University Hospitals Bristol NHS
NHS Foundation Trust

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

Date: Thursday 30 October 2014

Time: 10.30 am – 13.00

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

Distribution

Chair:	John Savage	Trust Chairman
Board Members:	David Armstrong	Non-executive Director
	Kelvin Blake	Non-executive Director
	Julian Dennis	Non-executive Director
	Lisa Gardner	Non-executive Director
	John Moore	Non-executive Director
	Guy Orpen	Non-executive Director
	Alison Ryan	Non-executive Director
	Emma Woollett	Deputy Chair and Senior Independent Director
	Jill Youds	Non-executive Director
	Robert Woolley	Chief Executive
	Sue Donaldson	Director of Workforce and Organisational Development
	Deborah Lee	Director of Strategic Development and Deputy Chief Executive
	Paul Mapson	Director of Finance and Information
	Carolyn Mills	Chief Nurse
	Sean O'Kelly	Medical Director
	James Rimmer	Chief Operating Officer
In attendance:	Julie Dawes	Interim Trust Secretary
	Debbie Henderson	Trust Secretary
Observers:	Aiden Fowler	NHS Fast Track Executive
	Penny Hilton	NHS Fast Track Executive
	Council of Governors	Members
Apologies:	Deborah Lee	Director of Strategic Development and Deputy Chief Executive
	Carolyn Mills	Chief Nurse
Copy for Information:	Lynn Pamment*	PwC – External Auditor
	Jenny McCall*	Audit South West – Internal Auditor

*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 October 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

	Item	*Sponsor*	*Page*
1.	**Chairman's Introduction and Apologies** To **note** apologies for absence received.	Chairman	
2.	**Declarations of Interest** In accordance with Trust Standing Orders, all members present are required to declare any 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 September 2014 for **approval.**	Chairman	5
4.	**Matters Arising** To review the status of actions agreed for **assurance.**	Chairman	15
5.	**Chief Executive's Report** To receive this report from the Chief Executive to **note.**	Chief Executive	17
	Delivering Best Care		
6.	**Patient Experience Story** To receive the Patient Experience Story for **review.**	Chief Nurse	20
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.	NHS Fast Track Executive Director Aiden Fowler.	23
8.	**Half year Update on Corporate Quality Objectives** To receive this report from the Chief Nurse for **assurance.**	Chief Nurse	114
9.	**Transforming Care Report** To receive this report from the Chief Executive for **assurance.**	Chief Executive	122

	Item	*Sponsor*	*Page*
	Strategy		
10.	**Quarterly Capital Projects Status Report** To receive this report by the Director of Strategic Development and Deputy Chief Executive for **information**	NHS Fast Track Executive Director Aiden Fowler.	128
	Delivering Best Value		
12.	**Finance Report** To receive this report by the Director of Finance and Information for **assurance.**	Director of Finance and Information	132
13.	**Finance Committee Chair's Report** To receive this verbal report by the Chair of the Finance Committee for **assurance.**	Director of Committee Chair	
	Corporate Governance		
14.	**Risk Assessment Framework Monitoring and Declaration Report – 2014/15 Quarter 2** To receive this report from the Chief Executive for **approval.**	Chief Executive	152
15.	**Well Led Governance Review** To receive an update report for **assurance**	Interim Trust Secretary	179
16.	**Board Assurance Framework Report** To receive this report by the Director of Strategic Development and Deputy Chief Executive for **assurance.**	NHS Fast Track Executive Director Aiden Fowler.	185
17.	**Corporate Risk Register** To receive this report from the Chief Executive for **assurance.**	Chief Executive	Report to follow
18.	**Governors' Log of Communications** To receive this report from the Chairman to **note.**	Chairman	194
	Information and Other		
20.	**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	

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

	Item	*Sponsor*	*Page*
21.	**Date of Next Meeting:** Trust Board meeting held in public, 27 November 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU	Chairman	

Unconfirmed MINUTES of a Meeting of the Trust Board of Directors to be held in Public on 30 September 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
- Deborah Lee – Director of Strategic Development and Deputy Chief Executive
- Emma Woollett – Non-executive Director (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
- Jill Youds – Non-executive Director
- Lisa Gardner - Non-executive Director

Others in Attendance

- Penny Hilton – Fast Track Executive
- Julie Dawes – Interim Trust Secretary
- Brian Courtney – Joint Interim Head of Membership and Governance

Observers

- Wendy Gregory – Patient Governor
- Clive Hamilton – Public Governor
- Janette Jones – Partnership, Joint Union Committee

Item

1. Chairman's Introduction and Apologies

The Chairman explained she was standing in as chair in the absence of the Chairman. Apologies had been received from John Savage (Chair) and Kelvin Blake Non-executive Director

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 July 2014 and **approved** them as an accurate record, subject to the following amendments:

Page 5, first para. Quality and Outcomes Committee Chair's Report, to be taken away and addressed outside the Board
Page 5 3rd para, amend to "encouraged by the reduction in rates"

Page 5, Para 4, change "they" to Committee
Page 11, Sect 21. Julie Dawes to supply the appropriate resolution

The minutes were approved as an accurate record subject to the above amendments

4. Matters Arising

Actions:

Action 221: (Partnership Programme Board) Work on business case with N Bristol continues, aim is for November but risk that this will slip till January. Robert Woolley advised unless he received assurance in the next couple of weeks that the preparation of the business case was sufficiently advanced, he would advise the Board to call a halt and restart the work at a later date in order to mitigate any risk to clinical services caused by continuing uncertainty for staff. The Board would be kept up to date with developments.

Action 2632: (Patient Experience Story) On Agenda.

Action 295: (Visit from the New Congenital Heart Disease Review Team) Service Standards have been produced and are out to a 3 month consultation. Self-Assessment will be undertaken and the Trust will respond to the consultation. Both will be reported to the Board in due course. Item to be placed on the forward planner and removed from matters arising

Action 320: (Medication errors) Matter has been discussed. Governors need to be informed about how the Trust is learning from errors, the method for doing this is being finalised. To be taken forward through the Governors Quality Group – Action Closed

Action 334: (Action Plans to address Governance and Risk at the Childrens Hospital) Action Plans to be taken through QOC - Action Closed.

Action 357: (Board Assurance Framework) Deborah Lee taking forward, will be resolved by Q2 - Action Closed.

Action 298: (Noticeboards) The Chief Nurse advised that Boards had been updated and where consistent, the work was completed in time for the CQC visit - Action Closed.

Action 319: (Quality & Performance Report) The Chief Nurse advised that it would not be possible to normalise the data in respect of age, because of the way data is now collected. The age adjusted incidence rate is no longer collected - Action closed.

Action 324: (Staffing levels) An additional column had been added to the website. Action closed.

Action 347: (Quality and Performance Report) The Chief Nurse advised that she was confident that divisional reporting arrangements were appropriate - Action closed.

Action 348: (Quality and Performance Report) Completed - Action closed.

Action 350: (Complaints) The Chief Nurse advised that there was no national system for grading complaints. This would be taken up with the complaints team to see if a local system could be developed - Action closed.

Action 351: (Complaints) Completed - Action closed.

Action 350: (Complaints) The Chief Nurse advised that there was no national system for grading complaints. This would be taken up with the complaints team to see if a local system could be developed - Action closed.

Action 336: (Patient Experience Story) James Rimmer advised that the environment in the outpatients department had been reviewed, seating increased and water was now available in all areas. James also noted that information regarding the drop-off zones were currently only being sent to BRI patients; this was being rectified and information will be sent to all patients in the future. Regarding the physical bed state in the Oncology Clinics James Rimmer noted that the current areas were now as good as they could be. Wendy Gregory (Patient Carer Governor) asked a question of Non-executive Directors as to whether they are satisfied with the action taken. She did not dispute that some action had been taken but feedback from patients was that they remained unhappy with the environment. The Chair thanked the Governor and explained that were an Executive outlined an action had been taken this should be accepted, however if concerns remained then the issue should be raised again Clive Hamilton (Public Governor – North Somerset) raised a question about over-booking. James Rimmer responded by explaining that over-booking was used to manage capacity and demand and was a constant balancing act. – Action Closed.

Action 282: (NIHRCRN) Passed to Audit Committee to address - Action closed.

Action 353: (Governors Log of Communication) Paul Mapson explained that the Cancer Network did not project forward to estimate demand. Deborah Lee explained the detailed data was not available, however the trust projected future demand based on historical trends – Action Closed

Action 333: (Chief Executive's Report) Sue Donaldson explained a specific paper was being taken to QOC in October, which would be reported to the Board - Action closed.

Action 335: (Chief Executive's Report) sue Donaldson explained that the final outcome of the bid to run training for the MoD was still awaited. The matter will be reported to the Board in due course.

Action 337: (Chief Executive's Report) Sue Donaldson and Sean O'Kelly had provided and the matter had been discussed at QOC - Action closed.

Action 339: (Patient Experience Story) Sue Donaldson confirmed agency staff were screened in exactly the same way as permanent staff - Action closed.

Action 318: (Quality & Performance report) Sean O'Kelly confirmed that the information was contained in this month's report Pg. 67 - Action closed.

There were no further Matters Arising.

5. Chief Executive's Report

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

- Paper provided an update on matters discussed by the Senior Leadership Team in September and August. He then provided a number of verbal updates.
- The CQC visit took place on the 8/9 September, with a follow-up unannounced visit on 21 September. The timetable is for the trust to receive a draft report on 4 November, and will have 10 days to respond to any issues of factual accuracy. This will be followed by a Quality summit on 28 November which will also involve Commissioners and Monitor. The final report will be published on 3 December. The Board will be kept informed.
- Two Tripartite letters, signed by NHS England, Monitor and the NHS Trust Development Authority have been received:
    - First letter – set out the financial challenge facing the NHS this year and next. At Q1 over 60% of trusts in England are in deficit which now stands at £500m. Robert Woolley outlined how the position is likely to get worse with an affordability gap estimated at between 6-7%, well above the efficiency requirement of 4% Trusts have worked with in recent years. NHS England will issue planning guidance in December. They will also issue a 5 year strategic plan in October. The letter also set out the expectation that all the key national standards around A&E, RTT, Cancer, diagnostics and ambulance wait times will be met in 2014/15;
    - Second letter - related to the backlog of over 18 week waiters and extended the national amnesty from end of September to end of November. Additional funding will be available to meet the cost of treating the additional patients, and the Trust is in discussion with commissioners to agree an appropriate plan.
- Trades Unions are consulting on industrial action with UNISON, UNITE and the Royal College of Midwifes all voting for strike action. This will involve a 4hour strike on 13 October followed by a 4 day work to rule. Other unions are balloting members and may decide to join the strike. The Trust is putting in place contingency plans to mitigate the action.
- Robert Woolley highlighted the national review of whistleblowing being led by Robert Francis QC. The Trust was already undertaking a review of its own Whistlebowing policy and this will be brought back to the Board in due course.

The 5 year business plan has been submitted to Monitor and the executive are now working on a 5year Strategic Implementation Plan which will make the link between the 5 year plan and operational plans. The divisions are

being involved, and the Strategic Implementation Plan will be brought back to the Board at the end of November.

- Finally Robert Woolley outlined that the Trust was running another *"Breaking the Cycle Together"* week, focusing on the Childrens Hospital and St Michaels, which had not previously been involved. This was underway, other departments were also running their own weeks, so this was a Trust wide event. There had been a very positive response to the call for volunteers, to act as Ward Liaison Officers for the week.

The Chair asked for any questions and Jill Youds asked if the Quality summit was a normal part of the CQC process or an exception. Robert Woolley explained in the new regime a Quality Summit was a normal and important element of the Care Quality Commission's inspection process.

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, advising board members that this was a third party story that had been developed by the NHS Institute for Innovation. She highlighted that story underlines the importance of communication in End of Life Care. She explained it referred to the use of the Liverpool Care Pathway, which had never been used in the Trust.

David Armstrong asked whether the Trust worked with St Peter's Hospice to support end of life care. Carolyn Mills explained that there was a joint appointment between the Trust the hospice. She highlighted that the Trust had not received a single complaint in the previous 12 months relating to end of life care.

Alison Ryan raised the issue of the paucity of information available to relatives and how this was markedly different in private hospitals, as she had experienced this herself. Lisa Gardner and Julian Dennis commented on the importance of clear communication between patients, their families and medical staff, noting that communication was a two way process and that relative's needed support.

Jill Youds asked what learning lessons could be drawn from the story. Carolyn Mills explained that the key lesson that could be drawn was the importance of accurate, timely communication between patients, relatives and the complexity of communicating. David Armstrong highlighted the role technology could play in supporting staff and underpinning communications. Wendy Gregory highlighted the issue of supporting relatives who were going through a very traumatic and challenging time.

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.

Deborah Lee highlighted changes to the style and lay out of the report and that further changes were planned for October, to try and meet concerns raised by the Board. There has been improvements in three areas:

- Pressure ulcers
- Quality of nursing care; and
- Staff sickness

In terms of areas which had shown deterioration there were two key areas: Referral to Treatment Times (RTT), which was part of the Trust's planned failure and slippage on delivery of the Trust's cost improvement programme.

Quality and Outcomes Committee Chair's Report

Alison Ryan, Chair of the Quality and Outcomes Committee, advised the Board that two meetings had been held since the last Board meeting.

Significant work has taken place on RTT and the Committee is gaining a greater understanding of this complex issues. The Committee had received the IMAS report and had discussed in depth the proposed changes to the management of waiting lists and the move away from quotas. The Committee had some concerns around demand and how increasing demand would impact upon the trusts plans to recover the position regarding the 18 week standard. The Committee constantly sought assurance that patients were not put at risk because of delays in treatment.

The Committee now received reports and minutes from the Clinical Quality Group which gave them significant assurance. They were also spending time trying to identify hotspots. The first area identified had been the Eye Hospital and they had received an interesting and useful report and presentation from the Eye Hospital and now had a much greater understanding of the issues.

The committee had also received reports on workforce and the final audit report which had proved useful.

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. The Committee would be looking at revised metrics in the future.

Board Review

The Chair asked for questions on the three areas of the report.

Quality

- Robert Woolley pointed to a discrepancy in the reporting of Clostridium Difficile infection. this is due to the need for validation by commissioners and will be rectified for next time
- The revised trajectories are appreciated by the Non-executive Directors. Deborah Lee pointed out that in relation to the MRSA trajectory the Trust could only afford a single breach each month from now to the end of the year if it was to remain compliant
- Emma Wollett expressed her appreciation of the progress around dementia assessment and the plans to deliver by the autumn.

Workforce

- Jill Youds raised the issue that **t**urnover, sickness and vacancies are all interlinked and there was growing evidence that the Trust was reaching a critical level in some areas. She asked what focus was being put on recruitment. Sue Donaldson outlined the programme of work including a recruitment 'deep dive' which was looking at both the approach to recruitment in a tight labour market and the timeliness of the recruitment process. She said that there were national problems recruiting a number of key staff, including qualified nurses. Nursing vacancies were running nationally at 10% and locally at 8%. It was important to ensure UH Bristol remained an attractive employer to attract staff but there needed to be an equal focus on retention.
- John Moore raised the issue of KPIs relating to agency spend. Sue Donaldson stated that work continued in an endeavour to reduce agency costs and the detailed work would be taken to the next Finance Committee. This work linked to more effective workforce planning and rostering, in particular covering shifts at weekends. Regular meetings are held with senior nurses in Divisions and the Divisions are now receiving much higher quality information to facilitate better planning. Robert Woolley also referenced the action from the Finance Committee to produce a comprehensive and integrated look at addressing spiralling agency costs and associated workforce risks and hotspots throughout the organisation. He said this will come to Finance Committee at the end of the month
- **Access**

The Chair raised the issue of risk to the Trust's Monitor ratings

James Rimmer explained that the challenges facing the Trust were similar to the overall national position. Recovery plans have been submitted to Monitor and as a result the governance rating has returned to green. In terms of the 4

hour waiting time standard in A&E the Trust had hoped to deliver for September, but it had actually failed to meet the standard. Indeed none of the local Trusts would achieve the target in September which was unprecedented. The government has announced another £300m to support winter plans which the Trust will bid against. Staffing remains a major issue

RTT amnesty has been extended to end of November; the Trust is developing plans. However demand continues to rise above planned levels. Negotiations are on-going with Monitor and commissioners to resolve this situation

In terms of Cancer James Rimmer set out the overall position which remained extremely tight but the targets are achievable in Q3.

David Armstrong raised the issue of capacity, particularly in the community. James Rimmer explained that capacity remained as at previous years, but 100 nursing home beds had been lost in Bristol in the last year. The Trust with community providers was seeking to provide additional senior nurse support to homes to try and bring beds back on line.

Alison Ryan stated that Shepton Mallet had spare capacity and she asked whether the Trust had explored the use of that facility. James Rimmer explained that once a person was referred to the Trust, arranging treatment elsewhere opened up clinical governance issue. Trust is speaking to commissioners about referring directly to other providers, but this is proving difficult. Deborah Lee explained that theatre capacity was an issue at the Trust and that UHB consultants would operate at Emmerson Green, taking patients on their waiting lists. Jill Youlds asked about when it would be appropriated to review the operational plan, Deborah Lee responded that the winter plan was being taken to QOC and that this would be the appropriate time to review the plans.

Clive Hamilton commended the Trust for providing action plans for addressing fractured neck of femur patients which he stated were comprehensive and addressed the issues.

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

8. Patient Complaints and Experience Quarterly Report

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

Report has been through QOC.

Carolyn Mills presented the report. She highlighted that response times were now back to 5 days which was encouraging.

She also highlighted the positive feedback received through surveys, including the Friends and Family Tests, which were consistently better than the national average. She highlighted a number of hotspots, maternity being one, and that plans were in place to address the issues. She also noted that there was a general upward trend in the number of complaints. She pointed out a discrepancy in the report, and that the increase in complaints in the surgical division was not 153%.

Jill Youlds raised the question, about how the Trust benchmarked itself. She sought assurance that rather than comparing with the average the Trust should provide evidence as to how it compared against the “best”. The Trust always should be ambitious in becoming the best rather than average.

David Armstrong queried the audience for the report, was it internal or external? Deborah Lee explained that it was both and that the report would be posted on the Trust website. Its main purpose was to give the Board assurance that complaints were being dealt with appropriately.

Julie Dawes stated that there was a need for clarity as to were reports of this nature were approved, by which committees. The Chair pointed out that the report was given for assurance, not for approval by the Board, and whilst it was important to understand the key issues, the Board should not go through the report line by line

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

9. Safeguarding Annual Report

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

Carolyn Mills explained there was a legal requirement to provide a report. She highlighted an increase in activity across the Trust and that the issue of Deprivation of Liberty had become an increased issue for the Trust following a High Court ruling.

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

10. Equality and Diversity Annual Report

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

Sue Donaldson presented the report advising the Board. She highlighted that an action plan was in place and would be monitored by Senior Leadership Team. Alison Ryan pointed out that cover sheets for Board papers needed to contain a statement about the impact on equality and diversity and that this was being introduced.

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

11. Quarterly Workforce Report April-June 2014

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

This report has been QOC. Sue Donaldson presented the report advising the Board that KPIs are ambitious, and that achieving all of them by March 2015 may be unrealistic. She suggested an action plan to March 2015 needed to be put in place and then a plan to deliver all the KPIs.

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

12. Culture of Compassion (Action 263)

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

Sue Donaldson presented the report, highlighting that Penny Hilton had done the detailed work and asked her to comment. Penny highlighted three priority areas:

- Listening to patients in a more pro-active way;
- Embedding the compassion culture in the Divisions; and
- Developing leadership skills, particularly at middle management level, to challenge inappropriate behaviours.

Alison Ryan commended the work and stressed that patient care involved every member of staff, not just front line carers.

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

13. Regulatory Changes

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

The legislation has been delayed in Parliament but will come into force in November. Paper has been considered by QOC. Detailed action plans are being developed to ensure the Trust is fully compliant in both areas. The Duty of Candour Action Plan will be considered by QOC, Fit and Proper Person will be considered by Audit.

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

Strategy

14. Workforce and Organisational Development Strategy

The Board received and reviewed this report from the Director of Workforce and Organisational Development for approval

Sue Donaldson spoke to the report and highlighted that whilst the report was relatively short it did not reflect the significant amount of time and energy which had been expended in developing the strategy. Next steps were to put in place high level action plans and to develop supporting programmes to turn the vision into reality. The strategy had been endorsed by both the SLT and QOC.

The Chair commended the report. The Trust Secretary advised that the report would be included in the next Council of Governors Development session.

The Board approved the Strategy

Delivering Best Value

15. Finance Report

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

The Director of Finance and Information advised the Board that;

- Situation across the NHS was difficult. Whilst the £300million deficit in non-Foundation Trust sector was not necessarily surprising the £200 million deficit in the Foundation Trust sector was unexpected. Only 61 Foundation Trusts are in surplus at Quarter 1;
- At Month 5 the Trust is close to a £1.8million surplus, which is £0.639m adverse to plan. Low activity across the board was delivered in August. Agency spend was increasing as vacancies increased;
- Trust would be providing a forecast next month of the year end position;
- An audit of increments had been undertaken. The Trust had budgeted £2.4 million for 2014/15, however actual spend was now likely to be in the order of £900k, which reflected the high turnover of staff;
- Efficiency for 20015/16 was potentially in the order of 3-5%;
- Cash and capital expenditure were broadly on track

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

16. Finance Committee Chair 's Report

Lisa Gardner as Chair of the Finance Committee, advised the Board that:

- Endorsed the comments of the Director of Finance and Information, particularly around recent activity levels and agency spend. In relation to activity it was important that the trust had plans to return to appropriate activity levels as there was a danger that commissioners would use current levels as a capped baseline for the contract next year;
- CIP delivery had reduced to 82%, which still placed the Trust in a strong position, as the maturity assessment of each scheme was rigorous

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

17. Compliance with the Department of Health's new Principle of Parking Policy

The Board received this report from the Chief Operating Officer for assurance.

James Rimmer highlighted:

- Principles had been published in August and the Trust was broadly compliant, only gap related to information on the Trust's website;
- Trust still sort to encourage non-car visits to the Trust, and the use of the free bus service supported this;

Wendy Gregory asked whether the provision of parking permits for long stay patients would continue and James Rimmer confirmed this was the case and that ward staff were well aware of this provision. More information would be provided on the Trust's website.

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

Leading in Partnership

18. Partnership Programme Report

The Chief Executive presented the routine report from the Partnership Programme Board. Chairmanship of the Board moves to UHB for the next meeting scheduled for October. The Chair highlighted the importance of this Board as a key means of maintaining a positive relationship with the other acute provider

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

Corporate Governance

19. Monitor's letter regarding University Hospitals Bristol performance in Quarter 1

The Board received this report from the Chief Executive to note:

- Monitor had rated the Trust as a 4 for continuity of service, and restored a green rating for governance
- This will be reviewed by Monitor again in October, and as the Board where aware the Trust was not on trajectory in relation to RTT

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

20. Audit Committee Chair Report

The Board received this report from the Chair of the Audit Committee for assurance.

John Moore raised the following points:

- Internal audit had red risk rated the Trust in relation to its risk management arrangements. An action plan was in place and would be monitored.
- Counter Fraud – leadership had recently changed and a report had been received which was very comprehensive and helpful. It confirmed that the trust was focusing in the right areas
- Losses Report – much higher this quarter as a number of outstanding invoices relating to foreign patients had been written off.

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

21. 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. Clive Hamilton confirmed that governors were satisfied with the Trust's actions. The Trust Secretary confirmed that work was ongoing on putting in place

a system to ensure that governors were content with the answers provided by the Trust.

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

22. Register of Seals.

The Board received this report from the Trust Secretary, to note.

Information and Other

23. Communications to the Wider Organisation

The Board received this verbal report from the Chief Executive:

The Chief Executive highlighted that communication on a wide range of initiatives was underway. The Trust Secretary suggested that some form of communication to staff following each Board meeting may be appropriate. The Chief Executive said that he would consider this and discuss with colleagues and bring back next month.

Action 372: Robert Woolley to bring back to the next Board Meeting.

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

24. Any Other Business

Wendy Gregory asked why the results of the National Cancer Patient Experience Survey were not on the agenda. Robert Woolley explained the results had only just been received and the Trust would evaluate the results and develop a response and bring it back to the Board in November.

It was agreed that the written questions and answers from the Annual Members meeting would be circulated to all governors.

Action 373: Trust Secretary to circulate Q&A from the Annual Members Meeting.

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

25. Date of Next Meeting

Meeting of the Trust Board of Directors to be held in Public: 30 October 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
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.	23/10/14. Business case in preparation for submission to both Trust Boards in November 30/09/14 Work on business case with N Bristol continues, aim is for November approvals but risk that this will slip till January. Robert Woolley advised unless he received assurance in the next couple of weeks he would advise the Board to call a halt and restart the work at a later date that the preparation of the business case was sufficiently advanced in order to investigate any risks to clinical services caused by continuing uncertainty for staff. The Board would be kept up to date with developments. 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	
Chief Executive	**372**	30/09/2014	Public	Communications to the Wider Organisation	The Chief Executive highlighted that communication on a wide range of initiatives was underway. The Trust Secretary suggested that some form of communication to staff following each Board meeting may be appropriate. The Chief Executive said that he would consider this and discuss with colleagues and bring back next month.	23/10/14 Proposal is to retain agenda item for Board consideration of any exceptional reporting arising from each meeting. 30/09/14 Robert Woolley to bring back to the next Board Meeting.	30/10/2014
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
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
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
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
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
Director of Workforce and Organisational Development	**335**	30/07/2014	Public	Chief Executive's Report		30/09/14 sue Donaldson explained that the final outcome of the bid to run training for the MoD was still awaited. The matter will be reported to the Board in due course. 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.	

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
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
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
Trust Secretary	**373**	30/09/2014	Public	Any Other Business	Wendy Gregory asked why the results of the National Cancer Patient Experience Survey were not on the agenda. Robert Woolley explained the results had only just been received and the Trust would evaluate the results and develop a response and bring it back to the Board in November. It was agreed that the written questions and answers from the Annual Members meeting would be circulated to all governors.	30/09/14 Trust Secretary to circulate Q&A from the Annual Members Meeting.	30/10/2014

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting to be held on 30 October 2014 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

TRUST MANAGEMENT EXECUTIVE

REPORT TO TRUST BOARD –OCTOBER 2014

1. INTRODUCTION

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

2. QUALITY, PERFORMANCE AND COMPLIANCE

The group noted the current position in respect of performance for Quarter 2 2014/2015 against Monitor's Risk Assessment Framework.

The group **agreed** the recommendation to the Trust Board to declare the standards failed in quarter 2 2014/2015 to be the Referral to Treatment Non-Admitted, Admitted and Ongoing pathways standards, the Accident and Emergency 4-hour standard and the 62-day GP cancer standard. The group also **agreed** the recommendation that the planning ongoing failure of Referral to Treatment standards, in line with the current 'national amnesty', are flagged to Monitor, along with specific risks to achievement of the 62-day screening cancer standard and the Accident and Emergency 4-hour standard, as part of the narrative that accompanies the declaration.

The group received and **approved** the plan highlighting how the Trust would develop its recovery trajectories for referral to treatment 18 week standards for submission to Monitor in December.

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

The group **noted** an update on the latest position with essential training compliance for full achievement by the end of March 2015.

3. STRATEGY AND BUSINESS PLANNING

The group received and **noted** an update on work being undertaken in the production of the Strategic Implementation Plan.

The group **received** an update on Business Planning Guidance 2015/2016 and **agreed** next steps.

The group **approved** the procurement of a new risk and incident reporting and management system for implementation by July 2015.

The group received a proposal for addressing immediate staff recruitment challenges in 2014/2015 and **agreed** non-recurrent resource for four additional posts in the Recruitment Team but requested further review of requirements going forward.

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

4. RISK, FINANCE AND GOVERNANCE

The group received and **approved** updated terms of reference for the Clinical Strategy Group.

The group received an update on progress against the corporate quality objectives for Quarter 2 of 2014/2015 to **note**.

The group received and **approved** the Board Assurance Framework Quarter 2 update report, for onward submission to the Trust Board.

The group received and **approved** the Corporate Risk Register, for onward submission to the Trust Board.

The group received to **note** Internal Audit Reports in relation to Clinical Audit Governance and Safeguarding. Progress in respect of completed actions and the Internal Audit Plan was also **noted.**

Reports from subsidiary management groups were **noted**, including an update on the work of the Transforming Care programme and on the activities of the Communications Department.

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

5. 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
October 2014

University Hospitals Bristol NHS
NHS Foundation Trust

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

6. Patient Experience Story

Purpose

This patient story reflects care and compassion in practice in UHBristol. It shows the essence of high-quality care that is safe, effective and focused on patient experience, reflecting the needs and preferences of patients and their families, with their involvement and consultation about care and treatment.

Abstract

A small survey undertaken as part of the Trust understanding what compassionate care means to our staff identified the following words identified as being associated with compassion:

- Compassion is...

The story reflects many of the above elements. A further piece of work is underway to develop a lasting piece of work that summarises what University Hospital Bristol (UHB) staff feel the word 'compassion' means. The ouptut can be shared amongst Trust staff and with the people who use our services and hospitals so that we can all better understand what compassionate care at UHBristol looks and feels like.

Recommendations

The Board is asked receive the report for assurance

Report Sponsor

Carolyn Mills, Chief Nurse (presented by Helen E Morgan)

Appendices

Appendix 1 – Patient Story

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

Patient Story – October Board

A 76-year-old lady (Mrs D) with metastatic breast cancer admitted to Ward 61 for management of symptoms and assessment. She had been living at home, in Weston, with her husband as main carer but he was becoming increasingly unwell and unable to cope. She was admitted with uncontrolled pain, weakness, nausea and was unable to stand, walk or move around the bed unassisted. UHBristol Palliative care team and Ward 61 Team assessed Mrs D, and with her and her family's agreement a referral was made to Weston Hospice Team for End of Life Care. Mr and Mrs D's daughter, Ms T, lived with her two young children in Cornwall.

Two days after Mrs D's admission to Ward 61 Mr D was admitted to Bristol Royal Infirmary (BRI), Emergency Department (ED) with a suspected cerebro-vascular accident (CVA). He was reviewed by the Stroke Team and admission was planned for Ward 12 – then the Stroke Rehabilitation Unit for the correct care pathway for this gentleman. Ms T was contacted as next of kin. She called Ward 61 very distressed as she had just got back to her home after an extended stay in Bristol and now she had both her parents in hospital, her father's condition was serious and she had been warned that he may not regain consciousness.

Mrs D was also very distressed as she was not able to visit her husband, and was worried she may not see him before he died.

Nursing staff on Ward 61 negotiated with medical teams, site team and oncologists, Mrs D and Ms T and arranged for Mr D to be transferred to Ward 61. Mr and Mrs D were nursed in a side room together - although a single room it was large enough for two beds and portable oxygen and suction were brought in on standby if required. A second side room was available next door to move one bed into it if Mrs D required some rest (Mr D was quite agitated and restless) and to maintain privacy. Mr and Mrs D were able to hold hands and although Mr D remained unconscious he was aware his wife was present as he became less agitated when she spoke to him. Ms T was able to stay with both her parents during the day and accommodation was found for her locally overnight in the Bristol Heart Institute (BHI) relatives' room.

Being together gave each member of the family comfort.

The MDT team on Ward 61 liaised closely with the medical team caring for Mr D to ensure he received all appropriate nursing, medical and physiotherapy care whilst he was on Ward 61.

During the week Mr D was admitted to Ward 61 a bed became available at St Peter's Hospice and Ward 61 staff and the Palliative Care Team negotiated with the support of Ms T for her father to be admitted too. Mrs D decided to move there. Mr D was transferred later that day.

Mr and Mrs D were cared for at Weston Hospice in a shared room. They died within a week of each other. Ms T was able to be with both her patents until their deaths.

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 October 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
		27/10/14			

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

October 2014

CONTENTS

PERFORMANCE OVERVIEW

A Performance Overview _____

B Organisational health barometer _____

C Monitor's Compliance Framework _____

1. QUALITY

1.1 Quality dashboard _____

1.2 Summary _____

1.3 Changes in the period _____

1.4 Exception reports _____

1.5 Supporting Information _____

2. WORKFORCE

2.1 Summary _____

2.2 Exception Reports _____

2.3 Supporting Information _____

3. ACCESS STANDARDS

3.1 Summary

3.2 Access dashboard

3.3 Changes in the period

3.4 Exception reports

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 – 1 indicator

- Savings Plan Achievement – with achievement in the month increasing from 68 to 91%; for further details please see the Finance Report.

Deteriorations in the period:

Moving from GREEN to RED – 2 indicators

- Monitor Governance Risk Rating – updated quarterly, so Previous and Current are as reported last month;
- 30-day emergency readmissions – rising from 295 in July to 302 in August, although levels of emergency readmissions are within the GREEN threshold for the quarter to date

Moving from AMBER to RED – 1 indicator

- Staff sickness – an increase from 3.6% to 4.0%, further details of which can be found in the exception report in the Workforce section

Moving from GREEN to AMBER – 2 indicators

- Summary Hospital-level Mortality Indicator (SHMI) – moving from a SHMI score of 56.2 to 66.7, but remaining within normal limits of monthly variation;
- Percentage of research studies meeting the 70 day standard (submission to recruitment) – with monthly performance moving from 53.6% to 51.0% in the period, but also reflecting changes made to the thresholds to take account of the latest peer group performance

The Organisational Health Barometer continues to highlight the challenges in meeting national waiting times standards in the face of rising demand and increasing patient complexity. The impact of the Trust's performance against the access standards is reflected in the Monitor Risk Rating, and also in the contract penalties forecast. Sustained improvements were seen in the period in measures of patient flow at the 'back door' of the hospital, including the number of long-stay patients in hospital at month-end maintaining its amber rating after eight consecutive months of being red rated. However, the improvements seen in the last two months were insufficient to support consistent achievement of the A&E 4-hour standard, reduce the level of cancellations of surgery, or to reduce the time patients spent outlying from the correct specialty ward. These latter measures are two of the Trust's quality objectives this year, in recognition of their importance they play in a good patient experience, and the potential impact they can have on quality of care. Whilst challenges in maintaining patient flow continue, importantly there was a significant reduction in the number of

ambulance hand-over delays in the period, and the Trust continued to achieve the Emergency Department clinical quality indicators.

During quarter 2 the Trust failed five of the standards in Monitor's Risk Assessment Framework. These were the A&E 4-hour standard, the Referral to Treatment Time (RTT) Non-admitted and Ongoing standards, the 62-day GP Cancer Standard, and the RTT Admitted pathways standard, the latter being part of a planned failure nationally at the request of NHS England. 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 this gives the Trust a Service Performance Score of 4.0 against Monitor's Risk Assessment Framework, but in the context of Monitor having already investigated and taken account of the failure of three of these standards, by restoring the Trust to a GREEN rating for quarter 1.

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	88	89	N/A	Green: >= 86 Red: < 85	↑	Current month is August 2014.
A02	Patient Complaints as a Proportion of Activity	0.321%	0.266%	0.268%	Green: <0.21% Red: >0.25%	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	0	0	Green: 0 Red> >0	→	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	0	0	2	Green: 0 Red: >= 1	→	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	4.59	4.26	4.65	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)	3	7	42		↑	
C02	Cumulative Number of C.Diff cases	3	5	5	Below Trajectory	↑	Previous = commissioner agreed potentially avoidable cases Apr to Aug; Current & YTD = total cases (Apr to Sep), including 2 agreed cases confirmed for Sep. Limit for the end Q2 = 20.

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	84.4%	82.4%	87.8%	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	93.7%	92.4%	93.7%	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	56.2	66.7	60.9	Green: <65 Red: >=75	↑	Previous is July 2014 and Current is August 2014.
E02	30 Day Emergency Readmissions	295	302	1541	Below 13/14 Readmission Rate	↑	Previous is July's discharges where there was an emergency Readmission within 30 days. Current is August's discharges. Threshold changed to be based on 2013/14 data.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
F01	Overall Length of Stay (Spell)	4.29	4.25	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	86.7%	86.6%	88.0%	Green: >= 90% Red: < 90%	→	
F04	Outpatient appointment hospital cancellation rate	9.3%	9.1%	9.4%	Green: <=6.0% Red: >=10.7%	↓	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Turnover	12.9%	13.3%	12.1%	Green: < target Red: >=10% above target	↑	
G02	Staff Sickness	3.6%	4.0%	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	20,338	24,283	24,283	Green: Above 2012 Red: Below 2012		Current (and YTD) is rolling Calendar YTD position. Previous is Jan-Jun 2014 and Current is Jan-Jul 2014
H03	Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment)	53.6%	51.0%	51.0%	Green: >=53% (Upper Quartile) Red: <48% (Median)	↓	Previous is Q1 2013/14 – Q4 2013-14. Current is Q2 2012/13 - Q1 2014/15. Updated Quarterly. Thresholds have changed to reflect it is 12 months since last target change.

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 5. Current (and YTD) represents Month 6 2014/15.

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£6.49	£6.55	£6.55	> 50% Green < 50% Red	↑	This is Potential year-end rewards and reflects assessment of performance as at August (69%).
K02	Contract Penalties Incurred - Variance From Plan (£millions)	£0.29	£0.49	£0.49	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

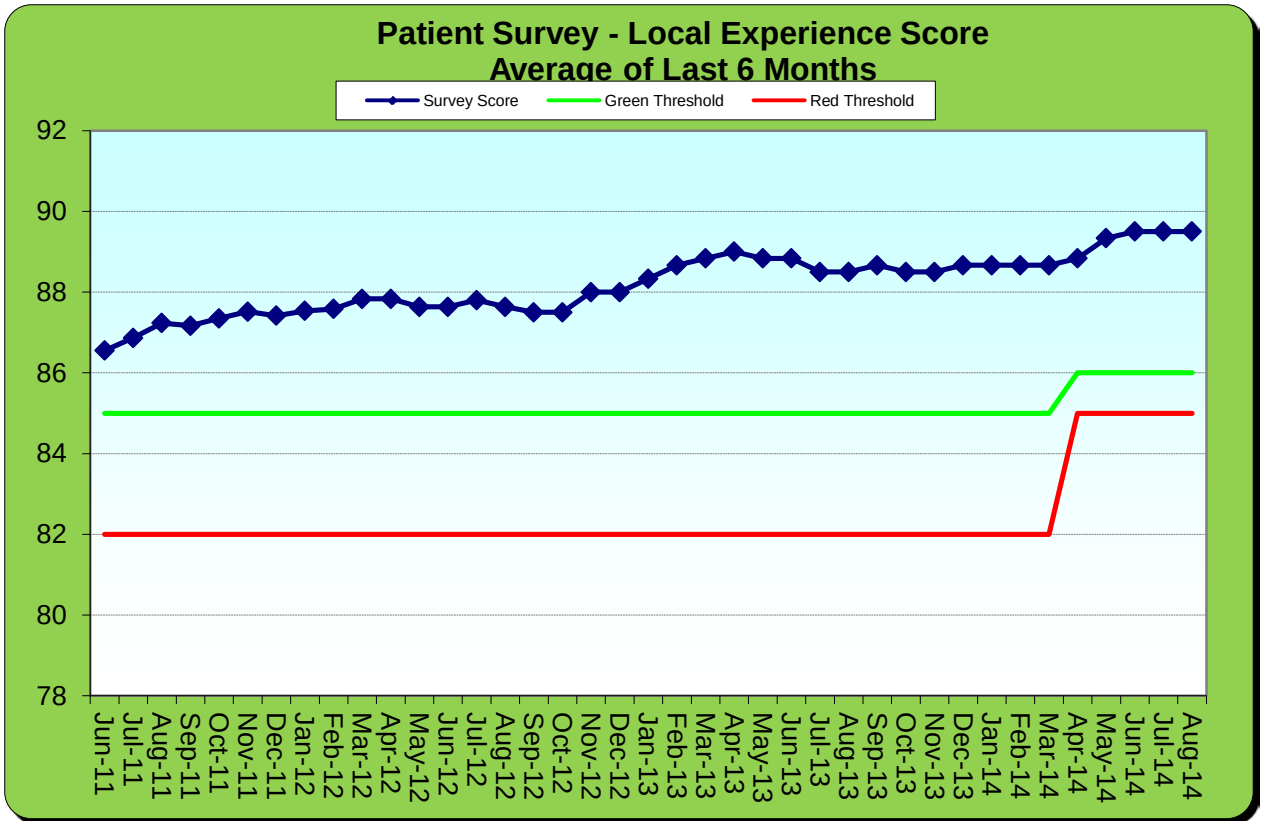
ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
L01	Monitor Continuity of Service	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	For financial measures except CRES, Current and YTD is Current Year To Date. For Savings there is a separate total for latest month and YTD. Previous is previous 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	68%	91%	74.9%	Green: >=90% Red: < 75%	↑	

Notes

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

YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2014 up to and including the current month

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


Patient Survey - Local Experience Score
Average of Last 6 Months
Survey Score
Green Threshold
Red Threshold
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
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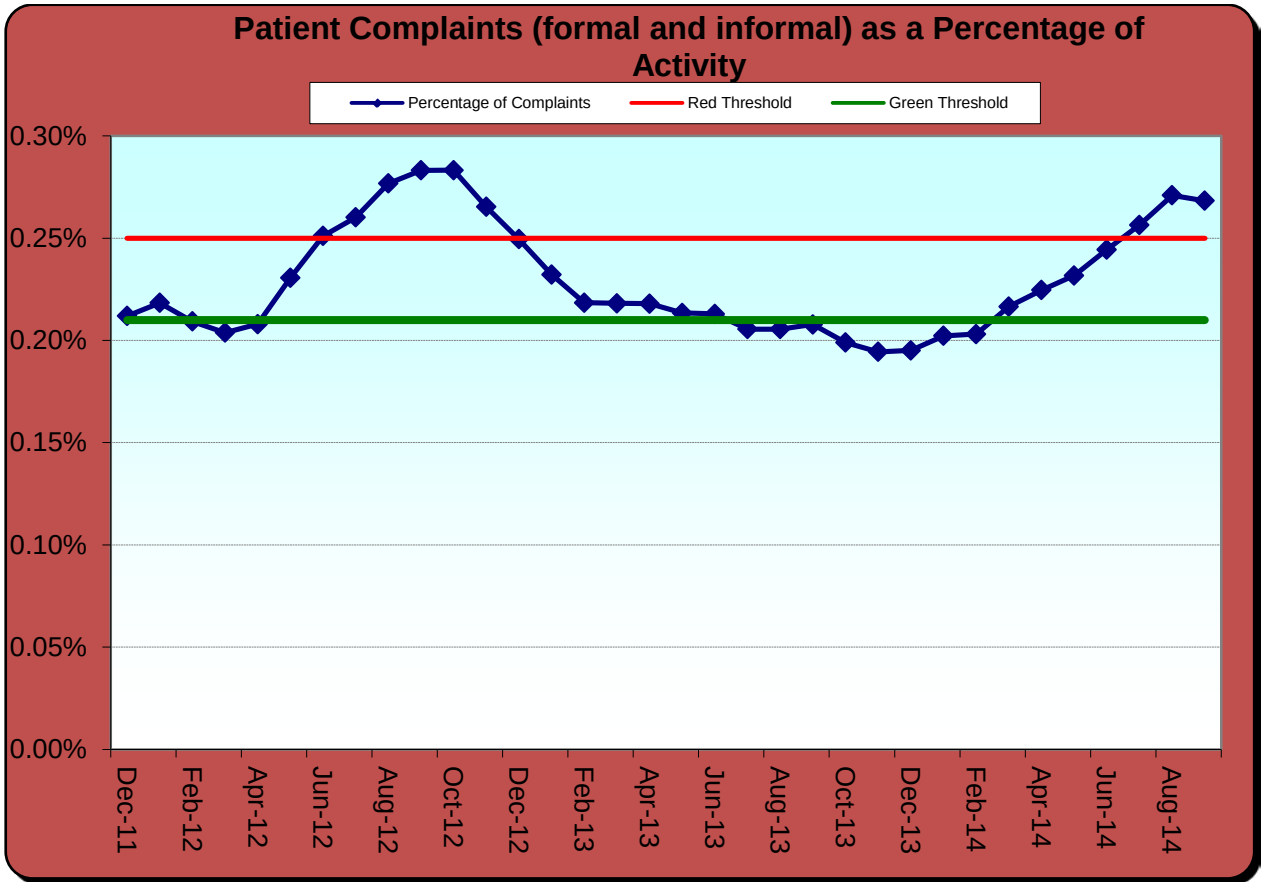
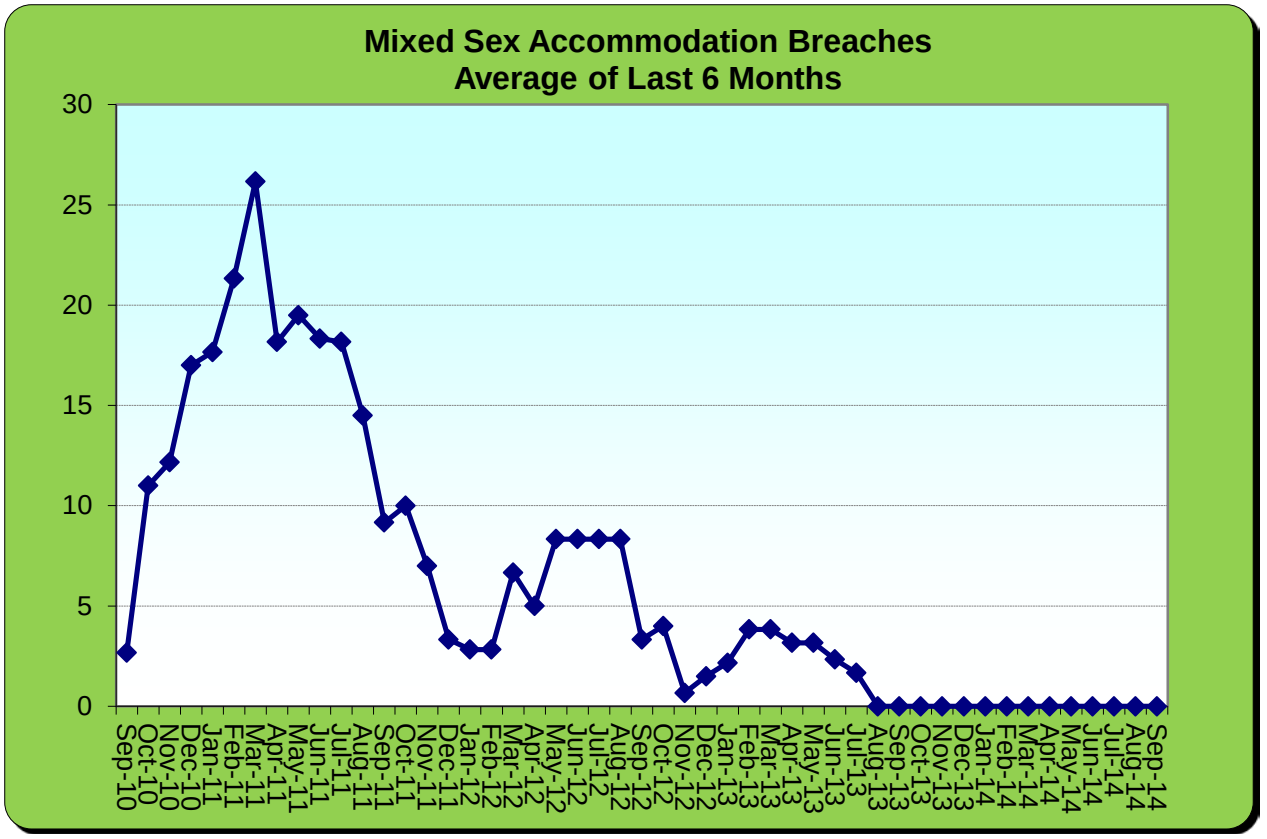

Patient Complaints (formal and informal) as a Percentage of Activity
Percentage of Complaints
Red Threshold
Green Threshold
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
Dec-11
Feb-12
Apr-12
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14


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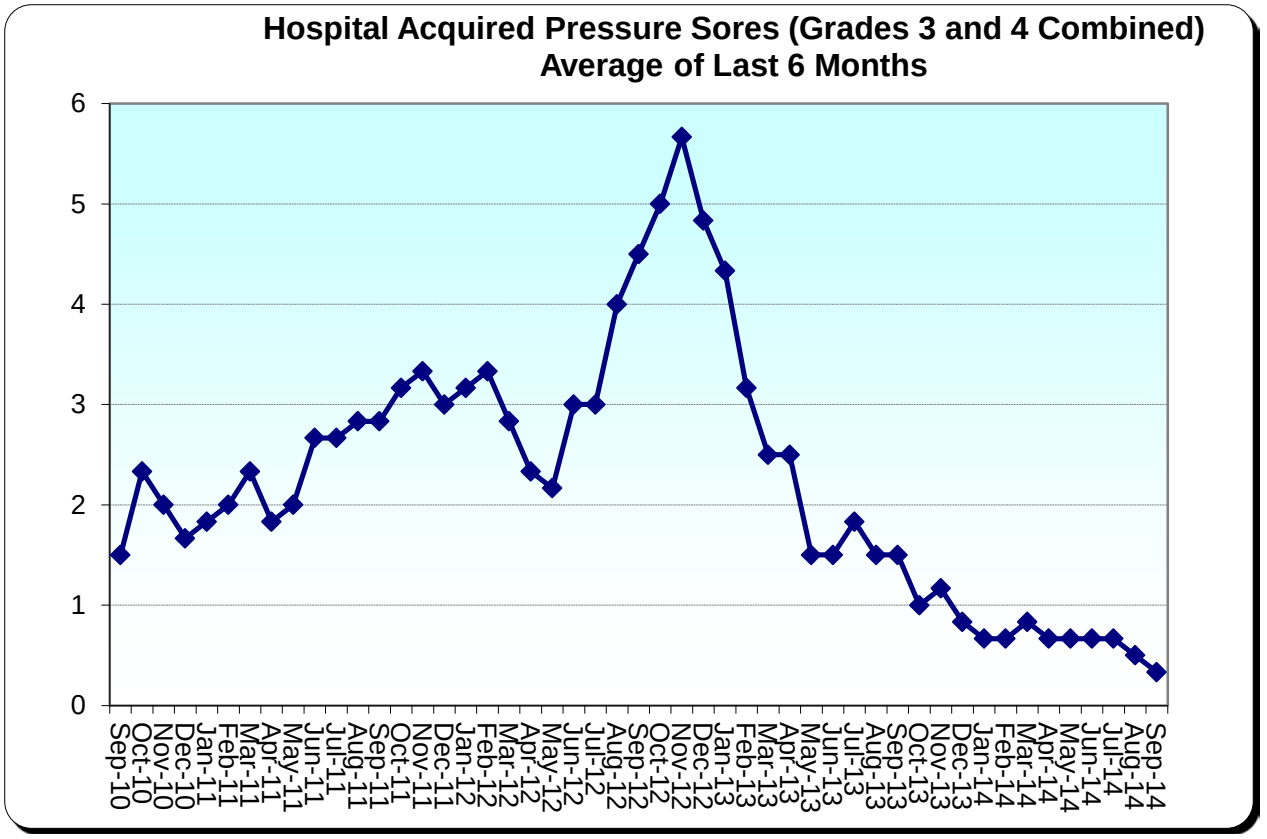
Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Average of Last 6 Months
6
5
4
3
2
1
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
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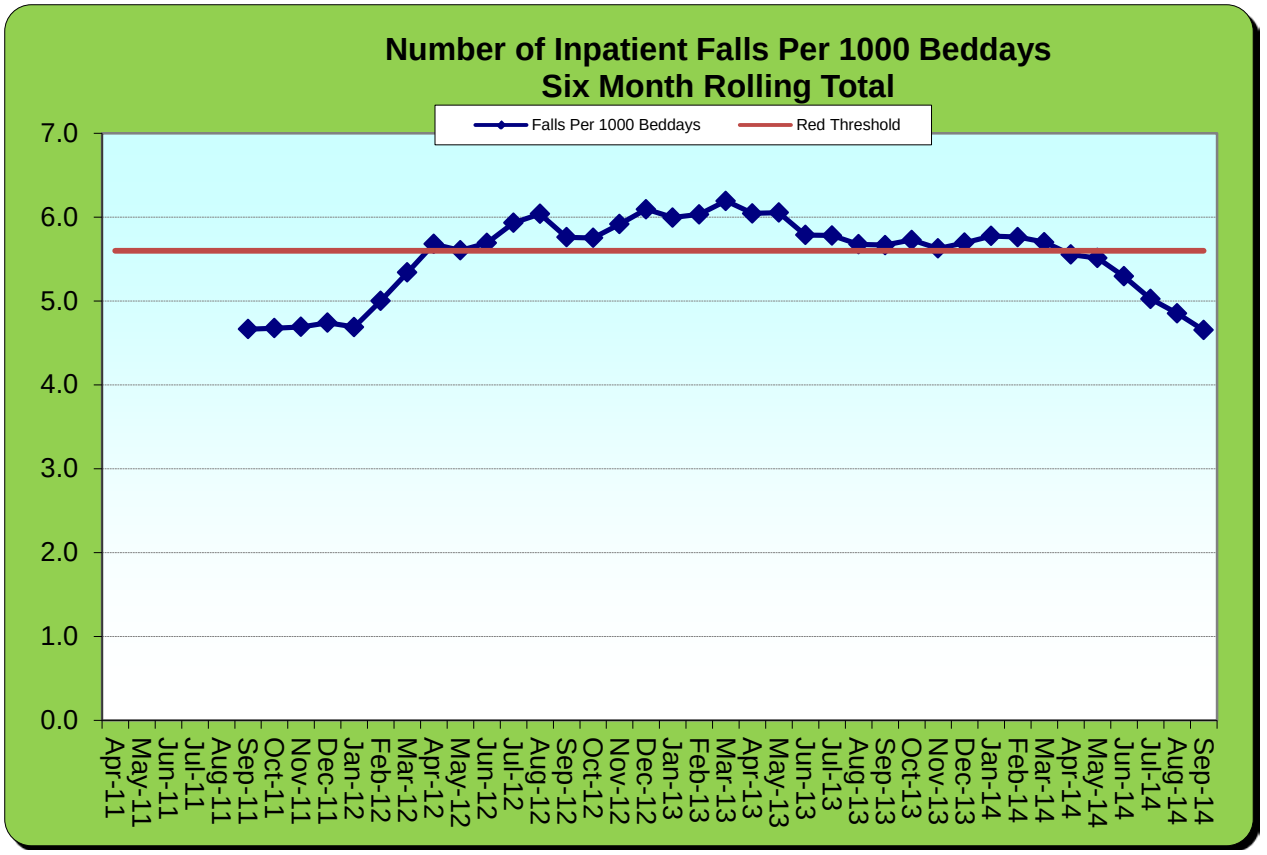
Sep-14


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
Sep-13
Oct-13
Nov-13
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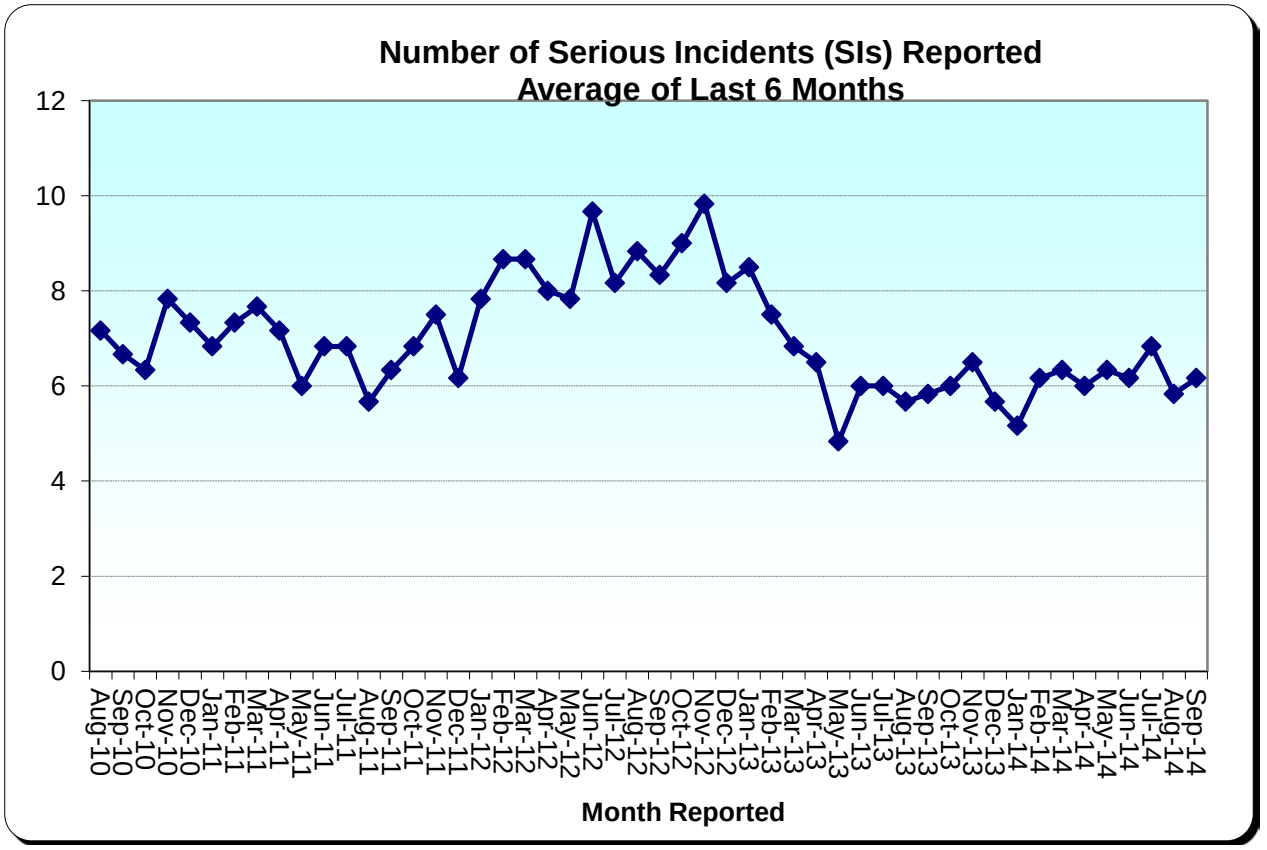
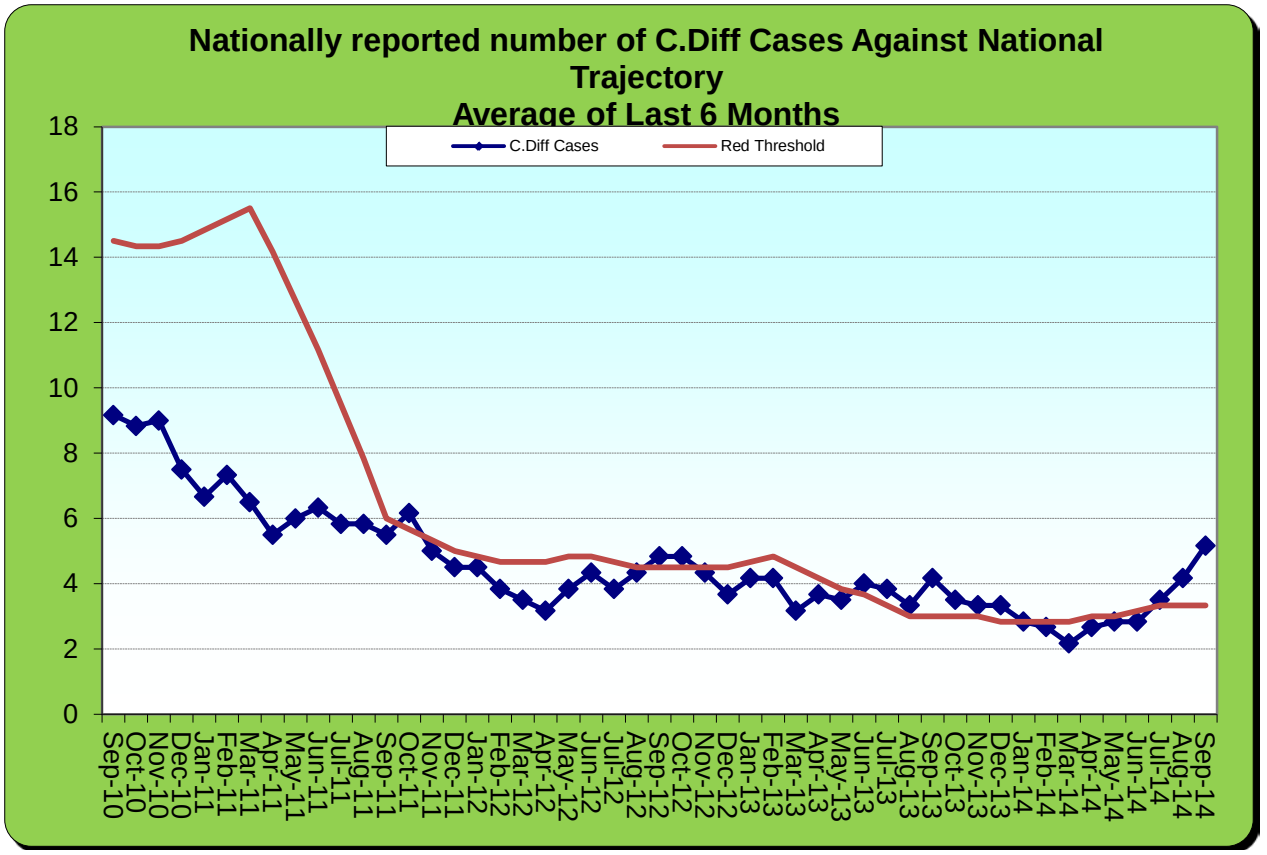
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14


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


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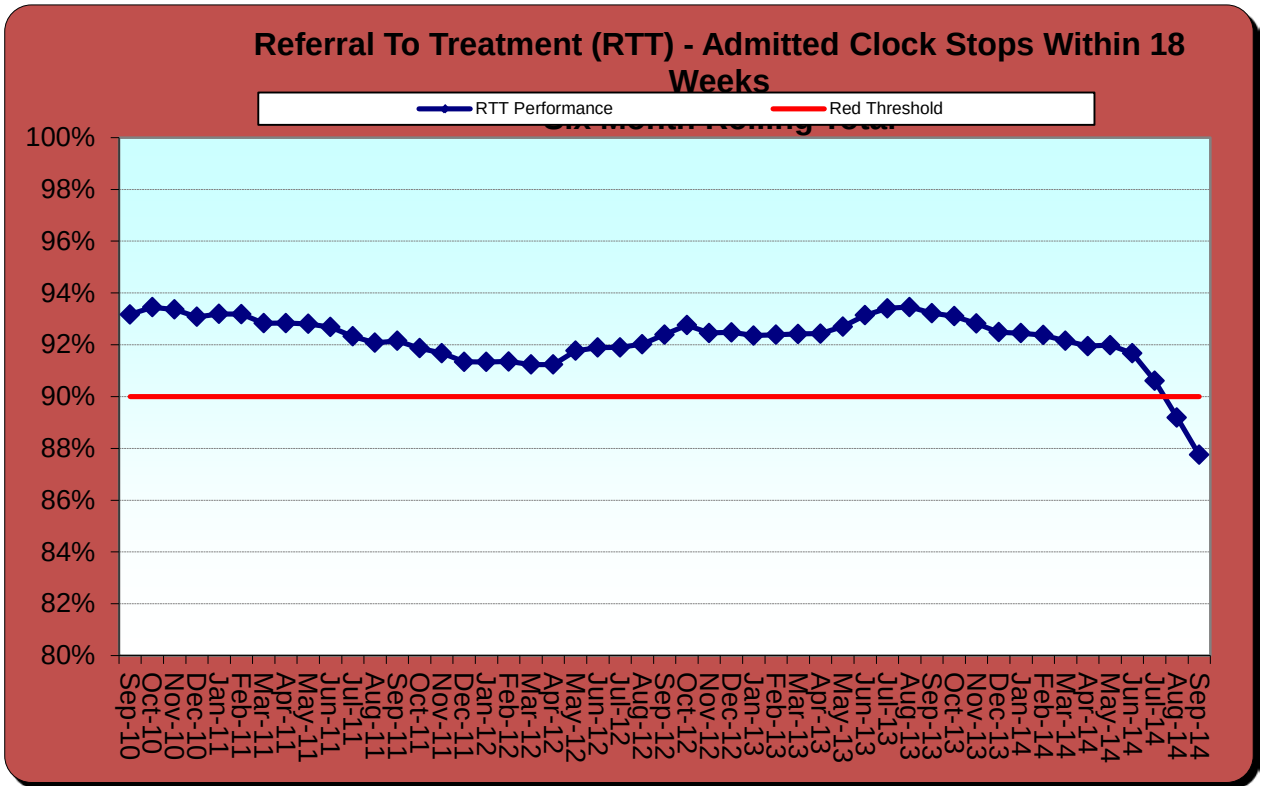
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14


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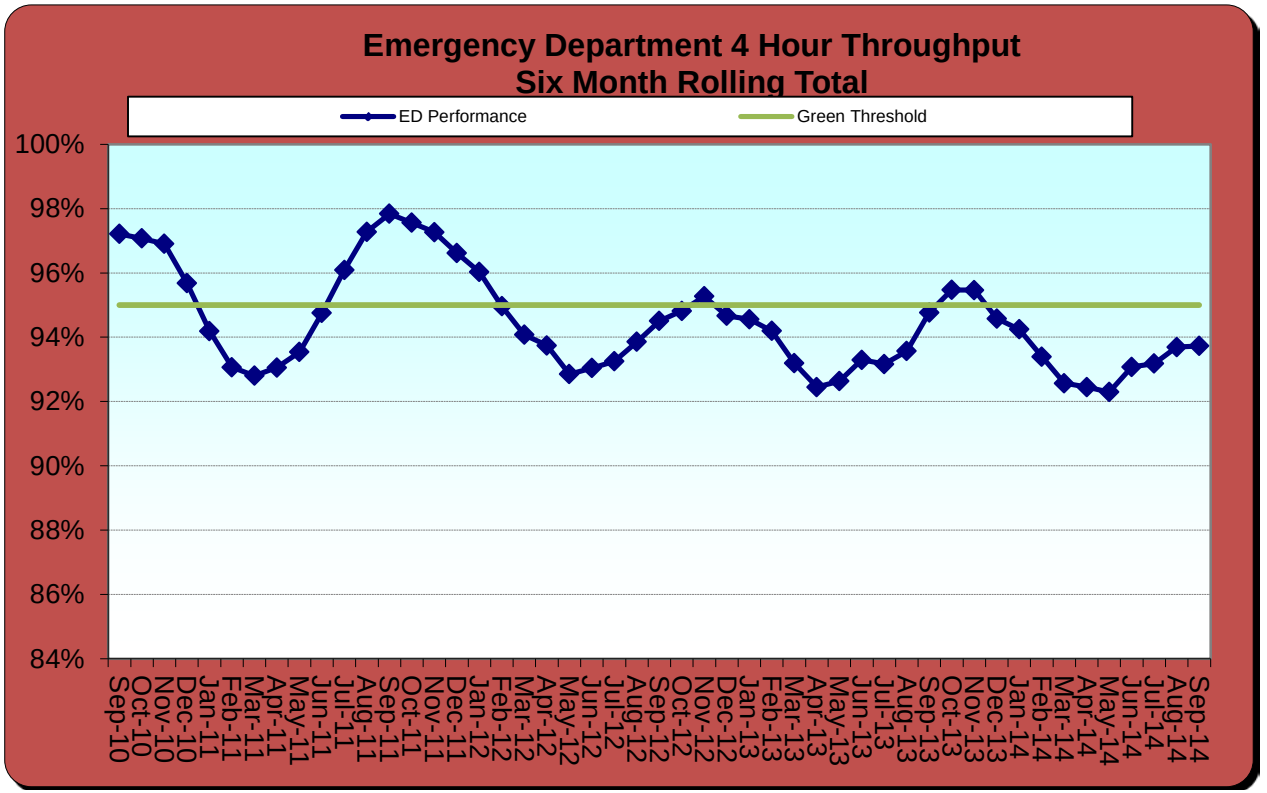
May-14
Jun-14
Jul-14
Aug-14
Sep-14


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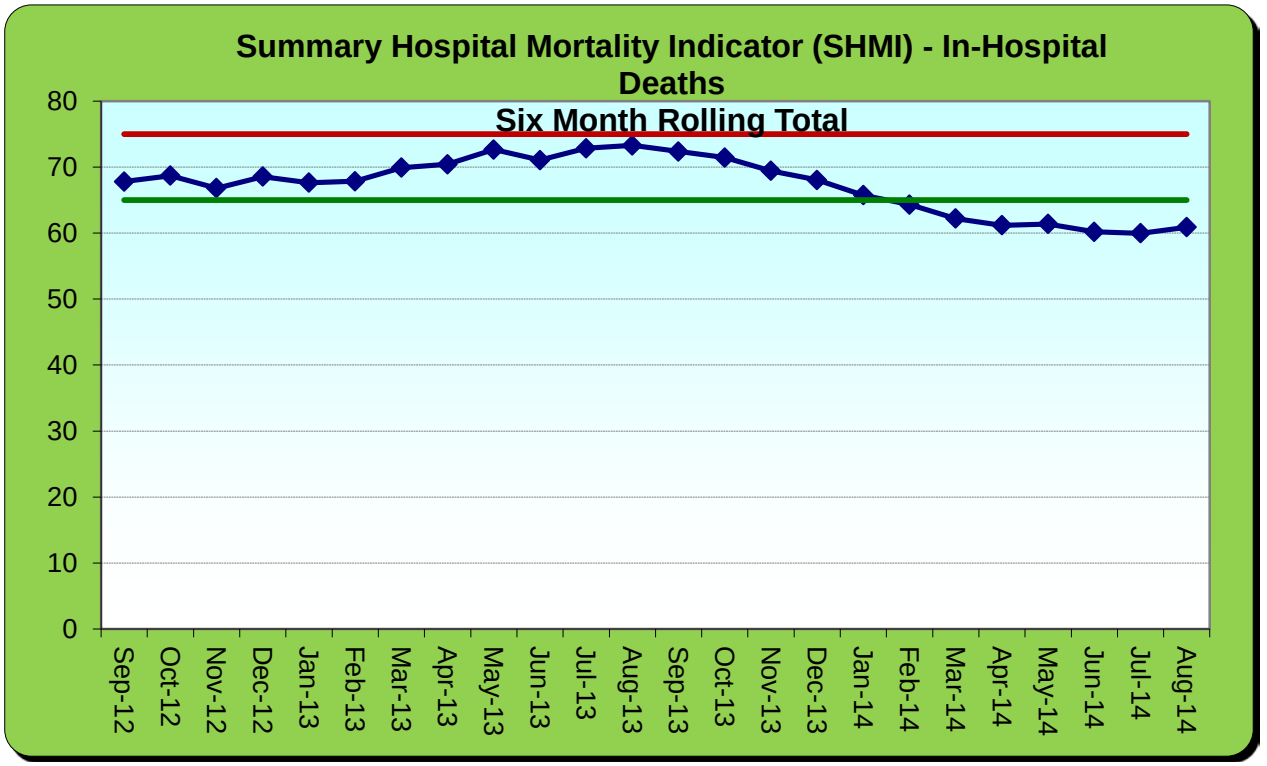
Jun-14
Jul-14
Aug-14
Sep-14


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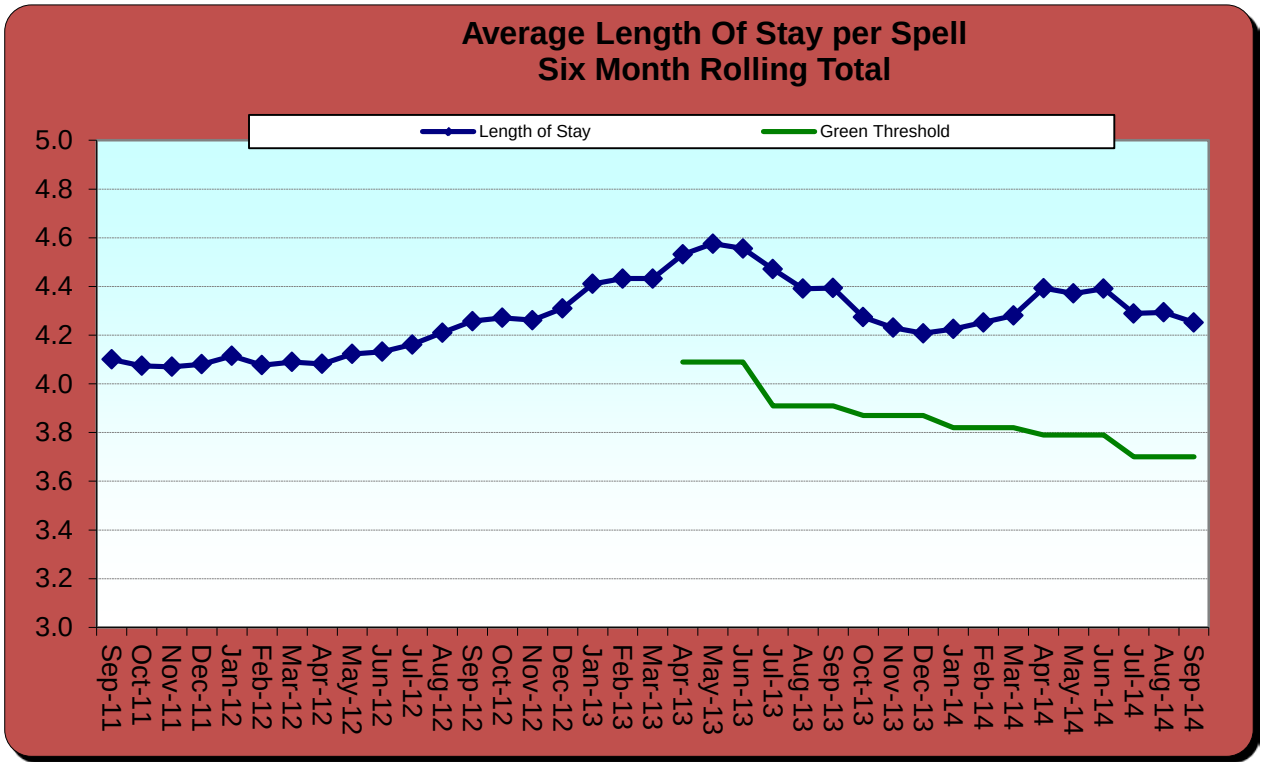
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14


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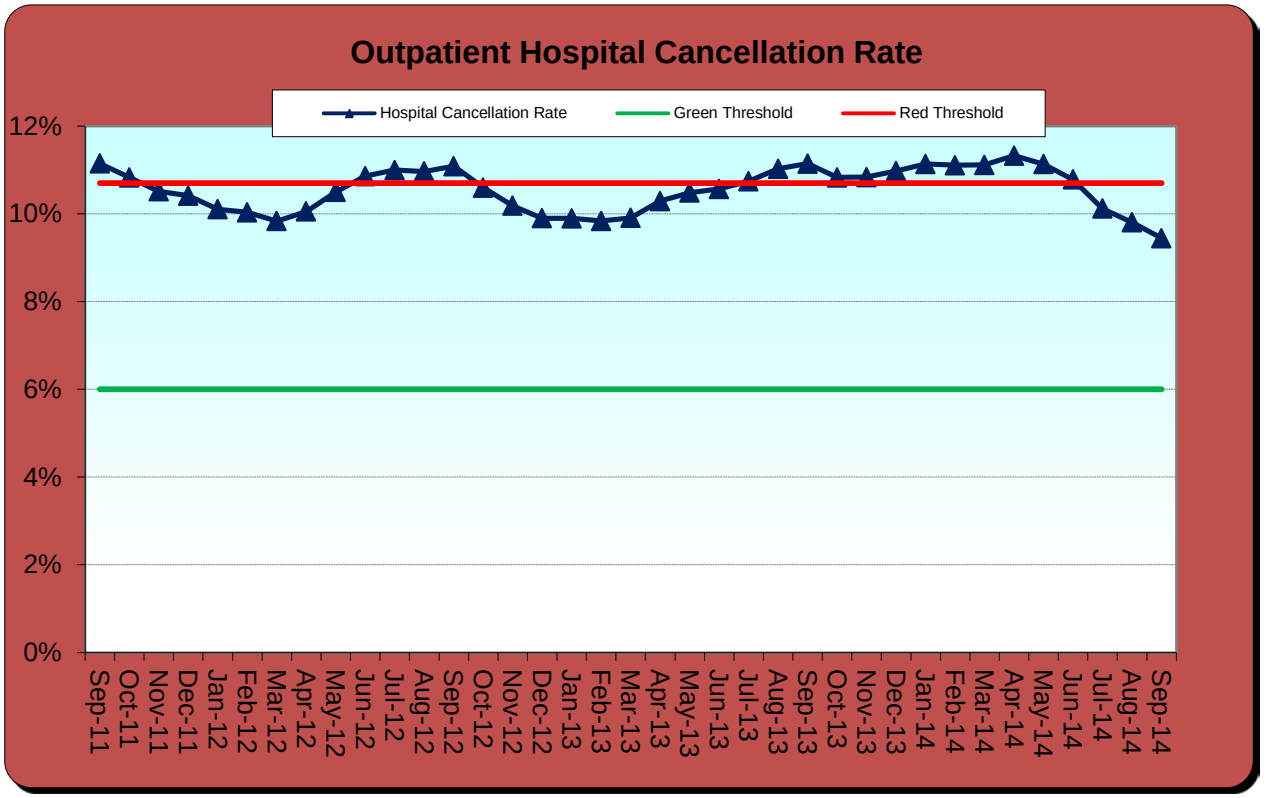
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14


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
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May-14
Jun-14
Jul-14
Aug-14
Sep-14

PERFORMANCE OVERVIEW

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 of this report	
A&E 4-hour standard	In *Access* section of this report	
30-day emergency readmission	In the *Quality* section of this report	
Overall Length of Stay	See Additional Information	Length of Stay remained similar to last month, with a similar proportion of long stay patients being discharged in the month. Consistent with this, the number of long-stay patients in hospital at month-end maintained the amber rating achieved in August, after eight consecutive months of being red rated, prior to that.
Theatre productivity	See Additional Information	Overall theatre utilisation was similar in September to that in August and 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.
Staff sickness	In the *Workforce* section of this report	
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*	

SECTION C – Monitor Risk Assessment Framework

For quarter 2 as a whole 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 this gives the Trust a Service Performance Score of 4.0 against Monitor's Risk Assessment Framework, but in the context of Monitor having already investigated and taken account of the failure of three of these standards, by restoring the Trust to a GREEN rating for quarter 1.

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 Quarter-end*	Notes	Q2 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	5	✗	✗	✗	✓	5	✓	18 cases reported Q1/Q2, 5 were deemed potentially avoidable.	Achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.8%	✓	✓	✓	✓	99.7%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	95.3%	✓	✓	✓	✓	94.2%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.5%	✓	✓	✓	✓	97.8%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	79.6%	✗	✓	✗	✗	76.9%	✗	62-day Screening standard expected to be achieved for the quarter at final validation or through breach reallocation.	Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	90.9%	✓	✓	✓	✗	90.8%	✓		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	87.8%	Achieved each month	Achieved each month	Achieved each month	✓	84.7%	✗	Planned failure, as requested by NHS England.	Not achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	91.4%	Not achieved	Not achieved	Not achieved	✗	89.5%	✗		Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	91.7%	Achieved each month	Achieved each month	Achieved each month	✓	91.0%	✗	Standard failed - but scores for RTT failure capped at 2.0	Not achieved (see notes)
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	96.9%	✓	✓	✓	✓	96.0%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks		93%	96.0%	✓	✓	✓	✓	95.0%	✓		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%	93.7%	✓	✗	✗	✗	92.8%	✗		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 reported figures for July and August, plus draft figures for September. The C diff figures is shown as the cumulative position against the quarter-end target with exclusions agreed with commissioners applied for Q1 and Q2.

4.0
Meets criteria for triggering further investigation (but see notes in Overview section)

QUALITY

1.1 QUALITY TRACKER

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15	Monthly Totals Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Quarterly Totals 13/14	13/14	14/15	14/15
Patient Safety																						
Infections	DA01a	MRSA Cumulative Cases Against National Trajectory	0	1	2	3	1	1	1	1	2	2	1	1	2	3	3	3	1	2	2	3
	DA03	C.Diff Cases Against National Trajectory - Monthly Totals	-	-	38	31	2	3	4	0	2	2	5	4	4	4	6	8	9	4	13	18
	DA03c	C.Diff Cumulative Avoidable Cases Against National Trajectory	40	40	-	5	-	-	-	-	-	-	0	1	1	2	3	5	-	-	1	5
	DA02	MSSA Cases Against Trajectory	25	25	27	16	3	3	3	1	2	2	1	0	3	7	1	4	9	5	4	12
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%	94.3%	95.2%	94.9%	95.2%	95%	95.2%	95.3%	96%	95.5%	94.9%	94.3%	95.3%	90.6%	95.1%	95.2%	95.4%	93.3%
Infection Checklists	DB01	Hand Hygiene Audit Compliance	95%	80%	96.8%	97.2%	96.4%	96.1%	96%	98.3%	98.3%	97.2%	97.6%	96.9%	97.8%	96.8%	96.9%	97.1%	96.2%	97.8%	97.4%	97%
	DB02	Antibiotic Compliance	90%	80%	88%	88.9%	85.9%	86.5%	86.5%	88.6%	90.1%	90.7%	91.8%	88.2%	87.9%	89.6%	86.2%	88.5%	86.2%	89.9%	89.4%	88.2%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	87%	79%	95%	93%	95%	95%	94%	94%	94%	96%	96%	95%	96%	90%	91%	89%	95%	95%	96%	90%
	DC02	Cleanliness Monitoring - Very High Risk Areas	98%	89%	96%	95%	95%	96%	96%	95%	96%	96%	95%	97%	95%	94%	95%	95%	96%	96%	96%	95%
	DC03	Cleanliness Monitoring - High Risk Areas	95%	79%	95%	94%	94%	96%	95%	95%	95%	96%	96%	96%	96%	91%	92%	91%	95%	95%	96%	92%
Serious Incidents	S02	Number of Serious Incidents Reported	-	-	73	42	7	5	6	6	9	5	5	7	5	15	3	7	18	20	17	25
	S02a	Number of Confirmed Serious Incidents	-	-	71	23	7	5	6	6	9	5	5	7	5	6	-	-	18	20	17	6
	S02b	Number of Serious Incidents Still Open	-	-	-	17	-	-	-	-	-	-	-	-	-	7	3	7	-	-	-	17
	S03	Serious Incidents Reported Within 48 Hours	80%	80%	83.6%	88.1%	85.7%	100%	83.3%	100%	88.9%	100%	80%	57.1%	80%	100%	100%	100%	88.9%	95%	70.6%	100%
	S04	Percentage of Serious Incident Investigations Completed Within Timesca	80%	80%	92.4%	82.1%	87.5%	100%	100%	87.5%	75%	100%	100%	50%	83.3%	70%	85.7%	100%	93.8%	89.5%	82.4%	81.8%
Never Events	S01	Total Never Events	0	1	2	2	0	0	1	0	0	0	1	1	0	0	0	0	1	0	2	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	-	-	12090	5039	1064	1052	958	1060	954	986	933	954	1010	1104	1038	-	3074	3000	2897	2142
	S06a	Patient Safety Incidents Per 100 Admissions	-	-	9.24	9	9.09	9.57	9.41	9.43	9.27	9	8.71	8.56	9.07	9.14	9.52	-	9.35	9.23	8.78	9.32
	S07	Number of Patient Safety Incidents - Severe Harm	-	-	44	27	7	3	3	3	7	6	4	6	8	5	4	-	13	16	18	9
Patient Falls	AB01	Falls Per 1,000 Beddays	5.6	5.6	5.68	4.65	5.96	5.42	5.59	6.1	5.67	5.46	5.08	5.18	4.28	4.51	4.59	4.26	5.66	5.74	4.85	4.45
	AB06a	Total Number of Patient Falls Resulting in Harm	24	25	27	16	1	4	2	2	4	2	1	5	2	0	3	5	7	8	8	8
Falls (CQUIN Improvement)	AB07a	Number of Inpatient Falls (CQUIN)	429	429	0	714	0	0	0	0	0	0	129	136	109	116	116	108	0	0	374	340
	AB07b	Inpatient Falls (CQUIN) - Improvement from Baseline	0	0	0	-175	0	0	0	0	0	0	-12	-8	-35	-44	-33	-43	0	0	-55	-120
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.651	0.651	0.656	0.384	0.706	0.526	0.555	0.69	0.417	0.417	0.433	0.343	0.314	0.427	0.396	0.394	0.596	0.51	0.363	0.406
	DE02	Pressure Ulcers - Grade 2	-	-	184	57	17	12	14	17	9	10	11	8	8	10	10	10	43	36	27	30
	DE03	Pressure Ulcers - Grade 3	0	1	13	2	1	1	0	1	1	1	0	1	0	1	0	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
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	96%	95%	98%	98.6%	98%	98.5%	98.2%	98.6%	98.7%	98.5%	98.9%	98.7%	98.1%	98.4%	98.6%	98.9%	98.2%	98.6%	98.6%	98.7%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	90%	93.4%	95%	94.6%	95.1%	97.1%	94.9%	96.6%	94.5%	96.4%	94.3%	94%	95.3%	96.6%	93.2%	95.6%	95.3%	94.9%	95.1%
Nutrition	WB05	Nutrition: Screening Tool Completed	90%	90%	-	92.9%	-	-	-	-	-	-	-	-	-	92.8%	91.8%	94.2%	-	-	-	92.9%
	WB03	Nutrition: Food Chart Review	90%	85%	82.5%	89.9%	83.8%	76.9%	84.1%	91.2%	91.8%	78.2%	94.7%	87.4%	87.7%	89%	89.3%	93.1%	82.1%	87.7%	89.5%	90.4%
Safety	Y01	WHO Surgical Checklist Compliance	100%	99.5%	99.6%	99.6%	99.6%	99.5%	99.7%	99.9%	99.6%	99.6%	99.7%	99.6%	99.4%	99.4%	99.7%	99.6%	99.6%	99.7%	99.6%	99.6%

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15	Monthly Totals Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Quarterly Totals 13/14	13/14	14/15	14/15
Patient Safety																						
Medicines	WA01	Medication Errors Resulting in Harm	1.61%	2%	0.68%	0.72%	0.61%	0.56%	0%	1%	0.54%	0%	1.3%	0%	0.78%	1.09%	0.52%	-	0.41%	0.52%	0.66%	0.8%
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	95%	95%	97.9%	97.7%	99.1%	100%	100%	99.1%	99%	100%	98.6%	100%	95.6%	95.2%	99%	97.8%	99.7%	99.4%	98.1%	97.3%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	85%	75%	92%	94.4%	89.5%	90.8%	83.3%	85%	100%	100%	98.8%	99.1%	90.9%	86.4%	94.7%	98.8%	88.1%	94.1%	96.1%	92.6%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.5%	2%	1.91%	0.96%	2.75%	2.32%	2.6%	1.08%	0.91%	1.66%	1.18%	0.55%	0.38%	1.41%	1.42%	0.69%	2.56%	1.23%	0.68%	1.19%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	95.6%	92.8%	94.1%	96.4%	93.5%	95.8%	95%	95.6%	96.2%	95.2%	95.7%	96.7%	96%	96.7%	96.9%	96.5%	94.7%	95.7%	96.1%	96.7%
	AK04	Safety Thermometer - No New Harms	98.2%	97%	97.2%	98.4%	96.7%	97.4%	97.9%	98.5%	97.8%	97.6%	98.2%	98.4%	98.5%	98.9%	98.7%	98%	97.3%	98%	98.3%	98.5%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	95%	90%	84%	89%	84%	82%	76%	91%	86%	88%	89%	83%	91%	91%	96%	88%	81%	89%	88%	92%
	CA01	Number of Verified Crash Calls from Adult General Wards	92	108	-	29	-	-	-	-	-	-	3	5	5	4	9	3	-	-	13	16
Discharges	TD04	Out of Hours Discharges			9%	8.5%	8.7%	8.8%	8.6%	8.1%	10%	9.8%	9.5%	9%	8.2%	8.6%	7.6%	8.1%	8.7%	9.3%	8.9%	8.1%
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	90%	80%	-	96.4%	-	-	-	-	-	-	-	-	-	-	90%	100%	-	-	-	96.4%
	CS03	Number of CAS Alerts Overdue At Month End	0	0	-	0	-	-	-	-	-	-	-	-	-	-	0	0	-	-	-	0
Clinical Effectiveness																						
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital D	65	75	67.2	60.9	65.4	64.3	64.7	57.5	60.5	60.6	59.3	64.9	57.4	56.2	66.7	-	64.8	59.5	60.7	61.3
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	-	-	94.9	-	-	-	95.1	-	-	-	-	-	-	-	-	-	95.1	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI)	80	90	75.8	66.1	69.8	66.8	78.7	66.2	75.2	73.2	67.6	66.1	64.2	58.3	74.9	-	72	71.3	66	66.4
Learning Disability	AA03	Learning Disability (Adults) - Percentage Adjustments Made	80%	50%	83.9%	88.8%	100%	95%	77.8%	95%	90.5%	92.3%	100%	78.9%	100%	76.2%	82.4%	91.3%	91.7%	92.6%	93.8%	83.6%
Readmissions	C01	Emergency Readmissions Percentage	2.7%	2.7%	2.71%	2.77%	2.7%	2.68%	2.83%	2.89%	2.93%	2.86%	2.71%	2.92%	2.96%	2.48%	2.8%	-	2.73%	2.89%	2.87%	2.63%
Maternity	G04	Percentage of Normal Births	64%	61%	61.7%	62.5%	61.4%	63.9%	62.7%	59.9%	62.6%	61.4%	63.6%	58.9%	62.4%	64.7%	61.4%	63.7%	62.7%	61.3%	61.7%	63.3%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	90%	90%	77.4%	74.7%	90.5%	95.5%	87.8%	55.9%	92.6%	85.7%	88.9%	70%	82.6%	82.1%	71.4%	61.3%	90.5%	76.4%	78.9%	71.3%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	90%	90%	78.8%	95.6%	81%	95.5%	100%	97.1%	100%	100%	94.4%	93.3%	95.7%	100%	96.4%	93.5%	94%	98.9%	94.4%	96.6%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	80%	61.7%	70.9%	71.4%	90.9%	87.8%	52.9%	92.6%	85.7%	83.3%	66.7%	78.3%	82.1%	67.9%	54.8%	84.5%	75.3%	74.6%	67.8%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	50%	55.1%	48.9%	58%	36.1%	66.7%	62.2%	56.8%	63.9%	52.3%	53.6%	36.8%	48.6%	53.7%	-	55.2%	60.8%	47.3%	51.3%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90%	80%	84.2%	88.3%	86%	83.3%	87.5%	86.7%	79.5%	86.1%	90.9%	96.4%	81.6%	97.3%	78%	-	85.8%	84%	89.1%	87.2%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	60%	55.8%	56.2%	73.3%	40%	61.1%	50%	45.5%	50%	60%	30%	57.1%	25%	72.2%	66.7%	63.2%	48.8%	48.3%	61.4%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	90%	80%	67.7%	59.2%	83.4%	74.9%	49.7%	46.6%	45.3%	46.9%	57.1%	52.3%	49%	62.1%	67.5%	66.6%	68.7%	46.3%	52.6%	65.4%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	90%	80%	60.6%	78.4%	59%	57.7%	66.7%	75.5%	78%	66.7%	71.7%	78.3%	59.5%	84.7%	81.7%	87.3%	60.7%	73%	70.3%	84.7%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	90%	80%	65.4%	44.1%	75%	75.9%	61.5%	57.9%	38.5%	52.4%	47.6%	56.5%	22.7%	55.2%	50%	35.9%	70.7%	48.5%	42.4%	44.8%
	AC04	Percentage of Dementia Carers Feeling Supported			-	66%	-	-	-	-	-	-	60%	62.5%	90%	-	-	70%	-	-	69.7%	57.1%
Outliers	J05	Ward Outliers - Beddays	9029	9029	10626	4733	862	759	1043	1277	1169	962	697	951	769	659	749	908	2664	3408	2417	2316

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15	Monthly Totals Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Quarterly Totals 13/14	13/14	14/15	14/15
Patient Experience																						
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	-	-	88	89	89	88	89	89	89	92	90	88	89	-	89	89	90	89
	P01g	Patient Survey - Kindness and Understanding	-	-	-	-	93	93	93	93	91	94	94	94	93	92	93	-	93	93	94	93
Friends and Family Test	P03a	Friends and Family Test Inpatient Coverage	30%	25%	29.6%	37.8%	42.2%	45.2%	37.4%	37.9%	43.8%	46.7%	45.9%	40%	39.5%	35.5%	32.9%	33.1%	41.6%	42.7%	41.8%	33.8%
	P03b	Friends and Family Test ED Coverage	20%	15%	13.3%	20.2%	19.1%	18.6%	11.6%	13.8%	16.4%	26.7%	15.7%	21.4%	19.2%	16.1%	22.7%	26.2%	16.6%	19.2%	18.9%	21.6%
	P04a	Friends and Family Test Score - Inpatients	70	64	75.9	75	76.5	75.7	74.4	75.5	76.5	76.1	78.4	73.3	73.5	72.4	75	76.8	75.6	76	75.2	74.8
	P04b	Friends and Family Test Score - ED	51	42	70.1	70.5	71.6	70.8	66.3	70.3	70.1	68.7	75.8	71.4	69.3	72.4	69.7	67.1	70.1	69.5	71.8	69.4
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.21%	0.25%	0.212%	0.268%	0.192%	0.185%	0.199%	0.214%	0.227%	0.282%	0.238%	0.226%	0.277%	0.282%	0.321%	0.266%	0.192%	0.241%	0.248%	0.288%
	T03a	Complaints Responded To Within Trust Timeframe	95%	85%	76.4%	87.9%	84.9%	82.2%	88.1%	76.1%	92%	88.7%	93.1%	82.5%	83.3%	91.5%	88.3%	88.1%	85%	84.7%	86.3%	89.5%
	T03b	Complaints Responded To Within Divisional Timeframe			71.1%	83%	69.9%	66.7%	57.1%	77.6%	86%	75.5%	82.8%	86%	91.7%	74.6%	83.3%	81.4%	65.6%	79.4%	86.9%	79.5%
	T04a	Complainants Disatisfied with Response			62	35	7	2	6	6	3	5	6	4	11	8	4	2	15	14	21	14
Ward Moves	J06	Average Number of Ward Moves			2.26	2.35	2.34	2.36	2.3	2.37	2.31	2.37	2.34	2.3	2.33	2.34	2.38	2.42	2.34	2.35	2.32	2.38
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.92%	0.92%	1.02%	1.09%	0.65%	0.94%	1.02%	1.18%	1.44%	0.92%	0.98%	0.96%	1.1%	1.35%	0.97%	1.14%	0.85%	1.17%	1.02%	1.16%
	F01a	Number of Last Minute Cancelled Operations	-	-	690	378	40	54	47	70	78	52	54	54	64	84	54	68	141	200	172	206

1.2 SUMMARY

This month we have provided additional information to clarify the reporting of cases of *Clostridium difficile*. There are now two metrics reported. One showing the total number of cases reported nationally, as previously, and a second showing cumulative Trust apportioned potentially avoidable cases, as agreed with commissioners following their monthly reviews. This second metric has a red threshold of the previously established monthly cumulative trajectory, for our nationally determined limit of 40 cases for 2014/15 as a whole.

We continue to have sustained improvements in all our patient experience survey measures and in overall falls and pressure ulcer incidence, and are also making progress against some of the dementia and stroke metrics. However the challenges in meeting the flow performance measures remain, as demonstrated in the dashboard and associated exception reports.

Achieving set threshold (36)	**Thresholds not met or no change on previous month (11)**
- MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – elective - Trust apportioned Clostridium difficile cases against national trajectory - 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 - 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 - Nutritional screening completed - 72 hour Food Chart review - 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	- MRSA screening – emergency - Antibiotic prescribing compliance - Cleanliness monitoring: high risk areas - Cleanliness monitoring: very high risk areas - Percentage adult in-patients who received thrombo-prophylaxis - WHO surgical checklist compliance - NHS Safety thermometer-no new harms - Summary Hospital Mortality Indicator (SHMI) in-hospital deaths - Percentage of normal births - Dementia admissions-assessment completed - Percentage of complaints resolved within agreed timescale

QUALITY

- Reduction in medication errors resulting in moderate or severe harm - NHS Safety thermometer- harm free care - Deteriorating patient- reduction in cardiac arrest calls from adult general ward areas - Central Alerting System (CAS) alerts completed within timescale - Percentage of CAS alerts overdue at month end. - Summary Hospital Mortality Indicator (SHMI) including out of hospital-deaths within 30 days of discharge - Risk Adjusted Mortality (Hospital Standardised Mortality Ratio equivalent) - Learning disability (adults)-percentage adjustments made - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Stroke care: percentage receiving brain imaging within 1 hour - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - 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 (14)	**Quality metrics not rated (11)**
- MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemias against trajectory - Falls resulting in harm - Deteriorating patient- appropriate response to an Early Warning Score of 2 or more. - 30 day emergency re-admissions	**Thresholds to be agreed** - Dementia-carers feeling supported - Out of hours discharges **Metrics for information** - Total number of *Clostridium difficile* cases year to date - Number of serious incidents - Confirmed number of serious incidents

QUALITY

- Fractured neck of femur patients treated with 36 hours - Fractured neck of femur patients achieving Best Practice Tariff - Stroke care: percentage spending 90% + time on a stroke unit - 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	- 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 September the percentage of documented appropriate responses for adult patients with a EWS of 2 or more was 88% 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 September the number of cardiac arrest calls was 3 against the GREEN threshold target of 7. We remain below our cumulative trajectory of 42 by the end of September with 29 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 September there were 43 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. 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.

QUALITY

Performance in September was 33.1% against a target of 25% for inpatients, and 26.2% 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 September was 66.6% against a target of 90%
    2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in September was 87.3% against a target of 90%
    3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in September was 35.9% against a target of 90%

Our survey of carers looking after people with dementia was conducted in September with 50 surveys issued. Ten responses were received and 70% of carers felt supported. Our Band 3 clinical support to the Dementia Project Nurse, when in place, 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 up ↑ from 1 in August to 4 in September.
- Number of cardiac arrest calls from adult general wards down ↓ from 9 in August to 3 in September
- Percentage of stroke patients spending at least 90% of the time on a stroke unit ↓ from 97.3% in August to 78% in September
- Friends and family test coverage in the emergency department up ↑ again from 22.7% in August to 26.2% in September

Exception reports are provided for thirteen RED rated indicators and one amber* rated indicator, fourteen indicators 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 September 2014.

1. MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory
2. MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemias against trajectory
3. Falls resulting in harm
4. Deteriorating patient- appropriate response to an Early Warning Score of 2 or more.
5. 30 day emergency re-admissions
6. Fractured neck of femur patients treated with 36 hours
7. Fractured neck of femur patients achieving Best Practice Tariff
8. Stroke care: percentage spending 90% + time on a stroke unit
9. Dementia admissions-case finding applied
10. Dementia admissions-assessment completed*
11. Dementia admissions-referred on to specialist services
12. Ward outliers bed-days
13. Patient complaints as a proportion of all activity
14. Average number of ward moves
15. 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: Meticillin Sensitive Staphylococcus Aureus (MSSA) cases	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of MSSA cases in patients that have been in hospital for more than 2 days at the point symptoms occurred and the patients was tested. There should be no more than 25 cases in year. This limit has no financial penalties and there is no standard relating to MSSA in Monitor's Risk Assessment Framework.

Performance in the period, including reasons for the exception:

There were four Trust assigned cases of MSSA in September 2014. This is one more than the Trust's limit of three cases for the month.

Recovery plan, including expected date performance will be restored.

Actions to prevent MSSA are similar to those for MRSA, although at present routine, widespread screening for MSSA is not recommended nationally. The number of people who harmlessly carry MSSA (approximately one third) is far greater than MRSA. MSSA screening continues in Cardiac and Renal services.

All cases of MSSA identified in patients that have been in hospital two days or more prior to testing, are investigated by the clinical team with learning shared at the Infection Control Group bi monthly meeting, chaired by the Chief Nurse. There were no common themes or links found regarding the cases in September.

QUALITY

Q2. EXCEPTION REPORT: Falls resulting in harm	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

Performance in the month for falls incidence was 4.26 per 1,000 bed days against the national benchmark of 5.6. There were 108 inpatient falls in September. This means that overall performance was below the green threshold for the seventh month in a row. The degree of harm, based on National Patient Safety Agency guidance, arising from the falls in September was:

Degree of Harm	Jan 14	Feb 14	Mar 14	April 14	May 14	June 14	July 14	August 14	Sept 14
Near Miss	0	0	0	0	0	0	0	0	0
Negligible	120	114	109	88	98	67	80	92	72
Minor	37	18	32	40	33	40	36	21	31
Moderate	0	0	0	0	1	1	0	1	1
Major	2	4	3	1	4		0	2	4
Catastrophic	0	0	0	0	0	1	0	0	0
Total	**159**	**136**	**144**	**129**	**136**	**109**	**116**	**116**	**108**

Divisional Data	Jan 14	Feb 14	Mar 14	April 14	May 14	June 14	July 14	August 14	Sept 14
Diagnostics & Therapies	3	3	3	1	2	2	2	3	1
Medicine	102	93	97	89	64	64	62	72	68
Specialised Services	22	19	15	19	30	21	23	12	10
Surgery Head & Neck	27	19	23	19	33	15	29	24	24
Women's & Children's	4	2	6	1	7	5	0	5	4
Other	1					2			1
Total	**159**	**136**	**144**	**129**	**136**	**109**	**116**	**116**	**108**

QUALITY

Whilst the overall performance this month is below the green threshold, there were four falls resulting in major harm where three patients sustained a fractured hip and 1 patient a subdural bleed. One patient fell and fractured their wrist, which is categorised as moderate harm. All five incidents were un-witnessed, with three occurring overnight. A request for one patient to have one-to-one supervision was not filled. All patients were identified as high risk and had the relevant documentation completed. Root Cause Analyses are underway to determine what actions, if any, could have been taken to prevent the falls, with any lessons learnt to be shared. An early indication suggests that at times, the dignity of patients is given a higher priority than safety. This can be a difficult judgement to make, but a safety briefing is being developed, to alert staff to this issue.

Recovery plan, including expected date performance will be restored:

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 being tested in a number of ward areas. This was discussed at a Falls Network day hosted by U. H. Bristol. 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 Divisions where this is being tested will be monitored at the Trust Falls Group with a report due at the November meeting to review its effectiveness;
- Trust-wide Safety Briefing on preventing falls;
- Ward top 10 tips for reducing falls will be presented at the next Falls Group for approval and Trust-wide distribution.

QUALITY

Q3. EXCEPTION REPORT: Deteriorating Adult Patient-response to an early warning score of 2 or more	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

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

Performance in the period, including reasons for the exception:

Performance in September was 88%. Thirty-six out of 41 patients with an Early Warning Score of two or more had documented evidence of a response consistent with the protocol.

The gaps for five patients occurred on one ward in the Division of Medicine, and three in the Division of Surgery Head & Neck. Each case has been followed-up with the Ward Sister concerned with a full review of the patient's notes.

On investigation, in the vast majority of cases the correct response was enacted, but this was not documented on the Bristol Observations Chart.

Recovery plan, including expected date performance will be restored:

Local action has been taken in all the relevant wards at Safety Briefs and via ward newsletters, to remind staff of the importance of documenting the response enacted.

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. The project has now been implemented in eight wards. There is a plan to implement in all adult general ward areas by the end of March 2015, but the timing of some elements is dependent on ward moves into the new ward block which, if delayed, may result in slippage.

QUALITY

Q4. EXCEPTION REPORT: 30-day emergency readmissions	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

In August there were 302 emergency readmissions within 30 days of discharge, which equates to 2.80% of discharges. This is 0.10% above the target level of readmissions of no more than 2.70%. The rate of readmissions in quarter 2 to date is 2.63%, which is lower than the 2.70% target. However, the Trust continues to review any specialties which are identified through benchmarking reports as having a higher than expected readmission rate, relative to national and clinical peers.

Recovery plan, including expected date performance will be restored:

- Reviews of the causes of any specialties identified as having a high emergency readmission rate, relative to the national average and clinical peer group, to continue to be commissioned by the Quality Intelligence Group. These reviews include the following:
  - Clinical coding review of the readmissions (including an assessment of whether the type of admissions has been correctly classified) that happened during any period for which levels of readmissions were identified as being statistically high;
  - Following any amendments to clinical coding, the revised data to be reviewed to assess whether the specialty is still showing as an outlier from the national average and clinical peer group level, with the corrected data;
  - Where the clinical coding data changes have not addressed the variance, the initiation of a formal clinical review of the readmission cases, to determine what the causes of readmissions were and whether there are any themes, in terms of avoidable reasons for readmission which need to be addressed.

QUALITY

Q5-6. 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:

The standard for treatment within 36 hours was not met for 12 patients out of a total of 31, meaning 61.3% of patients were treated within the standard against a target of 90%. The reasons for the delays were:

- 10 patients breached due to lack of theatre capacity;
- 2 patients breached due to clinical complexities

The combination of these 12 breaches, plus 2 patients not being seen by an ortho-geriatrician within 72 hours, resulted in September's Best Practice Tariff performance being 54.8% against the 90% target.

Recovery plan, including expected date performance will be restored:

Last month the Board received a detailed action plan to address the current performance concerns, and a trajectory for achievement of 90% by Quarter 4 is in place. Specific updates are as follows:

- Prioritisation of fractured Neck of Femur cases: a process is in place and review is ongoing;
- An additional all day operating list every other week from 6th October is now in place;
- Use of winter pressure funding to pilot an increase of weekend operating with 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.

QUALITY

Q7. EXCEPTION REPORT: Stroke Care: Percentage of patients spending at least 90% of their time on a stroke unit.	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

The number of stroke patients discharged in the month who spent 90% of their time on a stroke unit, expressed as a percentage of the total number of stroke patients discharged in the month.

Performance in the period, including reasons for the exception:

The performance for August 2014 was 78% against target of 80%, meaning that we ensured 32 stroke patients out of 41 spent 90% of their time on a stroke unit. The breakdown of the causes of the nine patients not meeting the 90% stay standard are as follows:

- 5 patients were admitted to Medical Assessment Unit before the Acute Stroke Unit
- 1 patient was admitted to Older Persons Assessment Unit before Acute Stroke Unit
- 2 patients had a stroke during their admission (rather than prior to arrival at hospital), resulting in a stroke diagnosis being recorded on their discharge summary, but the Stroke Team not being aware of them through a referral to the unit
- 1 patient had a stroke during admission and was not transferred to the Acute Stroke Unit for 13 days post stroke

The pathway work is now focussing on supporting the direct admission pathway ensuring that patient moves are made to transfer non-stroke patients out of the Acute Stroke Unit, when these patients are on ward 15, and to ensure direct admission for stroke patients.

Recovery plan, including expected date performance will be restored:

- The Standard Operating Procedure for the stroke pathway has been revised and continues to be promoted internally;
- A bed on the Stroke Unit is protected at all times for a stroke patient (except to manage a 12 hour access breach);
- Non-stroke patients on the Stroke Unit are discussed, and a plan agreed for their transfer, as an agenda item at each daily Patient Flow Meeting;
- A pro-active approach to utilising the stroke beds at South Bristol Community Hospital is being undertaken.

QUALITY

Q8-10. 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 Clinical Quality Indicator (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 September for stage 1 was 66.6%, compared with 67.5% in August.

Divisional performance

Medicine 742.7%; Surgery Head & Neck 55.9%; Specialised Services 50%

Stage 2 – Assessment and Investigation – status AMBER

Performance in September for stage 2 was 87.3% against a target of 90%, compared with 81.7% in August.

QUALITY

Divisional performance

Medicine 85.7%; Surgery Head & Neck 100%; Specialised Services 100%

Stage 3 – Referral on to GP – status RED

Performance in September for stage 3 was 35.9% compared with 50% in August.

Divisional performance

Medicine 42.3%; Surgery Head & Neck 0%; Specialised Services 100%

Performance against the CQUIN continues to vary in both stages 1 and 3. It is encouraging to see a continued improvement in stage 2 of the CQUIN. A further breakdown of data has been made available to Divisions, which identifies wards achieving against the CQUIN and those requiring further support. The Project Nurse will focus attention in these areas.

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;

- The start date for the Trust Lead for Dementia has been confirmed as 3rd November 2014;
- Development by IM&T of an electronic system for flagging, recording and monitoring all stages of the FAIR process;
- Band 7 Whole Time Equivalents (WTE) two year secondment / fixed term project post holder is working closely with the admission area teams (Medical, Older Persons, Surgical & Trauma Assessment Units) to ensure the timely screening, assessment and referral on were 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;
- Focus by the Project Nurse on individual wards identified from the September data as requiring further support.

QUALITY

Q11. 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 908 outlier bed-days within the month of September 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 via the Patient Access Team 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;
- There is plan to establish a triage and seated area within the new build Medical Admissions Unit. This will allow medically expected patients to go directly to the Medical Assessment Unit, thus avoiding the Emergency Department. From the triage area the patients can be directed to Medical Admission Unit, Older Persons Assessment Unit, Stroke or Ambulatory Care Unit: there should be less pressure on the Medical Admissions Unit to transfer patients to down-stream inpatient wards outside of specialty, which will help to ensure the right patient gets to the right ward.

QUALITY

Q12. 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 September 2014, complaints received represented 0.27% of clinical activity (approximately one in every 375 patient episodes of care). This is an improvement on the 0.32% reported in August, although the actual number of complaints received remained the same, at 170. Eighty-six of the complaints received in September are being progressed through formal resolution. The share of complaints received by the Trust's Divisions remained broadly consistent with the previous month as shown below:

Division	Total Complaints Received In September 2014	Percentage of Patient Activity	Areas With Highest Number Of Complaints In September 2014
Diagnostics & Therapies	10 (6 in August)	Not recorded for this Division	No specific trends noted
Surgery, Head & Neck	63 (70 in August)	0.23%	Trauma & Orthopaedics x 12 Ear Nose & Throat x 11 Bristol Dental Hospital x 8
Medicine	29 (27 in August)	0.22%	Emergency Department x 11
Women & Children	33 (29 in August) Bristol Children's Hospital - 22 St Michael's Hospital - 11	0.22%	Children's Hospital Paediatric Orthopaedics x 7
Specialised Services	29 (28 in August) Bristol Heart Institute - 15 Bristol Haematology & Oncology Centre - 13 Homeopathic Hospital - 1	0.36%	Bristol Heart Institute Outpatients x 8 Chemo Day Unit/Outpatients x 6 Ward D603 (previously Ward 61) - 5

In the Division of Surgery Head & Neck, there was a decrease in complaints received by the Bristol Dental Hospital, with 8 complaints in September

compared to 12 in August. There were, however, increases in the number of complaints received by adult Ear, Nose & Throat Outpatients, with 11 complaints (compared with 7 in August) and 12 complaints received by Trauma & Orthopaedics (compared with 7 in August).

In the Division of Medicine, 11 complaints related to the Emergency Department in September, compared with 6 in August. No other discernible changes were noted.

In the Division of Women's & Children's Services, 11 complaints were received for St Michael's Hospital (5 in August) and 22 for Bristol Royal Hospital for Children (24 in August). Nine of the complaints received by the Children's Hospital were about Paediatric Outpatient Departments (compared with 10 in August) and 7 of these were for Paediatric Orthopaedics.

In the Division of Specialised Services, 15 complaints were received for the Bristol Heart Institute (a slight decrease on the 19 received in August) and 13 for Bristol Haematology & Oncology Centre (compared with 8 in August). Eight of the complaints received by the Bristol Heart Institute were for the Outpatients Department, 6 of the complaints relate to the Chemotherapy Day Unit and 5 complaints relate to Ward D603 (previously Ward 61).

This is the fourth consecutive month when the Trust has received in excess of 160 complaints; twelve months ago, the typical monthly volume of complaints received was 100 to120. The recent increase in complaints received appears to be a statistical step change. Further analysis will be provided in the Quarter 2 complaints report, which is due to be received by the Board in December; potential causes include improvements in the visibility of the complaints service (team location, Trust-wide posters, leaflets, staff training, etc).

Recovery plan, including expected date performance will be restored:

August and September monthly 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

Q13. 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), 2.20 (Quarter 2), 2.09 (Quarter 3) and 1.97 (Quarter 4).

Performance in the period, including reasons for the exception:

In the month of September 2014 there was an average of 2.42 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 inpatient 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;
- A triage area in the new Medical Assessment Unit to facilitate decision making re: directing the patient to the right ward for their care.

1.6 SUPPORTING INFORMATION

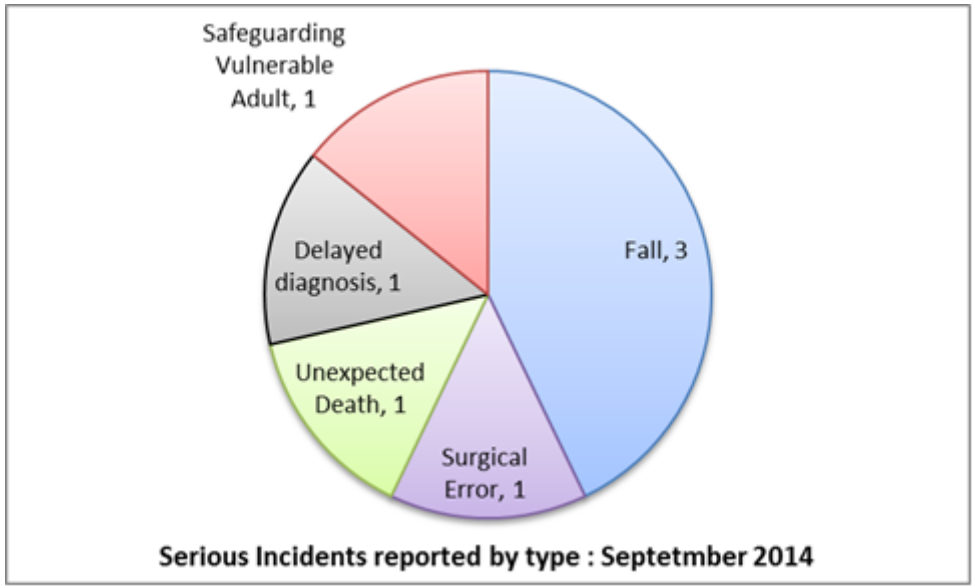
1.6.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the **Division of Diagnostics & Therapies:**

- The Division is progressing CQUINs target delivery for 2014/15:
    - To undertake a quarterly medicines management audit of re-attendance rates related to safe medicines use comprising a detailed review of at least 50 patients per quarter. Fifty-seven and 62 patients have been reviewed in Q1 and Q2 respectively, which has resulted in beneficial learning, and the likelihood of 100% CQUIN achievement;
    - To achieve perinatal pathology reporting within 42 calendar days from the examination to the final reporting in 70% of cases, and 90% of all perinatal autopsies should be issued within 56 days. Currently at 70% confidence of delivery;
    - Weight Management Support In Maternity For Obese Ladies - This involves the weight management service and midwives working collaboratively to improve referral rates of obese (Body Mass Index – BMI - of 30 kg/m^2 or more) pregnant ladies to the specialist weight management service for personalised advice on how to maintain a healthy weight in pregnancy
- Our Divisional Quality Group is continuing post the Care Quality Commission (CQC) visit, to continue focussed improvement work on hot spot areas identified via CQC self- assessment process;
- The pharmacy Production Unit and Parenteral Services Unit were externally audited in the last quarter and were categorised as 'low risk' (the best possible categorisation), therefore providing assurance of safe patient care;
- The measurement of omitted doses of critical medicines indicates ongoing improvement with the year-to-date percentage in 2014/15 being below 1%;
- The first joint pre-registration pharmacy placement between hospital, community pharmacy and a GP practice has been agreed, to be hosted by U. H. Bristol and was mentioned by Earl Howe in a national ministerial speech;
- The transfer of the paediatric outpatient pharmacy to Boots has been successfully implemented to date, adding to the outpatient pharmacy services already provided to our other hospitals;
- The Radiotherapy Physics team were recently awarded research funding of c. £800,000 from the National Institute for Health Research as part of their i4i (Invention for Innovation) programme. This project aims to measure the radiation coming out of a treatment machine while the patient is being treated and present the operator with information on how well this matches the planned dose;
- Successful audiology database merge between UH Bristol and Southmead, including outreach clinics, to ensure fully integrated service for patients with their electronic information accessible for clinical care;
- Radiology Departments have developed safer care standards detailing turnaround times for diagnostic tests to support wards with their patient care and length of stay reductions.

1.6.2 SERIOUS INCIDENT THEMES

There were seven serious incidents reported in September as shown below:



Further details are provided in the table below:

Date of Incident	SI Number	Reported within 48 hours	Status	Incident Details	Initial assessment of harm	Investigation
05/09/2014	2014 29071	Yes	Open	Fall resulting in fracture.	Major	Investigation underway
06/09/2014	2014 29291	Yes	Open	Child died following cardiac arrest in the Emergency Department; the child had attended the department earlier in the day.	Not currently able to state whether death was avoidable or not.	Investigation underway

QUALITY

Date of Incident	SI Number	Reported within 48 hours	Status	Incident Details	Initial assessment of harm	Investigation
04/08/2014	2014 29490	Yes	Open	24 hour delay in diagnosing and starting treatment for sepsis.	Not currently able to state whether death was avoidable or not.	Investigation underway
15/09/2014	2014 29906	Yes	Open	Patient fell and sustained a subdural haematoma.	Major	Investigation underway
14/09/2014	2014 29919	Yes	Open	Surgical error: intentionally retained swabs, not subsequently removed at a later date.	Moderate	Investigation underway
04/09/2014	2014 29925	Yes	Open	Safeguarding.	Minor	Investigation underway
24/09/2014	2014 31187	Yes	Open	Fall resulting in fracture.	Major	Investigation underway

WORKFORCE

2.1 SUMMARY

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

 **Achieving**	 **Underachieving**	 **Failing**
	- Workforce expenditure - compared with budget	- Workforce numbers - compared with budgeted establishment - Bank and agency usage - compared with target - Sickness absence – 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 Key Performance Indicator (KPI), an exception report is provided for each of the RED-rated indicators, which in September 2014 were as follows:

- Workforce numbers – compared with budgeted establishment
- Bank and agency usage – compared with target
- Sickness – 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.

Thresholds for the workforce KPIs were determined on the basis of previous years' performance and through benchmarking with other comparable trusts. Some ambition was built into the KPIs thresholds 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 to June 2014, the intense focus on our workforce agenda continues. A Mid-Year review of our KPIs has been undertaken. Indications of expected out-turn are included here, and a more detailed assessment will be provided in the quarterly report.

WORKFORCE

W1. 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) were 1.3% above budgeted FTE, a reduction of 0.4% compared with August 2014. This reduction is mirrored in the variance in pay spend, which was amber rated at 0.9% above budgeted establishment compared with 1.3% last month.

	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates and Facilities)	Facilities & Estates
September 2014	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE
Actual Employed	7342.2	901.3	1014.4	794.0	1626.6	1671.9	638.6	695.5
Bank and Agency	493.3	17.0	149.7	62.7	85.3	73.8	39.0	65.8
Total Workforce Numbers	7835.5	918.3	1164.1	856.7	1711.9	1745.7	677.6	761.2
Budgeted Numbers	7733.4	926.5	1099.4	808.7	1696.8	1737.6	691.6	772.8
variance target +/-	(102.07)	8.2	(64.7)	(48.0)	(15.1)	(8.1)	13.9	(11.6)
	1.3%	-0.9%	5.9%	5.9%	0.9%	0.5%	-2.0%	-1.5%

Key variances are as follows:

- Medicine - Workforce numbers were over budget by 5.9% (64.7 FTE) compared with 6.7% last month;
- Specialised Services - Workforce numbers were over budget by 5.9% (48.0 FTE) compared with 5.2% last month.

Recovery plan, including progress and expected date performance will be restored: Work to target excess bank and agency usage is described in W2 below.

WORKFORCE

W2. 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 a reduction in the proportion of temporary staffing utilised. During September, temporary staffing comprised 6.3% of total staffing numbers (FTE), compared with 7.3% for 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 September, compared with the average for the year of 1.2%.

However, the cost of temporary staffing as a proportion of the pay budget was higher this month, accounting for 6.4% of spend, compared with 6.1% last month. This compares favourably with the percentages reported at North Bristol Trust, (12.8% in August), and Weston, (9.9% in July). The increased percentage at UH Bristol this month was due to the greater proportion and increased unit cost of agency, as a result of more non-framework agencies being used. Agency costs showed the sharpest increase in Specialised Services and Women's & Children's Divisions, although in the case of the latter, August was artificially low due to a backdated correction.

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

- Workload and clinical needs, extra capacity and administrative workload – this increased to 31.5% of overall usage, compared with 31.0% last month, with ongoing high usage in Specialised Services to support the required staffing levels in the Bone Marrow Transplant Service and typing backlogs driving administrative and clerical usage in Women's & Children's;
- Cover for vacancies – this increased to 31.5% from 27.0% - there was an increase of 28% in usage for this reason in Specialised Services particularly in Coronary Intensive Care Unit, and a specific temporary issue in Gynaecology in Women's & Children's resulting from an unusually high number of leavers;
- Cover for sickness absence – this reduced to 14.5% compared with 14.8% last month, with reductions in usage for this reason for every division except Trust Services;
- Nursing assistant one-to-one care – this reduced this month, from 7.3% to 5.8% of usage.

In addition, there were new starters undergoing orientation in all bed holding Divisions, with 34 Nursing and Midwifery registered nurses starting this month, compared with a monthly average of 20 over the previous three months.

The overview by Division separates bank and agency usage, in recognition of the greater need to drive down agency usage due to the high premium paid, and also to illustrate the comparative position last year.

WORKFORCE

Bank (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
September 2013	291.3	10.6	95.4	31.3	54.2	49.6	22.5	27.8
Actual September 2014	**384.9**	**11.3**	**115.1**	**43.4**	**72.3**	**59.4**	**28.5**	**54.8**
Target	252.9	11.1	68.0	30.5	57.4	42.9	28.0	14.9

Agency (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
September 2013	111.8	5.7	43.5	14.5	21.8	21.0	8.8	2.2
Actual September 2014	**108.4**	**5.7**	**34.6**	**19.4**	**12.9**	**14.4**	**10.5**	**10.9**
Target	48.3	3.2	10.7	5.0	8.6	6.4	8.8	5.5

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

The action plan to target excess bank and agency usage includes action on recruitment, retention and sickness absence, together with the following:

Improved rostering:

- Rostering KPIs have been set and guidance recently published by the Corporate Nursing team, which include rostering 8 weeks ahead and booking annual leave 12 months in advance. Requests for bank staff are often received less than two days prior to the shift even for vacancy and long term sick cover, increasing the chances of needing to resort to agency usage;
- BRI ward moves for Surgery Head & Neck have been rostered well in advance to accommodate annual leave of newly formed ward teams.

Improved use of bank:

There is a longer term plan to reduce premium agency usage by improving the availability of bank staff through the following measures:

- Improved marketing to recruit staff to the bank for both administrative and clerical and nursing and midwifery staff, including re-publicising the option for payment at overtime rates, where appropriate, to increase the attractiveness of bank work;
- Continuing to develop Information Technology solutions by exploring options for staff to view and offer to work shifts by text.

WORKFORCE

Target usage due to workload, clinical need and enhanced observation

- Revise “reasons for booking” options for staff booking shifts to improve the understanding of issues;
- Further strengthen authorisation processes to ensure the reason is explicit;
- Ensure the “Enhanced Observation” policy is implemented.

WORKFORCE

W3. EXCEPTION REPORT: Sickness compliance	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured:

Sickness absence figures are shown as percentage of available FTE (full time equivalent) absent.

Performance in the period, including reasons for the exception:

Sickness absence has increased to 4.0% in September, compared to 3.6% in August 2014, and 3.9% in September 2013. This is 0.6 percentage points above the monthly target of 3.4%. Monthly targets contribute to an overall target for 2014/15 of 3.5%. Benchmarking data for 2013/14 shows that UH Bristol levels compare favourably with those of similar Trusts. UH Bristol sickness absence was 4% for 2013/14 compared with 4.1% for benchmarked counterparts (*Iview* data) and 4.4% (Health Education South West) as an average of all health organisations in the South West.

Detail by Division is provided in the following table:

	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Absence September 2013	3.9%	2.3%	4.4%	4.0%	3.8%	4.0%	3.0%	6.0%
Target September 2014	3.4%	1.9%	3.6%	3.7%	3.5%	3.4%	2.6%	5.1%
Absence September 2014	**4.0%**	**2.9%**	**5.7%**	**4.1%**	**3.3%**	**3.2%**	**3.2%**	**6.8%**
Cumulative absence September 2014	3.8%	2.3%	4.5%	3.7%	3.7%	3.5%	2.9%	6.4%
	0.6%	1.0%	2.1%	0.4%	-0.2%	-0.2%	0.6%	1.7%

The biggest increase compared with last month has been in the Division of Medicine, where sickness absence has increased from 4.1% last month to 5.7%. This contrasts with Surgery Head & Neck and Women's & Children's Divisions, where sickness absence has reduced by 0.2% points. The main reason for the Trust-wide increase is a 41% increase in absence related to coughs, colds and flu, which is part of a seasonal fluctuation, although somewhat earlier than in 2013 when the increase occurred during October. There was also a 16.5% increase in gastro-intestinal related absence this month, although stress, anxiety and depression continues to be the leading cause of absence. The top five reasons for absence are included in the

supporting information, see section 2.3.1.

Progress against recovery plan

Recognising we have a cumulative year to date absence rate of 3.8% compared with a target of 3.4%, it is unlikely that the KPI of 3.5% will be achieved by for March 2015. Work with Divisions on trajectories indicates an anticipated out turn of 3.8%, compared to 4.0% for 2013/14. Progress on the Trust-wide sickness absence management action plan continues and recent actions include the following:

Stress, Anxiety and Depression

- 36 staff have completed all 5 of the "Lighten Up" sessions, which finish on 12th November;
- There has been a slight increase in demand in the last two months for one-to-one counselling which is at full capacity with 83 staff receiving counselling and 19 on the waiting list;
- A an initial report has been received in respect of the Employee Assistance Programme in Women's & Children's Division, with a full evaluation anticipated in January 2015. Since the 1st May, there have been 35 contacts made for a wide range of personal issues, including emotional, physical and relationship and family. Thirteen work related issues have been presented during this period. Women's & Children's Division was one of only two Divisions to achieve their sickness absence target this month.

Musculo-skeletal and back problems

- A range of activities are planned for back care week which takes place in October, including workplace workouts, expert advice, resources and information. This is aimed at preventing back related absence, which is one of the top five reasons for absence.

Flu - Influenza

- The 2014/15 flu vaccination campaign has been initiated, 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. The impact of year-on-year vaccination rates on cold and flu related absence is being tracked and will be included in the next quarterly report.

Progress on division-specific initiatives is described below.

- Medicine: a centralised hotline was introduced in June as a three-month pilot, to target weekend sickness. A full report to Senior Leadership Team is due later in October, and will be included in the next quarterly report;
  There is focused work to tackle stress related absence, which increased by 25% this month in the Division, including the following:
  - All departments are required to complete the Health and Safety Executive Stress Questionnaire and action plans;
  - Referral to Occupational Health will be made as soon as stress related absence is identified;
  - Work with wards affected by the BRI Redevelopment including Stress Risk Assessments.
- Facilities & Estates: the Division continues to implement their action plan, including provision of monthly absence data with costs for managers

and implementation of recommendations from the Divisional Return to Work audit to ensure the Trust Policy is being followed.

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 was a reduction from 5.6% to 5.1% in vacancies this month, which is marginally above the KPI threshold of 5%. 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
September 2013	4.5%	2.3%	6.4%	5.5%	7.7%	5.7%	6.0%	6.8%
Actual September 2014	5.6%	1.7%	8.4%	2.3%	5.7%	5.3%	7.0%	9.6%
FTE vacancy September 2014	391.2	25.2	85.1	14.8	70.2	65.8	52.9	77.4

Vacancies reduced in all four of the bed-holding Divisions, although they increased in Facilities and Estates.

- Vacancies in Facilities & Estates increased to 10% this month, compared with 9.6 % last month, due to an increase in budgeted establishment;
- Nursing & Midwifery vacancies Trust-wide reduced from 8.0% to 6.3% this month. Rates are highest in the Division of Medicine which increased from 11% to 11.5%;
- There are also "hot spots" of vacancies which may not be indicated in the overall data, including Coronary Intensive Care Unit, Paediatric Intensive Care Unit, Gynaecology, Medicine Wards, and key consultant posts in Diagnostics & Therapies and Specialised Services.

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

Recruitment progress this month is summarised below in respect of the two staff groups with the highest vacancy levels:

Ancillary (Cleaning, Catering and Portering) Recruitment

There were 10 new starters in September. Domestic Assistant vacancies, including for the BRI Redevelopment, currently stand at 77 FTE. Two open

days were held to recruit to the BRI Redevelopment, with offers made on 25 of these posts, and further interviews planned for October.

Nurse Recruitment

Highlights are as follows:

- 67 applications have been received in response to the generic nursing campaign, of which there have been 33 shortlisted and 26 conditional offers made with more interviews pending;
- 20 newly qualified nurses came through the assessment centre. All of these candidates have been given verbal offers;
- 5 conditional offers were made at the Royal College of Nursing Job Fair in London. Unfortunately, 4 of these have subsequently withdrawn;
- The return to practice advert has resulted in 18 applications, of these 6 were shortlisted with 2 proceeding to final offer stage;
- A total of 42 conditional offers have been made to Nursing Assistants through the Assessment Centres run in September and October.

A “deep dive” was held by the Senior Leadership Team on 1st October and a range of actions was supported, including:

- Focussed effort on reducing the time taken to recruit, supported by procurement of a recruitment management system;
- Divisions will identify key recruitment leads locally to support the co-ordination of divisional recruitment activity and on-boarding of candidates;
- Improved resourcing of the Recruitment team;
- Improved marketing of UH Bristol – better targeting within the national labour market.

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 (FTE) permanent employees who have left, as a percentage of the 12 month average total (FTE) 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 13.3% in September, compared with 12.9% 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
Cumulative Rolling Turnover September 2013	11.6%	9.5%	13.0%	10.6%	13.5%	11.6%	10.9%	10.8%
Actual Cumulative Rolling Turnover September 2014	13.3%	10.3%	15.9%	16.5%	14.4%	10.2%	13.0%	14.9%
Target	10.5%	8.9%	11.7%	11.3%	10.5%	9.7%	10.8%	10.9%

Specialised Services and Medicine had the highest rates of turnover, mainly amongst nursing staff, for a range of reasons including relocation and work life balance, and for nursing assistants in Medicine Division, the main reason given was promotion. There were 94 FTE (112 headcount) leavers in September 2014 compared with 75.3 FTE (96 headcount) in September2013, an increase of nearly 25%.

Reasons for exceeding target include:

- Nursing Assistants generally have the highest turnover, particularly during August and September as they leave to go to university for nurse, medical or other health professional training, but turnover rate has reached exceptional levels of 22.5% this month;
- For other staff groups, including Facilities & Estates, there were no particularly significant reasons emerging, although overall, relocation continues to account for the largest proportion of leavers (26 in September compared with 33 in August);
- Major change has previously been associated with turnover, and this is reflected on the BRI Redevelopment project risk register and there appears to have been a general increase in turnover in wards affected by the changes;
- Retirements have continued to reduce, comprising only 1.0% of leaver FTE during September, compared to 4.8% August.

WORKFORCE

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

Response rates for exit questionnaires and interviews have typically been about 20%. A project group has been established to map the process for gathering exit information to increase the response rates. It is intended that as soon as an employee hands in his/her resignation, the process will be as follows:

- The manager will have an informal discussion with the individual about why they are leaving and explore options to address these issues;
- If there are no options for rescinding the resignation, the manager initiates a formal leavers process including an exit interview with the line manager or HR representative;
- The line manager will complete a web-based exit questionnaire (similar to the existing form) during the exit interview with the individual;
- The results will be collated by Employee Services.

Termination of contract forms also provide an important source of information, and the completeness of data has been improved this month by the removal of the "don't know" option in respect of the destination of leavers and reasons for leaving.

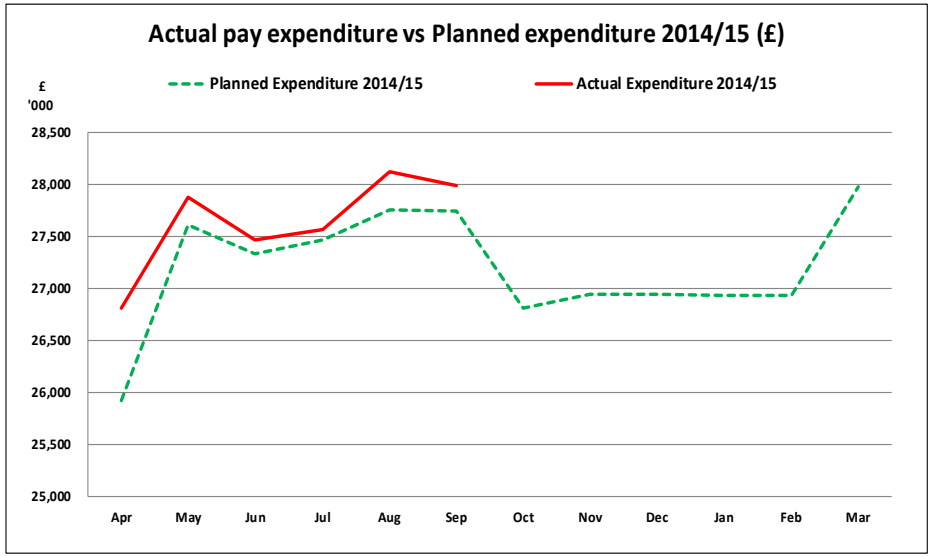
There are already extensive programmes of work in place as part of the staff engagement programme which are anticipated to impact on turnover, including actions to tackle bullying and harassment including an advice line, divisional engagement activities, for example, listening events, actions to tackle stress at work including stress audits.

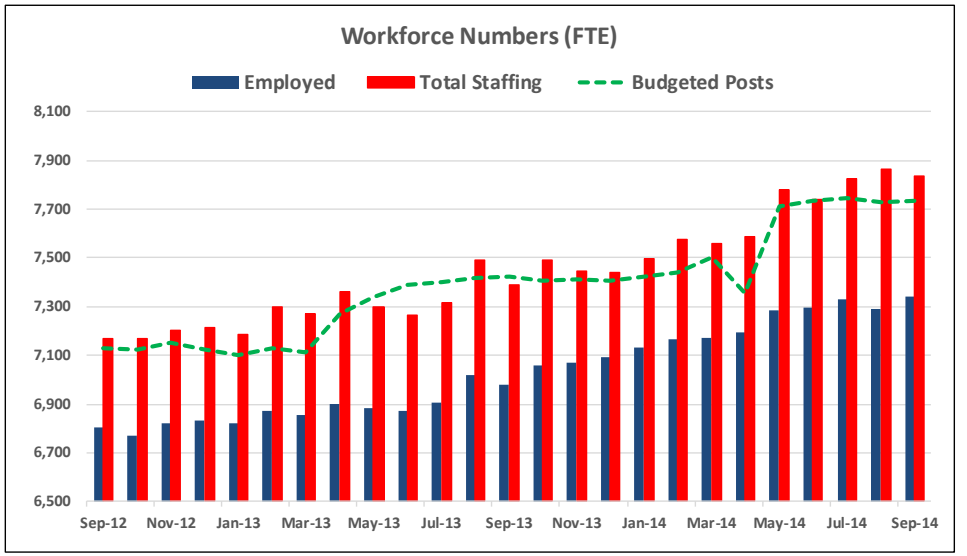
However, despite the positive work underway, the detailed work to project numbers of leavers suggests that the out turn is unlikely to be below circa 13.0% by March 2015. This is due in part to the way that turnover is measured; UH Bristol, in line with other trusts, reports turnover rates as a rolling 12-month indicator, which means that the high levels in the period July to September will contribute towards the out turn figure. Work with Divisional HR Business Partners is underway to develop trajectories, based on anticipated numbers of leavers, as part of the mid-year review.

2.3 SUPPORTING INFORMATION

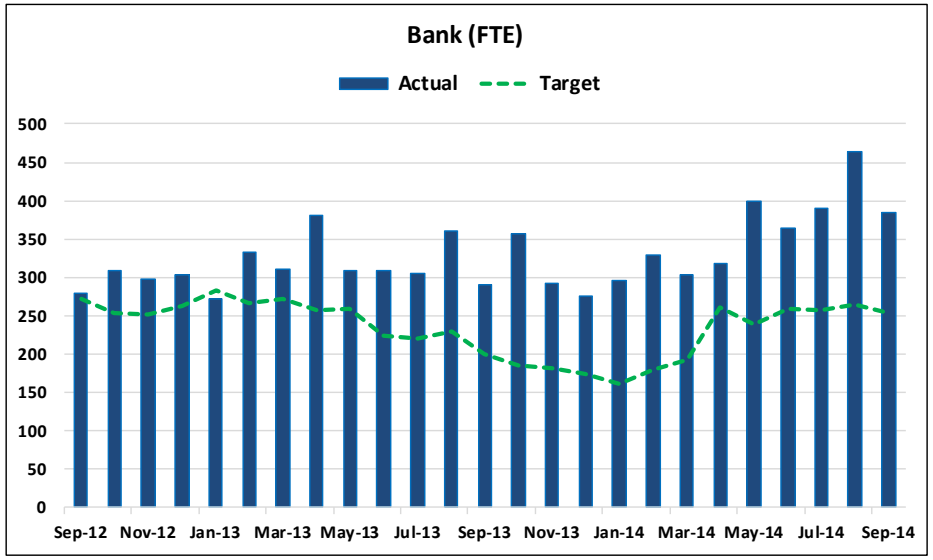
2.3.1 Performance against key workforce standards

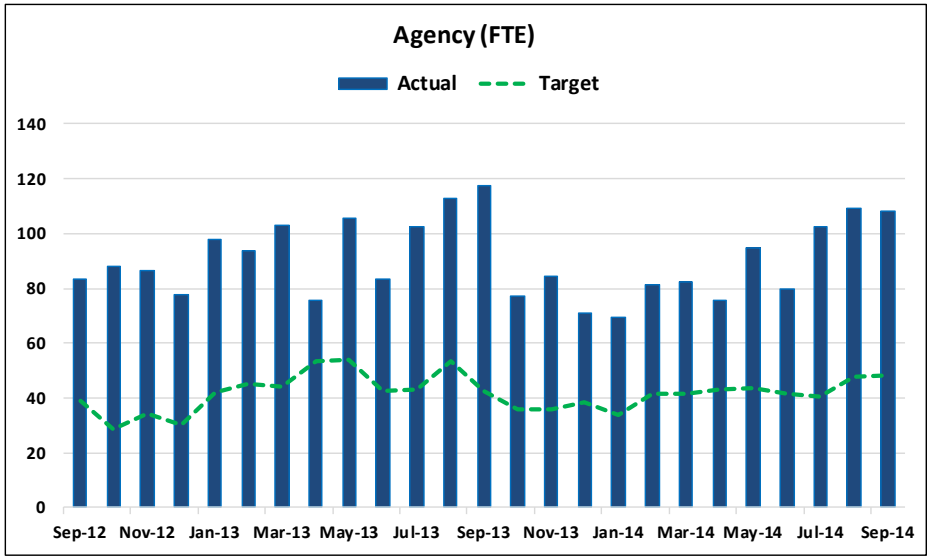
This section provides an outline of the Trust's performance against workforce indicators for workforce expenditure, workforce numbers, and bank and agency usage, with an additional chart to show how the variance against target for agency usage has reduced. There are also graphs to show nursing agency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

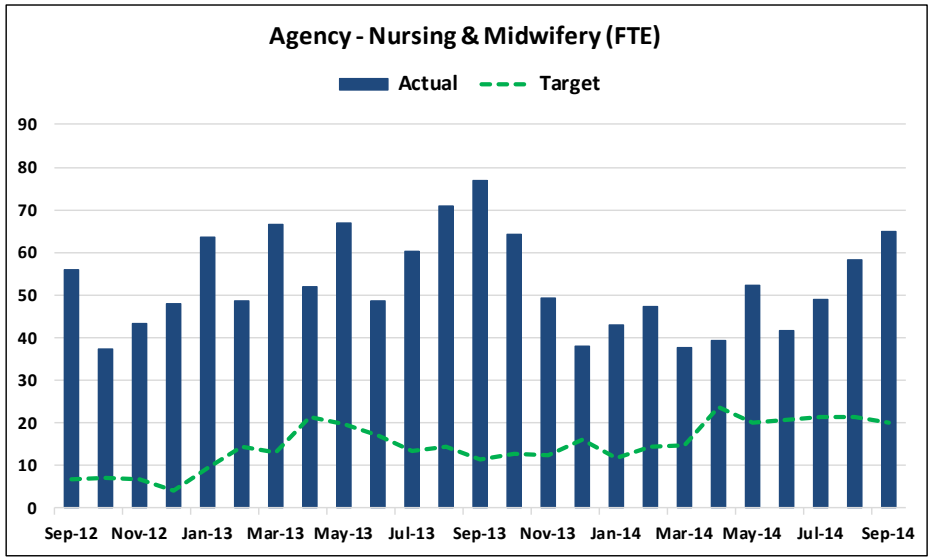


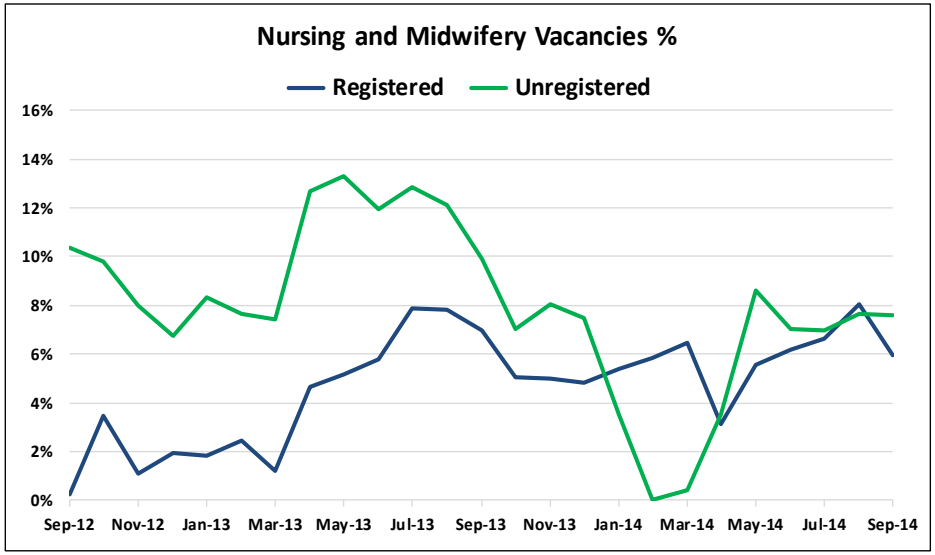


WORKFORCE

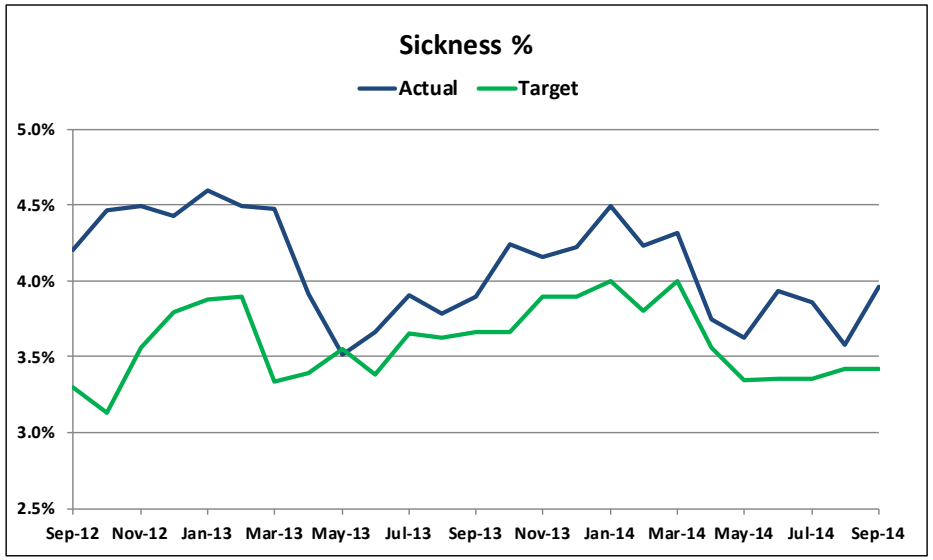

Bank (FTE)
Actual
Target
500
450
400
350
300
250
200
150
100
50
0
Sep-12 Nov-12 Jan-13 Mar-13 May-13 Jul-13 Sep-13 Nov-13 Jan-14 Mar-14 May-14 Jul-14 Sep-14

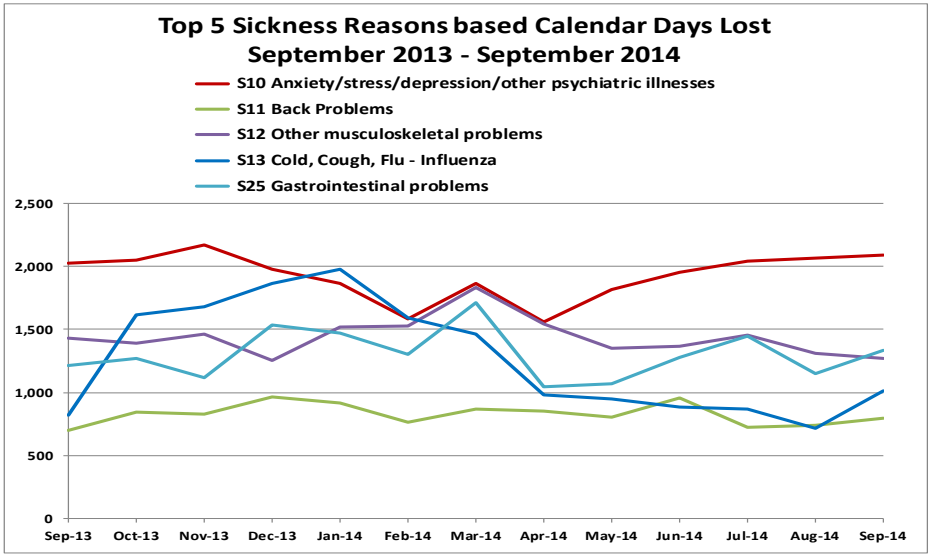

Agency (FTE)
Actual
Target
140
120
100
80
60
40
20
0
Sep-12 Nov-12 Jan-13 Mar-13 May-13 Jul-13 Sep-13 Nov-13 Jan-14 Mar-14 May-14 Jul-14 Sep-14

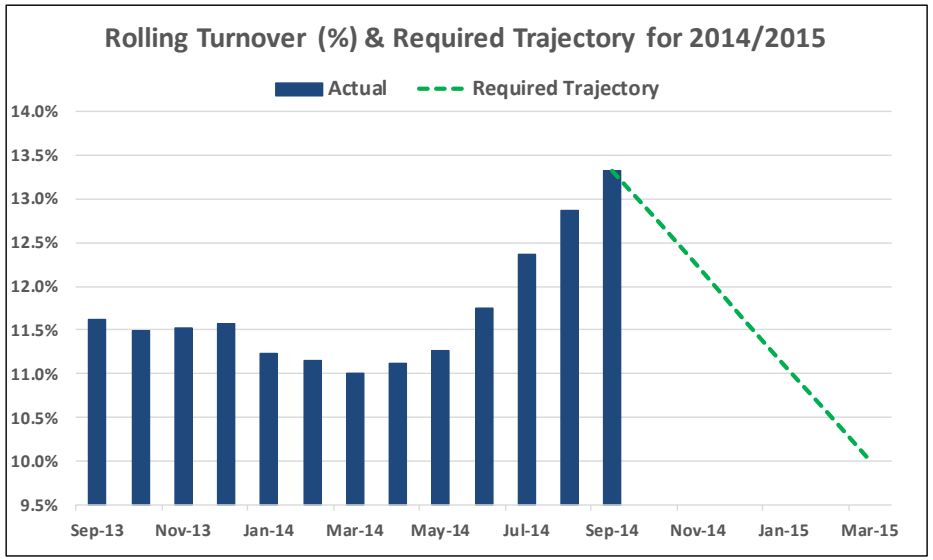

Agency - Nursing & Midwifery (FTE)
Actual
Target
90
80
70
60
50
40
30
20
10
0
Sep-12 Nov-12 Jan-13 Mar-13 May-13 Jul-13 Sep-13 Nov-13 Jan-14 Mar-14 May-14 Jul-14 Sep-14


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

WORKFORCE


Sickness %
Actual
Target
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14


Top 5 Sickness Reasons based Calendar Days Lost
September 2013 - September 2014
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
2,500
2,000
1,500
1,000
500
0
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14


Rolling Turnover (%) & Required Trajectory for 2014/2015
Actual
Required Trajectory
14.0%
13.5%
13.0%
12.5%
12.0%
11.5%
11.0%
10.5%
10.0%
9.5%
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15

2.3.3 Changes in the period

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

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Expenditure (£)	A ↓	Workforce expenditure adverse variance from budget reduced from 1.33% to 0.87 in month compared with August 2014.	See summary, supporting information.
Workforce Numbers (FTE)	R ↓	Total workforce numbers including bank and agency reduced by 29.4 FTE compared with the previous month. Workforce numbers were 1.3% above budgeted FTE. This compares with August 2014, when numbers were 1.8% above budgeted establishment.	See summary, supporting information and exception report.
Bank (FTE)	R ↓	Bank reduced by 78.3 FTE to 384.9 FTE (compared with a target of 252.9 FTE) in September 2014.	See summary, supporting information and exception report.
Agency (FTE)	R ↓	Agency reduced by 0.8 FTE to 108.4 FTE (compared with a target of 48.3 FTE) in September 2014.	See summary, supporting information and exception report.
Sickness absence (%)	R ↑	Sickness absence has increased to 4.0% in September; compared to 3.6% in August 2014.This is 0.6 percentage points above the monthly target of 3.4%.	See summary, supporting information and exception report.
Turnover (%)	R ↑	Rolling turnover (excluding fixed term contracts, junior doctors, and bank) increased to 13.3% compared a target of 10.5% and up 0.4 percentage points compared with August.	See summary, supporting information and exception report.
Vacancy (%)	R ↓	Vacancies reduced from 5.6% last month to 5.1%, 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	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	September 14 Target
Budgeted Posts (FTE)	7420.3	7408.3	7411.1	7406.4	7424.8	7442.0	7499.3	7355.2	7709.5	7732.9	7744.9	7729.1	7733.4	7775.4
Total Staffing (FTE)	6979.7	7056.7	7071.7	7093.7	7130.2	7167.3	7170.6	7193.7	7285.6	7296.4	7330.0	7292.5	7342.2	7451.8
Bank (FTE) Admin & Clerical	67.1	80.0	63.9	58.4	59.0	67.4	64.9	71.3	89.2	83.7	88.8	103.5	86.4	65.6
Bank (FTE) Ancillary Staff	27.4	36.7	27.0	25.6	30.7	35.2	34.6	38.0	54.6	51.8	51.9	73.3	59.0	20.9
Bank (FTE) Nursing & Midwifery	188.6	232.2	194.5	184.2	197.0	220.2	197.4	203.6	249.5	220.8	241.8	274.2	233.7	156.6
Agency (FTE) Admin & Clerical	27.3	12.2	14.8	17.4	13.5	27.1	25.7	23.4	22.4	21.1	19.3	27.7	26.4	16.4
Agency (FTE) Ancillary Staff	-0.5	-10.0	10.7	10.5	3.7	0.0	8.3	0.0	6.8	4.9	15.0	12.1	7.6	3.7
Agency (FTE) Nursing & Midwifery	76.9	64.1	49.4	38.1	43.1	47.2	37.5	39.2	52.4	41.6	49.1	58.3	65.0	20.0
Overtime	96.1	67.7	55.8	58.2	60.1	54.7	83.7	76.4	48.2	62.3	49.6	67.5	60.2	54.0
Sickness absence[1] Rate (%)	3.9%	4.2%	4.2%	4.2%	4.5%	4.2%	4.3%	3.7%	3.6%	3.9%	3.9%	3.6%	4.0%	3.4%
Appraisal (%)	85.5%	86.1%	87.3%	88.8%	88.5%	87.9%	85.9%	87.1%	86.3%	87.2%	86.3%	86.9%	85.3%	85.0%
Consultant Appraisal[5] (%)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	89.1%	89.2%	83.0%	85.5%	88.8%	89.1%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	18.5%	18.4%	18.3%	18.3%	17.9%	18.0%	17.8%	17.8%	18.0%	18.6%	19.0%	19.3%	19.7%	
Rolling Average Turnover[3] (with exclusions) (%)	11.6%	11.5%	11.5%	11.6%	11.2%	11.2%	11.0%	11.1%	11.3%	11.7%	12.4%	12.9%	13.3%	10.5%
Vacancy[4] Rate (%)	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%	≤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 September 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 (10)	**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 (door to balloon time of 90 minutes)	- Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved*
Failing (10)	**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 - 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 September. Indicators are shown as being **failed** where the required standard is not achieved for the quarter to date. Indicators are shown as being **underachieved** if there has been a failure to achieve the national target in the current month, but the quarter is currently being achieved, or where a local standard is not being met.*

3.2 ACCESS DASHBOARD

Access Standards - dashboard

		Thresholds		Previous YTD	Year to date (YTD)	Month												Quarter			
	Target	Green	Red			Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	96.6%	96.0%	97.2%	95.0%	96.3%	98.0%	95.4%	98.0%	98.4%	97.1%	97.0%	96.0%	97.0%	93.2%	Cancer standards report two months in arrears	96.4%	97.4%	96.7%	95.1%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.7%	96.9%	94.3%	96.9%	99.5%	97.6%	96.2%	94.0%	97.8%	97.5%	97.9%	96.2%	96.8%	96.2%		98.0%	96.0%	97.2%	96.5%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.8%	99.8%	100.0%	100.0%	100.0%	98.9%	99.3%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%		99.7%	99.7%	99.7%	100.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.8%	95.3%	89.3%	100.0%	93.5%	95.0%	93.5%	97.6%	91.8%	97.9%	93.2%	93.5%	94.0%	97.8%		96.9%	94.1%	94.9%	95.8%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	98.4%	97.5%	97.1%	97.1%	97.6%	99.0%	92.3%	99.5%	95.6%	97.9%	98.9%	95.1%	97.6%	98.4%		97.8%	95.7%	97.2%	98.0%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.8%	79.6%	82.7%	85.6%	83.1%	85.2%	72.9%	77.4%	74.8%	75.3%	81.1%	85.1%	79.4%	77.6%		84.6%	75.1%	80.4%	78.5%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	94.7%	90.9%	93.9%	91.8%	84.2%	97.6%	98.0%	94.9%	88.9%	90.3%	90.2%	90.9%	90.2%	94.3%		90.5%	94.4%	90.4%	91.9%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	96.1%	91.8%	100.0%	86.7%	84.2%	93.1%	79.3%	75.6%	97.0%	97.5%	86.1%	100.0%	86.7%	70.0%		88.3%	85.3%	95.3%	83.3%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	93.2%	87.8%	92.2%	92.9%	91.6%	92.1%	92.8%	92.4%	90.5%	91.9%	91.8%	90.1%	87.2%	84.4%	82.4%	92.3%	92.0%	91.2%	84.7%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	93.7%	91.4%	91.3%	92.4%	91.3%	94.0%	92.0%	92.7%	93.1%	93.6%	94.0%	92.8%	89.7%	90.0%	89.0%	92.5%	92.6%	93.4%	89.5%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.4%	91.7%	92.6%	92.9%	93.1%	92.2%	92.6%	92.4%	93.1%	92.7%	92.5%	92.1%	92.0%	91.1%	90.0%	92.7%	92.7%	92.4%	91.0%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	94.8%	93.7%	97.1%	95.1%	95.4%	90.8%	91.6%	90.1%	92.1%	94.5%	94.3%	95.2%	92.4%	93.7%	92.4%	93.7%	91.3%	94.7%	92.8%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	23	12	12	13	13	14	12	24	15	14	12	11	13	12	11	13	14	12	12
	A&E Time to treatment decision (median) - in minutes	60	60	51	54	49	53	53	53	46	55	54	53	57	55	59	47	55	53	51	55	54
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	1.6%	2.1%	0.6%	2.3%	2.2%	3.0%	2.8%	2.5%	2.4%	2.7%	2.2%	2.4%	0.2%	2.5%	2.6%	2.5%	2.5%	2.4%	1.7%
	A&E Left without being seen	5%	5%	1.7%	1.8%	1.8%	2.2%	2.1%	2.1%	2.0%	1.8%	1.7%	1.5%	1.9%	1.4%	2.2%	2.0%	2.0%	2.1%	1.8%	1.6%	2.1%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.02%	1.09%	0.72%	0.65%	0.96%	1.02%	1.18%	1.44%	0.92%	0.98%	0.96%	1.10%	1.35%	0.97%	1.14%	0.85%	1.17%	1.02%	1.16%
	28 Day Readmissions	95%	85%	87.8%	90.9%	93.6%	95.0%	95.0%	92.6%	93.6%	88.6%	89.7%	94.2%	85.2%	94.4%	95.3%	90.5%	85.2%	94.0%	90.3%	91.3%	90.6%
	6-week wait for key diagnostics	99%	99%	98.1%	97.5%	98.5%	98.9%	99.5%	98.8%	98.0%	99.2%	99.2%	98.3%	96.6%	97.3%	97.7%	97.0%	98.1%	99.1%	98.8%	97.4%	97.6%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	83.1%	79.1%	65.0%	86.2%	91.2%	81.6%	77.5%	82.9%	77.1%	78.6%	78.3%	82.1%	80.6%	76.9%		86.1%	78.9%	79.4%	78.7%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	93.4%	93.8%	95.0%	96.6%	97.1%	89.5%	90.0%	91.4%	91.7%	96.4%	93.5%	96.4%	88.9%	94.9%		94.1%	91.1%	95.1%	92.0%
	Delayed discharges (Green to Go List)	30	41	Not applicable	54.3	65	57	50	52	60	73	58	56	51	58	50	53	58	53.0	63.7	55.0	53.7
	Ambulance hand-over delays (over 30 minutes) - 10% *reduction (year to date)*	0	92.0	102.7	109.7	44	63	70	120	94	137	105	96	100	79	139	144	100	84.3	112.0	91.7	127.7

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:

- Cancer 2-week wait ↓ (down from 97.0% in July to 93.2% in August)
- Cancer 31-day diagnosis to treatment (subsequent surgery) ↑ (up from 94.0% in July to 97.8% in August)
- Diagnostic 6-week wait ↑ (up from 97.0% in August to 98.1% in September)
- Reperfusion times (door to balloon time of 90 minutes) ↑ (up from 88.9% in July to 94.9% in August)
- Ambulance hand-over delays over 30 minutes ↓ (down from 144 in August to 100 in September)

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 seven 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 a last minute cancellation
3) 62-day referral to treatment cancer standard – GP referred
4) Referral to Treatment Time (RTT) Non-admitted pathways standard
5) Referral to Treatment Time (RTT) Incomplete pathways standard
6) A&E 4-hour maximum wait
7) Six week wait for diagnostic tests

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 68 last-minute cancellations (LMCs) of surgery in September (1.14% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in September were as follows:

- 26% (18 cancellations) were due to no ward bed being available to admit a patient to
- 25% (17 cancellations) were due to no intensive therapy unit (ITU)/ high dependency unit (HDU) bed being available to admit a patient to
- 19% (13 cancellations) were due to other emergency patients being prioritised on lists
- 29% (20 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging

Of the 68 cancellations, 19 were day-cases and 49 were inpatients (28% day-cases). On average, seventy percent of the Trust's admissions in a month are day-cases. The higher rate of inpatient cancellations reflects the high cancellation rate due to emergency patients needing to take priority and the lack of a critical care bed, which is more likely to impact inpatient than day-case procedures.

In contrast to July and August, ward bed availability was the single highest cause of cancellations this month. This reflects the emergency pressures in the period.

In September 85.2% of patients cancelled in the previous month were readmitted within 28 days of the cancellation. There were 8 breaches of standard in the month. Five of these patients were due for readmission to the Bristol Children's Hospital, one of which could not be re-admitted within 28-days due to more urgent patients taking priority with the other four unable to be readmitted due to a combination of clinician leave and other more clinically urgent patients requiring treatment. The remaining three patients were due for surgery within the Bristol Royal Infirmary; two were not re-admitted within 28-days due to more clinically urgent patients requiring admission. The final patient was originally re-dated within 28 days, but had to be cancelled again due to equipment not being sterile.

ACCESS STANDARDS

Recovery plan, including expected date performance will be restored:

The following actions continue to be taken to reduce last-minute cancellations and support achievement of the 0.8% standard (*please note: actions completed in previous months have been removed from the following list*):

- Ongoing implementation of 4-hour plans, the actions from which should reduce cancellations related to bed availability (see A&E 4-hour Exception Report – A6);
- Escalation of all LMCs not re-booked within 7 days of cancellation (ongoing); patient list now also being reviewed at the weekly or fortnightly Referral to Treatment Time (RTT) meetings with Divisions;
- Monthly validation of all potential LMCs re-established, to ensure we are not inappropriately reporting last-minute cancelled operations, or failures to re-admit within 28 days, and that we understand the reasons for cancellations (ongoing);
- Outputs of the weekly scheduling meeting are reviewed by Surgery, Head & Neck team, to be clear on the accountability for making sure theatre lists are appropriately booked (i.e. will not over-run), and the necessary equipment/staffing are available (ongoing);
- Weekly reviews of future week's operating lists continue, to ensure the demand for critical care beds is spread as evenly as possible across the week; daily reviews of current demand for critical care beds, and flexible critical care bed-usage across Divisions to minimise cancellations (ongoing);
- Daily e-mails circulated of all on-the-day cancellations within the Bristol Royal Infirmary by the nominated Patient Flow Co-ordinator, to help ensure patients are re-booked within target (ongoing);
- In addition to the opening of the twentieth 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) **Complete 6/10/2014**
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. **Commenced 6/10/2014**
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

ACCESS STANDARDS

	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) **At Risk - Recruitment/Retention Challenges**
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 September. This was primarily due to clinician unavailability and emergency pressures on theatres.

Performance against the 28-day readmission standard was 85.2% and so continued to be 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 A6), 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 September is 74.5%. This figure is subject to further validation and final national reporting, which will take place early in November. The recovery trajectory target of 81.8% is not expected to be achieved for the month, for the reasons shown in the final section of this exception report.

Performance in August was reported as 77.6% against the 85% standard. Breach analysis has shown the reasons for the breaches to be as follows:

Breach reasons	August	Percentage of breaches	
Late referral	4.0	25%	53% of breaches were due to primarily unavoidable reasons, including late referral, medical deferral, clinical complexity and delays at other providers.
Medical deferral/Clinical complexity	2.0	13%	
Patient choice to delay	1.0	6%	
Delayed radiology diagnostic	1.0	6%	
Admin delay/pathway planning issue	4.5	28%	There were 8 breaches (50%) relating to internally managed pathways and 8 breaches (16 pathways x 0.5 accountability) relating to shared pathways.
Elective capacity/cancellation	1.0	6%	
High dependency unit bed availability	0.5	3%	
Outpatient appointment delay	0.5	3%	
Delays at other provider	1.5	9%	
	16.0	**100%**	

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:

- Implement joint clinics between respiratory physicians and thoracic surgeons, both internally and at referring providers, effectively removing the need for a second outpatient appointment. This has been implemented and UH Bristol and at North Bristol Trust. Once minor operational issues with the North Bristol Trust clinics are resolved, the perfected model is ready to roll-out to Taunton, and then to Yeovil and Weston. Discussions will also be held with Gloucester and Bath hospitals with a view to rolling out there;
- Reduce maximum wait for 2-week wait step to 7 days for 90% patients in six specialities where this will likely make a material difference to pathways. Three out of six specialities are achieving this, with two others on target to achieve and a sixth that has been delayed for safety reasons, but is now working towards this. The threshold will be revised slightly for some areas to take into account higher than expected patient choice i.e. patients not wishing to be seen in seven days but prepared to be seen in 7-14 days;
- Additional capacity for ENT has been established. Dental screening for head and neck patients is carried out on the day and dental extractions usually within the same week as the screening, when required. This has significantly improved the head and neck pathway;
- Additional thoracic and hepato-billiary theatre sessions established from October 2014, (following the move of the Vascular service to North Bristol Trust);
- Additional thoracic surgery lists have been carried out. Some additional theatre sessions were carried out on Saturdays in September, to bring forward treatment dates for patients requiring thoracic (lung) cancer surgery;

ACCESS STANDARDS

- The pre-operative assessment process has been revised to improve communication and timeliness, and is being monitored on an ongoing basis. Tracking systems for patients have been altered to keep patients under review administratively until pre-operative assessment is completed;
- Revisions to the colorectal two-week wait pathway are planned for January 2015, to support improved pathways for patients (fewer appointments) and ongoing attainment of waiting times standards in a time of rising demand;
- Improving referral to reporting times of CT colonoscopies; outsourcing of routine work will free up specialist radiologists to report these complex scans in shorter timescales;
- Competency based training and assessment for Multi Disciplinary Team (MDT) coordinators and all administrative staff involved in booking cancer patients (both at start of post and on an ongoing basis) in development to reduce risk of administrative errors

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 figures for July to September are still subject to final validation and will be confirmed on final national reporting early in November. August and September's performance is below trajectory, mainly due to the high number of late tertiary referrals and complex cases in the period, but also due to capacity constraints in the thoracic service for which a longer term solution has now been implemented.

	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%	77.6%	74.5%	76.9%								

ACCESS STANDARDS

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

Description of how the target is measured:

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

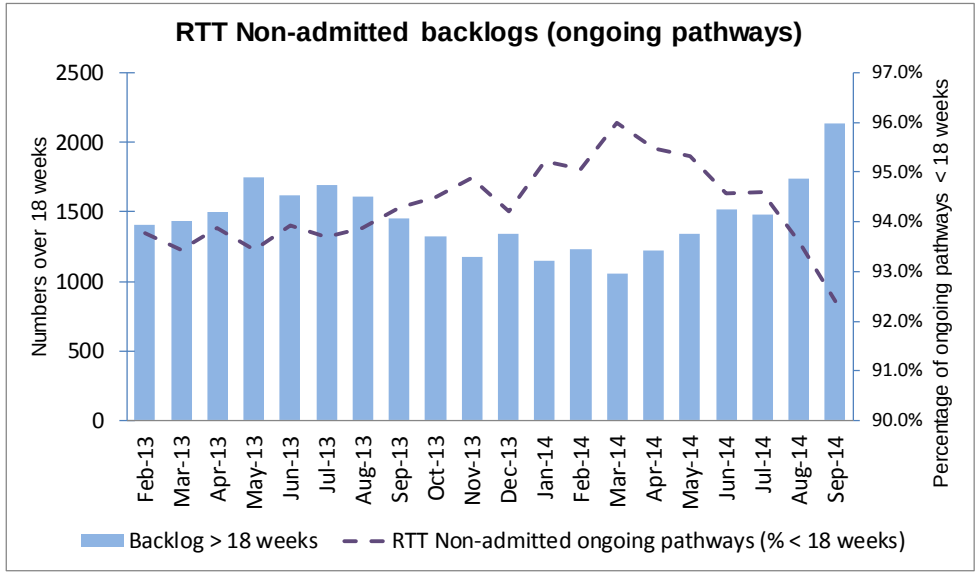
Performance is assessed by Monitor at an aggregated Trust level.

Monitor measurement period: Monthly achievement required but quarterly monitoring

Performance during the period, including reasons for exceptions:

Performance in September was 89.0% against the Non-admitted standard, which is below the revised monthly trajectory (92.5%).

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 has dipped below 95% since then. This rise in the backlog is primarily due t o 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. However, this level of capacity has not been able to be sustained. Overall non-admitted RTT activity (treatments) increased by 1102 in September relative to August (17% up on August). In addition, 190 more long

waiting (breach) patients were treated in September relative to August, which represents a 28% increase.

The analysis of the patients treated in the month who had waited over 18 weeks, shows the following:

- 38% were in dental specialties – a reduction on last month (46%) and reflecting a reduction in the level of capacity previously put in place;
- 12% were in Adult Ear, Nose & Throat (ENT) – similar to last month
- 7% were in Cardiology – an increase from 4% last month and reflecting additional activity undertaken in outpatients

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

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
Cardiology	135	62	197	**68.5%**
Cardiothoracic Surgery	28	4	32	**87.5%**
Dermatology	447	28	475	**94.1%**
E.N.T.	565	100	665	**85.0%**
Gastroenterology	37	10	47	**78.7%**
General Medicine	180	1	181	**99.4%**
Geriatric Medicine	49	0	49	**100.0%**
Gynaecology	332	24	356	**93.3%**
Neurology	64	7	71	**90.1%**
Ophthalmology	1029	36	1065	**96.6%**
Oral Surgery	307	47	354	**86.7%**
OTHER	3256	492	3748	**86.9%**
Rheumatology	126	11	137	**92.0%**
Thoracic Medicine	262	6	268	**97.8%**
Trauma & Orthopaedics	92	29	121	**76.0%**
TOTAL	**6909**	**857**	**7766**	**89.0%**

In September, four of fifteen specialties achieved the 95% standard, compared with eight in August. This in part reflects the fact that more long waiting patients were treated in the month, particularly in Cardiology, Dermatology and dental specialties reported under 'Other'.

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 was 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, a final report was agreed and the recommendations form the basis of a detailed recovery plan. The actions are now in the process of being implemented. One of the key actions of the recovery plan is to treat clinically urgent patients first and then all patients in turn and a significant number of patients have been treated from the >40 weeks backlog;
- The nationally agreed period of planned failure of the non-admitted standard was extended to end of November 2014; the Trust also took a decision to extend the nationally agreed period of failure for the admitted standard to end of December 2014;
- A full Demand and Capacity modelling using an IMAS developed planning tool is underway. The outputs will help inform discussions regarding the additional activity that is required to be delivered to achieve a sustainable backlog going forward. The modelling will be completed by the end of November 2014;
- The application of the Trust's Patient Access policy has been re-visited, to ensure that appropriate action is being taken when patients delay their outpatient appointments or elective admissions. A local (community-wide) Patient Access Policy has recently been reviewed and will be implemented during November 2014.

Progress against the recovery plan:

The modelling which has been undertaken of the impact of shortening first outpatient waits originally forecast achievement of the 95% standard from October 2014, as shown in the trajectory below.

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
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%	89.0%						

However, although activity levels have been broadly on plan, the non-admitted backlogs have risen since that assessment was undertaken, due to the higher levels of demand than accounted for in the specialty level plans. Trusts across the country have been asked to take action to reduce both admitted and non-admitted backlogs in October and November in order to restore waiting lists to a sustainable position as quickly as possible. So a

further two months failure of the non-admitted standard is now assumed in October and November.

ACCESS STANDARDS

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 September was 90.0% against the 92% standard. The continued failure of this standard is a result of: 1) the admitted backlog remaining high, 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 2) 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 in primarily specialties such as Upper GI (gastrointestinal), Dermatology and Ophthalmology. In Dermatology we have seen a significant increase in outpatient referrals. As can be seen from Table 1, Dermatology performed at 96.1% against the 92% standard in September. However, the specialty's backlog is double what it was in July. The Upper GI admitted backlog (reported under the national specialty of 'Other') continues to increase, with the rate of additions to the elective waiting list being significantly higher than expected from the number of outpatient attendances. This may be due to increasing complexity of patients. The main other areas with backlogs within the specialty of 'Other' are Paediatric specialties (admitted and non-admitted backlogs), and dental specialties (non-admitted backlogs), due to a combination of capacity constraints and increasing demand. The Cardiology admitted backlog remains high, but the non-admitted backlog has also recently worsened, due to increasing volumes of referrals.

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

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Ongoing	%age Under 18 Weeks
Cardiology	2046	583	2628	77.9%
Dermatology	2070	87	2155	96.1%
E.N.T.	2503	170	2673	93.6%
Gastroenterology	491	30	521	94.2%
General Medicine	125	3	128	97.7%

Gynaecology	1107	36	1143	96.9%
Neurology	245	46	291	84.2%
Ophthalmology	4440	207	4647	95.5%
Oral Surgery	2529	127	2655	95.3%
OTHER	13406	2091	15496	86.5%
Rheumatology	353	3	356	99.2%
Thoracic Medicine	754	4	758	99.5%
Trauma & Orthopaedics	944	76	1020	92.5%
Cardiothoracic Surgery	382	25	407	93.9%
Geriatric Medicine	210	14	224	93.8%
TOTAL	**31605**	**3502**	**35102**	**90.0%**

In September, twelve of fifteen specialties achieved the 92% standard, the same as in August.

Recovery plan, including expected date performance will be restored:

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

- As per sections RTT regarding admitted and non-admitted standards:
- Full demand and capacity modelling is underway. Specialty-level capacity plans were 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;
- A review of 'picking' patterns was completed and Divisions have more robust systems in place to ensure patients are booked according to clinical need, in chronological order.

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.

ACCESS STANDARDS

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

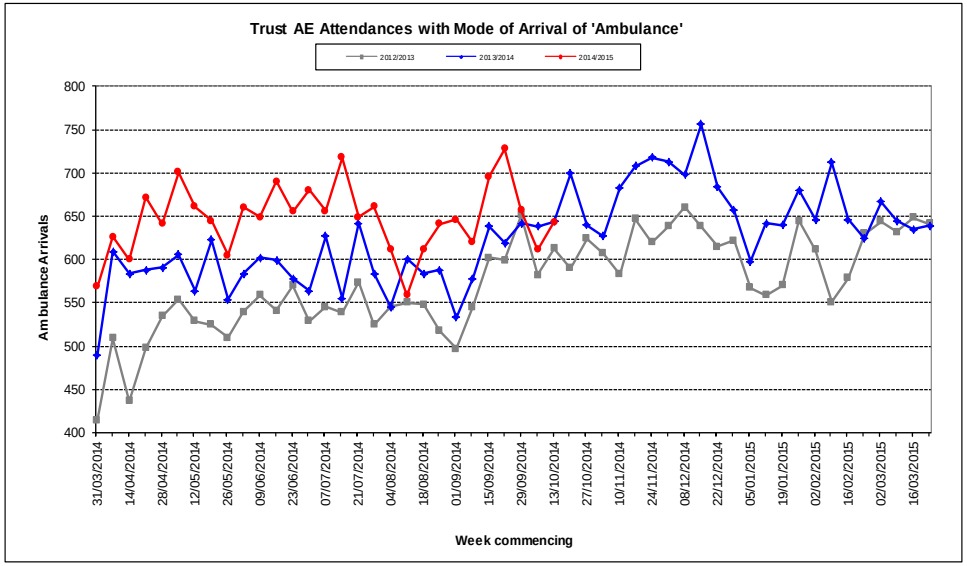
Description of how the target is measured:

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 92.4% in September, against the 95% national standard. Performance against the 4-hour standard at the Bristol Children's Hospital was 96.8% in September, compared with 99.1% in August. Performance within the BRI also decreased, from 89.5% in August to 88.0% in September. The Bristol Eye Hospital achieved 99.5% 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 5.5% higher in September than the same period last year. Levels of emergency admissions were 1.6% higher than in September last year. The lower conversion rate may be due to the work of the BRI Ambulatory Care Unit.

In contrast to the previous month, the Bristol Children's Hospital saw a 18.7% increase in ambulance arrivals in September, relative to the same period last year. However, emergency admissions were 30.8% 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).

The overall length of stay for patients discharged in the month stayed similar to that of the previous month. Consistent with this the proportion of long stay patients discharged in the period, and the number of long-stay patients in hospital at month-end, was similar to that of August, the latter retaining an amber retaining following the improvements seen in August. The lower level of over 14 day stays attained in the last two months cannot be attributed to a decrease in the number of delayed discharges, with the numbers showing a slight rise between August and September (see Table 1

below).

Table 1 – Number of Delayed Discharges on the Green to Go list at the end of September 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
September 2014	58

The number of ambulance hand-over delays in the period decreased, from 144 in August to 100 in September. This reflects the reduction seen in ambulance arrivals in September relative to August (although still being significant above last year's levels). Despite the high levels 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 749 in August to 908 in September.

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)	Progress to date
Reduction in minors breaches		
Increase Consultant cover in Emergency Department (ED) 7 days/week to support see and treat at peak times.	November onwards	Agreement to support an additional 0.2 whole time equivalents. Job out to advert. Ongoing breach analysis to understand the themes. Business case for further increased consultant cover to go to Divisional

		Board at the end of October. On track.
Additional Emergency Nurse Practitioner (ENP) cover 7 days week 18.00 – 00:00 hrs to cover minors.	September onwards	Options considered for improving pay incentives to increase ENP cover. Not approved by the Trust. Further actions considered to improve consultant cover to minors. Business case developed for new consultant funding to double-up late shifts, to be presented to Divisional Board at the end of October. New target date 1st November.
Increase numbers of ED slots available in GP Support Unit from 1045-2115. Total 206 ED slots per week.	September onwards	Lead Band 7s regularly checking on the use of GPSU slots (monitor at least 3 times daily). In-depth review of minors working underway. Minors' safety and flow will be a priority in the redesign. This redesign will require additional staffing resource and different ways of working. Further work required.
7 day liaison Psychiatry service.	September onwards	7-day, 14-hour service in place from mid September. Breach validation continues. Review date set for March 2015.
Reducing ED attendances		
Extension to opening times of South Bristol Urgent Care Centre (BrisDoc).	November onwards	Agreed and signed-off by Bristol Community Health. Funding approved. Work to be scoped and impact agreed. Further update awaited.
Implementation of ambulance trust to GP Support Unit (GPSU) pathway 5 days/week (BrisDoc).	October onwards	Criteria for ambulance trust direct admissions agreed; pilot commenced at the end of September; review to be undertaken early November.
Admission avoidance and/or reduction in length of stay		
Consultant-led Rapid Assessment Team to cover Older Persons Assessment Unit (OPAU) and Emergency Department Team led by Care of the Elderly Consultant supported by Therapists and Nurses (in association with Bristol Community Health).	November onwards	Bids agreed with commissioners. Internal business case developed; proposal to go to Medicine Divisional Board end of October; job plans completed. Pilot support to OPAU from REACT

		services completed; recruitment now commenced.
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	Proposal complete; new model described in consultant business case; plan agreed. Meeting planned to finalise business case.
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	Project scoped and plan developed; recruitment in progress, project on track.
Extended REACT service supported by Social worker 6 days/week (Bristol Community Health).	August onwards	Additional social worker in post from end August (complete).
Advanced Nurse Practitioner support to REACT 5 days /week 08:00-20:00 hours (Bristol Community Health).	August onwards	Funding agreed in August; Final agreement to progress recruitment in September (ongoing).
New pathways from Callington Road (BrisDoc/Avon & Wiltshire Mental Health Partnership).	September onwards	Working group established; BrisDoc telephone support-line in place to provide 24-hour medical support for Callington Road. Standard Operating Procedure (SOP) for patient admission into Ambulatory Care Unit under review.
Commencement of Heart Failure service to Medicine.	September onwards	Service in place from 26th August, and accepting referrals (complete).
Winter/Interim beds (Bristol City Council).	November onwards	Ongoing use of interim bed sock.
Increased Community rehab beds (Bristol City Council - BCC).	November onwards	System-wide review of bed capacity complete; further update on progress awaited from BCC.
Increase Echocardiogram capacity in evenings 5 days a week.	November onwards	Funding now agreed; Agreement in principle to carry-out electives at weekends, to increase weekday inpatient capacity; staffing now being reviewed.
An additional inpatient catheter laboratory session over the weekend. This will improve weekend discharge rates and further support delivery of elective targets.	November onwards	Funding now agreed; Agreement in principle to use on-call cardiologist to cover inpatient lists at weekends; staffing now being reviewed.
Safe Haven beds for people (Bristol Community Health)	November onwards	Medical cover for Safe Haven beds reviewed. Four additional South Bristol Community Hospital beds

		now in use as Safe Haven beds, with four beds existing ones used for rehabilitation. Standard Operating Procedure in place and tariffs agreed,
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	Funding requested, plan developed. Recruitment in place and project on track.
Increase Medical cover to the Division of Medicine over the weekend. This scheme includes a Consultant, Registrar, additional Pharmacy and portering support.	November onwards	Acute model of care approved and posts out to recruitment; closing date end October for interviews early December. Current additional cover remains in place.
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	Funding approval for additional Trauma/Surgery cover received mid September; sessions to be in place from November; project on track.
Increase ward round cover at weekends within the Bristol Heart Institute (BHI). This scheme includes Consultant, Nursing, Admin and Pharmacy.	November onwards	Funding agreed mid September. In place from mid October.
Decrease weekend admissions		
GP Support Unit (GPSU) weekend cover (BrisDoc)	October onwards	Funding agreed; service expected to start last weekend in October (subject to confirmation).
Improve flow		
Introduction of Senior Navigator to ED 10:00-20:00 hrs weekdays.	August to September	Rota agreed in August; professional standards template revised and in use. Revised rota now in place until the end of October at present.
Surgical escalation triggers/new roles/additional surgical pathways.	September onwards	Surgical escalation in place from end of August; surgical flows clarified and new elective model implemented from 13th October. Agree, treat and transfer protocol now in place for Urology patients

		needing to be seen by North Bristol Trust. Direct access pathways in place for Ear, Nose & Throat patients needing admission/treatment.

Progress against the recovery plan:

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 was below 95% despite the majority of the actions in the plan being on track. 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.

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	2014/15 Q3	2014/15 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%	92.4%									

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 September was 98.13% against the 99% national standard for 6-week diagnostic waits. This is a 1.2% improvement from August's performance of 97.0% and the best reported performance since April 14. There were 128 breaches of the 6-week standard at month-end, of which 44 were for MRI scans (down from 68 in August), 31 were for gastrointestinal endoscopies (an increase from 29 in August) and 46 were for Cardiac Stress Echocardiograms (down from 95 in August). There were also 4 breaches of standard for patients awaiting audiology tests, and 3 non-obstetric ultrasound.

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 2 adult gastrointestinal endoscopy long waiters at month-end (for clinical rather than capacity reasons), with the remaining 29 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.

The planned additional MRI sessions in September, above the routine level of capacity, have helped to reduce the backlog and result in an overall improvement against the 6-week standard.

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. However, a significant reduction in the backlog was achieved in September.

Recovery plan, including expected date performance will be restored:

ACCESS STANDARDS

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 has been recruited; 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:

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. Performance in September was a significant improvement on August, but just below the recovery target of 98.44%.

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	128			
Actual performance	**96.96%**	**98.13%**			

University Hospitals Bristol NHS
NHS Foundation Trust

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

8. Half Year Update on Corporate Quality Objectives

Purpose

To update the Board regarding progress towards achieving the Trust's corporate quality objectives for 2014/15.

Abstract

In May 2014, the Board approved the Trust's Quality Report for 2013/14, which included a number of specific quality objectives for 2014/15. This year, following public consultation, the Trust has a much smaller number of objectives which are focused largely on improving the 'flow' of patients through our hospitals. The Quality Report states that the Trust will achieve these objectives through implementation of the following executive-led Transformation projects:

- Creation of integrated discharge services, co-locating organisations responsible for managing patients with complex care needs
- Working with partners to commission of out of hospital transitional care beds
- Earlier supported discharge pathways; a Trust-wide review of critical care services
- Implementation of an operational model which enables elective and urgent tertiary activity to continue during periods of high demand for acute medical care through the emergency department.

An additional objective is to review and refresh the Trust's approach to patient and public involvement and engagement. These same objectives also form part of the Trust's Annual Plan and Board Assurance Framework.

Three of the flow objectives (cancelled operations; minimising patient moves between wards; and treating patients on the right ward for their clinical condition) were red-rated at the end of Quarter 2.

Recommendations

The Board is recommended to note the report.

Report Sponsor

Chief Nurse, Carolyn Mills

Appendices

Quarter 2 update on Corporate Quality Objectives

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
	22/10/14	27/10/14			

University Hospitals Bristol NHS
NHS Foundation Trust

Subject: **Quarter 2 update on Corporate Quality Objectives**

Report to: **Quality and Outcomes Committee**

Author: **Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)**

Date: **17th October 2014**

Introduction

In May 2014, the Board approved the Trust's Quality Report for 2013/14, which included a number of specific quality objectives for 2014/15. This year, following public consultation, the Trust has a much smaller number of objectives which are focused largely on improving the 'flow' of patients through our hospitals. The Quality Report states that the Trust will achieve these objectives through implementation of the following executive-led Transformation projects:

- Creation of integrated discharge services, co-locating organisations responsible for managing patients with complex care needs
- Commissioning of out of hospital transitional care beds
- Earlier supported discharge pathways; a Trust-wide review of critical care services
- Implementation of an operational model which enables elective and urgent tertiary activity to continue during periods of high demand for acute medical care through the emergency department.

An additional objective is to review and refresh the Trust's approach to patient and public involvement and engagement. These same objectives also form part of the Trust's Annual Plan and Board Assurance Framework.

Quarter 2 performance

The Trust's quality objectives for 2014/15 are summarised below with two RAG ratings: one indicating progress to date; the other indicating a predicted RAG rating for the annual Quality Report (Account).

We said we would:	Progress to date	Predicted RAG rating in Quality Account
1. Reduce numbers of cancelled operations	Red	Amber
2. Minimise patient moves between wards, including out of hours	Red	Amber
3. Ensure patients are treated on the right ward for their clinical condition	Red	Amber

4. Ensure no patients are discharged from our hospitals out of hours	Green	Green
5. Review and refresh the Trust's approach to patient and public partnership	Green	Green

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

Quality objectives

1. Reducing numbers of cancelled operations

Cancelled operations have a major impact on the service provided for patients causing distress and inconvenience; they are also a cause of inefficiency as they waste time and resources. In order to address this issue, a protected bed/pathway model is being developed which aims to ensure we have identified theatre, ITU/HDU and ward resources in line with our planned care schedule.

This new model of care was implemented from 6th October 2014 and is aimed at ensuring that a ward bed is allocated on the right ward for elective and non-elective patients at the start of each day.

The bed base on Bristol Royal Infirmary wards 700 and 800 and in the Bristol Heart Institute is defined as separate from the general bed base to ensure that these beds are available when needed for elective patients. This new model is co-ordinated each day through the divisional bed management processes, working closely with the Clinical Site Team. Planning is also done each day for the allocated of beds on wards for patients fit to come out of ITU, meaning that beds can be pre-planned in intensive care, for elective patients requiring admission, which allows the lists for the long cases to start on time, avoiding cancellations.

This new bed management process also includes new booking rules and training for booking teams, along with a new scheduling process to avoid scheduling errors.

There have been no on-the-day cancellations of elective surgery since 6th October which were due to availability of beds or critical care beds.

Our Quarter 2 target was for no more than 0.82% of operations to be cancelled at the last minute for non-clinical reasons: we achieved 1.16%.

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Percentage of operations cancelled at last minute for non-clinical reasons	1.02%	0.92%	10% reduction - applied to seasonal variation	Target 1.03%	Target 0.82%	Target 0.81%	Target 1.00%
Performance to date		1.09%		1.02%	1.16%		

2. Minimising patient moves between wards, including out of hours

Risks of healthcare associated infection are greatly increased by the extensive movement of patients. We also know from patient feedback that moves between wards for non-clinical reasons impact adversely on their experience of care. Our aim in 2014/15 is to reduce unnecessary ward moves by 15%. Baseline data was established in Quarter 1.

In Quarter 2, the move into the new ward block commenced for the Surgery Head & Neck Division. Although the bed base has not changed, the ward areas are larger and consequently patient ward moves are reduced.

In October 2014, a new managed beds programme was implemented in Surgery and Specialised Services in order to support the delivery of the new model of care associated with the new ward lay out following the Bristol Royal Infirmary redevelopment. In November, the Division of Medicine will commence the move into the new ward block. The first moves are the two assessment wards (MAU and OPAU) which will move into areas with an increased bed base and increased isolation facilities. The pathways for medical expected patients, which are aimed at reducing ward moves, will be rehearsed at a table top exercise planned for 22nd October 2014.

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Average number of ward moves per patient	2.26	1.92	Target reduction increasing to 15% in Quarter 4, applied to seasonal variation	Baseline 2.32	Target 2.20	Target 2.09	Target 1.97
Performance to date		2.35		2.32	2.38		

3. Ensuring patients are treated on the right ward for their clinical condition

There is emerging evidence of a correlation between increased mortality and the practice of 'outlying' patients[1]. Our aim is to reduce the number of days patients spend as ward outliers (except for reasons of infection control) in order to improve patient experience and outcomes of care. Baseline data was established in Quarter 1.

Our Quarter 2 target was a total number of outlier bed-days of no more 1688: we achieved 2316.

A Standard Operating Procedure has been ratified by the Division of Medicine that identifies the linked teams for patients outlying in other Divisions. The move into the new BRI ward block and the associated new pathways for elective and emergency patients are aimed at reducing the number of Divisional outliers; however it is recognised that there will be an increased number of beds required for the winter period to offset the rise in emergency admissions in Medicine. There is a planned increase in the medical bed base form 214 beds to 239 beds from Quarter 4, which will reduce the number of Medical outliers.

[1] NHS Institute for Innovation and Improvement

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Number of outlier bed-days	10622	9029	Overall 15% reduction – applied to seasonal variation with increasing improvements across the quarters	Target 2444	Target 1688	Target 2114	Target 2783
Performance to date		4733		2417	2316		

4. Ensuring no patients are inappropriately discharged from our hospitals out of hours

Our aim is to ensure that no patients are inappropriately discharged out of hours, as defined in our hospital discharge policy.

A briefing relating to this objective has been presented to the Service Delivery Group, outlining the auditing process, which considers all BRI patients discharged between 22:00 and 07:00, excluding short stay areas and pathways which routinely involve early morning discharge (e.g. Sleep Studies). Cases are audited on a daily basis; senior ward staff are responsible for providing narrative explanations and validation where patients had been discharged on Medway between 22:00 and 07:00. The majority of occurrences relate to late data entry rather than actual out of hours discharges; once data has been validated by wards or cross-referenced with discharge summary completion times, any recording errors are corrected. Aggregated data from these daily audits will be presented in the Q3 update.

Overall, the proportion of discharges out of hours during Quarter 2 was 8.1% (8.5% YTD), compared to 9% in 2013/14.

5. Reviewing and refreshing the Trust's approach to patient and public partnership

The Trust has a strong record of patient and public involvement (PPI). We recognise that this involvement is not always systematic and mainstreamed within the organisation. This objective is about developing a new approach to patient and public partnership in the Trust. This work is currently in its formative phase.

- **Q1 - Defining the scope:**
  The scope of the work has been defined to include how we work with people in specific service developments, Trust-wide initiatives and strategic development with an eye to an emerging system wide approach across the BNSSG health community.

- **Q2 and Q3 - Development:**
  Quarter 2 and 3 is our developmental and synthesis phase. During Q2 we have been discussing with our partners how the Trust currently operates in this field. Further conversations will take place during Q3 with Trust members, Governors, members of the public and other experts in the field. This will include Healthwatch, INVOLVE (a national advisory group that supports greater

public involvement in NHS, public health and social care research) and representatives from the People in Research West of England team. Emerging thinking from these conversations suggest our approach will enhance developments in process, people and methodology issues. These include:

Emerging thinking:

Our external partners suggest:

- There is a willingness to engage with some excellent examples of involvement yet they can be piecemeal and personality rather than process led.
- It is not clear how to get involved and whether involvement makes any difference – does it really influence anything?
- Working collaboratively with other organisations on joint PPI activities will be beneficial.

An internal perspective suggests:

- There are some great examples of patients and their families getting involved in developments but the influence they have is variable.
- There is no common understanding of the value the patient perspective can bring to discussions.
- People know they should engage with PPI but don't know how to. They don't have the tools.

Drawing on these perspectives and initiatives elsewhere there is emerging thinking that will influence our new approach to PPI. This may include:

a) Process issues:
   - Simple tools to enable colleagues to undertake PPI activities in a systematic way.
   - Improved profile of the impact PPI can have on a service development including an evaluation process.
   - A formal link between PPI activities with the Trust Equality agenda.

b) People issues:
   - Building capacity through the training and development of staff and patient leaders referencing the developing model of People in Research West of England.
   - Developing the relationship between the members and the PPI agenda (see Patient Assembly below).

c) Methodology issues
   - Developing and supporting core methodologies for PPI in the Trust.
   - Establishing and recruiting to a diverse UH Bristol Patient Assembly which will will act as an independent and 'critical friend' to the organisation. The group will aid the Trust in planning and shaping services and influencing changes taking place now and in the future.
   - Developing a wider reach by working collaboratively across the health community on common PPI issues. This includes working with Healthwatch to access their comprehensive network of voluntary sector, community organisations and equality team.
   - Develop the relationship with Neighbourhood Partnerships/Forums as a mechanism to engage with local people.

As part of our commitment to deliver the patient and public involvement aspects of our Patient Experience & Involvement action plan for 2014/15, we are developing delivering PPI activities

relating to patients with, for example, learning disabilities, specifically to inform the methodologies we use to engage people in our work. Preparation is being made to work with adolescent grown up congenital heart patients with learning disabilities to inform new approaches to involving patients and their carers in our work. We are also supporting and advising on Listening events within the Paediatric Cardiac Surgery service.

During Q3 we will publish and test a discussion paper as part of our plans to formulate a preferred option for Q4. During Quarter 4 we will publish our new approach to working with patients, our members and the wider public establishing the mechanisms by which this will be implemented starting in Quarter 1, 2015/16.

University Hospitals Bristol NHS
NHS Foundation Trust

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

9. Transforming Care Report – Quarter 2 2014/15
Purpose
The purpose of this report is to update Trust Board on the progress of the Transforming Care programme over the last quarter.
Abstract
The report describes the development of the Trust wide transformation projects which are being delivered, highlights of progress to date and the next steps.
Recommendations
The Board is recommended to receive the report for assurance
Report Sponsor
Chief Executive
Appendices
1. Transformation programme summary 2. Programme milestone status update to Transformation Board October 6th 2014

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

Transforming Care Update to Trust Board

October 2014

The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. The report sets out the highlights of progress to date and the next steps.

1. In the Spring of this year we undertook a review of progress against the aims of each pillar, and in response to this we scoped and mobilised the following projects:

1. 7 day early senior medical review
2. Compassion in Clinical Staff
3. Transformation through Electronic Data Management
4. Breaking the Cycle Together - follow up
5. Operating Model - Children's
6. Operating Model - Planned Care
7. Operating Model - Unscheduled Care & Discharge
8. Leadership programme
9. Staff engagement programme

The purpose and aims of each of these is captured in appendix 1 along with the project leads.

2. A detailed milestone plan was developed for each project to support tracking of progress, and the Executive Lead for each provides an update to Transformation Board monthly. At appendix 2 is shown the milestone status update provided to the October Transformation Board.

This report allows a review of completed milestones and a forward view of milestones due over the coming three months. This is to ensure we remain focussed on delivering the key short term activities which will deliver demonstrable progress and achieve the project aims.

3. Recent progress reported by some of the projects includes:

- Following the use of values based recruitment for Nursing Assistants we have extended the approach in a pilot for registered nurses. We have launched an initiative to highlight compassion inviting staff to submit notable examples of their own experiences of compassion in care (Compassion in Clinical Staff)

- We are implementing simplified processes in admin areas in preparation for the St Michael's initial implementation of the Evolve Electronic Data Management system (Transformation from Electronic Data Management)

- We implemented the Managed Beds system across elective beds in Surgery Head & Neck and Specialise Services on 6th October. Teams across divisions and from the Clinical Site Team have provided day to day support from to help the new methods bed in. As a result, outliers in the managed beds areas have been controlled, and the impact on emergency flows has to date been manageable. The impact on elective care has been notable with a sharp reduction in cancellations due to lack of ward and ITU beds. (Operating Model – Planned Care)

- We have started the roll out of Enhanced Recovery methods for Care of the Elderly patients, initially on wards 7 and 100 (SBCH). Staff have received training, and then patient diaries have been launched to help patients take greater ownership for their recovery goals. Ward 23 will follow, and work with Chief Nurse's team will provide volunteer capacity to support this. Meanwhile an interim solution to physically integrate the Hospital Discharge, Social Care and Community Care teams on site is being pursued after a delay of some months to the proposed location on level 9. Teams are already taking steps to mix together more routinely, share IT systems and work more closely. (Operating Model – Unscheduled care and Integrated Discharge)

- In the Children's Hospital the new escalation and winter plans have been agreed and are being rolled out. The pilot of a new hospital wide communications tools (Jabber instant messaging) has commenced. Pathways for common diagnoses have been agreed and training is being rolled out. Text messaging will be used to inform staff of bank shifts that are available. And changes to the Children's ED layout are due for completion in November. (Operating Model – Children's Flow).

- We have identified the target cohorts for the priority leadership development work, and design of the programme is underway. (Leadership development). And we are planning a pilot of team based working adopting the principles of Professor Michael West. Through this approach we will a team of internal coaches to work with our teams. (Staff engagement/Staff experience)

We have maintained a strong focus on delivery of actions over quarter 2 to ensure that capability issues are addressed as we go into the winter period. Progress has been monitored monthly by the Transformation Programme Management Office, and reviewed by Transformation Board. As a result, most of the Operating Model scope will be delivered by the end of November.

Transformation Board has also ensured that our Transformation resource has been aligned to these priority projects.

4. In the last quarter we have also used the Breaking the Cycle Together method on two occasions:

In August we ran "Delivering Best Care Week" as part of our preparations for the CQC inspection. Ahead of the week we developed a self-assessment tool designed around the CQC's key lines of

enquiry. Teams in clinical areas across the Trust were then asked to assess themselves. This highlighted both areas where we perform well, as well as those requiring improvement. During the "Delivering Best Care Week" itself, teams took action to address their improvement areas. Teams were invited to escalate areas where they needed help, and senior teams and executives provided focussed support to help and encourage their work. The week was successful, in raising awareness of the key lines of enquiry, in catalysing actions to improve, and in building positive engagement in preparations for the CQC visit itself.

At the end of September we ran a Breaking the Cycle Together event across BRCH and St Michael's Hospital. As with the event in April, the aim of the event was to reaffirm our standards of safety and quality and to address some of the barriers to achieving them. In preparation, clinical teams across the two hospitals developed "SAFER bundles" which capture their key operational standards. During the week, with the support of Ward Liaison Officers drawn from across the Trust, teams highlighted and escalated issues which get in the way of delivering high quality care. Senior management and executive teams were highly active in addressing the issues which were identified. There was a very strong level of engagement in the week from staff across BRCH and St Michael's, and a positive effect on the morale of the staff involved. A detailed review of findings has been undertaken with the Women's and Children's Divisional leadership team, and follow up plans are being finalised.

In November, SLT will review the learning from all of the Breaking the Cycle events we have run to date, to develop plans to capitalise on the improved engagement and positive impact this approach has had on the Trust.

5. Next steps:

During the coming month our focus will be:

- To ensure the Operating Model changes are effectively embedded in Division ways of working
- To scope and get started on further areas of work further areas of work to build on the progress that is being made
- Maintain the momentum of the projects through continued scrutiny via SLT and Transformation Board.

Simon Chamberlain

Director of Transformation

22nd October 2014

Appendix 1: Transformation Programme Summary

Pillar	Project	Purpose:	What will we do:	Exec Lead	Project lead
Delivering Best Care	7 day early senior medical review	To deliver consistent quality of care for patients admitted at weekends, consistent with a minimum standard of 14 hours to consultant review for emergency admissions	Define the weekend medical staffing levels consistent with our standards of care. Scope and cost a feasible solution, agree, and implement.	Sean	Peter Collins
	Compassion in Clinical Staff	To ensure that the majority of patients/carers would report that they receive person centred care - kind, sympathetic and sensitive.	Assess our current position, learning from what others do; scope the areas where we need to do better, and the right type of interventions; mobilise a programme, including training (both general and targeted), and feedback mechanisms.	Carolyn/ Sue	Helen Morgan, Alex Nestor
	Transformation through Electronic Data Management	To ensure the transformational improvement opportunities made possible by the Evolve Electronic Data Management are realised	Roll out a structured approach to identify and prioritise the opportunities created by the Evolve system. Implement agreed change projects so that staff are fully engaged and benefits are delivered, consistent with the Evolve implementation.	Paul	Sarah Wright, Mel Jeffries
Improving Patient Flow	Breaking the Cycle Together	To deliver a step change in our compliance with the SAFER bundles, and in operational performance, as measured by the BTCT scorecard and avoidance of escalation. To sustain the cultural shift observed during the BTCT week	Establish the day to day routines and reporting which replicate the key features of the BTCT week. Establish the minimum standards expected and audit our progress against these. Scope further work required from the feedback and learning from the week	James	Andy Hollowood, Anne Frampton
	Operating Model Children's	To ensure our operating model in our Children's Hospital is resilient, especially to winter pressures	Deliver a programme of change to improve flow. Our vision is to deliver nine projects prior to winter 14/15 to facilitate flow, focusing on: Nursing, Communication, CED Refurbishment, Ward Processes, Elective Pathways, Winter Planning & Escalation, Paediatric OPAT, Complex Discharge, and a Breaking the Cycle Together week	James	Anne Frampton
	Operating Model - Planned Care	To ensure that elective and urgent tertiary activity proceeds unhindered through periods of high demand for acute medical care through our hospitals	Implement a Managed Pathways model across planned care services including a protected beds strategy, supporting scheduling tool and processes, updated Trust Escalation Policy, and performance monitoring. Implement a transformation programme across all theatre areas Establish short and long term changes as required to our critical care capacity	James	Andy Hollowood, Alan Bryan
	Operating Model - Unscheduled Care & Discharge	To establish an unscheduled care pathway, supported by a fully integrated Health and Social care team which reduces occupied bed days whilst improving patient outcomes and experience	Jointly design and implement new processes, performance management, reporting, roles & responsibilities and communications across organisations for complex discharge. Co-locate staff from the three organisations into one space. Ensure Out of Hospital bed capacity is consistent with our requirements. Extend the use of Early Supported Discharge principles within the integrated pathway	James	Rowena Green
Building Capability	Leadership programme	To deliver a leadership programme to build capability and drive organisational development, so that Transforming Care is at the core of the organisations practice and culture	Develop a tailored leadership development programme for priority groups. Agree the competencies and standards required. Provide support through a coaching and mentoring framework, aligned to personal development plans, and supported by a programme of quarterly leadership forums	Sue	Alex Nestor, Sam Chapman
	Staff engagement programme	To deliver a step change in staff experience, satisfaction and engagement, supporting a step change in patient experience and performance.	Design and roll out of a programme of staff engagement /staff experience activities. Engage our staff with the vision for the Trust, identify how teams should work locally to bring this vision to life, and roll out appraisal/ team working methods which support continuous improvement. This is a cultural change programme with a full three year action/implementation plan	Sue	Trish Ferguson-Jay

Appendix 2: Transformation Milestone Status report

		Milestone review last month	Milestone plan next three months		
		September 2014	October 2014	November 2014	December 2014
Delivering Best Care	**Project:** 7 day early senior medical review **Exec Lead:** Sean O'Kelly **Project lead:** Peter Collins **Progress status:** Red **Project health status:** TBC	✓ • Develop new plan to establish current compliance with CQUIN standard for 7 day senior review ✓ • Patients for data sampling selected and notes retrieved ● • Commence review of patient notes	• Complete the review of patient notes • Carry out analysis of findings and prepare conclusions	• Share findings with SLT and agree next steps • Plan implementation actions	
	Project: Compassion in clinical staff **Exec Lead:** Carolyn Mills/Sue Donaldson **Project lead:** Helen Morgan **Progress status:** Green **Project health status:** Green	✓ • A competition style event around compassion developed and publicised ● • Values based recruitment approach evaluated ✓ • Focus group/workshops on concept of compassion in nursing practice events publicised ✓ •Pilot values based recruitment for registered nurses ✓ •Face to face survey carried out	•Staff and patient focus groups planned •Start the development of a UHBristol video for use in a variety of settings to support compassion •Complete and review the pilot of value based recruitment for registered nurses •Adapt values based recruitment approach for registered nurses based on pilot outcomes	•Development of a toolkit around compassion of different resources for clinical teams to use •Development of a UHBristol video that can be used in a variety of settings across the Trust •Advertise focus groups	•Toolkit of different resources for clinical teams to use completed •Focus group/workshops on concept of compassion in nursing practice take place
	Project: Transformation support to EDM **Exec Lead:** Paul Mapson **Project Lead:** Melanie Jeffries **Progress status:** Green **Project health status:** Green	✓ • Log of documents in each area developed ✓ • Triage of opportunities complete for Foetal Medicine, Child Protection, NICU ENT ✓ • Plans developed to realise the identified opportunities	•Scoping of electronic cause for concern referral •Log and review all documents in StMH ward areas, and review for opportunities •Update EDM plans to reflect agreed improvement opportunities	•Review of next cohort of departments for opportunities	
Improving Patient Flow	**Project:** BTCT follow up **Exec Lead:** James Rimmer **Project Lead:** Caroline Daley, Mel Jeffries **Progress status:** Green **Project health status:** Green	✓ • Finalise planning for W&C BTCT week ✓ • Scope and plan activities in adult inpatient area in support of Managed Beds ✓ • Mobilise teams and run events across Trust in w/c 29/9	• Analyse, review and share data gathered in W&C • Hold feedback event for W&C teams • Plan and mobilise actions in response to W&C event • Review progress made in adult inpatient areas • Agree Division and cross-Division ongoing actions • Agree actions with support areas (eg Facilities & Estates, IM&T)	•Share overall learning with SLT and agree further actions	
	Project: Children's Flow **Exec Lead:** James Rimmer **Project Lead:** Anne Frampton **Progress status:** Amber **Project health status:** Amber	● •New devices for communication technology trial available ✓ •Support processes for the Communication Project drafted ✓ •"Complex needs" definition agreed with clinical teams ✓ •Use Breaking the Cycle Together to audit numbers of patients with complex needs ● •Elective pathways cancellation Protocol implemented ✓ •Funding agreed with commissioners for 5 month pilot of Home Intravenous Antibiotic Service ✓ •Recruitment process for Home Intravenous Antibiotic Service commenced ✓ •Agree plans for implementation of nursing recruitment actions ✓ •Building works in Children's ED phase one - on track for completion early October ✓ •Discharge criteria and standard template for discharge information agreed for key clinical pathways ✓ •Workshop held to review revised Escalation plans ✓ •Escalation policy reviewed	•Confirm system and supporting processes for the Communication Project •Pilot trial of real time communication tools •E-handover discharge logger in use to manage complex discharge plans •Clinical Pathways and Documentation of Home Intravenous Antibiotic Service, including Out of Hours Management written, printed, uploaded to BRHC Clinical Guideline Intranet Site •Recruitment to paediatric Outpatient Parental Antibiotic Therapy service posts completed - Inpatient and Community Team •Configuration of text reminder system to publicise available bank shifts •Recruitment Matron appointed •New ways of working Children's ED implemented •Building works Children's ED phase one completed •Phase two building works commenced •Hotel Services Assistants supporting bed changes during winter period implemented •New ward processes written and agreed •Standard equipment trollies on each ward •Reviewed escalation policy signed off	•Implement agreed system and ways of working for the Communication Project •Review pilot and agree roll out •Complex discharge pathway implemented •Discharge Coordinator available for all ward areas/specialties •Allocation of key professional / clinician for complex patients implemented •Home Intravenous Antibiotic Service set up and functioning •Text appointment reminder system to send message to staff re available bank shifts implemented •Children's ED refurbishment completed •Integrated Care pathways implemented •New ward processes embedded as business as usual •2014/15 winter plan complete, implemented and new escalation policy published	
	Project: Managed Pathways **Exec Lead:** James Rimmer **Project Lead:** Sarah Nadin / Andrew Hollowood **Progress status:** Green **Project health status:** Amber	✓ •Scheduling tool approved and on workspace ✓ •Training on scheduling tool complete ● •Training plan managed beds & escalation approved ● •Training delivery managed beds & escalation complete ✓ • Implementation date of scheduling tool approved ✓ • New weekly scheduling meeting launched ✓ •Phase 1 & 2 implementation date of managed beds & escalation approved ✓ •SLT approval of updated escalation policy ✓ •Updated escalation policy published and communicated ✓ • Phase 2 planning initiated ✓	•Managed beds & escalation launched on Ward 700 and Ward 800 launched •Surgical Flow dashboard approved •Lessons Learned review meeting for scheduling tool complete •Ongoing performance monitoring of managed beds and escalation underway •Snagging list agreed and actions completed •Phase 2 scoping and planning complete	•Phase 2 scope approved •Phase 2 project team appointed •Phase 2 initiated	•Phase 2 ongoing delivery
	Project: Unscheduled care & discharge **Exec Lead:** James Rimmer **Project Lead:** Caroline Daley **Progress status:** Green **Project health status:** Amber	✓ •First Integrated Discharge team joint team meeting held ● •Sign off fit for purpose building specification for Integrated Discharge hub ✓ •Tools , methodology and ways of working completed for "Enhanced Recovery" for Medicine ✓ •Agree teams input to support Enhanced Recovery Programme for Care of the Elderly ✓ •"Enhanced Recovery Programme" diaries drafted ● • Drafting of pathways for PEG, bariatric and non-weight bearing patients commenced ✓ •Further updates from partners on development of community capacity	•Sharing and update on progress event for attendees from July workshops •Teams, seating arrangements and working practices for Integrated Discharge hub agreed •Complete documentation for bariatric pathway •Complete documentation for non weight bearing patients requiring interim beds •Training of teams to support Enhanced Recovery Programme for Care of the Elderly •Implement Enhanced Recovery Programme for Care of the Elderly on wards 7, 23 & 100 • Joint work with partners to maximise use of external capacity	•Building works Integrated Discharge hub commenced •Implement complex PEG patient pathway across all medical wards •Implement patient pathway for bariatric patients •Implement patient pathway for non weight bearing patients requiring interim beds •Evaluation of Enhanced Recovery Programme for Care of the Elderly •Recruit voluntary services to support Enhanced Recovery Programme for Care of the Elderly on wards 7, 23 & 100 •Working practices for Integrated Discharge hub started • Identify scope of further Trust led actions regarding out of hospital capacity	•Develop and communicate Rollout plan for Enhanced Recovery for Medicine •Implement changes to ways of working for Integrated Discharge Team
Building Capability	**Project:** Leadership programme **Exec Lead:** Sue Donaldson **Project Lead:** Alex Nestor & Sam Chapman **Progress status:** Green **Project health status:** Amber	● •Identify the leadership/management community to identify target cohorts for development programmes ✓ •Scope out the priorities for the leadership forum and develop an ongoing programmes	•Design leadership programme building on the existing programmes & Leadership healthcare model •Clearly articulate and agree what it means to be a leader	•Plan new Leadership Forums, annual conference & Action learning sets •Prepare roll-out of business skills	•Pilot Aston team based working •Finalise Leadership Forums to go live in Jan 2015 •Final Review of Leadership Development programmes to go Live in Jan 2015
	Project: Staff engagement programme **Exec Lead:** Sue Donaldson **Project Lead:** Trish Ferguson-Jay **Progress status:** Green **Project health status:** Amber	✓ •Plan/deliver communications to wider organisation on renewed mission and vision ✓ •Guidance for managers on team meetings shared ✓ •Full Census-Based Staff Survey scoped, tendered for, contracted for publicised and rolled out. ✓ •Secure agreement for the proposed for team working inventories (Aston) from Transformation Board, recommending pilot areas	•Commence Schwartz Rounds •Full Evaluation of Values Training •Publish coaching/guidance tool on effective consultations for managers •Scope out appraisal process & pilot •Plan the deployment of the Aston pilot	•Loud and Clear survey results triangulated •Respecting Everyone (tackling bullying) month in November •Evaluation of Values Training report	•Launch the pilot of Aston team based working •Evaluation of Appraisal Process •Feedback from Respecting Everyone in November

✓ Milestone complete / Activities on plan to achieve milestone
● Milestone behind plan, with action to remedy
✗ Milestone behind plan, project/programme risk

University Hospitals Bristol NHS
NHS Foundation Trust

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

10. Quarterly Capital Projects Status Report

Purpose

To update the Board on the current status of the Trust's major capital development schemes.

Abstract

The purpose of this report is to update the Board on progress, issues and risks' arising from the Trust's remaining major capital developments which are governed through the Strategic Development Department and associated programme infrastructure.

Levels 3,4,5,6,7&8 of the ward block have completed with Levels 5,7&8 fully operational. Level 9 of the ward block is currently on programme to achieve a January 2015 occupation date.

Post contract works are under way in the new Intensive Treatment Unit to create additional isolation bays and will be complete in January 20-15 to allow occupation.

The final design for the Queens facade project is progressing, however the finalisation of all details and the number of planning conditions that have to be resolved are affecting the programme.

Recommendations

The Trust Board is recommended to receive this report by the Director of Strategic Development and Deputy Chief Executive.

Report Sponsor

Director of Strategic Development and Deputy Chief Executive

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

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Item 10 – 30th Oct 2014 Trust Board

1. Introduction

This status report provides a summary update for Quarter 2 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. Project Updates

Centralisation of Specialist Paediatrics and the Bristol Haematology and Oncology Centre have both now completed, with final accounts almost settled and final submissions made to HMRC to finalise VAT recovery amounts.

BRISTOL ROYAL INFIRMARY PROJECT INCLUDING AIR AMBULANCE ACCESS, GENERATORS AND QUEEN'S FAÇADE		
1	**Decisions required**	None
2	**Progress**	**BRI Phase 3** –The progress is as set out below Level 3,4,5,6,7&8 completed. Levels 5,7&8 fully operational Level 3&4 operational 3rd/4th November Post contract works commenced on level 6 to form 4no additional isolation bays, occupation scheduled for Jan 2015 Level 9 on programme to achieve planned operational date of 21st Jan 2015 **BRI Phase 4** – The space allocation for all departments remains robust, however further work is required to fully utilise Central Health Clinic. 2 Schemes have commenced on site • Surgical Assessment Suite- due to complete Jan 15 some slippage incurred due to redesign of scaffolding works • Conversion of Lecture Theatre- Project currently on hold due to Health and Safety issue. Reported to HSE, but concluded no further action required. Revised method statement required to ensure work can complete safely , may require a significantly revised programme. The second phase of the discharge lounge has been brought forward in the programme and will be complete by Dec 14. The phase 4 programme of the existing ward accommodation refurbishment has commenced. Wards A602/604 completed and occupied. Ward 605 due to complete on 5th November. Work commenced on Ward A515. **Queens Façade** –Sample panels have been installed to resolve final design

		and planning condition details. User group established to gauge feedback and further design development will be required to finalise scheme. The programme is under review pending a final design solution. An enabling scheme to rationalise all air conditioning units within the level 1 courtyard has commenced and due to complete shortly.	
	Budget	A total capital allocation of £115.7m is in the capital programme which includes funding for façade and assumes charitable funding support of £2m. The scheme remains within its capital budget.	
4	**Programme**	The ward block contract is being managed to ensure planned operational dates can still be met.	
5	**Risks**	**Risk**	**Mitigation Actions**
	2741	**Activity and Capacity; internal plans to reduce LOS and other efficiencies may not deliver in a timely way to meet planned bed base.** Risk that there will be a reduced ability to capture clinical and activity (financial link) information about patients as a result of not having CIS	Division of Medicine are now fully engaged with CIS Trustwide project and included in the implementation and roll out of the new system. Paper based collection of data through ward watcher would need to be continued for longer, already in place.
	2748	**Limited contingency proves insufficient to manage construction risks.** Overspend against GMP and agreed capital programme	Close management of spend and control of change processes in place
	2752	**Increased levels of sickness and staff turnover associated with change and uncertainty.** Risk of increased bank and agency usage impacting on workforce costs and service delivery	Clear divisional plans to ensure consistent messages and adequate support/preparation and training for staff. Coordination through workforce and engagement sub group.
	2766	**Division of Medicine operational requirement for beds currently greater than planned capacity.** Could result in delays to release LOS reductions, and efficiencies in pathways, e.g. medical outliers and delayed discharges. Risk to impact upon performance as patient flow compromised.	Discussion at BRI Project Board requested that operational capacity position be taken to SDG.
	2877	**Risk of high levels of vacancies coincides with timings of main moves.** Ongoing vacancies across registered and unregistered staff, making it difficult to release staff for training and orientation. Also vacancies in Hotel Services, Carpenters and Mechanics staff could	• Scope use of bank and agency to support any shortfall. • Focused recruitment to key staff areas. • For facilities staff, block agency contract ensures vacancies are covered at most cost effective rate.

		potentially impact on staff available to support the move.	• Recruitment of dedicated lead in Recruitment to lead on facilities recruitment

3. Conclusion

The Trust Board is requested to receive this report for information, noting the risks that have been identified and the mitigation/contingency plans that have been developed.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 16.10.2014

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 October 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

12. 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 £3.120m (before technical items) for the six month period to 30th September 2014. This represents a favourable variance of £0.220m against plan to date. Whilst the Divisional position has deteriorated to an overspending of £4.667m this is a substantial slowdown (i.e. £0.404m overspend in the month compared with the £0.850m monthly average overspending for the previous 5 months). Of particular note is the Trust performance in September for 'income from activities'. This was greater than plan for the month and is a significant improvement on the August performance, for example, which saw an in month under performance of £1.119m.

With the offsets in reserves and capital charges underspendings the overall position has improved for the Trust. Reserves have improved and a year to date underspend of £2.525m is now reported. This position is described in more detail in section 2 (Forecast Outturn). The position may improve further in the second half of the year – the principal factors which will influence the projections made at this stage are set out in the overview on page 1.

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 – September 2014

Previous Meetings

This report was presented to the Senior Leadership Team meeting held on 22 October 2014.
This report was presented to the Finance Committee meeting held on 24 October 2014.

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £3.120m (before technical items) for the first six months of 2014/15. This represents a favourable variance of £0.220m against plan year to date. The September position is encouraging with the Trust moving to a favourable variance to plan for the six month period.

Whilst the Divisional position has deteriorated to an overspending of £4.667m this is a substantial slowdown (i.e. £0.404m overspend in the month compared with the £0.850m monthly average overspending for the previous 5 months).

Therefore, with the offsets in reserves and capital charges underspendings the overall position has improved for the Trust. The capital charges underspending is in line with previous months and will result in a £3m year end underspend (this is however a non-recurring benefit for 2014/15 only). Reserves have improved and a year to date underspend of £2.525m is now reported. This position is described in more detail in section 2 (Forecast Outturn) below. The position may improve further in the second half of the year – the factors which cannot yet be reliably forecast include:

- The level of energy prices – they were predicted to rise but are currently falling;
- The calls on contingency funds;
- Funding notifications from various bodies such as Health Education England, NHS England and Monitor in areas such as MPET contracts, system resilience etc.;
- The level of commissioner disputes – last year these only became apparent in the latter part of the year;
- The level of non-recurrent expenditure on such areas as transitional costs re major capital schemes, MARS, etc.;
- The level of provisions required for areas such as employment claims;
- The level of performance fines due to RTT, 6 week diagnostic, cancer and A&E waiting time breaches.

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 £4.667m. Detailed information and commentary for each Division is to be considered by the Finance Committee.

Divisional Variances	Variance to 31 August	September Variance	Variance to 30 September
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,544)	(74)	(1,618)
Non Pay	3,363	(213)	3,150
Operating Income	(152)	82	(70)
Income from Activities	(2,793)	234	(2,559)
Sub Totals	(1,126)	29	(1,097)
Savings Programme	(3,137)	(433)	(3,570)
Totals	**(4,263)**	**(404)**	**(4,667)**

Pay budgets have an overspending of £0.074m in the month and a cumulative overspending of £1.618m. Substantive staff pay costs decreased by £0.133m in September to £25.762m. For the Trust as a whole, bank, agency, overtime, waiting list initiative and other payments were broadly unchanged at £2.2m in September (cumulative expenditure £12.3m).

N**on-pay budgets** show an adverse variance of £0.213m in the month thereby reducing the cumulative favourable variance to £3.150m for the half year. 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 a favourable variance of £82k for the month, and a cumulative overspending of £70k.

Income from Activities shows a favourable variance of £0.234m in the month. This reduces the cumulative under performance to £2.559m. September is the first month in 2014/15 in which income from activities is greater than plan for the month and is a significant improvement on the August performance for example which saw an in month under performance of £1.119m.

The principal variances are the in-month over performance recorded for Medicine (£0.115m), Surgery, Head and Neck (£0.325m) offset by income being less than planned for Diagnostic and Therapies (£0.045m), Specialised Services (£0.388m) and Women's and Children's (£0.104m) Divisions.

The table below summarises the financial performance in September for each of the Trust's management divisions.

	Variance to 31 August	September Variance	Variance to 30 September
	Fav / (Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Diagnostic and Therapies	44	(44)	-
Medicine	(1,011)	4	(1,007)
Specialised Services	(196)	(271)	(467)
Surgery, Head and Neck	(2,003)	(198)	(2,201)
Women's and Children's	(1,260)	(60)	(1,320)
Estates and Facilities	45	23	68
Trust HQ	8	(12)	(4)
Trust Services	110	154	264
Totals	**(4,263)**	**(404)**	**(4,667)**

The results to 30 September are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 4.0, August 4.0). Further information on the financial risk rating is given in section 5 below and appendix 6.

Trust Risk Register item 1858 has been removed from the Risk Matrix summary (appendix 5) as pledges of charitable moneys donations have been secured.

2. Forecast Outturn

The financial plan for the year is an income and expenditure surplus of £5.8m before technical items. The table shown below provides a comparison of the actual results for the 6 months to 30th September with the original financial plan and 3 projections (optimistic, realistic and pessimistic) for the year.

			Projections for the Year		
	Quarter 2 Actual	Original Plan for Year	Optimistic	Realistic	Pessimistic
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Clinical Divisions					
– Diagnostics & Therapies	-	5	20	-	(100)
– Medicine	(1,007)	(483)	(1,507)	(2,000)	(2,500)
– Specialised Services	(467)	(103)	(728)	(930)	(1,200)
– Surgery, Head & Neck	(2,201)	(3,449)	(3,076)	(4,400)	(4,500)
– Women's & Children's	(1,320)	(723)	(1,791)	(2,640)	(3,000)
Sub Totals	**(4,995)**	**(4,753)**	**(7,082)**	**(9,970)**	**(11,300)**
Corporate Divisions					
– Facilities & Estates	68	-	150	100	-
– Miscellaneous Support Services	209	-	400	400	250
– Research & Innovation	55	-	150	110	50
– Other Corporate Divisions	(4)	21	-	-	-
– Corporate share of activity over performance	938	-	2,000	1,870	1,500
Sub Totals	**1,266**	**21**	**2,700**	**2,480**	**1,800**
Reserves					
– Contingency	-	-	900	800	600
– Inflation Reserve	-	-	2,500	2,300	2,200
– Other Reserves	2,525	2,032	1,072	990	800
– Transfers to Capital	-	-	400	400	400
Sub Totals	**2,525**	**2,032**	**4,872**	**4,490**	**4,000**
Financing Items					
– Depreciation on Owned Assets	1,314	2,700	2,800	2,790	2,500
– PDC Dividend	157	-	300	300	300
– Interest Payable	(47)	-	(90)	(90)	(100)
Sub Total	**1,424**	**2,700**	**3,010**	**3,000**	**2,700**
Planned Operating Surplus for the Year	**2.900**	**5,800**	**5,800**	**5,800**	**5,800**
Planned / Projected Operating Surplus for the Year before Technical Items	**3,120**	**5,800**	**9,300**	**5,800**	**3,000**

Contingency – the current balance at month 6 is £1.49m;

Inflation Reserve – the projected surplus on inflation is due primarily to the following -

- Energy – prices have not increased as expected but remain potentially volatile. The range of surplus is from £0.5m (optimistic) to £0.2m (pessimistic);
- Pay awards and incremental drift – the position is largely known and the surplus is in the order of £1.7m;
- Other inflation provisions account for the balance.

Transfers to Capital – this is the capitalisation of items purchased from revenue budgets (mostly PCs) and is predictable at a c£0.4m surplus.

Other Reserves – these include a range of headings such as -

- Slippage on non-recurring budgets e.g. spend to save, change costs, cost pressures;
- Improvements in transitional funding e.g. Health Education England MPET funding;
- Slippage on developments.

Provisions – it is assumed that provisions at the year-end will be similar to those made at the beginning of the year. This will however require reassessment in quarter 4 to take account of the issues in play for the Trust e.g. SLA disputes, employment related claims / disputes.

The above projections take no account of the impact of possible new funding in respect of system resilience bids. These could be up to £4m but the net impact on the income and expenditure position cannot be judged at this point.

The overall projections exclude technical items and represent the income and expenditure position for Operating Services. They can be summarised as follows:

	Original Plan	Projection for Year End		
		Optimistic	Realistic	Pessimistic
	£'000	£'000	£'000	£'000
Planned Income and Expenditure Surplus	5,800	5,800	5,800	5,800
Variance to Plan	-	3,500	-	(2,800)
Actual Income and Expenditure Surplus	**5,800**	**9,300**	**5,800**	**3,000**

The position will become firmer in the latter half of the year. However, the Trust is on track to deliver the planned surplus for 2014/15. The important issue is consideration of the Trust's underlying position going into 2015/16 and not being complacent by using non-recurring funding or savings to deliver the financial plan.

A preliminary assessment of the 2015/16 financial plan will be produced in November.

The Trust will need to recognise a number of technical items before closing the Annual Accounts for 2014/15. The nature of these transactions will mean that the actual impact will not be known until at least the fourth quarter of the financial year. To date the four headings on the summary statement show a small positive variance, when compared with plan.

3. Savings Programme

The Trust's Savings Programme for 2014/15 is £20.771m. Savings of £6.816m have been realised for the six months to 30 September (75% of Plan), a shortfall of £2.286m against divisional plans. The forecast outturn for savings this year is £16.799m – equivalent to 81% 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 30 September			1/12ths Phasing Adj Fav / (Adv)	Total Variance Fav / (Adv)
	Plan	Actual	Variance Fav / (Adv)		
	£'000	£'000	£'000	£'000	£'000
Diagnostics and Therapies	771	929	158	(108)	50
Medicine	1,191	846	(345)	(328)	(673)
Specialised Services	1,059	787	(272)	(261)	(533)
Surgery, Head and Neck	2,176	926	(1,250)	(286)	(1,536)
Women's and Children's	1,555	938	(617)	(236)	(853)
Estates and Facilities	483	513	30	(67)	(37)
Trust HQ	522	522	-	2	2
Other Services	1,345	1,355	10	-	10
Totals	**9,102**	**6,816**	**(2,286)**	**(1,284)**	**(3,570)**

4. Income

Contract income is £4.21m lower than plan for the 6 month period to 30 September. Activity based contract performance at £203.34m is £3.26m less than plan. Contract rewards / penalties at a net income of £2.00m is £0.52m less than plan. Income of £28.98m for 'Pass through' payments is £0.43m lower than Plan.

Clinical Income by Worktype	**Plan**	**Actual**	**Variance**
	£'m	£'m	£'m
Activity Based			
Accident & Emergency	6.83	6.74	(0.09)
Emergency Inpatients	36.25	36.52	0.27
Day Cases	18.52	17.44	(1.08
Elective Inpatients	26.00	24.25	(1.75)
Non-Elective Inpatients	8.50	7.85	(0.65)
Excess Bed days	3.64	3.93	0.29
Outpatients	36.64	35.64	(1.00)
Bone Marrow Transplants	4.26	5.17	0.91
Critical Care Bed days	21.26	20.69	(0.57)
Other	44.70	45.11	0.41
Sub Totals	**206.60**	**203.34**	**(3.26)**
Contract Rewards / Penalties	2.52	2.00	(0.52)
Pass through payments	29.41	28.98	(0.43)
Totals	**238.53**	**234.32**	**(4.21)**

5. Expenditure

In total, Divisions have overspent by £0.404m in September. 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 £1.007m for the six month period to 30 September, a favourable variance in the month of £4k.

The Division has an overspending of £0.382m to date on pay budgets. The underspending in the month reflects a reprofiling of savings plans together with a net savings on operational budgets of £109k. Nursing staff expenditure of £2.214m in September was £55k lower than August and represents the most significant variance with a cumulative overspending of £0.444m. This is as a result of staff in post being higher than budgeted due to extra capacity wards together with a need for a high level of 1:1 observations and excess agency costs.

Non-pay budgets have an adverse variance of £0.243m in the month (this includes the impact of a savings reprofiling adjustment of £0.226m) and a cumulative underspending of £0.208m. The clinical supplies heading records a favourable variance of £0.208m to date. The Division is reviewing the significant increase in patient transport costs with expenditure to date of £0.184m representing an unplanned increase on costs when compared with the £44k spent last year. Drugs and blood and blood products are £107k favourable to plan. The Division reports a cumulative favourable variance of £115k on its Operating Income budgets.

Income from Activities shows an over achievement of £0.115m in the month and a cumulative adverse variance of £0.275m. The improvement in September includes a savings reproofing adjustment of 62k. The favourable performance in September also includes a backdated increase in income in respect of the cystic fibrosis 'year of care' tariff.

The Surgery, Head and Neck Division reports an adverse variance of £2.201m for the six month period to 30 September, an overspending of £0.198m in the month.

Pay budgets are overspent by £1.474m to date - this represents the pay proportion of the Division's underlying deficit (£1.927m) offset by a net underspending on other pay headings (£0.453m).

Non pay budgets are overspent by £29k in the month, a reprofiling of the savings plan gives a cumulative underspending of £0.640m. This is mainly due to the release of $6/12^{th}$ 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 a favourable variance in September to give a positive cumulative position of £74k. Ophthalmology, ITU and oral and maxillo facial surgery services show notable higher than planned activity in the month. Operating Income budgets show a favourable variance to date of £94k.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £1.32m for the six months to 30 September, an increase of £60k in the month.

Pay budgets overspent by £26k in the month and now show a cumulative adverse position of £33k. Nurse staffing vacancies exist in a number of areas. Junior doctor staffing is affected by high levels of maternity leave and sickness and agency staff are covering vacancies in NICU.

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

Non-pay budgets show an underspending of £0.194m in the month and £1.218m 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 £1.568m to date, an increase of £0.104m in the month. 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 October onwards. In addition there are other significant variances such as CSP related services (£0.378m adverse) and Bone Marrow Transplants (£0.289m favourable).

Income from Operations budgets show an adverse variance of £24k in September to give a cumulative overspending of £84k.

One Division is now Amber / Red rated (formerly Green rated)

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £0.467m for the six month period to 30 September, a deterioration of £0.271m in the month.

Pay budgets show an overspending of £0.214m for the month, cumulative overspend £0.553m. This includes a CIP reprofiling adjustment of £70k adverse. The overspending in September on nursing staff was £88k, cumulatively £0.396m 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 £0.906m to date. The principal reason for this is the allocation of contract transfer funds (£0.262m) and Trust support funding (£0.710m).

Income from activities shows an adverse variance £0.389m in September. Cardiac surgery and cardiology activity was less than plan by £98k and £76k respectively. The oncology service, with a number of consultant vacancies, was £115k behind plan in the month. The Division is planning the recovery of the activity underperformance.

One Division is Amber / Green rated (formerly Green rated)

Trust Headquarters Services report a £12k overspending in September and a cumulative overspending of £4k for the six month period to 30 September.

Two divisions are green rated.

The **Diagnostic and Therapies Division** reports an overspending for the month of £44k and a breakeven position to date. Income from Activities shows an adverse variance of £45k in the month and cumulatively £0.320m. Operating income, mainly histopathology test income, was also lower than planned by £43k in the month.

The Facilities and Estates Division reports a £23k surplus for the month thereby increasing its cumulative underspending to £68k.

6. Continuity of Service Risk Rating

The Trust's overall financial risk rating, based on results for the 6 months ending 30 September is 4. The actual financial risk rating is 4.0 (August 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	September	Annual Plan 2014/15
Liquidity				
Metric Performance	2.71	7.35	4.90	2.53
Rating	4	4	4	4
Capital Service Capacity				
Metric Performance	3.04	2.88	2.91	2.51
Rating	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**

7. Capital Programme

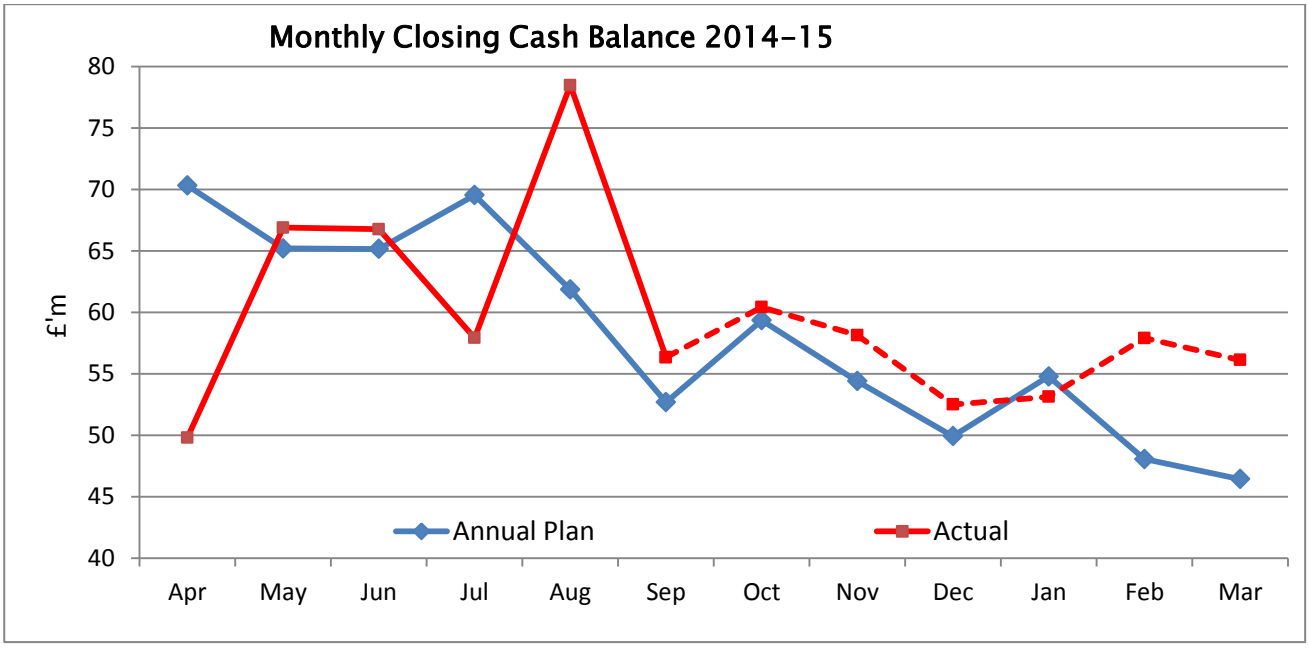
A summary of income and expenditure for the six months ending 30 September is given in the table below. Expenditure for the period of £27.188m equates to 95% of the current capital expenditure plan.

	Annual Plan	**Six Months Ending 30 September**		
		Plan	**Actual**	**Variance Fav / (Adv)**
	£'000	£'000	£'000	£'000
Sources of Funding				
Public Dividend Capital	2,625	609	609	-
Donations	8,758	1,520	1,520	-
Retained Depreciation	19,211	9,280	9,230	(50)
Prudential Borrowing	20,000	20,000	20,000	-
Sale of Property	700	700	700	-
Recovery of VAT	954	-	-	-
Cash balances	5,405	(3,564)	(4,871)	(1,307)
Total Funding	**57,653**	**28,545**	**27,188**	**(1,357)**
Expenditure				
Strategic Schemes	(32,920)	(19,740)	(19,361)	379
Medical Equipment	(7,277)	(2,285)	(2,218)	67
Information Technology	(9,024)	(2,083)	(2,056)	27
Roll Over Schemes	(2,932)	(838)	(736)	102
Operational / Other	(12,967)	(3,599)	(2,817)	782
Anticipated Slippage	7,467	-	-	-
Total Expenditure	**(57,653)**	**(28,545)**	**(27,188)**	**1,357**

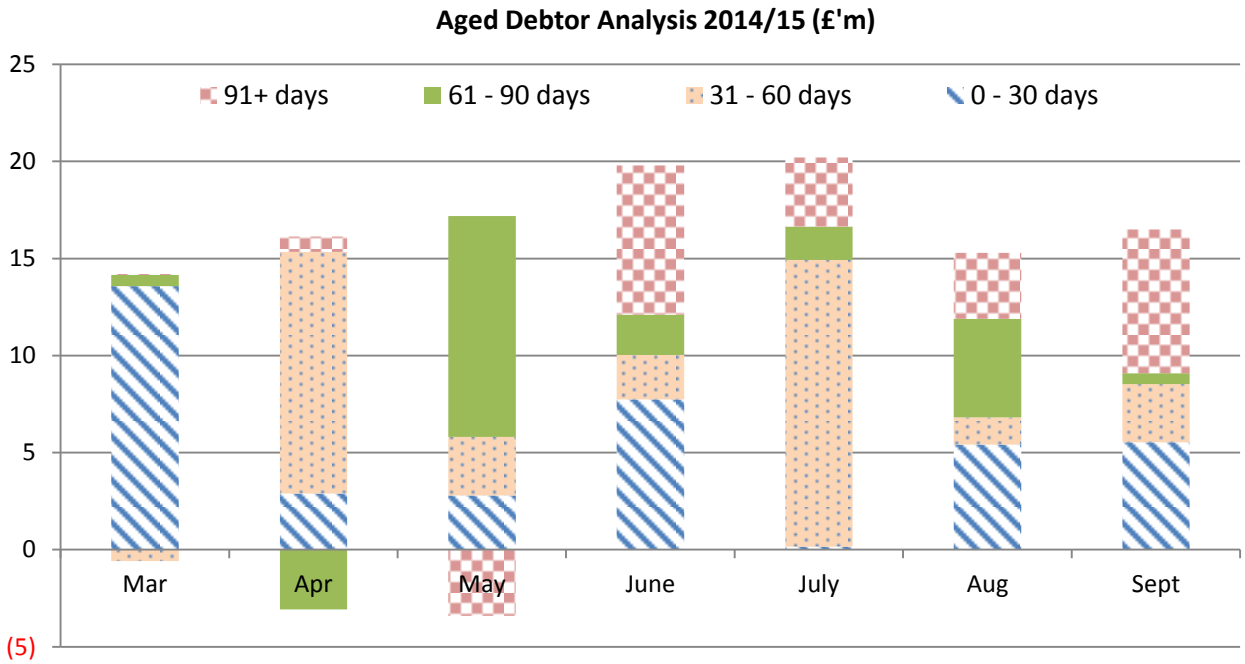
The Finance Committee is provided with further information on this under agenda item 6.

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

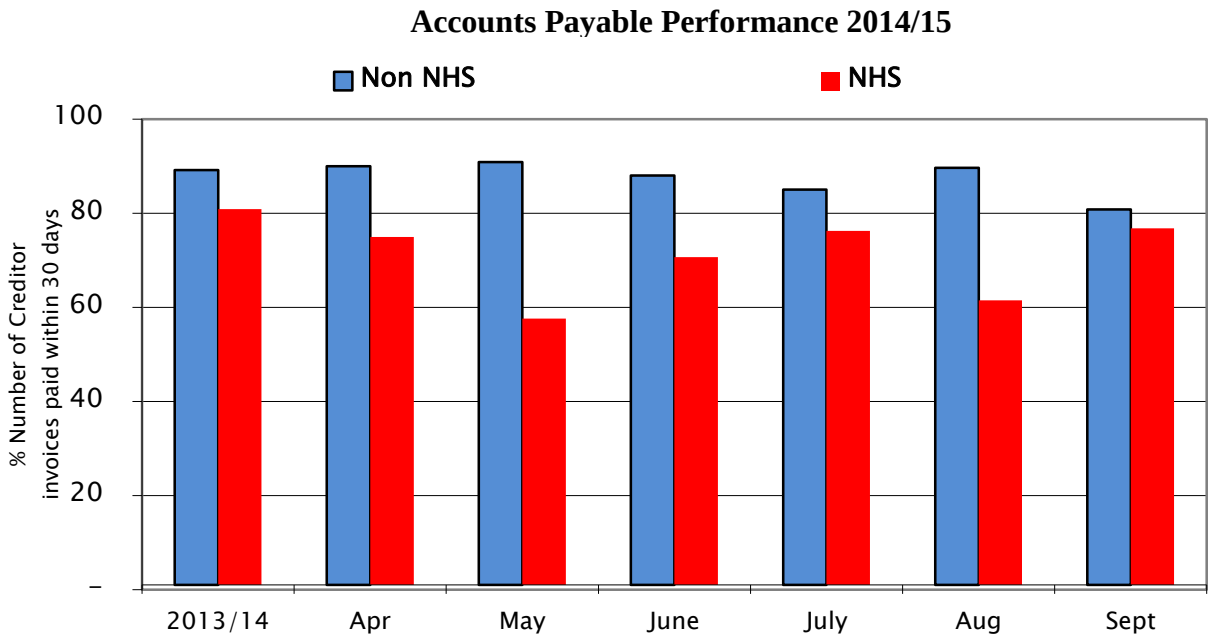
Cash - The Trust held a cash balance of £56.34m as at 30 September.



Debtors - The total value of invoiced debtors has increased by £1.209m during September to a closing balance of £16.5m. The total amount owing is equivalent to 10.6 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In September the Trust achieved 77% and 81% 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 September 2014

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

Approved Budget / Plan 2014/15	Heading	Position as at 30th September			Actual to 31st August	Forecast Outturn
		Plan	Actual	Variance Fav / (Adv)		
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
482,865	From Activities	240,700	238,533	(2,167)	196,550	487,669
90,896	Other Operating Income	45,265	45,002	(263)	37,379	89,840
573,761	**Sub totals income**	**285,965**	**283,535**	**(2,430)**	**233,929**	**577,509**
	Expenditure					
(326,376)	Staffing	(163,840)	(165,837)	(1,997)	(137,850)	(327,983)
(198,893)	Supplies and Services	(100,030)	(99,380)	650	(81,562)	(212,542)
(525,269)	**Sub totals expenditure**	**(263,870)**	**(265,217)**	**(1,347)**	**(219,412)**	**(540,525)**
(8,532)	Reserves	(2,525)	–	2,525	–	–
39,959	**EBITDA**	**19,570**	**18,318**	**(1,252)**	**14,517**	**36,984**
	Financing					
(12)	Profit/(Loss) on Sale of Asset	(12)	(12)	–	(12)	
(21,808)	Depreciation & Amortisation – Owned	(10,544)	(9,230)	1,314	(7,767)	(19,181)
150	Interest Receivable	75	123	48	101	202
(338)	Interest Payable on Leases	(169)	(173)	(4)	(144)	(345)
(3,117)	Interest Payable on Loans	(1,504)	(1,547)	(43)	(1,284)	(3,142)
(9,031)	PDC Dividend	(4,516)	(4,359)	157	(3,633)	(8,718)
(34,156)	**Sub totals financing**	**(16,670)**	**(15,198)**	**1,472**	**(12,739)**	**5,800**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**2,900**	**3,120**	**220**	**1,778**	**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)	–	(2,073)	(24,204)
1,232	Reversal of Impairments	–	–	–	–	1,232
(1,219)	Depreciation & Amortisation – Donated	(430)	(421)	9	(357)	(1,200)
(9,800)	**SURPLUS / (DEFICIT) after Technical Items**	**1,897**	**2,163**	**266**	**885**	**(9,734)**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report September 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 August
			Pay	Non Pay	Operating Income	Income from Activities	CRES		
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements								
478,710	Service Agreements	238,528	–	–	(56)	56	–	–	(1)
(4,719)	Overheads	(1,421)	–	–	–	938	–	938	754
40,019	NHSE Income	20,118	–	–	–	–	–	–	(4)
514,010	**Sub Total Service Agreements**	**257,225**	**–**	**–**	**(56)**	**994**	**–**	**938**	**749**
	Clinical Divisions								
(48,365)	Diagnostic & Therapies	(24,204)	337	(158)	91	(320)	50	–	44
(66,425)	Medicine	(34,006)	(382)	208	115	(275)	(673)	(1,007)	(1,011)
(80,912)	Specialised Services	(40,218)	(553)	906	109	(396)	(533)	(467)	(196)
(96,792)	Surgery Head & Neck	(50,794)	(1,472)	640	94	74	(1,537)	(2,201)	(2,003)
(108,221)	Women's & Children's	(55,037)	(34)	1,218	(84)	(1,568)	(852)	(1,320)	(1,260)
(400,715)	**Sub Total – Clinical Divisions**	**(204,259)**	**(2,104)**	**2,814**	**325**	**(2,485)**	**(3,545)**	**(4,995)**	**(4,426)**
	Corporate Services								
(34,518)	Facilities And Estates	(17,248)	141	76	(87)	(25)	(37)	68	45
(23,768)	Trust Services	(11,832)	314	(308)	(60)	–	2	(52)	(30)
(6,518)	Other	(5,568)	31	520	(248)	(49)	10	264	110
(64,804)	**Sub Totals – Corporate Services**	**(34,648)**	**486**	**288**	**(395)**	**(74)**	**(25)**	**280**	**125**
(465,519)	**Sub Total (Clinical Divisions & Corporate Services)**	**(238,907)**	**(1,618)**	**3,102**	**(70)**	**(2,559)**	**(3,570)**	**(4,715)**	**(4,301)**
(8,532)	Reserves	–	–	2,525	–	–	–	2,525	1,688
(8,532)	**Sub Total Reserves**	**–**	**–**	**2,525**	**–**	**–**	**–**	**2,525**	**1,688**
39,959	**Trust Totals Unprofiled**	**18,318**	**(1,618)**	**5,627**	**(126)**	**(1,565)**	**(3,570)**	**(1,252)**	**(1,864)**
	Financing								
(12)	(Profit)/Loss on Sale of Asset	(12)	–	–	–	–	–	–	–
(21,808)	Depreciation & Amortisation – Owned	(9,230)	–	1,314	–	–	–	1,314	1,094
150	Interest Receivable	123	–	48	–	–	–	48	38
(338)	Interest Payable on Leases	(173)	–	(4)	–	–	–	(4)	(3)
(3,117)	Interest Payable on Loans	(1,547)	–	(43)	–	–	–	(43)	(34)
(9,031)	PDC Dividend	(4,359)	–	157	–	–	–	157	130
(34,156)	**Sub Total Financing**	**(15,198)**	**–**	**1,472**	**–**	**–**	**–**	**1,472**	**1,225**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**3,120**	**(1,618)**	**7,099**	**(126)**	**(1,565)**	**(3,570)**	**220**	**(639)**
	Technical Items								
8,588	Donations & Grants (PPE/Intangible Assets)	1,537	–	–	37	–	–	37	37
(24,204)	Impairments	(2,073)	–	–	–	–	–	–	–
1,232	Reversal of Impairments	–	–	–	–	–	–	–	–
(1,219)	Depreciation & Amortisation – Donated	(421)	–	9	–	–	–	9	8
–	Profiling Adjustment	–	–	–	–	–	–	–	–
(15,603)	**Sub Total Technical Items**	**(957)**	**–**	**9**	**37**	**–**	**–**	**46**	**45**
(9,800)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**2,163**	**(1,618)**	**7,108**	**(89)**	**(1,565)**	**(3,570)**	**266**	**(594)**

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14	2014/15										2013/14	2013/14
		Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	39,526	3,300	3,438	3,424	10,162	3,411	3,362	3,293	10,066	20,228	3,371		3,294	
	Bank	306	16	27	22	64	25	39	27	91	155	26	0.8%	26	0.8%
	Agency	340	22	40	17	79	78	93	13	184	263	44	1.3%	28	0.9%
	Waiting List initiative	225	7	21	17	45	23	8	15	46	91	15	0.5%	19	0.6%
	Overtime	314	34	29	38	102	36	35	23	94	196	33	1.0%	26	0.8%
	Other pay	38,153	3,247	3,297	3,228	9,772	3,151	3,143	3,140	9,435	19,207	3,201	96.5%	3,179	97.0%
	Total Pay expenditure	39,339	3,326	3,414	3,322	10,062	3,312	3,319	3,218	9,850	19,912	3,319	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	187	(26)	24	102	100	99	43	75	216	317	53		16	
Medicine	Pay budget	44,151	3,747	3,932	3,930	11,609	3,925	3,975	3,997	11,897	23,506	3,918		3,679	
	Bank	3,305	253	319	233	805	264	319	287	870	1,675	279	7.0%	275	6.9%
	Agency	2,354	116	133	202	451	167	193	270	630	1,081	180	4.5%	196	4.9%
	Waiting List initiative	151	21	3	2	26	12	17	10	39	65	11	0.3%	13	0.3%
	Overtime	197	11	6	7	24	7	7	9	24	48	8	0.2%	16	0.4%
	Other pay	41,743	3,638	3,615	3,514	10,767	3,541	3,523	3,380	10,445	21,212	3,535	88.1%	3,479	87.4%
	Total Pay expenditure	47,751	4,040	4,075	3,958	12,073	3,991	4,059	3,957	12,007	24,080	4,013	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(3,600)	(292)	(144)	(28)	(464)	(66)	(84)	40	(110)	(574)	(96)		(300)	
Specialised Services	Pay budget	36,718	3,138	3,184	3,255	9,577	3,177	3,215	3,261	9,653	19,230	3,205		3,060	
	Bank	1,184	89	122	98	309	108	104	123	335	644	107	3.3%	99	3.1%
	Agency	1,882	116	170	223	509	255	183	225	664	1,173	195	5.9%	157	5.0%
	Waiting List initiative	379	21	47	23	91	34	31	25	90	181	30	0.9%	32	1.0%
	Overtime	182	10	13	19	43	16	21	19	56	99	17	0.5%	15	0.5%
	Other pay	34,079	2,947	2,931	2,945	8,823	2,883	2,989	3,005	8,877	17,700	2,950	89.4%	2,840	90.4%
	Total Pay expenditure	37,705	3,184	3,284	3,309	9,775	3,296	3,329	3,397	10,022	19,798	3,300	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(988)	(45)	(100)	(54)	(199)	(119)	(114)	(136)	(369)	(568)	(95)		(82)	
Surgery Head and Neck	Pay budget	70,927	5,902	6,011	6,038	17,951	5,876	6,130	6,020	18,025	35,976	5,996		5,911	
	Bank	1,859	140	190	133	463	173	172	167	511	974	162	2.6%	155	2.5%
	Agency	808	60	91	75	226	120	102	105	327	554	92	1.5%	67	1.1%
	Waiting List initiative	1,394	121	112	133	366	133	162	161	456	822	137	2.2%	116	1.9%
	Overtime	485	37	47	35	118	59	56	41	156	275	46	0.7%	40	0.7%
	Other pay	69,195	5,798	5,806	5,927	17,531	5,639	5,872	5,846	17,357	34,888	5,815	93.0%	5,766	93.8%
	Total Pay expenditure	73,741	6,156	6,245	6,302	18,704	6,123	6,364	6,321	18,808	37,512	6,252	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(2,814)	(254)	(234)	(264)	(753)	(247)	(235)	(301)	(783)	(1,536)	(256)		(235)	

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14	2014/15										2013/14	2013/14
		Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	73,478	6,188	7,195	7,051	20,433	7,117	7,161	7,243	21,521	41,954	6,992		6,123	
	Bank	1,813	172	195	163	530	151	172	162	485	1,015	169	2.4%	151	2.5%
	Agency	1,398	88	178	118	384	159	70	168	397	781	130	1.9%	117	1.9%
	Waiting List initiative	365	18	51	19	88	28	30	29	87	175	29	0.4%	30	0.5%
	Overtime	226	27	25	30	82	20	36	23	78	160	27	0.4%	19	0.3%
	Other pay	70,112	6,021	6,750	6,683	19,455	6,734	6,832	6,863	20,429	39,884	6,647	94.9%	5,843	94.9%
	Total Pay expenditure	73,913	6,326	7,199	7,014	20,539	7,092	7,140	7,244	21,476	42,015	7,002	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(435)	(139)	(4)	37	(106)	25	22	(1)	45	(61)	(10)		(36)	
Facilities & Estates	Pay budget	18,435	1,535	1,594	1,509	4,638	1,616	1,679	1,621	4,916	9,554	1,592		1,536	
	Bank	555	60	93	74	228	82	133	102	316	544	91	5.7%	46	3.0%
	Agency	346	21	18	41	80	29	46	40	115	195	33	2.1%	29	1.9%
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	895	93	70	81	245	76	103	76	255	500	83	5.3%	75	4.9%
	Other pay	16,397	1,393	1,407	1,308	4,109	1,361	1,416	1,351	4,129	8,238	1,373	86.9%	1,366	90.1%
	Total Pay expenditure	18,193	1,568	1,589	1,505	4,662	1,548	1,698	1,569	4,815	9,477	1,580	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	242	(32)	5	4	(24)	68	(19)	53	101	77	13		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	2,310	6,885	13,392	2,232		2,458	
	Bank	680	52	65	47	165	50	48	56	154	319	53	2.4%	57	2.4%
	Agency	375	64	30	41	135	64	34	40	139	274	46	2.1%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	114	11	9	11	31	8	11	9	28	59	10	0.5%	9	0.4%
	Other pay	27,425	2,083	1,967	1,960	6,011	2,087	2,118	2,176	6,381	12,392	2,065	95.0%	2,285	95.9%
	Total Pay expenditure	28,595	2,211	2,070	2,060	6,342	2,209	2,212	2,282	6,703	13,044	2,174	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	897	(94)	190	68	165	136	17	28	183	348	58		75	
Trust Total	Pay budget	312,726	25,928	27,613	27,335	80,876	27,467	27,752	27,745	82,964	163,839	27,307		26,060	
	Bank	9,702	783	1,010	771	2,564	852	988	923	2,762	5,326	888	3.2%	809	3.0%
	Agency	7,506	488	659	718	1,865	872	722	862	2,455	4,320	720	2.6%	625	2.4%
	Waiting List initiative	2,514	188	234	194	616	230	248	240	718	1,334	222	0.8%	210	0.8%
	Overtime	2,413	224	200	221	645	222	270	200	692	1,337	223	0.8%	201	0.8%
	Other pay	297,103	25,127	25,774	25,566	76,467	25,395	25,895	25,762	77,053	153,520	25,587	92.6%	24,759	93.1%
	Total Pay expenditure	319,238	26,810	27,876	27,469	82,157	27,571	28,121	27,987	83,681	165,837	27,640	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(6,514)	(883)	(263)	(135)	(1,281)	(104)	(369)	(243)	(717)	(1,997)	(333)		(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 six months ending 30 September is 4 (actual score 4.0, August 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 £4.20m lower than plan for the 6 month period to 30 September. Activity based contract performance at £203.34m is £3.25m less than plan. Contract rewards / penalties at a net income of £2.00m is £0.52m less than plan. Income of £28.98m for ‘Pass through’ payments is £0.43m lower than Plan.
<table>
<tr><th rowspan="2">Clinical Service</th><th rowspan="2">Activity to 30 September</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>60,098</td><td></td><td></td><td>488</td><td>0.8</td></tr>
<tr><td>Emergency
Non Elective</td><td>18,980
1,269</td><td>159</td><td>0.8</td><td>
118</td><td>
8.5</td></tr>
<tr><td>Elective
Day Cases</td><td>6,919
27,018</td><td>
137</td><td>
0.5</td><td>630</td><td>8.3</td></tr>
<tr><td>Outpatient Procedures
New Outpatients
Follow up Outpatients</td><td>26,026
75,395
153,385</td><td></td><td></td><td>1,733
7,306
13,860</td><td>6.2
8.8
8.3</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 £16.799m – equivalent to 81% of the Plan for the year. Actual savings achieved for the six months to 30 September total £6.816m (75% of Plan before the 1/12ths phasing adjustment), a shortfall of £2.286m against divisional plans.</td><td>Agenda Item 5.4</td></tr>
</table>

Key Issue	RAG	Executive Summary	Table
Income and Expenditure		The surplus before technical items for the first six months of 2014/15 is £3.120m. This represents an over performance of £0.220m when compared with the planned surplus to date of £2.900m. Total income of £283.535m is £2.430m lower than Plan. Expenditure at £265.217m is lower than Plan by £1.178m. Financing costs are £1.472m lower than Plan.	Agenda Item 5.3
D&T		The Division reports a balanced income and expenditure position to date. Pay budgets continue to underspend as a result of vacancies. Income from activities continues to run behind plan.	
Med		Cumulative overspending is £1.007m adverse, a £4k improvement in the month. The improvement in the run rate reflects better performance on pay budgets and income from activities.	
Spec Serv		Overspending of £0.271m increases the cumulative overspending to £0.467m. Position reflects non achieved savings (£0.533m) and underperformance on cardiac surgery, cardiology and oncology.	
SH&N		Overspending to date of £2.201m represents an overspending of £198k in September. Causal factors are historical non achievement of savings programme and an underachievement of planned activity to date. The Division has delivered higher than planned activity in September and is planning for further overperformance to March 2015.	
W&C		Overspending to date totals £1.32m, an increase of £60k in September. Principal factors are underperformance on income from activities (£1.568m) and non achievement of savings programme (£0.853m).	
F&E		The cumulative underspending is £68k, an improvement of £23k in the month.	
THQ		Overspending of £12k in September now results in a cumulative overspending of £4k.	
Capital		The Monitor capital expenditure performance target is to deliver the programme within 85% -115% of the Annual Plan. Expenditure for the first six months totals £27.188m – this equates to 95% of the current plan for the period.	Agenda Item 6
Statement of Financial Position and Treasury Management		The cash balance on 30 September was £56.340m. The balance on Invoiced Debtors has increased by £1.209m in the month to £16.5m. The invoiced debtor balance equates to 10.6 debtor days. Creditors and accrual account balances total £77.3m. Invoiced Creditors - payment performance for the month for Non NHS invoices and NHS invoices within 30 days was 81% and 77% respectively. Payment performance to date by invoice value is 86% for Non NHS and 88% for NHS invoices.	Agenda Item 7 SFP 1 SFP 2 SFP 3

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report September 2014 - Risk Matrix

Risk Register Ref.	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Residual Risk	
		Risk Score	Value			Risk Score	Value
			£'m				£'m
741	Savings Programme	High	10.0	Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed.	JR	High	6.0
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	High	8.0
1240	SLA Performance Fines	High	3.0	Regular review of performance.	DL	Medium	1.0
	Commissioner Income challenges	Medium	3.0	Maintain reviews of data, minmise risk of bad debts	PM	Medium	2.0
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	-

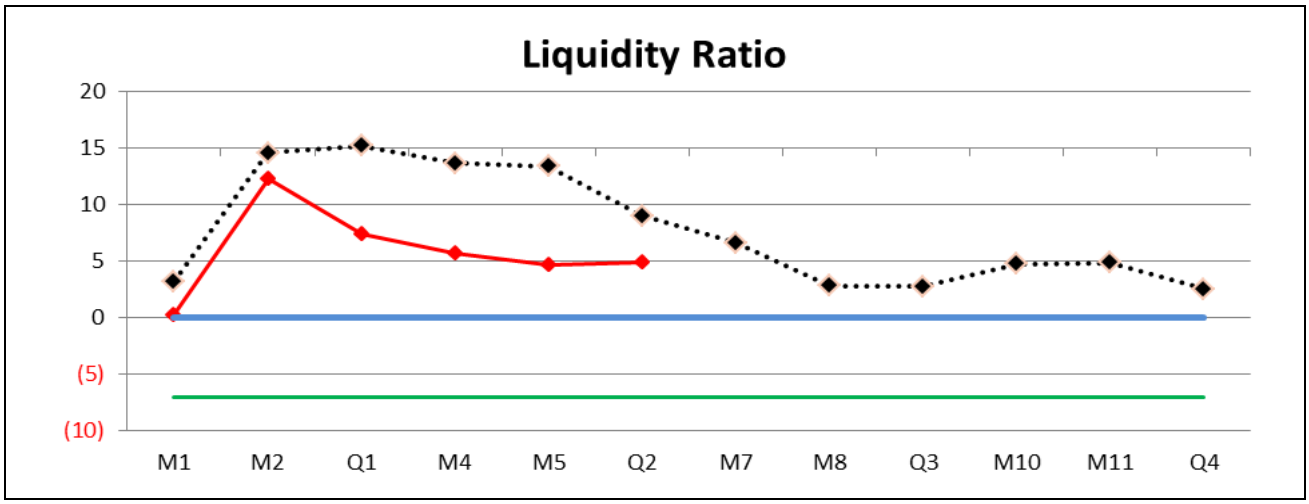
University Hospitals Bristol NHS
NHS Foundation Trust

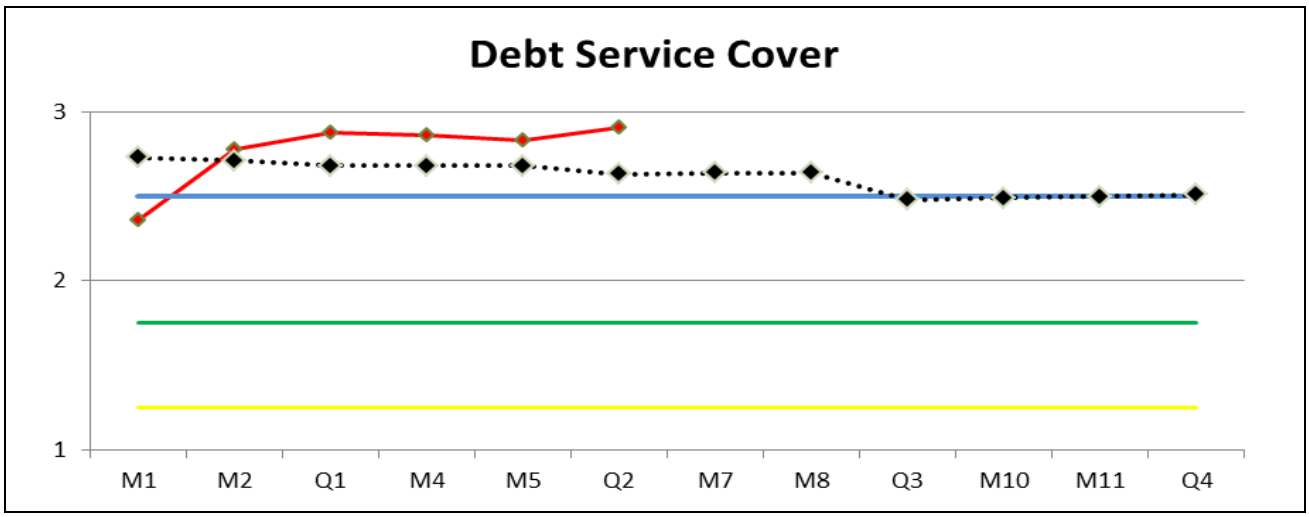
Appendix 6

Continuity of Service Risk Rating – September 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	July	August	September
Liquidity						
Metric Performance	2.71	2.53	7.35	5.70	4.66	4.90
Rating	4	4	4	4	4	4
Debt Service Cover						
Metric Performance	3.04	2.51	2.88	2.86	2.83	2.91
Rating	4	4	4	4	4	4
Overall Rating	**4**	**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
August Movements	(12)	(321)	(242)	-	(431)	(25)	(1,031)	260	86	80	140	229	74	70	92	1,031
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
Month 6 Movements																
Cleft transfer			(327)				(327)				327					327
Divisional Support			(1,057)				(1,057)	117	162	196	234	265	83			1,057
BRI redev FM costs					(379)		(379)						379			379
Pathology double teaching SIFT					(50)		(50)								50	50
EWTD					(103)		(103)	7	21	14	18	41	1	1		103
Incremental Drift		(97)					(97)	15	12	9	14	36	3	9		98
Cardiac Review	(30)						(30)							30		30
Other	(38)	(34)			(42)	(14)	(128)	42	3	3	5	11	17	45	2	128
Month 6 balances	1,503	3,200	3,699	487	3,440	1,599	13,928	3,355	6,542	10,785	11,843	20,790	2,382	6,872	3,046	65,615

University Hospitals Bristol NHS
NHS Foundation Trust

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

14. Compliance Framework Monitoring and Declaration Report – 2014/15 Quarter 2

Purpose

The purpose of this paper is to set-out the proposed declaration against Monitor's Risk Assessment Framework for quarter 2, for approval.

Abstract

Since 1 April 2013, all NHS Foundation Trusts (FTs) require a licence from Monitor stipulating specific conditions that they must meet to operate. Key among these are financial sustainability and governance requirements. The 'Ris*k Assessment Framework'* constitutes Monitor's approach to overseeing the sector under the new rules. It explains how Monitor will use the framework to assess individual FTs compliance with two specific aspects of their work: the continuity of services and governance conditions in their provider licences.

The aim of a Monitor assessment under the Risk Assessment Framework is to show when there is:

- a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or
- poor governance at a NHS Foundation Trust.

These will be assessed separately using new types of risk categories set out in the Framework; each FT will be assigned two ratings. The role of ratings is to indicate when there is a cause for concern at a provider. It is important to note that concerns do not automatically indicate a breach of the licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk.

This report sets out the Trust's risk rating for governance and finance, as calculated using the criteria set out in the Risk Assessment Framework.

The Director of Strategic Development and Deputy Chief Executive have provided an analysis of governance risk (Appendix A).

The Director of Finance and Information has provided commentary on financial risk to the Finance Committee (Appendix B).

Following making the necessary enquires, the Senior Leadership Team confirms that it is not aware of any matters arising during the quarter requiring an exception report to Monitor which have not previously been reported.

Recommendations

The Trust Board of Directors is recommended to approve the following Quarter 2 declaration for submission to Monitor by 31 October 2014:

- A submission against the 'Governance Rating' reflecting the standards failed in quarter 2 to be, the RTT Admitted, Non-Admitted and Incomplete pathways standards, the A&E 4-

hour standard and the 62-day GP cancer standard;

- The narrative accompanying the submission notes the Trust will be supporting the planned ongoing failure of the RTT standards, in line with the national 'amnesty' on failure, and the specific risks to achievement of the 62-day screening cancer standard and the A&E 4-hour standard in quarter 3;
- Confirmation that the Board anticipates that the Trust will continue to maintain a 'Continuity of Service' risk rating of 4 against a plan of 4; and
- Confirmation that as far as the Board is aware, there are no matters arising in the quarter requiring an exception report (as per Diagram 6, page 22 of the Risk Assessment Framework).

Report Sponsor

Chief Executive

Appendices

A – Draft Declaration against the Risk Assessment Framework

B – Finance Risk Assessment

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
	22/10/14	27/10/14			

Monitor Quarter 2 declaration against the 2014/15 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 2 declaration of compliance with the 2014/15 Monitor Risk Assessment Framework by 31st October 2014.

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 2, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

- Service Performance Score of 4 or greater (i.e. four or more standards failed in the period)
- A single target being failed for three consecutive quarters
- The A&E 4-hour standard being failed for two quarters in any four-quarter period *and* in any additional quarter over the subsequent three-quarter period
- Breaching the annual *Clostridium difficile* objective by failing three consecutive year-to-date quarters *or* failing the full-year objective at any point in the year
- CQC warning notices

In the future Monitor intends to include in its list of Governance Concerns patient and staff metrics including changes in satisfaction rates, turn-over rates, levels of temporary staffing and cost reduction plans in excess of 5%.

The resultant Governance Rating that Monitor publishes will depend on further investigations it conducts following Governance Concerns being triggered. The following shows the rationale for the application or either a GREEN or a RED rating:

Table 1 Monitor's process for determining the Governance 'status' of a Foundation Trust

Governance 'status' of the Foundation Trust		Governance rating: What Monitor will publish
No evident concerns	→	Green
Issue identification Prioritisation Consideration of breach	Emerging concerns (e.g. persistently failing access targets; major third party concerns, financial issues) Further information requested Concerns serious enough to trigger formal investigation Breach or likely breach identified; formal/informal action pending	Current status and a description of: • Factors driving concerns • Actions Monitor is taking/considering • Next steps
Action Formal regulatory action under sections 105 (Enforcement undertakings), 106 (Discretionary requirements), and/or 111 (Licence condition and Powers of removal, suspension and disqualification of directors and governors)	→	Red

Each quarterly declaration to Monitor must take account of performance in the quarter, and also note expected performance risks in the coming quarter. The forecast risks will be declared to Monitor as part of the narrative that accompanies the submission.

Monitor compares the quarterly declarations a trust makes with its Annual Plan risk assessment. If a trust declares a standard as not met as part of its quarterly declaration, which it did not declare at risk in the annual plan risk assessment, the trust may be required to commission an independent

review of its self-certification and associated processes. In the 2014/15 Monitor Annual Plan the Trust declared three standards to be at risk of failure in the year:

- A&E 4-hour maximum wait
- 62-day GP cancer standard
- 18-week Referral to Treatment Time (RTT) non-admitted standard

2. Performance in the period

Table 2 shows the performance in quarter 2 against each of the standards in Monitor's Risk Assessment Framework. The following five standards were not achieved in the quarter:

- A&E 4-hour standard (1.0)
- 62-day GP Cancer standard (1.0)
- RTT Non-admitted pathways standard (1.0)
- RTT Admitted pathways standard (1.0) – following a request from NHS England for all trusts to reduce the number of patients on their elective waiting lists
- RTT Incomplete/Ongoing pathways standard (no score - RTT standards failure capped at 2.0)

With the cap on the failure of the three RTT standards taken into consideration, this gives a Service Performance Score of 4.0. Under the rules set-out within the Risk Assessment Framework, the failure of the RTT Non-admitted, 62-day GP standard and the A&E 4-hour standards in quarter 2 would trigger Governance Concerns for repeated failures of the same standard. However, Monitor has already reviewed performance against these standards and restored the Trust to a GREEN rating. Monitor has also confirmed that the Trust will only being taken into escalation if the agreed recovery trajectories are not achieved.

Please note that performance against the cancer standards is still subject to final national reporting at the beginning of November and therefore the position shown in Table 2 remains draft. Performance against the 62-day screening standard is currently 1.0% below the 90% standard, mainly due to breaches at treating providers. For this reason the Trust is pursuing breach reallocation to secure achievement of this standard if final validation by other providers does not take overall performance above the 90% standard.

3. Quarter 3 2014/15 risk assessment

The risk assessment detailed in Table 2 sets-out the performance against each standard in Monitor's 2014/15 Risk Assessment Framework in quarter 2, along with the key risks to target achievement for quarter 3 2014/15. The mitigating actions that are being taken are also provided, along with the residual risk.

All three RTT standards are expected to be failed during quarter 3, reflecting the planned failure of RTT standards across the country in order to reduce the number of patients waiting for treatment. Whilst the expectation is that the Non-admitted standard will be achieved from the beginning of December, the planned failure of the standard for the first two months of the quarter will result in the standard being failed for the quarter as a whole from a regulatory perspective. The RTT Incomplete/Ongoing pathways standard is expected to be failed for a minimum of October and November, during which time backlogs are addressed.

There is also the potential failure of the 62-day Screening standard, following the transfer out of the Avon Breast Screening service. Whilst in the previous four quarters the Trust would have achieved the 90% standard with bowel and gynaecology screening pathways alone, the 90% standard would have been failed in quarter 2 has breast pathways not been contributing to performance. This reflects the inability to absorb unavoidable patient choice and medical deferral related breaches, when the total numbers of pathways that are reported are so low (circa 15 per quarter in the future). Whilst it is expected the 90% standard will be achieved most quarters, it is unlikely to be

achieved every quarter for this reason. It is therefore recommended that failure of this standard is flagged as a risk to Monitor in future quarters. Whilst flagged as having a moderate residual risk of failure, it is also recommended in the narrative that accompanies this declaration that the potential risk of failure of the A&E 4-hour standard is noted for two specific reasons, which are if partner organisations fail to deliver on the actions set-out in the shared improvement plan, and demand exceeds that which has been reasonably planned for.

Two further standards are flagged as having a moderate residual risk of failure, which are the 62-day GP cancer standard, and the 31-day subsequent surgery cancer standard. Further details of the risks to achievement of these standards are detailed in Table 2. These standards will remain under close scrutiny through the Service Delivery Group (SDG) and the Senior Leadership Team (SLT).

4. Recommendation

The recommendation to the Senior Leadership Team is to declare the standards failed in quarter 2 2014/15 as being the three RTT standards, the 62-day GP cancer standard and the A&E 4hour standard. It is also recommended that the narrative that accompanies the declaration should flag potential risks to failure against the A&E 4-hour standard and the 62-day screening standard, for the specific reasons set-out in section 3 above.

Table 2 Summary of performance in quarter 2 2014/15, and the risks to quarter 3 compliance

Indicator	Score	Achieved in Q2 2014/15?	New risks to Q3 2014/15?	Risks/Issues	Steps being taken to mitigate risks	Original risk rating	Residual risk rating[1]
18-weeks Referral to Treatment for admitted pathways (aggregate)	1.0	No – failed each month as part of the national planned failure	No – ongoing risk from Q2 of high backlogs	- Long waits for first outpatient appointments in Adult ENT, Dermatology, Dental and some paediatric specialties. - Admitted backlogs high and above sustainable levels in Paediatric specialties (ENT, Plastics, Surgery and T&O) Upper GI, Cardiology, and Ophthalmology. - NHS England has requested a further reduction of the RTT waiting lists in October and November (with the Trust planning to take further action to reduce backlogs in December), which will result in a failure of the Admitted standard, and as such the risk to admitted RTT performance is noted as high*	- In accordance with NHS England request, additional activity planned during quarters 3, to reduce the size of the backlog - Waiting list transfers to other providers (e.g. Independent Sector Treatment Centre) - Robust monitoring and escalation to optimise the number of long waiters booked each month.	High*	High*

[1] The 'Residual' Risk Rating represents the most likely risk level that will remain once the impact of mitigating actions have been applied to the 'Original' risk. The 'Original' risk is the risk rating before any mitigating actions have been taken. For this reason the terms are different from the 'Current' and Target' risk categories used on the Trust's Risk Register for the management of risk.

18-weeks Referral to Treatment for non-admitted pathways (aggregate)	1.0	No – failed as part of the recovery trajectory	Yes – see Risk/Issues section	- Additional new outpatient appointments planned in Cardiology, Dental specialties, Adult ENT and Dermatology to reduce the volume of Non-admitted pathways, which in time will also effect shorter Admitted RTT pathways - NHS England has extended the 'amnesty' on failure of the RTT standards to October/November, in order to reduce waiting times (*the Trust will therefore be extending the failure of the Non-admitted standard in order to bring about more optimal waiting times, and for this reason is flagging the Non-admitted standard failure as High risk) - Non admitted RTT performance cannot be planned/managed in the same way as admitted pathways, because attendance at an outpatient appointment may, or may not, stop a patient's RTT clock	- Additional activity planned in quarter 3, with continued weekly monitored and re-profiling of required capacity; - RTT steering group overseeing the implementation of the plans to reduce outpatient and other stage of treatment waits, with a weekly RTT working group reporting into this.	High*	High*
18-weeks Referral to Treatment for	1.0	No – failed in August and	No – ongoing	- Same as for RTT admitted - NHS England has extended	- See RTT admitted and non-admitted plans	High*	High*

incomplete pathways (aggregate)		September	risk of high admitted and non-admitted backlogs from quarter 2	the 'amnesty' on failure of the RTT standards to October/November, in order to reduce waiting times (*the RTT incomplete/ongoing pathways standard is being flagged as High risk for this reason)	- Plans to reduce further reduce first outpatient waiting times should reduce the non-admitted backlog and help off-set the high admitted backlog - Extension of the national planned failure of the RTT standards into quarter 3 will allow more admitted backlog cases to be brought-in - Small team of temporary staff appointed to validate 'On hold' patients on Medway, which is also likely to drive improvements in RTT Incomplete/Ongoing performance through more pro-active pathway management		
A&E Maximum waiting time 4 hours	1.0	No – performance in Q2 = 92.8%	Yes – additional risks due to winter pressures	- Ambulance arrivals 10% higher and emergency admissions 8% higher than in Q2 last year. These levels are above that planned for to account for the Frenchay Emergency Department closure - Delayed Discharges remain high at circa 60 patients at any point in time, and delays to assessment have increased - Short-term loss of Emergency Department (ED) observation bed capacity at the Bristol Children's Hospital during the planned expansion of	- System-wide Resilience Plan, supported by additional funding (full impact of the plan not expected to take effect until November); - Implementation of Breaking the Cycle at the Children's Hospital during the week commencing the 29th September - Learning and actions taken forward to support performance at the Bristol Children's Hospital in future years if there is another spike in respiratory cases (expected impact quarter 3)	High	Moderate

				the ED - Expected increase in emergency admissions/age profile over the winter, which will impact towards the end of quarter 3 - Quarter 3 is typically the period during which the peak in respiratory admissions is seen at the Children's Hospital, which in previous years has had a significant impact on 4-hour performance			
Cancer: 62-day wait for first treatment – GP Referred	1.0	No	No – continued risks from Q2	- High levels of late tertiary referrals - Thoracic surgical capacity below levels required to be fully responsive to demand - High levels of medical deferral, patient choice, and clinical complexity (none of which can be accounted for in waiting times and are very difficult to mitigate) - Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard - Intensive Therapy Unit (ITU) / High Dependency Unit (HDU) bed related cancellations –	- Cancer Performance Improvement Group focusing on pathway redesign for high volume, lower performing, tumour sites and improving steps in the pathway for high volume causes of breaches - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work - Additional Thoracic Surgery theatre capacity made available from early October, with the planned transfer out of the Vascular service; - Patients on the cancer patient tracking list continue to be actively managed and any delays escalated to Divisional Directors and Chief Operating Officer	High	Moderate

				improvements seen since the opening of the twentieth ITU bed at the end of February, but cancellations still impacting at peak levels of demand - Improvements against trajectory have not been seen in quarter 2, but this is thought to be due to the higher than expected pressures on thoracic surgical capacity, for which there wasn't a sustainable solution available in quarter 2.	- Breach reallocations to be agreed with late referring providers as necessary and where possible - See also A&E 4-hour plans		
Cancer: 62-day wait for first treatment – Screening Referred		Yes – 90% standard expected to be achieved upon final validation and/or with breach reallocation (5 out of 5.5 breaches outside of the control of the Trust)	Yes – transfer of Avon Breast Screening (full effect expected by end of Q3)	- Following the transfer of the Avon Breast Screening Service in quarter 2, the majority of the Breast Screening pathways will no longer be reported under this standard; breast pathways normally completed in under 62 days, although more recently performance at other providers has deteriorated - In quarter 2 the 90% standard would have been failed with bowel and gynaecology pathways along (this is the first time	- Specialist practitioner and colonoscopy waiting times remain short and continue to be closely monitored - Any patients on shared pathways continue to be actively tracked via our Cancer Register until treated at other providers - Need for additional elective capacity for colorectal surgery continuously reviewed - All CT colon scanning and reporting delays escalated, and further work is planned to reduce delays - Patient choice and medical deferral related breaches cannot be fully mitigated, and for this	High	High

				this would have happened in 5 of the last quarters) - All bowel screening pathways originate at the Trust, and therefore capacity constraints at other providers will have a knock-on impact on our performance - Patient choice in bowel screening pathway - Age extension to the bowel screening programme - Colorectal elective capacity not always sufficient to meet demand - High volumes of bowel screening patients needing CT colonography, for which there is a capacity constraint - Numbers of cases reported under this standard will in the future be low, due to the loss of the breast pathways, so small numbers of breaches may have a large impact	reason the residual risk remains high.		
Cancer: 31-day wait for subsequent treatment - subsequent surgery	1.0	Yes	No	- Cancellations of surgery due to emergency pressures (mainly ITU/HDU beds) - Having enough surgical capacity to meet peaks in	- Book dates for surgery at least 7 days before the breach date to enable the patient to be re-booked if cancelled on the day for unavoidable reasons - Impact of 'Managed beds' project,	High	Moderate

				demand, especially for the hepatobiliary service - Unpredictably high volume of delays due to medical deferrals in some quarters	which should reduce cancellations due to no ward bed being available; this should also free-up ITU/HDU capacity - Twentieth ITU bed operational, which has helped to reduce cancellations for this reason although cancellations still impact on performance at peak levels of demand		
Cancer: 31-day wait for subsequent treatment - subsequent drug therapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for subsequent treatment - subsequent radiotherapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for first definitive treatment	1.0	Yes	No	- Thoracic surgery capacity shortfall - Unpredictably higher volumes of breaches, in previous quarters, due to medical deferrals and cancellations of surgery (mainly as a result of ITU/HDU bed availability)	- Additional thoracic capacity comes online early in October, following the planned transfer-out of the Vascular service, which has reduced the level of risk - Book dates for surgery at least 7 days before the breach date to enable the patient to be re-booked if cancelled on the day for unavoidable reasons - Twentieth ITU bed operational, which has helped to reduce cancellations for this reason	Moderate	Low

					- Review of Critical Care capacity ongoing as part of the 2014/15 Operating Model - Head & Neck pathway review action plan continues to be implemented, including work to reduce delays to dental extractions prior to radiotherapy - Continue to pro-actively manage patients on the Cancer patient tracking list		
Cancer: Two-week wait - urgent GP referral seen within 2 weeks	1.0	Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Clostridium difficile	1.0	Yes – 5 potentially avoidable cases in Q1/Q2, which is below the target of 20	No	- Target for 2014/15 as a whole is 40 cases (5 more than in 2013/14), - Flat profiling of annual target continues to be imposed by Monitor - Bristol community is an outlier for antibiotic prescribing	- Procalcitonin testing of high risk patients in the Elderly Assessment Unit (EAU) and Medical Assessment Unit (MAU) continues, to reduce the use of un-necessary antibiotics - An antibiotic prescribing phone application has been implemented - Use of Fidaxomicin to treat patients at high risk of C. diff recurrence or relapse - Awareness sessions for GPs and Nursing Home Managers - Rigorous Root Cause Analysis of cases to continue to enable any C. diff cases not resulting from a lapse in quality of care to be demonstrated to the commissioners.	Moderate	Low
Certification	1.0	Yes	No	- No significant risks	See the standard set-out in Appendix	Low	Low

against compliance with requirements regarding access to healthcare for patients with a learning disability					1, which the Trust is declaring compliance with.		

Appendix 1 – Learning Disability Access Criteria

Criteria	Trust evidence
1. Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	• The Trust has a clinical alert system which has approximately 3,000 patients registered and is managed by the learning disabilities Nurse/team. This system has proven to be an effective way of identifying known patients with learning disabilities when accessing both inpatient and outpatient services • The Trust has an informative learning disabilities internal web page which includes referral pathways and documentation tools to support assessments, implementation and reasonable adjustments. The learning disabilities risk assessment gives opportunity for staff teams to record all reasonable adjustments made against the identified needs • When individuals with learning disabilities are referred to the learning disabilities team from carers or external providers (local authority), the team is able to support pre-planned admissions and make reasonable adjustments according to identified needs. As a Trust we are able to provide multiple procedures under one general anaesthetic, bringing diverse teams together as required for treatment and/or investigations
2. Does the NHS foundation trust provide readily available and comprehensive information to patients with learning disabilities about the following criteria: - Treatment options - Complaints and procedures and - Appointments?	• The Trust has a series of `Easy Read' leaflets. Easy Read uses pictures to support the meaning of text. It can be used by a carer/staff teams in support of the decision making process regarding treatment and care • The Trust 'Easy Read' range includes: ➢ Healthcare and treatment options ➢ Consent ➢ How to contact patient support and complaints team ➢ Going into hospital and what happens ➢ Learning disabilities liaison nurse ➢ Being discharged from hospital • The Trust has various appointment letters to support individuals individual needs
3. Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	• The trust has a `Welcome pack' which profiles the Trust providing a range of information around admission and orientation when visiting • The learning disabilities risk assessment has a section to identify the needs of family and carers to ensure reasonable adjustments are made for them as well

	as the individual receiving direct care • The learning disabilities team provide support to all carers identified for individuals accessing both inpatient and outpatient services and continues from preadmission through to discharge planning. • The Trust has a Carers' Strategy and Carer support worker to support the needs of carers
4. Does the NHS foundation trust have protocols in place to routinely include training on providing health care to patients with learning disabilities for all staff?	• The Trust `essential training' programme including at Trust induction learning disabilities awareness training for non-clinical and clinical staff and includes medical staff • The LD nurse delivers custom made training to meet the needs of existing staff groups as required • Annual training events are hosted for link nurses to support their knowledge and skills in caring for patients with learning disabilities
5. Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	• The Trust consults with Learning Disability user groups when strategies and Easy Read materials are in draft format for comments • The Trust provides annual training events whereby users groups attend and receive training around health needs, procedures and support systems available when accessing acute services
6. Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	• The Trust has a Learning Disabilities Strategy that informs the work plan for the Steering Group and sets the standards • Service delivery and outcomes are captured by the learning disabilities team and are incorporated into Trust and divisional objectives • The learning disabilities team monitor monthly the risk assessment and reasonable adjustment compliance to deliver the CQUIN and ensure best care • The Learning Disability Steering Group reports to the Patient Experience Group

Appendix 2 – Draft declaration to Monitor for Quarter 2

Declaration of risks against healthcare targets and indicators for 2014-15 by University Hospitals Bristol

These targets and indicators are set out in the Risk Assessment Framework

Definitions can be found in Appendix A of the Risk Assessment Framework

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring under Risk Assessment Framework	Risk declared at Annual Plan	Scoring under Risk Assessment Framework	Quarter 2 Actual Performance	Achieved/Not Met	Any comments or explanations
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	No		82.4%	Not met	Failed as part of the national planned failure. Achieved 84.7% for the quarter as a whole.
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	Yes		89.0%	Not met	*Achieved 89.5% for the quarter as a whole (lowest month Sep - 89.0%)*
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	1	90.0%	Not met	*Achieved 91.0% for the quarter as a whole (lowest month Sep - 90.0%)*
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	Yes	1	92.8%	Not met	*Average for the quarter = 92.8%.*
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	Yes		76.9%	Not met	*Breach reallocations not being sought; 26 late referrals were receieved (c. 5% impact)*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	No	1	90.8%	Achieved	*Expecting to achieve 90% following final validation and/or breach reallocation.*
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					76.9%		*Figures subject to final national reporting*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation					89.9%		5 of 5.5 breaches outside of the control of the Trust.
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No		94.2%	Achieved	*Figures subject to final national reporting*
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No		99.7%	Achieved	*Figures subject to final national reporting*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	0	97.8%	Achieved	Figures subject to final national reporting
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	0	96.0%	Achieved	Figures subject to final national reporting
Cancer 2 week (all cancers)	93%	1.0	No		95.0%	Achieved	*Figures subject to final national reporting*
Cancer 2 week (breast symptoms)	93%	1.0	No	0	0.0%	Not relevant	
C.Diff due to lapses in care	20	1.0	No	0	5	Achieved	*A total of 5 cases in Q1/Q2 were deemed to be due to lapses in care.*
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)					31		
C.Diff cases under review					0		
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	No	0	N/A	Achieved	

Risk of, or actual, failure to deliver Commissioner Requested Services		Report by Exception	No	No	
CQC compliance action outstanding (as at time of submission)			No	No	
CQC enforcement action within last 12 months (as at time of submission)			No	No	
CQC enforcement action (including notices) currently in effect (as at time of submission)			No	No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)			No	No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)			No	No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration			No	No	

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A There are five targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 2. These are: the A&E 4-hour standard, the RTT Non-admitted, Admitted and Incomplete pathways standards, and the 62-day GP cancer standard. The Trust performed at 92.8% against the A&E 4-hour standard in the period. During quarter 2, the Trust continued to experience system pressures, including an 10% increase in ambulance arrivals above the same period last year. In contrast to quarter 3 and quarter 4 of 2013/14, when overall levels of emergency admissions stayed similar to the previous year, in quarter 2 this year the rise in ambulance arrivals was associated with an 8% increase in emergency admissions. An estimated two thirds of the increase in emeregency admissions is due to the change in emergency flows following the relocation of Frenchay Emergency Department and is broadly in line with our planning assumptions. However, the remaining rise is above that forecast from the Trust and community planning assumptions, and does not appear to reflect a change in admissions practices internally. At any point in time there continues to be 50 to 60 delayed discharge patients un-necessarily occupying acute beds. The changing age-profile of emergency admissions, with a further 8% rise in emergency admissions for patients aged 75 years and over experienced in quarter 3 and 4 2013/14, over and above that seen in the previous winter, poses risks to achievement of the 95% standard in quarters 3 and 4, as does the still emerging pattern and scale of emergency admissions following the relocation of Frenchay Emergency Department. The Trust is planning to mitigate these (continued below).

B system risks through an action plan with partner organisations which was put in place during the latter half of quarter 2, the full impact of which is expected to be felt from November. The impact of the schemes within the actions plan have been assessed, from which an improvement trajectory has been developed. It is estimated that 35% of the forecast improvement in performance against the 4-hour standard will arise from actions taken by partner orgnaisations.
Due to the transfer of Head & Neck services from North Bristol NHS Trust and the associated transfer of a large number of patients with extended waits, the Trust declared in its 2013/14 Annual Plan significant risks to the Trust's achievement of the non-admitted RTT standard, with the potential risk of failure in two quarters. The 95% standard was failed in quarter 2 and 3 2013/14, but then again in quarter 4 and quarter 1, despite backlog levels reaching a sustainable level (i.e. greater than 95% of patients on ongoing non-admitted pathways were waiting less than 18 weeks). Over the last 12 months the Trust has seen a significant increase in GP referrals, especially in capacity constrained specialties such as dental specialties and dermatology, the latter reflecting lack of adequate service provision in other parts of the community. The Trust continues to implement a plan of reduce waiting times for first outpatient appointments, which has required significant additional capacity, especially in Dental specialties. The recovery plan ran during quarters 1 and 2 of 2014/15, during which the 95% standard was not expected be achieved as a result of backlog clearance. Further work was undertaken to support the national initiative to reduce admitted RTT backlogs throughout Q2. (cont'd below).

C However, there has been a significant growth in additions to the elective waiting list, which in combination with the non-admitted backlog has led to failure of the RTT Incomplete pathways standard. The Trust has initiated a programme of work to assess capacity and demand, supported by the Interim Management and Support (IMAS) team. The Trust has also embarked upon discussions with the commissioners around options for further demand management in pressurised services. The 62-day GP cancer standard was failed in quarter 4 and quarter 1, primarily due to high levels of unavoidable breaches (late referrals, medical deferrals/clinical complexity and patient choice). A programme of work on improving cancer pathways has continued into 2014/15, focusing on both further minimising internal causes of breaches, but also on working with other providers to reduce late referrals. The Board therefore declared a risk against this standard in quarter 1 and 2. During quarter 2 the Avon Breast Screening service transfers to North Bristol Trust. As a result the majority of 62-day breast screening pathways will no longer be shared with other providers; a small number of radiotherapy and chemotherapy treatments will still be undertaken in the Trust's Haematology & Oncology Centre. The remaining number of pathways reported by the Trust will be small, and therefore a small variation in the number of breaches will result in large fluctuations in performance. The main risks of delays in the remaining 62-day screening pathways (bowel and cervical cancers) arise from patient choice and capacity constraints at other providers, which are largely outside of the control of the Trust.

University Hospitals Bristol NHS
NHS Foundation Trust

For consideration and approval by

Finance Committee	24th October 2014 – Agenda Item 8
Trust Board	30th October 2014

QUARTER 2 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURN

Director of Finance
October 2014

1. EXECUTIVE SUMMARY

This commentary covers the results for the 6 months ending 30th September 2014. The Trust reports an EBITDA[1] surplus of £18.318m. This is £0.477m lower than the Annual Plan projection to date of £18.795m. The Continuity of Service Risk rating is 4 (actual 4.0).

	2013/14	September 2014	Plan 2014/15
Liquidity			
Metric Performance	2.71	4.90	2.53
Rating	4	4	4
Capital Service Capacity			
Metric Performance	3.04	2.91	2.51
Rating	4	4	4
Overall Rating	**4**	**4**	**4**

4	**3**	**2**	**1**
0	**(7)**	**(14)**	**<(14)**
2.5	**1.75**	**1.25**	**<1.25**

The financial plan for the year is a £5.800m income and expenditure surplus before technical items.

The Trust remains on target to deliver the planned surplus for the year.

[1] Earnings Before Interest Taxation Depreciation and Amortisation

2. NHS CLINICAL INCOME

NHS Clinical income is £6.213m lower than the Monitor Annual Plan, standing at £231.569m for the period. NHS Clinical income includes income from NHS commissioners and territorial bodies.

The variance for the half year is explained in table 1 below:

Table 1 – Clinical Income – Quarters 1&2 - Variance from Plan

	£m
Monitor Plan	238.369
Under Performance (See Table 2 Below)	(3.503)
Year To Date Income	234.866

Activity and Income by Worktype

Performance against the current plan for the first two quarters is summarised below by worktype.

i. Elective Inpatients

Overall Elective Inpatients are £1.223m behind plan. Impacts from temporary capacity restrictions as a result of construction work are continuing to affect Cardiology & Cardiac Surgery volumes, offset by some over performing areas including Upper Gastrointestinal Surgery.

ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £5.179m behind plan for the quarter. The key driver of this is the transfer of Maternity Delivery activity into the Pathway work type which appears as part of Other NHS Income. There is also an underperformance in General Medicine / Geriatrics / Hepatology and an overperformance in Vascular Surgery.

iii. Day Cases

Day Cases are £0.444m behind plan for the period. Clinical & Medical Oncology are both below plan, this will be affected by challenges in recruitment of consultant staff. This underperformance is partly offset by strong performance in radiotherapy which includes the Gamma Knife.

iv. Outpatients

Outpatient activity has under-performed by £3.198; this is most largely driven by Genito-urinary Medicine activity transferring from NHS commissioners to local authorities, which appears under other Non-mandatory/Non Protected Clinical Revenue. There is also a general under performance against paediatric specialties following the transfer of specialised paediatric services from North Bristol Trust on 6/7th May as well as an underperformance against dermatology related to expected transfers that have not yet transpired.

v. Accident and Emergency

A&E has under-performed by £0.124m against plan.

vi. Other NHS

Other NHS activity includes Direct Access, Radiotherapy, Critical Care, PbR Excluded Drugs & Devices, Contract Penalties, CQUINs and specialised services such as Bone Marrow Transplants. This category is £6.665m ahead of plan for the period, the most significant element of this is the transfer of Maternity delivery Pathway activity from other work types, although there is also an anticipated under performance against CQUIN plan and for contract penalties. CQUIN targets are more challenging this year.

Table 2 – NHS Clinical Income by Worktype

Worktype	Plan £m	Actual £m	Variance £m
Elective Inpatient	25.471	24.248	(1.223)
Day Case	18.033	17.589	(0.444)
Non-Elective Inpatient	49.010	43.831	(5.179)
Outpatient	37.030	33.832	(3.198)
Accident & Emergency	6.897	6.772	(0.124)
Other NHS	101.928	108.593	6.665
Totals	238.369	234.866	(3.502)

Over Performance by Commissioner

During the Local Delivery Plan process the Trust agreed to reduce Service Level Agreement values for demand management schemes put forward by Clinical Commissioning Groups that the Trust believed were over optimistic. Because the Trust did not expect these activity reductions to materialise the clinical income budgets were not reduced, and an income budget was created for a dummy commissioner - Variable Estimates. Table 3 below shows the cumulative income variances by commissioner and how the Variable Estimates income target then adjusts this for the overall position.

Table 3 Performance by Commissioner

Commissioner	Variance £'m	Variance %
NHS Bristol	(8.111)	(10.03)
NHS North Somerset	(3.728)	(17.08)
NHS South Gloucestershire	(1.738)	(11.51)
NHS Bath & NE Somerset	(0.890)	(17.24)
NHS Somerset	(0.248)	(6.16)
NHS Gloucestershire	(0.352)	(13.71)
NHS England	3.186	3.17
Other	3.841	29.88
Variable Estimates	4.538	97.69
Totals	(3.502)	(1.47)

Non Mandatory/Non Protected Revenue

Private Patient Revenue

Private Patient Revenue has under-performed by £0.703m for the period.

Other Clinical Revenue

Other Clinical Revenue is over-performing by £1.252m mainly due to over performance of non patient care services, distinction awards and sales of goods and services.

3. OTHER OPERATING INCOME

Overall other income is £2.144m higher than planned for the period. The main reasons are:

- Higher than planned income from the Trust's Research and Development CLRN contract £0.527m.
- Higher than planned Education and Training Income £0.105m.
- Higher than planned other income £1.512m. This includes higher than planned income for distinction awards, sales of goods and services, and charges for non patient care services.

4. EXPENDITURE

Overall operating costs of £264.533m for the half year are £0.333m higher than plan. Trust pay costs are £1.812 m higher than plan and non pay costs are £1.479m lower than plan.

4.1 Pay Costs

Pay costs at £165.862m for the six month period were £1.812m, higher than plan due to lower than planned CIP delivery and higher than planned spend on agency staff offset by lower than planned spend on permanent staff and vacancies.

4.2 Drugs

Drug costs of £30.956m are £0.176m lower than plan for the period.

4.3 Clinical supplies and services

Clinical supplies and services costs at £29.027m for the period were £0.303m lower than plan mainly due to volume.

4.4 Other Operating Expenses including non clinical supplies

Other costs were £1.000m lower than plan. This is due mainly to lower than expected savings delivery and lower than planned spend on non clinical supplies. Please note that there has been a re categorisation of expenditure in the plan from non clinical supplies to other expenditure relating to hard FM costs at the South Bristol Community Hospital resulting in a lower than planned spend on non clinical supplies .

4.5 Depreciation

Depreciation charges at £9.651m were lower than the Annual Plan projection of £10.221m. This was due to the revaluation of assets at the end of 2013/14 which was completed after the annual plan was submitted.

4.6 Impairment Losses

The Annual Plan provides for an impairment loss of £2m in the first half year in respect of the Helipad incorporated within the BRI Phase III Redevelopment. The actual cost of this was £2.073m. Further impairment charges will be made later in the year for a number of other significant BRI Redevelopment schemes.

5. CAPITAL

There have been a number of approved changes to the Trust's Capital Programme since the submission of the Annual Plan in April. At that stage expenditure for the year was projected to be £57.621m with expenditure for the half year of £31.068m. Actual expenditure at £27.182m equates to 87.5% of the Annual Plan projection.

The table provided below shows a comparison of the Trust's current plan with actual expenditure to date.

	6 months to 30th September 2014		
	Plan	Actual	Variance Fav / (Adv)
	£'000	£'000	£'000
Sources of Funding			
Donations	1,520	1,520	-
Retained Depreciation	9,280	9,230	(50)
Prudential Borrowing	20,000	20,000	-
PDC	609	609	
Sale of Assets	700	700	
Cash balances	(3,564)	(4,871)	(1,307)
Total Funding	**28,545**	**27,188**	**(1,357)**
Expenditure			
Strategic Schemes	(19,740)	(19,361)	379
Medical Equipment	(2,285)	(2,218)	67
Information Technology	(2,083)	(2,056)	27
Roll Over Schemes	(838)	(736)	102
Operational / Other	(3,599)	(2,817)	782
Total Expenditure	**(28,545)**	**(27,188)**	**1,357**

6. STATEMENT OF FINANCIAL POSITION

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £403.662m at the end of September is £3.841m lower than plan. This mainly reflects capital slippage partly offset by higher than planned opening figures at 1 April.

6.2 Inventories (formerly referred to as Stock)

The value of inventories held totalled £11.868m. This is £2.410m higher than planned due to stock increases for services transferred from North Bristol NHS Trust and short-term increases in Pharmacy drugs related to unplanned additional clinical trials.

6.3 Current Tax Receivables

The balance of £2.034m at the end of September represents moneys owed to from Trust by the HMRC for additional VAT that is recoverable under legislation. These moneys either relate to invoices paid to suppliers in September which will be refunded by the HMRC in October or in the case of those recoverable under the BRI redevelopment scheme at the end of the build project.

6.4 Trade and Other Receivables (Including Other Financial Assets)

The balance of trade and other receivables £14.555m is £6.891m higher than plan however moneys owed to the Trust but not yet invoiced, are shown as accrued income and this is currently £8.327m which is £7.438m lower than the plan figure. The Trust continues seeking to reduce the amount of money owed to the Trust. The invoiced debtor balance at 30th September equates to 10.6 debtor days.

6.5 Prepayments

The prepayment balance at the end of September is £3.201m. This is mainly due to payments for maintenance contracts for servicing of equipment. This is broadly in line with the plan of £3.025m.

6.6 Non Current Assets held for Sale

This item relates to the planned disposal of the Grange site. The Trust expects to complete the sale of this asset in the first quarter of 2015/16.

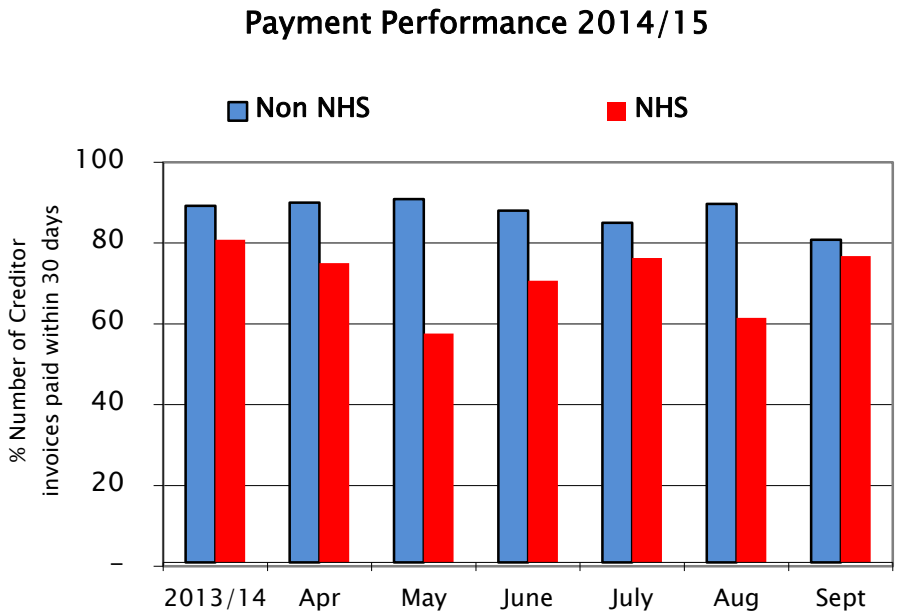
6.7 Deferred Income

Deferred income of £3.133m is £425k higher than the plan of £2.708m. This relates to monies received in divisions for spend later in the year.

6.8 Trade Creditors / Other Creditors / Capital Creditors

Trade, 'Other' and Capital Creditors total £22.972m at the end of September. This is £1.7m above the plan projection of £21.272m.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. For Quarters 1 and 2 of 2014/15 the Trust achieved 69% (88% by value) and 87% (86% by value) compliance against the Better Payment Practice Code for NHS and Non NHS creditors respectively.



6.9 Other Financial Liabilities

The closing balance for accruals at £34.350m is £12.961m higher than the plan of £21.389m reflecting the Trust's current estimate of amounts owing for which invoices had not been received at the quarter end.

6.10 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 30th September together with comparative information taken from the Trust's Annual Plan.

Summary Statement of Financial Position

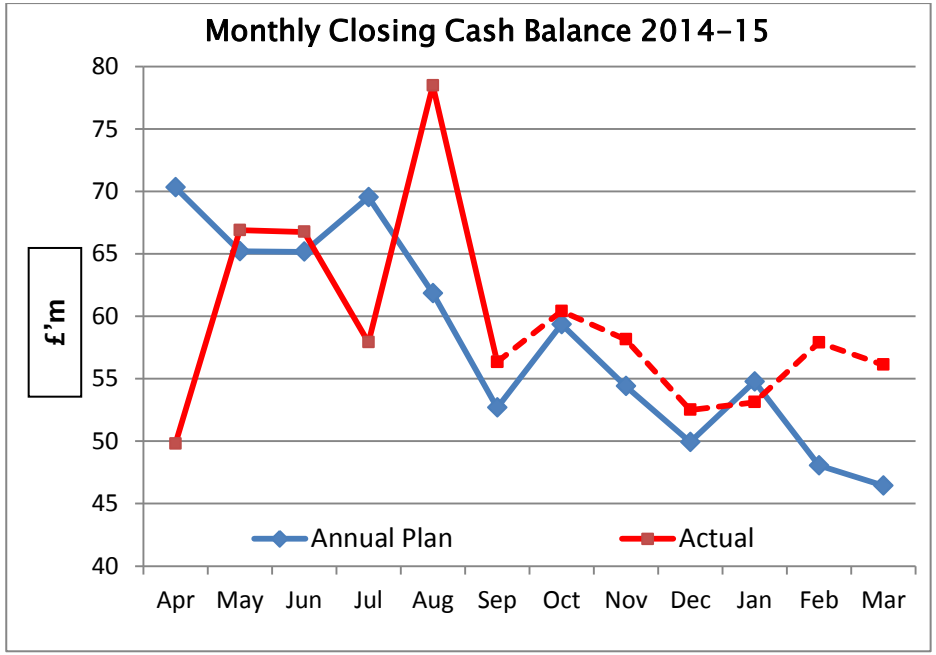
	Position as at 30th September 2014		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Non current assets			
Intangible	8,112	6,615	(1,497)
PPE – Donated	18,642	15,477	(3,165)
PPE – Purchased / Constructed	380,749	381,570	821
Non current assets total	**407,503**	**403,662**	**(3,841)**
Current assets			
Inventories	9,458	11,868	2,410
Current Tax Receivables	684	2,034	1,350
Trade and Other Receivables	7,664	14,555	6,891
Other Financial Assets	15,765	8,327	(7,438)
Prepayments	3,025	3,201	176
Cash & Cash Equivalents	48,708	56,401	7,693
Non Current Assets held for sale	-	1,090	1,090
Current assets total	**85,304**	**97,476**	**12,172**
ASSETS TOTALS	**492,807**	**501,138**	**8,331**
Current Liabilities			
Loans	(3,713)	(3,713)	-
Deferred Income	(2,708)	(3,133)	(425)
Provisions	(260)	(133)	127
Current Tax Payables	(6,500)	(6,397)	103
Trade and Other Payables	(21,272)	(22,972)	(1,700)
Other Financial Liabilities	(22,626)	(35,561)	(12,935)
Other Liabilities	(5,500)	(5,385)	115
Current liabilities total	**(62,579)**	**(77,294)**	**(14,715)**
NET CURRENT ASSETS/(LIABILITIES)	**22,725**	**20,182**	**(2,543)**

	Position as at 30th September 2014		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Non current liabilities			
Loans	(90,847)	(90,847)	-
Provisions	(177)	(169)	8
Finance Leases	(5,456)	(5,430)	26
Non current liabilities total	**(96,480)**	**(96,446)**	**34**
TOTAL ASSETS EMPLOYED	**333,748**	**327,398**	**(6,350)**
Taxpayers' and Others' Equity			
Public Dividend Capital	193,966	192,109	(1,857)
Retained Earnings	83,638	83,108	(620)
Revaluation Reserve	56,059	52,186	(3,873)
Other Reserves	85	85	-
TAXPAYERS' EQUITY TOTALS	**333,748**	**327,398**	**(6,350)**

PPE – Property, Plant and Equipment

7. Cash and Cash Flow

The Trust held cash balances at the end of September of £56.401m. This is £7.693m more than the Annual Plan projection of £48.708m. The graph shown below provides a comparison of actual and projected month-end cash balances for 2014/15.



University Hospitals Bristol NHS
NHS Foundation Trust

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

15. Well Led Governance Review

Purpose

This report updates the Board on plans for a well-led governance framework review, further to the Board development seminar held in July 2014.

Abstract

The 'Well-led framework for governance reviews' was published in May 2014, as a result of collaboration between Monitor, the Care Quality Commission and the NHS Trust Development Authority. UH Bristol will be undertaking a well-led governance review, commencing with a comprehensive self-assessment during the late autumn of 2014. The review will enable the Trust to build on any learning from the CQC comprehensive inspection associated with the 'Well-led' Key Line of Enquiry and presents a significant further opportunity to test the extent to which good governance is embedded within the organisation.

Recommendations

The Board is recommended to note the report.

Report Sponsor

Chief Executive, Robert Woolley

Report Authors

Head of Quality (Patient Experience & Clinical Effectiveness), Chris Swonnell
Regulatory Compliance and Quality Project Manager, Susanne Hayward
Interim Trust Secretary, Julie Dawes
Joint Interim Head of Membership and Governance, Brian Courtney

Appendices

Well-led framework for governance reviews

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

Subject: Well-led framework for governance reviews

To: Trust Board

Authors: Chris Swonnell, Head of Quality (Patient Experience & Clinical Effectiveness)
Susanne Hayward, Regulatory Compliance and Quality Project Manager
Julie Dawes, Interim Trust Secretary
Brian Courtney, Joint Interim Head of Membership and Governance

Date: 22nd October 2014

1. Summary

This report updates the Board on plans for a well-led governance framework review, further to the Board development seminar held in July 2014.

The 'Well-led framework for governance reviews' was published in May 2014, as a result of collaboration between Monitor, the Care Quality Commission and the NHS Trust Development Authority. UH Bristol will be undertaking a well-led governance review, commencing with a comprehensive self-assessment during the late autumn of 2014. The review will enable the Trust to build on any learning from the CQC comprehensive inspection associated with the 'Well-led' Key Line of Enquiry and presents a significant further opportunity to test the extent to which good governance is embedded within the organisation.

2. Introduction – Good Governance

Good governance is essential to address financial and operational challenges and to ensure high quality services; Foundation Trust Boards are responsible for ensuring governance remains fit for purpose. The Care Quality Commission has also recently placed an increased emphasis on the importance of good governance through the inclusion of 'Well-led' as one of its five Key Lines of Enquiry for comprehensive inspections:

> "By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality care for patients, support learning and innovation and promote an open and fair culture."[1]

The Trust is currently awaiting the draft outcome of its first CQC comprehensive inspection, which will include an assessment of 'Well-led', across the organisation and within each of its core services.

3. The Well-led framework for governance reviews

The 'Well-led framework for governance reviews' was published in May 2014, as a result of collaboration between Monitor, the Care Quality Commission and the NHS Trust Development

[1] Care Quality Commission Key Lines of Enquiry; also in Well-led framework for governance reviews, p6

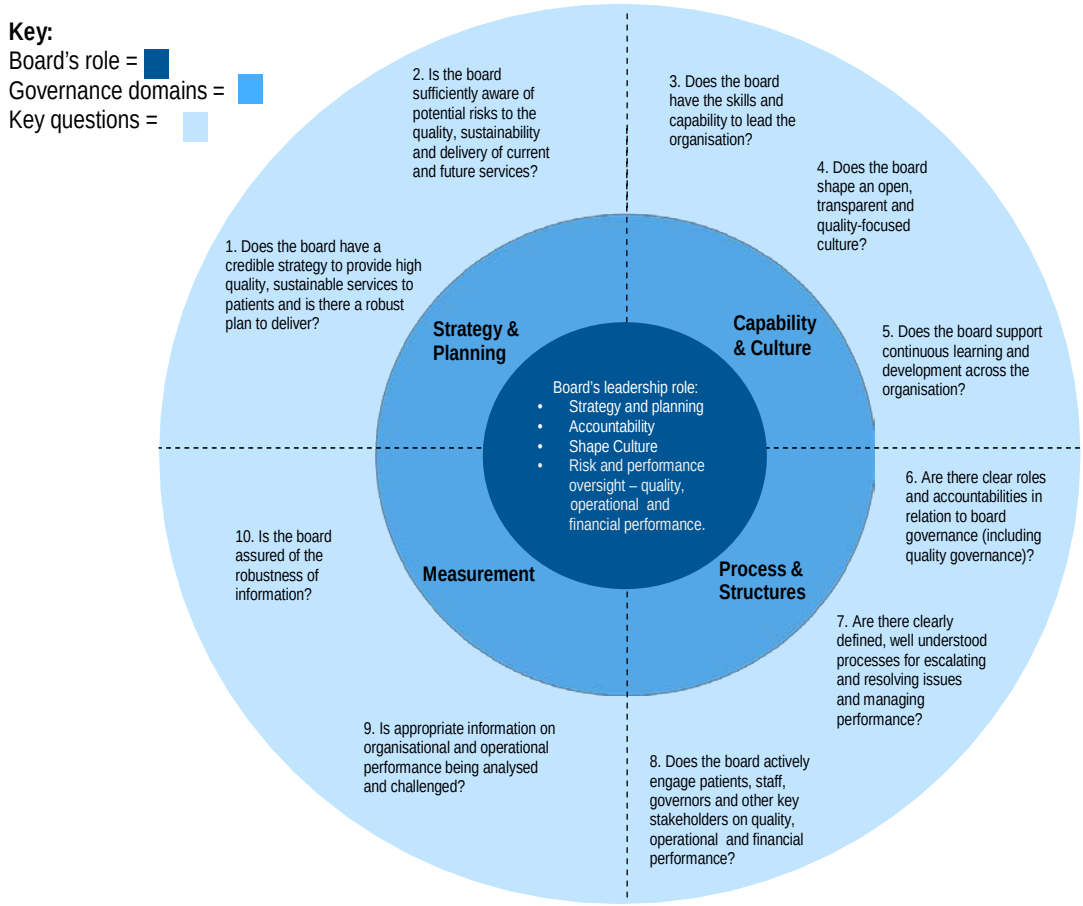
Authority, and prompted in part by the need highlighted by Robert Francis QC for trusts to establish and support governance cultures that put patients first.

The well led framework for governance reviews (WLFGR) brings together the previous Monitor Quality Governance Framework (QGF) and Board Governance Assurance Framework (BGAF) as a single framework. The governance review process consists of an internal assessment followed by an external review. By undertaking this review, Foundation trusts fulfil the Monitor's expectation for FTs to carry out an external governance review every three years (in line with its Code of Governance and Risk Assessment Framework); whilst compliance with the framework also counts as substantial evidence towards compliance with the CQC's expectations for 'Well led'.

The framework consists of 10 questions split into four domains (see Diagram 1 below). Each question is supported by examples of good practice. Monitor emphasises that:

> "The evidence base is not intended to be a 'box-ticking' exercise, rather it should be used to guide trusts' and assessors' views in considering whether the processes and overall organisational culture in these areas are fit for purpose."[2]

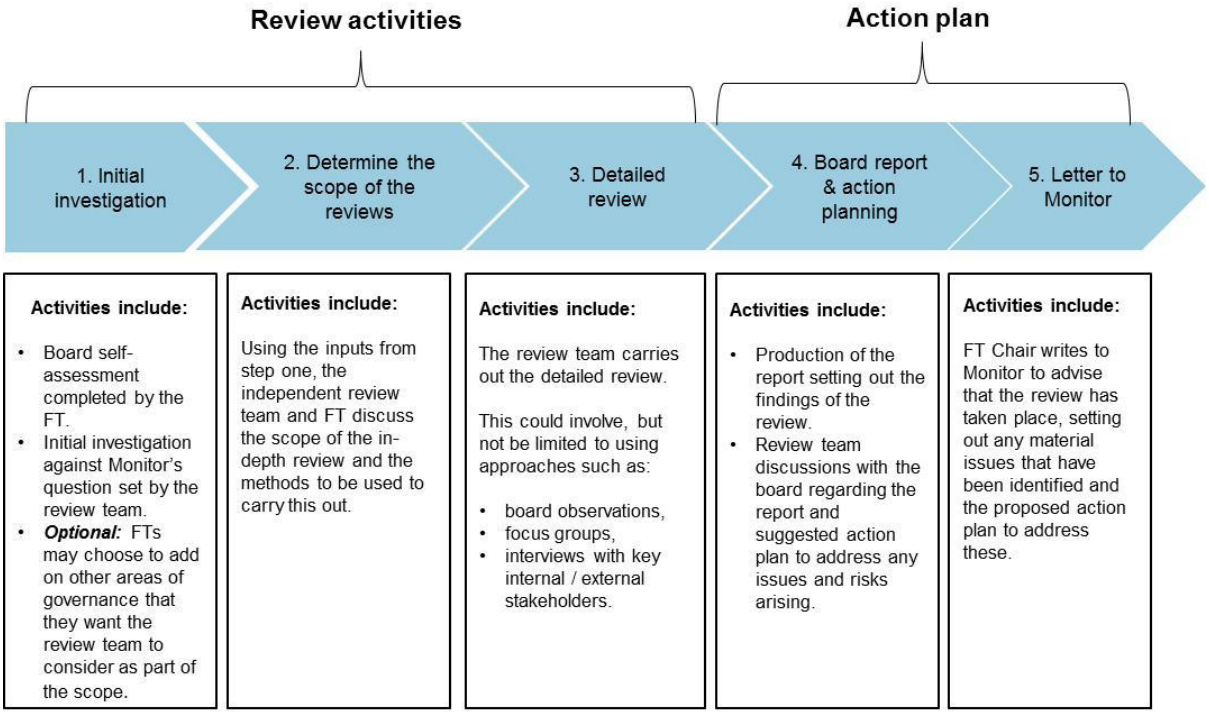
Diagram 1. How the 'well-led framework for governance reviews' fits together and the main areas for review



[2] WLFGR p4

4. Stages of the well-led governance review

Monitor describes the process as follows (WLFGR, p16):



5. Planning a well-led governance review at UH Bristol

Well-led governance reviews (WLGRs) are to be commissioned by trusts, for trusts. Foundation trusts are free to commission reviews from whomever they want (there is no procurement framework). Whilst FTs have freedom to schedule when the review takes place, Monitor has requested that UH Bristol's review commences by the end of January 2015[3]. The timing of the review will enable the Trust to build on any learning from the CQC comprehensive inspection and presents a significant further opportunity to test the extent to which good governance is embedded within the organisation. The external review will also provide independent assurance that the Trust/Board's own self-assessment was sound and demonstrated strong self-awareness.

The lead Executive director for the WLGR is the Chief Nurse[4] and the WLGR will be managed as a project by the Trust's Regulatory Compliance and Quality Project Manager, supported by the Head of Quality (Patient Experience and Clinical Experience), working in collaboration with the Trust Secretariat.

A previous QGF self-assessment was undertaken by the Trust Secretary and reported to the Board in March 2012; this was subsequently updated by the Heads of Quality (at the request of the Trust Secretary) and reported to the Quality & Outcomes Committee of the Board in January 2014. The QGF review was undertaken as a high-level exercise based to a large extent on the knowledge, experience and opinions of senior staff in the organisation. Unlike the QGF, the WLGR will involve formal gathering, collation and scrutiny of supporting evidence.

[3] Letter from Monitor to UH Bristol dated 28 July 2014 requests that the review commences within six months
[4] This decision has been taken to ensure continuity at a time of personnel changes in the Trust Secretariat

6. Trust self-assessment

The initial self-assessment process will be overseen by the Regulatory Compliance and Quality Project Manager with guidance from the Head of Quality (Patient Experience and Clinical Experience) and Trust Secretariat. Leads will be identified for each line of enquiry within the ten questions. The self-assessment will be an iterative process driven by a desktop review of documented evidence supplemented by conversations with key staff (including Directors) where appropriate. The self-assessment will not attempt to replicate the scale and depth of the formal external review which will follow in early 2015, nonetheless any key gaps identified by the self-assessment will be discussed by the Board in January 2015 and actions agreed where appropriate in advance of the external review.

As part of the self-assessment RAG ratings will be assigned to the ten questions plus an overall provisional rating. The findings of the self-assessment will be used in discussion with the appointed auditors to help shape the content of the formal review.

7. Review by external auditor

The formal external review will take approximately eight weeks. As well as a desktop review of documentation, the review is likely to include (but not be limited to): one to one interviews with Board members, staff, and the Lead Governor; Board, stakeholder and governor surveys; focus groups with internal and external stakeholders including the Council of Governors ; Board and Committee observations; and a Board skills inventory.

8. Presentation of findings

The proposed project timescale envisages a presentation of initial findings by the external auditor to a private session of the Board in April 2015, after which the report will be released to the Trust (and to Monitor) and an action plan will be developed. The final report, including action plan, will be presented and discussed at a public board meeting in June 2015.

9. Project governance and communications

Progress of the WLGR project will be monitored by a small steering group comprising the Chief Nurse, Trust Secretary, Head of Quality (Patient Experience & Clinical Effectiveness) and the Regulatory Compliance & Quality Project Manager. This group will meet weekly to ensure the project is a delivered according to timescale.

The project timeline includes an opportunity for the Quality & Outcomes Committee (QOC) to sense-check progress in December 2014 on behalf of the Board, prior to the Board receiving the finalised self-assessment in January 2015: specifically to consider whether there have been any gaps in the self-assessment exercise which may need to be addressed before the exercise is closed.

This paper is being shared with members of the Senior Leadership Team for awareness and dissemination within Divisions. Governors have received an initial briefing about the well led framework from the Trust Secretary as part of a development day earlier in October 2014. The Council of Governors will receive the completed self-assessment, and governors will also be involved in the process of determining any actions relating to their role and responsibilities as a result of the formal review.

10. Project timescale

The project has already commenced: leadership, team, scope and timeline have been agreed, and planning for the procurement exercise to appoint an external auditor has also begun. The external review will commence in January 2015 and the project is due to conclude with a presentation of findings, recommendations and planned actions to the Board in June 2015.

Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
First steps									
- Identify project leadership, team, scope and timeline	■								
- Communications – tell everyone what's happening and why	■								
Self-assessment									
- Initial review of 10 questions and good practice prompts by project leads to agree scope of evidence	■								
- Send out internal requests for evidence / meetings	■	■							
- Gather and review evidence; identify potential gaps		■	■						
- Discuss initial findings with Quality & Outcomes Committee – opportunity for QOC to challenge any perceived gaps in process/evidence to this point (to be rectified)			■						
- Potential Board development seminar to discuss findings of self-assessment				■					
- Initial action planning aligned with CQC inspection report				■					
- Internal self-assessment presented to public Board and Council of Governors				■					
Procurement									
- Commence procurement process	■								
- Review tender submissions from external reviewers		■							
- At Executive level confirm appointment of independent reviewer		■							
Independent review									
- Commencement of 8 week independent Well-Led Governance Review				■					
- Independent reviewer focus groups and interviews					■	■			
- Independent reviewer presents initial findings to private Board							■		
- Independent reviewer issues report to the Board and Monitor							■		
- Develop Governance improvement action plan and Board/Governor development plan to address any specific shortcomings identified								■	
- Papers and recommendations written and issued for June Board meeting									■

University Hospitals Bristol NHS
NHS Foundation Trust

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

16. Board Assurance Framework Report

Purpose

The purpose of the Board Assurance Framework is to track progress against the Trust's stated medium term objectives and specifically to track progress against the annual milestones which were derived as part of the 2014/15 annual planning cycle

Abstract

Following a re-fresh of the Trust's Strategy, the Strategic Objectives have been revised to reflect the agreed vision for the Trust and the objectives that underpin its delivery. The annual milestones reflect the progress required in the current year to ensure delivery of the strategic objective. Importantly, the framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

Risks to delivery, arising from or linked to known risks, are referenced through the BAF to their entry on the Corporate Risk Register (CRR). Predicted failure to achieve one or more objectives within the BAF, is also recorded as a risk in its own right on the Corporate Risk Register.

The BAF is a major source of assurance to the Board that the Trust is on track to meet its strategic objectives. Greater emphasis has been applied to the provision of assurance, notably from external sources, in completing the Q2 framework however, it is recognised, that this requires further emphasis.

Quarter 2 Position

There is 1 (2) objective where the inherent risk to delivery is considered high and is therefore RED rated meaning delivery of the objective at the year-end is in jeopardy. This is:

- To deliver the annual Cash Releasing Efficiency Savings programme in line with the LTFP requirements.

Finally, there are 34 (35) objectives where delivery is forecast therefore with a residual rating of GREEN and 9 (7) AMBER rated objectives which means the milestone is delayed but is expected to recover and achieve by the year end.

NB. Q1 figures noted in brackets.

Recommendations

The Group is advised to **approve** this report having noted progress against the Trust's strategic objectives and received assurance that all risks to achievement of the Trust's strategic objectives are identified and being appropriately controlled.

Report Sponsor
Director of Strategic Development and Deputy Chief Executive
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
	22nd October				Risk Management Group 8th October

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
1	We will consistently deliver high quality individual care, delivered with compassion.	To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model	Develop integrated discharge processes, team and hub Undertake a review of the need for, and nature of, further additional out of hospital capacity Establish early supported discharge for priority pathways Develop plans for weekend discharge based on findings from diagnostic and Breaking the Cycle Implement a protected beds model covering key planned care pathways Review adult critical care provision across the organisation with the aim of eliminating cancelled operations due to access to critical care Ensure a robust operating model for BCH before next winter to prevent repeat of last year's dip in performance Plan and co-ordination of the Breaking the Cycle week and mobilise follow up plan	25%-50%	First steps towards the delivery of these actions have been delivered but not at the pace required in many cases. These will now be pulled together in overarching themes - protected pathways, discharge processes, Out of Hospital Care and Breaking the Cycle Follow up.	Risk of lack of momentum through diverse leadership causing a delay in implementation.	Risk mitigated through bringing the individual projects together in coordinated themes.	Review by Emergency Care Intensive Support Team		753	COO	Senior Leadership Team	
		To ensure patients receive evidence based care by achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners	Reach final agreement with specialised commissioners on standards that they will derogate Develop action plan to achieve compliance with all areas where derogation has not been agreed, in line with timescales set by commissioners.	75% - 100%	Final agreement with commissioners reached with exception of two areas (endocrinology services and e-prescribing of chemotherapy). Action plan in hand to address.	Commissioners decline to derogate standards in areas where compliance cannot be readily secured resulting in financial penalties and the need for Trust investment to achieve compliance	Working proactively with commissioners to understand rationale for derogation and providing appropriate evidence in support of request.	Compliance position reported to Clinical Strategy Group and SLT. Non-compliance recorded on Divisional Risk Registers. External Assessment of compliance by NHS England.			D of SD	Clinical Strategy Group	24th September 2014
		Deliver a programme designed to enhance compassion in clinical staff	Review values training to incl. evaluation of impact on behaviours Implement values based recruitment for RN's Midwives, NA's , domestic assistants, medical staff Develop Compassionate care programme for UH Bristol nurses and midwives - following focus work to identify understanding/barriers to deliver of compassionate care	25% - 50%	Evaluation of value based assment centres in process. Commencment for RN recruitment planned Jan 15. Focussed group to determine what compassion means undertaken in July. Face to face compassion survey undertaken in Sept.	Stress in staff in the workplace (personal and work related) & vacancy rates, staff feeling unsupported impacts on people's ability to deliver compassionate care Weak leadership at team/dept level so team feel unsupported and uninformed	Development and implementation of a health and well being strategy, specific action plans to address any hotspots identified via staff FFT and "pulse checks", develop and implement a trust wide work related stress programme Leadership development of these in key leadership positions to be effective leaders	Delivery of transformational project plan, deliver against UH Bristol staff experience and engagement action plan			CN	Transformation Board	Sep-14
		To establish an effective and sustainable complaints function to ensure patients receive timely and comprehensive responses to the concerns they raise and that learning from complaints inform service planning and day to day practice	To strengthen the Patient Support and Complaints Team resources to address the current lack of resilience. Deliver the complaints annual work plan, which includes learning from Francis/Clywd Hart	50%-75%	Case for increased resources approved May 2013. Recruitment to three new posts will be completed by end of October 2014, increasing team WTE from 4.8 to 7.8. Progress with delivery of some actions in complaints work plan has been affected by backlog of enquiries to Patient Support and Complaints Team, however all actions will be delivered and progress is regularly reviewed by the Head of Quality (Patient Experience and Clinical Effectiveness) and the Patient Experience Group.	Planned increased in WTE has been achieved but risk that sick leave will reduce impact; also risk that a sustained increase in the volume of complaints being received by the Trust (50% more than 12 months ago) will reduce the impact of increased resources (i.e. 'running to stand still').	Occupational Health support.	Delivery of complaints KPIs as per monthly complaints reporting		ref 2647	CN	Executive Directors	PEG Sept 2014
		To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.	Deliver the stretch and quality improvements as per 14/15 CQUIN schedule Deliver all annual quality objectives described in the Trust's quality report	0% - 25%	CQUIN. Specialist CQUINs have been agreed and baselines set in the majority of cases. Local CQUINs have not yet been finalised. Corporate quality objectives. Four objectives have been agreed which will be delivered through the Trust's Transformation Programme: reducing cancelled operations, ensuring no discharges out of hours, reducing inpatient moves and ensuring patients are treated on the right ward for their condition. Board-reported performance to the end of August 2014 is as follows: Last minute cancelled operations YTD is above (worse than) target (1.08% vs 0.92%); outlier bed days YTD is above (worse than) target, with three out of the last four months red-rated; out of hours discharges YTD 8.6%; average number of ward moves also above (worse than) target - red-rated board-reported performance for four of the last five months. The fifth objective is to review and refresh the Trust's approach to patient and public partnership. The scope of the work has been defined to include how we work with people in specific service developments, Trust-wide initiatives and strategic development with an eye to an emerging system wide approach across the BNSSG health community. Q2/Q3 consultation with partners to develop	Delayed sign off with commissioners and/or, lack of clear senior leadership ownership of delivery. Risk of not achieving flow-based corporate quality objectives.	Nominated SLT leads to oversee delivery of individual CQUIN's, robust governance of delivery of CQUIN monitored via SLT, robust monitoring of annual quality objectives, delivery of flow projects. For flow-based quality objectives, see first BAF objective above.	delivery against annual quality objectives reviewed monthly via Flow Group, CQC and Trust Board.			CN	Clinical Quality Group & SDG	CQC Sept 2014
		To achieve upper quartile performance in process and outcome	Implement FFT in outpatient and day case settings	50%-75%	OPD / day case FFT will be implemented from 1st October, as per national schedule. OPD approach	FFT performance is difficult to predict and is affected by service pressures. OPD FFT is	For ED, maternity, inpatient and day case FFT, constant reinforcement and vigilance to	Patient Experience Group monitors FFT (meets bi-			CN	Clinical Quality Group	

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
		measures for the Friends and Family Test (FFT)	Explore options for increasing monthly response rate to meet increased national targets		will include training use of technologies including touchscreen kiosks, SMS texting, QR codes, etc. Monthly response rates for inpatient and ED FFT using paper-based solutions remain on course to achieve 2014/15 national CQUIN targets. Dramatic improvement in maternity FFT response rates during summer 2014. Monthly FFT results are now being displayed on wards across the Trust (professional,colour A3 laminates).	based on giving patients the opportunity to participate, i.e. impossible to personally target every outpatient due to scale. Risk that OPD response rates will initially be very low (but note that CQUIN does not stipulate a minimum required response rate). Overall BAF target (upper quartile performance) is dependent upon the performance of all other providers. Current postition is that FFT scores are above average but fall short of upper quartile; response rates reflect the national average.	maintain response rates. For OPD FFT, initial close monitoring of take-up rate; use of targetted paper-based surveys (from November 2014) to provide 'guaranteed' foundation response.	monthly).						
		To ensure services are compliant with national quality standards including compliance with the draft standards for paediatric cardiac services	To ensure services are compliant with national quality standards including compliance with the draft standards for paediatric cardiac services	0% - 25%	Standards remain in draft form	Workforce or other resource constraints prevent compliance.	Audit of compliance to assess gaps and risks to compliance. Close working with service and commissioners to ensure appropriate developments are supported to address non-compliance.	W&C quality and governance committee			MD	Clinical Strategy Group	
		To ensure the Trust's reputation reflects the quality of the services it provides	Fully engage with Sir Ian Kennedy Review of children's heart services with the aim of restoring trust and confidence in the service and addressing any shortcomings in care quality identified through the Review	50% - 75%	Programme Director for Review appointed and initial engagement with Eleanor Grey QC in hand. Stock take of compliance with standards and prior recommendations underway and held through Cardiac Services Review Group. Proactive media continues, supported by external consultants with signifcant posiitve coverage in the quarter.	Risk that the media does not accurately reflect the quality of the Trust's service offer and/or risk that areas of service quality fall below that expected	Proactive engagement with local media through Trust Communications Team. Programme approach to Kennedy review established to ensure effective engagement. Robust systems of clinical governance and assurance to ensure services are compliant with all necessary standards and specifications.	Weekly media summaries and monthly communications report to Senior Leadership Team. Overview of medai activities through Paediatric cardiac Steering Group. No external assurance available in period.			D of SD	Senior Leadership Team	16th September 2014
			Work proactively with media and other key stakeholders to actively promote positive coverage of the Trust's activities										
		To achieve upper quartile performance standards for all nationally benchmarked patient safety measures	Monitor performance and take corrective action when appropriate.	25% - 50%	Patient safety group function review completed. Trust signed up to Sign up for Safety. No signifcant variance on key safety measures.	Risk that action plans and recovery actions are not progressed	Frequent and regular monitoring of safety performance parameters with regular Patient Safety updates through the Trust's Patient Safety Group				MD	Senior Leadership Team	
			Review Patient Safety Group function within Trust governance apparatus.										
2	We will ensure a safe, friendly and modern environment for our patients and our staff	To successfully deliver phase 3 and 4 of the BRI Redevelopment	Helideck operational May 2014	25%-50%	Helideck operational May 2014. Level 5 handed over June 2014. Progress is monitored by the BRI Redevelopment Board; progress remains on track for delivery.	Risk that acute medical model of care will not be in place in time for October 2014.	1. Division of Medicine asked to re-submit operating plan by end of June 2014 to deliver affordability of model. 2. ECIST to review acute medical model in June 2014 to understand model and to offer suggestions/support/alternatives.	Office of Governance and Commerce (Green rating received in May 2014).		2476 & 759	COO	Senior Leadership Team	
			ITU relocated (Aug), new surgical wards restructured (Aug), new assessment units (Oct), closure of Old Building to inpatient wards (Oct) and completion of inpatient provision in the new ward block (Jan)										
			Complete and handover level 5 of new ward block to Children's Hospital (June)										
			Completion of refurbished wards and ward move plan implemented by Q4 Queen's Lecture Theatre conversion completed and levels 9 & 10 remodelled by end of Q3 Surgical Assessment Unit completed and operational in Q3 Integrated Discharge Hub established. Q3. Staff Restaurant opened Q4.		On target to plan Version 19B, Phase 4 programme. Design changes to the Lecture Theatre require alternative programme to align with Public Health England vacation. Discharge Hub: Delays subject to Lecture Theatre design changes. Staff restaurant on track.							
			Successfully deliver Queen's Building Façade Project										
		Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audit have been implemented	Interim Major Incident plan and Business Continuity plans in place to reflect changes to operational physical estate during BRI redevelopment and service moves by end Q2	50%-75%	Key elements of Major Incident and Business Continuity issues identified in the internal and external audits have been addressed. Remaining outstanding issue is Board paper to be presented June 2014. Ongoing updates of plan remain on track for Q2 and Q4 delivery.	One individual responsible for Emergency Planning therefore, limited resource to enable full commitment to the process and a single point of failure for Resilience within the Trust.	Risk mitigated through changing the staff mix in the COO office.	Internal and External Audits			COO	Senior Leadership Team	
			Six month review following EPRR audit completed										
			Major Incident Plan revised to reflect new BRI build by end of Q4										
		Set out the future direction for the Trust's Estate	Estates and Asset Management Strategy agreed by Board June 2014	25% - 50%	Estates Strategy approved by Board and work to develop Outlines Business Case now underway and on track for consideration by Board in Autumn. Process to evaluate priorities for residual estate yet to commence but planning in hand.	Workforce capacity prevents timelines for strategy and Business Cases (BC) being met	Risk mitigated through externally sourced capacity	Strategy and BCs delivered to Board. External assurance for direction of work forthcoming from Capita who have been retaind as advisers on the project.			D of SD	Senior Leadership Team	June 2014. September update deferred to October to reflect OBC timeline.
			Business Case for future use of Old Building Site and developed and agreed by Board by end of September										
			Scope future priorities for refurbishment of remaining estate post BRI Phase IV and incorporate into forward strategic capital programme										
		Deliver against the National Quality Board 10 safe staffing expectations for Trust Boards	Deliver expectations 1,3,7,8 (June 2014)	75% - 100%	Expectations 1,3,7,8 completed B Detailed report of planned and actual staffing levels presented and reviewed by workforce steering group at first meeting in September. Governance of reporting has been reviewed i n light iof the above group only meeting bimonthly and the requirement to report to Board monthly. This report will thereofre also be presented to SLT and QOC monthly from October	Delay in the procurement of an effective IT solution for measuring patient acuity and dependency	Clear project plan/close working with IT/procurement and supplier (for IT element once identified)				CN	Workforce and Od group - bimonthly. SLT and QOC monthly.	WFODG Sept 14
			Deliver remaining expectations										
3		We will ensure that the workforce feel highly engaged and empowered by implementing a range of agreed actions to develop staff in their place of work and demonstrate a year on year improvement in the annual staff survey engagement score.	Structured programme of listening events to follow up Breaking the Cycle Together - consideration of Listening into Action methodology to equip managers	0% - 25%	A detailed programme of work is underway. The engagement programme includes work on recognising success,, tackling harassment and bullying, positive perfomance management, improved team working and addressing wellbeing - specifically wrok related stress (see below). A new Leadership programme was launched in January;	Slippage of projects due to absence of key project leads / resources. Slippage of one project impacting adversely on another objective/action due to interdependencies.	Continuous monitoring of resources and project plans to identify and rectify resourcing gaps as early as possible. Closely manage interdependent projects to timescale, with frequent updates.	Review by Transformation Board Quarterly Report on Progress at October 2014 QOC			DWOD	Senior Leadership Team	Quarterly update recevied at: CQOC, SLT, T&L SG, and workforce and OD group. Worforce and
			To create a cohesive performance management framework for all staff groups, enabling staff to delivery high quality patient care										

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	We will strive to employ the best and help all our staff fulfil their individual potential.		Development and implementation of a Staff Recognition and Suggestion Scheme Build the capability of our leaders to embed a culture of behaviour and style of management which supports staff in fulfilling their duty of candour Ensure managers build their skills to enable high quality appraisals and objective setting		277 delagates have attended one of the 9 avalable courses which includes appraisal and objective setting. Delivery is supported by a cross-Trust working group.								OD Group have requested updates on Engagement plan at each meeting.
		We will take appropriate action to reduce the incidences of work related stress by introducing a number of measures that support all staff to undertake their role safely	Develop a Trust-Wide Work-Related Stress Action plan - using existing Divisional Stress plans to run in parallel with the development of a Trust Health and Well Being Strategy Health & Safety - evaluate policy and practice to focus high quality patient care to support the reporting learning from incidents including physical violence Discrimination - review and scope opportunities for revised e-learning package to support managers	25% - 50%	Action plan developed - to be considered at the next Health and Safety Committee.	Failure to implement Health and Wellbeing/Stress action plan due to lack of funding and resource.	Appropriate investment in HWB with identified resource and funding. Continuous monitoring of resources and project plans to address resourcing and funding gaps.	Review by Health and Safety Risk Manager Group			DWOD	Risk Management Group	October 2014
		We will equip our leaders with the requisite skills, behaviours and tools to develop high performing teams, so staff have objectives with a clear line of sight to the Trust's vision.	Identify and agree who are our leaders and managers , clearly articulating and agreeing what it means to be a leader, with clear competencies and standards of behaviour. Introduce comprehensive programme of quarterly leadership forums, annual leadership conference and access to learning sets - to ensure leaders understand the opportunities and challenges Revise appraisals to include feedback on leadership competencies and behaviours - to include 360 or staff feedback. Develop and agree a 1 - 3 year Organisational Development plan to provide continuous and systematic leadership development and the need to understand what leadership means as a cultural proposition.	0% - 25%	Broader definition of who is a leader - to pick up front-line supervisors under discussion. New style leaders forum to be developed. Workforce and Organisational Development Strategy to be considered by Senior Leadership Team and Trust Board over the next few months.	Failure to comprehensively identify all staff with leadership roles due to limited definition of "leaders".	Agree definition of leaders e.g. those who are responsible for the development, performance and wellbeing of a number of staff and identify all those who fall within the definition, rather than relying on grade to indicate leadership.	Review by Transformation Board Workforce and OD Group			DWOD	Senior Leadership Team Transformation Board September 2014	Update on Leadership Developmet being pressented to Workforce and OD Group November 2014
		We will revise the Teaching and Learning strategy to ensure the strategic priorities support an attractive and viable learning environment whilst continuing to provide exceptional care to our patients.	To review the existing strategic priorities with the Teaching & Learning Steering Group Revise the priorities in line with the draft strategic vision for UH Bristol To provide a revised Teaching & Learning Strategy in March 2015	25% - 50%	Review of UH Bristol's approach to Education, Teaching and Learning underway, including governance arrangements. A update on strategic priorities to be presented at Board in October	Misalignment of priorities with Trust strategic risk. Failure to work in partnership with providers and HEE.	Comprehensive review of education, teaching and learning.	Review by Teaching and Learning Group, October 2014. SLT November 2014			DWOD	Senior Leadership Team	Update provided to T&L SG in October 2014. Board update in October
4	We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	Implement modern clinical information systems in the Trust	Phase 2 Implementation Phase 3 Design	50%-75%	Programme in hand and will be implemented by the year end. Phase 3 ongoing progress.	IT implementations are inherently high but with adequate mitigation.	Proper programme monitoring and management processes will manage the risks through the IM&T Committee and CSIP Committee.	IM&T Committee and CSIP Committee			DoF	Information Management and Technology Committee	17/09/2014
		We will maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR)maintain our performance in initiating research) and remaining the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR)	(a) Monitor our performance and analyse reasons for failure to meet the benchmark (performance initiating research), putting in place measures to address those reasons (b) Develop and implement, in collaboration with the division of W&C, a sustainable staffing model to deliver paediatric research by the end of 2014/15 (c) Work towards developing a more flexible and agile mechanism to deploy the research delivery workforce across the trust in line with the R&I 'Workforce' work plan. (d) Provide clinical divisions with the information they need to oversee and manage research performance, increasing visibility within divisional boards. (e) Achieve common agreed processes across clinical divisions for job planning and recommendation of research SPA allocation.	25% - 50%	a) Progress is being maintained and performance in quarter 4 was good. 75-100% on this element of the objective. b) Progress on track to deliver by 31/3/15 - 0-25%. c) on track - 0-25% d) Well on track; information provided via TRG; 50-75% e) Discussions ongoing with clinical divisions; 0-25%.	(a) failure to engage with services which can influence our performance in meeting the benchmark. (b) multiple stakeholders have different agendas and priorities (c) resistance of workforce to taking on more flexible (cross specialty) roles; true flexibility and mobility of research funding is required. (d) focus on clinical pressures consumes clinical divisions making it difficult to focus on research. (e) 'one size fits all' approach may not be suitable	(a) identify areas where there are blocks and work with them to streamline processes and help them understand their part and impact in delivering research. (b) clear communication, defined work plan and accountabilities agreed between R&I and division of W&C (c) standardised core JDs for research delivery staff; engagement by research matron with B7 research staff to understand need for flexibility (d) increased engagement and regular meetings with divisional staff at all levels. (e) work with each division to reach suitable solution.	Progress reports to Trust Research Group			MD	Trust Research Group	(a) KPI review with Director of Research 18/9/14. (b) Review every week with DW and through project steering group (c)Project steering group every week (d) & (e) TRG 31/7/14
		We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR)	(a) Oversee and performance manage small grants which have been pump-primed by UH Bristol/Above and Beyond funding to deliver their objectives, increasing the conversion rate to NIHR grants over 2013/14 levels. (b(Identify opportunities for new submissions for NIHR grant funding within existing external and pump-priming grant holders (c) identify collaborative opportunities for grant applications with our local and regional partners.	0% - 25%	a) and b) - new post banded and approved.	(a) and (b) capacity to manage process effectively may impact on performance (c) focus solely on UH Bristol opportunities may detract from allocating time to collaborative work	(a) and (b) new post (in development) to support research grants manager will release capacity (c) use cross-organisational networks currently in existence to maintain awareness of opportunities	Progress reports to Trust Research Group			MD	Trust Research Group	(a) 2-monthly review with Director of Research 12/8/14. (b) and (c) Ongoing rolling review feeding into 2-monthly review with DofR.
		We will demonstrate the value of research to decision makers within and outside the trust	(a) Routinely identify recently completed grants and collate information about the outputs and potential impact (b) Identify clinical areas where the conduct of research has had a defined impact on the service delivery (c) Disseminate information to relevant stakeholders (internal and external)	0% to 25%	a) rolling programme of review just initiated Work ongoing.	(a) clinical impact difficult to identify/quantify until some time after research has taken place (b) recognition of impact can be difficult to quantify (c) failure to identify appropriate stakeholders within the organisation	(a) maintain rolling programme of review; include impact on clinical care of the research practice during conduct. (b) engagement with clinical and research staff both directly and through the network of research staff (c) engagement with clinical division	Progress reports to Trust Research Group			MD	Trust Research Group	(a), (b), (c) Weekly review against plan at project steering group (18/9/14). KPI in development, will be reviewed quarterly.
		Transformation Priorities	Refresh our Transforming care programme, renewing the priority projects to achieve the aims of each pillar and mobilising focussed, benefits driven, rapid delivery project teams	50%-75%	Scope and aims of each project have been approved by Transformation Board, and teams have been mobilised against each. A detialed review of progress is held monthly	Do not identify the right actions to address underlying issues We allow progress to drift	Scope sign off and monthly progress review by Transformation Board	Progress updates to Trust Board			COO	Transformation Board	

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			Establish structured progress monitoring by PMO reporting monthly to Transformation Board	50%-75%	Milestone plans are in place for each project. A monthly cycle of monitroing and reporting is in place to allow intervention by exception	Do not intervene to keep progress on track	Structured review by Transformation Board	Progress updates to Trust Board			COO	Transformation Board	
			Mobilise delivery at pace; Communicate intentions to build organisation engagement and buy in	50%-75%	Each project to have clear near term milestones to get actions underway and to build momentum	Do not act with pace	Transformation Board to hold to account for delivery	Progress updates to Trust Board			COO	Transformation Board	
5	We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	Ensure organisation support for developments under the Better Care Fund	UH Bristol to be represented at BFC meetings and provide steer on changes to the services we provide Model any impact on UH Bristol services from proposed changes to models of care developed through the BCF Programme	25%-50%	Initial outline plan has been delivered by Bristol CCG and Bristol City Council with minimal involvement from stakeholders. COO or nominated deputy will sit on the steering group to ensure UH Bristol is involved/informed of the plans as they develop.	Risk that the plans do not fully consider the existing savings plans required by the Trust (4%) and other partners.	Risk mitigated by highlighting this risk in the Bristol BCF submissions and ongoing attendance at meetings.	Better Care Fund external reviews.			COO	Senior Leadership Team	
		We will effectively host the Operational Delivery Networks that we are responsible for.	Establish governance arrangements for both Critical Care Networks.	25% - 50%	Clinical Directors appointed for both networks	Clinical Directors for ODNs do not lead on agenda.	Hold assurance meetings with ODN Clinical Leads.	Evidence of delivery against objectives			MD	Senior Leadership Team	
		We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care.	Fully engage with BHP agenda and governance. Fully engage with AHSC governance and assist with strategic planning.	25% - 50%	Trust input to BHP at Board level active.	Trust does not contribute to AHSc and BHP research agendas	Attendance at key AHSN and BHP Board and Executive meetings	Minutes evidencing attendance			MD	Senior Leadership Team	
		We will be an effective host to the networks we are responsible for including the CLARHC and Clinical Research Network	Establish robust internal governance including Board reporting for the CRN and CLARHC	0% - 25%	CRN Host governance meetings established.	Risk that CRN leads fail to lead on research agenda.	Monthly governance meetings with CRN Clinical Lead and Chief Operating Officer.	Minutes from governance meeting and feedback to Executive Team via work programme			MD	Senior Leadership Team	
6	We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal	Deliver minimum normalised surplus	Achieve full delivery of annual CRES programme (detail provide below) and positive contract settlement with CCG and NHSE commissioners	50%-75%	SLA signed in line with Heads of Terms	Under performance of activity	Monthly Divisional Reviews	Oversight by operational planning core group			DoF	Finance Committee	22/08/2014
		Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas.	SLR development Use of result in informing Business Planning	50%-75%	Q4 13/14 published.	Delivery of cost improvements.	Risks not yet mitigated particularly re Medicine Division.				DoF	Finance Committee	22/08/2014
		Deliver minimum cash balance	Maintain ratio of at least 15 days and cash balance of no less than £15m	75%-100%	Trust remains on target to meet objective this year.	No risk at present.	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.			DoF	Finance Committee	22/08/2014
		Deliver the annual Cost Improvement Plan (CIP) programme in line with the LTFP requirements	Ensure robust in year oversight of Divisional CRES plans through monthly Finance & Operations Review. Develop recurrent CIP plans to ensure all non-recurrent CIP is secured recurrently by Q4 2014 and delivery 14/15 CRES requirement on a normalised basis	75%-100%	As at 31st August 2014 82% of the 2014/15 target has been identified on a risk assessed basis The Trust has a savings target for 2014/15 of £20.770m the current identified plans amount to £17.56m. It is imperative that new savings schemes are implemented urgently in order to improve this percentage. At the present time there is little assurance that the Trust will achieve the target set for this financial year. hence the red RAG rating. Within the forecast outturn of £17.56m there remains non recurring savings identified of £3,540m. The Trust also operates a pipeline system under which schemes that have not reached sufficient maturity to be included in the official plan are held until the schemes have robust plans and are deemed to be deliverable. As at 31st August 2014 the value associated with these schemes was £7.854m	It is considered that there is minimum risk to the plans currently identified. The real risk to delivering the target is a lack of new schemes coming through the pipeline process. There is a risk that there is a lack of knowledge and skill set amongst Trust staff in order to identify new savings schemes as well as a potential shortage of capacity in terms of time available for existing staff to focus on savings programme delivery.	Savings Programme plans are regularly reviewed each month at Divisional and Work stream accountability meetings . This helps to ensure that the current forecast delivery is robust. Work streams have been refreshed and are identifying additional savings through productivity.	Divisions are held to account for this both at Monthly Divisional Savings Programme Reviews and more importantly the monthly Operational and Financial reviews chaired by the COO and attended by the DOF and other Directors. Monthly reports on progress are presented to the Finance Committee		741	DoF	Finance Committee	22/08/2014
		Refresh the Trust's Strategy including its direction for research & innovation and teaching & learning	Complete sustainability review of Trust key service areas and incorporate findings and response into Trust strategy and Monitor Five Year Strategic Plan concluded and approved by Board in June 2014	75% - 100%	Plan approved by Board in June.	Workforce constraints prevent strategic plan from being completed.	Prioritisation of tasks within SD and Finance Teams	Programme Update to Clinical Strategy Group and Board on regular basis. Internal Audit Review of Commisisoning & planning Function in 2013 and planned for 2014 as part of Annulqa Audit Plan. Monitor self-assessment of strategic planning function undertaken as part of Monitor Strategic Plan submission - feedback awaited.			D of SD	Senior Leadership Team	16th September 2014

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		Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decision as they arise.	Appraise the risks and benefits associated with forthcoming major, strategic choices e.g. SBCH, Community Child Health, Weston Area Health Trust and ensure the Board is adequately briefed and supported to make choices.	25% - 50%	Clinical Strategy Group leading work and reporting to SLT. Weston strategic analysis completed for consideration at September Board. Agreement to secure additional project support to Childrens Communiyt Health tender and recruitment in hand; tentative discussions with partners underway.	Workforce constraints prevent strategic plan from being completed and/or access to information to adequately evaluate strategic choices is not accessible	Prioritisation of tasks within SD and Finance Teams. Working closely with procurement leads in tendering organisations to ensure access to information.	Programme Update to Clinical Strategy Group and Board on regular basis. No external assurance avaiable in this period.			D of SD	Senior Leadership Team	16th September 2014
		Continue to develop private patient offer for the Trust	Private patient 'front door' up and running and Private Medical Insurance contracts signed by end of Q1 Private Patient Strategy for 2015-2020 developed and presented to the Board by end of Q4 Monthly income and expenditure reports in place by end of Q2	25% - 50%	PP Steering Group supported proposal to develop PP visual identity Scheme for front door is all agreed with the exception of confirmation of the visual identity but is ready to progress once this has been approved. Interim Deputy Chief Operating Officer in post 4th August 2014.	Development of PP marketing approach is taking longer than anticipated which is impacting on agreement of the colour scheme for the 'front door' Private Patients Manager vacancy resulting in gap in resources for 3 month period.	Work underway between private services and communications to develop proposal for marketing approach. Interim Deputy Chief Operating Officer to be recruited whilst substantive position recruited. Responsibility for Private Patients to be incorporated into the Performance Manager post.	Private Patients Steering Group			COO	Senior Leadership Team	SLT 3rd September 2014
7	We will ensure we are soundly governed and are compliant with the requirements of our regulators	Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above.	Achieve EBITDA, Return on Assets, Net Surplus Margin and Liquidity ratio in line with plan	50%-75%	COSRR of 4 in 2014/15.	Delivery of CRES plans and reduction of premium cost services. Increase in volume of clinical activity to secure income from activities income in line with SLA and Trust Plan	Monthly Operational and Financial Reviews chaired by COO with Exec Director support.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.			DoF	Finance Committee	22/08/2014
		Establish an effective Trust Secretariat to ensure all principles of good governance are embedded in practice and policy	Review, develop, consult and establish a new structure for the Trust Secretariat and recruit to all vacant post by end of December 2014.	25% - 50%	Revised structure developed with Interim Trust Secretary and in-coming Secretary. Formal staff consultation to commence late September. Additional interim support recruited to cover vacacnies and sickness absence. Recruitment for Head of Risk Management & Assurance underway (interviews 17th october 2014)	Failure to secure staff support for proposed structure and/or recruitment to vacant posts is not achieved in a timely fashion.	Engage staff and their representatives in development of future structure and formally consult staff. Ensure roles, responsibilities and salaries are such that roles are attractive in market place.	Regular updates to Executive team through work programme oversight. Oversight of approach to staff consultation by Staff Side represenatives.			Deputy CEO	Risk Management Group	9th July 2014
			Develop and deliver actions arsing from on-going external governance reviews e.g. Lawson Review, W&C Governance Review	0%-25%	Trust Secretary now appointed but not yet commenced (16th October 2014). This work will form part of Well Led Governance Review due to commence in November 2014. Additional interim resource to support work recruited and in place.	Failure to secure staff support for proposed structure and/or recruitment to vacant posts is not achieved in a timely fashion.	Establish satisfactory interim arrangements and commence recruitment as soon as practical with aim of new TS starting in October 2014.	Regular updates to Executive team through work programme oversight. External assurance to be provided from indepdent Governance Review commencing Q4 2014/15.			Deputy CEO	Risk Management Group	9th July 2014
			To scope and develop Terms of Reference for work programme to address current shortcomings in approach to Procedural Document Management.	0%-25%	Project scoping phase commenced. Trust wide steering group established. Immediate risks identiifed through Internal Audit addressed.	Workforce constraints prevent project from being scoped and progressed.	Interim Trust Risk Manager appointed and PDM an early priority.	Regular updates to Executive team through work programme oversight. CQC reviewed area of policy and document management with some immediate recommendations for action which have been implemented. Final report due November 2014.			Deputy CEO	Risk Management Group	9th July 2014
		Robustly prepare for the planned Care Quality Commission inspection.	Develop and coordinate delivery of an action plan to coordinate preparation for CQC visit. To develop a clear communicational support plan for staff.	75%-100%	CQC inspection announced for 10th-12th September 2014. Action plan developed and monitored via short term CQC Inspection Steering Group, with agreement of SLT. Included plans for communications and on-site logistics. CQC project manager appointed as internal secondment, commencing mid-July. 'Delivering Best Care' week in August 2014 formed key part of preparation - focus on key risks. Positive feedback from CQC about how the inspection was managed and organised. Draft report due 4th November 2014.	No risks - objective achieved.	Not applicable	Regular reports to CQC steering group and SLT/Execs			CN CN	Senior Leadership Team Senior Leadership Team	
		Prepare for and achieve successful outcome from proposed Monitor investigation into performance concerns with the aim of reverting to a GREEN rating by Q2	To provide all necessary information, in a comprehensive and robust fashion, in advance of visit	75%-100%	Completed	Workforce capacity constraints	Prioritisation of this work, above lower priorities	Regular updates to Executive team through work programme oversight. Monitor investigation completed and governance rating restored to GREEN.			Director of SD	Executive Directors	n/a
			Ensure team are adequately prepared for Monitor visit and key messages are appropriately develop and clearly communicated throughout the process.	75%-100%	Completed	Lack of preparation and availability of key personnel.	Adequate preparation	Monitor rating.			Chief Executive	Executive Directors	31/07/2014
		Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways	To review findings of IST following their visit and agree actions to address recommendations and any resulting impact on RTT performance Recovery plan for non-admitted monitored weekly and RTT non-admitted delivered by end of Q2	25% - 50%	Draft report received from IST, draft action plan presented to and approved by the RTT Steering Group on 18th September 2014. The plan will be presented to SLT on 1st October 2014. There has been a significant increase in the number ofadmitted patients treated >40 weeks. The extension of the period of planned failure to 30th	Activity is not as yet on track against plan. The non-admitted backlog is not reducing as per trajectory. Increases in demand over and above planned trajectory.	Weekly tracking of delivery against the first outpatient wait recovery plan. Improvements in the first outpatient wait PTL process, supported by validation to ensure PAS holds accurate data. Additional 1st OP activity in place +/- reduction in 1st OP	RTT Steering Group RTT Operational Group Divisional PTL Meetings Elective Care (ECIST)		1967	COO	Senior Leadership Team	RTTSG 18th September 2014

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
			To be consistently achieving agreed waiting time standards - No patient waiting over 13 weeks for outpatients, no elective patient cancelled due to lack of beds and no patient waiting >40 weeks on a RTT pathway		November 2014, will enable the Trust to make a further significant reduction in the admitted backlog. Weekly monitoring in place and variance from plan being reviewed via the RTT Operational Group. Further work on data quality of the first outpatient waiting list has been completed with ability to flag RTT / non-RTT pathways introduced to support PTL Management.	Ability to recruit to vacancies / new consultant posts to support increased demand in system.	wait for specific specialties. Discussions with Emerson's Green to assess options for outsourcing where capacity issues exist.	external review Service Delivery Group					
		Improve cancer performance to ensure delivery of all key cancer targets	Establishment of monthly Cancer Performance Steering Group Achievement of 62 day cancer standard from Q3 onwards Transfer of breast screening patients on the cancer register to have been completed accurately by end of Q2	25% - 50%	Cancer Performance Improvement Group TOR has been approved and group is meeting fortnightly to track progress against plan. SNH increased theatre apacity for Thoracic patients ahead of the current target date of October but osme was not used due to lack of ITU / HDU capacity. Performance for 62 day GP cancer currently not on target against recovery trajectory.	Ability to increase capacity for Thoracic pathways ahead of the vascular transfer. Vascular transfer not occurring in October 2014. ITU / HDU capacity and acuity. Where delays occur due to late referral, risk they will not accept responsibility for the breach.	Assessing further options to put on non-recurrent additional capacity to tackle the short term capacity pressures. Recruiting to Cancer Network posts who will take forward improvements in timeliness of inter-provider referrals. Vascular service transfer being overseen by the BRI Redevelopment Board. Operating Model 2014/15 - Planned Care / Protected Pathways project.	Cancer Steering Group Cancer Operational Group Cancer PTL Meeting Service Delivery Group		1412	COO	Senior Leadership Team	

University Hospitals Bristol NHS
NHS Foundation Trust

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

17. Corporate Risk Register
Purpose
Report to Follow
Abstract
Recommendations
Report Sponsor
Chief Executive
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

University Hospitals Bristol NHS
NHS Foundation Trust

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

18. Governor's 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.

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

ID Governor Name

106 Clive Hamilton **Title: Safe Staffing Levels**

Query 17/10/2014

The Trust's expected and actual staffing levels for August are displayed on the Trust's web pages at:
http://www.uhbristol.nhs.uk/media/2234372/august_pdf.pdf
The revised format with a comments column is much appreciated as it explains maybe higher than expected shortfalls.
To what if any extent are clinicians engaged in surgical procedures, diagnostic procedures, pharmacy and outpatient clinics covered by this table?
Does the table include all Trust ward locations?
Is there merit in producing a total for all Actual Hours versus all Expected Hours to give a general assessment of safe staffing levels?

Do the Non-Executive Directors have assurance that the August shortfall of expected levels on wards 71-74 at St. Michaels Hospital amounting to a deficit of 1142 hours (22.7%) was adequately covered and the reasons fully assessed for remedial action.

Clive Hamilton 16th October 2014.

Response 23/10/2014

Assigned to Executive Lead 23 October 2014.

Status *Assigned to Executive Lead*

105 Bob Bennett **Title: Patients' problems with appointments at BRI**

Query 15/10/2014

(Reworded by Trust Secretariat by agreement) Bob Bennett provided anecdotal evidence from several patients who had attended the BRI for different reasons, but had experienced the same type of problem - confusion over appointment times which had resulted in difficult encounters with reception staff.

He enquired whether there was a problem with the appointments system being computer generated or otherwise, or whether there was a need to review support and training for receptionists.

Response 17/10/2014

Original question passed to Patient Support and Complaints Team 17/10/2014. Executives to note.

Status *Archived*

104 Clive Hamilton **Title: Workforce statistics - staff turnover**

Query 14/10/2014

Origin - page 79 of Public Trust Board pack September 2014 (Workforce Statistics report)
Rolling turnover of staff is stated as 12.9% in August compared to 12.1% in the previous month. The September Board report for 2010 indicates that staff turnover was 7.7%. Taking the data from successive board reports for September since 2010 the following trend emerges:
2010 ..... 7.7%
2011 ..... 8.5%
2012 ..... 10.8%
2013 ..... 11.6%
On page 79 of the September board report (which relates to data from August) it is noted that the staff turnover rate for University Hospitals Bristol is significantly above the national average rate of 9.5% and that the Trust has therefore set a target of reduction to 10.6% but also mentions a target of 10% by the end of 2014/15; which is correct?
Do the Non-Executive Directors accept the lack of ambition represented by this target in view of the national average and is there assurance that an improved target less than the national average should be the aim?
Clive Hamilton 14th October 2014.

Response 15/10/2014

Assigned to Executive Lead.

Status *Assigned to Executive Lead*

ID	Governor Name		
103	**Clive Hamilton**	**Title:**	**Workforce statistics - staff shortfall**

Query **14/10/2014**

Origin - pages 73-75 of Public Trust Board pack September 2014 (Workforce report)

I need some clarification and assurance regarding the figures quoted at pages 73 to 75 of the September 2014 Board Report.
1. I understand that the trust had a shortfall of 430 full time equivalent staff in August (5.56%); is this correct?
2. On page 75 the August 2013 bank and agency usage is quoted as 474.1 full time equivalents. On page 73 the number of bank and agency staff full time equivalents for August 2014 is quoted as 570.8. This is a 20.4% increase.

Have the Non-Executive Directors assurance that the Trust is sufficiently engaged in programmes to recruit replacement staff, retaining existing staff and forward planning to cope with any shortfalls due to known retirement numbers? Is there assurance that the Mutually Agreed Resignation and unpaid leave Schemes do not have an adverse effect on 1 and 2 above.
Clive Hamilton 14th October 2014.

Response **22/10/2014**

1. I understand that the trust had a shortfall of 430 full time equivalent staff in August (5.56%); is this correct?
2. On page 75 the August 2013 bank and agency usage is quoted as 474.1 full time equivalents. On page 73 the number of bank and agency staff full time equivalents for August 2014 is quoted as 570.8. This is a 20.4% increase.

The vacancy rate reported in August was 5.56%, 430 WTE. Vacancies are the gap between the budgeted establishment and the substantively employed staff. This is different to a "shortfall" because where necessary, vacancies would be covered by bank and agency to ensure that there is no impact on patient care. Some temporary staff usage will always be required and when used appropriately, can be a cost effective way of flexing our workforce to cover peaks and troughs of demand.
Recruiting replacement staff:
Assurance is provided by the plans in place which include:
Focussed effort on reducing the time taken to recruit, supported by procurement of a recruitment management system,

- Divisions will identify key recruitment leads locally to support the co-ordination of divisional recruitment activity and on-boarding of candidates improved resourcing of the Recruitment team;
- Improved marketing of UH Bristol– better targeting within the national labour market

Retaining existing staff
A project group has been established to map the process for gathering exit information to increase the response rates. There are already extensive programmes of work in place as part of the staff engagement programme which are anticipated to impact on turnover, including actions to tackle bullying and harassment including an advice line, divisional engagement activities, for example, listening events, actions to tackle stress at work including stress audits.

Planning for retirements
Each year, in advance of the start of the annual operating planning cycle when divisional workforce plans are developed, HR Business Partners receive a full breakdown of any staff over 55 and are asked to undertake a risk assessment to ensure that there are plans in place to address potential retirements in any difficult to recruit staff groups.

Is there assurance that the Mutually Agreed Resignation and unpaid leave Schemes do not have an adverse effect on 1 and 2 above?

Any application under MARS must demonstrate that the departure of an employee on voluntary terms would be in the financial and operational interests of UH Bristol.

A MAR is only approved where either the post can genuinely be removed from the structure, so that a cost saving to the Trust is made, or where the hours/banding can be reduced, as part of a revised skill mix or where the post will remain but will offer an opportunity to another person at risk of redundancy (so that the Trust avoids a redundancy payment and the individual retains employment). A role which, it is demonstrably necessary, will need to be retained at its current hours and banding (e.g. the majority of front line roles) will be very unlikely to meet the MARS Criteria.

Status *Responded*

ID Governor Name

102 Glyn Davies **Title:** **Delays in responding to complaints**

Query **25/09/2014**

In view of continued public dissatisfaction with delays
in responding to complaints to the Trust,
what steps are being taken to improve performance?

Response **30/09/2014**

Response from Chief Nurse: Since the beginning of 2014, the Trust has been experiencing delays in responding to enquiries to its Patient Support & Complaints Team (which is the Trust's integrated PALS and Complaints function). A backlog of enquiries began to develop around the time when the PSCT relocated to a prominent and highly visible location at the front of the new Bristol Royal Infirmary Welcome Centre in December 2013; this included the re-opening of the drop-in service which had been closed during the second half of 2013 whilst the PSCT was temporarily located in the Chapter House of the Bristol Dental Hospital. More recently, the position has been exacerbated by a significant increase in the number of complaints being received by the Trust: in recent months, 50% more than in the corresponding period 12 months previously.

Throughout 2014, all enquiries to the PSCT have been acknowledged in a timely way, as required by the NHS Constitution. However delays have been occurring in the amount of time it has then taken for a caseworker to follow up the initial enquiry to discuss this in detail and agree a way forward. At the peak of the backlog, it was taking more than four weeks for this follow up conversation to take place. At the time of writing (29th September 2014), the position has improved significantly: follow-up is currently taking approximately five working days, although we continue to be concerned about any delays experienced by people who contact the service.

The Board and Executive team have been monitoring the position closely and have invested resources to ensure the situation improves. In the spring of 2014, the Trust brought in two experienced agency caseworkers to help to deal with the backlog – these staff remained with the PSCT until the summer. In parallel to this, a business case was developed and approved for the recruitment of three additional full-time staff, increasing the PSCT's total staffing capacity by 63%. Recruitment to these positions has been ongoing through the summer of 2014 and will be completed by the end of October 2014, at which point the team will consist of a manager, deputy manager, four caseworkers and three administrators (total 7.8 whole time equivalent). With these staff in post, we are confident that we will be able to remove any remaining delays currently being experienced by people who contact the PSCT and return to a situation of being able to response to enquiries in real time.

Status *Closed*

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 **10/10/2014**

Response from Medical Director:
Q1: The vast majority of consultants at UHBristol are available for referral on Choose and Book, enabling patients to exercise their right to choose their consultant-led team.

Enabling the naming of a named clinician on Choose and Book (and identifying appropriate appointments) is a technical process that requires the following to be in place:

1. The clinician must have a registration on the NHS Spine as a consultant employed at this Trust
2. The spine registration must identify them as a Choose and Book Consultant
3. The clinician needs to associated with the appropriate services on CaB
4. To identify appointments as belong specifically to them, their spine registration code must be recorded against them correctly in Medway

When a consultant joins the Trust or establishes a new service it is incumbent upon the Clinical Division to contact the Registration Authority Agent to ensure that the spine registration is in place. After that, they must notify the Directory of Services administrator for Choose and Book so that the clinician can be associated with the correct services, and the Medway Support Office to get the spine code added to Medway.

Where clinicians are not named on Medway it is usually for one of 3 reasons:

1. The Division has not notified the relevant teams to get the clinician set up
2. The clinician only offers a tertiary service, and so is not appropriate for Choose and Book
3. The service is booked into generic clinics (for example, cataracts) so no specific clinician (or clinicians) can be identified as delivering the associated appointments.

Q 2
With respect to the UHBristol website, it is possible for Consultant profiles to be included and this is currently part of the programme of work for the Trust's Communications team. Consultants have been encouraged to submit a profile to the Trust for inclusion, though this has not been mandatory, and a number of Consultant profiles have already been uploaded.

Status *Responded*