University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Council of Governors meeting to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough St, Bristol, BS1 3NU

Item	*Sponsor*	*Page*	*Time*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman		14:00
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman		14:02
3. Minutes from the Previous Meeting To consider the minutes of the meeting of the Council of Governors on 29 January 2015 for **approval**.	Chairman	3	14:05
4. Matters Arising (Action Log) To consider the status of Actions from previous meetings.	Chairman	12	14:10
Statutory and Foundation Trust Constitutional Duties			
5. Lead Governor Appointment To **approve** the appointment of a Lead Governor for the Council of Governors for 2015/16.	Chairman	Verbal	14:15
6. Nominations and Appointments Committee report - To receive and **note** this report. - To **approve** the recommendation to continue the appointment of John Savage as Chairman subject to annual review. - To **appoint** Angelo Micciche, Local Patient Governor, to the Nominations and Appointments Committee.	Chairman	13	14:25
7. Governor Development Seminar report - To receive and **note** this report. - To receive and **note** a verbal report from the NHS Providers Governors Conference (Wendy Gregory)	Head of Membership and Governance	15	14:30
8. Governor Project Focus Groups reports To receive and **note** the following reports: a) Governors' Strategy Group (formerly Annual Plan Project Focus Group) b) Quality Project Focus Group c) Constitution Project Focus Group	Project Focus Group Governor Leads	16 18 20	14:35
9. Membership and Governor Engagement To receive and **note** the following reports: a) Membership Engagement Strategy (including Membership Activity) b) Governor Activity Report: To **note** that 2 new governors have joined the Council of Governors, and to **note** a report of governors' attendance at meetings and events.	Head of Membership and Governance	To follow 22	14:45
10. Governors' Register of Business Interests	Trust	27	14:50

Item	*Sponsor*	*Page*	*Time*
To **note** the updated Governors' Register of Business Interests.	Secretary		
11. Council of Governors Meetings Forward Planner for 2015/2016 To receive the forward planner for 2015/16 for Council of Governors meetings business to **note**.	Trust Secretary	32	14:52
12. External Auditors – Extension of Contract To receive the recommendation from the Audit Committee to re-appoint PriceWaterhouseCoopers for a further period of 12 months from 1st July 2015 – 30th June 2016.	Chairman	To follow	14:55
13. Governors' Log of Communications - To **note** the current position of the Governors' Log of Communications. - To **note** the new Standard Operating Procedure for the Governors' Log of Communications.	Chairman	34	15:00
Strategic Outlook			
14. Performance Update and Strategic Outlook a) **Chief Executive's report** To receive and **note** a verbal update from the Chief Executive. b) **Quarterly Patient Experience and Complaints Reports** To receive and **note** these reports from the Chief Nurse.	Chief Executive Chief Nurse	Verbal 43	15:15
15. Monitor Annual Plan 2015/16 To **receive** the Monitor Operational Plan Document 2015-16 and **approve** prior to submission.	Chief Executive		15:30
Governors' Questions			
16. Governors' Questions arising from the meeting of the Trust Board of Directors To respond to questions arising from matters of business discussed at the preceding meeting of the Trust Board of Directors, including quality and performance.	Chairman		15:40
17. Any Other Business To **note** any other relevant matters.	Chairman		15:50
Members' Questions			
18. Foundation Trust Members' Questions To **receive** questions from Foundation Trust members and members of the public present (preferably notified in advance of the meeting).	Chairman		15:55
19. Meeting Close and Date of Next Meeting The next meeting of the Council of Governors will be held at 2pm on Thursday 30 July 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.			

University Hospitals Bristol NHS
NHS Foundation Trust

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Minutes of the Council of Governors Meeting held on
29 January 2015 at 2:00pm in the Conference Room, Trust Headquarters, Marlborough Street, BS1 3NU

Present:
John Savage – Chairman
Sue Silvey – Lead Governor and Public Governor
Pauline Beddoes – Public Governor
Bob Bennett – Public Governor
Clive Hamilton – Public Governor
Brenda Rowe – Public Governor
Mo Schiller – Public Governor
Tony Tanner – Public Governor
Anne Skinner – Patient Governor
John Steeds – Patient Governor
Pam Yabsley – Patient Governor
Wendy Gregory – Patient Governor – Carer
Philip Mackie – Patient Governor – Carer
Nick Marsh – Staff Governor
Karen Stevens – Staff Governor
Florene Jordan - Staff Governor
Marc Griffiths – Appointed Governor
Jeanette Jones – Appointed Governor
Tim Peters – Appointed Governor
Sue Hall – Appointed Governor
Jim Petter – Appointed Governor

Board of Directors present:
Robert Woolley – Chief Executive
Deborah Lee – Deputy Chief Executive and Director of Strategic Development
Sean O'Kelly – Medical Director
Sue Donaldson – Director of Workforce and Organisational Development
James Rimmer – Chief Operating Officer
Paul Mapson – Director of Finance
Carolyn Mills – Chief Nurse
Aidan Fowler – Fast-track Executive
Emma Woollett – Non-executive Director
David Armstrong – Non-executive Director
Alison Ryan – Non-executive Director
Jill Youds – Non-executive Director
Julian Dennis – Non-executive Director
John Moore – Non-executive Director

01/01/15 Chairman's Introduction and Apologies
The Chairman, John Savage, welcomed everyone to the meeting. He advised governors that plans to change the start time of future Public Trust Board meetings may have an effect on the start time of Council of Governors meetings.

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Apologies had been received from:
Abbas Akram (Appointed Governor), Graham Briscoe (Public Governor), Edmund Brooks (Patient Governor), Mani Chauhan (Public Governor), Ian Davies (Staff Governor), Thomas Davies (Staff Governor), Lukon Miah (Appointed Governor), Angelo Micciche (Patient Governor), Sue Milestone (Patient/Carer Governor), Tony Rance (Public Governor), Bill Payne (Appointed Governor), Ben Trumper (Staff Governor), Lorna Watson (Patient/Carer Governor), Guy Orpen (Non-executive Director) and Lisa Gardner (Non-Executive Director).

02/01/15 Declarations of Interest
In accordance with Trust Standing Orders, all members present were required to declare any conflicts of interest with items on the Meeting Agenda. There were no declarations of interest.

Change to the agenda: The Chairman announced, that in response to feedback from governors and directors, today's meeting would be restructured to deal with the standard items quickly at the start to enable a longer discussion time.

03/01/15 Minutes from Previous Meeting
Governors considered the minutes of the meeting of the Council of Governors on 30 October 2014 and approved them as an accurate record of the meeting. It was:

RESOLVED:
- **That the minutes of the meeting held on 30 October 2014 be approved as an accurate record of proceedings.**

04/01/15 Matters Arising (Action Log)
The Action Log was noted.

In reference to Page 5 of the minutes of the previous meeting, Clive Hamilton, Public Governor, enquired whether Robert Woolley had yet considered how the lessons learnt by the Trust through Serious Incidents could be best shared with governors. Robert confirmed that a process was now in place and would be shared with governors at their Quality Project Focus Group on 3 March.

Governor' Log of Communications: Sue Silvey, Lead Governor, informed governors that any actions that related to the Governors' Log of Communications would now be considered by the Constitution Project Focus Group at their meetings. John Savage encouraged governors to continue using the Governors' Log of Communications.

05/01/15 Performance Update and Strategic Outlook

05/01/15 a) Chief Executive's Report
Governors received and noted a verbal update from the Chief Executive, Robert Woolley.

Robert highlighted the following issues:

University Hospital Bristol NHS Foundation Trust Performance: Robert described the Trust's current position as challenging, explaining that the Trust had declared to Monitor that it was non-compliant against the Monitor Risk Assessment Framework for the 4-hour A&E standard, all three Referral-to-Treatment standards, and the combined 62-day GP and Screening Cancer Standards. The Trust was also concerned about throughput on 6-week diagnostic waits, but there had been positive progress in terms of the level of last-minute cancellations, which reflected some of the internal work carried out in relation to managing the surgical planned pathways in a more active way.

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As the Board of Directors had been informed this morning, Monitor had written to the Trust saying that if the Trust could not meet its planned trajectories for recovery, then Monitor would consider opening a formal investigation into the governance of the Trust.

The National Perspective: The national context was also challenging. The Kings Fund Quarter 3 monitoring report on the NHS had revealed that activity across England continued on an upward trend in every category. The A&E 4-hour waiting time target was failed across the whole of England (92.6% against a target of 95%), with nearly 50% of hospitals with A&Es failing the target in the period. Referral-to-treatment times were also failed across England in November. The Kings Fund estimated that 5,000 patients were fit for discharge but delayed in hospital every day, while 42% of Trusts were forecasting a financial deficit this year. The King's Fund had stated: "*Services are stretched to the limit. With financial problems also endemic among hospitals and staff morale a significant cause for concern, the situation is now critical."*

In this context, there had been a significant injection of short-term 'resilience funding' into local health economies. As a result, nearly £4m had been received exceptionally by the Trust this winter, though the Trust was likely to have to pay £2.5m of it back in contract penalties for performance breaches. Activity had been bought from the independent/private sector for hospitals to use. Also, the Trust had just heard that 12 week packages of funding from central government had been agreed with voluntary sector partners to help the NHS tackle delayed discharges and blockages.

Robert explained that there was a significant amount of uncertainty about funding for next year. The Trust was in the middle of a planning round to decide its business plan for next year. However, there was uncertainty around the contract (it was not yet clear what commissioners were going to buy at this stage), and uncertainty about the contract terms (whether the Trust would be fined even more next year for breaching performance standards).

There was also considerable uncertainty around the 2015-16 tariffs (the national price list), which Monitor had confirmed this morning had been rejected by providers, and could therefore not be issued. Formal objections lodged by providers had clearly breached the 51% threshold at which the pricing authorities must either refer their proposals to the Competition and Markets Authority for review, or consult the health service again on revised prices taking into account the objections.

This could take some time, and as a result, NHS organisations were in the unprecedented position of not knowing what the price list would be for next year. Planning would continue on the basis of the guidance already issued.

Robert assured governors that the Trust understood the scale of challenges and was working very hard as an Executive team and with the divisional leadership to make sure that there were robust delivery plans in place. He cautioned that it might be necessary to make a judgment with the support of the Board and Governors to go 'at risk' on some of those delivery plans.

He added that capacity would need to be increased next year, and that the Trust was considering every option including opening new beds. The strategy hitherto had been to reduce beds because the Trust had believed that commissioners would take activity away from acute hospitals, but, as demonstrated by the Kings Fund report, this had not happened.

A key focus for the Board was how to retain staff when morale was under stress and how to recruit additional staff. It would also consider whether the Trust needed to restrict demand where it was possible to do so.

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Robert added that it was difficult to be certain about the strategic outlook in the current context, particularly given that there could be a potential change in government. However, it could be assumed that there would be no significant change in the economic climate, and public services would continue to remain under pressure, and the Trust would still have to start working more intensely with its partners to redesign care across the sectors of primary, community, acute and social care. Meanwhile, the Trust's operational focus would remain on the pressures of delivering services every day and trying to decide its plans for next year.

He took the opportunity to remind governors that this Trust was not one of the 42% that were forecasting a deficit, and that while the recent Care Quality Commission inspection report had rated the Trust as 'requires improvement', he had taken enormous amount of assurance from the report about the quality of care that was being delivered: it was clear that the biggest issues were patient flow issues and the Trust was working with system partners to try and ameliorate the impact of emergency demand in particular.

05/01/15 b) Quarterly Patient Experience and Complaints Report

Carolyn Mills, Chief Nurse, asked governor to note this report.

RESOLVED:
- **That the Council of Governors receive the performance update and strategic outlook and the quarterly patient experience and complaints report to note.**

06/01/15 Governors' Questions arising from the meeting of the Trust Board of Directors
As agreed at the start of the meeting, governors' questions were postponed until the end.

07/01/15 Governors Log of Communications
Governors received and noted the current position of the Governors' Log of Communications.

RESOLVED:
- **That the Council of Governors receive the Governors' Log of Communications for information.**

08/01/15 Foundation Trust Constitution
The Chairman noted that there had been a significant amount of work on revising the constitution over the past year. The revisions had been discussed at that morning's meeting of the Trust Board of Directors, and the Board had approved the revised constitution, subject to several minor amendments, which were outlined as follows by Debbie Henderson, Trust Secretary:
- To remove Annex 9 – Role of the Governor and to review this document at the next Constitution Project Focus Group in March. This document would be maintained separately, so would not impact on the constitution in future.
- To remove paragraph 31.1.10 of the constitution (that a person may not become or continue as a Director '*if they were an Executive or Executive Director of another NHS Foundation Trust or a 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')* - due to changes in legislation, this was no longer a requirement.
- After some discussion it had been decided to retain for now the paragraph relating to Trust Board quoracy (Annex 7 – Standing Orders for the Practice and Procedure of the Board of Directors, paragraph 3.43 – '*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'), but it was agreed that this should be revisited next year as part of the annual review of the constitution.
- It had also been agreed to review the Trust Board's compliance with its Code of Conduct to report to the Board meeting in March.

Governors approved the revisions to the constitution and the revised Governors' Code of Conduct.

RESOLVED:
- **That the Council of Governors approve the revised Foundation Trust Constitution subject to minor amendments.**
- **That the Council of Governors approve the revised Governors' Code of Conduct.**
- **That Appendix 9 - the 'Role of the Governor' document be removed and reviewed at Constitution Project Focus Group meeting in March.**

09/01/15 Nominations and Appointments Committee report

Governors received and noted this report.

The Committee had noted that the term of office of Non-executive Lisa Gardner was due to end in May. John Savage reported that he had since discussed with Lisa whether she would be prepared to serve another three-year term, and she had agreed. He added that her re-appointment would need to be subject to an annual review to establish her continued independence.

John also asked governors to formally approve the appointment of Jill Youds as Non-executive Director, following the end of Kelvin Blake's term of office. Jill had been appointed in 2013 as a Non-executive Observer.

RESOLVED:
- **That the Council of Governors receive the Nomination and Appointments Committee report for information**
- **That the Council of Governors approve the re-appointment of Lisa Gardner, subject to an annual review.**
- **That the Council of Governors formally approve the appointment of Jill Youds as Non-executive Director.**

10/01/15 Governor Development Seminar report

Sue Silvey reported that there had been a Governor Development Seminar on 14 January which had included a talk about media relations, a briefing from the Chief Operating Officer about the Trust's Access Recovery Plans, and a workshop session on Public & Patient Involvement and membership engagement. Governors had also started the process of performance effectiveness evaluation of the Council of Governors, and she encouraged governors to submit their completed self-evaluation questionnaires if they had not already done so.

RESOLVED:
- **That the Council of Governors receive the Governor Development Seminar report for information.**

11/01/15 Governor Project Focus Group Meeting reports

<u>Annual Plan Project Focus Group</u>

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Wendy Gregory, Lead Governor for the Annual Plan Project Focus Group, reported that the group had met on 4 December 2014 with David Relph, Head of Strategy, and had received an update on the Annual Plan and the Operating Plan, and a review of the Trust's Capital Prioritisation work.

It had been suggested that the name of the group be changed to the Governors' Strategy Group to reflect the broader scope of the group's remit.

Quality Project Focus Group
Clive Hamilton, Lead Governor for the Quality Project Focus Group, reported back from the group's meetings on 13 November and 13 January. Items discussed had included the Trust's performance, presentations on Medicines Safety and Dementia, an update about the Care Quality Commission Inspection and Histopathology, and a report about learning from complaints.

He advised governors that there would be a special meeting of this group on 12 February, at which Chris Swonnell, Head of Patient Safety, (Patient Experience and Clinical Effectiveness) would be seeking the views of governors on the Quality Report. Debbie Henderson added that this meeting would include the governors' selection of a local indicator for the Quality Report. More information about this meeting would be circulated in due course.

Clive Hamilton announced that future QPFG meetings would have updates on discharge planning, end-of-life care, research update and productive outpatients, and he encouraged all governors to attend or give their views.

Constitution Project Focus Group
Sue Silvey, Lead Governor for the Foundation Trust Constitution Project Focus Group, reported back from the meeting on 4 December, which had considered the constitutional review.

RESOLVED:
- **That the Council of Governors receive the following updates**
  - **Annual Plan Project Focus Group**
  - **Quality Project Focus Group**
  - **Constitution Project Focus Group**

12/01/15 Governor and Membership Activity Reports
Membership Activity Report
Governor Activity Report
These reports were noted.

RESOLVED:
- **That the Council of Governors receive the Governor and Membership activity report for information**

13/01/15 Any Other Business

DISCUSSION TIME
The Chairman invited questions from governors about any of the issues discussed at the Council of Governors meeting or at the preceding meeting of the Trust Board of Directors.

a) John Steeds, Patient Governor**,** referred to the £4 million resilience funding that Robert Woolley had spoken about, and enquired where it had come from.

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Robert Woolley, Chief Executive, responded that it was received through third parties, from Clinical Commissioning Groups or via Monitor directly. The Trust had submitted a plan against the expectations set out by commissioners and Monitor, with a series of initiatives aimed at assisting the flow of patients through the hospital and delivery of the 4-hour target, and the money had been granted in support of those initiatives. John further enquired how this related to the 12-week packages of funding from central government agreed with voluntary sector partners to help the NHS tackle throughput. Robert responded that the 12-week funding would be provided to Royal Voluntary Services, and that the Trust would need to liaise with RVS about its use. Robert described to governors the difficulties in planning services with very short-term injections of money and no certainty of continuing funding.

b) John Moore, Non-executive Director, expressed an interest in the Key Performance Indicators that the Trust's partners were working to that were affecting the time that people were on the Green-to-go list, and requested a presentation to the Board about the actions being taken in the community to speed up discharge.
Robert responded that there had been a significant amount of progress over the past year in setting system-level performance indicators to monitor system capacity and system dynamics. The challenge was now to demonstrate the difference that these were making. He agreed to consider pertinent examples to share with the Board.

c) Clive Hamilton, Public Governor noted that there were increasing indications in the Board reports that the Trust was using the independent and private sector for additional help. He enquired whether the additional money available for the Trust to spend in the independent and private sector was the same as resilience money, and whether it was conditional on being spent in this way.
Robert clarified that this was not resilience money: that it did not in fact represent extra funding coming into the Trust, but rather the Trust was being asked to identify patients that were suitable for independent or private provision and was seeking to transfer patients where they were willing or able to go.

d) There was some discussion about the Trust's current efforts to recruit and retain staff in the face of high turnover. John Steeds enquired whether there was a danger of nursing staff leaving the Trust due to better terms of employment in the private sector. Sue Donaldson, Director of Workforce and Organisational Development, responded that this was generally not the case, adding that staff were typically moving to other NHS providers rather than the private sector.

Wendy Gregory, Patient –Carer Governor, asked that alongside recruitment efforts, the Trust also seek to gain an improved understanding of why staff were leaving, for example exit interviews. Sue Donaldson responded that a significant amount of work was being carried out, not only to understand why staff were leaving, but also to improve staff experience. The quarterly workforce report to the Board in February would include information about this.

Jeanette Jones, Appointed Governor – Joint Union Committee, added that as part of the work to retain staff, she was involved in the re-launch of the staff disability group. Now called Living and Working with Disease, Injury and Illness (LAWDII), its first meeting was scheduled for 18 February, 1-6pm in the Education Centre, and all were welcome to attend.

In response to a question from Anne Skinner, Patient Governor, about whether the Trust provided sufficient number of opportunities for nursing assistants to train as nurses, Carolyn Mills, Chief Nurse, responded that Health Education South West was this year widening the access programme, and this would be advertised at UH Bristol in due course. Marc Griffiths, Appointed Governor – University of the West of England, added that UWE had commissioned 20 training

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places for nurses for Sept 2015 who would train in their first year with their Trust and would join UWE for their second and third year.

Florene Jordan, Staff Governor, gave a personal example of the effect of high staff turnover – today, three of her colleagues had announced that they were leaving, and she described the effect on morale of those who were still there. It was suggested that Florene discuss this particular issue with Sue Donaldson after the meeting.

Mo Schiller, Public Governor, asked about the Trust's plans in relation to the recruitment of theatre nurses. Sue Donaldson added that a comprehensive plan was in place, and efforts were going into trying to market Bristol as an attractive location. There was a discussion around incentives to encourage trainee nursing staff to stay with the Trust once they were qualified.

John Moore, Non-executive Director, enquired whether if staff wanted to leave, the Trust attempted to find out whether they would be interested in redeployment elsewhere in the Trust. Sue Donaldson responded that the Trust had always offered redeployment, but there were plans to make it much more transparent to staff.

John Moore further enquired that the Trust look at its processes to establish whether there was anything that staff were doing that was not essential. Robert responded that this was a constant endeavour but variable across the organisation. The savings programme every year was based on how the Trust could become more efficient, but the ability to free staff up to map pathways and remove unproductive steps was a constraint. Improvements had been made in some areas, and there were advances that had productivity as well as quality benefits for patients, for example enhanced surgical recovery.

e) Referring to the Patient Experience story discussed at the Trust Board meeting that morning, Wendy Gregory emphasised the importance of staff who carry out impact assessments on major capital projects 'walking the patient pathway' to find out how changes were going to impact patients, particularly those most vulnerable. Robert Woolley agreed.

f) Wendy also enquired whether Foundation Trusts were collectively lobbying Monitor in an effective manner, for example on the issue of penalties for not achieving targets. Robert affirmed that the Trust regularly expressed its views to Monitor in relation to whether penalties were reasonable, and that it had a good relationship with Monitor. He clarified that the fines were not imposed by Monitor, but by the commissioners, and governors were interested to hear that by the end of this financial year, the Trust would have paid £2.5m in fines.

Robert added that the Trust lobbied collectively both through NHS Providers (formerly the Foundation Trust Network) and the Association of UK University Hospitals. He cited the example of the veto of the national tariff as effective collective action.

There followed a discussion about the role of Monitor and NHS England and the areas of conflict between the roles of commissioner and regulator. There was discussion around the conflicts in the system and concerns were raised about the impact these might have on the Trust's delivery of its targets.

Clive Hamilton enquired whether the increased emphasis on collaborative and integrated work meant that Monitor would incorporate a policing role into the licence to ensure that all healthcare organisations worked collaboratively and integrated their care. Robert clarified that there had been a duty to collaborate for a long time, but there was now a new proposed licence condition

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enacting Monitor's duty to foster integration by potentially penalising Foundation Trusts for exhibiting behaviour that was contrary to the objective of integration.

g) John Steeds noted that the recent bid to secure a genomics centre for the area (which had involved UH Bristol and had been led by North Bristol Trust) had not been successful and enquired about the Trust's plans for the next bid. Robert explained that the Trusts had taken feedback on the bid that had been submitted, and understood that more clarity was required about its footprint and stakeholders. Sean O'Kelly, Medical Director was liaising with North Bristol Trust, but it was not yet clear which organisation would lead the bid going forward.

h) Wendy Gregory expressed concern about the findings in the Quarter 2 Patient Experience and Complaints report that the two main reasons for a negative patient experience were communications and involvement in care decisions. She enquired whether this related to patients or carers. Carolyn Mills, Chief Nurse, responded that she understood it to be a combination of both, and assured Wendy that she was confident that there were no underlying themes arising from the report.

i) Sue Silvey, Lead Governor, asked Sean O'Kelly, Medical Director, to comment on the recent Schwarz Rounds meeting. Sean explained that the meeting had involved presentations from three members of staff in Bristol Royal Hospital for Children on the topic of 'A patient I'll never forget'. Attendance and discussion had been very good, and there had been positive feedback.

14/01/15 Foundation Trust Members' Questions
Garry Williams, a Foundation Trust member, stated that he had written a letter to the Chairman on the matter of car-parking asking that the contract be rigorously examined on an ongoing basis. The Chairman confirmed that he had received this letter today and would respond in due course.

Meeting close and Date and Time of Next Meeting
The new format of the meeting was welcomed.

Debbie Henderson introduced the new Head of Membership and Governance, Amanda Saunders, who would be starting with the team on 9 March.

Sue Silvey reminded those present that the next Health Matters Event would be on the topic of Dermatology and was scheduled for 5 March.

There being no other business, the Chair declared the meeting **closed**.
The next meeting of the Council of Governors will be held on Thursday 30 April 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

…………………………………….(Chair) …………………2015 (Date)

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University Hospitals Bristol NHS
NHS Foundation Trust

Council of Governors meeting
Item 04 - Action tracker

Outstanding actions following meeting held 29 January 2015				
Minute reference	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
	No outstanding actions to note.			
Completed actions following meeting held 29 January 2015				
08/01/15	**Foundation Trust Constitution Revisions** • Minor amendments to the constitution. • Implementation of new governors' Code of Conduct. • Review of 'Role of a Governor' document at Constitution Project Focus Group meeting in March.	Trust Secretary	April 2015	Complete.
10/10/14	**Governor and Membership Activity Report** Membership and Engagement Strategy to be submitted to the Council of Governors for consideration and approval	Trust Secretary	April 2015	Complete – agenda item 9a – incorporates outcome of Governors' Annual Self-Assessment.

Nominations and Appointments Committee Report for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 06 - Nominations and Appointments Committee Report

Purpose

The purpose of this report is to provide the Council of Governors with an update on the activities of the Governors' Nominations and Appointments Committee.

Abstract

The Nominations and Appointments Committee is a formal Committee of the Council of Governors established for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment, removal, remuneration and other terms of service of the Chairman and Non-executive Directors.

Recommendations

The Council of Governors is asked to **note** the report and:

- To **approve** the recommendation to continue the appointment of John Savage as Chairman subject to annual review in line with the Monitor Code of Governance
- To **appoint** Angelo Micciche, Local Patient Governor, to the Nominations and Appointments Committee.

Report Sponsor or Other Author

Sponsor: Trust Secretary

The Nominations and Appointments Committee has held **two** meetings since the last Council of Governors meeting.

Nominations and Appointments Committee: 25 February 2015

Governors present: Sue Silvey, Mo Schiller, John Steeds, Pam Yabsley, Wendy Gregory, Philip Mackie, Florene Jordan, and Jeanette Jones.

Others present or in attendance: John Savage – Chairman, Debbie Henderson – Trust Secretary and Sarah Murch – Membership & Governance Administrator.

Topics discussed:

- **Appraisal and Annual Review process for Chairman and Non-executive Directors:** Governors approved a new and more rigorous system for assessing the performance of the Chairman and the Non-executive Directors. Under the new system, they would be subject to an annual appraisal/review, which would be conducted by the Chairman (for the Non-executive Directors), and the Senior Independent Director (for the Chairman). Feedback would be sought from Trust Board members and governors. The results of the appraisals would then be reported back to governors in the Nominations and Appointments Committee for review.
- **Terms of Reference and Forward Planner:** Governors approved the forward planner for the committee's business for the year, and the revised terms of reference (subject to a minor change around committee membership). It was noted that, due to the new appraisal/annual review process for the Chairman and Non-executive Directors, two extra meetings of the Nominations and Appointments Committee would be required in the year.

- **Chairman's term of office**: It was agreed that the Trust Secretary should consider the implications of the terms of office of both the Chairman and Vice-Chair being due to expire at the same time (May 2017).

Nominations and Appointments Committee: 15 April 2015

Governors present: Sue Silvey, Mo Schiller, John Steeds, Pam Yabsley and Anne Skinner.

Others present or in attendance: Emma Woollett – Senior Independent Director, Debbie Henderson – Trust Secretary, and Sarah Murch – Membership & Governance Administrator.

- **Appraisal and Annual Review for John Savage, Chairman-** Governors received and discussed the Chairman's appraisal paperwork. A report on the Chairman's Appraisal is attached at Appendix A.
- **Re-appointment of Chairman** – The Committee agreed to continue to support John and formally recommend that his appointment be continued subject to the annual review.
- **Guy Orpen's term of office:** As Guy Orpen's term of office was due to end, the Committee agreed to extend his appointment until July, and postpone his appraisal and consideration of a re-appointment of a second term of office until the next Committee meeting on 23 June 2015 for recommendation to the Council of Governors meeting on 30 July.

The next meeting of the Nominations and Appointments Committee will take place on Wednesday 23 June 2015 at 13:30-14:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

Committee Vacancy

There is 1 vacancy on the Nominations and Appointments Committee for an elected Public or Patient Governor. An application supported by a statement has been received by Angelo Micciche (Local Patient Governor). The Council of Governors is asked therefore to approve Angelo's appointment to this committee.

Appendices

Appendix A – Report of Chairman's Appraisal **– to follow.**

Council of Governors

Nomination and Appointments Committee Report

Recommendation to re-appoint Mr John Savage, Chairman, University Hospitals Bristol NHS Foundation Trust

1. INTRODUCTION

Governors will be aware that it is one of their statutory duties to appoint the Chairman of the NHS Foundation Trust. The Council of Governors have delegated this responsibility to a formally constituted Nomination and Appointments Committee comprised of Governor representatives, selected by the Council. The recommendations of the Committee are brought to the full Council for review and ratification.

2. BACKGROUND

The present Chairman of the Trust, Mr John Savage, was re-appointed on 1st June 2011 for a second three year term of office, which expired on 31st May 2014.

Mr Savage was then re-appointed for a further third term of office on 1st June 2014. It was acknowledged by the Committee that this would represent Mr Savage's seventh year as Chairman and at the Nomination and Appointments Committee meeting in February 2015, it was agreed to implement a revised, rigorous annual appraisal process for all Non-Executive Directors to reflect the requirements of Monitor's Code of Governance for Non Executives who serve longer than six years. The Code of Governance states:

"Non-executive directors may, in exceptional circumstances, serve longer than six years but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence".

3. APPRAISAL/ANNUAL REVIEW PROCESS

An appraisal/annual review is a tool used in managing performance and acts as a vehicle for assessing the performance of staff (including Board members) to identify requirements for training and development moving forward. The Appointments Commission stated that the appraisal process for Non-Executive Directors should aim to achieve the following:

- Hold all Non-Executive Director's to account for their performance
- Set appropriate objectives consistent with the role, and the objectives of the organisation
- Identify learning and development needs
- Support succession planning for the organisation

The appraisal/review process for the Chairman and Non-Executive Directors included:

- Self-assessment against the core competencies for NHS Non-Executive Directors as defined by the NHS Leadership Academy. The Core Competencies are; shaping corporate strategy; adding value to the Board; patient, carer and community focus; acting as a team player; balance of understanding; holding colleagues to account; intellectual flexibility; and self-belief and emotional resilience;
- Curriculum vitae information;

- Summary of Trust involvement during the period;
- feedback from the Non-Executive Director cohort;
- feedback from the Chief Executive, on behalf of all Executive members of the Board; and
- feedback from the Council of Governors
- Statement from the Senior Independent Director

Emma Woollett, Senior Independent Director chaired the meeting of the Nomination and Appointments Committee on 15th April 2015. Following the Committee's review of the appraisal/annual review paperwork, the Committee came to the view that Mr Savage is an excellent chair. Positive feedback was received from Non-Executive Directors, Executive Directors and Governors about his performance over the last year particularly with regard to:

- Ability to clearly articulate a moral purpose for the Board, which has an important influence on the culture and leadership of the Board. This was specifically commented on by Executives, Non-Executive Directors and Governors.

- Strong patient, carer and community focus ensures that all discussions are grounded in patient benefit. Again, specifically mentioned by all three groups.

- Strong relationships with the Council of Governors and uses this to influence the strategic direction of the trust.

- Authority and confidence – both in chairing the Board and in his willingness to challenge regulators when necessary

4. RECOMMENDATION

The Committee acknowledged the challenges facing the Trust over the next 12 36 months and the importance of maintaining continuity and stability on the Board at this time, particularly with regard to the leadership role of the Chairman.

The Nomination and Appointments Committee therefore recommend to the Council of Governors the following:

- That Mr John Savage has his term of office extended initially by one year, to 31st May 2016 and that any subsequent extension should be based upon the annual appraisal / review process in line with the guidance outlined in Monitors' Code of Governance

Debbie Henderson
Trust Secretary, for and on behalf of the Nomination and Appointments Committee
23rd April 2015

A Governor Development Seminar Report for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 07 – Governor Development Seminar Report

Purpose

To provide the Council of Governors with an update on the governor development programme.

Abstract

The governor development programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively. The programme was co-created with governors using self-assessment and short-life task and finish groups.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Author: Head of Membership and Governance

Report

There have been **no** Governor Development Seminars since the last Council of Governors meeting.

The programme for Governor Development Seminars for 2015/2016 is being developed to address topics previously raised as being useful by governors – for example making effective use of data resources available for performance and finance.

In addition the programme for Seminars and Informal Meetings will also be deigned to ensure topics relate to key themes from the Trust's Strategy and Operational Plan and cover the 2015/16 Corporate Quality Objectives, with the aim of providing Governors with an overview and insight that will enable them to best undertake their role and support the Board in the year ahead.

The next Governor Development Seminar will be held on 10 June 2015 from 10:00-15:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

Governors' Strategy Group Meeting Account for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08a – Governors' Strategy Group Meeting Account
Purpose
To provide the Council of Governors with an update on meetings of the Governors' Strategy Group.
Abstract
The Governors' Strategy Group (formerly known as the Annual Plan Project Focus Group) provides an opportunity for engagement with governors to develop the Monitor Annual Plan and to contribute to the Trust's strategic planning. David Relph is the Chair and Executive Lead for the Governors' Strategy Group and the Lead Governor for the group is Wendy Gregory. There are around 6 meetings a year, and they are open to all governors.
Recommendations
The Council of Governors is asked to **note** the meeting account.
Report Sponsor or Other Author
Sponsor: Governor Lead for Strategy Project Focus Group

The Governors' Strategy Group has held **two** meetings since the last Council of Governors meeting.

Governors' Strategy Group: 5 February 2015

Governors attending: Wendy Gregory *(Lead Governor for the Focus Group)*, Bob Bennett, Graham Briscoe, Clive Hamilton, Florene Jordan, Angelo Micciche, Mo Schiller, John Steeds, Anne Skinner, Thomas Davies, Nick Marsh, Sue Milestone and Brenda Rowe.

Others present or in attendance: David Relph – Head of Strategy and Business Planning *(Focus Group Chair)*, Paul Tanner – Head of Finance, Alex Crawford – Deputy Head of Commissioning and Planning, Debbie Marks – Membership Support Assistant.

Topics discussed:

- The group decided to change its name from the **Annual Plan Project Focus Group** to the **Governors' Strategy Group**, to better reflect the scope of its remit.
- **Monitor Planning Update:** David Relph, Head of Strategy and Business Planning, gave governors an update on the production of the Monitor Annual Operational Plan, including the timeline, structure, content, risks and priorities. Key themes would be sustainability and resilience.
- **Longer-term investment priorities – campus phase 5**: The group briefly discussed potential future plans and their implications.
- **Organisations within the health sector:** David shared with the group an overview chart and video to help them understand the different organisations within today's health sector.
- **Update on Weston Hospital:** David agreed to keep governors updated about the acquisition of Weston Hospital by Taunton and Somerset NHS Foundation Trust and the implications for UH Bristol.

Governors' Strategy Group: 20 April 2015

Governors attending: Bob Bennett, Graham Briscoe, Thomas Davies, Wendy Gregory, Clive Hamilton, Florene Jordan, Sue Milestone, Brenda Rowe, Mo Schiller, Anne Skinner, John Steeds, Ben Trumper.

Others present or in attendance: David Relph – Head of Strategy and Business Planning *(Focus Group Chair)*, Deborah Lee – Deputy Chief Executive and Director of Strategic Development, Paul Tanner – Head of Finance, Alex Crawford – Deputy Head of Commissioning and Planning, Amanda Saunders – Head of Membership and Governance, and Debbie Marks – Membership Support Assistant.

Topics discussed:

Monitor Operation Plan: Governors received the draft Monitor Annual Plan for discussion. David Relph, Head of Strategy and Business Planning, gave a presentation about the development of the plan. Deborah Lee, Director of Strategic Development was also in attendance for part of the meeting to answer governors' questions. Headlines included:

- Explicit focus on resilience.
- Deficit plan despite the savings we have made.
- Recently, generally positive direction in terms of performance but still much to be done.
- Patient flow remains the main challenge.
- Much recent work on capacity planning and recovery of performance with regard to access.
- Acknowledgment that staff engagement needs to improve – and that staff morale is an issue.
- Five year forward view agenda is moving slowly, and the likely impact of the Better Care Bristol programme has yet to be agreed.
- 2015/16 will be challenging for everyone in the provider sector but we believe we are in better shape than many in terms of our ability to deal with the challenge.

The Plan was well-received and noted as being well-written.

- **Specialised Service Specifications:** Governors received an update on specialised service specifications from Alex Crawford, Deputy Head of Commissioning and Planning.

Governors also received an update on Weston Hospital, and discussed the implications of the election on Trust strategic planning.

As the next scheduled meeting was not until October, it was agreed to convene an extra meeting of the Annual Plan Project Focus Group **in July (date, time and venue to be confirmed).**

Quality Project Focus Group Meeting Account for a Council of Governors Meeting, to be held at 14:00 on 30 April 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08b - Quality Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Quality Project Focus Group.

Abstract

The objectives of the Quality Project Focus Group are to provide:

a) engagement with governors to develop the Board's Annual Quality Report;
b) regular support to enable governors to understand and interpret the Board Quality and Performance Report;
c) regular support to enable governors to understand and interpret reported progress on the Board's Quality Objectives; and,
d) opportunities for input from governors on quality matters.

The group is jointly chaired by Sean O'Kelly and Carolyn Mills (previously Deborah Lee), and its Lead Governor is Clive Hamilton. Meetings are held bi-monthly and open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Trust Secretary/ Governor Lead for the Quality Project Focus Group

The Quality Project Focus Group has held **two** meetings since the last Council of Governors meeting.

Extraordinary Quality Project Focus Group Meeting: 12 February 2015

Governors attending: Clive Hamilton (Lead governor for the group), Bob Bennett, Wendy Gregory, Angelo Micciche, Sue Milestone, John Steeds, Karen Stevens, Ben Trumper, Marc Griffiths and Bill Payne.

Others present or in attendance: Chris Swonnell – Head of Quality, Patient Experience and Clinical Effectiveness (meeting chair), Sarah Murch – Membership & Governance Administrator.

Topics discussed:

This was an extraordinary meeting convened as an opportunity for governors to have input into shaping the content of the Trust's Quality Report and to agree a quality indicator that could be tested by External Audit.

Chris Swonnell, Head of Quality, Patient Experience and Clinical Effectiveness, explained the background and the purpose of the Quality Report and the timeline. He gave governors an outline of topics likely to be covered in the 2015/16 report and governors had the opportunity to comment on these. Based on this list of topics, governors were then required to identify a local indicator

which would be scrutinised by external audit. Governors suggested the selection of **delayed discharges** or **Dementia.**

Quality Project Focus Group Meeting: 3 March 2015

Governors attending: Clive Hamilton (Lead governor for the group), Sue Silvey, Florene Jordan, Angelo Micciche, Bill Payne, Brenda Rowe, Lorna Watson, Edmund Brooks, Graham Briscoe, Marc Griffiths and Pam Yabsley.

Others present or in attendance:, Sean O'Kelly – Medical Director, Carolyn Mills – Chief Nurse, Hannah Marder – Cancer Manager, Colette Reid – Palliative Medicine Consultant (End of Life Care), Rachel McCoubrie – Palliative Medicine Consultant, Karen Forbes – Clinical Lead, Debbie Marks – Membership Support Assistant.

Topics discussed:

- **Trust Board Quality and Performance Report:** Governors received the Quality & Performance report. Clive provided a governors' summary of the performance of the Trust, seeking assurance in particular on the Trust's under-performance in relation to Fractured Neck of Femur targets.
- **Serious Incident Report (quarterly):** Carolyn Mills discussed this report with governors.
- **Quality Report:** It was agreed that Dementia would be the governors' chosen local indicator for the Quality Report.
- **National Cancer Survey Update:** Hannah Marder, Cancer Manager attended to update the group on the National Cancer Survey.
- **End of Life Care Update:** Colette Reid, Palliative Medicine Consultant (End of Life Care), Rachel McCoubrie, Palliative Medicine Consultant gave a presentation to update governors on End of Life Care in the Trust, in the context of the national perspective, the CQC report and the Commissioning for Quality and Innovation (CQUIN) achievements. Governors voiced their support for the team in this challenging area of work.
- **Standing items: Histopathology update and Governors' Log of Communications.**

The next meeting of the Quality Project Focus Group will be held on Tuesday 5 May 2015, 10:00 – 12:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**.**

Constitution Project Focus Group Meeting Account for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08c – Constitution Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Constitution Project Focus Group.

Abstract

The objectives of the Constitution Project Focus Group are to provide:

(i) engagement with governors in drafting Constitutional changes;

(ii) assessing the membership profile; and,

(iii) advice from governors on communications and engagement activities for Foundation Trust members.

The group meets quarterly and is open to all governors. The Chair of the Group is Sue Silvey, Lead Governor, and the executive lead for the Group is Debbie Henderson, Trust Secretary.

Recommendations

The Council of Governors is asked to **note** the update.

Report Sponsor or Other Author

Sponsor: Trust Secretary/Lead Governor for the Constitution Project Focus Group

The Constitution Project Focus Group has held **one** meeting since the last Council of Governors meeting.

Constitution Project Focus Group Meeting: 10 March 2015

Governors attending: Sue Silvey (Lead governor for the group and meeting Chair), Clive Hamilton, Angelo Micciche, John Steeds, Wendy Gregory, Ian Davies, Sue Milestone, Bill Payne and Mo Schiller.

Others present or in attendance: Debbie Henderson - Trust Secretary, Amanda Saunders – Head of Membership and Governance, Tony Watkin – Patient Experience Lead (Engagement and Involvement), Sarah Murch – Membership & Governance Administrator, Debbie Marks – Membership Support Assistant.

Topics discussed:

- **Emerging Public & Patient Involvement Proposal:** Tony Watkin, Patient Experience Lead (Engagement and Involvement), talked to governors about new ideas in the Trust's approach to Patient and Public Involvement (such as the suggestion of setting up a UH Bristol 'Citizen's Assembly') and how members and governors could be involved.
- **Draft membership and engagement strategy:** Governors received a draft of the new membership and engagement strategy, which had been rewritten to reflect the Trust's overarching objectives.
- **Revised Role of the Governor document:** Governors asked for some minor changes to this document, particularly in relation to the Lead Governor role and remit.
- **Governors' Effectiveness Evaluation – initial feedback:** Governors had completed an evaluation survey to assess their effectiveness as a Council of Governors. Of the 20 responses

received, comments were largely positive. The key issue appeared to be the weakness with regard to member engagement, which would hopefully be addressed through the refreshed membership and engagement strategy.

The next meeting of the Constitution Project Focus Group will be held on Tuesday 12 May 2015 from 10:30-12:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Membership Activity Report for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 9a - Membership Engagement and Governor Development Strategy, including Membership Activity Report

Purpose

To provide the Council of Governors with current membership details, a summary of membership engagement since the last Council of Governors meeting on 29 January and to seek feedback on the draft Membership Engagement and Governor Development Strategy.

Abstract

The Trust has a formal requirement to maintain a Foundation Trust membership and a responsibility to engage with its membership. Membership statistics and recent engagement, recruitment and involvement opportunities for members are listed below.

Recommendations

The Council of Governors is recommended to **note** the Membership Activity Report and to **receive** and **approve** the draft Membership Engagement and Governor Development Strategy

Report Sponsor or Other Author

Sponsor: Head of Membership and Governance

Report

As of 31 March 2015, Foundation Trust membership stands at 21,090 (6,466 public members, 4,763 patient members and 9,861 staff members).
This compares with membership of 21,109 (6,498 public members, 4,808 patient members and 9,803 staff members).

Membership can be broken down as follows:

Member Type Breakdown	Total
Public Constituencies	**6,462**
Out of Trust Area	4
Bristol	3,147
North Somerset	1,275
South Gloucester	1,250
Rest of England and Wales	786
Patient Constituencies	**4,760**
Unspecified	29

Page 2 of 3 of a Membership Activity Summary Report for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Carer of patients 16 years and over	208
Carer of patients 15 years and under	540
Patient - Local	3,983
Staff Classes	**9,859**
Unspecified	0(0)
Medical and Dental	1,189
Nursing and Midwifery	2,826
Other clinical healthcare professionals	1,957

Engagement

Feb 2015	Voices sent to all members by email and post
13 Feb 2015	Patient and Public members invited to give their views on UH Bristol's quality objectives via an online survey.
13 March 2015	• Patient members invited to drop-in sessions to test new Patient Self Check-In kiosks • Patient members also invited to attend feedback groups to facilitate improvements to the University of Bristol medical curriculum
5 March	The March Health Matters event included a session on Dermatology and an update on the centralisation of Histopathology. The event was attended by around 55 people and included Q&A sessions after each topic.

Recruitment

20/01/2015 – 31/03/15	There has been an overall reduction in member numbers by 19.

Other communications with members

A member queried the Trust performance against NICE quality standards and was provided with a response with input from the relevant Trust team.

Forthcoming engagement with members:

Health Matters Events

- **Thursday 7 May 2015: 5.30-7.00pm – Health Matters: Diabetes and Outpatient Services**
- **Thursday 2 July 2015: 5.30-7.00pm – Health Matters: Chronic Kidney**

Disease.

- **November 2015: Health Matters - Osteoporosis**

Members are also welcome to attend our quarterly **Council of Governors meetings** and our **Annual Members Meeting/AGM – 15/09/2015.**

Voices magazine

Voices, the magazine for the UH Bristol community, is sent to Foundation Trust members 3 times a year. The May/ June issue will feature details of Governors' involvement in PLACE visits, and an update regarding the forthcoming AGM.

Membership Engagement and Governor Development Strategy

A revised Strategy is presented for further review and feedback. The strategy will focus on:

- Membership Development and Engagement
- Governor Support and Development
- Working in collaboration

Appendices

Appendix A – Membership Engagement and Governor Development Strategy 2015 v3

Membership Engagement and Governor Development Strategy

April 2015

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Version	Status	Action	Author
0.1	Draft	Draft copy	B Courtney
0.2	Draft	Reviewed at CPFG	A Saunders
0.3	Draft	Revised for COG	A Saunders

1. Introduction

University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of hospitals in the heart of Bristol, a vibrant and culturally diverse city. We have over 8,000 staff who deliver over 100 different clinical services from nine individual sites. With services from neonatal intensive care unit to older people's care, we offer care to the people of Bristol and the South West from the very beginning of life to its later stages. We are one of the largest acute NHS Trusts, with an annual income of £575m.

As an NHS Foundation Trust, UH Bristol is accountable to the local community, patients it cares for and staff it employs. By becoming members and governors, local people, patients, their carers, and our staff can have a say in how services will be designed and delivered.

This Membership Engagement and Governor Development Strategy sets out a series of aims and objectives for the Trust to grow and engage its' membership and continue to develop valuable governor involvement. The strategy will also outline how the Membership and Governance Team, led by the Trust Secretariat, Chief Executive and Chair, will work with colleagues internally and externally to achieve its aims.

Whilst this strategy outlines a direction of travel to span the coming years, it will have a focus on the immediate 2 years, which will take us from the status of our membership body and Council of Governors today, through to the next round of Governor elections in 2016 and 2017.

The strategy will be delivered within the wider framework of Trust strategies and supports the Trust's overall vision "*Rising to the Challenge – our 2020 vision".* The aims and objectives in the strategy will reflect the values of the Trust – Respecting Everyone, Working Together, Embracing Change and Recognising Success.

2. Development of the Strategy

This strategy reflects plans produced in previous years by the Trust Secretariat Team. It has been developed to date with input and review from governors, with detailed feedback provided at the March 2015 Constitution Project Focus Group meeting.

The strategy has incorporated elements of best practice activity from other Foundation Trusts, and input from the Membership & Governance Team, who under the Head of Membership & Governance, will be responsible for implementation.

As the strategy may be used within the Trust to promote membership and governance, it includes an overview of the rationale and role of the membership and governor function.

3. Membership – an overview

Who can become a member and how?

A member can be a patient, a carer, a member of the public or an employee of the Trust. Public, patient or carer members are required to complete a brief application form to register their request to join the Trust, or staff members are automatically listed as members unless they select to opt-out.

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What value do members bring to the Trust?

Having a dedicated membership provides the Trust with a ready pool of warm contacts for feedback, local knowledge and support.

Those members who go on to undertake a governor role participate in forums that hold the Trust Board to account for the performance of the Trust, and represent members' interests. Governors therefore form an integral part of the Trust's governance structure.

What does the Trust offer members?

Individual members may be interested in different levels of involvement in the work of the Trust, and this strategy will acknowledge that we must offer members a choice of engagement activities that reflects this and caters to the widest audience.

There are a number of ways in which members can be involved, which include but are not limited to:

- Receive regular Trust news updates
- Take part in patient and public involvement activities to enable service co-design
- Provide feedback via e-surveys
- Learn more about our services at Health Matters Events
- Take part in consultation about specific Trust plans and capital developments
- Be kept up to date about our work with our Health Partners locally
- Take on a Volunteer role at the Trust
- Elect governors to represent their constituency
- Stand for election as a governor
- Act as an advocate for the Trust

Defining the membership community

The Trust's membership is designed to relate to the geography in which patients will reside, reflect their needs and recognise the value that staff contribute to the organisation. On this basis, the constituencies from which governors are appointed to elected members are groups as follows:

Public Constituencies

All NHS Foundation Trusts will cover at least one public constituency. Boundaries are defined on the basis of local government electoral areas. Reflecting local referral patterns and the configuration of local Clinical commissioning Groups, the Trust has defined Public Constituency areas of Bristol, North Somerset and South Gloucestershire. In addition, as a tertiary hospital with a large number of specialist services, the Trust treats patients from a wide geographical base. To reflect this the Trust has created a Rest of England and Wales constituency.

Staff Constituency

The Trust employs over 8,000 staff and operates an opt-out system for any employees who do not wish to become members of the Staff Constituency, although very few staff select this option. The Trust also welcomes volunteers, academic staff and locum/agency

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staff, and staff employed by external contractors as members, when they have been in the function for a year.

Patient and Carers of Patient Constituency

The Trust also has Patient and Carers of Patient constituencies, with the carer of patient roles defined to cover patients both under and over 16 years of age. The Trust is committed to patient involvement and recognises the unique and valuable perspective that a patient or carer can bring to the organisation, especially in relation to their experiences of the Trust.

Appointed Roles

Appointed governor roles are designed to ensure the Trust achieves input from a wide ranging perspective across the community and other 'constituent' groups, including stakeholders from the Council, local educational bodies and health partners.

The Trust developed two appointed Youth Council roles, recognising the wide ranging services delivered at the Bristol Royal Hospital for Children, and giving a voice to our younger members.

4. The role of a Governor

Governors were given important duties when the first foundation Trusts were established, and the role has significantly developed since that time. Governors have an important part to play by listening to the views of the Trust's members, the public and other stakeholders, and representing their interests in the Trust. Governors also have a role in communicating information from the Trust to members and the public, for example about the Trust's strategic plans.

In addition to representing and engaging the views of its membership, the governors also have the statutory role of holding the Non-Executive Directors to account for the performance of the Trust Board.

At UH Bristol the governor body has developed to become a group of 36 representatives, from a range of differing backgrounds, each representing a constituent group. In addition to the Council of Governors forum, governors have a range of sub-groups that facilitate their role, these range from Development Seminars to Project Focus Groups that enable theme specific work and the opportunity for reflection of the Trust's position.

The governor body is recognised by the Trust Board as being engaged and not only fulfilling its statutory role but also bringing added value to the organisation.

5. Purpose of the Strategy

The purpose of the strategy is to set out the way forward for the membership and governor development and engagement programme. It will outline key actions determined to be required to help achieve these aims and objectives.

The strategy seeks to deliver a straightforward and uncomplicated, but hopefully effective approach, that will deliver sustainable improvements.

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The strategy will address three key areas:

- Membership Development and Engagement
- Governor Support and Development
- Working in collaboration

6. Membership Development and Engagement

It is important that that the Trust develops a stronger dialogue with members, enabling those who seek more active engagement the chance to regularly share their views. In turn the Trust must commit to listening to members, and offer them ways to get involved with the design and improvement of services.

The key actions as outlined below are expected to see the Trust achieve some core improvements to membership, that will include:

- a membership that is representative and reflective of the communities served by the Trust
- an informed membership that is provided with useful and engaging information about the Trust
- an involved membership where as many members as possible are actively engaged in the development of the Trust and its activities.

At the end of the financial year 2014/15 the changes to the overall membership base were as shown below:

Membership size and movements	
Public constituency	**Last year (2014/15)**
At year start (April 1)	6,607
New members	52
Members leaving	193
At year end (March 31)	**6,466**
Staff constituency	**Last year (2014/15)**
At year start (April 1)	9,442
New members	1,720
Members leaving	1,301
At year end (March 31)	**9,861**
Patient constituency	**Last year (2014/15)**
At year start (April 1)	4,933
New members	25
Members leaving	195
At year end (March 31)	**4,763**

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As at March 31st 2015 the detailed profile of the **public** UH Bristol membership base was as below:

	Public	% of Membership	Base population figure	Scale to show Under/ Over Representation
Age 0-22	**6,660**	**100.00**	**917,651**	
0-16	353	5.30	179,369	
17-21	607	9.11	65,186	
Age 22+	**5,458**	**81.95**	**673,096**	
22-29	383	5.75	115,540	
30-39	658	9.88	124,904	
40-49	1,017	15.27	126,862	
50-59	993	14.91	107,020	
60-74	1,439	21.61	127,767	
75+	968	14.53	71,003	
Gender	**6,654**	**99.91**	**916,188**	
Male	2,866	43.03	454,969	
Female	3,657	54.91	461,219	
Ethnicity	**6,654**	**99.91**	**893,567**	
White - British	5,583	83.83	765,596	
White - Irish	41	0.62	6,187	
White - Any other White background	106	1.59	34,459	
Mixed - White and Black Caribbean	26	0.39	9,586	
Mixed - White and Black African	15	0.23	2,185	
Mixed - White and Asian	17	0.26	5,116	
Mixed - Any other mixed background	28	0.42	4,251	
Asian or Asian British - Indian	63	0.95	10,063	
Asian or Asian British - Pakistani	61	0.92	7,672	
Asian or Asian British - Bangladeshi	13	0.20	2,641	
Asian or Asian British - Any other Asian bac	31	0.47	6,338	
Black or Black British - Caribbean	56	0.84	7,895	
Black or Black British - African	72	1.08	13,455	
Black or Black British - Any other Black back	16	0.24	7,234	
Other Ethnic Groups - Chinese	17	0.26	5,817	
Other Ethnic Groups - Any other ethnic gro	1	0.02	5,072	
Acorn Socio-Economic Category	**6,654**	**99.91**	**916,188**	
Affluent Achievers [1]	2,080	31.23	217,616	
Rising Prosperity [2]	567	8.51	101,229	
Comfortable Communities [3]	1,965	29.50	271,163	
Financially Stretched [4]	1,276	19.16	201,589	
Urban Adversity [5]	696	10.45	116,024	
Not Private Households [6]	65	0.98	8,567	
ONS/Monitor Classifications	**6,612**	**99.28**	**284,457**	
AB	1,933	29.02	72,696	
C1	1,966	29.52	91,716	
C2	1,319	19.80	56,721	
DE	1,394	20.93	63,324	
Wellbeing Acorn Group	**6,654**	**99.91**	**907,621**	
Health Challenges [1]	866	13.00	105,479	
At Risk [2]	1,320	19.82	219,267	
Caution [3]	1,919	28.81	288,711	
Healthy [4]	2,538	38.11	294,164	
Not Private Households [5]	0	0.00	0	
Total membership	**6,660**	**100.00**	**917,651**	

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These tables show overall a drop in membership numbers against the year 2013/2014, conversely in a year when the Trust was expanding services, treating more patients and recruiting more staff.

The Trust has the benefit of a highly effective database used to manage and monitor membership (Membership Engagement Services), and using this we are able to profile that not only has the Trust lost members, it continues to be under-representative in the following groups:

- those in the age group 22-39
- Males are under-represented in all age groups
- Members from certain ethnic groups including Black, Asian and Other White groups

Key Actions

Noting the benefits to both Members and the Trust of the role, the key actions of the membership development and engagement strategy will therefore be:

- Review our membership sign up process to ensure it is compliant with current guidance and best practice, and also simple and accessible

- Maintain an accurate membership database, utilise the information it can provide at regular intervals and work with Membership Engagement Services to maximise use of this tool

- To run a more proactive membership recruitment programme, via opportunities within the Trust (e.g. sign up sessions in the BRI Main reception) and outside the Trust (e.g. linking with Above & Beyond and partners in the local Health Community)

- Work with governors to undertake membership engagement activities in their constituency, to capture feedback and provide members with their 'local' point of contact, including Staff Governors

- Undertake targeted recruitment and engagement activities to increase membership in under-represented groups (e.g. men's health promotion at local sporting events, linking with Healthwatch to reach specific ethnic groups)

- Continue to provide members with information about the Trust via circulation of Voices, but also by improving member targeted information on the Trust website

- At all opportunities seek to obtain email addresses from members, old and new, in order that we can provide them with more frequent communications and updates

- Offer our members more stakeholder engagement activities, via the use of our database email survey tool (e.g. members to vote on a range of subjects for Health Matters events in 2016/2017, extend the Health Matters events to include more interactive elements)

- Record contact with more active members in order to develop a reference group that can called upon as required to undertake a more active role in the Trust, e.g. participation in PPI activities, invited to run for a governor role

- As we run into 2016 and 2017 engage our members in the governor election process – both in voting and standing for a role on the governing body

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7. Governor Support and Development

It is important that governors and the organisation have a close working relationship; a mutual sense of responsibility and governors have a sense of belonging to the Trust whilst maintaining their position to hold the Trust board to account when required.

The governor support and development programme seeks to provide governors with the necessary core training and skills to carry out their statutory duties effectively and to discharge their responsibilities with enhanced levels of insight.

A core component of the governor development approach will be the Governor Development Seminars and more strategic use of the Informal Meetings. Topics for these will be chosen in line with Monitor's guidance and governors input, but will also reflect the Trust's vision and strategy, for example an overview of the Trust's selected Corporate Quality Objectives. Providing more detail on these objectives, and how well the Trust is performing in their delivery, will help governors understand the challenges the Trust is experiencing, what is working well and ultimately leave them in an informed position to challenge the Trust Board as required.

It is the governors' duty to attend these development opportunities, and this is clearly outlined in their role, recruitment and induction information.

The wider support offered to governors will comprise a number of elements:

- ***Externally:***
  - Networking opportunities with other Foundation Trust governors
  - Participation in NHS Providers and Governwell activities
  - Links with relevant local partners such as Healthwatch

- ***Internally***:
  - Consistent support from the Trust Secretariat, particularly the Membership & Governance team
  - A comprehensive induction programme
  - Buddying new governors with an existing experienced governor to support them in their role
  - Specific support to Youth Council Governors, to help them to feel confident in their role and able to engage with the Trust in a manner that reflects their age and experience
  - In partnership with governors undertake a skills analysis to better understand the strengths and experiences individual governors bring to the group overall
  - Improve communication to our governors by developing a weekly e-newsletter (with internal and external updates) and improving information held on the Trust website
  - Continue to support activities that are already well developed and received by both governors and the Trust such as Chair and Chief Executive Walkrounds and participation in PLACE visits
  - Develop actions tailored to each governor that will support membership development and engagement, reflecting their constituency, time they have available to the role, the level of support they need, etc.
  - Ongoing close working with the Trust Board, and sustained support for good working relations with the Executive and Non-Executive team e.g. guest chairs to

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facilitate the Chairman's council sessions, close working via the Project Focus Groups
  - Specific support to Youth Council Governors, to ensure they feel welcom

8. Working in collaboration

To ensure delivery of this strategy, and best support the Trust's overall vision, it is recognised that that working with colleagues, internally and externally, will be of benefit. This will include joint working with:

Communications Team

Central to the strategy will be effective communications and a consistent promotion of the Trust brand and values. We will work closely with colleagues in the Communications Team to:

- Promote and expand the use of social media for membership engagement
- Maximise use of Voices and the website – using these vehicles to promote membership, facilitate membership sign up and supporting engagement
- Work to develop a communication plan to manage the 2016 and 2017 governor election campaigns
- Develop an improved suite of materials that will include a welcome pack, posters, email templates, that all consistently tie with Trust brand and messaging
- Develop a simple but effective e-bulletin that can be distributed on a weekly basis to Governors
- Develop improved marketing materials to support membership sign up and promotion at events
- Support opportunities for PR that celebrate and recognise the role of member and governor

Patient and Public Involvement Team

Development of a more active membership and continued governor engagement offers the Trust a pool of contacts who can participate in patient and public involvement (PPI) activities. The Trust continues to build a substantial programme of PPI work, including plans in development for a Citizens Assembly.

This strategy promotes closer partnership working with the Trust's PPI team to promote opportunities to members, continue to support governors who have already developed a competence for valuable PPI activities and explore new ways of working together.

Workforce and Organisational Development (OD) Team

Recently Governors have become more engaged in the Trust's workforce agenda, and are keen to support the organisation to improve recruitment and retention of staff and their experience of working at the Trust.

Staff Governors in particular have a remit to act as representatives for their colleagues, and with improved support from the Membership and Governance Team and closer working links with the Workforce and OD Team, we will help them to facilitate more staff engagement and contribute to the Trust's overall approach to the further development of an organisational culture.

Young Person's Involvement Worker & Youth Council

In 2015 we have already set an improved process for the nomination and election to the two Youth Council Appointed Governor Roles. This includes an easy to understand overview of the

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role, a guide to the commitment required, support provided and benefits of the role, and an interactive session to generate interest in the posts.

Working closely with Sara Reynolds, Young Person's Involvement Worker, we will hopefully appoint two new Youth Council Governors in May 2015, and then follow their appointment with a programme of support and engagement for the year ahead. This will include working with them to undertake activities with the Youth Council, and hopefully in their peer groups in school, college and even patient networks they have developed.

Voluntary Services

A benefit the Trust can promote to members, that is mutually beneficial, is the opportunity to undertake voluntary work within the Trust. Volunteering can provide members with a chance to 'give something back', learn new skills and meet others who chose to get involved. We will work closely with colleagues in this team to support this agenda. In addition, volunteers who come to the Trust independent of a member role may want to join and hear more about the organisation they are now involved with and join as members after a year in service as a volunteer.

Above & Beyond and The Grand Appeal

The Trust is fortunate to have the support of two charities, raising funds and awareness of the organisation. Through partner working we can explore opportunities to work together to promote both fundraising and membership activities, for example by offering the charities exposure at our Health Matters Events and by joining them as they undertake activities in the local community.

Local Health Partners

UH Bristol is a hospital at the heart of the city, and in many ways at the heart of the local health community. It has established links with a wide range of health and social care providers, ranging from charity partners to Council led services, and of course neighbouring hospital Trusts in Weston-super-Mare and North Bristol.

We aim to extend contact to these partner organisations, as this should again benefit membership activities. We will link with partners to actively promote shared service developments, to seek feedback on how well we provide patients with a joined up patient pathway, and to demonstrate how we will continue to work together to improve the health outcomes of the local population.

9. Resourcing the Membership Strategy

Due to the increasing constraints on the health sector as a whole, the approach undertaken by this strategy will seek to prioritise activity based on expected value added.

Many of the actions referenced require minimal, if any investment, but will need a concerted and focussed effort from the Membership & Governance Team to deliver results. This team is currently staffed to establishment, and with guidance from the Trust Secretary who has considerable experience in this area, is now well placed to make significant progress.

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10. Evaluating success of the Membership Engagement and Governor Development Strategy

Delivery of the strategy will be reviewed at each Constitution Project Focus Group, and the Membership & Governance Team will provide an update for this session on progress being made. With input from governors, a full overview will then be reported to the Council of Governor meetings, for comment and feedback from all members, and including the Trust Board.

The success of the strategy will be measured in part by:

- Increased membership recruitment figures and more representative membership
- Increased participation in membership activities, such as voting rates at elections and the number of members standing for election
- Tracking of the numbers of active members, and reporting on the contributions engagement is bringing to the organisation
- Questions and concerns of existing and potential members reaching governors and the Trust board
- Improved levels of governor attendance at meetings and engagement with the Trust

An annual report will be provided to the Trust Board to provide assurance regarding their duty to "act with a view of promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public".

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Governor Activity Report for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 9b – Governor Activity Report

Purpose

To provide the Council of Governors with a summary of governor activity since the last Council of Governors meeting on 29 January 2015.

Abstract

Governors fulfil their statutory responsibilities through involvement in various meetings, events and engagement activities. A summary of governors' attendance at recent activities is below.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Report

Changes to the Council of Governors in this period:

- Since the last Council of Governors meeting, two new governors have joined the Council of Governors: Sylvia Townsend (Public-Bristol, replacing Glyn Davies), and Ray Phipps (Patient-Local, replacing Elliott Westhoff).
- The term of office of Youth Council governors Abbas Akram and Lukon Miah ended on 31 March. The Membership team is working with Sara Reynolds (Young Persons' Involvement Worker) and the Youth Council to appoint two new Youth Governors by the end of May.
- As at 1 April 2015 there were 33 governors in post and 3 vacancies.

Governors' Activity:

Date	Event	Governors attending
29/01/2015	Public Trust Board meeting	Sue Silvey, Florene Jordan, Karen Stevens, Brenda Rowe, Clive Hamilton, Bob Bennett, Pam Yabsley, Anne Skinner, John Steeds, Wendy Gregory, Marc Griffiths, Jeanette Jones, Mo Schiller, Thomas Davies.
29/01/2015	Council of Governors meeting	Sue Silvey, Pauline Beddoes, Bob Bennett, Clive Hamilton, Brenda Rowe, Mo Schiller, Tony Tanner, Anne Skinner, John Steeds, Pam Yabsley, Wendy Gregory, Philip Mackie, Nick Marsh, Karen Stevens, Florene Jordan, Marc Griffiths, Jeanette Jones, Tim Peters, Sue Hall, Jim Petter.

05/02/2015	Annual Plan Project Focus Group (now Governors' Strategy Group) meeting	Wendy Gregory, Bob Bennett, Graham Briscoe, Clive Hamilton, Florene Jordan, Angelo Micciche, Mo Schiller, John Steeds, Anne Skinner, Thomas Davies, Nick Marsh, Sue Milestone and Brenda Rowe.
12/02/2015	Extraordinary Quality Project Focus Group meeting	Clive Hamilton, Bob Bennett, Wendy Gregory, Angelo Micciche, Sue Milestone, John Steeds, Karen Stevens, Ben Trumper, Marc Griffiths and Bill Payne.
17/02/2015	Chair & Chief Executive Walkround (Medicine)	Sue Silvey and Angelo Micciche *(Attendance restricted - 2 governors)*
17/02/2015	Reverse mentoring	Florene Jordan *(Attendance restricted - 1 governor*
24/02/2015	End of Life Focus Group	Clive Hamilton *(Attendance restricted - 1 governor)*
25/02/2015	Paediatric Cardiac Surgery listening event, Bristol	Anne Skinner and Wendy Gregory *(Attendance restricted - 2 governors)*
25/02/2015	Governors' Informal Meeting *(including presentation from Martyn Carter, Deputy Headteacher, Bristol Hospital Education Service – overview of the service and his role).* Chairman's Counsel Meeting	Bob Bennett, Graham Briscoe, Thomas Davies, Wendy Gregory, Clive Hamilton, Jeanette Jones, Florene Jordan, Philip Mackie, Nick Marsh, Angelo Micciche, Sue Milestone, Bill Payne, Tony Rance, Brenda Rowe, Mo Schiller, Sue Silvey, Anne Skinner, John Steeds, Tony Tanner, Ben Trumper, Lorna Watson and Pam Yabsley.
25/02/2015	Nominations and Appointments Committee	Sue Silvey, Mo Schiller, Anne Skinner, John Steeds, Pam Yabsley, Wendy Gregory, Marc Griffiths, Philip Mackie, Florene Jordan and Jeanette Jones. *(Attendance restricted to committee members only)*
27/02/2015	Public Trust Board Meeting	Sue Silvey, Tony Tanner, Angelo Micciche, Pauline Beddoes, Florene Jordan, Brenda Rowe, Clive Hamilton, Pam Yabsley, John Steeds, Wendy Gregory, Jeanette Jones, Sue Milestone, Thomas Davies.
27/02/2015	15 Steps inspection of the New Stroke Ward	Bob Bennett *(Attendance restricted)*

27/02/2015	Face-to-face patient interviews	Anne Skinner *(Attendance restricted)*
03/03/2015	Quality Project Focus Group Meeting	Clive Hamilton, Sue Silvey, Florene Jordan, Angelo Micciche, Bill Payne, Brenda Rowe, Lorna Watson, Edmund Brooks, Graham Briscoe, Marc Griffiths and Pam Yabsley.
03/03/2015	Reverse mentoring	Florene Jordan *(Attendance restricted - 1 governor)*
04/03/2015	PLACE Inspections - BEH	Bob Bennett
05/03/2015	Patient Safety Workshop ('A Single Early Warning Score for the West of England')	Wendy Gregory and Bill Payne *(Attendance restricted - 2 governors)*
05/03/2015	Health Matters Event - Dermatology	Wendy Gregory, Clive Hamilton, Angelo Micciche, Ben Trumper, Sue Silvey.
06/03/2015	Patient Safety Workshop – Human Factors	Jeanette Jones. *(Attendance restricted to 1 governor)*
10/03/2015	Governors' Meeting re Well-led Governance Review (Deloittes)	Sue Silvey, Thomas Davies, Tony Rance, Brenda Rowe, Ian Davies, Sue Milestone, Anne Skinner, Bill Payne, Clive Hamilton, Florene Jordan, Karen Stevens, Mo Schiller.
10/03/2015	Constitution Project Focus Group meeting	Sue Silvey, Clive Hamilton, Angelo Micciche, John Steeds, Wendy Gregory, Ian Davies, Sue Milestone, Bill Payne and Mo Schiller.
11/03/2015	South West Governors' Exchange Network meeting, Taunton	Tony Rance, Karen Stevens, Anne Skinner, Bill Payne. *(Attendance restricted - 4 governors)*
11/03/2015	Chair & Chief Exec Walkround - Specialised Services (Oncology)	Wendy Gregory and Sue Silvey *(Attendance restricted - 2 governors)*
13/03/2015	Decontamination meeting	Florene Jordan *(Attendance restricted)*
24/03/2015	Carers Strategy Meeting	Lorna Watson *(Attendance restricted)*
26/03/2015	End of Life Focus Group	Clive Hamilton *(Attendance restricted)*

27/03/2015	Governors' Informal Meeting *(Including talk on the Specialised Services Division from Owen Ainsley, Divisional Director, Hayley Long, BHOC Matron and James Griffin, Consultant Haematologist – overview of progress, plans and challenges in the division.)* Chairman's Counsel Meeting	Anne Skinner, Wendy Gregory, Sylvia Townsend, Sue Silvey, John Steeds, Bob Bennett, Graham Briscoe, Mo Schiller, Jeanette Jones, Pauline Beddoes, Brenda Rowe, Ray Phipps, Clive Hamilton, Thomas Davies, Karen Stevens, Sue Milestone, Angelo Micciche, Tony Rance, Tony Tanner, Pam Yabsley.
12/03/2015	Signage & Wayfinding meeting	Anne Skinner *(Attendance restricted)*
31/03/2015	Public Trust Board Meeting	Jeanette Jones, Clive Hamilton, Florene Jordan, John Steeds, Marc Griffiths, Ian Davies, Brenda Rowe, Graham Briscoe, Pam Yabsley, Ray Phipps, Angelo Micciche, Thomas Davies, and Wendy Gregory
08/04/2015 All day	NHS Providers - Governor Focus Conference 2015, London	Wendy Gregory and Sue Silvey. *(Attendance restricted - 2 governors)*
08/04/2015	Shortlisting for Nurses Day Awards	Mo Schiller *(Attendance restricted)*
10/04/2015	Signage and Wayfinding meeting	Anne Skinner *(Attendance restricted)*
14/04/2015	Face-to-Face interviews	Mo Schiller *(Attendance restricted)*
15/04/2015	PLACE Assessments, BCH	Philip Mackie, Anne Skinner, Bob Bennett, Pam Yabsley and Nick Marsh.
15/04/2015	Chair and CE Walkround – Surgery Head and Neck	Angelo Micciche *(Attendance restricted - 2 governors)*
15/04/2015	Nominations and Appointments Committee meeting	Pam Yabsley, John Steeds, Sue Silvey, Anne Skinner, Mo Schiller. *(Attendance restricted – committee members only)*
16/04/2015	Face-to-Face interviews	Anne Skinner *(Attendance restricted)*
16/04/2015	Patient Experience Group meeting	Pam Yabsley *(Attendance restricted)*
17/04/2015	15 Steps	Bob Bennett *(Attendance restricted)*

20/04/2015	Governors' Strategy Group Meeting (formerly Annual Plan Project Focus Group)	Bob Bennett, Graham Briscoe, Thomas Davies, Wendy Gregory, Clive Hamilton, Florene Jordan, Sue Milestone, Brenda Rowe, Mo Schiller, Anne Skinner, John Steeds, Ben Trumper.
22/04/2015	PLACE Assessments, BHOC	Mo Schiller, Sue Milestone, Bill Payne and Nick Marsh
28/04/2015	*PLACE Assessments, SBCH*	*Bill Payne*
29/04/2015	*PLACE Assessments, BRI*	
30/04/2015	*Public Trust Board meeting* *Council of Governors meeting*	

In addition to these various groups, meetings and activities, additional areas of focus for governors during this period included:

- Governors were asked to review and comment on the Trust's draft Education, Learning and Development Strategy.
- Governors were asked for their views on the Trust's quality objectives via an online survey.
- Governors participated in the Trust's Well-Led Governance Review.
- Governors reviewed their own performance in a Governors' Effectiveness self-assessment Survey, and also took part in a survey to review the performance of the Chair, John Savage.
- Governors received revised Governwell/Monitor guidance on representing the interests of members and the public, and the Trust's results from the National Staff Survey were shared with governors.
- Governors signed a new Code of Conduct and made their annual declaration for the Register of Business Interests.
- The induction process for new governors was reviewed and strengthened.

Cover Sheet for a Report for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10: Annual Review of Governors' Interests

Purpose

The purpose of this report is to present the Governors' Register of Business Interests for the Council of Governors to **note**.

Abstract

In accordance with the Constitution of University Hospitals Bristol NHS Foundation Trust, 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 Constitution also requires that the Trust maintain a register of interests of Governors.

The current Register of Governors' Business Interests is attached. This register is updated by the Trust Secretariat annually.

Governors should note that in accordance with best practice, the Register of Interests will be published on the Trust's website. It is the responsibility of governors to keep the Trust Secretariat informed of any changes.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor

Trust Secretary

Appendices

Appendix A: Register of Governors' Business Interests (updated April 2015)

Governors' Register of Business Interests updated April 2015

University Hospitals Bristol NHS
NHS Foundation Trust

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
Pauline	Beddoes	Governor -Public, South Gloucestershire	n/a	None	n/a	25/03/2015
Bob	Bennett	Governor - Public, Bristol		Independent Hospital Manager, The Priory Group	Yes - when attending patient reviews.	26/03/2015
Graham	Briscoe	Governor - Public, North Somerset	n/a	None	n/a	25/03/2015
Edmund	Brooks	Governor - Patient, Local	n/a	None	n/a	25/03/2015
Mani	Chauhan	Governor - Public, Rest of England and Wales	1994-ongoing	- Director/Shareholder East Park Investments (Leics) Ltd. - Director/Shareholder Makan Developments Ltd	Yes	08/04/2015
Ian	Davies	Governor - Staff, Medical and Dental	n/a	None	n/a	26/03/2015
Thomas	Davies	Governor - Staff, Other Clinical Healthcare Professionals	n/a	None	n/a	13/04/2015
Wendy	Gregory	Governor - Patients, Carers (patients 16 years and over)	2012/3 - ongoing	Carers Support Centre Bristol and South Gloucestershire	No	13/04/2015
Marc	Griffiths	Governor - Appointed, University of the West of England		Current employee - University of the West of England	Yes	20/04/2015
Sue	Hall	Governor - Appointed, Avon & Wiltshire Mental Health Trust		Director - PJH Management Consulting Ltd Director - Raregift Ltd (T/A Alison Miles Couture) Chair - Pound Arts Centre Trust, Corsham Director - Pound Café Corsham (Community Interest Company) Director of Resources - AWP	Yes	26/03/2015
Clive	Hamilton	Governor - Public, North Somerset	n/a	None	n/a	26/03/2015

Governors' Register of Business Interests updated April 2015

University Hospitals Bristol NHS
NHS Foundation Trust

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
Jeanette	Jones	Governor - Partnership, Joint Union Committee	n/a	None	n/a	20/04/2015
Florene	Jordan	Governor - Staff, Nursing and Midwifery	n/a	None	n/a	29/03/2015
Philip	Mackie	Governor - Patients, Carers (patients under 16 years)	n/a	None	n/a	21/04/2015
Nick	Marsh	Governor - Staff, Non-clinical Healthcare Professional	n/a	None	n/a	25/03/2015
Angelo	Micciche	Governor - Patients, Local		Current employee – Manager of North Bristol Trust	Yes	25/03/2015
Sue	Milestone	Governor - Patients, Carers (patients 16 years and over)		Labour & Co-operative Party Councillor at Bristol City Council - St George West Ward.	Yes	14/04/2015
Bill	Payne	Governor - Appointed, Bristol City Council		TBC *(Bristol City Council – Labour Councillor for Frome Vale* *- Trustee and Board Member for the Haemophilia Society* *- Chair of the Management Committee of the Bristol Hospital Education Service.)*		
Tim	Peters	Governor - Appointed, University of Bristol	2011-ongoing	Employee of the University of Bristol	Yes	25/03/2015
Jim	Petter	Appointed, SW Ambulance Service NHS FT		- Employed by South Western Ambulance Service NHSFT. -Director – College of Paramedics - UK Paramedics Professional Body -Trustee of the patient safety charity AvMA: Action for Victims of Medical Accidents (unpaid).	Yes No	07/04/2015

Governors' Register of Business Interests updated April 2015

University Hospitals Bristol NHS
NHS Foundation Trust

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
Ray	Phipps	Governor – Patients, Local	n/a	- Daughter is employed by pharmaceutical company Astra Zenica as quality control manager at bulk manufacturing plant. - Niece works as Research Associate in Clinical Trials Management in CTEU with University of Bristol School of Clinical Sciences.	No	17/03/2015
Tony	Rance	Governor - Public, Rest of England and Wales		- The Toastmaster Partnership – Managing Partner - Tony Rance Toastmaster – Sole Trader - Rance Regalia - Proprietor	Yes Yes Yes	27/03/2015
Brenda	Rowe	Governor - Public, Bristol	n/a	None	n/a	20/04/2015
Mo	Schiller	Governor - Public, Bristol	n/a	None	n/a	25/03/2015
Sue	Silvey	Governor - Public, Bristol	Linkage: 2013 - ongoing RSVP West: 2012 -ongoing	- Linkage - Charity preventing social isolation in older people. Director. - RSVP West - Volunteer recruitment charity for over 50s. Bristol Surgery Schemes Organiser	No No	25/03/2015
Anne	Skinner	Governor - Patients, Local	n/a	None	n/a	26/03/2015
John	Steeds	Governor - Patients, Local	n/a	None	n/a	25/03/2015
Karen	Stevens	Governor - Staff, Non-clinical Healthcare Professional	n/a	None	n/a	25/03/2015
Tony	Tanner	Governor - Public, South Gloucestershire	n/a	None	n/a	25/03/2015
Sylvia	Townsend	Governor – Public, Bristol	n/a	None	n/a	27/03/2015

Governors' Register of Business Interests updated April 2015

University Hospitals Bristol NHS
NHS Foundation Trust

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
Ben	Trumper	Governor - Staff, Nursing and Midwifery	n/a	None	n/a	09/04/2015
Lorna	Watson	Governor - Patients, Carers (patients under 16 years)	n/a	None	n/a	14/4/2015
Pam	Yabsley	Governor - Patients, Local	n/a	None	n/a	13/04/2015

Cover Sheet for a report for a Council of Governors Meeting to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11 – Forward Planner for Council of Governors Meetings 2015-2016
Purpose
The purpose of this report is to note the forward planner for the business of Council of Governors Meetings for 2015-2016.
Recommendations
The Council of Governors is asked to receive the forward planner to **note**.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Forward Planner for Council of Governors Meetings 2015-16

Council of Governors Reports must be:

To ***Approve*** (Strategy, Policy, Finance, Business Case, Recommended course of action)
To ***Ratify*** (endorse a decision made elsewhere that requires Board approval)
For **Review** (assess status, challenge performance, make recommendations for change)
To ***Note*** (provided for formal awareness)
For ***Information*** (provided for general reading, not formal)

Council Committees may: Approve, Review, Monitor, Audit, Scrutinise, depending on their delegated role and function.

						Council of Governors Public Meeting	**Council of Governors Public Meeting**	**Annual Members' Meeting**	**Council of Governors Public Meeting**	**Council of Governors Public Meeting**
				Meeting Date		**Thu 30 Apr 2015**	**Thu 30 Jul 2015**	**Tue 15 Sep 2015**	**Fri 30 Oct 2015**	**Fri 29 Jan 2016**
				Start Time		**14:00**	**14:00**	**17::00**	**14:00**	**14:00**
				Location		**Conference Room, Trust HQ**	**Conference Room, Trust HQ**	**Lecture Theatre 1, Education Centre**	**Conference Room, Trust HQ**	**Conference Room, Trust HQ**
				Deadline for Inclusion						
			Number of Meetings =>	**4**	**Annual Reporting Data**	18	16	6	14	15
Scheduled Reports	**Category**	**Regularity**	**Sponsor**	**Other Author**	**Number of times seen by Council**	**Purpose**	**Purpose**	**Purpose**	**Purpose**	**Purpose**
Chairman's Welcome and Apologies	Corporate Governance	Standing	Chairman	Chairman	5	Note	Note	Note	Note	Note
Declarations of Interest	Corporate Governance	Standing	Chairman	Chairman	4	Note	Note		Note	Note
Minutes and matters arising from previous meetings	Corporate Governance	Standing	Chairman	Chairman	4	Approve	Approve		Approve	Approve
Governors' Log of Communications	Governors' Questions	Standing	Chairman	Governors	4	Review	Review		Review	Review
Nominations & Appointments Committee Report	Statutory and Foundation Trust Constitutional Duties	Standing	Chairman	Chairman	4	Note	Note		Note	Note
Governor Development Seminar Report	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Trust Secretary	4	Note	Note		Note	Note
Project Focus Groups Report (including reports from Quality Project Focus Group, Constitution Project Focus Group, Governors' Strategy Group and any others)	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Trust Secretary	4	Note	Note		Note	Note
Governor Activity Report	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Membership Office	4	Note	Note		Note	Note
Chief Executive's Report	Strategic Outlook	Standing	Chief Executive	Chief Executive	4	Note	Note		Note	Note
Membership and Engagement Strategy (including Membership report)	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Head of Membership & Governance	5	Approve	Approve	Approve	Approve	Approve
Quarterly Patient Experience and Complaints reports	Performance Update and Strategic Outlook	Standing	Chief Nurse		4	Note	Note		Note	Note
Governors' Questions arising from the meeting of the Trust Board of Directors	Governors' Questions	Standing	Chairman	Governors	4	Review	Review		Review	Review
Foundation Trust Members' Questions	Corporate Governance	Standing	Chairman	FT Members	5	Note	Note	Note	Note	Note
Selection of audit indicators for annual Quality Report.	Statutory and Foundation Trust Constitutional Duties	Annual	Chief Nurse	Head of Quality (Chris Swonnell)	1					Approve
Appointment of Lead Governor	Corporate Governance	Annual	Trust Secretary	Membership Manager	1	Approve				
Foundation Trust Constitution	Statutory and Foundation Trust Constitutional Duties	Annual	Chairman	Trust Secretary	1					Approve
Council of Governors Register of Interests	Corporate Governance	Annual	Trust Secretary	Trust Secretary	1	Note				
Election and Appointment of Governors	Statutory and Foundation Trust Constitutional Duties	Annual (July in election years)	Trust Secretary	Head of Membership & Governance	1	Note				
Forward Planner 2015/16	Statutory and Foundation Trust Constitutional Duties	Annual	Trust Secretary	Head of Membership & Governance	1	Note				
Governors Meeting Dates for 2016/17	Statutory and Foundation Trust Constitutional Duties	Annual	Trust Secretary	Trust Secretary	1				Approve	
Appointment/Re-appointment of the Trust's External Auditors	Statutory and Foundation Trust Constitutional Duties	As required	Trust Secretary	Trust Secretary	1	Approve				
Monitor Annual Plan	Performance Update and Strategic Outlook	Annual	Chief Executive	Chief Executive	1		Note			
Independent Auditor's Report to the Governors on the Quality Report 2014-15	Performance Update and Strategic Outlook	Annual	Chief Nurse	Chief Nurse	1		Note			
UH Bristol Quality Report 2014-2015	Performance Update and Strategic Outlook	Annual	Chief Nurse	Chief Nurse	1		Note			
Report on Significant Transactions	Strategic Outlook	Ad hoc	Chairman	Chairman	0					
Report on Integration / Reconfiguration	Strategic Outlook	Ad hoc	Chief Executive	Chief Executive	0					
Report on Major Capital Projects	Strategic Outlook	Ad hoc	Chairman	Chairman	0					
Legislative and Regulatory Items	Statutory and Foundation Trust Constitutional Duties	Ad hoc	Chairman	Various	0					
Achievement on Corporate Quality Objectives	Performance Update and Strategic Outlook	Ad hoc	Chief Nurse	Chief Nurse	0					
Presentation of the Annual Report and Accounts	Statutory and Foundation Trust Constitutional Duties	Annual	Chief Executive and Director of Finance	Chief Executive and Director of Finance	1			Note		
Presentation of the External Auditors Opinion on the Annual Report (Annual Audit Letter)	Statutory and Foundation Trust Constitutional Duties	Annual	Chief Executive	Chief Executive	1			Note		
Governors' Annual Report of Governor and Membership Activity	Statutory and Foundation Trust Constitutional Duties	Annual	Lead Governor	Head of Membership & Governance	1			Note		
		Checksum	0	69	69	18	16	6	14	15

University Hospitals Bristol NHS
NHS Foundation Trust

A report for the Council of Governor Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 12 – External Auditor Review

Purpose

This paper provides the Council of Governors with a proposal and recommendation from the Trust's Audit Committee to extend the contract of the External Auditors, Price Waterhouse Coopers for a further period of 12 months. Governors have a statutory duty to appoint; re-appointment; or remove the Trust's External Auditors.

Abstract

In response to discussions undertaken by the Audit Committee relating to the overall positive view regarding the performance of the Trust's External Auditors, Price Waterhouse Coopers (PWC), this paper sets out a proposal to extend the existing contract by a further period of 12 months as of 1st July 2015, subject to the formal approval of the Council of Governors on 30th April 2015.

The contract for external audit services was awarded to PWC on 1 July 2012 for an initial period of three years with an option to extend of 2 x 12 months. The contract was for statutory audit services, auditing services, accounting, auditing and fiscal services.

Recommendations

The Council of Governors is recommended to **approve** the recommendation to extend the current contract of the External Auditors, PWC, by a period of 12 months as of 1st July 2015.

Report Sponsor or Other Author

Sponsor: John Moore, Non-Executive Director and Audit Committee Chair

Author: Debbie Henderson, Trust Secretary

External Audit – Contract Review

1. Introduction

University Hospitals Bristol NHS Foundation Trust requires a comprehensive and efficient external audit service which can demonstrate the required level of professional independence. The contract for external audit services was awarded to PricewaterhouseCoopers on 1 July 2012 for an initial period of three years with an option to extend of 2 x 12 months. The contract was for statutory audit services, auditing services, accounting, auditing and fiscal services.

The contract is, therefore, due to expire on the 30th June 2015 (in line with the original OJEU award notice UK-Bristol: accounting, auditing and fiscal services 2012/S 166-275211 of 30th August 2012).

2. Options

The Trust has two options with regard to the contract for External Audit Services:

a) Extend the existing contract for a further period of 12 months; and

b) Re-tender for an alternative provider

A re-tendering exercise is likely to take 4 – 6 months to complete.

3. Recommendation

Given that there is general satisfaction with the performance of PricewaterhouseCoopers over the past three years it is felt by the Trust's Audit Committee that an extension of the contract by a further 12 months as per the terms of the original contract is the most sensible option.

The final decision is one for the Council of Governors, as set out in the Constitution:

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"

It is therefore recommended that the Council of Governors approve the extension of the contract. A draft letter to PricewaterhouseCoopers is attached at Annex A.

John Moore
Non-Executive Director
Audit Committee Chair

University Hospitals Bristol NHS
NHS Foundation Trust

Bristol and Weston Purchasing Consortium
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Heather Ancient
PricewaterhouseCoopers LLP
1 Embankment Place,
London
WC2N 6RH

2015

Dear Ms Ancient,

Re: RFT2055 Contract for the Provision of BWPC - RA7 - External Audit Service on behalf of University Hospitals Bristol NHS Foundation Trust.

As you are aware the above initial period of contract is due to expire on the 30th June 2015 in line with the original OJEU award notice *UK-Bristol: accounting, auditing and fiscal services 2012/S 166-275211 of 30th August 2012*.

I am pleased to inform you that the Trust would like to extend the above contract until 30th June 2016, as per the below option also of notice *2012/S 166-275211*. '*The contract will be for an initial 3 financial years starting in 2012 plus an option to extend of 2 x 12 months. Total contract term is 5 years'.*

This extension is subject to your written confirmation that the services awarded will be available for the duration of the extension period on the existing Terms and Conditions of Contract and that no price increases will be applied.

You are reminded that the Trust's authorised representative for the contract is ……………and any variations to the agreement may only be made with their written permission.

Please sign and return one copy of the attached indicating your acceptance of the extension on the terms stated.

If you have any questions regarding this extension please contact me.

Yours sincerely

Lucy Barker BSc Hons MCIPS
Head of Non Clinical Procurement
Bristol & Weston NHS Purchasing Consortium

Re: RFT2055 Contract for the Provision of BWPC - RA7 - External Audit Service on behalf of University Hospitals Bristol NHS Foundation Trust.

I hereby confirm on behalf of **PricewaterhouseCoopers LLP** the acceptance of the above contract extension.

It is guaranteed that the services awarded will be available for the duration of the extension period on the existing Terms and Conditions of Contract.

Signed …………………………………………………………………………..

Name (Please print) …………………………………………………………

Position …………………………………………………………………………

Company …………………………………………………………………………..

Date ………………………………………………………………………………..

Witnessed by ………………………………………………………………………

Name (Please print) …………………………………………………………

Position …………………………………………………………………………

Date ……………………………………………………………………………….

Cover Sheet for a Report for a Council of Governors Meeting to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 13 – Governors' Log of Communications
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. Governors are advised that the procedure for processing questions submitted to the Governors' Log has been reviewed. A copy of the revised Standard Operating Procedure is attached at Appendix B.
The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.
Recommendations
The Council of Governors is asked to **note** the report.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Governor Log – Items since the previous meeting. Appendix B – Revised Standard Operating Procedure for the Governors' Log of Communications.

ID Governor Name

118 **Clive Hamilton** **Title:** **Infusion Pumps**

Query **21/04/2015**

I have been made aware by my constituents of concern regarding the availability and use of Infusion Pumps for treatment. Can you provide appropriate assurance that there are sufficient infusion pumps, readily available, in good repair and with an adequate pool of trained staff to ensure safe use?

Response **21/04/2015**

Notified to Exec, awaiting response.

Status *Assigned to Executive Lead*

117 **Mo Schiller** **Title:** **Performance & Finance - Waiting List Initatives**

Query **21/04/2015**

In the financial year 2014/2015 how many surgical Waiting List Initiatives were undertaken across the Trust by Speciality, including Lists that were outsourced to other Providers? What is the cost of running a WLI list against a 'normal list'? Finally, when is it determined that a Waiting List Initiative is required and what is the criteria for patient selection?

Response **21/04/2015**

Notified to Exec, awaiting response.

Status *Assigned to Executive Lead*

116 **Wendy Gregory** **Title:** **Never Event and Serious Incident**

Query **17/04/2015**

What is the criteria used to define an incident as a "never event" and/or "serious incident"? How does the Trust define the two categories of incident intelligently so that the term is proportionate to the incident both in the short and long term. Also, what is the policy regarding the time taken to respond to incidents of this type?

Response **17/04/2015**

Pending response

Status *Assigned to Executive Lead*

115 **Brenda Rowe** **Title:** **Safeguarding in relation to hospital visitors**

Query **03/03/2015**

In the wake of the Jimmy Saville and Stoke Mandeville Hospital scandal, what measures does the Trust Board have in place/ or will introduce to provide assurance that our patients are safeguarded appropriately and what background checks are currently carried out in relation to those individuals (i.e., carers, celebrities, external advisors) who frequent our hospitals?
(Brenda Rowe, Public Governor)

Response **01/04/2015**

Safeguarding Arrangements:
The Trust has robust arrangements for Safeguarding Children within University Hospitals Bristol NHS Foundation Trust, under-pinned by the statutory requirements detailed in 'Section 11' of the Children Act 2004, including clear lines of accountability with a designated Executive Lead. These arrangements and safeguarding activities are overseen internally by the Safeguarding Children Steering Group and monitored externally by the Local Safeguarding Children's Boards and NHS Commissioners. All Trust staff have a responsibility to safeguard children and are required to complete safeguarding children training at a level appropriate to their role and responsibility. The Trust also has a comprehensive set of Safeguarding Children policies and procedures which are regularly reviewed and updated in response to changes in legislation and best practice. These policies are in line with the South West Child Protection Procedures.

The Trust has robust arrangements for Safeguarding Adults within University Hospitals Bristol NHS Foundation Trust, including clear lines of accountability with a designated Executive Lead. These arrangements and safeguarding activities are overseen internally by the Safeguarding Adults Steering Group and monitored externally by the Local Safeguarding Adult Boards and NHS Commissioners. All Trust staff have a responsibility to safeguard adults and are required to complete safeguarding adult training at a level appropriate to their role and responsibility

Volunteer and celebrity access to patients:
The Trust has in place a robust system to monitor volunteers' access to patients, which includes a detailed recruitment, selection and supervision process, as specified within the Volunteer Policy. Volunteers are expected to commit to a minimum of six months' service. Prior to commencement of their placement, all volunteers have a DBS check (enhanced for the Children's Hospital). All volunteers have to complete safeguarding children and adults training.

The Trust has a VIP and celebrity visitor procedure which is there to protect the privacy of patients, families and staff. The Trust takes reasonably practical measures to:
•Handle external visits safely and minimise the disruption they may have on the Trust's hospitals.
•Advise staff of potential visits in their areas where appropriate and work with them to minimise impact of visits on wards and other clinical areas.
•Ensure all media activity and handling during visits adheres to the procedures set out in the Trust's media policy.
•Ensure robust procedures are in place to organise

Status *Awaiting Governor Response*

ID	Governor Name		
114	Angelo Micciche	Title:	Ward moves - transfer of cystic fibrosis nursing staff

Query **10/02/2015**

With regard to the move of Ward C808 specialising in the care of cystic fibrosis patients to the new ward A900, it does not appear that the existing experienced cf ward nursing staff are being moved at this stage. Are patients aware of the transfer of nursing staff? For regular inpatients after many years of care, this may have a significant impact.

The nursing team have formed strong rapport and knowledge of each of their patients over many years and have been well trained and built extensive experience in cf. Could we receive assurance that this body of knowledge and experience will not be lost in the move, as it provides invaluable care to patients, built over a significant period of time?

There is anecdotal evidence that there was a lack of clarity at consultation stage which led to the nursing staff making a decision to move to a different ward. Could you please provide some detail of the rationale behind the decision not to move experienced nursing staff for this particular speciality to ensure there is no deterioration in standards of care due to a lack of specialist knowledge and experience on the new ward?

Response **16/03/2015**

A consultation was carried out with all Divisional nursing staff in medicine to support them in expressing their preference when the wards in medicine are reconfigured. Some staff chose to stay with their specialties and some chose to stay with their Ward Sister and remain as part of a team, even if it meant changing specialties. The ward sisters were all offered all the new wards and configurations and invited to express their 1st, 2nd and 3rd preference. Without exception, every ward sister got their first preference for wards.

In the new bed model, the cystic fibrosis service moved to A900 because the environment is most suited for the care of patients with CF (12 single side rooms with en suite bathrooms) and accommodated the additional beds the service required following the expansion and centralisation of services. The Division recognised that a change in ward leadership and in members of the nursing team could be risk to continuity of care and knowledge and skills in the speciality, they therefore put extensive and detailed plans in place to ensure the team on A900 were as prepared as possible for the service transfer and mitigate any risks associated with the change.

Specific actions put in place ahead of the planned change:

•The CF Clinical Nurse Specialists (CFCNS) set up a band 5 nurse rotation to allow staff from the inpatient ward to rotate for half their hours between the ward and the CF nursing team. This was to develop their skills and knowledge in CF and allow them to feed these skills back into the ward where they worked. This worked well and it also meant that patients that may not be regularly admitted also became familiar with the ward staff in the outpatient setting. This 'placement' recognised the need to prepare the RN's who would be working on A900 for their role as the specialist CF ward in the future

•One of the band 5 nurses from C808 was successful at interview and moved to be the Senior Staff Nurse a number of months before the ward moved to share clinical skills and CF models of care

•During the opening week on A900 the CF nurses planned their workload to ensure there was at least one CFCNS present on the ward to welcome patients and work alongside the ward staff. Two of the CF CNS' came in out of hours at the weekend to support the staff with IV antibiotics and in addition have drawn up a detailed user guide of regular IV antibiotics and their administration specifically for CF patients

•Since A900 opened there has been a CF CNS up on the ward on a daily basis and the ward made aware they are contactable Monday to Friday. When there are teaching opportunities such as port training, the CFCNS support nursing staff to become competent and where possible, organise this to allow these opportunities to fall within working hours

•A week before the actual move there was multi-professional study day for all Ward A900 staff of which all but 2 staff attended from the A900 team. It was organised as 2 half day sessions to allow maximum attendance. The physiotherapy team are also delivering weekly teaching. There are additional planned teaching sessions with input from all members of the MDT on a rotational basis

•2 RN's from ward C808 have been allocated to work on A900 until the end of the summer on a rotational basis (1 on nights and 1 days)

•During the first few weeks following the move and for as long as required, senior staff from C808 have made themselves available on a daily basis to support A900 staff, either by visiting or on the telephone

•A weekly operational meeting has been set up to review the progress of the transfer and manage any issues (should they arise) swiftly

To ensure we hear the views of all the patients on the ward since it opened, including the CF patients, we have been running a programme for inpatients to submit comment cards for ideas of improvements and suggestions and then responding to these weekly with a plan, when the request is deliverable and reasonable.

Status *Assigned to Executive Lead*

113	Angelo Micciche	Title:	Staffing levels

Query **06/02/2015**

Within the last 18 months the board took the decision to "over recruit" across the wards to help cover holiday and sickness and improve general staffing levels thereby improving patient safety, staff moral, reduce bank usage, etc.

Whilst I acknowledge the current challenges faced with recuritment, please could all governors have an update on what has progress has been made in this period and the impacts achieved accordingly.

Response **11/02/2015**

Response from Chief Nurse: 'Over recruiting' against establishment is not formally taking place within the Trust. Our funded nursing establishments are set to take into account of annual leave, sickness absence, study leave and maternity leave, they have a 21% uplift to cover these areas. The Trust's aim is to always ensure that our staffing numbers match these agreed establishments. To mitigate the impact of turnover nursing staff numbers may be slightly higher than actual vacancies at a point in time, as we know that further vacant posts will have arisen at the point the new starter is ready to take up post. We are currently have a registered nurse vacancy factor of 6.9% (end of December) , which benchmarks 9% against our peers.

Status *Responded*

ID Governor Name

112 **Mo Schiller** **Title:** **Nursing staff question to patients: 'Are we getting the care right'?**

Query **30/01/2015**

When nursing staff do rounding do they ask ,"Are we getting the care right" to patients?.Doing the Face to Face interviews gave me the impression especially last year in St Michaels post natal ward that maybe complaints would not proceed if we enquired on patients satisfaction at the time they were with us.

Response **11/02/2015**

Response from Chief Nurse:
The key aspects that are usually checked during comfort rounds in acute care areas include the "Four P's" , Positioning: Making sure the patient is comfortable and assessing the risk of pressure ulcers , Personal needs: Scheduling patient trips to the bathroom to avoid risk of falls , Pain: Asking patients to describe their pain level on a scale of 0 - 10 , Placement: Making sure the items a patient needs are within easy reach. During each round the nurse will ask the patient if there is anything else that they need. Reported evidence based improvements in clinical outcomes include: pain management, decrease in falls and pressure ulcers reported improvements in patient reported outcomes include: better patient experience and satisfaction, reduction in patient complaints reduction in the frequency of call bell usage and the length of time patients wait to have their call bells answered. Maternity services are not an area where comfort rounds are common, however recognising the benefits that they can bring they have been introduced into maternity services 3 times a day where women are told about facilities on the ward and asked if they have any issues that they are concerned about and how the staff can help them with these.

Status *Responded*

111 **Mo Schiller** **Title:** **OPD appointments problems**

Query **30/01/2015**

OPD complaints highlight the continuing problem booking appts./changing appts via the telephone,waiting times in clinic and updating the white boards info system.Despite the work carried out this does not appear to be resolved.Are there plans for electronic booking in and updating waiting time and online booking in the future?

Response **25/03/2015**

The Trust invited the Elective Care Intensive Support Team (ECIST) to review Referral to Treatment pathways, systems and processes. The review included aspects of the Outpatient service.

ECIST made a number of recommendations to improve patient access and experience, including the patient facing "front end" booking process, e.g. strengthening the Appointments Centre to adopt a broader Referral Management Centre approach, the receipt of all electronic referrals (Choose and Book); paper referrals; registration on PAS; tracking of all referrals; and to act as a single point of contact for patients.

Some specialties had unacceptable first appointment times and / or long delays in clinic. One of the key underlying drivers is insufficient capacity to manage demand for new and follow up appointments. ECIST supported the Divisions to carry out detailed demand and capacity modelling across all specialties. The outputs of the modelling have helped the Divisions to gain a much better understanding of their services, and to quantify what additional capacity is required to offer a high quality, sustainable service for our patients. Specialty level proposals have been included in the Trust's operating plans for 2015/16 and are currently under discussion.

An interim Outpatient Services Manager has started to implement agreed changes in the management of core Outpatients services. She will also support the specific RTT actions referred to earlier. The priority actions include an increase in the uptake of Choose and Book; simplification of booking and changing of appointments via the telephone; reduction in waiting times in clinics and working with Divisions to ensure there is sufficient capacity to manage advance bookings.

A substantive Outpatients Manager has been appointed and will be in post mid June 2015.

Status *Responded*

110 **Mo Schiller** **Title:** **Paediatric Cardiac Surgery - 3D imaging**

Query **30/01/2015**

Are the paediatric cardiac surgeons planning to use 3D imaging,printing and using a resin cast of the child's heart to create patches to repair holes in the heart on young children with complex cardiac deformities? Recent reports show that this is a way forward to safer surgery and it also reduces the operation time.

Response **16/02/2015**

Paediatric cardiac surgeons are now planning to use 3D imaging.
Response from Aidan Fowler, Fast-track Executive.

Status *Closed*

University Hospitals Bristol NHS
NHS Foundation Trust

Governors' Log Standard Operating Procedure

Background

The Governors' Log of Communications was established as a means of channelling communications between the Governors and the Trust Executive Team. It provides a central resource for logging queries from Governors and the corresponding responses from Executives. A summary report of communications registered on the log is produced as required for review at, for example, Trust Board.

Standard Process

A flow process map outlining all steps of the agreed management process for the Governors' Log can be found at Appendix A.

In summary, the process for administering the Governors' Log is as follows:

1. Governor submits query to Head of Membership & Governance for uploading to the Log. Query generated e.g. from contact with constituent, Governor checks to ensure query has not arisen before. The Governor also advises of the 'Origin' of the query e.g. Governor Project Focus Group, or as required the Head of Membership notes this e.g. when query is documented at Trust Public Board.
2. Head of Membership & Governance checks appropriateness of query (e.g. to ensure doesn't breach Information Governance standards) and registers query on Governors Log accordingly.
3. Head of Membership & Governance emails Executive Lead who has responsibility for providing response, and Board and Council of Governors to alert them to the update to the Log.
4. A return of response from the Executive Lead is required within a maximum of 10 working days. The Executive Lead returns their response to the Head of Membership & Governance, who in turn updates the Governors' Log with the information provided.
5. The Head of Membership & Governance emails the originating Governor with detail of the response, and for information sends the detail to the Board and Council of Governors.
6. If the response provided is determined to be adequate by the Governor the query is closed on the Log, if further or supplementary questions are asked the Log is updated to reflect this. In both cases detail is forwarded to the Executive and Non-Executive Team and the Council of Governors.

All required fields for entry to the Governors' Log are detailed at Appendix B.

Reporting of the Governors' Log

The Head of Membership & Governance will collate a monthly report of all Governors' Log activity and circulate this to the following groups in the order as stated:

1. Trust Executive Team
2. Council of Governors

At this point any further comments are noted and reflected in the report by the Trust Secretary. The Trust Secretary will then submit the final report to:

3. Public Trust Board

DRAFT

The purpose of reporting to the Trust Board is to ensure all queries are adequately addressed in a forum attended by the Executive and Non-Executive Teams, and the Governors.

In addition to this, on a quarterly basis the Head of Membership & Governance will submit a report detailed all closed queries registered on the Log to the following groups in order as stated:

1. Council of Governors Quality Project Focus Group
2. Council of Governors

The purpose of reporting to the Council of Governors Quality Project Focus Group and Council of Governors is to allow Governors to collectively ascertain if they are confident that the response and assurance provided by Executives' stand.

Intended benefits of the Governors' Log

The Governors' Log is a practical mechanism for supporting a good two way communication flow between Governors, on behalf of their Constituent, and Trust Executives. It can run continually throughout the year, and enables queries to be addressed in real-time, outwith the need for a formal or scheduled meeting.

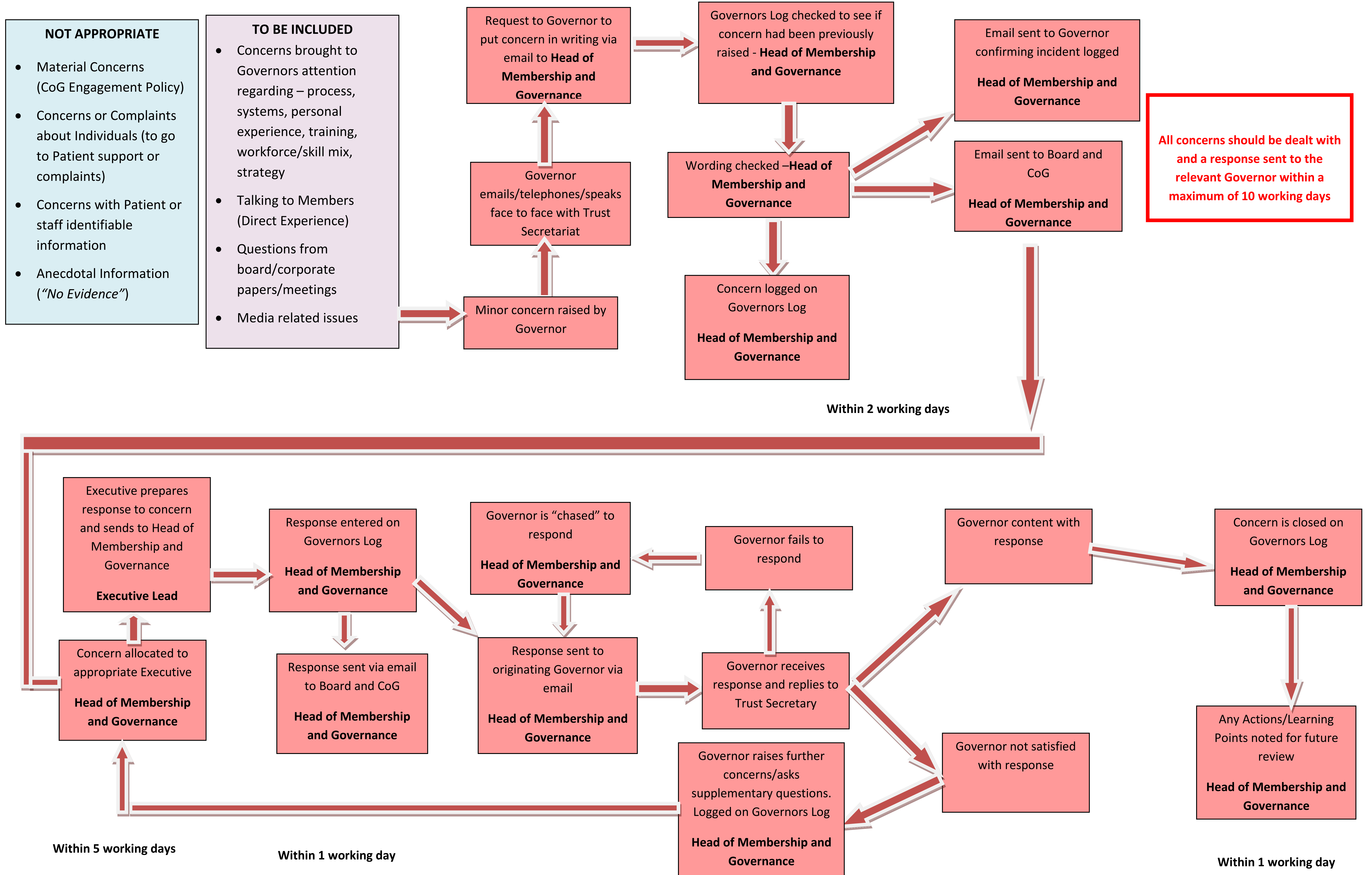
In addition, the Governors' Log facilitates a transparent process that demonstrates Governor's fulfilling their duty of accountability to their local community.

It is on this basis that the responsibility of the Executive team to provide comprehensive and timely responses to the Governors queries is required.

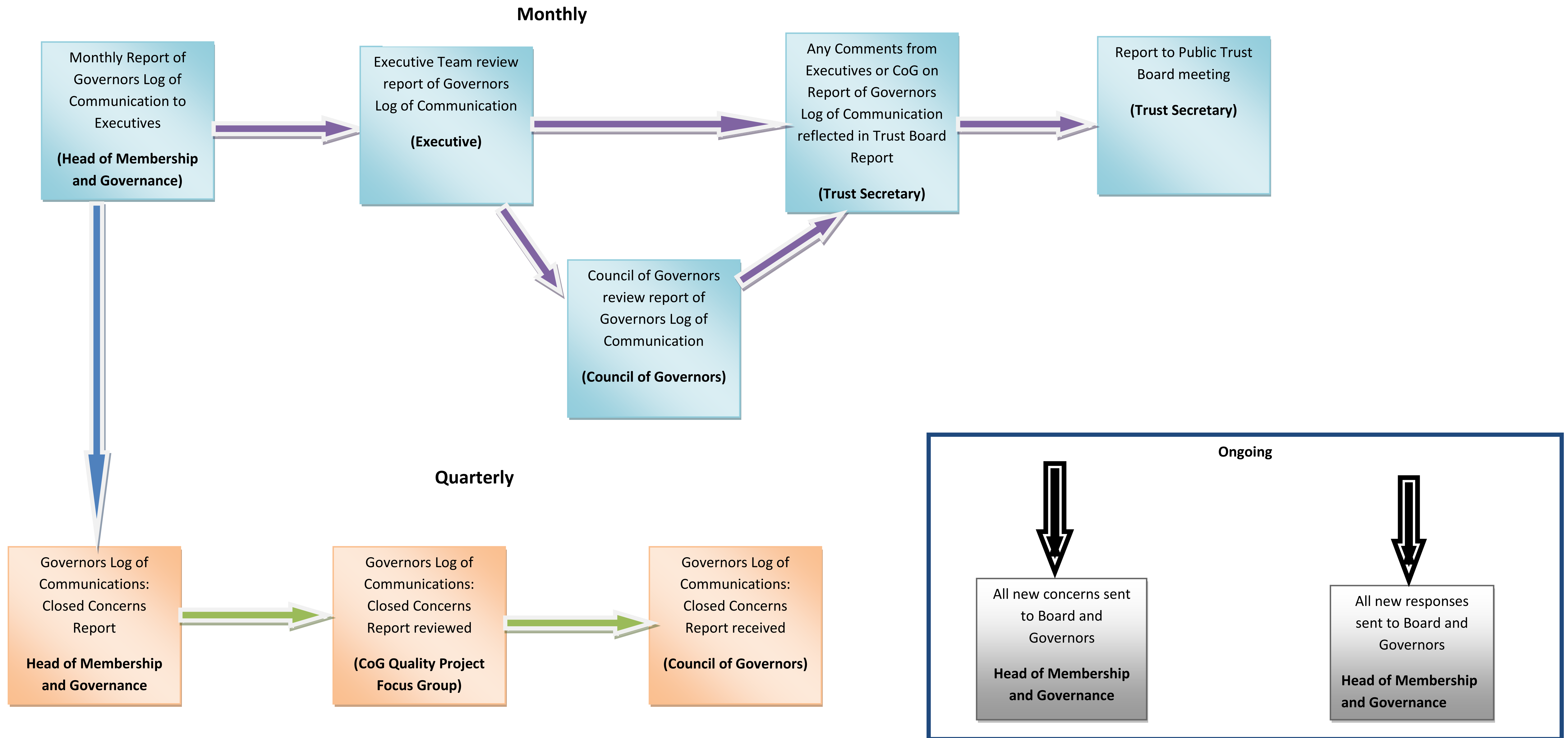
The Governors' Log should be viewed by the Trust as a tool for enabling accountability, and for supporting staff, patient and public engagement.

DRAFT

PROCESS MAP: GOVERNORS LOG OF COMMUNICATIONS - HANDLING OF GOVERNOR CONCERNS



PROCESS MAP: GOVERNORS LOG OF COMMUNICATIONS – REPORTING OF CONCERNS/LEARNING POINTS



Appendix B

<u>Governors' Log – Required Data Fields</u>

1. Date Submitted
2. Governor Name
3. Governor Constituency
4. Origin *(Meeting title/ via Member/ via Public Trust Board/ etc)*
5. Theme/ Summary Description
6. Question
7. Division *(relevant to within the Trust or whole Trust)*
8. Executive Lead (assigned to provide response)
9. Response Date
10. Status *(closed/ pending Governor review/ open)*
11. Status date
12. Secretariat Notes *(use as required)*

Cover Sheet for a Report for a Council of Governors Meeting, to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 14b: Q3 Complaints Report and Patient Experience Reports

Purpose

Purpose

This quarterly agenda item covers the following reports:

- Quarter 3 Complaints Report
- Quarter 3 Patient Experience Report

Key issues to note

Patient Experience

- Key quality assurance indicators (kindness and understanding, patient experience tracker, Friends and Family Test scores) continue to be "green"
- New day case FFT in operation since October: scores are strong; although thresholds have not been set yet, scores are well above the inpatient thresholds
- Postnatal wards continue to attract lower scores on the key metrics, however they remain in line with their respective national benchmarks (and in some cases better)
- South Bristol Community Hospital also tends to get lower scores, however (having fully explored this) we are confident that this is an artefact of the patient population (i.e. complex, long-stay). The recent CQC inspection confirmed the high quality of care delivered at SBCH.

Complaints

- 421 complaints were received in Q3 (0.23% of activity) – a reduction compared to 518 (0.29%) in Q2
- The Trust's performance in responding to complaints within the timescales agreed with complainants was 83.4% compared to 89.5% in Q2.
- The number of cases where the original response deadline was extended continued to rise, with 46 cases in Q3 compared with 41 in Q2.
- There was an increase in complainants telling us that they were unhappy with our investigation of their concerns: 24 compared to 14 in Q2.
- In Q3, complaints relating to appointments and admissions continued to account for over a third (140) of the total complaints received by the Trust (in line with Q1 and Q2), however complaints about cancelled or delayed appointments and operations decreased notably in Q3.
- Complaints about failure to answer telephones rose again in Q3
- Complaints about Children's A&E and Ward 39 increased significantly in Q3.

Triangulation

- As reported in Q2, Ward B301 (old Ward 7, care of the elderly) receives consistently low scores on key patient experience metrics. A wider quality review by the Head of Nursing for the Medical Division has found no evidence of wider care failings and the

majority of feedback received by the ward is positive. *Face-to-face* interviews are also being carried out in February (delayed from January). 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).

- Q3 patient experience scores from Ward A605 were also low, however this was not reflected in complaints data. The likelihood is that lower survey scores have resulted from ward moves (old Ward 6 moved out in August; old Ward 9 moved in in October) and a large number of medical outliers on the ward. The ward will close altogether in March.

Recommendations

The Council of Governors is asked to receive these papers to **note**.

Report Sponsor or Other Author

Sponsor:
Chief Nurse, Carolyn Mills

Authors:
Paul Lewis, Patient Experience Lead (Surveys and Evaluation)
Tanya Tofts, Patient Support & Complaints Manager
Chris Swonnell, Head of Quality (Patient Experience & Involvement)
Jane Palmer, Head of Nursing, Surgery Head & Neck Division

Appendices

Appendix A - Quarter 3 Patient Experience Report
Appendix B - Quarter 3 Complaints Report

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Experience Report

Quarter 3, 2014/15

(1 October to 31 December 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 3 (October-December 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 Friends and Family Test was introduced to UH Bristol's day case areas in October 2014. We do not have national benchmarks yet (these will be available from May 2015) but, as an interim guide, the day case scores that the Trust has received to date exceed the equivalent inpatient scores.
- UH Bristol received a good set of results of the 2014 National Accident and Emergency patient experience survey, comparing favourably with local and national peer Trusts.

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 3 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[1].

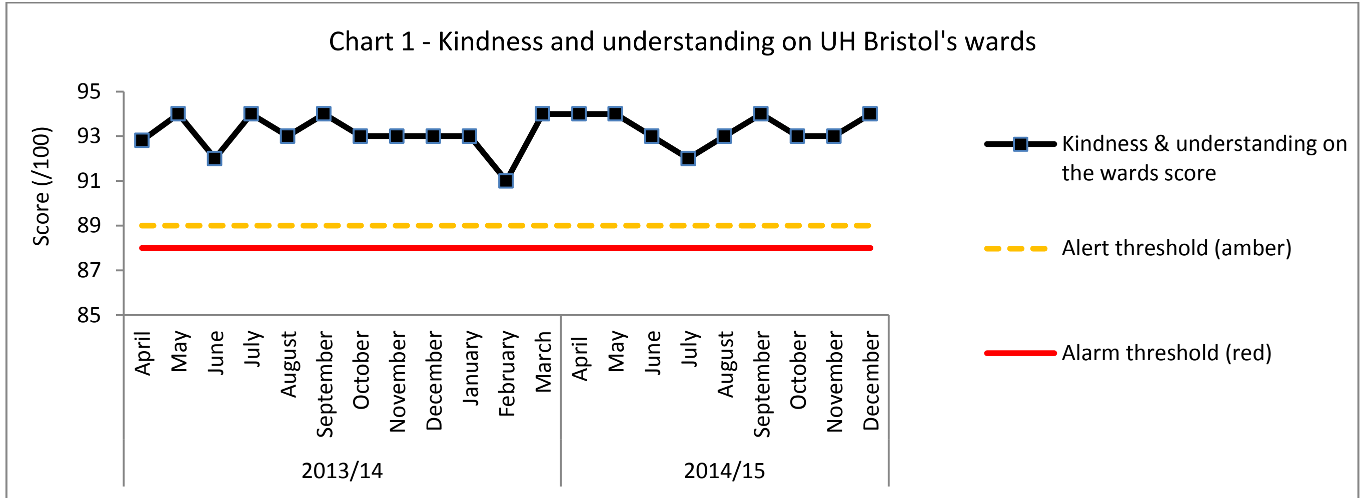
Please note that surveys work most effectively at a population (or "system") level, and tend to offer less insight into the unique experience of each individual patient. Therefore, the survey data presented in this report should be used in conjunction with other sources of information to provide a coherent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

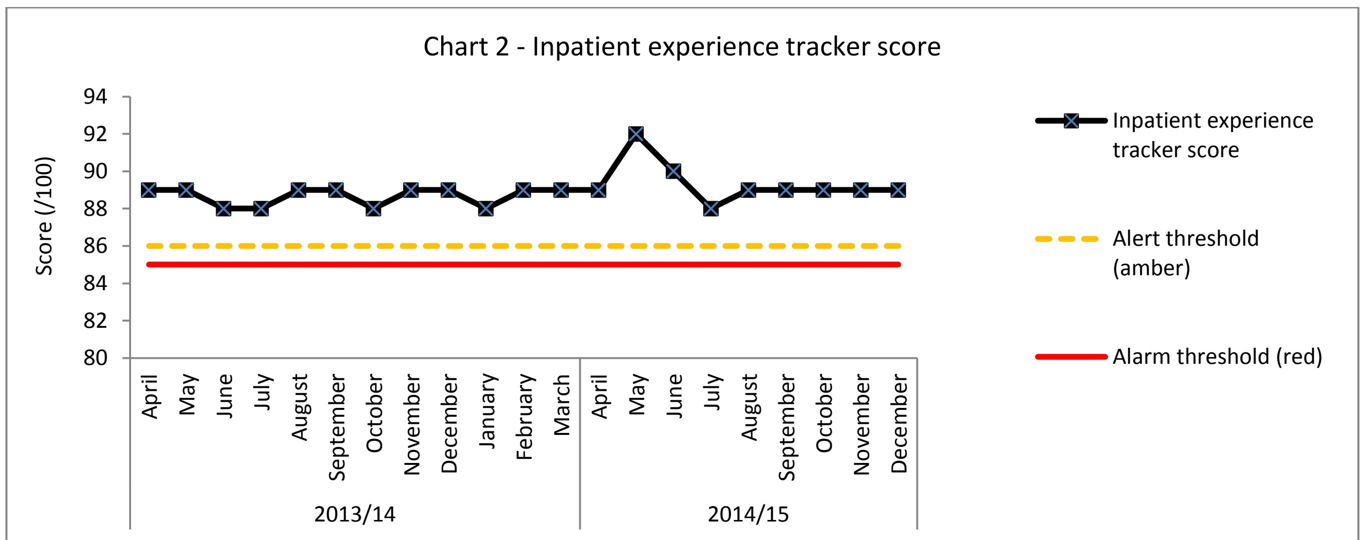
3. Trust-level patient experience data

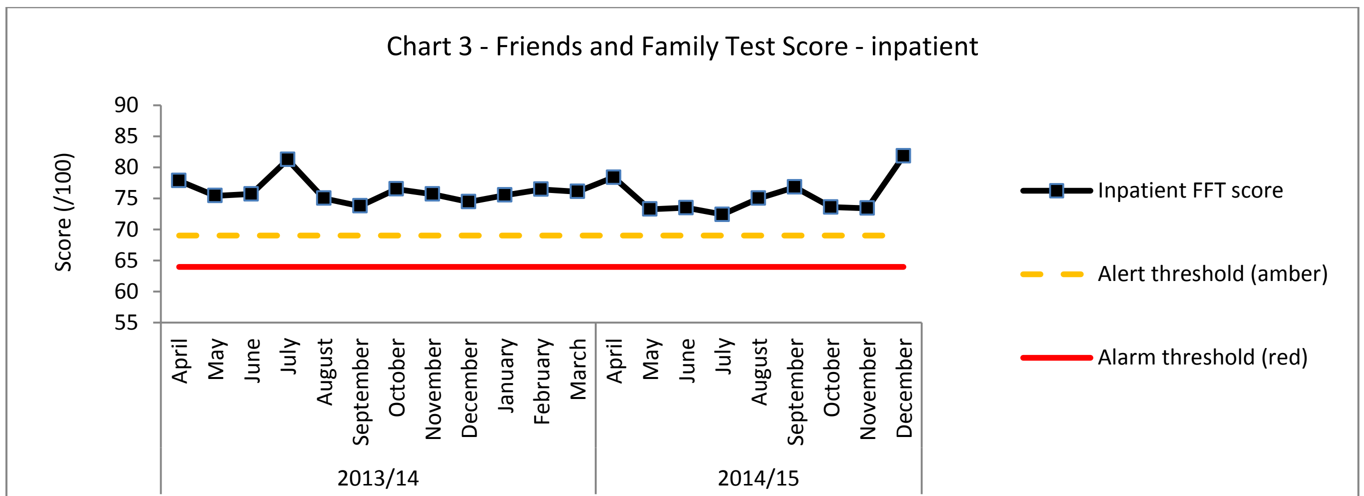
Charts 1 to 4 (over) show the four headline metrics that are used by the Trust Board to monitor the overall quality of patient-reported experience at UH Bristol[2]. These scores have been consistently rated "green" in the periods shown[3], indicating that a high standard of patient experience is being maintained at the Trust. The scores

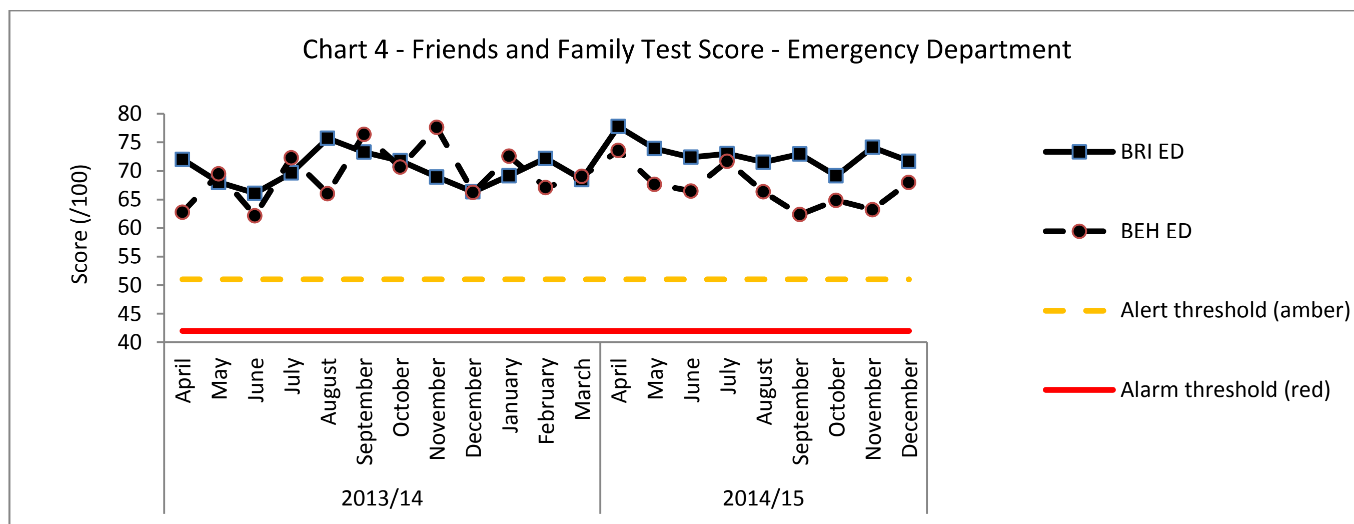
[1] A programme of engagement with patients of the Trust's cancer services is currently being undertaken to fully explore these survey results. The outcomes of this activity will inform a substantive improvement plan.
[2] Kindness and understanding is used as a key measure, because it is a fundamental 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.
[3] Note: the Friends and Family Test data is available around one month before the postal survey data.

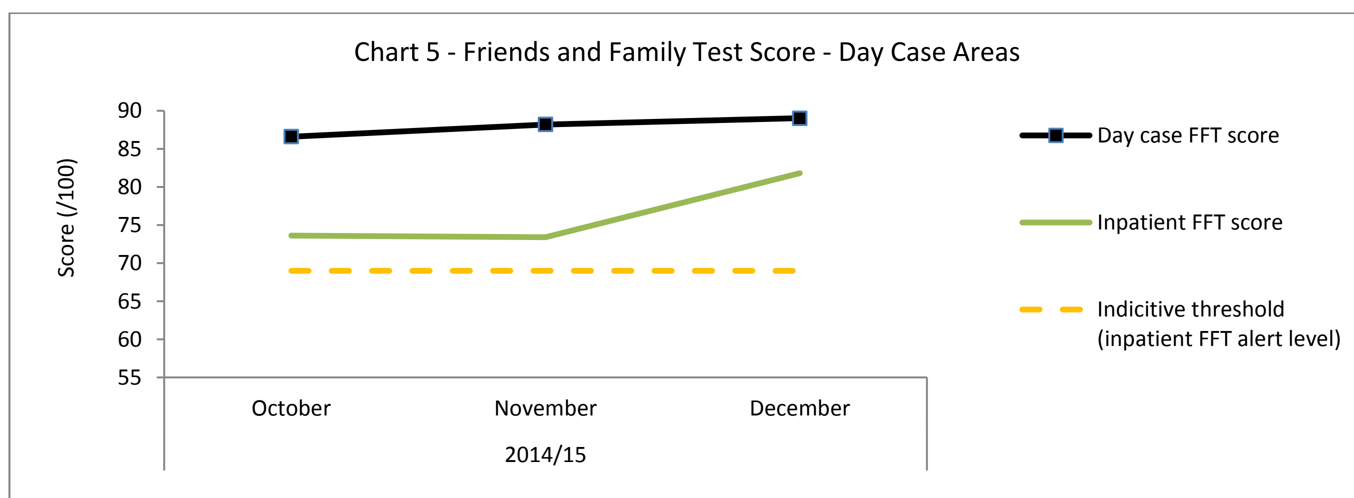
would turn "amber" or "red" if they fell significantly, alerting the senior management team to a deterioration in this position. Chart 5 (page 4) shows the results from the Trust's new Day Case Friends and Family Test survey (see Appendix D for further information about the Friends and Family Test). Although we won't have national comparison data until May 2015, it can be seen that the scores received so far exceed those achieved being achieved by inpatient areas (which in turn are broadly in line with national inpatient norms).







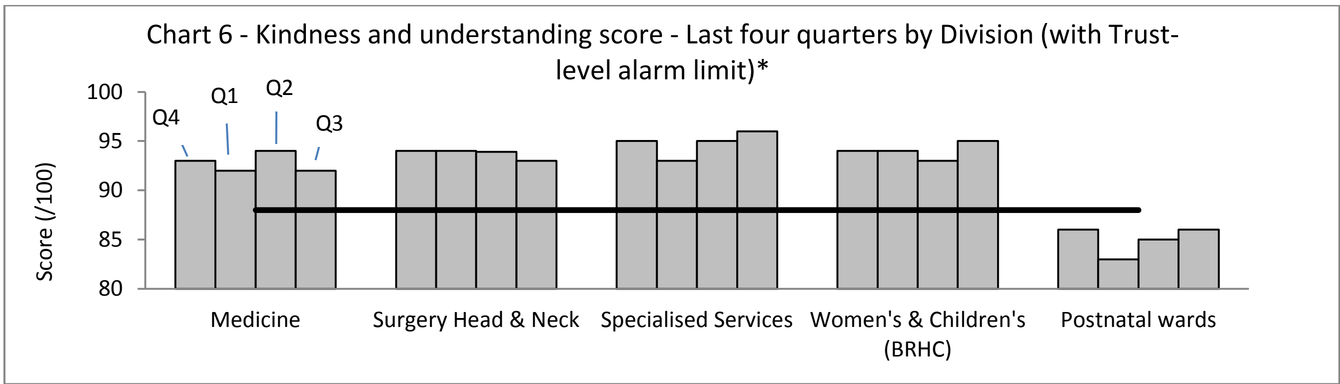


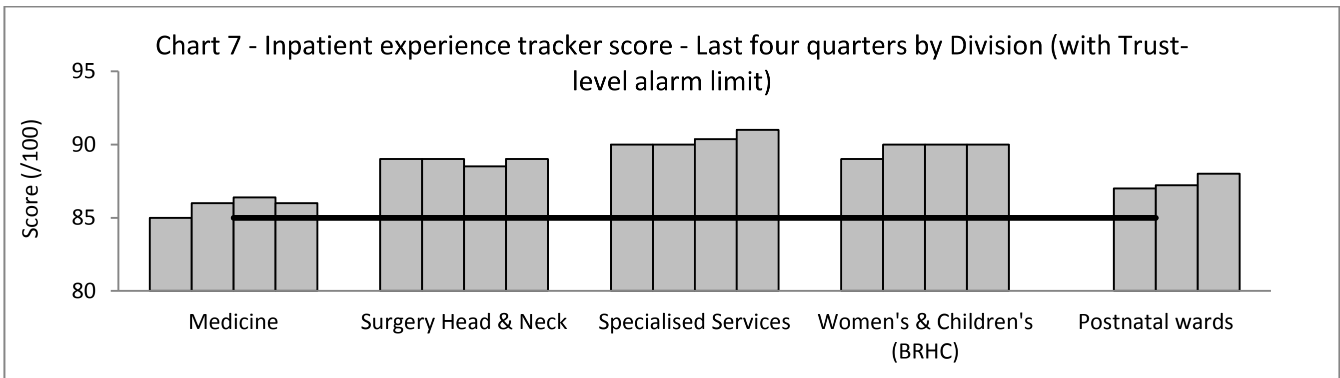


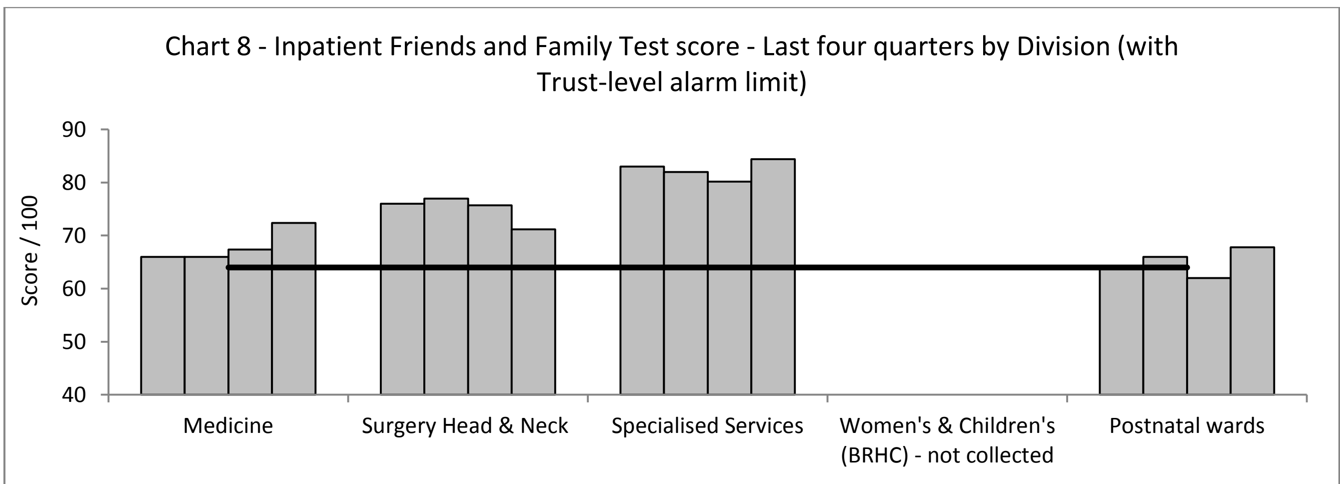
4. Divisional-level patient experience data

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 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, improvement initiatives continue to be carried out in the service to improve these scores (see Section 5)[5].

[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.







**Note: Q4 = Quarter 4 (January-March 2014); Q1 = April-June 2014; Q2 = July-September 2014; Q3 = October-December 2014).*

5. Hospital-level patient experience data

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

[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.

South Bristol Community Hospital (Wards 100 and 200)

The written feedback received for South Bristol Community Hospital via the surveys contains extensive praise for staff. Furthermore, a recent Care Quality Commission inspection rated the management of / care at the hospital as "Good"[7]. This is reflected in the Friends and Family Test survey scores, which are given by the patient at the point of discharge from hospital (Chart 12). However, when surveyed after leaving hospital via the Trust's monthly postal survey, the scores are much less positive (Charts 10 and 11). This disparity between on-site and post-discharge ratings is common in patient experience surveys, with the latter usually providing a more reflective / constructively critical account of the whole experience. In the case of patients at South Bristol Community Hospital, their overall experience will often have involved a relatively long hospital stay, at more than one UH Bristol hospital, for complex medical care that in many cases won't have a definitive "cure" as an end-point (e.g. rehabilitation following a stroke). This type of context has been found to correlate with relatively low patient survey scores (see footnote 4 above). Although this explains the results in Charts 10 and 11 to some extent, they are still a real reflection of peoples' experiences. Further analysis of these survey scores has shown that it is the "communication" and "involvement in care decisions" elements of patient experience that are below the UH Bristol average. Whilst this is a realistic reflection of the challenges in caring for the patient group at South Bristol Community Hospital, the management team recognise that it is important to constantly improve patient experience, and a number of initiatives have been undertaken to address these themes, 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.

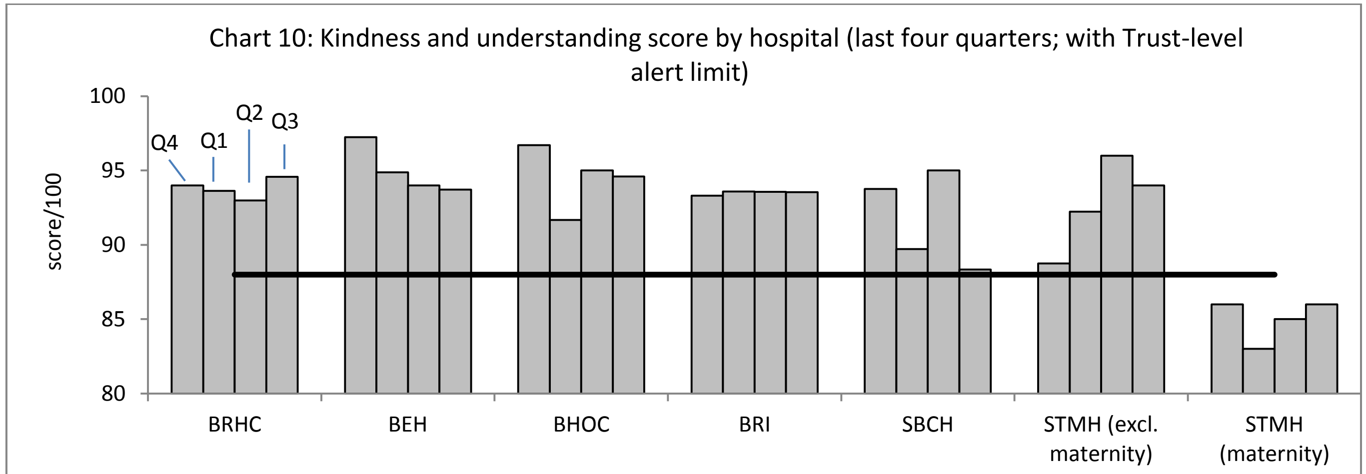
Postnatal wards (71,74,76)

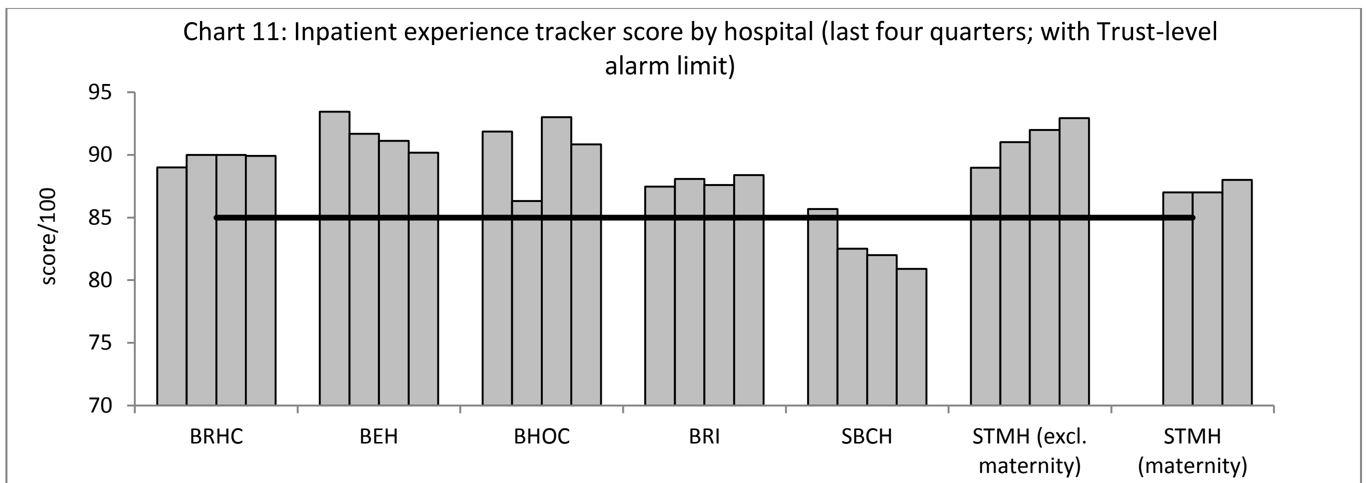
Postnatal ward satisfaction scores are typically lower than other inpatient areas of the Trust, but they are in line with (and in some respects much better than) the national maternity average (see Section 8). It is not clear why there is this divergence between satisfaction ratings on postnatal wards and general inpatient wards (e.g. whether this is a real reflection of care, or reflective of the demographic differences between these populations). There is however merit in taking these results at face-value, and so ongoing service improvement work has been undertaken at St Michael's Hospital in response to the survey, including:

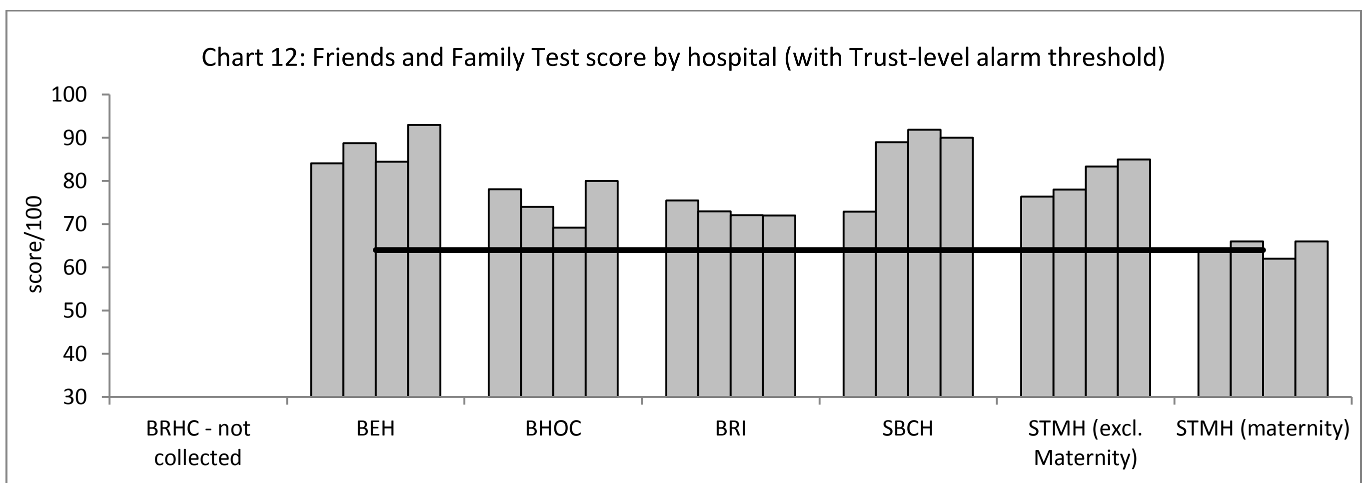
- In-depth analysis of survey data and regular "deep-dive" interviews with women on the postnatal wards
- Reconfiguration of the postnatal wards, based on service-user feedback
- Recruitment to additional midwifery and midwifery support worker posts
- Running workshops for doctors, midwives and midwifery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

[7] http://www.cqc.org.uk/location/RA773

These activities resulted in 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.





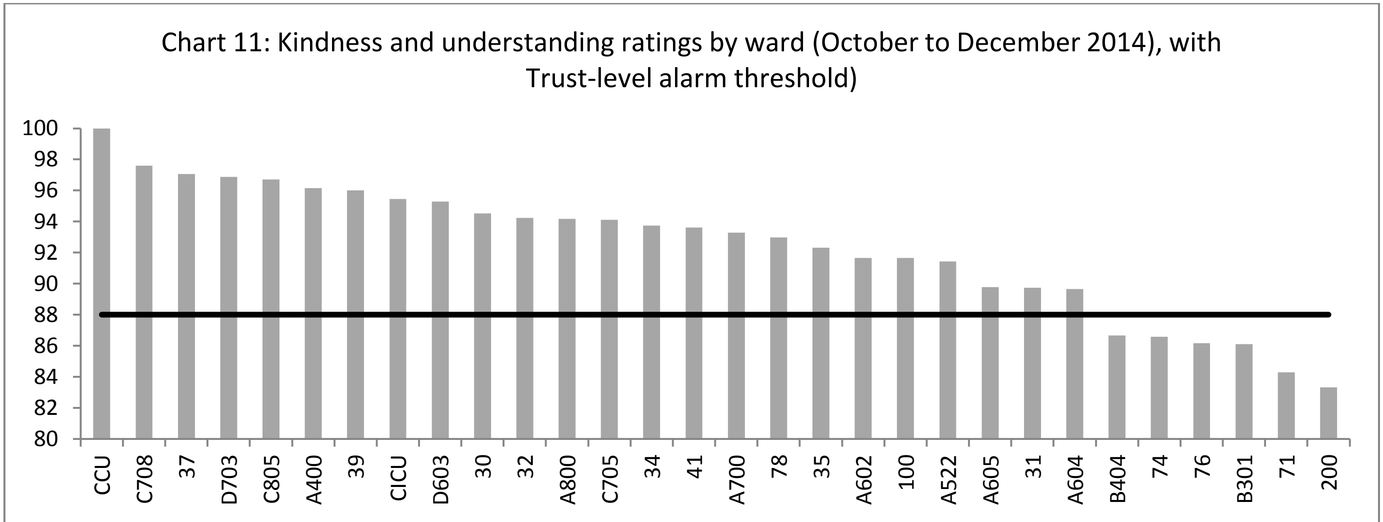


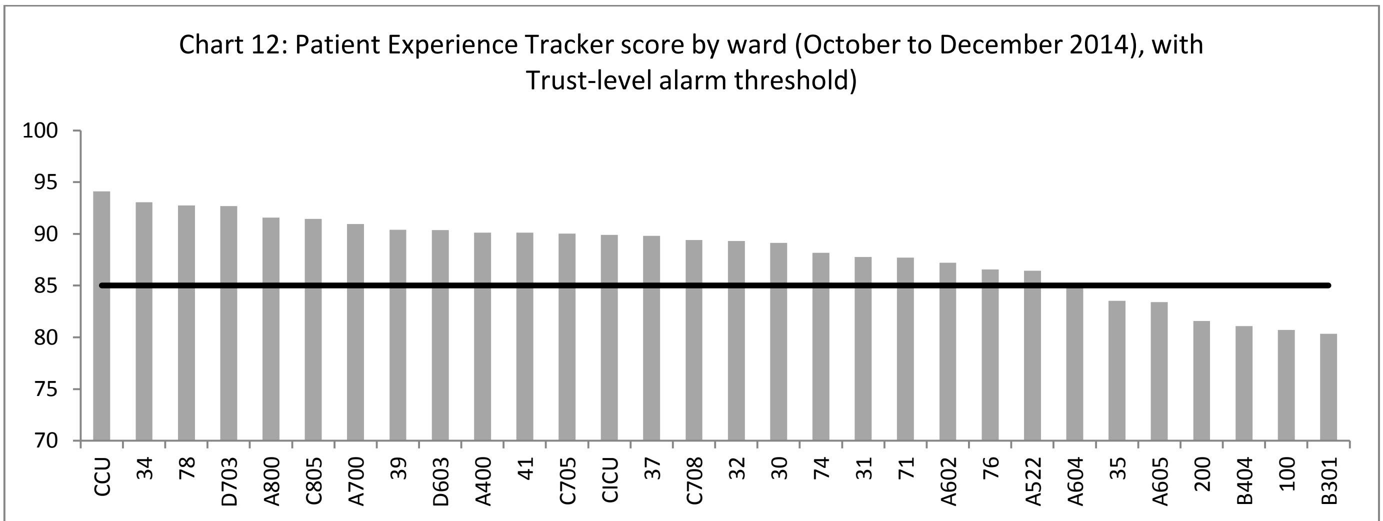
Key: BRHC (Bristol Royal Hospital for Children); BEH (Bristol Eye Hospital – Ward 41); BHOC (Bristol Haematology and Oncology Centre); BRI (Bristol Royal Infirmary); SBCH (South Bristol Community Hospital); STMH (St Michael’s Hospital)

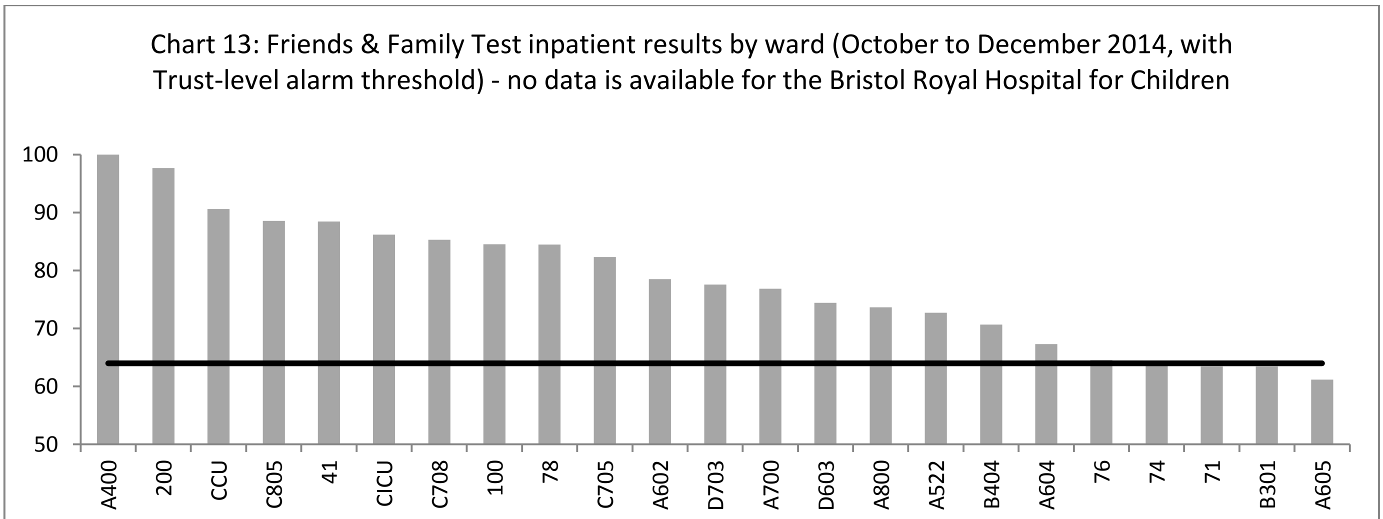
6. Ward-level data

The ward-level inpatient survey and Friends and Family Test data is presented in charts 11 to 13 (over). The sample sizes are relatively small at this level, decreasing the levels of accuracy in the data. Furthermore, a large number of the ward moves / refurbishments / closures are currently taking place within the Trust. Efforts have been made within the following analysis to take into account these moves, but ultimately it is very difficult to do this with a great degree of accuracy. In short: even more caution that usual should be attached to the ward-level data in this report but, even so, some consistency across the surveys does 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).
- Ward B301 (formally Ward 7), which is primarily provides care for an elderly patient population, received relatively low patient experience ratings in the period shown. As with South Bristol Community Hospital, this is in many ways a realistic reflection of the challenges 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 the 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 by the Head of Nursing for the Division of Medicine. This assurance will be further tested in February 2015, when the ward is a focus for the Trust's *Face2Face* interview survey (see Appendix C).
- Ward A605 received the lowest Friends and Family Test score (Chart 13) and a relatively low patient experience tracker score (Chart 12). This ward hasn't been flagged in this Quarterly report before, and there hasn't been a corresponding rise in complaints or concerns in other quality data. Furthermore, the great majority of written comments received from patients contain praise for the staff, and 94% said that they would be likely to recommend the ward to friends and family. Nevertheless, two separate surveys are showing that satisfaction scores were *relatively* low compared to other wards. During the period covered in the data, there were some ward moves involving A605: the previous specialty (Thoracic) moved to a new location, with a new specialty (Vascular) being temporarily housed on the ward until it closes altogether in March 2015. This is the only major contributing factor that we have been able to correlate with the survey results.







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.

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 December 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[8]
Staff	Positive	60%
Communication	Negative	14%
Waiting/delays	Negative	9%
Staff	Negative	9%
Food/catering	Negative	8%

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.

Division of Medicine

Theme	Valence	% of comments
Staff	Positive	56%
Communication	Negative	10%
Waiting/delays	Negative	8%

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.

Division of Specialised Services

Theme	Valence	% of comments
Staff	Positive	60%
Communication	Negative	14%
Food/catering	Negative	10%

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.

Division of Surgery, Head and Neck

Theme	Valence	% of comments
Staff	Positive	59%
Communication	Negative	14%
Staff	Negative	10%

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.

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

Theme	Valence	% of comments
Staff	Positive	65%
Communication	Negative	17%
Staff	Positive	11%

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

Maternity comments

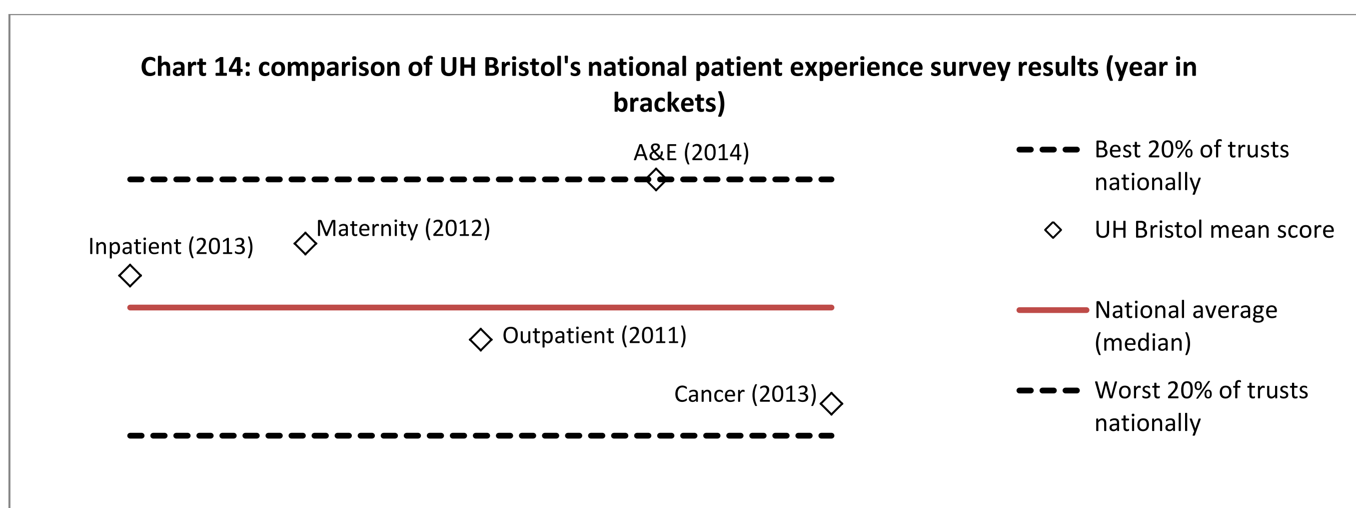
Theme	Valence	% of comments
Staff	Positive	62%
Care during labour	Positive	29%
Information/advice	Negative	18%

For maternity services, the two most common themes relate to praise for staff and praise for care during labour and birth.

[8] 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).

7. 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[9] 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[10], 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.



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%

[9] 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.
[10] 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 • Awareness of the complaints process • Delays at discharge • Explaining potential medication side effects to patients at discharge	March 2015
2013 National Maternity Survey	14 scores were in line with the national average; 3 were better than the national average	January 2014	Six-monthly	• Continuity of antenatal care • Communication during labour and birth • Care on postnatal wards	January 2016
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 • Validate survey results • Understanding the shared-cancer care model, both within UH Bristol and across Trusts	September 2015
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	December 2014
2011 National Outpatient Survey	All UH Bristol scores in line with the national average	March 2012	Six monthly	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments • Copy patients in to hospital letters to GPs	No longer in the national survey programme

Appendix B: Full quarterly Divisional-level inpatient/parent survey dataset (Quarter 3 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	92	94	92	n/a	92
How would you rate the hospital food you / your child received?	61	58	59	64	56	60
Did you / your child get enough help from staff to eat meals?	79	84	88	83	n/a	83
In your opinion, how clean was the hospital room or ward you (or your child) were in?	94	95	94	92	89	94
How clean were the toilets and bathrooms that you / your child used on the ward?	90	92	90	90	81	91
Were you / your child ever bothered by noise at night from hospital staff?	80	83	78	82	n/a	81
Do you feel you / your child was treated with respect and dignity on the ward?	94	94	98	95	91	95
Were you / your child treated with kindness and understanding on the ward?	92	93	96	95	86	94
How would you rate the care you / your child received on the ward?	84	86	89	88	80	87
When you had important questions to ask a doctor, did you get answers you could understand?	83	86	89	88	87	87
When you had important questions to ask a nurse, did you get answers you could understand?	83	86	87	90	86	87
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	71	69	72	76	72	72
If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so?	79	82	84	89	80	83
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	77	83	85	88	84	83
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	85	87	89	87	n/a	87
Did you / your child find someone to talk to about your worries and fears?	68	70	71	79	77	72

	MDC	SHN	SPS	WAC (Excl. Maternity)	Maternity	Trust (excl Mat.)
Staff explained why you needed these test(s) in a way you could understand?	80	86	86	90	n/a	85
Staff tell you when you would find out the results of your test(s)?	68	69	70	74	n/a	70
Staff explain the results of the test(s) in a way you could understand?	71	78	77	80	n/a	76
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	78	92	94	91	n/a	90
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	69	77	78	83	n/a	77
Staff were respectful any decisions you made about your / your child's care and treatement	90	91	93	93	n/a	92
During your hospital stay, were you asked to give your views on the quality of your care?	20	23	19	19	39	21
Do you feel you were kept well informed about your / your child's expected date of discharge?	82	90	92	90	n/a	88
On the day you / your child left hospital, was your / their discharge delayed for any reason?	65	60	52	69	59	62
Did a member of staff tell you what medication side effects to watch for when you went home?	47	62	62	67	n/a	59
Total responses	*472*	*573*	*369*	*423*	*217*	*2054*

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

Appendix C – UH Bristol corporate patient experience programme

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

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

Appendix D: survey scoring methodologies

Postal surveys

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

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

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

Friends and Family Test Score

The Friends and Family Test (FFT) is a given to patients at the point of discharge from hospital. It contains one main question, with space to write in comments: How likely are you to recommend our <<ward>> to Friends and Family if they needed similar care or treatment?

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

Complaints Report

Quarter 3, 2014/2015

(1 October to 31 December 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 421 complaints in Quarter 3 of 2014/15 (Q3), which equates to 0.23% of patient activity, against a target of 0.21%. In the previous quarter, the Trust had received 518 complaints, representing 0.29% of patient activity.

The Trust's performance in responding to complaints within the timescales agreed with complainants was 83.4% compared to 89.5% in Q2.

In Q3, complaints relating to appointments and admissions continued to account for over a third (140) of the total complaints received by the Trust (in line with Q1 and Q2). There was an increase in complainants telling us that they were unhappy with our investigation of their concerns: 24 compared to 14 in Q2. The number of cases where the original deadline was extended continued to rise, with 46 cases in Q3 compared with 41 in Q2.

This report includes an analysis of the themes arising from complaints received in Q3, 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 421 complaints in Q3, which equates to 0.23% 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 Q3 represents a decrease of approximately 19% compared to Q2 (518) but still a 26% 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.

	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
Total complaints received (inc. TS and F&E from April 2013)	104	127	124	164	131	130	166	178	170	170	148	140	133
Formal/Informal split	55/49	55/72	62/62	89/75	60/71	64/66	64/102	79/99	73/97	86/84	68/80	61/79	52/81
Number & % of complaints per patient attendance in the month	*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*	*0.22% 148 of 66,104*	*0.25% 140 of 55,703*	*0.22% 133 of 59,487*
% responded to within the agreed timescale (i.e. response posted to complainant)	*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)*	*84.4% (65 of 77)*	*82.9% (58 of 70)*	*82.9% (58 of 70)*
% responded to by Division within required timescale for executive review	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)	77.9% (60 of 77)	78.6% (55 of 70)	87.1% (61 of 70)
Number of breached cases where the breached deadline is attributable to the Division	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	6 of 12	6 of 12	1 of 12
Number of extensions to originally agreed timescale (formal investigation process only)	9	16	13	11	5	21	8	19	5	17	20	15	11
Number of Complainants Dissatisfied with Response	*6* 6***	*6* 3***	*3* 5***	*5* 2***	*6* 10***	*4* 2***	*11* 4***	*8* 2***	*4* 5***	*2* 4***	*7* 2***	*9* 3***	*8* 2***

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

Figures 1 and 2 show the decrease in the volume of complaints received in Q3 compared to Q2 but that volumes are still higher than for the same period last year

Figure 1: Number of complaints received

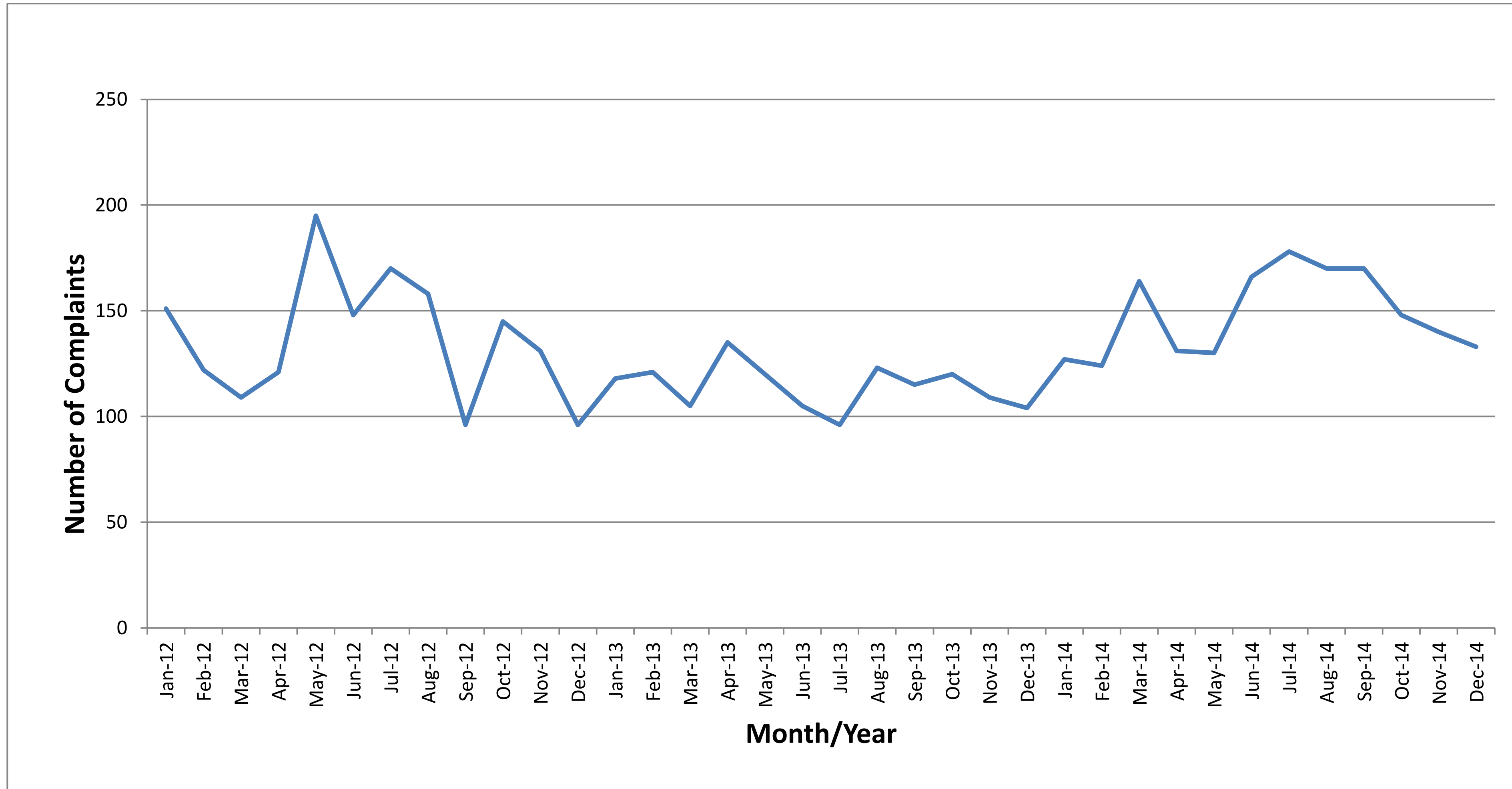
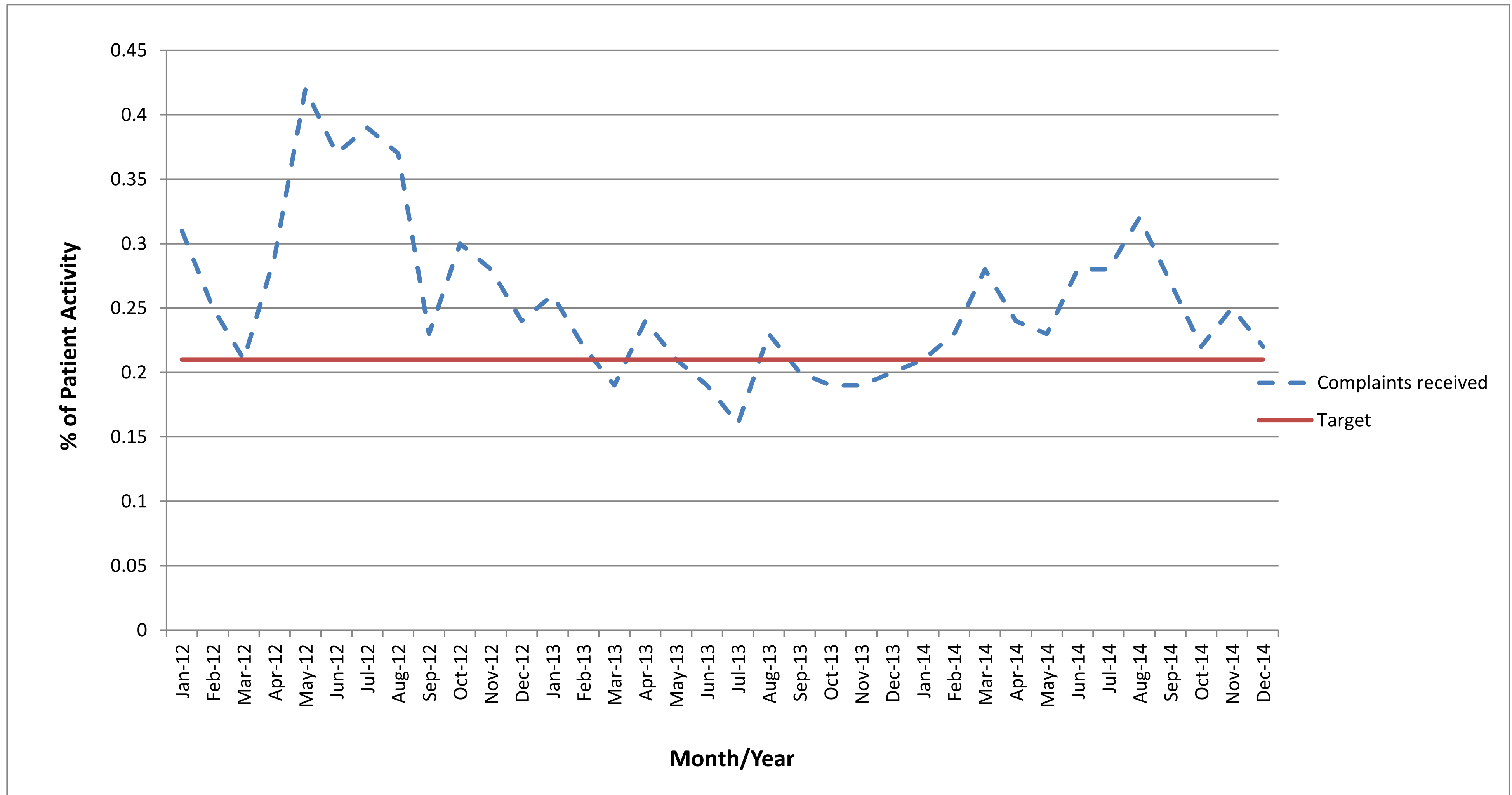


Figure 2: Complaints received, as a percentage of patient activity

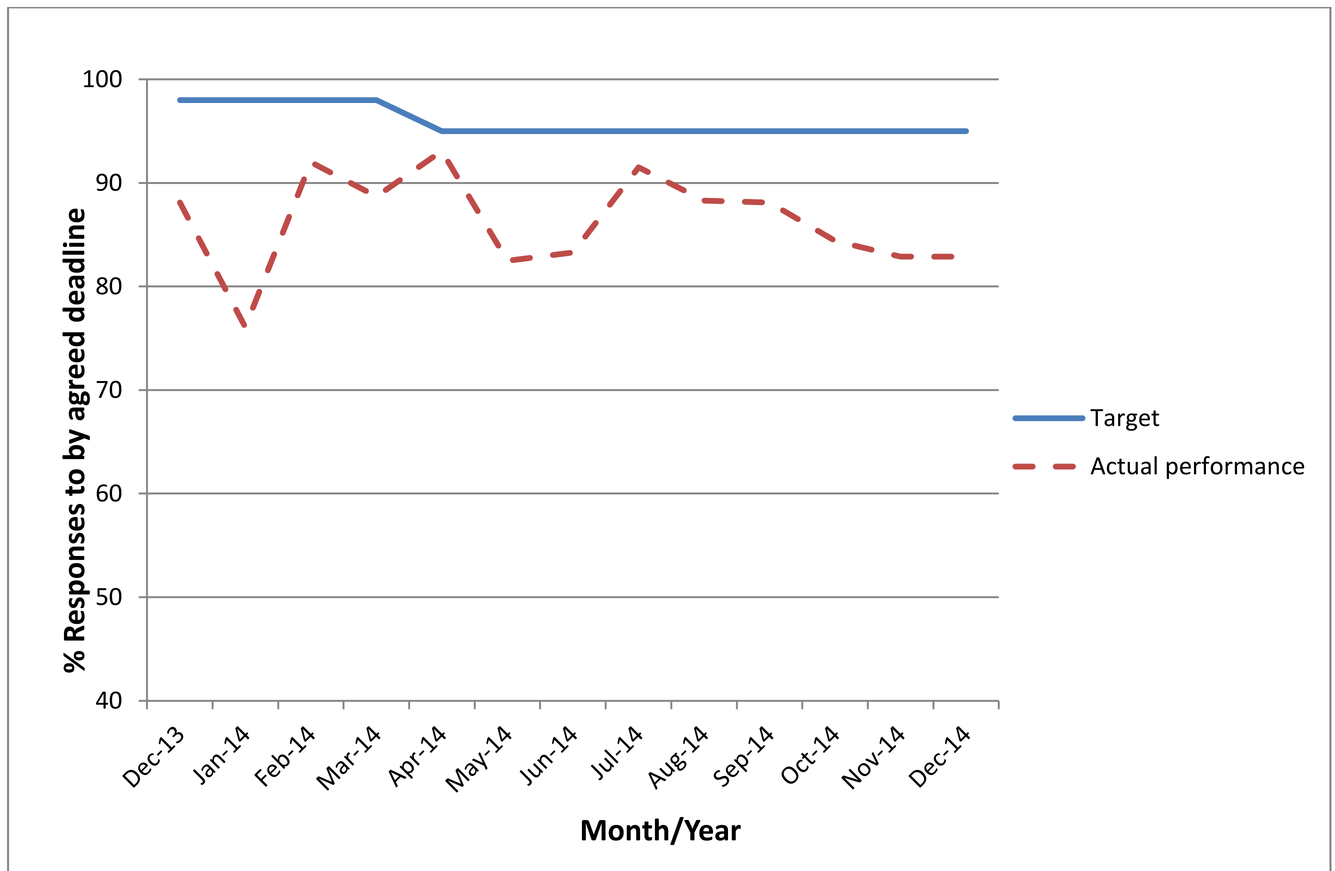


2.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days in Medicine, Surgery Head and Neck and Specialised Services[2] and 25 working days in other areas[3]. **With effect from January 2015, it has been agreed that all Divisions will be given a deadline of 30 working days for consistency[4].**

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 Q3, 83.4% of responses were made within the agreed timescale, compared to 89.5% in Q2. This represents 36 breaches out of 217 formal complaints which were due to receive a response during Q3[5]. Divisional management teams remain focussed on improving the quality and timeliness of complaints responses. Figure 3 shows the Trust's performance in responding to complaints since December 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] Discussed and agreed by Patient Experience Group, December 2014
[5] Note that this will be a slightly different figure to the number of complainants who *made* a complaint in that quarter.

2.3 Number of dissatisfied complainants

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

In Q3, there were 24 cases where the complainant felt that the investigation was incomplete or inaccurate. This represents a 71% increase on Q2 (14 cases). There were a further 7 cases where new questions were raised, compared to 11 cases in Q2.

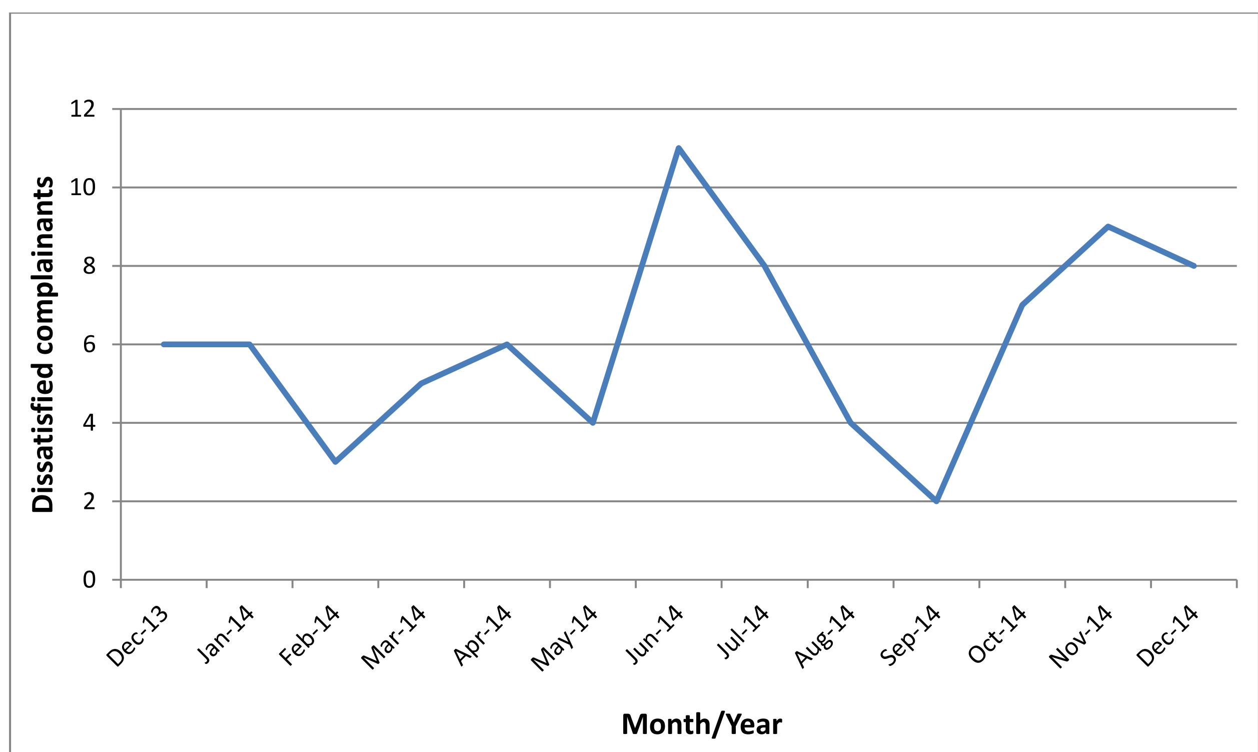
The 24 cases where the complainant was dissatisfied were associated with the following lead Divisions:

- 11 cases for the Division of Surgery, Head & Neck (compared to 6 in Q2) ↑
- 1 cases for the Division of Medicine (compared to 1 cases in Q2) =
- 7 cases for the Division of Women & Children (compared to 2 in Q2) ↑
- 4 cases for the Division of Specialised Services (compared to 5 in Q2) ↓
- 1 cases for the Division of Diagnostics & Therapies (compared to 0 in Q2) ↑
- 0 cases for the Division of Facilities & Estates (compared to 0 in Q2) =

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 increased significantly in Q3, with the largest increase being seen in the Division of Surgery, Head & Neck. 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 Q3 compared to Q2. Complaints about all category types decreased in Q3 in real terms, although 'attitude & communication', 'clinical care', 'access' and 'information & support' all showed a slight decrease when measured as a proportion of complaints received.

Category Type	Number of complaints received – Q3 2014/15	Number of complaints received – Q2 2014/15
Appointments & Admissions	140 (33% of total complaints) ↓	178 ↑ (34.4% of total complaints)
Attitude & Communication	105 (25%) ↓	119 ↑ (23%)
Clinical Care	122 (29%) ↓	150 ↑ (28.9%)
Facilities & Environment	25 (6%) ↓	38 ↑ (7.3%)
Access	12 (3%) ↓	14 ↑ (2.7%)
Information & Support	17 (4%) ↓	19 ↑ (3.7%)
Total	**421**	**518**

Each complaint is then assigned to a more specific category (of which there are 121 in total). The table below lists the seven most consistently reported complaint categories. In total, these seven categories account for 65% of the complaints received in Q2 (338/518)

Sub-category	Number of complaints received – Q3 2014/15	Q2 2014/15	Q1 2014/15	Q4 2013/14
Cancelled or delayed appointments and operations	124 ↓ **(18% decrease *compared to Q2*)**	152	129	111
Clinical Care (Medical/Surgical)	58 ↓ **(6% decrease)**	62	54	47
Communication with patient/relative	28 ↓ **(20% decrease)**	35	27	32
Clinical Care (Nursing/Midwifery)	26 ↓ **(23% decrease)**	34	30	26
Attitude of Nursing/Midwifery	14 ↓ **(36% decrease)**	22	16	
Attitude of Medical Staff	15 ↓ **(28% decrease)**	21	20	30
Failure to answer telephones	19 ↑ **(58% increase)**	12	4	18

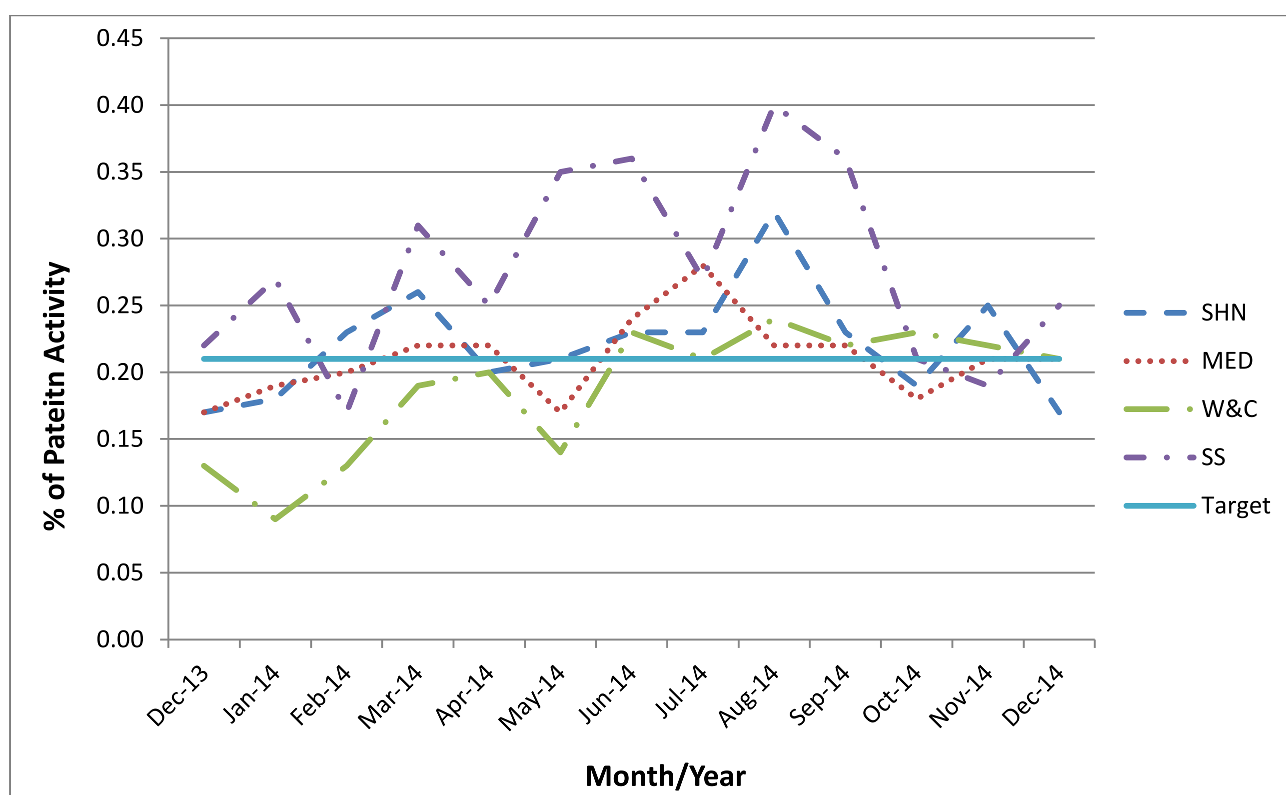
Most notably, the issue of cancelled or delayed appointments and operations has seen a sizeable decrease in Q3 after this was highlighted in the Care Quality Commission's recent inspection report. The Trust, working in conjunction with local health and social care partners, has been tasked by the CQC 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. There has been a further increase in complaints about failure to answer telephones – this trebled between Q1 and Q2 (although numbers were relatively small) and there has been a further 58% increase in Q3.

3. Divisional performance

3.1 Total complaints received

A divisional breakdown of percentage of complaints per patient attendance is provided in Figure 5. This shows an overall upturn in the volume of complaints received in the bed-holding Divisions towards the end of Q3, although the Division of Surgery, Head & Neck did show a fairly significant downturn at the end of Q3.

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 January 2014 have been as follows:

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

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

3.2 Divisional analysis of complaints received

Table 3 provides an analysis of Q3 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	147 (193) ↓	79 (93) ↓	51 (79) ↓	97 (94) ↑	22 (33) ↓
Total complaints received as a proportion of patient activity	0.20% (0.26%) ↓	0.20% (0.24%) ↓	0.22% (0.34%) ↓	0.22% (0.22%) =	N/A
Number of complaints about appointments and admissions	54 (106) ↓	22 (12) ↑	17 (27) ↓	33 (34) ↓	7 (8) ↓
Number of complaints about staff attitude and communication	40 (42) ↓	23 (32) ↓	10 (19) ↓	21 (23) ↓	6 (10) ↓
Number of complaints about clinical care	38 (45) ↓	25 (37) ↓	20 (34) ↓	37 (43) ↓	4 (5) ↓
Areas where the most complaints have been received in Q3	Bristol Eye Hospital – 38 (41) ↓ Bristol Dental Hospital – 26 (29) ↓ Ear Nose and Throat – 16 (29) ↓ Upper GI – 12 (15) ↓	A&E –16 (20) ↓ Dermatology – 10 (7) ↑ Respiratory Department (including Sleep Unit) – 6 (6) =	Cardiology GUCH Services – 9 (11) ↓	Paediatric Outpatients – 13 (7) ↑ Ward 31 – 3 (4) ↓ Ward 35 – 3 (2) ↑ Ward 38 – 3 (3) = Ward 74 – 4 (3) ↑	
Notable deteriorations compared to Q2	Ward A800 – 6 (3) ↑	Ward A300 (MAU) – 4 (0) ↑ Gastroenterology & Hepatology - 10 (4) ↑	Ward C705 5 (1) ↑	Children's ED & W39 – 17 (4) ↑	Audiology – 9 (1) ↑
Notable improvements compared to Q2	Trauma & Orthopaedics 19 (34) ↓ Lower GI 4 (11) ↓	Ward 200 (SBCH) – 0 (5) ↓	Chemotherapy Day Unit and Outpatients – 8 (16) ↓ Bristol Heart Institute Outpatients 9 (25) ↓	Paediatric Orthopaedics 7 (21) ↓	BEH Pharmacy – 4 (9) ↓ Radiology – 6 (12) ↓

3.3 Areas where the most complaints were received in Q3 – additional analysis

3.3.1 Division of Surgery, Head & Neck

Complaints by category type[6]

Category Type	Number and % of complaints received – Q3 2014/15	Number and % of complaints received – Q2 2014/15
Access	5 (3.4% of total complaints) ↑	3 (1.6% of total complaints) =
Appointments & Admissions	54 (36.7%) ↓	102 (52.7%) ↑
Attitude & Communication	40 (27.2%) =	40 (20.7%) ↑
Clinical Care	38 (25.9%) ↓	42 (21.8%) ↑
Facilities & Environment	5 (3.4%) ↑	3 (1.6%) =
Information & Support	5 (3.4%) ↑	3 (1.6%) ↑
Total	**147**	**193**

Top sub-categories

Sub-category	Number of complaints received – Q3 2014/15	Number of complaints received – Q2 2014/15
Cancelled or delayed appointments and operations	46 ↓ (52.6% decrease compared to Q2)	97 ↑ (27.6% increase compared to Q1)
Clinical Care (Medical/Surgical)	24 ↑ (20% increase)	20 ↑ (5.3% increase)
Communication with patient/relative	14 ↑ (27.3% increase)	11 ↑ (10% increase)
Attitude of Medical Staff	6 ↑ (20% increase)	5 ↓ (44.4% decrease)
Attitude of Nursing/Midwifery	3 ↓ (57.1% decrease)	7 ↑ (16.7% increase)
Clinical Care (Nursing/Midwifery)	4 ↑ (33.3% increase)	3 ↓ (62.5% decrease)
Failure to answer telephones	9 ↑ (50% increase)	6 ↑ (500% increase)

Divisional response to concerns highlighted by Q3 data

Concern	Explanation	Action
There was a further increase in the number of complaints about the failure of some departments within the Division to answer their telephones. Four of these complaints related to the ENT Outpatient Department; three were for Bristol Dental Hospital; and one each for Bristol Eye Hospital and the Waiting List Office.	Bristol Dental Hospital has now appointed a third member of call centre staff, so the number of related complaints should decrease. However, it should be noted that the volume of complaints received about failure to answer phones is significantly less than 12 months ago. Communication between the Call Centre and ENT Outpatients has improved and a meeting has taken place with the manager, resulting in a better understanding of each department's respective	There has been continued focus on introducing and embedding the call centre. The Division is investing in a trainer who will work with the call centre staff to help them deliver a good service. Phase 2 of the managed beds project includes a quality assurance programme for administrative standards. Training programme for administrative staff planned and booked across the Divisional booking teams.

[6] Arrows in Q3 column denote increase or decrease compared to Q2. Arrows in Q2 column denote increase or decrease compared to Q1. Increases and decreases refer to actual numbers rather than to proportion of total complaints received.

	role and responsibilities.	
Complaints under the Category Type "Attitude & Communication" account for over 27% of the Division's total complaints and are the second highest reason for complaints after "Appointments & Admissions". Of particular concern are the number of complaints received for this category type by Bristol dental Hospital (ten); Bristol Eye Hospital (seven); ENT Outpatients Department (seven); and Trauma & Orthopaedics (four).	Bristol Dental Hospital has seen a significant increase in the number of its patients who have mental health problems. This is of particular relevance to a proportion of the complaints received around attitude and communication, as in many cases their treatment options and the limitation of our facilities has been explained to them on a number of occasions but they can find this difficult to understand or accept. Appointments with this cohort of patients can also take a longer time, which in itself has a knock-on effect on the length of time that other patients wait to be seen and can leave students and junior staff unsupervised. With regards to the four complaints about the failure to answer telephones, we have now recruited a further call centre member of staff and are still in the process of removing the receptionist and waiting list officer numbers from the letters. Once this has been done, the majority of incoming calls will come to the call centre.	Phase 2 of the managed beds project includes a quality assurance programme for administrative standards. Training programme for administrative staff planned and booked across the Divisional booking teams.

3.3.2 Division of Medicine

Complaints by category type

Category Type	**Number and % of complaints received – Q3 2014/15**	**Number and % of complaints received – Q2 2014/15**
Access	0 (0% of total complaints)	2 (2.1% of total complaints) ↑
Appointments & Admissions	22 (27.8%) ↑	12 (13%) ↓
Attitude & Communication	23 (29.1%) ↓	31 (33.3%) ↑
Clinical Care	25 (31.6%) ↓	35 (37.6%) ↑
Facilities & Environment	4 (5.2%) ↓	9 (9.7%) ↑
Information & Support	5 (6.3%) ↑	4 (4.3%) =
Total	**79**	**93**

Top sub-categories

Category	**Number of complaints received – Q3 2014/15**	**Number of complaints received – Q2 2014/15**
Cancelled or delayed appointments and operations	19 ↑ (280% increase compared to Q2)	5 ↓ (44.4% decrease compared to Q1)
Clinical Care (Medical/Surgical)	9 ↓ (30.8% decrease)	13 ↑ (30% increase)
Communication with patient/relative	7 ↓ (22.2% decrease)	9 ↑ (28.6% increase)
Attitude of Medical Staff	7 ↑ (16.7% increase)	6 ↑ (50% increase)
Attitude of Nursing/Midwifery	5 ↓ (54.5% decrease)	11 ↑ (22.2% increase)
Clinical Care (Nursing/Midwifery)	10 ↓ (37.5% decrease)	16 ↑ (220% increase)
Failure to answer telephones	1 =	1 =

Divisional response to concerns highlighted by Q3 data

Concern	**Explanation**	**Action**
Complaints regarding cancelled or delayed appointments and operations have reduced for every Division, with the exception of Medicine, where there has been a significant increase.	This relates to the issues described below in the specialities and relates to the opening of additional outpatient capacity and the challenges of then moving appointments to fill the availability.	We will continue to monitor both within specialities and at Divisional level, to understand the impact of this and what could be done differently to reduce the negative impact for patients.
There was an increase in complaints received for Dermatology. The majority of these (four) were in respect of cancelled or delayed appointments and three were about attitude and communication.	This has been as a consequence of bringing forward appointments that have been booked beyond 18 weeks, now that additional capacity in the department has become available via a locum consultant.	Despite the disruption to the patients, the bringing forward of appointments should be seen as positive as a number of appointments were booked a long way in advance and as capacity has become available sooner, patients are being moved to fill this additional capacity. The Clinical Lead is following up on the complaints relating to the attitude of medical staff.
There was an increase in the number of complaints received for the Gastroenterology & Hepatology Department, with the majority of these (seven) being about cancelled or delayed appointments.	This was due to appointments being booked beyond six weeks and medical staff being required to give six weeks' notice for leave, resulting in cancelling and rebooking of cancelled appointments. Clinics have not always been cancelled in the correct timeframe following notification of annual leave. Gastroenterology have also seen a spike in referrals between September and December.	Medical staff annual leave is being booked in advance where possible. Close monitoring of clinics through "look ahead" and medical leave workspace. Additional Waiting List Initiative clinics put on to support cancelled clinics and increase in referrals. Clinic templates adjusted to assist with cancelled clinics. Close monitoring of referral rates.

3.3.3 Division of Specialised Services

Complaints by category type

Category Type	Number and % of complaints received – Q3 2014/15	Number and % of complaints received – Q2 2014/15
Access	0 (0% of total complaints)	1 (1.3% of total complaints) =
Appointments & Admissions	17 (33.3%) ↓	24 (30.4%) ↓
Attitude & Communication	10 (19.6%) ↓	17 (21.5%) ↑
Clinical Care	20 (39.3%) ↓	31 (39.2%) ↑
Facilities & Environment	2 (3.9%) ↓	3 (3.8%) =
Information & Support	2 (3.9%) ↓	3 (3.8%) ↑
Total	**51**	**79**

Top sub-categories

Category	Number of complaints received – Q3 2014/15	Number of complaints received – Q2 2014/15
Cancelled or delayed appointments and operations	14 ↓ (41.7% decrease compared to Q2)	24 =
Clinical Care (Medical/Surgical)	8 ↓ (20% decrease)	10 =
Communication with patient/relative	1 ↓ (85.7% decrease)	7 =
Attitude of Medical Staff	1 ↓ (66.7% decrease)	3 ↑
Attitude of Nursing/Midwifery	2 ↑ (100% increase)	1 ↑
Clinical Care (Nursing/Midwifery)	1 ↓ (83.3% decrease)	6 ↓
Failure to answer telephones	3 ↑ (50% increase)	2 =

Divisional response to concerns highlighted by Q3 data

Concern	Explanation	Action
Ward C705 in Bristol Heart Institute has seen an increase in the number of complaints received, from just one in Q2 to five in Q3. Two of these complaints were in respect of delayed operations; and one each about communication, discharge arrangements and follow up treatment.	Of the five complaints received, two were around administration errors, two were in respect of clinical care and assessment (one relating to the management of an invasive line and one about discharge planning) and one complaint related to delays with cardiac surgery. The administration errors may reflect some vacant hours in ward clerk positions on C705 and the clinical complaints reflect the increase in newly qualified staff within the area in Q3.	The Divisional management team is working closely with the Ward Sister and Matron to ensure that issues are identified and managed actively at ward level to prevent formal complaints. A review of supervision and support for the newly qualified members of the team is underway. Divisional complaints training is taking place in March 2015.

3.3.4 Division of Women & Children

Complaints by category type

Category Type	**Number and % of complaints received – Q3 2014/15**	**Number and % of complaints received – Q2 2014/15**
Access	1 (1% of total complaints) ↑	0 (0% of total complaints) =
Appointments & Admissions	33 (34.1%) ↑	30 (32%) ↑
Attitude & Communication	21 (21.6%) ↑	20 (21.3%) ↑
Clinical Care	37 (38.1%) ↓	40 (42.5%) ↑
Facilities & Environment	5 (5.2%) ↑	3 (3.2%) ↑
Information & Support	0 (0%) ↓	1 (1%) =
Total	**97**	**94**

Top sub-categories

Category	**Number of complaints received – Q3 2014/15**	**Number of complaints received – Q2 2014/15**
Cancelled or delayed appointments and operations	30 ↓ (9.1% decrease compared to Q2)	33 ↑ (120% increase compared to Q1)
Clinical Care (Medical/Surgical)	19 ↑ (26.7% increase)	15 ↑ (7.1% increase)
Communication with patient/relative	3 ↓ (62.5% decrease)	8 ↑ (60.5% increase)
Attitude of Medical Staff	1 ↓ (83.3% decrease)	6 =
Attitude of Nursing/Midwifery	4 ↓ (20% decrease)	5 ↑
Clinical Care (Nursing/Midwifery)	11 ↓ (8.3% decrease)	12 ↑ (33.3% increase)
Failure to answer telephones	3 ↑ (200% increase)	1 ↑

Divisional response to concerns highlighted by Q3 data

Concern	**Explanation**	**Action**
There has been a notable increase in the number of complaints received about the Children's Emergency Department & Ward 39. The majority of these complaints (nine) relate to clinical care and five were in respect of attitude of staff.	The Paediatric Emergency Department has undergone significant redevelopment works, which have caused disruption to the working environment. New ways of working have been implemented and are currently being embedded. A higher volume of patients were seen in the winter 2014/15 period, following the centralisation of specialist paediatrics. During this challenging winter period, staff have been working under immense pressure. Some complaints have been received about patients admitted via the Emergency Department to be seen by speciality care teams , rather	There are good governance structures in the Emergency Department, with all complaints investigated promptly and fully, using a multidisciplinary approach. Themes from complaints are identified and discussed with teams at training days. Support for staff is being explored through Care First and a psychologist. Regular education/team days organised to ensure that staff possess the correct skills, and have access to appropriate education and support. Band 6 hours are being used to work alongside new staff to ensure

	than through the Emergency Department directly.	support and education. Family & Friends Test touch-screen kiosks are being installed in the Emergency Department to capture real time feedback. Staff satisfaction feedback system in place to ensure real time feedback and information from this will inform action plans. Robust system in place for ensuring good skills mix and numbers of medical, Emergency Nurse Practitioner and nursing staff on shift.

3.3.5 Division of Diagnostics & Therapies

Complaints by category type

Category Type	Number and % of complaints received – Q3 2014/15	Number and % of complaints received – Q2 2014/15
Access	2 (9.1% of total complaints) ↓	6 (18.2% of total complaints) ↑
Appointments & Admissions	7 (31.8%) ↓	8 (24.3 %) ↑
Attitude & Communication	6 (27.3%) ↓	10 (30.3%) ↑
Clinical Care	4 (18.2%) ↓	6 (18.2%) ↓
Facilities & Environment	0 (0%) ↓	2 (6%) =
Information & Support	3 (13.6%) ↑	1 (3%) ↑
Total	**22**	**33**

Top sub-categories

Category	Number of complaints received – Q3 2014/15	Number of complaints received – Q2 2014/15
Cancelled or delayed appointments and operations	5 ↓ (16.7% decrease compared to Q2)	6 ↑ (20% increase compared to Q1)
Clinical Care (Medical/Surgical)	0 ↓ (100% decrease)	2 ↑ (100% increase)
Communication with patient/relative	3 ↑ (50% increase)	2 ↑
Attitude of Medical Staff	0 ↓ (100% decrease)	2 ↑
Attitude of Nursing/Midwifery	0 =	0 =
Clinical Care (Nursing/Midwifery)	0 =	0 =
Failure to answer telephones	1 ↓ (66.7% decrease)	3 ↑

Divisional response to concerns highlighted by Q3 data

Concern	Explanation	Action
There was an eight-fold increase in the number of complaints received for the Audiology Department. Three of these complaints related to	From 1st October to 31st December 2014, eight informal complaints were received relating to the audiology service, compared to one	A new call waiting system was introduced across the audiology service on 28th January 2015. This new service will transfer the call to another designated telephone if it

delayed appointments and two were received about failure to answer telephones/respond.	complaint in the previous quarter. Four of the complaints related to delayed responses when emailing the department and telephone calls not being answered. The remaining four cases did not have a common theme. However, all of the individual issues have been resolved.	is not answered within a specified number of rings. Since the introduction of the call waiting function, there has been a noticeable reduction in verbal complaints made to staff and there is greatly improved accessibility by telephone. The audiology service has a generic email address. The administration team monitor the inbox and respond to all emails received within 24-48 hours. On one occasion, an email was blocked by the Trust email filter as "spam" and the administration team did not act upon the email alert that was delivered to the inbox to enable the message to be delivered. Following this incident, IM&T have made amendments to the filters for the generic inbox and all staff were notified of the necessary steps to taken when reviewing spam notices.

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 – Q3 2014/15	Number and % of complaints received – Q2 2014/15
Bristol Royal Infirmary (BRI)	180 (42.8% of total complaints) ↓	207 (40% of total complaints) ↑
Bristol Eye Hospital (BEH)	36 (8.6%) ↓	46 (8.9%) ↑
Bristol Dental Hospital BDH)	25 (5.9%) ↓	30 (5.7%) ↑
St Michael's Hospital (STMH)	54 (12.8%) ↑	52 (10.1%) ↓
Bristol Heart Institute (BHI)	41 (9.7%) ↓	56 (10.8%) ↑
Bristol Haematology & Oncology Centre (BHOC)	13 (3.1%) ↓	31 (6%) ↑
Bristol Royal Hospital for Children (BCH)	70 (16.6%) ↓	79 (15.3%) ↑
South Bristol Community Hospital (inc. Homeopathic Outpatients) (SBCH)	2 (0.5%) ↓	17 (3.2%) ↑
Total	**421**	**518**

The following table breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints a hospital site receives is broadly in line with its proportion of attendances. For example, the Bristol Heart Institute had 3.15% of the total attendances but 9.7% of all complaints.

Q3 2014/15

Site	No. of Complaints	No. of Attendances	Complaints Rate	Percentage of Attendances	Percentage of Complaints
BRI	180	55,228	0.33%	31.8%	42.8%
BEH	36	29,503	0.12%	17.0%	8.6%
BDH	25	21,481	0.12%	12.4%	5.9%
STMH	54	21,789	0.25%	12.6%	12.8%
BHI	41	5,460	0.75%	3.2%	9.7%
BHOC	13	14,247	0.09%	8.2%	3.1%
BCH	70	21,847	0.32%	12.6%	16.6%
SBCH	2	3,895	0.05%	2.3%	0.5%
TOTAL	**421**	**173,450**	**0.24%**		

3.5 Complaints responded to within agreed timescale

All of the clinical Divisions, with the exception of Diagnostics & Therapies reported breaches in Quarter 3, totalling 32 breaches, which is a 68% increase on Quarter 2. It should be noted that the Divisions of Facilities & Estates and Trust Services each had two breaches, which gives an overall total of 36 breaches as stated in section 2.2.

	Q3 2014/15	**Q2 2014/15**	**Q1 2014/15**	**Q4 2013/14**
Surgery Head and Neck	12 (14.6%)	5 (7.1%)	9 (14.3%)	8 (11%)
Medicine	10 (23.8%)	4 (11.1%)	7 (21.2%)	7 (21.2%)
Specialised Services	4 (15.4%)	1 (4.3%)	2 (8.7%)	0
Women and Children	6 (12.5%)	8 (17%)	6 (19.4%)	9 (36%)
Diagnostics & Therapies	0 (0%)	1 (11.1%)	0 (0%)	1 (8.3%)
All	**32 breaches**	**19 breaches**	**24 breaches**	**25 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. It should be noted that in addition to the figures shown in the table below, there were two breaches by the Division of Facilities & Estates and one breach by the Division of Trust Services, giving a total of 36 (see section 2.2). The column headed "Other" relates to other sources of delay. In Q3, both of these breaches were due to delays in other organisations providing their input to the Trust's response.

	Source of delays (Q3, 2014/2015)				**Totals**
	Division	**Patient Support and Complaints Team**	**Executive sign-off**	**Other**	
Surgery Head and Neck	7	1	4	0	**12**
Medicine	5	1	3	1	**10**
Specialised Services	2	0	2	0	**4**
Women and Children	5	0	0	1	**6**
Diagnostics & Therapies	0	0	0	0	**0**
All	19 breaches	2 breaches	9 breaches	2 breaches	**32**

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).
- An escalation process is in place, to be followed by the Patient Support & Complaints Team in the event that divisional staff fail to respond by agreed deadlines to requests for assistance in resolving informal complaints. The agreed process is that the PSCT caseworker will chase the relevant person once if they have not responded (or updated on progress) by the agreed date, and they will then escalate to the relevant Head of Nursing. If the Head of Nursing fails to respond, the PSCT caseworker will again chase them once before escalating to the relevant Divisional Director. If there is still no response, the PSCT caseworker will chase the Divisional Director once and then escalate to the Chief Nurse. Of course sense and discretion should be used when invoking this process, to allow for the possibility that someone may be on annual leave, off sick or otherwise unavailable.
- 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 24 cases in Q3 where complainants were dissatisfied with the quality of our response: a return to levels reported in Q1 following an improvement in Q2.

	Q3 2014/15	**Q2 2014/15**	**Q1 2014/15**	**Q4 2013/14**
Surgery Head and Neck	**11**	6	8	5
Medicine	**1**	1	5	4
Specialised Services	**4**	5	2	1
Women and Children	**7**	2	5	3
Diagnostics & Therapies	**1**	0	1	1
All	**24**	14	21	14

Actions agreed via Patient Experience Group:

- Divisions are notified of any case where the complainant is dissatisfied. The 24 cases recorded in Q3 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 Q3, the team dealt with 135 such enquiries, compared to 132 in Q2. These enquiries can be categorised as:

- 96 requests for advice and information (79 in Q2)
- 32 compliments (46 in Q2)
- 7 requests for support (7 in Q2)

5. PHSO cases

During Q3, the Trust has been advised of new Parliamentary & Health Service Ombudsman (PHSO) interest in two complaints (compared to one in Q2 and five in Q1). The new complaints are listed first (16353 and 14650).

One PHSO case (10805) was closed in Q3 and one other (13987) remained open at the end of the quarter.

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
16353	AH	CH	24/07/2014	BRCH	Paediatric Orthopaedics	Women & Children
14650	CF	MS	23/12/2013	BRI	Upper GI	Surgery, Head & Neck

10805	AJ	MM-L	17/05/2012	BRI	Ward 9	Surgery, Head & Neck
Closed: The PHSO's final report stated that the complaint regarding clinical care and treatment and about the handling of the complaint had not been upheld and that the Trust acted appropriately and proportionately in all respects.						
13987	AB	DJ	10/09/2013	BRI	QDU (Endoscopy)	Surgery, Head & Neck
Open: The PHSO's final report states that the complaint made is partially upheld. A request has been made of the Trust for a letter of apology and a payment of £250 to be sent to the patient, and an Action Plan prepared detailing what has been done and will be done to avoid a recurrence.						

6. Protected Characteristics

For the first time, the Quarterly Complaints Report includes statistics relating to the Protected Characteristics of patients who have made a complaint. The areas recorded are age, ethnic group and gender.

It should be noted that all of **these statistics relate to the patient** and not the complainant (if someone else has complained on their behalf).

6.1 Age

Age Group	Number of Complaints Received – Q3 2014/15
0-15	62
16-24	27
25-29	14
30-34	23
35-39	16
40-44	17
45-49	23
50-54	25
55-59	34
60-64	29
65+	139
Not Known	12
Total Complaints	**421**

6.2 Ethnic Group

Ethnic Group	Number of Complaints Received – Q3 2014/15
Any Other Mixed Background	1
Any Other White Background	5
Asian Or Asian British - Any Other Asian Background	2
Asian Or Asian British - Bangladeshi	1
Asian Or Asian British - Indian	5
Asian Or Asian British - Pakistani	1
Black Or Black British - African	1
Mixed - Any Other Mixed Background	1
Mixed - White And Asian	2
Mixed - White And Black Caribbean	6
Other Ethnic Groups - Any Other Ethnic Group	1
Other Ethnic Groups - Chinese	1
Other Ethnic Groups - Not Stated	12
White - Any Other White Background	13
White - British	321
White - Irish	4
Not Collected At This Time	36
Not Known	8
Not Stated/Given	0
Total Complaints	**421**

6.3 Religion

Religion	Number of Complaints Received – Q3 2014/15
Agnostic	4
Buddhist	5
Catholic – Not Roman Catholic	4
Christian	28
Church of England	81
Hindu	2
Methodist	4
Mormon	2
Muslim	11
No Religious Affiliation	104
Other	4
Roman Catholic	15
Sikh	4
Unknown	153
Total Complaints	**421**

6.4 Civil Status

Civil Status	Number of Complaints Received – Q3 2014/15
Co-habiting	21
Divorced/Dissolved Civil Partnership	5
Married/Civil Partnership	75
Single	188
Unknown	120
Widowed/Surviving Civil Partner	12
Total Complaints	**421**

6.5 Gender

Of the 421 complaints received in Q3 2014/15, 193 of the patients involved were female and 228 were male.

7. Acknowledgement of complaints received by the Patient Support & Complaints Team

This quarter, we are reporting a new performance measure: the length of time taken by the Patient Support and Complaints Team to acknowledge receipt of complaints.

The Trust's Complaints and Concerns Policy states that verbal complaints should be acknowledged within 24 hours and written complaints within 48 hours, and that this acknowledgement will take the form of a telephone call or email, followed by a written acknowledgement for all formal complaints. If the team is unable to contact the complainant by telephone or email, a written acknowledgement must be sent within three working days.

The following table shows the number of days taken to acknowledge all complaints received by the team during Q3.

Days to Acknowledge	Number of Complaints
1 day	382
2 days	25
3 days	12
4 days	2
Total	**421**

The 382 complaints that were acknowledged within one day were made up of 325 complaints that were received verbally and 57 complaints received in writing. The 25 complaints acknowledged in two days were complaints received in writing.

14/421 (3.3%) were therefore not acknowledged according to the required timeframe; these complaints were received in October and November when the Patient Support & Complaints Team was dealing with a backlog of enquiries that had been in existence throughout 2014 prior to being cleared at the end of November 2014 (see below).

8. Management of backlog of enquiries to the Patient Support and Complaints Team

The Patient Support & Complaints Team cleared its backlog of enquiries in November 2014 and has continued to maintain an up to date service since that time. The team also continues to provide a daily drop-in service that is open from 9.00am until 4.00pm. Staff who have recently been appointed to strengthen the team are now fully trained and managing their own caseloads.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a report for a Council of Governors Meeting to be held on 30 April 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 15 – Monitor Annual Plan 2015/16

Purpose

As a Foundation Trust we are required by our regulator, Monitor, to provide an operational plan covering the financial year 2015/16, which addresses the issues set out in Monitor's drafting guidance (Appendix 1).

The drafting requirement has changed from last year in a number of ways:

- We are only required to submit one plan, not two, as was the case in 2014 when we submitted both operational and strategic plans.
- Monitor have further cut down the requirement for that one (operational) plan – we are required to produce a c20 page plan covering 2015/16 in contrast to previous plans which covered two years and required significantly more detail to be included.
- We are required to produce a public version of the plan, for publication on the Monitor website, which will be produced following submission and by mid-May.

Section 1 describes the context of our operational plan, and includes a review of our performance (financial, operational and quality) in 2014/15, a summary of local and national commissioning considerations, and a formal recommitment to the 5 year strategic plan that we submitted to Monitor in June 2014. This section requires the Trust to recommit, refresh or recreate the strategy developed last year – UH Bristol has recommitted to the existing strategy reflecting the fact that it remains broadly valid for the operating context we now find ourselves in.

Section 2 updates the strategic work we have done in the last 12 months, and describes how we, and others across the local heath economy, are responding to the NHS 5 year forward view. This section also sets out our Corporate Objectives, including a summary of our Workforce and Organisational Development Strategy and importantly a summary of our "Declaration of Compliance" with regulatory standards, which must accompany the submission – in contrast to previous years, the Trust is required not only to describe the standards at risk but to indicate the quarters in which failure may occur.

Section 3 contains the detail of our operational plans, setting out how we will achieve short term resilience in what we have acknowledged will be a difficult year from an operational perspective. This section contains summaries of our capacity planning, IM&T, short term workforce, and financial plans.

Finally, the plan has been developed having had regard to the views of Governors who have shaped the priorities set out in the plan and have commented upon the draft plan. Governors will be asked to play a central role in confirming the content and readability of the public facing version of the plan.

Recommendations

The Council of Governors is asked to **receive** the Monitor Operational Plan Document 2015-16

and **approve** prior to submission.

Report Sponsor or Other Author

Deborah Lee, Director of Strategic Development and Deputy Chief Executive

Appendices

Appendix A – UH Bristol Monitor Plan 2015/16
Appendix B - Monitor's drafting guidance

Operational Plan Document for 2015-16

University Hospitals Bristol NHS Foundation Trust

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Operational Plan for y/e 31 March 2016

This document completed by (and Monitor queries to be directed to):

Name	**Deborah Lee**
Job Title	**Chief Operating Officer and Deputy Chief Executive**
e-mail address	**deborah.lee@uhbristol.nhs.uk**
Tel. no. for contact	**0117 3423606**
Date	**14 May 15**

The attached Operational Plan is intended to reflect the Trust's business plan over the next financial year. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	

Signature

Section 1 – The Strategic Context for our Plan

1.1 This year's challenge – and our focus

Welcome to the Operational Plan for University Hospitals Bristol, for the year 2015/16. It has been written in the context of the longer term direction which we set out last year in our 5 year strategic plan which, in broad terms, remains strategically valid. Our strategy - to develop our regional and tertiary services, whilst focusing upon the quality and efficiency of our local secondary care services - continues to serve us well but this plan also takes account of the way in which the environment in which we operate has changed and developed in the last year.

This change has a local component, driven by the developing work in which we are engaged across our local health economy, but it also has a national component; first in terms of the way in which national commissioning is developing, and secondly in terms of the direction that has been set – and the challenge issued – by the NHS Five Year Forward View[1].

The other key element that has shaped our plan this year is the combined forces of operational challenges – and that of flow in particular – alongside the tightening financial context. We signalled in last year's plans the difficulty we anticipated in 2015/16, and this year we are declaring a deficit plan (£5m before technical items) for the first time in 13 years despite planned delivery of 5.5% savings.

Finally, the deteriorating financial position of our nearest acute partner, North Bristol NHS Trust, and the ongoing operational and clinical challenges facing Weston Area Health NHS Trust (associated with their on-going acquisition) also provide an important operating context for the Trust.

Whilst our strategy remains sound, the aims we set out in last year's Operational Plan, to deliver significant performance improvements were not achieved. The issue which continues to most frustrate our efforts to deliver exceptional care, which meets all national standards, is the challenge of patient flow - this remains our key focus for the year ahead. However, the extent of progress should not be underestimated. Aided by the catalyst of the Care Quality Commission (CQC) inspection findings, which provided a further impetus to system working across the partner organisations, progress has been made on a number of fronts. As signalled in last year's plan, we have further integrated working between system partners and have recently set up a joint discharge hub comprising staff from all sectors across both health and social care, we have embedded weekly, multi-agency reviews of all inpatients, and in line with our transformation priorities, adopted new approaches to scheduling theatres and managing surgical beds. As a result of this, and other work, we have seen:

- Achievement of both RTT and A&E recovery plans, ahead of trajectory at the time of writing;
- Delivery of the A&E four hour standard in March 2015, the first month since June 2014
- Bed days lost to delayed discharge drop by 20% over the last winter compared to that of 2013/14 and fall from a high of 1523 in April 14 to 604 in April 15
- the number of patients delayed over 24 hours in in critical care, drop from 13.8 per month to 2.1
- Surgical length of stay reduce by 25% April 14 to April 15, from 6.8 to 5.1 days.
- Surgical productivity improvements lead to a 14%, average increase in monthly activity.
- 89% of orthopaedic patients are now typically admitted to the right ward, compared to 36% last year.

Further progress needs to be made, but results like this give us confidence that we are moving in the right direction in operational terms. There will be big challenges this year, but we are better placed than many to meet them. Our focus is explicitly on operational resilience in the next 12 months, and the content of this plan reflects that.

Our mission as a Trust remains to improve the health of the people we serve by delivering exceptional care, teaching and research every day.

[1] http://www.england.nhs.uk/ourwork/futurenhs/

Our vision – as set out last year and to which we recommit - is for Bristol, and our hospitals, to be among the best and safest places in the country to receive care. We want to be characterised by:

- High quality individual care, delivered with compassion.
- A safe, friendly and modern environment.
- Employing the best and helping all our staff fulfil their potential.
- Pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
- Providing leadership to the networks we are part of, for the benefit of the region and people we serve.

Finally, both the CQC inspection findings and the recent staff survey, serve to highlight the challenge that remains ahead in relation to our workforce. The Trust's national staff survey results left the Trust in the lower quartile of performers in many areas and notably in relation to staff engagement and morale. 2015 will reflect a renewed focus on the plans and strategies to re-engage our staff in the things that matter most to them and our patients.

1.2 Reviewing and evolving our Trust strategy

1.2.1 Review of Operational Performance

In the 2014/15 Annual Plan we identified risks to compliance with a number of standards - Accident and Emergency 4-hour standard, the Referral to Treatment Time (RTT) Non-admitted standard and the 62-day GP cancer standards. Our performance last year was consistent with this, with the exception of a wider scale of failure against the RTT standards and the additional failure of the 62-day referral to treatment cancer standard, for patients referred from the national screening programmes. A summary at a glance, of our current performance against national standards, is included at Annex A with further detail below.

<u>Control of Infection</u>

Although the Trust reported an increase in the total number of cases of Clostridium difficile infections in 2014/15 compared with 2013/14 (50 in 2014/15 compared with 38 in 2013/14), the commissioners' review of these cases confirmed that only eight of the fifty cases were considered avoidable by the Trust. The Trust was therefore confirmed as having far fewer cases than the centrally set annual limit that of 40 cases, and also achieved the limit set for each quarter of 2014/15. Disappointingly, the target of zero MRSA (Meticillin Resistant Staphylococcus Aureus) bacteraemias was not achieved in 2014/15, with five cases being reported in 2014/15. Of these five cases, two were confirmed to be contaminated samples, although were still attributed to the Trust for reporting purposes. The three confirmed cases is an increase in the two cases reported in 2013/14.

<u>Access Standards</u>

There was a decline in performance against the three Referral to Treatment Time (RTT) standards during 2014/15 which resulted in failure of all three standards in quarters two, three and four. The failure to sustain achievement of the RTT standards initially was due to a growth in the number of over 18-week waiters, with demand exceeding the level of capacity which could be put in place. However, the rise in the number of over 18 week waiters during the first quarter of the year led to a detailed review of the capacity required to both address the backlogs, and achieve sustainable 18-week waits going forward and the decision to embark upon a period of planned failure to address these backlogs. There were clear signs of recovery during quarter 4, with material reductions in the backlogs for both admitted and non-admitted patient pathways being realised, beyond that set-out in the recovery trajectories.

High levels of demand also brought challenges for achievement of the maximum 6 week wait for a diagnostic test. A recovery trajectory was put in place, underpinned by detailed capacity and demand modelling, with achievement of the 99% standard now expected by the end of quarter 1 2015/16.

Overall, performance against the cancer waiting times standards remained strong, with six of the eight national standards being achieved in every quarter. However, the 62-day wait from referral to treatment for patients referred by their GP with a suspected cancer, was not achieved in 2014/15. The biggest single reason for the failure to achieve the 85% national standard was the late receipt of referrals from other providers, which alone accounted for approximately 40% of breaches in a month. Performance for solely internally managed pathways was above 85% in three quarters in 2014/15. The Trust continued to take action to reduce the length of wait for key steps in cancer pathways in 2014/15, including offering as many patients as possible the opportunity to be seen within 7 days of referral by the GP, instead of the national requirement of 14 days.

Disappointingly, the Trust failed to achieve maximum 4-hour wait in Accident & Emergency for at least 95% of patients in every quarter of the year. However, the Trust met the national Accident & Emergency clinical quality indicators in the period. The level of ambulance hand-over delays remained at a similar level to 2013/14, although significant improvements were seen in the latter half of quarter 4. A system-wide resilience plan was developed during the year, in association with partner organisations, in recognition of the increasing pressure on emergency services both locally and nationally. Encouragingly, the recovery trajectory which was developed from the expected impacts of the joint plan was achieved by the Trust in quarter 4, with year being rounded-off with achievement of the 95% standard in March.

Looking forward, the Trust is declaring a large number of indicators at risk of non-achievement. In part this reflects the planned failure of RTT standards but also reflects the inherent risk to cancer arising from our cancer portfolio (both case mix and tertiary status) and the on-going journey to sustainable A&E performance. The table below summarises the proposed declaration for 2015/16, based on the standards that we forecast are at risk of being achieved.

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Standards	RTT Non-admitted RTT Admitted RTT Incomplete/Ongoing 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted RTT Incomplete/Ongoing 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted 62-day GP cancer 62-day Screening cancer A&E 4-hours	RTT Admitted 62-day GP cancer 62-day Screening cancer A&E 4-hours
Score	**3.0**	**3.0**	**4.0**	**3.0**

1.2.2 Reviewing our financial performance

The results for 2014/15 confirm another year of strong performance and delivery for the seventh year of our financial strategy as a Foundation Trust, including:

- Delivery of an income and expenditure surplus of £6.3m, before technical items;
- A Continuity of Services financial risk rating of 4;
- An EBITDA (Earnings before interest, taxes, depreciation and amortization – ie operating surplus) of £35.8m (6.2%);
- Achievement of cash releasing efficiency savings of £16.5m;
- Expenditure on capital schemes of £44.3m;
- A healthy cash position (£63.4m) and a strong Balance Sheet.

We have already acknowledged the challenges ahead in general terms. In particular, they relate to the delivery of managing service level agreement activity, realisation of more than £24m of savings and continued service transformation to ensure the Trust's strategic objectives continue to be progressed.

1.2.3 Review of the Local and national commissioning landscape

The local commissioning landscape largely reflects the national landscape. The Trust's services are commissioned in the majority by the four local Clinical Commissioning Groups (Bristol, North Somerset, Somerset and South Gloucestershire – BNSSSG) and NHS England; all of whom continue to develop and mature. We are planning to have signed Heads of Terms by 27 April for major commissioners.

1.2.3.1 NHS England – Specialised Services

- Specialised Services now make up around 45% of our proposed contract income.
- NHS England has signalled its strong intent of aligned positions on risk share arrangements with the acute sector. University Hospitals Bristol opted for Enhance Tariff Option which values this risk share at 70% above stated baseline value (SBV).
- Our service development proposals are currently being reviewed by NHS England's regional prioritisation panel.
- With regard to meeting national service specifications, we are seeking clarity on the extent of compliance, as it had previously been against key requirements and full compliance against all requirements will require significant additional commissioner investment. This position is however, no different from the national position. And H Bristol is performing well against key requirements with some outstanding actions on derogated services
- NHS England has mandated QIPP (Quality, Innovation, Productivity and Prevention), CQUINs (Commissioning for Quality and Innovation), and the implementation of a new Clinical Utilisation Review nationally. The potential effect of these initiatives may be to have significant impact on current delivery of key IM&T projects and the latter is not supported by clinicians. We are seeking to ensure CQUINs are earnable, as per national guidance, at circa 80% of earnable income.
- The affordability of activity proposals – particularly RTT backlogs – is still under discussion.

1.2.3.2 Local Commissioning.

- BNSSSG CCGs[2] have seen some benefit of the pledged £1.5bn government funding following the publication of the 5 year forward view, discussion about how this will be allocated locally is ongoing; current agreements are reflected in our 2015/16 financial plan.
- A key consideration this year is the effect of programmes designed to divert services away from acute settings. Clinical Commissioning Groups aim to achieve this through levers such as the Better Care Fund (BCF), moving urgent care into the community, reviewing pathways (e.g. stroke, falls, diabetes, respiratory, obesity, Deep Vein Thrombosis), and integration. The Trust is actively engaged in these initiatives and the projected impact of the BCF is incorporated in contracts.
- Coding and Counting – Commissioners would like to implement a number of coding and counting changes, some of which are pricing changes, including the findings of an audit undertaken by an external party. We have agreed neutrality on coding and counting and pricing issues with all commissioners in line with 2015/16 commissioning intentions and planning guidance.
- Re-procurement of sexual health services has been put back to 2016/17 whilst Councils refresh their needs assessments and develop a joint BNSSG commissioning strategy. This is likely to include some integrated services commissioned by Bristol Clinic al Commissioning Group.
- Re-procurement of children's community services has also been delayed until 2017 pending clarity regarding the scope and specification of services.
- We have agreed activity levels and a resilience funding plan for 2015/16. Discussions continue regarding the impact of QIPP schemes.

[2] Bristol, North Somerset, Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs)

1.3 Recommitting to our 2020 Strategy

Our strategic intent was set out last year in our five year plan, and it remains to;

- *Provide excellent local, regional and tertiary services, exploiting the synergies that flow from this portfolio whilst addressing the resulting operational tensions that have the potential to impact upon the success of one or more areas. Our focus for growth (in the medium term) remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare.*
- *Deliver the benefits that flow from combining teaching, research and care delivery will remain our key advantage, along with recruiting, developing and retaining exceptionally talented and engaged staff.*
- *Do whatever it takes to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or out sourcing services that others are better placed to provide and delivering new services where patients will be better served.*
- *Ensure that our patients – past, present and future - their families, and their representatives, will be central to the way we design, deliver and evaluate our services. The success of our vision to provide "High quality individual care, delivered with compassion" will be judged by them.*

In our judgement, the underpinning assumptions that we made last year are still valid. Accordingly, **we recommit to our strategic plan**, but acknowledge the work to be done to describe the medium term (3 to 5 year) path of implementation beyond the immediate operational challenge of this next financial year.

Using the Monitor Strategic Planning Toolkit[3], we judged that our work to produce the Monitor Strategic Plan last year took us, de facto, through the early elements of the of the toolkit (frame, diagnose, forecast, generate options and prioritise. We continue to focus on the 'deliver' and 'evolve' stages of the toolkit.

[3] https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers

Section 2 – Delivering our 2020 Strategy

2.1 Delivering progress against our strategy

For the year ahead, delivering progress against our strategy will be achieved by working with a refreshed set of corporate objectives, derived from our Vision, as described in section 1.1 above and set out in our strategic plan in 2014. They are still the basis for our activity as a Trust and are summarised below and in more detail at Annex B.

Operational and financial issues make this an unprecedentedly challenging year ahead for the Trust. Accordingly, we are collectively focussed on the resilience of our services in the short term, which has to some extent partly crowded out our collective work to address some of the longer term issues of sustainability though all immediate threats and risks have been addressed. Accordingly, our Strategic Implementation Plan, designed to develop the outline plans for years 3 to 5 that we set out in our Strategic Plan, is still being developed. Where essential, we have linked developments in our operating plans to longer term aspirations, but we have had limited joint capacity – or resources – at our disposal to work toward, or invest in, the medium term. We will address this over the summer, and develop the detail of our 3-5 year plans by September, summarising strategic initiatives, goals, targets and Key Performance Indicators for years 3 to 5 of our 2014-19 plan.

2.2 Our Corporate Objectives

Our detailed corporate objectives are described in Annex B but flow from our 2014 Strategic Plan and in summary are:

- To consistently deliver high quality individual care, delivered with compassion.
- To ensure a safe, friendly and modern environment for our patients and our staff.
- To strive to employ the best and help all our staff fulfil their individual potential.
- To deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
- To provide leadership to the networks we are part of, for the benefit of the region and people we serve
- To ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.
- To ensure we are soundly governed and are compliant with the requirements of our regulators.

2.3 Responding to the 'Five Year Forward View'

We have considered the challenge set out in the NHS 5 year forward view and are working with others across the Local Health Economy to consider its implications for the Bristol health system of which we are an integral part. There are two key mechanisms by which this work is being taken forward.

The first is the **System Leadership Group**. This group, set up by local providers and commissioners, now includes the full range of organisations connected to and concerned with the local health economy (including the major local community providers and Bristol City Council). The agenda for this group is currently focussed on:

- Developing a joint vision for the Local Health System.
- Formally assessing the current 'readiness' of the local health economy to progress the Five Year Forward View agenda.
- Identifying – and committing, to a series of 3-5 year work streams as well as potential 'early wins' and a joint approach to resourcing this work.

The Trust has assessed and revised aspect of the executive portfolio to ensure that there is a clear, senior leadership focus on the way the Trust shapes the wider system within which it operates. The role of Director of Strategy and Transformation has been established to lead on this agenda.

The second key piece of work bringing organisations together across the local health economy is **Better Care Bristol** (the local Better Care Fund). As with other initiatives across England, the desired outcomes of Better Care Bristol are:

- Improved services, despite greater demand and less money.
- People cared for in their own homes, with reduced admissions to, and lengths of stay in, hospital.
- Help for people to better manage their own health conditions.
- Spending money on supporting people to live well in their communities, to prevent them needing costly health or social care services later.

We are a full partner in this work, and support the outline financial plan that underpins Better Care Bristol. However, the commissioning and provider sectors are not yet aligned on the impact of the initiatives. All parties have supported the aim of a 1.75% reduction in emergency admissions for each of the next two years (of those over 65) and an expectation that activity growth arising from demographic changes will be offset by further demand management initiatives. However, greater reductions in demand which commissioners have assumed, but which we have been assessed as high risk, have not been incorporated in the Trust's plan. To respond to these "tentative" initiatives, with capacity reductions would, in our view, jeopardise operational performance. However, we remain committed to working closely with our community partners to reduce reliance on hospital services.

2.4 Our Plans to Address Poor Performance

The Trust has been working closely with its commissioners and regulators to develop recovery plans to address those areas which the Care Quality Commission found not to be meeting fundamental standards and the three areas of poor performance in relation to national access standards – A&E, RTT and 62 day cancer standards. The key initiatives to address these access standards include

- A comprehensive capacity assessment of the demand for elective care, both outpatients and admitted, using external support (IMAS) resulting in the development of robust supply plans to eliminate backlogs and address shortfalls in recurrent capacity
- Instigation of demand management initiatives in some serves, to support timely access to care.
- Full validation of RTT pathways and migration of reporting to the Trust's Patient Administration System – Medway.
- A "resetting" and expansion of the Trust's bed base to support improved flow through a reduction in the occupancy level at which the Trust operates its bed stock.
- Further expansion of community initiatives, funded by the Better Care Fund, to avoid hospital admissions and promote early discharge.
- Implementation of a series of cancer improvement initiatives to address known bottlenecks in cancer services, including the introduction of incentives, through the CQUIN scheme, of partner Trusts to refer patients in a timely way.

An access recovery plan is included at Annex C and has been endorsed by the Board and our commissioners.

2.5 Our People – our workforce and organisational development strategy

We have made considerable progress with regard to our workforce strategy in the last 12 months. As described in section 6 of our Monitor Strategic Plan 2014-19, we have identified the workforce strengths, weaknesses, opportunities and threats for the University Hospitals Bristol, and from this, developed six key strategic themes. This analysis subsequently formed the basis of the Trust Workforce and Organisational Development Strategy, which was agreed by the Trust board in September 2014.

An action plan has been developed and approved, which is monitored by the Workforce and Organisational Development Group. Strategic themes provide the long term direction for workforce sustainability at University Hospitals Bristol. In addition, there are short term work programmes focussed on key operational resilience, which are described more fully in the section 3.2.3.

The key areas of progress over the past year and priorities for the coming year include the following.

Developing Leadership and Management Capability	• To date, we have put in place a comprehensive leadership programme for all front line supervisors and managers. • Our priority for 2015/16 is ensuring that all managers and leaders have the skills and competencies to support and develop staff creating a culture of high performance and continuous improvement.
Staff Engagement	• To date, we have focussed on improvement of two-way communication, including a programme of listening events, focusing on areas indicated by our staff, from the staff survey and other local feedback mechanisms. • Our focus in 2015/16 will be on implementation of the approach developed by Aston University to improve team working.
Recruiting and Retaining the Best	• To date, we have developed a marketing approach to attract suitable candidates, including social media for cleaning staff. • In 2015/16, we aim to improve the speed of recruitment from application to appointment by streamlining all processes, whilst continuing to ensure there are robust employment checks.
Reward and Performance Management	• To date, we have implemented a revised performance management policy which now links pay progression with performance management. • In 2015/16, we will improve the quality and application of staff appraisal.
Education and Research	• We have been focussed to date on the development of a forward looking Education and Development Strategy 2015 to 20, with a revised integrated governance process. • In 2015/16 we will focus on providing high quality training and development programmes to support a diverse, flexible workforce, underpinned by effective training needs analysis and planning.
Strategic Workforce Planning	• Over the last year, we have been working with Health Education South West to secure funding for robust Workforce Planning Training for Human Resources Business Partners • Our priorities for 2015/16 are to develop a framework to roll out training on workforce planning for key service managers.

2.6 Capital Investment

The Trust has invested significantly in the last three years to modernise its estate and 2014/15 saw the culmination of many of the strategic estates plans, including the opening of the new 10 storey ward block and the retirement of the Old Building to inpatient services. Whilst early days, there is significant evidence that this new estate, designed around the optimal adjacencies and co-location of services, is supporting the transformation of services in the way set out in the original business case. As discussed earlier, new models of surgical care, only possible because of the new estate have supported a 13% reduction in length of stay since the model was launched.

Plans for 2015/16 include the investment of an additional £34.2m of capital (net of slippage) – £15.8m in the conclusion of ongoing strategic schemes associated with the refurbishment of the BRI Queens and King Edward buildings (BRI Phase 4). £2.2m in backlog maintenance, £8.7m in operational capital and £7.5m in equipment and IM&T related investments. The vast majority of this latter investment is in support of mitigating immediate risks, enabling performance recovery through additional equipment or replacement / repair of obsolete equipment or estate. However, there remain challenges in supporting the liquidity position to maintain a CoSRR of 3 and as such £11.8m of slippage is presently assumed within the plan. The impact of this on quality has been assessed and the key impact is the continuation

of outpatient based services from the Old Building for a further three months and, whilst not ideal, is tolerable.

2.7 Productivity, Efficiency and Cost Improvement

The Trust's CIP programme for 2015/16 is £24.4m, with 37% of this sum still to be identified. The target is a combination of new efficiency requirements and undelivered cost efficiency from previous years. The nature of the initiatives to realise this saving are both transformational are transactional, as in previous years.

Transactional work streams for 2015/16 will see a renewed focus on controls, both pay and non-pay and the development of specific work streams to address those areas with a known high Reference Cost Index (RCI) - for 2015/16 the focus will be general medicine, cardiology and ENT , starting with diagnostic work to identify the "best in class" and then working with those organisations to understand how the Trust's services need to be reconfigured or transformed to achieve their levels of efficiency. Only those Trusts with services of demonstrably good quality have been included in the diagnostic.

Transformation initiatives are broad with the Trust starting the year with another Breaking The Cycle Together initiative and will include a significant revision to the acute model of care for emergency pathways, with the explicit goal of sustaining strong A&E performance and reducing length of stay sufficiently to restore the bed base back to planned levels – this is critical to future financial stability as these beds are partly funded non-recurrently from external resilience funds.

Our other transformation priorities for 2015/16 are:

- Further developing our Operating Model, driving improvements in patient flow and quality in our services. Our Operating Model work is managed through three strands: Unscheduled care, which with our health and social care economy partners is delivering improvement in emergency flow, ward processes and complex discharge pathways; Planned Care, which is transforming our elective care pathways to reduce cancellations and improve elective length of stay; and Children's Surgical flow, where improvements in capacity are being underpinned with changes to scheduling processes and team capability
- Under our Delivering Best Care programme we are taking forward specific agreed projects to develop 7 day working, and further developing our End of Life Care services
- We are delivering a programme of theatre transformation across all our theatre suites, to improve patient experience and improve utilisation of theatre capacity
- Improving staff engagement and communications – we will take forward a Trust wide programme to strengthen communications and engagement with our staff and respond to feedback from staff survey results
- We will further build our relationships with health economy partners, supporting system wide work in support of the Better Care Fund initiative.

We will start the year with a Breaking the Cycle Together initiative to reaffirm standards of quality and safety across our services and to gather further feedback to provide focus for our Operating Model work.

Section 3 – The Year ahead: Our Plan for short-term resilience

3.1 Our focus on Resilience

The focus of our plan this year is the resilience of our services and our finances – the challenge of maintaining quality (and thus performance) in the context of considerable operational and financial challenges. This section sets out our quality objectives, our operational requirements and what all of this means for deployment of our resources and our financial plan.

3.2 Our commitment to Quality

The Trust's quality strategy remains focused on patient safety, patient experience and effectiveness of care and our commitment to address the aspects of care that matter most to our patients. It outlines our plans to address these areas as well as to mitigate any quality risks that result from our challenging financial cost improvement plans. The quality of our clinical services will not be compromised. We view quality, safety and efficiency as mutually beneficial. Our commitment to this principle underpins both our quality priorities outlined in our 2014/15 Quality Account and the Trust's quality objectives for 2015/16, which are outlined below.

We continue to use the following four questions to examine our approach to quality:

- Do we understand quality and patient experience well enough in the Trust?
- How do we know that the services we provide are safe?
- What will it take to make all our services as good as they can be?
- How well do we involve our staff and patients in this agenda?

The Trust was inspected by the Care Quality Commission this year which has helped shape our quality priorities for the year ahead. Much of the Care Quality Commission report was positive, with urgent and emergency services, Intensive and critical care services, maternity and gynaecology services, services for children and young people and end of life care receiving a good rating. Medical, surgery and outpatient service were identified as requiring improvement. The Trust is working internally and with our partners in health and social care to make improvements in the areas identified as not meeting the required standards. An update on our CQC action plan – summarising our work in response to the report – is included at Annex D. Follow up of the responsive review by the Care Quality Commission of the operating department at the Bristol Royal Hospital for Children in November 2013 and the themed review of Dementia in 2014 were included in scope of our comprehensive review.

The Trust has received very positive patient feedback throughout the year with patients reporting their experience of kind and compassionate care and treatment. Friends and Family scores for our hospitals are better than the national average, with the vast majority of patients saying that they would recommend the hospital.

3.2.1 Our Quality Objectives

Looking forward, each year we consider national and local commissioning priorities related to provision of high quality services alongside available intelligence about the quality of all of our services (internal and external) and, with the involvement of our local stakeholders, patients and governors, agree a set of corporate quality objectives to reflect our agreed priorities. As a result of this approach, our quality objectives for 2015/16 the will focus on:

- Working with people to provide a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm;

- Achieving clinical outcomes for our patients that are consistently in the upper quartile of comparable Trust's performance.

The specific Trust Quality Objectives for the year ahead are shown below. As this report is submitted, these objectives are still draft, but will be confirmed as part of the ongoing development of the Trust Quality Report. Objectives 1, 2 and 3 are continued from last year's objectives. This is because, despite some improvements, the Trust has not delivered the level of quality improvement that it wanted to see in these areas. All three of these objectives relate to, and support, the Trust's strategic operational priority to improve the flow of patients though the Trust.

- Objective 1 - To reduce the number of cancelled operations
- Objective 2 - To minimise inappropriate patient moves between wards (time and place)
- Objective 3 - To ensure patients are treated on the right ward for their clinical condition
- Objective 4 - To improve the process/experience of patients discharge
- Objective 5 - To improve standards of written communication with patients
- Objective 6 - To improve the management of patients with a clinical diagnosis of sepsis
- Objective 7 - To improve the experience of cancer patients
- Objective 8 - To improve the quality of written complaints responses
- Objective 9 - To reduce appointment delays in outpatients; and to keep patients better informed about any delays

3.2.2. Quality assurance

Our Trust objectives, values, quality and efficiency strategies provide a clear message to all staff that high quality services and excellent patient experience are the first priority for the Trust Board. This message is reinforced through our five clinical divisions having specific, measurable quality goals as part of the process of producing their Annual Operating Plans. Progress against these plans is monitored monthly by Divisional Boards and by the Executive Team through the Divisional Performance Review process. The Board Quality and Outcomes Committee will also continue to review our progress against a range of quality performance indicators and our performance against Care Quality Commission's fundamental standards. Feedback and discussion is undertaken with governors via the Patient Experience Group, Strategy Focus Group and Quality Focus Group. Each quarter, the Board and its sub-committees receive the Board Assurance Framework which reports high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement.

Additionally, the Board's Audit Committee works with the Trust's Clinical Audit and Effectiveness team to consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

3.2.3 Risks to our Quality Objectives.

Despite our quality strategy and work to improve our patient flow, we have declared that the Trust is at risk of not achieving some healthcare targets and indicators in 2015/16. Firstly, we have declared that we may not achieve the threshold of 95% patients spending less than four hours in our A&E department in quarter 4. The issues that contribute to not meeting this target are complex. We have several pieces of work underway to address these issues. We are an active member of the Strategic Resilience group, one of the key aims of which is to provide a local whole system approach to addressing local emergency care and patient flow pressures.

The final, but significant risk to achieving our quality objectives is the risk that our staff are not engaged in our plans and motivated to support their delivery. All staff working in the NHS are facing huge challenges and our recent national staff survey demonstrates that for UH Bristol this issue is one that we must address if we are to succeed. Significant attention is being given to this agenda and emerging plans to address this are set out in the workforce section of this plan.

3.2.4 Managing the Risk of Cost Improvement Plans on Quality

The Trust has a robust approach to the assessment of the impact of cost reduction programmes on the quality of services. This includes a formal Quality Impact Assessment for all Cost Improvement Plans with a financial impact of greater than £50k and ANY scheme that eliminates a post involved in front line service delivery. These QIAs are required to be reviewed through Divisional quality governance mechanisms to ensure robust clinical oversight of plans, from those service areas affected.

In addition to this internal assurance of the impact of CIPs on quality, local commissioners also review plans, on a sample basis, to assure both the quality of approach and the impact of the most significant schemes (in financial terms).

Finally, the Medical Director and Chief Nurse are responsible for assuring themselves and the Board that cost improvement plans will not have an adverse impact on quality.

3.3 Our Operational requirements – the capability we need to achieve our objectives

3.3.1 Capacity Planning

During quarter 3 of 2014/15, the Trust undertook a detailed capacity and demand planning exercise, supported by the Interim Management and Support Team (IMAS). IMAS provided a modelling tool for planning the level of capacity required to reduce waiting times for first outpatient, diagnostic and elective admission, and achieve a sustainable waiting time for follow-up attendances. The Trust modelled the capacity required to reduce these stage of treatment waits in order to realise 18-week compliant Referral to Treatment Time (RTT) pathways. This exercise has informed the amount of recurrent activity that the Trust needs to provide to maintain 18-week waits once waiting times have been reduced and backlogs have been addressed. The level of non-recurrent work needed to reduce existing backlogs of long waiting patients has also been assessed and represents a significant increase in activity which brings with it operational challenges.

From these inputs the Trust has modelled the activity it requires commissioners to contract for in 2015/16. This level of planned activity for 2015/16 also takes account of the impact of in-year and planned service transfers, service developments, recurrent (demographic) growth and other known planned changes to activity levels. Below is a summary of the additional activity required in 2015/16 over last year, of which around 65% is recurrent growth.

- 1423 additional elective inpatients (10.1% increase)
- 3250 additional elective day cases (5.9% increase)
- 4113 additional outpatient procedures (7.4% increase)
- 15,471 additional outpatient new attendances (8.86% increase)
- 24,866 additional outpatient follow ups (7.06% increase).

Required activity, alongside our projections for the impact of demographic growth and system wide initiatives to reduce demand and improve flow, have led to a re-statement of the Trust's required bed base. Of significant note is the decision to invest in reductions in occupancy (to 90%) given the increasingly clear relationship between flow and occupancy levels – significant funding from commissioners, through the Strategic Resilience Group has enabled this to be achieved. Improvements in the surgical length of stay, on the back of the planned care transformation initiative, have also enabled a ward to swing from medicine to surgery which will further support optimal occupancy and ensure all patients are cared for in the right environment..

More detail on the activity and capacity requirements are set out in Annex C but in summary the following are the key physical inputs required.

- 18 fewer surgical beds, within the BRI bed base.
- 16.5 additional adult theatre sessions per week and 13.5 paediatric theatre sessions.

- 75 additional adult outpatient clinics and 14 paediatric clinics per week.
- Modelled requirement for 400 waiting list initiatives, 104 paediatric.

Key workforce impacts are assessed to be:

- 82.75 additional surgical and dental medical sessions per week to deliver RTT activity.
- 5 WTE consultants and 59 additional ward nursing staff to support expanded medical bed base.
- 41 WTE additional surgical nursing and therapy staff (excluding paediatric theatres).
- 14.5 WTE paediatric theatre staff.
- 17 WTE additional administrative staff.

3.3.2 Information management and technology (IM&T)

The IM&T Operational Plan for 2015-16 is focussed on the delivery of a Programme to support the long-term vision of the Trust's Clinical Systems Strategy (2012) whereby *every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again*. The Programme is overseen by the IT Management Group chaired by the Director of Finance and Information, and the planned benefits will include:

- Maximising value for money through competitive procurement and systems review.
- Improving efficiency e.g. records management; patient flow.
- Consolidating and integrating systems and information.
- Improving access to on-line patient information.
- Improving clinical communication and responsiveness.
- Providing Clinical Decision Support e.g. electronic prescribing.
- Supporting Patient Safety, including formal system assessments with clinical staff.
- Supporting good Information Governance including record keeping and audit.
- Supporting clinical research e.g. searchable clinical records.
- Improving workload planning e.g. new theatres scheduling system.
- Reducing the use and generation of paper-based documentation.

3.3.3 Workforce

There have been a number of workforce challenges in 2014/15. The buildings redevelopment, whilst welcomed by the majority, resulted in the loss of some staff who found the change to new ways of working was not for them; time from advert to recruitment has been lengthy and resulted in vacancies being long standing with high use of bank and agency to fill gaps and changes to the ways essential training is delivered have been significant and impacted on many staff. Positively, work streams to address these challenges are in train and the Trust achieved 88% for essential training at the end of March, which, whilst just shy of our 90% target, is significantly better than many Trusts – of note is the uptake of e-learning as a means of delivering core training requirements.

Changes in staff numbers planned for 2015/16 include reductions due to the transfer of cellular pathology to North Bristol Trust, and reductions due to savings programmes, and increases associated with Operational Resilience Cost Pressures and service transfers. These are summarised in the table below.

Staff Type	Month 12 2014/15 Brought Forward	Changes 2015/16					March 2016
		Operational Resilience	Service Developments	Service Transfers	Additional Recruitment to fill Vacancies	Savings Programme 2015/16	
	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Medical and Dental	1,100.25	13.81	7.54	(8.15)	8.76	2.60	1,124.81
AHP Scientific/Technical	1,300.12	1.00	8.95	(21.01)	1.84	(7.40)	1,283.50
Nursing and Midwifery Staff	2,869.97	39.67	10.86	6.81	5.01	(9.21)	2,923.11
Ancillary staff	737.55	2.00	1.00	-		(5.33)	735.22
Admin and Clerical and Senior Managers	1,536.21	4.14	11.60	(6.09)	19.49	(8.51)	1,556.84
Sub-total	**7,544.10**	**60.62**	**39.95**	**(28.44)**	**35.10**	**(27.85)**	**7,623.48**
Bank	416.23	No change on 14/15 Outturn					416.23
Agency	170.29	26% Reduction on 14/15 Outturn					126.01
Grand Totals	**8,130.62**						**8,165.72**

Recruitment

The monthly average vacancy level for University Hospitals Bristol was 5.3% and the target for 2015/16 is 5%. Registered nursing vacancies at University Hospitals Bristol at 7.1%, continue to be below the benchmark of 9% for similar Trusts in the Associated United Kingdom University Hospitals (AUKUH) cohort. An action plan to achieve the phased filling of vacancies was established in 2014/15, and this will continue into 2015/16, including procurement of a recruitment management system, and improved resources in the recruitment team. Given the demand for nursing staff in the tight labour market, with reduced numbers of newly qualified and experienced staff available, a trust-wide overseas recruitment initiative is being developed.

Workforce affordability

Regarding affordability, our main priorities in 2015/16 will be to reduce agency spend by recruiting to fill vacancies and reducing turnover, together with decreased sickness absence. Savings plans will result in a reduction of approximately 28 WTE in 2015/16. However, some savings will not have WTE reductions associated, but will reduce pay costs and increase productivity, including plans to change skill mix and reduce premium payments.

Bank and Agency Usage

The workforce plan assumes a 26% reduction on agency spend. The main reason for booking bank and agency is to provide cover for vacancies, and therefore the recruitment and retention programme will be essential to reducing temporary staffing spend. Agency spend will also be reduced through improved rostering, and better and earlier alignment of operational plans with workforce planning. This process ensures all agency requests are appropriately approved, with controls in place to monitor this. Options to improve the incentives for staff to undertake bank shifts are being developed and any changes will be implemented in 2015/16.

Retention

The target for turnover in 2015/16 is 11.5%. Turnover has increased in the previous year to 13.8%. In addition to work described in section 2.5, our focus is to retain staff (particularly nursing assistants, where turnover is particularly high) together with incentives and benefits for all new and existing staff.

Sickness Absence

The most recently available benchmark data shows that UH Bristol absence rates are broadly in line with comparable Trusts. The target for 2015/16 is 3.7%. Work to reduce absence over the next two years will build on existing programmes with a particular focus on addressing psychological causes of absence through a programme of stress management audits and support for staff.

Changes to junior doctor numbers

Work by the Director of Medical Education has helped to confirm that 10 posts will be lost from 2016 (5 Foundation Year 1 doctors and 5 Foundation Year 2 doctors) as a result of the national change to increase community placements. Work programmes to address the shortfall will be developed when the specialties have been identified, but are likely to include changes in workforce models and roles.

3.3.4 Key risks to the delivery of our Plan

The operational plan has been worked up in considerable detail in recent months and "stress tested" against a range of potential impacts. The key risks to delivery of the plan are set out below and mitigations to these risks have been largely identified and are described in summary below

- Commissioners do not contract for sufficient activity to enable RTT performance to be achieved – this risk is largely mitigated following agreement of contract activity levels, though the contract remains unsigned.
- Resilience funding is insufficient to support the enhanced bed base and investment in paediatric flow and winter pressures – this risk is expected to be mitigated through the reinvestment of RTT and other fines though not all commissioners have agreed to this approach.
- There are two primary risks to the workforce element of the plan; these are the supply of suitably qualified staff and the timeliness in which staff are recruited, and plans therefore able to be mobilised. In respect of the former, a range of recruitment and retention initiatives are being corporately led and supported, targeted to known 'problem' areas such as theatre staffing, where London-based recruitment fairs are planned. Where there are known staff shortages, alternative workforce models have been developed - for example, in restorative dentistry a new workforce model is being introduced, utilising dental nurses instead of dental consultants. Infrastructure to support this peak in recruitment activity is being strengthened to include additional recruitment staff and appointment panels. Finally, recruitment plans for all specialties have been developed and where recurrent posts will not be established from the outset, non-recurrent initiatives are in place to ensure backlogs do not grow.
- Demand for both elective and urgent care exceeds the levels assumed within the plan – this risk has been mitigated through comprehensive demand assessments and dialogue with commissioners. A range of initiatives to manage demand have been developed over recent months and historic gaps in supply have been addressed following the IMAS work which affords for limited excess demand to be managed without detriment to performance. Planning for occupancy at 90% also affords a degree of mitigation for unplanned peaks in demand, though consistent increases in occupancy will import risk to access standard achievement.
- Residual Cost Improvement savings are not achieved, expenditure exceeds plan or income is not achieved in line with plan – all of these issues have the potential to lead to the Trust being unable to deliver its financial plan. There are very limited contingencies within the plan to cover such eventualities and as such the focus will be unrelenting attention to financial controls and activity delivery. Further detail on financial risks is included in section 3.4 of the plan.

3.4 Our Financial Plan

3.4.1 Introduction

The financial plan narrative describes the Trust's current assessment and presents the 2015/16 position in outline. The 2015/16 financial year is extremely challenging. For the first time in 13 years, the Trust is forecasting a net income and expenditure deficit of £5m before technical items (£6.4m deficit after technical items including impairments). It should be noted that the current assessment of 2015/16 is the draft position and is based on the following key drivers:

- The Trust opted for the Enhanced Tariff Offer (ETO) under protest in March. The Trust opted for ETO with the expectation that a reasonable level of CQUIN income was earnable. The plan relies on this expectation being realised. We are concerned that this expectation is being frustrated by unreasonable Commissioner requirements re CQUINs.

- Service Level Agreement (SLA) discussions are now progressing with local Clinical Commissioning Groups (CCGs). However, discussions with NHS England are at an early stage. There is a reasonable expectation that Heads of Terms could be signed by the 27th April.

- The single biggest risk relates to CQUINs. The proposed CQUIN schemes are extremely difficult to achieve with exceptionally high trigger points for payment. Other schemes require substantial investment to deliver the CQUIN including recurrent costs, thereby mitigating the benefit of CQUIN income i.e. the net earnability (i.e. CQUIN income less the costs of delivery) is well below that anticipated both in the financial plan and the ETO tariff selection. We will not be able to agree SLAs without significant revision to proposed CQUINs for national, local, urgent care and specialised schemes.

- The Trust identifying savings plans necessary to achieve the 2015/16 saving requirement of £24.4m. The savings requirement is summarised below:

ETO National requirement	£15.7m	3.5%
Divisions underlying position c/fwd	£8.7m	2.0%
2015/16 Savings requirement	**£24.4m**	**5.5%**

  Note – The percentage quoted is based on the net management budget affected e.g. excluding 'pass through' cost, R&D, hosting etc.

- The activity required to meet clinical demand and to deliver national performance targets (e.g. RTT) will be commissioned. Early indications are encouraging in this area.

- The Trust will receive adequate resilience funding from Commissioners to enable the Trust to operate effectively and prevent emergency system pressures compromising the delivery of elective activity. This has now been secured in principle. The Trust has made it clear that this funding must be included in the signed 2015/16 SLA.

3.4.2 Financial Plan

The Trust's 2015/16 financial plan is constructed as follows:

Item	Amount	Comment
Underlying position brought forward	£9.5m	
Marginal Tariff loss at 70%	(£3.5m)	On NHS England Specialised Services
Impact of National Tariff	(£1.4m)	Other impacts of 2015/16 National Tariff
Division's CIPs shortfall	(£4.5m)	Assumes 2.5% of the 3.5% is deliverable
BRI Redevelopment	(£2.3m)	Capital charges and Facilities Management costs
Other capital charges	£0.6m	Excludes the BRI Redevelopment
PDC dividend offset	£0.7m	The loan interest reduces the PDC dividend
Dental & Medical SIFT	(£0.6m)	Due to reduction in teaching activity/student numbers
Risk reserve	(£0.7m)	Provision for Corporate cost pressures
Service Transfers – net loss	(£0.7m)	Breast Screening, Histopathology & Vascular Surgery
Reduction in contingency reserve	£1.0m	Reduction from £2m in 2014/15
Inflation contribution to capital charges	£0.9m	Capital charges growth
CNST contribution	£2.0m	Tariff funding above increases in premiums
Recurring position c/fwd	**£1.0m**	
Non Recurring costs		
Change Costs	(£1.0m)	Non recurring – redundancy/spend to save costs
Provision for performance fines	(£3.5m)	£1m is a recurring level - £3.5m includes RTT fines
Risk reserve	(£0.5m)	Provision for Corporate cost pressures
Transitional costs	(£0.2m)	Temporary revenue costs of capital schemes
Technology implementation	£0.8m	Clinical system technology implementation
Net income & expenditure deficit	(£5.0m)	**Before technical items**
Impairments	(£4.2m)	BRI Redevelopment Phase 3 and BRI Façade
Donations	£4.3m	In support of the Trust's capital programme
Donated asset depreciation	(£1.5m)	
Net income and expenditure deficit	**(£6.4m)**	**After technical items**

3.4.3 Income

The 2015/16 income plan is subject to further negotiation of SLAs with Commissioners and the resolution of the following key issues:

- The setting of enhanced baselines with NHS England to minimise the impact of the 70% marginal tariff;
- Negotiating the waiving of Referral to Treatment Times (RTT) fines with commissioners focusing on specific areas such as specialist paediatrics where the position can be ascribed to factors outside of the Trust's control;
- Agreeing an effective operational resilience plan thereby enabling the Trust to operate an urgent care service that can operate without compromising the delivery of RTT performance; an
- It is not yet clear that Commissioners will be prepared to agree SLAs at a level which enables activity convergence to be achieved. However, any divergence will be understood and explicitly described in the Heads of Terms. Any divergence is not likely to exceed 1% of SLA income.

Heads of Terms and SLAs are not expected to be signed until the end of April 2015 but, with the exception of national CQUINS, good progress is being made.

The current 2015/16 income plan is £590.3m and includes the following key assumptions:

2015/16 Rollover recurrent income	**£576.2m**	
Tariff deflation	(£6.5m)	Net of 1.9% and 3.5% national efficiency
CNST	£2.8m	Equivalent to 1.1% of the PbR baseline
2015/16 National Tariff – further impact	(£1.4m)	Impact of 2015/16 National Tariff guidance
Service Transfers	£0.1m	Histopathology, PICU and Vascular
Developments	£2.6m	Commissioner revenue proposals
Activity growth	£10.4m	Includes non- recurrent funding to clear RTT
Operational resilience	£2.6m	Anticipated funding by Commissioners
NICE, drugs & devices - RS	£5.0m	Based on 2015/16 horizon scanning
Marginal Tariff impact	(£3.5m)	Impact on specialised services at 70% rate
Performance Fines	(£3.5m)	Estimated impact of contract penalties
CQUINS	£0.7m	Net impact
Donation income	£4.3m	In support of the Trust's capital programme
Other	£0.5m	
2015/16 Proposed Income Plan	**£590.3m**	

3.4.4 Costs

The 2015/16 cost outlook for the Trust is challenging and should be considered in the context of operational pressures on spending, the full delivery of savings plans and transformation initiatives. Firm control will continue to be required to avoid the Trust's medium term plans being undermined beyond 2015/16. The main assumptions included in the Trust's cost projections are:

- Pay award at 1.6%, employer pension costs at 0.8%;
- Drugs at 5%, clinical supplies 1.6%, rates 2.3% and capital charges at 2%;
- Savings requirement of £24.4m;
- Payment of loan interest at £3.1m; and
- Depreciation of £20.8m pending the District Valuer's (DV) assessment of the Trust's forecast net impairments of £4.2m following completion of the ward elements of Phase 4.

The 2015/16 position includes £6.05m of non-recurring costs as follows:

- £1.0m change / invest to save costs;
- £0.25m transitional costs in support of the strategic schemes;
- £0.8m Clinical Systems Implementation Programme (CSIP);
- £0.5m risk reserve; and
- £3.5m provision for SLA fines.

3.4.5 Comparison with 2015/16 Plan submitted in June 2014

The Trust's 2015/16 Plan is a net deficit of £5.0m excluding technical items. This compares with a surplus of £5.8m submitted in June 2014. The deterioration of £10.8m is primarily due to CIP being 1.5% higher at 3.5% at £7.7m, the impact of National Tariff at £1.4m and the impact of the marginal tariff loss at 70% at £3.5m.

The Trust's plan for 2015/16 shows a deterioration in liquidity from a metric score of 4 to a metric score of 3. The deterioration is primarily due to the reduction in the Trust's planned income and expenditure net surplus (excluding technical items) from a surplus of £5.8m previously to deficit of £5.0m. An increase in stocks, adverse movement in working capital have also reduced the liquidity.

The Capital Service Cover metric has reduced from a metric score of 3 to a metric score of 2. This is due to the net surplus reduction of £10.8m. The position is summarised below:

	Liquidity		Debt Service Cover		CoSRR
	£m	Score	Times	Score	
2015/16 Plan (June 2014)	**3.5**	**4**	**2.2**	**3**	**4**
I&E deterioration 2015/16	(10.8)		(0.7)		
Increase in stocks	(0.8)				
Working capital movement	(1.7)				
Non cash backed surplus 2014/15	(6.0)				
Liquidity Restoration	8.3				
BRI Old Building	2.1				
2015/16 Plan (April 2015)	**(5.4)**	**3**	**1.5**	**2**	**3**

3.4.6 Cost Improvement Plans (CIP)

The Trust has established a Savings Board chaired by the Director of Finance, in order to improve governance and control over the delivery of CIP in 2015/16 and beyond. The delivery of CIP is an essential element in the Trust delivering its 2015/16 financial plan, including the conversion of non-recurring schemes to recurring schemes. The Trust continues to develop its savings programme, maintaining quality whilst addressing the requirement to reduce costs in line with the National efficiency requirement of 3.5% under ETO. We set Cost Improvement Plan targets in the light of:

- National efficiency requirements;
- Underlying deficits in divisions carried forward from the previous year; and
- An assessment of the requirement for investment to address risks or quality improvements it believes is necessary.

Divisional CIP targets are set at 3.5% of recurring budgets plus the assessed underlying deficit carried forward from 2014/15 generating a target of £24.4m for 2015/16. Currently, risk assessed plans exist for £15.4m. The Trust has an established process for generating CIPs. It operates an established programme of transformation, called Transforming Care.

The key transformational work streams which support CIP are as follows:

- Theatre Productivity transformation programme to focus on improving theatre efficiency. Additional objectives include reducing cancelled operations, reducing late start times to improve patient experience, reducing daily scheduling conflicts and better aligning capacity with demand in support of RTT targets.
- The Model of Care Programme is our patient flow programme and focuses on reductions in length of stay. It is well established and provides a focus on improving patient flow from presentation to discharge with specific aims of supporting strong A&E 4 hour performance, reduced length of stay, reduced numbers of patients for whom discharge is delayed and a reduction in the rate of cancelled operations arising from a lack of available beds.
- The Diagnostic Testing project addresses the processes for delivering efficient diagnostic testing across the Trust for Pathology and Radiology services. The workstream is seeking to generate cross division opportunities to improve productivity, introduce common ways of working use benchmarking and detailed analysis to identify opportunities and scope changes. The work stream is also focusing on benchmarking with other trusts to identify further opportunities for efficiencies.

The Trust has established a further group of work streams dedicated to delivering transactional CIPs, for example:

- Improving purchasing and efficient usage of non-pay including drugs and blood;

- Job Planning and links to capacity and demand for the medical workforce. We are developing specific improvement projects working jointly with the Local Negotiating Committee to generate savings projects alongside the consultant job planning process;
- Ensuring best value in the use of the Trust's Estates and Facilities This includes a review of the delivery of specific services, and further improvement s in energy efficiencies;
- Ensuring best use of technology to improve efficiency, linking productivity improvement with the introduction of new tools in clinical records management and patient administration; and
- Addressing and reducing spend on premium payments including agency spend.

The Trust's risk assessed CIP plan is summarised below:

Workstreams	£'000
Allied Healthcare Professionals Productivity	678
Medical Staff Efficiencies Productivity	180
Nursing & Midwifery Productivity	997
Technology / Admin & Senior Managers Productivity	368
Reducing and Controlling Non Pay	2,096
Diagnostic Testing	610
Medicines Savings	1,535
Outpatients Productivity	179
Theatre Productivity	254
Model of care	1,453
Facilities & Estates	853
Trust Services	335
Income	3,046
Corporate and other savings	2,840
To be identified	8,931
	24,355

3.4.7 Capital expenditure

The Trust has a significant capital expenditure programme investing £405.9m from April 2008 until March 2019 in the development of its estate. In 2015/16, the Trust's planned capital expenditure totals £34.2m and incorporates slippage of £11.8m at scheme level into 2016/17 to provide further liquidity headroom. The capital plan for 2015/16 is summarised below:

Source of funds	2015/16 Plan £m	Application of funds	2015/16 Plan £m
Cash	7.1	Backlog maintenance	2.2
Depreciation	20.8	IM&T	3.2
Disposals	1.1	Medical equipment	4.3
Donations	4.2	Operational capital	8.7
VAT recovery	1.0	Strategic schemes	15.8
Totals	**34.2**	**Totals**	**34.2**

The Trust's major strategic schemes in 2015/16 are:

BRI Redevelopment Phase 4 £13.1m

Phase 4 of the BRI Redevelopment is the refurbishment phase of ward areas vacated in the Queens Building and the reconfiguration of clinical space in the King Edward Building. Phase 4 enables the decommissioning and closure of the BRI Old Building by 30th June 2016.

BRI Redevelopment – Façade £2.7m

The façade scheme delivers a contemporary frontage for the Queens Building.

3.4.8 Continuity of Services Risk Rating

Liquidity

The Trust's 2015/16 forecast year end cash balance is £43.7m, a forecast reduction of £19.7m from £63.4m as at 31st March 2015. The Statement of Financial Position forecasts net current assets of £4.7m as at the 31st March 2016, a reduction of £16.9m. The forecast reduction is primarily due to: the Trust's 2015/16 planned deficit of £5m excluding technical items; £7.1m cash requirement in support of the 2015/16 capital plan of £34.2m and £5.8m loan principal repayment. It should be noted that the 2015/16 capital plan includes liquidity restoration action of £8.3m resulting in capital expenditure deferral of £7.3m into 2016/17 and a reduction in stocks of £1.0m.

Capital Servicing Capacity

The loan principal repayment of £5.8m and interest payable on the loans of £3.1m is due in full in 2015/16 for the first time therefore creating a lower metric score of 2. The Trust's forecast Continuity of Services Risk Rating (CoSRR) performance for 2015/16 is 3. The Trust's forecast liquidity at 31st March 2016 is -3.5 days giving a liquidity metric rating of 3. The Capital Servicing Cover (CSC) metric performance is 1.52 times, a metric rating of 2. The components of the CoSRR are summarised below:

	2015/16 Plan	
	Metric	**Score**
Liquidity	-3.5 days	**3**
Capital Servicing	1.52 times	**2**
Overall CoSRR		**3**

Rating 4	Rating 3	Rating 2	Rating 1
0 days	-7 days	-14 days	<-14 days
2.5 times	1.75	1.25	<1.25

3.4.9 Risks and mitigation

The key risks to the delivery of the 2015/16 net income and expenditure deficit plan of £5m are:

Risks to Contract Settlement

Whilst good progress has been made to date with both NHS England and local CCG commissioners, a small number of risks to income remain. The most significant of which is the final settlement on CQUINs with both groups of commissioners, and of note the impact of the nationally proposed CQUINs on achievability of income, in line with previous years and guidance issued alongside tariff options. This plan is predicated upon 80% net income achievement of CQUINs and any shortfall in this regard will import risk into the financial plan. This risk is assessed as ***medium***.

Risk of not delivering CIP

This includes the conversion of non-recurring savings to recurring schemes. Given the track record over the past three years this risk can be assessed as ***high***. Close monitoring of achievement and effective mitigation of any under-achievement will be in place. The 2015/16 target will be extremely challenging.

Risk that Performance Fines are imposed

Operational Delivery planning is the key to ensuring fines are not incurred. In addition there is no recurring budget set for any additional costs of measures to deliver performance targets other than those funded activity through SLAs so any such costs must be minimised and if recurring will require the delivery of self-funding improvements (e.g. length of stay, drug costs etc.). Due to performance issues experienced in 2014/15 and expected RTT breaches in 2015/16, this risk is assessed as ***high***.

Risk that activity is unfunded

This is unlikely due to the structure of the SLAs likely to be in place. There are issues with elective and out-patient activity which will be addressed. The risk is, however, assessed overall as ***high*** due to the National Tariff requirement for payment of additional specialised services activity at the marginal rate (of 70%). In addition, the Commissioners approach to CQUINs is

concerning such that the schemes proposed may not be deliverable and the income earned falls below planned levels.

Risk of Managing Cost Pressures

This includes inflation and other local/national pressures. The previous good track record of the Trust means that this risk is ***medium***. Likely factors both locally and nationally have been taken into account in assessing the 2015/16 plan.

Risk of External Factors impacting on the Financial Position

The Trust has limited exposure to this and has allowed for factors in the plan, for example, energy prices. Therefore the risk is assessed as ***low.***

Risk of not achieving a CoSRR of 3

The plan provides for headroom of £5.5m on liquidity to a liquidity metric of 2. Hence the risk of not achieving an overall CoSRR of 3 is ***high.***

3.4.10 Summary Statement of Comprehensive Income

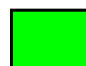
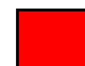
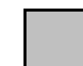
	2015/16 Plan £m
Income Operating expenditure	590.3 (558.8)
EBITDA Non-operating expenditure	31.5 (37.9)
Net surplus / (deficit)	(6.4)
Net surplus / (deficit) (excluding technical items)	(5.0)
Year-end cash **Continuity of Services Risk Rating**	43.7 **3**

3.4.11 Conclusion

The 2015/16 financial plan will require significant measures and action in order to deliver, or improve, the planned deficit of £5m. At its meeting of 31st March 2015, the Trust Board approved the draft plan submission and recognised the risks outlined above to the Trust's financial position. It was noted that as the planning assumptions firm up, savings plans are implemented and SLA negotiations with Commissioners progress to an agreed position, the Trust may need to formulate and implement further risk mitigation measures.

Annex A - Our Performance against national standards – updated to February 2015

National standard	2012/13	2013/14	2014/15 Target	2014/15[4]	Notes
A&E maximum wait of 4 hours	93.8%	93.7%	95%	92.0%	Target failed in each quarter in 2014/15
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes	57	15	15 mins	13	Target met in every quarter in 2014/15
A&E Time to Treatment (minutes) median within 60 minutes	53	52	60 mins	54	Target met in every quarter in 2014/15
A&E Unplanned re-attendance within 7 days	2.6%	1.5%	< 5 %	2.3%	Target met in every quarter in 2014/15
A&E Left without being seen	1.9%	1.8%	< 5%	1.8%	Target met in every quarter in 2014/15
Ambulance hand-over delays (greater than 30 minutes) per month	See note[5]	100.4	Zero	107.3	Target failed in every month in 2014/15
MRSA Bloodstream Cases against trajectory	10	2	Trajectory	5	Two of the five cases were contaminated samples only
C. diff Infections against trajectory	48	38	Trajectory	50[6]	Target met in every quarter in 2014/15
Cancer - 2 Week wait (urgent GP referral)	95.0%	96.8%	93%	95.8%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (First treatment)	97.0%	97.1%	96%	96.7%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94.9%	94.8%	94%	94.8%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.8%	99.8%	98%	99.7%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	98.7%	97.4%	94%	97.7%	Target met in every quarter in 2014/15
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	84.1%	80.1%	85%	79.7%	Target failed in each quarter in 2014/15
Cancer 62 Day Referral To Treatment (Screenings)	90.0%	93.8%	90%	89.4%	Target met in quarter 1 and 2 of 2014/15
18-week Referral to treatment time (RTT) admitted patients	92.6%	92.7%	90%	85.4%	Target met until June 2014, but failed thereafter
18-week Referral to treatment time (RTT) non-admitted patients	95.7%	93.1%	95%	90.4%	Target failed in every month in 2014/15
18-week Referral to treatment time (RTT) incomplete pathways	92.2%	92.5%	92%	90.4%	Target met up until July 2014, but failed thereafter
Number of Last Minute Cancelled Operations	1.13%	1.02%	0.80%	1.08%	Target failed in each quarter in 2014/15
28 Day Readmissions *(following a last minute cancellation)*[7]	91.1%	89.6%	95%	89.4%	Target failed in each quarter in 2014/15
6-week diagnostic wait	89.7%	98.6%	99%	97.4%	Target failed in each quarter in 2014/15
Primary PCI - 90 Minutes Door To Balloon Time	91.7%	92.7%	90%	92.2%	Target met in three quarters in 2014/15 (failed in Q3)

 Achieved for the year and each quarter Achieved for the year, but not each quarter  Not achieved for the year  Target not in effect

[4] Due to the timing of this report the figures shown for 2014/15 are for the year to date ending February 2015, with the exception of cancer and primary PCI, which are up to and including January 2015, and ambulance hand-over delays, which includes March 2015.

[5] Validated data not available in 2012/13.

[6] Please note, the figures quoted for 2014/15 are the total number of cases reported. However, of these, eight were deemed to be potentially avoidable against the limit of 40. For this reason this indicator is RAG rated Green.

[7] IMPORTANT NOTE: this indicator must not be confused with the mandatory indicator reported elsewhere in this Quality Report which measures emergency readmissions to hospital within 28 days *following a previous discharge*

Annex B – Our Corporate Objectives for 2015/16

We will consistently deliver high quality individual care, delivered with compassion. Specifically, we aim to:

- 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 continuing to delivering the agreed changes to our Operating Model set out in our 2014 plan.
- Achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners
- To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.
- To ensure the Trust's reputation reflects the quality of the services it provides.
- Reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.

We will ensure a safe, friendly and modern environment for our patients and our staff. Specifically, we aim to:

- To successfully complete the next phase of our Campus Redevelopment.
- Ensure Emergency Planning processes for the Trust are ‘fit for purpose’ and that recommendations from internal and external audit have been implemented
- Set out the future direction for the Trust's Estate in line with our Estates Strategy published in 2014.

We will strive to employ the best and help all our staff fulfil their individual potential. Specifically, we aim to:

- Deliver a comprehensive approach to leadership and management training and development.
- Improve Staff Engagement.
- Develop a structured marketing approach which is tailored to target staff groups, improve the speed of recruitment application to appointment
- Improve the quality and application of staff appraisal
- Education, Learning and Development: Provide high quality training and development programmes to support a diverse, flexible workforce
- Improve workforce planning capability, aligning our staffing levels with capacity and financial resource, using workforce models and benchmarks which ensure safe and effective staffing levels.

We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation. Specifically, we aim to:

- We will continue to deliver a programme to support the long-term vision that every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again.

- 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 the National Institute of Health Research (NIHR)) maintain our performance in initiating research) and remaining the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR).
- We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR).

We will provide leadership to the networks we are part of, for the benefit of the region and people we serve. Specifically, we aim to:

- Ensure organisation support for developments under the Better Care Fund.
- We will effectively host the Operational Delivery Networks that we are responsible for.
- We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care.
- We will be an effective host to the networks we are responsible for including the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and Clinical Research Network.

We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal. Specifically, we aim to:

- Deliver agreed financial plan including a minimum cash balance.
- Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas.
- Deliver the annual Cost Improvement Plan (CIP) programme in line with the Long Term Financial Plan requirements
- Ensure 2015-16 Operating Plans help to address risks to sustainability.
- Continue to develop private patient offer for the Trust.

We will ensure we are soundly governed and are compliant with the requirements of our regulators. Specifically, this will involve:

- Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above.
- Ensure all principles of good governance are embedded in practice and policy
- To achieve regulatory compliance against Care Quality Commission fundamental standards.
- Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways
- Improve cancer performance to ensure delivery of all key cancer targets
- Restore compliance with the A&E 4 hour standard from Q1 2015.

ANNEX C – PERFORMANCE RECOVERY PLAN

1 Introduction

This paper updates the Board about the performance recovery plan within the Trust's operating plan for 2015/16. It summarises the key challenges to be addressed, the key initiatives proposed at a Trust and Divisional level in response to those challenges and the implications for the Board's financial plan for the year. The paper has a significant focus on recovery against referral to treatment time targets, given its importance to the plan, but also addresses 4 hour performance and delivery of the cancer standards.

The Board is asked for formal approval of the plan prior to final submission to Monitor.

2 Structure of this paper

The paper is divided into the following sections:

- Context
- Approach to planning
- Demand assessment, for planned care and unplanned care (including cancer services)
- Capacity planning, for planned care and unplanned care (including cancer services)
- Capacity plan risks and mitigations
- Performance management framework
- Recommendations

3 Context

The Operating Plan for 2015/16 needs to respond to:

- demand for clinical services, both commissioned and un-commissioned
- regulatory compliance requirements, particularly with regard to quality and access standards and the Care Quality Commission (CQC) "should do" actions
- a range of internal and external factors affecting financial affordability and liquidity, including regulatory continuity of services requirements
- the Board's strategic intent and the resulting priorities set out in the Strategic Implementation Plan.

4 Approach

The process to develop the annual operating plan is managed by the corporate planning team, formally approved at the Senior Leadership Team each year and notified to the Board. It requires Divisional management teams to work to documented corporate guidelines to produce a range of outputs which in turn inform:

- contract negotiations with commissioners – both activity and contract terms
- joint priority-setting through the Service Delivery Group and the Senior Leadership Team, and the associated allocation of capital and revenue resources to support delivery of the agreed priorities
- Divisional operating plans.

This year, the process has been supplemented with enhanced executive support through director "buddying" arrangements and a fortnightly Chief Executive-chaired planning meeting with the senior Divisional leadership.

Final operating plans have been submitted and have been reviewed and risk assessed by the Executive Team. Given the financial and non-financial position presented by some Divisions, plans will continue to be iterated throughout the coming months. All divisions have been asked to present a balanced financial position (the key area of risk remaining within the plans) by the end of Quarter 1 (end of June 2015).

5 Demand assessment

Extensive trend analysis, both historic and prospective, has informed assessment of the core, predicted demand for clinical services next year, across all work-types in both planned and unplanned care specialties.

Schedules of activity required to meet demand include adjustments for national waiting time standards, in particular the 18 week referral to treatment (RTT) standard, where the Trust's analysis has been supported by NHS Interim Management and Support (IMAS) and the Trust's own assessment about the likely future demand for urgent care and the impact of system-wide initiatives to reduce the number of patients admitted to hospital and the number whose discharge is delayed.

The Trust and its commissioners have now reached broad agreement on planning assumptions for planned and unplanned care; where differences occur, as in previous years, these will be addressed through variable estimates in the contract.

5.1 Planned Care

The IMAS model has helped determine the specialty-level capacity needed to ensure that excess waiting list backlogs are eliminated and do not recur. The following assumptions underpin the modelling for planned care activity:

Sufficient non-recurrent activity to reduce the existing backlogs to the target level of no more than 0.7 of one week's activity for admitted pathways and no more than 5% of non-admitted pathways exceeding 18 weeks at any time.

- Sufficient recurrent activity to sustain waits at the appropriate level by "right-sizing" predicted future demand and supply, this requires significant additional recurrent capacity in a small number of specialties.
- reduction in demand for some specialities (dental and cardiology) associated with the application of geographical access criteria
- impact of trended growth, beyond demographic, where it is well evidenced - such as endoscopy, where the Trust has seen 5% growth per annum for the last four consecutive years.

Significant validation of the waiting lists has been commissioned and is on-going. Once complete, this expected to further improve the RTT backlog position. The RTT recovery trajectories are set out in Appendix 1 and current performance against the trajectories is set out in Appendix 2.

The summary outputs from the demand analysis for planned care are as follows and reflect the contract proposal put to commissioners for 2015/16:

Additional activity, over 2014/15 forecast outturn, comprising:
- 1423 additional elective inpatients (10.1% increase)
- 3250 additional elective day cases (5.9% increase)
- 4113 additional outpatient procedures (7.4% increase)
- 15,471 additional outpatient new attendances (8.86% increase)
- 24,866 additional outpatient follow ups (7.06% increase).

Approximately 50% of the elective activity growth is non-recurrent, compared to c. 25% of the outpatient activity.

5.2 Unplanned Care

The Trust's own model has been used to model the demand for urgent care activity. The following assumptions underpin the model:

- impact of the Better Care Fund (BCF) initiatives assumed to result in a 1.75% reduction in demand for urgent care, in patients over 65 in 2015/16
- impact of predicted demographic growth, based on ONS projections.

The summary outputs from the demand analysis for planned care are as follows:

Additional activity, over 2014/15 forecast outturn, comprising:
- 253 emergency admissions (0.65% recurring increase)
- 129 non-elective admissions (1.47% recurring increase)

6 Capacity Plan

Based on the demand analysis set out above, each Division has developed capacity, workforce and associated resource plans to deliver the projected activity by service line. Whilst the detail is set out below in terms of planned and unplanned care, of particular note is the critical interdependency of the two elements. Specifically, the RTT recovery plan is reliant upon uninterrupted access to the surgical bed base and theatre suite (including recovery areas), throughout the year.

6.1 Planned care

Throughput assumptions at service line have been developed to model the requirement for bed, theatre and outpatient capacity. Divisions have identified options to maximize capacity including extended days, weekend working and productivity gains such as increasing throughput on lists, and plans have been developed that will deliver these gains.

Significant changes to the use of South Bristol Community Hospital are proposed, including the establishment of paediatric theatre lists for the first time. Other technology innovations have been introduced to optimise use of the Trust's theatre infrastructure, notably investment in equipment to extend the case-mix which can be managed at St Michael's Hospital.

Delivery plans are also reliant upon a level of outsourced activity, some delivered from within Trust estate and others from independent providers such as Nuffield Private Hospital and Care UK at Emerson's Green NHS Treatment Centre.

Bed requirements for planned care have been modelled, applying current length of stay, and reducing occupancy to 90% from current levels of c. 94%. This leads to a modelled requirement for 18 fewer adult surgical beds, as a benefit from the Planned Care Programme (which has delivered a 13% reduction in length of stay). In response, ward 605 will be closed to surgical care in early April 2015.

The RTT recovery trajectories demonstrate that Trust compliance with the 95% non-admitted standard will be achieved in December 2015 and the 90% admitted standard in March 2016. Following detailed scrutiny, the Executive team has confidence that Divisional plans are commensurate with the recovery trajectories, realistic and achievable. Detail of the Divisional capacity plans is provided in Annex 3.

In summary, the physical capacity required to deliver the planned care activity is:

- 18 fewer surgical beds, within the BRI bed base
- Additional 16.5 adult theatre sessions per week and 13.5 paediatric theatre sessions
- Additional 75 adult outpatient clinics and 14 paediatric clinics per week
- Modelled requirement for 400 waiting list initiatives, 104 paediatric

Key workforce impacts are assessed to be:

- 82.75 additional consultant sessions per week
- 41 WTE additional nursing and therapy staff (excluding paediatric theatres)
- 14.5 WTE paediatric theatre staff
- 17 WTE additional administrative staff

6.2 Unplanned care

Key to delivery of the A&E waiting time standards and related standards such as cancelled operations and readmissions, is the sizing of the bed base for unplanned care services and its operation at an occupancy level commensurate with timely patient flow and appropriate skilled, substantive staffing. Without this approach, the Trust will rely upon escalation capacity, as it has this year, with the associated impact on both cost, continuity and quality of the workforce.

Whilst the BRI Redevelopment plan assumed average bed occupancy at 90%, failure to achieve planned length of stay reductions has resulted in occupancy levels regularly in excess of 95%, with additional escalation beds being established for long periods in winter.

Medicine bed capacity has therefore been re-modelled at more conservative assumptions for length of stay and an optimal bed occupancy level of 90%, resulting in requirement for 35 additional inpatient beds. 18 beds will be established on Ward A605 which is no longer required for surgical services and a further 17 established in Ward A518.

This step effectively represents the conversion of interim escalation beds to core, permanent capacity for Medicine and is a fundamental component of the plan for 2015/16. Physically

there remains no further opportunity to create “flex” capacity at peak times and, as described above, it is an important feature of the operating model the that medical emergency patients do not outlie in surgical beds. It is proposed that for the two quarters when demand is predicted to exceed the core bed base on occasions, increases in bed occupancy will be the mechanism to manage activity in the short term, with the goal of achieving length of stay reductions over time to eliminate the need. There is good evidence that, when bed occupancy is at 90% or less, length of stay can be reduced and the four hour A&E standard is more likely to be met - this will therefore be a primary focus of transformation activities in unplanned care next year.

In order to mobilise the plan set out above, additional funding has been allocated by commissioners on a non-recurrent basis. It is expected that one of the medical wards will move from core capacity to flex capacity in 2016/17 as an output of increased efficiency within the Trust and improved patient flow across the health and social care system.

The key elements of the Trust’s plan are:

- Investment in occupancy, through the establishment of an extra ward
- Investment in 7 day working
- Investments in a range of children’s Winter initiatives, all year round
- Investments in creating more sustainable workforce solutions in key areas such A&E

The workforce implications of these bids are as follows:

- 93 additional nursing staff, registered and unregistered
- 6.6 WTE medical staff
- Therapy and ancillary staff requirements (under review)

6.3 Cancer services

The most significant risks to delivery of the plans described above concern the ability to mobilise workforce and associated capacity to deliver the level of activity required.

The Trust continues to deliver mixed performance in respect of cancer standards, notably the 62 day referral to treatment standards. The reasons for this remain multi-factorial, noting that the Trust’s unusual case mix (following the transfer out of breast and urology services) carries an in-built negative risk of c. 3.5% of performance.

The most recent breach analysis demonstrates that the majority (86%) of reasons for breach are now outside of the Trust’s control - with 52% attributable to late tertiary referrals and 13% related to complex clinical pathways that cannot, by their design, be delivered in 62 days.

Commissioners have now agreed to include a CQUIN indicator in the contracts for Bristol, North Somerset and South Gloucestershire providers which affords these providers significant financial incentive for timely cancer referrals – this affects referrals to UH Bristol from North Bristol Trust and Weston which currently account for 61% of late referrals to the Trust. The Trust has asked commissioners in BaNES and Somerset to consider a similar approach for their providers.

However, 14% of breach causes are related to factors over which the Trust has greater influence and the Cancer Performance Improvement Programme continues to work on administrative delays / errors and diagnostic delays.

High impact changes to mitigate the risk of avoidable breaches include dropping the time for first review to 7 days from 14 days, addressing diagnostic bottlenecks and reducing the risk of cancellation arising from a lack of critical care capacity – this latter being the most recent issue affecting internal performance and arising from the recent surge in Level 3 critical care activity which has impact on the availability of HDU beds to support cancer pathways.

6.4 Capacity Risks and Mitigations

The most significant risks to delivery of the plans described above concern the ability to mobilise workforce and associated capacity to deliver the level of activity required.

Particular risks include:

- known national shortages of specific staff groups including consultants and theatre nursing staff / operating department practitioners;
- constraints on mobilising sufficient physical capacity in short timeframes

Each Division has been tasked with developing a Delivery Oversight Plan to which will enable close monitoring of all the key actions necessary for success. These will form the basis of performance management in 2015/16.

6.4.1 Workforce

There are two primary risks to the workforce element of the plan; these are the supply of suitably qualified staff and the timeliness in which staff are recruited, and plans therefore able to be mobilised. In respect of the former, a range of recruitment and retention initiatives are being corporately led and supported, targeted to known 'problem' areas such as theatre staffing, where London-based recruitment fairs are planned. Where there are known staff shortages, alternative workforce models have been developed - for example, in restorative dentistry a new workforce model is being introduced, utilising dental nurses instead of dental consultants.

Infrastructure to support this peak in recruitment activity is being strengthened to include additional recruitment staff and appointment panels.

Finally, recruitment plans for all specialties have been developed and where recurrent posts will not be established from the outset, non-recurrent initiatives are in place to ensure backlogs do not grow.

6.4.2. Demand management

Trust activity and delivery plans do not assume significant impacts from demand management beyond geographical restrictions on referral for restorative dentistry and interventional cardiology. However, commissioners have signalled an appetite to work on further plans in year, which have the potential to provide (an unquantifiable) benefit to recovery plans through a further reduction in demand, providing they sit outside the contract proposals.

6.4.3. Alternative supply

The Trust had a Memorandum of Understanding with local Independent Sector providers based on a National contract which highlighted that a total of c. 540 patients were to be seen and discharged by 31st March 2015; this plan was broadly delivered. In 2015/16 Divisions will build upon this to place contracts with independent providers to reduce RTT backlogs, particularly in upper GI, ophthalmology, diagnostics, gynaecology and some paediatric specialties.

The Trust has established a new model of working, with an independent supplier of theatre workforce, called GLANSO, within an innovative framework that drives productivity. This was piloted in Surgery, Head and Neck in 2014/15 and is a proposed part of delivery plans for this Division as well as for Specialised Services and Women's and Children's next year.

6.4.4. Waiting list management

The Trust implemented the new Bristol, North Somerset and South Gloucestershire Access Policy in December 2014 and key elements of the policy are included in the mandatory administrative training programme launched in February 2015.

A competency-based assessment is included to ensure that all staff are fully conversant with referral to treatment times and understand how to manage and record pathways correctly. On-going oversight of this important area has been built into the new Trust-wide Outpatients function.

The Trust has completed the design of a new Patient Tracker List (PTL) that sits directly on the Medway Patient Administration System. The PTL was signed off by IMAS in February 2015 (and commended as best practice).

These initiatives bring potential benefits to the delivery plan through the impact of further validation and improved management of waiting lists.

6.4.5. Productivity improvements

Divisional plans currently make modest assumptions about the impact of further improvements in productivity. Improvements developed in the coming year will mitigate the risks inherent in such a significant and complex plan. Related to these, are the re-design of the South Bristol Community Hospital theatre timetable and some minor physical adaptations to improve throughput in outpatient areas.

6.4.6. Clinical risk

The Medical Director continues to hold Clinical Chairs of the Divisions to account for mitigation of risk of clinical harm to patients on waiting lists.

6.4.7. Quota management

The Trust's mitigation plans currently include no proposal to restore quota management as a means of managing waiting times.

7. Performance Management of the Plans

The Trust Board will receive a monthly update of delivery against the recovery trajectories and these will be performance managed by the Strategic Leadership Team with appropriate performance management at divisional or work stream level as appropriate depending on which areas require escalation. The incoming Chief Operating Officer will be reviewing the performance management regime in light of any feedback from the Deloitte Well-Led Governance Review.

8. Summary

It is noted that this report gives assurance that:

- the Executive Directors have overseen a robust approach to the development of the Operating Plan for 2015/16, and the Divisional Plans that underpin it, taking account of the need to deliver sustainable compliance against Monitor's Risk Assessment Framework in a realistic timescale
- the Executive Directors are sighted on the risks to contract settlement and operational delivery and have set out mitigations to offset the risks
- performance management arrangements exist and will be enhanced as appropriate to ensure early identification and remedy of risks to delivery next year.

Robert Woolley

Chief Executive

22 April 2015

Appendix 1a

RTT/PAS specialty	RTT ONGOING performance												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total paediatric admitted backlog	916	837	757	686	589	541	473	401	359	267	206	147	91
Total adult admitted backlog	856	874	776	662	590	529	468	419	409	394	384	374	374
Total paediatric non-admitted backlog	681	601	524	436	394	350	315	289	272	262	253	248	243
Total adult non-admitted backlog	1388	1319	1229	1180	1154	1115	1076	985	921	863	803	774	742
Total paediatric backlog	1597	1438	1281	1122	983	891	788	690	631	529	459	395	334
Total adult backlog	2244	2193	2005	1842	1744	1644	1544	1404	1330	1257	1187	1148	1116
Trust total backlog	3840	3631	3287	2964	2727	2535	2332	2093	1961	1786	1646	1543	1450
Trust total ongoing pathways (estimate)	32000	31750	31500	31300	31150	31050	31000	31000	31000	31000	31000	31000	31000
Trust level RTT Ongoing performance	88.0%	88.6%	89.6%	90.5%	91.2%	91.8%	92.5%	93.2%	93.7%	94.2%	94.7%	95.0%	95.3%

Please note: the Trust total ongoing pathways is an estimate, based upon the existing pathways numbers and the likely impact of validation each month. It should be noted that whole scale validation of pathways held on Medway is underway, and the estimate of the number of open pathways may need to be amended in light if this, and prior to the move to reporting directly off Medway.

RTT/PAS specialty	RTT NON-ADMITTED performance												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total paediatric backlog	732	633	552	459	404	359	323	296	279	269	259	254	249
Total adult backlog	1492	1388	1294	1242	1184	1144	1104	1010	945	885	824	794	761
Total paediatric backlog (less validation)	681	601	524	436	394	350	315	289	272	262	253	248	243
Total adult backlog (less validation)	1388	1319	1229	1180	1154	1115	1076	985	921	863	803	774	742
Trust total backlog	2068	1920	1754	1616	1548	1465	1391	1273	1193	1125	1056	1022	985
Forecast total non-admitted clock stops	7288	7288	6923	8017	8381	7288	8017	8017	7652	7652	7288	7652	8381
Forecast total non breaching clock stops	6501	6501	6176	7151	7476	6574	7359	7407	7162	7270	6931	7285	7979
Forecast performance	89.2%	89.2%	89.2%	89.2%	89.2%	90.2%	91.8%	92.4%	93.6%	95.0%	95.1%	95.2%	95.2%

Please see the note under Ongoing pathways, relating to the potential risk around the accuracy of the forecast performance and backlog levels.

RTT/PAS specialty	RTT ADMITTED performance												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total paediatric backlog	916	837	757	686	589	541	473	401	359	267	206	147	91
Total adult backlog	856	874	776	662	590	529	468	419	409	394	384	374	374
Trust total backlog	1772	1711	1533	1348	1179	1070	941	820	768	661	590	521	465
Forecast total admitted clock stops	2895	2895	2750	3184	3329	2895	3184	3184	3040	3040	2895	3040	3329
Forecast total non breaching clock stops	2316	2322	2222	2573	2690	2377	2684	2754	2650	2693	2591	2729	3006
Forecast performance	80.0%	80.2%	80.8%	80.8%	80.8%	82.1%	84.3%	86.5%	87.2%	88.6%	89.5%	89.8%	90.3%

Please see the note under Ongoing pathways, relating to the potential risk around the accuracy of the forecast performance and backlog levels.

Appendix 1b

RTT/PAS specialty	ADMITTED - Monthly backlog size															
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Paediatric ENT	342	300	260	240	180	162	139	102	76	46	30	20	13	13	13	13
Paediatric T&O	160	120	110	90	85	80	75	70	60	50	38	24	18	12	6	6
Paediatric Surgery & Urology	190	200	180	160	150	140	120	110	119	67	48	34	16	16	16	16
Paediatric plastic surgery	130	115	110	105	95	90	80	70	60	60	50	35	15	8	4	4
Paediatric Max Facs	28	28	27	25	21	17	14	10	8	8	7	4	1	1	1	1
Paediatric Cardiac Surgery	12	12	11	10	9	8	7	6	5	5	4	3	3	3	3	3
Paediatric Cleft	18	18	17	16	15	14	12	10	8	8	6	4	2	2	2	2
Gynaecology	30	50	45	28	26	26	26	26	26	26	26	26	26	26	26	26
Ophthalmology	140	180	155	126	126	126	126	126	126	126	126	126	126	126	126	126
Adult Orthopaedics	15	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13
Colorectal	25	65	60	55	50	45	40	35	30	20	10	10	10	10	10	10
ENT	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Upper GI	175	118	110	100	79	53	29	15	15	15	15	15	15	15	15	15
Maxillo facial	10	18	15	12	9	9	9	9	9	9	9	9	9	9	9	9
Oral Surgery	55	77	67	57	46	46	46	46	46	46	46	46	46	46	46	46
Paediatric dentistry	14	22	20	18	12	8	4	1	1	1	1	1	1	1	1	1
Thoracic surgery	17	13	11	11	11	11	11	11	11	11	11	11	11	11	11	11
Cardiology	280	250	220	190	160	130	100	70	65	60	60	50	50	50	50	50
Cardiac Surgery	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Dermatology	65	48	38	28	28	28	28	28	28	28	28	28	28	28	28	28
Other - paediatric	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22
Other - adult	22	20	20	20	20	20	18	18	18	18	18	18	18	18	18	18
Total paediatric	916	837	757	686	589	541	473	401	359	267	206	147	91	78	68	68
Total adult	856	874	776	662	590	529	468	419	409	394	384	374	374	374	374	374
Trust total	1772	1711	1533	1348	1179	1070	941	820	768	661	590	521	465	452	442	442

Appendix 1c

RTT/PAS specialty	NON-ADMITTED Monthly backlog size															
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Paediatric medicine	55	45	35	25	19	19	19	19	19	19	19	19	19	19	19	19
Paediatric respiratory medicine	35	24	18	11	11	11	11	11	11	11	11	11	11	11	11	11
Paediatric T&O	190	175	155	130	115	95	75	55	45	40	35	30	25	25	25	25
Paediatric surgery and urology	60	55	55	50	45	40	35	30	26	24	22	22	22	22	22	22
Paediatric dermatology	40	35	30	24	20	16	16	16	16	16	16	16	16	16	16	16
Paediatric cardiology	45	32	24	17	17	17	17	17	17	17	17	17	17	17	17	17
Paediatric gastroenterology	52	45	40	35	25	18	10	10	10	10	10	10	10	10	10	10
Paediatric neurology	50	45	35	25	15	9	9	9	9	9	9	9	9	9	9	9
Paediatric plastic surgery	40	35	33	30	28	25	22	20	17	14	11	11	11	11	11	11
Clinical genetics	160	150	140	130	120	110	100	90	80	70	60	50	40	40	40	40
Dermatology	85	80	70	70	70	70	70	70	70	70	70	70	70	70	70	70
Gastroenterology	30	26	24	24	24	24	24	24	24	24	24	24	24	24	24	24
ENT	90	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60
Maxillo facial	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
Ophthalmology	132	132	132	132	132	132	132	132	132	132	120	110	100	100	100	100
Neurology	55	60	60	60	60	60	60	25	20	20	17	17	14	14	14	14
Oral Medicine	35	31	31	31	28	28	28	24	24	24	22	22	22	22	22	22
Oral Surgery	90	83	83	83	83	83	83	83	83	83	75	65	55	55	55	55
Orthodontics	26	50	40	30	26	26	26	26	26	26	26	26	26	26	26	26
Paediatric ophthalmology	40	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22
Paediatric dentistry	35	40	35	30	27	27	27	27	27	27	27	27	27	27	27	27
Paediatric cleft	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
Periodental	31	60	45	35	26	26	26	26	26	26	26	26	26	26	26	26
Physiology	25	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15
Restorative dentistry	366	320	300	300	280	260	240	200	150	100	74	74	74	74	74	74
Pain Relief	20	19	17	15	13	13	13	13	13	13	13	13	13	13	13	13
Orthopaedics	42	42	42	42	42	42	42	42	42	42	42	42	42	42	42	42
Cardiology (including GUCH)	170	150	130	110	100	90	80	75	75	75	75	75	75	75	75	75
Other paediatric	70	60	50	40	40	40	40	40	40	40	40	40	40	40	40	40
Other adult	120	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90
Expected impact of validation	-156	-101	-92	-85	-40	-38	-36	-33	-31	-29	-27	-26	-25	-25	-25	-25
Total paediatric	732	633	552	459	404	359	323	296	279	269	259	254	249	249	249	249
Total adult	1492	1388	1294	1242	1184	1144	1104	1010	945	885	824	794	761	761	761	761
Total paediatric (less validation)	681	601	524	436	394	350	315	289	272	262	253	248	243	243	243	243
Total adult (less validation)	1388	1319	1229	1180	1154	1115	1076	985	921	863	803	774	742	742	742	742
Trust total	2068	1920	1754	1616	1548	1465	1391	1273	1193	1125	1056	1022	985	985	985	985

Appendix 2a

RTT Non-admitted backlogs (over 18-week waiters)

Please note - this table only shows specialties with significant backlogs, although Divisional totals show all over 18-week waiters

	End April	End Nov	End Dec	End Jan	End Feb	End March	Current week	April RTT trajectory	variance
							April		
			Trajectory	**2455**	**2044**	**2068**	**1920**		
Clinical genetics	115	147	167	151	181	205	246	150	96
Paed cardiology	25	50	57	65	70	50	49	32	17
Paed gastro	35	48	50	47	31	28	37	45	-8
Paed T&O	17	164	176	146	131	68	70	175	-105
Paed dermatology	7	64	48	37	21	38	39	35	4
Paed endocrinology	4	88	15	12	10	13	9	Inc in other	
Paed medicine	8	41	65	37	35	35	32	45	-13
Paed neurology	9	46	58	34	22	20	17	45	-28
Paed plastics	0	26	37	43	46	36	26	35	-9
Paed respiratory med	9	33	43	28	30	18	17	24	-7
Paed spinal	0	17	17	39	37	28	29	Inc in other	
Paed surgery	6	18	24	17	23	25	23	25	-2
Paed urology	24	31	31	29	20	25	27	30	-3
W&C Total	**282**	**837**	**859**	**751**	**698**	**645**	**693**		693
Colorectal Surgery	11	9	9	7	8	11	31	Inc in other	
ENT	100	101	78	44	20	31	59	60	-1
Max Facs	1	35	25	15	8	10	14	15	-1
Neurology	0	49	52	46	65	89	97	60	37
Ophthalmology	11	89	104	81	53	53	68	132	-64
Oral med	177	62	34	19	14	24	34	31	3
Oral surgery	18	66	79	54	41	37	52	83	-31
Orthodontics	41	28	29	41	49	56	66	50	16
Paed dentistry	15	54	48	39	29	37	56	40	16
Paed ophthalmology	1	56	70	59	35	11	19	22	-3
Paed cleft	0	0	47	87	16	2	3	20	-17
Periodontal	116	74	86	63	75	79	96	60	36
Pain Relief	23	2	28	15	16	10	11	19	-8
Physiology	0	7	34	59	47	40	30	20	10
Restorative	181	225	237	251	301	340	377	320	57
T&O	36	51	40	28	26	17	23	42	-19
Surgery total	**743**	**984**	**1089**	**937**	**827**	**863**	**1076**		
Cardiology	82	99	141	101	132	132	180	130	50
GUCH	19	50	44	39	20	17	15	20	-5
Specialised total	**106**	**152**	**186**	**141**	**154**	**157**	**222**		
Dermatology	8	60	67	62	72	90	99	80	19
NCC-Diab Spec Nurse	4	13	15	0	3	4	7	Inc in other	
Endocrinology	6	7	9	9	8	7	15	Inc in other	
Gastroenterology	16	42	37	36	41	39	58	26	32
Hepatology	28	19	7	4	1	4	15	Inc in other	
Medicine total	**95**	**171**	**171**	**140**	**139**	**161**	**227**		
Chemical pathology	1	2	2	2	0	0	0	Inc in other	
Diagnostics & Therapies total	**1**	**2**	**3**	**3**	**1**	**0**	**0**		
Trust Total	**1482**	**2146**	**2308**	**1972**	**1819**	**1826**	**2218**	**1871**	

Other paed	60
Other adult	90
Less validation	101
Total in trajectory =	**1920**
Overall position	298

Appendix 2b

RTT Admitted backlogs (over 18-week waiters)

								April
				Trajectory	1857	1819	1772	1713

Please note - this table only shows specialties with unsustainable backlogs, although Divisional totals show all over 18-week waiters

	End April	End Oct	End Nov	End Dec	End January	End Feb	End March	Current week	April RTT trajectory	variance
Gynaecology	73	41	47	52	55	68	68	57	50	7
Paed T&O	98	96	92	90	92	85	73	71	120	-49
Paed ENT	96	220	267	285	260	266	243	251	300	-49
Paed plastics	49	83	87	98	93	87	75	86	115	-29
Paed urology	0	40	58	53	55	60	59	50	70	-20
Paed surgery	135	81	84	100	104	87	82	88	130	-42
W&C Total	**478**	**586**	**664**	**737**	**706**	**703**	**674**	**677**		677
ENT	27	13	14	7	5	7	19	23	10	13
Colorectal surgery	46	54	47	46	47	59	71	75	65	10
Maxillo facial	15	17	16	13	19	19	26	26	18	8
Ophthalmology	253	163	205	231	207	216	189	203	180	23
Oral surgery	39	82	99	91	78	83	68	80	77	3
Paed cleft	3	12	14	18	12	9	5	7	18	-11
Paed dentistry	5	17	17	16	23	22	25	24	22	2
Thoracic surgery	25	30	33	27	18	18	13	15	13	2
Upper GI	85	165	179	189	168	127	110	91	118	-27
T&O	21	37	27	29	11	9	11	16	13	3
Surgery total	**526**	**603**	**659**	**681**	**605**	**587**	**558**	**584**		
Cardiology	197	247	236	285	270	248	194	44	12	32
Cardiac Surgery	17	19	26	24	29	31	32	214	250	-36
Specialised total	**219**	**266**	**262**	**309**	**299**	**280**	**226**	**258**		
Interventional radiology	0	0	1	1	1	0	0	0	inc in Other	N/A
Diagnostics & Therapies	**0**	**0**	**1**	**1**	**1**	**0**	**0**	**0**	inc in Other	N/A
Dermatology	46	42	34	79	61	57	57	59	48	11
Sleep study				7	4	0	4	9	inc in Other	N/A
Medicine total	**59**	**46**	**38**	**86**	**66**	**57**	**61**	**68**		
Trust Total	1282	1501	1624	1814	1677	1627	1519	1587	1629	

Other paed + paed max facs + paed cardiac surgery	62
Other adult	22
Total in trajectory =	1713
Overall position	-126

Annex D – An update on our response to the report of the Care Quality Commission

Part 1 – Internal Actions and Progress. This section is a summary of internal actions taken to respond to the CQC report.

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
Diagnostic and screening procedures; Treatment of disease, disorder or injury	The fracture clinic was not a safe environment in which patients were to wait for and receive treatment (risks associated with the ongoing building work).	The programme of works has been completed and the risks addressed. Continue to use the standard construction industry Health and Safety Risk Assessments/Method Statements (which include consideration for patients, staff and visitors). This will be recorded in the standard operating procedure (SOP) and will be audited by the Clerk of Works regularly	Complete	A check list has been produced and will be audited by Facility and Estates Quality Assurance & Systems Manager on a monthly basis in line with the monthly Trust audit reporting on compliance and risk. The SOP was updated on 12 January 2015 and auditing will be undertaken monthly – first audit planned for 16 February 2015.
	Not all fire exits were clear and accessible	The Fire officer now walk all corridors on a two week basis to audit the 'housekeeping' of fire exits	On-going	All fire exits have been included on an inspection schedule for inspection on a monthly basis by F&E - Quality Assurance & Systems Manager. A report will be produced with information obtained from the fire exit inspection audit; the report is to be submitted to the Director of Facilities & Estates by the end of each month for inclusion in Trust audit reporting on compliance and risk. Any failures are been addressed immediately and escalated to ward/department managers. These will be audited as per our audit plan. We continue to communicate verbally to staff the importance of keeping exists clear during our inspections. Findings from recent audits: We are still finding exits blocks and we are escalating in accordance to our SOP which involves issuing internal 'Non Compliance Notice'

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	There were not always sufficient numbers of suitably qualified, skilled and experienced staff employed on surgical wards and in operating theatres.	1. Matrons will continue to review staffing levels, across all wards, on a daily basis. 2. Monitor low staffing incidents, within Divisional and Trust governance arrangements. 3. Develop additional actions to address high vacancy rates in key areas, notably theatres and surgical wards, including: a) Appointment of Recruitment Lead Nurse for Division of Surgery, Head & Neck b) Embark upon international recruitment venture for hard to recruit posts, commencing with theatres. c) Review merits of introducing new Recruitment and Retention premia in hard to recruit areas d) Utilise advance block booking in theatres for bank and/or agency staff, to reduce risk of unfilled shifts 4. Undertake work to better understand reasons for high turnover of staff in some areas (theatres and ward 700) 5. Augment registered staffing establishment by 1wte on weekend days (ward 700) 6. Augment registered staffing establishment by 1wte on weekday nights to provide additional support (wards 602, 604, 605) to meet Trust recommendation guidelines of 1:8 7. Review adequacy of staff of evening hours (Queen's day unit recovery)	Actions 1, 2, 5 and 6 are complete. All residual actions: 31 March 2015	Action 3a: Theatres have temporarily appointed Sister and lead ward Matron. Action 3b: Working closely with our HR Business Partner and Head of recruitment and retention on this initiative – currently assessing the need across the Trust. Action 3c: Awaiting feedback from review at Trust senior level. Action 3d: This is in place in Theatres and ward areas and working well. Action 4: HR Business Partner has investigated the turnover of the staff in HGT and A700 – the theme that transpired was that some staff who have left A700 found the ward too big and wanted to work on a smaller ward. Recruitment in both areas highlighted has picked up and active recruitment continues. Action 5: complete – staff member recruited. Action 7: Surgical Trauma Assessment Unit (STAU) has moved to a new ward with increased staffing for out of hours. Queens's day unit work closely with Heygroves Theatre (HGT) to reduce the risk to the patients and a SOP has been produced to clarify the requirement for staff.
Diagnostic and screening procedures	Not all staff on medical wards were able to attend and carry out mandatory training,	During 2013/14, the Trust undertook a comprehensive review of Essential Training (Mandatory & Statutory training) and	31 March 2015	In relation to the actions, we have continued to monitor the trajectory. January compliance for the Trust was 83%; Medicine was 82% against a target of

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
Treatment of disease, disorder or injury	particularly annual resuscitation training, in order to care for and treat patients effectively.	implementing revised training topics, new training programmes and a new teaching and learning portal. 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. The Division of Medicine has an overall plan for achieving Essential Training compliance, in line with the Trust KPI with a specific trajectory for resuscitation training. Ward sisters will now maintain their own departmental spreadsheet and ensure staff are booked on necessary training. During appraisals ward sisters will identify staff that may become non-compliant and ensure forward planning for training is in place.		81% for January. Reports showing gaps in divisional compliance will be circulated during w/c 9th February and will identify staff need to attend their update training and those who are due to become non complaint within the next month. The Trust experienced periods of black escalation during January, however training continued, with the Medicine division ensuring that staff were released for their training, in particular attending Resuscitation training. A letter was sent to all non-compliant staff week commencing 16th February from the Chief Executive reminding staff to complete their Essential training before 31st March 2015.
Management of medicines	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.	Medicines security within the Trust will continue to be audited on an ongoing basis. Results of the ongoing audits will be presented to the Medicines Governance Group (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. The Local Security Management Specialist will be alerted to any clinical areas of concern in order to investigate potentially poor practice. A risk assessment has been completed	Secure drop box roll-out 31 March 2015 NHS Protect self-assessment 30 June 2015 Expansion of Pharmacy 'top-up' service 1 September 2015 (if approved)	The further roll-out of secure drop boxes has been undertaken and completed for the adult central site departments. The paediatric wards and SBCH will be completed by March 31st 2015. Some software problems have arisen with the bar-code scanning and these are being resolved at present. The repeat 'NHS Protect Medicines Security' self-assessment will commence in April 2015 following the present ward reorganisations, so will be completed by June 2015. Operating plan submitted for the expansion of 'top-

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
		regarding the issues raised concerning the Controlled Drugs 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. This process is presently being extended to a number of clinical areas. 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. Intermittent audit is undertaken, and the 'NHS Protect Medicines Security self-assessment' has been completed and action plan implemented within 2014/15. 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. The Trust is currently implementing the recording of room temperature for ward and department treatment rooms. 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).	Trial of medicines storage will be piloted 2015/16 NICE red flag 28 February 2015	up' service 1; awaiting outcome. Major capital proposal submitted for trial of medicines storage; awaiting outcome. Ongoing – reports to be reviewed at March, May and July Medicines Governance meetings to provide assurance that process is operating effectively.
Surgical procedures	Patients whose surgery was cancelled did not always have	Develop a Standard Operating Procedure (SOP) which describes the actions required to ensure	SOP 31 January 2015	The Standard Operating Procedure was taken to the Nutrition and Hydration Group on 12 Jan 2015 and

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
Treatment of disease, disorder or injury	their nutritional needs met.	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	Policy approval and dissemination February 2015	requires further amendments prior to approval. Amendments will be taken back to the March meeting for approval. Final approval is required by Clinical Quality Group – end of March/beginning April.
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Patient records in outpatient clinics were not always stored securely and were not always available to clinicians when required.	1. Reminder to be sent to all services of the need to store notes safely and out of view. 2. Develop a short training presentation for services to share with teams. 3. Measure initial compliance via a small audit. 4. Ensure that there is access to clinical records out of hours by Clinical Site Managers. 5. Review the flow of patient records within outpatient areas to ensure they are secure at all stages of the process. 6. 3-6 monthly audits to be undertaken on a Trust-wide basis (all areas of the Trust to be	31 March 2015	Action 1: All Health Records Managers within the Trust will be instructed that they must inform the appropriate management teams in their hospital(s) of their responsibility that Outpatient notes stored within their area(s) must be stored securely pre, during and post clinic. Entry to be submitted in Newsbeat on a 3 monthly basis, to remind all departments re case note security. Local managers will need to manage and monitor compliance. Action 2: PowerPoint slides Action 3: Health Records Management team to

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
		included over a 12 months period) to ensure patient notes are being stored securely in outpatient clinic areas. 7. Check patient record security in the Trauma & Orthopaedic clinic post the completion of the major refurbishment work. 8. Continue the Trust-wide 6 monthly 2 week audit of outpatient missing case notes. 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.		initiate audits within departments, that should then be reviewed locally and then by the Health Records Management team and the Trust Clinical Record Keeping Group Action 4: In progress. Action 5: This needs to be undertaken locally by appropriate Manager(s). Should form part of regular local audits. Action 6: A plan needs to be agreed. Vince Coombes will organise a 3 monthly visit to various areas. A plan will be produced. Action 7: Site visits in February (17/2) and June (4/6). A brief post visit report to be produced. Action 8: This work is already in progress. Go-live at St Michaels Hospital (STMH) is planned for 18th May. Then ongoing roll-out Trust wide.
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	The trust had not ensured that all resuscitation and safety equipment was checked regularly and available for use in the event of an emergency.	All resuscitation and safety equipment will be checked after every use, or monthly. A new daily check list has been devised, providing further clarification of requirements for items of equipment on resuscitation trolleys which require daily checks. The checklist requires a staff signature confirming that the checks have been carried out. Annual check/audits will be carried out by the Resuscitation Services Team.	Resuscitation checking on-going Issuing of daily checklist complete Annual audit 31 March 2015	Carried out by the wards and evidence of this provided by Resuscitation team. Complete. The annual audit is on track to be carried prior to 31 March 2015. Once complete a written report will be provided by Resuscitation team
Diagnostic and screening procedures Surgical	On the A&E department's observation ward, same-sex accommodation was not provided in accordance with	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.	Single-sex accommodation 31 January 2015	The bathroom signs are in place (action complete). Compliance is being monitored daily via the ED co-ordinator and recorded.

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
procedures Treatment of disease, disorder or injury	guidance from the Department of Health, to protect the dignity of patients. Patients who remained in recovery areas overnight did not always have their privacy and dignity maintained.	A request has been made to the Clinical Commissioning Group regarding a single sex exception for the A&E Observation Bay. Privacy and dignity in Recovery: Work closely with the site team to avoid patients being placed in Recovery. 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.	Privacy and Dignity in Recovery completed	The draft SOP for the operational management of Single sex accommodation has been written and is being followed in Emergency Departments Observation. This SOP is currently in draft format pending feedback from CCG of their agreement.

Part 2 – Improving Patient Flow. This section is a summary of actions we are taking with others in our local health economy, in response to the report of the Care Quality Commission

Update on the progress against the CQC System Action Plan to support flow within University Hospitals Bristol

Regulation and activity: Diagnostic and screening procedures, Surgical procedures, Treatment of disease, disorder or injury

How the regulation was not met: 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.

Process

The CQC system action plan has been incorporated into the existing and on-going whole system 4 hour recovery plan. The plan is owned and regularly monitored by the Bristol Urgent Care Working Group (UCWG) 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 signed off the plan in January 2015.

There are 6 organisational elements to the action plan that address A&E queue, mental health needs, discharge and admission avoidance to deliver sustained improvement to patient flow. Initial progress against plans was reviewed by the UCWG at their January 2015 meeting and a detailed reporting mechanism agreed. Further progress against organisational actions was reviewed by the UCWG on 26th February 2015 and the progress is detailed below.

Progress

Progress has been made in securing the staff resource and capacity to deliver the workstreams and mitigation has been put in place (mainly by utilising bank staff), where recruitment has been delayed; as well as embedding and mainstreaming the new service models and functions. There has been an increase in referrals to alternative pathways to ED, better use of direct access pathways and increase in reablement. The 'Green to Go' list (medically fit patients waiting for community/social care supported discharge) was at its lowest at 40 on Wednesday, 11th March. Recognising that further improvements still need to be realised, the focus is now in removing blockages and resolving delays, and further promotion amongst staff to optimise utilisation and delivery.

Progress by organisational action plans:

Action	Who is the action?	Resource required if any?	Date when actions will be completed	Update on actions
System flow plan 1: To use a dedicated Clinical Advisor (CA) resource to review calls with A&E dispositions and ensure only appropriate onward referrals take place to reduce of A&E attendances by the utilisation of an alternate Pathway, reduce unnecessary hospital admissions via A&E, achieve more streamlined flow of care throughout the Urgent Care system, 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, achieve delivery against the target of 5% for referrals to A&E (transfers from 111 to A&E).	Head of NHS 111, SW Care UK	2 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 has been allocated.	15.12.2014	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%. Overall in January, of the 351 calls to the ED intervention line, 242 patients (69%) were referred to a destination other than the original disposition of 'Attend Emergency Department'. Overall in February, out of 25,382 calls answered by NHS111 2,186 were advised to attend ED in BNSSG. This is equates to 5.5% against a target of 5%.

System flow plan 2: Increased target for direct referrals from ambulance paramedics to the GP Support Unit (GPSU) as part of an existing pilot to further reduce pressure at Bristol Royal Infirmary A&E by reducing A&E attendances and to provide patients presenting with medical conditions with the most appropriate care pathway, improve patient flow within the BRI, improve patient experiences and standardise medical assessment/admission procedure between primary care and the ambulance service. The revised target is 3 referrals/day Provision of dedicated Hospital Winter Pressure Patient Support Vehicles. Additional PSV grade ambulance resources have been commissioned for the winter pressure period. The dedicated Hospital Winter Pressure PSV vehicles are in place to carry out discharges and transfers for the BRI. 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	Head of Operations (North), SWASFT		31.01.2015	The target of 3 referrals per day has not been met consistently during December-February. Two weeks, w/c 15.12 and 5.1 referrals reached 14 and 12 respectively. The average number of referrals per week was 7 in December and 5 in January. This reduced to 4 in February, but w/c 2.3 saw referrals go up to 8. GPSU and SWASFT are working to promote the use of the service by: • Meeting regularly, reviewing data and identifying ways to increase referrals- last meeting on the 3rd March • Marketing campaign, by having posters in bases and in ED to promote the service to staff • All paramedics were given a letter and a laminate. SWASFT to send out more as new staff is recruited • To use the 'perfect week' to have a presence outside the ED to promote the service with staff and pose a challenge to conveyance to hospital 85% of PSV shifts (total for BNSSG) were covered in December. 94% of all BRI facing PSV shifts were covered in January, and 89% of shifts were covered in February; compared to 90% and 96% respectively for BNSSG. PSV provision has been extended till 10th April 2015.

discharge or transfer work outstanding for the vehicle). 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. 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 turnaround times and improved working relationship between primary and secondary care and the ambulance service. The HALO will also, where appropriate be responsible for redirection to the GPSU.				The HALO role has been implemented with 9/10th’s establishment from 26/1/15.
System flow plan 3: Provision of mental health support in A&E outside of UH Bristol’s Liaison Service hours, and enhanced liaison discharge support to frail and elderly people with the hospital. 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.	AWP Bristol CCG Bristol City Council	Additional non-recurrent resources have been secured	01.04.2015 01.04.2015	A Local Government Association (LGA)-led Peer Challenge on the Mental Health Act (MHA) Pathway has been completed and will report in April 2015, leading to an improvement action plan. A linked event will also be held to share learning and recommend improvements to the pathway from crisis to disposal of the affected person. The Bristol Crisis Care Concordat for Mental Health has been signed by partners, and sets out improvements to the experience of people with mental health problems, including A&E. The Concordat is committed to supporting the full implementation of newly commissioned mental health services in Bristol which will all commence by April 2015. The impact of the full implementation of the newly

				commissioned mental health services will be the availability of new services for people in mental health crisis to go to apart from A&E, such as the Mental Health Sanctuary, and additional support will be available in the new Mental Health Assertive Engagement Programme to support people to keep people engaged with services. The Concordat will also ensure greater awareness of carers of alternative support other than Urgent Care. The development of the Mental Health First Aid Training will be delivered to stakeholders and carers to assist with recognising the early onset of a crisis and ways of accessing help other than through A&E attendance.
			01.04.2015	The local offer of two Crisis Houses will continue, and Bristol CCG is investigating the option of developing a third Crisis House. The Women's Crisis House has 10 beds and usually operates at 95% capacity; The Men's Crisis House has 10 beds and usually operates at 100% capacity.
				The Psychiatric Liaison Service offered in A&E at University Hospital Bristol NHS Foundation Trust has extended its hours of operation, and workforce capacity in the Emergency Department to provide greater levels of support to people with mental health problems in A&E.
			01.04.2015	• New hours of operation From 01 October 2014 are 8am – 10pm, 7 days per week (increased from Monday to Friday 9am – 5pm • Staffing increases – an additional 4 WTE Band 7 Nurses • An WTE Consultant Psychiatrist for Older Adults in ED. This post has been filled on an interim basis since July 2014, and the substantive post holder will start in March 2015. • A Self Harm Health Integration Team has been

			01.04.2015 01.04.2015	established in the borough by Bristol Health Partners to drive improvements, learning and innovation in managing suicidal/self-harming patients in the borough • A new educational package on Self harm, which includes people with lived experience in the delivery, has been rolled out to all staff in ED and is delivered every two weeks • Personal support plans are in place for all patients who regularly present in ED following an episode of self -harm The Emergency Duty Team (EDT) has recently changed its operations to ensure they always respond to requests for MHA assessments out of hours, even if no bed has been identified, where admission is warranted. The EDT prioritises A&E assessments over other mental health assessments; however there are higher priorities such as safeguarding children that will gain more rapid assessments. Securing access to Bristol adult inpatient mental health beds on an emergency basis has improved following an Inpatient Redesign Project to reduce length of stay and further improvements in access are anticipated due to implementation of the newly commissioned mental health services. Demand for inpatient mental health beds has also reduced due to the implementation of those newly commissioned mental health services which have been operational since October 2014, such as the Assessment and Recovery and Crisis Services.

System flow plan 4: Increase in total resource to services to support facilitated discharge for patients 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 (OPAU) 7 days a week providing senior community presence in the hospital to facilitate discharge decision making and 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 and to deliver 3 additional discharges per week from 8/12/14 and 5 additional discharges per week from 26/1/15.	Deputy Director of Operations, Bristol Community Health	2 x advanced nurse / therapy practitioner 3 x senior therapist (physiotherapy)	28.02.2015 Interim capacity from mid-December 2014.	Therapy roles implemented in December 2014, Advanced Nurse Practioner role in January 2015 Model has been agreed with the services on OPAU. Bank staff being used to support community services to manage increases in activity. Targeted adverts for required posts to speed recruitment. Since in-reach to OPAU commencement, performance data shows that the service is achieving target of an average of 5 discharges per week. Recently there has been a reduction of the number of patients identified for Rapid Response in-reach. Monitoring in place to ensure this is not an ongoing issue.
System flow plan 5: Support discharge process by increasing reablement capacity to take an additional 30 people per month in total from both acute trusts as part of the BCP action to begin in April with a phasing up to 30. April's target is 10. Social Care Practitioner working with the REACT service in A&E and in the Older Persons Assessment Unit to provide information, advice and signposting, restarting care plans and undertaking quick turnaround of assessment in order to avoid unnecessary admissions and reduce length of stay. 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 expedite discharge. 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	Joint Strategic Service Manager Intermediate Care and Reablement, BCC/BCH Service Manager, Hospital/Front Door Social Work, BCC	3 OTs 12 x21 hour Reablement workers 3x Social Care Practitioners	31.03.2015	Increased Reablement provision. Fast tracked with local CQC the registration of additional beds in reablement service. Interviewing Reablement workers w/b 9th March Advertising for Social care Practitioners in Community Discharge Co-ordination Centre. Social Care Practitioner in ED - practitioner in place and extended till end of March 2016. Brokerage staff in Hospital in place. Supporting Discharge to Assess and enabling quicker sourcing and discharge to Package of Care and placements Additional community assessment staff. 3 x OTs in place to ensure quick reduction of new home care packages and reduce double handling to free up capacity for other

reduce hospital delays for people waiting for a home care or reablement services as well as avoid any risk of readmission. Social care practitioners will reduce length of stay by assessing people where case finding by the Community Discharge Co-ordination Centre would otherwise have generated a S2 to the Social Work Department, thus reducing length of stay by a minimum of one day.				discharges. Launch 2nd March 2015 OT staff now in place.
System flow plan 6: Five key actions to promote early discharge and ensure patients are cared for in the most appropriate bed: i)Reinforce the SAFER care bundles: these were introduced in April 2014	Divisional Director of Medicine, UHB		31.03. 2015 (with exception of new ward block 31.08.15)	KPIs for flow, front door and discharge developed , across all Adult Divisions Communicate to Multidisciplinary team that 3 patients to be constantly identifiable as suitable for outlying on each ward at the afternoon board round (3 before 3) Plan for each medical base ward to have an empty bed by 5pm each evening to allow for admissions overnight (90% occupancy model). Communications to all clinical teams on Standard definition of Estimated Date of Discharge, re-launch of "what makes a good and effective board round" with a consultant led peer review with feedback to multidisciplinary team
ii)Electronic completion of CM7 documentation: This project will move from manual documentation to an electronic record that can be shared easily among the multi professional team.			April 2015	Software developed for electronic CM7, successfully piloted, Rollout across medicine to be completed by 10/04/15 . Rollout to all Adult wards to be completed in April. CM7 provides information for a safe and effective discharge of a patient to Care/Nursing home or complex patient. This will ensure that there is no lost documentation, it is legible, and timely.

iii)Patient Progress MDT Meeting: The Division of Medicine will have a weekly 'patient progress' meeting to progress chase any patients whose discharged is delayed.			February 2015	Meeting held weekly with external partners (Social Care, Bristol CCG, Bristol Community Health, Intermediate Care & Reablement) including therapists Standard agenda and meeting format agreed and in place. Attendance record maintained. Actions agreed, documented and followed up. Barriers to flow are being immediately actioned with Senior staff taking responsibility to progress those barriers which can not immediately be actioned.
iv)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.			31.03.2015	All Divisions submitting detailed plans to support earlier in the day discharges, for sign off on 16/3/15 09/03/15 Medicine Division trialling extra staff to support nursing teams on wards to prepare patient for discharge. Implementation of proactive identification of early discharges for the next day enabling Discharge Lounge to proactively "pull patients". Recording of barriers to early discharge documented, reviewed with lessons learned being fed back to ward teams. Communication plan being delivered, such as posters, screen savers, team briefings etc., See Appendix 1
v)Appropriate Ward and Reducing Unnecessary Moves: 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.				

Monitor Drafting Guidance 2015/16 Operational Plan

Section 1 – Strategic Context For The Plan – max. 3 pages

We expect foundation trusts to have a robust strategy to deliver high quality care for patients sustainably. Each trust's overarching strategy should have been set out in its strategic plan submission to Monitor in June 2014.

However, strategy development and planning should be an ongoing process and we therefore expect boards to have considered if, and how, the strategy needs to evolve as part of this operational plan.

The process of evolving the strategy will involve, primarily**, a review of the performance (financial, operational and quality) of the foundation trust in 2014/15 and consideration of the trust's external environment.**

Such analysis might include, but not necessarily be limited to:

- Significant variations in performance on strategic goals or in the progress of strategic initiatives: this involves effective performance tracking and open recognition of both good and poor performance.

- Changes in the overall performance of the foundation trust, such as a deterioration in financial or quality performance (in particular we would expect some brief commentary of performance against plan in 2014/15 and drivers of any major variance), or significant missed access targets.

- Significant changes in the external environment, such as an unexpected merger of other healthcare providers, deteriorating financial stability at the commissioning organisation, the collapse of a local provider or part of the primary care system, or the emergence of previously unavailable strategic options.

- Local commissioning assumptions and affordability restraints, so the foundation trust only puts in place initiatives that the LHE has the resources to support.

- Significant changes in government or regulatory policy: such as post-election shifts in policy on access targets, tariff levels and structure; organisational restructuring; or changes in regulatory standards.

Depending on the outcome of this analysis, this section of the operational plan should briefly explain how the board has, or intends to:

1) **Recommit** to the strategy: If the strategy's underpinning assumptions are still accurate, and implementation is on track, the foundation trust is likely to recommit to the strategy. This means briefly revisiting its delivery and ongoing development.

2) **Refresh** the strategy: If the foundation trust is happy with its strategy but the external environment has changed, it may want to refresh its strategy. This would involve checking whether it needs to change any assumptions or outputs.

Recreate the strategy: If the foundation trust does not have a strategy to meet its goals –

perhaps because the LHE has changed or the trust has identified new performance issues – it is likely to need to recreate its strategy.

Section 2 - Progress against delivery of the strategy – max. 5 pages

The operational plan needs to set out how the Trust will achieve sufficient progress on its strategic agenda, ie how the strategy will be delivered over the plan period. Monitor expect this section to include:

The operational plan needs to set out how the foundation trust will achieve sufficient progress on its strategic agenda, ie how the strategy will be delivered over the plan period. We would expect this section to include:

- A summary of how the foundation trust and its LHE partners intend to respond to the 'Five Year Forward View', particularly in the context of the joint planning guidance set out in 'The Forward View into action: partnership and planning for 2015/16'.
- Translation of the strategic initiatives into goals, targets and KPIs by year, so that they are reflected in the operating plan from year one onwards.
- Clear actions to address any poor performance identified, as part of effective performance management undertaken in the strategic context.
- A summary of productivity, efficiency and CIP programmes[18], including key themes and the extent to which these are tactical or transformational schemes. This should include plans to improve efficiency and productivity through the more effective use of information and technology (may also be addressed in the capital programme).
- A description of the capital programme, with particular reference to how it supports the strategic agenda.
- How resources have been reallocated over the period to reflect strategic priorities. This will mean agreeing responsibility for delivery and providing individuals with the support they need.

Section 3 - Plan for short-term resilience

Progress against the long-term sustainability agenda should also be balanced with the need to improve resilience in the immediate term. The latter should involve consideration of the Trusts quality priorities, its operational requirements for the period, and what this all means for the financial forecasts.

Quality priorities – max. 2 pages

The foundation trust should have a series of **quality priorities** for the next year, which connect to the needs of the local population and to the NHS mandate. It should do this by considering:

- national and local commissioning priorities
- the foundation trust's quality goals, as defined by its strategy and quality account
- an outline of existing quality concerns (from Care Quality Commission or other parties) and plans to address them
- the key quality risks inherent in the plan and how these will be managed.

Operational requirements – max. 3 pages

Foundation trusts should outline their assessment of **operational requirements** over the next year, based on robust activity and capacity modelling, and building on lessons from this year's winter and system resilience planning. This section should cover:

- an assessment of the inputs needed (such as physical capacity, workforce, workforce development, IT and beds), based on the foundation trust's understanding of its expected activity levels
- an analysis of the key risks, and how the foundation trust will be able to adjust its inputs to match different levels of demand.

Financial forecasts – max. 7 pages

This should all connect to the **financial forecasts** in the foundation trust's final operational plan. These will comprise one year of financial projections, and should be well-modelled and based on reasonable assumptions.[19] The forecasts should also be supported by a clear financial commentary narrative.

Collectively these should articulate the impact of:

1) **financial pressure,** being the local reflection of the planning assumptions set out in the joint planning guidance preceding this document

2) **activity,** relating to underlying demand movements and the impact of commissioning intentions

3) **other** key movements, such as investment in quality or non-recurrent income or expenditure

4) **Strategic initiatives,** such as, but not limited to, CIPs, service developments and transactions.

The financial template has been refreshed for 2015/16 to reflect these four key drivers, and it now has a number of summary tables and bridges which you may wish to include in the narrative document to support the commentary.

The first three items of the list above collectively represent the baseline or 'do nothing' scenario. The strategic initiatives (in item four) are the tactical and transformational responses by the foundation trust designed to close this gap.

The narrative financial commentary should address:

- assumptions underpinning these drivers.
- impact of these drivers on the overall financial forecasts, and in particular on forecast risk ratings and liquidity
- consideration of any sensitivity analysis[20]
- material variances between the financial projections for 2015/16 in last year's five year plan, and forecasts for the same one-year period in this year's operational plan (this should either be explained in silo or cross-referred to the strategic context).

Please note that material variances between the financial projections for 2014/15 in last year's plan and the actual 2014/15 outturn should have been covered in the strategic context.

Because of the required submission dates (27 February 2015 and 10 April 2015), each foundation trust's draft and final operational plans will be developed before a final 2014/15 year-end financial position is known. Therefore foundation trusts should use a projected year end outturn for 2014/15 based on the most up-to date and relevant information available.

We expect the 2014/15 outturn to be an accurate and carefully-considered indication of the foundation trust's year-end position. The outturn will be compared to the actual results reported in the quarter four submission. Unreasonable variances, which may constitute an indication of poor governance, may be subject to further investigation.
The template to be completed by foundation trusts for the 2015/16 quarterly submissions will also be amended, so that it reflects the key changes we have made to the annual planning template.