University Hospitals Bristol NHS
NHS Foundation Trust

# MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC

**Date:** Thursday 29 January 2015
**Time:** 10.30 am – 13.00 pm
**Venue:** Conference Room, Trust Headquarters

**Distribution:**

| | | |
|---|---|---|
| **Chair:** | John Savage | Trust Chairman |
| **Board Members:** | David Armstrong | Non-executive Director |
| | Julian Dennis | Non-executive Director |
| | Lisa Gardner | Non-executive Director |
| | John Moore | Non-executive Director |
| | Guy Orpen | Non-executive Director |
| | Alison Ryan | Non-executive Director |
| | Emma Woollett | Non-executive Director |
| | Jill Youds | Non-executive Director |
| | Robert Woolley | Chief Executive |
| | Sue Donaldson | Director of Workforce and Organisational Development |
| | Deborah Lee | Director of Strategic Development and Deputy Chief Executive |
| | Paul Mapson | Director of Finance and Information |
| | Carolyn Mills | Chief Nurse |
| | Sean O'Kelly | Medical Director |
| | James Rimmer | Chief Operating Officer |
| **In attendance:** | Debbie Henderson | Trust Secretary |
| | Isobel Vanstone | Corporate Governance Administrator (Minutes) |
| **Apologies:** | Aiden Fowler | NHS Fast-Track Executive |
| **Observers:** | Penny Hilton | NHS Fast-Track Executive |
| | Members of the Council of Governors | |
| **Copy for Information:** | Members of Council of Governors | |
| | Heather Ancient* | 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:**

Isobel Vanstone, Corporate Governance Administrator, Trust Headquarters. Telephone: 0117 34 23702
Email: isobel.vanstone@uhbristol.nhs.uk

University Hospitals Bristol NHS
NHS Foundation Trust

**Agenda for the Meeting of the Trust Board of Directors held in Public**
**Scheduled to take place on 29 January 2015 at 10.30am**
**in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

| *Item* | *Sponsor* | *Page No* |
|---|---|---|
| **1. Chairman's Introduction and Apologies**<br>To note apologies for absence received | Chair | |
| **2. Declarations of Interest**<br>To declare any conflicts of interest arising from items on the meeting agenda | Chair | |
| **3. Minutes from previous meeting**<br>To approve the Minutes of the Extra-ordinary Board of Directors Meeting held on 22 December 2014 | Chair | 5 |
| **4. Matters Arising**<br>To review the status of actions agreed | Chair | 12 |
| **5. Chief Executive's Report**<br>To receive this report from the Chief Executive to note | Chief Executive | 13 |
| *Delivering Best Care and Improving Patient Flow* | | |
| **6. Patient Experience Story**<br>To receive the Patient Experience Story for review | Chief Nurse | 17 |
| **7. Care Quality Commission Action Plans**<br>To receive the CQC Action Plans for assurance | Chief Nurse | 21 |
| **8. Q2 Complaints and Patient Experience Reports**<br>To receive these reports for assurance | Chief Nurse | 64 |
| **9. Quality and Performance Report**<br>To receive and consider this report for assurance:<br>a) Performance Overview<br>b) Quality and Outcomes Committee Chair's report<br>c) Board Review – Quality, Workforce, Access | Deputy Chief Executive/ Director of Strategic Development | 105 |
| **10. Performance Recovery Plan Update**<br>To receive this report for assurance | Chief Operating Officer | 216 |
| **11. Transforming Care Report**<br>To receive this report for approval | Chief Operating Officer | 222 |

| | | |
|---|---|---|
| **12. Report on Staffing Levels Adult Inpatient Wards Including Midwifery, Bristol Children's Hospital & Non Ward Based Nursing and Midwifery Workforce January 2015**<br>To receive this report for assurance | Chief Nurse | 228 |
| *Delivering Best Value* | | |
| **13. Finance Committee Chair's Report**<br>To receive this verbal report for assurance | Finance Committee Chair | 245 |
| **14. Finance Report**<br>To receive this report for assurance | Director of Finance & Information | 263 |
| *Renewing our Hospitals* | | |
| **15. Quarterly Capital Projects Status Report**<br>To receive this report to note | Deputy Chief Executive/ Director of Strategic Development | 263 |
| *Compliance, Regulation and Governance* | | |
| **16. Monitor feedback on Q2 Risk Assessment Framework Submission**<br>To receive this report to note | Chief Executive | 267 |
| **17. Q3 Risk Assessment Framework Monitoring and Declaration Report**<br>To receive the Quarter 3 submission to Monitor | Chief Executive | 271 |
| **18. Audit Committee Chair's Report**<br>To receive this verbal report to note | Audit Committee Chair | |
| **19. Board Assurance Framework Report**<br>To receive this report for approval | Deputy Chief Executive/ Director of Strategic Development | 298 |
| **20. Corporate Risk Register**<br>To receive this report to review | Chief Executive | 309 |
| **21. Revised Trust Constitution**<br>To approve the amendments to the Trust Constitution and associated documentation as outlined in the report | Chairman | 318 |
| **22. Register of Seals**<br>To receive this report to note | Trust Secretary | 420 |

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|---|---|---|
| *Information* | | |
| **23. Big Green Scheme Annual Report**<br>To receive this report to note | Chief Operating Officer | 422 |
| **24. Governors' Log of Communications**<br>To receive this report to note | Chairman | 433 |
| **25. Any Other Business**<br>To consider any other relevant matters not on the Agenda | Chair | |
| **Date of Next Meeting of the Board of Directors held in public:**<br>27 February 2015, 10:00 – 12:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU | | |

University Hospitals Bristol NHS
NHS Foundation Trust

**Unconfirmed Minutes of the Meeting of the Trust Board of Directors held in Public on 22 December 2014 at 10:30, the Conference Room, Trust Head Quarters, Marlborough Street, BS1 3NU**

**Board members present:**
John Savage - Chairman
Robert Woolley – Chief Executive
Deborah Lee - Deputy Chief Executive/Director of Strategic Development
Sue Donaldson – Director of Workforce and Organisational Development
Paul Mapson – Director of Finance & Information
Sean O'Kelly – Medical Director
James Rimmer – Chief Operating Officer
Emma Woollett – Non-Executive Director
David Armstrong – Non-Executive Director
Julian Dennis – Non-Executive Director
John Moore – Non-Executive Director
Guy Orpen – Non-Executive Director
Jill Youds – Non-Executive Director

**Present or in attendance:**
Helen Morgan – Deputy Chief Nurse
Debbie Henderson – Trust Secretary
Dr Robert Pitcher - Joint Clinical Lead for Cellular Pathology Services
Isobel Vanstone – Interim Corporate Governance PA (Minute Taker)
Penny Hilton – Fast-Track Executive
Fiona Reid – Head of Communications
Fiona Jones – Divisional Director Diagnostic Services and Therapies
John Steeds – Patient Governor
Angelo Micciche – Patient Governor
Clive Hamilton – Public Governor South Somerset
Pam Yabsley – Patient Governor
Tom Davies – Staff Governor
Graham Briscoe – Public Governor, North Somerset
Jeanette Jones – Appointed Governor
Pauline Beddoes – Public Governor
Florene Jordan – Staff Governor

**47/12/14 Chairman's Introduction and Apologies**
Apologies had been received from Carolyn Mills (Chief Nurse), Alison Ryan (Non-Executive Director), Lisa Gardner (Non-Executive Director) and Aidan Fowler (Fast Track Executive)

**48/12/14 Declarations of Interest**
In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. No new declarations of interests were received.

**49/12/14 Minutes and Actions from Previous Meeting**
The Board considered the minutes of the meeting of the Trust Board of Directors held in public on 27 November 2014 and approved them as an accurate record, subject to minor amendments. The Chairman requested that the minutes be circulated after the meeting subject to the amendments. Emma Woollett referred to the approval of the Terms of Reference for the Trust's Remuneration and Nomination Committee and noted that the Board agreed that a further review to include key performance indicators would be carried out over the next 12 months.

**50/12/14 Matters Arising**
Matters arising and actions complete were noted by the Board.

**51/12/14 Histopathology Business Case**
Robert Woolley referred to the Histopathology Business Case and the recommendations from the independent enquiry of Histopathology Services in Bristol. The Board fully accepted the recommendations in December 2010, one of which referred to the centralisation of histopathology services under the management of a single organisation. Robert stated that the Trust had worked closely with colleagues in North Bristol NHS Trust (NBT) and it was agreed that NBT were best placed to manage the service. Robert noted a delay during the options appraisal for the centralisation of pathology services across all disciplines, and confirmed that both organisations have put significant effort to developing a free standing business case for the cellular pathology transfer.

Sean O'Kelly provided an overview of the proposed clinical model referred to as 'the conglomerate model', describing how the service will operate with an essential services laboratory on site at University Hospitals Bristol NHS FT (UHB) and a central laboratory at the NBT Site. Sean discussed in detail the services and operational management including arrangements for frozen sections, operational management issues for multi-disciplinary teams, one stop cytology clinics and specimen dissections. Sean confirmed that the proposals allow the benefit of little noticeable difference in delivery for service users.

Emma Woollett queried the impact of the proposals and changes on the whole pathology service. Sean O'Kelly confirmed that this is a distinct service and confirmed that there is no degree of conflict as a result of the proposals.

Jill Youds stated that she wished to understand the difference between integration and conglomeration. Robert Woolley explained that the Business Case had been subject to a full options appraisal and invited Dr Robert Pitcher, Joint Clinical Lead for Cellular Pathology Services to respond. Dr Pitcher stated that the team took part in a series of workshops to analyse the options for the future of cellular pathology. These options included: operating two separate services; a collaborative model working together more; and full integration of services. Dr Pitcher referred to concerns regarding full integration in terms of supporting the clinical services at UHB. The conglomerate model included an emphasis on the need for the specialist teams at UHB and NBT to work together in terms of the immediate services provided i.e., frozen sections. However, it also included the longer term service required to support clinical teams in the future. Dr Pitcher emphasised that the key to delivering an improved, reliable service is the ability to work collaboratively between Trusts and clinical teams. Dr Pitcher also confirmed that the Business Case does not include proposals for higher workforce costs.

John Moore made reference to Appendix 9, Operating Standards and queried the pragmatics of implementing this agreement. Dr Pitcher confirmed that the staff had been part of the design of the operating standards via the Bristol Cellular Pathology Forum, a joint meeting of the Cellular Pathologists and Senior Biomedical Staff in Bristol. It was agreed that the standards are challenging and he referred to concerns referenced in the Business Case relating to turnaround times for pathology and stated that the Trust do not achieve the recommended Key Performance Indicators as outlined by the Royal College of Pathologists. Dr Pitcher confirmed that these standards have been developed to mitigate this. With regard to capacity planning, Dr Pitcher provided assurance that resource is reflected in a new staffing model which supports delivery of the service. It was also confirmed that the Trust does not have an increasing backlog of work which provided further assurance that the Trust has the right level of capacity to manage the work, although the time frames remain an issue. This will be mitigated as part of the new staffing structure and Dr Pitcher confirmed that discussions had already commenced with staff regarding these proposals.

In response to a query from John Moore regarding timescales for achievement of these standards, Dr Pitcher stated that this is dependent on a number of external factors including the Laboratory Information Management System and the building. Dr Pitcher also referred to the need for a clear Service Level Agreement between UHB and NBT.

A discussion took place with regard to funding and financial analysis relating to the project, and Paul Mapson confirmed the costs for the overall service and provided a detailed verbal report outlining the financial analysis. With regard to the cash impact, Paul Mapson confirmed this as £549k plus transitional costs which have been included in the figures for the next financial year.

Following a query from Clive Hamilton with regard to double reporting, Sean O'Kelly felt that the service may have a positive impact on recruitment into posts which have been challenging in the past. Dr Pitcher confirmed that the Service had already recruited 3 pathologists for UHB and one pathologist for the NBT.

John Steeds referred to £616k for capital charges for equipment and asked if this was a one off, shared equally between the two Trusts. Paul Mapson confirmed that this is an ongoing cost for NBT. Paul Mapson noted these costs relate to equipment and building work to accommodate the Service. Deborah Lee confirmed that £549k is the financial impact on UHB. Robert Woolley stated that the financial analysis has been agreed between UHB and NB and noted an inevitable cost pressure as a result of the project and confirmed that NBT Board of Directors have approved the Business Case. Robert provided assurance that both Boards are proceeding on the basis that the benefits in terms of sustainability, critical mass, ability to meet standards, double reporting and improved patient care, are considered appropriate in relation to cost pressures and risk.

Deborah Lee reported on a thorough debate that took place at the Trust's Senior Leadership Team which included input from clinicians to analyse the benefits of the proposals. Deborah confirmed that Mr Andrew Hollowood (Consultant Surgeon) represented the views of the Surgical Service Users who were keen to understand how the frozen section service would operate. Deborah confirmed that following robust debate there was absolute consensus at Senior Leadership Team that the Trust cannot address the issues of lack of resilience and other issues highlighted by the review in the absence of these proposals. Deborah also stated

that in order to provide an improved service for patients, it is recommended that the Trust support the Business Case.

Emma Woollett referred to previous discussion and consideration of the options for improvement to cellular pathology following the recommendations highlighted by the Histopathology Inquiry Report, and noted that the Board, including Non-Executive Directors have had appropriate oversight in preparation for these proposals. Emma requested further assurance as to how the Trust will continue that oversight. Robert Woolley clarified that the Board are asked to approve the Business Case; however, the proposals are subject to a satisfactory Service Level Agreement which would specify the Operating Standards, KPIs and the process by which the Trust will monitor compliance and an appropriate level of assurance going forward. Robert confirmed that NBT are also in agreement with this position. Robert reported that a working group has been established to design the contract specification and SLA. Guy Orpen asked whether the SLA will include planned timelines for compliance with the Key Performance Indicators for the Royal College of Pathologists and Robert confirmed that this would need to be agreed between the Trust and its partners.

The Chairman and Board took an opportunity to congratulate Dr Pitcher and everyone who had been involved with the development of the Business Case. The Chairman recommended the approval of the Business Case and the Board also thanked Dr Pitcher for his leadership, Mark Orrell, Laboratory Manager and Fiona Jones, Divisional Director of Diagnostics and Therapies. It was:

**RESOLVED:**

- **That the Board approve the business case for Histopathology and Cellular Pathology Service Transfer subject to the development of a robust Service Level Agreement**

**52/12/14 Care Quality Commission (CQC) Draft Action Plan**

Sean O'Kelly referred to the outcome of the recent CQC review and the requirement for the Trust to produce an action plan by 12 January 2015. He stated that the CQC have specified 'must do' actions in terms of regulatory compliance around patient flow and system wide working. Sean also noted that the outcomes highlighted 'should do' actions, and Robert Woolley expressed the importance of addressing these in addition to 'must do' actions. Sean provided assurance that actions have been noted and an action plan is being compiled which is realistic and measurable to aid implementation going forward.

James Rimmer confirmed that the issues relating to flow are being addressed following the Quality Summit by the Urgent Care Working Group (UCWG), which is chaired by the Commissioners. The UCWG will report to the Systems Resilience Group which is the Bristol, North Somerset and South Gloucestershire wide group.

James confirmed that all partners had responded to the recommendations and noted significant challenges relating to discharge planning and social care. It was noted that the new commissioning models will commence on 1st October 2015 as well as the Mental Health Act Assessments undertaken by social care colleagues. Board members were informed that the first draft of the action plans were currently under review by partner organisations internally and externally and made reference to proposals to appoint Advanced Nurse Practitioners in the Emergency Department and Older Persons Assessment Unit following a

successful pilot with one Advanced Nurse Practitioner, resulting in improvements to discharge planning.

Following a query from Clive Hamilton, Robert Woolley confirmed that a submission deadline extension has been given from 5th January 2015 to 12th January 2015 and that Governors would receive feedback on the plans at this time.

**53/12/14 Access Recovery Plan Progress Report**
James Rimmer confirmed that this report is a work in progress and briefed the Board on the three principal areas:

4-hour A&E waiting time performance
James described the five point action plan and continued working with partners to address issues including: avoiding admission to hospital; patient flow within the hospital; discharge planning; and working with partners to improve system governance. James confirmed that the plan had been submitted to Monitor.

James noted that there had been no reduction in average length of stay, particularly in regards to Medicine whereby performance is 5.7 days, against the Trust's planned target of 5. James stated that this has been reflected in significant movement in October with regard to long stay beds; however the Trust had been unable to sustain this. James referred to comments relating to discharge planning within the CQC report and this was consistent with current performance with increased admitted activity.

He reported that in terms of 4-hour performance, the Team had carried out work based on the revised national picture, and a reduction nationally of 1 – 2% and reported that the Trust had failed in achieving the target for Quarter 3. James provided assurance that work is ongoing with regard to longer term planning and he envisaged that the Trust would revert to a green rating in Q1 or Q2 2015/16.

Cancer targets
James confirmed that the 62 day target and 31 day target remain a challenge for the Trust and noted three breaches for the period. It was noted that the challenge continues to be related to shared pathways and James confirmed that UHB pathways are achieving the 85% standard. Key actions include first appointment wait reduction to 7 days where possible and the Trust has maintained this in the key pathways. Following a query from John Moore James confirmed that impact on performance relates to capacity and ensuring the booking and cancellation processes is as robust as possible.

Referral to Treatment
James confirmed that the Trust have commissioned the IMAS Team ("NHS Interim Management and Support") to analyse the pathway for each specific area. James stated that a revised trajectory is being developed subject to significant work relating to data quality. James briefed the Board on objectives in terms of reducing the number of breaches of the non-admitted and admitted patients. The challenging areas are Women and Children's and Surgery, Head and Neck (SHN) and James confirmed that for adult SHN, fairly robust plans are in place and the focus is on improving Paediatric Services around theatre capacity.

With regard to quota management and 10% breaches per month, James noted that the Trust is utilising the NHS Constitution Model by clinical urgency and by chronology and this has

resulted in a significant positive impact on long waiters and he envisaged the elimination of over 40-week waits for adults by the end of January 2015.

He confirmed that the Trust are working with National Teams around data quality and noted the recommendation from IMAS that the Trust should use real time data reporting and confirmed this will commence from April 2015. James noted that the Trust was making progress on elective capacity and the IMAS model highlights the shortfalls and these will be factored into the Trust's Operating Plans. James briefed the Board on Dermatology in detail and noted the shortfall in slots per week however provided assurance that locums will be brought in to manage this in the short term.

James confirmed that within Ophthalmology interventions had been put in place and the department is working with a private partner to relieve the backlog until the end of March 2015. James referred to discussions required with Commissioners around the potential capacity planning.

Jill Youds commented on the positive steps taken to address the 4-hour A&E performance but requested the level of impact envisaged as a consequence of the CQC action plan. James confirmed that the Trust continues to work closely with its partners on each action and the potential impact and confirmed that partnership working remains strong.

Deborah Lee referred to the Discharge to Assess Initiative and felt that this point could represent the most significant impact and asked if the Trust has milestones for this. James confirmed that all these action plans had gone back to the Trust's partners for comment.

Emma Woollett referred to winter pressure funding and the possibility of reinforcing poor behaviour in terms of agency costs and queried the potential to utilise these funds for long term sustainable projects. James Rimmer confirmed that the funding is used to address the national issue and confirmed that the funding had been costed as agency costs. Paul Mapson stated that if the funding made available nationally is made recurrent then the Trust will have the potential to invest in a sustainable way.

Following a query from John Moore relating to the current backlog and the impact on 7-day first appointment for cancer patients, James Rimmer confirmed that the vast majority of these are on track and the Trust is close to achieving 100%. Deborah Lee explained how the IMAS Model outlines current gaps and one off shortfalls and looks at the supply side of the model as well as deliverables and stated that Commissioners also impact on investments in terms of services commissioned. Deborah Lee confirmed that discussions need take place with Commissioners during February and March regarding both non-recurrent and recurrent activity and confirmed that the recovery plans will be submitted to the Board in January. However, these will be subject to these discussions.

The Chairman requested that the recovery plan be submitted for discussion at the January meeting of the Board to include the financial impact.

Emma Woollett queried the impact of the Specialist Paediatrics transfer on the Children's hospital and capacity problems and James Rimmer confirmed that there had been capacity issues relating to nurse staffing in theatres. Robert Woolley confirmed that the division believed that they would be able to recruit replacement staff but this does not account for all the referral to treatment backlog.

Robert Woolley emphasised that Monitor's concern relates to access standards and the report requested by the Chairman, to be submitted to the January Board meeting will include a plan which outlines the options, conditional upon commissioner input. The report should also include a summary of supply and demand scenarios, assumptions and financial impact. It was:

**RESOLVED:**

- **That a revised RTT recovery plan be submitted for discussion at the January meeting of the Board**

**54/12/14 Any Other Business**

Robert Woolley referred to the art project for the Level 5 Entrance at the rear of the new building. The Council of Governors and the Board of Directors were invited to comment on the proposed designs. Robert requested any comments to be provided the end of December.

**Meeting close and Date and Time of Next Meeting**

There being no other business, the Chair declared the meeting closed

The next meeting of the Trust Board of Directors will take place on Thursday 29 January 2015, 10.30am, the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

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Chair Date

University Hospitals Bristol NHS
NHS Foundation Trust

**Trust Board of Directors meeting held in Public 22nd December 2014**
**Action tracker**

| Outstanding actions following meeting held 22nd December 2014 | | | | |
|---|---|---|---|---|
| **Minute reference** | **Detail of action required** | **Responsible officer** | **Completion date** | **Additional comments** |
| **33/11/14** | Discussion regarding structure and format of the Quality and Performance Report to ensure it remains fit for purpose | Medical Director | 29/1/2015 | Verbal update to be provided 29/1/15 |
| **15/10/14** | A future Seminar Programme time to consider the Transformation Programme in depth | Trust Secretary | 27/2/2015 | Date subject to other items for discussion |
| **Completed actions following meeting held 22nd December 2014** | | | | |
| **53/12/14** | Revised RTT Recovery Plan to be submitted to the Board of Directors meeting for assurance | Chief Operating Officer | 29/1/2015 | Complete – agenda item 9 – Quality and Performance report |
| **38/11/14** | Time to be scheduled for the Board to consider financial outlook for 2015/16 | Paul Mapson | 27/03/2015 | Complete – Board seminar scheduled to take place 27/2/15 |
| **33/11/14** | Revised access trajectories to be shared with the Board | James Rimmer | 19/12/2014 | Complete – reported to Board 22/12/14 |
| **30/11/14** | Action plan in response to CQC report to be circulated | Chief Executive | 29/01/2015 | Complete – agenda item 7 |
| **221** | Options regarding further integration of histopathology services | Chief Executive | 22/12/2014 | Complete – approved by the Board 22/12/14 |

University Hospitals Bristol NHS
NHS Foundation Trust

**Cover Sheet for a Report for the Public Trust Board Meeting to be held on 29 January 2015 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

| **Item 05 – 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:<br>• Senior Leadership Team Report |

**APPENDIX A**

# SENIOR LEADERSHIP TEAM

# REPORT TO TRUST BOARD – JANUARY 2015

## 1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in December 2014 and January 2015.

## 2. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the current position in respect of performance for Quarter 3 2014/2015 against Monitor's Risk Assessment Framework.

The group **agreed** the recommendation to declare the standards failed in Quarter 3 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 and Screening cancer standards. The group also **agreed** the recommendation that the planned ongoing failure of the Referral to Treatment standards is flagged to Monitor, along with specific risks to achievement of the 62-day screening and GP cancer standards and the Accident and Emergency 4-hour standard, as part of the narrative that accompanies the declaration.

The group **noted** the current position in respect of Quarter 3 performance against the annual quality objectives.

The group **received** updates on the financial position for the current year and the Resource Plan for 2015/2016.

The group received and **approved** the Quarter 2 Complaint and Patient Experience reports for onward submission to the Trust Board.

The group received and **noted** a report on the number and type of serious incidents in Quarter 3, and the themes emerging to inform organisational learning.

## 3. STRATEGY AND BUSINESS PLANNING

The group received and **approved** the Business Case for the transfer of Cellular Pathology Services to North Bristol Trust, which was submitted to the Trust Board in December.

The group received the action plans that had been submitted to the Care Quality Commission by the deadline of 12 January 2015, **noting** that they would be monitored on a monthly basis by the Senior Leadership Team and Quality and Outcomes Committee.

The group **noted** updates on the business planning round 2015-2016 and development of Divisional and Trust Operating Plans for that period.

The group **approved** the 'Sign up to Safety' - Patient Safety Improvement Plan 2015-2018 which included the opportunity to submit a one-off bid for NHS Litigation Authority funding to address patient safety priorities.

The group received an overview of the issues affecting the Trust's ability to fill demand for bank shifts and the reduction in bank fill rates across the Trust and **agreed** to a number of recommendations to enhance the ability to increase its fill rates.

The group received and **noted** the partnership review report acknowledging that all partnerships presented a low or medium risk, with the exception of the Bristol North Somerset and South Gloucestershire System Leadership Group (formerly Healthy Futures Programme Board) which was noted as high risk, given its recent formation.

## 4. RISK, FINANCE AND GOVERNANCE

The group **noted** that the Information Commissioner's Office had been invited to undertake an Information Risk Review visit to the Trust in March 2015 and noted the work underway to prepare for that.

The group noted the outcome of the self-assessment exercise undertaken by the Trust Board against Monitor's Well Led Framework for submission to Deloitte in February, **noting** an action plan that would be developed to take any issues forward.

The group received and **approved** the Board Assurance Framework Quarter 3 update report, for onward submission to the Trust Board.

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

The group **noted** a green-rated Internal Audit Report in relation to Training Information Systems. A quarterly report on progress in the implementation of Internal Audit recommendations 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.

The group **agreed** that Divisional Management Board meeting minutes would be received for information, with access via the Senior Leadership Team workspace.

The group **reviewed** terms of reference for the Management Groups that reported to the Senior Leadership Team.

## 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**
**January 2015**

University Hospitals Bristol NHS
NHS Foundation Trust

**Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 29 January 2015 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

| **6. Patient Experience Story** |
|---|
| **Purpose** |
| The story reflects care and compassion in non-clinical practice in UHBristol and serves to remind us of the importance of listening to the needs and preferences of our patients and their carers. |
| **Abstract** |
| A family with two children with complex disabilities returned to visiting the Bristol Royal Hospital for Children (BRCH) after a period of receiving care outside of Bristol. They arrived on the first day that the new parking layout was in use between the BRCH and the Bristol Royal Infirmary BRI). Their experience suggested that the Trust was failing in its support of patients with disabilities. This patient story illustrates how, by working together, practical improvements can be made to enhance the patient experience. |
| **Recommendations** |
| The Board is asked receive the report for assurance. |
| **Report Sponsor** |
| Carolyn Mills, Chief Nurse |
| **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 – Women's and Children's Division**
**Working Together**

**Context**

A family with two children with complex disabilities returned to visiting the Bristol Royal Hospital for Children (BRHC) after a period of receiving care outside of Bristol. They arrived on the first day that a new parking layout was in use in the area between the BRHC and the Bristol Royal Infirmary (BRI). They noticed that the number of disabled bays had reduced since they had last visited the hospital (prior to the commencement of building work) and that the remaining spaces were full. Both of their children are wheelchair users and also require significant equipment to be brought with them to outpatient appointments, making it impossible to park at a distance from the hospital, particularly if only one parent is able to attend. Their daughter's condition is unusual and quite unstable, meaning she cannot be left without a carer for any length of time as she may unexpectedly require medical support from equipment or medication.

The family reported their concerns to the LIAISE team (the patient support and liaison service at BRHC).

**The issues**

The family felt that the Trust was failing in its support of patients with disabilities as follows:

- It had not considered the impact of the reorganisation of the parking arrangements on disabled patients
- It had not fully consulted with disabled patients on these changes so that the difficulties could be anticipated
- The provision for disabled users in the area did not meet the needs of Wheelchair Accessible Vehicles as the spaces were too short and a rear loading vehicle was obliged to unload into the roadway
- The only alternative parking space for a blue badge holder would be on double yellow lines outside of the hospital, putting the patient and families at risk whilst unloading from oncoming traffic

**Challenges faced in addressing the issues**

In addressing the issues raised by the family, the BRHC management team identified a number of challenges, being:

- Who should make decisions about shared spaces within the Trust?
- How could access in this area be improved for blue badge holders without having a knock-on effect for other patients and visitors?
- Who should take overall responsibility for managing any actions agreed and feeding back to the family?

**Actions**

A meeting was facilitated by James Rimmer, Chief Operating Officer supported by Caitlin Marnell, General Manager for Medicine at BRHC and Lisa Smith from the LIAISE support services. This allowed the family to express their thoughts directly to a member of the Board, and demonstrated that both the Trust and the Division were interested in understanding their concerns and offering solutions. From the meeting the following actions were agreed:

- Commencing October 2014 parking permits are now offered to all BRHC patients with hospital passports and blue badges to extend the use of the drop-off bays from 15 minutes to three hours
- Commencing October 2014 permission has been gained for the BRHC receptionists to alert the parking team on behalf of parents who are not badge or permit holders but have an exceptional need to use the space for a longer period of time. This means that the parking team are able to identify the registration plates of appropriate vehicles and in doing so offer extended parking times.
- Commencing October 2014 parents have the direct right of appeal via the Facilities team where parking tickets have been issued to parents in such circumstances. For other families we support them in appealing to TPS (the contractor) through their normal appeals process.
- During September 2014 a survey of users of this space was facilitated by the Patient Experience team to consider any other issues which might arise. The results of the survey were shared with Paul Wood (Head of Security and Transport) and have been used to inform improvements to signage, directional arrows and the pedestrian walkway between the BRCH and the BRI. In addition, the disabled spaces outside BRHC have been extended to allow more space for Wheelchair Accessible Vehicles making it safer to unload passengers.

**Embedding the Outcomes**

The parking permit scheme was initiated in October 2014 and was initially reviewed in January 2015 with the following outcomes:

- No concerns had been raised by other users or the parking team about the system and there has been no significant change to traffic flow in the area
- Parents of disabled children welcomed the scheme and actively sought to thank the hospital for recognising their needs. One parent noted, "I may not ever need to use it but it makes me feel so much better to know that I have it. It's the best thing you've ever done for children with disabilities."
- Parents who have received a ticket through misunderstanding the system or forgetting to display the permit have had their tickets cancelled promptly. There have been five incidents of this nature between October 2014 and January 16th this year all of which were resolved within 24 hours. The scheme has increased the parental uptake of the hospital passport ensuring better information on more complex children is available to support them at ward level

The parking permit system will be reviewed in October each year to ensure it is working correctly and benefiting those families in most need.

Hazel Moon
Head of Nursing
Division of Women and Children's Services

January 2015

**Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 29 January 2015 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 7. Care Quality Commission Action Plans

### Purpose

To brief the Board on action plans submitted to the Care Quality Commission.

### Abstract

The Trust received a comprehensive CQC inspection in September 2014. The inspection team identified a number of compliance ('must do') actions which are listed in the Chief Inspector of Hospitals' report (available in the public domain via CQC web site).

The Trust has submitted action plans to the CQC by the 12th January deadline agreed at the Trust's Quality Summit on 28th November 2014. These plans – presented here to the board for assurance – address internal compliance themes for the Trust, and system-wide themes which are largely concerned with improving the 'flow' of patients through our hospitals back into the community. Completion of actions will be monitored on a monthly basis by the Senior Leadership Team and the Quality and Outcomes Committee of the Board, commencing with progress reports in February.

### Recommendations

The Board is asked to receive the action plans for assurance.

### Report Sponsor

Carolyn Mills, Chief Nurse

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

### Appendices

Internal compliance themes are as follows:

- Ensuring fire exits are free from obstructions
- Assessment and mitigation of safety risk to patients during building works
- Resuscitation equipment checks
- Medicines storage and administration
- Ensuring nutritional needs are met if surgery is cancelled
- Provision of single-sex accommodation on the A&E observation ward
- Ensuring safe staffing on surgical wards and in theatres
- Ensuring the privacy and dignity for patients who stay overnight in recovery
- Availability and security of records in outpatient services
- Staff training compliance

System-wide themes are as follows:

- Avoiding delays for ambulances arriving at A&E
- Effective and timely discharge planning
- Treating each patient on the right ward for their clinical condition
- Ensuring patients with mental health needs receive prompt and effective support in A&E

## Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 29 January 2015 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

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|---|
| Plans addressing system-wide themes are accompanied by an overview report which carries the names of the respective operational leads from University Hospitals Bristol, Bristol Clinical Commissioning Group, Bristol Community Health and Bristol City Council. |

### 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 |
|---|---|---|---|---|---|
| | | | | | |

## Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

| | |
|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust (NHS 111 – Care UK) – Flow plan 1 |

**(For regulations requiring actions: Require one page per regulation)**

| Regulated activity(ies) | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** |
| | **How the regulation was not being met:** |
| | The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and medical care to meet their needs and ensure their welfare and safety.<br><br>Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.<br><br>Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.<br><br>The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.<br><br>Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents. |

| **Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve** | |
|---|---|
| A&E<br>Outline of scheme:<br><br>To use a dedicated Clinical Advisor (CA) resource to review calls with A&E dispositions and ensure only appropriate onward referrals take place.<br><br>Objectives:<br>• Reduce of A&E attendances by the utilisation of an alternate Pathway, reduce unnecessary hospital admissions via A&E, and achieve more streamlined flow of care throughout the Urgent Care system.<br>• Improve patient satisfaction and experience and allow for a more tailored approach to care especially those who are elderly and/or those with complex needs.<br>• Achieve delivery against the target of 5% for referrals to A&E (transfers from 111 to A&E)<br><br>We have identified high peak demand times as follow:<br>Weekdays 5pm-10pm<br>Weekends 8am-10pm<br><br>Currently, if a Health Advisor (HA) reaches A&E disposition, patients are sent to A&E without any clinical intervention. This initiative will ensure only appropriate patients are referred to A&E after CA's intervention<br><br>This project will reduce the number of attendances to A&E and provide patients with an alternative service or offer self-care advice. This project will be reviewed to consider its ongoing viability. | |
| **Who is responsible?** | Sue Brooks, Head of NHS 111 SW Care UK |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**<br>. | |
| The improvements are being tracked on a daily basis via a monitoring tool, that measures the impact of the project and the number of referrals being made to A&E. The monitoring tool also measures the outcomes that are reached following the intervention of a CA. The CA resource is currently available and sustainable until the end of March 2015.<br><br>Since the implementation of this additional capacity (15 December), the average for A&E disposition for the Bristol North Somerset South Gloucestershire (BNSSG) service for the period of 15 December 2014 to 4 January 2015 was 4.79%, against a target of 5%. The average for the month of December 2014 was 5.18%. | |
| **Who is responsible?** | |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| This initiative will ensure two Clinical Advisors (CA) are dedicated to 'ED Line' during the peak hours to monitor all A&E dispositions from 15 December - 31 march 2014. Resource | |

| | |
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| has been allocated. | |
| **Date actions will be completed:** | 15 December 2014 |

| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** |
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| Not relevant to this scheme |

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|---|---|
| **Completed by:** | Sue Brooks |
| **Position(s):** | Head of NHS 111 SW for Care UK |
| **Date:** | 16th December 2014 |

## Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

| | |
|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust (South Western Ambulance Service NHS Foundation Trust – Flow plan 2) |

**(For regulations requiring actions: Require one page per regulation)**

| Regulated activity(ies) | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** |
| | **How the regulation was not being met:** |
| | The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and medical care to meet their needs and ensure their welfare and safety.<br><br>Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.<br><br>Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.<br><br>The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.<br><br>Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents. |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

**Implementation of direct referrals to GP Support Unit (GPSU)**
Patients can be referred to GPSU from the A&E following conveyance by ambulance, however they have had to be triaged, assessed and deemed appropriate for GPSU by an A&E clinician. This potentially contributes to the challenges of blockages in the A&E department and adds another layer when the patient has already been assessed by a healthcare professional such as a Paramedic. A number of these patients could potentially benefit from direct GPSU admission for assessment, diagnostics and onward referral to an alternative care pathway, medical admission or discharge. This could provide an opportunity to reduce pressure at Bristol Royal Infirmary A&E. The Trust has therefore agreed a direct ambulance referral pilot with the GPSU.

Implementation will:

- Provide patients presenting with medical conditions with the most appropriate care pathway in line with the Right Care2 Project
- Improve patient flow within the BRI
- Improve patient experiences
- Standardise medical assessment/admission procedure between primary care and the ambulance service
- Increase the number of direct referrals to GPSU by ambulance clinicians
- Evaluate the demand and the resources required to manage patients in GPSU
- Reduce BRI A&E attendances

The current referral rate is on average eight per week. The aim is to increase this to three per day. This being supported by awareness to crews through literature and support/education from the trust's Operational Officers and from Hospital Ambulance Liaison Officers (HALOs).

**Provision of PSVs (patient support vehicles)**
The winter period has historically been a time of increased pressure for the NHS as there is a greater demand for services across all areas of the healthcare system. This year the CCGs have released additional funding for the winter period to allow for the provision of additional resources and services in order to mitigate the pressures of increased demand. The commissioners in the BNSSG area of the North locality of the SWAST area have allocated funds which will be used to provide an additional service for the provision of dedicated Hospital Winter Pressure PSV vehicles. Additional PSV grade ambulance resources have been commissioned for the winter pressure period. These resources will be dedicated to carry out transport to support:

- Discharges
- Transfers
- Admissions

The dedicated Hospital Winter Pressure PSV vehicles are in place to carry out discharges and transfers for the BRI. The patients should be low acuity and suitable for a PSV crew (i.e. not require clinical interventions during transport). They will also carry out Health Care Professionals (HCP) Admissions suitable for the PSV that are being admitted to the BRI (this is the secondary function of the vehicle and HCP Admissions will only be undertaken when there is no discharge or transfer work outstanding for the vehicle). In the event that a vehicle reaches capacity and no more bookings can be taken, the hospital will still be able to negotiate changes in bookings should they so wish (i.e. the hospital will be able to request

that an outstanding booking be cancelled to accommodate discharge/transfer of a different patient).

**Implementation of HALO (hospital ambulance liaison officers)**
Based within acute hospitals during times of increased pressure, HALOs will be responsible for the effective and efficient management of ambulance turnaround times and patient flow within A&Es in order to support support the delivery of a performance management framework within the area of responsibility. The allocated HALO will identify measures to ensure that the highest standards of service are achieved in managing ambulance turnaround times and patient flow in the interests of patient care and contractual requirements. When in place, the HALO will be an initial point of contact for hospital staff, emergency staff and patients in order to promote a continuous service improvement approach to ambulance turnaround times and patient flow. This role will also establish strong links with hospital staff at all levels to foster mutual understanding of roles and ensure the efficient and effective use of staff and resources. The HALO will be responsible for liaison with the A&E, Patient Flow/Bed Managers to ensure the effective and efficient use of information in relation to “Bed Status” and trolley waits. The HALO will support improved patient satisfaction, reduction in pressure on acute A&E, improved 999 resourcing due to release of crews as a result of quicker turn around times and improved working relationship between primary / secondary care and the ambulance service. The HALO will also where appropriate be responsbile for redirection to the GPSU.

| **Who is responsible for the action?** | Paul Birkett-Wendes, Head of Operations (North) |
|---|---|

**How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**

**GPSU:**
The weekly GPSU snap shot is distributed to SWAST to monitor Paramedic referrals.

**PSVs:**
The SWAST north clinical hub will monitor all bookings and provide feedback on utilisation rates as requested. The vehicles are externally sourced through agency to gaurentee their daily availability.

**HALOs:**
Monitor KPIs monthly.
HALO to submit reports at end of each shift
Feedback on system to be collated from partners
Patient experience audit

| **Who is responsible?** | Paul Birkett-Wendes, Head of Operations (North) |
|---|---|

**What resources (if any) are needed to implement the change(s) and are these resources available?**

Nine HALOs have been appointed; a tenth post is currently being recruited to. The team’s anticipated ‘go live’ date is 26 January.

| **Date actions will be completed:** | PSVs and GPSU are in place; HALOs go live by end of January 2015. |
|---|---|

| How will people who use the service(s) be affected by you not meeting this regulation until this date? |
|---|
| There will be minimal effect as the Operational Officers and trusts' Lead Paramedics are capable of taking on the HALO role as and when required. |

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| **Completed by:** | Sarah Jenkins |
| **Position(s):** | Operations Manager Bristol |
| **Date:** | 15 December 2014 |

## Report on actions you plan to take

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| | |
|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust (Bristol CCG / Avon and Wiltshire Mental Health Partnership NHS Trust) – Flow plan 3 |

**(For regulations requiring actions: Require one page per regulation)**

| Regulated activity(ies) | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** |
| | **How the regulation was not being met:** |
| | The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and medical care to meet their needs and ensure their welfare and safety.<br><br>Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.<br><br>Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.<br><br>The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.<br><br>Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents. |

| Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve | |
|---|---|
| For adults, work with our newly recomissioned mental health services to continue to provision of mental health support in A&E outside of UHB's liaison service hours, and provide enhanced liaison discharge support to frail and elderly people with the hospital.Commissioners and mental health service providers will look at whether providing Avon Mental Health Partnership input out-of-hours from Friday to Sunday is viable, considering the governance and funding arrangements as well as consideration of the availability of Section 12 doctors to support any enhanced provision for Mental Health Act Assessments.<br>Timely access to inpatient mental health care off site from the Bristol Royal Infirmary when assessed as required and timely support in assessing the cognitive needs of frail and complex patients as part of the discharge process will form part of this review. | |
| **Who is responsible for the action?** | Richard Lyle, Programme Director Bristol CCG |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| Key performance indicators and monitoring arrangements are in place for each of the service components and are being monitored on a monthly basis via our Integrated Quality and Performance Meetings with health and social care providers. This will be reviewed by the Urgent Care Working Group.<br>Discussions will be led by Bristol CCG, regarding Avon Mental Health partnership and S12 input, at the contract meetings and the Urgent Care working group. | |
| **Who is responsible?** | Richard Lyle, Programme Director Bristol CCG |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| The majority of resources have been secured, although not all are yet fully implemented or embedded. Implementation of the first phase of the model began in October 2014 with the final phase due to commence in April 2015. Additional non recurrent resources have been secured to implement and quantify the benefits of additional psychiatric laison at the main Bristol Hospital sites. | |
| **Date actions will be completed:** | The majority between January and April 2015. Final phase of some services beginning April 2015 |

| How will people who use the service(s) be affected by you not meeting this regulation until this date? |
|---|
| Likely delays to assessment, poor patient experience, sub-optimal care, possible breach of 4 hr standard, longer length of stay in hospital, additional stress for staff not appropriately trained to treat or support people with a mental illness. The new arrangements should mitigate the risks and will be monitored via the KPIs. |

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| **Completed by:** | Richard Lyle |
| **Position(s):** | Programme Director for Community & Partnerships Bristol Clinical Commisisoning Group |
| **Date:** | 15 December 2015 |

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|---|---|
| **Ownership:** | James Eldred, AWP<br>Richard Lyle, CCQ<br>Mike Hennessey, Bristol City Council |
| **Executive lead:** | James Rimmer, Chief Operating Office, UH Bristol |

## Report on actions you plan to take

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| | |
|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust (Bristol Community Health) – Flow plan 4 |

**(For regulations requiring actions: Require one page per regulation)**

| Regulated activity(ies) | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** |
| | **How the regulation was not being met:** |
| | The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and medical care to meet their needs and ensure their welfare and safety.<br><br>Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.<br><br>Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.<br><br>The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.<br><br>Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents. |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

Bristol Community Health is increasing the resources to services to support facilitated discharge for patients that have required a significant hospital admission (through additional resource to support the Community Discharge Co-ordination Centre) and through in-reach services via our Rapid Response service into the A&E and Older Persons Assessment Unit.

The additional resource will include Advanced Nurse / Therapy Practioners (ANP/AP) and physiotherapists working across the Rapid Response, REACT and CDCC services. This enhanced service will work with existing and newly developed pathways 7 days a week. With additional ANP / AP support, the service will provide a senior community presence in the hospital to facilitate discharge decision making. With the additional therapy resources, this will provide the capacity to take patients back into community settings rapidly along a rehabilitation / reablement pathway. The teams will work with hospital teams to ensure that discharges are appropriately planned.

The following actions will be taken to achieve this:

- Implementation of therapy roles (December 2014)
- Implementation of the ANP role (January 2015)

(role details below)

As part of this work BCH has modelled the target impact of the additional ANP and therapy resource on facilitating discharges from A&E/MAU and OPAU. This will be:

- 3 additional discharges per week from 8/12/14
- 5 additional discharges per week from 26/1/15

| **Who is responsible for the action?** | Ceridwen Massey Deputy Director of Operations |
|---|---|

**How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**

These actions will support the Trust in achieving its reduction in Length Of Stay and numbers on the Delayed Transfer Of Care list.

The agreed measures specifically against this action are:

- Number of discharges to rehabilitation / reablement services (combined with measure below of 3 from 8/12/14 and 5 from 26/1/15)
- Number of discharges to rapid response service (combined with measure above of 3 from 8/12/14 and 5 from 26/1/15)
- Bed occupancy of rehabilitation / reablement beds. Target occupancy of 85%.

Reporting will be part of the urgent care governance process.

The resource has been agreed as part of ORCP funding; long term sustainable changes will be discussed as part of the contracting round.

| **Who is responsible?** | Ceridwen Massey, Deputy Director of Operations |
|---|---|

**What resources (if any) are needed to implement the change(s) and are these resources available?**

Resources identified are:

- 2 x advanced nurse / therapy practitioner

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|---|
| • 3 x senior therapist (physiotherapy)<br>Funding is available through tranche 1 ORCP investment. The project will be evaluated and ongoing resource sought from Commissioners to sustain if and where appropriate. |

| | |
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| **Date actions will be completed:** | 28 February 2015 |

| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** |
|---|
| Interim capacity is being identified through the use of agency and bank staff. This started in mid-December 2014. |

| | |
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| **Completed by:** | Ceridwen Massey |
| **Position(s):** | Deputy Director of Operations |
| **Date:** | 16 December 2014 |

## Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

| | |
|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust (Bristol City Council) – Flow plan 5 |

**(For regulations requiring actions: Require one page per regulation)**

| Regulated activity(ies) | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** |
| | **How the regulation was not being met:** |
| | The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and medical care to meet their needs and ensure their welfare and safety.<br><br>Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.<br><br>Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.<br><br>**The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.**<br><br>Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents. |

| Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve | |
|---|---|
| **Support discharge process by increasing reablement capacity**<br>1. Bristol Intermediate Care and Reablement is advertising posts to increase Reablement capacity to take an additional 30 people per month in total from both acute trusts. This additional capacity is funded via Better Care Programme. Advertising for three Social Care Practitioners to become part of the Community Discharge Coordination Centre (CDCC). Better Care funding will enable the CDCC to process requests for Reablement or domicillary care without having to refer back to the Social Work Department in the hospital, saving beds days and duplication. The Intermediate Care Partnership (Bristol City Council and Bristol Community Health) is working to develop the "Discharge to Assess" model. Again this is supported by the Better Care Programme and is in line with further closer integration.<br><br>2. We have employed a Social Care Practitioner working with the REACT service in A&E and in the Older Persons Asessment Unit to provide information, advice and signposting, restarting care plans and undertaking quick turn around of assessment in order to avoid unnecessary admissions and reduce length of stay.<br><br>3. We are recruiting two Support Planning Coordinators to work within the Bristol Royal Infirmary as part of our Care Brokerage service focussing on specific wards in order to source care providers and expediate discharge.<br><br>4. We are going to recruit three* additional Social Work staff in our community teams to undertake early reviews of patients being discharged from hospital in order to free up capacity which will reduce hospital delays for people waiting for a home care or reablement services as well as avoid any risk of readmission.<br><br>Social care practitioners will reduce length of stay by assessing people where case finding by the CDCC would otherwise have generated a S2 to the Social Work Dept, thus reducing length of stay by a minimum of one day.<br><br>A meeting has been set for January with Bristol Community Health and Care management to look at the skill mix required to further develop the discharge to assess model.<br><br>* subject to confirmation | |
| **Who is responsible for the action?** | 1. Jayne Clifford Joint Strategic Service Manager Intermediate Care and Reablement.<br>2. Stephen Beet, Service Manager, Hospital/ Front Door Social Work |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| 1. We will monitor the numbers of people leaving hospital with Reablement services above our current baseline of activity and capacity.<br><br>2. Reduction in number of patients on Green to Go list to the target of 30 and reduced average length of stay. | |

| | |
|---|---|
| **Who is responsible?** | Jayne Clifford, joint Strategic Service Manager Intermediate Care and Reablement.<br>Stephen Beet, Service Manager, Service Manager, Hospital/ Front Door Social Work. |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| Resources are available from Better Care Funding. Recruitment of staff is required for initiative 1 and may be a limiting factor for full implementation.<br>Resources available from Bristol CCG ORCP funds. BCH to follow up with commissioners regarding sustainability. | |
| **Date actions will be completed:** | 31 March 2015 |

| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** |
|---|
| Not relevant to this scheme. |

| | |
|---|---|
| **Completed by:** | Jayne Clifford, joint Strategic Service Manager Intermediate Care and Reablement.<br>Stephen Beet, Service Manager, Service Manager, Hospital/ Front Door Social Work |
| **Position(s):** | As above |
| **Date:** | 9 January 2015 |

## Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

| | |
|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust – Flow plan 6 |

**(For regulations requiring actions: Require one page per regulation)**

| Regulated activity(ies) | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** |
| | **How the regulation was not being met:** |
| | The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and medical care to meet their needs and ensure their welfare and safety.<br><br>Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.<br><br>Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.<br><br>The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.<br><br>Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents. |

| **Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve** | |
|---|---|
| The Trust is prioritising five key actions to promote early discharge and ensure patients are cared for in the most appropriate bed:<br><br>Reinforce the SAFER care bundles: these were introduced in April 2014 as part of the Trust's "Breaking the Cycle Together" initiative and are designed to improve flow and ensure discharge planning is given increased priority. The plan will include a communication campaign.<br><br>Electronic completion of CM7 documentation: this is a formal assessment for all patients requiring residential/nursing home placements. This is a substantial multi professional document that is currently completed manually. Significant delays in completing the assessment will result in delays transferring patients within acceptable timeframes. This project will move from manual documentation to an electronic record that can be shared easily among the multi professional team. The electronic document can be started on admission and any changes can be made without having to start the process again. An electronic version is safe and cannot be lost and is also legible. This project will further support partnership working.<br><br>Patient Progress MDT Meeting: The Division of Medicine will have a weekly 'patient progress' meeting. The purpose of this meeting will be to progress chase any patients whose discharged is delayed. All partner organisations will attend and alternative discharge destinations will be agreed. Each medical matron will attend and have 20 minutes to present their top six patients who have been in hospital over 14 days. All actions will be recorded using an action log and patient progress against the agreed action followed up daily. Any failure in progress will be escalated to medicine silver control; any further delays will be escalated to medicine gold (silver and gold are levels of escalation).<br><br>10 before 10: 10 patients will be identified for discharge before 10.00am in order to get patient flow moving within the hospital. This will increase from 1 February 2015, rising to 15 patients before 10.00am by 31 March. Earlier discharge planning should result in more patient transport being booked in advance i.e. the day before discharge, facilitating a more timely response, and reducing discharge and transfer journeys late in the day, and also the subsequent need to backfill vacated ward beds after 8pm.<br><br>Appropriate Ward and Reducing Unnecessary Moves: New ward block opened since the inspection, which has increased the number of beds on the Medical Assessment Unit (MAU). This should allow patients to be discharged directly from MAU where appropriate without moving them to a base ward. The Managed Care Pathways and Emergency Patient Standard Operating Procedures for the three bed-holding divisions have now been implemented, which will articulate the safe pathways for internal movement of patients. Daily decisions about moving patients to non BRI wards to create acute capacity now take place earlier in the day to help facilitate earlier transfer of patients. Extra capacity beds have been opened earlier than planned. Plans were in place to open 17 beds on Ward A518 on 1 January, however this was brought forward to mid-November 2014.<br><br>Note: more detailed plans supporting these actions can be provided by the Trust upon request. | |
| **Who is responsible for the action?** | Rowena Green, Director, Division of Medicine |

| How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this? | |
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| • The processes will be built into the daily and weekly operational procedures for the divisional teams. (Divisional Operating Plans, 31 March 2015).<br>• A communication programme to support the implementation of the SAFER care bundles will be developed. (31 March 2015)<br>• The new ward block will be fully open in the autumn (31 August 2015). | |
| **Who is responsible?** | Rowena Green, Divisional Director of Medicine |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| • Resourcing for the new medical model of care for the new ward block has been agreed.<br>• Plans for Resilience (extra capacity) will be developed as part of the 2015/16 operating plans.<br>• Resourcing for the IT developments to support the implementation of the SAFER bundle will be developed in line with the development of the plan. | |
| **Date actions will be completed:** | 31 March 2015<br>(with exception of new ward block - 31 August 2015) |

| How will people who use the service(s) be affected by you not meeting this regulation until this date? |
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| The risk that A&E queueing will persist ahead of '10 before 10' being fully delivered will be mitigated by close working with the ambulance service and by additional staff in A&E to care for patients whilst in the queue.<br>Inappropriate patient moves will be mitigated by adherence to the Standard Operating Procedures (which have come into effect with the opening of the new ward block post CQC visit). |

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| **Completed by:** | Rowena Green |
| **Position(s):** | Director, Division of Medicine |
| **Date:** | 16 December 2014 |
| **Executive lead:** | James Rimmer, Chief Operating Officer |

**Report on actions you plan to take**

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|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust |

**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| Diagnostic and screening procedures; Treatment of disease, disorder or injury | **Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises** |
| | **How the regulation was not being met:** |
| | The provider had failed to ensure that service users and others were protected against the risks associated with unsafe or unsuitable premises.<br>Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>The fracture clinic was not a safe environment in which patients were to wait for and receive treatment. Patients and others were not protected from the risks associated with the ongoing building work.<br><br>Not all fire exits were clear and accessible. |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

Fracture clinic and all future construction works in live areas:

Health & Safety control measures were in place but not followed in the fracture clinic. This programme of works has now been completed and the risks have been addressed. Lessons will be learnt for future redevelopment projects.

We will continue to use standard construction industry Health & Safety Risk Assessments/ Method Statements (RAMS) which include consideration for patients, staff and visitors in a healthcare setting for all capital redevelopment projects. This will be included and recorded in project managers' training and Standard Operating Procedure (SOP) and will be regularly audited.

A Clerk of Works is being appointed for each project, with a remit to audit and check on-site practice performed by the contractor's supervisor against the RAMS covering standard and project specific risks. The Clerk of Works will undertake regular site safety inspections for live construction sites, then working with the contractors to undertake improvements.

This is in parallel with and in addition to the Construction Design Management Co-ordinator

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| (CDMC) role who is also required to audit site.<br><br>This will provide assurance that any environment undergoing building works is safe of patients and staff to use.<br><br>Fire exits:<br><br>Keeping exits clear is already included in the Fire Safety Policy. A letter will be sent by the Director of Facilities & Estates to all Divisional Directors & Clinical Chairs on an annual basis to be cascaded to staff to remind them of policy and the requirements of this action. Keeping clear fire exits is now included as an item on the Estates audit plan.<br><br>The Fire Officer and other key named members of the estates team now walk all corridors areas on a two week basis to audit the 'house keeping' to ensure fire exits are kept clear. If issues of non-compliance persist, the audit team will increase frequency and escalate risks/actions to local ward/department management to address. |

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| **Who is responsible for the action?** | Director of Estates and Facilities |

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| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** |
| The Estates Quality & Systems Manager audits the record sheets produced by the Clerk of Works and the Estates Fire Officer. |

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| **Who is responsible?** | Director of Facilities & Estates |

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| **What resources (if any) are needed to implement the change(s) and are these resources available?** |
| Fracture Clinic and all future construction works in live areas:<br>Continued provision of Capital Team Clerk of Works role now provides regular site safety inspections to ensure contractor's safety resilence does not falter during the construction period. Levels of attendance of both the NHS Clerk of Works and the Contractor's Supervisor will vary according to the Risk Assessments & Method Statements (RAMS).<br><br>Fire Exits:<br>No additional resource. Audits are part of role of Estates Fire Officer. Estates Quality & Systems Manager will be able to provide the overarching audit role as part of their job plan, reporting to the Director of Facilities & Estates. |

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| **Date actions will be completed:** | Fracture Clinic and changes to planned future construction works audits in live areas are now in place – actions completed.<br><br>Letters to staff and an audit of fire exits will be ongoing. Assurance measures and audit plan now in place. |

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| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** |
| Fracture Clinic works have now been completed. Systems are now in place to audit all future construction works in live areas.<br><br>Fire Exits – All fire exits have been cleared; reviews and audit plans have commenced to ensure safety will be maintained. |

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| **Completed by:** | Leigh Adams |
| **Position(s):** | Director of Facilities & Estates |
| **Date:** | 6 January 2014 |
| **Executive lead:** | James Rimmer, Chief Operating Officer |

## Report on actions you plan to take

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| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
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**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | **Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff** |
| | **How the regulation was not being met:** |
| | The provider had failed to have suitable arrangements in place to ensure that all staff were supported to receive appropriate training to enable them to deliver care and treatment to service users safely and to an appropriate standard.<br><br>Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>Not all staff on medical wards were able to attend and carry out mandatory training, particularly annual resuscitation training, in order to care for and treat patients effectively. |
| **Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve** | |
| During 2013/14, the Trust undertook a comprehensive review of Essential Training (Mandatory & Statutory training) and implementing revised training topics, new training programmes and a new teaching and learning portal. The review also focussed on confirming the accuracy of centrally held training compliance data to improve assurance.<br><br>In October 2014, all data was verified and released to Divisional Boards. The same month, a number of key Essential Training topics were made available on an e-Learning platform. The e-learning suite provides the flexibility for staff to complete training at their location of work rather than physically attending an update session. This option has proved successful in improving compliance.<br><br>Given the step-change in approach, we have agreed a trajectory to achieve 90% Essential Training compliance by the end of March 2015. Progress is being monitored monthly by the Senior Leadership Team and the Service Delivery Group. | |

In respect of medical wards, the Division of Medicine has an overall plan for achieving Essential Training compliance, in line with the Trust KPI by the end of March 2015. This contains a specific trajectory for resuscitation training and a supporting action plan for ward managers which includes:

- Ward Sisters maintaining their own departmental spreadsheet and ensuring staff are booked onto training as necessary;
- Ward Sisters, during the appraisal process, identifying when staff will become non-compliant to ensure a forward plan of training is in place.

In November and December, the Trust was ahead of trajectory with its target towards reaching 90% compliance and there was an increase in E-Learning through the development of self-service. This reflected a shift towards staff being more pro-active with achieving compliance ahead of dates lapsing.

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| **Who is responsible for the action?** | Trust-wide: Sue Donaldson, Director of Workforce and Organisational Development<br>Division of Medicine: Rowena Green, Divisional Director |

**How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**

The measures that are being put in place are to continue to develop a blended learning approach to provide maximum flexibility for staff to achieve compliance, this includes increasing e-learning topics and micro teaching in the workplace to ensure staff have a variety of options to achieve compliance.

With the introduction of electronic self-service on the teaching and learning portal, staff now have access to their training records and have the ability to manage and own their training compliance.

Essential Training is monitored in a number of senior management meetings on a regular basis, the review of each trajectory will continue monthly to ensure that all divisions are on track with achieving 90% compliance by the end of March 2015.

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| **Who is responsible?** | Alex Nestor, Deputy Director of Workforce and Organisational Development |

**What resources (if any) are needed to implement the change(s) and are these resources available?**

No further resources are required as all necessary actions are in place.

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| **Date actions will be completed:** | 31 March 2015 |

**How will people who use the service(s) be affected by you not meeting this regulation until this date?**

The risk for patients is mitigated as staff who are currently non-compliant are spread throughout the division within both clinical and non-clinical roles. Where there is lower than required compliance, staff are not working alone but as part of a wider team and are therefore supported by colleagues who are in date for their training. Access to experienced

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| senior nurses and medical staff with Advanced Life Support Skills is also available almost immediately via the emergency call system. |

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| **Completed by:** | Sue Donaldson |
| **Position(s):** | Director of Workforce and Organisational Development |
| **Date:** | 6 January 2015 |
| **Executive lead:** | Sue Donaldson, Director of Workforce and Organisational Development |

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| **Trust name** | University Hospitals Bristol NHS Foundation Trust |

**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| **Management of medicines** | **Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010**<br><br>**Management of medicines** |
| | **How the regulation was not being met:** |
| | The provider had failed to protect services users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.<br><br>Medicines were not always stored securely in critical care areas and on medical and surgical wards. Records of medicines administration on surgical wards were not always maintained to accurately reflect the time at which medicines were administered. |
| **Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve** | |
| Medicines security within the Trust will continue to be audited on an ongoing basis in order to assess practice and to work with staff where improvement is needed within the organisation.<br><br>The results of the ongoing audits will be presented to the Medicines Governance Group which meets every two months and will focus attention on those clinical areas where performance does not meet the requirements detailed in the trust 'Secure handling and safe storage of medicines' policy (Chapter 3 of the Medicines Policy).<br><br>The Local Security Management Specialist will be alerted to any clinical areas of concern in order to investigate potentially poor practice, and will also have an ongoing role in 'penetration testing' of clinical areas in order to ensure that safe systems are in place. | |

The Pharmacy staff have also been empowered to escalate any observed deficiencies during their visits to clinical areas.

One specific concern reported was that one of the locks was missing from the Controlled Drugs cabinet in the Cardiac Intensive Care Unit; this has now been replaced. A risk assessment has been completed regarding the issues raised concerning the CD cabinet fixings in the new building.

Ongoing security improvements have been made, and the secure 'drop boxes' in clinical areas are now in regular use; these maintain medicines security whilst avoiding drawing nursing staff away from clinical duties and patient care. This process is presently being extended to a number of clinical areas in the trust that were not covered in the initial roll-out. Bar code scanning is also now being implemented for deliveries to the drop boxes and this gives a more robust audit trail for the delivery of medicines.

The ongoing focus with regard to medicines security is, in our view, more effective than periodic audits, and will further develop the environment in which medicines security is an embedded principle, with all staff automatically treating safe handling of medicines as a priority.

Intermittent audit is, however, also undertaken, and the 'NHS Protect Medicines Security self-assessment' has been completed and action plan implemented within 2014/15. This was a helpful audit process and will be revisited in 2015 to ensure that secure systems are being maintained, and also to reconsider whether further actions should be taken.

There is a significant movement of wards at present with the transfer to the new hospital building, so the repeat of the self-assessment will be helpful to consider whether the anticipated improvements in the security of medicines in the new building are achieved.

The goal is to further embed the principles of secure handling and safe storage of medicines into the practice of every clinical area within the trust, so that the isolated examples of poor practice documented in the CQC report no longer occur.

The Trust is currently implementing the recording of room temperature for ward and department treatment rooms.

The above actions are aimed at strengthening the existing governance and quality management arrangements with regard to the safe and secure handling of medicines.

With regard to the recording of medicines administration, the NICE staffing red flag of "unplanned omission in providing patient medications" is being integrated into the incident reporting system, and will be incorporated in the real time electronic acuity and dependency system (once procured). This will provide real time and retrospective reporting to support real time and strategic actions as appropriate to address any shortfalls in skills or numbers of staff which are having an impact on medication omission.*

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| **Who is responsible for the action?** | Stephen Brown, Director of Pharmacy and Chair of the Medicines Governance Group.<br>Except *, responsiblility of Carolyn Mills, Chief Nurse |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| As detailed in the previous section, the ongoing maintenance of medicines security will be overseen by the Medicines Governance Group.<br><br>The UH Bristol 'Quality in Care Tool' is locally developed and used in clinical areas on a regular basis. This incorporates standards around medicines security and addresses the issues identified in the CQC inspection; there are clear expectations in place for ward clinical environments.<br><br>The expansion of the Pharmacy medicines 'top up' service is being explored in order for Pharmacy staff to visit the majority of clinical areas to manage medicines stock. This would improve the control of medicines in these areas, providing greater assurance of expiry date monitoring and maintenance of neat, ordered storage environments. | |
| **Who is responsible?** | Stephen Brown, Director of Pharmacy and Chair of the Medicines Governance Group. |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| The medicines security work is a fundamental element of the service and no additional resources are required to further embed the principle of medicines security.<br><br>There would, however, be benefit from extending the Pharmacy medicines 'top up' service to clinical areas currently not covered by this service, and this is being addressed in the present business planning process for 2015/16.<br><br>With regard to the new hospital wards, the environment should be conducive to secure medicines storage, but some additional cabinets may be required in the new wards if the anticipated storage facilities are found to be inadequate; any such requirements are being addressed.<br><br>It is recognised from experience elsewhere in the NHS and a previous UH Bristol pilot, that electronic storage equipment is extremely effective with regard to maintaining medicines security, with access through fingerprint technology and complete audit trails. The technology has moved forward in recent years so it is recognised that there may be benefits to explore this further for specific clinical areas. The Pharmacy are assessing whether a pilot project can be undertaken to investigate further the benefits of such technology locally. | |
| **Date actions will be completed:** | The majority of the actions detailed are ongoing, such as the regular review of local medicines security.<br>The further roll-out of secure drop boxes and implementation of bar code technology will be complete by 31 March 2015.<br>The NHS Protect Medicines Security Self-Assessment will be |

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| | repeated by 30 June 2015.<br>The expansion of the Pharmacy top-up service will be submitted into the current 2015/16 planning process for implementation, if approved, by 1 September 2015.<br>The trial of electronic medicines storage will be progressed, and if funding is available, this will be piloted in a ward area in 2015/16.<br>The NICE 'red flag' action will be completed by 28 February 2015. |

| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** |
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| The vast majority of clinical areas inspected were operating at a high level of security with regard to medicines so the present risk of harm is considered to be extremely low. |

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| **Completed by:** | Stephen Brown |
| **Position(s):** | Director of Pharmacy |
| **Date:** | 6 January 2015 |
| **Executive lead:** | Sean O'Kelly, Medical Director |

## Report on actions you plan to take

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| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust |

**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs** |
| | **How the regulation was not being met:** |
| | The provider had failed to ensure that service users were protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs.<br><br>Regulation 14(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>Patients whose surgery was cancelled did not always have their nutritional needs met. |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

- Develop a Standard Operating Procedure (SOP) which describes the actions required to ensure that patients, whose operation is cancelled, have their nutritional needs met. SOP to include
  - Defined nutritional standards for patients in pre-operative period
  - The process by which the ward will be alerted to the cancellation of a patient's operation
  - Defined responsibility, within each ward to ensure that when cancellations occur, the house keeping team and nursing staff are made aware of the cancellation and the patient is given appropriate nutrition.
  - Required practice for maintaining nutritional status of a patient who needs to remain "nil by mouth" following delay or cancellation of their operation.

- Incorporate nutritional status into daily safety brief so that staff remain aware of the importance of maintaining nutritional needs of patients whose operation has been delayed or cancelled.

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| **Who is responsible for the action?** | Head of Nursing, Surgery, Head & Neck Division |

| How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this? | |
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| (1) Audit of compliance with Standard Operating Procedure – to be completed by 30 June 2015.<br>(2) A Trust-wide Nil by Mouth policy will be developed for presentation/approval at Clinical Quality Group in early February 2015. Dissemination and implementation during February 2015. | |
| **Who is responsible?** | (1) Head of Nursing, Surgery, Head & Neck Division<br>(2) Trust Nutrition and Hydration Group |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| No additional resources are required. | |
| **Date actions will be completed:** | Standard Operating Procedure has been drafted and will be signed off by Divisional Governance arrangements by 31 January 2015.<br>Policy approval, dissemination and implementation during February 2015. |

| How will people who use the service(s) be affected by you not meeting this regulation until this date? |
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| - Number of patients affected by this risk has been reduced following a reduction in number of cancelled operations.<br>- All staff have been reminded of the importance of maintaining adequate nutrition through immediate introduction of this issue to daily safety briefings. |

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| **Completed by:** | Deborah Lee |
| **Position(s):** | Director of Strategic Development and Divisional Interim Director for Surgery Head & Neck services |
| **Date:** | 6 January 2015 |
| **Executive lead:** | Carolyn Mills, Chief Nurse |

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**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records** |
| | **How the regulation was not being met:** |
| | The provider had not ensured that records in respect of service users' care and treatment were kept securely and could be located promptly when required.<br>Patient records in outpatient clinics were not always stored securely and were not always available to clinicians when required. |

| **Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve** | |
|---|---|
| 1. Reminder to be sent to all services of the need to store notes safely and out of view.<br>2. Develop a short training presentation for services to share with teams.<br>3. Measure initial compliance via a small audit.<br>4. Ensure that there is access to clinical records out of hours by Clinical Site Managers.<br>5. Review the flow of patient records within outpatient ares to ensure they are secure at all stages of the process.<br>6. 3-6 monthly audits to be undertaken on a Trust-wide basis (all areas of the Trust to be included over a 12 months period) to ensure patient notes are being stored securely in outpatient clinic areas.<br>7. Check patient record security in the Trauma & Orthopaedic clinic post the completion of the major refurbishment work.<br>8. Continue the Trust-wide 6 monthly 2 week audit of outpatient missing case notes.<br>9. Transition to an electronic document management system to begin in 2015 and roll out within two years – will allow access to all patient records electronically. | |
| **Who is responsible for the action?** | Head of IM&T / Health Records Manager |

| How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this? | |
|---|---|
| • Divisional Outpatient Managers to monitor and report any issues/concerns to the Health Records Manager<br>• Clinical Record Keeping Group to continue to monitor clinical incidents relating to clinical records not being available and audit of missing outpatient notes and report to the Clinical Quality Group<br>• Security of notes storage and accessibility checks to be included on Executive patient safety walkrounds. | |
| **Who is responsible?** | As indicated above |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| • No additional manpower will be required to ensure that patient records are stored securely. The monitoring process should be an integral part of the appropriate managers role and responsibility<br>• Physical changes to working environments may be required in some areas, to ensure that staff are able to securely store the patient records | |
| **Date actions will be completed:** | 31 March 2015 |

| How will people who use the service(s) be affected by you not meeting this regulation until this date? |
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| Risk to quality of care if patient records are not available.<br>Information Governance risk if records are not held securely as potential breach of confidentiality. |

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| **Completed by:** | Jane Luker |
| **Position(s):** | Deputy Medical Director |
| **Date:** | 6 January 2015 |
| **Executive lead:** | Sean O'Kelly, Medical Director |

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**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment** |
| | **How the regulation was not being met:** |
| | The provider had failed to ensure that service users and others were protected from the risks of the use of unsafe equipment by ensuring that equipment is properly maintained and suitable for its purpose and is available in sufficient quantities.<br><br>Regulation 16 (1)(a) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>The trust had not ensured that all resuscitation and safety equipment was checked regularly and available for use in the event of an emergency. |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

1. **All** resuscitation and safety equipment will be checked after every use, or monthly, or if an item goes out of date, as per the Trust's existing policy.
2. In addition, a new daily check list has been devised, providing further clarification of requirements for items of equipment on resuscitation trolleys which require daily checks (for example: oxygen cylinder at least half full; suction tested and on charge; defibrillator self-test carried out). The checklist requires a staff signature confirming that the checks have been carried out. The checklist has been discussed by the Resuscitation Clinical Skills Services Manager at high level professional meetings/forums to ensure awareness and accountability for these checks, and has been disseminated to Ward Sisters, Matrons, Patient Safety Advisors, Heads of Nursing and Midwifery and Divisional Directors for implementation. In addition to the annual audit described below, implementation is being checked by Resuscitation Officers during regular visits to clinical areas: any issues identified, including incorrect stock levels, will be reported verbally and in writing to the nurse in charge for action.

| | |
|---|---|
| 3. Resuscitation Services will continue to carry out an annual check/audit of all resuscitation trolleys, the latest of which commenced in December 2014 and continue until early March 2015. | |
| **Who is responsible for the action?** | Joanna Bruce-Jones, Lead for Resuscitation Services; Resuscitation Services Team; Ward and Departmental Managers |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| • Regular checks by ward/departmental staff as detailed above<br>• Ad hoc checks by Resucitation Services during visits to wards/departments and when attending resuscitation attempts<br>• Annual audit by Resuscitation Services | |
| **Who is responsible?** | Joanna Bruce-Jones, Lead for Resuscitation Services; Resuscitation Services Team; Ward and Departmental Managers |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| N/A | |
| **Date actions will be completed:** | Action 1 is a continuation of existing established practice<br>Action 2 completed.<br>Action 3 will be completed by 31 March 2015 |

| |
|---|
| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** |
| With the above arrangements in place, we are confident that the risk identified by the CQC has been addressed. |

| | |
|---|---|
| **Completed by:** | Joanna Bruce-Jones |
| **Position(s):** | Resuscitation Officer |
| **Date:** | 6/1/15 |
| **Executive lead:** | Sean O'Kelly, Medical Director |

## Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

| | |
|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust |

**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services** |
| | **How the regulation was not being met:** |
| | The provider had failed at times to deliver care to patients that ensured their privacy and dignity were respected.<br><br>Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>On the A&E department's observation ward, same-sex accommodation was not provided in accordance with guidance from the Department of Health, to protect the dignity of patients.<br><br>Patients who remained in recovery areas overnight did not always have their privacy and dignity maintained. |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

Single-sex accommodation, A&E:

- The bathroom signs within the A&E Observation Bay will be changed so that they can switch from male to female and vice versa when required to ensure whenever possible access to same sex bathrooms without walking past a member of the opposite sex.
- This will be monitored daily, and will be added as a patient experience indicator to the A&E dashboard and reported at appropriate department and divisional meetings.
- A request has been made to the CCG regarding a single sex exception for the A&E Observation Bay to ensure patient safety and flow throughout the hospital is maintained.

Privacy and dignity in Recovery:

- Work closely with the site team to avoid patients being placed in Recovery overnight and only ever in line with the established standard operating procedure.
- Ensure patients are repatriated to appropriate ward bed as a priority.
- If patients are placed in Recovery – ensure privacy screens are used and staff respond quickly to patient's needs. Assess the quality for the current privacy screens and

purchase new ones if considered appropriate.

- Ensure the lighting is dimmed overnight where appropriate to enable patients to sleep and remind staff of the importance of reducing noise levels.
- Ensure recovery staff liaise with ward staff to provide food as required for overnight patients. Ward A605 is the closest ward.
- Ensure patients are aware of the nearest available bathroom facilities and are provided with appropriate attire to enable them to use the facilities without compromising their dignity.

| | |
|---|---|
| **Who is responsible for the action?** | Single-sex accommodation: Head of Nursing, Division of Medicine<br>Privacy and dignity in Recovery: Head of Nursing, Division of Surgery Head & Neck |

**How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**

Single-sex accommodation:

- This will be monitored daily, and will be added as a patient experience indicator to the A&E dashboard and reported at appropriate department and divisional meetings.

Privacy and dignity in Recovery:

- The key measurement is a reduction in the number of patients being cared for in Recovery overnight. In the event of a patient being cared for in this environment, an incident form will be completed and reviewed to ensure the admission is in line with the SOP.

| | |
|---|---|
| **Who is responsible?** | Single-sex accommodation: Head of Nursing, Division of Medicine<br>Privacy and dignity in Recovery: Head of Nursing, Division of Surgery Head & Neck |

**What resources (if any) are needed to implement the change(s) and are these resources available?**

N/A

| | |
|---|---|
| **Date actions will be completed:** | Single-sex accommodation: 31 January 2015<br>Privacy and dignity in Recovery: completed |

**How will people who use the service(s) be affected by you not meeting this regulation until this date?**

Single-sex accommodation: On occasion, patients in A&E may not be treated in a single-sex environment.

Privacy and dignity in Recovery: N/A (completed)

| | |
|---|---|
| **Completed by:** | Helen Morgan, Deputy Chief Nurse<br>Divisional Heads of Nursing |
| **Date:** | 10 December 2014 |
| **Executive lead:** | Carolyn Mills, Chief Nurse |

## Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

| | |
|---|---|
| **Account number** | RA7 |
| **Our reference** | SPL1-1378230880 |
| **Trust name** | University Hospitals Bristol NHS Foundation Trust |

**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing** |
| | **How the regulation was not being met:** |
| | The provider had failed to consistently safeguard the health, safety and welfare of service users, because they did not ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activity.<br><br>Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>There were not always sufficient numbers of suitably qualified, skilled and experienced staff employed on surgical wards and in operating theatres. |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

1. Matrons continue to review staffing levels, across all wards, on a daily basis, and allocate available staffing to maintain safe practice.
2. Continue to monitor low staffing incidents, within Divisional and Trust governance arrangements, to ensure themes are identified and remedial actions taken.
3. Develop additional actions to address high vacancy rates in key areas, notably theatres and surgical wards, including:
   - Appointment of Recruitment Lead Nurse for Division of Surgery, Head & Neck (SH&N) to drive reduction in time from staff resignation to commencement of new staff
   - Embark upon international recruitment venture for hard to recruit posts, commencing with theatres.
   - Review merits of introducing new Recruitment and Retention premia in hard to recruit areas
   - Utilise advance block booking in theatres for bank and/or agency staff, to reduce risk of unfilled shifts, when temporary staffing is likely to be required as this will increase

| |
|---|
| chance of securing staff<br>4. Undertake work to better understand reasons for high turnover in some areas, notably theatres and Ward 700, and develop actions to address, where possible.<br>5. Augment registered staffing establishment by 1 WTE on weekend days, on ward 700 to address shortfall associated with ENT treatment room activity.<br>6. Augment registered night time staffing establishment by 1 WTE on weekday nights, to provide additional support to wards 602, 604 and 605 to ensure night time staffing meets Trust recommended guidelines of 1:8 overnight.<br>7. Review adequacy of staffing of evening hours for Queen's Day Unit Recovery and Surgical Trauma Assessment Unit (STAU) assessment chairs and ensure robust risk assessment and mitigations in place for occasions when staffing falls below established levels. |

| | |
|---|---|
| **Who is responsible for the action?** | Head of Nursing, Surgery Head & Neck Division |

| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** |
|---|
| (1) Divisional Action plan developed, with oversight held by Divisional Governance Committee, and reviewed monthly to ensure actions are progressed and sustained.<br>(2) Monthly review of incidents via Divisional governance arrangements and corporately via Nursing and Midwifery Workforce Group relating to low staffing with remedial action taken as required.<br>(3) Monthly tracking of vacancy rates and recruitment progress against recruitment Performance Indicators. |

| | |
|---|---|
| **Who is responsible?** | Head of Nursing, Surgery Head & Neck Division |

| **What resources (if any) are needed to implement the change(s) and are these resources available?** |
|---|
| Investment is required to augment staffing on wards 700, 602 and 604 and this has been secured and recruitment commenced. |

| | |
|---|---|
| **Date actions will be completed:** | Actions 1,2,5 and 6 are complete and all residual actions are commenced and will be completed by 31 March 2015. |

| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** |
|---|
| The use of temporary staffing and the daily assessment of staffing levels across the wards will ensure there risk of detriment to patients is minimised. Incident monitoring will ensure any detriment to patients is identified and actions to address are promptly taken. |

| | |
|---|---|
| **Completed by:** | Deborah Lee |
| **Position(s):** | Director of Strategic Development and Divisional Interim Director for Surgery Head & Neck services |
| **Date:** | 6 January 2015 |
| **Executive lead:** | Carolyn Mills, Chief Nurse |

University Hospitals Bristol NHS
NHS Foundation Trust

# System Plan for Bristol

Response to the CQC report for University Hospitals Bristol

## Introduction

The Care Quality Commission's (CQC) report for University Hospitals Bristol (UH Bristol) states as its first action for improvement that "the Trust must take action, with others as needed, to improve the flow of patients into and through the Trust. This includes improving access to services, including A&E services, and ensuring that patients are cared for in the most appropriate place and that they are supported to leave hospital when they are ready to do so". The CQC highlighted this issue very clearly as system flow at the quality summit on 28 November 2014 to which partners were invited. The compliance action specified by CQC is against Regulation 9 of the Health and Social Care Act 2008 in relation to the care and welfare of people who use services, specifically:

- Patients arriving by ambulance at the Bristol Royal Infirmary A&E Department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.

- Patients in the Bristol Royal Infirmary A&E Department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.

- The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.

- Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night, however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents.

## Response

The Bristol system has an ongoing 4 hour recovery action plan. The CQC tracker indicators outlined below will sit within the overall plan.

The health community considered the system flow issues identified by the CQC Report at the Bristol Urgent Care Working Group in December 2014. It was agreed to pull together a system response with key actions being prioritised by the cross-organisational weekly Operational Group (UHBristol, Bristol CCG, Bristol Community Health and Bristol City Council). Key actions were prioritised for organisations (often working in partnership) as below:

| | Lead Organisation | Action | Regulated Action Area |
|---|---|---|---|
| 1. | NHS 111 | A&E activity to target levels | A&E Queue |
| 2. | South Western Ambulance Service NHS Foundation Trust (SWAST) | Direct admissions to GPSU pathways (plus HALO & PSV) | A&E Queue |

| | | | |
|---|---|---|---|
| 3. | Avon and Wiltshire Mental Health Partnership NHS Trust / Bristol City Council / Bristol Clinical Commissioning Group | Prompt mental health assessment and support | Mental Health needs |
| | | Timely Mental Health Act assessment | Mental Health needs |
| 4. | Bristol Community Health | Increased resource to Community Discharge Co-ordination Centre | Discharge |
| | | Increased resource to inreach into OPAU and A&E | Discharge (and Admission Avoidance) |
| 5. | Bristol City Council | Implement 'Discharge to Assess' model through enhanced Intermediate Care and Reablement resource | Discharge |
| | | Enhanced social worker support to REACT team in A&E and OPAU | Discharge (and Admission Avoidance) |
| 6. | University Hospitals Bristol NHS Foundation Trust | Full implementation of SAFER bundles to enhance early discharge | Discharge |
| | | Developing an electronic CM7 to enhance earlier discharges | Discharge |
| | | Initiating a weekly patient progress multi-disciplinary meeting | Discharge |
| | | Delivering 10 early discharges before 10.00am in the new ward block rising to 15 | Discharge and appropriate ward |
| | | Reduced night time and unnecessary moves | Appropriate ward |

Supporting plans have also been received from South Gloucestershire CCG, North Somerset CCG and North Somerset Council.

## Governance

This action plan will be overseen by the Bristol Urgent Care Working Group as the urgent care System Resilience Group for the local (Bristol) health community. This group links to the Strategic Resilience Group for Bristol, North Somerset and South Gloucestershire, which will sign off the plan in January 2015. The Strategic Resilience Group is important in this context as it has oversight of issues for cross-CCG providers e.g. ambulance service, out of hours and 111.

The Trust Chief Operating Officer will be the lead for delivery of this plan and operationally momentum will be maintained through the weekly providers' operational urgent care group.

**James Rimmer**
**Chief Operating Officer**
**UHBristol**

**Judith Brown**
**Director of Operations**
**Bristol CCG**

**Michele Narey**
**Director of Operations**
**Bristol Community Health**

**Mike Hennessey**
**Service Director, Care and Support Adults**
**Bristol City Council**

University Hospitals Bristol NHS
NHS Foundation Trust

**Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 29 January 2015 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 8. Q2 Complaints Report and Patient Experience Reports

### Purpose

The attached reports describe patient-reported feedback from complaints and surveys during the second quarter of 2014/15. The reports are presented to together to enable and encourage discussion about common themes, however it should be remembered that the nature of the data presented in the two reports is different. The patient experience report describes trust and ward-level feedback around key predetermined quality themes, the overwhelming majority of which is positive; whereas the complaints themes are, by definition, an expression of the dissatisfaction of patients with one or more aspects of our services, wherever they have been provided.

### Abstract


Patient Experience

In Q2, the Trust continued to achieve "green" ratings in the Trust Board Quality Dashboard, reflecting high quality patient-reported experience at UH Bristol as a whole, however there continues to be significant variation in patient-reported experience between wards. Detailed analysis of survey data suggests that these differences are primarily a reflection of differing patient populations, rather than an indication of care failings. Key improvement themes arising from written feedback received from patients (via surveys) in Q2 were communication and waiting times/delays.

Data from the annual UH Bristol Outpatient Survey for 2014 showed high levels of patient satisfaction. Improvement themes included: waiting times (for receiving appointments and whilst in clinic); being kept updated if there are delays in clinic; ease of contacting the Trust; and timely letters/test results/follow-up appointments.

The Trust received a disappointing set of results from the 2013/14 National Cancer Survey, with nearly half of the Trust's scores being among the lowest 20% nationally. A plan to understand and address the key issues raised was received and endorsed by the Board.

Complaints

In Q2, the Trust received 518 complaints, compared to 427 during Q1. The Trust's performance in responding to complaints within the timescales agreed with complainants was 89.5% compared to 86.3% in Q1. Complaints relating to appointments and admissions continued to account for over a third of the total complaints received by the Trust (as per Q1). There was a decrease in the number of complainants telling us that they were unhappy with our investigation of their concerns: 14 compared to 21 in Q1. The number of cases where the original response deadline was extended continued to rise, with 41 cases in Q2, compared with 34 in Q1.

Triangulation

Ward B301 (formerly Ward 7), which is a care of the elderly ward, achieved disappointing patient experience ratings in Q2. This included the Trust's patient experience tracker, where the "communication" and "involvement in care decisions" elements of this aggregate measure

| |
|---|
| scored well below the Trust average. At the same time, the ward experienced a marked increase in complaints (seven compared to one in Q1), although there were no consistent themes. This was discussed at the Patient Experience Group in December: it has been agreed to focus February's *Face to face* wards interviews on Ward B301 in order to gather more information about patients' experience of care. This information will then be used to inform a decision about whether and when to adopt the Trust's *Patient experience at heart* co-design methodology to support the ward to explore patient experience in greater depth (either before or after the ward is relocated in 2015). |
| **Recommendations** |
| The Board is asked to receive these reports for assurance |
| **Report Sponsor** |
| Carolyn Mills, Chief Nurse |
| **Appendices** |
| Quarter 2 Patient Experience Report<br>Quarter 2 Complaints Report |

## Previous Meetings

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

| Executive Team | Senior Leadership Team | Quality & Outcomes Committee | Finance Committee | Audit Committee | Other |
|---|---|---|---|---|---|
| | 17/12/14 | 22/12/14 | | | Patient Experience Group, 11/12/14 |

University Hospitals Bristol NHS
NHS Foundation Trust

# Complaints Report

## Quarter 2, 2014/2015

**(1st July – 30th September 2014)**

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

## 1. Executive summary

The Trust received 518 complaints in Quarter 2 of 2014/15 (Q2), which equates to 0.29% of patient activity, against a target of 0.21%. In the previous quarter, the Trust had received 427 complaints, representing 0.25% of patient activity.

The Trust's performance in responding to complaints within the timescales agreed with complainants was 89.5% compared to 86.3% in Q1.

In Q2, complaints relating to appointments and admissions continued to account for over a third of the total complaints received by the Trust (in line with Q1). There was a decrease in complainants telling us that they were unhappy with our investigation of their concerns: 14 compared to 21 in Q1. The number of cases where the original deadline was extended continued to rise, with 41 cases in Q2 compared with 34 in Q1.

This report includes an analysis of the themes arising from complaints received in Q2, possible causes, and details of how the Trust is responding.

## 2. Complaints performance – Trust overview

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

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

The table on page 3 of this report provides a comprehensive 13 month overview of complaints performance including these three key indicators.

### 2.1 Total complaints received

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

We received 518 complaints in Q2, which equates to 0.29% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]; the figures do not include concerns which may be raised by patients and dealt with immediately by front line staff. The volume of complaints received in Q2 represents an increase of approximately 21% compared to Q1 (427) and a 55% increase on the corresponding period a year ago.

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

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

**Table 1 – Complaints performance**

Items in italics are reportable to the Trust Board.

Other data items are for internal monitoring / reporting to Patient Experience Group where appropriate.

| | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total complaints received (inc. TS and F&E from April 2013) | 115 | 120 | 109 | 104 | 127 | 124 | 164 | 131 | 130 | 166 | 178 | 170 | 170 |
| Formal/Informal split | 60/55 | 54/66 | 63/46 | 55/49 | 55/72 | 62/62 | 89/75 | 60/71 | 64/66 | 64/102 | 79/99 | 73/97 | 86/84 |
| *Number & % of complaints per patient attendance in the month* | *0.20% 115 of 56869* | *0.19% 120 of 62480* | *0.19% 109 of 58783* | *0.20% 104 of 52194* | *0.21% 127 of 59288* | *0.23% 124 of 54507* | *0.28% 164 of 58180* | *0.24% 131 of 54981* | *0.23% 130 of 57463* | *0.28% 166 of 60027* | *0.28% 178 of 63,039* | *0.32% 170 of 52,879* | *0.27& 170 of 63,794* |
| *% responded to within the agreed timescale (i.e. response posted to complainant)* | *87.8% (43 of 49)* | *84.9% (62 of 73)* | *82.2% (37 of 45)* | *88.1% (37 of 42)* | *76.1% (51 of 67)* | *92.0% (46 of 50)* | *88.7% (47 of 53)* | *93.1% (54 of 58)* | *82.5% (47 of 57)* | *83.3% (50 of 60)* | *91.5% (65 of 71)* | *88.3% (53 of 60)* | *88.1% (52 of 59)* |
| % responded to by Division within required timescale for executive review | 83.7% (41 of 49) | 69.9% (51 of 73) | 66.7% (30 of 45) | 57.1% (24 of 42) | 77.6% (52 of 67) | 86.0% (43 of 50) | 71.7% (38 of 53) | 82.8% (48 of 58) | 86.0% (49 of 57) | 91.7% (55 of 60) | 76.1% (54 of 71) | 83.3% (50 of 60) | 81.4% (48 of 59) |
| Number of breached cases where the breached deadline is attributable to the Division | 4 of 6 | 10 of 11 | 5 of 8 | 3 of 5 | 7 of 16 | 2 of 4 | 3 of 6 | 2 of 4 | 2 of 10 | 6 of 10 | 4 of 6 | 4 of 7 | 6 of 7 |
| Number of extensions to originally agreed timescale (formal investigation process only) | 7 | 14 | 14 | 9 | 16 | 13 | 11 | 5 | 21 | 8 | 19 | 5 | 17 |
| *Number of Complainants Dissatisfied with Response* | *1* 4*** | *7* 8*** | *2* 3*** | *6* 6*** | *6* 3*** | *3* 5*** | *5* 2*** | *6* 10*** | *4* 2*** | *11* 4*** | *8* 2*** | *4* 5*** | *2* 4*** |

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

Figures 1 and 2 show the increase in the volume of complaints received towards the end of 2013/14, continuing into the second quarter of 2014/15.

**Figure 1: Number of complaints received**

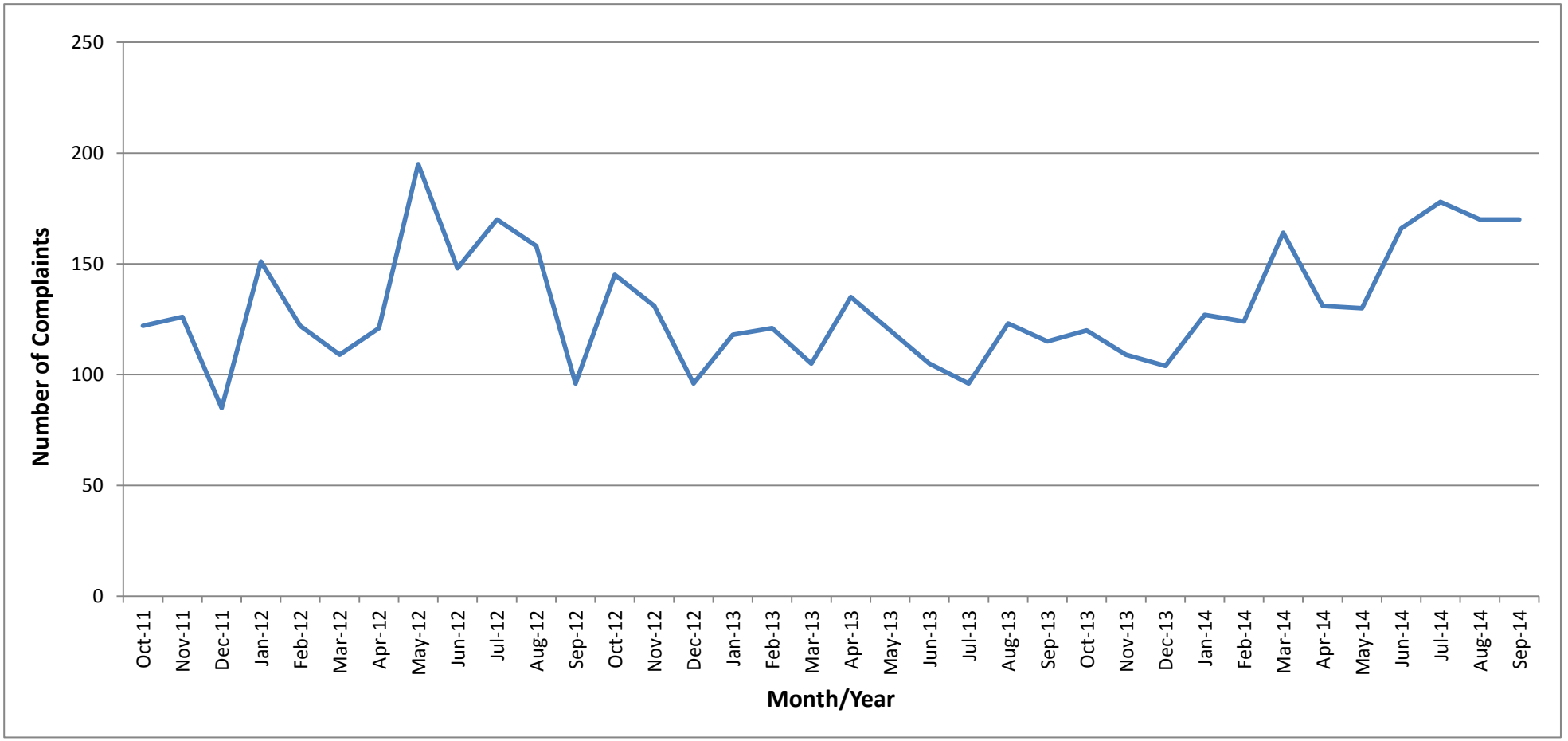
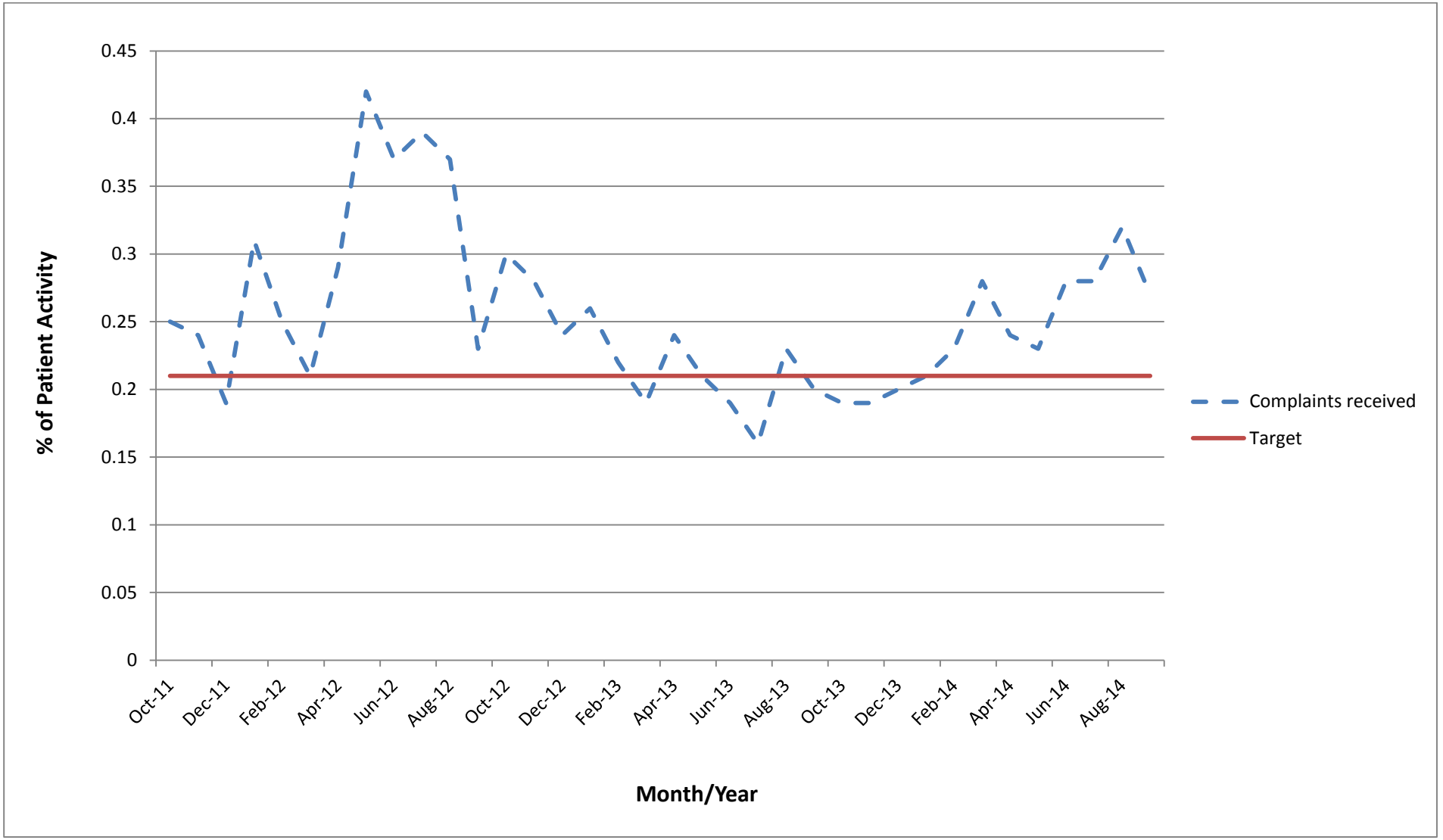


**Figure 2: Complaints received, as a percentage of patient activity**

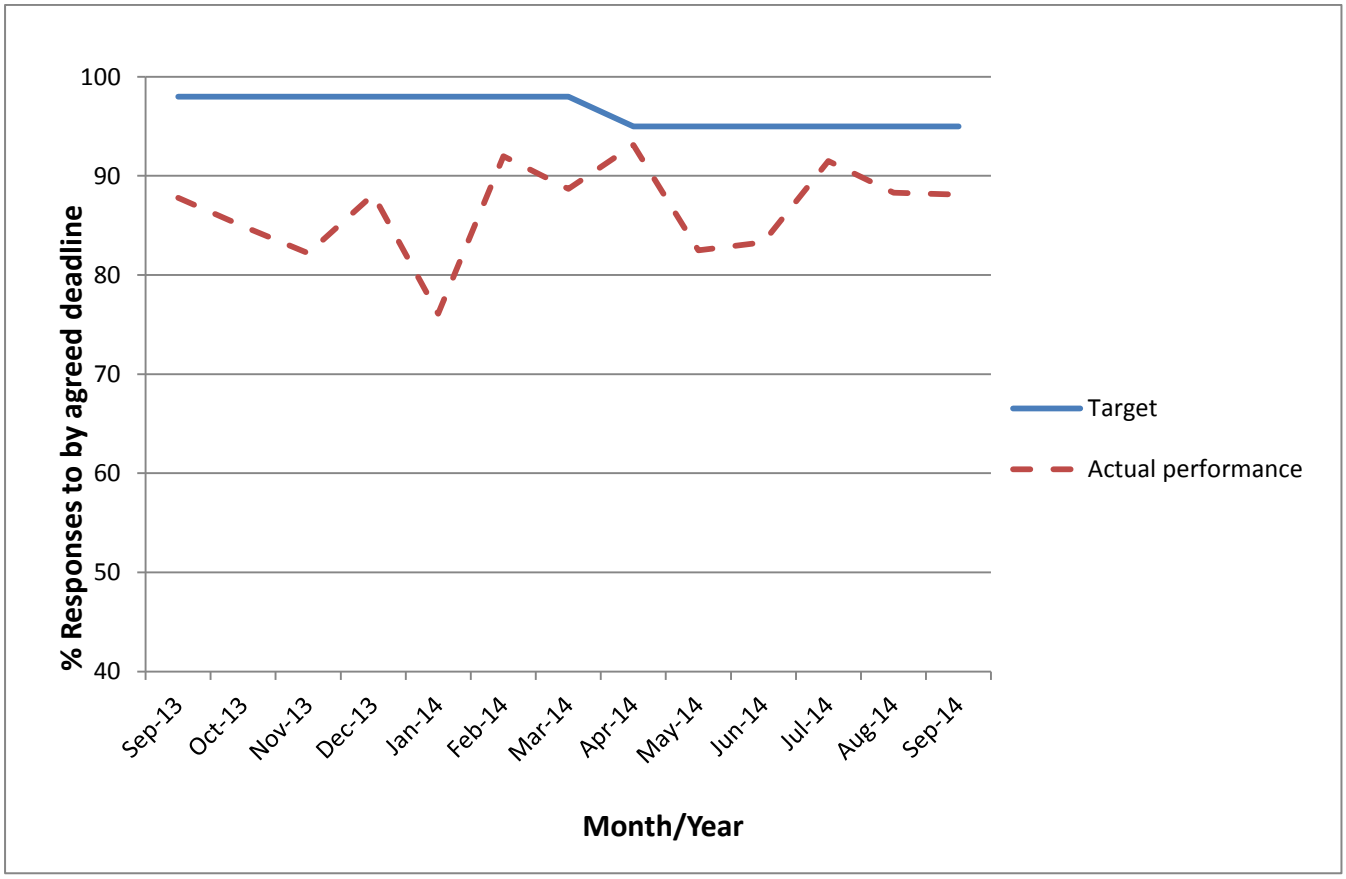


## 2.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days in Medicine, Surgery Head and Neck and Specialised Services[2] and 25 working days in other areas[3].

Prior to April 2014, our target was to respond to at least 98% of complainants within the agreed timescale. Since 1st April, this target has been adjusted slightly downwards to 95%. The end point is measured as the date when the Trust's response is posted to the complainant. In Q2, 89.5% of responses were made within the agreed timescale, compared to 86.3% in Q1. This represents 19 breaches out of 190 formal complaints which were due to receive a response during Q2[4]. Divisional management teams remain focussed on improving the quality and timeliness of complaints responses. Figure 3 shows the Trust's performance in responding to complaints since September 2013.

**Figure 3. Percentage of complaints responded to within agreed timescale**




[2] Based on experience, due to relative complexity and numbers received
[3] 25 working days used to be an NHS standard
[4] Note that this will be a slightly different figure to the number of complainants who *made* a complaint in that quarter.

### 2.3 Number of dissatisfied complainants

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

In Q2, there were 14 cases where the complainant felt that the investigation was incomplete or inaccurate. This represents a 33% reduction on Q1 (21 cases). There were a further 11 cases where new questions were raised, compared to 16 cases in Q1.

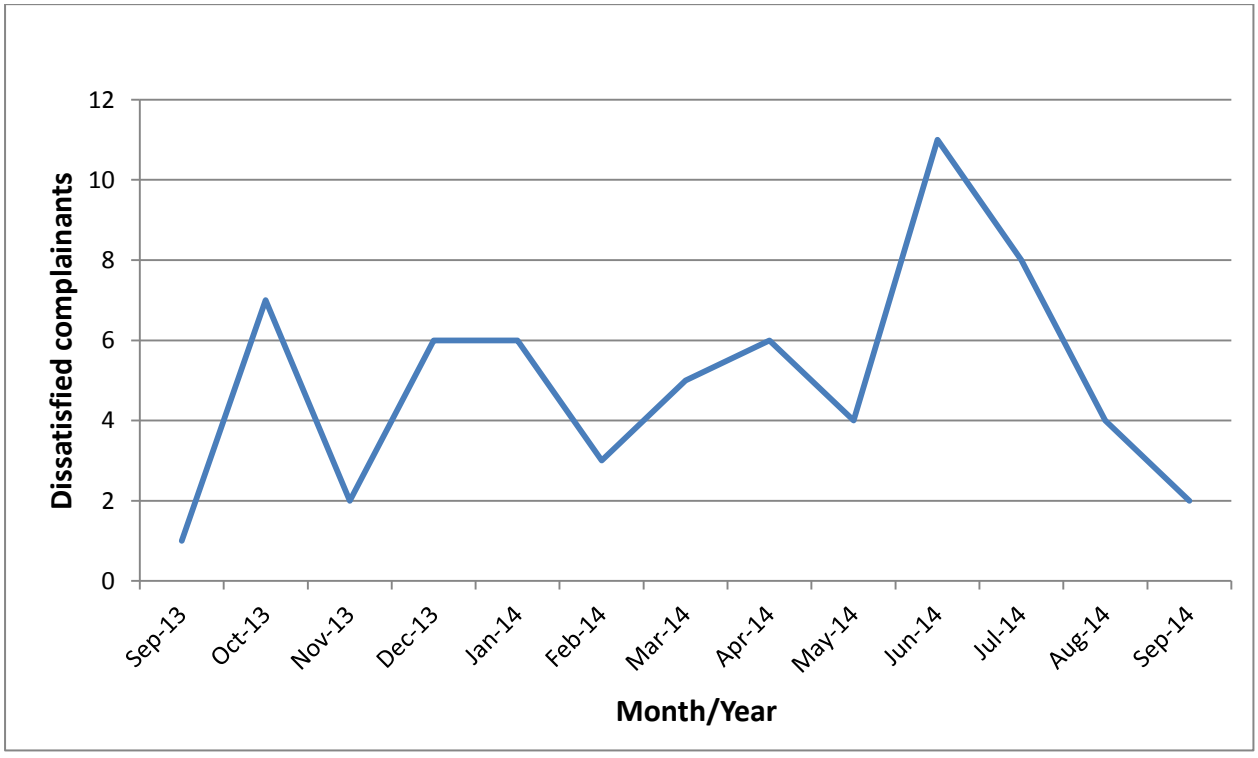
The 14 cases where the complainant was dissatisfied were associated with the following lead Divisions:

- 6 cases for the Division of Surgery, Head & Neck (compared to 8 in Q1) ↓
- 1 cases for the Division of Medicine (compared to 5 cases in Q1) ↓
- 2 cases for the Division of Women & Children (compared to 5 in Q1) ↓
- 5 cases for the Division of Specialised Services (compared to 2 in Q1) ↑
- 0 cases for the Division of Diagnostics & Therapies (compared to 1 in Q1) ↓
- 0 cases for the Division of Facilities & Estates (compared to 0 in Q1) =

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

The number of dissatisfied complainants has decreased overall in Q2, with the only increase being for the Division of Specialised Services. Actions agreed to address this increase are detailed in section 3.6 of this report.

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



**2.4 Complaints themes – Trust overview**

Every complaint received by the Trust is allocated to one of six major themes. The table below provides a breakdown of complaints received in Q2 compared to Q1. Complaints about all category types increased in Q2 in real terms, although 'appointments & admissions' and 'clinical care' showed a slight decrease when measured as a proportion of complaints received.

| **Category Type** | **Number of complaints received – Q2 2014/15** | **Number of complaints received – Q1 2014/15** |
|---|---|---|
| Appointments & Admissions | 178 ↑ (34.4% of total complaints) | 152 (35.6% of total complaints) |
| Attitude & Communication | 119 ↑ (23%) | 91 (21.3%) |
| Clinical Care | 150 ↑ (28.9%) | 132 (30.9%) |
| Facilities & Environment | 38 ↑ (7.3%) | 27 (6.3%) |
| Access | 14 ↑ (2.7%) | 9 (2.2%) |
| Information & Support | 19 ↑ (3.7%) | 16 (3.7%) |
| **Total** | **518** | **427** |

Each complaint is then assigned to a more specific category (of which there are 121 in total). The table below previously listed the six most consistently reported complaint categories. One complaint category that was notable in Q1: Attitude of Nursing Staff (16) was found to have increased further in Q2 and this has now been included in this quarterly report (as proposed in the Q1 report). In total, these seven categories account for 65% of the complaints received in Q2 (338/518)

| **Sub-category** | **Number of complaints received – Q2 2014/15** | **Q1 2014/15** | **Q4 2013/14** | **Q3 2013/14** |
|---|---|---|---|---|
| Cancelled or delayed appointments and operations | 152 ↑ **(18% increase *compared to Q1*)** | 129 | 111 | 86 |
| Clinical Care (Medical/Surgical) | 62 ↑ **(15% increase)** | 54 | 47 | 45 |
| Communication with patient/relative | 35 ↑ **(30% increase)** | 27 | 32 | 14 |
| Clinical Care (Nursing/Midwifery) | 34 ↑ **(13% increase)** | 30 | 26 | 23 |
| Attitude of Nursing/Midwifery | 22 ↑ **(37% increase)** | 16 | | |
| Attitude of Medical Staff | 21 ↑ **(5% increase)** | 20 | 30 | 13 |
| Failure to answer telephones | 12 ↑ **(200% increase)** | 4 | 18 | 16 |

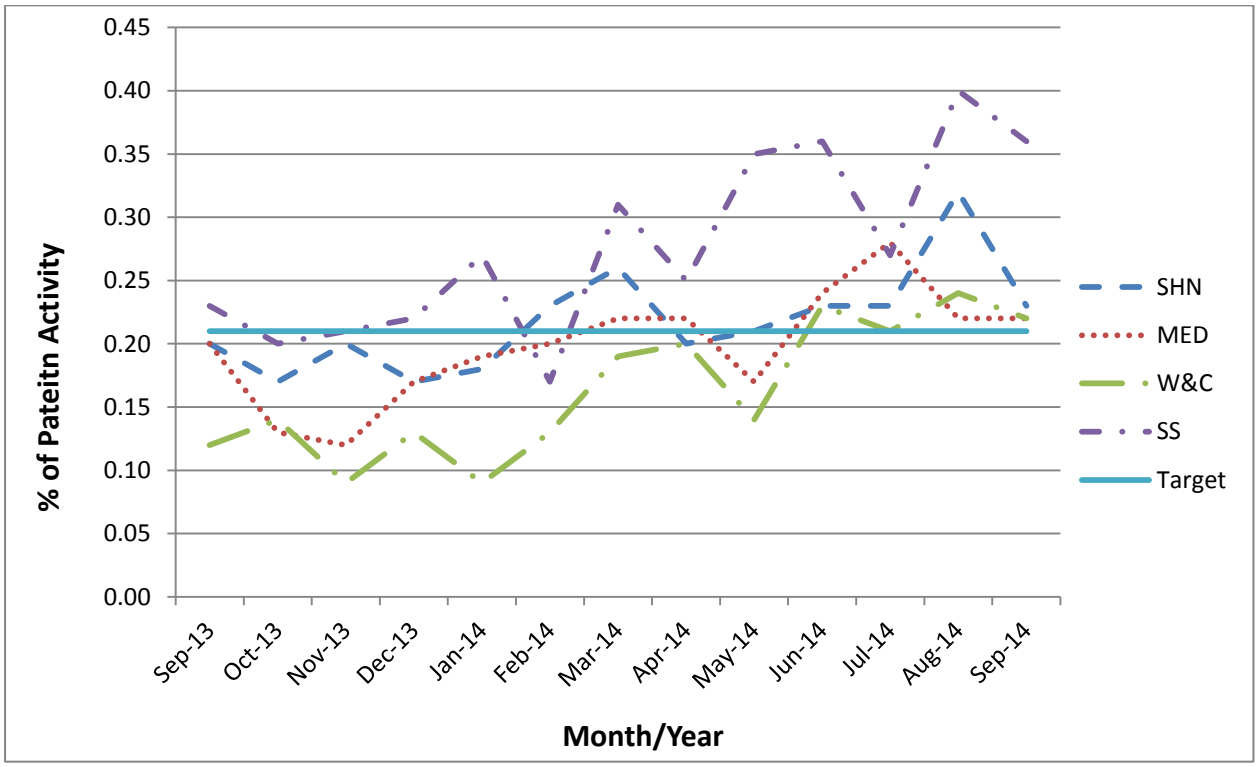
Most notably, complaints about cancelled or delayed appointments and operations continued to increase in Q2. The issue is recognised by the Trust and was highlighted in the Care Quality Commission's recent inspection report. The Trust, working in conjunction with local health and social care partners, has been tasked by the CQC and Monitor with developing a robust action plan to deliver transformational change to patient flow during the final quarter of 2014/15; the Trust's Chief Operating Officer is leading this work on behalf of the Board.

## 3. Divisional performance

### 3.1 Total complaints received

A divisional breakdown of percentage of complaints per patient attendance is provided in Figure 5. This shows a downturn in the volume of complaints received in all bed-holding Divisions at the end of Q2 following an upturn at the beginning of Q2.

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




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

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

| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of complaints received | 12 | 9 | 11 | 14 | 11 | 7 | 9 | 6 | 8 | 17 | 6 | 10 |

### 3.2 Divisional analysis of complaints received

Table 3 provides an analysis of Q2 complaints performance by Division. The table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

**Table 3.**

| | **Surgery Head and Neck** | **Medicine** | **Specialised Services** | **Women and Children** | **Diagnostics and Therapies** |
|---|---|---|---|---|---|
| Total number of complaints received | 193 (156) ↑ | 93 (81) ↑ | 79 (73) ↑ | 94 (69) ↑ | 33 (23) ↑ |
| Total complaints received as a proportion of patient activity | 0.26% (0.21%) ↑ | 0.24% (0.21%) ↑ | 0.34% (0.33%) ↑ | 0.22% (0.19%) ↑ | N/A |
| Number of complaints about appointments and admissions | 106 (80) ↑ | 12 (24) ↓ | 27 (26) ↑ | 34 (19) ↑ | 8 (6) ↑ |
| Number of complaints about staff attitude and communication | 42 (34) ↑ | 32 (32) = | 19 (15) ↑ | 23 (11) ↑ | 10 (5) ↑ |
| Number of complaints about clinical care | 45 (44) ↑ | 37 (19) ↑ | 34 (26) ↑ | 43 (37) ↑ | 5 (10) ↑ |
| Areas where the most complaints have been received in Q2 | Bristol Eye Hospital – 41 (38) ↑<br>Bristol Dental Hospital – 29 (25) ↑<br>Ear Nose and Throat – 29 (28) ↑<br>Upper GI – 15 (12) ↑<br>Lower GI – 11 (7) ↑ | A&E – 20 (15) ↑<br>Dermatology – 7 (8) ↓<br>Respiratory Department (including Sleep Unit) – 6 (10) ↓<br>Ward 200 (SBCH) – 5 (2) ↑<br>Ward 15 – 4 (2) ↑<br>Ward 17 (A515) – 4 (7) ↓<br>Ward 26 – 4 (3) ↑ | Chemotherapy Day Unit and Outpatients – 16 (7) ↑<br>Cardiology GUCH Services – 11 (11) =<br>Ward 52 (C708) – 8 (5) ↑<br>Ward 61 (D603) – 7 (5) ↑<br>Ward 62 & 62a (D703 & D703a) – 3 (7) ↓ | Children's ED & Ward 39 – 4 (8) ↓<br>Paediatric Orthopaedics – 21 (7) ↑<br>Paediatric Neurology – 9 (4) ↑<br>Ward 30 – 5 (0) ↑ | Radiology – 12 (12) = |
| Notable deteriorations compared to Q1 | Trauma & Orthopaedics – 34 (29) ↑ | Ward 7 – 7 (1) ↑ | Bristol Heart Institute Outpatients – 25 (16) ↑ | Paediatric Orthopaedics – 21 (7) ↑ | BEH Pharmacy – 9 (0) ↑ |
| Notable improvements compared to Q1 | N/A | N/A | Ward 62 & 62a (D703 & D703a) – 3 (7) ↓ | Ward 78 – 1 (5) ↓ | N/A |

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

#### 3.3.1 Division of Surgery, Head & Neck

**Complaints by category type**[5]

| Category Type | Number and % of complaints received – Q2 2014/15 | Number and % of complaints received – Q1 2014/15 |
|---|---|---|
| Access | 3 (1.6% of total complaints) = | 3 (1.8% of total complaints) |
| Appointments & Admissions | 102 (52.7%) ↑ | 76 (48.5%) |
| Attitude & Communication | 40 (20.7%) ↑ | 32 (20.6%) |
| Clinical Care | 42 (21.8%) ↑ | 41 (26.7%) |
| Facilities & Environment | 3 (1.6%) = | 3 (1.8%) |
| Information & Support | 3 (1.6%) ↑ | 1 (0.6%) |
| **Total** | **193** | **156** |

**Top sub-categories**

| Sub-category | Number of complaints received – Q2 2014/15 | Number of complaints received – Q1 2014/15 |
|---|---|---|
| Cancelled or delayed appointments and operations | 97 ↑ (27.6% increase compared to Q1) | 76 ↑ (7% increase compared to Q4) |
| Clinical Care (Medical/Surgical) | 20 ↑ (5.3% increase) | 19 = |
| Communication with patient/relative | 11 ↑ (10% increase) | 10 ↓ (37.5% decrease) |
| Attitude of Medical Staff | 5 ↓ (44.4% decrease) | 9 ↓ (18% decrease) |
| Attitude of Nursing/Midwifery | 7 ↑ (16.7% increase) | 6 (not previously reported) |
| Clinical Care (Nursing/Midwifery) | 3 ↓ (62.5% decrease) | 8 ↑ (14% increase) |
| Failure to answer telephones | 6 ↑ (500% increase) | 1 ↓ (85% decrease) |

**Divisional response to concerns highlighted by Q2 data**

| Concern | Explanation | Action |
|---|---|---|
| The Ear Nose & Throat Service continued to receive a large number of complaints (29 compared to 28 in Q1). All complaints received in Q2 again related to cancelled or delayed appointments. | Two specialty doctors started in the department in August. As a result, this has increased clinic capacity substantially, enabling patient appointments to be brought forward. Waiting times have reduced from 18 weeks in Q1 to 9 weeks in Q2. | It is anticipated that increased overall clinic capacity and reduced waiting times will lead to a reduction in the number of patients waiting an excessive length of time for their appointments. |
| Bristol Dental Hospital received 29 complaints in Q2; a further 16% increase compared to Q1. 15 (52%) of these complaints were for Adult Restorative Dentistry. | Ongoing complaints for Adult Restorative Dentistry relate to the problems in replacing a consultant who left the Trust approximately six months ago.<br><br>With regard to appointments and failure to answer telephones, further | Several of the sessions run by the consultant who has left the Trust have now been allocated to non-consultant clinicians and the backlog is beginning to reduce. There is however still a risk relating to the lack of a consultant, as a further restorative clinician plans to retire in 2015. |

[5] Arrows in Q2 column denote increase or decrease compared to Q1. Arrows in Q1 column denote increase or decrease compared to Q4. Increases and decreases refer to actual numbers rather than to proportion of total complaints received.

| | | |
|---|---|---|
| | recruitment has taken place in the call centre and the administrative teams, to support the volume of administrative tasks associated with a quarterly footfall of over 19,500 patient attendances. | |
| Bristol Eye Hospital received 41 complaints in Q2, of which 21 (51%) were in respect of Outpatients. These complaints were a mixture of cancelled/delayed appointments and communication issues. | Cancelled and delayed appointments are being addressed through the additional recruitment and outreach of glaucoma and medical retinal services. Some communication issues remain with patients not understanding treatments or procedures/likely outcomes. | There has been an increased focus on the patient experience in the Bristol Eye Hospital. As part of this, a full time Patient Support & Liaison Nurse has been employed and is available to patients who have informal concerns. Two WTE Nurse Injectors have also been employed following positive feedback from patients that these nurses have more time to talk to them and to explain procedures and outcomes than perhaps a doctor would. |
| Trauma & Orthopaedics received 34 complaints in Q2, an increase of 17% compared to Q1. Of these complaints, 16 (47%) were in respect of cancelled/delayed operations and appointments. | Complaints relating to cancellations and delays have often been in respect of dates for surgery at Southmead Hospital (North Bristol NHS Trust) following a complex diagnostic pathway at Bristol Royal Infirmary. NBT is currently working with commissioners and independent sector providers to address the unstable 18 week backlog for surgery. There was also a theme relating to poor or conflicting advice given to patients when they contacted the department following appointments; the administrative manager and clinic sister are working on a package of training for clerical staff to be better able to deal with these enquiries. | The Trauma & Orthopaedics Department has recently introduced a multi-disciplinary executive meeting, which will review complaint trends on a quarterly basis and oversee any action plans resulting from complaints. |

### 3.3.2 Division of Medicine

**Complaints by category type**

| Category Type | Number and % of complaints received – Q2 2014/15 | Number and % of complaints received – Q1 2014/15 |
|---|---|---|
| Access | 2 (2.1% of total complaints) ↑ | 1 (1.2% of total complaints) = |
| Appointments & Admissions | 12 (13%) ↓ | 22 (27.2%) ↑ |
| Attitude & Communication | 31 (33.3%) ↑ | 30 (37%) ↑ |
| Clinical Care | 35 (37.6%) ↑ | 17 (21%) ↓ |
| Facilities & Environment | 9 (9.7%) ↑ | 7 (8.6%) ↑ |
| Information & Support | 4 (4.3%) = | 4 (5%) ↑ |
| **Total** | **93** | **81** |

**Top sub-categories**

| Category | Number of complaints received – Q2 2014/15 | Number of complaints received – Q1 2014/15 |
|---|---|---|
| Cancelled or delayed appointments and operations | 5 ↓ (44.4% decrease compared to Q1) | 9 ↓ (40% decrease compared to Q4) |
| Clinical Care (Medical/Surgical) | 13 ↑ (30% increase) | 10 ↓ (9% decrease) |
| Communication with patient/relative | 9 ↑ (28.6% increase) | 7 ↑ (75% increase) |
| Attitude of Medical Staff | 6 ↑ (50% increase) | 4 ↓ (20% decrease) |
| Attitude of Nursing/Midwifery | 11 ↑ (22.2% increase) | 9 (not previously reported) |
| Clinical Care (Nursing/Midwifery) | 16 ↑ (220% increase) | 5 ↓ (44% decrease) |
| Failure to answer telephones | 1 = | 1 ↓ (66% decrease) |

**Divisional response to concerns highlighted by Q2 data**

| Concern | Explanation | Action |
|---|---|---|
| The Accident & Emergency Department received 20 complaints in Q2; a 33% increase on the 15 received in Q1. 10 of these complaints were about attitude and communication and 7 were in respect of clinical care. | All 20 complaints/incidents have been reviewed – 14 formal and 6 informal. No themes have been identified, although complaints included concerns about waiting times. Complaints about attitude and communication included perceived queue-jumping in radiology, treatment of patients with mental health issues and the response of security staff. | Complaints were discussed at the Emergency Department team meeting on 11th November 2014, to agree additional improvement actions. |
| There was a seven-fold increase in complaints received by Ward 7 (7 in Q2 compared to just 1 in Q1). The majority of these complaints (5) were in respect of clinical care. | All 7 complaints have been reviewed by the Division – 5 informal and 2 formal. The informal complaints included: lost dentures on transfer to the ward; appropriate refusal to cut toenails on a gangrenous foot; and concerns about discharge. The two formal complaints related to a disagreement about end of life care and best interests. One of the formal | The lead consultant reviewed all of the complaints to determine any additional actions that are required and emailed his findings to the wider team. |

| | | |
|---|---|---|
| | complaints only related in part to Ward 7, with the majority of the issues being in respect of South Bristol Community Hospital. | |

### 3.3.3 Division of Specialised Services

**Complaints by category type**

| Category Type | Number and % of complaints received – Q2 2014/15 | Number and % of complaints received – Q1 2014/15 |
|---|---|---|
| Access | 1 (1.3% of total complaints) = | 1 (1.4% of total complaints) = |
| Appointments & Admissions | 24 (30.4%) ↓ | 26 (35.6%) ↑ |
| Attitude & Communication | 17 (21.5%) ↑ | 15 (20.6%) ↑ |
| Clinical Care | 31 (39.2%) ↑ | 26 (35.6%) ↑ |
| Facilities & Environment | 3 (3.8%) = | 3 (4.1%) = |
| Information & Support | 3 (3.8%) ↑ | 2 (2.7%) ↑ |
| **Total** | **79** | **73** |

**Top sub-categories**

| Category | Number of complaints received – Q2 2014/15 | Number of complaints received – Q1 2014/15 |
|---|---|---|
| Cancelled or delayed appointments and operations | 24 = | 24 ↑ (41% increase compared to Q4) |
| Clinical Care (Medical/Surgical) | 10 = | 10 ↑ (43% increase) |
| Communication with patient/relative | 7 = | 7 ↑ (40% increase) |
| Attitude of Medical Staff | 3 ↑ (200% increase) | 1 ↓ (50% decrease) |
| Attitude of Nursing/Midwifery | 1 ↑ | 0 (not previously reported) |
| Clinical Care (Nursing/Midwifery) | 6 ↓ (25% decrease) | 8 ↑ (166% increase) |
| Failure to answer telephones | 2 = | 2 ↑ (100% increase) |

**Divisional response to concerns highlighted by Q2 data**

| Concern | Explanation | Action |
|---|---|---|
| Bristol Heart Institute outpatients received 25 complaints; an increase of 56% on the 16 received in Q1. 12 of the complaints related to problems around appointments, i.e. cancelled or delayed appointments or procedures. There were no discernible trends for the remainder of the complaints received. | The outpatient cardiology service has experienced lengthy waiting times for a number of consultants during the past year. This has led to individual patient appointments being delayed or re-booked to reflect changing clinical priorities (i.e. more urgent patients being referred). | The Division carried out a large number of additional clinics in Q2, leading to an additional 200 clinic appointments and allowing the service to reduce its backlog of long-waiting patients from 550 in July 2014 to 154 at the end of November 2014. This work will continue into the New Year. |
| There was a significant increase in the number of complaints received by the Bristol Haematology & | The increase in the number of complaints related to excessive heat in the BHOC outpatient environment during the | A business case has been approved to install air conditioning and this will be installed by the end of February/beginning of March 2015. |

| | | |
|---|---|---|
| Oncology Centre's Chemotherapy Day Unit & Outpatients, with a total of 16 complaints received in Q2, a 128% increase on the 7 received in Q1. | summer months.<br><br>There was a further increase in complaints related to delays in waiting for chemotherapy. | Pharmacy, medical and nursing staff are continuing to work together to reduce delays in on-day waits for chemotherapy. The Chemotherapy Group are reviewing these issues at their next meeting and the Head of Nursing has requested that the Interim General Manager takes a 'fresh look' at this issue. |

### 3.3.4 Division of Women & Children

**Complaints by category type**

| Category Type | Number and % of complaints received – Q2 2014/15 | Number and % of complaints received – Q1 2014/15 |
|---|---|---|
| Access | 0 (0% of total complaints) = | 0 (0% of total complaints) ↓ |
| Appointments & Admissions | 30 (32%) ↑ | 19 (27.5%) ↑ |
| Attitude & Communication | 20 (21.3%) ↑ | 11 (16%) ↓ |
| Clinical Care | 40 (42.5%) ↑ | 36 (52.2%) ↑ |
| Facilities & Environment | 3 (3.2%) ↑ | 2 (2.9%) ↑ |
| Information & Support | 1 (1%) = | 1 (1.4%) = |
| **Total** | **94** | **69** |

**Top sub-categories**

| Category | Number of complaints received – Q2 2014/15 | Number of complaints received – Q1 2014/15 |
|---|---|---|
| Cancelled or delayed appointments and operations | 33 ↑ (120% increase compared to Q1) | 15 (50% increase compared to Q4) ↑ |
| Clinical Care (Medical/Surgical) | 15 ↑ (7.1% increase) | 14 (55.5% increase) ↑ |
| Communication with patient/relative | 8 ↑ (60.5% increase) | 3 (40% decrease) ↓ |
| Attitude of Medical Staff | 6 = | 6 (25% decrease) ↓ |
| Attitude of Nursing/Midwifery | 5 ↑ | 0 (not previously reported) |
| Clinical Care (Nursing/Midwifery) | 12 ↑ (33.3% increase) | 9 (50% increase) ↑ |
| Failure to answer telephones | 1 ↑ | 0 (100% decrease) ↓ |

**Divisional response to concerns highlighted by Q2 data**

| Concern | Explanation | Action |
|---|---|---|
| There has been a significant increase in the number of complaints received by Paediatric Orthopaedics, with 21 complaints received in Q2, an increase of 200% on the 7 complaints received in Q1. Of these, 13 complaints were | The business case for the Centralisation of Specialist Paediatrics (CSP) transfer planned for an additional 19 theatre sessions with on-call arrangements to cover emergencies overnight. The additional staffing requirements | Work is taking place to address these issues and to improve capacity within the operating theatres and outpatients, including private sector provision.<br>Post transfer, a further nine additional theatre sessions and on-site theatre night staff cover has |

| | | |
|---|---|---|
| about cancelled or delayed appointments or operations and 5 were about attitude and communication. | were up and running at the point of transfer. However, post-transfer, is became evident that the theatre and outpatient capacity planned was insufficient to meet the needs of patients within these services and those of existing services. | been identified.<br>Recruitment for the additional theatre staff required is being proactively managed: national adverts and open days have been placed and a Senior Nurse Lead (Matron) has been appointed to focus solely on this - with dedicated Employee Services support - for the next year.<br>However, it is not anticipated that all of the additional staff required will be fully in place until early in the New Year (January to April).<br>The additional capacity required in outpatients requires 'physical space' to be identified and the Division is exploring the potential use of South Bristol Community Hospital to provide the additional capacity required.<br>The Division is working to prioritise patients based on clinical need, to ensure that those patients identified receive timely diagnosis and treatment.<br>Families who have been delayed have been contacted to explain the current situation and to give assurance that their child will be seen and treated according to clinical priority. |
| Complaints received by Paediatric Neurology increased from 4 in Q1 to 9 in Q2 (a 125% increase); 5 of these complaints were about cancelled/delayed appointments. | *As above* | *As above* |
| The Children's Hospital received 12 complaints about clinical care in Q2. Whilst the majority of these were isolated, Ward 30 received 5 complaints in Q2 (2 related to the same patient), compared to none in Q1. | There is no obvious pattern of complaints within this category. 7 of the 12 complaints received related to clinical care provided by medical staff and 5 of the 12 complaints received related to clinical care provided by nursing staff. Of the 5 complaints received on Ward 30, 2 related to the same complainant and there were no common themes identified. | On receipt of complaints, the teams involved receive a copy and are asked to reflect on their practice, learn lessons and take action, where appropriate, to make changes. |

### 3.3.5 Division of Diagnostics & Therapies

**Complaints by category type**

| Category Type | Number and % of complaints received – Q2 2014/15 | Number and % of complaints received – Q1 2014/15 |
|---|---|---|
| Access | 6 (18.2% of total complaints) ↑ | 1 (4.4% of total complaints) ↓ |
| Appointments & Admissions | 8 (24.3 %) ↑ | 6 (26%) ↓ |
| Attitude & Communication | 10 (30.3%) ↑ | 5 (21.8%) ↓ |
| Clinical Care | 6 (18.2%) ↓ | 9 (39%) ↑ |
| Facilities & Environment | 2 (6%) = | 2 (8.8%) ↓ |
| Information & Support | 1 (3%) ↑ | 0 (0%) ↓ |
| **Total** | **33** | **23** |

**Top sub-categories**

| Category | Number of complaints received – Q2 2014/15 | Number of complaints received – Q1 2014/15 |
|---|---|---|
| Cancelled or delayed appointments and operations | 6 ↑ | 5 = |
| Clinical Care (Medical/Surgical) | 2 ↑ | 1 ↑ |
| Communication with patient/relative | 2 ↑ | 0 = |
| Attitude of Medical Staff | 2 ↑ | 0 ↓ |
| Attitude of Nursing/Midwifery | 0 = | 0 (not previously reported) |
| Clinical Care (Nursing/Midwifery) | 0 = | 0 = |
| Failure to answer telephones | 3 ↑ | 0 ↓ |

**Divisional response to concerns highlighted by Q2 data**

| Concern | Explanation | Action |
|---|---|---|
| There was a sharp rise in the number of complaints received about the Bristol Eye Hospital Pharmacy, from none in Q1 to 9 in Q2. All 9 complaints related to the service no longer being available and patients having to collect their prescriptions from Bristol Royal Infirmary. | The BEH pharmacy dispensing service was transferred to Boots BRI, located in the Trust Welcome Centre, in June 2014. Patients now collect their eye prescriptions from this pharmacy, however other options are available: collection from another Boots branch more local to home; or home delivery. If a prescription is urgent on the day in clinic, medication could be dispensed in BEH. Unfortunately there has been insufficient communication between pharmacy/BEH clinicians and patients about the new service and the options available. A key benefits of the new Boots service was supposed to be reduced waiting times for collecting medicines; unfortunately, Boots were overwhelmed with the increase in workload and only | Improve communication about the Boots service:<br>1. Flow chart summary of service options to be cascaded through Ophthalmology departments in order to ensure high levels of awareness.<br>2. Posters for patients in reception areas.<br>3. Patient appointment letters to have information about new service and options for collecting medication<br>4. BEH lead pharmacist attending Eye Hospital strategy meetings to continue to raise awareness about the service and the options for collecting medication available to patients.<br>5. Information leaflet given to patients when they check in for their appointment. |

| | | |
|---|---|---|
| | achieved a 30 minute turnaround for 64% of prescriptions in July. | Trust staff have already supported Boots to increase their staff numbers to a level that can manage the workload, and to review their systems and processes to reduce patient waiting times. (November waiting time 96% within 30 minutes). |
| The number of complaints received by Radiology rose from 7 in Q4 to 12 in Q1. In Q2, the number of complaints remained the same at 12. These were spread across a number of categories, with three each relating to clinical care, attitude of staff and lost or delayed test results. | Of the 12 complaints, 10 were formal and two were informal. One of the complaints about clinical care related to a historical (2006) case where the incident unfortunately could not be fully investigated as the member of staff involved is no longer in the organisation. Another case related to a patient whose MRI scan was halted because they had metal in their ear; this was picked up during the safety check. The patient subsequently had a CT scan instead. A third complaint related to an incorrect address, due to information not being updated on Medway in another department. In two cases, patients had their scans cancelled due to capacity issues, and the department has apologised for the distress caused. | Action plans are in place for those complaints where change / learning was required. In one case, a patient complained about a breach of their privacy and dignity whilst having an Ultrasound scan in St Michael's. As a result of this, screens have been ordered to ensure privacy when patients are changing.<br><br>Capacity and demand issues are being taken forward via the division's Operating Plan. |

**Complaints by hospital site**

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

| **Hospital/Site** | **Number and % of complaints received – Q2 2014/15** | **Number and % of complaints received – Q1 2014/15** |
|---|---|---|
| Bristol Royal Infirmary | 207 (40% of total complaints) ↑ | 170 (39.8% of total complaints) ↓ |
| Bristol Eye Hospital | 46 (8.9%) ↑ | 38 (8.9%) ↓ |
| Bristol Dental Hospital | 30 (5.7%) ↑ | 26 (6%) ↑ |
| St Michael's Hospital | 52 (10.1%) ↓ | 57 (13.3%) ↑ |
| Bristol Heart Institute | 56 (10.8%) ↑ | 50 (11.7%) ↑ |
| Bristol Haematology & Oncology Centre | 31 (6%) ↑ | 25 (5.9%) ↑ |
| Bristol Royal Hospital for Children | 79 (15.3%) ↑ | 50 (11.7%) ↑ |
| South Bristol Community Hospital (inc. Homeopathic Outpatients) | 17 (3.2%) ↑ | 11 (2.7%) ↑ |
| **Total** | **518** | **427** |

### 3.5 Complaints responded to within agreed timescale

The Trust's aim is to respond to complaints within the timescale we have agreed with the complainant. All five of the clinical Divisions reported breaches in Quarter 2, totalling 19 breaches.

| | **Q2 2014/14** | **Q1 2014/15** | **Q4 2013/14** | **Q3 2013/14** |
|---|---|---|---|---|
| Surgery Head and Neck | 5 (7.1%) | 9 (14.3%) | 8 (11%) | 6 (10%) |
| Medicine | 4 (11.1%) | 7 (21.2%) | 7 (21.2%) | 11 (25%) |
| Specialised Services | 1 (4.3%) | 2 (8.7%) | 0 | 2 (11%) |
| Women and Children | 8 (17%) | 6 (19.4%) | 9 (36%) | 4 (17%) |
| Diagnostics & Therapies | 1 (11.1%) | 0 (0%) | 1 (8.3%) | 0 |
| All | **19 breaches** | **24 breaches** | **25 breaches** | **23 breaches** |

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

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

| | **Source of delays (Q2, 2014/2015)** | | |
|---|---|---|---|
| | **Division** | **Patient Support and Complaints Team** | **Executive sign-off** |
| Surgery Head and Neck | 1 | 0 | 4 |
| Medicine | 3 | 0 | 1 |
| Specialised Services | 0 | 0 | 1 |
| Women and Children | 8 | 0 | 0 |
| Diagnostics & Therapies | 1 | 0 | 0 |
| All | 13 breaches | 0 breaches | 6 breaches |

*Actions agreed via Patient Experience Group:*

- New KPIs have been agreed in respect of turnaround times for the Patient Support and Complaints Team and for the Executives, in addition to the four working days allowed for the Divisions. The Patient Support and Complaints Team must send the response letter to the Executives for signing within 24 hours of receipt from the Division. The Executives then have up to three working days (maximum) to review, sign and return the response to the Patient Support and Complaints Team.
- Divisions have been reminded of the importance of providing the Patient Support and Complaints Team with draft final response letters at least four working days prior to the date they are due with the complainant.
- The Patient Support and Complaints Team continue to actively follow up Divisions if responses are not received on time; Divisional staff are also reminded of the need to contact the complainant to agree an extension to the deadline if necessary.
- Longer deadlines are agreed with Divisions if the complainant requests a meeting rather than a written response. This allows for the additional time needed to co-ordinate the diaries of clinical staff required to attend these meetings. (Note that deadlines agreed with Surgery, Head and Neck, Medicine and Specialised Services are longer than for the other Divisions, to reflect the larger patient numbers and subsequent complaints received by these Divisions).
- Ongoing vigilance to avoid any delays by Patient Support and Complaints Team.

### 3.6 Number of dissatisfied complainants

As reported in section 1.3, there were 14 cases in Q2 where complainants were dissatisfied with the quality of our response.

At their December Divisional Board Meeting, the divisional management team for Specialised Services will review recent cases where complainants were dissatisfied, in order to rule out any common themes (in terms of how the Division responded) for future learning. Any appropriate actions that arise will be completed by the end of January 2015.

| | Q2 2014/15 | Q1 2014/15 | Q4 2013/14 | Q3 2013/14 |
|---|---|---|---|---|
| Surgery Head and Neck | **6** | 8 | 5 | 8 |
| Medicine | **1** | 5 | 4 | 4 |
| Specialised Services | **5** | 2 | 1 | 3 |
| Women and Children | **2** | 5 | 3 | 0 |
| Diagnostics & Therapies | **0** | 1 | 1 | 0 |
| All | **14** | 21 | 14 | 15 |

*Actions agreed via Patient Experience Group:*

- Divisions are notified of any case where the complainant is dissatisfied. The 14 cases recorded in Q2 have now either been responded to in full, or have had revised response deadlines agreed with the complainants.
- The Patient Support and Complaints Team continues to monitor response letters to ensure that all aspects of each complaint have been fully addressed – there has recently been an increase in the number of draft responses which the Patient Support and Complaints Team has queried with the Division prior to submitting for sign-off.
- Trust-level complaints data is replicated at divisional level to enable Divisions to monitor progress and identify areas where improvements are needed. This data will also be used for quarterly Divisional performance reviews.
- Response letter cover sheets are sent to Executive Directors with each letter to be signed off. This includes details of who investigated the complaint, who drafted the letter and who at senior divisional letter signed it off as ready to be sent. The Executive signing the responses can then make direct contact with these members of staff should they need to query any of the content of the response.
- Training on writing response letters has being delivered to key staff across all Divisions with input from the Patients Association. This training was well received and further training on this subject matter is being planned. A draft training plan has now been drafted and work is underway for the Patient Support & Complaints Team to roll out a series of focussed training sessions over the coming year.

## 4. Information, advice and support

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

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

In Q1, the team dealt with 132 such enquiries, compared to 174 in Q1. These enquiries can be categorised as:

- 79 requests for advice and information (104 in Q1)

- 46 compliments (60 in Q1)
- 7 requests for support (10 in Q1)

## 5. PHSO cases

During Q2, the Trust has been advised of new Parliamentary & Health Service Ombudsman (PHSO) interest in one complaint (compared to five in Q1 and seven in Q4). The new complaint is the first case listed (15125). The other two cases are ones where the Trust was initially notified of PHSO interest prior to Q2 but remain open/under investigation.

| Case Number | Complainant (patient unless stated) | On behalf of (patient) | Date original complaint received | Site | Department | Division |
|---|---|---|---|---|---|---|
| 15125 | NHS England | CP | 24/02/2014 | BDH | Adult Restorative Dentistry | Surgery, Head & Neck |
| Not upheld: The PHSO requested details of this complaint on 06/08/2014 and advised on 24/10/2014 that they were taking no further action in respect of this complaint. | | | | | | |
| 10805 | AJ | MM-L | 17/05/2012 | BRI | Ward 9 | Surgery, Head & Neck |
| Open: Received PHSO's draft report on 30/09/2014. They are not upholding the complaint and the Trust has confirmed it has no comment to make. Awaiting receipt of final report. | | | | | | |
| 13987 | AB | DJ | 10/09/2013 | BRI | QDU (Endoscopy) | Surgery, Head & Neck |
| Open: Further documentation sent to PHSO on 10/11/2014. Awaiting receipt of report. | | | | | | |

## 6. Corporate developments in Q2

Recruitment to the Patient Support & Complaints Team has been completed. The team now has a full complement of 7.6 (WTE) staff. The team's focus has continued to be to reduce and eliminate the backlog of complaints enquiries[6].

[6] The backlog was subsequently eliminated in November 2014

University Hospitals Bristol NHS
NHS Foundation Trust

# Patient Experience Report

## Quarter 2 2014/15

**(1st July – 30th September 2014)**

**Author:** **Paul Lewis, Patient Experience Lead (Surveys and Evaluation)**

## 1. Executive Summary

This report presents quality assurance data arising from the UH Bristol patient experience survey programme, principally: the Friends and Family Test survey, the monthly inpatient/parent and maternity postal surveys, and the national patient surveys. Summary analysis is provided which draws on discussions held at the Trust's Patient Experience Group, where the data is reviewed at each meeting. The key headlines from Quarter 2 (July-September 2014) are:

- The Trust continued to achieve "green" ratings in the Trust Board Quality Dashboard: reflecting the provision of a high quality patient experience at UH Bristol.
- Improved "communication" and reducing waiting/delays were key themes arising from the written feedback received from patients.
- There continues to be significant variation in patient-reported experience between wards within the Trust. Detailed analysis of the survey data suggests that these differences are primarily a reflection of differing patient populations, rather than an indication of deeper care failings.
- The UH Bristol 2014 Outpatient Survey showed high levels of patient satisfaction. Improvement themes centred on reduced waiting times (for appointments and in clinic), being kept updated if there are delays in clinic, ease of contacting the Trust, and timely letters/test results/follow-up appointments.
- UH Bristol received a disappointing set of results of the 2013/14 National Cancer Survey, with nearly half of the Trust's scores being among the lowest 20% nationally. A plan to understand and address the key issues raised was received and endorsed by the Board.

## 2. Overview of patient experience at UH Bristol

Overall, the feedback received via the UH Bristol corporate patient experience survey programme shows that a positive experience is provided to the majority of patients. However, there is significant variation between wards, and also between individual patients (as demonstrated by the compliments and complaints that the Trust receives - see the linked Quarter 2 Complaints report). By far the most frequent form of feedback from patients conveys praise for UH Bristol staff, but this praise is often accompanied by suggestions for improvement: most typically relating to better communication and reducing waiting/delays. The Trust broadly performs in line with the national average in patient experience surveys, with the exception of the 2013/14 National Cancer Survey where a number of below-average scores were received.

Surveys work most effectively at a population (or "system") level, and tend to offer less insight into the unique experience of each individual patient. Therefore, the survey data presented in this report should be used in conjunction with other sources of information to provide a coherent and reliable view of "quality".

## 3. Trust-level patient experience data

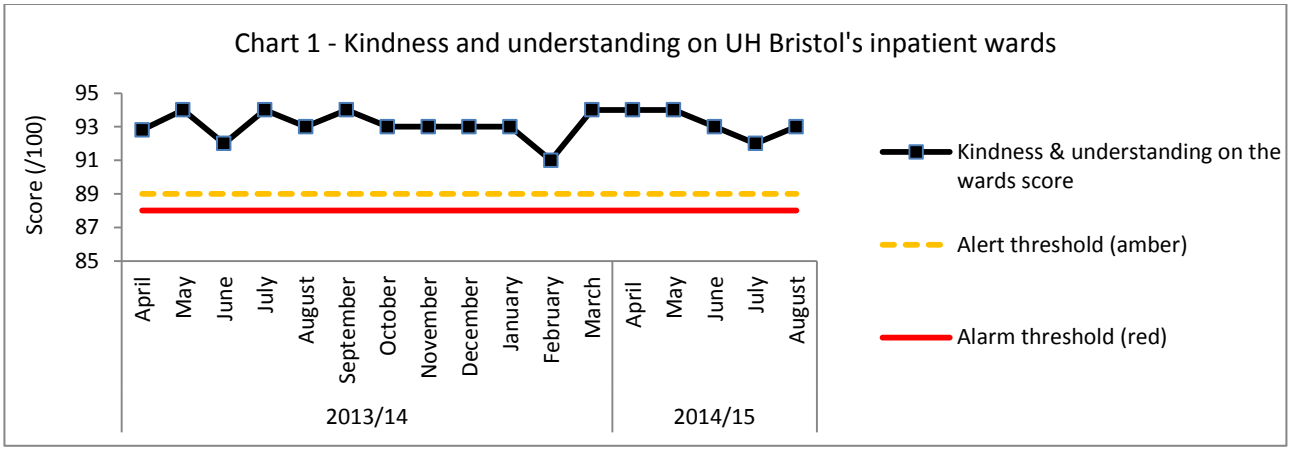
Charts 1 to 4 (over) show the four headline metrics that are used by the Trust Board to monitor the overall quality of patient-reported experience at UH Bristol[1]. These scores have been consistently rated "green" in the periods shown[2], indicating that a high standard of patient experience is being maintained at the Trust. The scores

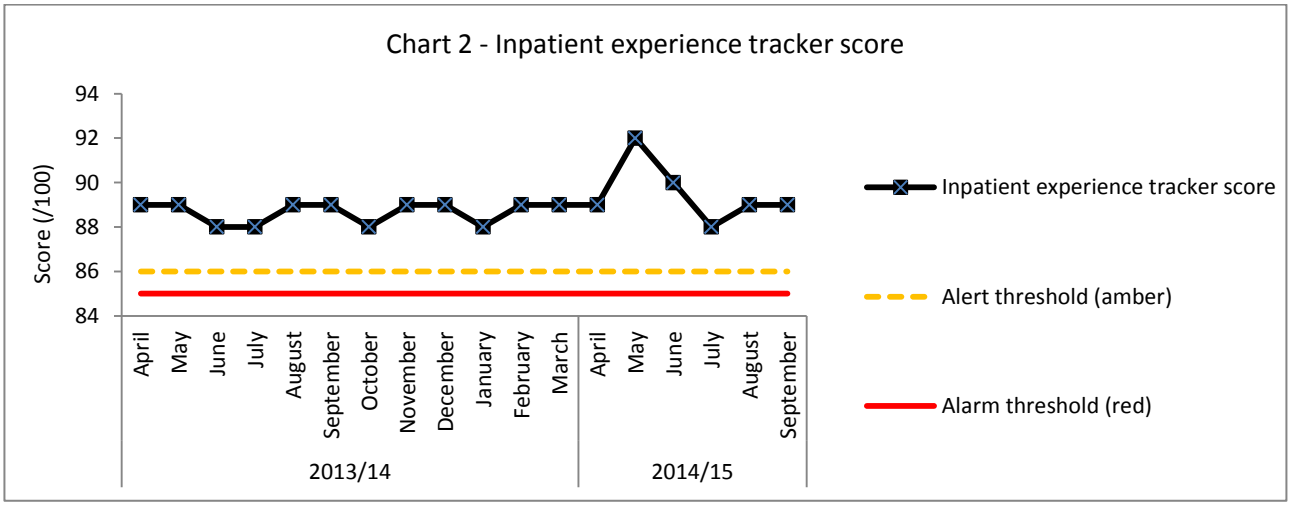
[1] Kindness and understanding is used as a key measure, because it is a fundamental component of compassionate care. The "patient experience tracker" is a broader measure of patient experience, made up of five questions from the UH Bristol monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via statistical analysis and patient focus groups conducted by the UH Bristol Patient Experience and Involvement Team.

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

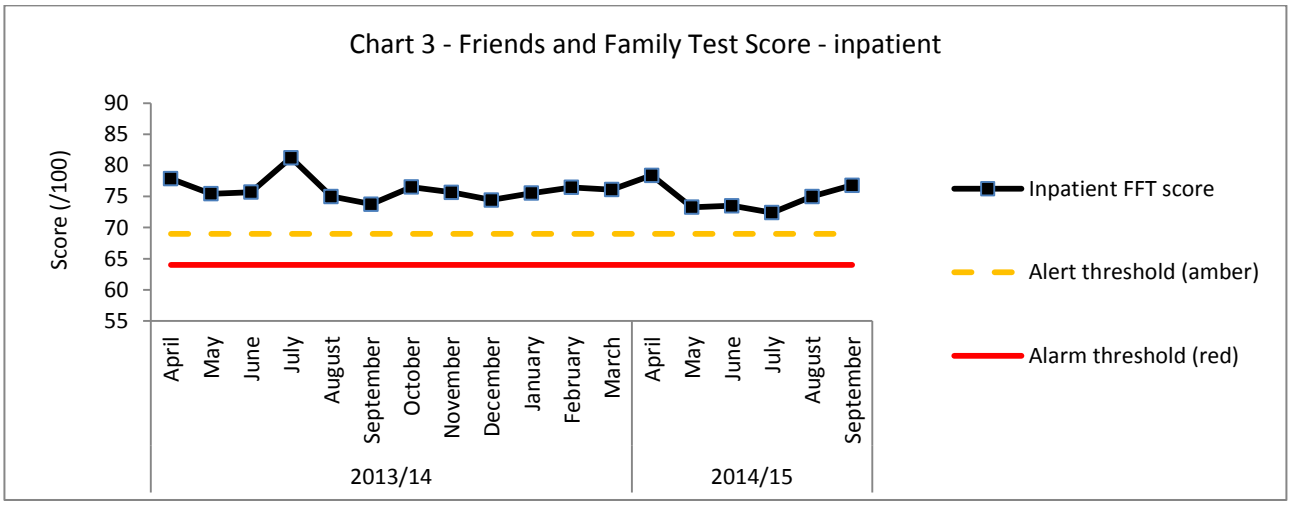
would turn “amber” or “red” if they fell significantly, alerting the senior management team to a deterioration in this position.

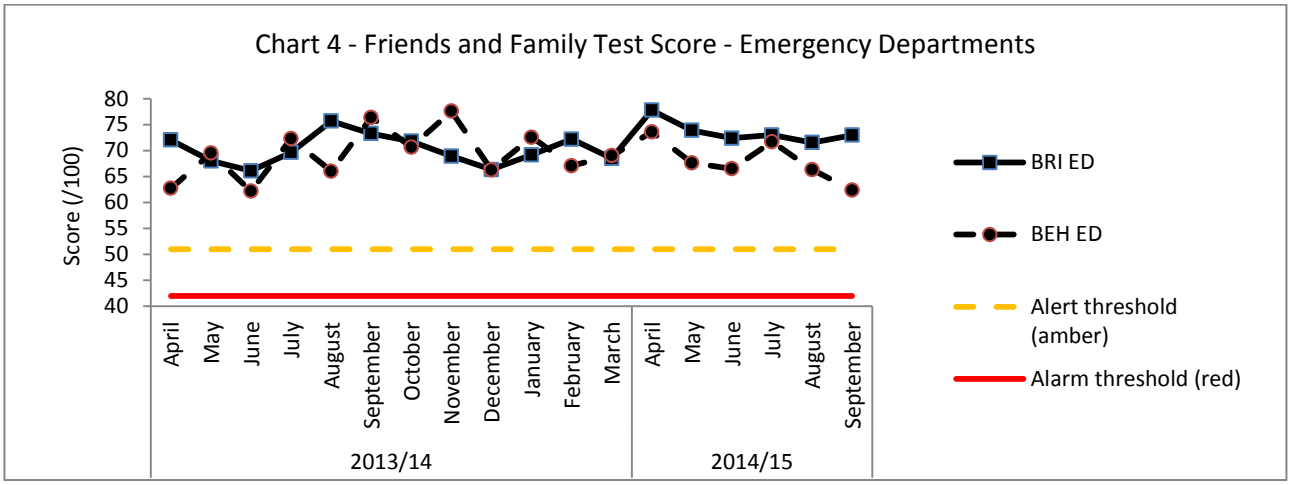
Chart 5 (on page 4) shows that 98% of outpatients rated their care as excellent, very good, or good in the 2014 UH Bristol annual outpatient survey[3]. Nevertheless, the survey encouraged respondents to put forward improvement suggestions: the main themes here were around waiting/delays (at all stages of the experience, particularly in clinic), ease of contacting the Trust, and timely letters/follow-up appointments/test results. The survey showed some positive improvements in scores for specialties involved in the Productive Outpatient programme, particularly in terms of keeping patients informed of waiting times in clinic (although at a Trust-level this remained among the lowest scores). There was no improvement in scores around ease of contacting the Trust, which is disappointing given the investment that has been made in this respect (including opening a new appointments centre - which itself attracted high satisfaction ratings), and because there has been a significant reduction in complaints around this issue. Further expansion of the appointments centre service may have an impact on this score in future surveys, or it may be that a single survey question cannot adequately measure this deceptively complex issue. The outpatient survey data is provided in full in Appendix C. An action plan is currently being formulated in response to the results.

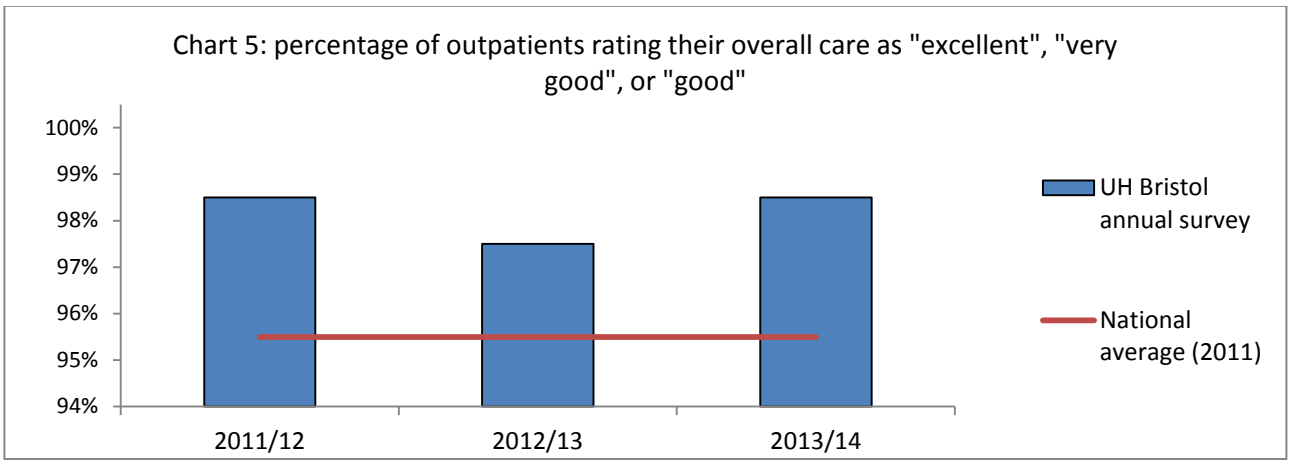



[3] Based on responses from 1,839 patients (or parents of 0-11 year olds) who attended in February 2014.




## 4. Divisional-level patient experience data

Charts 6-8 (over) split the headline patient experience metrics by UH Bristol Division. The Trust-level "alarm threshold" is shown in these charts, but this is a guide only - caution is needed in applying this directly because there is a higher margin of error in the data at this level. The Specialised Services Division tends to receive the highest (best) patient experience ratings, with the Division of Medicine attracting slightly lower survey ratings. An important factor here is that the Division of Medicine cares for a relatively high proportion of elderly patients with chronic, complex conditions: research has shown that this affects patient experience ratings over and above

the quality of the care provided[4]. Nevertheless, these scores are reflective of the experience as the survey respondents saw it, and so the Division of Medicine are carrying out a number of monitoring and improvement activities in this respect (see Sections 5 and 6). Postnatal maternity care also attracts lower survey ratings: although these scores are in line with (or better than) the national maternity average, a number of improvement initiatives are underway to improve these scores (see Section 5)[5].

Chart 6 - Inpatient kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)

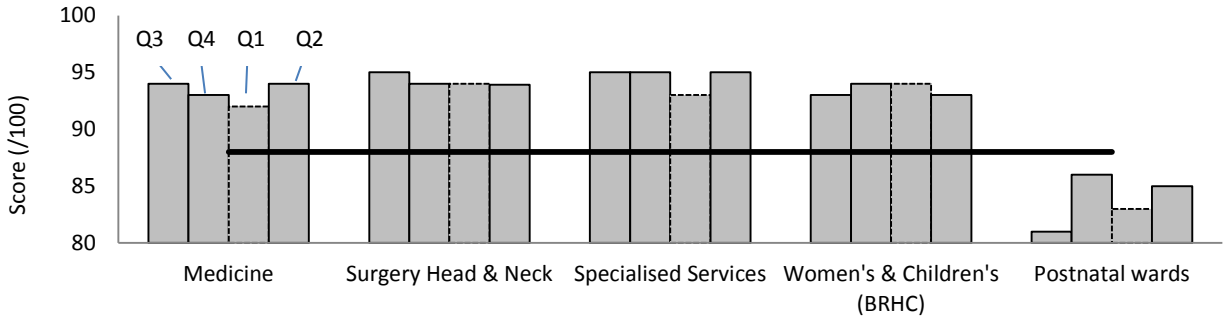



Chart 7- Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

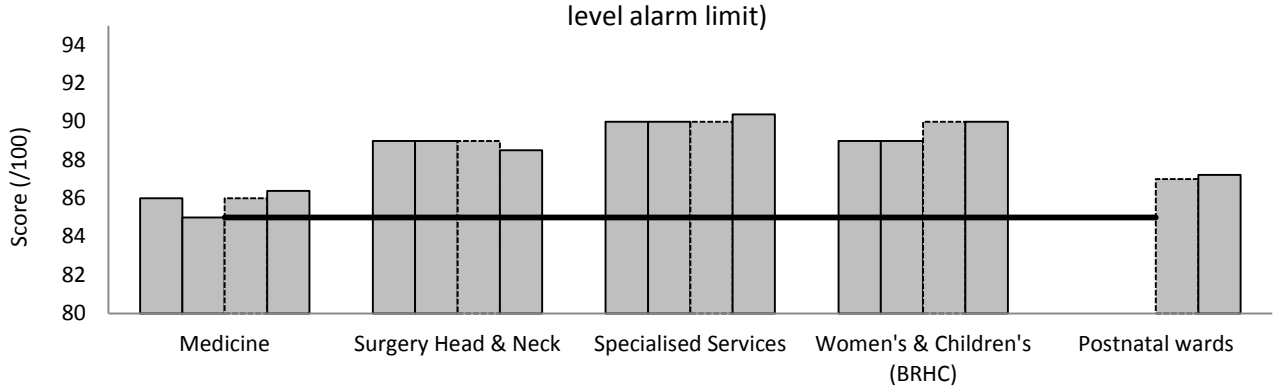
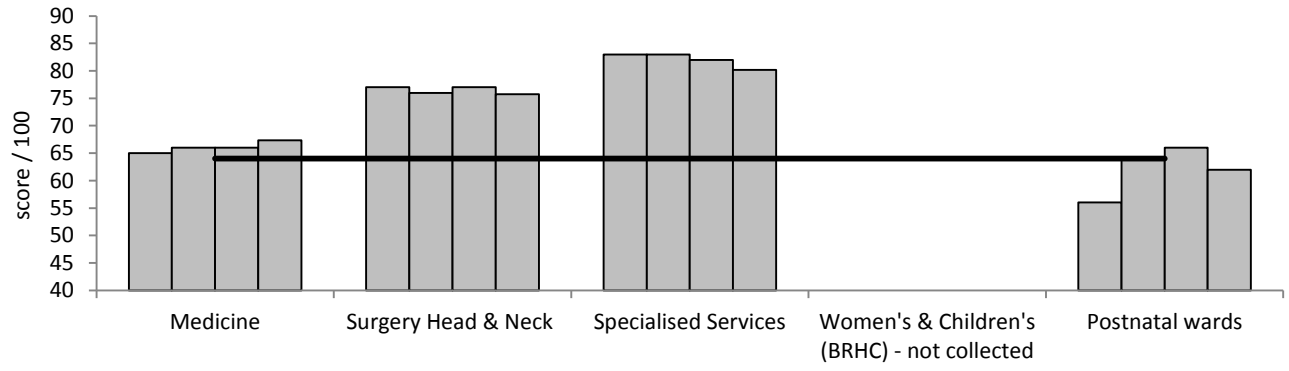



Chart 8 - Inpatient Friends and Family Test score - Last four quarters by Division (with Trust-level alarm limit)




[4] http://www.pickereurope.org/wp-content/uploads/2014/10/Multi-level-analysis-of-inpatient-experience.pdf

[5] The FFT is not currently in paediatric inpatient wards (it will be implemented by March 2015). The Patient Experience Tracker has been collected for postnatal wards since April 2014.

## 5. Hospital-level patient experience data

Charts 9-11 (over) show the headline survey results by hospital[6]. The only scores that fall below the Trust-level alarm thresholds relate to South Bristol Community Hospital (in Chart 10) and the postnatal wards (charts 9 and 11).

*South Bristol Community Hospital (Wards 100 and 200)*

The written feedback received for South Bristol Community Hospital (SBCH) via the surveys contains extensive praise for staff, and a recent Care Quality Commission inspection rated inpatient care at the hospital as "Good". However, the inpatient experience ratings for SBCH are difficult to explain: the Friends and Family Test (FFT) survey scores have seen step improvements over the four quarters shown, whilst the Patient Experience Tracker score (an aggregate of five questions from the UH Bristol post-discharge survey) has shown the opposite trend. Further analysis of the Tracker score has shown that it is the "communication" and "involvement in care decisions" elements of this measure that are below the UH Bristol average. Whilst this is a realistic reflection of the challenges in caring for the patient group at SBCH, the management team constantly strive to improve these elements of the service, for example:

- There are two "case manager" posts at SBCH, established to provide a dedicated link between staff and patients/families/carers, allowing clear lines of communication to be established.
- For each patient, the SBCH staff complete a daily diary which details conversations and actions relating to the patient's care. This can be read by the patient/family/carer at any point during their stay, and is given to the patient at discharge.
- On arrival, all patients are given an orientation of the ward and an explanation of how care is provided. A Standard Operating Procedure was also introduced to ensure patients are transferred into the hospital by 5pm, to ensure they have sufficient time to settle in. An audit is currently being carried out to assess adherence to this protocol, and actions will be undertaken to improve compliance if necessary.

*Postnatal wards (71,74,76)*

Postnatal ward satisfaction scores are typically lower than other inpatient areas of the Trust, but they are in line with (and in some respects much better than) the national maternity average (see Section 8). Nevertheless, since 2011/12 ongoing service improvement work has been undertaken at St Michael's Hospital in response to the survey results, including:

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

[6] The FFT is not currently in paediatric inpatient wards (it will be implemented by March 2015). The Patient Experience Tracker has been collected for postnatal wards since April 2014.

These activities resulted in improvements in local survey scores, and a "kindness and understanding" score that was rated better than the national average by the Care Quality Commission in the 2013 national maternity survey (having been on the verge of being among the worst quintile of trusts nationally in 2011). There have also been improvements in satisfaction with food quality and availability, as monitored through the UH Bristol monthly maternity survey. Through the national maternity survey action plan (see Section 8) and Divisional quality objectives, there is a continued focus on improving experiences of maternity care in 2014/15.

Chart 9: Inpatient kindness and understanding score - Last four quarters by hospital (with Trust-level alarm limit)

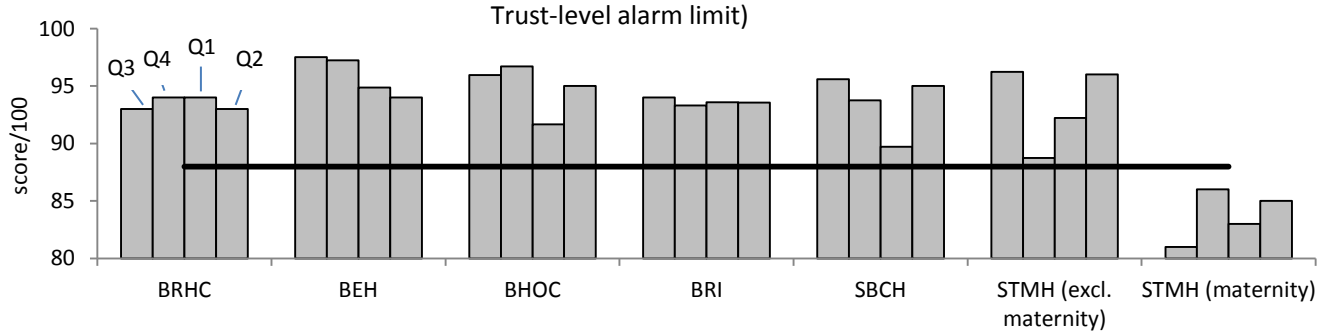



Chart 10: Inpatient experience tracker score by hospital - Last four quarters by hospital (with Trust-level alarm limit)

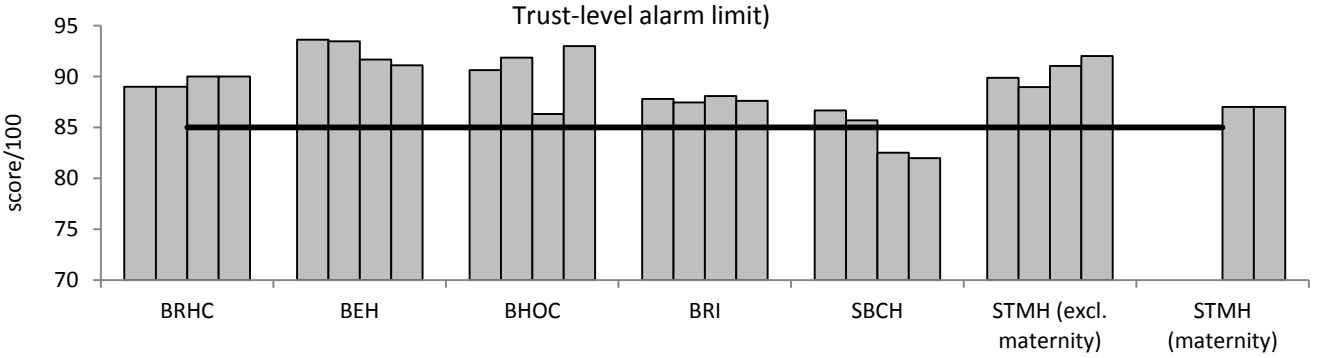
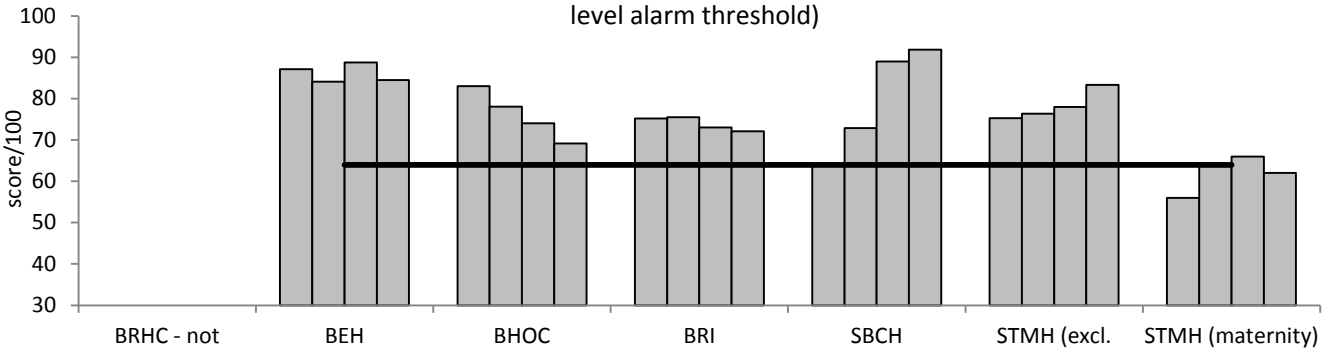



Chart 11: Inpatient Friends and Family Test score - Last four quarters by hospital (with Trust-level alarm threshold)




*Key: BRHC (Bristol Royal Hospital for Children); BEH (Bristol Eye Hospital – Ward 41); BHOC (Bristol Haematology and Oncology Centre); BRI (Bristol Royal Infirmary); SBCH (South Bristol Community Hospital); STMH (St Michael's Hospital)*

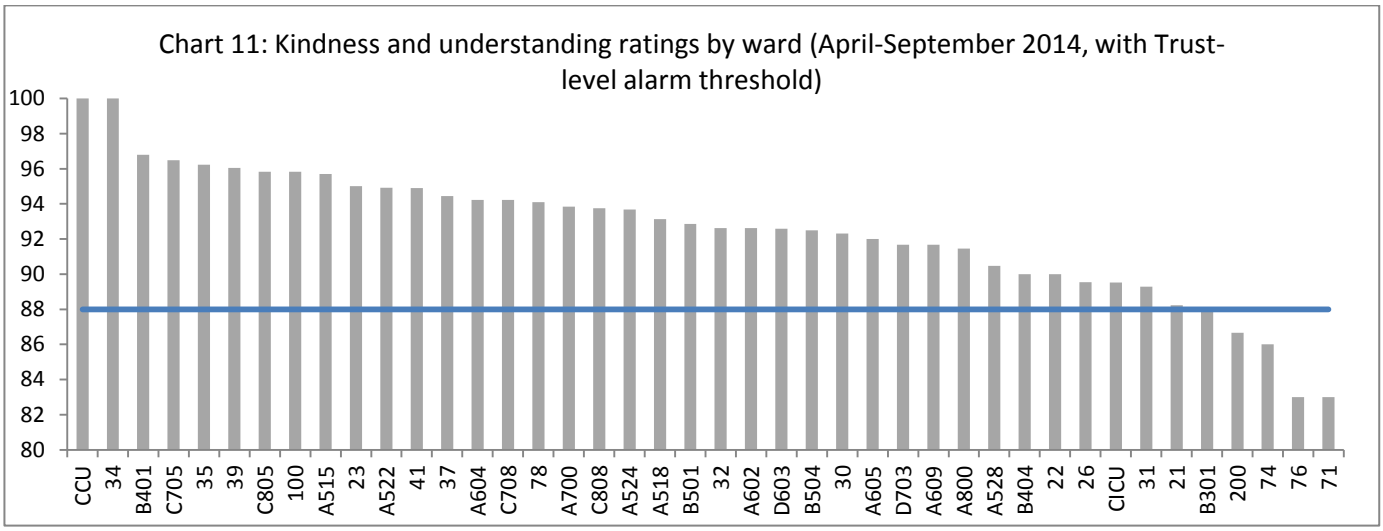
6. Ward-level data

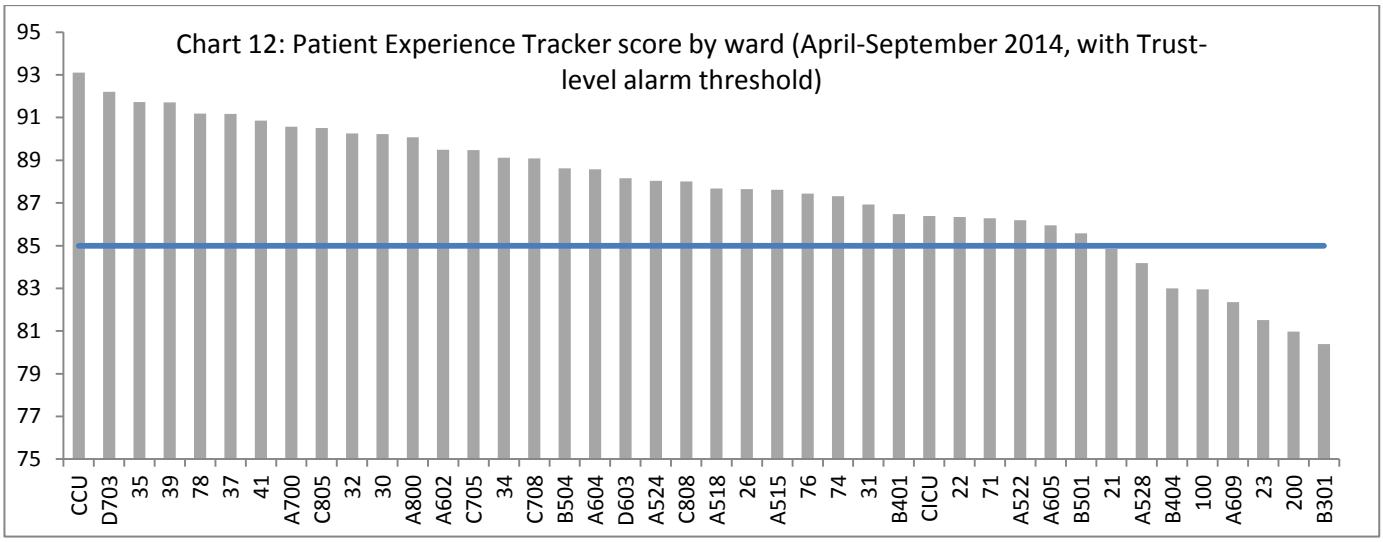
The ward-level inpatient survey and Friends and Family Test data is presented in charts 11 to 13 (over). As the sample sizes are relatively small at this level, to make the data more robust it has to be aggregated to a six-month period. This data is complicated by the ward name changes and ward moves that are currently taking place. However, in looking for consistency across the surveys ("triangulation"), some trends do emerge:

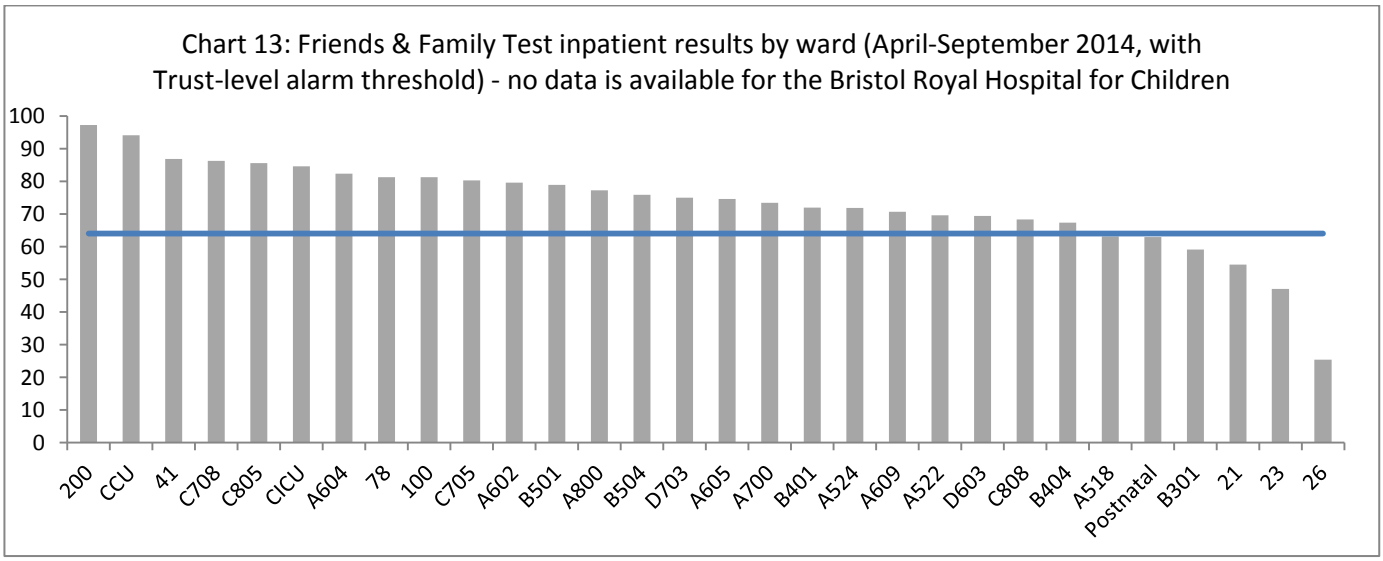
- The Coronary Care Unit (CCU) consistently achieves the highest scores.
- The postnatal wards tend to receive lower scores (see the previous discussion in Section 5)
- The wards in the Old Building (21, 23, 26) have now closed and are in the process of moving to new accommodation within the Trust, but they tended to receive lower ratings from patients. Further analysis of the data showed that this was primarily attributable to the ward environment (i.e. being in a very old building). A wider review of quality data carried out by the Division of Medicine also found no evidence of care failings.

Ward B301 (formally Ward 7), which is a care of the elderly ward in the Bristol Royal Infirmary, received relatively low patient experience ratings in the period shown. In particular, the ward had the lowest score on the Patient Experience Tracker (Chart 12), with the "communication" and "involvement in care decisions" elements of this aggregate measure being well below the Trust-average. As with South Bristol Community Hospital, this is in many ways a realistic reflection of the difficulties in caring for this patient group. A theme also emerges in the Friends and Family Test feedback for ward B301 around noise and disruption from other patients. This is likely to be because some patients on the ward will have severe Dementia: early discussions are taking place within Division of Medicine around whether it remains appropriate to care for these patients on the same ward(s) as patients with mild or no Dementia. Despite these challenges, the feedback for Ward B301 contains very high levels of praise for the staff and care provided. Furthermore, no evidence of deeper care failings has been found in a wider review of quality data for the ward that was carried out recently by the Head of Nursing for the Division of Medicine. This assurance will be further tested in early 2015, when the ward is a focus for the Trust's *Face2Face* interview survey (see Appendix C) and a "Back to the Floor" visit from a senior UH Bristol nurse (which encompasses a debrief and "next steps" discussion between the senior nurse and ward leads).

Table 1 (on page 10) provides an indication of ward performance on the "kindness and understanding" question over the last four quarters. At this level there can be quite large movements in scores from quarter-to-quarter, much of which can be attributable to margin of error (i.e. random fluctuation rather than a "real" change in service standards). Therefore, it is important to look for consistency in the scores (i.e. more than one quarter shaded red or green in this table). The margin of error also makes it difficult to determine the trend over time for individual wards, but an attempt has been made to do this in Table 1 by highlighting any large differences in scores between Quarter 3 2013/14 and Quarter 2 2014/15. Overall, the picture is one of relatively little substantive change in the ward scores over the twelve-month period shown.




Note: the Friends and Family Test Survey is not currently operating in paediatric inpatient wards (it will however be implemented by March 2015). The Patient Experience Tracker has been collected for postnatal wards since April 2014.

**Table 1: Quarterly ward "kindness and understanding" score.** The top five scores in each quarter are shaded green, the lowest five scores are shaded red. The "direction of travel" highlights changes of 10 points or more between Quarter 3 2013/14 and Quarter 2 2014/15. Wards marked with a * have now moved and/or closed.

| New ward name | *Old ward name* | *October-December 2013 (Q3)* | *January-March 2014 (Q4)* | *April-June 2014 (Q1)* | Q2 (July-Sept 2014) | *Direction of travel (Q3 13/14 to Q214/15)* |
|---|---|---|---|---|---|---|
| 19 | 19 | 88 | 86 | 89 | 93 | No change |
| 21* | 21 | 85 | 92 | 85 | n/a* | No change |
| 22* | 22 | 89 | 94 | 95 | 86 | No change |
| 23* | 23 | 89 | 83 | 91 | n/a* | No change |
| 26* | 26 | 91 | 81 | 88 | 94 | No change |
| 30 | 30 | 95 | 93 | 93 | 91 | No change |
| 31 | 31 | 95 | 95 | 89 | 90 | No change |
| 32 | 32 | 95 | 92 | 94 | 91 | No change |
| 34 | 34 | 95 | 100 | 100 | 100 | No change |
| 35 | 35 | 90 | 97 | 94 | 100 | Better |
| 37 | 37 | 88 | 88 | 95 | 92 | No change |
| 39 | 39 | 94 | 95 | 97 | 96 | No change |
| 41 | 41 | 98 | 97 | 95 | 95 | No change |
| 71 | 71 | 77 | 86 | 84 | 83 | No change |
| 74 | 74 | 87 | 88 | 85 | 87 | No change |
| 76 | 76 | 76 | 81 | 82 | 84 | No change |
| 78 | 78 | 96 | 89 | 92 | 96 | No change |
| 100 | 100 | 98 | 90 | 94 | 97 | No change |
| 200 | 200 | 94 | 94 | 84 | 92 | No change |
| A515 | 17 | 96 | 95 | 97 | 95 | No change |
| A518 | 18 | 97 | 93 | 91 | 98 | No change |
| A522 | 10 | 98 | 95 | 92 | 98 | No change |
| A524 | 4 | 91 | 98 | 93 | 96 | No change |
| 5B* | 5B | 96 | 98 | 95 | 89 | No change |
| 5A* | 5A | 94 | 95 | 96 | 90 | No change |
| A605 | 6 | 96 | 92 | 93 | 93 | No change |
| A609 | 14 | 90 | 88 | 89 | 95 | No change |
| B301 | 7 | 83 | 86 | 92 | 85 | No change |
| B401 | 9 | 91 | 85 | 95 | 100 | No change |
| B404 | 11 | 92 | 92 | 87 | 94 | No change |
| B501 | 12 | 98 | 88 | 91 | 95 | No change |
| B504 | 15 | 93 | 94 | 95 | 89 | No change |
| C705 | 51 | 96 | 96 | 97 | 95 | No change |
| C708 | 52 | 94 | 93 | 95 | 94 | No change |
| C805 | 53 | 97 | 95 | 95 | 97 | No change |
| C808 | 54 | 95 | 93 | 94 | 96 | No change |
| CCU | CCU | 94 | 100 | 100 | 100 | No change |
| CICU | CICU | 92 | 91 | 93 | 87 | No change |
| D603 | 61 | 95 | 96 | 89 | 96 | No change |
| D703 | 62 | 98 | 98 | 93 | 94 | No change |

7. Themes arising from inpatient free-text comments in the monthly postal surveys

At the end of our postal survey questionnaires, patients are invited to comment on any aspect of their stay – in particular anything that was worthy or praise or that could have been improved. All comments are reviewed by the relevant Heads of Nursing and shared with ward staff for wider learning. In the twelve months to September 2014 around 5,000 written comments were received in this way. The over-arching themes from these comments are provided below. Please note that "**valence**" is a technical term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed).

*All inpatients/parent comments (excluding maternity)*

| Theme | Valence | % of comments[7] | |
|---|---|---|---|
| Staff | Positive | 61% | *61% of the comments received contained praise for UH Bristol staff, making this by far the most common theme. Improvement themes centre on communication, staff, waiting/delays, and food.* |
| Communication | Negative | 14% | |
| Waiting/delays | Negative | 10% | |
| Staff | Negative | 9% | |
| Food/catering | Negative | 8% | |

*Division of Medicine*

| Theme | Valence | % of comments | |
|---|---|---|---|
| Staff | Positive | 57% | *Negative comments about "staff" are often linked to other thematic categories (e.g. poor communication from a member of staff). This demonstrates that our staff are often the key determinant of a good or poor patient experience.* |
| Communication | Negative | 11% | |
| Waiting/delays | Negative | 9% | |

*Division of Specialised Services*

| Theme | Valence | % of comments | |
|---|---|---|---|
| Staff | Positive | 60% | *Negative comments about staff also often relate to a one-off experience with a single member of staff, showing how important each individual can be in a patient's experience of care.* |
| Communication | Negative | 15% | |
| Waiting/delays | Negative | 9% | |

*Division of Surgery, Head and Neck*

| Theme | Valence | % of comments | |
|---|---|---|---|
| Staff | Positive | 62% | *Improving patient flow (including delays at discharge) is a key priority for the Trust. A number of major projects are being undertaken in relation to this during 2014/15.* |
| Communication | Negative | 14% | |
| Waiting/delays | Negative | 9% | |

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

| Theme | Valence | % of comments | |
|---|---|---|---|
| Staff | Positive | 65% | *This data includes feedback from parents of 0-11 year olds who stayed in the Bristol Royal Hospital for Children. Again the themes are similar to other areas of the Trust.* |
| Communication | Negative | 18% | |
| Staff | Positive | 9% | |

*Maternity comments*

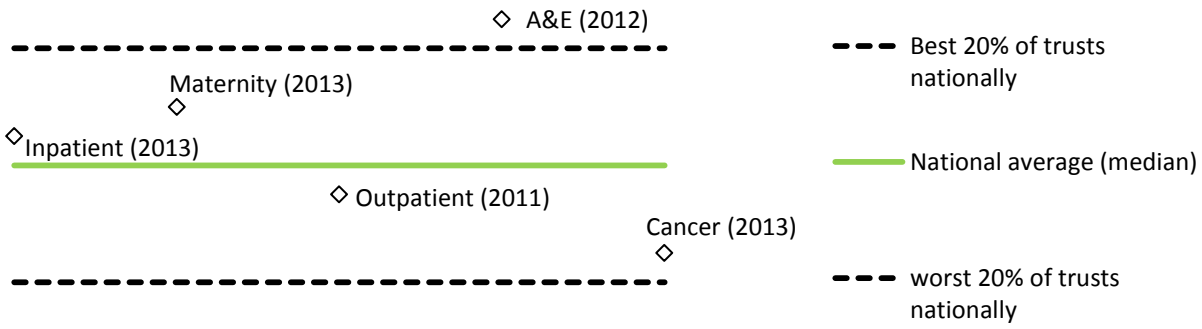
| Theme | Valence | % of comments | |
|---|---|---|---|
| Staff | Positive | 64% | *For maternity services, the two most common themes relate to praise for staff and praise for care during labour and birth.* |
| Care during labour | Positive | 35% | |
| Information/advice | Negative | 16% | |

[7] Each of the patient comments received may contain several themes within it. Each of these themes is given a code (e.g. "staff: positive"). This table shows the most frequently applied codes, as a percentage of the total comments received (e.g. 61% of the comments received contained the "staff positive" thematic code).

8. National patient survey programme

Along with other English NHS trusts, UH Bristol participates in the Care Quality Commission (CQC) national patient survey programme. This provides useful benchmarking data - a summary of which is provided in chart 14 below[8] and Appendix A. It can be seen that UH Bristol broadly performs among the mid-performing trusts nationally. The main exception here is the 2012 national Accident and Emergency survey[9], where UH Bristol performed well above the national average. The national cancer survey (NCS) on the other hand tends to produce scores for UH Bristol that are lower than the national average. The latest set of NCS results were received during Quarter 2 (although the sample of patients surveyed had attended UH Bristol in late 2013). Despite a large number of service improvement actions at the Trust, the scores had not improved significantly from previous NCS results. A comprehensive engagement programme with patients receiving cancer services will be carried out by the Trust, in collaboration with the Patient's Association, to fully understand these results and inform the substantive action plan. In addition, the Trust will participate in an NHS England programme which will involve working closely with a peer Trust that performs consistently well in the NCS. These activities will lead to the development of a comprehensive and far-reaching action plan during 2015.

Chart 14: comparison of UH Bristol's national patient survey results (year in brackets)




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

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

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

[9] The 2014 national A&E survey results have just been received and will be explored in more detail in the next quarterly report. The results remain broadly positive, although scores have declined slightly compared to 2012.

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

| *Survey* | *Headline results for UH Bristol* | *Report and action plan approved by the Trust Board* | *Action plan progress reviewed by Patient Experience Group* | *Key issues addressed in action plan* | *Next survey results due (approximate)* |
|---|---|---|---|---|---|
| 2013 National Inpatient Survey | 59/60 scores were in line with the national average. One score was below the national average (privacy in the Emergency Department) | May 2014 | Quarterly | • Privacy in the Emergency Department<br>• Awareness of the complaints process<br>• Delays at discharge<br>• Explaining potential medication side effects to patients at discharge | March 2015 |
| 2013 National Maternity Survey | 14 scores were in line with the national average; 3 were better than the national average | January 2014 | Six-monthly | • Continuity of antenatal care<br>• Communication during labour and birth<br>• Care on postnatal wards | January 2016 |
| 2013 National Cancer Survey | 30/60 scores were in line with the national average; 28 scores were below the national average; 2 were better than the national average | November 2014 | Six-monthly | • Providing patient-centred care<br>• Validate survey results<br>• Understanding the shared-cancer care model, both within UH Bristol and across Trusts | September 2015 |
| 2012 National Accident and Emergency surveys | 21/37 scores in line with the national average; 16 scores were better than the national average | January 2013 | Six-monthly | • Awareness of the complaints process<br>• Waiting times in the Emergency Dept. and being kept informed of any delays<br>• Patients feeling safe in the Department<br>• Explaining potential medication side effects to patients at discharge | December 2014 |
| 2011 National Outpatient Survey | All UH Bristol scores in line with the national average | March 2012 | Six monthly | • Waiting times in the department and being kept informed of any delays<br>• Telephone answering/response<br>• Cancelled appointments<br>• Copy patients in to hospital letters to GPs | Unknown |

**Appendix B: Full quarterly Divisional-level inpatient/parent survey dataset (Quarter 1 2014/15)**

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

| | MDC | SHN | SPS | WAC (Excl. maternity) | Maternity | Trust (excl Mat.) |
|---|---|---|---|---|---|---|
| Were you / your child given enough privacy when discussing your condition or treatment? | 91 | 91 | 92 | 94 | n/a | 92 |
| How would you rate the hospital food you / your child received? | 60 | 58 | 56 | 64 | 57 | 59 |
| Did you / your child get enough help from staff to eat meals? | 79 | 87 | 84 | 77 | n/a | 82 |
| In your opinion, how clean was the hospital room or ward you (or your child) were in? | 92 | 93 | 96 | 94 | 87 | 93 |
| How clean were the toilets and bathrooms that you / your child used on the ward? | 88 | 90 | 91 | 91 | 80 | 90 |
| Were you / your child ever bothered by noise at night from hospital staff? | 78 | 86 | 80 | 87 | n/a | 83 |
| Do you feel you / your child was treated with respect and dignity on the ward? | 94 | 95 | 96 | 95 | 88 | 95 |
| Were you / your child treated with kindness and understanding on the ward? | 94 | 94 | 95 | 93 | 85 | 94 |
| How would you rate the care you / your child received on the ward? | 84 | 86 | 87 | 87 | 79 | 86 |
| When you had important questions to ask a doctor, did you get answers you could understand? | 82 | 86 | 87 | 89 | 84 | 85 |
| When you had important questions to ask a nurse, did you get answers you could understand? | 85 | 87 | 89 | 87 | 89 | 87 |
| If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so? | 73 | 72 | 74 | 73 | 69 | 73 |
| If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so? | 83 | 83 | 86 | 84 | 83 | 84 |
| Were you involved as much as you wanted to be in decisions about your / your child's care and treatment? | 79 | 83 | 82 | 86 | 85 | 82 |
| Do you feel that the medical staff had all of the information that they needed in order to care for you / your child? | 84 | 86 | 87 | 84 | n/a | 85 |
| Did you / your child find someone to talk to about your worries and fears? | 65 | 70 | 72 | 82 | 76 | 71 |

| | MDC | SHN | SPS | WAC (Excl. Maternity) | Maternity | Trust (excl Mat.) |
|---|---|---|---|---|---|---|
| Staff explained why you needed these test(s) in a way you could understand? | 82 | 86 | 85 | 91 | n/a | 85 |
| Staff tell you when you would find out the results of your test(s)? | 68 | 69 | 71 | 83 | n/a | 71 |
| Staff explain the results of the test(s) in a way you could understand? | 74 | 76 | 75 | 83 | n/a | 76 |
| Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand? | 80 | 91 | 92 | 94 | n/a | 91 |
| Did a member of staff explain how you / your child could expect to feel after the operation or procedure? | 67 | 75 | 81 | 85 | n/a | 78 |
| Staff were respectful any decisions you made about your / your child's care and treatement | 89 | 91 | 92 | 92 | n/a | 91 |
| During your hospital stay, were you asked to give your views on the quality of your care? | 76 | 82 | 77 | 79 | 53 | 79 |
| Do you feel you were kept well informed about your / your child's expected date of discharge? | 84 | 89 | 88 | 90 | n/a | 88 |
| On the day you / your child left hospital, was your / their discharge delayed for any reason? | 63 | 63 | 57 | 63 | 55 | 61 |
| % of patients delayed for more than four hours at discharge | 20 | 19 | 25 | 12 | 29 | 20 |
| Did a member of staff tell you what medication side effects to watch for when you went home? | 53 | 66 | 60 | 63 | n/a | 60 |
| Did a member of staff tell you who to contact if you were worried about your / your child's condition or treatment after you had left hospital? | 77 | 85 | 87 | 90 | n/a | 84 |
| *Total responses* | *424* | *508* | *345* | *259* | *301* | *1837* |

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

**Appendix C: 2014 UH Bristol Outpatient Survey Results**

| Question | Response option | 2014 | 2013 | 2011 | Direction of travel[10] |
|---|---|---|---|---|---|
| Were you able to find a place to sit in the waiting area? | Yes | 99% | 99% | n/a | No change |
| Overall, how would you rate the care you received during the outpatient appointment? | Excellent, very good, good | 98% | 97% | 98% | No change |
| Were you treated with respect and dignity during the outpatient appointment? | Yes, all of the time | 96% | 95% | 95% | No change |
| How would you rate the courtesy of the receptionist? | Excellent, very good, good | 95% | 95% | n/a | No change |
| How likely are you to recommend the outpatient department to friends and family? | Extremely likely/likely | 92% | 90% | n/a | No change |
| Did (the medical professional) listen to you? | Yes, definitely | 90% | 90% | 90% | No change |
| How would you rate the service that you received from the appointment centre? | Excellent, very good, good | 90% | 91% | n/a | No change |
| Was your appointment cancelled and re-arranged? | No | 88% | 85% | 88% | No change |
| Did you find the text message reminder useful? | Yes | 85% | n/a | n/a | |
| Did you have enough time to discuss your health or medical problem? | Yes, definitely | 83% | 82% | 81% | No change |
| If you had important questions to ask, did you get answers that you could understand? | Yes, definitely | 83% | 82% | 82% | No change |
| did the person you saw have all of the information needed to care for you? | Yes, definitely | 81% | 82% | n/a | No change |
| did a member of staff explain any risks and / or benefits of the treatment | Yes, completely | 79% | 76% | 72% | **Better** |
| In your opinion, how clean was the outpatient dept? | Very clean | 74% | 73% | 76% | No change |
| How long after the stated appointment time did the appointment start? | 15 minutes or less | 72% | 70% | 70% | No change |
| Did a member of staff explain the results of the test(s) in a way you could understand? | Yes, completely | 71% | 70% | 66% | **Better** |
| Did the appointment centre resolve your query for you? | Yes, completely | 66% | 68% | n/a | No change |
| When you contacted the hospital, was it easy to get through to a member of staff who could help you? | Yes, definitely | 58% | 59% | n/a | No change |
| Did a member of staff tell you about medication side effects to watch for when you went home? | Yes, completely | 54% | 53% | 55% | No change |
| Did you see a display board in the clinic with waiting time information on it? | Yes | 47% | 40% | n/a | **Better** |
| Were you told how long you would have to wait? | Yes | 44% | 42% | 40% | No change |
| Were you told how much time you could expect to spend at the hospital for the appointment? | Yes | 40% | 40% | n/a | No change |
| When you first booked the appointment, were you given a choice of appointment date and time? | Yes | 38% | 40% | 44% | **Worse**[11] |
| Were you told why you had to wait? | Yes | 27% | 27% | 30% | No change |

[10] Differences in scores of over five points from the baseline are highlighted as better or worse: this threshold represents a pragmatic combination of statistical significant (i.e. taking into account margins of error in the survey) and whether there has been a *significant impact* on patient's experience of our services.

[11] Note: UH Bristol is often not responsible for the initial booking of patients.

**Appendix D – UH Bristol corporate patient experience programme**

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

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

**Appendix E: survey scoring methodologies**

*Postal surveys*

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

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

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

*Friends and Family Test Score*

The FFT score is calculated as follows:

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

Minus

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

University Hospitals Bristol NHS
NHS Foundation Trust

**Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 09. 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

- None

### 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 |
|---|---|---|---|---|---|
| | | 27/01/15 | | | |

University Hospitals Bristol NHS
NHS Foundation Trust

# SUMMARY QUALITY & PERFORMANCE REPORT

**January 2015**

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## 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 AMBER – 1 indicator

- Patient complaints (as a percentage of activity) – now 0.014% above the GREEN threshold;

Deteriorations in the period:

Moving from AMBER to RED – 2 indicators

- Summary Hospital-level Mortality Indicator (SHMI) – moving from a SHMI score of 66.0 to a draft position of 86.9; the total number of deaths was marginally above average in November; a higher proportion of cases had not been clinically coded at the point of data submission, which may be having a bearing on this draft SHMI figure, which will be refreshed with full clinical coding next month;
- Savings plan achievement – for further information see the separate Finance Report

Moving from GREEN to AMBER – 1 indicator

- Percentage of research studies meeting the 70 day standard (submission to recruitment) – this is a quarterly reported standard, and as reported last month the amber rating reflects 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. Patient flow at the 'front door' of the Bristol Royal Infirmary (BRI) remained challenging, with an increase in times to initial assessment in the Emergency Department, and poorer performance against the 4-hour standard. The number of emergency admissions increased relative to November. But more importantly, the proportion of emergency admissions for patients aged 75 years and over increased. This led to an increase in bed occupancy and more patients outlying from their specialty wards. Although there were fewer long stay patients in hospital at the end of December, this increase in elderly patients, needing more medical input and packages of care for discharge, has resulted in more delayed discharges and longer stays during January. Achievement of the Referral to Treatment Times (RTT) standards remains a challenge due to high levels of demand. However, detailed capacity and demand modelling has now been completed for all under-performing specialties, supported by the NHS Interim Management and Support (IMAS) team. This modelling work is now enabling informed discussions to take place with commissioners around the level of

activity that needs to be commissioned or managed, to support sustained achievement of RTT standards during 2015/16 to take place.

For quarter 3 as a whole the Trust failed six 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 combined 62-day GP and Screening Cancer Standards, and the RTT Admitted pathways standard, the latter being extending following 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. The forecast for 31-day first definitive treatment is for the standard to be met for the quarter as a whole on final validation, and for this reason is not scored against the framework. 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. Monitor has however requested further information following multiple breaches of the A&E, Referral to Treatment and cancer waiting time targets, before deciding next steps.

# SECTION B – Organisational Health Barometer

## Providing a Good Patient Experience

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| A01 | Patient Experience Tracker Score | 89 | 89 | N/A | Green: >= 86<br>Red: < 85 | ➡ | Current month is November 2014. |
| A02 | Patient Complaints as a Proportion of Activity | 0.251% | 0.224% | 0.256% | Green: <0.21%<br>Red: >0.25% | ⬇ | |
| A03 | Same Sex Accommodation Breaches (Number of Patients Affected) | 0 | 0 | 0 | Green: 0<br>Red> >0 | ➡ | |

## Delivering High Quality Care

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| B01 | Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4) | 1 | 2 | 5 | Green: 0<br>Red: >= 1 | ⬆ | No RAG rating for YTD. |
| B02 | Number of Inpatient Falls Per 1,000 Beddays | 4.50 | 5.59 | 4.80 | Green < 5.6<br>Red: >= 5.6 | ⬆ | |

## Keeping People Safe

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| C01 | Number of Serious Incidents (SIs) | 6 | 8 | 61 | | ⬆ | |
| C02 | Cumulative Number of Avoidable C.Diff cases | 5 | 6 | 6 | Below Trajectory | ⬆ | Previous = commissioner agreed potentially avoidable cases Apr to Sep; Current & YTD = Apr-Dec |

## Being Accessible

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| D01 | 18 Weeks Admitted Pathways | 83.1% | 84.3% | 86.6% | Green: >=90%<br>Red: <85% | ⬆ | |
| D02 | Number of Cancer Standards Failed | 1 | 1 | 1 | Green: 0<br>Red: >=2 | ➡ | Previous is confirmed Q1. Current and YTD is confirmed Q2. |
| D03 | A&E 4 Hour Standard | 88.6% | 86.3% | 92.3% | Green: >=95%<br>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 | 66.0 | 86.9 | 64.6 | Green: <65<br>Red: >=75 | ↑ | Previous is October 2014 and Current is November 2014. |
| E02 | 30 Day Emergency Readmissions | 297 | 152 | 2176 | Below 13/14 Readmission Rate | ↓ | Previous is October's discharges where there was an emergency Readmission within 30 days. Current is November's discharges. |

## Being Efficient

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| F01 | Overall Length of Stay (Spell) | 4.00 | 4.31 | 4.22 | Green: <= Quarterly target 3.70<br>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 | 84.2% | 83.5% | 87.2% | Green: >= 90%<br>Red: < 90% | ↓ | |
| F04 | Outpatient appointment hospital cancellation rate | 8.0% | 8.7% | 8.9% | Green: <=6.0%<br>Red: >=10.7% | ↑ | |

## Valuing Our Staff

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| G01 | Turnover | 13.4% | 13.5% | 12.5% | Green: < target<br>Red: >=10% above target | ↑ | |
| G02 | Staff Sickness | 4.4% | 4.6% | 4.0% | Green: < target<br>Red: >=0.5 percent pts above target | ↑ | |

## Promoting Research

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| H02 | Cumulative Weighted Recruitment | 31,026 | 35,675 | 35,675 | Green: Above 2012<br>Red: Below 2012 | | Current (and YTD) is rolling Calendar YTD position. Previous is Jan-Sep 2014 and Current is Jan-Oct 2014 |
| H03 | Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment) | 53.6% | 51.0% | 51.0% | Green: >=53% (Upper Quartile)<br>Red: <48% (Median) | ↓ | Previous is Q1 2013/14 – Q4 2013-14. Current is Q2 2012/13 - Q1 2014/15. Updated Quarterly. No change from last month. |

# PERFORMANCE OVERVIEW

## Governing Well

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| J01 | Monitor Governance Risk Rating | 4 | 4 | N/A | Green: < 4<br>Red: > = 4 | ➡ | Previous shows the Q2 declared poisition. Current shows the position in quarter 3 to date. Please note that Monitor is still to confirm the Trust's official rating for quarter 2. |

## Delivering Our Contracts

The Previous column represents Month 8. Current (and YTD) represents Month 9 2014/15.

| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| K01 | Financial Performance Against CQUINs (£millions) | £7.06 | £7.55 | £7.55 | > 50% Green<br>< 50% Red | ⬆ | This is Potential year-end rewards and reflects assessment of performance as at November (72%). |
| K02 | Contract Penalties Incurred - Variance From Plan (£millions) | £0.73 | £0.71 | £0.71 | Green: Below Plan<br>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 December 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

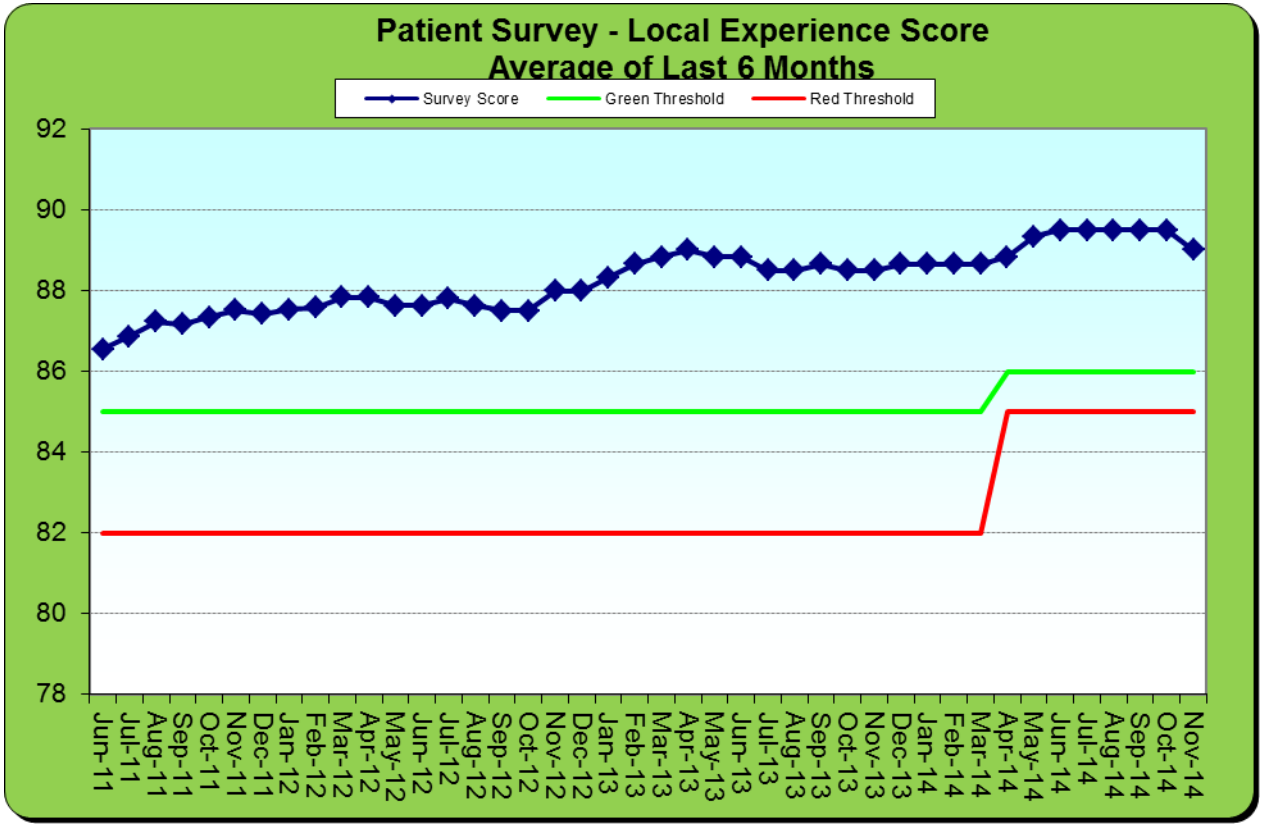
| ID | Indicator | Previous | Current | YTD | Thresholds | Change from previous | Notes |
|---|---|---|---|---|---|---|---|
| L01 | Monitor Continuity of Service | 4.0 | 4.0 | 4.0 | Green: >=3.0<br>Red: <2.5 | ➡ | For financial measures except CRES, Current and YTD is Current Year To Date. For Savings 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<br>Red: <2.5 | ➡ | |
| L03 | Capital Service Capacity | 4.0 | 4.0 | 4.0 | Green: >=3.0<br>Red: <2.5 | ➡ | |
| L04 | Savings plan achievement | 85% | 71% | 77% | Green: >=90%<br>Red: < 75% | ⬇ | |

## Notes

Unless otherwise stated, Previous is November 2014 and Current is December 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
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
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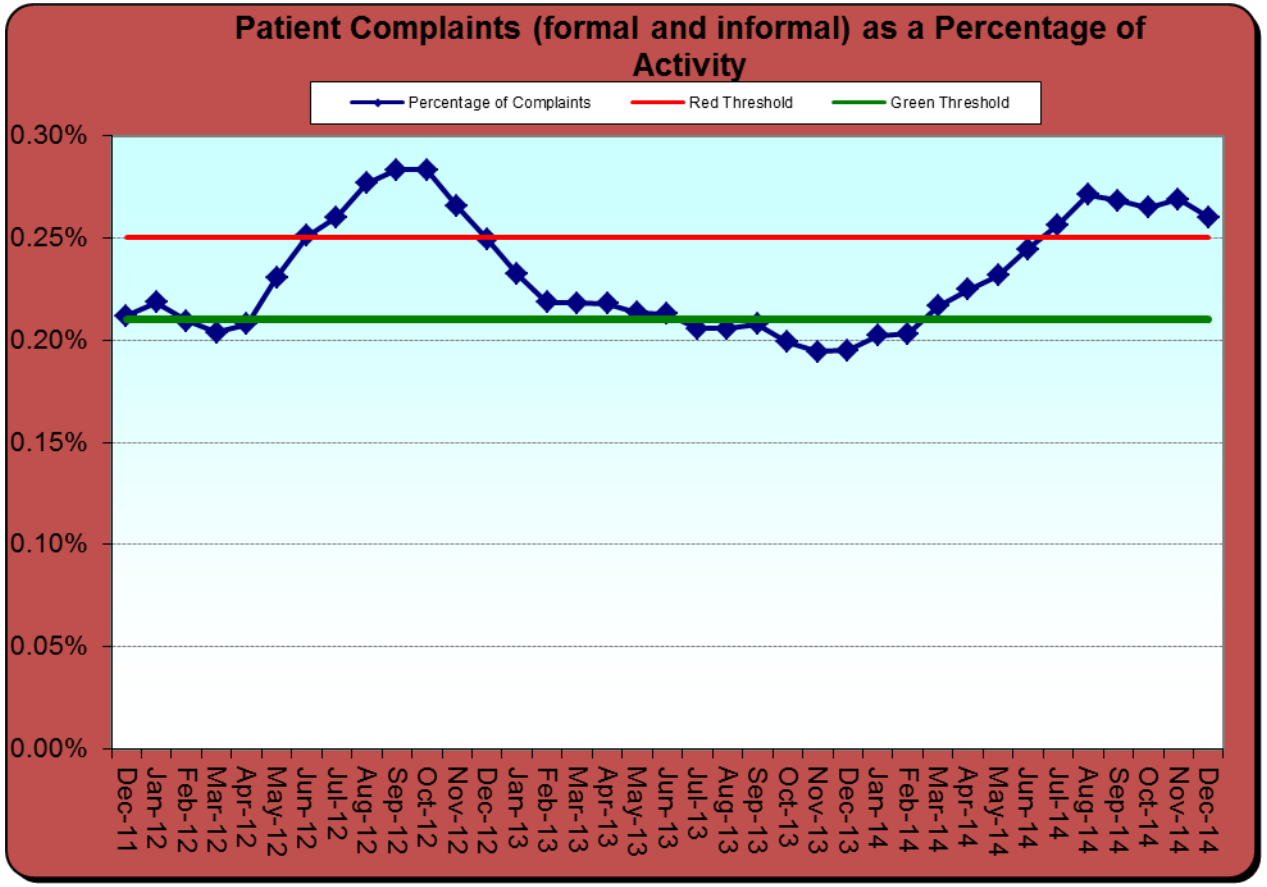
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14


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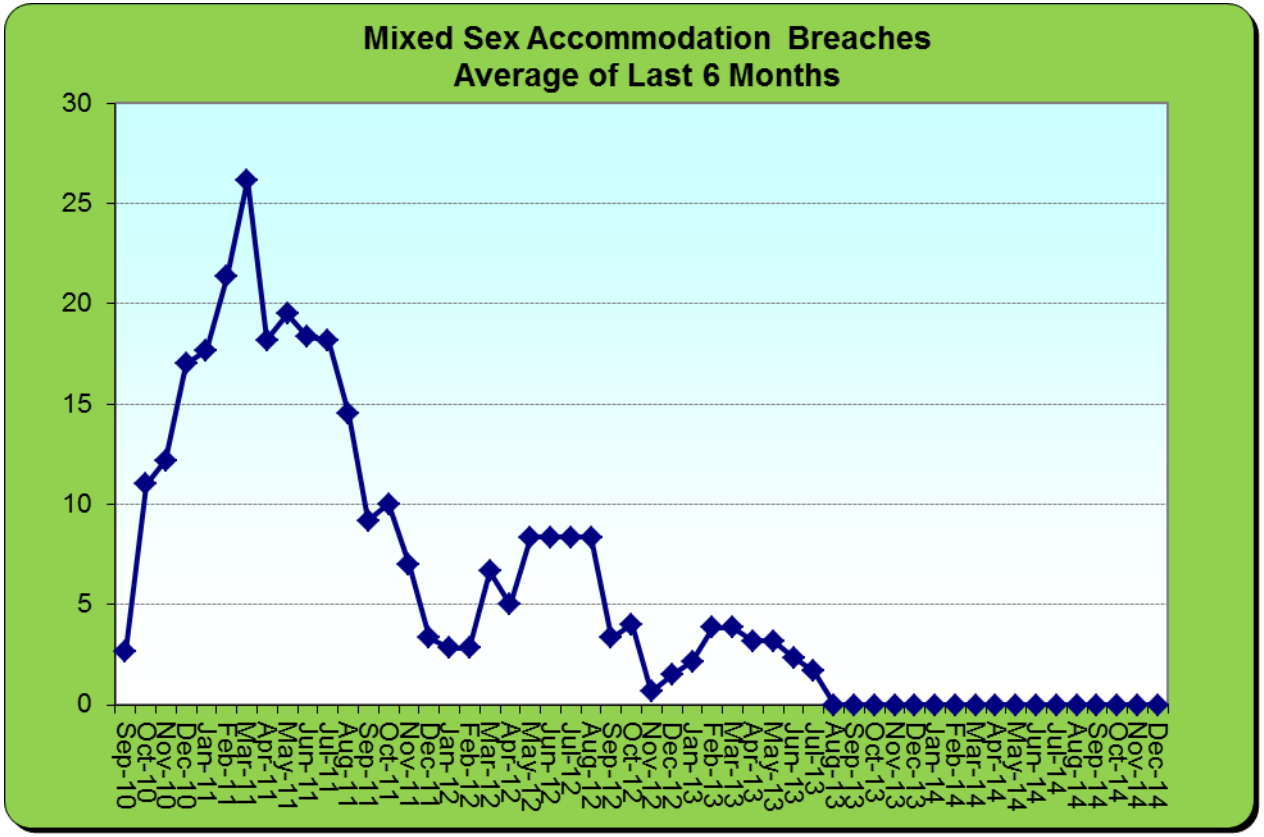
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14


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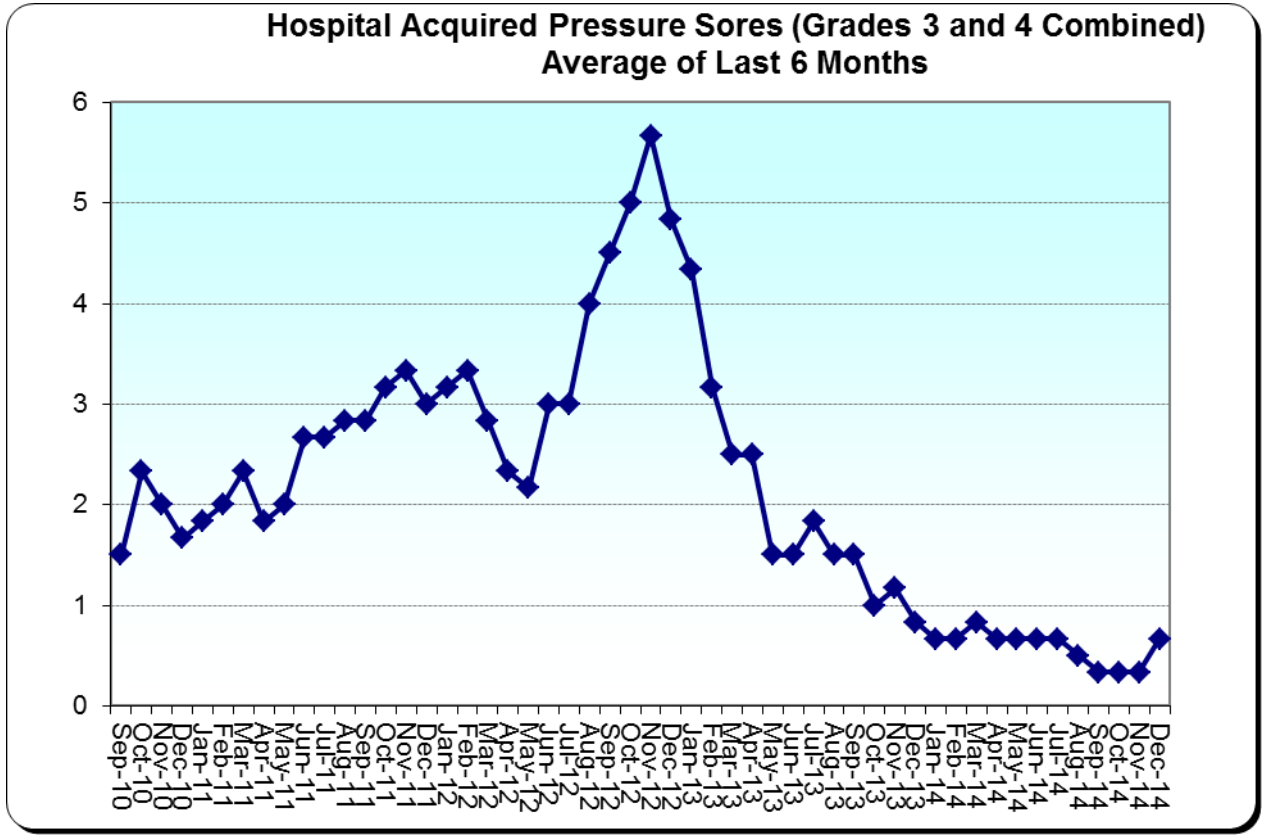
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14


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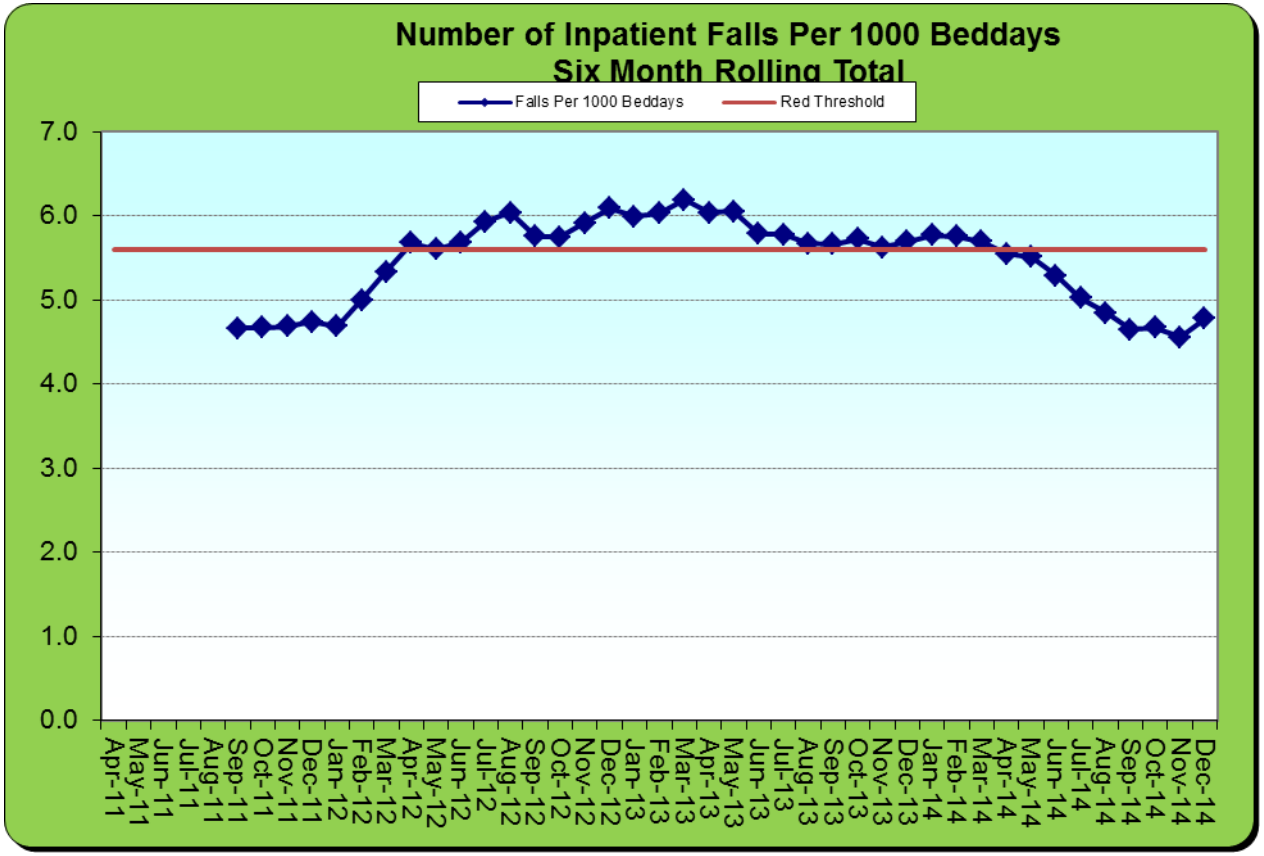
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14


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
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Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
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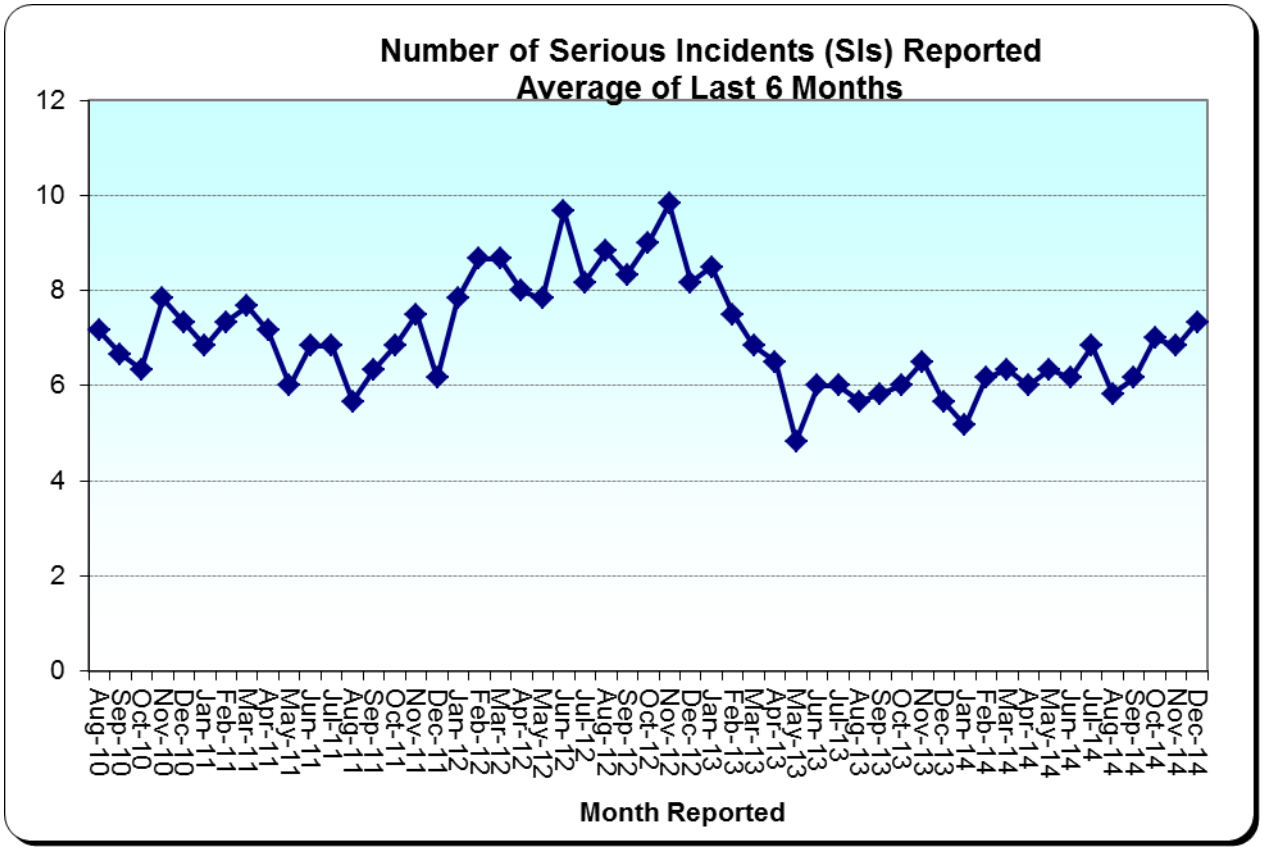
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14


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-13
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
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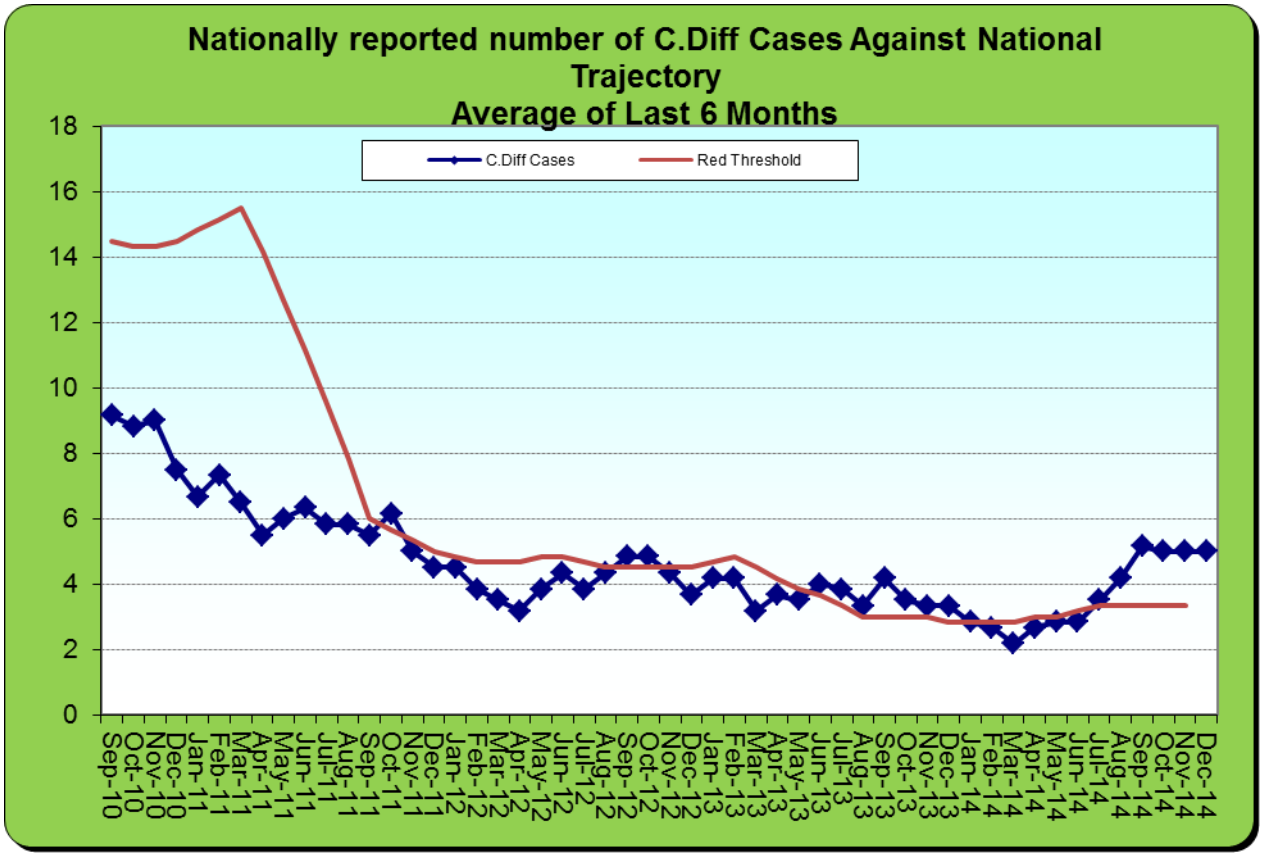
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Month Reported


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
Nov-13
Dec-13
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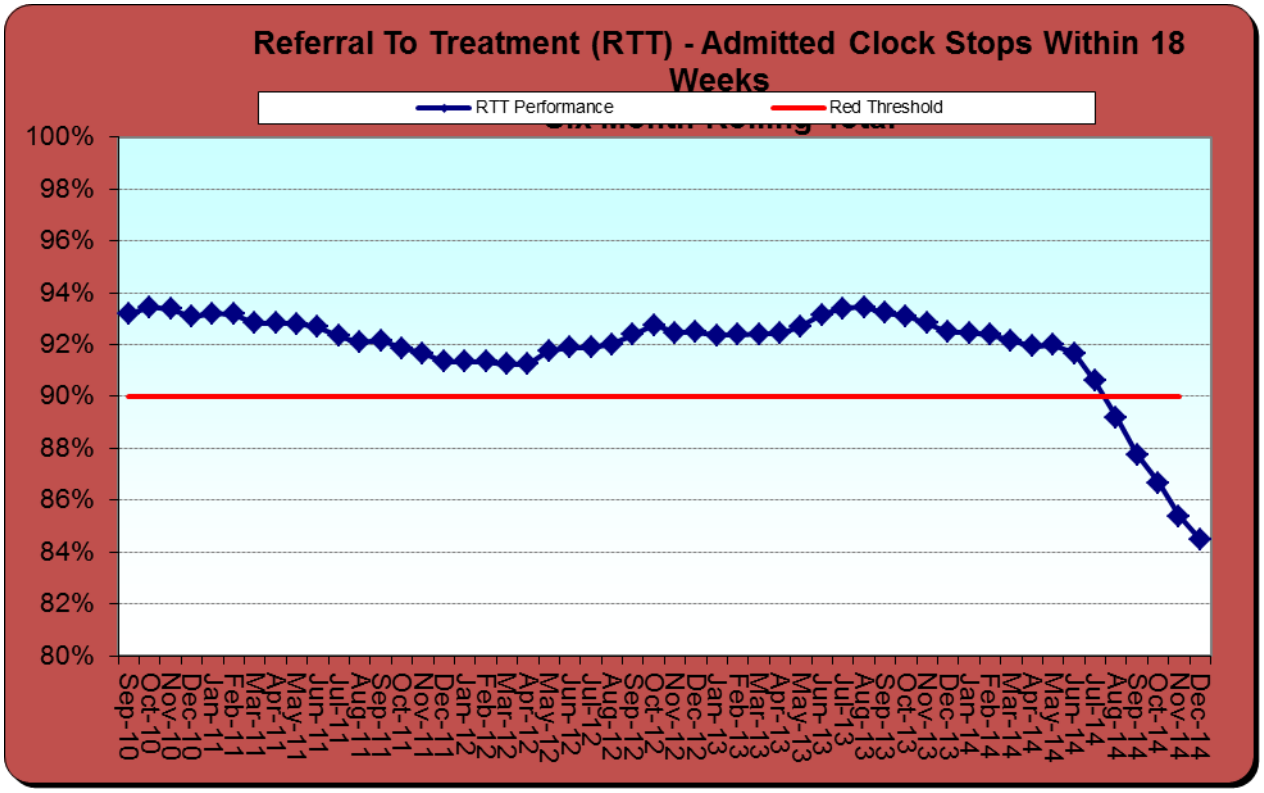
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14


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
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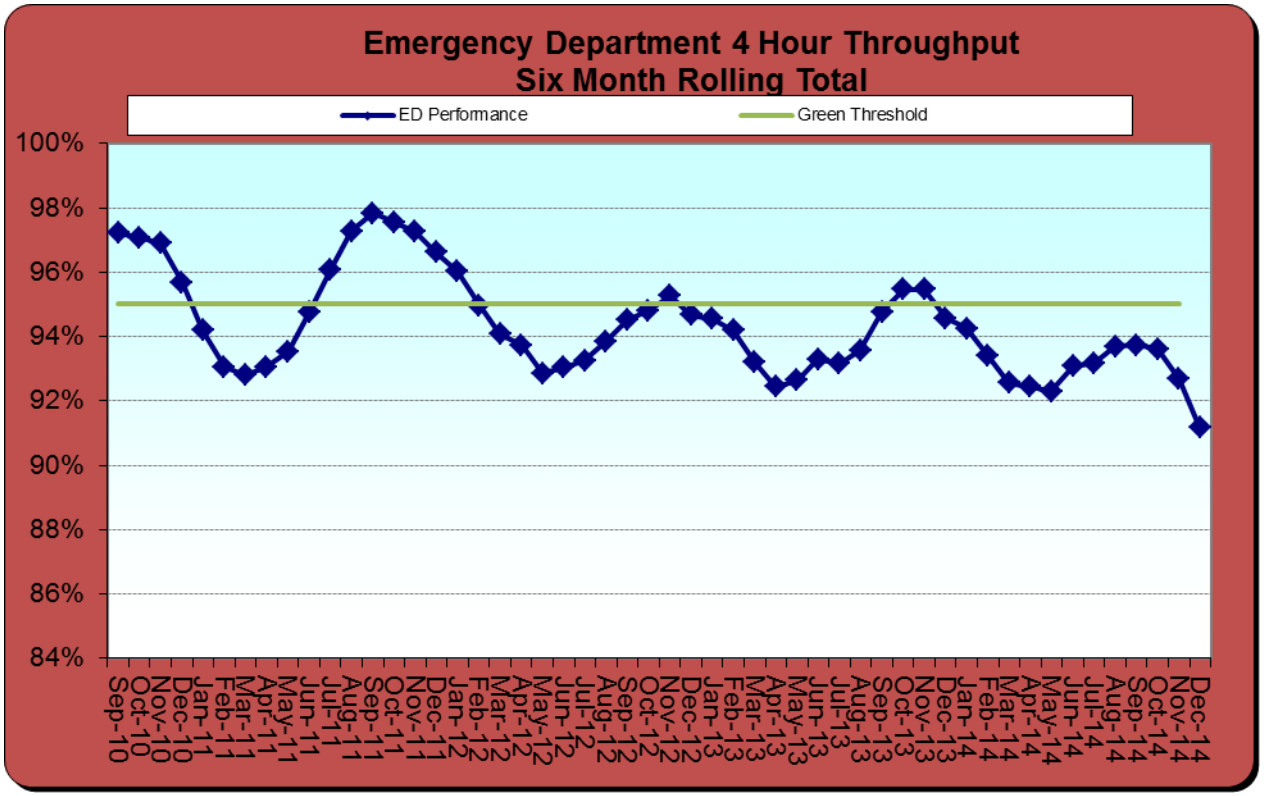
Oct-14
Nov-14
Dec-14


Emergency Department 4 Hour Throughput
Six Month Rolling Total
ED Performance
Green Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
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Nov-12
Dec-12
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Aug-13
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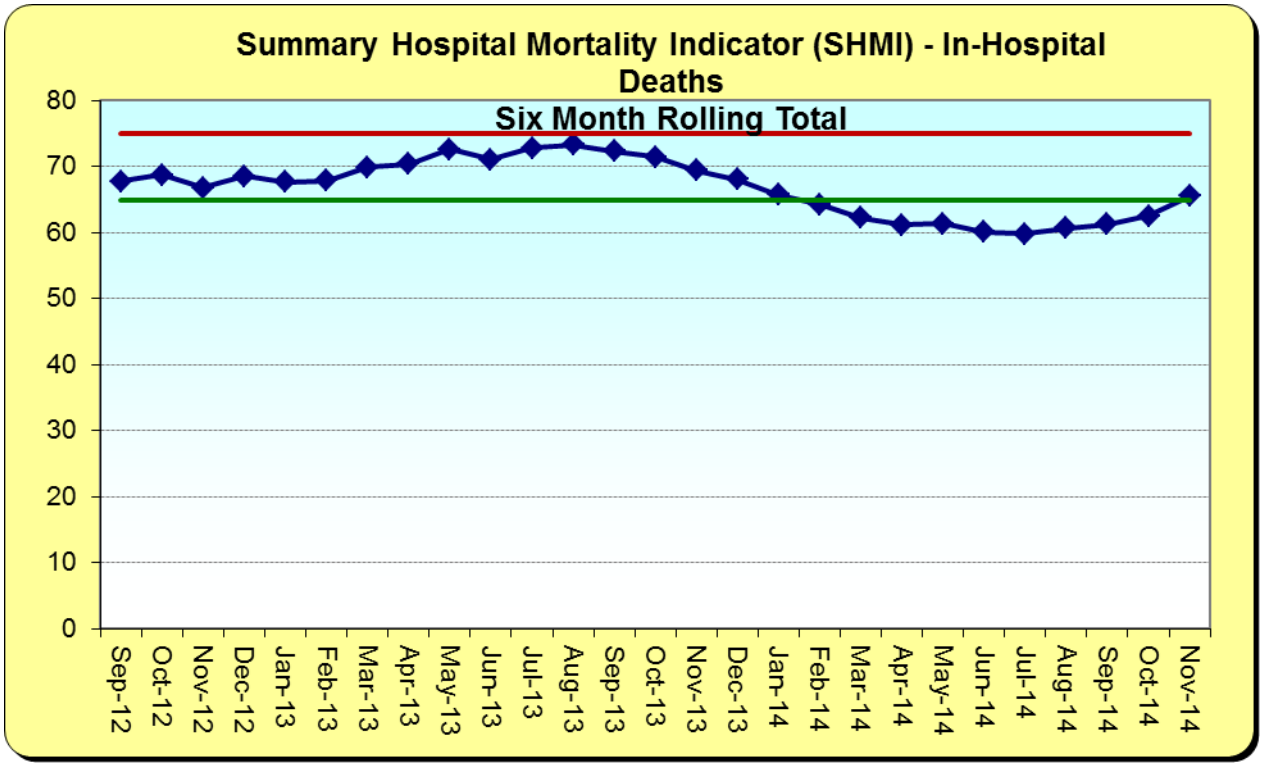
Nov-14
Dec-14


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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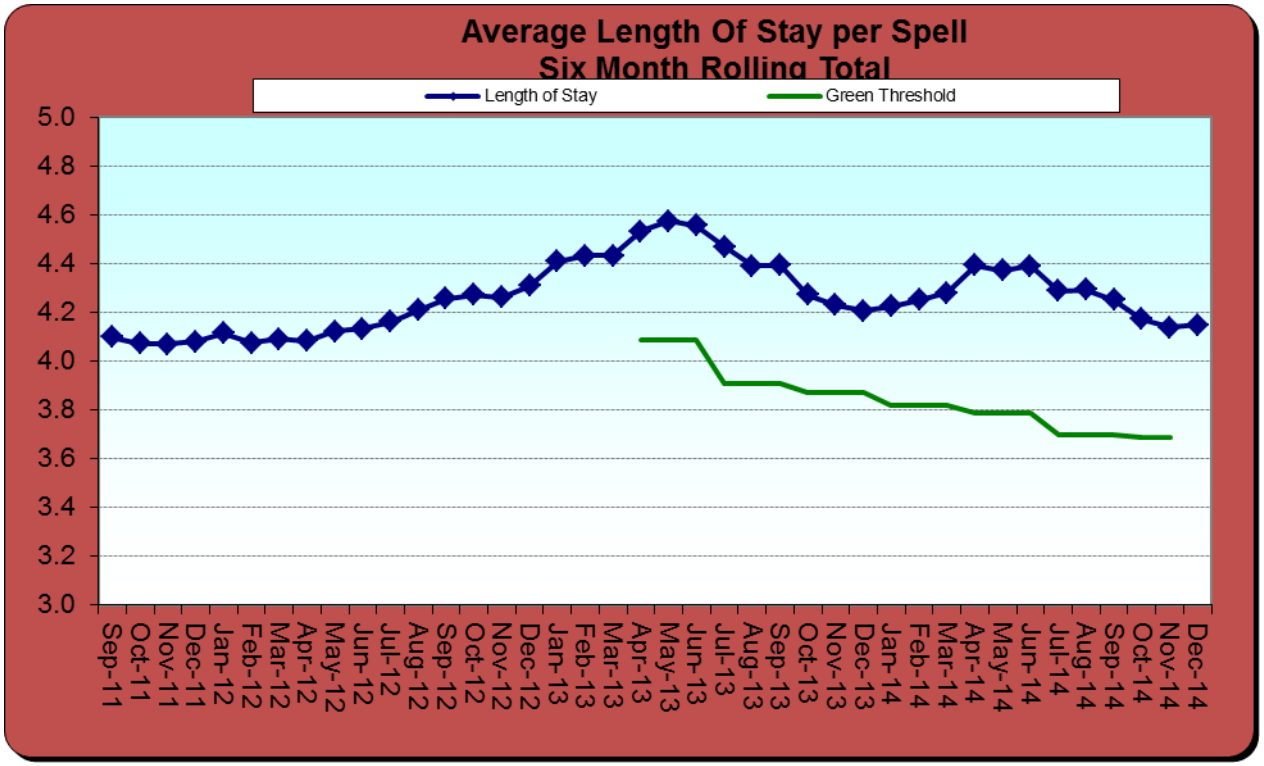
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14


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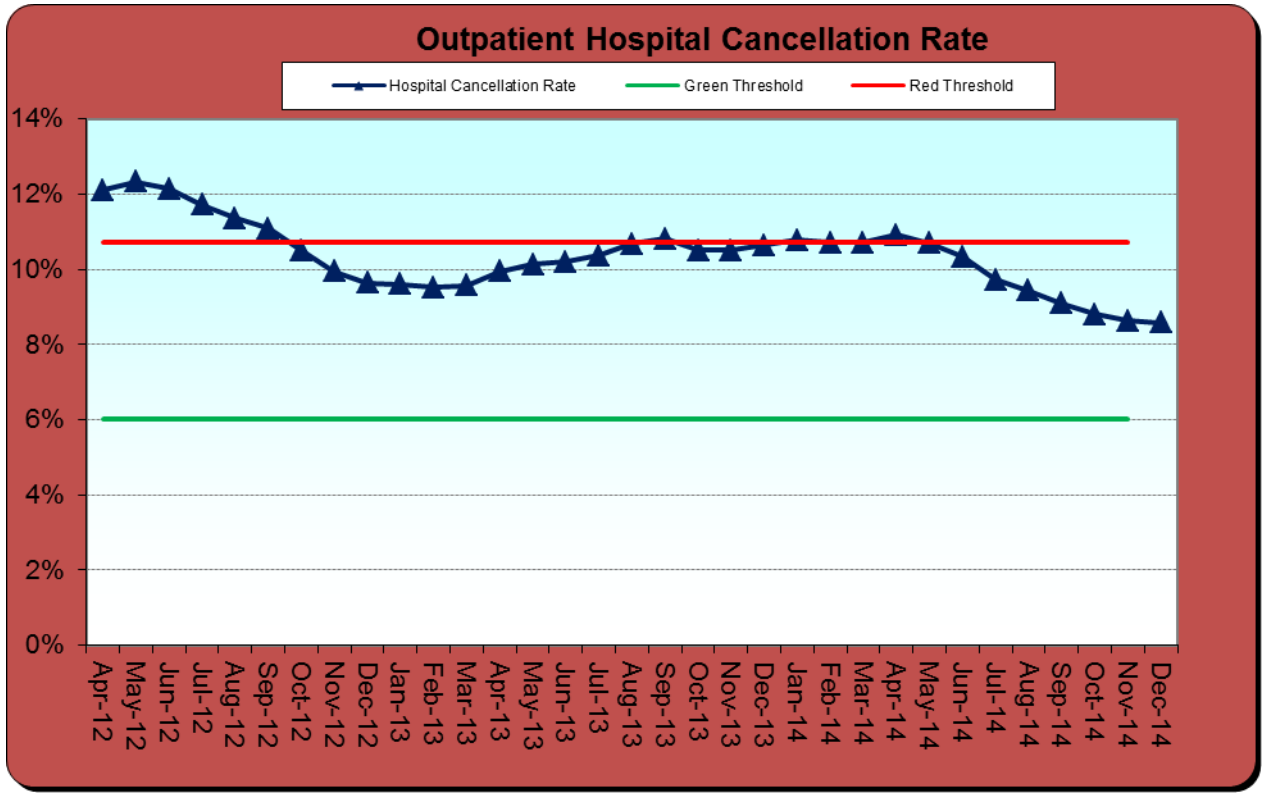
Nov-14
Dec-14


Outpatient Hospital Cancellation Rate
Hospital Cancellation Rate
Green Threshold
Red Threshold
14%
12%
10%
8%
6%
4%
2%
0%
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
Oct-14
Nov-14
Dec-14

**Organisational Health Barometer – exceptions summary table**

| Indicator in exception | Exception Report | Additional information |
|---|---|---|
| Hospital acquired pressure ulcers (grade 3 or 4) | In *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 | |
| Summary Hospital Mortality Indicator (SHMI) | In *Quality* section of this report | |
| Overall Length of Stay | See A&E 4-hour Exception Report in the *Access* section of this report. | |
| Theatre productivity | See Additional Information | Overall theatre utilisation was lower than in October. This was mainly due to high levels of theatre staff sickness in the month, mainly at the Children's Hospital. |
| 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* | |
| Savings plan achievement | See separate *Finance Report* | |

## SECTION C – Monitor Risk Assessment Framework

During Quarter 3 the Trust did not meet six of the standards in Monitor's 2014/15 Risk Assessment Framework. Exception reports are provided for five of these six 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 and 62-day Screening Cancer standards (1.0 combined standard) – *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.

The 31-day Diagnosis to First Definitive Treatment Cancer Standard was below the national standard in October and November, but was achieved in December. It is expected that final reporting will confirm achievement of the 96% national standard for the quarter as a whole. An exception report is, however, provided.

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. Monitor has requested further information following multiple breaches of the A&E, Referral to Treatment and cancer waiting time targets, before deciding next steps.

*Please see the Monitor dashboard on the following page, for details of reported position for quarter 3 2014/15.*

# PERFORMANCE OVERVIEW

## Monitor's Risk Assessment Framework - dashboard

| | Number | Target | Weighting | Target threshold | Reported Year To Date | Risk Assessment Framework: Q3 13/14 | Q4 13/14 | Q1 14/15 | Q2 14/15 | Q3 14/15* | Q3 Actual* | Notes | Q3 Draft Risk Rating Risk rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Monitor Risk Assessment Framework | 1 | Infection Control - C.Diff Infections Against Trajectory | 1.0 | < or = trajectory | 6 | ✖ | ✖ | ✓ | ✓ | 6 | ✓ | 6 potentially avoidable cases year to date, against a limit of 30. | Achieved |
| | 2a | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) | 1.0 | 98% | 99.8% | ✓ | ✓ | ✓ | ✓ | 99.6% | ✓ | | Achieved |
| | 2b | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | | 94% | 94.7% | ✓ | ✓ | ✓ | ✓ | 94.7% | ✓ | | |
| | 2c | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) | | 94% | 97.8% | ✓ | ✓ | ✓ | ✓ | 98.3% | ✓ | | |
| | 3a | Cancer 62 Day Referral To Treatment (Urgent GP Referral) | 1.0 | 85% | 79.0% | ✓ | ✖ | ✖ | ✖ | 80.6% | ✖ | | Not achieved |
| | 3b | Cancer 62 Day Referral To Treatment (Screenings) | | 90% | 89.9% | ✓ | ✓ | ✓ | ✓ | 81.8% | ✖ | | |
| | 4 | Referral to treatment time for admitted patients < 18 weeks | 1.0 | 90% | 86.6% | Achieved each month | Achieved each month | Achieved each month | Not achieved | 84.3% | ✖ | Planned failure, as requested by NHS England in Oct/Nov. | Not achieved |
| | 5 | Referral to treatment time for non-admitted patients < 18 weeks | 1.0 | 95% | 90.7% | Not achieved | Not achieved | Not achieved | Not achieved | 89.3% | ✖ | | Not achieved |
| | 6 | Referral to treatment time for incomplete pathways < 18 weeks | 1.0 | 92% | 90.7% | Achieved each month | Achieved each month | Achieved each month | Not achieved | 88.5% | ✖ | 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% | 96.3% | ✓ | ✓ | ✓ | ✓ | 96.1% | ✓ | Achieved subject to final reporting (draft figures 95.9%) | Achieved |
| | 8a | Cancer - Urgent Referrals Seen In Under 2 Weeks | 1.0 | 93% | 95.7% | ✓ | ✓ | ✓ | ✓ | 96.1% | ✓ | | Achieved |
| | 8b | Cancer - Symptomatic Breast in Under 2 Weeks | | 93% | Not applicable | Not applicable | Not applicable | Not applicable | Not applicable | Not applicable | Not applicable | | |
| | 9 | A&E Total time in A&E 4 hours | 1.0 | 95% | 92.3% | ✖ | ✖ | ✖ | ✖ | 89.6% | ✖ | | 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 | Actions implemented | Not applicable | Not applicable | Not applicable | Not applicable | Not applicable | | Achieved |
| | | | | | Risk Rating | GREEN | GREEN | GREEN | Triggers further investigation | 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.

***Q3 Cancer figures based upon reported figures for October and November, and draft figures for December. The C diff figures are for April to December.**

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

# 1.1 QUALITY TRACKER

## TRUST LEVEL QUALITY SCORECARD

| Topic | ID | Title | Annual Target Green | Annual Target Red | Annual 13/14 | Annual 14/15 YTD | Monthly Totals Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Quarterly Totals 13/14 Q4 | 14/15 Q1 | 14/15 Q2 | 14/15 Q3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Safety** | | | | | | | | | | | | | | | | | | | | | | |
| Infections | DA01a | MRSA Bloodstream Cases - Cumulative Totals | 0 | 1 | 2 | 4 | 1 | 2 | 2 | 1 | 1 | 2 | 3 | 3 | 3 | 3 | 3 | 4 | 2 | 2 | 3 | 4 |
| | DA03 | C.Diff Cases - Monthly Totals | - | - | 38 | 43 | 0 | 2 | 2 | 5 | 4 | 4 | 4 | 6 | 8 | 4 | 4 | 4 | 4 | 13 | 18 | 12 |
| | DA03c | C.Diff Avoidable Cases - Cumulative Totals | 40 | 40 | - | 6 | - | - | - | 0 | 1 | 1 | 2 | 3 | 5 | 6 | 6 | 6 | - | 1 | 5 | 6 |
| | DA02 | MSSA Cases - Monthly Totals | 25 | 25 | 27 | 24 | 1 | 2 | 2 | 1 | 0 | 3 | 7 | 1 | 4 | 1 | 3 | 4 | 5 | 4 | 12 | 8 |
| MRSA Screenings | DD01 | MRSA Pre-Op Elective Screenings | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99.6% | 100% | 100% | 100% | 99.9% |
| | DD02 | MRSA Emergency Screenings | 95% | 80% | 94.8% | 91.9% | 95% | 95.2% | 95.3% | 96% | 95.5% | 94.9% | 94.3% | 95.3% | 90.6% | 89.3% | 87.9% | 87.1% | 95.2% | 95.4% | 93.3% | 88.1% |
| Infection Checklists | DB01 | Hand Hygiene Audit Compliance | 95% | 80% | 96.8% | 97.1% | 98.3% | 98.3% | 97.2% | 97.6% | 96.9% | 97.8% | 96.8% | 96.9% | 97.1% | 96.3% | 97.2% | 97.6% | 97.8% | 97.4% | 97% | 97% |
| | DB02 | Antibiotic Compliance | 90% | 80% | 88% | 89.3% | 88.6% | 90.1% | 90.7% | 91.8% | 88.2% | 87.9% | 89.6% | 86.2% | 88.5% | 90.3% | 91.2% | 89.1% | 89.9% | 89.4% | 88.2% | 90.3% |
| Cleanliness Monitoring | DC01 | Cleanliness Monitoring - Overall Score | 87% | 79% | 95% | 95% | 94% | 94% | 96% | 96% | 95% | 96% | 93% | 96% | 96% | 95% | 95% | 94% | 95% | 96% | 95% | 95% |
| | DC02 | Cleanliness Monitoring - Very High Risk Areas | 98% | 89% | 96% | 96% | 95% | 96% | 96% | 95% | 97% | 95% | 96% | 97% | 97% | 97% | 98% | 98% | 96% | 96% | 97% | 97% |
| | DC03 | Cleanliness Monitoring - High Risk Areas | 95% | 79% | 95% | 95% | 95% | 95% | 96% | 96% | 96% | 96% | 91% | 96% | 95% | 95% | 96% | 95% | 95% | 96% | 94% | 95% |
| Serious Incidents | S02 | Number of Serious Incidents Reported | - | - | 73 | 61 | 6 | 9 | 5 | 5 | 7 | 5 | 10 | 3 | 7 | 10 | 6 | 8 | 20 | 17 | 20 | 24 |
| | S02a | Number of Confirmed Serious Incidents | - | - | 71 | 38 | 6 | 9 | 5 | 5 | 7 | 5 | 8 | 3 | 5 | 5 | - | - | 20 | 17 | 16 | 5 |
| | S02b | Number of Serious Incidents Still Open | - | - | - | 20 | - | - | - | - | - | - | - | - | 1 | 5 | 6 | 8 | - | - | 1 | 19 |
| | S03 | Serious Incidents Reported Within 48 Hours | 80% | 80% | 83.6% | 86.9% | 100% | 88.9% | 100% | 80% | 57.1% | 80% | 100% | 100% | 100% | 80% | 83.3% | 100% | 95% | 70.6% | 100% | 87.5% |
| | S04 | Percentage of Serious Incident Investigations Completed Within Timesca | 80% | 80% | 92.4% | 72.2% | 87.5% | 75% | 100% | 100% | 50% | 83.3% | 70% | 85.7% | 100% | 50% | 66.7% | 37.5% | 89.5% | 82.4% | 81.8% | 46.7% |
| Never Events | S01 | Total Never Events | 0 | 1 | 2 | 4 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 1 |
| Patient Safety Incidents | S06 | Number of Patient Safety Incidents Reported | - | - | 12090 | 8476 | 1060 | 954 | 986 | 933 | 954 | 1010 | 1104 | 1038 | 1258 | 1151 | 1028 | - | 3000 | 2897 | 3400 | 2179 |
| | S06a | Patient Safety Incidents Per 100 Admissions | - | - | 9.24 | 9.36 | 9.43 | 9.27 | 9 | 8.71 | 8.56 | 9.07 | 9.14 | 9.52 | 10.48 | 9.84 | 9.45 | - | 9.23 | 8.78 | 9.72 | 9.65 |
| | S07 | Number of Patient Safety Incidents - Severe Harm | - | - | 44 | 58 | 3 | 7 | 6 | 4 | 6 | 8 | 5 | 4 | 16 | 3 | 12 | - | 16 | 18 | 25 | 15 |
| Patient Falls | AB01 | Falls Per 1,000 Beddays | 5.6 | 5.6 | 5.68 | 4.8 | 6.1 | 5.67 | 5.46 | 5.08 | 5.18 | 4.28 | 4.51 | 4.59 | 4.26 | 5.23 | 4.5 | 5.59 | 5.74 | 4.85 | 4.45 | 5.11 |
| | AB06a | Total Number of Patient Falls Resulting in Harm | 24 | 25 | 27 | 23 | 2 | 4 | 2 | 1 | 5 | 2 | 0 | 3 | 5 | 2 | 4 | 1 | 8 | 8 | 8 | 7 |
| Falls (CQUIN Improvement) | AB07a | Number of Inpatient Falls (CQUIN) | 429 | 429 | 0 | 1106 | 0 | 0 | 0 | 129 | 136 | 109 | 116 | 116 | 108 | 134 | 114 | 144 | 0 | 374 | 340 | 392 |
| | AB07b | Inpatient Falls (CQUIN) - Improvement from Baseline | 0 | 0 | 0 | -231 | 0 | 0 | 0 | -12 | -8 | -35 | -44 | -33 | -43 | -22 | -26 | -8 | 0 | -55 | -120 | -56 |
| Pressure Ulcers Developed in the Trust | DE01 | Pressure Ulcers Per 1,000 Beddays | 0.651 | 0.651 | 0.656 | 0.395 | 0.69 | 0.417 | 0.417 | 0.433 | 0.343 | 0.314 | 0.427 | 0.396 | 0.394 | 0.312 | 0.553 | 0.388 | 0.51 | 0.363 | 0.406 | 0.417 |
| | DE02 | Pressure Ulcers - Grade 2 | - | - | 184 | 86 | 17 | 9 | 10 | 11 | 8 | 8 | 10 | 10 | 10 | 8 | 13 | 8 | 36 | 27 | 30 | 29 |
| | DE03 | Pressure Ulcers - Grade 3 | 0 | 1 | 13 | 5 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 2 | 3 | 1 | 1 | 3 |
| | 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% | 98.7% | 98.6% | 98.7% | 98.5% | 98.9% | 98.7% | 98.1% | 98.4% | 98.6% | 98.9% | 98.7% | 99% | 99% | 98.6% | 98.6% | 98.7% | 98.9% |
| | N02 | Percentage of Adult Inpatients who Received Thrombo-prophylaxis | 95% | 90% | 93.4% | 94.6% | 94.9% | 96.6% | 94.5% | 96.4% | 94.3% | 94% | 95.3% | 96.6% | 93.2% | 92.6% | 92.3% | 96.7% | 95.3% | 94.9% | 95.1% | 93.8% |
| Nutrition | WB05 | Nutrition: Screening Tool Completed | 90% | 90% | - | 93.5% | - | - | - | - | - | - | 92.8% | 91.8% | 94.2% | 93.4% | 95.1% | 93.7% | - | - | 92.9% | 94.1% |
| | WB03 | Nutrition: Food Chart Review | 90% | 85% | 82.5% | 89.3% | 91.2% | 91.8% | 78.2% | 94.7% | 87.4% | 87.7% | 89% | 89.3% | 93.1% | 88.3% | 87.2% | 87.8% | 87.7% | 89.5% | 90.4% | 87.8% |
| Safety | Y01 | WHO Surgical Checklist Compliance | 100% | 99.5% | 99.6% | 99.6% | 99.9% | 99.6% | 99.6% | 99.7% | 99.6% | 99.4% | 99.5% | 99.7% | 99.6% | 99.7% | 99.6% | 99.4% | 99.7% | 99.6% | 99.6% | 99.6% |

# QUALITY

| Topic | ID | Title | Annual Target Green | Annual Target Red | Annual 13/14 | Annual 14/15 YTD | Monthly Totals Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Quarterly Totals 13/14 Q4 | 14/15 Q1 | 14/15 Q2 | 14/15 Q3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Safety** | | | | | | | | | | | | | | | | | | | | | | |
| Medicines | WA01 | Medication Errors Resulting in Harm | 1.61% | 2% | 0.68% | 0.59% | 1% | 0.54% | 0% | 1.3% | 0% | 0.78% | 1.09% | 0.52% | 0.56% | 0% | 0.57% | - | 0.52% | 0.66% | 0.72% | 0.28% |
| | WA10a | Medication Reconciliation Within 1 Day (Assessment and BHI Wards) | 95% | 95% | 98% | 97.6% | 99.3% | 99.2% | 100% | 98.8% | 100% | 96.5% | 93.3% | 97.4% | 97.6% | 98.6% | 97.8% | 98.3% | 99.5% | 98.4% | 96% | 98.3% |
| | WA10b | Medication Reconciliation Within 1 Day (BHOC and Gynae Wards) | 85% | 75% | 92% | 95.2% | 85% | 100% | 100% | 98.8% | 99.1% | 90.9% | 86.4% | 94.7% | 98.8% | 98.3% | 98.3% | 93.8% | 94.1% | 96.1% | 92.6% | 96.9% |
| | WA03 | Non-Purposeful Omitted Doses of the Listed Critical Medication | 1.5% | 2% | 1.91% | 0.92% | 1.08% | 0.91% | 1.66% | 1.18% | 0.55% | 0.38% | 1.41% | 1.42% | 0.69% | 1.21% | 0.86% | 0.37% | 1.23% | 0.68% | 1.19% | 0.84% |
| Safety Thermometer | AK03 | Safety Thermometer - Harm Free Care | 95.6% | 92.8% | 94.1% | 96.5% | 95.6% | 96.2% | 95.2% | 95.7% | 96.7% | 96% | 96.7% | 96.9% | 96.5% | 96.1% | 96.7% | 97% | 95.7% | 96.1% | 96.7% | 96.6% |
| | AK04 | Safety Thermometer - No New Harms | 98.2% | 97% | 97.2% | 98.3% | 98.5% | 97.8% | 97.6% | 98.2% | 98.4% | 98.5% | 98.9% | 98.7% | 98% | 97.9% | 97.8% | 98.5% | 98% | 98.3% | 98.5% | 98.1% |
| Deteriorating Patient | AR03 | Early Warning Scores (EWS) Acted Upon | 95% | 90% | 84% | 88% | 91% | 86% | 88% | 89% | 83% | 91% | 91% | 96% | 88% | 88% | 86% | 83% | 89% | 88% | 92% | 86% |
| | CA01 | Number of Verified Crash Calls from Adult General Wards | 92 | 108 | - | 36 | - | - | - | 3 | 5 | 5 | 4 | 9 | 3 | 2 | 2 | 3 | - | 13 | 16 | 7 |
| Discharges | TD04 | Out of Hours Discharges | | | 9% | 8.2% | 8.1% | 10% | 9.8% | 9.5% | 9% | 8.2% | 8.6% | 7.6% | 8.1% | 7.7% | 7.3% | 7.6% | 9.3% | 8.9% | 8.1% | 7.5% |
| CAS Alerts | CS01 | CAS Alerts Completed Within Timescale | 90% | 80% | - | 96.7% | - | - | - | - | - | - | - | 90% | 100% | 85.7% | 100% | 100% | - | - | 96.4% | 97% |
| | CS03 | Number of CAS Alerts Overdue At Month End | 0 | 0 | - | 0 | - | - | - | - | - | - | - | 0 | 0 | 0 | 0 | 0 | - | - | 0 | 0 |
| **Clinical Effectiveness** | | | | | | | | | | | | | | | | | | | | | | |
| Mortality | X05 | Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital D | 65 | 75 | 67.2 | 64.6 | 57.5 | 60.5 | 60.6 | 59.2 | 64.9 | 57.3 | 56.2 | 65.9 | 64.1 | 66 | 86.9 | - | 59.5 | 60.6 | 62 | 75.2 |
| | X04 | Summary Hospital Mortality Indicator (SHMI) - National Data | - | - | 95.2 | - | - | - | 96.1 | - | - | - | - | - | - | - | - | - | 96.1 | - | - | - |
| | X06 | Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline | 80 | 90 | 75.8 | 70.5 | 66.2 | 75.2 | 73.2 | 67.6 | 66.1 | 63.2 | 58.1 | 74.7 | 73.9 | 69.4 | 94.7 | - | 71.3 | 65.6 | 68.9 | 80.8 |
| Learning Disability | AA03 | Learning Disability (Adults) - Percentage Adjustments Made | 80% | 50% | 83.9% | 90% | 95% | 90.5% | 92.3% | 100% | 78.9% | 100% | 76.2% | 82.4% | 91.3% | 90.5% | 85% | 100% | 92.6% | 93.8% | 83.6% | 92.3% |
| Readmissions | C01 | Emergency Readmissions Percentage | 2.7% | 2.7% | 2.71% | 2.42% | 2.89% | 2.93% | 2.86% | 2.71% | 2.92% | 2.96% | 2.48% | 2.8% | 1.59% | 2.54% | 1.38% | - | 2.89% | 2.87% | 2.28% | 1.98% |
| Maternity | G04 | Percentage of Normal Births | 64% | 61% | 61.7% | 62.2% | 59.9% | 62.6% | 61.4% | 63.6% | 58.9% | 62.4% | 64.7% | 61.4% | 63.8% | 58.9% | 65.5% | 59.6% | 61.3% | 61.7% | 63.4% | 61.3% |
| Fracture Neck of Femur | U02 | Fracture Neck of Femur Patients Treated Within 36 Hours | 90% | 90% | 77.4% | 74.3% | 55.9% | 92.6% | 85.7% | 88.9% | 70% | 82.6% | 82.1% | 71.4% | 61.3% | 77.8% | 73.3% | 70% | 76.4% | 78.9% | 71.3% | 73.6% |
| | U03 | Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours | 90% | 90% | 78.8% | 93.9% | 97.1% | 100% | 100% | 94.4% | 93.3% | 95.7% | 100% | 96.4% | 93.5% | 88.9% | 86.7% | 93.3% | 98.9% | 94.4% | 96.6% | 90.3% |
| | U04 | Fracture Neck of Femur Patients Achieving Best Practice Tariff | 90% | 80% | 61.7% | 69.6% | 52.9% | 92.6% | 85.7% | 83.3% | 66.7% | 78.3% | 82.1% | 67.9% | 54.8% | 70.4% | 60% | 66.7% | 75.3% | 74.6% | 67.8% | 66.7% |
| Stroke Care | O01 | Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour | 50% | 50% | 55.1% | 53.6% | 62.2% | 56.8% | 63.9% | 52.3% | 53.6% | 36.8% | 48.6% | 53.7% | 61.1% | 62.8% | 59% | - | 60.8% | 47.3% | 54.4% | 61% |
| | O02 | Stroke Care: Percentage Spending 90%+ Time On Stroke Unit | 90% | 80% | 84.2% | 87.9% | 86.7% | 79.5% | 86.1% | 90.9% | 96.4% | 81.6% | 97.3% | 78% | 86.1% | 88.6% | 87.2% | - | 84% | 89.1% | 86.8% | 88% |
| | O03 | High Risk TIA Patients Starting Treatment Within 24 Hours | 60% | 60% | 55.8% | 59.8% | 50% | 45.5% | 50% | 60% | 30% | 57.1% | 25% | 72.2% | 66.7% | 58.8% | 73.3% | 64.7% | 48.8% | 48.3% | 61.4% | 65.3% |
| Dementia | AC01 | Dementia - Find, Assess, Investigate and Refer Q1 | 90% | 80% | 67.7% | 60.5% | 46.6% | 45.3% | 46.9% | 57.1% | 52.3% | 49% | 62.1% | 67.5% | 66.6% | 61.4% | 63.7% | 62.9% | 46.3% | 52.6% | 65.4% | 62.6% |
| | AC02 | Dementia - Find, Assess, Investigate and Refer Q2 | 90% | 80% | 60.6% | 81.4% | 75.5% | 78% | 66.7% | 71.7% | 78.3% | 59.5% | 84.7% | 81.7% | 87.3% | 87.1% | 92.2% | 82.2% | 73% | 70.3% | 84.7% | 86.3% |
| | AC03 | Dementia - Find, Assess, Investigate and Refer Q3 | 90% | 80% | 65.4% | 53.8% | 57.9% | 38.5% | 52.4% | 47.6% | 56.5% | 22.7% | 55.2% | 50% | 35.9% | 78.3% | 73.3% | 68% | 48.5% | 42.4% | 44.8% | 74.3% |
| | AC04 | Percentage of Dementia Carers Feeling Supported | | | - | 73.8% | - | - | - | 60% | 62.5% | 90% | - | - | 70% | 80% | 88.9% | - | - | 69.7% | 57.1% | 84.8% |
| Outliers | J05 | Ward Outliers - Beddays | 9029 | 9029 | 10626 | 8116 | 1277 | 1169 | 962 | 697 | 951 | 769 | 659 | 749 | 908 | 1338 | 876 | 1169 | 3408 | 2417 | 2316 | 3383 |

# QUALITY

| Topic | ID | Title | Annual Target Green | Annual Target Red | Annual 13/14 | Annual 14/15 YTD | Monthly Totals Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Quarterly Totals 13/14 Q4 | 14/15 Q1 | 14/15 Q2 | 14/15 Q3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Experience** | | | | | | | | | | | | | | | | | | | | | | |
| Monthly Patient Surveys | P01d | Patient Survey - Patient Experience Tracker Score | - | - | - | - | 88 | 89 | 89 | 89 | 92 | 90 | 88 | 89 | 89 | 89 | 89 | - | 89 | 90 | 89 | 89 |
| | P01g | Patient Survey - Kindness and Understanding | - | - | - | - | 93 | 91 | 94 | 94 | 94 | 93 | 92 | 93 | 94 | 93 | 93 | - | 93 | 94 | 93 | 93 |
| Friends and Family Test | P03a | Friends and Family Test Inpatient Coverage | 30% | 25% | 29.6% | 37.6% | 37.9% | 43.8% | 46.7% | 45.9% | 40% | 39.5% | 35.5% | 32.9% | 33.1% | 36.1% | 42.8% | 32.6% | 42.7% | 41.8% | 33.8% | 37.1% |
| | P03b | Friends and Family Test ED Coverage | 20% | 15% | 13.3% | 19.2% | 13.8% | 16.4% | 26.7% | 15.7% | 21.4% | 19.2% | 16.1% | 22.7% | 26.2% | 20.2% | 14.9% | 16% | 19.2% | 18.9% | 21.6% | 17.1% |
| | P04a | Friends and Family Test Score - Inpatients | 70 | 64 | 75.9 | 75.3 | 75.5 | 76.5 | 76.1 | 78.4 | 73.3 | 73.5 | 72.4 | 75 | 76.8 | 73.6 | 73.4 | 81.8 | 76 | 75.2 | 74.8 | 75.8 |
| | P04b | Friends and Family Test Score - ED | 51 | 42 | 70.1 | 70 | 70.3 | 70.1 | 68.7 | 75.8 | 71.4 | 69.3 | 72.4 | 69.7 | 67.1 | 67 | 69.5 | 69.8 | 69.5 | 71.8 | 69.4 | 68.6 |
| Patient Complaints | T01a | Patient Complaints as a Proportion of Activity | 0.21% | 0.25% | 0.212% | 0.256% | 0.216% | 0.227% | 0.282% | 0.238% | 0.226% | 0.277% | 0.282% | 0.321% | 0.266% | 0.224% | 0.251% | 0.224% | 0.242% | 0.248% | 0.288% | 0.232% |
| | T03a | Complaints Responded To Within Trust Timeframe | 95% | 85% | 76.4% | 86.3% | 76.1% | 92% | 88.7% | 93.1% | 82.5% | 83.3% | 91.5% | 88.3% | 88.1% | 84.4% | 82.9% | 82.9% | 84.7% | 86.3% | 89.5% | 83.4% |
| | T03b | Complaints Responded To Within Divisional Timeframe | | | 71.1% | 82.5% | 77.6% | 86% | 75.5% | 82.8% | 86% | 91.7% | 76.1% | 83.3% | 81.4% | 77.9% | 78.6% | 87.1% | 79.4% | 86.9% | 80% | 81.1% |
| | T04a | Complainants Disatisfied with Response | | | 62 | 59 | 6 | 3 | 5 | 6 | 4 | 11 | 8 | 4 | 2 | 7 | 9 | 8 | 14 | 21 | 14 | 24 |
| Ward Moves | J06 | Average Number of Ward Moves | | | 2.26 | 2.34 | 2.37 | 2.31 | 2.37 | 2.34 | 2.3 | 2.33 | 2.34 | 2.38 | 2.42 | 2.32 | 2.37 | 2.25 | 2.35 | 2.32 | 2.38 | 2.31 |
| Cancelled Operations | F01q | Percentage of Last Minute Cancelled Operations (Quality Objective) | 0.92% | 0.92% | 1.02% | 1.11% | 1.18% | 1.44% | 0.92% | 0.98% | 0.96% | 1.1% | 1.35% | 0.97% | 1.14% | 0.84% | 1.96% | 0.73% | 1.17% | 1.02% | 1.16% | 1.16% |
| | F01a | Number of Last Minute Cancelled Operations | - | - | 690 | 579 | 70 | 78 | 52 | 54 | 54 | 64 | 84 | 54 | 68 | 52 | 108 | 41 | 200 | 172 | 206 | 201 |

## 1.2 SUMMARY

Of particular note this month is the reduction in the percentage of last minute cancellations of operations for non-clinical reasons, which reflects a reduction in actual numbers of cancelled operations from 108 in November to 41 in December. The reduction in last-minute cancellations is mainly a result of the ongoing implementation of the Managed Beds protocol, in combination with a reduction in cancellations due to a critical care bed not being available, as well as some of the more exceptional causes of breaches seen in recent months.

There has been one new case each of Meticillin Resistant *Staphylococcus aureus* and Meticillin Sensitive *Staphylococcus aureus* in December; however our cleanliness metrics in all areas and hand hygiene audits continue to demonstrate high levels of compliance with the requisite standards.

The Board is recommended to note the details in the exception report for mortality indicators explaining the reasons for the current reported position.

| **Achieving set threshold (37)** | **Thresholds not met or no change on previous month (7)** |
|---|---|
| - Trust apportioned Clostridium difficile cases against national trajectory<br>- Hand Hygiene Audit<br>- Cleanliness monitoring: overall Trust score<br>- Cleanliness monitoring: very high risk areas<br>- Cleanliness monitoring: high risk areas<br>- Serious Incidents reported with 48 hours<br>- Never Events<br>- Inpatient falls incidence per 1,000 bed days<br>- Falls resulting in harm<br>- Falls improvement from baseline<br>- Total pressure ulcer incidence per 1,000 bed days<br>- Number of grade 4 hospital acquired pressure ulcers<br>- Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment<br>- Percentage adult in-patients who received thrombo-prophylaxis<br>- Nutritional screening completed<br>- Medicines reconciliation performed within one day of admission (Assessment and cardiac wards)<br>- Medicines reconciliation performed within one day of admission | - MRSA screening – emergency<br>- Antibiotic prescribing compliance<br>- 72 hour Food Chart review<br>- Stroke care: percentage spending 90% + time on a stroke unit<br>- Dementia admissions-assessment completed<br>- Friends and Family Test (FFT) coverage: Emergency Department<br>- Patient complaints as a proportion of all activity |

## QUALITY

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|---|---|
| (Oncology and Gynaecology wards)<br>- Non-purposeful omitted doses of listed critical medication<br>- Reduction in medication errors resulting in moderate or severe harm<br>- NHS Safety thermometer- harm free care<br>- NHS Safety thermometer-no new harms<br>- Deteriorating patient- reduction in cardiac arrest calls from adult general ward areas<br>- Central Alerting System (CAS) alerts completed within timescale<br>- Percentage of CAS alerts overdue at month end.<br>- Summary Hospital Mortality Indicator (SHMI) including out of hospital-deaths within 30 days of discharge<br>- Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours<br>- 30 day emergency re-admissions<br>- Learning disability (adults)-percentage adjustments made<br>- Stroke care: percentage receiving brain imaging within 1 hour<br>- High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hour<br>- Patient experience local patient experience tracker<br>- Monthly patient survey: kindness and understanding<br>- Friends and Family Test (FFT) coverage: Inpatients<br>- FFT Score: Inpatients<br>- FFT Score: Emergency Department<br>- Number of complainants dissatisfied with our response (not responded in full)<br>- Last minute cancelled operations: percentage of admissions | |
| **Quality metrics not achieved or requiring attention (17)** | **Quality metrics not rated (11)** |
| - MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemias against trajectory<br>- MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory<br>- MRSA (Meticillin Resistant Staphylococcus aureus) screening – elective | **Thresholds to be agreed**<br>- Dementia-carers feeling supported<br>- Out of hours discharges<br>**Metrics for information**<br>- Monthly number of *Clostridium difficile* cases |

| QUALITY | |
|---|---|
| - Serious incident investigations completed within required timescale<br>- Number of grade 3 hospital acquired pressure ulcers<br>- WHO surgical checklist compliance<br>- Deteriorating patient- appropriate response to an Early Warning Score of 2 or more.<br>- Summary Hospital Mortality Indicator (SHMI) in-hospital deaths<br>- Risk Adjusted Mortality (Hospital Standardised Mortality Ratio equivalent)<br>- Fractured neck of femur patients treated with 36 hours<br>- Fractured neck of femur patients achieving Best Practice Tariff<br>- Percentage of normal births<br>- Dementia admissions-case finding applied<br>- Dementia admissions-referred on to specialist services<br>- Ward outliers bed-days<br>- Percentage of complaints resolved within agreed timescale<br>- Average number of ward moves | - Number of serious incidents<br>- Confirmed number of serious incidents<br>- Total number of patient safety incidents reported<br>- Total number of patient safety incidents per 100 admissions<br>- Number of patient safety incidents severe harm<br>- Number of grade 2 hospital acquired pressure ulcers<br>- Number of falls<br>- 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. December the percentage of documented appropriate responses for adult patients with a EWS of 2 or more was 83% against an improvement target of 95% for Q4. We have therefore not achieved 25% of this CQUIN as we did not achieve the Q3 milestone 90% for Q3 as a whole. Please see exception report for further details;
- 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 December the number of cardiac arrest calls was 3 against the GREEN threshold target of 7. We remain below our cumulative trajectory of 68 by the end of December with 36 cardiac arrest calls year to date and therefore on track to achieve the second part of 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 December there were 8 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. Performance in December was 32.6% against a target of 25% for inpatients, and 16.0% 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 December was 62.9% against a target of 90%
    2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in December was 82.2% against a target of 90%
    3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in December was 68.0% against a target of 90%.

## 1.4 CHANGES IN THE PERIOD

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

- Number of serious incident investigations completed with timescale down ↓ from 66.7% in November to 33.5% in December;
- Falls resulting in harm down ↓ from 4 in November to 1 in December;
- Percentage of fracture neck of femur patients receiving ortho-geriatrician review within 72 hours up ↑ from 86.7% in November to 93.3% in December;
- Number of ward outlier bed-days up ↑ from 876 in November to 1169 in December;
- Percentage of last minute cancelled operations down ↓ from 1.96% in November to 0.73% in December.

Exception reports are provided for seventeen RED rated indicators and one amber rated metric*.

1. MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory
2. MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory
3. MRSA (Meticillin Resistant Staphylococcus aureus) screening – elective
4. Antibiotic prescribing compliance*
5. Serious incident investigations completed within required timescale
6. Number of grade 3 hospital acquired pressure ulcers
7. WHO surgical checklist compliance
8. Deteriorating patient- appropriate response to an Early Warning Score of 2 or more.
9. Summary Hospital Mortality Indicator (SHMI) in-hospital deaths
10. Risk Adjusted Mortality (Hospital Standardised Mortality Ratio equivalent)
11. Fractured neck of femur patients treated with 36 hours
12. Fractured neck of femur patients achieving Best Practice Tariff
13. Percentage of normal births
14. Dementia admissions-case finding applied
15. Dementia admissions-referred on to specialist services
16. Ward outliers bed-days
17. Percentage of complaints resolved within agreed timescale
18. Average number of ward moves

## QUALITY

| Q1. EXCEPTION REPORT: Meticillin Resistant Staphylococcus Aureus ( MRSA) cases against trajectory | RESPONSIBLE DIRECTOR: Chief Nurse |
|---|---|

**Description of how the standard is measured:**

Positive blood cultures taken from patients in hospital for more than 2 days. The Trust has a zero tolerance to avoidable MRSA bacteraemia. There are no financial penalties and does not contribute to the Monitor Risk Assessment Framework.

**Performance in the period, including reasons for the exception:**

There was one Trust apportioned case of MRSA bacteraemia in December 2014.

| Division | Monthly Objective | Number of cases in the month |
|---|---|---|
| Specialised Services | 0 | 0 |
| Surgery, Head and Neck | 0 | 1 |
| Women's and Children's | 0 | 0 |
| Medicine | 0 | 0 |

Widespread screening for MRSA is undertaken in the Trust.

**Recovery plan, including expected date performance will be restored:**

- A Post Infection Review has been undertaken. A Post Infection Review meeting has been set up with the multidisciplinary team to discuss any actions that may need to be implemented. An action plan will be put in place and a full report will go to Infection Control Group in March.

## QUALITY

| Q2. EXCEPTION REPORT: Meticillin Sensitive Staphylococcus Aureus (MSSA) cases against Trust limit. | RESPONSIBLE DIRECTOR: Chief Nurse |
|---|---|

**Description of how the standard is measured:**

The number of MSSA cases of patients in hospital for more than 2 days. This equates to no more than 25 cases in year. This limit has no financial penalties and does not contribute to the Monitor Risk Assessment Framework.

**Performance in the period, including reasons for the exception:**

There were four Trust apportioned cases of MSSA in December 2014. This is two over the Trust's limit for December of two cases. The distribution of cases was as follows:

- Two cases in Women's and Children's
- Two cases in Specialise Services.

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

**Recovery plan, including expected date performance will be restored:**

All cases identified in patients that have been in hospitals for more than two days are investigated by the clinical team with learning shared at the Infection Control Group bi-monthly meeting, chaired by the Chief Nurse. The current actions for limiting the number of MSSA cases is as follows:

- MSSA screening continues in Cardiac and Renal services;
- Extra Hand Hygiene and Aseptic Non Touch Technique (ANTT) training sessions have been instigated for staff.

## QUALITY

| Q3. EXCEPTION REPORT: Compliance with Meticillin Resistant Staphylococcus Aureus ( MRSA) Screening for Elective Patients. | RESPONSIBLE DIRECTOR: Chief Nurse |
|---|---|

**Description of how the standard is measured:**

Compliance with MRSA screening for elective patients is based on the percentage of patients attending pre-operative assessment clinic that are screened, in line with the contract agreed the Clinical Commissioning Group. The compliant threshold is 100%.

**Performance in the period, including reasons for the exception:**

For the month of December compliance was at 99.6% (257 out of 258 patients screened). One patient was re-assessed as needing an urgent operation, and the date for surgery was brought forward, and therefore they were no longer classed as an elective patient under the definition of the agreed screening protocol.

**Recovery plan, including expected date performance will be restored.**

The MRSA screening performance information continues to be sent to Heads of Nursing on a weekly basis.

| Q4. EXCEPTION REPORT: Antibiotic Prescribing Compliance | RESPONSIBLE DIRECTOR: Medical Director |
|---|---|

**Description of how the standard is measured:**

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

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

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

**Performance in the period, including reasons for the exception:**

The overall percentage decreased in December to 89.1%. Two Divisions (Specialised Services and Medicine) achieved the target of 90%.

There was an increase in compliance in one Division:

- Medicine (92.7%, an increase from 89.8%)

The remaining Divisions had a decrease in compliance:

- Women's and children's (84.4%, a decrease from 93.8%)
- Surgery, Head and Neck (82.2% a decrease from 90.4%)
- Specialised Services (92.3% a decrease from 94.0%)

Reasons for the exception:

- 615 antimicrobials were reviewed in December, 67 were non-compliant. Of these, 45 (7.3%) did not include a valid stop or review date. Our number of prescriptions with no stop or review date has increased since November. Neonatal Intensive Care Unit (NICU) was one of the main areas with poorer compliance, with 9 out of the 17 antibiotics reviewed not having a valid stop/review date;
- 17 (2.8%) of the antimicrobials reviewed did not contain an indication. The majority of prescriptions with no indication were in Surgery, Head and Neck. The prescribers in this area have been contacted;
- Our percentage of antimicrobials prescribed not according to the guidelines remains low at 1.6%;
- Although not at 90%, this is the best performing December we have had, with Medicine achieving their highest ever result.

**Recovery plan, including expected date performance will be restored:**

- Continue to monitor compliance through Divisional Boards;
- The ward pharmacists for all wards who failed to reach 90% have been contacted. They are highlighting the antibiotic prescribing bundle on the ward to improve compliance and signposting prescriptions which need attention on the ward rounds;
- The poor prescribers have been contacted to highlight their prescribing errors;
- The Neonatal Intensive Care Unit team will be contacted to discuss the reasons behind their low compliance figures and to understand any additional actions that can be taken to support compliance;
- Continue to use antimicrobial stickers (introduced in November) as these have had a positive impact on prescribing;
- Expected date performance will be restored is January 2015 (to be reported in February's report).

## QUALITY

| Q5. EXCEPTION REPORT: Serious incident investigations completed within timescale | RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse |
|---|---|

**Description of how the standard is measured:**

Serious incidents investigations are required to be completed within timescales set-out in the NHS England's Serious Incident Framework (March 2013). Investigations are required to be completed within 45 working days for a grade 1, and 60 working days for a grade 2 serious incident.

The target in commissioning contracts is 80%, measured quarterly.

**Performance in the period, including reasons for the exception:**

Eight serious incident investigations were completed during December, of these five investigations breached the 45 working day timescale resulting in performance of 37.5%. The reasons are described below:

| SI number | Incident | Division | Reason for delay |
|---|---|---|---|
| 2014 29071 | Fall resulting in fracture. | Medicine | Amendments required to draft Root Cause Analysis (RCA) and sent back to Division. Delay from the Division in returning the amended RCA which resulted in breach of timescale. |
| 2014 29490 | Delay in diagnosing and starting treatment for sepsis. | Surgery, Head and Neck | Delay from the Division in submitting the RCA to Trust Headquarters for review and closure. |
| 2014 29919 | Retained swabs found in mouth. | Surgery, Head and Neck | Delay from Trust Headquarters in reviewing the RCA. |
| 2014 31187 | Fall resulting in fracture. | Medicine | Delay from the Division in submitting the RCA to Trust Headquarters for review and closure. |
| 2014 32044 | Patient lost to follow up. Last seen 12 months ago. Visual loss. | Surgery, Head and Neck | Delay from Trust Headquarters in reviewing the RCA. |

**Recovery plan, including expected date performance will be restored:**

- The likely deterioration in performance was forecast for December, as reported last month. This is due to the need for clinicians conducting these investigations to prioritise clinical care, and to delays in the quality assurance process for Root Cause Analysis investigations in the central Patient Safety Team caused by a combination of covering a vacancy in the team and covering essential patient safety training sessions;
- Performance is not expected to be restored in January for the reasons cited above.

## QUALITY

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

**Description of how the standard is measured:**

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

**Performance in the period, including reasons for the exception:**

The rate of hospital acquired pressure ulcers grade 2 and above for December 2014 was 0.388 per 1,000 bed days against a target of 0.651.

| Division | Dec 14 | Nov 14 | Oct 14 | Sep 14 | Aug 14 | July 14 |
|---|---|---|---|---|---|---|
| Medicine | 0.303 | 0.65 | 0.213 | 0.439 | 0.332 | 0.677 |
| Specialised Services | 0.231 | 0.72 | 0.47 | 0.481 | 0.723 | 0.459 |
| Surgery Head &Neck | 1.282 | 0.96 | 0.893 | 0.862 | 0.802 | 0.574 |
| Women & Children's | 0.132 | 0.26 | 0.000 | 0.000 | 0.000 | 0.000 |
| **Trust** | **0.388** | **0.59** | **0.312** | **0.394** | **0.396** | **0.427** |

There were two grade 3 hospital acquired pressure ulcers reported for the month of December 2014, one in Medicine and one in the Children's Hospital.

1. A rapid review indicates that that there are lessons to learn in the Division of Medicine regarding staff training in the extra capacity ward (staffed by a higher percentage of bank and agency staff than usual) regarding documentation and use of appropriate equipment;
2. The second grade 3 pressure ulcer which occurred in Paediatric Intensive Care Unit appears to have been unavoidable as the equipment causing the pressure was used in a lifesaving attempt on a critically ill premature baby. The ulcer is now healing.

Full Root Cause Analyses are underway and the lessons learned will be shared at the next Trust Tissue Viability meeting.

**Recovery plan, including expected date performance will be restored:**

The Trust has seen a small number of grade 3 hospital acquired pressure ulcers over the last couple of months. The lead Tissue Viability Nurse will

**QUALITY**

undertake a review of all cases to help identify any themes or further action required and present this at the next Tissue Viability meeting.

## QUALITY

| Q7. EXCEPTION REPORT: WHO Surgical Safety Checklist | RESPONSIBLE DIRECTOR: Medical Director |
|---|---|

**Description of how the standard is measured:**

The measure of compliance of this standard is all three elements of the WHO Surgical Safety checklist: Sign In, Time out, Sign Out are completed and recorded on the Medway system by theatre staff. Data is pulled from the Medway system for all theatre visits across adult and paediatric theatres.

All three sections need to be completed with 'Yes' response for an overall 'Yes' to be achieved. This data is reviewed both weekly and monthly, retrospectively, by the Senior Manager for Theatres and within the Perioperative Patient Safety Group.

**Performance in the period, including reasons for the exception:**

In December, the compliance with the WHO checklist, as measured by the three elements is 99.4% overall. The divisional breakdown is shown below:

| Division | Percentage compliance | Number of breaches |
|---|---|---|
| Surgery, Head and Neck | 99.6% | 8 out of 2005 operations/interventional procedures |
| Women's and Children's | 98.9% | 9 out of 849 operations/interventional procedures |
| Specialised Services | 98.8% | 2 out of 171 operations/interventional procedures |
| Medicine | 100% | 0 out of 17 operations/interventional procedures |

The division of Surgery, Head & Neck is currently 99.6% against a minimum standard of 99.5%. However, there have been a small number of breaches within the Division. Actions to improve compliance are in the section below.

**Recovery plan, including expected date performance will be restored:**

Surgery Head and Neck:

- Ensuring the WHO checklist is undertaken and completed and signed off on Medway in all areas, which will be mentioned at the Safety Brief;
- Working with Central Delivery Suite to ensure the "red sign in" is complete and then full WHO sign is completed once mother and baby are safe;
- Ensuring compliance in Endoscopy/ Trans-oesophageal Echocardiogram procedures and all varicose vein procedures in Queens Day Unit with the WHO checklist;
- Weekly review by theatre leads in all areas to capture and validate data;

**QUALITY**

- Undertake a quality audit which has been specifically designed to monitor compliance.

Women's and Children's:

- The cases in the Children's Hospital showing as non-compliant with the WHO checklist have been reviewed and are found to be reporting errors as opposed to actual process breaches;
- It has been reinforced with the team that any WHO checklist breach must be reported through the incident reporting system with full details, and that it is the team leader's role to ensure Medway inputs are correct on a daily basis.

## QUALITY

| Q8. 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 December was 83%. Thirty five out of 42 patients with an Early Warning Score (EWS) of two or more had documented evidence of a response consistent with the escalation protocol.

The seven patients who did not have documented evidence of a response to an Early Warning Score of two or more were spread across Divisions and wards, apart from one ward which had two incidences.

**Recovery plan, including expected date performance will be restored:**

- Each case has been followed-up by the Ward Sister concerned, and learning shared with relevant staff;
- Areas with regular bank and agency use have incorporated a reminder of the EWS response into their daily safety briefs;
- Safety Thermometer audits (including EWS) now reported in to Clinical Quality Group to raise visibility;
- The Senior Nurse "Back to the Floor" days have focused on the EWS responses. The one held 06/01/2015 showed high levels of compliance in charts reviewed;
- Deteriorating patient remains a key part patient safety training on Induction and updates;
- Deteriorating patient project continues. This includes face-to-face training, with all nursing staff in conducting manual observations and a reminder about EWS escalation and SBAR. Progress has been difficult as times with pressure on clinical areas being unable to release staff for on the spot training;
- We have also successfully piloted use of visual cues in the form of magnets for "status at a glance" boards for EWS of 2+ and EWS 4+. These

will be spread to all wards.

| Q9-Q10 EXCEPTION REPORT: SHMI Summary Hospital Mortality Indicator (In-hospital deaths) + Risk Adjusted Mortality Indicator | RESPONSIBLE DIRECTOR: Medical Director |
|---|---|

**Description of how the standard is measured:**

1. Summary Hospital Mortality Indicator (SHMI): SHMI is the national hospital-level indicator used for reporting mortality across the NHS. The SHMI indicator gives an indication of whether the number of inpatient deaths in a provider is as expected, higher than expected or lower than expected when compared to the national baseline (England). The SHMI is a ratio of the observed number of deaths to the expected (risk adjusted)[1] number of deaths for a provider, multiplied by 100. A SHMI of 100 means that the number of observed deaths equals the number of expected deaths.
2. The Risk Adjusted Mortality Indicator (RAMI) is based on the same principle of a ratio of observed to expected deaths. However RAMI is a methodology owned by CHKS Ltd (in a similar vein to HSMR being owned by Dr Foster). In the RAMI there are different rules for modelling the expected number of deaths

It is important to note that when we refer to "expected" deaths, this is based on statistical modelling of a provider, compared to the whole of England. If a provider's actual number of deaths exceeds the "expected", this DOES NOT mean the excess number of deaths are "avoidable". Nor is it possible to identify the actual deaths that were "excess".

We report two measures of SHMI in our dashboard:

- For the national SHMI comparator for benchmarking in the NHS, the observed number of deaths is the total number of patients who died in hospital plus those that died within 30 days of discharge. There is a significant delay in these figures being available due to the need for post discharge deaths recorded in community systems to be validated against a hospital admission. So we also look at in-hospital SHMI as a more timely indicator of mortality;
- For In-hospital SHMI the observed number of deaths is the total number of patients who died in hospital. However, the expected deaths figure used is calculated using data that includes both in-hospital deaths AND out-of-hospital deaths within 30 days. Therefore, the expected deaths are over-predicted and an index below 100 does not necessarily mean that deaths are lower than expected. The average in-hospital SHMI amongst trusts is likely to be about 80.This is why we set our green target so low at 65, with an amber target of 75.

Risk Adjusted Mortality Indicator (RAMI): RAMI is a slightly different way at looking at risk adjusted mortality and can be useful to triangulate other information. The basis of a ratio of the observed number of deaths to the expected (risk adjusted) number of deaths is the same as SHMI, but palliative care deaths are excluded. RAMI only includes in-hospital deaths and can be viewed at patient level. At the Trust level, changes in SMHI and RAMI are

[1] Risk adjustment takes into account the characteristics of patients treated such as age, gender, conditions and underlying conditions the patient has, and whether they were admitted as an emergency or not.

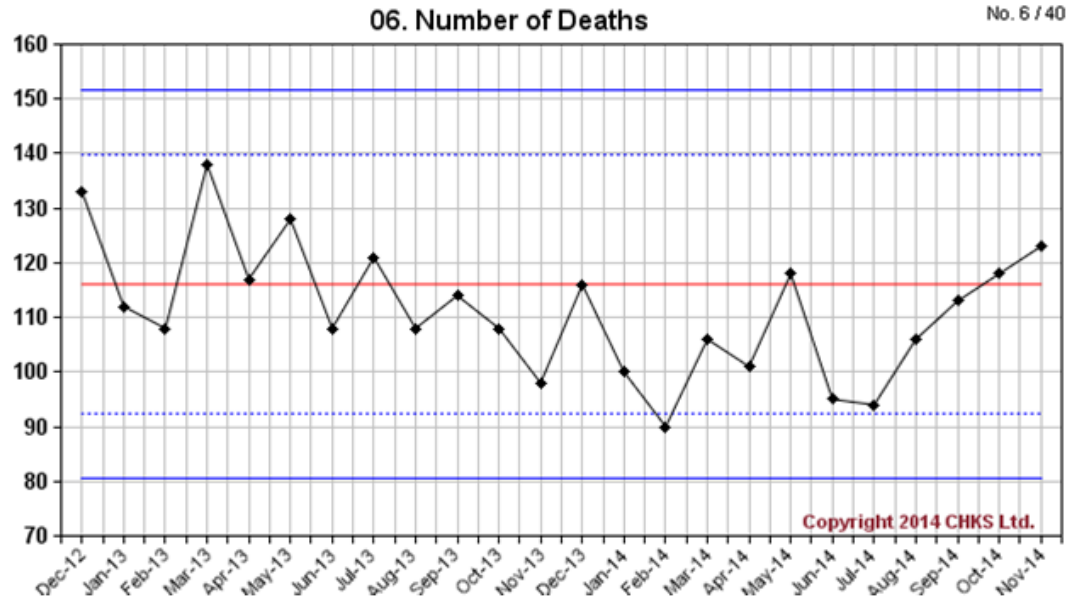
usually similar.

**Performance in the period, including reasons for the exception:**

In December 2014, in-hospital SHMI was 86.9 against a green target of 65. RAMI was 94.7 against a green target of 80.

The higher reported SHMI and RAMI figures for November are thought to be related to a combination of two factors:

1. Ten of the deaths which occurred in November have yet to be clinically coded, and therefore no risk adjustment for these cases has been taken into account when calculating both in-hospital SHMI and RAMI. This does not usually happen. This means that the draft SHMI figure quoted for November has underestimated the level of risk for these patients, and therefore the relative 'expected' number of deaths used to calculate the SHMI ratio will be lower (i.e. SHMI will be over-estimated);
2. The actual number of deaths in November was higher than in previous months; the crude (unadjusted) mortality increase in November is as shown in the graph below. The level is slightly above the average but within the statistical upper and lower confidence intervals. An understanding of case mix, which will be available once the clinical coding has been updated and the SHMI figures have been refreshed, is needed to draw any further conclusions from this.




**Recovery plan, including expected date performance will be restored.**

**QUALITY**

- Coding for the ten deaths will be completed and submitted to the Health and Social Care Information Centre which is likely to lead to changes in both in-hospital SHMI and RAMI. The final figures are expected to be available within two months and the dashboard will be refreshed as soon as they are available;
- The Trust's Quality Intelligence Group will continue to review mortality indicators on a six weekly basis, including reviewing any SHMI categories with adverse scores (i.e. both lower and upper confidence intervals above 100), and the top five categories with the highest levels of 'excess' deaths; the review process involves a review of clinical coding and data classification first, to ensure all risk factors have been correctly captured, and then proceeding to a clinically led review of the individual cases, looking for any themes or any common contributory factors.

## QUALITY

| Q11. EXCEPTION REPORT: Percentage of normal births | RESPONSIBLE DIRECTOR: Chief Nurse |
|---|---|

**Description of how the standard is measured:**

Percentage of all births at St Michael's that are "normal". Normal births are defined as when labour starts spontaneously, progresses spontaneously without drugs, and the woman gives birth spontaneously.

Women who experience any one or more of the following are excluded: induction of labour (with prostaglandins, oxytocics or artificial rupture of membranes), epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section, or episiotomy.

This data is taken from Patient Administration System (PAS) Medway Maternity each month, via an analyst using the above criteria. This includes births in all clinical settings both in the hospital and at home, whether planned or by accident.

**Performance in the period, including reasons for the exception:**

The percentage of normal births in December was 59.6% against a target of 64%. The previous month was 65.5%.

- The number of normal births in December was 33 less than November. This is attributed to a high induction rate at 30%, due to the use of oxytocin and artificial rupture of membranes. Even if these women go on to have non-instrumental delivery without requiring drugs to progress labour they are excluded from the count of "normal births";
- There are also many high risk women who have given birth at St. Michael's due to fetal reasons and referral from other south west areas as their babies are likely to require neonatal intensive care facilities and neonatal surgical facilities. For many of these women and babies induction or caesarean section will be the safest mode of delivery. This will impact our normal birth figures

**Recovery plan, including expected date performance will be restored:**

- The maternity service is always considering normal birth and encouraging women, both during the ante-natal and intra-partum period, to give birth normally; this will continue;
- A high percentage of inductions is noted here at St. Michael's and there is audit work underway to review this percentage as this will undoubtedly affect the normal birth rate as induction will lead to oxytocin being used and artificial rupture of membranes. Hence, 30% of women are excluded each month from having had a "normal birth" from the outset.

## QUALITY

| Q12-13. EXCEPTION REPORT: | RESPONSIBLE DIRECTOR: Medical Director |
|---|---|
| • **Fractured neck of femur patients treated with 36 hours**<br>• **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:**

December's Best Practice Tariff performance was 66%, with 10 patients' care not meeting all of best practice indicators. The reasons for this are as follows:

- One patient died before completion of pre-discharge Abbreviated Mental Test;
- Nine patients did not receive surgery within 36 hours (70% of patients did receive surgery in 36 hours):
    - 3 patients delayed due to clinical reasons (low blood count, fasting instructions & high INR – the latter being a measure of the blood not clotting well, resulting in surgery being too risky);
    - 2 patients delayed due to high volumes of trauma and insufficient theatre capacity
    - 2 patients delayed due to lack of available theatre kit at weekend;
    - 2 patients delayed due to operational problems (over-running theatre list & flow problems in recovery);

**Recovery plan, including expected date performance will be restored:** :

The recovery trajectory for Time to Theatre (Surgery within 36 hours) is shown below. Had there been no clinical exceptions, performance would have been 80%, and one breach above the number expected in the trajectory. The new Trust-wide theatre transformation programme has a work stream

focussing on trauma and orthopaedic efficiencies and team culture. Team meetings planned to start from February when objectives will be agreed.

| Month (of patient discharge) | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 |
|---|---|---|---|---|---|---|---|
| Total patients | 31 | 27 | 15 | 30 | | | |
| Expected 36 hour breaches | **7** | **7** | **6** | **5** | **5** | **3** | **3** |
| **Performance trajectory** | **77%** | **77%** | **80%** | **83%** | **83%** | **90%** | **90%** |
| Actual 36 hour breaches | 12 | 6 | 4 | 9 | | | |
| **Actual performance** | **61%** | **78%** | **73%** | **70%** | | | |

## QUALITY

| Q14-15. EXCEPTION REPORT: Dementia<br>Stage 1 - Find<br>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 December for stage 1 was 62.9% % against a target of 90%, compared with 63.7% in November

Divisional performance

Medicine 69.9%; Surgery Head & Neck 47.5 %; Specialised Services 48.9%

**Stage 3 – Referral on to GP – status RED**

Performance in December for stage 3 was 68% against a target of 90% compared with 73.3% in November.

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Divisional performance

Medicine 69.6%; Surgery Head & Neck 100%; Specialised Services 0%

**Recovery plan, including expected date performance will be restored:**

A simple to use electronic solution to capture the CQUIN data has been launched across the Trust, together with clear guidance. Data indicating which wards are achieving against the CQUIN and those requiring further support is available on a monthly basis to all the relevant Divisions. The Project Nurse continues to focus attention in these areas.

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

- Development of an IM&T system to flag, record and monitor all stages of the FAIR process has been launched together with clear guidance. This has been widely advertised and support sought from all senior Divisional teams to use the electronic system;
- Project Nurse (two year secondment / fixed term project post holder) is working closely with the admission area teams (Medical, Surgical & Trauma and Older Persons Assessment Units), to ensure the timely screening, assessment and referral on where appropriate;
- A step change in improvement is anticipated in March 2015.

| Q16. 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 1169 outlier bed-days within the month of December against the seasonally adjusted target of 705 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;
- The Medical Assessment Unit (MAU) now has 32 beds, allowing more medically expected patients to be directly admitted assessed and discharged from MAU. From MAU patients can be directed to MAU, Older Persons Assessment Unit Stroke or Ambulatory Care Unit: there should be less pressure on MAU to transfer patients to downstream wards outside of specialty and supports the theme of right patient, right ward;
- Standard Operating Procedures have been produced for each Division to identify pathways for elective and non-elective patients to support right patient, right ward;
- A new target of 15 patients discharged before 10 a.m. has now been agreed. This will achieve lower occupancy earlier in the day and support

patients being directed to the right ward first time.

| Q17. EXCEPTION REPORT: Number and percentage of complaints resolved within Local Resolution Plan timescale | RESPONSIBLE DIRECTOR: Chief Nurse |
|---|---|

**Description of how the standard is measured:**

The number of complaints which are resolved within the timescale originally agreed (or subsequently renegotiated) with the complainant. The target for the percentage to be resolved within the formal timescale is 95% each month with an amber threshold of 85%.

**Performance in the period, including reasons for the exception:**

In December 2014, 58 responses out of the 70 which had been due in that month were posted to the complainant by the date agreed (82.9%, unchanged from November performance). Of the 12 breaches, 6 were attributable to delays in Divisions (2 in the Division of Surgery Head & Neck; 2 in the Division of Medicine; and 1 each in the Divisions of Women's & Children's Services and Specialised Services). The remaining 6 breaches were due to delays during the Executive sign-off process.

The Division of Diagnostics & Therapies recorded zero breached deadlines in November.

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

**Recovery plan, including expected date performance will be restored:**

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

## QUALITY

| Q18. 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 December 2014 there was an average of 2.25 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 the Medical Assessment Unit will decrease the need for transfers off to down-stream inpatient wards. The move took place on November 4th 2014;
- The current timetable for moving to the new wards 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 do not necessitate a further move.

## 1.6 SUPPORTING INFORMATION

### 1.6.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the **Division of Surgery, Head & Neck:**

**Patient Support and Liaison Nurse at the Bristol Eye Hospital**

- Mary McGrory, Patient Support and Liaison Nurse, is based in the Bristol Eye Hospital, in the accessible ground floor Patient Liaison Office, which was refurbished by the friends of the Bristol Eye Hospital. Mary is a Registered Nurse and trained Eye Clinic Liaison Officer. In the first month of her post she saw 80 patients and we are looking to make this post full time. This is proving a very successful appointment – and is highly visible within the hospital. Mary targets specific clinics where her support is needed and bases herself upstairs on Level 2 when the clinics are running so she is able to give patients her full attention.

**Current state of Enhanced Recovery: Update from Trudy Reed, Enhanced Recovery Practitioner**

- We are expanding our enhanced recovery programme so that so that all elective surgical patients are placed on an enhanced recovery pathway. This will enable patients to recover more quickly from elective surgery and to maximise their health post-operatively;
- Alongside the enhanced recovery pathways we have produced Clinical Professional Standards to provide evidence based guidance on important topics such as mouth-care, chest drain care, tracheostomy care and nutrition;
- A teaching programme has begun to raise awareness on Enhanced Recovery Programme. The areas that we need to focus on are early mobilisation (using the great new space on Wards 700 & 800), and patient feedback via the diaries and this will be my focus over the coming months. There is an identified need to build stronger links within the adult Intensive Therapy Unit (ITU), and the Pre-operative Assessment Unit to support staff in understanding enhanced recovery and the role they play. There is a plan to put new safe systems in place so that the use of ITU for elective surgery is reduced and the stay much shorter.
- Part of the nurse practitioner's role is to follow the patients that have been through ITU and onto the wards. Patients are reviewed in ITU and the nurse practitioner liaises with the teams to facilitate early discharge. The patient and their family see them daily and are encouraged to progress the enhanced recovery elements of their pathway. The nurse practitioner aims to identify at risk patients before they deteriorate and will work with the nursing team/students and others, to do point of care teaching. The nurse practitioner is a point of contact for teams if there is a patient who will benefit from further input. The nurse practitioner will often do a midday review of the patient, as this is when the surgeons are in theatre, and try and keep the patient journey moving (for example feeding back if the patient's condition has improved since the morning ward round and revise their length of stay accordingly).

## QUALITY

- Staff have been really positive about enhanced recovery and have now got full engagement from most of the teams. We are building links with other trusts and a visit to Cardiff is planned to see their enhanced recovery programme as well as building links with North Bristol.

### Staffing Update

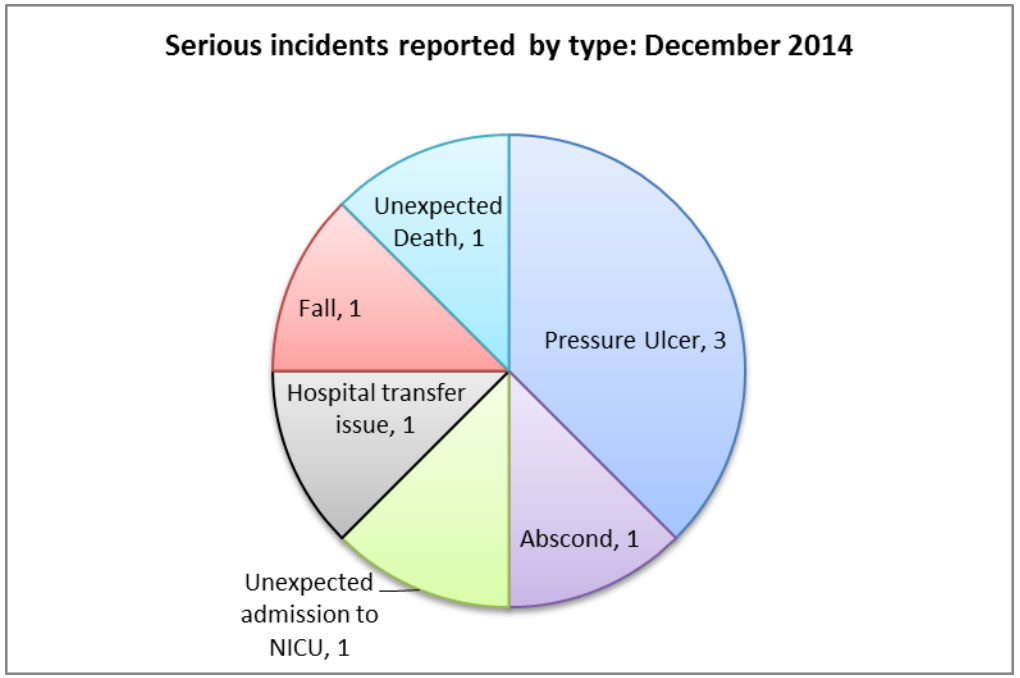
- Reported incidents of lower than expected staffing levels are decreasing, with 21 in October and 5 in November. The Division has increased the staffing on Ward 700 by an extra Registered Nurse on a long day on Saturday and Sunday, and we have also increased the staffing at night covering wards A602/A604/A605, improving night nurse to patient ratio to one registered nurse to 8.3 patients. Although this was highlighted as an issue when the Care Quality Commission inspected the Trust in September 2014, the Division had already put plans in place to increase the staffing.

### Proposed Management restructure

- We are developing a proposed management restructure in the Division. We recognise that our managers and staff are very committed to the Trust and Divisional agenda and work very hard to deliver it to the benefit of both the Division and patients. However, we intend to create a more connected, resilient and responsive structure capable of meeting the challenges the Division continues to face;
- The proposal has been developed in recognition of the need to strengthen the opportunities for medical, nursing and management teams to work together, and in doing so strengthen communication and opportunities for engagement within and between services and overall improve quality in the services we deliver.

### 1.6.2 SERIOUS INCIDENT THEMES

There were eight serious incidents reported in December as shown below:




As reported last month, one of the hospital acquired grade 3 pressure ulcers included in this month's figures occurred in November, but it was identified as a serious incident and reported as such in December. This explains why the quality dashboard is showing two grade 3 pressure ulcers this month and the chart above, three.

Further details are provided in the table below:

| Date of Incident | SI Number | Division | Incident Details | Investigation |
|---|---|---|---|---|
| 28/11/2014 | 2014 38997 | Surgery, Head and Neck | Grade 3 Pressure Ulcer | Investigation underway |

## QUALITY

| Date of Incident | SI Number | Division | Incident Details | Investigation |
|---|---|---|---|---|
| 02/12/2014 | 2014 39491 | Women's and Children's | Mother with 4 day old infant left the hospital without discharge preparation or any discussion with staff. Police search, both later found dead. | Investigation underway |
| 28/11/2014 | 2014 39641 | Women's and Children's | Delivery in Midwife Led Unit, unexpected admission to Neonatal Intensive Care Unit. | Investigation underway |
| 08/12/2014 | 2014 40329 | Medicine | Approx. 40 hours delay in finding psychiatric bed for high risk mental health patient. | Investigation underway |
| 09/12/2014 | 2014 40377 | Medicine | Grade 3 Pressure Ulcer | Investigation underway |
| 20/12/2014 | 2014 41724 | Women's and Children's | Grade 3 Pressure Ulcer | Investigation underway |
| 24/12/2014 | 2014 41950 | Surgery, Head and Neck | Fall resulting in fracture. | Investigation underway |
| 28/12/2014 | 2014 42618 | Surgery, Head and Neck | Failure to respond to a deteriorating patient, delay in escalation to doctor. | 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<br>- Workforce numbers - compared with budgeted establishment<br>- Bank and agency usage - compared with target<br>- Sickness absence – compared with target<br>- Vacancies - compared with target<br>- 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 December 2014 were as follows:

- Workforce expenditure - compared with budget
- 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.

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

Detailed programmes of work to underpin delivery of workforce KPIs are described in the Quarterly Workforce report. This exception report provides a summary update on progress and issues arising from the latest report covering the period July to September 2014. A further report covering the period October to December 2014 will be presented in February 2015.

## WORKFORCE

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

**Description of how the standard is measured:** Workforce expenditure in £'000 including substantive, bank and agency staff, waiting list initiative and overtime compared with budget.

**Performance in the period, including reasons for the exception:**

During December, there was an adverse variance on the pay expenditure compared to budget of 2.4% compared with 0.5% in November. The cumulative position at the end of month 9 was an overspend of 1.4%.

| | UH Bristol | Diagnostics and Therapies | Medicine | Specialised Services | Surgery Head and Neck | Women's and Children's | Trust Services (exc Estates and Facilities) | Facilities and Estates |
|---|---|---|---|---|---|---|---|---|
| December 2014 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Planned Expenditure | 28,417 | 3,364 | 4,351 | 3,271 | 6,044 | 7,327 | 1,865 | 1,699 |
| Actual Expenditure | 29,086 | 3,540 | 4,452 | 3,396 | 6,408 | 7,341 | 1,845 | 1,676 |
| variance target +/- | (669) | (177) | (101) | (125) | (363) | (15) | 20 | 23 |
| Percentage variance | 2.4% | 5.3% | 2.3% | 3.8% | 6.0% | 0.2% | (1.1%) | (1.4%) |

Trust-wide, the adverse variance increased by £525k this month. Total spend on agency reduced by £89k, but bank increased by £245k, and substantive staffing increased by £578k, due to recruitment and overtime and other additional payments. Budgets since October have included Operational Capacity and Resilience funding, which has been agreed by NHS England for a range of providers including NHS Trusts and GP practices, in recognition of the additional capacity pressures the NHS is facing on a national level. Between October and April, UH Bristol has been granted £3.8 million Operational Capacity and Resilience funding, including for December approximately £600.3k in pay costs.

The Divisional exceptions were as follows:

Diagnostic and Therapies: adverse variance increased in month by £145k, largely due to back pay for substantive radiology medical staff;

Medicine: received approximately £334.6K Operational Resilience funding in December, adverse variance increased by £85k, due to additional consultant payments, recruitment to nursing vacancies, and bank costs;

Specialised Services: adverse variance reduced by £55k;

Surgery Head & Neck: adverse variance increased in month by £222k, mainly due to increased consultant payments to reduce waiting lists combined

with increased nursing bank and agency.

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

The recovery plan is described in the bank and agency section in Exception Report W3 below.

## WORKFORCE

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

**Description of how the standard is measured:**

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

**Performance in the period, including reasons for the exception:**

Total workforce numbers (substantive and bank and agency) were 1.9% above budgeted FTE, compared with 1.0% in November.

| Total workforce numbers including bank and agency | UH Bristol | Diagnostics & Therapies | Medicine | Specialised Services | Surgery Head & Neck | Women's & Children's | Trust Services (exc Estates and Facilities) | Facilities & Estates |
|---|---|---|---|---|---|---|---|---|
| December 2014 | FTE | FTE | FTE | FTE | FTE | FTE | FTE | FTE |
| Actual Employed | 7388.5 | 909.2 | 1037.6 | 786.8 | 1616.2 | 1684.1 | 644.1 | 710.5 |
| Bank and Agency | 634.2 | 22.0 | 215.9 | 71.3 | 121.2 | 83.1 | 50.7 | 70.0 |
| Total Workforce Numbers | 8022.7 | 931.2 | 1253.5 | 858.1 | 1737.4 | 1767.3 | 694.9 | 780.4 |
| Budgeted Numbers | 7872.4 | 942.2 | 1164.7 | 818.5 | 1713.9 | 1750.5 | 696.8 | 785.9 |
| **variance target +/-** | **(150.3)** | **11.1** | **(88.8)** | **(39.6)** | **(23.5)** | **(16.7)** | **1.9** | **5.4** |
| Percentage variance | 1.9% | (1.2%) | 7.6% | 4.8% | 1.4% | 1.0% | (0.3%) | (0.7%) |

We are mindful that the additional temporary staff associated with Operational Resilience funding have impacted on the position for FTE, and this impact has been estimated in the table below, based on average costs of bank and agency, to show total workforce numbers including bank and agency and the underlying position of variance against budgeted establishment .

| Total workforce numbers including bank and agency | UH Bristol | Diagnostics & Therapies | Medicine | Specialised Services | Surgery Head & Neck | Women's & Children's | Trust Services (exc Estates and Facilities) | Facilities & Estates |
|---|---|---|---|---|---|---|---|---|
| December 2014 | FTE | FTE | FTE | FTE | FTE | FTE | FTE | FTE |
| Actual Employed | 7388.5 | 909.2 | 1037.6 | 786.8 | 1616.2 | 1684.1 | 644.1 | 710.5 |
| Bank and agency actual (FTE) **minus** | 558.2 | 16.4 | 162.0 | 65.2 | 117.6 | 76.4 | 50.7 | 70.0 |

## WORKFORCE

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| usage funded by Operational Resilience | | | | | | | | |
| Total Workforce Numbers | 7946.7 | 925.6 | 1199.6 | 852.0 | 1733.8 | 1760.5 | 694.8 | 780.5 |
| Budgeted Numbers | 7872.4 | 942.2 | 1164.7 | 818.5 | 1713.9 | 1750.5 | 696.8 | 785.9 |
| **variance target +/-** | **(74.3)** | **16.6** | **(34.9)** | **(33.5)** | **(19.9)** | **(10.0)** | **2.0** | **5.4** |
| Percentage variance | 0.9% | (1.8%) | 3.0% | 4.1% | 1.2% | 0.6% | (0.3%) | (0.7%) |

When this estimated adjustment for the Operational Resilience funding is made, which has been based on average agency and bank costs provided by Finance Department, workforce numbers are within 0.9% of budgeted FTE.

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

Work to target excess bank and agency usage is described in W3 below.

## WORKFORCE

| W3. EXCEPTION REPORT: Bank and Agency compliance | RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development |
|---|---|

**Description of how the standard is measured:**

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

**Performance in the period, including reasons for the exception:**

During December, temporary staffing comprised 8% of total staffing numbers (FTE) compared with 7.1% last month, and an annual average of 5.9%. Agency staffing accounted for 2% of total staffing for December, compared to the annual average of 1.3%. Agency usage has reduced by 21.4 FTE and bank usage has increased by 97 FTE. Operational Resilience pressures funding has covered most of the increase in bank and agency. Given that Operational Resilience pressures will result in increased temporary staffing, a notional calculation from money to FTE has been undertaken and this is reflected in the tables below and in the graphs at the end of this report.

| Bank (FTE) | UH Bristol | Diagnostics & Therapies | Medicine | Specialised Services | Surgery Head & Neck | Women's & Children's | Trust Services (exc. Facilities & Estates) | Facilities & Estates |
|---|---|---|---|---|---|---|---|---|
| Bank December 2013 | 275.3 | 9.1 | 95.5 | 32.3 | 50.6 | 42.9 | 24.0 | 21.0 |
| **Target set by division** | 244.1 | 11.0 | 84.0 | 20.7 | 51.2 | 43.9 | 21.1 | 12.3 |
| **Bank December 2014** | 489.7 | 10.5 | 163.1 | 53.6 | 98.5 | 69.6 | 37.9 | 56.4 |
| **Variance from target (FTE)** | (245.5) | 0.5 | (79.1) | (32.9) | (47.3) | (25.7) | (16.9) | (44.1) |

| Agency (FTE) | UH Bristol | Diagnostics & Therapies | Medicine | Specialised Services | Surgery Head & Neck | Women's & Children's | Trust Services (exc. Facilities & Estates) | Facilities & Estates |
|---|---|---|---|---|---|---|---|---|
| Agency December 2013 | 69.2 | 1.8 | 19.3 | 17.3 | 7.2 | 9.6 | 4.8 | 11.1 |
| **Target set by division** | 40.3 | 0.7 | 8.8 | 3.5 | 7.5 | 8.8 | 6.2 | 4.8 |
| **Agency December 2014** | **144.5** | **11.5** | **52.8** | **17.7** | **22.7** | **13.5** | **12.8** | **13.6** |
| **Variance from target (FTE)** | (104.3) | (10.8) | (44.0) | (14.2) | (15.2) | (4.7) | (6.6) | (8.8) |

Trust-wide, bank and agency usage continues to be for the following reasons:

- Workload and clinical needs, extra capacity and administrative workload increased to 37.8% of overall usage, compared with 34.5% last month;
- Cover for vacancies reduced to 25.3% from 27%;

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- Cover for sickness absence reduced again from 13.2% to 12.9%;
- Nursing assistant one-to-one care increased again this month, from 8.8% to 10.1% of usage.

There were 39 nursing and midwifery new starters undergoing orientation in all bed-holding Divisions, which is above the typical monthly average of 30. The overview below by Division shows usage for bank and agency against the original thresholds set by Divisions. An overview of temporary staff over the last three months, excluding staffing associated with Operational Resilience money is set out below. This shows a small increase which varies by Division.

| Bank and agency actual (FTE) **excluding** usage funded by Operational Resilience | UH Bristol | Diagnostics & Therapies | Medicine | Specialised Services | Surgery Head & Neck | Women's & Children's | Trust Services (exc. Facilities & Estates) | Facilities & Estates |
|---|---|---|---|---|---|---|---|---|
| October 2014 | 517.6 | 15.2 | 163.1 | 62.9 | 93.6 | 80.4 | 63.1 | 39.2 |
| November 2014 | 522.9 | 21.5 | 161.6 | 64.2 | 96.0 | 80.5 | 62.5 | 36.6 |
| December 2014 | 558.3 | 16.4 | 162.0 | 65.2 | 117.6 | 76.4 | 70.0 | 50.7 |

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

The Bank & Agency Action Plan continues to be reviewed monthly at the Nursing Workforce Steering Group. Progress this month includes the following:

Enhanced Rostering, Operational and Workforce Planning:

- More detailed workforce data will be available to ward sisters as part of the ward dashboard from the end of January;
- Medicine Division has secured agency block booking to ensure safe staffing levels at a more cost effective rate than would otherwise be the case.

Reducing requests due to clinical need and enhanced observation

- "Reasons for booking" has been changed, and will be reflected in the report in February;
- An assessment of the effectiveness of the implementation of the Standard Operating Procedures for sign-off of bank and agency continues.

Improved Bank fill rate to reduce the proportion of premium agency staffing

- Discussions with local trusts have taken place to improve collaboration and increase cost effectiveness;
- Encouraging flexible hours to allow shorter shifts is being actively encouraged to improve bank fill rates;
- Options to improve the incentives for staff to undertake bank shifts are under review;

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- Opportunities to provide staff with access to view available shifts on their handsets are being explored with Information Management and Technology (IM&T) Department.

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| W4. 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 rates have increased this month to 4.6%, with increases compared with last month in every Division, except Diagnostics & Therapies which reduced by 0.5 percentage points, and Specialised Services, which reduced by 0.1 percentage points. Trust-wide sickness absence levels generally peak in January and February; the last time these levels were reached as early as December was in 2010. Last month we reported a 69% increase in coughs, colds and flu related absence, and this month there has been a further 46% increase in month in absence for this reason. There has also been an associated increase of 105% in absence due to respiratory problems. However, days lost due to stress, anxiety and depression are at their lowest level for 8 months, with a 16% reduction in month.

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 December 2013 | 4.2% | 2.6% | 4.3% | 4.8% | 3.5% | 4.5% | 3.9% | 7.1% |
| Target December 2014 | 3.8% | 2.6% | 3.8% | 4.1% | 3.5% | 3.9% | 2.9% | 5.9% |
| **Absence December 2014** | **4.6%** | **3.3%** | **5.5%** | **4.1%** | **3.9%** | **4.8%** | **3.9%** | **6.6%** |
| Cumulative absence December 2014 | 4.0% | 2.7% | 4.8% | 4.0% | 3.8% | 3.8% | 3.1% | 6.4% |
| | 0.8% | 0.7% | 1.7% | 0.0% | 0.4% | 0.9% | 1.0% | 0.7% |

**Progress against recovery plan**

In the context of our overall health and well-being programme, key activity to highlight is as follows:

Influenza

4044 staff including 3314 frontline staff (57.4% of frontline staff) have been vaccinated to date. To further increase the uptake, the following measures continue:

## WORKFORCE

- Flu vaccine continues to be offered at training events such as Induction for new staff and on Consultant away days;
- A mobile vaccination team is available, if any staff wish to be seen on a particular day or time;
- Staff who have had the vaccine via another provider are asked to advise Occupational Health, so that vaccination rates can be adjusted.

Stress Management

- Hot spots will be identified in partnership with Divisional HR Business Partners to identify where there are high incidences of three more of the following: sickness absence; turnover; Occupational Health counselling referrals; discipline and grievance cases; violence and aggression incidents; awareness of conflict and organisational change in process;
- 10 extended modules of 'Making Change' and 'Identifying and Managing Work Related Stress' will be made available to staff from hot spots identified. There will be up to 300 places for staff (150 each module) in late February/ March which will be evaluated as they progress;
- Divisions will continue to undertake the Health and Safety Executive questionnaire resulting in a ward/departmental action plan with priority given to those areas identified as hot spots outlined above in bullet point one;
- 28 wards/ departments undertook the Health & Safety Executive process during 2014;
- Occupational Health counsellors currently working with stress hotspots identified directly by each Division.

Musculo-skeletal

- Work station assessment compliance is currently 82%, this takes staff through risk assessment or their individual workstation and provides the manager with actions should there be any issues identified;
- Adjustable height desks are available for trial before purchase via the Safety Department, should a back condition be an issue that is helped by varying work position during the working day beyond taking adequate breaks.

Health and well-being

- Smoke free secondary care practitioners to be recruited for a fixed term of a year from April 2015. Duties will include the implementation of smoke free policy and providing cessation support for staff, patients and visitors (funded by public health, Bristol City Council);
- New Wellbeing steering group (under the auspices of the Workforce and Organisational Development Group) set up to reinvigorate Trust Well Being approach.

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| W5. EXCEPTION REPORT: Vacancy Levels | RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development |
|---|---|

**Description of how the standard is measured:**

Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) 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:**

Vacancies remained unchanged at 6.1% this month. Progress on recruitment, with 96 new starters in month, is potentially masked by the high levels of turnover. 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 |
|---|---|---|---|---|---|---|---|---|
| December 2013 | 4.2% | (6.0%) | 7.6% | 2.0% | 3.4% | 4.2% | 2.0% | 5.0% |
| **Actual December 2014** | **6.1%** | **3.5%** | **10.9%** | **3.9%** | **5.7%** | **3.8%** | **7.6%** | **9.6%** |
| FTE vacancy December 2014 | 483.9 | 33.0 | 127.1 | 31.7 | 97.7 | 66.4 | 52.6 | 75.4 |

Vacancies reduced in month in Facilities & Estates, Women`s and Children`s, Surgery Head & Neck, but increased in all the others Divisions. Nursing vacancies increased by 7.1 WTE to 244.6 FTE, all of the increase being in unregistered nursing and ancillary vacancies reduced by 4 FTE to 59.8 FTE.

There are also continued "hot spots" of high vacancies, including Coronary Intensive Care Unit, Paediatric and Neonatal Intensive Care Units, Bristol Eye Hospital Outpatients and Theatres, Medicine Wards, and key consultant posts in Diagnostics & Therapies and Specialised Services.

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

Progress on the recruitment action plan which was agreed with Senior Leadership team in November is as follows:

Increased speed of recruitment - conversion to hire

A project plan has been developed as a result of the review led by the Transformation Team to support the achievement of maximum efficiency in the end to end recruitment process. December 2014 saw the following actions and achievements:

- A number of Trusts have been contacted to benchmark good practice;
- An agreed escalation process has been developed to speed up health assessment clearances and ensure a more efficient management of

recruitment episodes where clearance is exceeding agreed timeframes;

- Pending the implementation of the Recruitment Management System a manual RAG rated system has been instigated for each individual Employment Check, to measure speed of completion.
- Processes have been changed to maximise speed and efficiency of recruiting substantive staff to the bank;

IT infrastructure within the end-to-end recruitment process

- A full procurement is underway for a fit-for-purpose recruitment management system.

Additional resources in the recruitment team, to deliver the challenges of recruitment over the next year

- The Recruitment team structure has been strengthened and training is taking place to improve capability.

Marketing campaign to target the national UK market

- A marketing campaign went live on Facebook Theatre Practitioners and general and Bank registered nurses prior to Christmas with further targeted media going live at the end of December /early January to publicise open days planned for late January and February;
- Women's & Children's Division had a successful Open day on 6 December 2014. 23 applicants were shown around the hospital on tours resulting in 14 employment offers;
- An overseas recruitment campaign for Theatres Division has been agreed for Theatre Practitioners.

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

- At the end of December there were x 51 vacancies for Domestic Assistants across the Trust, of which 37 have been offered to candidates;
- With the new Ward Block at BRI opening from August 2014 – January 2015, 35 Domestic Assistants are required, (this number will always change due to the gradual opening of new wards) and at present 30 of these posts have been offered to candidates of which 26 have already started.

Nurse Recruitment

Highlights are as follows for December:

- 70 final offer letters were issued to new starters, of these, 43 were registered nurses and 27 nursing assistants;
- Nursing assessment centres continue with an increased number of candidates being seen in each one.

Internal resource is being identified within the HR Service Centre to support the vacancy of the Nurse Recruitment Manager's position.

## WORKFORCE

| W6. 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 continues to exceed 13% at 13.5% in December (13.4% in November). 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 December 2013 | 11.6% | 8.4% | 13.7% | 11.2% | 13.5% | 10.6% | 11.1% | 11.7% |
| Actual Cumulative Rolling Turnover December 2014 | **13.5%** | **10.4%** | **14.7%** | **17.4%** | **14.8%** | **10.4%** | **14.5%** | **14.5%** |
| Target | 10.2% | 8.9% | 10.9% | 10.5% | 10.3% | 9.9% | 10.5% | 10.5% |

Permanent staff leaver numbers have increased slightly in December, to 85 compared with 80 one year ago. Specialised Services continues to have the highest rate of turnover, although rates are high across the Trust, other than in Women`s & Children`s and Diagnostics & Therapies Divisions. There were above average retirements this month (20 compared with a monthly average of 10.5) Numbers leaving due to "work life balance", "relocations" and "promotions" reduced slightly this month, from a combined total of 55 to 48. The highest turnover is amongst unregistered nursing, which increased from 23.6% to 24.3%.

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

Work to improve retention this month includes a focussed discussion by Senior Leadership team, ongoing work on staff engagement, and improving the exit process.

**Priorities for action**

Priorities for action on retention were agreed with the Senior Leadership Team. These are as follows, and work is currently underway.

## WORKFORCE

Nursing Assistants

- *Communication* - develop a Trust-wide Nursing Assistants Forum/listening events;
- *Career Progression* – provide clear career pathways; use success stories and vignettes from existing staff to attract prospective candidates and to motivate existing staff;
- *Pre and post-induction* – pilot a revised extended induction process with Nursing Assistants, providing regular additional management support at key stages throughout the first thirteen months of employment.

Incentives

- Explore the use of a range of incentives for particular staff groups where recruitment and retention difficulties can be evidenced;

Career Development

- Improve understanding of career development opportunities across the Trust through increased marketing and communication including raising awareness of postgraduate education opportunities and research opportunities;
- Optimise recruitment by identifying successful candidates short and long term development needs and provide them with a Personal Development plan as part of their induction and for immediate implementation;
- Review opportunities for nursing preceptorship courses.

Rotations and Staff 'Transfer Window'

- *Internal transfers and rotations* – encourage Divisions to increase opportunities for internal transfers and rotations across the Trust.

**Staff Engagement**

The comprehensive staff engagement programme continues to make good progress. Work during the month includes the following:

- Following "Respecting Everyone" month, funding from Above and Beyond will provide cards for all staff, with information, including contact numbers, on bullying harassment and bullying. Nominations for a "Respecting Everyone" award have been received and a winner selected;
- A survey on inpatient nursing staff views on shift patterns was rolled out during December and early January. Information from the survey and focus groups will be triangulated with sickness and turnover data and information from the national staff survey and Friends & Family Test.
- Divisional activities continue, including focus groups, Listening Events, Divisional Newsletters and updates, site visits by Senior Management Teams, Back to the Floor and Floor to Board rounds and creation of Staff Champions;
- The first draft of a revised Speaking Out policy and supporting information has been prepared and shared initially with the Trust Secretary and Head of Communications. A group to fully review the policy and process is being set up in January.

**Exit Management Process**

Progress on improving the exit process this month continues, which includes the following:

- A detailed process was agreed at Workforce Management Group, which places the emphasis on managers to make an initial attempt at retaining

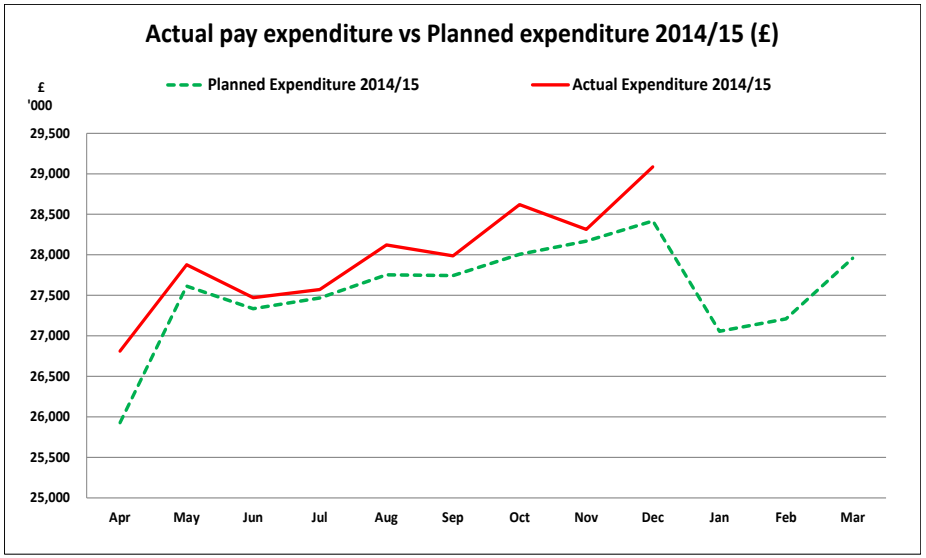
the staff member, where appropriate, and which will also improve the quality and quantity of data;

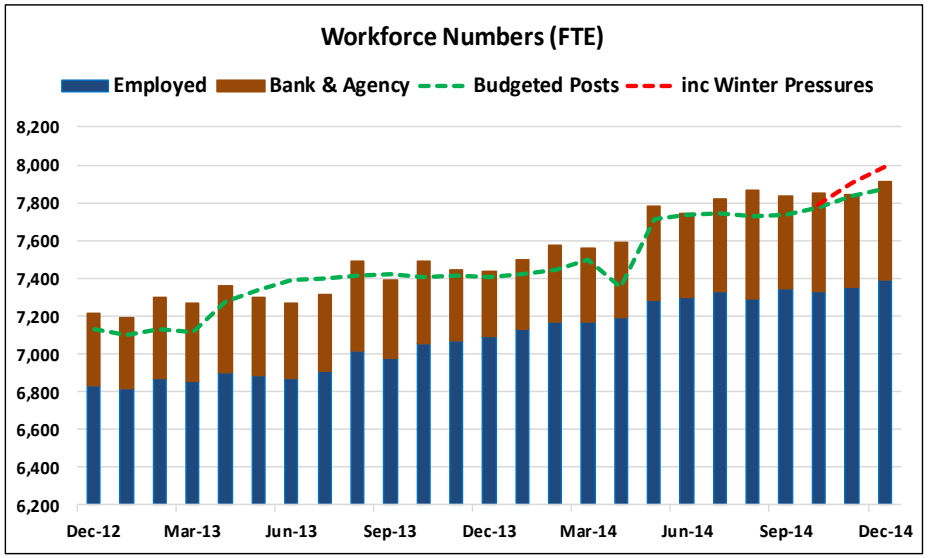
- The new system will be communicated through Newsbeat, HR Business Partners, manager training sessions, and the homepage of HR Web from 1st January.

## 2.3 SUPPORTING INFORMATION

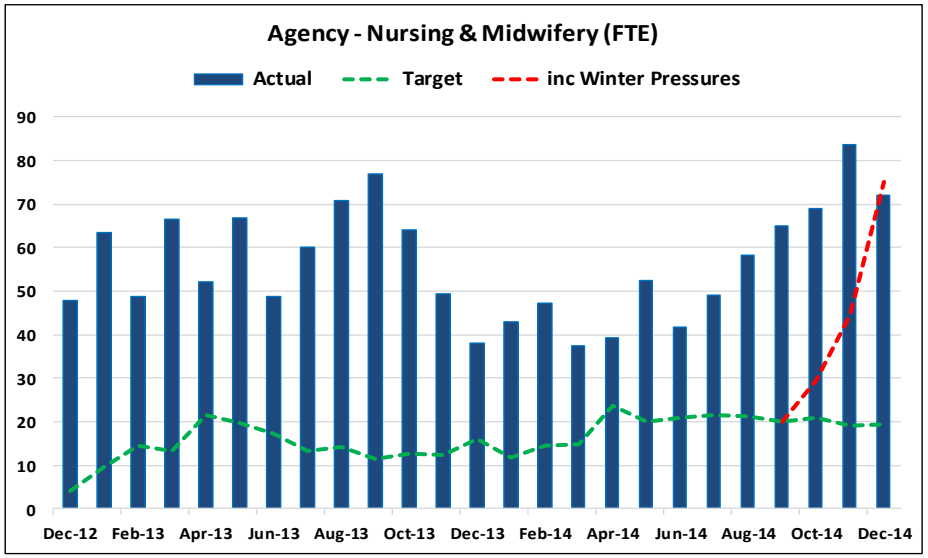
### 2.3.1 Performance against key workforce standards

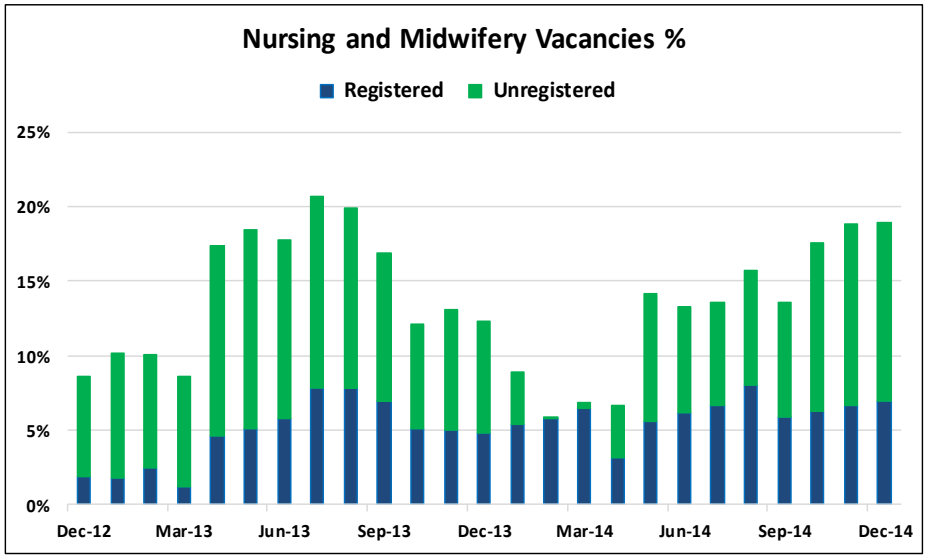
This section provides an outline of the Trust's performance against workforce indicators for workforce expenditure, workforce numbers, and bank and agency usage, with an additional chart to show how the variance against target for agency usage has reduced. There are also graphs to show nursing agency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

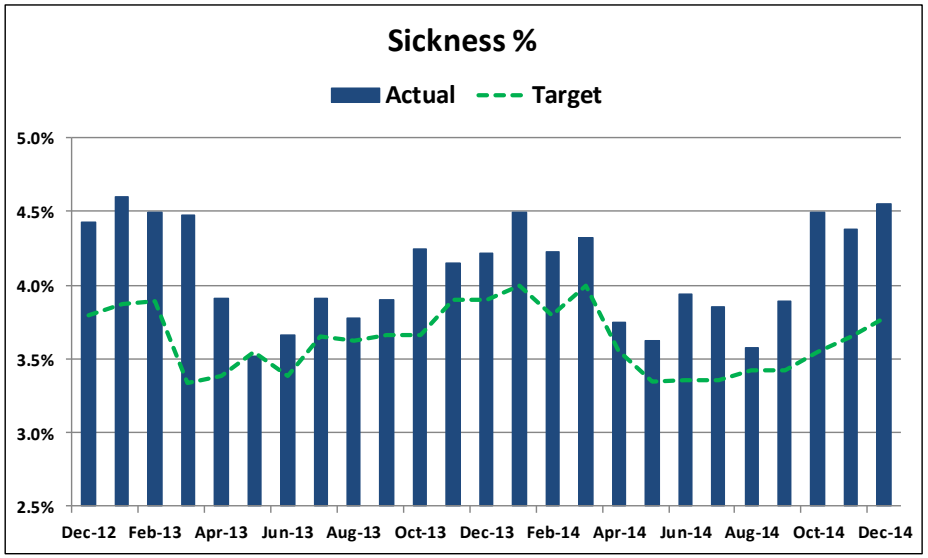


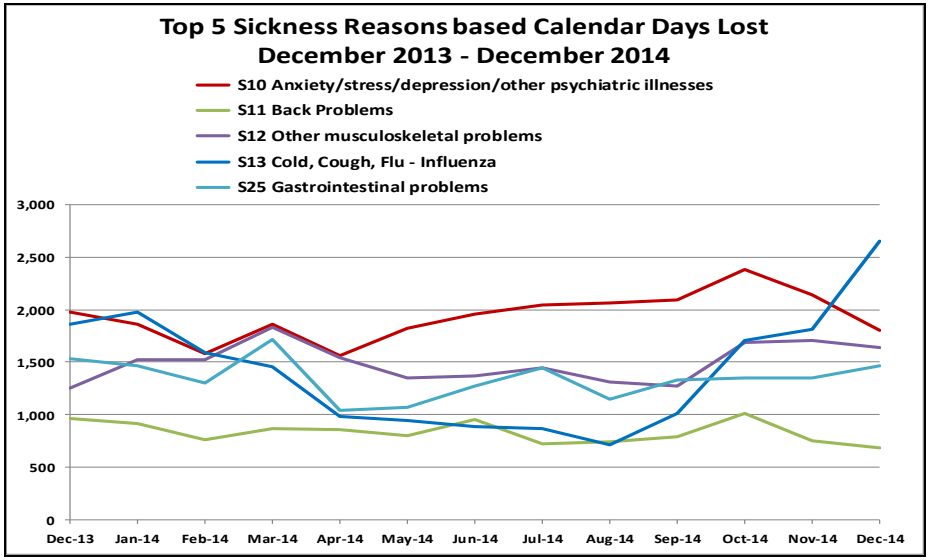



## WORKFORCE

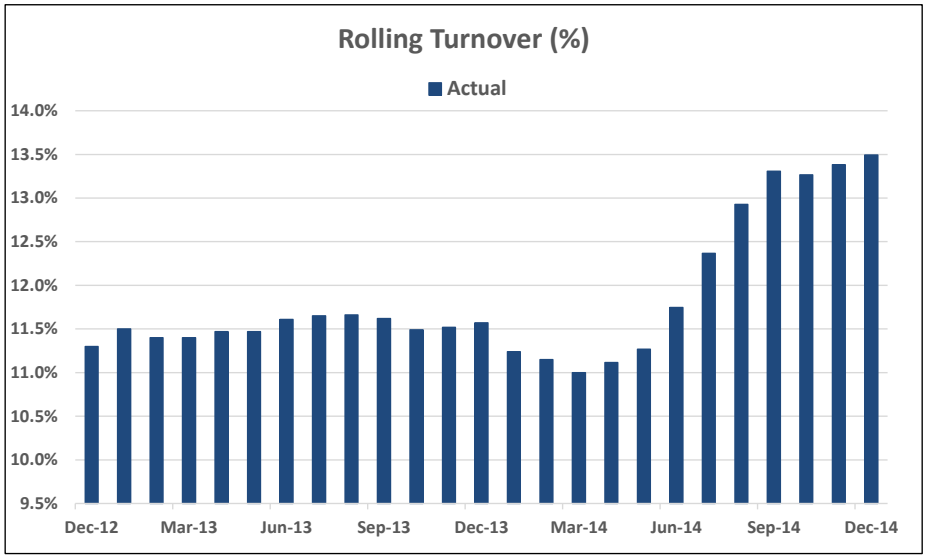

Agency - Nursing & Midwifery (FTE)
Actual
Target
inc Winter Pressures
90
80
70
60
50
40
30
20
10
0
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14


Nursing and Midwifery Vacancies %
Registered
Unregistered
25%
20%
15%
10%
5%
0%
Dec-12
Mar-13
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14


Sickness %
Actual
Target
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14

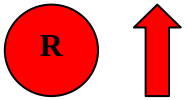
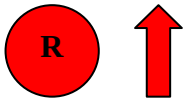
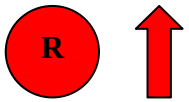
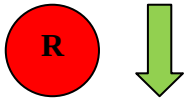
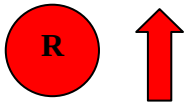
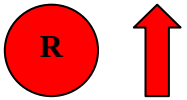
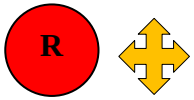

Top 5 Sickness Reasons based Calendar Days Lost
December 2013 - December 2014
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
3,000
2,500
2,000
1,500
1,000
500
0
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14

# WORKFORCE


Rolling Turnover (%)
Actual
14.0%
13.5%
13.0%
12.5%
12.0%
11.5%
11.0%
10.5%
10.0%
9.5%
Dec-12
Mar-13
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14

### 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 December. Red rated indicators are outside tolerance limits and exception reports are provided for these.

| Indicator | RAG Rating[2] | Commentary | Notes |
|---|---|---|---|
| Workforce Expenditure (£) |   | Workforce expenditure adverse variance from budget increased from 0.5% to 2.4% in month compared with November 2014. | See summary, supporting information and exception report. |
| Workforce Numbers (FTE) |   | Total workforce numbers including bank and agency increased by 111.9 FTE compared with the previous month. Workforce numbers were 1.9% above budgeted FTE but this becomes 0.5% when Operational Resilience pressures funding is included. This compares with November 2014, when numbers were 1.0% above budgeted establishment. | See summary, supporting information and exception report. |
| Bank (FTE) |   | Bank increased by 97.0 FTE to 489.7 FTE (compared with a target of 244.1 FTE) in December 2014. Operational Resilience Pressures equalled 10.7% (52.5 FTE) of total bank usage in December 2014 | See summary, supporting information and exception report. |
| Agency (FTE) |   | Agency reduced by 21.4 FTE to 144.5 FTE (compared with a target of 40.3 FTE) in December 2014. Operational Resilience Pressures equalled 42.2% (61.1 FTE) of total agency usage in December 2014 | See summary, supporting information and exception report. |
| Sickness absence (%) |   | Sickness absence has increased to 4.6% in December; compared to 4.4% in November 2014.This is 0.8 percentage points above the monthly target of 3.8%. | See summary, supporting information and exception report. |
| Turnover (%) |   | Rolling turnover (excluding fixed term contracts, junior doctors, and bank) increased to 13.5% compared a target of 10.2% and up 0.1 percentage points compared with November. | See summary, supporting information and exception report. |
| Vacancy (%) |   | Vacancies remained static at 6.1% this month, 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 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | December 14 Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Budgeted Posts (FTE) | 7406.4 | 7424.8 | 7442.0 | 7499.3 | 7355.2 | 7709.5 | 7732.9 | 7744.9 | 7729.1 | 7733.4 | 7775.8 | 7833.6 | 7872.4 | 7757.2 |
| Total Staffing (FTE) | 7440.0 | 7495.2 | 7578.1 | 7556.5 | 7588.1 | 7780.7 | 7739.6 | 7821.9 | 7864.8 | 7835.5 | 7859.9 | 7910.8 | 8022.7 | 7741.3 |
| Bank (FTE) Admin & Clerical | 58.4 | 59.0 | 67.4 | 64.9 | 71.3 | 89.2 | 83.7 | 88.8 | 103.5 | 86.4 | 95.8 | 93.5 | 121.0 | 53.7 |
| Bank (FTE) Ancillary Staff | 25.6 | 30.7 | 35.2 | 34.6 | 38.0 | 54.6 | 51.8 | 51.9 | 73.3 | 59.0 | 55.6 | 47.5 | 60.1 | 14.9 |
| Bank (FTE) Nursing & Midwifery | 184.2 | 197.0 | 220.2 | 197.4 | 203.6 | 249.5 | 220.8 | 241.8 | 274.2 | 233.7 | 247.2 | 245.0 | 300.0 | 171.1 |
| Agency (FTE) Admin & Clerical | 17.4 | 13.5 | 27.1 | 25.7 | 23.4 | 22.4 | 21.1 | 19.3 | 27.7 | 26.4 | 29.9 | 49.0 | 52.9 | 12.2 |
| Agency (FTE) Ancillary Staff | 10.5 | 3.7 | 0.0 | 8.3 | 0.0 | 6.8 | 4.9 | 15.0 | 12.1 | 7.6 | 7.9 | 14.3 | 9.7 | 4.5 |
| Agency (FTE) Nursing & Midwifery | 38.1 | 43.1 | 47.2 | 37.5 | 39.2 | 52.4 | 41.6 | 49.1 | 58.3 | 65.0 | 68.9 | 83.7 | 71.9 | 19.3 |
| Overtime | 58.2 | 60.1 | 54.7 | 83.7 | 76.4 | 48.2 | 62.3 | 49.6 | 67.5 | 60.2 | 78.9 | 64.3 | 76.9 | 43.2 |
| Sickness absence[1] Rate (%) | 4.2% | 4.5% | 4.2% | 4.3% | 3.7% | 3.6% | 3.9% | 3.9% | 3.6% | 3.9% | 4.5% | 4.4% | 4.6% | 3.8% |
| Appraisal (%) | 88.8% | 88.5% | 87.9% | 85.9% | 87.1% | 86.3% | 87.2% | 86.3% | 86.9% | 85.3% | 84.4% | 83.5% | 85.1% | 85.0% |
| Consultant Appraisal[5] (%) | 0.0% | 0.0% | 0.0% | 0.0% | 89.1% | 89.2% | 83.0% | 85.5% | 88.8% | 89.1% | 88.4% | 90.3% | 89.0% | 85.0% |
| Rolling Average Turnover[2] (all reasons) (%) | 18.3% | 17.9% | 18.0% | 17.8% | 17.8% | 18.0% | 18.6% | 19.0% | 19.4% | 19.7% | 19.5% | 19.5% | 19.5% | |
| Rolling Average Turnover[3] (with exclusions) (%) | 11.6% | 11.2% | 11.2% | 11.0% | 11.1% | 11.3% | 11.7% | 12.4% | 12.9% | 13.3% | 13.3% | 13.4% | 13.5% | 10.2% |
| Vacancy[4] Rate (%) | 4.2% | 4.0% | 3.7% | 4.4% | 2.2% | 5.5% | 5.6% | 5.4% | 5.6% | 5.1% | 5.7% | 6.1% | 6.1% | ≤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.
   Vacancy measures the number of vacant posts as a percentage of the budgeted establishment.

## 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 December 2014**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 3)***, 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 (8)** | **Underachieving (1)** |
|---|---|
| - 31-day diagnosis to treatment cancer standard - *subsequent drug*<br>- 31-day diagnosis to treatment cancer standard – *subsequent radiotherapy*<br>- 31-day diagnosis to treatment cancer standard - *subsequent surgery*<br>- 31-day diagnosis to treatment cancer standard - *first treatment*<br>- 2-week wait urgent GP referral cancer standard<br>- A&E Left without being seen rate<br>- A&E Time to Treatment<br>- A&E Unplanned re-attendance | - Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved* |
| **Failing (12)** | **Not reported/scored (0)** |
| - A&E Maximum waiting time (4-hours)<br>- A&E Time to Initial Assessment<br>- Ambulance hand-over delays over 30 minutes (year-on-year reduction)<br>- Delayed Discharges<br>- Referral to Treatment Time for non-admitted patients<br>- Referral to Treatment Time for admitted patients<br>- Referral to Treatment Time for incomplete pathways<br>- 62-day referral to treatment cancer standard – *GP referred*<br>- 62-day referral to treatment cancer standard - *Screening referred*<br>- Last-minute cancelled (LMC) operations + 28-day readmission<br>- Reperfusion times (door to balloon time of 90 minutes)<br>- 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 December. Indicators are shown as being **failed** where the required standard is not achieved for the quarter to date. Indicators are shown as being **underachieved** if there has been a failure to achieve the national target in the current month, but the quarter is currently being achieved, or where a local standard is not being met.*

# 3.2 ACCESS DASHBOARD

## Access Standards - dashboard

| | Target | Thresholds Green | Thresholds Red | Previous YTD | Year to date (YTD) | Month Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Quarter Q3 13/14 | Q4 13/14 | Q1 14/15 | Q2 14/15 | Q3 14/15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | Cancer - Urgent Referrals Seen In Under 2 Weeks | 93% | 93% | 96.4% | 95.7% | 95.4% | 98.0% | 98.4% | 97.1% | 97.0% | 96.0% | 97.0% | 93.2% | 94.8% | 94.6% | 96.3% | Cancer standards report two months in arrears | 96.4% | 97.4% | 96.7% | 95.0% | 95.4% |
| | Cancer - 31 Day Diagnosis To Treatment (First Treatments) | 96% | 96% | 97.5% | 96.3% | 96.2% | 94.0% | 97.8% | 97.5% | 97.9% | 96.2% | 96.8% | 96.2% | 96.2% | 95.1% | 94.3% | | 98.0% | 96.0% | 97.2% | 96.4% | 94.8% |
| | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) | 98% | 98% | 99.9% | 99.8% | 99.3% | 100.0% | 100.0% | 100.0% | 100.0% | 99.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.9% | | 99.7% | 99.7% | 99.7% | 100.0% | 99.5% |
| | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | 94% | 94% | 95.1% | 94.7% | 93.5% | 97.6% | 91.8% | 97.9% | 93.2% | 93.5% | 94.0% | 97.8% | 91.7% | 96.2% | 91.9% | | 96.9% | 94.1% | 94.9% | 94.6% | 94.4% |
| | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) | 94% | 94% | 98.0% | 97.8% | 92.3% | 99.5% | 95.6% | 97.9% | 98.9% | 95.1% | 97.6% | 98.4% | 97.4% | 98.2% | 99.5% | | 97.8% | 95.7% | 97.2% | 97.8% | 98.8% |
| | Cancer 62 Day Referral To Treatment (Urgent GP Referral) | 85% | 85% | 81.0% | 79.0% | 72.9% | 77.4% | 74.8% | 75.3% | 81.1% | 85.1% | 79.4% | 77.6% | 74.3% | 79.6% | 81.0% | | 84.6% | 75.1% | 80.4% | 76.8% | 80.3% |
| | Cancer 62 Day Referral To Treatment (Screenings) | 90% | 90% | 92.3% | 89.9% | 98.0% | 94.9% | 88.9% | 90.3% | 90.2% | 90.9% | 90.2% | 94.3% | 83.3% | 73.3% | 100.0% | | 90.5% | 94.4% | 90.4% | 90.8% | 81.0% |
| | Cancer 62 Day Referral To Treatment (Upgrades) | Not published | Not published | 93.8% | 90.7% | 79.3% | 75.6% | 97.0% | 97.5% | 86.1% | 100.0% | 86.7% | 70.0% | 89.3% | 85.7% | 100.0% | | 88.3% | 85.3% | 95.3% | 83.1% | 90.4% |
| Referral to Treatment | Referral To Treatment Admitted Under 18 Weeks | 90% | 90% | 92.9% | 86.6% | 92.8% | 92.4% | 90.5% | 91.9% | 91.8% | 90.1% | 87.2% | 84.4% | 82.4% | 85.2% | 83.1% | 84.3% | 92.3% | 92.0% | 91.2% | 84.7% | 84.3% |
| | Referral To Treatment Non Admitted Under 18 Weeks | 95% | 95% | 93.2% | 90.7% | 92.0% | 92.7% | 93.1% | 93.6% | 94.0% | 92.8% | 89.7% | 90.0% | 89.0% | 89.2% | 88.8% | 89.9% | 92.5% | 92.6% | 93.4% | 89.5% | 89.3% |
| | Referral To Treatment Incomplete pathways Under 18 Weeks | 92% | 92% | 92.5% | 90.7% | 92.6% | 92.4% | 93.1% | 92.7% | 92.5% | 92.1% | 92.0% | 91.1% | 90.0% | 89.4% | 88.7% | 87.5% | 92.7% | 92.7% | 92.4% | 91.0% | 88.5% |
| A&E Clinical Quality Indicators | A&E Total time in A&E 4 hours - without Walk in Centre attendances | 95% | 95% | 94.4% | 92.3% | 91.6% | 90.1% | 92.1% | 94.5% | 94.3% | 95.2% | 92.4% | 93.7% | 92.4% | 93.8% | 88.6% | 86.3% | 93.7% | 91.3% | 94.7% | 92.8% | 89.6% |
| | A&E Time to initial assessment (95th percentile) - in minutes | 15 | 15 | 15 | 13 | 12 | 24 | 15 | 14 | 12 | 11 | 13 | 12 | 11 | 12 | 12 | 36 | 13 | 14 | 12 | 12 | 15 |
| | A&E Time to treatment decision (median) - in minutes | 60 | 60 | 52 | 55 | 46 | 55 | 54 | 53 | 57 | 55 | 59 | 47 | 55 | 51 | 59 | 57 | 53 | 51 | 55 | 54 | 55 |
| | A&E Unplanned reattendance rate (within 7 days) | 5% | 5% | 1.3% | 2.2% | 2.8% | 2.5% | 2.4% | 2.7% | 2.2% | 2.4% | 0.2% | 2.5% | 2.6% | 2.5% | 2.6% | 2.4% | 2.5% | 2.5% | 2.4% | 1.7% | 2.5% |
| | A&E Left without being seen | 5% | 5% | 1.8% | 1.8% | 2.0% | 1.8% | 1.7% | 1.5% | 1.9% | 1.4% | 2.2% | 2.0% | 2.0% | 1.5% | 2.3% | 1.6% | 2.1% | 1.8% | 1.6% | 2.1% | 1.8% |
| Other key access standards | Last Minute Cancelled Operations | 0.80% | 1.50% | 0.97% | 1.11% | 1.18% | 1.44% | 0.92% | 0.98% | 0.96% | 1.10% | 1.35% | 0.97% | 1.14% | 0.84% | 1.96% | 0.73% | 0.85% | 1.17% | 1.02% | 1.16% | 1.16% |
| | 28 Day Readmissions | 95% | 85% | 89.4% | 89.5% | 93.6% | 88.6% | 89.7% | 94.2% | 85.2% | 94.4% | 95.3% | 90.5% | 85.2% | 85.3% | 90.4% | 87.0% | 94.0% | 90.3% | 91.3% | 90.6% | 87.3% |
| | 6-week wait for key diagnostics | 99% | 99% | 98.5% | 97.6% | 98.0% | 99.2% | 99.2% | 98.3% | 96.6% | 97.3% | 97.7% | 97.0% | 98.1% | 99.1% | 98.3% | 95.8% | 99.1% | 98.8% | 97.4% | 97.6% | 97.8% |
| | Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only) | 90% | 70% | 83.3% | 78.7% | 77.5% | 82.9% | 77.1% | 78.6% | 78.3% | 82.1% | 80.6% | 76.9% | 81.8% | 79.4% | 73.8% | | 86.1% | 78.9% | 79.4% | 78.7% | 76.3% |
| | Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only) | 90% | 90% | 94.0% | 91.6% | 90.0% | 91.4% | 91.7% | 96.4% | 93.5% | 96.4% | 88.9% | 94.9% | 90.9% | 94.1% | 81.0% | | 94.1% | 91.1% | 95.1% | 92.0% | 86.8% |
| | Delayed discharges (Green to Go List) | 30 | 41 | Not applicable | 51.8 | 60 | 73 | 58 | 56 | 51 | 58 | 50 | 53 | 57 | 44 | 55 | 42 | 53.0 | 63.7 | 55.0 | 53.7 | 47.0 |
| | Ambulance hand-over delays (over 30 minutes) - 10% reduction on 13/14 | 0 | 91.2 | 96.6 | 115.7 | 94 | 137 | 105 | 96 | 100 | 79 | 139 | 144 | 100 | 77 | 131 | 168 | 84.3 | 112.0 | 91.7 | 127.7 | 125.3 |

**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 relative to the last reported period:

- Cancer 31-day diagnosis to treatment (subsequent surgery) ↓ (down from 96.2% in October to 91.9% in November) – *expected to be confirmed as achieved for the quarter as a whole;*
- Cancer 62-day Screening referral to treatment ↑ (up from 73.3% in October to 100% in November) – *but standard not met for the quarter as a whole;*
- Last-minute cancelled operations ↓ (down from 1.96% in November to 0.73% in December);
- Diagnostic 6-week wait ↓ (down from 98.3% in November to 95.8% in December);
- Ambulance hand-over delays over 30 minutes ↑ (up from 131 in November to 168 in December);
- Time to initial assessment (number of minutes 95% seen within – target 15 minutes) ↑ (up from 12 minutes in November to 36 minutes in December);
- Primary Percutaneous Coronary Intervention (PCI) 90 minute Door to Balloon time for cardiac reperfusion ↓ (down from 94.1% in October to 81.0% in November)

*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 eleven 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) 62-day referral to treatment cancer standard – Screening referred
5) 31-day first definitive treatment cancer standard – exception report provided, as at risk
6) Referral to Treatment Time (RTT) Non-admitted pathways standard
7) Referral to Treatment Time (RTT) Incomplete pathways standard

## ACCESS STANDARDS

8) A&E 4-hour maximum wait

9) A&E Time to Initial Assessment (ambulance arrivals only)
10) Six-week diagnostic wait
11) Reperfusion times (door to balloon time of 90 minutes)

## ACCESS STANDARDS

| A1-A2. EXCEPTION REPORT: Last-minute cancellation (LMC) + 28-day readmission following a LMC | RESPONSIBLE DIRECTOR: Chief Operating Officer |
|---|---|

**Description of how the target is measured:**

1) The number of patients whose operation was cancelled at last minute for non clinical reasons, as a percentage of all admissions;
2) The number of patients cancelled at last-minute for non-clinical reasons who were not readmitted within 28 days of the date of the cancellation, as a percentage of all cancellations in the period.

This standard remains part of the NHS Constitution.

**Monitor measurement period:** Not applicable

**Performance during the period, including reasons for exception:**

There were 41 last-minute cancellations (LMCs) of surgery in December (0.73% of operations) which is within the national standard of 0.8%. Although this represents a significant improvement on the previous month, overall performance for the quarter was above the 0.8% standard, and above the target trajectory set for this quality objective. The main reasons for cancellations in December were as follows:

- 29% (12 cancellations) were due to no ward beds being available;
- 20% (8 cancellations) were due to the surgeon or anaesthetist being unwell or unavailable;
- 17% (7 cancellations) were due to a lack of theatre time due to clinically complicated patients needing more time in theatre than expected, and/or the morning theatre session running over;
- 12% (5 cancellations) were due to other patients needing to take priority;
- 22% (9 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging.

Of the 41 cancellations, 17 were day-cases and 24 were inpatients (41% day-cases). On average, seventy percent of the Trust's admissions in a month are day-cases. The higher cancellation rate for inpatient procedures is a result of the main causes of cancellation being lack of ward beds (on inpatient wards) and emergency patients being prioritised. Day-case procedures are usually conducted in theatre sessions that could not readily be used for emergency patients.

In December 87.0% of patients cancelled in the previous month were readmitted within 28 days of the cancellation, against a national standard of 95%. The relatively low level of re-booking within target is in part due to the high number of cancellations in November (108) which required re-booking, and also due to bed pressures and clinician availability in December. There were fourteen breaches of 28-day readmission standard in the month, of which thirteen were due for readmission for procedures within the Bristol Children's Hospital. Of these thirteen patients, six could not be readmitted due to pressure on beds in the period, and the remaining seven could not be readmitted in the month due to a combination of more urgent patients needing to take priority, elective lists having to be cancelled due to the level of emergency patients, and clinician availability. The remaining

patient needed to be readmitted for a procedure within the Bristol Royal Infirmary, but could not be re-admitted within 28-days due to more clinically urgent patients requiring admission.

**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 – A8);
- 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;
- Elective activity is routinely discussed at every 08:30 Site Team and the 16:45 Silver Command patient flow meetings. No patients are cancelled without a cross Divisional discussion to ensure other options have been explored.
- Specialty specific plans are shown below:

| Specialty | Action |
|---|---|
| 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. |

## ACCESS STANDARDS

| | |
|---|---|
| | Lists currently booked assuming lowest level of emergency admissions to maximise time available to clear Referral to Treatment Times backlog, although list space remains allocated for admissions through clinic. |
| All Paediatric | Through the Winter Planning Project within the Children's Flow Programme, increase medical bed capacity throughout winter to reduce impact on surgical bed capacity and thus last-minute cancellations (LMCs) **At Risk - Recruitment/Retention Challenges and staff sickness absence** |
| All Paediatric | Through the Elective Processes Project in the Children's Flow Programme, improve planning, communication and decision-making to reduce LMCs; decision taken to cancel a number of elective theatre lists during the winter months, as patients booked onto these lists were routinely having to be cancelled at last minute due to emergencies. |
| 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. |

**Progress against the recovery plan:**

The national standard of less than 0.8% of operations being cancelled at last-minute for non-clinical reasons was achieved in December. This is despite pressure on ward bed availability being higher than in previous months, as a result of a higher proportion of emergency patients being admitted being elderly and frail, and therefore having a longer length of stay. The principles of the Managed Beds protocol continues to be adhered to, to enable elective operations to proceed as planned. However, the need for medical emergency patients to occupy surgery and cardiac beds is assessed on a day-to-day basis, with clinical risk informing that decision making.

Performance against the 28-day readmission standard deteriorated in December, mainly due to the high level of cancellations seen in the previous month. Maintaining a lower level of ward-bed related cancellations remains the minimum requirement for 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 A8), should reduce levels of last-minute cancelled operations and improve performance against the 28-day readmission standard.

## ACCESS STANDARDS

| A3 – A4. EXCEPTION REPORT: 62-day referral to treatment cancer standard for GP and Screening 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 December is 82.7%. This figure is subject to further validation and final national reporting, which will take place early in February. The recovery trajectory target of 84.1% is not expected to be achieved for the month, for the reasons shown in the final section of this exception report. However, performance in December is significantly better than that reported in the last five months, and reflects the actions taken as part of the improvement plan starting to take effect.

Performance in November (latest reported month) was reported as 81.0% against the 85% standard. Performance for internally managed pathways was 90.2% against the 85% standard. Performance for shared pathways was 60.0%. If the breaches for those referrals received late (i.e. on or after day 46 in the pathway) were re-allocated in full to the referring provider, performance would have been 86.2%, and above the 85% standard. Breach analysis has shown the reasons for the breaches to be as follows:

| Breach reasons | November | Percentage of breaches |
|---|---|---|
| Late referral | 4.5 | 32% |
| Medical deferral/Clinical complexity | 3.5 | 25% |
| Delayed admitted diagnostic | 1.0 | 7% |
| Patient choice to delay | 1.5 | 11% |
| High dependency unit bed availability | 1.0 | 7% |
| Clinical pathway management | 1.5 | 11% |
| Delayed pre-operative assessment | 0.5 | 4% |
| Delayed outpatient appointment | 0.5 | 4% |
| | **14.0** | **100%** |

68% of breaches were due to primarily unavoidable reasons, including late referral, medical deferral, clinical complexity and patient choice.

There were 5 breaches (36%) relating to internally managed pathways and 9 breaches (18 pathways x 0.5 accountability) relating to shared pathways.

## ACCESS STANDARDS

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 November 2014, the 85% standard was only achieved for breast and skin cancers at a national level, with all other tumour sites performing below 80%. The national average performance across all tumour sites was 83.8%. The Trust is now the only acute provider in the country that provides neither breast nor urology cancer outpatients or surgical services. It is calculated that the impact of our tumour site case-mix equates to a 3.5% reduction in expected performance. This figure is without any adjustment for the tertiary nature of our services.

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.

62-day GP Screening

For quarter 2 as a whole 90.8% of patients were treated within 62-day of referral with a suspected cancer from the national screening programmes. The Avon Breast Screening service transferred to North Bristol Trust during quarter 2. This means that from quarter 3 onwards the Trust will only treat a small number of breast patients on 62-day screening pathways which are referred to us for chemotherapy or radiotherapy. The vast majority of patients the Trust will report under the 62-day screening pathway will be those referred-in by the bowel screening programme which the Trust hosts. National performance against the 62-day screening standard for bowel screening patients was 75.7% in November 2014. Although the Trust has over the last year performed well against the 90% standard for patients referred-in by the bowel screening programme, performance is variable and is often heavily impacted by patients' choice to delay diagnostic tests and also capacity at other treating providers.

During November our performance against the 90% standard was 100%. However, due to the breaches incurred at other treating providers in October, along with those expected to be confirmed in December (two shared breaches incurred due to late referral by another provider, and delayed treatment at another provider following timely referral to them by the Trust), the 90% standard will not be achieved for quarter 3 as a whole.

**Recovery plan, including expected date performance will be restored:**

A fortnightly cancer performance improvement group is taking forward further improvement priorities. These are identified from reviews of breaches, good practice from other providers, and in response to potential risks e.g. awareness campaigns. A specific action plan for cancer performance is maintained by the group and is also monitored at the Cancer Board and Service Delivery Group. The action plan is updated with new actions on an ongoing basis as these are identified, and all actions have an expected impact assigned to them which link through to the trajectory for performance improvement. The impact of some actions may take two months (i.e. the length of a pathway) to show the full effect, depending on the stage of the pathway they relate to. The action plan covers all cancer access targets, but with the primary focus being on those actions that will

support delivery of the 62 day GP standard. The current/recently completed 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 at UH Bristol and North Bristol Trust. An innovative project trialling remote pre-operative assessment via Skype technology has also started to support this clinic. Taunton clinics are due to start, followed by 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. Patient choice has been a challenge in some areas;
- A specific pathway improvement project for Head and Neck, most of which has now completed. The implementation of this project's actions has seen a three-fold reduction in breaches for this speciality and the learning from this project is being applied elsewhere;
- Additional capacity for thoracic surgery, hepato-pancreato biliary surgery and Ear, Nose & Throat minor procedures has been created, following the move of vascular services to North Bristol Trust. This has considerably improved capacity problems in these specialities, particularly thoracic surgery;
- 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; with a change to the organisation of reporting by radiologists and a review of the timings of lists and reporting sessions to ensure optimum timings;
- 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;
- Pathways with optimum timescales for lung and oesophago-gastric cancer (complex, relatively high volume specialities) have been devised and are in the second phase of clinical checking. Once agreed internally, the aim is for these to be adopted across the South West and this has been discussed at several regional meetings. North Bristol Trust is working with UH Bristol on the oesophago-gastric cancer pathway specifically;
- Pathway work for patients with lymphomas of the neck, who commonly have lengthy pathways due to passing between specialities, to design a smooth timely pathway with earlier transfer to haematology
- Additional bronchoscopes are being purchased, to reduce risks of delays due to equipment failure and enabling the Trust to carry out in-house certain types of bronchoscopy that currently have to be sent to North Bristol Trust, building in a delay;
- Plan to manage the impact of the 2015 national awareness campaign for oesophago-gastric cancer. This includes creating additional

endoscopy capacity, introducing a triage step in pathways, and undertaking some GP education to support primary care and ensure referrals are appropriate. Freedom of information requests to pilot Trusts have been made in order to forecast impact on treatments, as these data are not available nationally;

- Subject to agreement from commissioners, introduce direct booking of two week wait referrals via choose and book, which should increase the likelihood of patients attending their first appointments and doing so in a timely way, as well as having safety and patient experience benefits;
- Developing an improved system for providing theatre time in main theatres to the gynaecology team within shorter timescales, for high risk patients requiring intensive care/high dependency care;
- Improving proactive management systems for fast track patients in radiology and pathology;
- Development of a specific pathway for patients with head and neck lumps that are suspected to be lymphoma, to ensure smoother and faster transitions between head and neck and haematology.

**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 July to September are now confirmed following the completion of quarter 2 reporting. The figures for October and November are still subject to final validation and reporting. Performance for November is below trajectory, mainly due to the high number of late tertiary referrals and complex cases in the period.

| | Apr-14 | May-14 | Jun-14 | Q1 | Jul-14 | Aug-14 | Sep-14 | Q2 | Oct-14 | Nov-14 | Dec-14 | Q3 | Jan-15 | Feb-15 | Mar-15 | Q4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trajectory | 75.7% | 80.5% | 65.0% | 75.3% | 79.9% | 82.1% | 81.8% | 81.3% | 86.4% | 85.1% | 84.1% | 85.3% | 84.8% | 85.4% | 87.0% | 85.8% |
| Actual | 75.5% | 81.6% | 85.1% | 80.4% | 79.4% | 77.6% | 74.3% | 76.8% | 79.6% | 81.0% | | | | | | |

62-day screening

The 90% standard is considered at risk in quarter 3 following the transfer of the Avon Breast Screening service, for the reasons set-out in the previous section.

## ACCESS STANDARDS

| A5. EXCEPTION REPORT: 31-day diagnosis to treatment cancer standard for first definitive treatment | RESPONSIBLE DIRECTOR: Chief Operating Officer |
|---|---|

**Description of how the target is measured:**

The number of patients receiving first definitive treatment within 31 days of the decision to treat, as a percentage all cancer patients receiving first definitive treatment during the period.

**Monitor measurement period:** Quarterly (weighted 1.0)

**Performance during the period, including reasons for exceptions:**

Reported performance for October and November was 95.1% and 94.3% respectively. However, December's performance is currently at 98%, and the national standard is forecast to be achieved for the quarter as a whole on final validation.

The main risk to achievement of the 96% standard in future quarters, is the high level of elective cancellations due peaks in demand for critical care beds, as experienced during November. However, the Trust has also started to report more 31-day cancer treatments in the period for patients referred with skin cancers, following the transfer of the Dermatology service from Weston Area Health Trust. Performance against the 31-day standard for skin cancer treatments has historically been significantly above the 96% standard, so this should help to mitigate some of the overall performance risk.

**Recovery plan, including expected date performance will be restored:**

The current cancer action plan includes the following actions relating to the 31-day first definitive treatment standard, in addition to those already listed in the Exception Report A3/A4:

- Continued implementation of the 'managed beds' programme to reduce risk of cancellations;
- Demand for high dependency beds planned, to spread this across the week; the move to the new Intensive Therapy Unit should also help with patient flow in critical care;
- Introduction of standby lists for minor surgery patients (who agree to this) to enable lists to be utilised in the event of cancellation of major cases, freeing up capacity to re-date other cases and reducing the knock-on impact of cancellation;
- Continued monitoring of improvements made to the pre-operative assessment process to ensure patients are seen soon after decision to treat and any further tests required are carried out quickly, to enable patients to be fit for surgery within the timescale. This includes ensuring patients who

need notice to stop medication have this recorded by the booking team, so that surgery dates can be communicated in a timely way;

- Review of processes for theatre allocation for gynaecology patients requiring operations in Heygroves theatres, to ensure this runs smoothly and dates can be found in target.

**Progress against the recovery plan:**

Draft performance for December is 98%, as expected with the improvement in thoracic capacity. At present, draft performance is 95.9%. However, final validation of the breaches incurred in quarter 3 is still to be completed, and on this basis it is forecast that the 96% standard will be achieved for quarter 3 as a whole.

## ACCESS STANDARDS

| A6. 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.

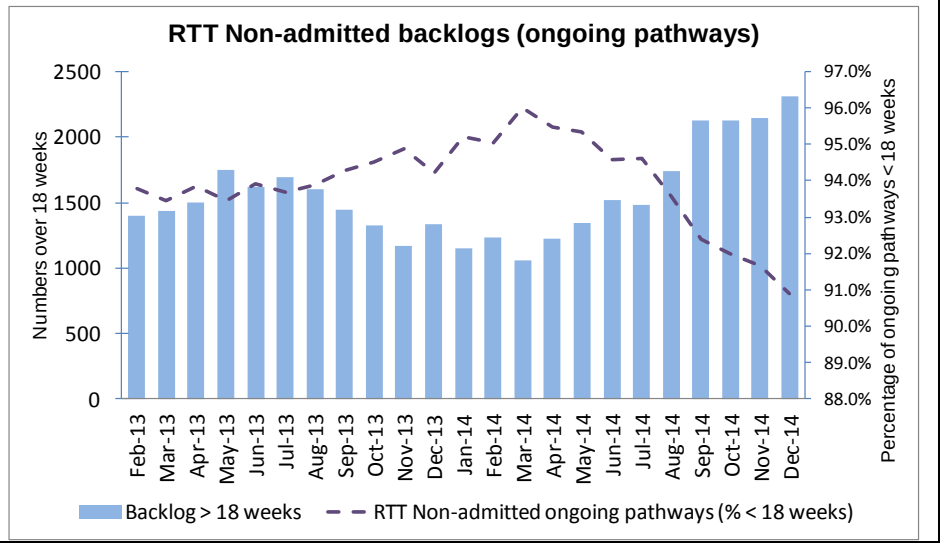
**Monitor measurement period:** Monthly achievement required but quarterly monitoring

**Performance during the period, including reasons for exceptions:**

Performance in December was 89.9% against the Non-admitted standard. This is below the trajectory of 95% following the decision to extend the period of failure in line with the national request, in order to support a reduction of longer waiting patients.

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.

Additional capacity continues to be put in place to ensure the backlog of

long waiting patients are treated as quickly as possible. In addition, the validation of backlogs is identifying a proportion of pathways which can now be stopped with treatment having already taken place, and also, additional extraneous pathways being generated as a result of the way referrals are being managed on Medway Patient Administration System (PAS). This will be addressed through the current extensive programme of validation.

Overall non-admitted RTT activity (treatments) decreased by 180 in December relative to November, reflecting a loss of capacity over the bank holiday and patient choice to delay treatment. One hundred and four fewer long waiting (breach) patients were treated in December than in November (12% decrease), for similar reasons. The reduction in activity over the Christmas period was significantly less than in previous years.

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

- 36% were in dental specialties – a decrease on last month (44%)
- 8% were in Adult Ear, Nose & Throat (ENT) – similar to last month (9%)
- 6% were in Cardiology – similar to last month (5%)

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

| RTT Specialty | Under 18 Weeks | 18+ Weeks | Total Clock Stops | Percentage Under 18 Weeks |
|---|---|---|---|---|
| Cardiology | 105 | 42 | 147 | **71.4%** |
| Cardiothoracic Surgery | 28 | 7 | 35 | **80.0%** |
| Dermatology | 454 | 15 | 469 | **96.8%** |
| E.N.T. | 663 | 63 | 726 | **91.3%** |
| Gastroenterology | 40 | 22 | 62 | **64.5%** |
| General Medicine | 150 | 0 | 150 | **100.0%** |
| Geriatric Medicine | 67 | 1 | 68 | **98.5%** |
| Gynaecology | 335 | 11 | 346 | **96.8%** |
| Neurology | 53 | 21 | 74 | **71.6%** |
| Ophthalmology | 964 | 38 | 1002 | **96.2%** |
| Oral Surgery | 304 | 54 | 358 | **84.9%** |
| OTHER | 2964 | 439 | 3403 | **87.1%** |
| Rheumatology | 112 | 0 | 112 | **100.0%** |
| Thoracic Medicine | 275 | 5 | 280 | **98.2%** |
| Trauma & Orthopaedics | 122 | 27 | 149 | **81.9%** |
| **TOTAL** | **6636** | **745** | **7381** | **89.9%** |

In December seven of the fifteen specialties achieved the 95% standard, compared with six in November. Poor performance in specialties such as Cardiology, Oral Surgery, ENT, and dental specialties reported under ‘Other’, reflects more long waiting patients being treated in the month as

planned.

**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 overall number of over 40-week waiters decreased from 140 at the end of October, to 117 at the end of November, but has increased to 177 in December due to a loss of capacity, growth in paediatric long waiters and patient choice);
- 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;
- Full Demand and Capacity modelling using an IMAS developed planning tool has been undertaken. The outputs are helping to inform discussions with commissioners regarding the additional activity that is required to be delivered to achieve a sustainable backlog going forward. The Trust submitted a "plan for a plan" to Monitor. It detailed the actions and timelines when the Trust expects to deliver the outputs of the Demand and Capacity modelling and revised trajectories for each specialty also due by mid-December; the high-level outputs of the modelling, which identified when stage of treatment milestones will be met which support achievement of 18-week compliant pathways, were shared with commissioners and Monitor on the 19th December; a more detailed plan has been prepared now that capacity plans have been evaluated and prepared;
- The Trust now has in place a team of external validators, to facilitate validation of all patients in the RTT backlogs. This has been supplemented by support from a national team; early indications are that a significant number of ongoing pathways may be closed down as a

result of this validation;

- A local (community-wide) Patient Access Policy has recently been reviewed and has been implemented; the new Policy will enable the Trust to take appropriate action when patients delay their outpatient appointments or elective admissions, and where funding decisions are not made within an acceptable time period.

**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. 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. The Trust continues to put additional capacity in place to reduce waiting times for first outpatient, further informed by the outputs of the IMAS modelling. In combination with the validation of pathways it is expected that a significant reduction in non-admitted pathways, and hence future breaches of standard, will be realised by the end of March 2015, especially in adult services.

| 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% | 89.4% | 88.8% | 89.9% | | | |

## ACCESS STANDARDS

| A7. 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 December was 87.5% 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 increased by 4% in the first half of the year, relative to the same period last year (this analysis excluded paediatric specialties, where waiting list transfers would have skewed the figures). This growth is primarily in specialties such as Upper GI (gastrointestinal), Dermatology, certain Dental specialties and Pain Relief. In Dermatology we have seen a significant increase in outpatient referrals. As can be seen from Table 1, Dermatology performed at 92.1% against the 92% standard in December, and has now successfully addressed the backlog which had built-up. The Upper GI admitted backlog (reported under the national specialty of 'Other') has increased over the past six month, with the rate of additions to the elective waiting list being significantly higher than expected from the number of outpatient attendances. A clinical validation of waiting patients has shown no obvious reason for this increase (i.e. the threshold for surgical intervention does not appear to have changed). However, plans are in place to reduce the backlog during quarter 4. 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. With additional capacity put in place during the last three months, dental backlogs have now reduced, although further work is needed to make the levels sustainable for continued RTT standard achievement. The Cardiology admitted backlog remains high, in part due to more outpatient work being undertaken to reduce the number of non-admitted long waiters. Plans to reduce the RTT backlogs within paediatrics specialties remain at risk due to the scale of the capacity gap. The Trust is in discussion with the commissioners over potential solutions.

Despite continued focus on booking the longest waiting patients in for treatment, the number of patients waiting over 40-weeks from referral to treatment increased from 117 at the end of November to 177 at the end of December. This was mainly due to a loss of capacity over the Christmas period, patient choice and lengthening waits for some paediatric services. There were thirteen over 52-week RTT waiters were reported at December

month-end. Twelve were within paediatric specialties (i.e. nine for Paediatric Plastic Surgery, two for Paediatric Trauma & Orthopaedics, one for paediatric urology), due to demand being significantly higher than capacity within these services. A further over 52-week waiter was reported for Oral Surgery, due to a patient not being listed for surgery following a previous decision to admit.

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

| RTT Specialty | Under 18 Weeks | 18+ Weeks | Total Ongoing | Percentage Under 18 Weeks |
|---|---|---|---|---|
| Cardiology | 1880 | 470 | 2350 | **80.0%** |
| Dermatology | 1710 | 146 | 1856 | 92.1% |
| E.N.T. | 2375 | 85 | 2460 | 96.5% |
| Gastroenterology | 492 | 38 | 530 | 92.8% |
| General Medicine | 123 | 6 | 129 | 95.3% |
| Gynaecology | 1226 | 65 | 1291 | 95.0% |
| Neurology | 281 | 52 | 333 | 84.4% |
| Ophthalmology | 4316 | 338 | 4653 | 92.8% |
| Oral Surgery | 2198 | 178 | 2376 | 92.5% |
| OTHER | 11807 | 2639 | 14442 | 81.8% |
| Rheumatology | 339 | 4 | 343 | 98.8% |
| Thoracic Medicine | 663 | 7 | 670 | 99.0% |
| Trauma & Orthopaedics | 846 | 69 | 915 | 92.5% |
| Cardiothoracic Surgery | 299 | 25 | 324 | 92.3% |
| Geriatric Medicine | 166 | 0 | 166 | 100.0% |
| **TOTAL** | **28721** | **4122** | **32838** | **87.5%** |

In December, twelve of fifteen specialties achieved the 92% standard, compared with nine in November. A further improvement in performance against the RTT Ongoing standard is expected following the full validation of over 18-week ongoing pathways, which is planned to be completed over the next two months.

**Recovery plan, including expected date performance will be restored:**

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

- Actions as detailed in Exception Report A6;

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- Continued weekly focus on treating longest waiting patients and improving 'picking' patterns to make best use of available capacity to reduce waiting times;
- Full demand and capacity modelling has been completed for all under-performing specialties, with the help of the Interim Management and Support (IMAS) team; these models 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; the modelling has been shared with the commissioners, and will inform the first round of contract discussions for 2015/16; material capacity gaps have been identified in some specialties (including paediatric specialties), which need to be addressed prior to the Trust being able to restore RTT performance on a sustainable basis;
- The Women's & Children's, Medicine and Surgery, Head & Neck Divisions are in discussion with external providers to provide treatment of patients waiting for paediatric ear, nose & throat (ENT), paediatric plastic surgery, paediatric Trauma & Orthopaedics, dermatology and upper gastro-intestinal surgery.

**Progress against the recovery plan:**

Trusts across the country were asked to continue to fail the admitted pathways standard until the end of November, in order to reduce backlogs of admitted long waiters. The Trust took the decision to extend this into December. Additional capacity is being put in place to enable more long waiters to be treated during in the coming 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, the number of longest waiting patients has started to reduce. 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

| A8 – A9. EXCEPTION REPORT:<br>• A&E maximum wait 4 hours<br>• Time to Initial assessment | RESPONSIBLE DIRECTOR: Chief Operating Officer |
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**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.

The assessment of patients arriving via ambulance should commence within 15 minutes of arrival. The target is for 95% of patients to be assessed within 15 minutes.

**Monitor measurement period:** Quarterly

**Performance during the period, including reasons for exceptions:**

Trust-level performance against the 4-hour standard was 86.3% in December, 2.3% down on November's performance of 88.6%. Performance nationally against the 4-hour standard for units reporting type 1 (major) activity was 91.0% for quarter 3 as a whole. National average performance for the four weeks between the 1st December and the 28th December varied between 88.8% and 91.8%.

Performance against the 4-hour standard at the Bristol Children's Hospital (BCH) was 85.9% in December, compared with 85.8% in November. Performance within the BRI reduced, from 87.0% in November to 82.6% in December. The Bristol Eye Hospital achieved 99.8% against the 95% national standard, as it did in October and November.

Activity levels at the BCH in December remained high and at a similar level to that experienced in November, with emergency admissions 17% above that seen in December 2013. This was not due to an increase in conversion rate, as Emergency Department attendances rose at an equivalent level, being 19% above the same period last year. However, positively, 375 more patients were treated within 4 hours in the month than the same month last year.

BRI Emergency Department admission levels increased by 12% in December relative to November, but stayed unchanged from the levels seen in December 2013. The proportion of emergency admissions for patients aged 75 years and over increased by 5% in quarter 3 2014/15, relative to quarter 3 2013/14. These patients are more likely even once medically optimised to need packages of care to be in place, and or placements in residential homes, before being discharged. For this reason and due to their medical complexity, they have longer lengths of stay. In January we have seen a rise in the level of delayed discharges, especially for patients awaiting placements for rehabilitation. This has resulted in delayed discharges from South Bristol Community Hospital, which has had a knock-on impact on flow out of the BRI. Delays in beds becoming available during each day lead to backlogs of patients being looked after in the Emergency Department. As a result of more patients needing to be cared for, there were

delays in patients arriving in ambulances being assessed, although 95% of patients were assessed within 36 minutes of arrival in the month. The number of over 30 minute ambulance hand-over delays in the period also increased from 131 in November to 168 in December, reflecting these flow-related pressures.

The overall length of stay for patients discharged in the month increased relative to the previous month. However, consistent with this the proportion of over 14 day patients discharged in the period was higher than in previous months, and the number of long-stay patients in hospital at month-end decreased markedly, from 194 at the end of November to 149 at the end of December. The decrease in the number of long stay patients in hospital at month-end was in part due to a decrease in the number of delayed discharges on the Green to Go list, with the number decreasing by 12 between November and December month-end. Both the number of Delayed Discharges and over 14 day stays have, however, increased markedly in January, reflecting the increase in older patients being admitted during quarter 3 and the shortages of placements, especially for rehabilitation in the community.

**Table 1** – Number of Delayed Discharges on the Green to Go list at the end of December 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 | 57 |
| October 2014 | 44 |
| November 2014 | 55 |
| December 2014 | 42 |

**Recovery plan, including expected date performance will be restored:**

The Trust takes part in the daily sector teleconference calls managed through ALAMAC. A full review of the previous day's 4 hour performance, key performance indicators, (included in the ALAMAC "kitbag"), and actions to improve performance are discussed and further actions agreed. The key areas for action have included reduction in the Trust's "Green to Go" list and addressing other operational constraints which impact on flow, which when addressed will help to improve performance.

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 went to Divisional Board at the end of October. Discussions to be held with Finance. Only one applicant to date for replacement post. New target date amended to 1st March 2015. |
| Increase numbers of ED slots available in GP Support Unit from 10:45-21:15. Total 206 ED slots per week. | September onwards<br><br>January onwards | Lead Band 7s regularly checking on the use of GPSU slots (monitor at least 3 times daily). Performance of category 1 attenders continues to be above target (Action complete).<br>In-depth review of minors working also underway. Minors' safety and flow will be a priority in the redesign. This redesign will require additional staffing resource and different ways of working. On track to deliver 24-hour Emergency Nurse Practitioner services from January 2015. All actions on plan. |
| 7 day liaison Psychiatry service. | September onwards | 7-day, 14-hour service in place from mid September (Action complete). 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. Start date agreed as week commencing 15/12/14. |
| 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 (Action complete); not as many referrals being received as expected. Ambulance trust contacted to ensure all |

| | | |
|---|---|---|
| | | clinicians received laminated copies of referral pathways and a letter to remind their staff. Posters on display in the Emergency Department and stations to prompt ambulance crews. Numbers of patients being referred to the GPSU now picking-up. |
| 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 went to Medicine Divisional Board end of October; job plans completed. Pilot undertaken, with support to OPAU from REACT services; recruitment now commenced. New target date 1st December. |
| 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). | January onwards | Proposal complete; new model described in consultant business case; plan agreed. Business case presented to Divisional Board at the end of October. Funding approved through Operational Resilience Capacity Planning. Remains on track for pilot to commence in January. |
| 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 | The provision of Speech and Language Therapy services commenced the w/c Nov 24th. Dietetic support could not be provided, due to unsuccessful recruitment. The service provides two days a week cover, to respond to individual assessments of vulnerable patients as well as providing for some time for education within the nursing homes. |
| Extended REACT service supported by Social worker 6 days/week (Bristol Community Health). | August onwards | Additional social worker in post from end August (Action complete). |
| Advanced Nurse Practitioner (ANP) 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). Previous recruitment round unsuccessful. Further round of recruitment initiated. Alternative skill mix now being considered, with a different model for utilisation of internal staff. Existing ANPs being used to support system in the interim, before substantive recruitment is completed. Agency staff identified with plan for additional support to |

| | | |
|---|---|---|
| | | be in place from the beginning of January. |
| 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 (Action complete).<br>Standard Operating Procedure (SOP) for patient admission into Ambulatory Care Unit distributed to BrisDoc clinicians for comment. |
| Commencement of Heart Failure service to Medicine. | September onwards | Service in place from 26th August, and accepting referrals (Action 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; bed allocation model implemented from 20th October; flexible use of community bed-base in increasing; Community Discharge Co-ordination Centre will act as bed managers for all community beds from 1st December, facilitating a daily bed management conference call with partners to improve flow in to and out of beds. Vacant Safe Haven beds at John Wills House now being used flexibly for patients with rehab needs. |
| Increase Echocardiogram capacity in evenings 5 days a week. | November onwards | Funding now agreed; Agreement to carry-out electives at weekends - extra lists running 20th, 21st, and 27th December and service continues to offer staff opportunities for weekend working. |
| 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; additional weekend catheter lab sessions now being run on an ongoing basis. |
| 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 (Action complete). |
| Increase weekend discharges | | |

| ACCESS STANDARDS | | |
|---|---|---|
| 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. Staff have signed up to some overtime. However, the uptake for Sat / Sun overtime is currently low. |
| 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 (Action complete). |
| Decrease weekend admissions | | |
| GP Support Unit (GPSU) weekend cover (BrisDoc) | October onwards | Funding agreed; GPSU open on an ad hoc basis at weekends according to GP availability; full cover for Saturdays and Sundays currently unavailable, further GPs are in the process of being recruited. |
| Improve flow | | |
| 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 (Action complete). |

## ACCESS STANDARDS

**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. Please note that due to changes in the assessment of the impact of the actions in the plan, and the continued decline in national performance, new trajectories have been developed, as shown below.

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 particular increases in ambulance arrivals at the weekend at earlier in the day. In conjunction with the increasing ago-profile of patients admitted to the Trust, this pose risks to achievement of the 95% standard over the winter, which may be difficult to mitigate fully, as reflected in the Realistic scenario.

| Scenario | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 |
|---|---|---|---|---|---|---|---|---|---|
| Best case | 91.9% | 91.5% | 94.0% | 94.7% | 94.5% | 96.4% | 97.3% | 95.8% | 94.2% |
| Realistic | 91.5% | 90.6% | 92.8% | 94.4% | 94.2% | 95.8% | 96.0% | 95.1% | 93.9% |

## ACCESS STANDARDS

| A10. EXCEPTION REPORT: 6-week wait for key diagnostic tests | RESPONSIBLE DIRECTOR: Chief Operating Officer |
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**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 December was 95.8% against the 99% national standard for 6-week diagnostic waits. This is a deterioration on November's position of 98.3%, which was above the improvement trajectory. There were 278 breaches of the 6-week standard at month-end, of which 92 were for MRI scans, 70 were for audiology tests, 69 were for echocardiography scans, 40 were for gastrointestinal endoscopies (paediatric), 4 were for sleep studies and 3 were for CT scans.

Demand for cardiac MRIs remains high. Excess demand for non-cardiac scans continues to be addressed through additional in-house sessions and outsourcing, to free-up capacity where possible for more cardiac scans. Additional Saturday lists have been established where possible. But capacity fell short of demand in the period. There was an increase in paediatric cardiac MRI breaches in December, due to three sessions being lost, in part due to the bank holiday. Slots for undertaking general paediatric MRI scans were also reduced. Recently the number of paediatric epilepsy patients needing to have a CT scan has increased, for reasons that are being investigated. The same anaesthetic team cover the CT and MRI scanning sessions, so the increase in demand for CT scans is also impacting on MRI capacity. The planned paediatric scanner servicing day earlier in January was cancelled at short-notice, and re-arranged for later in the month. Due to the capacity lost this is expected to result in an increase in paediatric MRI breaches at the end of January.

Audiology experienced exceptional levels of demand in the October and November, with demand for some diagnostic tests being double that of routine capacity. In particular, the number of complex test requests has risen. Some of this additional demand is attributable to increases in referrals and outpatient appointments for Ear, Nose & Throat. Additional sessions were established where possible, but it remains challenging to cover the number of required sessions, especially with difficulties recruiting additional staff.

There was also an increase in the number of over 6-week echocardiograms long waiters. This was due to a combination of staff sickness and paternity leave, resulting in fewer slots for patients to be seen.

The original dip in performance against the 6-week wait standard back in 2013/14 resulted from demand for the gastrointestinal endoscopies outstripping available service capacity. 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. However, there were no adult gastrointestinal endoscopy long waiters in December. There were 40 breaches for routine paediatric patients. The number of paediatric endoscopy long waiters remains similar to that of previous months, with sustainable changes in capacity planned by the end of quarter 4.

**Recovery plan, including expected date performance will be restored:**

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

- Options for undertaking MRI scans at the Chesterfield hospital continue to be explored; image sharing and reporting arrangements currently being worked-through; the Trust's own MRI scanners continue to be run at weekends and weekends, to increase capacity;
- Future paediatric MRI scanning capacity is being reviewed and plans for additional sessions are being taken forward; demand for epilepsy scans being investigated, as rising;
- 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);
- Patients are being offered appointments in community settings where capacity is available before hospital-based appointments; locum audiologists continue to be sought to manage high levels of demand in the short term, whilst more sustainable options are explored;
- A locum Echo Cardiographer is now in post; this person was going to be used to free-up a member of staff to train in Echocardiography, but this has not been possible due to the pressures on capacity; the substantive post has been recruited to and the successful candidate will be taking up the post in March 2015; additional sessions, including weekend lists, with current staff are also being run;
- A consultant paediatric gastroenterologist post has been recruited; the successful applicant will now be in post towards the end of quarter 4; additional sessions will be run during the quarter, with the aim of clearing the majority of the backlog by March.

**Progress against the recovery plan:**

During November the previously agreed improvement trajectory was revised, in light of the additional challenges from increased demand. Performance at the end of November was consistent with this trajectory. But there has been a deterioration in performance in December against trajectory, due to capacity being lost unexpectedly and several of the actions not being able to be taken, or having the expected impact, as planned.

| Month | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 |
|---|---|---|---|---|---|---|---|---|
| Waiting list size (estimate) | 6991 | 6842 | 6768 | 7000 | 6900 | 7000 | 6900 | 6900 |

## ACCESS STANDARDS

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Total > 6 weeks | 244 | 107 | 61 | 135 | 108 | 86 | 60 | 58 |
| **Performance trajectory** | **96.51%** | **98.44%** | **99.10%** | **98.07%** | **98.43%** | **98.77%** | **99.13%** | **99.16%** |
| Actual total > 6 weeks | 210 | 128 | 61 | 117 | 278 | | | |
| **Actual performance** | **96.96%** | **98.13%** | **99.14%** | **98.32%** | **95.8%** | | | |

## ACCESS STANDARDS

| A11. EXCEPTION REPORT: Primary Percutaneous Coronary Intervention (PPCI) cardiac reperfusion times (door to balloon time of 90 minutes) | RESPONSIBLE DIRECTOR: Chief Operating Officer |
|---|---|

**Description of how the target is measured:**

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

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

**Performance during the period, including reasons for exceptions:**

Of the forty-two patients treated in November 2014, eight had waits to treatment of over 90 minutes. The pathways of the longer waiting cases have been reviewed, to identify whether anything could have been done to reduce their waiting times and to identify any common causes of the delays. The reasons for the delays were as follows:

- 2 x delays in access to the catheter laboratory due to patients already being in the laboratory and receiving treatment;
- 1 x a medical complication prior to the procedure; the patient required additional treatment prior to proceeding with the procedure;
- 1 x the ambulance Electrocardiogram (ECG) was unclear and therefore needed to be repeated prior to the procedure being undertaken;
- 4 x the ambulance ECG was non diagnostic and did not confirm a PPCI was required; these cases were taken to the Emergency Department for a second ECG 9which as hospital-based usually provides a more definitive diagnosis); these patients were subsequently diagnosed over a period of time; all patients received appropriate treatment.

**Recovery plan, including expected date performance will be restored:**

At present no additional actions need to be taken. However, this position will be reviewed if anything further information emerges from the more detailed case reviewed.

**Progress against the recovery plan:**

To date in 2014/15, 91.6% of patients have received reperfusion within 90 minutes, which is above the 90% standard. The 90% standard was consistently achieved between August and October.

# ACCESS STANDARDS

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

| **Access Performance Recovery Plan** |
|---|
| **Purpose** |
| This paper sets out the current performance issues with access targets and highlights the proposed recovery trajectory. |
| **Abstract** |
| This paper sets out the Trust's recovery plan for the key access performance targets for emergency care (4 hour standard), elective care (18 week referral to treatment times) and cancer (with a particular focus on the 62 day referral standard) The paper highlights the current performance issues and the planned improvement trajectories. |
| **Recommendations** |
| The Board is recommended to discuss the report. |
| **Report Sponsor** |
| • James Rimmer, Chief Operating Officer |
| **Authors** |
| • James Rimmer, Chief Operating Officer, Anne Gorman, Deputy Chief Operating Officer |
| **Appendices** |
| • None |

**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 |
|---|---|---|---|---|---|
| | | | | | |

# Access Performance Recovery Plan

## Introduction

This paper sets out the Trust's recovery plan for the key access performance targets for emergency care (4 hour standard), elective care (18 week referral to treatment times) and cancer (with a particular focus on the 62 day referral standard) The paper highlights the current performance issues and the planned improvement trajectories.

## 4 Hour Standard

The Trust has struggled to meet the 4 hour standard since it was originally introduced in 2004, and since it was revised to 95% in 2010. This has also been the case for neighbouring acute Trusts. The 4 hour standard has been under increasing strain nationally with the target being failed nationally for the most recent quarter; the Trust achieved 89.6% for quarter 3 (October – December 2014). This position is clearly not acceptable to the Trust, our commissioners, regulators or patients.

The Trust has worked with the Bristol Urgent Care Working Group to address this issue across health and social care. A diagnostic of the system using the Alamac Toolkit (a product commissioned by the three local CCGs) has identified early discharge, 14 days plus length of stay, admissions exceeding early discharges and the volume of delayed discharges ('Green to Go' patients) as key determinants of performance. This diagnosis balances the issues to address internally and externally. The level of delayed discharges sit as an outlier when benchmarked nationally.

The Care Quality commission also identified patient flow as a concern in its recent review of the Trust (published December 2015) noting that the Trust needed to "work together with others" to improve.

A recover plan was developed in September 2014 to address the underperformance and reviewed resilience funding to help delivery. The plan focusses on:

- Admission avoidance
- Front door processes
- Hospital flow
- Discharge processes
- System Escalation

The plan has been strengthened further following the CQC report with six areas highlighted for action from partners including the 111 Service, South West Ambulance Service, Avon and Wiltshire Partnership Trust, Bristol City Council, Bristol Community Health and Bristol CCG. The plan is governed by the Urgent Care Working Group which is chaired by Bristol CCG; the Chief Operating Office is the Trust's representative and the Trust's Senior Responsible Owner for the plan.

The revised plan shows the following improvement trajectory:

| | Q4 2014/15 | Q1 2015/16 | Q2 2015/16 |
|---|---|---|---|
| Best Case | 92.5% | 95.2% | 95.8% |
| Most Realistic | 91.7% | 94.8% | 95.0% |

The Urgent Care Working Group is currently reviewing additional actions required to improve the 2015/16 Q1 position by 0.2% (approximately 60 patients) in order to hit compliance in Q1. A city-wide

'Perfect Week' is currently being considered (akin to the Trust's 'Breaking the Cycle Together' initiative and building on the Trust's SAFER Care Bundles).

## Cancer Standards

The Trust has eight key cancer waiting times standards to achieve. The two 62 day targets (screen and GP Referral) are the key challenges due to the range of cancer services the Trust provides which tend to be the more complex cancer pathways.

The 62 day cancer standard requires a cancer patient to have their first definitive treatment within 62 day from referral by either their GP or from an NHS screening service. The key challenges are due to i) the complex case mix of patients the Trust sees and ii) with late referrals (over day 46) from another provider. Where a breach occurs on a shared pathway each Trust share the breach (0.5 of a breach each); for a late referral this can fully sit with one Trust but only by agreement with the Trust. When the Trust performance takes account of the case mix of patients treated (typically have a -3.5% impact on performance) and late referrals into the Trust on or after day 46 (estimated to have a -5.2% impact in quarter 3), then the 62 day standard is achieved. The Trust has previously tried to monitor late referral rules across Trust providers but no agreement has been reached; Monitor have recommended that the Trust re-looks at the option for such an agreement as these do exist elsewhere.

The Board agreed a cancer recovery plan and delivery trajectory in 2014. Whilst current performance is off trajectory, cancer performance against the 62 day GP standard continues to improve. Reducing first appointment waits to seven days, increased capacity for thoracic surgery, and the managed beds programme should continue to contribute to more timely pathways. Pathway work on oesophago-gastric and lung cancer is progressing well, and other partners are engaged with this. Cancellations due to high acuity on the critical care unit, late referrals from other providers, and an increasingly complex workload remain significant challenges. This work has led to a more robust and proactive system of managing the patient pathways which should underpin more sustainable performance and enable a greater corporate focus on resolving underlying problems and working with other providers. The performance against 62 day screening is at risk, however this is due almost exclusively to issues at other providers, and is an area the Trust has limited control over.

Performance against the 31 day first definitive treatment standard is helped by many of the same actions as those supporting 62 day pathways. Cancellations due to critical care acuity, medical deferrals and patient choice are the main risks to this standard. Increased surgical capacity in thoracics, improved pre-operative assessment processes and the managed beds programmes are important actions to improve this standard. The improvement trajectory set therefore remains extant (as below) as does the improvement plan. Further work will now be undertaken to review the implementation of a breach reallocation process for late referrals.

## Cancer Targets

| Oct 14 | Nov 14 | Dec 14 | Q3 | Jan 15 | Feb 15 | Mar 15 | Q4 |
|---|---|---|---|---|---|---|---|
| 86.4% | 85.1% | 84.1% | 85.3% | 84.6% | 85.4% | 87.0% | 85.8% |

## Referral to Treatment Times (RTT)

### Current performance

The end of M9 position was 84.33% for admitted patients, 89.91% for non-admitted, 87.46% for ongoing and 177 patients waiting over 40 weeks (13 over 52 weeks).

### Progress against the "Plan for a Plan"

The Plan for a Plan presented to the Board in October 2014 described how the Trust:

- Would gain a clear understanding of the underlying demand and capacity gaps for each specialty
- Develop robust, recovery trajectories at Trust and individual specialty level and in doing so quantify the additional recurrent and non-recurrent activity required for admitted and non-admitted
- Reduce the backlog of patients waiting over 40 weeks
- Clarify and address the data quality raised in the Elective Care Intensive Support Team (ECIST) report published in July 2014.

### 1 Demand & Capacity Modelling

The Divisions have completed modelling at specialty and, in some cases, sub-specialty level. There was good engagement from clinical and management teams, many of whom agreed that the outputs reflected the reality for their specialties. ECIST has formally endorsed the Trust's application of their model and provided independent assurance to Monitor, NHS England and the Clinical Commissioning Group.

### 2 Service Delivery Plans and Development of the Trajectories

The outputs have been used to inform revised service delivery plans and RTT recovery trajectories. It should be noted that the ECIST model was developed to include *all elective* rather than discrete 18 weeks RTT demand and capacity. In some instances, the outputs do not reflect the most likely scenario based on current backlogs and performance. Where necessary, inputs and outputs have been revised to better reflect achievement of RTT, i.e. the Stages of Treatment required to deliver a compliant 18 weeks pathway along with a reduction in the total backlog required to deliver sustainable achievement of the 18 weeks standards.

### 3 Clinical and Trust Trajectories for Admitted and Non-Admitted

The Divisions have submitted a delivery plan for each specialty which is based on the information available as at 22nd January 2015, therefore prior to the completion of the validation programme described in section 4 below Table 1 (Admitted) and Table 2 (Non-admitted), demonstrate the trajectories for delivering at Trust Level.

The plan has been assessed and a RAG assigned as follows:

RED – 90% or 95% standards not achieved

AMBER – standards may be achieved but not on a consistent basis

GREEN – standards achieved on a consistent and sustainable basis

### 3.1 Admitted

The trajectory suggests that at an aggregate level, the Trust will start to achieve from January 2016.

Table 1: 18 weeks admitted trajectory at aggregate Trust level

| Quarter | Q4 14/15 | Q1 15/16 | Q2 15/16 | Q3 15/16 | Q4 15/16 | Q1 16/17 |
|---|---|---|---|---|---|---|
| RAG Rating | Red | Red | Red | Red | Amber | Green |

### 3.2 Non-admitted

The modelling for non-admitted is more complex than for admitted. Poor data quality is a known factor, notably for the backlog position. The most realistic trajectory suggests an aggregate level, and the Trust will achieve this from August / September 2015.

Table 2: 18 weeks non-admitted trajectory at aggregate Trust level

| Quarter | Q4 14/15 | Q1 15/16 | Q2 15/16 | Q3 15/16 | Q4 15/16 | Q1 16/17 |
|---|---|---|---|---|---|---|
| RAG Rating | Red | Red | Amber | Green | Green | Green |

## 4 Actions and next steps

### 4.1 Validation

The Trust awarded a 2 month contract to an external data validation company in December 2014. A team of 6 staff will validate all ongoing patients on Medway PAS.

The Trust also successfully applied to be included in the national RTT Validation Programme, and a further team of 6 staff commenced in January 2015. This team will validate ongoing patients >6weeks on the Trust's RTT Patient Tracking List (PTL).

The intention is to carry out a full RTT data cleansing programme prior to reporting and validation on Medway. To do so it is likely that the validation resource will need to be extended to 31st March 2015.

### 4.2 Reporting and Validation on Medway and the "New" PTL

The build of new RTT reports that sit on top of Medway is well underway. ECIST will continue to offer technical support during the development and, if required, will assist during the implementation.

The Trust aims to report RTT performance from Medway from 1st April 2015. The date is entirely dependent on the successful completion of the validation programme and RTT performance data reconciliation.

### 4.3 Reducing over 40 week waits

Good progress has been made on reducing the numbers of adults over 40 weeks, including use of the independent sector. Further steps are being taken to address the number of paediatric cases over 40 weeks.

**Summary and recommendation**

Delivering these trajectories will be dependent to an extent on joint working with providers of health and social care partners, in particular for 4 hours and cancer, and with commissioners, in particular for referral to treatment times.

The Board of Directors is asked to discuss the proposed performance recovery plan.

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

| **11. Transforming Care Report** |
|---|
| **Purpose** |
| The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. |
| **Abstract** |
| The report sets out the highlights of progress over the last quarter and the next steps. |
| **Recommendations** |
| The Board is recommended to receive the report for **approval** |
| **Report Sponsor** |
| Robert Woolley, Chief Executive |
| **Author** |
| • Simon Chamberlain, Director of Transformation |
| **Appendices** |
| • Appendix 1: Transformation Milestone Status report<br>• Appendix 2: Transformation Programme Summary |

## 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**

**January 2015**

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

1. In the October update to Trust Board we shared the progress across 9 Trust wide programmes. Since the last update progress has continued to be made across all areas. Transformation Board and the Senior Leadership Team continue to receive monthly updates on progress versus milestones. Each meeting also receives detailed briefings on specific projects; In January we received detailed updates on progress in Compassion in Clinical Care and Transformational Leadership programmes. These briefings provide greater awareness of the good work being done and provide assurance on future plans

2. The latest update on milestone progress is attached at appendix 1, along with the summary of scope at appendix 2. In these latest versions details of the Operating Model programmes are excluded, as the agreed scope has largely been delivered and we are now planning further work. This reflects the intention of these projects to deliver change ahead of winter 2014/15. The following paragraphs therefore summarise the achievements of these key projects in the last quarter.

3. Operating Model – Planned Care: The aim of this project was to ensure that elective and urgent tertiary activity could proceed unhindered through periods of high demand for acute medical care. We aimed to achieve this by establishing a managed pathways model across planned care services including a protected beds strategy and supporting scheduling tool and processes.

4. The agreed scope of change was largely implemented by the beginning of October. The initial feedback in October was positive, as Surgery Head & Neck (SH&N) reported their highest monthly level of elective activity for the year and a step improvement in same day cancellations. Specialised Services also reported improved activity during the month. In November, performance fell back specifically due to a high level of acuity in Critical Care causing a bottleneck in flow through theatres. However in December the level of activity recovered and SH&N recorded “green” performance versus its targets for cancelled procedures. October and December were the only months in 2014 where this was achieved. The Division has also shown improved bed occupancy across the OND quarter. The methods have supported improved “pulling” of surgical emergency patients by wards into surgical beds, demonstrated by achievement for the first time of 100% fractured neck of femur patients being transferred directly from ED to a the correct specialist bed.

The Planned Care programme has been supported by changes in the day to day management of flow and escalation of issues. These methods – along with strong cross-Division support – have enabled the managed pathways operating procedures to be maintained through the busy periods of December and January. There has been a positive reaction from staff to the new ways of working.

5. In the light of experience in the last quarter, the scope of the Planned Care programme is now being renewed to build on progress to date. Two areas of scope have been identified, with the aim of further improving patient and staff experience and making best use of capacity in surgical services:

- Improvement to the day to day management of flow through provision of real-time accurate information supported by better use of existing IT, real time communications (applying learning from the Children's Flow programme), and real time reporting of barriers to flow

- A programme of transformation in the surgical administration services, which will address training, skills and ways of working and team working in the elective booking offices. This is aimed at ensuring elective planning is more robust and timely and is fully aligned with our RTT improvement plans.

6. The Unscheduled Care and Integrated Discharge programme aimed (with partners in Social Care and Bristol Community Health) to establish an unscheduled care pathway, supported by a fully integrated Health and Social care team, to reduce occupied bed days whilst improving patient outcomes and experience.

A major benefit of this project has been the further development of joint working between staff from the Trust, Social Care and Community Care, both in project work and in day to day operations. For example social care and community care team members have become permanent participants in key board rounds, and have jointly contributed to a number of discharge pathway developments. This will be further helped by the co-location of discharge teams into a single working area at the end of January when the new facility on level 7 is ready. Another key output has been the successful pilot of the Enhanced Recovery Programme on Care of the Elderly wards. Volunteers from Royal Voluntary Service have been part of this initiative which is now to be extended to the OPAU.

7. In the light of learnings during the recent period of escalation and feedback from the CQC the scope of this programme is now being revised and forward milestones reset. The plan will deliver the transformational elements such as the electronic CM7 form and further cross-team improvements to management of discharge. The plan will align with both the CQC action plan and the 4 hour action plan agreed with Monitor.

8. The Children's Hospital Flow programme was designed to ensure our operating model in our Children's Hospital is resilient, especially to winter pressures. It aimed to deliver nine projects, developed through workshops with clinical teams, prior to winter 2014/15.

The programme has now successfully implemented new escalation and winter planning methods, including a daily whole hospital status meeting to better focus attention on key risks. The refurbishment of the children's ED has improved flow and safety in the department. Real time communications (iPod Touch) devices were implemented to support real time messaging and reduce waiting for bleeps between key clinical roles. New guidance on key pathways and complex discharge have been put in place, along with ward process and equipment improvements. The pilot of a home intravenous antibiotics service is saving upwards of 260 bed days based on patients recruited to date.

Feedback on the changes from staff has been positive. During a period where activity has been significantly above the increase expected due to the centralisation of specialist paediatrics, the BRCH

leadership describes greater awareness and control of day to day operational risk. The project has increased the resilience of our services.

9. The transformational work in the Children's Hospital will now address surgical services. A programme of work is being scoped to improve both elective and non-elective pathways to make better use of capacity and improve experience for both patients and staff. This programme will address how we best use theatre capacity to meet recurring and non-recurring demand, will redesign processes for handling non-elective demand, introduce the elective scheduling tools developed in the Planned Care programme, ensure we support staff with the right training and development and make available the right equipment.

10. Alongside these programme we are scoping a Trust wide theatre transformation programme which will work across all the theatre suites to improve both quality and efficiency, also contributing to an improved experience for both patients and staff. A full time project manager has been appointed to lead this work. The programme will dovetail with the Planned Care and Children's Surgical programmes, and will ensure the benefits of pathway improvements are realised in all of our theatre suites across the Trust.

11. As these programmes of work have been delivered, the Senior Leadership Team has received regular updates on progress. Local communications plans have been enacted to allow staff to contribute ideas and remain aware of progress and plans. Feedback on the changes has been broadly positive, and as we plan the next phases of work we are mindful of the factors which have contributed to progress:

- Strong support from leadership at Division and Trust level to addresses barriers to progress
- Listening and incorporating ideas generated by staff
- Sharing the best ideas across Divisions and service areas
- Using our Transformation capacity and capability to add pace
- A clear shared purpose for the work – to improve services for all our patients

12. Next steps: During the next quarter our focus will be:

- To complete the planning of the revised scope, ensuring effective communications and engagement with staff in the relevant areas
- To get teams mobilised on the agreed work to build on the progress that has been made
- To maintain the momentum of the projects through continued scrutiny via SLT and Transformation Board.

Simon Chamberlain,

Director of Transformation

22nd January 2015

# Appendix 1: Transformation Milestone Status report

| | | Purpose | Milstone review last month | | Milestone plan next three months | | |
|---|---|---|---|---|---|---|---|
| | | | December 2014 | | January 2015 | February 2015 | March 2015 |
| Delivering best care | **Project:** 7 day early senior medical review<br>**Exec Lead:** Sean O'Kelly<br>**Project lead:** Peter Collins | **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** | ✓<br>✓ | • Review our evaluation of compliance with the standard for consultant review within 14 hours of emergency admission<br>• Progress through Division actions to develop weekend capacity | • Renew our assessment of compliance versus the ten NHS England standards for services across seven days<br>• Plan further notes review of compliance with the 14 hour standard in support of CQUIN targets | • Develop and agree the priority areas to address versus the ten NHS England standards<br>• Review the impact of changes implemented to date<br>• Align priority areas with any emerging commissioner requirements | • Plan and mobilise next phase of 7 day service projects<br>• Review findings from latest notes evaluation of 14 hour standard<br>• Agree renewed milestones and KPIs for the programme |
| | **Project:** Compassion in clinical staff<br>**Exec Lead:** Carolyn Mills/Sue Donaldson<br>**Project lead:** Helen Morgan, Alex Nestor | **To ensure that the majority of patients/carers would report that they receive person centred care - kind, sympathetic and sensitive.** | ●<br>✓<br>✓<br>✓ | •Toolkit of different resources for clinical teams to use completed<br>• Progress the development of a UHBristol video that can be used in a variety of settings across the Trust<br>•Briefing paper written outlining the concept of "Hello my name is" and recommendations<br>•Briefing paper on outcome of pilot for Registered Nurses values based recruitment written | •Paper with recommendations on values based recruitment for Registered Nurses/Midwives presented at NMC on 26/01/2015 (values based recruitment for Registered Nurses/Midwives to be rolled out in May 2015)<br>•Schwartz Rounds commenced<br>• Approach to deliver Compassion training within Trust values education discussed following evaluation of workshops and formalised<br>•Trial focus group/workshops on concept of compassion in nursing practice held | • Compassion training within Trust values education approach evaluated<br>• Start scoping incorporation of 'digital story telling'<br>• Focus group/workshop on concept of compassion in nursing practice evaluated<br>• Development of a toolkit to support and develop resilience in times of challenge commenced | • Scoping of incorporation of 'digital story telling' continued<br>• Development and planning of multi professional workshops, using outcome of the trial focus group/workshop on concept of compassion in nursing practice,<br>• Development of a toolkit to support and develop resilience in times of challenge continued |
| | | | | | • Staff "Compassion is..." advert responses translated into an art form<br>• Approach for the introduction of the "Hello my Name is" concept scoped and developed<br>• Development of UHBristol DVD which captures the values of the organisation, which can be used in a variety of settings across the Trust, aim of having the DVD ready for Nurses day in May 2015 | | |
| | **Project:** Transformation through Electronic Data Management<br>**Exec Lead:** Paul Mapson<br>**Project Lead:** Sarah Wright, Mel Jeffries | **To ensure the transformational improvement opportunities made possible by the Evolve Electronic Data Management are realised** | ✓<br>●<br>● | • Review of the next cohort of departments for opportunities is completed<br>• Confirmation of the process changes to take place and timings<br>• Scope and plans for building referral forms electronically are agreed | • Review of opportunities around case note movement is complete and opportunities triaged<br>• Scope the opportunity for whiteboards to improve workflow in Outpatient areas<br>• Transformation actions prioritised aligned with preparations for St Michaels go-live plans | • Electronic ED cause for concern process and form implemented<br>• Process changes for go-live following transformation actions are confirmed<br>• Transformation inputs to communications and local improvement plans agreed | • Preparations for go-live process changes completed<br>• Learnings from User Acceptance Testing are incorporated into transformation plans supporting preparation for go-live |
| Improving patient flow | **Project:** Operating Model Children's<br>**Exec Lead:** James Rimmer<br>**Project Lead:** Steve Sale and Lotty Jones | **To ensure the surgical pathways in our Children's Hospital meet the needs of all our patients and staff while making best use of available capacity** | 'The scope and milestones for these programmes are to be defined by January 2015 | | | | |
| | **Project:** Operating Model - Unscheduled Care & Discharge<br>**Exec Lead:** James Rimmer<br>**Project Lead:** Rowena Green | **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** | | | | | |
| | **Project:** Operating Model - Planned Care<br>**Exec Lead:** James Rimmer<br>**Project Lead:** Andy Hollowood & Alan Bryan | **To ensure that elective and urgent tertiary activity proceeds unhindered through periods of high demand for acute medical care through our hospitals** | | | | | |
| | **Project:**Theatre Transformation Programme<br>**Exec Lead:** Paul Mapson<br>**Project Lead:** Jan Belcher | **To ensure safe and efficient utilisation of all of our theatre services, avoiding waste as we deliver care** | | | | | |
| Building capability | **Project:** Leadership programme<br>**Exec Lead:** Sue Donaldson<br>**Project Lead:** Alex Nestor & Sam Chapman | **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** | ✓<br>✓ | • Leadership Forums to go live in Jan 2015 finalised<br>•Final Review of Leadership Development programmes to go Live in Jan 2015 completed | •Go live with new Leadership Framework, which includes:<br>• Leadership Forums<br>• Revised Leadership Development Programmes<br>• Leadership healthcare model competency framework pilot<br>• Work commenced with the nursing team skills competency framework as a pilot to develop an integrated approach for leadership roles that will be used across the Trust<br>• Three month review on leadership roles identification using ESR commenced<br>• Coaching and mentoring workshops commenced | • Pilot Action Learning Set approach commenced, using attendees from leadership development programmes<br>• Revised Values Plan incorporating 'Compassion in Care' rolled out<br>• Leadership Development programme for Divisional Directors and Clinical Chairs finalised<br>• Start set up of governance meetings for leadership development set up<br>• New Leading and Learning Together events commenced | • Business skills to launch in April 2015 finalised<br>• Five year leadership strategy to underpin workforce and OD strategy developed<br>• Working group to support the pilot of appraisal/succession planning/ talent management set up<br>• Governance meetings for leadership development set up<br>• Planning of Leadership Spring conference June 3rd commenced |
| | **Project:** Staff engagement programme<br>**Exec Lead:** Sue Donaldson<br>**Project Lead:** Trish Ferguson-Jay | **To deliver a step change in staff experience, satisfaction and engagement, supporting a step change in patient experience and performance.** | ✓<br>✓<br>✓<br>✓<br>✓<br>✓ | • "High performing teams" work using the Michael West evidence-based approach progressed - plans with Aston for delivery of pilot formalised<br>• Applications to participate in pilot publicised, invited and considered and success criteria for pilot identified<br>• Recruitment process for team coaches developed<br>• Divisions supported in carrying out and further developing the listening events and focus groups at Divisional level<br>• Feedback and learning from Respecting Everyone month in November gathered<br>• Nursing shift pattenrs surveyed | • Schwartz Rounds commenced<br>• Central and divisional staff recognition schemes further developed<br>• As part of the development of structured listening events and organisational learning - Speaking Out process and policy reviewed<br>• Team coaches for Aston Team journey recruited and development of programme commenced<br>• Initial work on Speaking Out Policy and Procedure commenced & publicity materials prepared<br>• Working group established, to design and implement improved speaking out reporting and recording to ensure that Francis Recommendations can be fully met.<br>• Focus groups held to inform Nursing review of shift patterns | • Recruitment and initial training for coaches/teams re Aston "high performing teams" model continued and monitored<br>• Learning from Nursing Shift pattern survey/focus groups, in respect of shift patterns and the impact on health, work-life balance and staff retention, commenced | • Pilot of Aston "high performing teams" model with new coaches commenced and teams identified for them to work with.<br>• Simplified, more effective and clearer Speaking Out policy/process presented to Board.<br>• Speaking Out processes communicated across the Organisation<br>• National Staff Survey findings communicated across Organisation and Action plans developed<br>• Learning from Nursing Shift pattern survey/focus groups, in respect of shift patterns and the impact on health, work-life balance and staff retention, shared across organisation with recommendations regarding shift patterns |

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

**Version: 22/01/2015**

## Appendix 2: 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 | 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 | Operating Model Children's | To ensure the surgical pathways in our Children's Hospital meet the needs of all our patients and staff while making best use of available capacity | The scope of these programmes is to be defined by January 2015 | James | Steve Sale and Lotty Jones |
| | 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 | | 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 | | James | Rowena Green |
| | Theatre Transformation Programme | To ensure safe and efficient utilisation of all of our theatre services, avoiding waste as we deliver care | | Paul | Jan Belcher |
| 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.<br>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 |

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 12. Report on Staffing Levels Adult Inpatient Wards including Midwifery and Bristol Children's Hospital and Non Ward Based Nursing and Midwifery Workforce January 2015

### Purpose

To provide the Board with a further update to support it to deliver on its responsibilities for ensuring safe nurse staffing levels.

### Abstract

This paper details:

- What are the significant changes in the last 6 months for nursing staffing levels at UHBristol adult inpatient wards, including Midwifery and Bristol Children's Hospital
- How the Trust knows the wards have been safe over the last 6 months
- Information on the non- ward based nursing and midwifery workforce, and the principles of safe staffing (where in existence) that the Trust uses to set and review establishments and skill mix for these non ward based areas

The paper considers:

- Demonstration of the use of evidence based tool(s)
- The difference between current establishment and recommendations following reviews using evidence based tool(s) where available
- The skill mix ratio before a review, and recommendations for change after the review
- The difference between the current staff in post and current establishment and details of how this gap is being covered and resourced

Boards must be able to demonstrate to their patients, carers and families, commissioners, the CQC and Monitor, that robust systems are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in the Trust is sufficient to deliver safe and effective care.

This report builds on previous paper presented in June 2014 and the monthly safe staffing reports received and reviewed by the Quality and Outcomes Committee

Risks:

The Board may have to agree in year changes or additional actions should there be concerns over capacity within the nursing and midwifery workforce.

Publishing of the data at ward level and on our websites increases transparency but may also bring adverse media coverage.

### Recommendations

The Board of Directors is asked to **note** the update, progress and actions being taken and **confirm** the support and give the authority to the Chief Nurse to be the senior responsible officer

## Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

| **Report Sponsor** |
|---|
| Carolyn Mills, Chief Nurse |
| **Authors** |
| Carolyn Mills, Chief Nurse |
| **Appendices** |
| • Appendix 1 – Report on Staffing Levels at UH Bristol adult inpatient wards including Midwifery and Bristol Children's Hospital and non-ward based nursing and midwifery workforce. |

### 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 |
|---|---|---|---|---|---|
| | | | | | |

Appendix 1.

University Hospitals Bristol NHS
NHS Foundation Trust

**Report on staffing levels for UHBristol adult inpatient wards including Midwifery and Bristol Children's Hospital and non-ward based nursing and midwifery workforce – January 2015**

## 1.0 Introduction & background

There is a requirement, post the publication of the Francis Report 2013 and the new nursing vision: Compassion in Practice that all NHS organizations will take a six monthly report to their public Board Boards on staffing capacity and capability which has involved the use of an evidence-based tool.

This report must:

- Draw on expert professional opinion and insight into local clinical need and context
- Make recommendations to the Board which are considered and discussed
- Be presented to and discussed at the public Board meeting
- Prompt agreement of actions which are recorded and followed up on
- Be posted on the Trust's public website along with all the other public Board papers.

In June 2014 the Board of Directors received the first report from the Chief Nurse in line with new NHS guidance detailing staffing levels for UH Bristol adult inpatient wards, including Midwifery and Bristol Children's Hospital. In 2014, following the last nursing and midwifery staffing paper they also received an adhoc report detailing the principles for setting safe staffing levels in other professional groups. The Board also receives detailed quarterly workforce reports.

This report details:

a) What are the significant changes in the last 6 months for nursing staffing levels at UHBristol adult inpatient wards, including Midwifery and Bristol Children's Hospital
b) How the Trust knows the wards have been safe over the last 6 months
c) Information on the non- ward based nursing and midwifery workforce, and the principles of safe staffing (where in existence) that the Trust uses to set and review establishments and skill mix for these non-ward based areas.

This report demonstrates a continued commitment in UHBristol to ensure that we have the right number of staff in place with the right skills.

**Specific expectations of the Board (NHS England/CQC)**

Boards are expected to take full responsibility for the quality of care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Responsibilities

include:

- Managing staffing capacity and capability by agreeing staffing establishments
- Considering the impact of wider initiatives (such as cost improvement plans) on staffing
- Monitoring staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-by-shift basis versus planned staffing levels
- Examining trends in the context of key quality and outcome measures
- Asking about the recruitment, training, skills and experience, and management of nurses, midwives and care staff and giving authority to the Chief Nurse to oversee and report on this at Board level.

**2.0 Significant Changes to nursing staffing levels**

2.1 Adult inpatient areas

The Trust continues to monitor the acuity of our patients using the 'Safer Nursing Care Acuity Tool'. For adult inpatient areas this tool is now on a web based system and the acuity and dependency of patients is monitored and recorded daily. This information supports both daily decisions and more strategic decisions regard staffing levels, skill mix and establishment.

Maternity continues to use birth rate plus, as part of their annual staffing review, they are not currently using an acuity and dependency scoring on a daily basis.

2.2 Children's Hospital
BRCH continues to record acuity and dependency 6 monthly snap shot audits.

2.3 Adjustments in staffing

Since the last report adjustments to nurse staffing levels have taken place within a number of inpatient areas detailed further in the report.

As described previously under the Trust Policy for setting Safe Nurse Establishments there are number of triggers that indicate when a staffing review is required, in addition to the annual review of nursing establishments and skill mix (appendix 1).

Since the last report the Chief Nurse and Deputy Chief Nurse in conjunction with the relevant Divisional Head of Nursing, Divisional Director and Matrons have completed all the annual reviews for inpatient areas against the Board agreed principles for safe staffing (Appendix 2). The scope of these reviews was for the funded establishments in place at the time of the review and funded establishments for the areas planned to move to a new location within the next 6 months. The annual review did identify the need to agree staffing principles for assessment areas, as the principles used for setting these were found to be variable through the review process, varying between 1 RN per 4 patients and 1 RN per 5 patients. This will be undertaken by

All the inpatient ward areas reviewed were in line with the Trust's agreed principles of safe staffing with the exception of two surgical wards as detailed in monthly reports to the Quality and Outcomes Committee. These wards were imminently moving at the time of the review into the new ward block and the funded establishments for the new ward configurations met the agreed staffing principles of the Trust.

UH Bristol's funded establishment provides a ratio of the number of patients per RN between 2.3 - 8 on a day shift and 2.3 - 8 on a night shift. As of Jan 2015 the ratio of registered to unregistered staff for UHB for adult inpatient areas ranged between 50:50 and 90:10. Where the ratio of registered nurses is less than 60% this is based on the professional judgment of the senior nurses and supported by patient acuity and dependency scoring. There have been no changes to the areas that do not fully meet the agreed ratios or the rationale for these variations since the last report.

Three additional staffing reviews have been triggered in line with Trust policy these were:

- A review of ward A700 (general surgery), which opened in September 2014. This review was planned as part of the post ward reconfiguration review but expedited due to concerns are raised about staffing levels by staff associated with ENT treatment room activity. As a result of the review the RN staffing establishment has been increased to support an additional RN in duty on weekend days.
- A review of the newly combined orthopeadic and trauma and surgical wards A602, A604 and A605 was undertaken due to concerns raised by staff associated re the impact of the new ward configuration on staffing at night. As a result of the review the RN staffing on night shifts has been increased to support an additional RN on weekday nights.
- An external review of ward D703 (Haematology & Bone Marrow Transplant)staffing was undertaken in September 2014 by Stephen Rowley RN RSCN MSc, BSc (Hons), Divisional Senior Nurse for Haematology and BMT at University College London Hospitals NHS Foundation Trust, at the invitation of the Chief Nurse and Head of Nursing for Specialized Services Division. This review was commissioned following feedback from staff about quality the challenges posed by the new unit configuration/staffing levels, an increase in the number of clinical incidents and an indication from a benchmark group that UHBristol was an outlier in staffing levels for this type of service. Due to the number of clinical incidents and concerns regarding the quality of care being provided to patients, the Division supported by the Chief Nurse increased staffing levels using temporary staff ahead of the review being undertaken. The review has resulted in a permanent increase to the funded establishment and some other workforce changes.

Both of these concerns were risk assessed and put on the Divisional risk register

ahead of a permanent solution being agreed.

### 3.0 CQC inspection Sept 2014

The CQC review identified that under the regulated activity of diagnostic and screening procedures, treatment of disease, disorder or injury, Surgical Procedures, the Trust had failed to consistently safeguard the health, safety and welfare of service users because the Trust did not ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activity. Specifically that there were not always sufficient numbers of suitably qualified, skilled and experienced staff employed on surgical wards and theatres. The actions that the Trust has committed to undertake to address these are:

1. Matrons continue to review staffing levels, across all wards, on a daily basis, and allocate available staffing to maintain safe practice.
2. Matrons continue to review staffing levels, across all wards, on a daily basis, and allocate available staffing to maintain safe practice.
3. Continue to monitor low staffing incidents, within Divisional and Trust governance arrangements, to ensure themes are identified and remedial actions taken.
4. Develop additional actions to address high vacancy rates in key areas, notably theatres and surgical wards, including:
5. Appointment of Recruitment Lead Nurse for Division of Surgery, Head & Neck (SH&N) to drive reduction in time from staff resignation to commencement of new staff
6. Embark upon international recruitment venture for hard to recruit posts, commencing with theatres.
7. Review merits of introducing new Recruitment and Retention premia in hard to recruit areas
8. Utilise advance block booking in theatres for bank and/or agency staff, to reduce risk of unfilled shifts, when temporary staffing is likely to be required as this will increase
9. Undertake work to better understand reasons for high turnover in some areas, notably theatres and Ward 700, and develop actions to address, where possible.
10. Augment registered staffing establishment by 1 WTE on weekend days, on ward 700 to address shortfall associated with ENT treatment room activity.
11. Augment registered night time staffing establishment by 1 WTE on weekday nights, to provide additional support to wards 602, 604 and 605 to ensure night time staffing meets Trust recommended guidelines of 1:8 overnight.
12. Review adequacy of staffing of evening hours for Queen's Day Unit Recovery and Surgical Trauma Assessment Unit (STAU) assessment chairs and ensure robust risk assessment and mitigations in place for occasions when staffing falls below established levels.

Actions 1,2,5 and 6 are complete and all residual actions are commenced and will be completed by 31 March 2015

The CQC review did not identify any other concerns related to nursing and midwifery staffing levels.

**4.0 Review against NICE Safe Staffing Guidance for inpatient areas**

The above guideline was published in July 2014. It covers safe staffing for nursing in adult inpatient wards in acute hospitals. It recommends a systematic approach at ward level to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week.

The guideline identifies organisational and managerial factors that are required to support safe staffing for nursing, and makes recommendations for monitoring and taking action if there are not enough nursing staff available to meet the nursing needs of patients on the ward.

An assessment of compliance against these standards was completed. The review showed that the Trust was compliant with 38 out of 42 key standards. The four areas where the Trust was not fully compliant they were partially compliant. There were no areas where the Trust was non-compliant. The two actions arising from the assessment was to include the staffing red flags into the relevant existing policies/processes and into the draft Safer Staffing Policy by January 2015.

The outcomes of the compliance review provide assurance to Board that the Trust has systems and processes in place to support safe staffing.

**5.0 How the Trust knows the wards have been safe over the last 6 months**

5.1. Monthly Staffing Reports to Quality and Outcomes Committee.

Between June 2014 and December 2015 the Trust submitted monthly returns of the Department of Health via the NHS national staffing return. This return details the overall Trust position on actual hours worked versus expected hours worked for all inpatient areas, the percentage fill rate for Registered Nurses (RN) and Nursing Assistants (NA) for day and night shifts, together with the overall Trust percentage fill rate.

A monthly detailed report is received and reviewed at the monthly at the Quality and Outcomes Committee a Non-Executive sub-committee of the Board. This report gives a detailed breakdown of any variances by Division. A review of Trust wide data over the last six months for planned versus actual nursing hour's, which included

RN's and Nursing Assistants, shows that in every month the actual nursing hours were above plan. The Trust wide percentage fill rate for RN's over last six months on days has been 100% or above in 3 months, 99% in two months and 98% and 97% for other two months. The Trust wide percentage fill rate for RN's over last six months on nights has been 100% or above in 5 months, 98% in one month.

Where there is variance within specific areas there is a flexible approach to staffing, with wards providing cross cover where possible to support any shortfall in RN or NA staffing. Bank and agency staff are used as required to cover shifts and to ensure patient safety if cross cover is not possible. All divisions have a daily and robust review of staffing in place and decisions to move or use temporary staff to fill gaps are made on a risk assessment of the staff skill mix, the number of beds open and the acuity and dependency of the patients.

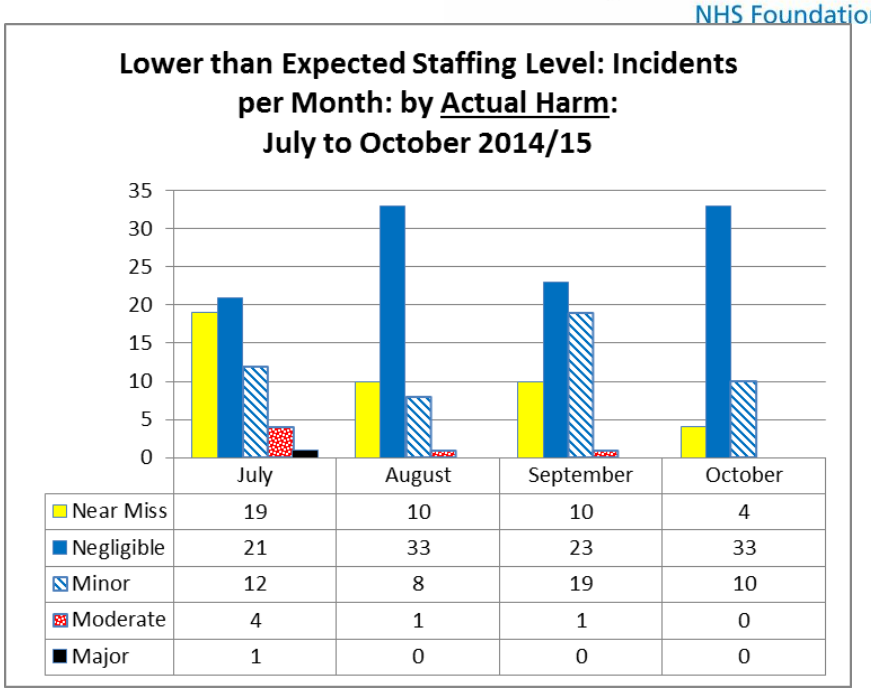
5.2 Quality metrics

The Trust level quality performance dashboard for the last six months indicates that overall the standard of patient care during this period was of good quality (safety/clinically effective/patient experience), however there has been a small increase in patient falls and two grade 3 hospital acquired pressure ulcer have occurred in December. All of these incidents have been subject of a full RCA to understand the impact, if any, of staffing levels/skills. The RCA's of two of the incidents where patients fell whilst in our care identified that these patients had been risk assessed as high risk of falling, and it was identified that 1:1 care would reduce the risk of falling. This was not able to be provided on the shift that they subsequently fell.

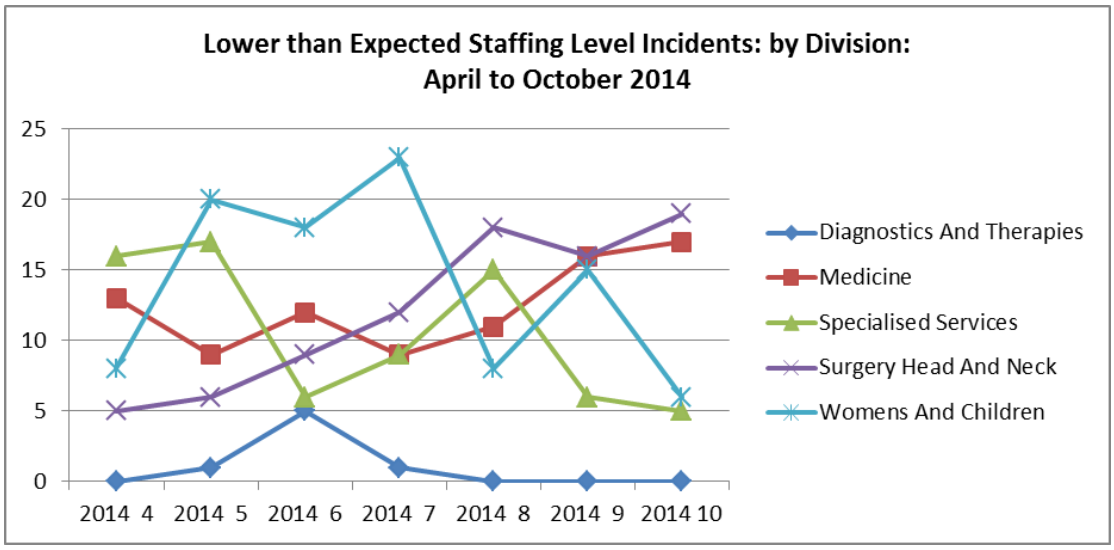
5.3 Staffing incidents

The number, content and any themes arising staffing incidents related to staffing levels are reviewed monthly and quarterly via the Nursing and Midwifery Workforce Committee. The data shows an average of 50 incidents a month. Since the last report specifc areas which have been highlighted Ward A700 and Wards A602 and A605.

It is interesting to note that where level of risk is assessed in most divisions is moderate to very high; the actual harm is assessed as near miss to minor.




| | July | August | September | October |
|---|---|---|---|---|
| Near Miss | 19 | 10 | 10 | 4 |
| Negligible | 21 | 33 | 23 | 33 |
| Minor | 12 | 8 | 19 | 10 |
| Moderate | 4 | 1 | 1 | 0 |
| Major | 1 | 0 | 0 | 0 |




**Overview of the non-ward/department based nursing and midwifery workforce:**

To accurately assess the size and shape of the non-ward based nursing workforce to ensure that it meets our requirements is a complex exercise compared with ward based establishments because in many cases staff provide a service across different settings and therefore cannot just be associated to one clinical area, e.g. a clinical nurse specialist may work across outpatients and a clinical department or ward.

The non-ward based workforce makes up for approximately X% of our total nursing workforce. The size and shape of our non-ward based workforce is very varied. For the purposes of this report and to support accurate external benchmarking of this part of the workforce has been is separated out into key groups.

For the purpose of this report, the following areas have been reviewed:

- Clinical Nurse Specialists
- Consultants Nurse
- Specialist Teams
- Matrons
- Clinical Research Nurses
- Ambulatory and Outpatient settings
- Accident and Emergency
- Critical Care*
- Theatres*

(* - areas where principles for setting establishments and national guidance used by Trust were detailed in previous report- these have not changed and no further detail is provided in this report)

**Clinical Nurse Specialists**

**Workforce Profile:**

| **Division** | **Budgeted WTE** |
|---|---|
| Medicine | 34.14 |
| Surgery/head and neck | 13.58 |
| BRCH | 37.61 |
| Specialized services | 24.77 |
| D&T | 1.00 |

Clinical Nurse Specialists are employed across all services. This staff group is crucial in the implementation of the Cancer Reform Strategy, European Working Time Directive and the need to deliver an increased level of activity in a range of settings.

The CNS deliver an important clinical role throughout the Trust.
The CNS role provides expert levels of direct patient care and care and shape and influence care at a variety of levels. This role is important in providing specialist clinical practice skills, patient advocacy, consultation, education and supporting research and audit activity. They play a leading role in the development of clinical guidelines, protocols, screening and assessment tools and implementation of research findings appropriate to their client group.

This workforce has been instrumental in the development of ambulatory models of care, where treatments previously requiring inpatient stays are now provided on an outpatient basis. This skilled/specialist workforce is also important in workforce planning to support the changing/reducing number of junior doctor roles.

There are no validated workforce tools for determining staffing levels for the CNS workforce. To make sure that this part of the workforce is utilized as effectively and efficiently as possible the following areas are key to review to ensure maximizing of productivity opportunities:

- Time spent on patient facing activities/standardized patient contact times
- Skill mix of teams, determining whether activities being undertaken are making the best use of specialist skills
- Income generation, to ensure that nurse specialists are being compensated for activities they carry out.

A review of CNS role was undertaken in 2012/13 as part of the Trust's Transformation Programme. This developed an evidence based, systematic process for the Divisions to undertake a review of their CNS workforce's contribution to service delivery. It identified areas in all Divisions for increased productivity of some CNS roles. The review recommended that going forward that a review of CNS roles should be an annual process to ensure that all the roles of CNS's are fully aligned to service requirements, financial planning, income, CRES, CQUINs etc.

It is proposed that the scope the annual divisional staffing review is expanded to include CNS's roles from 2015.

**Consultant Nurses**

**Workforce Profile:**

| **Division** | **Budgeted WTE** |
|---|---|
| Medicine | 1.80 |
| Surgery/head and neck | 0 |
| BRCH | 1.00 |
| Specialized services | 1.00 |
| D&T | * NB has 2 Allied Health Professionals Consultant posts |

The Consultant Nurse posts are one of the few nursing roles to be outlined and proscribed by the Department of Health. The expectation is that the post holder will be a clinical nursing leader, driving high quality service and standards as well as advancing clinical practice on both a local and a national scale. The minimum educational qualification is at Masters level with many having PhD's.

The contribution that Consultant Nurses can make in the current health service is more important than ever before. Current government reforms and strategies continue to raise the importance of person-centred, safe and effective care in tandem with increasing productivity and innovation. Consultant Nurses have expertise in developing workplace cultures of effectiveness that will sustain person centred, safe and effective care right along patient pathways. More than any other

role, Consultant Nurses possess the full range of integrated expertise necessary to achieve the current government agenda in practice, through bridging expert nursing practice with learning, evaluation and measurement in practice, and clinical and political leadership.

The 4 integrated sub roles of the CN are:
• expert clinical practice (at least 50% of time)
• professional leadership and consultancy
• education, training and development
• practice and service development

All Consultant Nurses have direct clinical roles; delivering individualised clinical care to patients on booked procedure or outpatients lists. They improve access and referral pathways for patients/ clients by designing and providing innovative services within their specialty. They enhance clinical care using advanced assessment, including diagnostics, prescribing medications, treatments and caseload management for people living with chronic disease. This has made a considerable financial contribution to the Trust, as direct income, reducing length of stay and readmission, reducing waiting times and providing “one stop” services.

All Consultant Nurses are involved in education, many holding visiting lecturer positions at UWE or other HE institutions and/or leading specialist training and courses locally and beyond. Through research collaborations post holders are able to contribute to the R&D agenda; providing a link with HEIs and raising the profile of the Trust through publications and conference presentations.

There are no validated workforce tools for determining staffing levels for the Consultant Nurse workforce. The Trust needs to understand and recognize the value and contribution that Consultant Nurses can provide using a defined framework in partnership with other relevant organizations.

**Specialist Teams**

There is a number of specialist nursing teams in the Trust this report focuses on those that perform a specific specialist clinical role led by a lead clinical nurse specialist.

**Workforce Profile:**

| Team | Budgeted WTE |
|---|---|
| Infection Control | 6.9 |
| Safeguarding Adults | 4.6 |
| Safeguarding Children | 4.1 |
| Tissue Viability | 1.5 |

Within the Trust we have a number of specialist teams that contribute to improving

patient outcomes, keeping patients safe and training the workforce. These services are largely responsible for the overarching delivery of key Trust objectives and targets. They provide leadership and support to all staff and patients. Many of these services are key to the implementation of national requirements and statutory regulations.

There is good benchmarking data available for most specialist teams providing an expert practice function. This would be used to provide assurance that the team establishment and skill mix is with the "normal range" for the size and type of organization. UH Bristol specialist teams with the exception of the Tissue Viability team are broadly within these benchmarks. Work is ongoing to explore options to provide further support into the Tissue Viability Team.

**Matrons**

**Workforce Profile:**

| Division | Budgeted WTE |
|---|---|
| Medicine | 6.0 |
| Surgery/head and neck | 6.0 |
| BRCH | 4.8 |
| Specialized services | 4.8 |
| D&T | 0.0 |

Matrons provide clinical leadership and support to Ward and Departmental Sisters/Charge Nurses to promote excellence in nursing and midwifery care to maintain and improve clinical standards.

Their role is extremely important in reducing and managing risk, identifying risks early and addressing the root causes. Within the nursing teams they are pivotal in ensuring that Trust values are upheld and that all patients are treated with compassion, dignity and respect. Their key responsibility is to ensure that the patient experience is of the highest quality and inspires patient and public confidence. This is achieved through high visibility, accessibility and surveillance. A minimum of 75% of their working activities are clinical.

**Clinical Research Nurses**

The role of the CRN is focused on:

- Supporting patients recruited into research studies either as part of their normal clinical pathway or to have access to trial treatments, which are otherwise not available to them.
- Data collection to provide greater information about a condition

The CRNs act as the patient advocate and ensures patient safety and adherence to

research governance requirements at all times. They work alongside other members of the research and clinical teams to identify and screen patients who may be suitable to be treated within a research study. Additional responsibilities within the role include

The current Clinical Research Nurses at UH Bristol are funded externally by grants generated by research activity. At the time of writing this report there were X WTE CRN in UH Bristol.

**Ambulatory and Outpatient Services**

Across our Trust we have a number of ambulatory and outpatient settings, many of which are nurse-led and prevent the need for patients to be admitted, for example, Chemotherapy Day Unit, dermatology services. These particular staff groups are hard to quantify and benchmark as many of the staff who support these areas are already captured within other groups, for example, under the CNS heading. Further work is required on to understand the core nursing and midwifery staffing within these areas and also to ensure we can provide education and training that is relevant to the service need of each of these department, to have the right skill mix to ensure patient safety, have the ability to cross cover services with specialties in the event of planned and unplanned leave or increased demand to ensure that the role of the nurse in the outpatient setting to ensure they take on a
role which ensures 'every contact counts' to focus on public health, for example, smoking, alcohol and obesity.

**Accident and Emergency**

**Workforce Profile:**

| Division | Budgeted WTE |
|---|---|
| Medicine | 66.0 |
| Surgery/head and neck | 10.4 |
| BRCH | 37.3 |

Currently there is no validated workforce tool to determine staffing levels, this has been identified as a gap nationally and there us a working a NICE working group developing NICE safe staffing guidelines for A&E departments which includes the development of a Safer Care Nursing Tool for A&E Units. UH Bristol's Consultant Nurse for A&E is part of the working group.

**Next Steps**

A number of national key developmental pieces of work (listed below) related to ensuring that we have the right staff with the right skills in the right place are being undertaken. The implications of the recommendations from these reports for UH

Bristol will be reviewed once they are published.

- National Nursing Research Unit report on 12 hour shifts – due Dec 2014 (not yet published)
- Safer Midwife Staffing in maternity settings – out for consultation
- Safer Care Nursing Tool for Paediatric inpatient settings – work complete awaiting launch date
- Safer Care Nursing Tool for A&E – out for consultation
- Research being commissioned – impact of supervisory ward sister role, links between staff numbers and outcomes, more in-depth research on 12hr shifts – impact on staff and patients.

**Conclusion**

In the last six months the Chief Nurse and Divisional Teams have undertaken a comprehensive ward by ward review of staffing levels to ensure they are staffed safely. This has also increased the understanding at ward level and all Ward Sisters and Charge Nurses have an understanding of their funded workforce resource, but that if required this will be adjusted to reflect the acuity and dependency of patients admitted and changes to ward environments.

This paper can assure the Board of Directors that UHBristol has safe staffing levels. However there is no element of complacency and there is a need to stabilise the workforce with an effective recruitment campaign and to ensure if the service model changes that staffing can be adjusted accordingly.

University Hospitals Bristol NHS
NHS Foundation Trust

**Appendix 1:**

**UHBristols principles for initiating a staffing review (2014)**

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

OR when there is:

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

**Appendix 2:**

**Principles of Safe Staffing for General Inpatient Wards**

**Ratio of registered to unregistered professionals**
Within UHB adult inpatient areas the Trust set staffing levels based on a principle of 60:40 ratio, registered nurse to nursing assistant in general inpatient areas. This will be higher in some specialist ward areas due to the increasing complexity of care, for example medication regimes and the number of intravenous drugs now given and increased dependency and complexity of elderly patients being admitted.

**Ratio of number of patients per nurse**
In setting wards establishment and skill mix UHB use the principles of one registered nurse per 6 patients on a day shift and one registered nurse to 8 patients on a night shift.

In adult critical care areas the ratio is one nurse per patient adult intensive care (level 3 patient) day and night and one nurse per two patients in adult high dependency (level 2 patients) day and night.

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 14. 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 £5.002m (before technical items) for the nine month period to 31st December 2014. This represents a favourable variance of £0.752m against plan to date. The Divisional position has deteriorated further by £1.548m in December to a cumulative overspending of £8.627m. This is offset, in line with practice reported in recent months, by the underspending on corporate services budgets together with contributions to the Trust's overall financial position from the corporate share of service agreement income, reserves, capital charges and financing costs. The Trust remains on target to deliver the planned surplus of £5.8m for the year.

The Trust's income for 'Operational Resilience' is £3.942m. For November and December £1.231m has been recognised as income to meet additional capacity costs incurred. It is expected that this funding will be fully utilised by 31 March 2015 and will not therefore contribute to the year-end financial position.

### Recommendations

The Board is recommended to receive the report for **assurance.**

### Report Sponsor

Paul Mapson, Director of Finance & Information

### Appendices

- Appendix 1 – Summary Income and Expenditure Statement
- Appendix 2 – Divisional Income and Expenditure Statement
- 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 – December 2014

**Previous Meetings -** Date the paper was presented to the relevant Group or Committee:

| Senior Leadership Team | Senior Leadership Team | Quality & Outcomes Committee | Finance Committee | Audit Committee | Other |
|---|---|---|---|---|---|
| | | | 26 January | | |

**REPORT OF THE FINANCE DIRECTOR**

## 1. Overview

The summary income and expenditure statement shows a surplus of £5.002m (before technical items) for the first nine months of 2014/15. This represents a favourable variance of £0.652m against plan year to date.

The divisional overspend is effectively being offset by underspending in a number of areas as follows:

| | **December** | **Year to Date** |
|---|---|---|
| | Fav / (Adv) | Fav / (Adv) |
| | £'000 | £'000 |
| Divisional overspends | (1,548) | (8,627) |
| Corporate services underspending | 53 | 537 |
| Service agreements corporate share | 184 | 1,979 |
| Reserves slippage | 421 | 3,788 |
| Capital charges – depreciation and PDC dividend | 1,084 | 3,044 |
| Financing Costs | (7) | (69) |
| **Favourable variance (before Technical Items)** | **187** | **652** |

The service agreement corporate share incudes the share of the increase in planned contract income for 2014/15. This amounts to £4.7m for the year (£3.539m year to date) but this is then reduced as follows:

| | **Year to Date** | **Projected Year End** |
|---|---|---|
| | Fav / (Adv) | Fav / (Adv) |
| | £'000 | £'000 |
| Corporate share of planned income | 3,539 | 4,719 |
| Performance fines (over £1m budget provided) | (642) | (1,506) |
| CQUINs over performance | 639 | 991 |
| Corporate share of income under performance | (1,557) | (1,704) |
| **Totals** | **1,979** | **2,500** |

The Operational Resilience (Winter Pressures) funding amounts to £3.942m for the year. It is expected that this funding will be fully utilised so will not contribute to the year-end financial position.

It should be noted that the forecast payment back to Commissioners for performance fines is £2.5m.

The increase in Capital Charges underspending to £3m to date and £4m at year end is due to the new ward block not being capitalised until January 2015 (Qtr 4) and therefore not generating a depreciation charge in year (£306k), delay in completion of phase 4 schemes into Qtr 4 (£181k) and equipment not being capitalised until Qtr 4 (£361k).

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 £8.090m. Detailed information and commentary for each Division is to be considered by the Finance Committee.

| Divisional Variances | Variance to 30 November | December Variance | Variance to 31 December |
|---|---|---|---|
| | Fav / (Adv) £'000 | Fav / (Adv) £'000 | Fav / (Adv) £'000 |
| Pay | (2,319) | (572) | (2,891) |
| Non Pay | 2,804 | (285) | 2,519 |
| Operating Income | 267 | 226 | 493 |
| Income from Activities | (3,289) | (374) | (3,663) |
| Sub Totals | (2,537) | (1,005) | (3,542) |
| Savings Programme | (4,058) | (490) | (4,548) |
| **Totals** | **(6,595)** | **(1,495)** | **(8,090)** |

**Pay budgets** have an overspending of £0.572m in the month and a cumulative overspending of £2.891m. Substantive staff pay costs increased by £0.578m in December to £26.487m. Agency staff expenditure of £0.978m represented a decrease of £89k when compared with November. For the Trust as a whole, bank, overtime, waiting list initiative and other payments increased by £0.283m to £1.621m in December (cumulative expenditure £12.375m).

N**on-pay budgets** show an adverse variance of £0.285m in the month thereby reducing the cumulative favourable variance to £2.519m for the 9 months to 31st December. The underspending to date 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 £0.226m for the month, and a cumulative underspending of £0.493m.

**Income from Activities** shows an adverse variance of £0.374m in the month. This increases the cumulative under performance to £3.663m. The principal variances are the in-month over performance recorded for Diagnostic and Therapies (£76k) and Medicine (£104k) offset by income being less than planned for Women's and Children's (£0.566m).

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

| | Variance to 30 November | December Variance | Variance to 31 December |
|---|---|---|---|
| | Fav / (Adv) | Fav / (Adv) | Fav / (Adv) |
| Diagnostic and Therapies | (50) | (212) | (262) |
| Medicine | (1,327) | (21) | (1,348) |
| Specialised Services | (548) | (198) | (746) |
| Surgery, Head and Neck | (3,508) | (675) | (4,183) |
| Women's and Children's | (1,646) | (442) | (2,088) |
| Estates and Facilities | 101 | 10 | 111 |
| Trust HQ | 134 | 10 | 144 |
| Trust Services | 249 | 33 | 282 |
| **Totals** | **(6,595)** | **(1,495)** | **(8,090)** |

The results to 31 December are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 4.0, November 4.0). Further information on the financial risk rating is given in section 6 below and appendix 6.

## 2. Forecast Outturn

Having fully considered the position to quarter 3 i.e. to December the forecast outturn remains that the original planned surplus of £5.8m will be delivered. The range of assumptions used in the quarter 2 forecast has been firmed up and the forecast can therefore be confidently predicted.

The Trust will need to recognise a number of technical items – namely donations and grants, impairments, reversal of impairments and depreciation on donated assets - 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.

The continuity of service risk rating is also forecast to be 4 at year end. The forecast cash balance is £68.175m compared with the original plan of £46.435m.

The capital programme spend has been reviewed in depth. The outcome is the identification of significant additional slippage. The forecast spend for the year is now £45.5m compared to the original plan of £57.6m. This will trigger the Monitor exception reporting percentage of 85% as the outturn will be in the order of 79% of Plan.

## 3. Savings Programme

The Trust's Savings Programme for 2014/15 is £20.771m. Savings of £11.027m have been realised for the nine months to 31 December (77% of Plan), a shortfall of £3.279m against divisional plans. The forecast outturn for savings this year is £16.797m – 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 31 December | | | 1/12ths Phasing Adj Fav / (Adv) | Total Variance Fav / (Adv) |
|---|---|---|---|---|---|
| | Plan | Actual | Variance Fav / (Adv) | | |
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| Diagnostics and Therapies | 1,245 | 1,280 | 35 | (73) | (38) |
| Medicine | 1,942 | 1,340 | (602) | (337) | (939) |
| Specialised Services | 1,619 | 1,550 | (69) | (361) | (430) |
| Surgery, Head and Neck | 3,506 | 1,711 | (1,795) | (188) | (1,983) |
| Women's and Children's | 2,455 | 1,535 | (920) | (230) | (1,150) |
| Estates and Facilities | 740 | 793 | 53 | (85) | (32) |
| Trust HQ | 781 | 784 | 3 | 2 | 5 |
| Other Services | 2,018 | 2,034 | 16 | - | 16 |
| **Totals** | **14,306** | **11,027** | **(3,279)** | **(1,272)** | **(4,551)** |

## 4. Income

Contract income is £3.57m lower than plan for the 9 month period to 31 December. Activity based contract performance at £307.78m is £3.86m less than plan. Contract rewards / penalties at a net income of £3.72m is £0.07m less than plan. Income of £44.86m for 'Pass through' payments is £0.36m higher than Plan.

| Clinical Income by Worktype | Plan<br>£'m | Actual<br>£'m | Variance<br>£'m |
|---|---|---|---|
| Activity Based | | | |
| Accident & Emergency | 10.30 | 10.12 | (0.18) |
| Emergency Inpatients | 54.47 | 54.97 | 0.50 |
| Day Cases | 27.82 | 26.30 | (1.52) |
| Elective Inpatients | 38.91 | 36.67 | (2.24) |
| Non-Elective Inpatients | 12.71 | 11.71 | (1.00) |
| Excess Bed days | 5.47 | 5.53 | 0.06 |
| Outpatients | 55.28 | 55.05 | (0.23) |
| Bone Marrow Transplants | 6.39 | 7.16 | 0.77 |
| Critical Care Bed days | 32.02 | 31.42 | (0.60) |
| Other | 68.27 | 68.85 | 0.58 |
| **Sub Totals** | **311.64** | **307.78** | **(3.86)** |
| Contract Rewards / Penalties | 3.79 | 3.72 | (0.07) |
| Pass through payments | 44.50 | 44.86 | 0.36 |
| **Totals** | **359.93** | **356.36** | **(3.57)** |

## 5. Expenditure

In total, Divisions have overspent by £1.495m in December. 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 £1.348m for the nine months to 31 December, an adverse variance in the month of £21k.

The Division has an overspending of £0.480m to date on pay budgets, an overspending in the month of £75k. There was a further underspending on medical staff budgets - £43k in the month and £0.740m to date. This has been partially offset by overspendings on other staff groups. Nursing staff budgets for example are overspent by £0.585m to date.

Non-pay budgets have an adverse variance of £37k in the month and a cumulative underspending of £0.272m. The principal in-month adverse variance was recorded against the drugs budget heading with an activity related overspending of £47k. The Division is using funds received as part of the 2014/15 contracts transfer to mitigate the impact of SLA underperformance. The associated costs of the additional ward and other seasonal costs have been funded from the Operational Resilience (ORCP) programme moneys. Patient transport costs continue above planned levels.

The Division reports a cumulative favourable variance of £0.212m on its Operating Income budgets. Income from Activities shows an over achievement of £104k in the month and a cumulative adverse variance of £0.413m.

**The Surgery, Head and Neck Division** reports an adverse variance of £4.183m for the nine months to 31 December, an overspending of £0.675m in the month.

Pay budgets are overspent by £2.340m to date, an increase of £0.371m in December. The overall position represents the pay proportion of the Division's underlying deficit (£2.882m) offset by a net underspending on other pay headings (£0.542m).

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

Non pay budgets are overspent by £134k in the month. The cumulative underspending of £0.192m is mainly due to the release of 9/12th 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 December of £19k thereby reducing the cumulative adverse position to £0.163m. Ophthalmology services continue to record higher than planned activity in the month (£0.228m). In total other clinical services income headings are less than plan to date. The Division has received a higher than planned share of income (£35k) for activities provided by other Divisions. Operating Income budgets show a favourable variance of £16k in the month and a cumulative underspending of £110k.

**The Division of Women's and Children's Services** reports an adverse variance on its income and expenditure position of £2.088m for the nine months to 31 December, an increase of £0.442m in the month.

Pay budgets overspent by £24k in the month and now show a cumulative adverse position of £0.216m. Medical staff vacancies and an inability to obtain locum cover resulted in an underspending in the month. Nursing and midwifery staff expenditure was £46k overspent mainly because of the higher than planned use of agency staff.

Non-pay budgets show an underspending of £0.262m in the month and an underspending of £1.679m 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 £2.394m to date, a deterioration of £0.566m in the month. The principal adverse variances are shown against maternity (£0.521m), paediatric cardiac (£0.675m), paediatric medicine (£0.429m). In addition there are other significant variances such as CSP related services (£0.679m adverse), hearing implants (£0.340m favourable) and renal services (£0.179m favourable).

Income from Operations budgets show an adverse variance of £14k in December to give a cumulative overspending of £8k.

*Two Divisions are now amber / red rated*

The **Diagnostic and Therapies Division** (previously green rated) reports an overspending for the month of £0.212m and a cumulative overspending of £0.262m. Pay budgets have overspent in the month by £65k – this includes £91k of late invoicing recharges. The overspending in December on non-pay headings also reflects the impact of late invoices together with higher than planned spend on clinical supplies and drugs.

Income from Activities shows a favourable variance of £76k in the month thereby reducing the cumulative adverse variance to £0.332m. Operating income was better than plan by £92k and now shows a year to date favourable variance of £0.355m.

The **Division of Specialised Services** (previously amber / green rated) reports an adverse variance on its income and expenditure position of £0.746m for the nine months to 31 December, an overspending of £198k in the month.

Pay budgets show an overspending of £0.131m for the month, cumulative overspending £1.063m. The overspending in December on nursing staff was £33k, cumulatively £0.659m adverse. Medical

staff costs were also higher than planned £71k in the month and cumulatively by £0.330m. Waiting List Initiatives have been paid for additional activity in cardiology, cardiac surgery and anaesthesia. The Division has incurred costs of £0.695m to date on agency staff required to cover vacancies and 1:1 nursing.

Non pay budgets have overspent by £86k in December thereby reducing the favourable variance to date to £0.621m. Adverse activity related variances were recorded in December against drugs (£14k), blood and blood products (£80k) and clinical supplies (£96k). The non pay budget heading is supported by favourable variances on the allocation of contract transfer funds (£0.259m) and Trust support funding (£1m).

Income from activities shows a favourable variance in month of £268k to give a cumulative adverse variance of £0.192m. Cardiac surgery was better than plan by £59k, cumulatively now £0.484m adverse. Cardiology services have under-performed against the service level agreement activity in December thereby increasing the cumulative under performance by £64k to ££0.467m.

*Two divisions are green rated.*

**The Facilities and Estates Division** reports a £10k surplus for the month thereby increasing its cumulative underspending to £111k.

**Trust Headquarters Services** report a £10k underspending in December and a cumulative underspending of £144k.

## 6. Continuity of Service Risk Rating

The Trust's overall financial risk rating, based on results for the 9 months ending 31 December is 4. The actual financial risk rating is 4.0 (November 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 | November | December | Annual Plan 2014/15 |
|---|---|---|---|---|
| **Liquidity** | | | | |
| Metric Performance | 2.71 | 8.18 | 5.45 | 2.53 |
| Rating | 4 | 4 | 4 | 4 |
| **Capital Service Capacity** | | | | |
| Metric Performance | 3.04 | 2.94 | 2.75 | 2.51 |
| Rating | 4 | 4 | 4 | 4 |
| | | | | |
| **Overall Rating** | **4** | **4** | **4** | **4** |

The reduction in the performance for the liquidity metric reflects the requirement to recognise as a current liability (i.e. payable within 12 months) the final tranche of the loan principal repayment plan. Performance on the capital service capacity metric deteriorated in December 2014 as a consequence of the Trust making the first repayment (£0.666m) of the £20m loan taken out in May 2014.

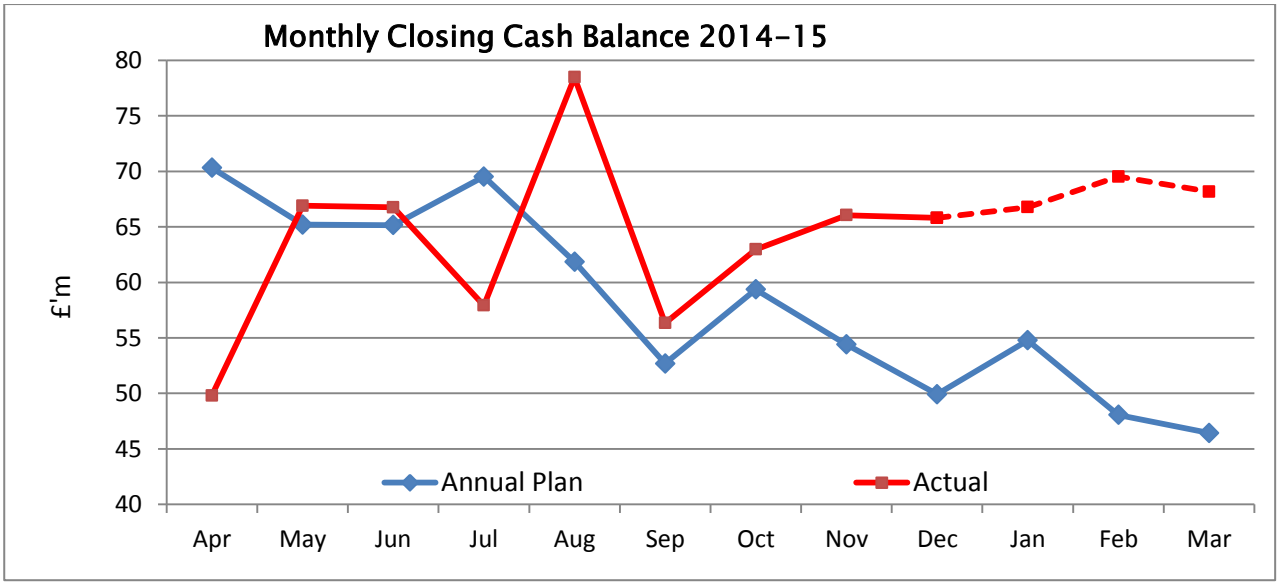
## 7. Capital Programme

A summary of income and expenditure for the nine months to 31 December is given in the table below. Expenditure for the period of £35.550m equates to 96% of the current capital expenditure plan. The year-end forecast shows slippage / underspending of £11.169m (19.7%).

| | Annual Plan | Nine Months Ending 31 December | | | Forecast Outturn |
|---|---|---|---|---|---|
| | | Plan | Actual | Variance Fav / (Adv) | |
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Sources of Funding** | | | | | |
| Public Dividend Capital | 2,625 | 609 | 609 | - | 2,625 |
| Donations | 10,721 | 6,312 | 6,312 | - | 10,471 |
| Retained Depreciation | 19,181 | 14,009 | 13,939 | (70) | 18,298 |
| Prudential Borrowing | 20,000 | 20,000 | 20,000 | - | 20,000 |
| Sale of Property | 700 | 700 | 700 | - | 700 |
| Recovery of VAT | 954 | - | - | - | 954 |
| Cash balances | 2,473 | (4,623) | (6,010) | (1,387) | (7,563) |
| **Total Funding** | **56,654** | **37,007** | **35,550** | **(1,457)** | **45,485** |
| **Expenditure** | | | | | |
| Strategic Schemes | (29,948) | (22,653) | (22,398) | 255 | (25,910) |
| Medical Equipment | (5,461) | (3,687) | (3,511) | 176 | (4,826) |
| Information Technology | (8,176) | (3,926) | (3,821) | 105 | (5,330) |
| Roll Over Schemes | (2,933) | (1,439) | (1,464) | (25) | (2,249) |
| Operational / Other | (10,136) | (5,302) | (4,356) | 946 | (7,170) |
| **Total Expenditure** | **(56,654)** | **(37,007)** | **(35,550)** | **1,457** | **(45,485)** |

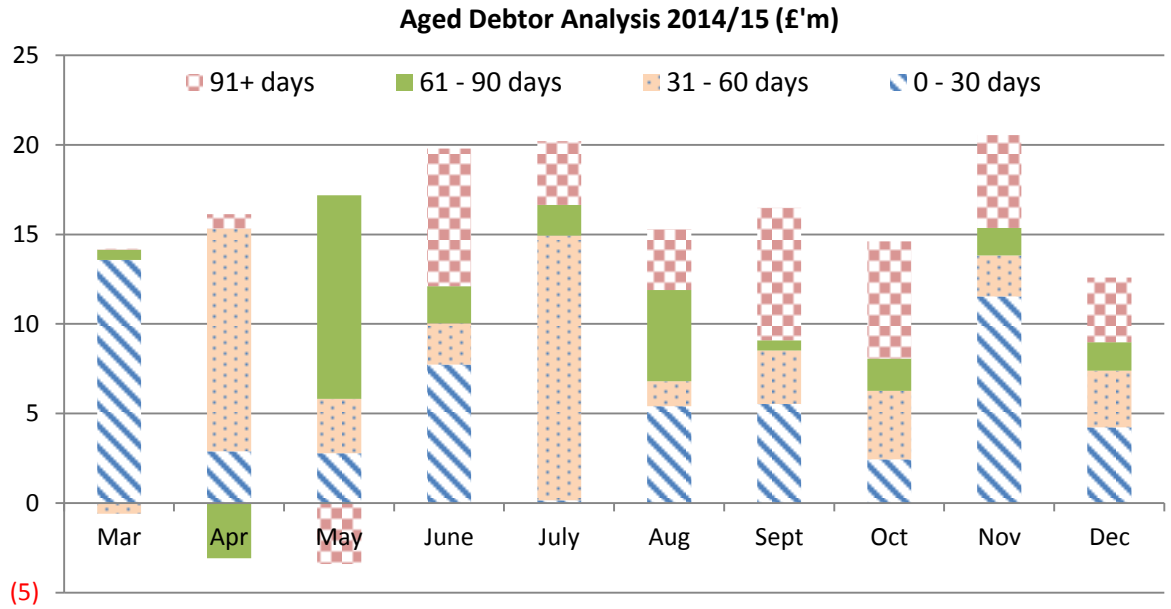
## 8. Statement of Financial Position (Balance Sheet) and Cashflow

**Cash -** The Trust held a cash balance of £65.801m as at 31 December.

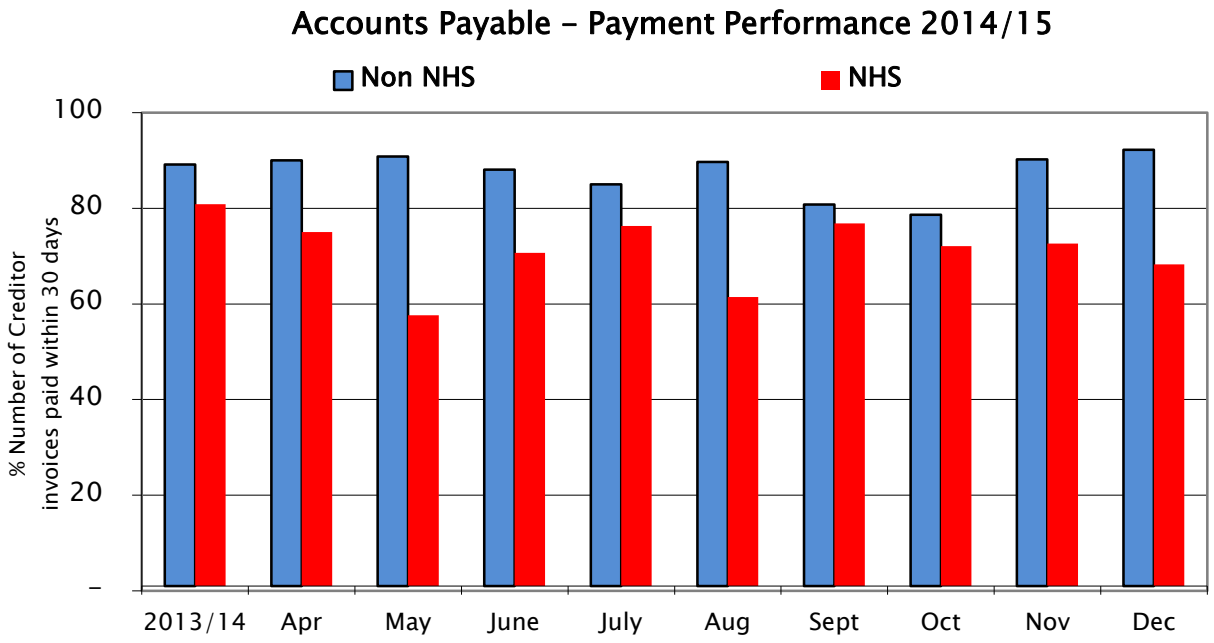



The higher forecast cash balance is due to some slippage on the Capital programme and a high level of provisions (mainly re employment issues).

**Debtors** - The total value of invoiced debtors has decreased by £7.954m during December to a closing balance of £12.599m. The total amount owing is equivalent to 7.9 debtor days.




**Accounts Payable Payments** - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In December the Trust achieved 68% and 92% compliance against the Better Payment Practice Code for invoices paid for NHS and Non NHS creditors. Managers have been reminded of the importance of prompt receipting of goods which has led to some delays in payment of suppliers. The Trust also continues to operate strict financial controls around supplier price increases.




*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 December 2014*

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

| Approved Budget / Plan 2014/15 | Heading | Position as at 31st December | | | Actual to 30th November | Forecast Outturn |
|---|---|---|---|---|---|---|
| | | Plan | Actual | Variance Fav / (Adv) | | |
| £'000 | | £'000 | £'000 | £'000 | £'000 | £'000 |
| | **Income (as per Table I and E 2)** | | | | | |
| 488,700 | From Activities | 364,664 | 362,934 | (1,730) | 321,583 | 486,853 |
| 91,515 | Other Operating Income | 68,379 | 68,630 | 251 | 60,625 | 91,221 |
| **580,215** | **Sub totals income** | **433,043** | **431,564** | **(1,479)** | **382,208** | **578,074** |
| | **Expenditure** | | | | | |
| (330,659) | Staffing | (248,432) | (251,856) | (3,424) | (222,770) | (337,266) |
| (200,492) | Supplies and Services | (150,738) | (152,022) | (1,284) | (134,831) | (204,734) |
| **(531,151)** | **Sub totals expenditure** | **(399,170)** | **(403,878)** | **(4,708)** | **(357,601)** | **(542,000)** |
| (8,858) | Reserves | (3,788) | – | 3,788 | – | – |
| **40,207** | **EBITDA** | **30,085** | **27,686** | **(2,399)** | **24,607** | **36,074** |
| | **Financing** | | | | | |
| (23) | Profit/(Loss) on Sale of Asset | (23) | (23) | – | (13) | (23) |
| (21,926) | Depreciation & Amortisation – Owned | (16,413) | (13,692) | 2,721 | (12,303) | (18,298) |
| 150 | Interest Receivable | 113 | 189 | 76 | 167 | 251 |
| (338) | Interest Payable on Leases | (254) | (259) | (5) | (230) | (345) |
| (3,117) | Interest Payable on Loans | (2,296) | (2,360) | (64) | (2,084) | (3,142) |
| (9,149) | PDC Dividend | (6,862) | (6,539) | 323 | (5,812) | (8,718) |
| **(34,404)** | **Sub totals financing** | **(25,735)** | **(22,684)** | **3,051** | **(20,275)** | **5,800** |
| **5,803** | **NET SURPLUS / (DEFICIT) before Technical Items** | **4,350** | **5,002** | **652** | **4,332** | **5,799** |
| | **Technical Items** | | | | | |
| 8,588 | Donations & Grants (PPE/Intangible Assets) | 6,357 | 6,357 | – | 6,340 | 8,588 |
| (24,204) | Impairments | (2,923) | (2,923) | – | (2,073) | (24,204) |
| 1,232 | Reversal of Impairments | – | – | – | – | 1,232 |
| (1,219) | Depreciation & Amortisation – Donated | (900) | (876) | 24 | (561) | (1,187) |
| **(9,800)** | **SURPLUS / (DEFICIT) after Technical Items** | **6,884** | **7,560** | **676** | **8,038** | **(9,772)** |

# UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

## Finance Report December 2014– Divisional Income & Expenditure Statement

| Approved Budget / Plan 2014/15 | Division | Total Net Expenditure / Income to Date | Variance [Favourable / (Adverse)] | | | | | Total Variance to date | Total Variance to 30th November |
|---|---|---|---|---|---|---|---|---|---|
| | | | Pay | Non Pay | Operating Income | Income from Activities | CRES | | |
| £'000 | | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| | **Service Agreements** | | | | | | | | |
| 482,366 | Service Agreements | 359,928 | – | – | (17) | 17 | – | – | – |
| (4,719) | Overheads | (1,561) | – | (500) | – | 2,479 | – | 1,979 | 1,795 |
| 40,865 | NHSE Income | 30,218 | – | – | – | – | – | – | – |
| **518,512** | **Sub Total Service Agreements** | **388,585** | **–** | **(500)** | **(17)** | **2,496** | **–** | **1,979** | **1,795** |
| | **Clinical Divisions** | | | | | | | | |
| (48,672) | Diagnostic & Therapies | (36,539) | 164 | (411) | 355 | (332) | (38) | (262) | (50) |
| (67,524) | Medicine | (51,845) | (480) | 272 | 212 | (413) | (939) | (1,348) | (1,327) |
| (81,160) | Specialised Services | (61,161) | (1,063) | 621 | 318 | (192) | (430) | (746) | (548) |
| (97,121) | Surgery Head & Neck | (76,959) | (2,340) | 192 | 110 | (163) | (1,982) | (4,183) | (3,508) |
| (109,199) | Women's & Children's | (83,904) | (216) | 1,679 | (8) | (2,394) | (1,149) | (2,088) | (1,646) |
| **(403,676)** | **Sub Total – Clinical Divisions** | **(310,408)** | **(3,935)** | **2,353** | **987** | **(3,494)** | **(4,538)** | **(8,627)** | **(7,079)** |
| | **Corporate Services** | | | | | | | | |
| (34,857) | Facilities And Estates | (26,431) | 151 | 87 | (72) | (23) | (32) | 111 | 101 |
| (24,110) | Trust Services | (18,009) | 441 | (451) | 73 | – | 5 | 68 | 67 |
| (6,804) | Other | (6,051) | 452 | 454 | (495) | (146) | 17 | 282 | 249 |
| **(65,771)** | **Sub Totals – Corporate Services** | **(50,491)** | **1,044** | **90** | **(494)** | **(169)** | **(10)** | **461** | **417** |
| **(469,447)** | **Sub Total (Clinical Divisions & Corporate Services)** | **(360,899)** | **(2,891)** | **2,443** | **493** | **(3,663)** | **(4,548)** | **(8,166)** | **(6,662)** |
| (8,858) | Reserves | – | – | 3,788 | – | – | – | 3,788 | 3,367 |
| **(8,858)** | **Sub Total Reserves** | **–** | **–** | **3,788** | **–** | **–** | **–** | **3,788** | **3,367** |
| **40,207** | **Trust Totals Unprofiled** | **27,686** | **(2,891)** | **5,731** | **476** | **(1,167)** | **(4,548)** | **(2,399)** | **(1,500)** |
| | **Financing** | | | | | | | | |
| (23) | (Profit)/Loss on Sale of Asset | (23) | – | – | – | – | – | – | – |
| (21,926) | Depreciation & Amortisation – Owned | (13,692) | – | 2,721 | – | – | – | 2,721 | 1,751 |
| 150 | Interest Receivable | 189 | – | 76 | – | – | – | 76 | 67 |
| (338) | Interest Payable on Leases | (259) | – | (5) | – | – | – | (5) | (4) |
| (3,117) | Interest Payable on Loans | (2,360) | – | (64) | – | – | – | (64) | (58) |
| (9,149) | PDC Dividend | (6,539) | – | 323 | – | – | – | 323 | 209 |
| **(34,404)** | **Sub Total Financing** | **(22,684)** | **–** | **3,051** | **–** | **–** | **–** | **3,051** | **1,965** |
| **5,803** | **NET SURPLUS / (DEFICIT) before Technical Items** | **5,002** | **(2,891)** | **8,782** | **476** | **(1,167)** | **(4,548)** | **652** | **465** |
| | **Technical Items** | | | | | | | | |
| 8,588 | Donations & Grants (PPE/Intangible Assets) | 6,357 | – | – | – | – | – | – | – |
| (24,204) | Impairments | (2,923) | – | – | – | – | – | – | – |
| 1,232 | Reversal of Impairments | – | – | – | – | – | – | – | – |
| (1,219) | Depreciation & Amortisation – Donated | (876) | – | 24 | – | – | – | 24 | 13 |
| – | Profiling Adjustment | – | – | – | – | – | – | – | – |
| **(15,603)** | **Sub Total Technical Items** | **2,558** | **–** | **24** | **–** | **–** | **–** | **24** | **13** |
| **(9,800)** | **SURPLUS / (DEFICIT) after Technical Items Unprofiled** | **7,560** | **(2,891)** | **8,806** | **476** | **(1,167)** | **(4,548)** | **676** | **478** |

**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 | Oct £'000 | Nov £'000 | Dec £'000 | Q3 £'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 | 3,356 | 3,317 | 3,364 | 10,037 | 30,265 | 3,363 | | 3,294 | |
| | Bank | 306 | 16 | 27 | 22 | 64 | 25 | 39 | 27 | 91 | 27 | 26 | 33 | 86 | 241 | 27 | 0.8% | 26 | 0.8% |
| | Agency | 340 | 22 | 40 | 17 | 79 | 78 | 93 | 13 | 184 | 178 | 103 | 106 | 387 | 650 | 72 | 2.1% | 28 | 0.9% |
| | Waiting List initiative | 225 | 7 | 21 | 17 | 45 | 23 | 8 | 15 | 46 | 19 | 16 | 30 | 65 | 156 | 17 | 0.5% | 19 | 0.6% |
| | Overtime | 314 | 34 | 29 | 38 | 102 | 36 | 35 | 23 | 94 | 36 | 33 | 41 | 111 | 307 | 34 | 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 | 3,176 | 3,170 | 3,329 | 9,675 | 28,882 | 3,209 | 95.5% | 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 | 3,436 | 3,348 | 3,540 | 10,324 | 30,236 | 3,360 | 100.0% | 3,278 | 100.0% |
| | | | | | | | | | | | | | | | | | | | |
| | Variance Fav / (Adverse) | 187 | (26) | 24 | 102 | 100 | 99 | 43 | 75 | 216 | (79) | (31) | (177) | (287) | 29 | 3 | | 16 | |
| Medicine | Pay budget | 44,151 | 3,747 | 3,932 | 3,930 | 11,609 | 3,925 | 3,975 | 3,997 | 11,897 | 3,976 | 4,197 | 4,351 | 12,524 | 36,030 | 4,003 | | 3,679 | |
| | Bank | 3,305 | 253 | 319 | 233 | 805 | 264 | 319 | 287 | 870 | 306 | 316 | 397 | 1,019 | 2,694 | 299 | 7.3% | 275 | 6.9% |
| | Agency | 2,354 | 116 | 133 | 202 | 451 | 167 | 193 | 270 | 630 | 322 | 378 | 359 | 1,058 | 2,139 | 238 | 5.8% | 196 | 4.9% |
| | Waiting List initiative | 151 | 21 | 3 | 2 | 26 | 12 | 17 | 10 | 39 | 11 | 13 | 10 | 34 | 99 | 11 | 0.3% | 13 | 0.3% |
| | Overtime | 197 | 21 | 10 | 5 | 36 | 6 | 12 | 2 | 19 | 5 | 3 | 8 | 16 | 71 | 8 | 0.2% | 16 | 0.4% |
| | Other pay | 41,743 | 3,629 | 3,611 | 3,515 | 10,755 | 3,543 | 3,519 | 3,388 | 10,449 | 3,458 | 3,503 | 3,677 | 10,638 | 31,842 | 3,538 | 86.4% | 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 | 4,101 | 4,213 | 4,452 | 12,766 | 36,846 | 4,094 | 100.0% | 3,979 | 100.0% |
| | | | | | | | | | | | | | | | | | | | |
| | Variance Fav / (Adverse) | (3,600) | (292) | (144) | (28) | (464) | (66) | (84) | 40 | (110) | (125) | (16) | (101) | (242) | (816) | (91) | | (300) | |
| Specialised Services | Pay budget | 36,718 | 3,138 | 3,184 | 3,255 | 9,577 | 3,177 | 3,215 | 3,261 | 9,653 | 3,223 | 3,233 | 3,271 | 9,727 | 28,957 | 3,217 | | 3,060 | |
| | Bank | 1,184 | 89 | 122 | 98 | 309 | 108 | 104 | 123 | 335 | 110 | 113 | 134 | 357 | 1,001 | 111 | 3.3% | 99 | 3.1% |
| | Agency | 1,882 | 116 | 170 | 223 | 509 | 255 | 183 | 225 | 664 | 223 | 218 | 237 | 677 | 1,850 | 206 | 6.2% | 157 | 5.0% |
| | Waiting List initiative | 379 | 21 | 47 | 23 | 91 | 34 | 31 | 25 | 90 | 48 | 51 | 34 | 133 | 314 | 35 | 1.0% | 32 | 1.0% |
| | Overtime | 182 | 30 | 10 | 15 | 55 | 14 | 20 | 6 | 40 | 8 | 7 | 6 | 22 | 117 | 13 | 0.4% | 15 | 0.5% |
| | Other pay | 34,079 | 2,927 | 2,935 | 2,949 | 8,811 | 2,886 | 2,990 | 3,018 | 8,894 | 3,017 | 3,025 | 2,986 | 9,027 | 26,732 | 2,970 | 89.1% | 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 | 3,406 | 3,413 | 3,396 | 10,216 | 30,013 | 3,335 | 100.0% | 3,142 | 100.0% |
| | | | | | | | | | | | | | | | | | | | |
| | Variance Fav / (Adverse) | (988) | (45) | (100) | (54) | (199) | (119) | (114) | (136) | (369) | (182) | (181) | (125) | (488) | (1,056) | (117) | | (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 | 6,114 | 6,030 | 6,044 | 18,188 | 54,164 | 6,018 | | 5,911 | |
| | Bank | 1,859 | 140 | 190 | 133 | 463 | 173 | 172 | 167 | 511 | 204 | 152 | 231 | 587 | 1,561 | 173 | 2.8% | 155 | 2.5% |
| | Agency | 808 | 60 | 91 | 75 | 226 | 120 | 102 | 105 | 327 | 79 | 91 | 106 | 275 | 829 | 92 | 1.5% | 67 | 1.1% |
| | Waiting List initiative | 1,394 | 121 | 112 | 133 | 366 | 133 | 162 | 161 | 456 | 146 | 136 | 164 | 446 | 1,268 | 141 | 2.2% | 116 | 1.9% |
| | Overtime | 485 | 103 | 37 | 44 | 184 | 37 | 65 | 12 | 114 | 14 | 12 | 13 | 40 | 337 | 37 | 0.6% | 40 | 0.7% |
| | Other pay | 69,195 | 5,732 | 5,816 | 5,917 | 17,465 | 5,660 | 5,863 | 5,876 | 17,400 | 5,965 | 5,780 | 5,894 | 17,639 | 52,504 | 5,834 | 92.9% | 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 | 6,408 | 6,172 | 6,408 | 18,988 | 56,500 | 6,278 | 100.0% | 6,145 | 100.0% |
| | | | | | | | | | | | | | | | | | | | |
| | Variance Fav / (Adverse) | (2,814) | (254) | (234) | (264) | (753) | (247) | (235) | (301) | (783) | (294) | (142) | (363) | (800) | (2,336) | (260) | | (235) | |

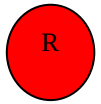
**Analysis of pay spend 2013/14 and 2014/15**

| 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 | Oct £'000 | Nov £'000 | Dec £'000 | Q3 £'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 | 7,301 | 7,317 | 7,327 | 21,945 | 63,899 | 7,100 | | 6,123 | |
| | Bank | 1,813 | 172 | 195 | 163 | 530 | 151 | 172 | 162 | 485 | 222 | 216 | 193 | 631 | 1,646 | 183 | 2.6% | 151 | 2.5% |
| | Agency | 1,398 | 88 | 178 | 118 | 384 | 159 | 70 | 168 | 397 | 145 | 163 | 104 | 411 | 1,193 | 133 | 1.9% | 117 | 1.9% |
| | Waiting List initiative | 365 | 18 | 51 | 19 | 88 | 28 | 30 | 29 | 87 | 13 | 27 | 36 | 76 | 251 | 28 | 0.4% | 30 | 0.5% |
| | Overtime | 226 | 4 | 2 | 28 | 34 | 23 | 37 | 20 | 80 | 2 | 5 | 4 | 10 | 124 | 14 | 0.2% | 19 | 0.3% |
| | Other pay | 70,112 | 6,044 | 6,773 | 6,686 | 19,503 | 6,730 | 6,831 | 6,866 | 20,427 | 7,044 | 6,910 | 7,006 | 20,960 | 60,890 | 6,766 | 95.0% | 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 | 7,425 | 7,322 | 7,341 | 22,088 | 64,103 | 7,123 | 100.0% | 6,159 | 100.0% |
| | | | | | | | | | | | | | | | | | | | |
| | Variance Fav / (Adverse) | (435) | (139) | (4) | 37 | (106) | 25 | 22 | (1) | 45 | (125) | (4) | (15) | (144) | (204) | (23) | | (36) | |
| Facilities & Estates | Pay budget | 18,435 | 1,535 | 1,594 | 1,509 | 4,638 | 1,616 | 1,679 | 1,621 | 4,916 | 1,619 | 1,614 | 1,699 | 4,931 | 14,485 | 1,609 | | 1,536 | |
| | Bank | 555 | 60 | 93 | 74 | 228 | 82 | 133 | 102 | 316 | 96 | 72 | 103 | 271 | 815 | 91 | 5.7% | 46 | 3.0% |
| | Agency | 346 | 21 | 18 | 41 | 80 | 29 | 46 | 40 | 115 | 33 | 68 | 32 | 133 | 328 | 36 | 2.3% | 29 | 1.9% |
| | Waiting List initiative | 0 | 0 | 0 | 0 | 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 | 98 | 90 | 85 | 273 | 773 | 86 | 5.4% | 75 | 4.9% |
| | Other pay | 16,397 | 1,393 | 1,407 | 1,308 | 4,109 | 1,361 | 1,416 | 1,351 | 4,129 | 1,441 | 1,376 | 1,456 | 4,274 | 12,512 | 1,390 | 86.7% | 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 | 1,669 | 1,607 | 1,676 | 4,951 | 14,427 | 1,603 | 100.0% | 1,516 | 100.0% |
| | | | | | | | | | | | | | | | | | | | |
| | Variance Fav / (Adverse) | 242 | (32) | 5 | 4 | (24) | 68 | (19) | 53 | 101 | (49) | 7 | 23 | (20) | 58 | 6 | | 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 | 2,417 | 2,462 | 2,361 | 7,240 | 20,632 | 2,292 | | 2,458 | |
| | Bank | 680 | 52 | 65 | 47 | 165 | 50 | 48 | 56 | 154 | 64 | 38 | 87 | 189 | 508 | 56 | 2.6% | 57 | 2.4% |
| | Agency | 375 | 64 | 30 | 41 | 135 | 64 | 34 | 40 | 139 | 72 | 47 | 35 | 154 | 427 | 47 | 2.2% | 31 | 1.3% |
| | Waiting List initiative | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% | 0 | 0.0% |
| | Overtime | 114 | 11 | 9 | 11 | 31 | 8 | 11 | 7 | 27 | 10 | 10 | 12 | 33 | 91 | 10 | 0.5% | 9 | 0.4% |
| | Other pay | 27,425 | 2,083 | 1,967 | 1,960 | 6,011 | 2,087 | 2,118 | 2,178 | 6,382 | 2,028 | 2,144 | 2,139 | 6,311 | 18,703 | 2,078 | 94.8% | 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 | 2,174 | 2,239 | 2,273 | 6,686 | 19,729 | 2,192 | 100.0% | 2,383 | 100.0% |
| | | | | | | | | | | | | | | | | | | | |
| | Variance Fav / (Adverse) | 897 | (94) | 190 | 68 | 165 | 136 | 17 | 28 | 183 | 242 | 223 | 88 | 554 | 902 | 100 | | 75 | |
| Trust Total | Pay budget | 312,726 | 25,928 | 27,613 | 27,335 | 80,876 | 27,467 | 27,752 | 27,745 | 82,964 | 28,006 | 28,169 | 28,417 | 84,593 | 248,432 | 27,604 | | 26,060 | |
| | Bank | 9,702 | 783 | 1,010 | 771 | 2,564 | 852 | 988 | 923 | 2,762 | 1,029 | 933 | 1,178 | 3,140 | 8,467 | 941 | 3.4% | 809 | 3.0% |
| | Agency | 7,506 | 488 | 659 | 718 | 1,865 | 872 | 722 | 862 | 2,455 | 1,051 | 1,067 | 978 | 3,096 | 7,416 | 824 | 2.9% | 625 | 2.4% |
| | Waiting List initiative | 2,514 | 188 | 234 | 194 | 616 | 230 | 248 | 240 | 718 | 237 | 243 | 274 | 754 | 2,088 | 232 | 0.8% | 210 | 0.8% |
| | Overtime | 2,413 | 296 | 168 | 222 | 686 | 199 | 284 | 147 | 630 | 173 | 162 | 169 | 504 | 1,820 | 202 | 0.7% | 201 | 0.8% |
| | Other pay | 297,103 | 25,055 | 25,806 | 25,565 | 76,426 | 25,418 | 25,880 | 25,816 | 77,115 | 26,129 | 25,909 | 26,487 | 78,525 | 232,065 | 25,785 | 92.1% | 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 | 28,619 | 28,313 | 29,086 | 86,019 | 251,857 | 27,984 | 100.0% | 26,603 | 100.0% |
| | | | | | | | | | | | | | | | | | | | |
| | Variance Fav / (Adverse) | (6,514) | (883) | (263) | (135) | (1,281) | (104) | (369) | (243) | (717) | (613) | (144) | (669) | (1,426) | (3,424) | (380) | | (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 nine months ending 31 December is 4 (actual score 4.0, November 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 £3.57m lower than plan for the 9 month period to 31 December. Activity based contract performance at £307.78m is £3.86m less than plan. Contract rewards / penalties at a net income of £3.72m is £0.07m less than plan. Income of £44.86m for ‘Pass through’ payments is £0.36m higher than Plan.
<table>
<tr><th rowspan="2">Clinical Service</th><th rowspan="2">Activity to 31 December</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>90,393</td><td></td><td></td><td>966</td><td>1.1</td></tr>
<tr><td>Emergency<br>Non Elective</td><td>28,823<br>1,882</td><td>504</td><td>1.8</td><td><br>197</td><td><br>9.5</td></tr>
<tr><td>Elective<br>Day Cases</td><td>10,383<br>40,710</td><td><br>362</td><td><br>0.9</td><td>910</td><td>8.1</td></tr>
<tr><td>Outpatient Procedures<br>New Outpatients<br>Follow up Outpatients</td><td>41,513<br>115,561<br>234,119</td><td></td><td></td><td>284<br>8,900<br>17,395</td><td>0.7<br>7.2<br>6.9</td></tr>
</table>
An income analysis by commissioner is shown at Table INC 2.<br>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 £16.797m – equivalent to 81% of the Plan for the year. Actual savings achieved for the nine months to 31 December total £11.027m (77% of Plan before the 1/12ths phasing adjustment), a shortfall of £3.279m 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 nine months of 2014/15 is £5.002m. This represents an over performance of £0.652m when compared with the planned surplus to date of £4.35m.<br><br>Total income of £431.564m is £1.479m lower than Plan. Expenditure at £403.878m is higher than Plan by £0.920m. Financing costs are £3.051m lower than Plan. | Agenda Item 5.3 |
| Diagnostic & Therapies |  | The Division reports an overspending of £0.212m for December and cumulatively £0.262m. The late receipt of a number of invoices is the principal reason for the adverse movement in December. | |
| Medicine |  | Cumulative overspending is £1.348m, a deterioration of £21k in the month. The principal areas of overspending are on nursing staff (£0.585m), under performance on SLA activity (£0.413m) and savings (£0.939m) . | |
| Specialised Services |  | An overspending of £0.198m increases the cumulative overspending to £0.746m. The position reflects overspendings on pay budgets (nursing and medical staff) non-achieved savings (£0.430m) and SLA underperformance (£0.192m). | |
| Surgery, Head & Neck |  | Overspending to date of £4.183m represents an overspending of £0.675m in December. Causal factors are historical non achievement of savings programme and an underachievement of planned activity to date. Non pay budgets spend is £134k higher than plan for December (mainly clinical supplies and out sourced activity). | |
| Women's & Children's |  | Overspending to date totals £2.088m, an increase of £0.442m in December. Principal factors are underperformance on income from activities (£2.394m) and non achievement of savings programme (£1.149m). | |
| Facitities & Estates |  | The cumulative underspending is £111k, an improvement of £10k in the month. | |
| THQ |  | The underspending of £10k in December increases the cumulative underspending to £144k. | |
| Capital |  | The Monitor capital expenditure performance target is to deliver the programme within 85% -115% of the Annual Plan. Expenditure for the first nine months totals £35.55m – this equates to 96% of the current plan for the period. The forecast outturn is for total expenditure of £45.485m ie 79% of the Annual Plan submission to Monitor. | Agenda Item 6 |
| Statement of Financial Position and Treasury Management |  | The cash balance on 31 December was £65.8m. The balance on Invoiced Debtors has decreased by £7.954m in the month to £12.599m. The invoiced debtor balance equates to 7.9 debtor days. Creditors and accrual account balances total £81.66m. Invoiced Creditors - payment performance for the month for Non NHS invoices and NHS invoices within 30 days was 92% and 68% respectively. Payment performance to date by invoice value is 87% for Non NHS and 87% for NHS invoices. | Agenda Item 7 |

**Appendix 5**

**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**

**Finance Report December 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. RTT fines increasing during the year. | DL | High | 3.0 |
| | 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 | - |

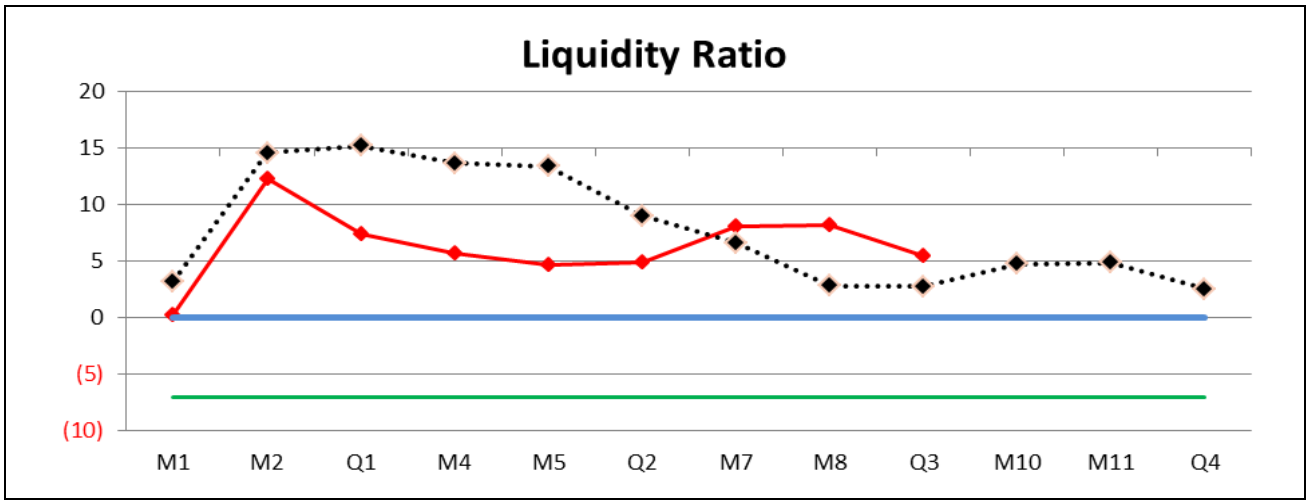
University Hospitals Bristol NHS
NHS Foundation Trust

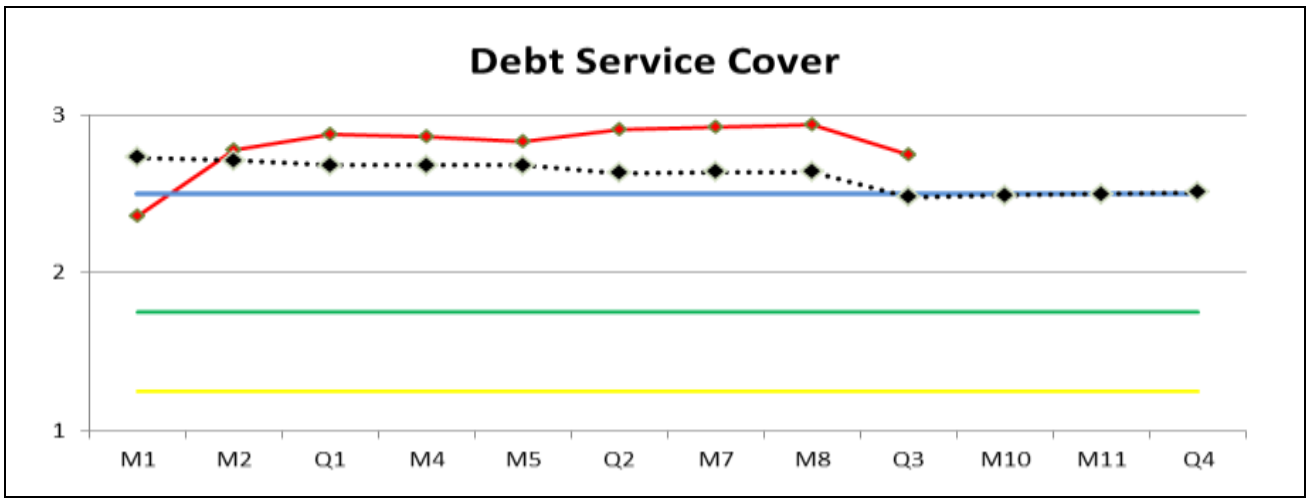
**Appendix 6**

## Continuity of Service Risk Rating – December 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 | Plan March 2015 | June | September | November | December |
|---|---|---|---|---|---|---|
| **Liquidity** | | | | | | |
| Metric Performance | 2.71 | 2.53 | 7.35 | 4.90 | 8.18 | 5.45 |
| Rating | 4 | 4 | 4 | 4 | 4 | 4 |
| **Debt Service Cover** | | | | | | |
| Metric Performance | 3.04 | 2.51 | 2.88 | 2.91 | 2.94 | 2.75 |
| 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 |
| September Movements | (68) | (131) | (1,384) | - | (574) | (14) | (2,171) | 181 | 198 | 222 | 598 | 353 | 483 | 85 | 51 | 2,171 |
| October Movements | (225) | (105) | (144) | - | 378 | (453) | (549) | 37 | 218 | 55 | 112 | 532 | 19 | 196 | (620) | 549 |
| November Movements | (35) | (90) | 3,313 | - | (434) | (69) | 2,685 | 94 | 319 | 50 | 58 | 197 | 233 | 128 | (3,764) | (2,685) |
| Month 8 balances | 1,243 | 3,005 | 6,868 | 487 | 3,384 | 1,077 | 16,064 | 3,486 | 7,079 | 10,890 | 12,013 | 21,519 | 2,634 | 7,196 | (1,339) | 63,478 |
| Month 9 Movements | | | | | | | | | | | | | | | | |
| Incremental drift funding | | (73) | | | | | (73) | 12 | 9 | 8 | 11 | 24 | 2 | 7 | | 73 |
| CSP Transitional costs | | | | | | (30) | (30) | 30 | | | | | | | | 30 |
| EWTD | | | | | (135) | | (135) | 9 | 30 | 18 | 26 | 50 | 1 | 1 | | 135 |
| MPET Funding | | | | | 110 | | 110 | 26 | | | 43 | | | | (179) | (110) |
| CQUINs | | | | (16) | | | (16) | | | | | | | 16 | | 16 |
| MARS | | | | | | (46) | (46) | | 35 | | | | | 11 | | 46 |
| Resilience Funding | | | | (808) | | | (808) | 37 | 422 | 42 | 38 | 158 | 3 | | 108 | 808 |
| Service Transfers | | | (307) | | | | (307) | | | | | | | 50 | 257 | 307 |
| Other | (35) | (21) | | | 57 | (86) | (85) | | | | 2 | | 21 | 58 | 4 | 85 |
| Month 9 balances | 1,208 | 2,911 | 6,561 | - 337 | 3,416 | 915 | 14,674 | 3,600 | 7,575 | 10,958 | 12,133 | 21,751 | 2,661 | 7,339 | (1,149) | 64,868 |

University Hospitals Bristol NHS
NHS Foundation Trust

**Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 29 January 2015 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 15 Quarterly Capital Projects Status Report

### Purpose

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

### 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. Following completion of the Bristol Haematology & Oncology Centre and Children's Hospital Schemes, the primary focus is upon the BRI components of the scheme.

The BRI Terrell Street Development achieved practical completion on the 19th December 2014 with the successful handover of level 9.

All cubicles on Ward A600 (ITU) have now been redeveloped and are complete with a planned occupation date of 3rd February. Final priorities within Terrell Street are to consider how the office space within the ward block is used and finalise the plan for the infection control cohort area, for which a revised location is being evaluated.

The final design for the Queens facade project is also progressing, however the panel designs are under review following design group feedback.

The final phase of the BRI Redevelopment is the completion of Phase lV which is focussed upon the redevelopment and refurbishment of existing space in the Queen's Building and King Edward Building (KEB). The next significant schemes are the re-modelling and refurbishment of wards 2,3 and 4 and the redevelopment of KEB to allow the transfer of rheumatology and other services from the Old Building. Consideration of the future demand of inpatient beds is being considered alongside these plans.

The project remains on programme and in budget, though there is some slippage on capital expenditure in the reporting period, reflecting slippage in aspects of the programme which will be recovered.

### Recommendations

The Trust Board is recommended to receive this report for **assurance** that the Trust's major capital schemes are being effectively managed and that all risks are understood and being actively managed.

### Report Sponsor

Director of Strategic Development and Deputy Chief Executive

## Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 29 January 2015 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

| 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**
**29th Jan 2015 Trust Board**

## 1. Introduction

This status report provides a summary update for Quarter 3 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**<br>Project achieved practical completion on the 19th December 2014 with the successful handover of level 9.<br>There remains a few external works to return the site to full operational use and some minor internal snagging to complete.<br>All building works relating to the new cubicles on Ward A600 are complete, with final commissioning underway and expected move date of 3rd February.<br>A process to dispose of the contractor's site village is now underway, having confirmed there is no further requirement for it.<br><br>**BRI Phase 4**<br>The following refurbishment schemes have been completed<br>Wards A515,602,604 & 605, phase 2 discharge lounge<br>The following schemes are in construction<br>• Surgical Assessment Suite- due to complete Feb 15 due to some slippage incurred due to redesign of scaffolding works<br>• Conversion of Lecture Theatre- Project recommenced following a design review<br>• Enabling works for the level 9 restaurant. Following provider fit out, target date for opening will be March/April<br>Refurbishment of wards A 524,525 & 528 are due to commence on site in February and works to the Central health Clinic are about to commence. |

| | | | |
|---|---|---|---|
| | | **Queens Façade**<br>Following the installation of sample panels and the user group feedback, further design work has been undertaken to review the design with alternative panels due to be installed imminently. This will inform the final design and costs.<br>The programme will then be further reviewed.<br>A submission has been made to Bristol City Council to discharge all planning conditions.<br>The enabling scheme to rationalise all air conditioning units within the level 1 courtyard will complete at the end of January. | |
| | **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.<br>The scheme remains within its capital budget. | |
| 4 | **Programme** | The construction contract has achieved practical completion and will be fully operational by the first week in February. | |
| 5 | **Risks** | **Risk** | **Mitigation Actions** |
| | **2741** | 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 |

## 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:** 06.01.2015

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 16. Monitor feedback on Q2 Risk Assessment Framework Submission

### Purpose

The purpose of this report is to inform the Trust Board of Directors of Monitor's analysis of the Trust's Quarter 2 submission.

### Abstract

Monitor's analysis of the quarter 2 submission is based on the Trust's risk ratings relating to Continuity of Services and Governance, which the Trust submission as follows:

- Continuity of Services Risk Rating – 4
- Governance Risk Rating – Under Review

These rating were published on Monitor's website in December reflecting the Trust's failure to meet targets relating to: Referral to Treatment admitted, non-admitted and incomplete; A&E four-hour waiting times; and cancer 62 day waits for first treatment (from urgent GP referral).

Monitor have confirmed that this submission has triggered consideration for further regulatory action. Monitor continues to work closely with the Trust to ensure improvements in these areas.

### Recommendations

The Board is recommended to receive the report to note

### Report Sponsor

Robert Woolley, Chief Executive

### Authors

Debbie Henderson, Trust Secretary

### Appendices

Monitor Feedback Letter dated 5th December 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 |
|---|---|---|---|---|---|
| N/A | N/A | N/A | N/A | N/A | N/A |

5 December 2014

Mr Robert Woolley
Chief Executive
University Hospitals Bristol NHS Foundation Trust
Trust HQ
Marlborough Street
Bristol
BS1 3NU

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Making the health sector work for patients

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London SE1 8UG

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W: www.monitor.gov.uk

Dear Robert

**Q2 2014/15 monitoring of NHS foundation trusts**

Our analysis of your Q2 submissions is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 4
- Governance risk rating - Under Review

These ratings will be published on Monitor's website later in December.

The Trust has failed to meet the following targets:

- Referral to Treatment admitted;
- Referral to Treatment non admitted;
- Referral to Treatment incomplete;
- A&E four hour waiting time; and
- Cancer 62 day waits for first treatment (from urgent GP referral)

which has triggered consideration for further regulatory action. For this reason the Trust's governance risk rating is Under Review. Monitor is working closely with the Trust to ensure it improves A&E, Referral to Treatment and cancer waiting time target performance, before deciding next steps.

Monitor uses the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the Trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the Health and Social Care Act 2012, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf

Monitor will write to you separately to inform you of the actions we expect the Trust, together with its system partners, to improve performance. The Trust's governance risk rating will remain Under Review until we have concluded our considerations for further regulatory action, at which point we will write to you again.

A report on the FT sector aggregate performance from Q2 2014/15 is now available on our website[3] which I hope you will find of interest.

We have also issued a press release[4] setting out a summary of the key findings across the FT sector from the Q2 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0485 or by email (Amanda.Lyons@Monitor.gov.uk).

Yours sincerely

**Amanda Lyons**
**Senior Regional Manager**

cc: Dr John Savage, Chairman
Mr Paul Mapson, Finance Director

[3] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-2-201415
[4] https://www.gov.uk/government/news/foundation-trusts-urged-to-tackle-financial-challenge

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 17. Q3 Risk Assessment Framework Monitoring and Declaration Report

### Purpose

The purpose of this paper is to set-out the proposed declaration against Monitor's Risk Assessment Framework for quarter 3, for approval.

### Abstract

Since 1 April 2013, all NHS Foundation Trusts (FT) require a licence from Monitor stipulating specific conditions that they must meet to operate. Key among these is financial sustainability and governance requirements. The 'Ri*sk Assessment Framework'* constitutes Monitor's approach to overseeing the sector under these rules and explains how Monitor will use the framework to assess individual FT 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 an FT

These will be assessed separately using new types of risk categories set out in the Framework and each FT will be assigned two ratings. 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 Framework. The Director of Strategic Development/Deputy Chief Executive has provided an analysis of governance risk (Appendix A) and the Director of Finance and Information has provided commentary on financial risk to the Finance Committee (Appendix B).

Following making the necessary enquiries, 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 3 declaration for submission to Monitor by 30 January 2015:

- A submission against the 'Governance Rating' reflecting the standards failed in quarter 3 to be, RTT non-admitted, admitted and ongoing pathway standards, the A&E four-hour waiting time standard, and the 62-day GP/Screening cancer standards;
- It is also recommended that the planned ongoing failure of these standards are flagged to Monitor, as part of the narrative that accompanies the declaration;
- Confirmation that the Board anticipates that the Trust will continue to maintain a Continuity of Services risk rating of at least 3 over the next 12 months; and

## Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

| |
|---|
| • 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** |
| Robert Woolley, Chief Executive |
| **Authors** |
| Deborah Lee, Deputy Chief Executive/Director of Strategic Development<br>Paul Mapson, Director of Finance and Information<br>Xanthe Whittaker, Head of Performance & Business Intelligence/Deputy Director of Strategic Development<br>Debbie Henderson, Trust Secretary |
| **Appendices** |
| A – Draft Declaration against the Risk Assessment Framework<br>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 |
|---|---|---|---|---|---|
| | 21/1/15 | 27/1/15 | | | |

# Monitor Quarter 3 declaration against the 2014/15 Risk Assessment Framework for Governance

## 1. Context

The Trust is required to make its quarter 3 declaration of compliance with the 2014/15 Monitor Risk Assessment Framework by the 30th January 2015.

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 3, 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<br>Prioritisation<br>Consideration of breach | Emerging concerns (e.g. persistently failing access targets; major third party concerns, financial issues)<br><br>Further information requested Concerns serious enough to trigger formal investigation<br><br>Breach or likely breach identified; formal/informal action pending | Current status and a description of:<br>• Factors driving concerns<br>• Actions Monitor is taking/considering<br>• Next steps |
| Action<br>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 3 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 and 62-day Screening 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 in October/November
- 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 3 would trigger Governance Concerns for repeated failures of the same standard. Although Monitor has previously reviewed performance against these standards and restored the Trust to a GREEN rating, it has now requested further information before deciding on next steps.

Please note that performance against the cancer standards is still subject to final national reporting at the beginning of February and therefore the position shown in Table 2 remains draft. Performance against the 31-day first definitive treatment cancer standard is currently at 95.9%, with one reported breach in excess of the 96% standard. It is currently forecast that the standard will be achieved on final validation.

## 3. Quarter 4 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 3, along with the key risks to target achievement for quarter 4 2014/15. The mitigating actions that are being taken are also provided, along with the residual risk.

Good progress has been made in reducing over 40-week waiters in a number of specialties. However, the current size of the RTT admitted over 18-week backlog, at three times the sustainable level, makes achievement of the 90% standard at a Trust level not possible in quarter 4. Performance against the RTT Non-admitted standard is expected to improve. But the non-admitted backlog also remains high, and is likely to result in the failure of the standard in January as a minimum. Failure for any month in 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 will be failed in quarter 4, whilst the admitted and non-admitted backlogs are being addressed.

The A&E 4-hour trajectory has now been revised. The revision builds-in to the baseline an underlying decline in performance, informed by the national deterioration in 4-hour performance over the last year. It also incorporates the impact of the additional actions planned in response to the Care Quality Commission (CQC) report, in addition to those already set-out in the shared improvement plan with partner organisations. The trajectory forecasts recovery of performance in quarters 1 and 2 2015/16, but not achievement in quarter 4 2014/15. It is recommended that the narrative that accompanies the declaration reflects the new trajectory.

There continues to be the potential for failure of the 62-day Screening standard, following the transfer out of the Avon Breast Screening service. Between quarter 2 2013/14 and quarter 1 2014/15 the Trust would have achieved the 90% standard with bowel and gynaecology screening pathways alone. However, the 90% standard was failed in quarter 3 2014/15 (and would have been failed in quarter 2), due to patient choice, late referrals from other providers and a shortfall of capacity at treating providers. Although it is expected the 90% standard will be achieved in some if not most quarters, it is unlikely to be achieved every quarter. It is therefore recommended that the high risk of failure of this standard is flagged to Monitor for quarter 4, and future quarters.

Two 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. It is recommended that the potential risk to failure of the 62-day GP cancer standard that our case-mix and late tertiary referrals brings, continues to be flagged to Monitor as part of the narrative that accompanies the declaration. These two standards, along with all those currently not being met, 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 3 2014/15 as being the three RTT standards, the 62-day GP cancer standard, the 62-day Screening cancer standard and the A&E 4-hour standard. It is also recommended that the narrative that accompanies the declaration should flag the specified potential risks to failure against the 62-day GP and 62-day screening standard, for the reasons set-out in section 3 above.

**Table 2** Summary of performance in quarter 3 2014/15, and the risks to quarter 4 compliance

| Indicator | Score | Achieved in Q3 2014/15? | New risks to Q4 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 Q3 of high backlogs and RTT non-admitted clearance | - Long waits for first outpatient appointments in Paediatric specialties and some dental in particular;<br>- Additional new outpatient appointments continue to be put in place for Cardiology, Paediatric specialties, Dental specialties, and Dermatology to reduce the volume of Non-admitted pathways, which in time will effect shorter Admitted RTT pathways, but in the interim will create a 'bulge' in the waiting list<br>- Admitted backlogs high and above sustainable levels in Paediatric specialties (ENT, Plastics, Surgery and T&O) Upper GI, Cardiology, and | - Further additional activity planned during quarter 4, to reduce the size of the backlog<br>- Waiting list transfers to other providers (e.g. Independent Sector Treatment Centre)<br>- Internal and external validation teams, focusing on validating long waiters and improving data quality<br>- 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.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Ophthalmology in particular | | | |
| 18-weeks Referral to Treatment for non-admitted pathways (aggregate) | 1.0 | No – failed as part of the recovery trajectory | No – Ongoing from Q3 | - 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<br>- See RTT admitted also | - Additional activity planned in quarter 4, with continued weekly monitored and re-profiling of required capacity;<br>- 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.<br>- See RTT admitted also | High | High |
| 18-weeks Referral to Treatment for incomplete pathways (aggregate) | 1.0 | No – failed in each month | No – ongoing risk of high admitted and non-admitted backlogs from quarter 3 | - Same as for RTT admitted | - See RTT admitted and non-admitted plans | High | High |
| A&E Maximum waiting time 4 hours | 1.0 | No – performance in Q3 = 89.6% | Yes – delayed discharges increasing along with increasing age profile | - Delayed Discharges have increased with increasing demand for care packages from frail elderly patients admitted in late December/early January;<br>- Typically increase seen in age profile of admitted patients December to February<br>- Shortfall in community capacity, for rehab beds and packages of care; | - Wide ranging system-wide Resilience Plan, supported by additional funding (although not implemented in full due to difficulties recruiting into some schemes);<br>- Additional actions, both internally and from partner organisations, planned in response to CQC report; | High | High |

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| | | | | - Pressure on other local Emergency Departments also very high and likely to result in diverts at times;<br>- Changing profiles of demand with higher levels of ambulance arrivals at weekends and earlier in the day | | | |
| Cancer: 62-day wait for first treatment – GP Referred | 1.0 | No – performance expected to be reported at circa 81.0%, which is an improvement on 76.8% in Q2 | No – continued risks from Q3 | - High levels of late tertiary referrals<br>- High levels of medical deferral, patient choice, and clinical complexity (none of which can be accounted for in waiting times and are difficult to mitigate)<br>- Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard<br>- Intensive Therapy Unit (ITU) / High Dependency Unit (HDU) bed related cancellations – improvements seen since the opening of the twentieth ITU bed at the end of February, but cancellations still impacting at peak levels of demand<br>- Awareness raising | - 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<br>- Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work<br>- Additional Thoracic Surgery theatre capacity made available from early October, now reducing breaches due to a shortfall in elective capacity;<br>- Patients on the cancer patient tracking list continue to be actively managed and any delays escalated to Divisional Directors and Chief Operating Officer<br>- Breach reallocations to be agreed with late referring providers as necessary and where possible<br>- See also A&E 4-hour plans | High | Moderate |

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| | | | | campaigns likely to increase demand for surgical treatments (oesophago-gastric cancer campaign in Q4) | | | |
| Cancer: 62-day wait for first treatment – Screening Referred | | No – performance expected to be reported at below 90% due to shared breaches incurred by other providers | No – continued risks from 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, unlike bowel which nationally performs well below the 90% standard;<br>- All bowel screening pathways originate at the Trust, and capacity constraints at other providers will have a knock-on impact on performance for shared pathways;<br>- Patient choice in bowel screening pathway;<br>- High volumes of bowel screening patients needing CT colonography, for which there is a capacity constraint;<br>- Numbers of cases reported under this standard will in the future | - Specialist practitioner and colonoscopy waiting times remain short and continue to be closely monitored<br>- Any patients on shared pathways continue to be actively tracked via our Cancer Register until treated at other providers<br>- Need for additional elective capacity for colorectal surgery continuously reviewed<br>- All CT colon scanning and reporting delays escalated, and further work is planned to reduce delays<br>- Patient choice and medical deferral related breaches cannot be fully mitigated, and for this reason the residual risk remains high. | High | High |

| | | | | | | | |
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| | | | | be low, due to the loss of the breast pathways, so small numbers of breaches may have a large impact. | | | |
| Cancer: 31-day wait for subsequent treatment - subsequent surgery | 1.0 | Yes | No | - Cancellations of surgery due to emergency pressures (mainly ITU/HDU beds)<br>- Having enough surgical capacity to meet peaks in demand, especially for the hepatobiliary service<br>- Unpredictably high volume of delays due to medical deferrals in some quarters | - 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<br>- Review of Critical Care capacity ongoing as part of the 2014/15 Operating Model<br>- Twentieth ITU bed operational, which has helped to reduce cancellations for this reason although cancellations still impact on performance at peak levels of demand | High | Moderate |
| 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 – subject to final reporting (draft position 95.9% against 96% standard) | No | - Peaks in demand from emergencies for ITU/HDU beds, resulting in cancellations of surgery<br>- Unpredictable shortfall in | - Additional thoracic capacity came online early in October, following the planned transfer-out of the Vascular service, which will continue to reduce the number of | Moderate | Low |

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| | | | | surgical capacity for certain specialties during peaks in demand<br>- Potential increase in demand for treatment following oesophago-gastric (OG) cancer awareness campaign in Q4<br>- Unexpectedly high levels of medical deferrals | breaches<br>- 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<br>- Twentieth ITU bed operational, which has helped to reduce cancellations for this reason<br>- Plans in place to manage potential increase in demand following OG awareness campaign<br>- Divisions to 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;<br>Q1 – 1 potentially avoidable case;<br>Q2 – 4 potentially avoidable cases;<br>Q3 - 1 potentially avoidable case + 8 still subject to review<br><br>**Total** = 6 potentially avoidable + 8 | No | - Target for 2014/15 as a whole is 40 cases (5 more than in 2013/14),<br>- Flat profiling of annual target continues to be imposed by Monitor<br>- 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<br>- An antibiotic prescribing phone application has been implemented<br>- Use of Fidaxomicin to treat patients at high risk of C. diff recurrence or relapse<br>- Awareness sessions for GPs and Nursing Home Managers<br>- Rigorous Root Cause Analysis of cases to continue to enable any C. diff cases not resulting from a | Moderate | Low |

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| | | cases to be reviewed, against a limit of 30 for the end of Q3 | | | lapse in quality of care to be demonstrated to the commissioners. | | |
| Certification against compliance with requirements regarding access to healthcare for patients with a learning disability | 1.0 | Yes | No | - No significant risks | See the standard set-out in Appendix 1, which the Trust is declaring compliance with. | Low | Low |

## 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<br>• 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<br>• 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:<br>– Treatment options<br>– Complaints and procedures and<br>– 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<br>• The Trust 'Easy Read' range includes:<br>➢ Healthcare and treatment options<br>➢ Consent<br>➢ How to contact patient support and complaints team<br>➢ Going into hospital and what happens<br>➢ Learning disabilities liaison nurse<br>➢ Being discharged from hospital<br>• 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<br>• The learning disabilities risk assessment has a section to identify the needs of |

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| | family and carers to ensure reasonable adjustments are made for them as well as the individual receiving direct care<br>• 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.<br>• 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<br>• The LD nurse delivers custom made training to meet the needs of existing staff groups as required<br>• 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<br>• 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<br>• Service delivery and outcomes are captured by the learning disabilities team and are incorporated into Trust and divisional objectives<br>• The learning disabilities team monitor monthly the risk assessment and reasonable adjustment compliance to deliver the CQUIN and ensure best care<br>• The Learning Disability Steering Group reports to the Patient Experience Group |

# Appendix 2 – Draft declaration to Monitor for Quarter 3

## 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 | Quarter 3 Actual Performance | Achieved/Not Met | Any comments or explanations |
|---|---|---|---|---|---|---|
| Referral to treatment time, 18 weeks in aggregate, admitted patients | 90% | 1.0 | No | 83.1% | Not met | *Performance for the quarter 84.3% (November lowest month, as shown)* |
| Referral to treatment time, 18 weeks in aggregate, non-admitted patients | 95% | 1.0 | Yes | 88.8% | Not met | *Performance for the quarter 89.3% (November lowest month, as shown)* |
| Referral to treatment time, 18 weeks in aggregate, incomplete pathways | 92% | 1.0 | No | 87.5% | Not met | *Performance for the quarter 88.5% (December lowest month, as shown)* |
| A&E Clinical Quality- Total Time in A&E under 4 hours | 95% | 1.0 | Yes | 89.6% | Not met | *Lowest month December at 86.3%* |
| Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation | 85% | 1.0 | Yes | 80.6% | Not met | *Performance with breach reallocation for late referrals 86.1% (but not agreed)* |
| Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation | 90% | 1.0 | No | 81.8% | Not met | *Subject to final national reporting* |
| Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation | | | | 80.6% | | *Subject to final national reporting* |
| Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation | | | | 81.8% | | *Subject to final national reporting* |
| Cancer 31 day wait for second or subsequent treatment - surgery | 94% | 1.0 | No | 94.7% | Achieved | *Subject to final national reporting* |
| Cancer 31 day wait for second or subsequent treatment - drug treatments | 98% | 1.0 | No | 99.6% | Achieved | *Subject to final national reporting* |
| Cancer 31 day wait for second or subsequent treatment - radiotherapy | 94% | 1.0 | No | 98.3% | Achieved | *Subject to final national reporting* |
| Cancer 31 day wait from diagnosis to first treatment | 96% | 1.0 | No | 96.1% | Achieved | *Draft performance 95.9%, but expected to improve to 96.1% on final reporting.* |
| Cancer 2 week (all cancers) | 93% | 1.0 | No | 96.1% | Achieved | *Subject to final national reporting* |
| Cancer 2 week (breast symptoms) | 93% | 1.0 | No | 0.0% | Not relevant | |
| C.Diff due to lapses in care | 30 | 1.0 | No | 6 | Achieved | *1 case deemed potentially avoidable in Q3, bringing the total to 6 for the YTD.* |
| Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review) | | | | 43 | | |
| C.Diff cases under review | | | | 0 | | |
| Risk of, or actual, failure to deliver Commissioner Requested Services | N/A | Report by Exception | No | | No | |
| CQC compliance action outstanding (as at time of submission) | N/A | | No | | No | |
| CQC enforcement action within last 12 months (as at time of submission) | N/A | | No | | No | |
| CQC enforcement action (including notices) currently in effect (as at time of submission) | N/A | | No | | No | |
| Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) | N/A | | No | | No | |
| Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) | N/A | | No | | No | |
| Trust unable to declare ongoing compliance with minimum standards of CQC registration | N/A | | No | | No | |

There are six targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 3. These are: the A&E 4-hour standard, the RTT Non-admitted, Admitted and Incomplete pathways standards, and the 62-day GP and 62-day screening cancer standards.

The Trust performed at 89.6% against the A&E 4-hour standard in the period. During quarter 3, there was a 6% increase in overall emergency admissions into the Trust. Most of this increase was in emergency admissions into the Children's Hospital, with a significant peak in respiratory illness above record levels seen in previous years. System pressures also continued in the quarter, with at any point in time 50 to 60 delayed discharge patients un-necessarily occupying acute beds. The age-profile of emergency admissions continues to change, with a 5% increase in emergency admissions for the over 75 year olds, relative to the same period last year. This is on top of the 8% increase experienced in the previous year. The changing age-profile of emergency admissions poses risks to achievement of the 95% standard in 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 system risks through an action plan with partner organisations which was put in place during the latter half of quarter 2. The impact of the schemes within the actions plan have been assessed, from which an improvement trajectory has been developed and more recently revised to take account of 1) the underlying decline in performance (continued below).

driven by changing levels of acuity and system pressures, mirroring the national picture, and 2) the impact of the actions to be taken in respond to the CQC report. 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 continued to be failed in 2014/15, 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 Q3. (cont'd below).

However, there continues to be 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 completed in Q3 work to assess service capacity and demand, supported by the Interim Management and Support 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 has been failed since quarter 4 2013/14, primarily due to high levels of unavoidable breaches (late referrals, medical deferrals/clinical complexity and patient choice). Cancer pathway improvement work continues, focusing on both further minimising internal causes of breaches, but also on working with other providers to reduce late referrals. Performance improved during quarter 3, with performance for internally managed pathways being well above the 85% standard. However, the case mix of patients treated (typically having a -3.5% impact on performance) and late referrals into the Trust (estimated to have a -5.2% impact in quarter 3), continues to make achievement of the 62-day GP standard challenging. During quarter 2 the Avon Breast Screening service transferred to North Bristol Trust. As a result performance against the screening standard is largely being now based on a relatively small number of bowel screening treatments, which nationally performs well below 90%. In quarter 3 a total of 3 breaches of standard in accountability terms were incurred, all for shared pathways, taking performance below the 90% standard. Breach analysis demonstrates the reasons for the breaches to be patient choice and delays at other providers.

University Hospitals Bristol NHS
NHS Foundation Trust

**For consideration and approval by**

| | |
|---|---|
| Finance Committee | 26th January 2015 – Agenda Item 8 |
| Trust Board | 29th January 2015 |

# QUARTER 3 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURN

**Director of Finance**
**January 2015**

## 1. EXECUTIVE SUMMARY

This commentary covers the results for the 9 months ending 31st December 2014. The Trust reports an EBITDA[1] surplus of £27.686m. This is £0.618m lower than the Annual Plan projection to date of £28.304m. The Continuity of Service Risk rating is 4 (actual 4.0).

| | 2013/14 | September 2014 | December 2014 | Plan 2014/15 |
|---|---|---|---|---|
| **Liquidity** | | | | |
| Metric Performance | 2.71 | 4.90 | 5.45 | 2.53 |
| Rating | 4 | 4 | 4 | 4 |
| **Capital Service Capacity** | | | | |
| Metric Performance | 3.04 | 2.91 | 2.75 | 2.51 |
| Rating | 4 | 4 | 4 | 4 |
| **Overall Rating** | **4** | **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 £0.750m lower than the Monitor Annual Plan at £357.472m for the period. NHS Clinical income includes income from NHS commissioners and territorial bodies.

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

Table 1 – Clinical Income – Quarters 1 - 3 - Variance from Plan

| | £m |
|---|---|
| Monitor Plan | 358.222 |
| Under Performance (See Table 2 Below) | (0.750) |
| **Year To Date Income** | 357.472 |

### Activity and Income by Worktype

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

#### i. Elective Inpatients

Overall Elective Inpatients are £1.503m behind plan. Impacts from temporary capacity restrictions earlier in the year that affected Cardiology activity at that time offset by some over performing areas including Upper Gastrointestinal Surgery.

#### ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £7.96m behind plan. This is due to the transfer of Maternity Delivery activity into Maternity Pathways which now reports under Other NHS Income. There is also an underperformance in Trauma & Orthopaedics (adult and paediatric) and an over performance in Vascular Surgery.

#### iii. Day Cases

Day Cases are £0.612m behind plan for the period. Clinical & Medical Oncology are both below plan and is affected by challenges in recruitment of consultant staff. This underperformance is partly offset by strong performance in Ophthalmology and Radiotherapy.

#### iv. Outpatients

Outpatient activity has under-performed by £3.684m and is largely driven by Genito-urinary Medicine activity at £2.195m transferring from NHS commissioners to local authorities which reports 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 6th May 2014.

#### v. Accident and Emergency

A&E has under-performed by £0.252m against the year to date plan of £10.403m. Performance to date of £10.151m is £0.377m ahead of this time last year.

#### 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 £13.261m ahead of plan. The most significant element of this is the transfer of Maternity Delivery activity at £7.875m, Cystic Fibrosis, £1.044m ahead of plan and increased levels of Pass Through income, £2.165m ahead of plan. There is also an anticipated under performance against the CQUIN plan and contract penalties.

Table 2 – NHS Clinical Income by Worktype

| Worktype | Plan £m | Actual £m | Variance £m |
|---|---|---|---|
| Elective Inpatient | 38.279 | 36.776 | (1.503) |
| Day Case | 27.098 | 26.486 | (0.612) |
| Non-Elective Inpatient | 73.763 | 65.803 | (7.960) |
| Outpatient | 55.675 | 51.991 | (3.684) |
| Accident & Emergency | 10.403 | 10.151 | (0.252) |
| Other NHS | 153.004 | 166.265 | 13.261 |
| **Totals** | 358.222 | 357.472 | (0.750) |

## 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.

A number of changes to commissioning rules were implemented after the Monitor plan submission with activity moving from CCGs to NHS England and Local Authorities. As the Monitor plan is fixed, this leads to an "under performance" against CCGs and "over performance" against NHS England and Other Commissioners.

Table 3 Performance by Commissioner

| Commissioner | Variance £'m | Variance % |
|---|---|---|
| NHS Bristol | (13.146) | (10.85) |
| NHS North Somerset | (4.879) | (14.96) |
| NHS South Gloucestershire | (2.148) | (9.50) |
| NHS Bath & NE Somerset | (1.467) | (19.15) |
| NHS Somerset | (0.437) | (7.26) |
| NHS Gloucestershire | (0.574) | (14.88) |
| NHS England | 7.593 | 4.99 |
| Other | 7.125 | 36.90 |
| Variable Estimates | 7.184 | 102.05 |
| **Totals** | (0.750) | (0.21) |

## Non Mandatory/Non Protected Revenue

## Private Patient Revenue

Private Patient Revenue has under-performed by £1.009m for the period.

## Other Clinical Revenue

Other Clinical Revenue is over-performing by £3.36m 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 £9.133m higher than planned for the period. The main reasons are:

- Higher than planned income from the Trust's Research and Development CLRN contract £1.435m.
- Higher than planned Education and Training Income £0.571m.
- Donations and grants £4.857m
- Higher than planned other income £2.271m. 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 £403.878m for the year to date are £6.495m higher than plan. Trust pay costs are £5.781 m higher than plan and non pay costs are £0.714m higher than plan.

### 4.1 Pay Costs

Pay costs at £251.856m for the year to date were £5.781m, 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 £47.587m are £0.795m higher than plan for the period.

### 4.3 Clinical supplies and services

Clinical supplies and services costs at £45.489m for the period were £1.405m higher than plan due to lower than planned CIP delivery.

### 4.4 Other Operating Expenses including non clinical supplies

Other costs were £1.486m lower than plan. 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 £14.568m were lower than the Annual Plan projection of £15.332m. This was due to the revaluation of assets at the end of 2013/14 which was completed after the annual plan was submitted and a delay in the completion of phase 4 schemes into quarter 4.

### 4.6 Impairment Losses

The Annual Plan provides for an impairment loss of £4.3m to date compared with an actual impairment of £2.923m, £1.377m lower than plan. This is primarily due to the delayed opening of the Trust's Surgical Assessment Suite Pod from quarter 3 to quarter 4. Significant impairment charges will be made in quarter 4 upon completion of Phase 3 of the BRI Redevelopment.

## 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 9 months to 31st December of £43.494m. Actual expenditure at £35.55m equates to 81.7% of the year to date plan.

NHS foundation trusts are required to inform Monitor should capital expenditure diverge by more than 15% (above or below) the Annual Plan during the year and provide a revised forecast for the year. Please see appendix 1 for further details.

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

| | 9 months to 31st December 2014 | | |
|---|---|---|---|
| | Plan | Actual | Variance Fav / (Adv) |
| | £'000 | £'000 | £'000 |
| **Sources of Funding** | | | |
| Donations | 6,312 | 6,312 | - |
| Retained Depreciation | 14,009 | 13,939 | (70) |
| Prudential Borrowing | 20,000 | 20,000 | - |
| PDC | 1,583 | 1,583 | - |
| Sale of Assets | 700 | 700 | - |
| Cash balances | (5,597) | (6,984) | (1,387) |
| **Total Funding** | **37,007** | **35,550** | **(1,457)** |
| | | | |
| **Expenditure** | | | |
| Strategic Schemes | (22,653) | (22,398) | 255 |
| Medical Equipment | (3,687) | (3,511) | 176 |
| Information Technology | (3,926) | (3,821) | 105 |
| Roll Over Schemes | (1,439) | (1,464) | (25) |
| Operational | (5,302) | (4,356) | 946 |
| **Total Expenditure** | **(37,007)** | **(35,550)** | **1,457** |

The Trust has reviewed the capital programme and is now forecasting capital expenditure of £45.485m for 2014/15, 79% of the Annual Plan. This is mainly due to programme delays for a number of projects such as the Queen's Building façade and BRI Redevelopment Phase 4. The Trust's corresponding increase in year-end cash balances arising from the capital slippage will be carried forward and committed in the 2015/16 capital plan.

## 6. STATEMENT OF FINANCIAL POSITION

The significant balance movements and variances are explained below.

### 6.1 Non Current Assets

The balance of £406.228m at the end of December is £6.29m 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 £11.871m. This is £2.134m higher than planned due to greater than expected stock levels for services transferred from North Bristol NHS Trust and increases in expensive cancer drugs held in Pharmacy.

### 6.3 Current Tax Receivables

The balance of £1.345m at the end of December represents moneys owed to the Trust by the HMRC for additional VAT that is recoverable under legislation. These moneys relate to VAT paid during Phase 3 of the BRI redevelopment scheme that is recoverable at the end of the project.

## 6.4 Trade and Other Receivables (Including Other Financial Assets)

The balance of trade and other receivables of £10.007m is £2.466m higher than plan however moneys owed to the Trust but not yet invoiced, are shown as accrued income and this is currently £9.656m which is £5.54m lower than the plan figure. The Trust continues seeking to reduce the amount of money owed, for example, debts of over 60 days have reduced by £1.512m in the month.

## 6.5 Prepayments

The prepayment balance at the end of December is £2.722m. This is mainly due to payments for maintenance contracts for servicing of equipment. This is broadly in line with the plan of £2.526m.

## 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.

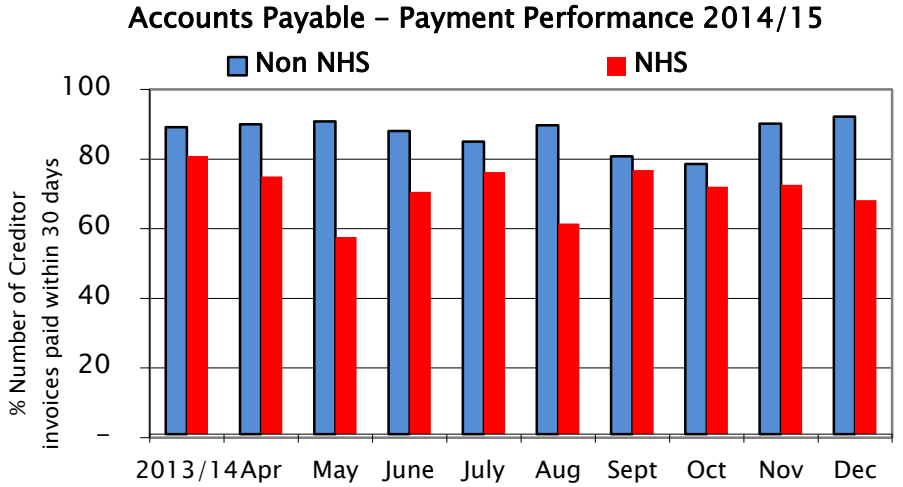
## 6.7 Deferred Income

Deferred income of £2.906m is broadly in line with plan of £2.855m. This relates to moneys received in divisions for specific projects with expenditure later in the year.

## 6.8 Trade Creditors / Other Creditors / Capital Creditors

Trade, 'Other' and Capital Creditors total £20.893m at the end of December. This is £1.46m above the plan projection of £19.433m.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. For Quarters 1 - 3 of 2014/15 the Trust achieved 68% (87% by value) and 87% (87% by value) compliance against the Better Payment Practice Code for NHS and Non NHS creditors respectively. The Trust also continues to operate strict financial controls around supplier price increases.




## 6.9 Other Financial Liabilities

The closing balance for accruals at £39.838m is £14.215m higher than the plan of £25.623m 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 31st December together with comparative information taken from the Trust's Annual Plan.

## Summary Statement of Financial Position

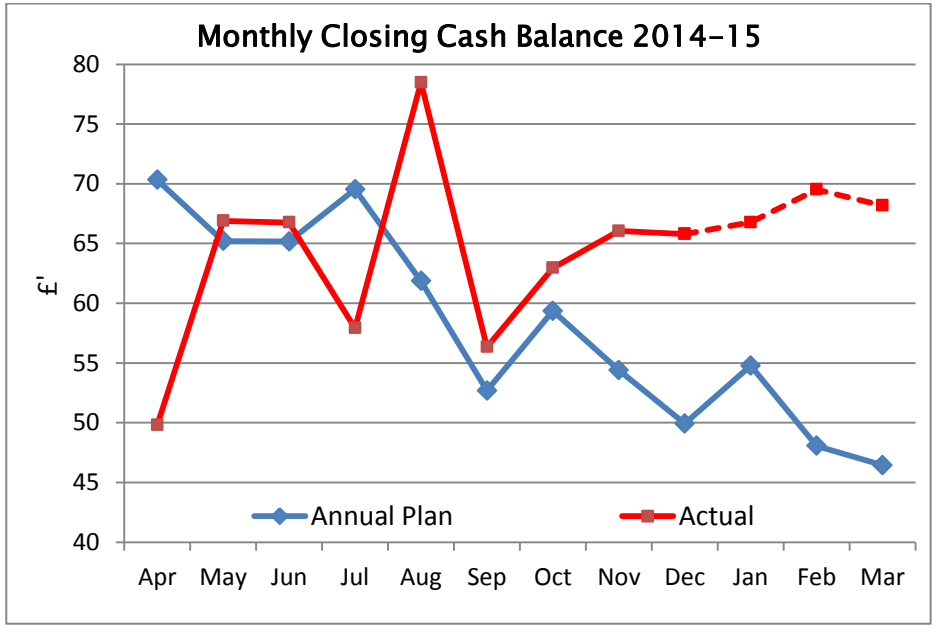
| | Position as at 31st December 2014 | | |
|---|---|---|---|
| | Plan | Actual | Variance Fav/ (Adv) |
| | £'000 | £'000 | £'000 |
| **Non current assets** | | | |
| Intangible | 8,117 | 6,668 | (1,449) |
| PPE* | 404,401 | 399,560 | (4,841) |
| **Non current assets total** | **412,518** | **406,228** | **(6,290)** |
| **Current assets** | | | |
| Inventories | 9,737 | 11,871 | 2,134 |
| Current Tax Receivables | 681 | 1,345 | 664 |
| Trade, Other Receivables | 7,541 | 10,007 | 2,466 |
| Other Financial Assets | 15,300 | 9,760 | (5,540) |
| Prepayments | 2,526 | 2,722 | 196 |
| Cash & Cash Equivalents | 44,043 | 65,975 | 21,932 |
| NCA held for sale** | - | 1,090 | 1,090 |
| **Current assets total** | **79,828** | **102,770** | **22,942** |
| **TOTAL ASSETS** | **492,346** | **508,998** | **16,652** |
| **Current Liabilities** | | | |
| Loans | (5,834) | (5,834) | - |
| Deferred Income | (2,855) | (2,906) | (51) |
| Provisions | (270) | (194) | 76 |
| Current Tax Payables | (6,500) | (6,610) | (110) |
| Trade and Other Payables | (19,433) | (20,893) | (1,460) |
| Other Financial Liabilities | (25,623) | (39,838) | (14,215) |
| Other Liabilities | (5,500) | (5,385) | (115) |
| **Current liabilities total** | **(66,015)** | **(81,660)** | **(15,645)** |
| **NET CURRENT ASSETS/(LIABILITIES)** | **13,813** | **21,110** | **7,297** |

| | Position as at 31st December 2014 | | |
|---|---|---|---|
| | Plan | Actual | Variance Fav/ (Adv) |
| | £'000 | £'000 | £'000 |
| **Non current liabilities** | | | |
| Loans | (88,060) | (88,059) | 1 |
| Provisions | (170) | (162) | 8 |
| Finance Leases | (5,393) | (5,348) | 45 |
| **Non current liabilities total** | **(93,623)** | **(93,569)** | **54** |
| **TOTAL ASSETS EMPLOYED** | **332,708** | **333,769** | **1,061** |
| **Taxpayers' and Others' Equity** | | | |
| Public Dividend Capital | 194,018 | 193,083 | (935) |
| Retained Earnings | 83,296 | 88,912 | 5,616 |
| Revaluation Reserve | 55,309 | 51,689 | (3,620) |
| Other Reserves | 85 | 85 | - |
| **TOTAL TAXPAYERS' EQUITY** | **332,708** | **333,769** | **1,061** |

*PPE – Property, Plant and Equipment
*NCA – Non Current Assets

## 7. Cash and Cash Flow

The Trust held cash balances at the end of December of £65.975m. This is £21.932m more than the Annual Plan projection of £44.043m. This is primarily due a higher opening cash position compared with the plan of £4.373m, cash donations received in quarter 3 of £6.357m and capital slippage of £7.944m. The graph shown below provides a comparison of actual and the Trust's projected month-end cash balances for 2014/15.



## Appendix 1 – 2014/15 Capital expenditure forecast outturn

The Monitor capital expenditure performance target is to deliver the programme within 85% -115% of the Annual Plan. As anticipated last month the Trust has not achieved the performance target at quarter 3. Capital expenditure at quarter 3 is £35.550m against the forecast of £43.494m which is 81.7% of the Annual Plan.

Following discussions with budget holders, the Head of Capital Accounting and Director of Finance has reviewed the capital programme for the remaining quarter in order to form a realistic assessment of capital expenditure for 2014/15. As a result of this exercise, the Trust is now forecasting capital expenditure of £45.485m in 2014/15.

| | 2014/15 Capital Expenditure | | | % target |
|---|---|---|---|---|
| | Original Plan | Forecast Outturn | Increase / (Decrease) | |
| | £'000 | £'000 | £'000 | |
| Strategic schemes | 35,443 | 25,910 | (9,533) | 73.1% |
| Backlog maintenance | 2,566 | 2,249 | (317) | 87.6% |
| Information Technology | 6,112 | 5,330 | (782) | 87.2% |
| Operational Capital | 8,530 | 7,170 | (1,360) | 84.1% |
| Medical equipment | 4,970 | 4,826 | (144) | 97.1% |
| **Total** | **57,621** | **45,485** | **(12,136)** | **78.9%** |

The significant movements and variance from target are within the strategic and operational capital schemes.

The main movements on the strategic schemes relate to the façade and the BRI Redevelopment Phase 4 programmes. The façade scheme is delayed due to manufacturing and implementation challenges of the approved design and has a £3.0m impact on the forecast outturn.

The delivery of the Phase 4 programme of works has been affected by delays in the transitioning of services from their previous location to the new ward block, operational pressures and resource constraints within the Estates Department. Consequently the forecast outturn has reduced by £6.0m.

The resource constraints in the Estates Department have also had a knock on effect onto the Operational programme reducing the forecast outturn by £1.3m.

The Trust Board anticipates that the Trust's 2014/15 capital expenditure will not materially differ from the revised forecast outturn.

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 19. Board Assurance Framework Report

### Purpose

To provide the Board with the quarterly update of progress against the Trust's objectives at the end of Quarter 3 and to provide assurance of the control of any associated risks to delivery.

### Abstract

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.

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 Q3 framework however, it is recognised, that this requires further emphasis.

**Quarter 3 Position**

There are 4 (1) objective where the inherent risk to delivery is considered high and is therefore RED rated meaning delivery of the objective at the yearend is in jeopardy. This are:

- To deliver the annual Cash Releasing Efficiency Savings programme in line with the LTFP requirements.
- To deliver all annual quality objectives and quality improvements as per the Trust's Quality Report and CQUIN schedule.
- To deliver the RTT recovery plans for admitted, non-admitted and on-going pathway performance.
- To improve cancer performance to ensure delivery of all key cancer targets.

Finally, there are 37 (34) objectives where delivery is forecast therefore with a residual rating of GREEN and 3 (9) AMBER rated objectives which means the milestone is delayed but is expected to recover and achieve by the year end, noting the limited time left to address recovery.

NB. Q2 figures noted in brackets.

## Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

| **Recommendations** |
|---|
| The Board is recommended to **approve** this report for assurance and request any further action required to address achievement of objectives at risk of delivery. |
| **Report Sponsor** |
| Deborah Lee, Deputy Chief Executive/Director of Strategic Development |
| **Authors** |
| Executive Directors |
| **Appendices** |
| Appendix 1 - Board Assurance Framework – Quarter 3 Update |

### 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 |
|---|---|---|---|---|---|
| | 21st January 2015 | | | | Risk Management Group – 14th January 2015 |

| 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 | | 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 | 50% - 75% | - The hub location and move timetable is agreed. Joint KPIs and greater team working, including joint board rounds are being rolled out.<br>- Jointly developed pathways for the most complex patients are in development. The enhanced recovery pilot is operating on Care of the Elderly wards.<br>- The protected beds model is operating in SH&N and Specialised Services. Positive initial results (reduced cancellations and LoS). Protection has been maintained through periods of escalation, but maintaining flow through critical care areas has been a challenge.<br>- The BRCH flow programme has made changes across the hospital, including the remodelling of CED, improved ward processes, better management of flow and escalation and the roll out of new real-time communications methods<br>- The October BTCT week provided the impetus for further changes to daily routines which have been adopted in children's and adult divisions | Risk of lack of momentum through diverse leadership causing a delay in implementation.<br><br>Lack of partner responsiveness during peaks in demand. Inadequate care home/package of care capacity to meet demand. | Risk mitigated through bringing the individual projects together in coordinated themes.<br><br>Through weekly operational meetings with partners, Via ALAMAC and Urgent Care Steering Board. | Regular progress and exception reports to Transformation Board<br><br>Review by Emergency Care Intensive Support Team | | 753 | COO | Senior Leadership Team | 17/12/14 Urgent Care Board |
| | | | 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 | | 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.<br>1. Social Services, ICT and IHDT move to new clinical hub mid January 2015, weekly monitoring allocation SW 24hours following receipt of section 2 and completion assessment within 5 days, weekly multi-organisational meetings to review/progress all patients over 7 days, plans to integrate brokeridge on OPAU to reduce waits for packages of care, Out of Hospital virtual bed meetings to commence 07/01/2015.<br>2. Out of Hospital bed capacity reviewed daily as part of the ED recovery plan. Additional beds in place for Winter and additional interim beds available.<br>3.Discharge Registrar at weekends in place, Ongoing work with BCC to improve transfers to Care Homes at weekends with the support from BRISDOC professional line, 6 day Therapy cover in place.<br>4. Surgery/Cardiac protected bed model in place. | | | | | | | | |
| | | 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 | 75% - 100% | 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 | 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 |
| | | | Develop action plan to achieve compliance with all areas where derogation has not been agreed, in line with timescales set by commissioners. | | | | | | | | | | |
| | | Deliver a programme designed to enhance compassion in clinical staff | Review values training to incl. evaluation of impact on behaviours | 50% - 75% | Review of outcome of evaluation of values training results underway, which will result in a revision of the training programme. Briefing paper to Jan 15 NMC following RN values recruitment pilot, with aim to roll out in May 15. Staff focus group planned for Jan 15, with further sessions planned in February. This will inform the development of a compassion resource tool kit for staff | 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 |
| | | | Implement values based recruitment for RN's Midwives, NA's , domestic assistants, medical staff | | | | | | | | | | |
| | | | Develop Compassionate care programme for UH Bristol nurses and midwives - following focus work to identify understanding/barriers to deliver of compassionate care | | | | | | | | | | |
| | | To establish an effective and sustainable complaints function to ensure patients receive timely and comprehensive responses to the concerns they raise and that learning from complaints inform service planning and day to day practice | To strengthen the Patient Support and Complaints Team resources to address the current lack of resilience. | 75% - 100% | Case for increased resources approved May 2014. Recruitment to three new posts completed autumn 2014, increasing team WTE from 4.8 to 7.6 Progress with delivery of some actions in complaints work plan were initially affected by backlog of enquiries to Patient Support and Complaints Team, how ever the backlog was successfully removed in November 2014. The work plan is regularly reviewed by the Head of Quality (Patient Experience and Clinical Effectiveness) and the Patient Experience Group - the majority of objectives for 2014/15 have already been achieved. | 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 | Patient Experience Group Oct 14 (August for work plan - next review due at Feb meeting) |
| | | | Deliver the complaints annual work plan, which includes learning from Francis/Clywd Hart | | | | | | | | | | |
| | | To address existing shortcomings in the quality of care and exceed national standards in areas where | Deliver the stretch and quality improvements as per 14/15 CQUIN schedule | 50% - 75% | CQUIN.<br>All CQUINs have been agreed with commissioners. Most CQUINs have achievement split several ways to minimise | CQUINs potentially at risk<br>-Dementia (FAIR)<br>Weight Management Support in Maternity | Nominated SLT leads to oversee delivery of individual CQUINs, robust governance of delivery of CQUIN monitored via SLT and | CQUINs supported by SLT leads, exception reports to CQG reviewed by Trust | | | MD / CN | SLT and CQG for CQUINs | CQUIN Dec CQG<br><br>Quality |

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | We will consistently deliver high quality individual care, delivered with compassion. | national standards in areas where the Trust is performing well. | Deliver all annual quality objectives described in the Trust's quality report | | CQUINs have achievement split several ways to minimise any risk from all or nothing measures. 19.6% of CQUIN money thus far achieved. Friends and Family Test (Staff) and Friends and Family Test (Early Implementation have been achieved in full. Dementia (FAIR) CQUIN is a significant challenge and 1/2 of CQUIN value has been lost due to non achievement in Q1 and Q2. Almost all CQUINs should be achieved or partially achieved. Tighter monitoring of progress is in place including SLT Sponsors, exception reporting to CQG and appropriate escalation.<br><br>Corporate quality objectives.<br>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 November 2014 is as follows: Last minute cancelled operations YTD is above (worse than) target (1.16% vs 0.92%) and has declined in Q3 to date - red-rated performance for the last six months; outlier bed days YTD is above (worse than) target, with the last five months red-rated; out of hours discharges YTD 8.2%; average number of ward moves also above (worse than) target - red-rated board-reported performance for last six months.<br><br>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 preferred option for new approach to working with patients, members and wider public; pilot work re. experience based co-design (e.g. BRI ED; congenital heart patients with learning disabilities). Q4 - recommendation to Board for future model of working, as part of revised Patient Experience & Involvement Strategy. Implementation Q1 2015/16. | Weight Management support in Maternity for Obese Women<br>-Older People's Rehabilitation<br>-End of Life (low confidence)<br>-7 day working (low confidence)<br>Friends and Family (increased response rate) - 50% achieved, other 50% at risk due to winter pressures in A&E<br><br>Risk of not achieving flow-based corporate quality objectives. | delivery of CQUIN monitored via SLT and CQG, robust monitoring of annual quality objectives, delivery of flow projects.<br><br>For flow-based quality objectives, see first BAF objective above. | CQG, reviewed by Trust quality team. Escalation to Execs as necessary.<br><br>Delivery against flow-based quality objectives is reviewed monthly via Flow Group, QOC and Trust Board. | | | | Clinical Quality Group for quality objectives; | Quality objectives - Nov CQG; |
| | | To achieve upper quartile performance in process and outcome measures for the Friends and Family Test (FFT) | Implement FFT in outpatient and day case settings<br><br>Explore options for increasing monthly response rate to meet increased national targets | 75% - 100% | OPD / day case FFT implemented from 1st October, as per national schedule. Strong early uptake for day cases. OPD approach includes trialling use of technologies including touchscreen kiosks, SMS texting, QR codes, etc. (touchscreens have provided majority of feedback to date). 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). | FFT performance is difficult to predict and is affected by service pressures. OPD FFT is based on giving patients the *opportunity* to participate, i.e. impossible to personally target every outpatient due to scale. OPD response rates have initially been low, as predicted, however CQUIN does not stipulate a minimum required response rate for 2014/15. Overall BAF target (upper quartile performance) is dependent upon the performance of all other providers. Current position is that FFT scores are above average but fall short of upper quartile; response rates reflect the national average. | For ED, maternity, inpatient and day case FFT, constant reinforcement and vigilance to maintain response rates. For OPD FFT, initial close monitoring of take-up rate; use of targeted paper-based surveys (now rescheduled for Quarter 4) to provide 'guaranteed' foundation response. | Patient Experience Group monitors FFT (meets bi-monthly). | | | CN | Patient Experience Group | Dec-14 |
| | | To ensure the Trust's reputation reflects the quality of the services it provides | To ensure services are compliant with national quality standards including compliance with the draft standards for paediatric cardiac services | 50% - 75% | 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 | |
| | | | 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. Interviews with c40 families planned for December & January with staff interviews to follow. Stock take of compliance with standards and prior recommendations underway and held through Cardiac Services Review Group. Proactive | 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 | Weekly media summaries and monthly communications report to Senior Leadership Team. Overview of media activities through Paediatric cardiac | | | D of SD | Senior Leadership Team | 16th September 2014 |

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| | | | Work proactively with media and other key stakeholders to actively promote positive coverage of the Trust's activities | | [illegible] media continues, supported by external consultants with significant positive coverage in the quarter. CQC Report positioned with key stakeholders to promote positive findings. | | [illegible] with all necessary standards and specifications. | [illegible] Steering Group. Significant external assurance of quality of service provided through CQC Inspection Report. | | | | | |
| | | To achieve upper quartile performance standards for all nationally benchmarked patient safety measures | Monitor performance and take corrective action when appropriate.<br>Review Patient Safety Group function within Trust governance apparatus. | 50% to 75% | Patient safety group function review completed. Trust signed up to Sign up for Safety. No significant 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 | |
| **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<br>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)<br>Complete and handover level 5 of new ward block to Children's Hospital (June)<br>Completion of refurbished wards and ward move plan implemented by Q4<br>Queen's Lecture Theatre conversion completed and levels 9 & 10 remodelled by end of Q3<br>Surgical Assessment Unit completed and operational in Q3<br>Integrated Discharge Hub established. Q3.<br>Staff Restaurant opened Q4.<br>Successfully deliver Queen's Building Façade Project | 50% to 75% | Helideck operational May 2014.<br>Level 5 handed over June 2014.<br>Levels 7 and 8 handed over Sept 2014. Levels 3 and 4 handed over Nov 2014.<br><br>On target to plan Version 21, Phase 4 programme. | Risk that Length of Stay will not reduce to planned levels. | Additional capacity opened ahead of Q4 with winter/resilience monies. | Office of Governance and Commerce (Green rating received in May 2014). | | 2476 & 759 | COO | Senior Leadership Team | 17/12/2014 |
| | | 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<br>Six month review following EPRR audit completed<br>Major Incident Plan revised to reflect new BRI build by end of Q4 | 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 | |
| | | Set out the future direction for the Trust's Estate | Estates and Asset Management Strategy agreed by Board June 2014<br>Business Case for future use of Old Building Site and developed and agreed by Board by end of September<br>Scope future priorities for refurbishment of remaining estate post BRI Phase IV and incorporate into forward strategic capital programme | 50% - 75% | Estates Strategy approved by Board and approach to Old Building site considered and approved by Board in November. Campus Phase V programme launched in quarter to scope future priorities for residual estate. | 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 retained as advisers on the project. Agents retained to provide assurance on Old Building site values. | | | D of SD | Senior Leadership Team | June 2014. September update deferred to October to reflect OBC timeline. |
| | | Deliver against the National Quality Board 10 safe staffing expectations for Trust Boards | Deliver expectations 1,3,7,8 (June 2014)<br>Deliver remaining expectations | 75% - 100% | Expectations 1,3,7,8 completed<br>B<br>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 in n light of the above group only meeting bimonthly and the requirement to report to Board monthly. This report will therefore 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 |
| **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<br>To create a cohesive performance management framework for all staff groups, enabling staff to delivery high quality patient care<br>Development and implementation of a Staff Recognition and Suggestion Scheme<br>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 | 50% to 75% | A detailed programme of work is underway. The engagement programme focusses on: improve two-way communications, including a programme of listening events, focussed action to reduce the incidence of work-related stress and bullying and harrassment, improved team based working using the Michael West evidence-based approach, review and develop our 'values' training to focus on treating everyone with respect, strengthen partnership working with staff side representatives and trade unions, conduct a full census staff survey and introduce more regular pulse checks - including staff FTT. It also includes work on recognising success, and a complete review of the Speaking Out process. Pilot the | We will not achieve a year on year improvement in staff engagement. | Comprehensive delivery programme. | Review by Transformation Board<br><br>Quarterly Report on Progress at October 2014 QOC. Review of engagement activity at Workforce and OD Committee. Measurements in National Staff Survey are also used as a measure of progress against the Agenda. | | | DWOD | Workforce and OD Committee 13 November 2014, QOC 27 October 2014. | Quarterly update received at: CQOC, SLT, T&L SG, and workforce and OD group. Workforce and OD Group have requested updates on Engagement plan at each meeting. |

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| | | | Ensure managers build their skills to enable high quality appraisals and objective setting | | Healthcare Leadership Model in January which describes the key skills and behaviours for all managers and leaders across the organisation. Work continues on t he revision of the training for building skills to enable high quality appraisals and objective setting.<br>Delivery is supported by a cross-Trust working group. | | | | | | | | |
| | We will strive to employ the best and help all our staff fulfil their individual potential. | 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 | 50% to 75% | Action plan developed and approved at Health and Safety/Fire Safety Committee in October 2014. British Safety Council Independent audit in October 2014. Appropriate investment in Health and Wellbeing with identified resource and funding has occurred. Resilience building (Lighten Up) and enhancement of 2 modules - Managing change and Identifying and Managing Stress to roll out in 2015. Employee Assistance Programme in pilot stage in Children's Hospital additional cost pressure if evaluates successfully and is to be rolled out Trust-wide. We will evaluate Health and Safety Policy to ensure learning from all incidents especially focusing on those where the impact of violence and aggression is high or moderate. We will review staff support post incident equipping managers and referrals to other support as required. We will develop a themed report in the area of violence and aggression so that training specific to role can be targeted to high risk areas as a priority.<br>Work to benchmark and develop e-learning package underway. | We will not significantly impact on work related stress. | Comprehensive delivery programme. | Internal - Review by Health and Safety/Fire Safety Committee and Workforce and Organisational Development Group. | | | DWOD | Risk Management Group | October 2014 and 6 January 2015. |
| | | | Health & Safety - evaluate policy and practice to focus high quality patient care to support the reporting learning from incidents including physical violence | | | | | | | | | | |
| | | | Discrimination - review and scope opportunities for revised e-learning package to support managers | | | | | | | | | | |
| | | We will equip our leaders with the requisite skills, behaviours and tools to develop high performing teams, so staff have objectives with a clear line of sight to the Trust's vision. | Identify and agree who are our leaders and managers , clearly articulating and agreeing what it means to be a leader, with clear competencies and standards of behaviour. | 50% to 75% | The exercise to determine who is a leader was completed, but requires further verification. The project plan for this commences in December and concludes end of March 2015.<br>New style leaders forum has been developed with the first session in February 2015 and leadership conferences is planned for the 3rd June - Action Learning Set facilitators have been trained this year and Action Learning Sets will commence in March 2015. A working OD group has been set up to review the appraisal system including 360 and Talent Management. A pilot of the appraisal system will be conducted between June and September 2015.<br>Workforce and Organisational Development Strategy has been signed off with clear objectives within the leadership capability section, a detailed plan is under development to be implemented in 2015. | Verification of leaders may not be completed by March 2015. | Whilst we have identified leaders and managers across the organisation, it does require further verification. This work will not impact on the roll out of the leadership programme for managers. | Review by Transformation Board<br><br>Workforce and OD Group | | | DWOD | Senior Leadership Team | Update on Leadership Development was presented to Workforce and OD Group November 2014. Transformation Board November 2014. |
| | | | Introduce comprehensive programme of quarterly leadership forums, annual leadership conference and access to learning sets - to ensure leaders understand the opportunities and challenges facing the Trust, share experiences, offer support and learn from best practice. | | | | | | | | | | |
| | | | Revise appraisals to include feedback on leadership competencies and behaviours - to include 360 or staff feedback. | | | | | | | | | | |
| | | | Develop and agree a 1 - 3 year Organisational Development plan to provide continuous and systematic leadership development and the need to understand what leadership means as a cultural proposition. | | | | | | | | | | |
| | | We will revise the Teaching and Learning strategy to ensure the strategic priorities support an 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 | 50% to 75% | An interim project lead has commenced in the Trust to further develop the following three key priorities as defined through Teaching and Learning Steering group: 1) Development of a revised Teaching and Learning Strategy which reflects the Trust's strategic vision, 2) Development of a Trust-wide training plan that aligns to the operating plans, 3) A review of governance for Teaching and Learning. All of these objectives will be delivered by March 2015. | No risks at this stage, as interim resource has been secured and work has commenced on the completion of the objectives. | Interim resource not able to complete within timescales/resource exits the organisation ahead of March 2015. | Review by Teaching and Learning Group, December 2014.<br><br>SLT update December 2014 | | | DWOD | Senior Leadership Team | Update provided to T&L SG in December 2014. |
| | | | Revise the priorities in line with the draft strategic vision for UH Bristol | | | | | | | | | | |
| | | | To provide a revised Teaching & Learning Strategy in March 2015 | | | | | | | | | | |
| 4 | | Implement modern clinical information systems in the Trust | Phase 2 Implementation | 50%-75% | Programme in hand and will be implemented by the year end.<br><br>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 |
| | | | Phase 3 Design | | | | | | | | | | |
| | | We will maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR)maintain our performance in initiating research) and remaining | (a) Monitor our performance and analyse reasons for failure to meet the benchmark (performance initiating research), putting in place measures to address those reasons | 50% to 75% | a) Progress is being maintained and continuous analysis undertaken of performance through regular reporting and KPI reviews, 75-100% achieved on this element of the objective.<br>b) Progress on track to deliver by 31/3/15 - 85%<br>c) on track 50%-75%<br>d) On track; standard performance information provided via TRG; 75-100% | (a) failure to engage with services which can influence our performance in meeting the benchmark.<br>(b) Failure to agree appropriate governance structures<br>(c) resistance of workforce to taking on more flexible (cross specialty) roles; true flexibility and mobility of research funding is | (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.<br>(b)Meeting planned early January to discuss structure and governance<br>(c) standardised core JDs for research delivery staff; engagement by research matron with | Progress reports to Trust Research Group | | | MD | Trust Research Group -Last meeting 23/10/2014 | (a) KPI review with Director of Research 18/12/14 and monthly KPI reviews with Head of Research & |
| | | | (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 | | | | | | | | | | |

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| | | the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR) | (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.<br>(d) Provide clinical divisions with the information they need to oversee and manage research performance, increasing visibility within divisional boards.<br>(e) Achieve common agreed processes across clinical divisions for job planning and recommendation of research SPA allocation. | | e) 100% | required.<br>(d) focus on clinical pressures consumes clinical divisions making it difficult to focus on research.<br>(e) N/A | B7 research staff to understand need for flexibility<br>(d) increased engagement and regular meetings with divisional staff at all levels.<br>(e) work with each division to reach suitable solution. | | | | | | Innovation.<br>(b) Review every week with DW and through project steering group<br>(c)Project steering group every week<br>(d) & (e) TRG 23/10/2014 |
| | We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation. | We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR) | (a) Oversee and performance manage small grants which have been pump-primed by UH Bristol/Above and Beyond funding to deliver their objectives, increasing the conversion rate to NIHR grants over 2013/14 levels.<br>(b( Identify opportunities for new submissions for NIHR grant funding within existing external and pump-priming grant holders<br>(c) identify collaborative opportunities for grant applications with our local and regional partners. | 50% to 75% | a) and b) - appointed to a new post within R&I to support Research Grants Manager, allowing her to focus on these activities. Post due to start mid Jan 15. | (a) and (b) training of new post holder may take resource away from grants manager.<br>(c) focus solely on UH Bristol opportunities may detract from allocating time to collaborative work | (a) and (b) new appointment has significant relevant experience therefore anticipate training needs to be low. Post holder will be integrated into department and will be supported during induction by all team members, who will also provide training as required.<br>(c) use cross-organisational networks currently in existence to maintain awareness of opportunities | Progress reports to Trust Research Group | | | MD | Trust Research Group-Last meeting 23/10/2014 | (a) 2-monthly review with Director of Research ongoing 12/12/2014.<br>(b) and (c) Ongoing rolling review feeding into 2-monthly review with Director of Research |
| | | 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<br>(b) Identify clinical areas where the conduct of research has had a defined impact on the service delivery<br>(c) Disseminate information to relevant stakeholders (internal and external) | 50% to 75% | a) rolling programme of review in place.<br>b) dissemination work stream ongoing which has implemented a successful process to capture case studies which are disseminated via the website and through internal good news stories. | (a) clinical impact difficult to identify/quantify until some time after research has taken place<br>(b) recognition of impact can be difficult to quantify<br>(c) failure to identify appropriate stakeholders within and outside the organisation | (a) maintain rolling programme of review; include impact on clinical care of the research practice during conduct.<br>(b) engagement with clinical and research staff both directly and through the network of research staff<br>(c) engagement with clinical divisions and partner organisations<br>a), b), c): initiate series of targeted one to one meetings with key researchers to draw out relevant information about impact of their research. | Progress reports to Trust Research Group | | | MD | Trust Research Group-Last meeting 23/10/2014 | (a), (b), (c) Weekly review against plan at project steering group (12/12/14). KPI in place and reviewed monthly. |
| | | 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 are approved by Transformation Board and renewed when required. Teams have been mobilised against each. A detailed review of progress is held monthly | Do not identify the right actions to address underlying issues<br>We allow progress to drift | Scope sign off and monthly progress review by Transformation Board | Progress updates to Trust Board | | | COO | Transformation Board | |
| | | | Establish structured progress monitoring by PMO reporting monthly to Transformation Board | 50%-75% | Milestone plans are in place for each project. A monthly cycle of monitoring 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 has clear near term milestones to get actions underway and to build momentum, and a communications plan | 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<br>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.<br>Fully engage with AHSC governance and assist with strategic planning. | 50% - 75% | 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 | 50% - 75% | 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 | | Deliver minimum normalised surplus | Achieve full delivery of annual CRES programme (detail provide below) and positive contract settlement with CCG and NHSE commissioners | 75% - 100% | SLA signed in line with Heads of Terms | Under performance of activity | Monthly Divisional Reviews | Oversight by operational planning core group | | | DoF | Finance Committee | 24/11/2014 |

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| | 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 | Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas. | SLR development<br>Use of result in informing Business Planning | 50%-75% | Q2 14/15 by Christmas 2014 | 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.<br>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 | 50% -75 | As at 31st August 2014 82% of the 2014/15 target has been identified on a risk assessed basis<br><br>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.<br><br>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.<br><br>Monthly reports on progress are presented to the Finance Committee | | 741 | COO | Finance Committee | 24/11/2014 |
| | | 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. Work in hand to finalise Strategic Implementation Plan for presentation to Board. 2015/16 Operating Plan guidance links to SIP. | 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 Commissioning & planning Function in 2013 and planned for 2014 as part of Annual Audit Plan. Monitor self-assessment of strategic planning function undertaken as part of Monitor Plan submission. Monitor feedback on plan rated as AMBER due to risks associated with savings delivery. | | | D of SD | Senior Leadership Team | 16th September 2014 |
| | | 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. | 50% - 75% | 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 Children's Community 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 available 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<br>Private Patient Strategy for 2015-2020 developed and presented to the Board by end of Q4<br>Monthly income and expenditure reports in place by end of Q2 | 50% - 75% | PP Steering Group supported proposal to develop PP visual identity<br><br>Scheme for front door is all agreed with the exception of confirmation of the visual identity. Ready to progress once this has been approved. | Development of PP marketing approach is taking longer than anticipated which is impacting on agreement of the colour scheme for the 'front door'<br><br>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.<br><br>Interim Deputy Chief Operating Officer to be recruited whilst substantive position recruited.<br>Responsibility for Private Patients has been incorporated into the Delivery and Service Improvement Manager post which will be recruited in January 2015. | Private Patients Steering Group | | | COO | Senior Leadership Team | SLT 3rd September 2014 |
| **7** | | Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above. | Achieve EBITDA, Return on Assets, Net Surplus Margin and Liquidity ratio in line with plan | 75% - 100% | 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 | 24/11/2014 |

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| | We will ensure we are soundly governed and are compliant with the requirements of our regulators | 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. | 50% - 75% | Structure agreed and Trust Secretary commenced. Revision to structure for risk management following two failed recruitment attempts. Successful recruitment to Head of Membership & Governance. | 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 representatives. | | | 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 | 50% - 75% | Internal Well Led Governance Review now in hand and external assessors appointed. Review to commence Feb 2015 and report to Board in Q1 2015. | 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 independent 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. | 25% - 50% | Project scoping phase commenced. Trust wide steering group established. Immediate risks identified through Internal Audit addressed. Option appraisal for future DMS platform in hand for consideration at January RMG. | 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. | 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. Quality Summit 28 November; inspection report published 2nd December - overall "Requires Improvement"; action plan by 12th January. | No risks - objective achieved. | Not applicable | Regular reports to CQC steering group, SLT, Execs, RMG | | | CN | Senior Leadership Team | Continuous throughout Q3 |
| | | | To develop a clear communicational support plan for staff. | | | | | | | | CN | Senior Leadership Team | |
| | | Prepare for and achieve successful outcome from proposed Monitor investigation into performance concerns with the aim of reverting to a GREEN rating by Q2 | To provide all necessary information, in a comprehensive and robust fashion, in advance of visit | 75%-100% | Initial objective completed. Monitor now considering further formal investigation pending outcome of system wide CQC action planning. | 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 but now reverted to "consideration of further investigation" as a result of non-compliance with recovery trajectories. | | | 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 16 June 2014. | 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 | 50% - 75% | IST report and action plan presented to and approved by Senior Leadership Team in October 2014. There has been a significant increase in the number of admitted patients treated >40 weeks. The further extension of the period of planned failure to 30th November 2014, will enable the Trust to make a further significant reduction in the admitted backlog for patients | Activity is not as yet on track against plan. The admitted and non-admitted backlog are not reducing as per previous trajectory. Aggregate/Trust level achievement of the standards is at risk until end Q4 at the earliest because most paediatric specialties have deteriorated. The main factor is | Weekly tracking of delivery against the first outpatient wait recovery plan.<br><br>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<br><br>RTT Operational Group<br><br>Divisional PTL Meetings<br><br>Elective Care (ECIST) | | 1967 | COO | Senior Leadership Team | RTTSG December 2014. |
| | | | Recovery plan for non-admitted monitored weekly and RTT non-admitted delivered by end of Q2 | | | | | | | | | | |

| 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 | | >30 weeks. Weekly monitoring in place and variance from plan being reviewed via the RTT Operational Group.<br><br>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. The Trust has completed the IMAS Demand and Capacity modelling and the outputs have been shared with Monitor, CCGs and NHSE. A number of specialties are in the process of 'outsourcing' a number of patients to be seen and treatment in the Independent Sector. A 2 months contract has been awarded to an external validation team, who will support the Trust with the RTT data cleansing programme and in preparation for validation and reporting on Medway. | insufficient theatre capacity to deliver both non-elective and elective activity.<br>Many specialties continue to receive increases in demand over and above planned trajectory.<br><br>Ability to recruit to vacancies / new consultant posts to support increased demand in system. | wait for specific specialties. Waiting list initiatives to reduce admitted backlogs.<br>Significant resource allocated to validate the RTT PTLs and all patients are currently 'on hold'. Where possible, patients will be treated by independent providers. | external review<br><br>Service Delivery Group | | | | | |
| | | Improve cancer performance to ensure delivery of all key cancer targets | Establishment of monthly Cancer Performance Steering Group<br><br>Achievement of 62 day cancer standard from Q3 onwards<br><br>Transfer of breast screening patients on the cancer register to have been completed accurately by end of Q2 | 50% - 75% | Cancer Performance Improvement Group is well established and meets fortnightly<br><br>The Cancer Action Plan is regularly updated and many actions have been successfully completed. However the impact of some of these has not yet been fully felt. Several of the most challenging areas such as late referrals require longer term strategies to address but work is progressing well<br><br>Performance for 62 day GP cancer currently not on target against recovery trajectory and achievement in quarter 3 is very unlikely. However improving performance is seen and attainment in quarter 4 remains possible.<br><br>The breast screening transfer was successfully completed in July with no problems identified with transferred records to date. | Cancellations of surgery, particularly due to acuity of patients on HDU/ITU causing a lack of critical care beds<br><br>Delayed impact of some key actions e.g. first appointment waits<br><br>Rising numbers of late referrals - work underway to influence this but still largely out of the Trust's control<br><br>National awareness campaign for oesophago-gastric cancer forecast to cause 50% increase in upper GI endoscopy demand.<br><br>Rising complexity of treatments, pathways and patients | Moving to new ITU in February is forecast to improve some of the challenges, also it is felt November was an exceptional month for acuity on critical care and not representative of the likely situation in future months<br><br>Impact of first appointment wait reduction should start to be seen in pathways ending from around December<br><br>A number of initiatives are underway to improve timeliness of referrals, such as agreeing improved pathways, improving communication, and seeking commissioner support<br><br>GP education event planned to manage demand in campaign, plus plans for increased capacity<br><br>Continual review of pathways and processes to identify new challenges due to complexity etc. and find ways to address them. | Cancer Board<br><br>Cancer Performance Improvement Group<br><br>Cancer PTL Meeting<br><br>Service Delivery Group<br><br>Progress on actions and risks regularly discussed with commissioners | | 1412 | COO | Senior Leadership Team | 22/12/2014, next review 05/01/2015 |

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 20. Corporate Risk Register

### Purpose

The Corporate Risk Register contains risks identified as having a potential impact on corporate objectives, including risks identified in and escalated from divisions.

Escalated risks from divisions may be reassessed against corporate objectives.

Risks are formally approved for inclusion on and removal from the Corporate Risk Register by the Senior Leadership Team.

This is a summary update of activity since the last report.

### Abstract


New Corporate Risks:

- None

Risks De-escalated to Divisions

- 2240 - Children's Emergency Department Crowding (Women's & Children's)
- 2664 - Risk of reputational damage to paediatric cardiac services arising from the independent review of the service

Risks Closed

- None

Amendments to Corporate Risks

- 1704 - Potential increased harm to patients queuing outside the main ED department in the corridor.
  - Target score reduced from 9 (3x3) to 6 (3x2)
- 2344 - Risk To Achievement of One or More Strategic Objectives
  - Current score increased from 12 (3x4) to 15 (3x5) to reflect certain failure to achieve at least one strategic objectives in the year
- 2126 - Reputational Damage Arising From Adverse Media Coverage of Trust Activities
  - Current score reduced from 15 (3x5) to 9 (3x3) reflecting reduced likelihood of reputational damage arising from media activity – from certain to possible.


### Recommendations

The Board is recommended to receive the report for approval

### Report Sponsor

Chief Executive

### Authors

Sarah Wright, Risk Manager

### Appendices

1. Corporate Risk register

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

## 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 RMG |
|---|---|---|---|---|---|
| | 21/01/2015 | 27/01/15 | | 26/01/2015 | 14/01/15 |

# Corporate Risk Register 16/01/2015

| Number | Risk Title | Executive Lead | Risk Rating |
|---|---|---|---|
| 741 | Cash Releasing Efficiency Savings (CRES) Schemes | Chief Operating Officer - James Rimmer | Very High (Red) |
| 1704 | Potential increased harm to patients queuing outside the main ED department in the corridor | Chief Operating Officer - James Rimmer | Very High (Red) |
| 2126 | Reputational Damage Arising From Adverse Media Coverage of Trust Activities | Director Of Strategic Development - Deborah Lee | High (Amber) |
| 2344 | Risk To Achievement of One or More Strategic Objectives | Director Of Strategic Development - Deborah Lee | Very High (Red) |
| 2479 | Performance Risk to Monitor Green Rating | Chief Operating Officer - James Rimmer | Very High (Red) |

# Corporate Risk Register Report

**Risk Number:** 741 **Status:** Action Required **Date:** 01/09/2006 **Risk Title:** Cash Releasing Efficiency Savings (CRES) Schemes

| Domain | Monitoring Group | Risk Assessor | Risk Owner | Executive Lead | Assessment Date | Next Review Due: | Current Risk Rating | Target Risk Rating |
|---|---|---|---|---|---|---|---|---|
| Financial | Programme Steering Group | Dean Bodill | James Rimmer | Chief Operating Officer - James Rimmer | 25/06/2012 | 28/01/2015 | 16 Very High (Red) | 12 High (Amber) |

***BAF Reference and details of strategic objective:***

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

| Risk Description | Details of Control or Assurance | Effectiveness |
|---|---|---|
| Risk of Plans under achieving and impacting on trust annual and planned outturn. Savings are not identified, are duplicated or double counted, slippage in delivery, activity growth consumes benefit, in year costs pressure or competing priorities eliminate gains. | Monthly Divisional CRES reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CRES Programme Steering Group, monthly updated at a glance reports | High |
| | Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed | High |
| This risk is also reflected in divisional risks 1912, 1420 and 1021 . | Divisional control of vacancies and procurement monitored at monthly performance meetings. Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery. | Medium |
| | Regular Reporting to the Finance Committee and Trust Board | High |
| | Risk is partially mitigated by slippage on reserves. | High |

**Action Plan for Risk:** 741 **Action Number:** 9 **Responsibility Of:** Dean Bodill **Target date:** 31/03/2015

Trust is working to develop savings plans to meet 2015/16 target.

**Action Plan for Risk:** 741 **Action Number:** 10 **Responsibility Of:** Dean Bodill **Target date:** 31/03/2015

Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.

# Corporate Risk Register Report

**Risk Number:** 1704 **Status:** Action Required **Date:** 05/11/2010 **Risk Title:** Potential increased harm to patients queuing outside the main ED department in the corridor

| Domain | Monitoring Group | Risk Assessor | Risk Owner | Executive Lead | Assessment Date | Next Review Due: | Current Risk Rating | Target Risk Rating |
|---|---|---|---|---|---|---|---|---|
| Patient Safety | Senior Leadership Team | Janice Sutton | Peter Collins | Chief Operating Officer - James Rimmer | 22/07/2014 | 29/01/2015 | 16 Very High (Red) | 6 Moderate (Yellow) |

**BAF Reference and details of strategic objective:**

1. We will consistently deliver high quality individual care, delivered with compassion.

**Risk Description**

At regular intervals patients on ambulance trolleys are queuing in the corridor outside of the E.D due to department at full capacity. Condition of these patients is not known and there is a risk of patient deterioration and/or collapse. However the controls in place ensure all patients are reviewed and observed on arrival to the department.

Patients could potentially wait up to two hours without assessment, treatment or care if the current mitigating controls were to fail. The frequency of ambulance conveyances is variable and not always within the receiving Trusts control. There is a lack of availability of oxygen, suction, privacy and dignity. However the controls in place mitigate the risk as either the patient will be transferred into the department or oxygen/suction will be supplied.

Patient experience could be compromised from being nursed in a public area, and the possibility of having to discuss confidential information in a public thoroughfare.

Patient may not have basic needs met and may be at an increased risk of developing pressure damage if the current controls fail.

Patients queuing in the corridor outside ED are likely to be delayed in transferring to the department and will therefore experience delays in starting treatment and will likely breach the 4 hour target.

Other recognised risk is the delay in releasing ambulance crews therefore risk to general public not having timely access to 999 ambulance support.

| Details of Control or Assurance | Effectiveness |
|---|---|
| SHINE Project will contribute toward reducing crowding in the ED | No Effect |
| CSMT to attend the ED as soon as a queue starts to form to progress flow throughout the hospital and reduce queuing | High |
| Essential nursing care and treatment, including the supply of oxygen and suction delivered by the queue nurse. | High |
| Ring fence cubicle in ED to use as rolling cubicle for toileting, undressing and immediate medical review. | Medium |
| Well tested escalation process and early liaison with SWAST bronze control. | Low |
| Patients in the queue are booked onto the ED system and will be visable on the ED tracker. | Low |
| RATTing protocol in place which ensures all queuing patients will be seen and assessed by a Senior Doctor and prioritised by clinical need. | Medium |
| -ED nursing planned over recruitment to ensure nurse available immediatly to attend the queue patients.<br>-Night duty pool nurse prioritised for the queue.<br>-Nurses allocated from each Division and names recorded in site office. | High |
| Standard Operating Procedure-managing the ambulance queue developed and ratified | High |
| The extended MAU in the new build opened on 04/11/2014, with 7 extra spaces. The function of the MAU is to receive all appropriate expected patients to prevent these patients defaulting to ED and increasing the overcrowding. | Medium |

**Action Plan for Risk:** 1704 **Action Number:** 25 **Responsibility Of:** Janice Sutton **Target date:** 28/02/2015

Additional 5.2 WTE band 5 nurses business case developed and awaiting approval.

**Action Plan for Risk:** 1704 **Action Number:** 17 **Responsibility Of:** Rowena Green **Target date:** 28/02/2015

Senior review - Gap analysis undertaken per all spec. identified areas to address are;
ENT, T&O, Vascular. Vascular has senior review with registrar. Transfer out will address issue with consultant cover. T&O options to increase consultant led presence being addressed through job planning
Escalation of Failure in other areas to be undertaken through agreed routes.

| | | | |
|---|---|---|---|
| ***Action Plan for Risk:*** 1704 | ***Action Number:*** 27 | ***Responsibility Of:*** Julia Wynn | ***Target date:*** 31/03/2015 |

The Integrated Discharge project aims to reduce the number of patients in acute hospital beds by early placement into appropriate community care

| | | | |
|---|---|---|---|
| ***Action Plan for Risk:*** 1704 | ***Action Number:*** 29 | ***Responsibility Of:*** Rowena Green | ***Target date:*** 31/03/2015 |

Deliver the whole system ED recovery plan.

| | | | |
|---|---|---|---|
| ***Action Plan for Risk:*** 1704 | ***Action Number:*** 23 | ***Responsibility Of:*** Richard Jeavons | ***Target date:*** 10/06/2015 |

Additional ED Consultants business case to provide extended cover in ED awaiting approval.

# *Corporate Risk Register Report*

***Risk Number:*** 2126 ***Status:*** Accepted ***Date:*** 03/06/2013 ***Risk Title:*** Reputational Damage Arising From Adverse Media Coverage of Trust Activities

| *Domain* | *Monitoring Group* | *Risk Assessor* | *Risk Owner* | *Executive Lead* | *Assessment Date* | *Next Review Due:* | *Current Risk Rating* | *Target Risk Rating* |
|---|---|---|---|---|---|---|---|---|
| Reputational | Senior Leadership Team | Fiona Reid | Deborah Lee | Director Of Strategic Development - Deborah Lee | 22/04/2014 | 14/04/2015 | 9 High (Amber) | 2 Low (Green) |

***BAF Reference and details of strategic objective:***

1. We will consistently deliver high quality individual care, delivered with compassion.

| *Risk Description* | *Details of Control or Assurance* | *Effectiveness* |
|---|---|---|
| Risk of reputational damage arising from adverse media coverage of Trust actiivties | Pro-active monitoring of forthcoming inquests, robust inquest preparation including pro-active & reactive communication and media management as considered appropriate. | Medium |

***Action Plan for Risk:*** 2126 ***Action Number:*** 1 ***Responsibility Of:*** Deborah Lee ***Target date:*** 30/04/2015

Identify Trust actiivties at risk of attracting adverse media and ensure proactive management and mitigation of these risks and associated supporting communications

# *Corporate Risk Register Report*

***Risk Number:*** 2344 ***Status:*** Accepted ***Date:*** 08/01/2014 ***Risk Title:*** Risk To Achievement of One or More Strategic Objectives

| *Domain* | *Monitoring Group* | *Risk Assessor* | *Risk Owner* | *Executive Lead* | *Assessment Date* | *Next Review Due:* | *Current Risk Rating* | *Target Risk Rating* |
|---|---|---|---|---|---|---|---|---|
| Business | Senior Leadership Team | Deborah Lee | Deborah Lee | Director Of Strategic Development - Deborah Lee | 08/01/2014 | 31/05/2015 | 15 Very High (Red) | 2 Low (Green) |

***BAF Reference and details of strategic objective:***

Achieve Full Compliance with Health & Safety Requirements / Achievement of CRES

| *Risk Description* | *Details of Control or Assurance* | *Effectiveness* |
|---|---|---|
| Risk of failure to achieve one or more strategic objectives within the Board Assurance Framework.<br>1. We will consistently deliver high quality individual care, delivered with compassion.<br>2. 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<br>7. We will ensure we are soundly governed and are compliant with the requirements of our regulators | Executive Director ownership and accountability for each stratgeic objective with responsibility for ensuring delivery and devloping remedial action plans where necessary | Medium |
| | Seek and describe external assurance to support assessment of progress towards objective | Medium |

***Action Plan for Risk:*** 2344 ***Action Number:*** 1 ***Responsibility Of:*** Deborah Lee ***Target date:*** 30/04/2015

Recovery plans for each high risk objectve to be developed alongside risk assessment of impact of non-achievement with approriate risk management and mitigation plans developed.

***Action Plan for Risk:*** 2344 ***Action Number:*** 2 ***Responsibility Of:*** Deborah Lee ***Target date:*** 30/04/2015

Evidence of external assurance tp be sought and described

# *Corporate Risk Register Report*

***Risk Number:*** 2479 ***Status:*** Action Required ***Date:*** 05/03/2014 ***Risk Title:*** Performance Risk to Monitor Green Rating

| *Domain* | *Monitoring Group* | *Risk Assessor* | *Risk Owner* | *Executive Lead* | *Assessment Date* | *Next Review Due:* | *Current Risk Rating* | *Target Risk Rating* |
|---|---|---|---|---|---|---|---|---|
| Statutory | Senior Leadership Team | Anne Gorman | James Rimmer | Chief Operating Officer - James Rimmer | 05/03/2014 | 28/01/2015 | 16 Very High (Red) | 4 Moderate (Yellow) |

***BAF Reference and details of strategic objective:***

7. We will ensure we are soundly governed and are compliant with the requirements of our regulators

| *Risk Description* | *Details of Control or Assurance* | *Effectiveness* |
|---|---|---|
| Prolonged failure of one of the following performance indicators, or concurrent failure of 4 or more indicators leading to loss of green status in Monitor risk rating: | RTT Steering Group (monthly and weekly) | Medium |
| | Cancer Steering Group | Medium |
| Referral to Treatment Time Standards<br>Cancer Standards<br>ED Standards<br>Healthcare Acquired Infections | Project plans for new Operating Model 2014/15 being overseen via the Senior Leadership Team (SLT) | Medium |
| | Weekly reporing of against performance indicators and escalation to Steering Groups, Service Delivery Group and Senior Leadership Team as appropriate. | High |

***Action Plan for Risk:*** 2479 ***Action Number:*** 2 ***Responsibility Of:*** Anne Gorman ***Target date:*** 30/03/2015

Monitoring of trajectories (activity and waiting list) to ensure first outpatient waiting times are reduced in line with target for end of quarter 2

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 21. Revised Trust Constitution

### Purpose

To receive and approve revisions to University Hospitals Bristol NHS Foundation Trust's Constitution, Standing Orders, Code of Conduct for Governors and Role Description for Governors.

### Abstract

The Foundation Trust Constitution has been under review during 2014 and input has been received from both the Council of Governors and the Trust Board of Directors.

The suggested amendments have been reviewed and have now been incorporated into a revised version of the Foundation Trust Constitution. This revised version includes amendments made to ensure consistency and alignment with Monitor's Model Core Constitution for NHS Foundation Trusts. They also include New Model Election Rules which allow Foundation Trusts to offer electronic voting in governor elections for the first time.

At a meeting of the Governors' Constitution Project Focus Group on 4 December 2014, governors considered and recommended the revised constitution for approval by the Council of Governors of Board of Directors.

### Recommendations

The Board of Directors is asked to **approve** the amended Constitution and associated documents detailed within the Annexes for implementation as of 30th January 2015.

### Report Sponsor

Chairman

### Authors

Trust Secretary

### Appendices

Revised Constitution (including Standing Orders, Code of Conduct for Governors and Role Description for Governors)

### 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 |
|---|---|---|---|---|---|
| | | | | | Constitutional Project Focus Group 4/12/14 and Council of Governors 29/1/15 (pending) |

# University Hospitals Bristol NHS Foundation Trust

# Draft Constitution

**[as at 29 January 2015]**

**University Hospitals Bristol NHS Foundation Trust Constitution**

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1. **Interpretation and definitions**

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the 2006 Act.

1.2 Words importing the masculine gender only shall include the feminine gender, words importing the singular shall import the plural and vice-versa.

1.3 References to statutory provisions shall be construed as references to those provisions as subsequently amended or re-enacted (whether before or after the date of this Agreement) from time to time and shall include any provisions of which they are re-enactments (whether with or without modification).

1.4 The following expressions have the following meanings, unless the context requires otherwise—

| | |
|---|---|
| **"the 2006 Act"** | is the National Health Service Act 2006 (as amended by the 2012 Act). |
| **"the 2012 Act"** | is the Health and Social Care Act 2012. |
| **"Accounting Officer"** | is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. |
| **"Annual Members Meeting"** | means an annual meeting of the Members. |
| **"constitution"** | means this constitution and all annexes to it. |
| **"Director"** | means a member of the Board of Directors of the Trust. |
| **"Governor"** | means a member of the Council of Governors of the Trust. |
| **"health service body"** | means an NHS foundation trust or any of the bodies listed in Section 9(4) of the 2006 Act. |
| **"Member"** | means a member of the Trust. |
| **"Monitor"** | is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act. |
| **"voluntary organisation"** | means a body, other than a public or local authority, the activities of which are not carried on for profit. |

2. **Name**

2.1 The name of the foundation trust is University Hospitals Bristol NHS Foundation Trust (the Trust).

3. **Principal purpose**

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health

service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to—

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph, for the purpose of making additional income available in order better to carry on its principal purpose.

4. **Powers**

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

5. **Membership and constituencies**

5.1 The Trust shall have Members, each of whom shall be a Member of one of the following constituencies—

5.1.1 a Public Constituency,

5.1.2 the Staff Constituency, or

5.1.3 the Patients and Carers Constituency

6. **Application for Membership**

6.1 An individual who is eligible to become a Member may do so on application to the Trust or by being invited by the Trust to become a Member of the Staff Constituency in accordance with paragraph 9.

6.2 An individual shall become a Member on the date his name is added to the Trust's register of Members, and shall cease to be a Member on the date is removed from the register of Members.

7. **Public Constituency**

7.1 An individual who lives in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a Member.

7.2 Those individuals who live in an area specified for a Public Constituency are referred to collectively as a Public Constituency.

7.3 An individual who ceases to live in any area specified in Annex 1 shall cease to be a Member of any Public Constituency. A Member who moves from one area to another shall become a Member of the Public Constituency for that new area. Members should notify the Trust of any change of address.

7.4 In the case of any doubt, the Trust's decision as to whether or not an individual lives in an area will be final.

7.5 The minimum number of Members for each Public Constituency is specified in Annex 1.

8. **Staff Constituency**

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member provided—

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months, or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the Staff Constituency if they have exercised these functions continuously for a period of at least 12 months. This category includes (but is not limited to) —

8.2.1 contractors who provide services to the Trust for at least 16 hours per week or 50% of their contracted hours (whichever is the lesser),

8.2.2 registered volunteers at the Trust or individuals who work at the Trust on behalf of a voluntary organisation, and

8.2.3 academic staff who have an honorary contract with the Trust and who work at the Trust

8.3 Those individuals who are eligible for membership by reason of this paragraph 8 are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a Staff Class within the Staff Constituency.

8.5 The minimum number of Members in each Staff Class is specified in Annex 2.

9. **Automatic membership by default – staff**

9.1 An individual who is—

9.1.1 Eligible under paragraph 8.1 to become a Member of the Staff Constituency, and

9.1.2 invited by the Trust to become a Member of the Staff Constituency and a Member of the appropriate Staff Class,

shall become a Member as a Member of the Staff Constituency and appropriate Staff Class without an application being made, unless he informs the Trust that he does not wish to do so.

10. **Patients and Carers Constituency**

10.1 An individual who has, within the preceding three years, attended any of the Trust's hospitals as either a patient or as the carer of a patient may become or continue as a Member.

10.2 Those individuals who are eligible for membership by reason of paragraph 10.1 are referred to collectively as the Patients and Carers Constituency.

10.3 An individual who has not attended any of the Trust's hospitals in the preceding three years as a patient or carer may not continue as a Member of the Patients and Carers Constituency.

10.4 The Patients and Carers Constituency shall be divided into three descriptions of individuals who are eligible for membership of the Patients and Carers Constituency. Each description of individuals is specified within Annex 3 and is referred to as a class of the Patients and Carers Constituency.

10.5 An individual providing care under a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, does not come within the category of those who qualify for membership of the Patients and Carers Constituency.

10.6 The minimum number of Members in each class of the Patients and Carers Constituency is specified in Annex 3.

10.7 An applicant for membership who notifies the Trust of his eligibility to be a Member of either a Public Constituency or of the Patients and Carers Constituency, shall become a Member of the appropriate class of the Patients and Carers Constituency unless he has informed the Trust in writing that he wishes instead to become a Member of a Public Constituency.

11. **Restriction on membership**

11.1 A Member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a Member of any other constituency or class.

11.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a Member of any constituency other than the Staff Constituency.

11.3 An individual shall not be eligible for membership if he—

11.3.1 fails or ceases to fulfil the criteria for membership of any of the constituencies,

11.3.2 was formerly employed by the Trust or its predecessor applicant NHS Trust and was dismissed for gross misconduct,

11.3.3 was formerly employed by the Trust and in the preceding two years was lawfully dismissed other than by reason of redundancy,

11.3.4 has been involved as a perpetrator in a serious incident of violence or abuse in the last five years at any of the Trust's hospitals or against any of the Trust's staff members or patients,

11.3.5 has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children & Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974,

11.3.6 does not agree to, or by his actions or conduct shows that he does not (in the reasonable opinion of the Trust), abide by the Trust values as set out in the Trust's Integrated Business Plan or elsewhere,

11.3.7 has been identified as a vexatious complainant by the Trust or other authority or has been excluded from treatment at any of the Trust's hospitals due to unacceptable behaviour,

11.3.8 is deemed, in the reasonable opinion of the Trust, to have acted in a manner contrary to the interests of the Trust,

11.3.9 is deemed, in the reasonable opinion of the Trust, to have failed to comply in a material way with the values and principles of the National

Health Service or the Trust, and/or this constitution, or

11.3.10 is under the age of seven (7) years.

11.4 Members should ensure their own eligibility for membership and inform the Trust if they cease to be eligible.

11.5 A Member shall cease to be a Member if—

11.5.1 he resigns by notice in writing to the Membership Manager,

11.5.2 he dies,

11.5.3 he ceases to be entitled under this constitution to be a Member,

11.5.4 he is expelled under this constitution, or

11.5.5 it appears to the Membership Manager that the Member no longer wishes to be involved in the affairs of the Trust as a Member, and after enquiries made in accordance with a process approved by the Governors, the Member does not establish that he has a continuing wish to be involved in the affairs of the Trust as a Member.

11.6 The Trust shall give any Member at least 14 days' written notice before removing him from Membership under paragraphs 11.5.3, 11.5.4, or 11.5.5. The Trust shall consider any representations made by the Member during that notice period.

## 12. Annual Members' Meeting

12.1 The Trust shall hold an Annual Members' Meeting no later than 30 September every year. The Annual Members' Meeting shall be open to the public.

12.2 Any Members' meetings other than the Annual Members' Meeting shall be called "Special Members' Meetings".

12.3 Special Members' Meetings shall be open to all Members, Governors and Directors, and to representatives of the Trust's financial auditors. Special Members' Meetings shall not be open to anyone else unless invited by the Trust.

12.4 All Members' meetings are to be convened by the Directors.

12.5 The Directors shall decide where any Members' meeting is to be held and may provide that the same meeting can be conducted in multiple venues.

12.6 The Directors shall set the quorum for any Members' meeting.

12.7 The Trust shall give at least 14 clear days' notice of any Members' meeting—

12.7.1 by notice in writing to all Members (by email where email addresses are held),

12.7.2 by notice prominently displayed at the Trust's main address and at all of the Trust's principal places of business,

12.7.3 by notice on the Trust's website, and

12.7.4 to the Governors and the Directors, and to the Trust's auditors,

stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting, giving the time, date and place of the meeting and indicating the business to be dealt with at the meeting.

12.8 The Directors shall present to the Members at the Annual Members' Meeting—

12.8.1 a report on steps taken to secure that (taken as a whole) the actual membership is representative of those eligible for such membership,

12.8.2 the progress of the membership strategy,

12.8.3 any proposed changes to the policy for the composition of the Governors and of the Non-Executive Directors,

12.8.4 the results of the election and appointment of Governors, and

12.8.5 any other reports or documentation it considers necessary or otherwise required by Monitor or the 2006 Act, including the annual accounts, any report of the auditor and the annual report.

12.9 The Chair or in his absence the Deputy Chair shall chair any Members' meetings. If neither the Chair nor the Deputy Chair is present, the Governors present shall elect one of their number to chair the meeting. If there is only one Governor present and willing to act that person shall chair the meeting. If no Governor is present and willing to chair the meeting within fifteen minutes after the notified start time of the meeting, the Members present and entitled to vote shall choose one of their number to chair the meeting.

## 13. Council of Governors – composition

13.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

13.2 The composition of the Council of Governors is specified in Annex 4.

13.3 The Governors, other than the appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency.

13.4 The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13.5 At all times more than half of the Governors shall be Governors who are elected by Members of the Public Constituency and the Patients and Carers Constituency.

## 14. Council of Governors – election of Governors

14.1 Elections for elected Governors shall be conducted in accordance with the Model Election Rules.

14.2 The Model Election Rules as published from time to time by the Department of Health form part of this constitution. The Model Election Rules current at the date of the Trust's Authorisation are attached at Annex 5.

14.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 45 of the constitution (amendment of the constitution).

14.4 An election, if contested, shall be by secret ballot.

14.5 A Member of a Public Constituency or the Patients and Carers Constituency standing for election as Governor must, at the time of his nomination, make a declaration for the purposes of Section 60 of the 2006 Act in the form specified by the Trust, stating the particulars of his qualification to vote as a Member and that he is not prevented from being a Governor by virtue of any provisions of this constitution.

15. **Council of Governors - tenure**

15.1 An elected Governor may hold office for a period of up to three years.

15.2 An elected Governor shall cease to hold office if he ceases to be a Member of the constituency or class by which he was elected (except that a Public Governor who moves from one Public Constituency to another during his term of office shall continue in office as a Public Governor for the constituency which elected him for the remainder of his term).

15.3 Subject to paragraph 15.7, an elected Governor shall be eligible for re-election at the end of his term.

15.4 An appointed Governor may hold office for a period of up to three years (except for Governors appointed by the Trust's Youth Council who may hold office for a period of up to one year).

15.5 An appointed Governor shall cease to hold office if the appointing organisation withdraws his appointment.

15.6 Subject to paragraph 15.7, an appointed Governor shall be eligible for re-appointment at the end of his term.

15.7 No Governor may serve for more than a total of nine years.

16. **Council of Governors – disqualification and removal**

16.1 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

16.2 A person may not become or continue as a Governor if he—

16.2.1 has been adjudged bankrupt or his estate has been sequestrated and (in either case) has not been discharged,

16.2.2 has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,

16.2.3 within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him,

16.2.4 has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a Health Service Body,

16.2.5 was formerly employed by the Trust or its predecessor application NHS trust and was dismissed for gross misconduct,

16.2.6 is a person whose term of office as the chair or as a member or director of a Health Service Body has been terminated on the grounds that his continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest,

16.2.7 has had his name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had his name included in such a list,

16.2.8 has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act or has spoken or voted in a meeting on a matter in which he had a direct or indirect pecuniary or

non-pecuniary interest and he is judged to have acted so by a majority of of the Council of Governors,

16.2.9 has been removed as a Governor, suspended from office or disqualified from holding office as a Governor by Monitor, or Monitor has exercised any of those powers in relation to him on any other occasion whether in relation to the Trust or some other NHS Foundation Trust,

16.2.10 has received a written warning from the Trust for verbal and/or physical abuse towards Trust staff or patients,

16.2.11 has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended) and his conviction is not spent under the Rehabilitation of Offenders Act 1974,

16.2.12 is a Member of a Staff Class and any professional registration relevant to his eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six months,

16.2.13 is incapable by reason of mental disorder, illness or injury in managing and administering his property and/or affairs,

16.2.14 is appointed by an organisation that ceases to exist,

16.2.15 is a member of the UK Parliament,

16.2.16 is a director or a governor of another NHS Foundation Trust,

16.2.17 is a member of a health related local authority overview and scrutiny committee, or

16.2.18 information revealed by a DBS check is such that it would be inappropriate for him to become or continue as a Governor on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.

16.3 A Governor who becomes disqualified must notify the Trust as soon as practicable and in any event within 14 days of first becoming aware that he is disqualified.

16.4 If the Trust becomes aware that a Governor is disqualified, the Trust will give him notice that he is disqualified as soon as practicable.

## 17. Council of Governors: Termination of Tenure

17.1 A Governor's term of office shall be terminated—

17.1.1 by the Governor giving notice in writing to the Trust of his resignation from office at any time during that term of office,

17.1.2 by the giving of a notice under either paragraph 16.3 or 16.4,

17.1.3 by the Council of Governors if he has failed to attend two successive meetings of the Council of Governors unless the Council of Governors is satisfied:

17.1.3.1 the absence was due to reasonable cause, and

17.1.3.2 that the Governor will resume attendance at meetings of the Council of Governors within such period as it considers reasonable.

17.1.4 if the Council of Governors resolves that—

17.1.4.1 his continuing as a Governor would or would be likely to prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this constitution or otherwise to discharge its duties and functions,

17.1.4.2 his continuing as a Governor would or would be likely to prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services,

17.1.4.3 his continuing as a Governor would or would be likely to adversely affect public confidence in the goods and services provided by the Trust,

17.1.4.4 his continuing as a Governor would or would be likely to otherwise bring the Trust into disrepute or be detrimental to the interest of the Trust,

17.1.4.5 it would not be in the best interests of the Council of Governors for him to continue in office as a Governor,

17.1.4.6 it would not be in the best interests of the Trust for him to continue in office as a Governor,

17.1.4.7 he is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and his continuance in office would not be in the best interests of the Trust,

17.1.4.8 he has failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required him to undertake in his capacity as a Governor,

17.1.4.9 he has in his conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust, and/ or this constitution, or

17.1.4.10 he has committed a material breach of any code of conduct applicable to Governors and/or the Standing Orders for Governors.

17.2 A resolution under paragraph 17.1.4 shall be proposed by the Chair (or in his absence, the Deputy Chair) and considered in a meeting of the Council of Governors convened for that purpose and to pass requires a majority of three quarters of the Governors voting at that meeting.

17.3 If the Chair is minded to propose a resolution under paragraph 17.1.4, the Chair shall first offer the Governor in question the opportunity to have the evidence reviewed by an independent assessor agreeable to that Governor and to the Chair.

17.4 The Standing Orders adopted by the Council of Governors may contain provisions governing its procedure for terminating a Governor's term of office.

17.5 A Governor whose term of office is terminated before it expires shall not be eligible to be a Governor for three years from the date of termination, except by resolution carried by a majority of the Council of Governors voting.

## 18. Council of Governors: vacancies

18.1 If an appointed Governor's term of office is terminated before it expires, the Trust will invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office.

18.2 If an elected Governor's term of office is terminated [more than 90 days before it] before it expires, the Trust will invite the candidate who secured the second highest number of votes in the last election for that office to assume the position for the remainder of the retiring Governor's term, provided that he achieved at least five percent (5%) of the number of votes for that constituency (or class of constituency, as the case may be). If that candidate does not accept, the vacancy will be offered to the candidate who secured the next highest number of votes (provided that he achieved at least five percent (5%) of the number of votes), and so on.

18.3 If no reserve candidate is available or willing to fill the vacancy, and an election is not due to be held within 6 months of the vacancy arising, an election will be held in accordance with the Election Scheme as soon as is reasonably practicable. If an election is due to be held within 6 months, the office will stand vacant until the next scheduled election, unless the vacancy causes the aggregate number of Public Governors and Patient and Carer Governors to be less than half the total membership of the Council of Governors. In that case an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

18.4 No defect in the election or appointment of a Governor or deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

## 19. Council of Governors – duties of Governors

19.1 The general duties of the Council of Governors are—

19.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

19.1.2 to represent the interests of the Members as a whole and the interests of the public.

19.2 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

## 20. Council of Governors – meetings of Governors

20.1 The Chair or, in his absence the Deputy Chair, shall preside at meetings of the Council of Governors.

20.2 Meetings of the Council of Governors shall be open to members of the public, unless members of the public are excluded for special reasons.

20.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting of the Council of Governors.

## 21. Council of Governors – standing orders

21.1 The standing orders for the practice and procedure of the Council of Governors are attached at Annex 6.

## 22. Council of Governors – referral to the Panel

22.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

22.1.1 to act in accordance with its Constitution, or

22.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

22.2 A Governor may refer a question to the Panel only if more than half of the Governors voting approve the referral.

23. **Council of Governors – conflicts of interest of Governors**

23.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the Governors as soon as he becomes aware of it.

23.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

24. **Council of Governors – travel expenses**

24.1 The Trust may pay travelling and other expenses to Governors at rates determined by the Trust.

25. **Board of Directors – composition**

25.1 The Trust has a Board of Directors, which comprises both Executive and Non-Executive Directors.

25.2 The Board of Directors comprises—

25.2.1 a Non-Executive Chairman,

25.2.2 up to 8 other Non-Executive Directors (one of whom may be nominated as the Senior Independent Director), and

25.2.3 up to 7 Executive Directors.

25.3 One of the Executive Directors is the Chief Executive.

25.4 The Chief Executive is the Accounting Officer

25.5 One of the Executive Directors is the Finance Director

25.6 One of the Executive Directors is a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)

25.7 One of the Executive Directors is a registered nurse or a registered midwife

25.8 The Board of Directors shall at all times be constituted so that the number of Non-Executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.

26. **Board of Directors – general duty**

26.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members as a whole and for the public.

27. **Board of Directors – qualification for appointment as a Non-Executive Director**

27.1 A person may be appointed as a Non-Executive Director only if—

27.1.1 he is a Member of a Public Constituency, or

27.1.2 he is a Member of the Patients and Carers Constituency, or

27.1.3 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

27.1.4 he is not disqualified by virtue of paragraph 31 below.

28. **Board of Directors – appointment and removal of the Chair and other Non-Executive Directors**

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors.

28.2 Removal of the Chair or another Non-Executive Director shall require the approval of at least three-quarters of the Council of Governors.

29. **Board of Directors – appointment of the Deputy Chair**

29.1 The Council of Governors at a general meeting shall appoint one of the Non-Executive Directors to be the Deputy Chair.

30. **Board of Directors - appointment and removal of the Chief Executive and other Executive Directors**

30.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

30.2 The appointment of the Chief Executive shall require the approval of the majority of the Council of Governors.

30.3 A committee consisting of the Chief Executive, the Chair and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

31. **Board of Directors – disqualification**

31.1 A person may not become or continue as a Director if he—

31.1.1 has been adjudged bankrupt or his estate has been sequestrated and (in either case) has not been discharged,

31.1.2 has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,

31.1.3 within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him,

31.1.4 in the case of a Non-Executive Director, no longer satisfies the relevant requirements for appointment,

31.1.5 is a person whose tenure of office as a Chair or as a member or Director of a Health Service Body has been terminated on the grounds that his appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest,

31.1.6 has within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a Health Service Body,

31.1.7 information revealed by a DBS check is such that it would be

inappropriate for him to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute,

31.1.8 in the case of an Executive Director, is no longer employed by the Trust,

31.1.9 has had his name removed by a Direction under section 154 of the 2006 Act from any list prepared under Part 4 of that Act, and has not subsequently had his name included on such a list,

31.1.10 is an Executive or Non-Executive Director of another NHS Foundation Trust, or Non-Executive Director, Chair, Chief Executive officer or equivalent of another Health Service Body or a body corporate whose business includes the provision of healthcare,

31.1.11 is a member of a patient and public involvement forum,

31.1.12 is a member of a local authority's overview and scrutiny committee,

31.1.13 is the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986,

31.1.14 has failed or refused to undertake any training which the Board of Directors requires all Directors to undertake,

31.1.15 has failed to sign and deliver to the Secretary in the form required by the Board of Directors confirmation that he accepts the Code of Conduct of NHS Managers,

31.1.16 is a partner or spouse of an existing Director,

31.1.17 is an 'unfit person' as defined in the Trust's provider licence (as may be amended from time to time), or

31.1.18 does not meet any other statutory requirement for being a Director of an NHS foundation trust.

## 32. Board of Directors – meetings

32.1 Meetings of the Board of Directors shall be open to members of the public, unless members of the public are excluded for special reasons.

32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

## 33. Board of Directors – standing orders

33.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 7.

## 34. Board of Directors - conflicts of interest of Directors

34.1 The duties that a Director has by virtue of being a Director include in particular—

34.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

34.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

34.2 The duty referred to in sub-paragraph 34.1.1 is not infringed if—

34.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

34.2.2 the matter has been authorised in accordance with the constitution.

34.3 The duty referred to in sub-paragraph 34.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

34.4 In sub-paragraph 34.1.2, "third party" means a person other than—

34.4.1 the Trust, or

34.4.2 a person acting on its behalf.

34.5 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

34.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

34.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

34.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

34.9 A Director need not declare an interest—

34.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest,

34.9.2 if, or to the extent that, the Directors are already aware of it, or

34.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered—

34.9.3.1 by a meeting of the Board of Directors, or

34.9.3.2 by a committee of the Directors appointed for the purpose under the constitution.

34.10 The Standing Orders of the Board of Directors shall include provisions about the disclosure of interests and arrangements for a Director with an interest to withdraw from a meeting in relation to the matter in respect of which he has declared an interest.

35. **Board of Directors – remuneration and terms of office**

35.1 The Council of Governors at a general meeting shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

35.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

36. **Registers**

36.1 The Trust shall have—

36.1.1 a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs,

36.1.2 a register of Governors,

36.1.3 a register of interests of Governors,

36.1.4 a register of Directors, and

36.1.5 a register of interests of Directors.

37. **Registers – inspection and copies**

37.1 The Trust shall make the registers specified in paragraph 366 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

37.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of—

37.2.1 any Member of the Public, Patients and Carers Constituency, or

37.2.2 any other Member, if he so requests.

37.3 So far as the registers are required to be made available—

37.3.1 they are to be available for inspection free of charge at all reasonable times, and

37.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

37.4 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

38. **Documents available for public inspection**

38.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times—

38.1.1 a copy of the current Constitution,

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times—

38.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act,

38.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act,

38.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act,

38.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act,

38.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act,

38.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act,

38.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act,

38.2.8 a copy of any final report published under section 65I (administrator's final report),

38.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act,

38.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

## 39. Auditor

39.1 The Trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor by a majority vote at a general meeting of the Council of Governors.

## 40. Audit committee

40.1 The Trust shall establish a statutory committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

## 41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the Trust's auditor.

41.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. **Annual report, forward plans and non-NHS work**

42.1 The Trust shall prepare an annual report and send it to Monitor.

42.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

42.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

42.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about—

42.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must—

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the Directors of its determination.

42.7 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, the Trust may implement the proposal only if more than half of the Governors voting approve its implementation.

43. **Presentation of the annual accounts and reports to the Governors and Members**

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors—

43.1.1 the annual accounts,

43.1.2 any report of the auditor on them, and

43.1.3 the annual report.

43.2 The documents shall also be presented to the Members at the Annual Members' Meeting by at least one Director in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. **Instruments**

44.1 The Trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. **Amendment of the Constitution**

45.1 The Trust may make amendments of its Constitution only if—

45.1.1 more than half of the Council of Governors voting approve the amendments, and

45.1.2 more than half of the Directors voting approve the amendments.

45.2 Amendments made under paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust)—

45.3.1 at least one Governor must attend the next Annual Members' Meeting and present the amendment,

45.3.2 the Trust must give the Members an opportunity to vote on whether they approve the amendment, and

45.3.3 if more than half of the Members voting approve the amendment, the amendment continues to have effect, otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

45.4 Amendments by the Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

## 46. Mergers etc. and significant transactions

46.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the Council of Governors.

46.2 The Trust may enter into a significant transaction only if more than half of the Council of Governors voting approve entering into the significant transaction.

46.3 Significant transaction is defined as investments, divestments or other transactions comprising more than 25% of the assets, income or capital of the NHS Foundation Trust, in line with Monitor's Risk Assessment Framework.

## 47. Indemnity

47.1 Governors and Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust and the Trust shall have the power to purchase suitable insurance or make appropriate arrangements with the National Health Service Litigation Authority to cover such costs.

**ANNEX 1**

THE PUBLIC CONSTITUENCIES

| **The Public Constituencies** | **Area of each Public Constituency (as defined by Local Authority boundaries)** | **Minimum Number of Members** |
|---|---|---|
| Bristol | Bristol City Council | 2163 |
| North Somerset | North Somerset District Council | 1022 |
| South Gloucestershire | South Gloucestershire Council | 1331 |
| Rest of England and Wales | Rest of England and Wales | 5 |

The minimum number of members is based on 0.5% of the population in each Public Constituency as reported in the ONS 2012 based sub-national population data:

Rest of England and Wales – fixed value at 5 members

**ANNEX 2**

THE STAFF CONSTITUENCY

| **Classes within the Staff Constituency** | **Individuals Eligible for Membership of that Staff Class** | **Minimum Number of Members in each Staff Class** |
|---|---|---|
| Medical and Dental Staff | Those individuals defined in paragraph 1 below. | 628 |
| Nursing and Midwifery Staff | Those individuals defined in paragraph 2 below. | 2372 |
| [Other Clinical Healthcare Staff] | Those individuals defined in paragraph 3 below. | 1023 |
| [Non-Clinical Healthcare Staff ] | Those individuals defined in paragraph 4 below. | 1882 |

**The minimum number of members is based on 75% of the headcount the workforce in each Staff Constituency as at December 2014.**

1. **Medical and Dental Staff**

1.1 Members of the Staff Constituency who are fully registered persons within the meaning of the Medical Act 1983 or the Dentists Act 1984 and who are otherwise fully authorised and licensed to practise in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist.

2. **Nursing and Midwifery Staff**

2.1 Members of the Staff Constituency who are registered under the Nurses, Midwifes and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practise in England and Wales or are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife and individuals who are health care assistants.

3. **Other Clinical Healthcare Staff**

3.1 Members of the Staff Constituency who do not come within paragraphs 1 or 2 above and are regulated by a regulatory body that falls within the remit of the Professional Standards Authority for Health and Social Care established by the NHS Reform Act 2002 (as amended by the 2012 Act), or who are otherwise designated by the Trust from time to time as eligible Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on such professions.

4. **Non-Clinical Staff**

4.1 Members of the Staff Constituency, who do not come within paragraphs 1, 2 or 3 above and are designated by the Trust from time to time as eligible to be a

Member of this Staff Class.

5. **Honorary contract holders**

5.1 Those individuals who are Members of the Staff Constituency pursuant to paragraph 8.2.3 of this constitution (academic staff under an honorary contract with the Trust) shall be members of a Staff Class detailed in paragraphs 1, 2 and 3 above as appropriate.

6. **Continuous Employment**

6.1 For the purposes of paragraph 8.1.2 and 8.2 of this constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

7. **Exercise of Functions**

7.1 For the purposes of paragraph 8.2 of this constitution it shall be for the Trust in its absolute discretion to determine whether an individual exercises functions for the purposes of the Trust and whether that individual has done so continuously for a period of at least twelve months.

**ANNEX 3**

THE PATIENTS AND CARERS CONSTITUENCY

| **Classes within the Patients and Carers Constituency** | **Individuals eligible for Membership of each Class** | **Minimum Number of Members in each Class** |
|---|---|---|
| Local Patients | Patients residing in any of the Bristol, North Somerset or South Gloucestershire Public Constituencies | 100 |
| Carers of Adult Patients | Carers who provide care to patients who are 16 years of age or over | 50 |
| Carers of Child Patients | Carers who provide care to patients who are under 16 years of age | 50 |

**ANNEX 4**

COMPOSITION OF COUNCIL OF GOVERNORS

| | **Electing/Appointing Body** | **Number of Governors** | **Total** |
|---|---|---|---|
| **1.** | **Public Constituencies** | | |
| | Bristol | 5 | |
| | South Gloucestershire | 2 | |
| | North Somerset | 2 | |
| | Rest of England and Wales | 2 | **11** |
| **2.** | **Staff Constituency** | | |
| | Medical and Dental Staff Class | 1 | |
| | Nursing and Midwifery Staff Class | 2 | |
| | Other Clinical Healthcare Staff Class | 1 | |
| | Non-Clinical Healthcare Staff Class | 2 | **6** |
| **3.** | **Patients and Carers Constituency** | | |
| | Carers of Adult Patients | 2 | |
| | Carers of Child Patients | 2 | |
| | Local Patients | 6 | **10** |
| **4.** | **Appointed Governors** | | |
| | Local Authority | | |
| | Bristol City Council | 1 | |
| | Universities | | |
| | University of Bristol | 1 | |
| | University of West of England | 1 | |
| | Partnership Organisations | | |
| | Avon and Wiltshire Mental Health Partnership NHS Trust | 1 | |
| | South Western Ambulance Service NHS Foundation Trust | 1 | |

| | | | |
|---|---|---|---|
| | Joint Union Committee | 1 | |
| | Community and Voluntary Sector | 1 | |
| | University Hospitals Bristol NHS Foundation Trust Youth Council | 2 | **9** |
| | **Total Number of Governors** | | **36** |

1. **Appointed Governors**

1.1 Each appointing body shall be entitled to appoint a Governor or Governors (as set out in the table above) in accordance with a process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not prevent an appointing body from appointing it Governor(s).

1.2 If Bristol City Council declines or fails to appoint a Governor within three months of being requested to do so by the Trust, the Trust shall consult North Somerset District Council and South Gloucestershire Council and the Trust shall invite one of those local authorities to appoint a Governor in substitution for Bristol City Council.

1.3 At the end of the term of appointment of that Governor the Trust shall in its absolute discretion decide whether to permit Bristol City Council to appoint a Governor for the next period of office (provided it remains eligible to do so) or to invite the local authority which had appointed a Governor in substitution to do so.

# ANNEX 5

## THE MODEL ELECTION RULES 2014

**PART 1: INTERPRETATION**

1. Interpretation

**PART 2: TIMETABLE FOR ELECTION**

2. Timetable
3. Computation of time

**PART 3: RETURNING OFFICER**

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

**PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS**

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

**PART 5: CONTESTED ELECTIONS**

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

*Action to be taken before the poll*

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

*The poll*

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

*Procedure for receipt of envelopes, internet votes, telephone vote and text message votes*

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

**PART 6: COUNTING THE VOTES**

STV41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
STV44. Rejected ballot papers and rejected text voting records
FPP44. Rejected ballot papers and rejected text voting records
STV45. First stage
STV46. The quota
STV47 Transfer of votes
STV48. Supplementary provisions on transfer
STV49. Exclusion of candidates
STV50. Filling of last vacancies
STV51. Order of election of candidates
FPP51. Equality of votes

**PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS**

FPP52. Declaration of result for contested elections
STV52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

**PART 8: DISPOSAL OF DOCUMENTS**

54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll
57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

**PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION**

FPP59. Countermand or abandonment of poll on death of candidate
STV59. Countermand or abandonment of poll on death of candidate

**PART 10: ELECTION EXPENSES AND PUBLICITY**

*Expenses*

60. Election expenses
61. Expenses and payments by candidates
62. Expenses incurred by other persons

*Publicity*

63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
65. Meaning of “for the purposes of an election”

**PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES**

66. Application to question an election

**PART 12: MISCELLANEOUS**

67. Secrecy
68. Prohibition of disclosure of vote
69. Disqualification
70. Delay in postal service through industrial action or unforeseen event

## 1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their

votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

**2. Timetable**

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

| Proceeding | Time |
|---|---|
| Publication of notice of election | Not later than the fortieth day before the day of the close of the poll. |
| Final day for delivery of nomination forms to returning officer | Not later than the twenty eighth day before the day of the close of the poll. |
| Publication of statement of nominated candidates | Not later than the twenty seventh day before the day of the close of the poll. |
| Final day for delivery of notices of withdrawals by candidates from election | Not later than twenty fifth day before the day of the close of the poll. |
| Notice of the poll | Not later than the fifteenth day before the day of the close of the poll. |
| Close of the poll | By 5.00pm on the final day of the election. |

**3. Computation of time**

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

**4. Returning Officer**

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

**5. Staff**

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

**6. Expenditure**

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

**7. Duty of co-operation**

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

**8. Notice of election**

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

**9. Nomination of candidates**

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

**10. Candidate's particulars**

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

**11. Declaration of interests**

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which

party,

and if the candidate has no such interests, the paper must include a statement to that effect.

**12. Declaration of eligibility**

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

**13. Signature of candidate**

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

**14. Decisions as to the validity of nomination**

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule

13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

**15. Publication of statement of candidates**

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

**16. Inspection of statement of nominated candidates and nomination forms**

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

**17. Withdrawal of candidates**

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

**18. Method of election**

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5

and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

**19. Poll to be taken by ballot**

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

**20. The ballot paper**

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

**21. The declaration of identity (public and patient constituencies)**

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

*Action to be taken before the poll*

**22. List of eligible voters**

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

**23. Notice of poll**

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

**24. Issue of voting information by returning officer**

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following

information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

**25. Ballot paper envelope and covering envelope**

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or

elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

**26. E-voting systems**

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that

comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

*The poll*

**27. Eligibility to vote**

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

**28. Voting by persons who require assistance**

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

**29. Spoilt ballot papers and spoilt text message votes**

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

**30. Lost voting information**

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

**31. Issue of replacement voting information**

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been

received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

**32. ID declaration form for replacement ballot papers (public and patient constituencies)**

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

*Polling by internet, telephone or text*

**33. Procedure for remote voting by internet**

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

**34. Voting procedure for remote voting by telephone**

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

**35. Voting procedure for remote voting by text message**

35.1 To cast his or her vote by text message the voter will need to gain access to the

text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

*Procedure for receipt of envelopes, internet votes, telephone votes and text message votes*

**36. Receipt of voting documents**

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

**37. Validity of votes**

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone

voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

**38. Declaration of identity but no ballot paper (public and patient constituency)[1]**

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

**39. De-duplication of votes**

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

**40. Sealing of packets**

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

**STV41. Interpretation of Part 6**

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

**42. Arrangements for counting of the votes**

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

**43. The count**

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

**STV44. Rejected ballot papers and rejected text voting records**

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

**FPP44. Rejected ballot papers and rejected text voting records**

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules

FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

**STV45. First stage**

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

**STV46. The quota**

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

**STV47. Transfer of votes**

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

**STV48. Supplementary provisions on transfer**

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

**STV49. Exclusion of candidates**

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who

are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

**STV50. Filling of last vacancies**

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

**STV51. Order of election of candidates**

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

**FPP51. Equality of votes**

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

**FPP52. Declaration of result for contested elections**

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

**STV52. Declaration of result for contested elections**

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at

which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

**53. Declaration of result for uncontested elections**

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

**54. Sealing up of documents relating to the poll**

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

**55. Delivery of documents**

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

**56. Forwarding of documents received after close of the poll**

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

**57. Retention and public inspection of documents**

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

**58. Application for inspection of certain documents relating to an election**

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

**FPP59. Countermand or abandonment of poll on death of candidate**

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

**STV59. Countermand or abandonment of poll on death of candidate**

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be

named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

*Election expenses*

**60. Election expenses**

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

**61. Expenses and payments by candidates**

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

**62. Election expenses incurred by other persons**

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

*Publicity*

**63. Publicity about election by the corporation**

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

**64. Information about candidates for inclusion with voting information**

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

**65. Meaning of "for the purposes of an election"**

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

**66. Application to question an election**

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel ( IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

**67. Secrecy**

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

**68. Prohibition of disclosure of vote**

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

**69. Disqualification**

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

**70. Delay in postal service through industrial action or unforeseen event**

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

# ANNEX 6

# STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

## 1. INTERPRETATION

1.1 In these Standing Orders, the provisions relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

## 2. MEETINGS OF THE COUNCIL OF GOVERNORS

### 2.1 Calling Meetings

2.1.1 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website.

2.1.2 The Secretary shall ensure that within the meeting cycle of the Council of Governors, general meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

2.1.3 If the Chair fails to call a meeting of the Council of Governors after a requisition for that purpose, signed by at least one-third of the whole number of the Council of Governors has been presented to him at Trust Headquarters, such one third or more members of the Council of Governors may forthwith call a meeting.

2.1.4 **Admission of the Public** and the Press– The meetings of the Council of Governors shall be open to members of the public and press unless the Council of Governors decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Council of Governors following the exclusion of members of the public and/or press shall be confidential to the members of the Council of Governors. Governors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

2.1.5 In the event that the public and press are admitted to all or part of a meeting by reason of SO 2.1.4 above, the Chair (or Deputy Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Council of Governors resolving "that in the interests of public order the meeting adjourn for (*the period to be specified*) to enable the Board to complete business without the presence of the public".

2.1.6 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Council of Governor meetings.

2.1.7 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Council of Governors. Such permission shall be granted only upon resolution of the Trust.

2.1.8 The Council of Governors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

2.1.9 **Chair of Meetings** – The Chair of the Trust, or in his absence, the Deputy Chair, is to preside at meetings of the Council of Governors.

2.1.10 The Deputy-Chair may preside at meetings of the Council of Governors in the following circumstances:

2.1.10.1 When there is a need for someone to have the authority to chair any meeting of the Council of Governors when the Chair is not present.

2.1.10.2 On those occasions when the Council of Governors is considering matters relating to Non-Executive Directors and it would be inappropriate for the Chair to preside.

2.1.10.3 When the remuneration, allowance and other terms and conditions of the Chair are being considered.

2.1.10.4 When the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment.

2.1.10.5 On occasions when the Chair declares a pecuniary interest that prevents him from taking part in the consideration or discussion of a matter before the Council of Governors.

2.1.11 **Setting the Agenda –** The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

2.1.12 **Agenda** – A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chair or Secretary at least three clear business days before Notice of the meeting is given. Requests made less than three days before the Notice is given may be included on the agenda at the discretion of the Chair.

2.1.13 **Notices of Motion** – A Governor desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair or Secretary, who shall insert in the agenda for the meeting all notices so received subject to the Notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without Notice on any business mentioned on the agenda in accordance with SO 2.1.13, subject to the Chair's discretion.

2.1.14 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

2.1.15 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be in writing, be in accordance of SO 2.1.14 and shall bear the signature of the Governor who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he considers it appropriate.

2.1.16 **Motions** – The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

2.1.17 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

2.1.17.1 An amendment to the motion.

2.1.17.2 The adjournment of the discussion or the meeting.

2.1.17.3 That the meeting proceed to the next business.

2.1.17.4 That the motion be now put.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

2.1.18 **Chair's Ruling** – Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Save as permitted by law, at any meeting the person presiding shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

2.1.19 **Voting** – Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Governor requests, a question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a casting vote.

2.1.20 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

2.1.21 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

2.1.22 If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

2.1.23 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

2.1.24 **Minutes** – The Minutes of the proceedings of a matter shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

2.1.25 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

2.1.26 **Suspension of Standing Orders** – Except where this would contravene any statutory provision, or any provision of the Constitution, any one or more of the SO's may be suspended at any meeting provided that at least two thirds of the Council of Governors are present, including one Public Governor, one Staff Governor and one Patients and Carers Governor, and that a majority of those present vote in favour of suspension.

2.1.27 A decision to suspend SO's shall be recorded in the minutes of the meeting.

2.1.28 A separate record of matters discussed during the suspension of SO's shall be made and shall be available to the Governors.

2.1.29 No formal business may be transacted while SO's are suspended.

2.1.30 **Record of Attendance** – the names of the Governors present at the meeting shall be recorded in the minutes.

2.1.31 **Quorum** – A meeting of the Council of Governors shall be quorate and quoracy shall require that there shall be present at the meeting not less than 50% of all Governors and of those not less than 51% shall be Elected Governors (excluding those Governors representing the Staff Constituency).

2.1.32 A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting. If a Governor has declared a pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

2.1.33 Subject to SO's in relation to interests, any Director or their nominated representatives shall have the right to attend meetings of the Council of Governors and, subject to the overall control of the Chair, to speak to any item under consideration.

## 3. COMMITTEES

3.1 Except as required by paragraph 9 of this Annex 6, the Council of Governors shall exercise its functions in general meeting and shall not delegate the exercise of any function or any power in relation to any function to a committee.

## 4. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

4.1 **Declaration of Interests** – in accordance with the Constitution, Governors are required to declare formally any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

4.2 A Governor must declare to the Secretary:

4.2.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, and

4.2.2 any interests which are relevant and material to the business of the Trust.

4.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these SO's and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within three working days.

4.4 If a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if he has declared a pecuniary interest, he shall not take part in the consideration or discussion of the matter. The provisions of this paragraph are subject to paragraph 4.5.

4.5 "relevant and material" interests may include but may not be limited to the following:

4.5.1 directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

4.5.2 ownership or part-ownership or directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

4.5.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

4.5.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

4.5.5 any connection with a voluntary or other organisation contracting for or commissioning NHS services;

4.5.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks;

4.5.7 research funding/grants that may be received by an individual or their department;

4.5.8 interests in pooled funds that are under separate management.

4.6 Any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

4.7 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

4.7.1 he, or a nominee of his, is a director of a company or other body not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

4.7.2 he is a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

4.8 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

4.8.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

4.8.1 of an interest in any company, body, or person with which he is connected as mentioned in paragraphs 4.2, 4.5 and 4.7, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

4.9 Where a Governor:

4.9.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

4.9.1 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

4.9.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

4.10 the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty disclose his interest.

4.11 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these SO's to be also an interest of the other.

4.12 If Governors have any doubt about the relevance of an interest, this should be discussed with the Trust Secretary.

4.13 **Register of Interests** - the Trust Secretary shall record any declarations of interest made in a Register of Interests kept by him in accordance with paragraph 36 of the Constitution. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.

4.14 The Register will be available for inspection by members of the public free of charge at all reasonable times. A person who requests it is to be provided with a copy or extract from the register. If the person requesting a copy or extract is not a member of the Trust then a reasonable charge may be made for doing so.

## 5. STANDARDS OF BUSINESS CONDUCT

5.1 **Policy –** in relation to their conduct as a Governor of the Trust, each Governor must comply with the Code of Conduct for Governors. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

5.2 **Interest of Governors in Contracts** – if it comes to the knowledge of a Governor that a contract in which he/she has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Secretary of the fact that he/she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

5.3 A Governor shall not solicit for any person any appointment in the Trust.

## 6. REMUNERATION

6.1 Governors are not to receive remuneration.

## 7. PAYMENT OF EXPENSES TO GOVERNORS

7.1 The Trust will pay travelling expenses to Governors at the prevalent NHS Public Transport rate for attendance at General Meetings of the Governors, or any other business authorised by the Trust Secretary as being under the auspices of the Council of Governors.

7.2 Expenses will be authorised and reimbursed through the Trust Secretary's office on receipt of a completed and signed expenses form provided by the Trust Secretary.

7.3 A summary of expenses paid to Governors will be published in the Trust's Annual Report.

## 8. MISCELLANEOUS

8.1 **Review of Standing Orders** – These Standing Orders shall be reviewed annually by the Council of Governors and any requirements for amendments must be directed to the joint meeting with the Board of Directors.

8.2 **Deputy-Chair** – In relation to any matter concerning the Council of Governors or a Governor outside a meeting of the Council of Governors, which arises the Deputy-Chair may exercise such power as the Chair would have in those circumstances.

8.3 **Notice** – Any written notice required by these SO's shall be deemed to have been given on the day the notice was sent to the recipient.

8.4 **Confidentiality** – A Governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

## 9. COUNCIL OF GOVERNORS : NOMINATIONS AND APPOINTMENTS COMMITTEE

9.1 The Chair and other Non-Executive directors shall be appointed following a process of open competition conducted in accordance with a policy to be agreed by the Council of Governors.

9.2 The Council of Governors shall establish a committee of its members to be called the Nominations and Appointments Committee ("the Committee") to discharge those functions in relation to the selection of the Chair and Non-Executive Directors described in Terms of Reference to be approved by the Council of Governors.

## ANNEX 7
## STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

### 1. INTERPRETATIONS AND DEFINITIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2 All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3 For convenience, and unless the context otherwise requires, the terms and expressions contained within the Interpretations and Definitions section of the Constitution at page 4 are incorporated and are deemed to have been repeated here verbatim for the purposes of interpreting words contained in this Annex 8 and in addition:

**"AUDIT COMMITTEE"** means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework.

**"COMMITTEE"** means a committee or sub-committee appointed by the Trust.

**"COMMITTEE MEMBERS"** shall be persons formally appointed by the Trust to sit on or to chair specific committees.

**"CONTRACTING AND PROCURING"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

**"FUNDS HELD ON TRUST"** means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 6, paragraph 8 of the 2006 Act. Such funds may or may not be charitable.

**"COMMISSIONING"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

**"NOMINATED OFFICER"** means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and standing financial instructions.

**"OFFICER"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

**"SFIs"** means standing financial instructions.

**"SOs"** means Standing Orders.

### 2. THE BOARD

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3 The power of the Trust shall be exercised in public or private session as provided for in SO 3.

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Schedule of Matters reserved to the Board and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

## 3. MEETINGS OF THE BOARD

3.1 **Admission of the Public and the Press** – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Deputy Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (*the period to be specified*) to enable the Board to complete business without the presence of the public".

3.3 The Board of Directors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

3.4 **Observers at Board Meetings** - The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committee. Such permission shall be granted only upon resolution of the Trust.

3.6 **Calling of Meetings** – Ordinary meetings of the Board shall be held at such times and places as the Board determines.

3.7 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.8 **Notice of Meetings** – Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least three clear days before the meeting.

3.9 Want of service of the notice on any Director shall not affect the validity of a meeting.

3.10 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.21.

3.11 Agendas will normally be sent to members of the Board five days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be

despatched no later than five clear days before the meeting, save in emergency. Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

3.12 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least five clear days before the meeting.

3.13 **Setting the Agenda** – The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

3.14 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least twelve clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than twelve days before a meeting may be included on the agenda at the discretion of the Chair.

3.15 **Petitions** - Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.16 **Chair of Meeting** – At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and he/she is present, shall preside. If the Chair and Deputy-Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.17 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

3.18 **Notices of Motion** – A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least twelve clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chief Executive shall insert in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. Subject to SO 3.21.8, this paragraph shall not prevent any motion being moved during the meeting without notice on any business mentioned on the agenda.

3.19 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.20 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if he/she considers it appropriate. This Standing Order 3.19 shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.21 **Motions** - A motion may be proposed by the Chair or any Director present at the meeting. Such motion shall be seconded by another Director. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

***Emergency Motions***

3.21.1 Subject to the agreement of the Chair and SO 3.22 below, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda (by reason of SO 3.6 and SO 3.9), up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

3.22 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

3.22.1 an amendment to the motion;

3.22.2 the adjournment of the discussion or the meeting;

3.22.3 that the meeting proceed to the next business; (*)

3.22.4 the appointment of an ad hoc committee to deal with a specific item of business;

3.22.5 that the motion be now put; (*)

3.22.6 that a Director be not further heard; (*)

3.22.7 that the public be excluded pursuant to SO 3.1;

3.23 *in the case of sub-paragraphs denoted by (*) above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

3.24 no amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved;

3.25 the Chair may (at his/her discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.16, other than a motion relating to:

(a) the reception of a report;

(b) consideration of any item of business before the Trust Board;

(c) the accuracy of minutes;

(d) that the Board proceed to next business;

(e) that the Board adjourn;

(f) that the question be now put.

3.26 **Chair's Ruling** - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matter shall be final.

3.27 **Voting** - Save as provided in SO 3.32 every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.28 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.29 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.30 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.31 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.32 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.33 **Minutes** - The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.34 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.35 Minutes shall be circulated in accordance with Director' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.36 **Joint Directors** – Where the Office of a Director is shared jointly by more than one person:

3.36.1 either or both of those persons may attend or take part in meetings of the Board:

3.36.2 if both are present at a meeting they should cast one vote if they agree:

3.36.3 in the case of disagreements no vote should be cast:

3.36.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.38 (Quorum).

3.37 **Suspension of Standing Orders** – Except where it would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present vote in favour of suspension.

3.38 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.39 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.40 No formal business may be transacted while Standing Orders are suspended.

3.41 The Audit and Assurance Committee shall review every decision to suspend Standing Orders.

3.42 **Record of Attendance** – The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.43 **Quorum** – No business shall be transacted at a meeting unless at least one half of the whole number of the voting Chair and Directors appointed are present (including at least one Non-Executive Director and one Executive Director).

3.44 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.45 If the Chair or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 or 7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Nominations Committee).

## 4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders (Standing Order 2.4) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

4.4 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 **Delegation to Officers** – Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain an accountability to the Trust.

4.6 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the

Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or Monitor requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

## 5. COMMITTEES

5.1 Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by the Monitor), the Trust may appoint committees of the Trust, or together with one or more Health Authorities or other Trusts, appoint joint committees, consisting wholly or partly of the Chair and members of the Trust or other health service bodies or wholly of persons who are not members of the Trust or other health service bodies in question.

5.2 A committee or joint committee appointed under SO 5.1 may, subject to such directions as may be given by the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

5.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute, or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.6 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.7 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.8 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.9 The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

## 6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of Interests** - The Constitution, the 2006 Act and the Code of Conduct and Accountability requires Board Directors to declare interests which are relevant and material to the NHS board of which they are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

6.2.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

6.2.4 a position of trust in a charity or voluntary organisation in the field of health and social care;

6.2.5 any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;

6.2.7 interests in pooled funds that are under separate management;

6.2.8 research funding/grants that may be received by an individual or their department;

6.2.9 any other commercial interest in the decision before the meeting.

6.3 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.4 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.6 There is no requirement in the Code of Conduct and Accountability for the interests of Board Directors' spouses or partners to be declared. However SO 7 requires that the interest of Directors' spouses, if living together, in contracts should be declared. Therefore

the interests of Board Directors' spouses and cohabiting partners should also be regarded as relevant.

6.7 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.8 **Register of Interests** - The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.9 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

6.10 The Register will be available to the public in accordance with paragraph 36 and 37 of the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.11 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their respective Directors for clarification.

## 7 DISABILITY OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Board may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

7.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 7.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.4.1 he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.4.2 he is a partner / associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

7.4.3 and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.5.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

7.5.2 of an interest in any company, body or person with which he is connected as mentioned in SO 7.4 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where the Chair or a Director has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his/her interest.

7.7 This SO 7 applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

## 8 STANDARDS OF BUSINESS CONDUCT POLICY

8.1 Staff should comply with the national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”. This section of Standing Orders should be read in conjunction with this document.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or the Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

8.4 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

8.5 **Canvassing of and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order 8 shall be included in application forms or otherwise brought to the attention of candidates.

8.6 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 8 shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.7 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.8 **Relatives of Directors or Officers** – Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

8.9 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

8.10 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8.11 Where the relationship to a Director of the Trust is disclosed, the Standing Order headed `Disability of Chair and Directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

## 9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

9.2 **Sealing of Documents** – The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee, thereof or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors, one Director and the Secretary or two senior managers (not being from the originating department) duly authorised by the Chief Executive and shall be attested by them.

9.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an Officer nominated by him/her who shall not be within the originating directorate).

9.4 **Register of Sealing** – An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly. (The report shall contain details of the seal number, a description of the document and the date of sealing).

## 10 SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

## 11 MISCELLANEOUS

11.1 **Standing Orders to be given to Directors and Officers** – It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are

notified of and understand their responsibilities within Standing Orders and standing financial instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

11.2 **Documents having the standing of Standing Orders** – standing financial instructions (including provisions as to tendering and contract procedures, disposals and in-house services), Schedule of Matters reserved to the Board and Scheme of Delegation, the Policy on the Register of Interests and Hospitality and the Staff Disciplinary and Appeals Procedures document shall be read in conjunction with the Standing Orders. The Board may also, from time to time, agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by the Trust. The decision to approve such policies and procedures shall be recorded in an appropriate Trust Board minute to be read in conjunction with these Standing Orders.

11.3 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Board and any requirements for amendments must be directed to the joint meeting with the Council of Governors unless paragraph 8.3.1 of Annex 9 applies. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

11.4 The Board may confirm contracts to purchase from a voluntary organisation or a local authority using appropriate powers under the 2006 Act and shall comply with procedures laid down by the Finance Director which shall be in accordance with this Act.

**ANNEX 8**
**COUNCIL OF GOVERNORS CODE OF CONDUCT**

**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**

**CODE OF CONDUCT FOR GOVERNORS**

## 1. Introduction

1.1 As defined by legislation, the Trust's Council of Governors have a formal role in the governance of the Trust, working with the Board of Directors to promote the success of the organisation for its members and the public. To support the proper discharge of the Council of Governors' statutory duties and to promote the success of the relationship between the Council of Governors and the Board of Directors, it is essential that Governors adopt high standards of personal conduct. Recognising this, this document sets out the Council's expectations for the way in which Governors will conduct themselves in all aspects of their role within the Trust.

## 2. Framework for Council of Governors

2.1 The Trust operates within a legal, regulatory and governance framework which includes the NHS Act 2006, the Health and Social Care Act 2012, the Foundation Trust Code of Governance and the Trust's Constitution. The Constitution defines the composition of the Council of Governors and the arrangements for appointing (and, where necessary, removing) Governors. The Constitution's annexes include the Standing Orders for the Council of Governors and Board of Directors.

2.2 The regulatory and governance framework is supplemented by the Terms of Reference for the Council of Governors, the Role Description for Governors and this Code of Conduct. This Code of Conduct, the Terms of Reference and the Role Description are subject to the Constitution; nothing within them shall take precedence over or in any way amend the Constitution or any legal or regulatory requirements. This Code of Conduct is to be read in the context of that legal and regulatory framework.

## 3. Role of the Council of Governors

3.1 The role of the Council of Governors is defined in law and in Monitor's regulatory and governance framework. Although the role definition is not repeated here it is important as context for this Code of Conduct to recognise that good governance in the Trust depends upon active and constructive engagement between the Board of Directors and the Council of Governors. Adopting this approach will ensure that the Council of Governors is able to discharge its statutory duties, particularly in relation to:

3.1.1 Holding the Non-Executive Directors individually and collectively to account for the performance of the Board; and

3.1.2 Representing the interests of the members as a whole and of the public

## 4. Board of Directors/Council of Governors Engagement

4.1 The Constitution and supporting guidance commit the Board of Directors and the Council of Governors (as a whole and Governors individually) to engaging proactively and constructively with the Board of Directors, acting through the Chairman, Senior Independent Director and the Lead Governor where appropriate according to their roles.

4.2 The Council of Governors will work with the Board of Directors for the best interests of the Trust as a whole, taking into account all relevant advice and information presented to, or requested by, the Council of Governors. The Council of Governors will not unduly delay responses to proposals or other reports from the Board of Directors, acting proactively to

agree with the Board of Directors the information which the Council of Governors will need in order properly to discharge its statutory duties.

## 5. Conduct of Governors

5.1 This section of the Code sets out the conduct which all Governors agree to abide by. These commitments are in addition to compliance with Monitor's requirements, the Code of Governance, the Constitution, and Terms of Reference for the Council of Governors and Role Description for Governors.

### 5.1.1 **Personal Conduct**

Governors agree that they will:

a) Act in the best interests of patients and the Trust as a whole in the delivery of services within relevant financial and operational parameters, seeking at all times to properly discharge their statutory duties;
b) Comply at all times with legal and regulatory requirements and with the Constitution, Standing Orders, relevant Terms of Reference, Role Descriptions, policies and guidance;
c) Be honest and act with integrity and probity at all times;
d) Respect and treat with dignity and fairness, the public; patients; relatives; carers; NHS staff and partners in other agencies;
e) Respect and value all Governors and Directors as colleagues;
f) Not seek to profit from their position as a Governor or in any way use their position to gain advantage for any person;
g) Accept responsibility for their actions and generally take seriously the responsibilities which are commensurate with the decision-making rights assigned to the Council of Governors through the legal and regulatory framework;
h) Ensure that the interests of the members as a whole and the public are represented and upheld in decision making such that in accordance with the requirements of the Constitution and relevant policies, those decisions are not influenced by gifts or inducements or any interests outside the Trust;
i) Not be influenced in any way and not represent any outside interests which they may hold, including any membership of trade unions or political organisations;
j) Ensure that no person is discriminated against on grounds of religion or belief; ethnic origin; gender; marital status; age; disability; sexual orientation or socio-economic status;
k) Show their commitment to team working by working constructively with their fellow Governors and the Board of Directors as well as with their colleagues in the NHS and the wider community;
l) Not make, permit or knowingly allow to be made, any untrue; misleading or misrepresentative statement either relating to their own role or to the functions or business of the Trust;
m) At all times, uphold the values and core principles of the NHS and the Trust as set out in its Constitution;
n) Conduct themselves in a manner which reflects positively on the Trust and not in any manner which could be regarded as bringing it into disrepute;
o) Seek to ensure that the membership of the constituency from which they are elected/their appointing organisation is both properly informed and represented
p) At all times, uphold the seven principles of public life as set out by the Committee on Standards in Public Life (also known as the Nolan Principles) as below:
    (i) Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves; their family or friends or other interested parties.
    (ii) Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
    (iii) Objectivity: In carrying out public business, including making public

appointments; awarding contracts or recommending individuals for awards or benefits, holders of public office should make choices on merit.

(iv) Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

(v) Openness: Holders of public office should be as open as possible about all the decision and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

(vi) Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

(vii) Leadership: Holders of public office shall promote and support these principles by leadership and example.

q) seek advice from the Chairman or the Trust Secretary on matters relating the Constitution, governance requirements or conduct, and have regard to the advice given to them.

5.1.2 **Confidentiality**

Governors agree that they will:

r) Respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors, except where information is made available in the public domain.

s) Understand, endorse and promote the Trust's Confidentiality and Data Protection Policy in every aspect of their work. A copy of this policy will be provided to each Governor and training will be provided where necessary.

t) Make no public statements on behalf of the Trust or communicate in any way with the media without the prior consent of the Chairman or a designated officer from the Trust's Communications Department.

5.1.3 **Declaration of Interests**

Governors agree that:

u) It is essential for good corporate governance and to maintain public confidence in the Trust that all decision making is robust and transparent. To support this, the Constitution and the Trust's Policy on Declaration of Interests set out requirements for Governors to declare relevant interests (as defined in the Constitution).

v) Governors will declare interests on request from the Trust Secretary or, as required by the Constitution, whenever they become aware of a potential conflict of interest in respect of a matter being considered by the Council of Governors. Governors should seek advice from the Trust Secretary or the Chairman where they are unsure as to whether an interest needs to be declared. Declared interests will be included in a Register of Interests, which will be published

## 6. Participation in Meetings and in Training and Development

6.1 The Council of Governors will hold a number of meetings per year, the number to be determined by the Chairman. The schedule for these meetings and for other activities will be proposed by the Trust Secretary and is subject to approval by the Council of Governors.

6.2 It is expected that Governors will attend meetings of the Council of Governors and of any committees or working groups (including Project Working Focus Groups) to which they are

appointed but it is accepted that there will be occasions on which Governors cannot attend, in which case they will give apologies for absence.

6.3 The Constitution provides for the Council of Governors to remove any Governor from office where he/she fails to attend two consecutive Council of Governor meetings and where the Council is not satisfied that the absence was due to a reasonable cause and that the attendance record will be rectified.

6.4 The Board of Directors has a statutory duty to take steps to ensure that the Governors are equipped with the skills and knowledge they need to discharge their responsibilities appropriately. A programme of training and development will be agreed with the Council of Governors and it is expected that Governors will participate in such activities unless, in reasonable circumstances, this is not possible.

## 7. Upholding this Code of Conduct

7.1 Following approval of this Code of Conduct by the Council of Governors, individual Governors agree to comply with all of its content.

7.2 Where possible or appropriate, any concerns about the conduct or performance of a Governor will be addressed under the leadership of the Chairman through training, development or other means which are considered appropriate. Where such concerns exist the Chairman will write to the Governor concerned to set out the concerns and the action agreed to rectify or otherwise address them.

7.3 The Constitution provides for the circumstances in which a Governor can be removed from office, including where any Governor fails to comply with this Code of Conduct. It is for the Chairman to propose removal from office if this is necessary after all other course of action, including training and development where relevant, have been exhausted. The Constitution provides for an independent review of evidence associated with such a proposal, reflecting the Foundation Trust Code of Governance. As required by the Constitution, it is for the Council of Governors to determine (in accordance with rules set out in the Constitution) whether any Governor should be removed from office following a proposal from the Chairman and an independent review if one is commissioned.

Approved by the Council of Governors on 29th January 2015

To be reviewed not later than January 2017

**ANNEX 9**
**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**

**CODE OF CONDUCT FOR GOVERNORS**

**DECLARATION OF ACCEPTANCE**

I confirm that I have received, read and understood the Code of Conduct for Governors (the Code).

I further confirm that I will comply with the provisions of the Code.

……
Signature of Governor

……
Name of Governor

……
……
……
……
……
Address for Governor

……
Date of signature

**Please return the completed form to:**

The Trust Secretariat
Trust Headquarters
University Hospitals Bristol NHS Foundation Trust

**ANNEX 9**
**ROLE DESCRIPTION FOR THE COUNCIL OF GOVERNORS**

## 1. Introduction

As members of the Trust's Council of Governors, our Governors play an important role in making the Trust publicly accountable for the services we provide and bring valuable perspectives and contributions to our activities.

In summary, they reflect the views of the Trust's Members, promote and support the Trust's strategy, hold the Board's Non-Executive Directors to account, and help the Trust to decide its future direction.

Our Public, Patient and Carer and Staff Governors are elected by our Foundation Trust's public and staff Members. We also have Appointed Governors who are nominated by stakeholders such as the local authority, commissioning groups, and our partner provider organisations.

Governors are not paid for the work they do, but can claim reasonable expenses incurred in connection with their duties in accordance with the Trust's expenses scheme.

## 2. Who can be a Governor?

In line with the Trust's Constitution, to be a Public, Patient, Carer or Staff Governor, Governors need to be:

- a member of the Trust
- at least 16 years old

You cannot be a Governor if you:

- are an Executive or Non-Executive Director of the Trust
- have been sentenced to 3 months imprisonment or more within the last five years
- are a bankrupt
- have been dismissed from an NHS job within the last two years
- have been disqualified from a health related professional body

## 3. What does a Governor do?

Governors of NHS Foundation Trusts have two main roles:

### 3.1 Acting as a link to the community

Governors form an important link to the community that the Trust serves. They are responsible for promoting and supporting the Trust's strategy, acting as a 'critical friend' to the Trust to help plan and steer its direction. They feed back information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them.

Governors are responsible for feeding back to the Trust, via the Council of Governors, the views and ideas of the members or organisations they represent. By doing this, they help the Board to make sure that the views of local communities and people who use the Trust's services are taken into account when plans for services are being developed.

They also help to develop the Membership of the Trust in two main ways by:

- overseeing the development and implementation of the Membership Strategy
- direct engagement with Members at Constituency meetings and other Trust events

3.2 Holding the Non-Executive Directors to account for the performance of the Board

The Board of Directors has overall responsibility for running the Trust. A number of Non-Executive Directors sit on the Board to make sure that the Trust meets its performance targets, and acts in accordance with the Trust's Constitution. The Council of Governors is expected to hold the Non-Executive Directors to account for the performance of the Board of Directors. The National Health Service Act 2006 (as revised by the Health & Social Care Act 2012) gives Governors several powers to help them do this. These powers enable Governors to:

- appoint or remove the Chairman and Non-Executive Directors
- decide the remuneration and allowances, and other terms and conditions of office, of the Chairman and other Non-Executive Directors
- approve the appointment of the Chief Executive
- appoint or remove the Trust's Auditor
- receive the annual report and accounts
- advise the Board of Directors and be consulted on proposed strategic decisions and forward plans

Performing these functions means that Governors can be confident in the skills and abilities of the Non-Executive Directors to hold the organisation to account. Governors can also be sure that the Auditor will give an independent and reliable view of the Trust's accounts. Taken together, these functions help to demonstrate to Members of the Trust, the public, and stakeholders that the Trust is well-led.

## 4. What can't a Governor do?

It is important to remember that the powers of Governors rest with them in Council as a collective, not as individuals. Overall responsibility for running the Trust lies with the Board of Directors. There are therefore some things that they cannot do as a Governor:

- they will not be involved in the day to day running of the Trust, setting budgets, staff pay or any other operational matters
- they cannot veto or over-rule decisions made by the Board of Directors
- they do not play a part in considering the appointment or dismissal, appraisal, pay levels or conditions of service of Executive Directors
- they should not raise complaints on behalf of individuals, or act as advocates, but should represent a broad range of interests in your constituency

## 5. What responsibilities does the Council of Governors have?

5.1 Statutory Responsibilities

The Council of Governors has some responsibilities that are set out in Acts of Parliament such as the National Health Service Act 2006 and more recently new powers within the Health and Social Care Act 2012. These statutory responsibilities are to:

- represent the interests of the Members of the Trust as a whole and the interests of the public
- hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- give a response when consulted by the Board of Directors on the Trust's Annual Plan
- appoint and (if necessary) remove the Trust Chairman and Non-Executive Directors
- receive performance appraisal information regarding the Trust Chairman and Non-Executive Directors
- set the pay and terms & conditions of appointment for the Trust Chairman and Non-Executive Directors
- approve the appointment of the Chief Executive - however, the Council of Governors will not appoint the Chief Executive

- appoint or (if necessary) remove the Trust's external auditors
- receive the Trust's Annual Report and Accounts, and the Auditor's report
- inform Monitor, via the Lead Governor, if there are any 'material concerns' about the actions of the Board of Directors which cannot be resolved locally
- satisfy itself that proposals in the Annual Plan (other than those relating to the provision of health services in England) will not significantly interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions
- approve any proposal to increase by 5% or more the proportion of the Trust's total annual income from activities other than the provision of health services in England
- approve any applications for significant transactions
- approve any applications for mergers, acquisitions, separation or dissolution of the Trust
- agree, in conjunction with the Board of Directors, changes to the Trust's Constitution

5.2 Other responsibilities

The Council of Governors has other responsibilities which are not set out in law. These include:

- supporting the Board of Directors in setting the long-term strategic direction for the Trust
- being assured that that the Non-Executive Directors act so that the Trust does not breach the conditions of its NHS Provider Licence
- developing the membership by overseeing the implementation of the Trust's Membership Strategy and by direct engagement with members at events and meetings
- providing a Governor perspective on the efficacy of staff engagement mechanisms

## 6. What other duties does an individual Governor have?

As a Governor they are expected to:

- promote and support the organisation's strategy
- feedback information about the Trust, its vision and its performance to your Members or stakeholder organisation
- attend meetings of the Council of Governors
- abide by the Governors Code of Conduct and uphold the Trust's values
- act in the best interests of the Trust and preserve the Trust's standing and reputation
- comply with the policies and procedures of the Trust, including its Authorisation and Constitution
- serve on at least one Governor Project Focus Group
- maintain an appropriate level of confidentiality in respect of information provided to the Council of Governors and its working groups
- attend such training events as may be necessary in order to fulfil the role
- represent the interests of the community, including service users and carers, by ensuring effective communication with Members, feeding back information to the Trust as necessary
- if invited, to advise on staff appointments

## 7. What skills will a Governor need?

The Governor's role is an important one. As well as representing their own views, they must be able to represent the views of people in their community.

They will also need the time to communicate with their constituents and to prepare for and attend several meetings each year, including some Governor Committee and Project Focus Group meetings and be able to absorb high level information.

## 8. What support will a Governor get to do the job?

To help them to perform this important role, the Trust will provide training and support. This will include:

- an induction session to familiarise them with the Trust and the services it provides, any relevant policies and legislation, and the role of the Governor within the Trust
- an opportunity to attend relevant parts of the Trust's corporate induction training
- training relevant to specific Governor roles such as recruitment of Non-Executive Directors, appointment of auditors, or approval of significant transactions
- assignment of an experienced Governor to act as a 'Buddy' in their first year
- an opportunity for Governors to engage in Patient-Led Assessments of the Care Environment (PLACE) assessments
- participation in joint events with other partner organisations
- access to training sessions and materials from the Foundation Trust Governors Network
- participation in engagement and community events

**9. How much time will it take up?**

There are four formal Council of Governor meetings, eight informal meetings (which include a Counsel meeting with the Chairman) each year. Each of the three Governor Project Focus Working Groups meets four times each year.

As a minimum, Governors should attend all the formal Council of Governor meetings and there is an expectation that individual Governors be a regular attender of at least one of the Governor Project Focus Groups – Quality Project Focus Group; Constitution Project Focus Group or Annual Plan Project Focus Group.

In addition, Governors are expected if possible to attend the training/ education seminars that are organised four times per year. These Governor Development Seminars provide briefings on current topics and developments being considered by the Board as well as formal training on skills and tools relevant to their role as Governor.

Most Governors find that they get more satisfaction from the role if they attend other activities as well as the formal Council of Governor and Governor Project Focus Group meetings. There are a number of Trust events throughout the year that Governors can take part in. Governors also sit on working groups from time to time, and are often involved in the interview process for new members of the Board.

In accordance with The Trust's Constitution, the Trust also holds an Annual Members Meeting which takes place in September and all Governors are expected to attend.

There are a range of other events that Governors are encouraged to attend if available, including:

- Chairman and Chief Executive walkabouts, PLACE assessments and other similar events to observe first-hand how the hospital is running
- Board of Directors meetings - all Governors should attend at least one Board meeting in each year, to see the Board 'in action'
- staff achievement and long-service awards
- events supporting the Trust's associated Charity – 'Above and Beyond'
- Ad-hoc presentations, celebrations and other events

All events are notified to Governors in advance by the Trust Secretariat, with as much notice as possible. The Trust Secretariat is available to discuss with individual Governors possible external events to attend if they feel they would be of benefit to support their Governor role.

**10. How long does a Governor serve for?**

- Public and Staff Governors are elected for a period of up to three years at a time
- Appointed Governors other than Local Authority Governors and Youth Governors (see below) may serve for up to three years at a time. They will cease to hold office if the appointing organisation withdraws their appointment.
- Governors appointed by the Youth Council may hold office of up to one year

- Local Authority Governors serve until they stand for re-election as a local councillor. They cannot be a Governor for more than two terms of office as a local councillor
- No Governors can serve for more than a total of nine years

## 11. Specific Governor Roles

11.1 The role of Lead Governor

Monitor did not intend the person holding this role to 'lead' the Council of Governors or assume greater power or responsibility than other Governors. However it is recognised that University Hospitals Bristol like many NHS Foundation Trusts have broadened the original intention of this role and given greater responsibility to their Lead Governor. The role of lead Governor for University Hospitals Bristol is described below and includes:

- acting as the point of contact between the Governors and Monitor
- ensuring a continuing good relationship between Governors and Directors
- bringing to the Trust Chair's notice any issues from the Governors
- working towards the effectiveness of the Council of Governors and its Project Focus Groups
- chairing meetings of the Council of Governors which cannot be chaired by the Trust Chair, Vice-Chair or other Non-Executive due to a conflict of interest (these occasions are likely to be infrequent)
- deputising for the Chairman/Vice Chairman at Members' events
- chairing the quarterly Informal Governors' meetings
- presenting the Membership report to the Annual Members' Meeting and lead the Governors in issues related to Membership
- presenting reports to the Board of Directors as Lead Governor
- being available to provide or approve quotes for press releases
- providing leadership & guidance; mentor new or less experienced Governors
- meeting regularly with the Chair and Chief Executive; be a point of contact through which channels of communication flow between Chair/Board of Directors and Council of Governors so as to foster good relations and openness
- providing a sounding board for the Chair and members of the Executive.
- liaising regularly with the Trust Secretary in relation to meetings, minutes, follow up action, progress chasing etc.
- ensuring that Governors, individually and as a body, maintain a good standard of conduct

11.2 What the Lead Governor cannot do

The Lead Governor is not a shadow or vice chair in the same way that the Council of Governors is not a shadow Board of Directors.

11.3 Conditions of appointment and Term of Office for the Lead Governor

The Lead Governor:

- should be a Governor of at least one year's standing but ideally 2 years
- should be appointed by the Council of Governors
- may hold the position of Lead Governor until the end of their term of office
- if they are reappointed they may be reappointed as Lead Governor by the Council of Governors - the reappointment may be delayed for 6 months to allow new Governors to get to know the incumbent
- removal of the Lead Governor will require the approval of three-quarters of the members of the whole membership of the Council of Governors
- understand the Trust's Constitution and how the Trust is influenced by other organisations
- represent the position and wishes of Governors and be able to commit the time necessary
- be IT literate and have the ability to influence and negotiate; and be able to present a well-reasoned argument

11.4 Process for appointment

The Trust Secretary will organise the process as follows:

- any Governor may nominate another Governor with the agreement of the nominee
- any Governor may nominate themselves with the support of one seconder
- each candidate, even if unopposed, will provide a one page statement setting out what they would bring to the role
- if there is more than one nomination there will be an election conducted by email – a simple majority will win
- if there is a tie the Trust Chair has a casting vote in consultation with the Nominations & Appointment Committee
- if there is a single nomination the Governors will be asked to endorse (or not) that nomination by voting for that person or abstaining
- if there are no nominations the Trust Chair in consultation with Nominations & Appointment Committee will nominate a Lead Governor for approval by the Council of Governors, for one year initially

11.5 Staff Governors

Staff Governors have a responsibility to the people who elect them. The role involves talking and listening to staff about issues and concerns, about what's working well and what could be improved, and feeding those views into the work of the Council. As ambassadors, Staff Governors should seek to engage with staff as much as possible about the work of the Council and the Trust and encourage staff to remain part of the FT membership so they can influence the formal governance structures of the Trust.

The role of Staff Governors at UHB includes:

- communicating with staff in their constituency and feeding the views of staff back to the Council of Governors and into any working groups they are part of
- advising the Council of the impact of decisions on staff and advise on how staff can contribute to improving services for patients
- regularly advising staff of work undertaken by the Council of Governors and seeking their views. The Trust will work with the staff governors to develop effective ways to make sure this happens
- being very clear about what information can be reported back to colleagues/staff members

All Governors are expected to sign-up to the Governors Code of Conduct. If it is believed a Staff Governor has failed to observe this Code of Conduct, the Trust Chair will deal with the case according to the procedure set out in the Code. However, the Trust's normal disciplinary procedures will be followed in the case of misconduct in a Staff Governors' substantive role.

11.6 What Staff Governors should not do

Staff Governors are not expected to always agree with other Staff Governors or other Governors in general but are expected to be professional if and when disagreement occurs. Staff Governors who disagree with or question the Board of Directors will not find their professional standing within the Trust affected in any way as long as the Code of Conduct is complied with. Staff Governors should not:

- pursue a personal agenda at the expense of others' or participate in discussions where they have a personal interest in the outcome
- get personally involved in staff members' individual problems or issues and never promise to solve someone's problem themselves
- deal with disciplinary or grievance issues which are dealt with by formal staff representatives

The role of Staff Governor is significantly different from that of a Trades Union or staff side representative. Formal staff representation and negotiation through the Joint Union Committee remains in place. It is intended that the work of these groups run alongside and where appropriate complements the Staff Governor role and vice versa. However, Staff Governors do have a responsibility for reporting staff views in the Council and other meetings and working groups where there may not be a staff-side representative.

Staff Governors should be able to advise Trust staff members on appropriate routes of action, keeping in mind the role of the individual's line Manager and/or Staff representative. If the individual staff member has not approached their Line Manager or staff representative first, then the Staff Governor should direct the individual back to these sources. If there is any concern on the part of the Staff Governor that this is not the appropriate course of action (and it is likely to be only in exceptional circumstances that it is not) then the Staff Governor should refer to the Line Manager's Line Manager and/or the Human Resources Department. The Staff Governor may also sign-post the availability of Trust policies and procedures, clinical standards etc.

11.7 Public, Patient and Carer Governors

Our Public Governors represent the local constituencies of Bristol, North Somerset, and South Gloucestershire and our diverse local community. As Bristol University Hospitals is a major tertiary centre for a range of specialist services, there is also Public Governor representation nationally from the rest of England and Wales.

Public Governors provide the Trust with a greater understanding of the issues affecting patients and visitors as well as representing our diverse local community and national populations who use our specialist services.

Patient and Carer Governors provide valid insight in the patient experience of our services at UHB and are supported to ensure they can fully interact with the Council should they require special arrangements such as transport or communication materials.

11.8 Appointed Governors

Appointed Governors are appointed by organisations that the Trust has identified as partner organisations. For University Hospitals Bristol these partners are considered to be:

- Bristol City Council
- University of Bristol
- University of West of England
- Avon and Wiltshire Mental Health Partnership NHS Trust
- South Western Ambulance Service NHS Trust
- Joint Union Committee
- University Hospitals Bristol NHS Foundation Trust Youth Council
- Community and Voluntary Sector representative

These partner organisations have the ability to nominate whomever it feels is appropriate to represent it on the Council of Governors and understands the time commitment and what will be involved in the role of being a Foundation Trust Governor.

It is recognised that sometimes an Appointed Governor may sometimes experience a conflict of interest between their duties to their primary organisation and duties as a Foundation Trust Governor. Appointed Governors should be asked to declare an interest in discussing matters such as contracts or significant transactions; and be allowed to voluntarily leave the meeting if they consider this the appropriate action in the interest of probity.

## 12. Summary

Ultimately Governors are accountable to the Membership of the Trust (with the exception of Appointed Governors, who are accountable to their own organisation) and shall demonstrate this by their communication with their electorate in order to best understand their views.

University Hospitals Bristol NHS
NHS Foundation Trust

**Report for a Public Trust Board Meeting, to be held on 29 January 2015 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 22. Register of Seals

### Purpose

To report applications of the Trust Seal as required by the Foundation Trust Constitution.

### Abstract

Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.

The attached report includes all new applications of the Trust Seal to January 2015 since the previous report on 23 September 2014.

### Recommendations

The Board is recommended to receive this report to note

### Report Sponsor

Sponsor – Chief Executive
Author – Trust Secretary

### Appendices

- Appendix A – Trust Seal Register 2015-01

# Register of Seals – September 2014 – January 2015

| Reference Number | Date signed | Document | Authorised Signatory 1 | Authorised Signatory 2 | Witness | Date Received |
|---|---|---|---|---|---|---|
| 745 | 27/11/2014 | Intermediate Building Contract 2011 (3 sets), Re-ordering of accommodation of OFMS, extension and external alterations to the Radiopharmacy. | Robert Woolley, Chief Executive | Paul Mapson, Director of Finance and Information | Debbie Henderson, Trust Secretary | 27/11/2014 |
| 746 | 07/01/2015 | Lease for the Fully Managed Infusion Centre at Concord Medical Centre | Robert Woolley, Chief Executive | Paul Mapson, Director of Finance and Information | Debbie Henderson, Trust Secretary | 07/01/2015 |
| 747 | 07/01/2015 | Contract documents in respect of the Fire Compartmentation Project within the Queens Building, BRI | Robert Woolley, Chief Executive | Paul Mapson, Director of Finance and Information | Debbie Henderson, Trust Secretary | 07/01/2015 |

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

## 23. Big Green Scheme Annual Report

### Purpose

The Trust has developed a sustainability action plan drawing all of the environmental activities of the Trust under the Big Green Scheme, including the development of sustainable models of care, procurement and travel. This report provides a summary of achievements and outlines plans for the future.

### Abstract


The overall aim of the Big Green Scheme is to reduce the Trust's environmental footprint and make our hospitals healthier places to work and visit.

| | |
|---|---|
| **1. Reducing our impact** | Reduce Trust CO2 emissions 5% p.a. |
| **2. Staff wellbeing** | Promote a healthier and more productive workforce. |
| **3. Sustainable models of care** | Encourage energy efficiency actions from staff that create the best environment for patients. |
| **4. Building commitment** | Increase awareness of Big Green Scheme activities external to the Trust. |

We continue to work in partnership with the University of Bristol to encourage and recognise staff through the Green Impact awards scheme in the NHS.

Our spend-to-save investment programme to reduce our energy consumption across the estate has focussed on improving the efficiency and control of heating, lighting and cooling.

We continue to work with our partners in the Avon Health Executive Resilience Group to ensure our obligations with regards to emergency preparedness and adaptation under the Climate Change Act are being complied with.


### Recommendations

The Board is recommended to receive the report to note.

### Report Sponsor

James Rimmer, Chief Operating Officer

### Authors


Sam Willitts, Energy and Sustainability Manager


### Appendices

- None

### 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 |
|---|---|---|---|---|---|
| | 19/11/2014 | | | | |

# Big Green Scheme Annual Report 2013- 2014

## 1. Summary

The Trust has developed a sustainability action plan drawing all of the environmental activities of the Trust under the Big Green Scheme, including the development of sustainable models of care, procurement and travel. The overall aim is to reduce the Trust's environmental footprint and make our hospitals healthier places to work and visit.

There are four themes underlying this aim each with relevant KPIs.

| | |
|---|---|
| **1. Reducing our impact** | Reduce Trust CO2 emissions 5% p.a. |
| **2. Staff wellbeing** | Promote a healthier and more productive workforce. |
| **3. Sustainable models of care** | Encourage energy efficiency actions from staff that create the best environment for patients. |
| **4. Building commitment** | Increase awareness of Big Green Scheme activities external to the Trust. |

We continue to work in partnership with the University of Bristol to encourage and recognise staff through the Green Impact awards scheme in the NHS.

Our spend-to-save investment programme to reduce our energy consumption across the estate has focussed on improving the efficiency and control of heating, lighting and cooling.

As well as implementing climate-change mitigation measures we continue to work with our partners in the Avon Health Executive Resilience Group to ensure our obligations with regards to emergency preparedness and adaptation under the Climate Change Act are being complied with. Regular exercises to test a range of scenarios have been undertaken and the lessons learned have been incorporated into our reviews and updates.

### (a) Performance against targets

| ID | Measure | Baseline | Target 2013/14 Q4 | Actual 2013/14 |
|---|---|---|---|---|
| ROI1 | Electricity consumption kWh | 23,365,702 | 22,197,417 | 23,269,166 |
| ROI2 | Imported Electricity expenditure £ | 2,051,381 | 1,948,812 | 2,256,541 |
| ROI3 | Gas consumption kWh | 62,422,069 | 59,300,966 | 57,338,267 |
| ROI4 | Steam expenditure £ | 2,061,726 | 1,958,639 | 1,925,418 |
| ROI5 | Water consumption litres | 205,242 | 194,980 | 223,017 |
| ROI6 | Total waste Tonnes | 2,652 | 2,519 | 2,071 |
| ROI7 | DMR waste Tonnes | 299 | 284 | 248 |
| ROI8 | Landfill waste Tonnes | 1,385 | 1,316 | 874 |
| ROI9 | Offensive waste Tonnes | | | 193 |
| ROI10 | Clinical waste Tonnes | | | 717 |
| ROI11 | Confidential waste Tonnes | | | 39 |
| ROI12 | Percentage of waste recycled | 11% | 25% | 14% |
| SW1 | Number of staff accessing CycleScheme | TBC | | 56 |
| SW2 | Number of staff travelling by bus | 14 % | | 24% |
| SW3 | Number of staff travelling by bike | 18% | | 17% |
| SW4 | Number of staff travelling by car (own) | 24% | | 17% |
| SW5 | Number of staff travelling by car (share) | 13% | | 10% |
| SW6 | Number of staff travelling by motorbike | 3% | | 2% |
| SW7 | Number of staff travelling by park n'ride | 5% | | 6% |
| SW8 | Number of staff travelling by walking | 17% | | 20% |
| SW9 | Number of staff travelling by other | 2% | | 5% |

| ID | Measure | Baseline | Target 2013/14 Q4 | Actual 2013/14 |
|---|---|---|---|---|
| SW10 | % of non-car travel | 62% | | 73% |
| SW11 | % of travelling by car who are sharing | 35% | | 38% |
| SW12 | Sickness absence by Division | See HR reports by Division | | |
| SW13 | Response rate for Commuter Count | Commuter Count 2013 | | 234 |
| MOC1 | Participating wards Patient Experience survey showing reduction in numbers of patients bothered by noise at night from hospital staff | 8.4 | 9.2 | |
| MOC2 | Participating wards Patient Experience survey showing increased patients that felt they were given enough privacy when discussing their condition | TBC | TBC | |
| MOC3 | Sound Ears scores on TLC wards. | TBC | TBC | |
| BC1 | Number of teams signed up to Green Impact Awards | 12 | 25 | 13 |
| BC2 | Number of bronze awards | 5 | 13 | 6 |
| BC3 | Number of silver awards | 4 | 9 | 1 |
| BC4 | Number of gold awards | 1 | 3 | 3 |
| BC5 | Financial saving attributed to Green Impact actions | 14000 | 33000 | 19751 |
| BC6 | Number of external awards for Trust environmental activities | 1 | 2 | 2 |
| BC7 | TLC awards | | | 4 |
| BC8 | Working Towards Award | | | 3 |
| BC9 | Number of staff involved | | | 564 |
| BC10 | Number of people on mailing list | | | 263 |

## (b) Summary action plan

| | Summary of key actions 2013/14 |
|---|---|
| **1. Reducing our impact** | Boiler house flue heat recovery fully operational. Installation of a 50kW solar photovoltaic panel array on St Michael's hospital. Improved controls of heating, cooling and lighting - improving patient environment. Carbon emissions reduced.<br><br>Increased recycling. Introduced offensive waste stream. Reduced waste to landfill. |
| **2. Staff wellbeing** | Promoted green travel through a number of initiatives including the cycle scheme, public transport discounts, city car club, free hospital bus and car sharing. |
| **3. Sustainable models of care** | Launched TLC campaign (Turning off unused equipment, switching off Lights, and Closing hospital doors) to improve patient care and save energy. Appointed Change Agent to support TLC campaign |
| **4. Building commitment** | Increased staff engagement and cost savings through Green Impact Awards. Trust received two external awards for carbon reduction. |

### (c) Context

In order to embed sustainability within our business it is important to show where in our process and procedures sustainability features.

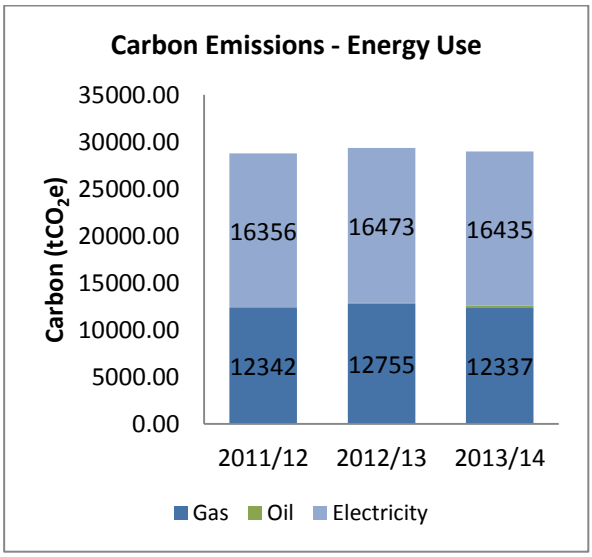
| Area | Is sustainability considered? |
|---|---|
| Travel | Yes |
| Procurement (environmental) | Yes |
| Procurement (social impact) | Yes |
| Suppliers' impact | Yes |

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how the organisation and its performance on sustainability has changed over time.

| Context info | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Floor Space ($m^2$) | 190061 | 190061 | 190061 |
| Number of Staff | - | 7439 | 7179 |
| Patient Contacts (admissions and outpatient attendances) | 595529 | 571861 | 585940 |

## *1.2 Reducing our impact*

As a part of the NHS, it is our duty to contribute towards the goal set in 2009 of reducing the carbon footprint of the NHS by 10% (from a 2007 baseline) by 2015. It is our strategic objective to exceed this target by reducing our carbon emissions 5% annually. We achieved a 1.25% reduction in 2013/14



## (a) Energy

| Resource | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Total Energy Spend | £ 4,340,587 | £ 4,900,097 | £ 4,888,194 |

| Resource | Target 5% reduction | 2013/14 |
|---|---|---|
| Steam Spend | £1,958,639 | £1,925,418 |
| Electricity Spend | £1,948,812 | £2,256,541 |

The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. We reduced our gas consumption, and despite increasing electricity use our expenditure has decreased by 4.3% in 2013/14.

We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next five years we expect to save £2,855,000 as a result of the measures implemented. As well as saving money, improvements to the hospitals' environment will benefit patient experience and staff wellbeing.

Energy consumption and carbon emissions

| Resource | | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|---|
| Gas | Use (kWh) | 60398962 | 62422069 | 58156407 |
| | $tCO_2e$ | 12342.53 | 12755.95 | 12337.30 |
| Oil | Use (kWh) | 220989 | 385397 | 666825 |
| | $tCO_2e$ | 70.46 | 122.88 | 212.95 |
| Electricity | Use (kWh) | 29187626 | 28860212 | 29352969 |
| | $tCO_2e$ | 16356.75 | 16473.70 | 16435.02 |
| Total Energy $CO_2e$ | | 28770 | 29353 | 28985 |

Our total energy consumption has decreased during the year, from 91,668 MWh to 88,176 MWh. 20% of our electricity is generated by our on-site combined heat and power (CHP) generation. 100% of the electricity we purchase is generated from renewable sources. The heat recovery system has been fully operational capturing waste heat from the boiler flues to provide heating and hot water to St Michael's hospital. The Trust in partnership with Bristol City Council has installed solar photovoltaic panels on St Michael's hospital roof.

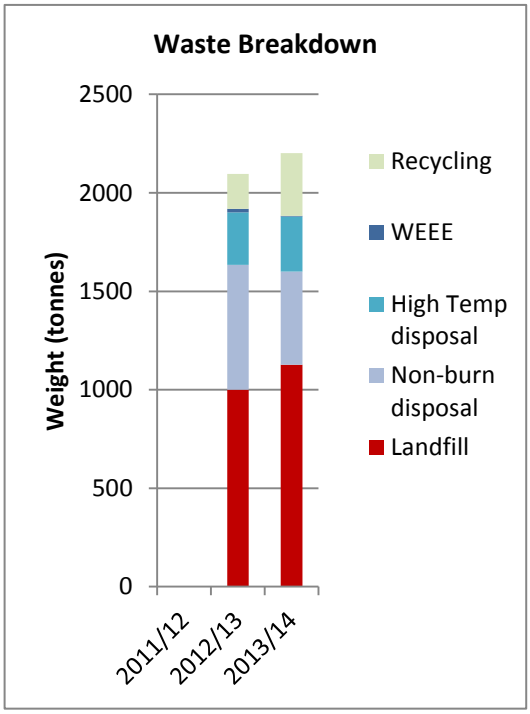
Greenhouse gas emissions from energy used have reduced by 38 tonnes this year. Our target is a 5% annual reduction we achieved a 1.25% reduction in 2013/14.

In future we need to develop our plans to:

- Achieve further reductions through staff awareness with the Green Impact TLC awards scheme.
- Develop a whole building energy efficiency approach to produce a Marginal Abatement Cost (MAC) Curve showing which carbon reduction measures save the most money. It will enable us to choose from a selection of possible measures and see which make best financial sense to invest in and which save the most carbon.
- Build on our partnership with Bristol City Council to increase our CHP capacity with city district heating.
- Generate assurance of our approach to energy through achieving a recognised accreditation such as ISO 14001, ISO 50001 or Carbon Trust Standard.

## (b) Waste

| Waste | | 2012/13 | 2013/14 |
|---|---|---|---|
| Recycling | (tonnes) | 176.4 | 318.99 |
| | $tCO_2e$ | 3.70 | 6.70 |
| Re-use | (tonnes) | 0.00 | 0.00 |
| | $tCO_2e$ | 0.00 | 0.00 |
| WEEE | (tonnes) | 17.40 | 2.40 |
| | $tCO_2e$ | 0.37 | 0.05 |
| High Temp disposal | (tonnes) | 266.61 | 280.94 |
| | $tCO_2e$ | 5.60 | 5.90 |
| Non-burn disposal | (tonnes) | 633.85 | 472.26 |
| | $tCO_2e$ | 13.31 | 9.92 |
| Landfill | (tonnes) | 1001.09 | 1127.10 |
| | $tCO_2e$ | 244.68 | 275.48 |
| Total Waste (tonnes) | | 2095.35 | 2201.69 |
| % Recycled or Re-used | | | 14% |
| Total Waste $tCO_2e$ | | 267.66 | 298.05 |




We recycle 14% of the total domestic waste we produce our target is 25%. We plan to continue increasing the amount we recycle. We will introduce composting of leaves (that currently go in black sacks to landfill) for community food growing.

## (c) Water consumption

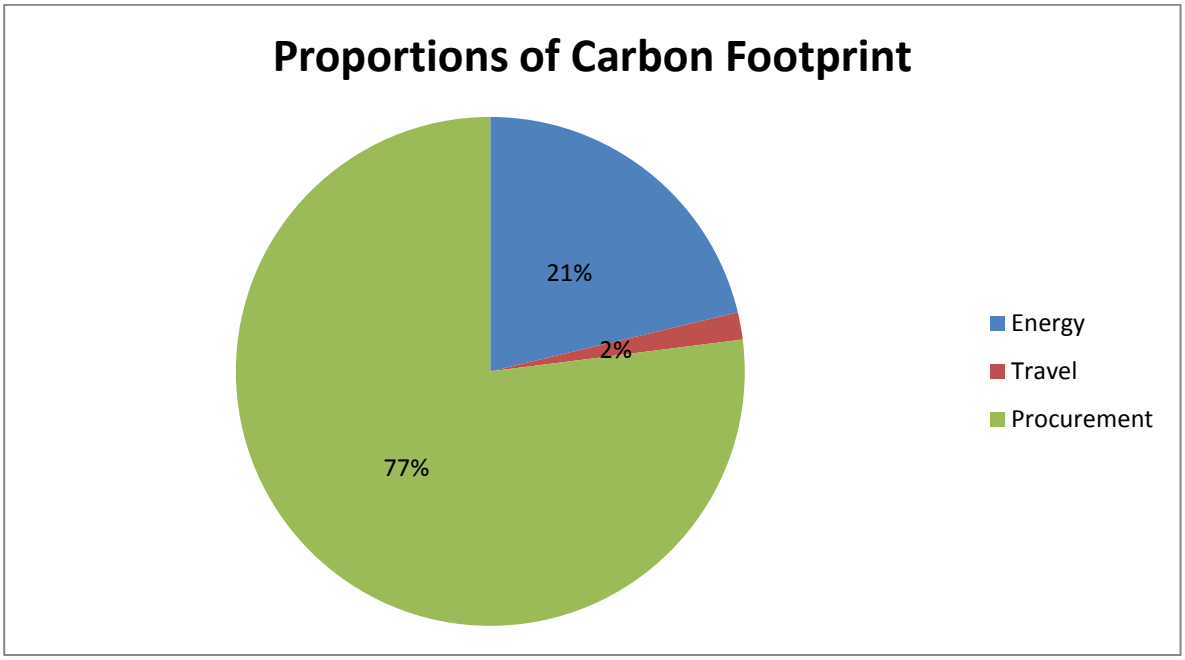
Our water consumption has increased by 17,775 cubic meters in the recent financial year. Our target is a 5% reduction we increased consumption by 8.7%. We will identify areas where we have seen an increase and develop plans to achieve reductions.

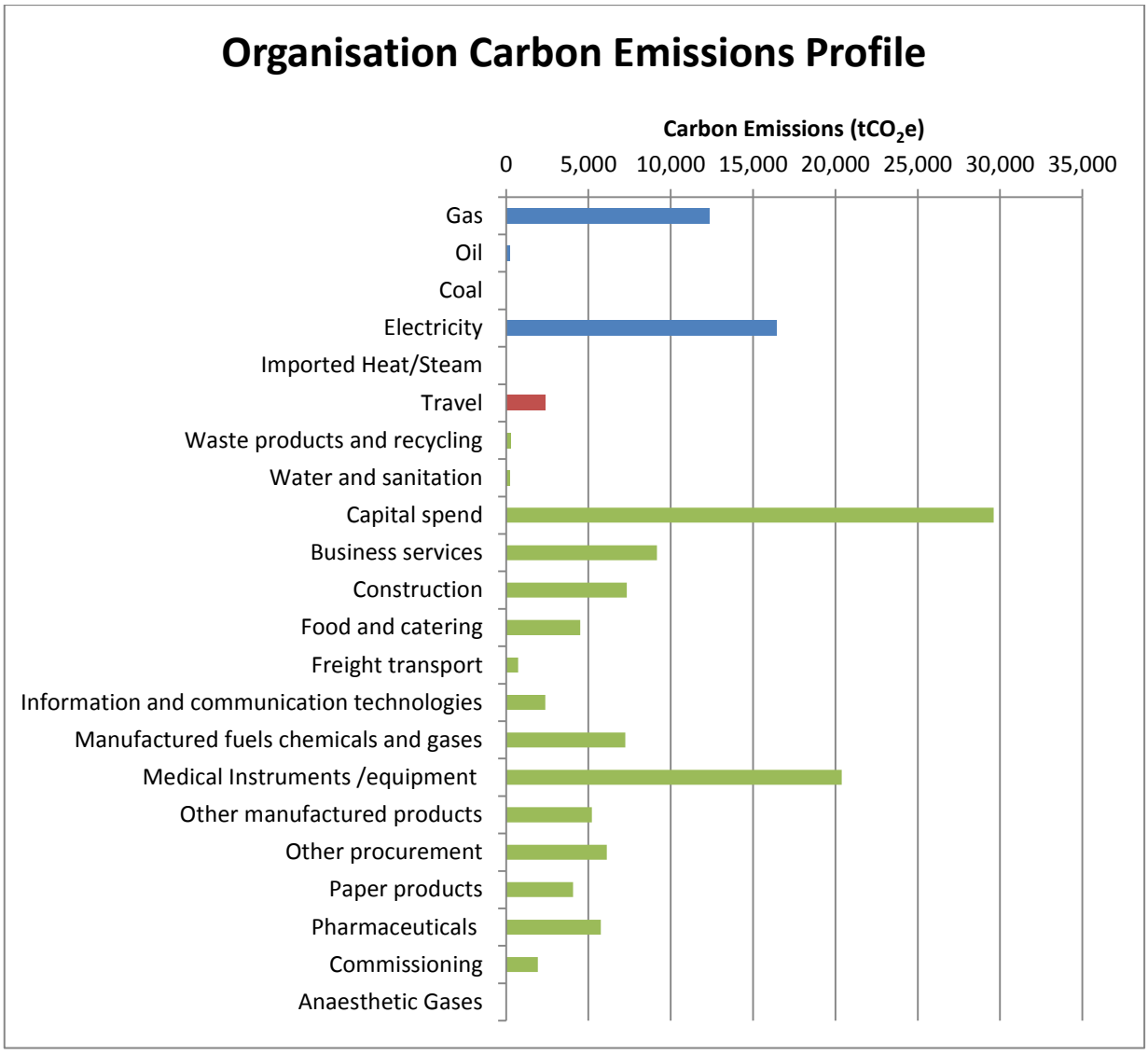
| Water | | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|---|
| Mains | $m^3$ | 218434 | 205242 | 224385 |
| | $tCO_2e$ | 198.97 | 186.95 | 204.39 |
| Water & Sewage Spend | | £301,835 | £343,648 | £375,289 |

## (d) Modelled carbon footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the NHS Sustainable Development Unit (SDU) in 2009/10.

Our estimated total carbon footprint is 136269 tonnes of equivalent carbon emissions.






We need to improve the detail of our understanding of our actual carbon emissions to enable effective targeting of reductions.

## *1.3 Staff wellbeing*

It is estimated that 1 in 20 vehicles on our roads is carrying NHS staff, patients or visitors. We can all help Bristol become a cleaner, quieter and healthier place to be in by using cars less and walking, cycling or using public transport more.

Road transport is the largest source of air pollution in urban areas of the county. Business mileage contributes to this pollution, as well as to local congestion and other traffic-related problems. In the UK air pollution is the cause of over 25,000 deaths every year.

We are committed to developing alternative transport options throughout Bristol by encouraging people to find ways they can get about without a car.

We promote green travel through a number of initiatives including the cycle scheme, public transport discounts, city car club, free hospital bus and car sharing. We are introducing, electric vehicles and improving cycling facilities.

As well as supporting "active travel" schemes for staff and visitors, we need to develop plans to enable our staff to be healthier and show leadership in our community:

- Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.
- Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes
- Promote the Workplace Wellbeing Charter and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health.

## *1.4 Sustainable models of care*

### (i) Sustainable Development

Our organisation has an up to date Sustainable Development Management Plan. Having an up to date Sustainable Development Management plan is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

Through our business continuity planning we have started to identify the risks we need to consider in adapting the organisation's activities and its buildings to cope with the results of climate change.

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations. Sustainability issues are included in our analysis of risks facing our organisation.

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This is set out within our policies on sustainable procurement.

A Board-level lead for sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation. All our staff have sustainability issues, such as carbon reduction, included in their job descriptions.

Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions. Our Green Impact staff energy awareness campaign is on-going and the efforts of our green champions continue to improve the Trust's sustainability.

In future we need to develop our plans to:

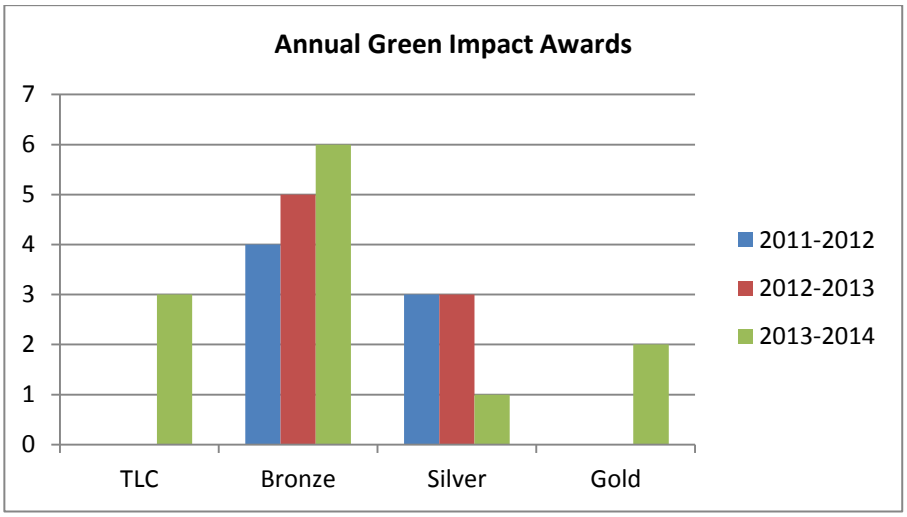
- Encourage professionals to consider sustainability principles when deciding what is right for patients.
- Service transformations deliver improved health outcomes coupled with social and environmental benefits in an integrated health system.
- Sustainability as a core and measurable dimension that underpins quality
- Work with commissioners, regulators and other providers to develop more sustainable models of care and enable the reconfiguration of services away from acute settings

## *1.5 Building commitment*

### (i) Green Impact Awards

The Green Impact Awards were introduced in 2011 as a way to inspire, support and reward staff participation in sustainable development around the Trust. The Green Impact workbook is an online resource providing examples of sustainable actions relevant to the workplace. Staff members log into the workbook and create or join a team which represents the department in which they work. The actions in the workbook are categorised into TLC, bronze, silver and gold awards depending on the perceived difficulty of the action. Once achieved, actions can be ticked off the workbook and when all actions are ticked off in a category, the team submits the workbook to be entered for the respective award.

Reports detailing workbook activity can be pulled from the system. Activity includes the people and teams registered to Green Impact, actions completed and targets reached for example. It is this activity that the following information is based on.




The above chart demonstrates an increase in the number of awards presented last year (2013-2014) compared to previous years. This can be partially accounted for by the introduction of the new TLC criteria group, which presents an achievable starting point particularly for ward areas. TLC stands for Turning off unused equipment, switching off Lights and Closing doors; all actions that can improve energy efficiency while enhancing the patient environment which is emphasised by the TLC slogan.

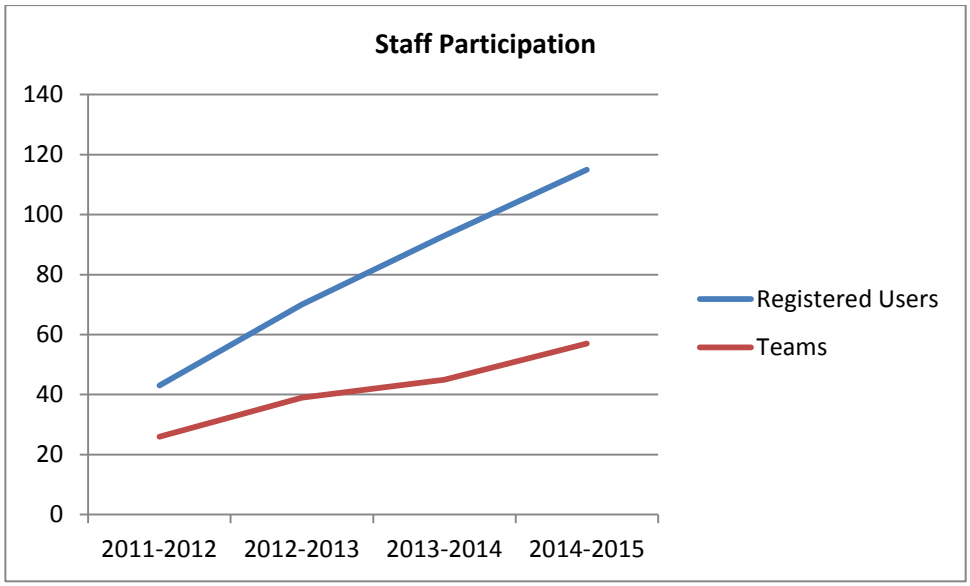
Promotion of the TLC campaign began in early March after the appointment of a 'Change Agent' in February 2014, whose primary target is to increase awareness and participation in the TLC campaign. The increased capacity due to Change Agent role has resulted in a significant increase in last year's awards, up by a third from 2012-2013 despite only starting 3 months before workbook submission. The TLC award represents 75% of this increase in awards despite the campaign being introduced in the last 2 months. With both the TLC campaign and the Change Agent present from the beginning of 2014-2015 there is scope for much more growth in Green Impact participation over the next year. There are already a further ward based Green Impact teams preparing to implement TLC imminently.

Many Green Impact members are signed up to the Big Green Scheme newsletter which has been sent out every month since March 2014; promoting Green Impact and associated sustainable news/events. Those who are not signed up to the workbook or the newsletter, find regular

references to Green Impact in features in Newsbeat (Trustwide newsletter) and occasional posts on the Connect, Trust homepage.

Within the newsletters and web page information there are links to the green pages where more information on Green Impact and other relevant information can be found. Competitions are introduced from time to time, for week long periods and there is one ongoing photo competition. As well as receiving entries for the competitions, staff are actively engaged and enabled to make suggestions about Trust facilities concerning waste, procurement, travel options and energy efficient options.

As well as the above and monthly information stalls held in the welcome centre, the message about sustainability and the Green Impact awards is spreading. This is reflected in the continuous growth achieved even in the initial months of the current year (2014-2015) as seen in the graph below:




(Submission date for 2014-2015 is in May 2015)

We will continue to widen staff involvement in our Green Impact and TLC campaigns and refine our measures of their effectiveness.

### (ii) External Awards

HSJ Energy Efficiency Award - Shortlisted

Green Apple Awards – Winner NHS Sector Carbon Reduction UK Bronze award

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 29 January 2015 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

| **24. Governors' Log of Communication** |
|---|
| **Purpose** |
| The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications added or modified since the previous Council of Governors meeting. |
| **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** |
| John Savage, Chairman of the Board |
| **Authors** |
| • Sarah Murch, Membership & Governance Administrator |
| **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

**108 Pam Yabsley** **Title: Provision in ED for patients experiencing mental health crisis**

**Query** **18/11/2014**

What provision does the Emergency Department have for a patient experiencing a mental health crisis?

**Response** **05/12/2014**

All patients with potential mental health issue (either presenting with symptoms suggestive of mental health illness – depression/psychosis/'requesting help' or self harm - overdose or deliberate self harm) have a mental health assessment matrix commenced at triage, this is then completed by the clinician seeing the patient.

Using the matrix we are able to assess a patient's risk into 3 categories – red, amber or green.

Patients with medical issues in addition to mental health problems – overdose or self injury – will have those conditions attended to in parallel to psychiatry assessment, this sometimes involves intravenous infusion (parvolex if serum paracetamol levels are high) and overnight stay on the ED observation ward.

Between the hours of 0800-2100 (7 days a week) we have access to the liaison psychiatry team - who will review all patients presenting with a psychiatric component. Liaison psychiatry work with the secondary mental health services to arrange follow up if needed

All patients can be given a 'services to help you' book outlining local services including social and psychological interventions

Out of hours – the patient is risk stratified using the matrix and depending on perceived risk

If the patient is high risk (red on the matrix), they are referred to the psychiatry SHO and crisis team, there is sometimes a significant delay in assessment by the AWP team

If the patient is moderate risk (amber on the matrix) they are admitted to the ED observation ward to wait for assessment by the liaison psychiatry team

If the patient is green on the matrix (low risk) the patient can be offered an outpatient appointment to see the liaison psychiatry team during the weekdays Monday to Friday.

***Status*** *Closed*

**107 Clive Hamilton** **Title: Staff turnover - supplementary question to Item 104**

**Query** **29/10/2014**

Supplementary question to Item 104:

I appreciate that exit interview information could be key to understanding the issues precipitating a resignation but that such information is not always obtained or might conceal the real reason. Is there any merit in a follow-up contact with the ex employee say 1 to 3 months after departure to offer re-employment (if available and suitable) and/or a fuller discussion relating to comparable conditions of employment. I am particularly concerned about the increasing presence of the healthcare independent sector and the loss of staff to that employment pool and the possibility that trained clinical staff may be able to obtain better conditions of employment in that sector which, I understand, is not subject to the same pay restraint as the public sector. This is particularly relevant as a consequence of the recent non-approval of the NHS independent pay review recommendation of 1% across the board pay increase. Is there any benchmark data for independent sector remuneration and conditions of service?

Clive Hamilton 29th October 2014.

**Response** **28/11/2014**

1. Is there any merit in a follow-up contact with the ex employee say 1 to 3 months after departure to offer re-employment (if available and suitable) and/or a fuller discussion relating to comparable conditions of employment.

We are currently undertaking a comprehensive review of the way we collect data to better understand the key reasons for staff leaving the Trust. As part of that we will consider the helpful suggestion of contacting staff three months after they have left. At present we are focussing on contacting staff before they leave, including asking, where appropriate what might influence them to stay.

As you may be aware, we do not have the flexibility to offer comparable remuneration packages to the private sector because the Trust`s terms and conditions of employment are determined at a national level. However, we are currently reviewing how we market our terms and conditions because there are a number of benefits where we compare more favourably than the private sector. We are also ensuring that where we have some flexibility on more localised benefits, such as health and wellbeing, training, etc. we invest in areas that staff value.

2. Is there any benchmark data for independent sector remuneration and conditions of service?

There are remuneration surveys which can be purchased. Hourly pay rates can be higher in the private sector, but this is typically offset by better terms and conditions offered in the NHS. These include pensions, sick pay, maternity allowance, and annual leave. The rationale behind providing our staff with their personal "total reward statement", which is newly available to all staff in the NHS nationally, is to ensure they are aware of the total benefits package which we provide, not just the pay rate.

***Status*** *Closed*

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 24/10/2014**

Response from Helen Morgan, Deputy Chief Nurse:

All Trusts were required to publish actual and planned staffing fill rates from June 2014. This requirement currently only applies to inpatient wards, it excludes day care wards, central delivery units and extra capacity wards. The data captures actual versus planned fill rates on a shift by shift basis for registered nurses, midwives, assistant practitioners, nursing and midwifery assistants. We are not currently required to capture any other groups of staff. The table includes all areas we are required publish data on.

Whilst the total actual versus planned gives a general overview of the Trust position, it is the data on a ward by ward basis which is proving of most value to Sisters and Divisional teams.

71/74 is one ward caring for both pre and post natal women. Staff work flexibly across all the maternity wards and are moved if required following a risk assessment. The acuity of the women together with the number of beds open at any one time is always considered. Capturing the change in the numbers of beds open together with the acuity of patients is one of the data capture challenges, but one which we are continuing to explore.

***Status*** *Closed*

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

**Query 15/10/2014**

(Reworded by Trust Secretariat by agreement with Bob Bennett) Anecdotal evidence was provided regarding negative patient experience at the Pain Clinic, BRI. Mr Bennett's query related particularly to the appointment process, including non-recording of appointments and staff attitude, resulting in distress and confusion for the patient. Mr Bennett queried whether there was an underlying issue in terms of the reliability of the appointments process, or whether there was a need to review support and training for staff.

**Response 24/10/2014**

The specific details were submitted to the Patient Support and Complaints Team and have been reviewed. Unfortunately, due to the lack of detail with regard to these incidents, it is not possible to investigate these issues. However, patients can be directed to the Patient Support and Complaints Team should they wish to make a formal complaint. The concerns expressed have also been forwarded to Jenny Holly, Assistant General Manager for the Pain Service.

In the meantime, following initial review, it has been confirmed that there have been no underlying issues identified with regard to the appointments process, and clarification has been provided that all appointments are booked onto the electronic booking system for the area in question. The Trust has in place a robust Induction and comprehensive mandatory training programme, which include Trust Values and Conflict Resolution training. Mandatory training for all staff is delivered every three years to ensure all staff are refreshed on the key messages on a regular basis.

***Status*** *Closed*

| ID | Governor Name | | |
|---|---|---|---|
| **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** **28/10/2014**

Response from Sue Donaldson, Director of Workforce and Organisational Development:

Firstly it might be helpful to explain how the KPI is set and why we report two figures as set out on page 79. Through the Divisional Operating plan processes, Divisions set a target for each KPI, and this is used to inform the Trust target for the year. In order to monitor the trajectory to the end point, a target is set for each month. The target for August was 10.6%, but the target to be achieved for the end of the year was 10%. This reflects the fact that turnover is a rolling cumulative figure, and therefore 11/12s of the monthly out turn have already been determined (because it is based on the previous 12 months).

We recognise historically our turnover has been increasing and appears much higher than other comparable trust. This is why we have set an ambitious target for reduction, with the full support of the Board.

We have comprehensive programmes in place to improve retention which have been described in our Board papers. These are largely in the context of improving staff experience and engagement, although considerable focus is also on developing a better understanding of why our staff are leaving . An update on this work is due in the Quarterly Workforce and OD Report coming to the board in November. Interestingly as part of this work we are refreshing our benchmarking and it looks as though other trusts are experiencing an upward trend in the number of staff leaving.

***Status*** *Closed*

| | | | |
|---|---|---|---|
| **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** **03/11/2014**

Revised response received from Director of Workforce and Organisational Development on 3/11/14:

1. I understand that the trust had a shortfall of 430 full time equivalent staff in August (5.56%); is this correct?
Response: The vacancy rate reported in August was 5.56%, 430 WTE. To qualify this, vacancies reported in our Board reports 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.

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.
Response: We recognise that year on year, our use of temporary staff has increased. This is due to additional capacity and other factors, including higher turnover and vacancy rates. 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. However, we are concerned about the cost of agency staff and there are plans in place to reduce this.

3. Is there assurance that the Mutually Agreed Resignation and unpaid leave Schemes do not have an adverse effect on 1 and 2 above.
Response: Any application under MARS or for unpaid leave schemes must demonstrate that they would be in the financial and operational interests of UH Bristol.

***Status*** *Closed*