quarterly report is now submitted to Risk Management Group, about the way workforce risks are being assessed, monitored and reported.

The detailed work on the strategy has led to the identification of six strategic workforce priorities which now have detailed plans in place to address. The Strategic Workforce Priorities are as follows:

- Developing Leadership Capability;
- Improving Staff Engagement;

- Recruiting and Retaining the Best;
- Strengthening Reward and Performance Management Systems;
- Education, Teaching and Learning;
- Strategic Workforce Planning.

Underpinning each of these priorities is a commitment to eliminating discrimination, promoting equality of opportunity and providing an environment which is inclusive for all, which includes delivering healthcare, teaching and research which are sensitive to the needs of the individual and communities. .The strategy also commits to providing equality of access to employment opportunities and an excellent employment experience for all.

An update on each of the six strategic priorities and progress being made against the detailed action plans is set out in the sections which follow.

2. DEVELOPING LEADERSHIP CAPABILITY

UH Bristol Leadership Development Programme

The Trust launched its new UH Bristol Leadership Development Programme in January 2014; these programmes are built on the foundation of the NHS Healthcare Leadership Model and have been designed around the 9 dimensions within this competency framework. The 9 programmes focus on the practical skills required for leading, managing and supervising teams effectively.

During the last quarter 22 workshops were delivered with a total of 154 delegates attending.

The following activity was also delivered in the last quarter:

- 4 Team Building events
- 7 Myers Briggs Facilitation Sessions
- 8 NHS Healthcare Leadership 360 Degree facilitated feedback sessions
- 5 Executive coaching sessions

Leadership Forum

The remit of the Leadership Forum has been reviewed. The Chief Executive has started a quarterly briefing session with key representatives of Divisional Management Teams and Corporate Departments to share key information and to improve onward cascade of messages. In addition a new leadership 'development' forum is being designed and will launch in Quarter Two.

Reverse Mentoring Scheme

The Trust and the Staff Black and Minority Ethnic (BME) Workers Forum has piloted a Reverse Mentoring Scheme Reverse Mentoring provides BME staff with the opportunity to talk directly, openly and honestly with an individual senior member of staff, about some of the organisational issues and barriers to progression in the Trust. This provides senior staff with a new perspective on the complex diversity issues in the Trust and improves their understanding and knowledge on equality issues. Senior staff involved in the pilot have included the Chief Operating Officer, the Deputy Chief Nurse and a Divisional and Deputy

Divisional Director. The pilot is currently being evaluated and based on positive feedback received to date, it is anticipated that the scheme will become part of the Trust's approach to Leadership development.

3. STAFF ENGAGEMENT/STAFF EXPERIENCE

In February 2014, the Transformation Board received a paper, '*Staff Experience and Engagement'* concerning the Trust's current and future approach to improving staff experience and staff engagement. Recognising there are many academic theories and approaches concerning engagement and experience, the paper focused specifically on the six elements of staff experience identified by Professor Michael West[1] and used extensively by NHS Employers[2]. Professor West places *engagement* as one key element, rather than the sole focus of his approach. He argues that when appropriate and rigorous actions are taken against six themes, it results in improved staff experience and engagement and improved patient experience and outcomes and better organisational performance.

These six themes are:

A staff experience/staff engagement action plan based in these themes, and responsive to the key findings of the National Staff Survey and, latterly, the Staff FFT has been endorsed by the Transformation Board and the Senior Leadership Team (SLT).

The elements of the plan which have been achieved include:

- Establishment of a cross-divisional multi-disciplinary Staff Experience/Staff Engagement steering group to take Staff Experience work forward;
- Staff Engagement work at Divisional level to implement action plans, including focus groups, use of newsletters, local recognition schemes;
- Development and implementation of first Staff Family and Friends Test (FFT);

[1] Michael West is Professor of Organisational Psychology 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*

[2] NHS Employers, Do Organisational Development

- Full Census-Based Staff Survey scoped and tendered for;
- Benchmarking against best practice from other organisations' appraisal processes;
- Pilot of an Employee Assistance Programme in the Women's and Children's Division.

In addition to the above, work continues on the following areas:

- Communication on renewed Mission and Vision.
- Development of toolkits – compassion/attitude/complaints.
- Swartz Rounds (gathering teams of staff together to discuss and learn from difficult cases) initiated and sustained.
- Carry out "Loud and Clear Survey" and triangulate results with Staff Survey/Workforce and Quality Data.
- Full Evaluation of Values Training scoped, drafted, piloted, revised and rolled out.
- Develop Micro-teach sessions on difficult conversations to support the work already underway.
- Establishment of support network for line managers to promote best practice management
- Publishing of coaching/guidance tool on effective consultations for managers
- Provision of support for staff in terms of wellbeing and tackling work-related stress via a range of Health and Wellbeing initiatives.

Each Division also has a local staff experience/staff engagement plan. HR Business Partners oversee the progress of the action plans, for their Divisional Boards. Best practice is shared across the HRBP community and the action plans and progress are assessed at Quarterly and Monthly Divisional Review meetings.

4. RECRUITING AND RETAINING THE BEST

With the **Centralisation of Specialist Paediatrics** expansion in the Bristol Royal Hospital for Children, 29 Domestic Assistants were required. In response to this challenge 3 Open Days were held to support the recruitment to these numbers, resulting in all the posts being filled. All candidates have now commenced employment with the Trust.

With the **new Ward Block at the Bristol Royal Infirmary** opening from August 2014 through to January 2015 there is a requirement of 41 Domestic Assistants. Again 2 Open Days were held and currently 22 of these posts have been offered to preferred candidates. Further interviews are taking place in August & September 2014.

Funding was extended for both the role of the **Nurse Recruitment & Retention Manager** and the ongoing additional support of a Recruitment Co-coordinator, allowing for momentum with nursing and midwifery recruitment, both registered and non-registered, as demonstrated over the last year. In total, between April 2014 and June 2014, 218 final offer letters were issued to new starters; of this 127 were Registered Nurses and 91 Nurse Assistants. 56 final offers were also issued to staff moving to new posts.

Nurse Assistant recruitment has seen a decrease in the numbers being appointed in the last quarter which is attributed to the new way of recruiting to these posts which was implemented at the end of May 2014. However, a clear, transparent and fit for purpose approach to the recruitment of this staff group has taken off with huge success, seeing

numeracy and literacy tests being introduced and values based recruitment activities as part of a formal assessment centre process, allowing for quality appointments being made. Pace will be seen as this new 'values based' approach is bedded down over the forthcoming months.

This approach has also seen the development of 4 newly defined career pathways for Nurse Assistants being recruited to - i) the Bank ii) internships iii) trainees and iv) experienced routes. A total of 61 conditional offers have been made since the assessment centre process began on 29 May and there have been only 4 withdrawals. It is intended that by January 2015, this assessment centre approach to recruitment will have been extended to all Band 5 nursing posts and all new nurse graduate vacancies.

April and May 2014 saw a series of recruitment and selection days for **nurse graduates**. 215 applications were received from new graduates from both the University of the West of England and other universities. 180 were shortlisted with 123 interviews taking place, resulting in 95 offers being made by the end of June.

Limited **external marketing** has been undertaken outside the use of NHS Jobs in the first quarter of the year, due to funding. However, work is being undertaken to produce a rigorous marketing schedule for 2014/15 with a proposal of marketing solutions to keep the momentum demonstrated with the activity undertaken in 2013/14. This platform of cost effective recruitment approaches without doubt has supported the Trust in consistently filling a high level of its Band 5 nurse vacancies, without the need for a targeted costly recruitment campaign to Europe and other international markets further afield. It is hoped that further marketing activity will be supported with funding as in 2013/14, especially in light of the known demand for Band 5 nurses over this next year and the ongoing high levels of turnover.

Future activities will include **Return to Practice** being implemented across the Divisions with a cohort of approximately 5 returnees commencing in October 2014. This is in line with the new Health Education England model where there is both an income and a bursary available for the Trust and the individuals wishing to return to practice, respectively.

The Trust has successfully confirmed a place at the **RCN Careers Fair** in London in early September 2014 with the view of successfully recruiting experienced Band 5 registered nurses.

Innovative solutions are being explored in in relation to **difficult to recruit to posts**, which include Medical Consultant roles in Cellular Pathology, Oncology and Radiology. Actions include international recruitment; targeting trainees; and, in partnership with the University of Bristol, a Chair of Paediatric Radiology has been advertised and has recently been offered. In the meantime short term pressures are being covered by existing Consultant staff and agency locums. Nurse practitioners and perfusionists in Specialised Services remain difficult to recruit. The Division is considering recruitment above budgeted establishment in order to ensure a continuing flow of staff to take account of turnover.

5. STRENGTHING REWARD AND PERFORMANCE MANAGEMENT SYSTEMS

Employee Relations Case Work

The Employee Services team provides managers with technical HR guidance and support to

effectively manage all employee relations issues across the Trust. The Trust has a workforce of 8,400 staff, arising from which, the Trust has 29 conduct cases, 15 performance management cases and 5 Bullying and Harassment cases on-going and under formal management processes. Additionally, given the financial impact of sickness absence, the Trust has a comprehensive supporting attendance policy and a focused sickness absence management strategy which has resulted in the pro-active management of 242 short term and 140 long term sickness cases under formal management and review. With regards to claims from employees against the Trust, Employee Services are currently managing 6 grievance and 4 Employment Tribunal claims which is a very low number in relation to workforce size.

Linking Pay Progression with Performance Management

The Trust has implemented the '*Linking Pay Progression with Performance Management'* policy, enabling incremental progression to be deferred if staff are placed on the Trust's formal performance management procedure or receive a disciplinary sanction. This initial phase will be reviewed in partnership with staff side representatives in October. Following this review, the second phase will also be implemented which includes deferral criteria relating to incomplete staff appraisal and essential training.

The second phase also includes a work plan which will develop a revised performance management framework for all staff groups, including improving the quality of appraisal processes, as well as sustained compliance with completion of appraisals targets. Benchmarking against best practice organisations has already been undertaken and work continues on improving training for managers to equip them with the skills to undertake effective appraisals.

The Trust continues to work with other NHS organisations in the South West reviewing terms and conditions and is part of the Regional Reward Network.

Recognition Events

Positive performance management requires that we focus attention on the many people and activities which support the Trust's mission and values. A range of recognition events take place across the Trust to celebrate the success of teams and individuals. These include:

Recognising Success Awards – this is an annual gala event, at which individuals and teams are recognised for transforming care for patients, bringing the values to life and going the extra mile for patients and colleagues. People are nominated for the following awards by their colleagues/managers/other staff. This year, the celebration will take place on 21st November 2014. The closing date for nominations is early September.

Divisional Schemes – Many Divisions have their own recognition awards – for example Facilities and Estates have recently started a Recognition Award for Excellence scheme – encouraging nominations for people in the Division who have achieved something special in terms of their service delivery towards patients, Trust staff and/or visitors or have overcome adversity or pressures/ demands within the Division, which is believed to deserve being recognised as being out of the ordinary.

International Nurses Day. Each year the Trust celebrates this by holding an event for the nurses of UHBristol at which Recognition Awards are presented to nurses and midwives, nominated by their peers, for their commitment and exceptional contribution to patient

care. The ceremony also awards the Davison Nursing and Midwifery Scholarships, set up to encourage and support nurses at all levels who have developed an innovative idea for practice and a passion for improving patient experience.

Teaching and Learning Celebration –This twice yearly celebration, is hosted in the Teaching and Learning Department at the Education Centre. Certificates are presented to all Nursing Assistants and Administrative Assistants who have achieved a QCF (similar to an NVQ) in the last six months. This year a new award has bene named in memory of Aggie Dyba – a late member of the team – for a Nursing Assistant who overcomes personal odds to achieve the qualification.

Future activities include reviewing staff benefits and additional opportunities for staff recognition; communicating and implementing the Pension Choice scheme.

6. EDUCATION TEACHING AND LEARNING

Teaching and Learning Review

A review of Education, Teaching and Learning was commissioned by the Director of Workforce and Organisational Development in May 2014 as part of a wider restructure of Human Resource Services within the Trust. The review seeks to determine whether our current organisational structure is fit for purpose to enable the Trust to deliver the highest quality education, teaching and learning for our staff and students.

The work, which is ongoing, has included benchmarking with other similar Trusts who form part of the AUKUH (Alliance of United Kingdom University Hospitals). An estimated time frame for completion of the Review is March 2015.

Teaching and Learning Strategy

The Trust Teaching and Learning Strategy 2011-2015 was ratified by the Board in April 2011. The programmes of work underpinning the strategy are monitored through the Quarterly Teaching and Learning Steering Group and a progress update is received by the Senior Leadership Team on a monthly basis.

In 2013 the Teaching and Learning Steering Group agreed a realignment of the priorities for the remainder of the life of the strategy and a final progress update will be received by Trust Board in September 2014.

The strategy will be reviewed during the last half of 2014/15 as part of the organisational review. A fully revised Teaching and Learning strategy will be in place by April 2015.

Update on Teaching and Learning Activities

- **Bands 1-4 Qualification Credit Framework (QCF) Clinical Staff** 80 nursing assistants were undertaking their QCF; either level 2 or 3 Diploma in Clinical Healthcare support.
- **Non-Clinical QCF** 34 staff have enrolled on the Cleaning and Support Service Level 1 and 2 and Customer Service QCF.
- **Apprentices** 35 UH Bristol staff are registered for an Apprenticeship scheme, with two external training providers. An additional 8 staff have enrolled on the apprenticeship training in the last quarter.

- **Induction** Corporate Induction continues to run fortnightly; the number of new starters inducted for the quarter was 384, and 11 bespoke Corporate Induction sessions covering 217 staff have been delivered to support the transfer of the Children's Specialist Paediatric and Cleft Team staff. The Induction and Training Leads Group provides the governance for the content of Induction and to ensure it is aligned to the Essential Training requirements for new starters.

7. STRATEGIC WORKFORCE PLANNING

The Trust is reviewing with Health Education South West how best to develop the capability of HR colleagues, managers and clinical leads to undertake robust and effective workforce planning. It is likely that the work programme will include one or two day workshops in collaboration with Skills for Health, which will provide an opportunity to understand workforce planning tools and techniques, followed by a session to utilise these skills in developing a workforce plan relevant to the work area of participants.

Work over the last two years has resulted in the development of the Qlikview system to provide managers with accessible data on their workforce to enable them to manage staff more effectively. Options to increase the range of data are currently being explored.

An acuity and dependency workforce tool is being piloted, led by the Chief Nurse, which is providing assurance that numbers of nurses are appropriate for varying levels of patient need.

A project is underway to improve the use of Rosterpro to ensure there are appropriate numbers of staff on each shift within the agreed resource envelop which aims to reduce use of excess bank and agency.

Limited Access Self Service for the Employee Staff Record will be implemented in October 2014. Advantages include enabling staff to check and amend their own employee data, and to view their Total Reward Statement which will be issued in November.

CONCLUSION

The Quality and Outcomes Committee are asked to

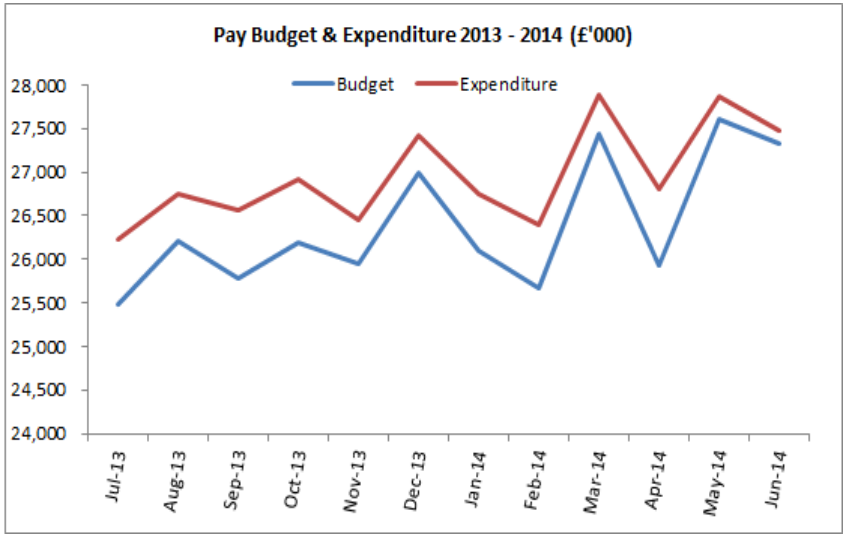
1. Note the contents of this report;
2. Discuss any issues arising in relation to the areas reported;
3. Provide feedback on how the content or presentation could be improved for future quarterly workforce reports.

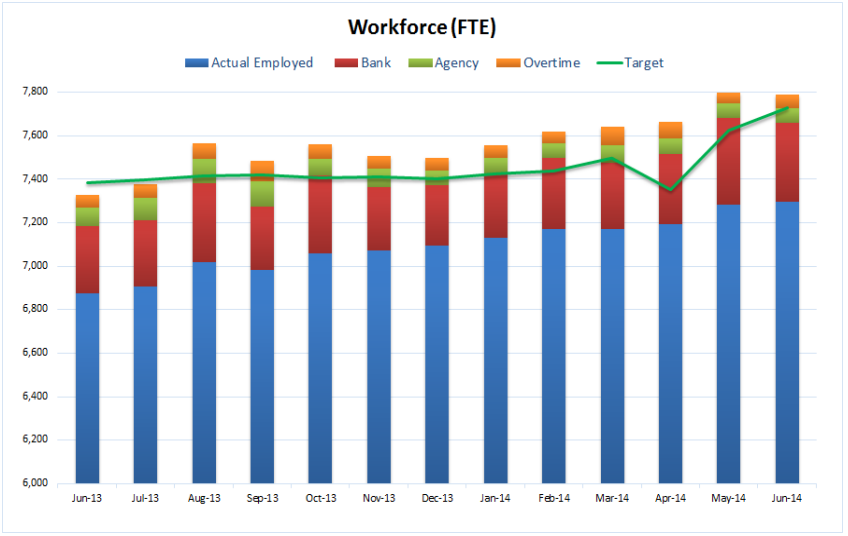
APPENDICES

Appendix 1 – Workforce Performance Dashboard
Appendix 2 – Divisional KPIs – Quarterly Comparisons
Appendix 3 – Staff Group KPIs – Quarterly Comparisons

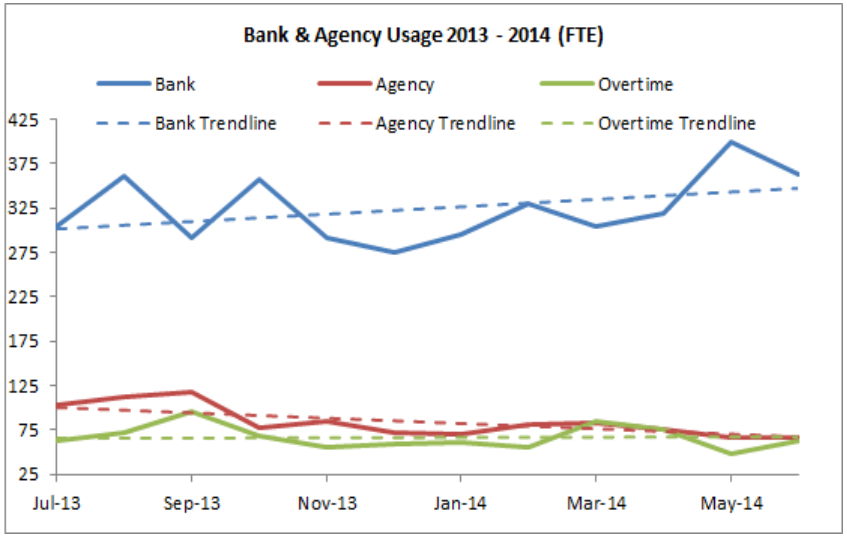
Appendix 1 – Workforce Performance Dashboard

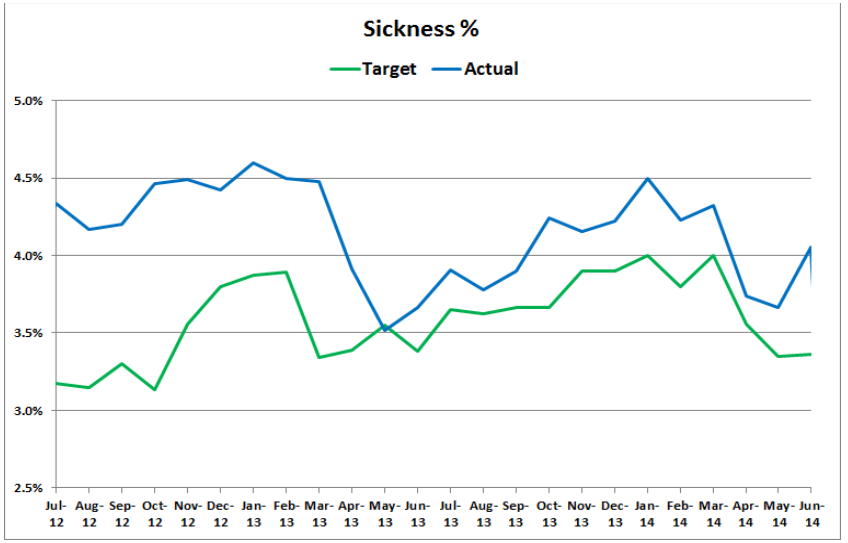
Workforce Costs/FTE





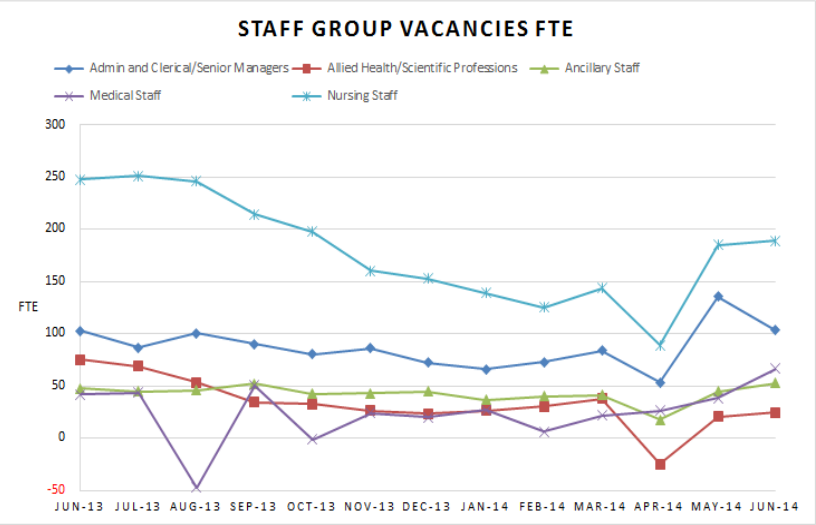
Workforce Costs/FTE

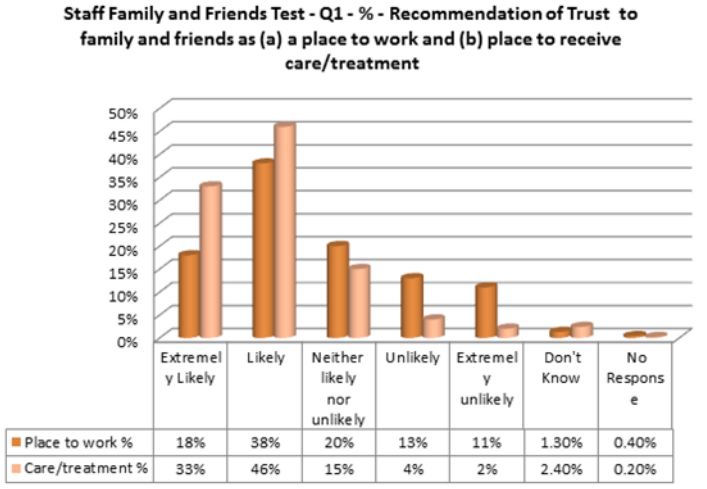




Appendix 1

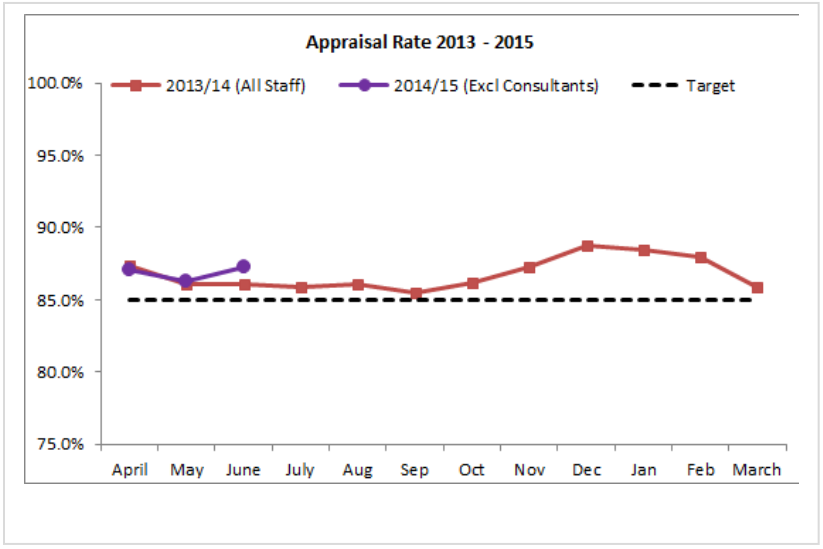
Staff Experience





	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Place to work %	18%	38%	20%	13%	11%	1.30%	0.40%
Care/treatment %	33%	46%	15%	4%	2%	2.40%	0.20%

Staff Development

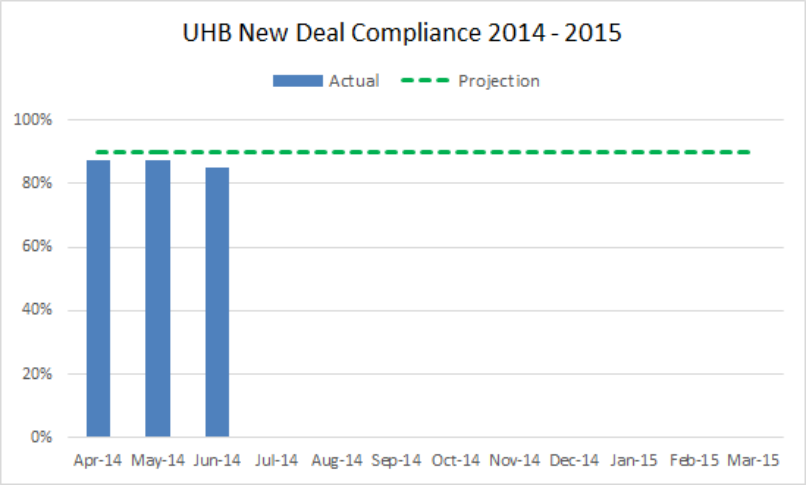


Compliance Statistics 22 August 2014

Accreditation	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery, Head & Neck	Trust Services	Women's & Children's	Compliance
Blood Transfusion	36%		56%	65%	60%	57%	70%	60%
Clinical Record Keeping	34%		52%	60%	57%	57%	68%	57%
Conflict Resolution Awareness	98%	99%	95%	97%	96%	97%	96%	97%
Conflict Resolution Training	53%		72%	74%	72%	67%	69%	69%
Consent	40%		55%	63%	62%	60%	72%	61%
Equality & Diversity	98%	100%	94%	96%	95%	98%	91%	95%
Fire Safety	99%	100%	95%	98%	97%	99%	96%	97%
Food Safety	97%	100%	94%	96%	95%	98%	91%	95%
Harassment & Bullying	99%	100%	95%	98%	97%	98%	93%	97%
Health & Safety	80%	74%	73%	77%	76%	83%	74%	76%
Induction	89%	98%	90%	84%	70%	94%	55%	74%
Infection Prevention & Control	75%	72%	73%	79%	80%	84%	77%	77%
Information Governance	99%	99%	95%	97%	97%	98%	96%	97%
Local Induction Checklist	49%	52%	38%	43%	28%	41%	15%	31%
Manual Handling	78%	75%	74%	79%	77%	80%	74%	76%
Medical Devices	34%		52%	60%	57%	57%	68%	57%
Medicines Management	36%		56%	64%	61%	59%	71%	61%
Nutrition	35%		71%	75%	64%	58%	69%	64%
Patient Safety	34%		52%	60%	57%	57%	68%	57%
Patient Slips, Trips and Falls	34%		52%	60%	57%	57%	68%	57%
Pressure Ulcer Prevention	34%		52%	60%	57%	57%	68%	57%
Resuscitation	33%		62%	67%	61%	58%	66%	60%
Safeguarding Adults L1	81%	79%	78%	86%	85%	84%	81%	82%
Safeguarding Adults L2	28%		36%	44%	43%	37%	35%	37%
Safeguarding Adults L3	0%	0%	0%	0%	0%	0%	0%	0%
Safeguarding Children L1	62%	63%	49%	58%	58%	70%		62%
Safeguarding Children L2	73%	45%	54%	78%	65%	75%	36%	63%
Venous Thromboembolism	34%		54%	61%	58%	58%	68%	58%
ALL:	65%	86%	70%	75%	73%	84%	75%	74%

Compliance Requirements

June 2014	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's	Trust Total
Manual Handling Risk Assessments	90%	100%	72%	87%	86%	68%	68%	75%
Stress Risk Assessments	90%	80%	72%	88%	86%	63%	87%	81%



Appendix 2 Divisional KPIs – Quarterly Comparisons

Workforce Costs/FTE

EXPENDITURE (£'000)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	£10,062	£10,162	£10,100	£9,739
Facilities & Estates	£4,667	£4,638	£4,515	£4,608
Medicine	£12,067	£11,609	£11,939	£11,292
Specialised Services	£9,776	£9,577	£9,546	£9,300
Surgery, Head & Neck	£18,704	£17,951	£18,691	£18,042
Trust Services	£6,342	£6,507	£6,527	£6,977
Women's & Children's	£20,539	£20,433	£18,289	£18,407
Trust Total	**£82,157**	**£80,876**	**£79,607**	**£78,365**

WORKFORCE NUMBERS, INCL BANK & AGENCY (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	954.4	968.0	954.9	985.8
Facilities & Estates	739.7	743.7	731.3	745.2
Medicine	1158.7	1072.0	1160.0	1050.6
Specialised Services	830.7	805.8	810.6	771.0
Surgery, Head & Neck	1699.6	1690.6	1695.4	1685.3
Trust Services	659.2	668.5	662.6	697.2
Women's & Children's	1646.4	1650.7	1528.5	1520.3
Trust Total	**7688.7**	**7599.2**	**7543.3**	**7455.4**

Workforce Costs/FTE

BANK (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	29.8	38.0	27.5	35.0
Facilities & Estates	130.1	48.1	92.0	33.7
Medicine	316.8	255.7	304.4	129.5
Specialised Services	120.4	49.9	110.9	52.9
Surgery, Head & Neck	226.6	147.2	181.3	130.1
Trust Services	80.9	131.5	76.6	35.4
Women's & Children's	177.6	86.6	136.1	117.4
Trust Total	**1082.4**	**756.9**	**928.8**	**534.0**

AGENCY (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	7.3	5.8	5.4	20.0
Facilities & Estates	18.0	10.7	16.7	20.9
Medicine	54.3	42.8	76.4	7.4
Specialised Services	59.8	12.3	67.2	14.7
Surgery, Head & Neck	18.6	20.7	19.1	14.7
Trust Services	21.4	24.4	19.3	0.0
Women's & Children's	28.5	11.3	28.8	39.5
Trust Total	**207.8**	**128.1**	**232.9**	**117.2**

Workforce Costs/FTE

OVERTIME (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	31.1	27.8	28.0	
Facilities & Estates	110.7	65.1	97.9	
Medicine	2.5	11.5	12.4	
Specialised Services	6.2	6.7	9.5	
Surgery, Head & Neck	12.0	26.9	15.8	
Trust Services	9.2	10.8	9.2	
Women's & Children's	15.4	3.8	25.9	
Trust Total	**186.9**	**152.5**	**198.5**	

SICKNESS ABSENCE (%)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	2.1%	2.4%	2.5%	2.9%
Facilities & Estates	6.6%	5.2%	7.3%	5.5%
Medicine	4.3%	4.1%	4.7%	4.3%
Specialised Services	3.7%	3.9%	4.1%	3.8%
Surgery, Head & Neck	3.8%	3.2%	4.3%	4.0%
Trust Services	3.1%	2.2%	4.0%	3.1%
Women's & Children's	3.6%	3.2%	4.2%	4.1%
Trust Total	**3.8%**	**3.4%**	**4.3%**	**3.9%**

Staff Experience

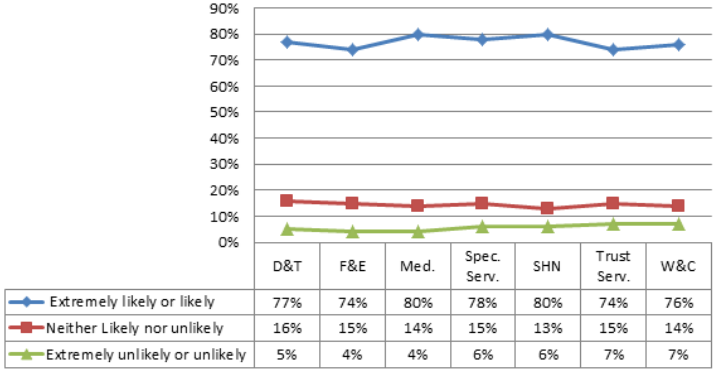
VACANCY (% FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	2.7%	5.0%	4.2%	5.0%
Facilities & Estates	7.1%	5.0%	6.7%	5.0%
Medicine	3.4%	5.0%	1.7%	5.0%
Specialised Services	4.4%	5.0%	2.6%	5.0%
Surgery, Head & Neck	4.3%	5.0%	3.4%	5.0%
Trust Services	6.4%	5.0%	9.5%	5.0%
Women's & Children's	4.3%	5.0%	3.1%	5.0%
Trust Total	**4.4%**	**5.0%**	**4.0%**	**5.0%**

TURNOVER (% FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	9.6%	8.8%	8.8%	
Facilities & Estates	14.9%	11.4%	12.1%	
Medicine	14.0%	12.4%	13.3%	
Specialised Services	14.6%	12.1%	12.8%	
Surgery, Head & Neck	10.6%	10.6%	10.9%	
Trust Services	11.7%	9.6%	11.3%	
Women's & Children's	9.1%	11.0%	9.4%	
Trust Total	**11.6%**	**10.7%**	**11.0%**	

Staff Experience



Staff Development

APPRAISAL COMPLIANCE (EXCL CONSULTANTS)

	Quarter 1	
	Actual	**Target**
Diagnostics & Therapies	89.0%	85.0%
Facilities & Estates	84.0%	85.0%
Medicine	87.4%	85.0%
Specialised Services	90.1%	85.0%
Surgery, Head & Neck	86.4%	85.0%
Trust Services	88.8%	85.0%
Women's & Children's	86.5%	85.0%
Trust Total	**87.2%**	**85.0%**

Appendix 3 Staff Group KPIs – Quarterly Comparisons

Workforce Costs/FTE

EXPENDITURE (£'000)

	Quarter 1	
	Actual	**Target**
Administrative & Clerical	£11,892	£12,035
Scientific & Professional	£12,142	£12,393
Estates & Ancillary	£4,506	£4,435
Medical & Dental	£25,866	£25,962
Nursing & Midwifery	£27,754	£27,353
Other*	-£2	-£1,302
Trust Total	**£82,157**	**£80,876**

* 'Others' relates to financial adjustments or provisions that cannot be identified as relating to a specific staff group

WORKFORCE NUMBERS, INCL BANK & AGENCY (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	1578.9	1572.5	1571.9	1560.3
Scientific & Professional	1264.1	1263.9	1207.8	1231.9
Estates & Ancillary	781.3	767.6	805.0	801.7
Medical & Dental	1065.9	1097.1	1038.1	1047.4
Nursing & Midwifery	2998.5	2898.0	2920.4	2814.0
Trust Total	**7688.7**	**7599.2**	**7543.3**	**7455.4**

Workforce Costs/FTE

BANK (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	244.2	201.1	191.3	114.4
Scientific & Professional	20.0	22.4	22.3	21.4
Estates & Ancillary	144.4	58.3	100.6	29.9
Medical & Dental	0.0	0.1	0.0	0.0
Nursing & Midwifery	673.8	474.9	614.6	368.3
Trust Total	**1082.4**	**756.9**	**928.8**	**534.0**

AGENCY (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	66.9	35.1	66.3	22.9
Scientific & Professional	1.0	0.0	0.0	8.0
Estates & Ancillary	11.7	8.3	11.9	22.6
Medical & Dental	37.4	20.3	26.9	22.7
Nursing & Midwifery	90.9	64.4	127.8	41.1
Trust Total	**207.8**	**128.1**	**232.9**	**117.2**

Workforce Costs/FTE

OVERTIME (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	18.9	25.2	23.7	
Scientific & Professional	38.2	28.7	31.3	
Estates & Ancillary	113.1	68.9	104.9	
Medical & Dental	0.4	0.2	0.3	
Nursing & Midwifery	16.4	29.5	38.3	
Trust Total	**186.9**	**152.5**	**198.5**	

SICKNESS ABSENCE (%)

	Quarter 1 Actual	Quarter 4 Actual
Add Prof Scientific & Technic	3.3%	3.3%
Additional Clinical Services	4.8%	4.2%
Administrative & Clerical	3.2%	3.9%
Allied Health Professionals	1.2%	2.4%
Estates & Ancillary	6.6%	7.5%
Healthcare Scientists	2.0%	1.9%
Medical & Dental	1.0%	1.1%
Nursing & Midwifery Registered	4.0%	4.7%
Nursing & Midwifery Unregistered	7.7%	8.0%
Trust Total	**3.8%**	**4.3%**

Staff Experience

VACANCY (% FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	6.2%	5.0%	4.8%	5.0%
Scientific & Professional	0.5%	5.0%	2.6%	5.0%
Estates & Ancillary	5.0%	5.0%	4.9%	5.0%
Medical & Dental	4.0%	5.0%	1.7%	5.0%
Nursing & Midwifery	5.3%	5.0%	4.8%	5.0%
Trust Total	**4.4%**	**5.0%**	**4.0%**	**5.0%**

TURNOVER (% FTE)

	Quarter 1 Actual	Quarter 4 Actual
Add Prof Scientific & Technic	9.7%	8.4%
Additional Clinical Services	9.5%	8.8%
Administrative & Clerical	11.6%	11.6%
Allied Health Professionals	9.7%	9.8%
Estates & Ancillary	14.3%	12.6%
Healthcare Scientists	6.8%	5.5%
Medical & Dental	7.3%	7.0%
Nursing & Midwifery Registered	11.0%	10.8%
Nursing & Midwifery Unregistered	18.4%	16.4%
Trust Total	**11.6%**	**11.0%**

Staff Development

APPRAISAL COMPLIANCE (EXCL CONSULTANTS)

	Quarter 1	
	Actual	**Target**
Add Prof Scientific & Technic	84.9%	85.0%
Additional Clinical Services	93.5%	85.0%
Administrative & Clerical	88.4%	85.0%
Allied Health Professionals	89.5%	85.0%
Estates & Ancillary	85.2%	85.0%
Healthcare Scientists	81.3%	85.0%
Medical & Dental	90.3%	85.0%
Nursing & Midwifery Registered	86.2%	85.0%
Nursing & Midwifery Unregistered	87.5%	85.0%
Trust Total	**87.2%**	**85.0%**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a meeting of the Trust Board of Directors to be held in Public on 30th September 2014 at 10:30 in the Board Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 12. Culture of Compassion Action 263

Purpose

To provide the Board with an update of progress towards the Trust's vision to be characterised by high quality individual care, delivered with compassion. To give re-assurance of the extensive work underway to advance a culture of compassion in a Trust wide consistent manner for every patient and their family.

Abstract

The Francis report clearly identified the risk in eliminating compassion, the report cites compassionate care as a priority and consistently refers to compassionate staff in putting the patient first.

Staff experience and engagement has become a recognised factor in patient experience with proven links through models such as Professor Michael West's work.

Actions have been taken to integrate a culture of compassion in all work undertaken and consideration of progress can be evaluated through patient and staff experience measures.

As a continuous cycle of learning further programs to embed this way of working across the Trust have been identified and will be reported to the Board in October 2014.

Recommendations

To note this report for assurance.

Executive Report Sponsor

Director of Workforce and Organisational Development

Authors

Author – Penny Hilton – Fast track Executive program

Associated Papers

1. Patient Experience & Complaints Report
2. Spiritual & Pastoral Care Annual Report
3. Friends & Family Patient Survey
4. Friends & Family Staff Survey
5. Workforce Quarterly Report
6. National Staff Survey
7. National Patient Survey

University Hospitals Bristol NHS
NHS Foundation Trust

A Culture of Compassion

1. Introduction

1.1 The purpose of this paper is to provide the Board with context and background information with regard to work already in progress in the Trust, action plans in place to drive forward the agenda of delivering consistently compassionate care and recommendations for additions.

2. Background

2.1 The Francis report clearly identified the risk in eliminating compassion. The report cites compassionate care as a priority and consistently refers to compassionate staff in putting the patient first. "The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff…."[1]

2.2 The focus of UHB has been exceptional in listening to patients and numerous applications of data collection and feedback have been in place for some time.

2.3 Board reports give an indication of changes in a culture of compassion and include the Workforce report (highlighting safe staffing level reporting, sickness, absence, vacancies levels), National Patient & staff surveys, Friends and Family reports and Patient Experience and Complaints Reports.

2.4 Staff experience and engagement has become a recognised factor in patient experience with proven links both through models such as Professor Michael West's work and the simple common sense approach that engaged staff will of course be able to give patients better care.

2.5 In April this year a working group with specific remit to consistently deliver compassionate care was created to embed this way of working from the initial recruitment of staff to ongoing training and in all change proposed within the Trust.

[1] Francis Report executive summary 1.122

3. Patient Experience

3.1 National Patient surveys annually provide quantitative information from which action plans are created by Divisions with support from the Patient Experience team of people. Friends & Family patient surveys provide an additional more frequent snapshot of how patients feel about the care they have received and feedback from these surveys are provided to Divisions to assist in their action plans.

3.2 Further qualitative work is undertaken in a more targeted way in order to ascertain inpatients experience across the Trust. Up to 1800 postal surveys are distributed monthly which provide comprehensive feedback as well as smaller face to face interviews with patients whilst they are still being cared for in our hospitals. Specific ward departments and teams of the Trust are given further insight from a patient point of view with 15 step challenge with volunteers giving feedback to the Patient Experience team on their impressions on first entering an area of either in or outpatients. All of the above are designed to feed into the action plans both at Trust and Divisional level to create a continual cycle of feedback and learning to drive forward the right prioritisation of improvements.

3.3 The complaints process is an indicator of how patients feel about the care they have received and a review and increase in additional staff to respond to patients and their carers in a timely and appropriate way has been made this year.

3.4 The Patient Experience Group has the patient at the heart of its considerations which includes reports such as the Spiritual & Pastoral Care Annual Report detailing care across the Trust for patients and staff in a non-secular and compassionate way.

4. Staff Delivering Care with Compassion

4.1 Staff engagement has been measured nationally in the annual Staff Survey and can be benchmarked against other Foundation Trusts. Recent implementation of Friends and Family Staff surveys also give more timely feedback and both measures form part of the actions plans for both Divisions and the Trust. In order to ensure the responses to the National survey are representative of a wide number of staff an investment has been made to include all staff who will be asked their views for the first time in September this year.

4.2 The comprehensive induction programme clearly sets out the priority the Trust places on delivering care with compassion and empowers new members to challenge behaviours out of line with this.

4.3 For revalidation of clinical staff with an enhanced appraisal system evidence of patient experience is required and consistently applied at all levels, enforced by the Medical Director and is being introduced for nurses from 2015.

4.4 Focus groups with both staff and patients around the Values of UHB was a large piece of work culminating in a renewal of the Values with all staff invited and attending sessions including engagement in the uncompromising care of people compassionately.

4.5 Leaders in the Trust continue to apply and develop a listening culture with Executive walks, delivery and support during “Breaking the Cycle” and “Delivering Best Care” weeks along with more localised sessions with Divisional leaders informally encouraging staff to come and talk at open sessions.

4.6 Support for all staff who are experiencing stress has been offered by the “Lighten up” campaign and specific additional support is also in pilot through an Employee Assistance programme for all staff in The Children’s Hospital. Anti-bullying campaigns and a culture of whistleblowing is being encouraged through both Divisional workshops and support for individuals.

5. In progress

5.1 Schwartz rounds will be introduced through specific areas of the hospital where it will be beneficial to allow staff to talk about delivering care with compassion and share across the team of people delivering care.

5.2 Friends and Family patient surveys will be extended to Outpatients, Day cases and the Children’s Hospital in a way which tests varying mechanics under which feedback can be given.

5.3 Real time listening to both patients and staff will be piloted to establish the benefits to patients through staff engagement for both technical and emotional support where required. This follows from a recommendation from the Utley review of Bristol Children’s Hospital in the need for a “staff temperature gauge to measure improvements in culture and facilitate identification of risks within the workforce”.[2] A bid, strongly backed by a clinical team, for funding to the Health

[2] Utley Report of BCH April 2014 recommendation 29

Foundation has been made to finance a pilot in the Surgical Division to enable real time feedback from staff via an Application to essentially deliver continuous improved patient care and experience through staff engagement.

5.4 Continued learning cycles will be established such as “Breaking the Cycle” to ensure barriers to delivering care with compassion are understood and removed. Additionally the increased visibility of leaders in the hospital will improve the culture in which staff and patients are able to express their experience and suggested learnings to continually improve care.

5.5 The action group will continue to ensure focus and priority is given to delivering care with compassion and learn from feedback from both patients and staff. This group will report through the Transformation Board.

6. What does success look like?

6.1 Definitions of compassionate care exist and the barriers to delivering this care have been identified [3], the translation of how this manifests in UHB will be sought through the culture audit currently being scoped.

[3] Barbara Schofield – University of Huddersfield

Associated Papers:

1. Patient Experience & Complaints Report
2. Spiritual & Pastoral Care Annual Report
3. Friends & Family Patient Survey
4. Friends & Family Staff Survey
5. Workforce Report
6. National Staff Survey
7. National Patient Survey

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a meeting of the Trust Board of Directors to be held in Public on 30 September 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

13. NHS Regulatory Changes: Statutory Duty of Candour and Fit and Proper Person Test

Purpose

To inform members of the proposed introduction of two NHS regulations on 1 October 2014:
A statutory duty of candour, and a fit and proper person requirement for directors

Abstract

New health and social care regulations setting out fundamental standards of care will come into force on 1 April 2015. However, from 1 October 2014, in addition to the existing regulations, NHS bodies must meet the fit and proper person requirement for directors and the duty of candour.

The introduction of a statutory duty of candour is an important step towards ensuring the open, honest and positive culture that Sir Robert Francis found was lacking at Mid Staffordshire NHS Foundation Trust. The fit and proper person requirement plays a major part in ensuring the accountability of directors of NHS bodies.

Recommendations

The Trust Board is asked to:

a) **note** the forthcoming changes to NHS regulations with effect from 1 October 2014 and the current Care Quality Commission consultation exercise;
b) **note** that a review of the '*Staff Support and Being Open Policy*' is currently being undertaken and recognising its increasing importance, it is recommended that this is presented in due course to the Board for approval; and
c) **note** that subject to the publication of further national guidance from the CQC (currently expected in October 2014), formal action plans will be developed to ensure the Trust's compliance with the new regulatory requirements as outlined at the paper and that the necessary assurance will be provided by the Quality and Outcomes Committee and the Audit Committee.

Report Sponsor

Robert Woolley – Chief Executive

Authors

Carolyn Mills – Chief Nurse
Julie Dawes – Interim Trust Secretary

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other
		25/09/14			

NHS Regulatory Changes: A Statutory Duty of Candour and Fit and Proper Person Requirements

1. Summary

New Health and Social Care regulations setting out fundamental standards of care will come into force on 1 April 2015. However, from 1 October 2014, in addition to the existing regulations, NHS bodies must meet the fit and proper person requirement for directors and the duty of candour.

The Care Quality Commission (CQC) published a consultation document in March 2014 to help providers meet the new CQC regulatory requirements.

2. Background

The CQC set out a new vision and direction in their strategy for 2013/16, proposing radical changes to the way they monitor, inspect and regulate health and social care services. Earlier this year, the Department of Health also consulted on new regulations that set out the fundamental standards of quality and safety that all providers must meet. The CQC has now issued guidance for providers to help them to meet the new regulations, and on how the CQC will use their enforcement powers to take action when they fail to do so.

3. New Regulations and Fundamental Standards

There are 11 new regulations that set out the fundamental standards of quality and safety, replacing the current 16 regulations/Outcomes. These new regulations are clearer statements of the standards which care should never fall below and are listed along with the two additional new regulations, as follows:

- Person-centered care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users from abuse
- Meeting nutritional needs
- Cleanliness, safety and suitability of premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper persons employed

- **Fit and proper person requirement for directors**
- **Duty of candour**

The regulations for all health and social care services (fundamental standards) come into force in April 2015.

The two new regulations: a duty of candour and a fit and proper person requirement for directors, will apply from 1 October 2014 (or very closely after this date subject to Parliamentary approval), are described in more detail below.

The introduction of a statutory duty of candour is an important step towards ensuring the open, honest and positive culture that Sir Robert Francis found was lacking at Mid Staffordshire NHS Foundation Trust. The fit and proper person requirement plays a major part in ensuring the accountability of directors of NHS bodies.

4. Regulation 20: The Duty of Candour

4.1 Background

All NHS healthcare services (with the exception of services commissioned under primary contracts) are now subject to contractual duty of care under the Standard Contract.

Under the contractual duty of candour the Trust is required to comply with obligations if a reportable patient safety incident (i.e. a patient safety incident involving moderate or severe harm or death) occurs or is suspected to have occurred. However this only relates to patient incidents arising in the course of services delivered under the contract

4.2 There is a general duty on all health service bodies to act in an open and transparent way in relation to the care and treatment provided to service users. This will apply at all times.

4.3 When a service is meeting the duty of candour our patients should expect:

- A culture within the service that is open and honest at all levels.
- To be told in a timely manner when certain safety incidents have happened.
- To receive a written and truthful account of the incident and an explanation about any enquiries and investigations that the service will make.
- To receive an apology in writing.
- Reasonable support if they were directly affected by the incident.

If a service fails to do any of these things, the CQC can take immediate legal action against that provider (refer section 6 below).

4.4 In addition "…*as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred*" a health service body must notify the "*relevant person*" that that the incident has occurred.

In respect of NHS bodies, a "*notifiable safety incident*" means any "*unintended or unexpected incident that occurred in respect of a service user during the provision of regulated activity that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:*

- *Death*
- *Severe harm*
- *Moderate harm*
- *Prolonged psychological harm*"

Severe harm is defined as "*a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb, or organ or brain damage*."

The definitions for both death and severe harm are qualified in that they only apply to the extent that the death or severe harm is "*related directly to the incident rather than the natural course of the service user's illness or underlying condition*."

Moderate harm is defined as "*harm that requires a moderate increase in treatment; and significant, but not permanent, harm.*" A moderate increase in treatment includes:

- An unplanned return to surgery
- An unplanned re-admission
- A prolonged episode of care
- Extra time in hospital or as an outpatient
- Cancelling of treatment
- Transfer to another area such as intensive care

It is not qualified in the same way as severe harm in terms of having to be "related directly to the incident" and could cover recognised complications if they are "unintended or unexpected".

The definition of prolonged psychological harm is also limited, being taken from the Care Quality Commission (Registration) Regulations 2009: "*psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days*.''

4.4 From 1st October 2014 it will be a criminal offence not to notify a service user of a notifiable safety incident or to fail to meet the requirements for such a notification. If the organisation is found guilty of the offence, they will be liable, on conviction, to a fine not exceeding £2,500.

However, if the registered person can prove that they took all appropriate steps and exercised all due diligence to ensure that they complied with the

duty, this will be a defence. A fixed penalty notice of £1,250 may be offered by the CQC as an alternative to prosecution.

4.6 Implications for UH Bristol

The implications for UH Bristol are three fold:

- Policy review, to ensure that the related policies of to ensure the policy is compliant with the detail within the new legislation, are clear to staff what is expected of them;
- Dissemination of any policy changes are disseminated in the organisation and training offered/amended to reflect the changes; and
- Review of the Trust's system for reporting incidents enables them to identify all incidents to which the duty applies, including those that only become notifiable when harm is presented or after a period of time has elapsed. Policy guidance should be issued to staff to ensure that they have a clear understanding of the reporting process; especially when they are presented with evidence of harm at a later date.

4.7 Specific Actions

1. Review the '*Staff Support and Being Open Policy'* to add minor further clarity as set out in the legislation.
2. Review staff induction slides on Duty of Candour to reflect further clarity as set out in the legislation.
3. Update the Duty of Candour pages on Connect to reflect further clarity as set out in the legislation.
4. Disseminate changes via relevant Trust forums to patient safety leads and divisional management teams.
5. Review with the Ulysses Safeguard System Manager (or the proposed replacement risk management and incident reporting system) how we can better capture compliance with Duty of Candour with new incident reporting system.
6. In conjunction with the Education and Training, consider the potential wider implications for both Post Graduate Medical Education and Essential Training.

Actions 1-3 will be completed by 1 October 2014

Action 4 will be completed by 31 October 2014

Actions 5-6 will be completed by 31 December 2014

4.8 Organisational Risk

Following review of the strengthened requirements in the Duty of Candour legislation against the Trust's current policy and practice in regard to delivering a duty of candour, no significant risks were identified. The Trust considers that is already largely compliant with the statutory requirement for Duty of Candour due to a well-established '*Being Open'* policy and existing contractual requirements.

5. Regulation 5: Fit and Proper Person Requirement for Directors

The Francis report made seven recommendations regarding 'fit and proper persons test'. Under the new regime, the CQC will maintain a record of concerns about individual directors (including those who resign before the regulator has had time to act and impose any conditions on their Trust). Any individual deemed unfit, would then be removed from their posts and/or barred from joining a new organisation, preventing movement between different providers.

The fit and proper person requirement for directors makes it clear that directors and people in 'equivalent' positions of authority are personally responsible for the overall quality and safety of care.

Currently, providers have a general obligation to ensure that they only employ individuals who are fit for their role. The CQC assesses the fitness of corporate providers by focusing on the fitness of their nominated individuals for each of its regulated activities. Providers are able to nominate, for themselves, who will be their nominated individuals.

The new fit and proper person requirement for directors will have a wider impact, in both the scope of its application and the nature of the test. It makes it clear that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care and, as such, can be held accountable if standards of care do not meet legal requirements.

It will apply to all directors and equivalents. This will include Executive and Non-executive Directors of both NHS Trusts and Foundation Trusts. It will ultimately be the responsibility of the Chair to ensure that all directors meet the fitness test and do not meet any of the unfit criteria. In practice, this will involve the Chair:

- Providing confirmation to the CQC that the fitness of all new directors has been assessed in line with the regulations; and
- Declaring to the CQC in writing that they are satisfied that they fit and proper individuals for that role.

The new regulations will enable the CQC to decide that a person is not fit to be a director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time, or working outside England.

The draft legislation describes that to qualify as a fit and proper person, a director must:

- Be of good character;
- Be competent (qualifications, skills and experience) for the role;
- Be capable of undertaking the position;
- Be able to supply information, such as certain checks and a full employment history.

A director could be deemed to be unfit:

- They have been convicted of a criminal offence or sentenced to three months in prison within the last five years;
- They are included on any barring list preventing them working with children and vulnerable adults;
- Been responsible for misconduct or mismanagement in the course of any employer with a CQC registered provider;
- They are an undischarged bankrupt; are subject to a bankruptcy order;
- They have undischarged arrangements with creditors;
- Be prohibited from holding the positon under existing laws.

As there is a currently a notification requirement to the CQC following a new director level appointment, the CCQ maintain that this new requirement is not intended to delay the appointment process, or increase the administrative workload significantly.

It is intended that further guidance will be published once the draft regulations become statute to facilitate implementation of new tests and corporate records. Our current understanding is that the test will be applied universally and will bar approximately seven individuals a year form holding a Director level role within healthcare organisations registered with the CQC. A copy of the draft legislation as currently laid before Parliament, together with the full consultation reports are available below for reference purposes:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/327562/Annex_A.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/327561/Consultation_response.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/298328/Corporate_accountability_consultation_response..pdf

6. Enforcement Powers

The Care Act 2014 also gives the CQC strengthened enforcement powers to:

- protect people who use regulated services from harm and the risk from harm;

- hold providers and individuals to account for failures in how the service is provided.

The proposed new changes will allow the CQC to take swifter action and use the most appropriate tool to target poor performing providers. Importantly, the CQC will be able to prosecute providers for certain breaches of regulation without first issuing them a 'warning notice'. The CQC will in effect become the main prosecuting authority for health and social care at a national level.

The CQC will have a number of actions they can take to require a care provider to make improvements or to hold them to account for failures in care. These powers will include:

- **Requirements**
  Where a provider is not meeting the fundamental standards (the regulations), but people are not at immediate risk of harm, the CQC will require the provider to send them a report. This must show what they will do to meet the standards. If they do not improve, the CQC will take further action.

- **Warning notices**
  Warning notices inform a provider that they are not meeting one of the fundamental standards and can be published immediately. If Foundation Trust (or NHS Trust) needs to make significant improvements the CQC will issue a special warning notice before they are placed into 'special measures'. The CQC will work closely with the Foundation Trust and Monitor (or the NHS Trust Development Authority for NHS Trusts)

- **Use of conditions**
  The CQC can impose conditions on a provider's registration with them. This will affect the way they provide care for people. The CQC can do this in a variety of ways to keep people safe and ensure that legal requirements are met. The CQC can lift the condition once the concern has been addressed.

- **Prosecution**
  The CQC can prosecute any provider that breaches certain requirements. For example, they may prosecute a provider if the service leads to harm or abuse of a person in their care. They will be able to prosecute providers for serious, multiple or persistent breaches of the fundamental standards without issuing a warning notice first.

The changes to the CQC's enforcement approach are expected to come into effect in April 2015.

7. Consultation

As the regulations come into force at different times, the CQC have been running two separate national consultations:

- The first consultation closed on Friday 5 September 2014 and asked for feedback on the fit and proper person requirement for directors and the duty of candour.

- The second consultation closes on Friday 17 October, and seeks feedback on the CQC guidance to help services meet fundamental standards, including the fit and proper person requirement for directors and duty of candour, and on guidance about enforcement powers.

A copy of full consultation report is available at:

http://www.cqc.org.uk/sites/default/files/20140725_fundamental_standards_and_enforcement_consultation_final.pdf

The CQC want to know whether the guidance they plan to produce for services is clear, helpful and formatted in the right way.

8. Next Steps for the Trust

In addition to the actions that have already been identified in relation the Duty of Candour and as outlined above under section 4.7, the Quality Team and Secretariat are jointly reviewing the currently available guidance from the CQC to map the extent to which the new fundamental standards are addressed through our existing governance/assurance arrangements. This exercise will identify if there are any current gaps in our assurance and escalation mechanisms that need to be addressed. The outcome will be reported in due course via the Quality and Outcomes Committee.

In addition, once further guidance clarifying the positon concerning [Act], has been published by the CQC, appropriate action plans will also being developed to address the two new regulatory requirements. Following an initial discussion with the respective Chairs, it is expected that the Quality and Outcomes Committee and the Audit Committee will be responsible for the required monitoring of compliance with the duty of candour regulations and the fit and proper persons requirements for directors respectively.

Given the importance of the '*Staff Support and Being Open Policy'*, it is recommended that this policy receives board approval but with the required consultation led through the Quality and Outcomes Committee, who in turn makes a recommendation to the Trust Board

To facilitate this process, it is further suggested that a board development seminar is held to explore and seek agreement on how the Board of Directors will in future respond to the new statutory duty of candour. This will then inform discussion at the public board meeting in January 2015 with the Board being a in a position to make a public pledge in relation to candour.

9. Recommendations

The Trust Board is asked to:

a) **note** the forthcoming changes to NHS regulations with effect from 1 October 2014 and the current Care Quality Commission consultation exercise;

b) **note** that a review of the *Staff Support and Being Open Policy* is currently being undertaken and recognising its increasing importance it is recommended that this is presented to the Board for approval; and

c) **note** that subject to the publication of further national guidance from the CQC (currently expected in October 2014), formal action plans will be developed to ensure the Trust's compliance with the new regulatory requirements as outlined at the meeting and that the necessary assurance will be provided by the Quality and Outcomes Committee and the Audit Committee.

University Hospitals Bristol NHS
NHS Foundation Trust

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

14. Workforce and Organisational Development Strategy

Purpose

The Workforce and Organisational Development Strategy describes the workforce vision for University Hospitals Bristol and provides a framework of underpinning strategic priorities which are required to deliver on the UH Bristol Trust Mission, Vision, Values and 2020 Strategy.

Abstract

The document has been produced in consultation with an extensive range of stakeholders throughout the Trust, including Trust Board, Strategic Leadership Team (SLT), Divisional Boards and relevant sub-groups, corporate leads for Nursing, Medical Staff, Allied Health Professionals, staff side representatives and HR colleagues. This work has culminated in SLT agreement of the strategy at a meeting on 17th September 2014 and is now recommended to Trust Board for final endorsement.

Recommendations

The Board are asked to formally ratify the Workforce and Organisational Development Strategy.

Report Sponsor

Sue Donaldson, Director of Workforce and Organisational Development

Appendices

Appendices

Appendix 1 Trust Workforce Profile

Appendix 2: Strategic Workforce Risks

Appendix 3 (SWOT analysis)

Appendix 4 Supporting Documents

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other
	17th September 2014	25th September 2014			Trust Board Seminar 18th July 2014 SLT/Trust Board Seminar 12th September 2014 Industrial Relations Group 16th September 2014

University Hospitals Bristol Workforce and Organisational Development Strategy 2014/15 to 2019/20

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

DRAFT **22.9.14 V44**

Category	
Summary	This Workforce and Organisational Development Strategy describes the workforce vision for University Hospitals Bristol and provides a framework of underpinning strategic priorities and work programmes which are required to deliver on the UH Bristol Trust Mission, Vision, Values and 2020 Strategy.
Equality Analysis	To follow
Valid From	tbc
Date of Next Review	tbc
Approval Date/Process	Workforce and Organisational Development Group 3rd September 2014 Industrial Relations Group 15th September 2014 Senior Leadership Team 17th September 2014 Quality and Outcomes Committee 25th September 2014 Trust Board 30th September 2014
Distribution	tbc
Related Documents	• UH Bristol's 2020 Strategy • Monitor Strategic Plan 2014-2019 • Monitor Operating Plan 2014-2016 • Annual Divisional Workforce plans • Teaching and Learning Strategy • Research and Innovation strategy • Staff Engagement and Experience Programme
Author	Heather Toyne, Assistant Director of Workforce and HR Information Systems Sue Donaldson, Director of Workforce and Organisational Development
Document Replaces	Workforce Strategy 2007-12
Lead Director	Sue Donaldson, Director of Workforce and Organisational Development
Issue Date	tbc

1. Introduction

This Workforce and Organisational Development Strategy supports the delivery of the Trust's, Mission, Vision and Values and aligns with the Trust`s overall 2020 Strategy, setting out the strategic workforce priorities for the next five years.

The Strategy was initiated during February 2014 at a workshop of Human Resources (HR) Business Partners and Senior HR team members, and has developed over a six month period, reflecting the extensive input of key stakeholders who have helped to shape it. Stakeholders include the Senior Leadership Team, Trust Board members, Divisional Boards and relevant sub-groups, corporate leads for Nursing, Medical Staff, Allied Health Professionals, our staff side representatives and HR colleagues. This process is important in ensuring that the Strategy is meaningful to all staff and managers across the Trust.

Stakeholders have been keen to recognise that the UH Bristol workforce is already highly skilled, and strongly committed to delivering compassionate, high quality individual care and there is considerable best practice in the way the Trust recruits, develops, supports and manages its staff. However, this Strategy is required in order to ensure that this position is sustained and further improved.

The terminology used in the sections which outline the context and vision do so from the perspective of the Trust.

2. UH Bristol Workforce 2014

The Trust employs more than 8,000 staff and workforce costs account for approximately 63% of operating costs. Bristol serves a socially and ethnically diverse population and as Appendix 1 shows, this is broadly reflected in the profile of the workforce. 84% of the Bristol area are classified as White compared with 84.3% of the UH Bristol Workforce. The UH Bristol workforce is predominantly female; only 23% are male. The workforce split by staff group is also shown in appendix 1, with nursing and midwifery accounting for the largest component of both workforce numbers and costs.

The development of the Trust Annual Operating Plans and Five Year Monitor Strategic Plan identified a range of workforce risks and issues, which are summarised below. Risks are described fully, together with mitigations, in Appendix 2:

- **Recruiting to hard to fill** consultant **posts**, notably in the areas of paediatric radiology, cellular pathology, oncology and acute physicians, and also recruitment to specialist technical roles including echocardiographers, perfusionists, vascular scientists and clinical engineers.
- Ensuring there are **sustainable junior doctor rotas**, and minimising the adverse impact of reduced numbers of junior doctors working in the Trust from 2016 due to national changes in junior doctor training.

- Managing the local impact of **predicted national shortages in qualified nurses** over the next three years, and the existing recruitment challenges for nurses in acute medicine, intensive and critical care, and theatres. National projections for supply and demand show a shortfall of nurses by 2016 (The Centre for Workforce Intelligence).
- Tackling the **high turnover** for some staff groups, for example nursing assistants and ancillary staff, ensuring there are approaches focussed on those hot spots. UH Bristol is located within a competitive local and regional labour market with a high employment rate, which increases the challenge for recruitment to keep pace with turnover.
- Planning for an **ageing workforce profile** which may result in loss of key skills or cohorts of staff retiring at the same time. The Trust`s age profile shows that whilst only 12.9% are over 55 years of age, (see appendix 1) this varies by staff group, with 22.2% of ancillary staff being over 55. In some ward areas, for example, in parts of the Bristol Eye Hospital and South Bristol Community Hospital, more than 50% of registered nurses are over 50 years old.
- Achieving and maintaining **Workforce Key Performance Indicators** (KPIs) for example, sickness absence, essential training, and bank and agency usage, which link to safe and efficient staffing levels.
- Delivering services and sustaining quality within a **reduced financial resource,** particularly given the increasingly complex health needs of patients and the requirement to provide services within extended hours.
- Ensuring the Trust has a workforce which reflects the **diversity** of the community it serves at all levels of the organisation and across all staff groups.

3. UH Bristol Workforce Strategic Context

To develop the Workforce and Organisational Development Strategy, an analysis has been undertaken of UH Bristol`s current workforce strengths, weaknesses, opportunities and threats, and this is provided in Appendix 3.

The Trust`s strengths, which will need to be maintained and built on, are: its highly skilled, dedicated workforce; traditionally good partnerships with trade union representatives, redevelopments which provide a better working environment for staff and a number of positive ratings in the staff attitude survey, including proportions of staff recommending the Trust as a place to work or receive treatment.

However, the analysis also shows that UH Bristol has a number of weaknesses, for example turnover and sickness absence rates, which are higher than those of similar Trusts, an apparently deteriorating staff experience and increased work related stress in some areas, as measured by the staff attitude survey and the Friends and Family Test, and financial challenges associated with the need to align staffing, activity and capacity. There are also some key threats in the future: recruitment to key staff groups in a tight labour market, and maintaining and developing the quality of services with fewer available resources. These threats will bring opportunities, making it more important to work in partnership with local organisations and staff side, and providing staff with the chance to work in new ways and train for new roles

4. Trust Strategic Context

As identified in the UH Bristol Monitor Strategic Plan 2014-19, the Trust delivers 100 different clinical services across nine individual sites, from the neonatal intensive care unit to older peoples care, offering care to the people of Bristol and the South West from the very beginning of life to its later stages, and is one of the country's largest acute NHS Trusts with an annual income of £575m.

Trust Values

The **Trust's Values** were developed between 2009 and 2010 by staff, governors and patients. These values are now embedded within Induction, Appraisal and key Trust policies and procedures. The Values are intended to guide behaviours such that all staff and leaders to develop and support a culture of empathy, integrity and a duty of candour.

The Trust Values are:

- **Respecting everyone**
- **Embracing change**
- **Recognising success**
- **Working together**

Trust Mission and Vision

The **Trust** Vision and Mission, which was refreshed in 2014, is as follows:

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.**

5. The Trust Workforce Vision

The Workforce Vision is an attempt to capture, following the extensive dialogue with staff, managers, leaders and other stakeholders consulted, what the ambition and focus for the workforce agenda of the Trust should look like in detail, and the underpinning strategy and supporting programmes.

This is the UH Bristol Workforce Vision:

> **The Trust will be an employer of choice, attracting, supporting and developing a workforce that is skilled, committed, compassionate and engaged, so that it can deliver exceptional care, teaching and research every day.**

6. Strategic Workforce Priorities

The SWOT analysis, initially developed in the context of the Monitor Strategic Plan, combined with the emerging 2020 Trust Strategy, has helped to identify six strategic workforce themes for attention. These are:

- Leaders at all levels with the skills and knowledge to transform the way care is delivered and who know how to bring about innovation and change.
- Engaging the workforce, so staff are central to decisions that affect them, their patients and their services.
- Recruiting and retaining highly skilled, talented and compassionate staff who reflect the community The Trust serves.
- Ensuring that staff are recognised and rewarded for high performance, and supported to realise their potential.
- Providing excellent teaching and research, building upon the excellent partnerships The Trust has with local universities and further education partners.
- Assessing workforce supply and service needs to ensure there us a constant supply of staff with the right skills and qualifications.

To illustrate what the Trust is aiming to achieve, a statement of ambition and key priority has been described for each strategic theme, which are described in more detail in the following section. These are written as expressed by staff themselves, using “we” to describe the aspirations.

Developing Leadership Capability

Our ambition:

We will have leaders and managers at all levels with the skills and knowledge to transform the way care is delivered and know how to bring about innovation and change to ensure exceptional care is provided to all our patients, every day. Our leaders and managers will at all times connect the values of the organisation to create a culture of accountability, high performance and continuous improvement.

Key Priority:

- A comprehensive approach to leadership and management training and development, so that all managers and leaders have the skills and competencies to support and develop staff creating a culture of high performance and continuous improvement. The immediate focus will be front line supervisory and managerial roles across the Trust.

Other considerations:

- Ensure training resources match demand by ensuring that the most appropriate training is being accessed by those who most need it.
- Build on the internal comprehensive Healthcare for Leaders Programme to include external leadership programmes, emotional intelligence, increased coaching and mentoring and action learning sets. Introduce integrated 360 degree feedback for leaders at all levels.

Staff Engagement

Our ambition:

We will fully engage with our Trust's mission to deliver exceptional care teaching and research every day. We are proud to work for UH Bristol and are passionate about delivery safe, quality care with compassion.

Key Priority:

- Improve two-way communication, including a programme of listening events.

Other considerations:

- Focussed action to reduce the incidence of work-related stress and bullying and harassment.
- Improve team based working using the Michael West evidence-based approach.
- Review and develop Our "Values" training to focus on treating everyone with respect.
- Conduct a full census staff survey and introduce more regular pulse checks.
- Strengthen partnership working with staff side representatives and trade unions

Recruiting and Retaining the Best

Our ambition:

We will work for an employer of choice, renowned for attracting and retaining highly skilled, talented and compassionate staff who reflect the community we serve, and demonstrate values through our behaviours.

Key Priority:

- Develop a structured marketing approach which is tailored to target staff groups, using the media and methods most likely to attract suitable candidates, which might include social media for cleaning staff or academic networks for medical staff.
- Improve the speed of recruitment from application to appointment by streamlining all processes, whilst continuing to ensure there are robust employment checks.

Other considerations:

- Recruit for values as well as skills, extending this approach to all staff groups.
- Improve recruitment branding and promote the Trust benefits package with a particular focus on what it means to work for a top teaching hospital.
- Ensure there is a clear understanding of reasons for staff leaving and take action where appropriate which will be reflected in turnover rates which benchmark with comparable Trusts.

Reward and Performance Management

Our ambition:

We will be part of a high performing team, and our contribution will be recognised and rewarded. There are appropriate consequences for under achievement.

Key Priority:

- Improve the quality and application of staff appraisal, to include:
    - Clarity of role, responsibilities and objectives for all individuals and teams.
    - Clearly identified competences, and training to enable staff to deliver against objectives.
    - Regular recognition for achievement, and holding to account where performance falls short of the required levels.

Other considerations:

- Develop a better understanding of what constitutes a 'high performing Team', including productivity measures/KPIs derived from best practise benchmarking
- Develop a pay and reward strategy which supports the development of high performing individuals and teams.

Education and Research

Our ambition:

Our Trust will be recognised nationally for the provision of excellent education and research, built upon mutually beneficial partnerships with higher and further education institutions. We, as staff of the Trust, will be developed to realise our potential in delivery of education, research and exceptional care to our patients.

Key Priority:

- Provide high quality training and development programmes to support a diverse, flexible workforce, underpinned by effective needs analysis and active individual review processes, so that the Trust has the right people with the right skills.

Other Considerations:

- Partner actively with local organisations, including healthcare providers, academic institutions and our own trade unions to formulate and deliver our development and training.
- Review and strengthen the governance arrangements and structures (both internal and external) for education and research delivery.
- Ensure equity of opportunity, consistency of approach and a measurable return on investment for all development and training activity.

Strategic Workforce Planning

Our ambition:

We will feel confident that there are sufficient staff in our teams, both now and in the future, to deliver exceptional patient care, by ensuring that service needs are properly assessed and that the right numbers of appropriate staff are available.

Key priority:

- Improve workforce planning capability, aligning our staffing levels with capacity and financial resource, using workforce models and benchmarks which ensure safe and effective staffing levels.

Other considerations:

- Develop a better understanding of what constitutes a 'high performing team' including productivity measures / KPIs derived for best practice benchmarking.
- Redesign services, ways of working and roles to maximise efficiency, focussing on services where there are identified cost-effectiveness issues, or where there are long term recruitment or staffing challenges.
- Review electronic rostering and management information to help ensure the right numbers of staff are in the right place at the right time, at the most efficient cost

7. General Principles

There are also some principles which underpin the Vision and Strategic Priorities:

- A commitment to eliminating discrimination, promoting equality of opportunity and providing an environment which is inclusive for all, delivering healthcare, teaching and research which are sensitive to the needs of the individual and communities. The Trust is also committed to providing equality of access to employment opportunities and an excellent employment experience for all.
- An understanding of the importance of working with partners across the health community and social care so that there is a joined-up approach to workforce planning and development, for example by leading, in partnership, the workforce agenda of the Better Care Programme.
- In recognition of the future challenge of maintaining and developing the quality of our services, whilst managing with fewer resources, we will optimise the productivity and efficiency of our systems, processes and staff.

8. Oversight, Support and Resources

The Workforce and Organisational Development (OD) Group will oversee the delivery of the Strategy and supporting action plans. There will also be regular progress reports to Senior Leadership Team, Quality and Outcomes Committee, and the Trust Board.

The following support and resources will be put in place:

- The Trust Board Quality, Outcomes Committee, Strategic Leadership Team and Workforce and OD Group and managerial and clinical leaders will prioritise delivery of the Workforce Strategy;
- The Strategy will be communicated appropriately to ensure staff understand the purpose and support its implementation;
- Training and development programmes will be put in place;
- Adequate and appropriate investment will be made in HR Systems, processes and resources.

9. Measures of Success

Each strategic priority will have clear action plans and outcome measures which will demonstrate that we have successfully achieved the aims of the Workforce and Organisational Strategy. These include:

- We recruit staff within agreed time limits, without difficulty, avoiding long term vacancies;

- Staff recommend UH Bristol as a place to work and to receive exceptional care;
- Our staff attitude scores will reflect positive year on year improvements and the ambition in the next three years will be to be in the top decile;
- Transformational leadership is embedded in the culture of the organisation;
- Leaders actively seek and participate in opportunities for leadership development;
- We will review our SWOT analysis each year and this will demonstrate changes in our strengths and weaknesses, reflecting the progress we have made;
- Achievement of agreed Key Performance Indicators in the "balanced score card" including:
    - *Reduced rates of turnover and sickness absence which take the Trust to upper quartile compared with our peers;*
    - *Workforce expenditure aligns with budget;*
    - *Temporary staffing is used appropriately to provide flexibility, and at the most efficient cost;*
    - *Appraisal rates achieve target compliance levels and show improved quality;*
    - *Junior Doctor New Deal compliance is achieved and sustained;*
    - *Essential Training levels reach and maintain target levels.*

Appendices

Appendix 1 Trust Workforce Profile

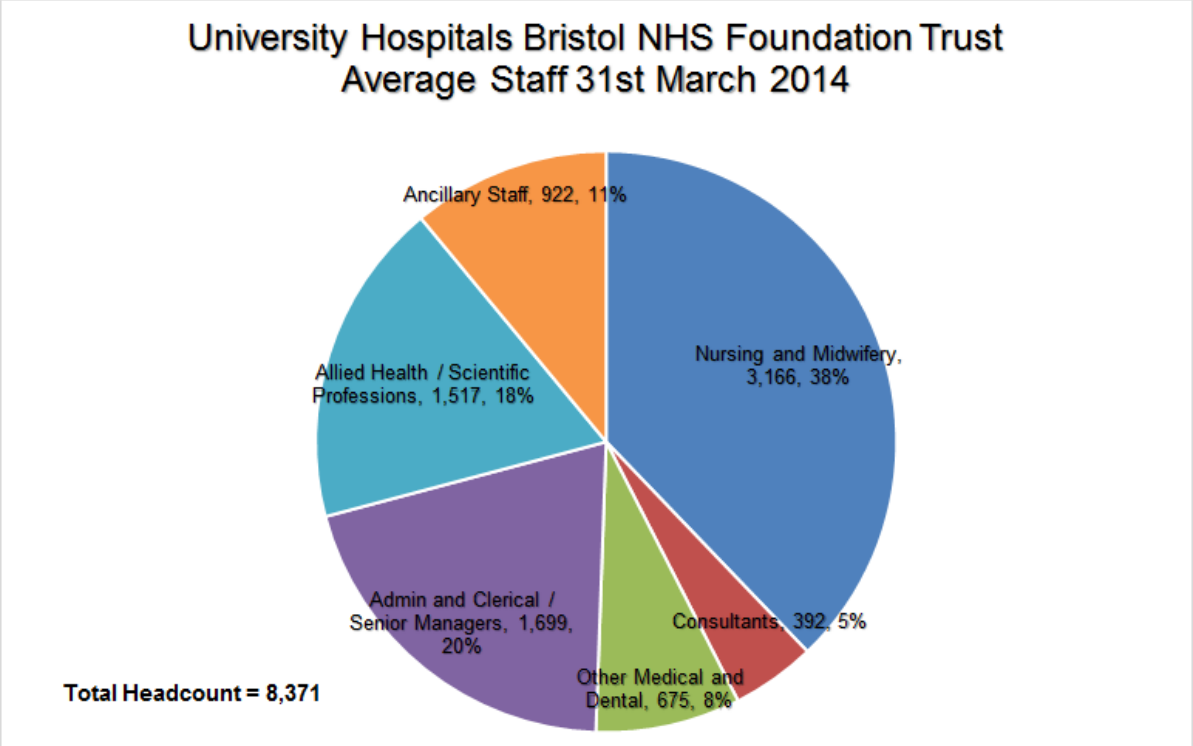
Appendix 2: Strategic Workforce Risks

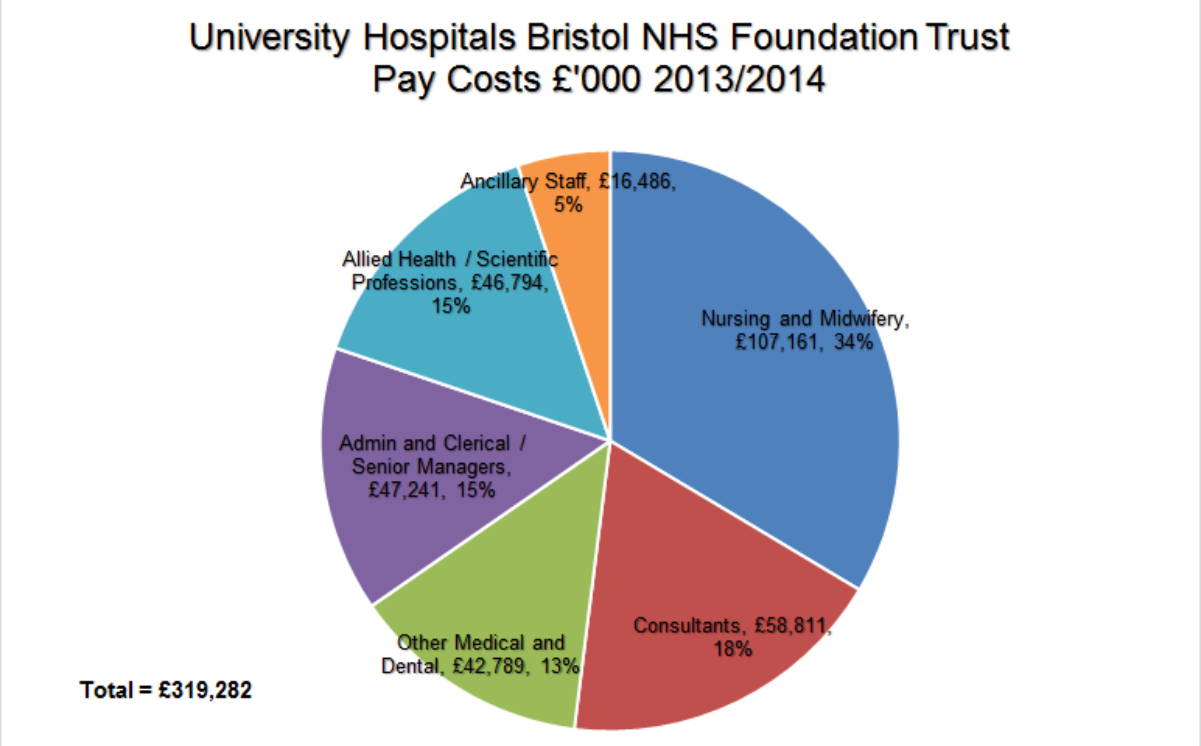
Appendix 3 (SWOT analysis)

Appendix 4 Supporting Documents

Appendix 1 - Our Workforce Profile –

a) Breakdown of Staff Numbers and Costs by Staff Group

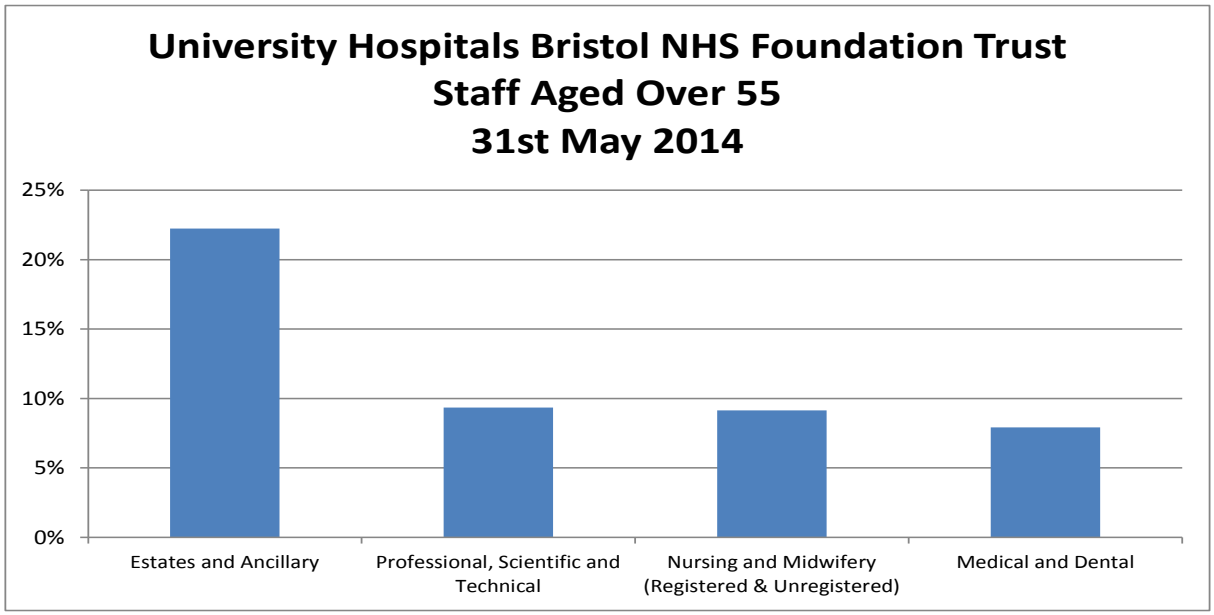




b) Ethnicity January 2014 ESR compared with 2011 Census for the Bristol area

Ethnic Group	Bristol Population		UH Bristol Staff	
White (including White Other)	**359,592**	**84.0%**	**8056**	**84.3%**
White: English/Welsh/Scottish/Northern Irish/British	333,432	77.9%	7405	77.5%
White: Irish	3,851	0.9%	136	1.4%
White: Gypsy or Irish Traveller	359	0.1%	0	0.0%
White: Other White	21,950	5.1%	515	5.4%
Mixed/multiple ethnic groups	**15,438**	**3.6%**	**149**	**1.6%**
Mixed/multiple ethnic groups: White and Black Caribbean	7,389	1.7%	42	0.4%
Mixed/multiple ethnic groups: White and Black African	1,533	0.4%	15	0.2%
Mixed/multiple ethnic groups: White and Asian	3,402	0.8%	26	0.3%
Mixed/multiple ethnic groups: Other Mixed	3,114	0.7%	66	0.7%
Asian/Asian British	**23,655**	**5.5%**	**727**	**7.6%**
Asian/Asian British: Indian	6,547	1.5%	393	4.1%
Asian/Asian British: Pakistani	6,863	1.6%	40	0.4%
Asian/Asian British: Bangladeshi	2,104	0.5%	8	0.1%
Asian/Asian British: Chinese	3,886	0.9%	52	0.5%
Asian/Asian British: Other Asian	4,255	1.0%	234	2.4%
Black/African/Caribbean/Black British	**25,734**	**6.0%**	**530**	**5.5%**
Black/African/Caribbean/Black British: African	12,085	2.8%	293	3.1%
Black/African/Caribbean/Black British: Caribbean	6,727	1.6%	157	1.6%
Black/African/Caribbean/Black British: Other Black	6,922	1.6%	80	0.8%
Other ethnic group	**3,815**	**0.9%**	**70**	**0.7%**
Other ethnic group: Arab	1,272	0.3%	0	0.0%
Other ethnic group: Any other ethnic group	2,543	0.6%	70	0.7%
Undefined	**0**	**0.0%**	**27**	**0.3%**
All usual residents	**428,234**	**100.0%**	**9559**	**100.0%**

The UH Bristol Age Profile May 2014



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Appendix 2- Strategic Workforce Risks

The following table provides detail of perceived risks which are addressed by the Workforce and Organisational Development Strategy.

Risk	Detail	Mitigation Plan	Addressed by Strategic Programme	Committee/ Group responsible for oversight
Recruitment and Retention	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.	There are 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. The Trust has aligned workforce plans with recruitment to anticipate demand resulting from turnover and service developments. The Trust is 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. The Trust has also 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.	*Recruiting and Retaining the Best*	Divisional performance reviews, Workforce and OD Committee
High Sickness rates	Our long term ambition is to achieve a sickness absence level of 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.	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 muscular 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.	*Staff Engagement*	Trust Board - Performance Reports Divisional quarterly performance reviews HR Governance Board
Major change	BRI Redevelopment brings a significant period of change. Increases in productivity and efficiency may require a fast pace of change which may be difficult for some staff	Extensive programme of work to communicate with, and engage staff. Well briefed managers.	*Staff Experience and Engagement, Health and Wellbeing*	Operational Delivery Groups for each service transfer

Risk	Detail	Mitigation Plan	Addressed by Strategic Programme	Committee/ Group responsible for oversight
Changes to junior doctor training	By 2015, 80% of Foundation posts will be required to contain a 4 month Community post, rising to100% 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. By 2015 80% of Foundation posts have to contain a 4 month 'Community' post. This has to be 100% by 2017, resulting in up to a 30% reduction in junior doctors. Shortages of juniors and middle grade doctors in key areas such as Emergency Department	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 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 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 the Trust continues to collaborate with Health Education South West Severn Post Graduate Medical Education Deanery to understand as early as possible the potential impact in future years beyond 2017.	*Strategic Workforce Planning*	Teaching and Learning Group

Risk	Detail	Mitigation Plan	Addressed by Strategic Programme	Committee/ Group responsible
Temporary Staffing Usage	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, when temporary staffing exceeds budget or relies on premium agency, this constitutes a risk.	There are 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 the 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 detailed reporting at Quality and Outcomes Committee and at Divisional Reviews to ensure that the agreed trajectory for reducing bank and agency usage is achieved.	*Strategic Workforce Planning*	Workforce and OD Group
Work-force affordability	Delivering excellent services within a reduced financial resource particularly given the increasingly complex health needs of patients, and the requirement to provide services within extended hours.	• The Trust has reviewed nursing levels, using the national Safer Care Nursing Tool, combined with external review, benchmarks and review of risks. This has resulted in agreed general ratios which are already being met and achieved, 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. • Work will be undertaken to review Consultant job plans against capacity and service requirements. In addition, there will continue to be a rigorous approach to ensuring that new consultant posts are not established without a clear business case. There is a specific workstream which will focus on securing further efficiencies from our medical workforce. The Trust is 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. • The Trust is 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	*Strategic Workforce Planning, Staff Engagement*	Workforce and OD Group

Appendix 3 - 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:
  ○ Numbers receiving job-relevant training, learning or development
  ○ Staff recommendation of the trust as a place to work or be treated
  ○ 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:
	  ○ Work related stress
	  ○ Health and safety training
	  ○ Well-structured appraisals
	  ○ Harassment and bullying from other staff
	  ○ Communication between senior management
	  ○ Equality and diversity training
	  ○ Discrimination at work
	  ○ Satisfaction with work quality

Opportunities	Threats
• Further opportunities to develop the workforce – new roles, different ways of working – providing staff with new opportunities and new skills • The Trust can do more to optimise the productivity and operational efficiency of its systems, processes and staff • The need to change and adapt will drive change and provide scope to transform the way in which care is delivered through service and workforce redesign • The Trust 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. • The Trust can do more to market potential employees the benefits of working at UH Bristol, including its 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 workforce development and service delivery. • Develop a recruitment and retention plan to support the Trust's Equality and Diversity Strategy	• 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

Appendix 4

Associated Documents

- Teaching And Learning Strategy
- Annual Divisional Workforce Plans
- Monitor UH Bristol Operating Plan 2014-2016
- Monitor UH Bristol Strategic Plan
- The Francis Report

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 September 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

15. 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 £1.778m (before technical items) for the five month period to 31st August 2014. This represents an adverse variance of £0.639m against plan to date. The Divisional position shows an overspending to date of £4.263m i.e. an increase of £0.928m in the month. The headline issues are:

- Activity is substantially (£1.56m) less than planned in August. The Trust's activity plans are phased throughout the year to reflect the expected pattern of activity to be delivered each month. Further information by patient type is provided in section 3 of the report.
- Pay costs increased by £0.55m in August. This includes the cost (£118k) of the overlap at the beginning of August for the 'change of house' for junior medical and dental staff.

The adverse position in Clinical Divisions is currently being offset by the following factors:

- Corporate share of income plan increases less the share of under-performance on SLA to date – a net favourable variance of £0.754m;
- Some estimated slippage on reserves of £1.688m due to increments, scheme slippage and provisions;
- An expected favourable variance on financing costs (depreciation and PDC Dividend) of £1.224m due to phasing of capital schemes and the District Valuer 5 year revaluation impact.

The level of incremental drift has been reviewed. The estimated cost is c£0.85m for the year with c£0.3m cost year to date. The £0.3m has been issued to Divisions with the balance of Corporate funding (i.e. £2.4m less £0.85m) being shown against reserves. This is therefore supporting the deteriorating divisional position.

The other reserves / provisions will be reviewed in full for Month 6 along with a revised forecast outturn for Divisions and for the Trust as a whole.

Recommendations

The Board is recommended to receive the report for assurance.

Report Sponsor

Director of Finance and Information

Appendices

- Appendix 1 – Summary Income and Expenditure Statement
- Appendix 2a – Divisional Income and Expenditure Statement
- Appendix 2b – Divisional Income and Expenditure Projection Graphs
- Appendix 3 – Analysis of Pay Expenditure 2014/15
- Appendix 4 – Executive Summary
- Appendix 5 – Financial Risk Matrix
- Appendix 6 – Financial Risk Ratings
- Appendix 7 – Release of Reserves – August 2014

Previous Meetings

This report was presented to the Finance Committee meeting held on 26 September 2014.

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £1.778m (before technical items) for the first five months of 2014/15. This represents an adverse variance of £0.639m against plan year to date.

The position needs to be seen in the context of Divisions' Operating Plans. The following table sets out the submitted Operating Plan position and compares the forecast out-turns assessed by Divisions after taking into account their Month 5 results.

	Operating Plans 2014/15			Position to 31 August	Forecast Outturn 2014/15
	Plan 1 July	Non Recurring Funding	Net Plan		
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Diagnostic and Therapies	5	200	205	44	202
Medicine	(483)	278	(205)	(1,011)	(206)
Specialised Services	(103)	336	233	(196)	1
Surgery, Head and Neck	(3,449)	400	(3,049)	(2,003)	(2,286)
Women's and Children's	(723)	452	(271)	(1,260)	(1,077)
Estates and Facilities	-	143	143	45	143
Trust HQ	21	-	21	8	40
Trust Services	-	-	-	110	-
Totals	**(4,732)**	**1,809**	**(2,923)**	**(4,263)**	**(3,183)**

The Divisional position shows an overspending to date of £4.263m i.e. an increase of £0.928m in the month. The headline issues are:

- Activity is substantially (£1.56m) less than planned in August. The Trust's activity plans are phased throughout the year to reflect the expected pattern of activity to be delivered each month. Further information by patient type is provided in section 3 below.
- Pay costs increased by £0.55m in August. This includes the cost (£118k) of the overlap at the beginning of August for the 'change of house' for junior medical and dental staff.

The adverse position in Clinical Divisions is currently being offset by the following factors:

- Corporate share of income plan increases less the share of under-performance on SLA to date – a net favourable variance of £0.754m;
- Some estimated slippage on reserves of £1.688m due to increments, scheme slippage and provisions;
- An expected favourable variance on financing costs (depreciation and PDC Dividend) of £1.224m due to phasing of capital schemes and the District Valuer 5 year revaluation impact.

It is anticipated that the year-end value for the above 3 lines will be sufficient to cover the expected overspend on Divisional services.

The main risks to this are as follows:-

- Performance fines exceed the £1m budget. This is currently the case due to RTT and 6 week diagnostic failures.
- Commissioner challenges resulting in non-payment of SLA charges.
- Activity delivery under plan or using premium rates.

The level of incremental drift has been reviewed. The estimated cost is c£0.85m for the year with c£0.3m cost year to date. The £0.3m has been issued to Divisions with the balance of Corporate funding (i.e. £2.4m less £0.85m) being shown against reserves. This is therefore supporting the deteriorating divisional position.

The other reserves / provisions will be reviewed in full for Month 6 along with a revised forecast outturn for Divisions and for the Trust as a whole.

The table below shows the Trust's income and expenditure position setting out the variances on the four main income and expenditure headings. This generates an overspending against divisional budgets of £4.263m. Detailed information and commentary for each Division is to be considered by the Finance Committee.

Divisional Variances	Variance to 31 July	August Variance	Variance to 31 August
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,278)	(266)	(1,544)
Non Pay	2,209	1,192	3,401
Operating Income	(86)	(104)	(190)
Income from Activities	(1,674)	(1,119)	(2,793)
Sub Totals	(829)	(297)	(1,126)
Savings Programme	(2,506)	(631)	(3,137)
Totals	**(3,335)**	**(928)**	**(4,263)**

Pay budgets have an overspending of £0.266m in the month and a cumulative overspending of £1.544m. Substantive staff pay costs increased by £0.5m in August to £25.895m. For the Trust as a whole, bank, agency, overtime, waiting list initiative and other payments were broadly unchanged at £2.2m in August (cumulative expenditure £10.1m).

N**on-pay budgets** show a favourable variance of £1.192m in the month and £3.401m to date. The underspending relates in the main to the proportion of contract transfer funding which has yet to be used – in effect offsetting the income from activities under performance.

Operating Income budgets show an adverse variance of £0.104m for the month, and a cumulative overspending of £190k. A re-profiling of the Research and Innovation budgets has seen a virement between income and non pay budgets which has resulted in a £0.207m adverse movement on its Operating Income heading, and a corresponding improvement on its non pay heading.

Income from Activities shows an adverse variance of £1.119m in the month and £2.793m year to date. For August the principal variances are the in-month under performance recorded for

Diagnostic and Therapies (£0.209m), Medicine (£0.327m), Surgery, Head and Neck (£0.189m) and Women's and Children's (£0.407m) Divisions.

The table below summarises the financial performance in August for each of the Trust's management divisions.

	Variance to 31 July	August Variance	Variance to 31 August
	Fav / (Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Diagnostic and Therapies	28	16	44
Medicine	(748)	(263)	(1,011)
Specialised Services	(68)	(128)	(196)
Surgery, Head and Neck	(1,601)	(402)	(2,003)
Women's and Children's	(1,050)	(210)	(1,260)
Estates and Facilities	43	2	45
Trust HQ	7	1	8
Trust Services	54	56	110
Totals	**(3,335)**	**(928)**	**(4,263)**

The results to 31 August are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 4.0, July 4.0). Further information on the financial risk rating is given in section 5 below and appendix 6.

2. Savings Programme

The Trust's Savings Programme for 2014/15 is £20.771m. Savings of £5.518m have been realised for the five months to 31 August (72% of Plan), a shortfall of £2.163m against divisional plans. The forecast outturn for savings this year is £17.056m – equivalent to 82% of the planning assumption of £20.771m. The Finance Committee will receive a more detailed report on the Savings Programme under item 5.4 on this month's agenda.

	Savings Programme to 31 August			1/12ths Phasing Adj Fav / (Adv)	Total Variance Fav / (Adv)
	Plan	Actual	Variance Fav / (Adv)		
	£'000	£'000	£'000	£'000	£'000
Diagnostics and Therapies	629	781	152	(104)	48
Medicine	1,042	723	(319)	(224)	(543)
Specialised Services	842	641	(201)	(258)	(459)
Surgery, Head and Neck	1,852	689	(1,163)	(201)	(1,364)
Women's and Children's	1,404	739	(665)	(87)	(752)
Estates and Facilities	419	430	11	(39)	(28)
Trust HQ	435	443	8	2	10
Other Services	1,058	1,072	14	(63)	(49)
Totals	**7,681**	**5,518**	**(2,163)**	**(974)**	**(3,137)**

3. Income

Contract income is £4.81m lower than plan for the 5 month period to 31 August. Activity based contract performance at £167.62m is £3.42m less than plan. Contract rewards / penalties at a net income of £1.76m is £0.35m less than plan. Income of £23.47m for 'Pass through' payments is £1.04m lower than Plan.

Clinical Income by Worktype	**Plan** £'m	**Actual** £'m	**Variance** £'m
Activity Based			
Accident & Emergency	5.70	5.61	(0.09)
Emergency Inpatients	30.22	29.95	(0.27)
Day Cases	15.26	14.39	(0.87)
Elective Inpatients	21.40	20.33	(1.07)
Non-Elective Inpatients	7.11	6.58	(0.53)
Excess Bed days	3.02	3.26	0.24
Outpatients	30.15	29.09	(1.06)
Bone Marrow Transplants	3.52	4.34	0.82
Critical Care Bed days	17.74	16.95	(0.79)
Other	36.92	37.12	0.20
Sub Totals	**171.04**	**167.62**	**(3.42)**
Contract Rewards / Penalties	2.11	1.76	(0.35)
Pass through payments	24.51	23.47	(1.04)
Totals	**197.66**	**192.85**	**(4.81)**

4. Expenditure

In total, Divisions have overspent by £0.928m in August. The table given in section 1 (page 3) summarises the financial performance for each of the Trust's management divisions. Further analysis of the variances by pay, non-pay and income categories is given at Appendix 2.

Three divisions are red rated[1] for their financial performance for the year to date.

The **Division of Medicine** has an adverse variance of £1.011m for the five month period to 31 August.

The Division has an overspending of £0.655m to date on pay budgets, an overspending of £50k in the month. Nursing staff expenditure of £2.269m in August was £108k higher than July and represents the most significant variance with a cumulative overspending of £0.573m. This is as a result of staff in post being higher than budgeted due to extra capacity wards in quarter 1 together with a need for a high level of 1:1 observations and excess agency costs.

Non-pay budgets have a favourable variance of £167k in the month and £0.451m after 5 months. The clinical supplies heading records a favourable variance of £0.291m to date. A contributory factor is the lower than anticipated expenditure on respiratory equipment (within the Sleep Unit). Drugs and blood and blood products are £78k favourable to plan.

The Division reports a cumulative favourable variance of £126k on its Operating Income budgets, an improvement of £46k in the month.

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

Income from Activities shows an under achievement of £0.327m in the month and a cumulative adverse variance of £0.390m. There has been a notable reduction in activity based income due primarily to fewer new and follow up attendances for Dermatology and GUM clinics. A further 1% reduction in emergency admissions and a 7% decrease in attendances to the emergency dept. have also contributed to the adverse variance in August.

The Surgery, Head and Neck Division reports an adverse variance on its income and expenditure position of £2.003m for the five month period to 31 August.

Pay budgets are overspent by £1.205m to date - this is represents the pay proportion of the Division's underlying deficit (£1.617m) offset by a net underspending on other pay headings (£0.412m).

Non pay budgets are underspent by £0.271m in the month, cumulative £1.090m. This is mainly due to the release of $5/12^{th}$ of the non-recurring funding allocated at the start of the year, the further non recurring funding allocated and the release of reserves to offset contract underperformance.

Income from Activities shows an adverse variance in August (£189k) to increase the cumulative shortfall on this heading to £0.532m. SLA over performance by colorectal surgery, Upper GI, together with oral and maxillo facial surgery services have all made a positive financial contribution to the Division's performance. The Division continues to refine its specialty capacity plans to improve SLA performance from September onwards. Operating Income budgets show a favourable variance to date of £7k.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £1.26m for the five months to 31 August, an increase of £0.21m in the month.

The overspending on pay budgets has reduced by £49k in August to give a cumulative adverse variance of £7k. Nurse staffing vacancies exist in PIC, ED and theatres. Junior doctor agency costs to cover gaps in out of hours rotas have led to an overspending on medical staff budgets, although the Division reports a decrease in usage due to the improved availability of internal locums.

Non-pay budgets show an underspending of £0.352m in the month and £1.024m to date. This includes an underspending against the funding linked to the contract transfer where the higher levels of activity have yet to be delivered and non recurrent Trust support moneys.

Income from Activities shows an adverse variance of £1.464m to date, an increase of £0.407m in the month. Income targets have been set at significantly higher levels than 2013/14 outturn. Over £2m of activity-related growth to clear waiting list backlogs and planned services transfers has been built into the plan, most of which will be delivered from Quarter 2 onwards hence £0.724m of underperformance year to date. In addition there are other significant variances such as CSP related services (£0.364m adverse) and Bone Marrow Transplants (£0.296m favourable).

Income from Operations budgets show an adverse variance of £19k in August to give a cumulative overspending of £60k.

Four divisions are green rated.

The **Diagnostic and Therapies Division** reports an underspending for the month of £16k and a cumulative favourable variance of £44k. Income from Activities shows a cumulative adverse variance of £0.275m. The increase of £0.209m in the month is a combination of the Division's share of the net contract underperformance by other divisions together with some reduced activity on its directly managed services.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £196k for the five month period to 31 August, a deterioration of £128k in the month.

Pay budgets show an overspending of £77k for the month, cumulative overspend £0.339m. This includes an overspending in August on nursing staff of £65k, cumulatively £0.247m adverse. Additional costs have been incurred to support the Adult BMT service and nursing staff agency costs elsewhere in the Division have increased to provide cover for higher than planned vacancies and sickness absence.

Non pay budgets show a favourable variance of £0.564m to date. The principal reason for this is the allocation of contract transfer funds (£0.222m) and Trust support funding (£0.592m).

Income from activities shows a favourable variance £46k in August thereby improving the cumulative position to £8k adverse. There was a marginal underperformance on Cardiac Surgery in August. Cardiology activity has also continued to underperform, by £113k in the month. Additional capacity is now available and the Division is planning to begin the recovery of the activity underperformance from September.

The Facilities and Estates Division reports a £2k surplus for the month thereby increasing its cumulative underspending to £45k.

Trust Headquarters Services report a £1k underspending in August and a cumulative underspending of £8k for the five month period to 31 August.

5. Continuity of Service Risk Rating

The Trust's overall financial risk rating, based on results for the 5 months ending 31 August is 4. The actual financial risk rating is 4.0 (July 4.0). The actual value for each of the metrics is given in the table below together with the bandings for each metric.

Further information showing performance to date is given at Appendix 6.

	March	June	July	August	Annual Plan 2014/15
Liquidity					
Metric Performance	2.71	7.35	5.70	4.66	2.53
Rating	4	4	4	4	4
Capital Service Capacity					
Metric Performance	3.04	2.88	2.86	2.83	2.51
Rating	4	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**	**4**

6. Capital Programme

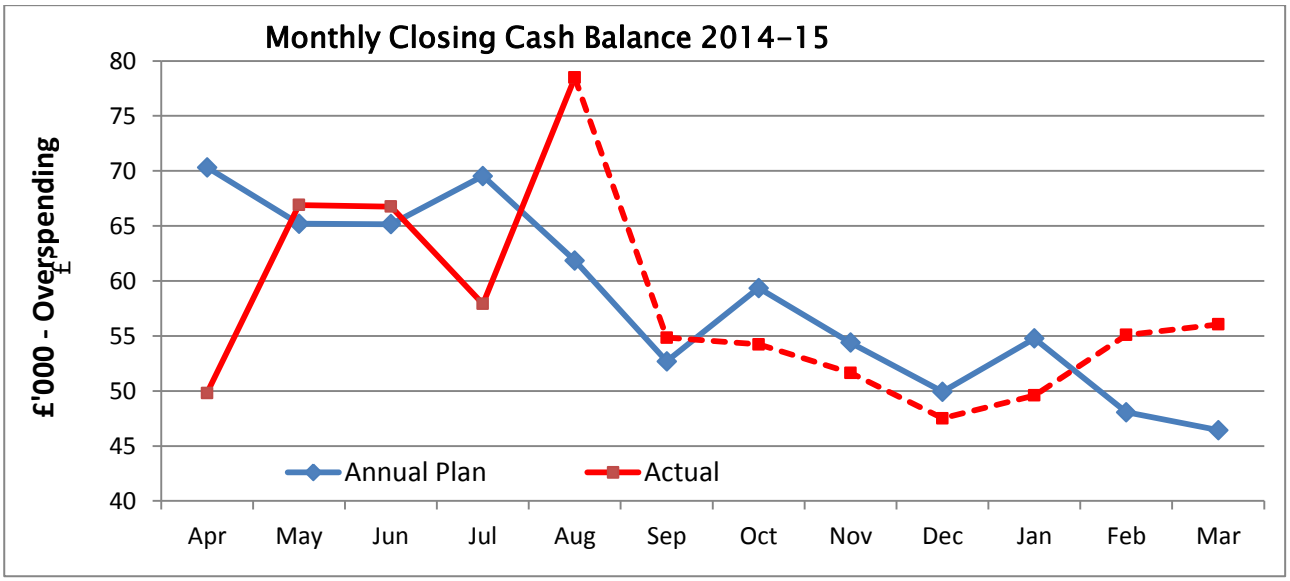
A summary of income and expenditure for the five months ending 31 August is given in the table below. Expenditure for the period of £24.323m equates to 93% of the current capital expenditure plan.

	Annual Plan	Five Months Ending 31 August		
		Plan	Actual	Variance Fav / (Adv)
	£'000	£'000	£'000	£'000
Sources of Funding				
Public Dividend Capital	2,625	609	609	-
Donations	8,712	1,520	1,520	-
Retained Depreciation	19,211	7,728	7,771	43
Prudential Borrowing	20,000	20,000	20,000	-
Sale of Property	700	700	700	-
Recovery of VAT	954	-	-	-
Cash balances	5,438	(4,299)	(6,277)	(1,978)
Total Funding	**57,640**	**26,258**	**24,323**	**(1,935)**
Expenditure				
Strategic Schemes	(32,740)	(18,656)	(17,833)	823
Medical Equipment	(8,049)	(2,405)	(2,206)	199
Information Technology	(9,024)	(1,998)	(1,756)	242
Roll Over Schemes	(2,932)	(690)	(520)	170
Operational / Other	(12,362)	(2,509)	(2,008)	501
Anticipated Slippage	7,467	-	-	-
Total Expenditure	**(57,640)**	**(26,258)**	**(24,323)**	**1,935**

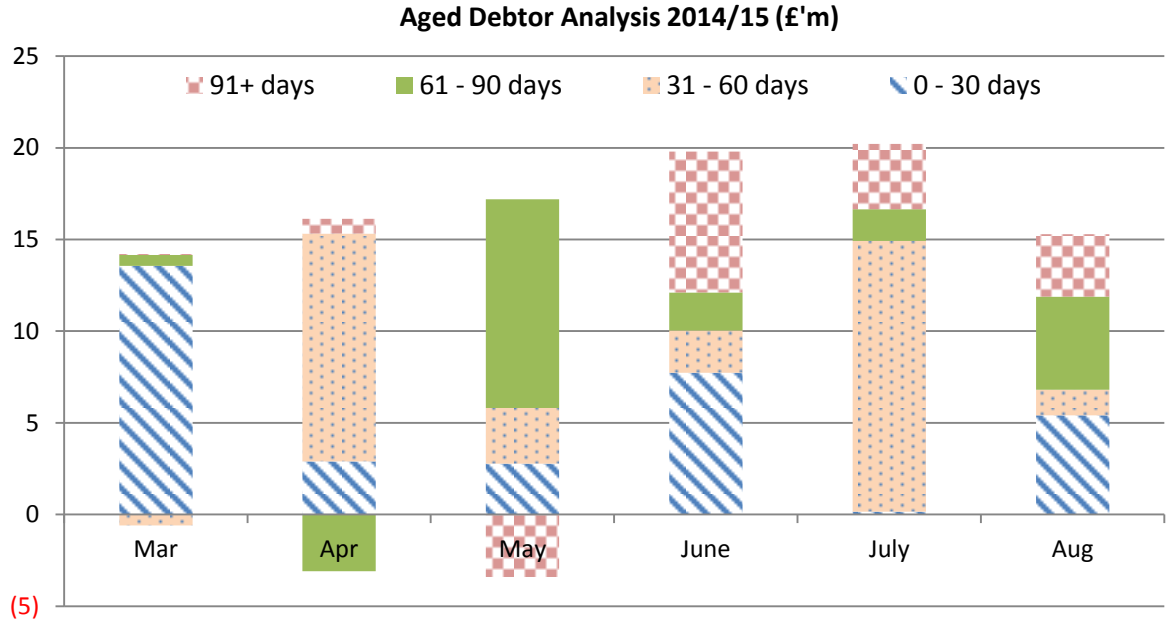
The Finance Committee is provided with further information on this under agenda item 6.

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

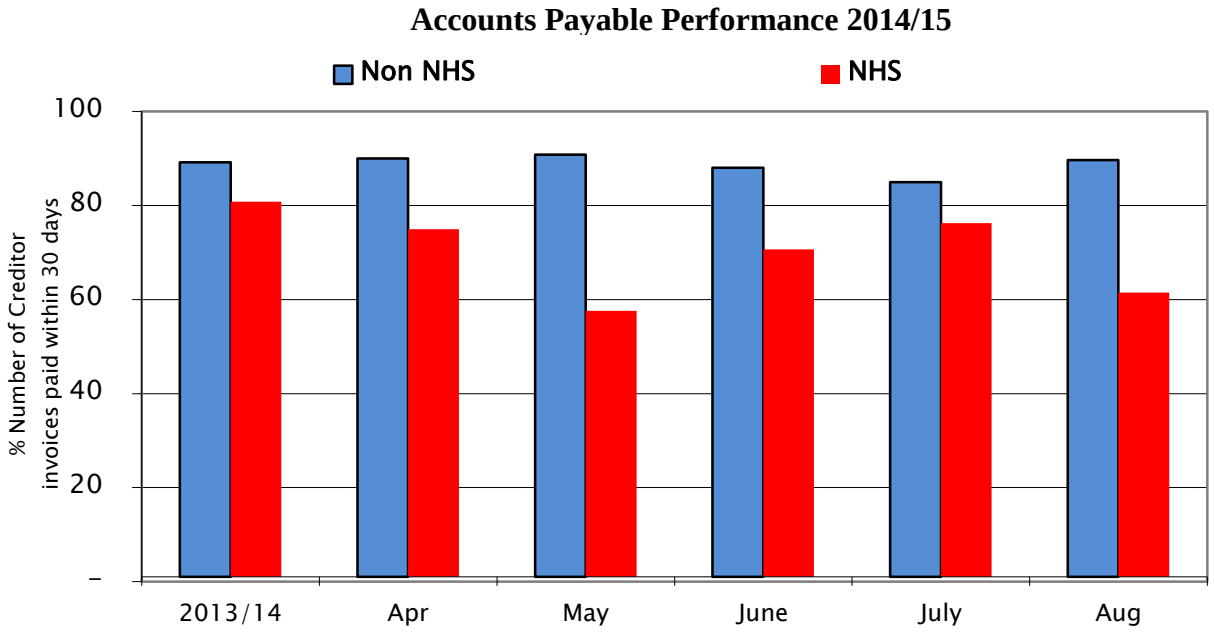
Cash - The Trust held a cash balance of £78.5m as at 31 August.



Debtors - The total value of invoiced debtors has decreased by £4.919m during August to a closing balance of £15.291m. The total amount owing is equivalent to 9.9 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In August the Trust achieved 61% and 90% compliance against the Better Payment Practice Code for invoices paid for NHS and Non NHS creditors.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2a – Divisional Income and Expenditure Statement
Appendix 2b – Divisional I&E Projection Graphs
Appendix 3 – Monthly Analysis of Pay Expenditure
Appendix 4 – Executive Summary
Appendix 5 – Financial Risk Matrix
Appendix 6 – Continuity of Service Risk Rating
Appendix 7 – Release of Reserves August 2014

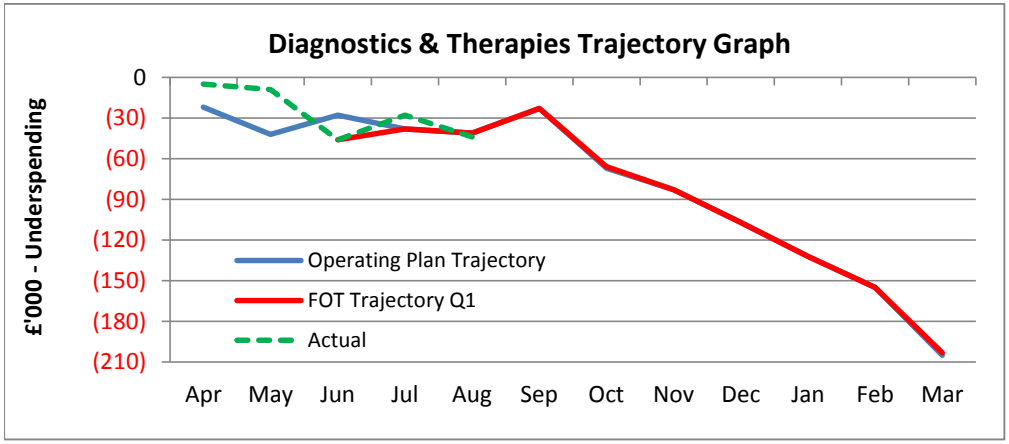
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report August 2014 – Summary Income & Expenditure Statement

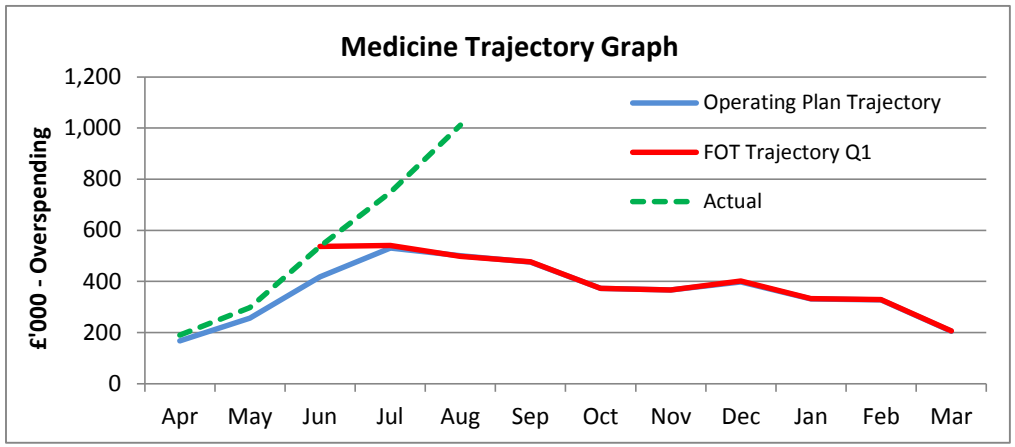
Approved Budget / Plan 2014/15	Heading	Position as at 31st August			Actual to 31st July	Forecast Outturn
		Plan	Actual	Variance Fav / (Adv)		
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
481,743	From Activities	198,791	196,550	(2,241)	158,670	487,669
90,590	Other Operating Income	37,595	37,379	(216)	29,844	89,323
572,333	**Sub totals income**	**236,386**	**233,929**	**(2,457)**	**188,514**	**576,992**
	Expenditure					
(324,473)	Staffing	(136,095)	(137,850)	(1,755)	(109,728)	(325,924)
(196,337)	Supplies and Services	(82,222)	(81,562)	660	(67,094)	(214,084)
(520,811)	**Sub totals expenditure**	**(218,317)**	**(219,412)**	**(1,095)**	**(176,822)**	**(540,008)**
(11,563)	Reserves	(1,688)	–	1,688	–	–
39,959	**EBITDA**	**16,381**	**14,517**	**(1,864)**	**11,692**	**36,984**
	Financing					
(12)	Profit/(Loss) on Sale of Asset	(12)	(12)	–	(12)	
(21,808)	Depreciation & Amortisation – Owned	(8,861)	(7,767)	1,094	(6,132)	(19,181)
150	Interest Receivable	63	101	38	79	202
(338)	Interest Payable on Leases	(141)	(144)	(3)	(115)	(345)
(3,117)	Interest Payable on Loans	(1,250)	(1,284)	(34)	(1,011)	(3,142)
(9,031)	PDC Dividend	(3,763)	(3,633)	130	(2,906)	(8,718)
(34,156)	**Sub totals financing**	**(13,964)**	**(12,739)**	**1,225**	**(10,097)**	**5,800**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**2,417**	**1,778**	**(639)**	**1,595**	**5,800**
	Technical Items					
8,588	Donations & Grants (PPE/Intangible Assets)	1,500	1,537	37	1,537	8,638
(24,204)	Impairments	(2,073)	(2,073)	–	–	(24,204)
1,232	Reversal of Impairments	–	–	–	–	1,232
(1,219)	Depreciation & Amortisation – Donated	(365)	(357)	8	(283)	(1,200)
(9,800)	**SURPLUS / (DEFICIT) after Technical Items**	**1,479**	**885**	**(594)**	**2,849**	**(9,734)**

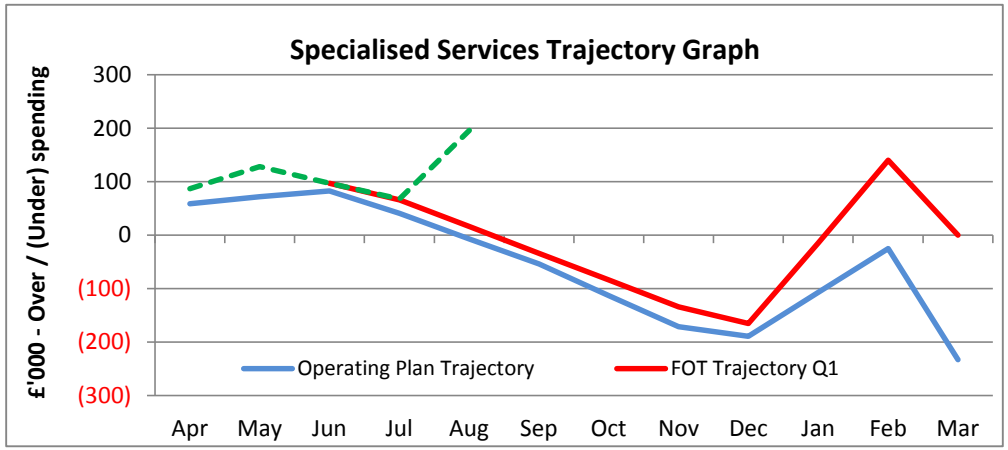
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

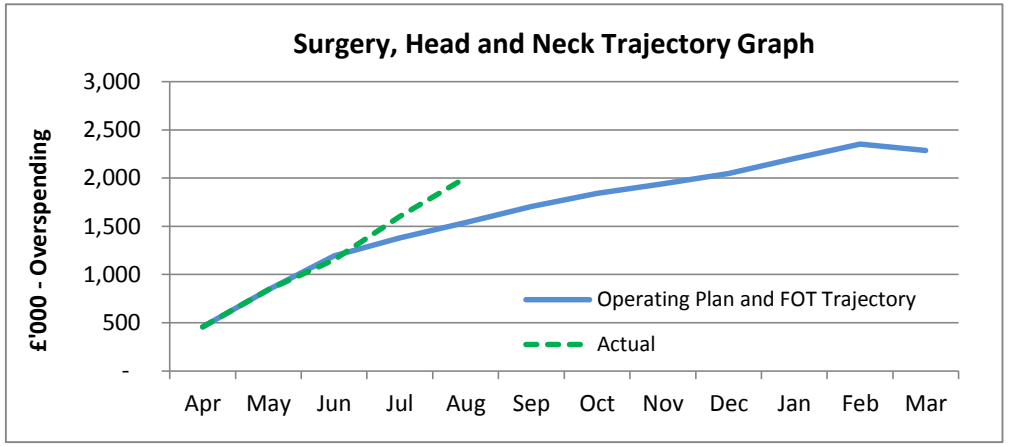
Finance Report August 2014- Divisional Income & Expenditure Statement

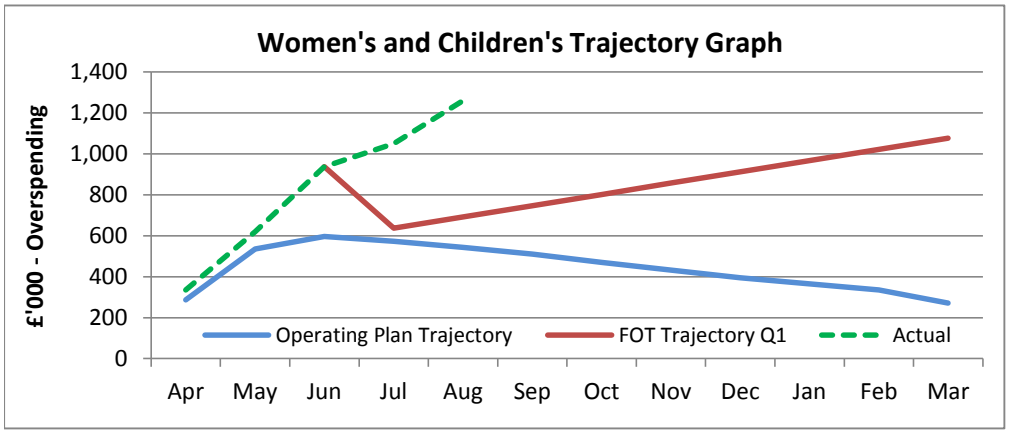
Approved Budget / Plan 2014/15	Division	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st July	Forecast Outturn variance
			Pay	Non Pay	Operating Income	Income from Activities	CRES			
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
478,306	Service Agreements	197,659	-	-	(6)	5	-	(1)	-	
(4,719)	Overheads	(1,213)	-	-	-	754	-	754	915	
39,679	NHSE Income	16,767	-	-	(4)	-	-	(4)	(7)	
513,266	**Sub Total Service Agreements**	**213,213**	**-**	**-**	**(10)**	**759**	**-**	**749**	**908**	**-**
	Clinical Divisions									
(48,139)	Diagnostic & Therapies	(20,136)	279	(141)	133	(275)	48	44	28	202
(66,230)	Medicine	(28,252)	(655)	451	126	(390)	(543)	(1,011)	(748)	(206)
(80,579)	Specialised Services	(33,184)	(339)	564	46	(8)	(459)	(196)	(68)	-
(95,719)	Surgery Head & Neck	(42,518)	(1,205)	1,090	7	(532)	(1,363)	(2,003)	(1,601)	(2,286)
(107,859)	Women's & Children's	(45,812)	(7)	1,024	(60)	(1,464)	(753)	(1,260)	(1,050)	(1,077)
(398,526)	**Sub Total - Clinical Divisions**	**(169,902)**	**(1,927)**	**2,988**	**252**	**(2,669)**	**(3,070)**	**(4,426)**	**(3,439)**	**(3,367)**
	Corporate Services									
(34,093)	Facilities And Estates	(14,409)	67	101	(69)	(26)	(28)	45	43	143
(23,578)	Trust Services	(9,779)	291	(275)	(56)	-	10	(30)	(22)	40
(5,547)	Other	(4,607)	25	549	(317)	(98)	(49)	110	54	(135)
(63,218)	**Sub Totals - Corporate Services**	**(28,795)**	**383**	**375**	**(442)**	**(124)**	**(67)**	**125**	**75**	**48**
(461,744)	**Sub Total (Clinical Divisions & Corporate Services)**	**(198,697)**	**(1,544)**	**3,363**	**(190)**	**(2,793)**	**(3,137)**	**(4,301)**	**(3,364)**	**(3,319)**
(11,563)	Reserves	-	-	1,688	-	-	-	1,688	828	3,678
(11,563)	**Sub Total Reserves**	**-**	**-**	**1,688**	**-**	**-**	**-**	**1,688**	**828**	**3,678**
39,960	**Trust Totals Unprofiled**	**14,517**	**(1,544)**	**5,051**	**(200)**	**(2,034)**	**(3,137)**	**(1,864)**	**(1,628)**	**(2,960)**
	Financing									
0	Reserves/Profiling		-	-	-	-	-	-	282	-
(12)	(Profit)/Loss on Sale of Asset	(12)	-	-	-	-	-	-	-	-
(21,808)	Depreciation & Amortisation - Owned	(7,767)	-	1,094	-	-	-	1,094	876	2,627
150	Interest Receivable	101	-	38	-	-	-	38	29	52
(338)	Interest Payable on Leases	(144)	-	(3)	-	-	-	(3)	(2)	(7)
(3,117)	Interest Payable on Loans	(1,284)	-	(34)	-	-	-	(34)	-	(25)
(9,031)	PDC Dividend	(3,633)	-	130	-	-	-	130	104	313
(34,156)	**Sub Total Financing**	**(12,739)**	**-**	**1,225**	**-**	**-**	**-**	**1,225**	**1,289**	**2,960**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**1,778**	**(1,544)**	**6,276**	**(200)**	**(2,034)**	**(3,137)**	**(639)**	**(339)**	**-**
	Technical Items									
8,588	Donations & Grants (PPE/Intangible Assets)	1,537	-	-	37	-	-	37	37	50
(24,204)	Impairments	(2,073)	-	-	-	-	-	-	-	-
1,232	Reversal of Impairments	-	-	-	-	-	-	-	-	-
(1,219)	Depreciation & Amortisation - Donated	(357)	-	8	-	-	-	8	6	19
-	Profiling Adjustment	-	-	-	-	-	-	-	0	-
(15,603)	**Sub Total Technical Items**	**(893)**	**-**	**8**	**37**	**-**	**-**	**45**	**43**	**69**
(9,800)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**885**	**(1,544)**	**6,284**	**(163)**	**(2,034)**	**(3,137)**	**(594)**	**(296)**	**69**

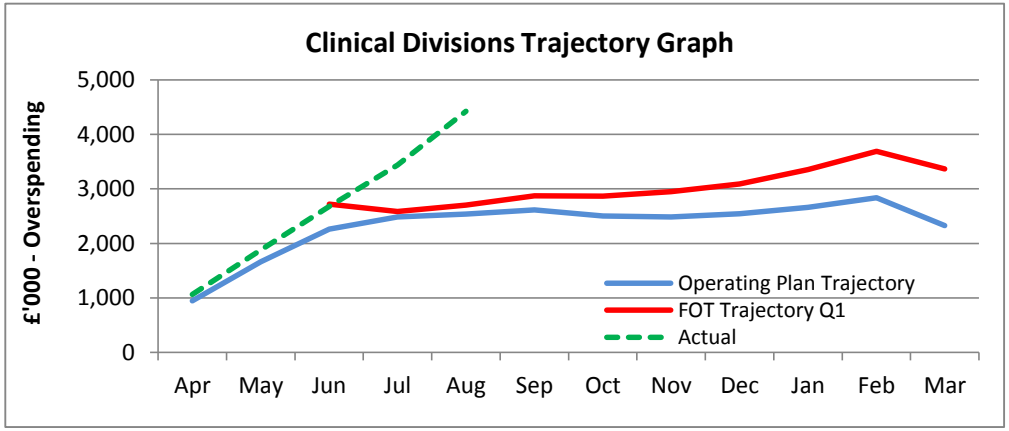

Diagnostics & Therapies Trajectory Graph
£'000 - Underspending
0
(30)
(60)
(90)
(120)
(150)
(180)
(210)
Operating Plan Trajectory
FOT Trajectory Q1
Actual
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Medicine Trajectory Graph
£'000 - Overspending
1,200
1,000
800
600
400
200
0
Operating Plan Trajectory
FOT Trajectory Q1
Actual
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Specialised Services Trajectory Graph
£'000 - Over / (Under) spending
300
200
100
0
(100)
(200)
(300)
Operating Plan Trajectory
FOT Trajectory Q1
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Surgery, Head and Neck Trajectory Graph
£'000 - Overspending
3,000
2,500
2,000
1,500
1,000
500
-
Operating Plan and FOT Trajectory
Actual
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Women's and Children's Trajectory Graph
£'000 - Overspending
1,400
1,200
1,000
800
600
400
200
0
Operating Plan Trajectory
FOT Trajectory Q1
Actual
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Clinical Divisions Trajectory Graph
£'000 - Overspending
5,000
4,000
3,000
2,000
1,000
0
Operating Plan Trajectory
FOT Trajectory Q1
Actual
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14	2014/15									2013/14	
		Total	Apr	May	Jun	Q1	Jul	Aug	Q2	Total	Mthly Average		Mthly Average	
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	%	£'000	%
Women's and Children's	Pay budget	73,478	6,188	7,195	7,051	20,433	7,117	7,161	14,278	34,711	6,942		6,123	
	Bank	1,813	172	195	163	530	151	172	323	853	171	2.5%	151	2.5%
	Agency	1,398	88	178	118	384	159	70	229	614	123	1.8%	117	1.9%
	Waiting List initiative	365	18	51	19	88	28	30	58	146	29	0.4%	30	0.5%
	Overtime	226	27	25	30	82	20	36	56	137	27	0.4%	19	0.3%
	Other pay	70,112	6,021	6,750	6,683	19,455	6,734	6,832	13,566	33,021	6,604	95.0%	5,843	94.9%
	Total Pay expenditure	73,913	6,326	7,199	7,014	20,539	7,092	7,140	14,232	34,771	6,954	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(435)	(139)	(4)	37	(106)	25	22	47	(59)	(12)		(36)	
Medicine	Pay budget	44,151	3,747	3,932	3,930	11,609	3,925	3,975	7,900	19,509	3,902		3,679	
	Bank	3,305	253	319	233	805	264	319	583	1,388	278	6.9%	275	6.9%
	Agency	2,354	116	133	202	451	167	193	359	810	162	4.0%	196	4.9%
	Waiting List initiative	151	21	3	2	26	12	17	29	55	11	0.3%	13	0.3%
	Overtime	197	11	6	7	24	7	7	15	39	8	0.2%	16	0.4%
	Other pay	41,743	3,638	3,615	3,514	10,767	3,541	3,523	7,065	17,831	3,566	88.6%	3,479	87.4%
	Total Pay expenditure	47,751	4,040	4,075	3,958	12,073	3,991	4,059	8,051	20,123	4,025	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(3,600)	(292)	(144)	(28)	(464)	(66)	(84)	(150)	(614)	(123)		(300)	
Surgery Head and Neck	Pay budget	70,927	5,902	6,011	6,038	17,951	5,876	6,130	12,006	29,957	5,991		5,911	
	Bank	1,859	140	190	133	463	173	172	344	807	161	2.6%	155	2.5%
	Agency	808	60	91	75	226	120	102	222	448	90	1.4%	67	1.1%
	Waiting List initiative	1,394	121	112	133	366	133	162	295	661	132	2.1%	116	1.9%
	Overtime	485	37	47	35	118	59	56	115	233	47	0.7%	40	0.7%
	Other pay	69,195	5,798	5,806	5,927	17,531	5,639	5,872	11,511	29,041	5,808	93.1%	5,766	93.8%
	Total Pay expenditure	73,741	6,156	6,245	6,302	18,704	6,123	6,364	12,487	31,191	6,238	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(2,814)	(254)	(234)	(264)	(753)	(247)	(234)	(482)	(1,235)	(247)		(235)	
Specialised Services	Pay budget	36,718	3,138	3,184	3,255	9,577	3,177	3,214	6,392	15,968	3,194		3,060	
	Bank	1,184	89	122	98	309	108	104	212	521	104	3.2%	99	3.1%
	Agency	1,882	116	170	223	509	255	183	439	948	190	5.8%	157	5.0%
	Waiting List initiative	379	21	47	23	91	34	31	65	156	31	1.0%	32	1.0%
	Overtime	182	10	13	19	43	16	21	37	80	16	0.5%	15	0.5%
	Other pay	34,079	2,947	2,931	2,945	8,823	2,883	2,989	5,872	14,695	2,939	89.6%	2,840	90.4%
	Total Pay expenditure	37,705	3,184	3,284	3,309	9,775	3,296	3,329	6,625	16,400	3,280	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(988)	(45)	(100)	(54)	(199)	(119)	(114)	(233)	(432)	(86)		(82)	

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14	2014/15									2013/14	
		Total	Apr	May	Jun	Q1	Jul	Aug	Q2	Total	Mthly Average		Mthly Average	
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	%	£'000	%
Diagnostic & Therapies	Pay budget	39,526	3,300	3,438	3,424	10,162	3,411	3,363	6,773	16,935	3,387		3,294	
	Bank	306	16	27	22	64	25	39	64	129	26	0.8%	26	0.8%
	Agency	340	22	40	17	79	78	93	171	250	50	1.5%	28	0.9%
	Waiting List initiative	225	7	21	17	45	23	8	31	76	15	0.5%	19	0.6%
	Overtime	314	34	29	38	102	36	35	71	173	35	1.0%	26	0.8%
	Other pay	38,153	3,247	3,297	3,228	9,772	3,151	3,143	6,294	16,067	3,213	96.2%	3,179	97.0%
	Total Pay expenditure	39,339	3,326	3,414	3,322	10,062	3,312	3,319	6,631	16,693	3,339	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	187	(26)	24	102	100	99	43	142	242	48		16	
Facilities & Estates	Pay budget	18,435	1,535	1,594	1,509	4,638	1,616	1,679	3,294	7,932	1,586		1,536	
	Bank	555	60	93	74	228	82	133	215	443	89	5.6%	46	3.0%
	Agency	346	21	18	41	80	29	46	75	155	31	2.0%	29	1.9%
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	895	93	70	81	245	76	103	179	424	85	5.4%	75	4.9%
	Other pay	16,397	1,393	1,407	1,308	4,109	1,361	1,416	2,777	6,887	1,377	87.1%	1,366	90.1%
	Total Pay expenditure	18,193	1,568	1,589	1,505	4,662	1,548	1,698	3,246	7,908	1,582	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	242	(32)	5	4	(24)	68	(19)	48	24	5		20	
Trust Services (Including R&I and Support Services)	Pay budget	29,492	2,118	2,261	2,128	6,507	2,345	2,230	4,575	11,081	2,216		2,458	
	Bank	680	52	65	47	165	50	48	98	263	53	2.4%	57	2.4%
	Agency	375	64	30	41	135	64	34	98	233	47	2.2%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	114	11	9	11	31	8	11	19	51	10	0.5%	9	0.4%
	Other pay	27,425	2,083	1,967	1,960	6,011	2,087	2,118	4,205	10,216	2,043	94.9%	2,285	95.9%
	Total Pay expenditure	28,595	2,211	2,070	2,060	6,342	2,209	2,212	4,421	10,763	2,153	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	897	(94)	190	68	165	136	17	154	319	64		75	
Trust Total	Pay budget	312,726	25,928	27,613	27,335	80,876	27,467	27,752	55,218	136,094	27,219		26,060	
	Bank	9,702	783	1,010	771	2,564	852	988	1,840	4,403	881	3.2%	809	3.0%
	Agency	7,506	488	659	718	1,865	872	722	1,593	3,458	692	2.5%	625	2.4%
	Waiting List initiative	2,514	188	234	194	616	230	248	478	1,094	219	0.8%	210	0.8%
	Overtime	2,413	224	200	221	645	222	270	492	1,136	227	0.8%	201	0.8%
	Other pay	297,103	25,127	25,774	25,566	76,467	25,395	25,895	51,290	127,757	25,551	92.7%	24,759	93.1%
	Total Pay expenditure	319,238	26,810	27,876	27,469	82,157	27,571	28,121	55,693	137,850	27,570	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(6,514)	(883)	(263)	(135)	(1,281)	(104)	(370)	(475)	(1,755)	(351)		(543)	

NOTE: Other Pay includes all employer's oncosts.

Appendix 4

<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 five months ending 31 August is 4 (actual score 4.0, July, 4.0).</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 £4.81m lower than plan for the 5 month period to 31 August. Activity based contract performance at £167.62m is £3.42m less than plan. Contract rewards / penalties at a net income of £1.76m is £0.35m less than plan. Income of £23.47m for ‘Pass through’ payments is £1.04m lower than Plan.
<table>
<tr><th rowspan="2">Clinical Service</th><th rowspan="2">Activity to 31 August</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>50,008</td><td></td><td></td><td>543</td><td>1.1</td></tr>
<tr><td>Emergency
Non Elective</td><td>15,700
1,059</td><td></td><td></td><td>7
101</td><td>-
8.7</td></tr>
<tr><td>Elective
Day Cases</td><td>5,852
22,317</td><td>145</td><td>0.7</td><td>368</td><td>5.9</td></tr>
<tr><td>Outpatient Procedures
New Outpatients
Follow up Outpatients</td><td>21,027
61,676
125,254</td><td></td><td></td><td>1,832
6,390
12,414</td><td>8.0
9.4
9.0</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. The forecast outturn has been revised to £17.056m – equivalent to 82% of the Plan for the year. Actual savings achieved for the five months to 31 August total £5.518m (72% of Plan before the 1/12ths phasing adjustment), a shortfall of £2.163m 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 five months of 2014/15 is £1.778m. This represents an under performance of £0.639m when compared with the planned surplus to date of £2.417m. Total income of £233.929m is £2.457m lower than Plan. Expenditure at £219.412m is lower than Plan by £0.593m. Financing costs are £1.225m lower than Plan.	Agenda Item 5.3
D&T	G	The Division reports an underspending in the month of £16k thereby increasing the cumulative position to £44k favourable.	
Med	R	Cumulative overspending is £1.011m adverse. Under performance on income from activities (£0.327m) and overspending on pay budgets (£50k) are principal drivers towards August in month overspend of £0.263m.	
Spec Serv	G	Overspending of £128k increases the cumulative overspending to £0.196m. Position reflects non achieved savings (£0.459m) and underperformance on cardiac surgery and cardiology.	
SH&N	R	Overspending to date of £2.003m represents an overspending of £0.402m in August. Causal factors are historical non achievement of savings programme and an underachievement of planned activity to date. The Division is progressing a number of initiatives to increase clinical services activity over the second half of the year.	
W&C	R	Overspending to date totals £1.260m, an increase of £0.210m in August. Principal factors are underperformance on income from activities (£1.464m) and non achievement of savings programme (£0.753m).	
F&E	G	The cumulative underspending is £45k, an improvement of £2k in the month.	
THQ	G	Underspending of £1k in August now results in a cumulative underspending of £8k.	
Capital	G	The Monitor capital expenditure performance target is to deliver the programme within 85% -115% of the Annual Plan. Expenditure for the first five months totals £24.323m – this equates to 93% of the current plan for the period.	Agenda Item 6
Statement of Financial Position and Treasury Management	G	The cash balance on 31 August was £78.483m. The balance on Invoiced Debtors has decreased by £4.919m in the month to £15.291m. The invoiced debtor balance equates to 9.9 debtor days. Creditors and accrual account balances total £97.2m. Invoiced Creditors - payment performance for the month for Non NHS invoices and NHS invoices within 30 days was 90% and 61% respectively. Payment performance to date by invoice value is 86% for Non NHS and 86% for NHS invoices.	Agenda Item 7 SFP 1 SFP 2 SFP 3

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 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	4.0	
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	-	
2116	Non delivery of contracted activity	High	10.0		JR	Medium	6.0	
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	-	

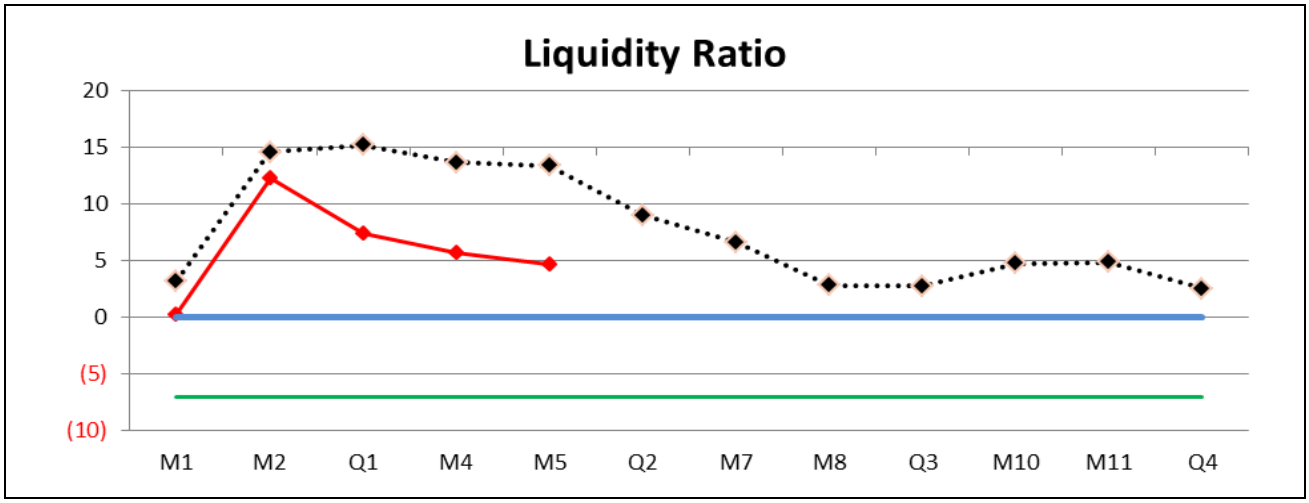
University Hospitals Bristol NHS
NHS Foundation Trust

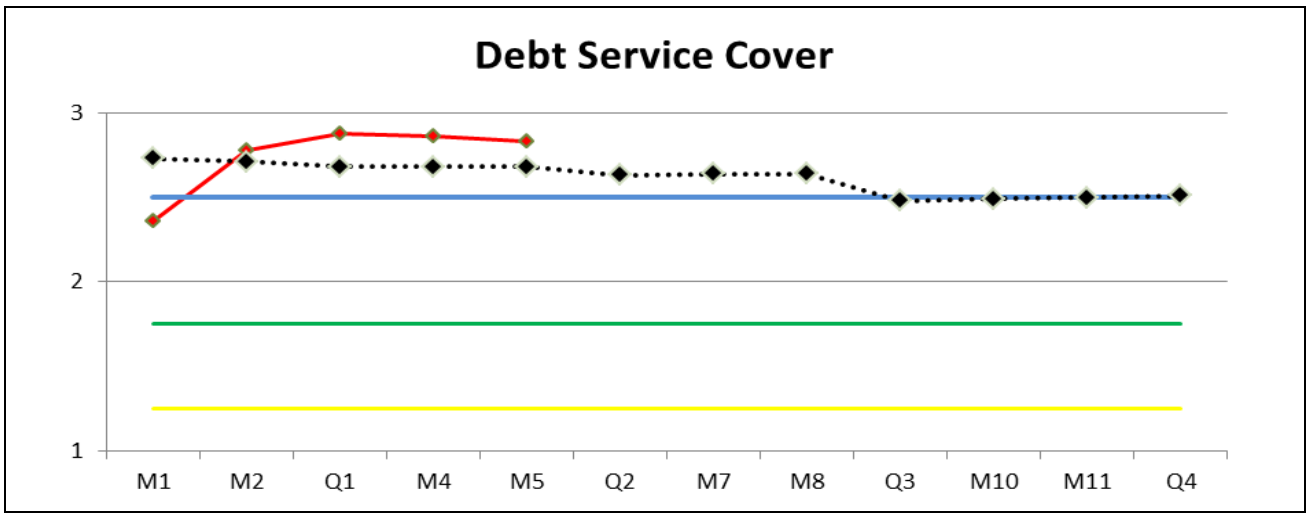
Appendix 6

Continuity of Service Risk Rating – August 2014 Performance

The following graphs show performance against the 2 Financial Risk Rating metrics. 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	June 2014	July 2014	August 2014
Liquidity					
Metric Performance	2.71	2.53	7.35	5.70	4.66
Rating	4	4	4	4	4
Debt Service Cover					
Metric Performance	3.04	2.51	2.88	2.86	2.83
Rating	4	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**	**4**





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

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'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
May Movements	(36)	(962)	(19,133)	-	(533)	(8)	(20,672)	1,622	154	205	1,326	12,583	989	345	3,448	20,672
June Movements	(65)	117	(2,146)	-	386	(1,028)	(2,736)	(72)	113	282	124	151	51	90	1,997	2,736
July Movements	(117)	(34)	(97)	-	(339)	(24)	(611)	22	5	95	287	7	33	124	38	611
Month 4 balances	1,583	3,652	5,325	487	4,445	1,638	17,130	2,914	6,258	10,483	11,105	20,208	1,825	6,717	2,902	62,412
Month 5 Movements																
BRI redevelopment					(211)	(17)	(228)	188			7		33			228
CSP Transition Funding			(56)				(56)					56				56
Division Support			(151)				(151)	17	23	28	33	38	12			151
EWTD					(128)		(128)	8	28	18	24	49	1			128
MPET Funding					(92)		(92)								92	92
Incremental Drift		(289)					(289)	47	35	34	63	76	11	23		289
Other	(12)	(32)	(35)			(8)	(87)				13	10	17	47		87
Month 5 balances	1,571	3,331	5,083	487	4,014	1,613	16,099	3,174	6,344	10,563	11,245	20,437	1,899	6,787	2,994	63,443

University Hospitals Bristol NHS
NHS Foundation Trust

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

17. Compliance with the Department of Health's new Principles on Patient Parking

Purpose

The purpose of this report is to provide assurance to the Board that the Trust's Car Parking Policy, and its service provision, appropriately reflects the principles set out in the recently issued Department of Health Guidance on NHS parking provision and that where the Trust is not fully compliant with a principle, it has plans to move towards compliance.

Abstract

The Department of Health has recently published guidance, in the form of a set of principles, for NHS Trusts in respect of car parking provision and associated policies.
https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles/nhs-patient-visitor-and-staff-car-parking-principles

The Trust has reviewed its own practice against these principles and is compliant with the majority. There is one principle, in respect of information provision, where the Trust is not compliant and steps are in hand to make information currently available to staff via the intranet, accessible for patients and visitors through our website.

Recommendations

The Board is asked to receive this report for **assurance** that the Trust is broadly compliant with the Department of Health's guidance on patient, visitor and staff car parking principles and has plans to address the area of non-compliance.

Report Sponsor

James Rimmer, Chief Operating Officer

Appendices

Report attached

Previous Meetings

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

Executive	Senior Leadership	Quality & Outcomes	Finance	Audit	Other

Team	Team	Committee	Committee	Committee	

Appendix 1 - Car Parking Principles Paper

Compliance with the Department of Health's new Principles on Patient Parking

1 Purpose of the Paper

1.1 The purpose of this report is to provide assurance to the Board that the Trust's Car Parking Policy, and its service provision, appropriately reflects the principles set out in the recently issued Department of Health Guidance on NHS parking provision and that where the Trust is not fully compliant with a principle, it has plans to move towards compliance.

2 Background

2.1 On 23 August 2014 the Department of Health published a guidance document, NHS patient, visitor and staff car parking principles. Patient and staff parking is of great importance to those needing to use parking facilities, it is also an emotive subject of interest politically, environmentally and is increasingly newsworthy.

3 Context

3.1 The opening statement of the new Department of Health's parking guidance clearly sets out the core principles that NHS organisations should work with their patients and staff, local authorities and public transport providers to make sure that users can get to the site (and park if necessary) as safely, conveniently and economically as possible.

4 Status

4.1 The Trust adopted the sixth iteration of its Car Parking Policy & Procedure in May 2014. This policy has been reviewed every two or three years since the first version in 2007. The core principles of the Trust car parking policy on which the scheme is based are:

- The Trust encourages staff, patients and visitors to travel to our hospitals without using cars wherever possible and has a number of measures in place to encourage travel by non-car methods. There are alternative travel options in addition to car travel that include effective public transport provision. The Trust is situated some 150 metres away from Bristol's main bus station that is served by a multitude of Local and National bus services. The hospital free bus service stops near to the bust station in Lower Maudlin Street 100 metres from the bus station.
- Pay and display tariff for the public is set to encourage short stays (up to 4 hours), which is a Bristol City Council and Green Travel requirement.

- Pay and display tariff for the public should not be cheaper than other parking available in the proximity in the city. This is to ensure that Trust onsite parking spaces are not more attractive to shoppers than alternatives.
- The Trust encourages staff to travel to work without using cars wherever possible and has a number of measures in place to encourage staff to travel by non-car methods.
- Where it is not possible for staff to use non-car methods of travel, the Trust works hard to provide onsite car parking and discounted offsite car parking for staff.
- Staff are assessed equally for access to onsite and discounted offsite car parking against the criteria set out in the parking policy.

5 UH Bristol NHS FT Compliance To New Parking Principles

5.1 The following are the principles set out in the Department of Health's new guidance on patient, visitor and staff car parking principles (23 August 2014) with a self-assessment of the Trust's compliance with each principle.

(a) NHS organisations should work with their patients and staff, local authorities and public transport providers to make sure that users can get to the site (and park if necessary) as safely, conveniently and economically as possible."

A UH Bristol hospital free bus service is provided by the Trust. It operates completely free of charge to the staff, patients and visitors of the BRI central precinct hospitals with a frequency of every 30 minutes from Bristol Temple Meads and every 15 Minutes from Cabot Circus. The Bus service continues to be popular amongst staff, Patients and visitors to the hospital and carries in excess of 12000 passengers per month.

(b) Charges should be reasonable for the area. Concessions, including free or reduced charges or caps, should be available for the following groups."

UHB. The car parking tariffs applied to the Trust car parks are generally in line with local commercial car parks in Bristol City Centre close to the Hospital Precinct, never dearer and sometimes cheaper.

(c) Concessions, including free or reduced charges or caps, should be available for the following groups

- ***people with disabilities***

UHB. People with disabilities who hold a registered Blue disability badge can park free of charge in our car parks for an unlimited period

- ***Frequent outpatient attenders***

UHB. Concessionary parking tickets are used in this instance at a cost of £3.40 which covers a 7 day period

- ***visitors with relatives who are gravely ill***

UHB. Concessionary parking tickets are used in this instance at a cost of £3.40 which covers a 7 day period

- ***visitors to relatives who have an extended stay in hospital***

UHB. Concessionary parking tickets are used in this instance at a cost of £3.40 which covers a 7 day period

- ***Staff working shifts that mean public transport cannot be used***

UHB. Parking for staff is free after 6pm overnight until 9am and at weekends

- ***Other Concessions e.g. for volunteers or staff who car-share, should be considered locally."***

UHB. These staff groups can use 6 monthly discounted parking tickets at NCP FOR £5.70

- ***Priority for staff parking should be based on need, e.g. staff whose daily duties require them to travel by car."***

UHB. The Trust has an approved staff car parking policy which covers the above.

(d) Trusts should consider installing 'pay on exit' or similar schemes so that drivers pay only for the time that they have used. Fines should only be imposed where reasonable[4] and should be waived when overstaying is beyond the driver's control (eg when treatment takes longer than planned, or when staff are required to work beyond their scheduled shift).

UHB. The Trust has 7 car parking areas for the Public to use, one of them is suitable for Pay on Exit, the other 6 are Pay and Display ,where fines are imposed for over staying there is an appeals process in place and the Trust regularly waives fines for when the over stay is beyond the drivers control. Such as appointments running late, treatment taking longer than expected. Staff pay a fixed daily charge so do not incur any charges.

(e) Details of charges, concessions and penalties should be well publicised including at car park entrances, wherever payment is made and inside the hospital. They should also be included on the hospital website and on patient letters and forms, where appropriate."

UHB. Each car parking area has appropriate signage in place displaying the above

in line with the British Parking Association's code of practice; these details are also displayed on the Trust website.

The guidance goes on to require that documents such as parking policy, financial information relating to parking charges and complaint procedures are published. At present parking charges are displayed clearly at each car park and plans are in place to publish policy and complaint information on the trust web site. This information is currently only available internally on the Trust intranet.

***(f)* Contracted-out car parking**

- ***NHS organisations are responsible for the actions of private contractors who run car parks on their behalf.***

UHB. Total Parking Solutions operate our car parks since 2007 and continue following a tender process in 2012.

- **NHS organisations should act against rogue contractors in line with the relevant codes of practice[5] where applicable."**

UHB. Total Parking Solutions are affiliated to the BPA [British Parking Association] and operate to their code of practice.

- ***Contracts should not be let on any basis that incentivises fines, e.g. 'income from penalties only'.***

UBH. Our contract with Total Parking Solutions has no incentives based on the number of fines issued or income from them and the Trust receives all income less any banking charges made by debit/credit card payments.

(g) Each site is different and very few will be able to provide spaces for everyone who needs one. Since 2010, national planning policy no longer imposes maximum parking standards on development, and no longer recommends the use of car parking charges as a demand management measure to discourage car use." ↩

UHB. Our car parking policy is clear, staff car parking is authorised on a basis of assessed need, Staff and public parking charges are not set to discourage car parking activity.

***(h) Consideration should be given to the needs of people with temporary disabilities as well as Blue Badge holders*.**"

UHB. For the public, providing they display a valid blue disabled badge parking is free in our car parks.
For staff the parking policy allows under category A parking for staff with

temporary Occupation Health issues or who are disabled.

(i) Such staff might include nurses or therapists who visit patients at home. Routine travel between hospital sites might more sensibly be managed by providing internal transport.

UHB. Community based staff use their own vehicles and are permitted under the car parking policy free access to staff car parks.

(j) Reasonable' fining practice might include fines for people who do not have legitimate reasons for parking (eg commuters), or who persistently flout parking regulations (eg blocking entrances). A period of grace should normally be applied before a fine is issued.

UHB. Fines are issued for such flouting as, parking on double yellow line, blocking blue light ambulance access routes, parking in Ambulance, Hatched or loading bays, parking over a number of parking bays, we have a Ten minute Grace period upon arrival at an offending vehicle before issuing tickets to offenders

(k) There are two trade associations – the British Parking Association and the Independent Parking Committee. If the car park operator is a member of either, their relevant code applies and an appeals service is available to motorists. NHS organisations should consider imposing a requirement for contractors to be members of such an association."

UHB. Total Parking Solutions are contracted by the Trust to operate the car parks, they are affiliated to the British Parking Association which is in line with the new guidelines.

8. Parking Charges Comparison

Bristol Parking Tariffs

University Hospitals Bristol NHS FT **Car parks**	**Bristol City Centre NCP** **Rupert /Nelson Street and St James Barton car parks**	**Bristol City Council Car parks**	**South Bristol Com** **Medirest**
4 to 8 hours £12.00	2 hours £6.20 2 to 4 hours £12.20	1 hour £1.00 2 hours £2.00	1 hour £1.50

		3 hours £3.00 4 hours £5.00		
12 hours 6am to 6pm £15.00	4 to 6 hours £15.20	Over 4hours £10.00	2hours £2.50	
na	6 to 24 hours £20.10	na	3hours £4.00	
Concessionary Parking Tickets for 7 days £3.40	na	na	4 hours and over £12.00	

9. Recommendation

The Board is asked to receive this report for **assurance** that the Trust is broadly compliant with the Department of Health's guidance on patient, visitor and staff car parking principles and has plans to address the area of non-compliance.

University Hospitals Bristol NHS
NHS Foundation Trust

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

18. Partnership Programme Board Report

Purpose

To provide the Board with an update on matters considered at the June 2014 meeting of the University Hospitals Bristol and North Bristol NHS Trust Partnership Programme Board.

Abstract

The Partnership Programme Board meets to consider matters of relevance to the partnership agenda between University Hospitals Bristol and North Bristol NHS Trust with the aim of promoting highly effective joint working between the partner trusts for the benefit of patients and staff within the two organisations.

A summary of the key issues discussed is provided to the Board, for information.

Recommendations

The Board is recommended to **note** the highlight report of the recent Partnership Programme Board.

Report Sponsor

- Sponsor – Chief Executive
- Author – Director of Strategic Development

Appendices

- Appendix A – Partnership Programme Board Highlight Report June 2014.

North Bristol NHS Trust
University Hospitals Bristol NHS Foundation Trust

The Partnership Programme Board (PPB)

Held on Thursday 19th June 2014

Key Points Summary

Histopathology
Work was underway to align both teams under the banner of a single service, hosted by NBT with a "go-live" date of spring 2015. Robert Woolley confirmed UH Bristol support for this.

Executive to Executive Meeting
Now established to support and ensure delivery of PPB priorities. Robert Woolley and Andrea Young committed to developing a coherent future work programme.

NBT update
Confirmation that the move to the Brunel Building had gone very well with high levels of morale streaming from good teamwork. Challenges facing the Trust would be how staff adapted to the new ways of working.

4 hour performance and patient flow continues to be difficult and calls have been made for improved system-wide working to tackle this problem.

Other issues include ongoing work to operating theatres to get them fully functioning, the forthcoming transfer of Vascular Services and Breast Care Services, laser services (in discussion with UH Bristol), the future of genetics services and the considerable pressures around RTT.

NBT would soon commence work on their 5-year strategy, and have made changes to some of the executive director portfolios.

UH Bristol update
Robert Woolley reported the successful transfer of specialist paediatrics from Frenchay hospital and the development of Level 5 of the Children's hospital. Robert also reported on the forthcoming developments to adult patient services and the move out of the Old Building in early Autumn.

Continued performance issues with 4 hour and RTT. CQC inspection planned for the 9th to 12th September and preparations underway.

Robert outlined the review on children's congenital heart services to commence on 23rd June with Eleanor Gray QC to lead the review, which has been commissioned by NHS England.

Joint Stakeholder Strategy
An initial draft of the joint key stakeholder strategy was presented for consideration. Joint lead directors to be identified for each key stakeholder.

Recruitment – Building the Bristol Brand
Agreement to take forward a joint piece of work to develop the Bristol "brand" with the aim of ensuring that Bristol was a place where the very best staff wanted to work..

Acute Services Strategy
Deborah Lee presented a paper outlining potential areas where the two Trusts might collaborate. This would also assist in building a stronger Bristol brand and support our influence over key stakeholders.

Harry Hayer noted that NBT's strategy development would potentially identify areas for future collaboration.

North Bristol NHS Trust
University Hospitals Bristol NHS Foundation Trust

Acquisition of Weston Area Health NHS Trust NBT confirmed they would not be proceeding to bid for Weston but were supportive of a UH Bristol bid should the Trust decide to express their interest. Robert Woolley advised that UH Bristol has expressed an interest in bidding for Weston. UH Bristol would give the invitation to procurement substantial consideration with the necessary due diligence.
Notes of the Board to Board meeting - 14th March These were noted.
Future PPB Meetings The group reflected that this Partnership Programme Board had been a useful and productive meeting. It was suggested that stakeholders be invited to meet with the PPB as and when required. It was agreed that future meetings should comprise 2 Executive Directors, 2 Non-executive Directors and both Chief Executive Officers.
Date of Next Meeting 20th October, 16.00 – 18.00, Seminar Room 10, Learning and Research Building, Southmead. The chair role would now switch to UH Bristol for the next 3 meetings.

Attendees
NBT
Avril Waterman-Pearson, Robert Mould, Harry Hayer and Chris Burton.
UH Bristol
John Savage, Emma Woollett, Robert Woolley and Deborah Lee.

Apologies
UH Bristol
Sean O'Kelly and Paul Mapson
NBT
Andrea Young and Catherine Phillips.

University Hospitals Bristol NHS
NHS Foundation Trust

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

19 – Monitor's Letter regarding University Hospital Bristol's Performance in Q1.

Purpose

To brief the Board on the results of the Quarter 1 Compliance Framework Monitoring Exercise.

Abstract

Monitor's analysis of Q1 is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 4
- Governance risk rating – Green

The Trust has failed to meet the A&E four hour waiting time target, the Referral to Treatment ("RTT") non-admitted target and the Cancer 62 day waits for first treatment (from urgent GP referral) target which has triggered consideration for further regulatory action.

We also note the following risk from our review of the Trust's Q1 submissions: significant under-delivery of YTD CIPs target and the adverse impact on the Trust's financial position.

Recommendations

The Board is recommended to note the report.

Report Sponsor

- Chief Executive

Appendices

- Appendix A – BRISTOL 1314 Q4 executive summary

17 September 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 Mr Woolley

Q1 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q1 submissions is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 4
- Governance risk rating - Green

These ratings will be published on Monitor's website later in September.

The Trust has failed to meet the A&E four hour waiting time target, the Referral to Treatment ("RTT") non-admitted target and the Cancer 62 day waits for first treatment (from urgent GP referral) target which has triggered consideration for further regulatory action.

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[1] and the Risk Assessment Framework[2].

We expect the Trust to address the issues leading to the target failure and achieve sustainable compliance with the target promptly.

As per our letter dated 28 July 2014, and as there have been no significant changes in circumstances since this letter, Monitor has decided not to open an investigation to assess whether the Trust could be in breach of its licence at this stage. The Trust's governance risk rating has been reflected as Green. Should any other relevant circumstances arise, Monitor will consider what, if any, further regulatory action may be appropriate.

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf

We also note the following risk from our review of the Trust's Q1 submissions:

- significant under-delivery of YTD CIPs target and the adverse impact on the Trust's financial position.

We expect the Trust to ensure there is sufficient focus on delivery of CIPs. Should the under-delivery of CIPs continue and adversely impact on the Trust's financial position we may request a re-forecast of the Trust's CIP schemes for 2014/15.

In addition, as discussed with Deborah Lee, we are expecting the Trust to provide us with further information on the impact of the reduction of the backlog on the Trust's RTT admitted and incomplete target performance by 12 September 2014.

A report on the FT sector aggregate performance from Q1 2014/15 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 Q1 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0485 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

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 September 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

21. Governors Log of Communications

Purpose

The purpose of this report is to provide the Trust Board of Directors with an update on all open questions on the Governors' Log of Communications, and those questions that have been added or modified since the previous meeting of the Trust Board of Directors.

Abstract

The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.

Recommendations

The Board is recommended to receive the report to note.

Report Sponsor

Chairman

Appendices

- Appendix A: Governor Log – Items since the previous meeting.

ID Governor Name

101 Mo Schiller **Title: 'Choose and Book' service**

Query 18/09/2014

Why is it that some of UHB consultants are not available in the "Choose and book" for patients? Is it possible for personal profiles to go on the UHB website so that potential patients can assess their age, experience and particular interest?

Response 22/09/2014

Assigned to Executive Lead.

100 Sue Milestone **Title: Delayed appointments at Eye Hospital**

Query 03/09/2014

Patients at the Eye Hospital are finding their appointments delayed. For example if the patient is told he will be given a follow-up appointment in 4 months time it's generally 7 months, or when the patient is told one year it is usually stretched to 18 months. If the patient then calls the hospital he is told it was "mistake".

Is the system delaying check-ups? This particular patient attended in March but the appointment was 6 months overdue. He was then sent by the consultant for treatment as an emergency.

Response 15/09/2014

Within Ophthalmology there currently exist a large number of patients for whom their follow-up appointment is overdue. These patients fall almost entirely under the care of the two high volume Ophthalmic sub-specialties: Glaucoma and medical retina. Historically within both specialties, follow-up capacity has been under-commissioned and therefore there is at present insufficient capacity to follow-up patients in accordance with clinically prescribed timescales.
Within Glaucoma there are three distinct categories: complex, stable and suspect, with complex being the most at risk. The list of overdue patients is stratified in accordance with the level of potential risk to patients and as such the backlog is comprised of the least at risk patients. Nevertheless, this issue has been logged on the Divisional risk register.
This risk is being addressed through the launch of an outreach service based in SBCH, providing additional capacity for stable and suspect Glaucoma patients. This service is due to commence in October. In addition, discussions are underway with CCGs to implement a community based OHT Monitoring scheme. This would involve discharging up to 2000 suspect glaucoma patients to appropriately trained and accredited community based Optometrists. Should indications show that the patient's condition has deteriorated then these patients would be referred back to the Bristol Eye Hospital to be seen by the Glaucoma specialist team.
Within Medical Retina, there are two significant sub-categories of patient: diabetic, and non-diabetic, with the former being more at risk. Again, this is logged on the Divisional risk register. The approach to addressing this is three-fold. Firstly revised follow-up protocols have been issued to junior staff to appropriately reduce the number of follow-up appointments in future. Secondly, the medical skill mix is being revised to shift away from being predominantly delivered by clinical fellows to being delivered by a combination of consultant and nursing staff. Finally a business case to increase consultant resource within this team is being worked up and will be submitted through the appropriate Divisional approval channels.

99 Sue Milestone **Title: Insulin Pump Therapy for Type 1 Diabetes**

Query 03/09/2014

Has Insulin Pump Therapy been withdrawn at the BRI as a way of controlling Type 1 Diabetes? If so what is the reason and is it going to be re-instated? (Reasons given to patient are 'staff on long-term sick leave' and 'no funding')

Response 22/09/2014

Insulin Pump Therapy has not been withdrawn at the BRI as a way of controlling Type 1 Diabetes. There has been a reduced service due to long term sickness of staff and difficulty in recruiting to this specialist nurse role. It is hoped that we can increase service provision later this year.

98 Graham Briscoe **Title: Budget for Membership and Governors**

Query 08/08/2014

Who sets it and how independent of the Trust Board, CEO and Board Chairman, is the annual operating budget for the running of the Council of Governors / Governors on the Membership Council.

The same question could be asked also for the annual budget for running the Trust Members structure / organisation.

Response 23/09/2014

The budget for the running of the of the Council of Governors and membership is set annually along with all other budgets for the operation of the Foundation Trust. Budgets are set within the overall finance available to the Foundation Trust. Budgets are set by the Finance Committee which is chaired by a NED. Neither the Chairman or Chief Executive are members of the committee. The budgets for Membership and Governors are contained within the Trust HQ budget. All budgets are approved by the Trust Board of Directors prior to being submitted to Monitor, who give the final approval. all the Trust's budgets and detailed in the Resources Book. This is placed on the Trust website as part of the Trust Board papers and sent to Governors.

ID	Governor Name		
97	**Graham Briscoe**	**Title:**	**Does the Chairman have a conflict of interest in chairing both Council of Governors and Trust Board?**

Query **08/08/2014**

Does the Trust Board Chairman, who is in NHS Foundation Trust governance terms a NED - (but is seen as a "first amongst equals" in his Board Chair role), not have a major conflict of interest when he Chairs the Council of Governors meetings, in that the Council of Governors is required to be seen to be and to operate independent of the Board (NEDs and EDs). How can the following statement apply (taken from the monitor Guide for NHS Foundation Trust Governors) when the Chair of the Governors Council is a NED of the Trust Board ?
How can he be held to account as a Trust Board NED when he chairs the meeting of the Group that is supposed to hold him (individually) to account?

" The over-riding role of the council of governors is to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public "

From my personal perspective I consider this aspect to cause a major flaw in the governance arrangements for NHS Foundation Trusts.

Another example :-

Quote (page 8 of the Monitor guide to Foundation Trust Governors)= " It is for the council of governors at a general meeting of the council to appoint or remove the Chair (of the Board) ".... BUT the Board Chair is chair of the council of governors meeting that could be meeting to remove him !

Response **23/09/2014**

The role of the Chair in an NHS Foundation Trust is clearly set out in Code of Governance, published by Monitor - the independent regulator of NHS Foundation Trusts. The Chair leads both the Board of directors and the Council of Governors. . The Chair acts as a key link between the Board and the Council of Governors. In leading the Council of Governors, the Chair is able to fully understand the views of the governing body and relay these to the Board. Similarly in leading the Board he is able to feedback decisions of the Board to the Council of Governors. This twin role is crucial to the successful operation of a Foundation Trust. For your information I have set out the relvenat paragraphs concering the role of the Chair from the Foundation Trust Code of Governance
below:
A.3a. states that 'The Chairperson is responsible for the leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings'.

A.5.5 The chairperson is responsible for leadership of both the board of directors and the council of governors but the governors also have responsibility to make the arrangements work and should take the lead in inviting the chief ececutive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant director present at the meeting about the affairs of the NHS foundation trust.

A.5.8 The council of governors should only excercise its power to remove the chairperson or any other non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.

96	**Clive Hamilton**	**Title:**	**Weston-super-Mare Hospital and Aviva**

Query **06/08/2014**

GOVERNORS LOG ITEM 6TH AUGUST 2014 – WESTON-SUPER-MARE HOSPITAL
Now that our trust has tendered a bid to take over running of this hospital, are the Non-Executive Directors satisfied that there will be adequate separation of the treatment pathways between patients attending the Aviva Private Health Insurance Waterside Suite and the NHS patients being treated in the main hospital.
Aviva sales literature indicates that, “by using private facilities within the NHS Trust hospitals on our Trust hospital list, you can reduce your monthly premiums by a further 25%.” Do Non-Executive Directors have assurance that the implications of this statement will not adversely affect NHS service capacity at Weston-Super-Mare and that there will be no waiting list queue jumping as a result.
Clive Hamilton 6th August 2014

Response **12/08/2014**

The Trust has not submitted a bid to take over the running of Weston Hospital though it will be considering its position in this regard, over the coming months – the deadline for submission of bids is 6th October. This Trust has clear policies and procedures to ensure that any form of private practice does not impact adversely on NHS services and such policies would be extended to any new services the Trust undertook to operate.
(Deborah Lee - Deputy Chief Executive and Director of Strategic Development)

ID	Governor Name		
95	**Mo Schiller**	**Title:**	**Ward staffing levels**

Query **11/07/2014**

The recent information regarding staffing levels on wards needs greater clarification as it is not clear how this can be interpreted. The public need to have assurance that all wards have the correct compliment of trained/untrained staff.

Response **29/07/2014**

The data set that is published on the Trust webs site and on NHS choices is a nationally mandated data set. From June 2014 all NHS hospitals are required to publish information about the nursing, midwifery, and care staff staffing levels on each ward, along with the percentage of shifts meeting safe staffing guidelines. This initiative is part of the NHS response to the Francis Report which called for greater openness and transparency in the health service. Find out how well a hospital's nursing and midwifery staffing requirements are being met.
Nurses, midwives and care staff are part of a wider team of healthcare professionals providing patient care. Often working alongside therapists, specialist nurses and psychologists, they play an important role in providing high quality and safe care to patients.
Safety of care relates to a number of factors, including the skills and experience of staff and the different needs of patients in their care. Each ward manager works closely with their senior nursing team to make decisions about staff requirements for each shift, and ensure patient needs can be met. The number of staff required at any time is called the planned staffing number.
The data is presented in two ways on NHS Choices:
1. You can see if a hospital's nursing and midwifery staffing requirements are being met overall.
2. For each hospital, you can also see as a percentage of hours in a day or night whether the actual number of nurses on duty met what was planned in a hospital or ward. It is presented for both registered and unregistered nurses.

Sometimes the actual staffing number is below the planned number. This may be the result of staff sickness, or because there is a lower number of patients on the ward than usual, so staff have been moved to work in another area.
Sometimes the actual staffing number will be higher than the planned number. This may be because there are a lot of patients on the ward who need extra care because of their physical or mental health condition.
Some hospitals will be unable to meet their staffing needs with permanent staff all of the time on every shift.
Information about staffing levels alone cannot tell you whether a hospital is safe or unsafe, but a regular lower percentage of the planned staff being in place is a cause for concern.
We are also displaying information for patients and visitors in all of our wards that shows the planned and actual staffing available at the start of every shift outside all inpatient areas.

University Hospitals Bristol NHS
NHS Foundation Trust

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

22 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 23 September 2014 since the previous report on 30 June 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 2014-09-30

Register of Seals July - September 2014

Ref:	Date Signed	Document Sealed	1st Sig.	2nd Sig.	Witness	Date Rec'd
740	01/07/2014	Licence for Alterations. UH Bristol and Toplsand Mercury Ltd. Block C, 9th Floor, Whitefriars, Lewins Mead, Bristol	D Lee	P Mapson	P Holt	26/06/2014 12:00
741	01/07/2014	Counterpart Lease. UH Bristol & Topland Mercury Ltd. Block C, Whitefriars, Lewins Mead, Bristol	D Lee	P Mapson	P Holt	26/06/2014 12:00
742	30/06/2014	Unilateral Undertaking. (Queens Facade) UH Bristol & Bristol City Council	P Mapson	None	P Holt	30/06/2014 16:00
743	11/07/2014	Intermediate Building Contract. UNB & Tribuild Ltd. £648,667.00 Clinic 2 Level 3 Queens Building.	D Lee	P Mapson	P Holt	19/07/2014 16:00
744	27/08/2014	Agreement between UH Bristol & Halsall Construction Ltd. Ward 6 refurbishment £1,783,586.00	R Woolley	S O'Kelly	P Holt	19/08/2014 09:00