Agenda for the Meeting of the Trust Board of Directors held in Public
To be held on Friday 29 January 2016 at 11.00am – 1.00pm
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page No*
1. Chairman's Introduction and Apologies To note apologies for absence received	Chairman	
2. Patient Story To receive the Patient Story for review	Chief Nurse	5
3. Declarations of Interest To declare any conflicts of interest arising from items on the agenda	Chairman	
4. Minutes from previous meeting To approve the Minutes of the Board of Directors Meeting held in public on 30 November 2015	Chairman	7
5. Matters Arising (Action log) To review the status of actions agreed	Chairman	21
6. Chief Executive's Report To receive the report to note	Chief Executive	23
Delivering Best Care and Improving Patient Flow		
7. Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Chief Operating Officer/Deputy CEO	27
8. Quality and Outcomes Committee Chair's Report To receive the report for assurance	Quality & Outcomes Committee Chair	To Follow
9. Quarterly Complaints and Patient Experience Report To receive the report for assurance	Chief Nurse	77
10. Transforming Care Programme Board Report To receive the report for assurance	Chief Executive	To Follow
11. Strategic Partnerships Report To receive the report for assurance	Interim Director of Strategy and Transformation	129
12. Report on Staffing Levels January 2016 To receive the bi-annual report for assurance	Chief Nurse	141

Item	Sponsor	Page No
13. **Quarterly Research and Innovation Update** To receive the report and presentation for assurance	Medical Director	153
14. **Update on the Transfer of the Cellular Pathology Service** To receive the report for assurance	Medical Director	161
15. **Post-Project Review of the Transfer of Specialist Paediatrics** To receive the report for assurance	Chief Operating Officer/Deputy CEO	171
Delivering Best Value		
16. **Finance Report** To receive the report for assurance	Director of Finance & Information	205
17. **Finance Committee Chair's Report** To receive the report for assurance	Finance Committee Chair	To Follow
18. **Standing Financial Instructions and Scheme of Delegation** To receive the revised SFIs and SoD for approval	Director of Finance & Information	239
19. **Quarterly Capital Projects Status Report** To receive the report for assurance	Chief Operating Officer / Deputy CEO	345
Compliance, Regulation and Governance		
20. **Monitor Q3 Risk Assessment Framework Declaration (incl. Quarterly Financials)** To approve the Declaration prior to Monitor submission	Chief Executive	351
21. **Board Assurance Framework Report** To receive the Board Assurance Framework for assurance	Chief Executive	367
22. **Corporate Risk Register** To receive the Corporate Risk Register for assurance	Chief Executive	379
23. **Audit Committee Chairs Report** To receive the Audit Committee Chairs report for assurance and to approve the revised Audit Committee Terms of Reference	Audit Committee Chair	385
24. **Acute Trust Mass Casualty Response Planning** To receive the Declaration Response to note	Chief Operating Officer/Deputy CEO	403
Information		
25. **Monitor Q2 Risk Assessment Framework feedback** To receive the feedback to note	Chief Executive	409

Item	*Sponsor*	*Page No*
26. Governors' Log of Communications To receive the Governors' log to note	Chairman	413
27. West of England Academic Health Science Network – Mid Year Report To receive the report for information	Chief Executive	417
28. Any Other Business To consider any other relevant matters not on the Agenda	Chairman	
Date of Next Meeting of the Board of Directors held in public: Monday 29 February 2016, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU		

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11.00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
02. Patient Experience Story									
Sponsor and Author(s)									
Sponsor: Carolyn Mills – Chief Nurse **Author**: Tony Watkin –Patient Experience Lead (Engagement and Involvement)									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality. The purpose of presenting a patient story to Board members is: • to set a patient-focussed context for the meeting. • for Board members to understand the impact of the lived experience for the patient • for Board members to reflect on what this experience reveals about our staff, morale and organisational culture, quality of care and the context in which our clinicians work. This story explores how, by being pro-active in addressing concerns and working together, Helen Bishop (Deputy Head of Nursing for Medicine) and Kathy turned a challenging patient experience into a positive force for change. The story explains how the patient's sight loss had an impact on the care she received and details the behaviours and actions experienced by the patient which she has been able to address through offering sight awareness sessions on the ward. The patient has, subsequently, gone on to participate in other learning opportunities in the Trust. In this instance the patient chose not to make a complaint. At the moment the Trust Complaints Team are not able to report specifically on people with disabilities. However, as Datix is embedded in the service it is anticipated that this situation will change. An assessment of complaints made in the context of protected characteristics including physical and sensory impairment between April and December 2015 suggests that this incident does not reflect a formally reported trend across the Trust.									
Recommendations									
To receive the patient story, and note the context from which it was generated.									
Impact Upon Board Assurance Framework									
Implementation of the learning associated with this story supports achievement of the Trust's corporate quality objective to improve communication with patients.									

Impact Upon Corporate Risk
No links to corporate risks.

Implications (Regulatory/Legal)
Learning from feedback supports compliance with CQC's fundamental standards – regulation 9, person centred care; regulation 10, dignity and respect; regulation 12, safe and appropriate treatment; regulation 17, good governance.

Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Minutes of the Meeting of the Trust Board of Directors held in Public on 30 November 2015 at 11:00am, Conference Room, Trust Headquarters, Marlborough Street, BS1 3NU

Board members present:
John Savage – Chairman
Robert Woolley – Chief Executive
Emma Woollett – Non-Executive Director/Vice Chair
Deborah Lee – Chief Operating Officer/Deputy Chief Executive
Paul Mapson – Director of Finance & Information
Carolyn Mills - Chief Nurse
Anita Randon - Interim Director of Strategy and Transformation
Sean O'Kelly – Medical Director
David Armstrong – Non-executive Director
Guy Orpen – Non-executive Director
Lisa Gardner – Non-executive Director
Alison Ryan - Non-executive Director
John Moore - Non-executive Director
Julian Dennis - Non-executive Director

Present or in attendance:
Debbie Henderson – Trust Secretary
Alex Nestor – Deputy Director of Workforce and Organisational Development
Amanda Saunders – Head of Membership and Governance
Tony Watkin – Patient Experience Lead (Engagement and Involvement)
Rachel Smith – Corporate Governance Administrator (Minutes)
Mo Schiller – Public Governor
John Steeds – Public Governor
Clive Hamilton – Public Governor
Bob Bennett – Public Governor
Florene Jordan – Staff Governor
Sue Milestone – Patient Governor
Graham Briscoe – Public Governor
Wendy Gregory – Carer Governor
Pam Yabsley – Patient Governor
Anne Skinner – Governor
Robert Skinner – Member of the public
Jim Houlihan – Member of the public
Fiona Reid – Head of Communications
Nettie Jones – Lead Steward RCN / JUC Governor
Jo Witherstone – Senior Nurse for Quality (shadowing Carolyn Mills)
Anoushka Winton – ST3, Anaesthetics
Helen Cain – ST8, Anaesthetics
Hannah Wilson – ST7, Anaesthetics
Ben Gupto – Member of the public

132/11/15 Chairman's Introduction and Apologies
John Savage, Chairman, welcomed everyone to the meeting. Apologies for absence were received from Jill Youds (Non-executive Director) and Sue Donaldson (Director of Workforce and Organisational Development).

133/11/15 Patient Experience Story
Carolyn Mills introduced Mr Jim Houlihan, who had been invited to the meeting to share his patient experience story. The Patient Experience Story provided insight into Mr Jim Houlihan's experiences as a patient and as a Lay Representative for the End of Life Steering Group.

Mr Houlihan detailed his most recent experience whereby he had been admitted, treated and discharged from the Emergency Department within 80 minutes. He had been impressed with the care and treatment he received from the four members of staff involved in his care and the whole experience had been very positive. This had been in stark contrast to a previous experience whereby he endured a 26 hour wait on a gurney and had felt immense pressure from the medical staff to allow for his discharge but he refused due to the nature of his injury. After the most recent injury, Mr Houlihan decided not to attend his local community hospital due to a previous experience with a back injury when the decision had been made not to admit him, despite the severe pain he was experiencing. Mr Houlihan utilised Choose and Book to receive treatment in a private care setting, due to the negative experience at his local community hospital.

Mr Houlihan volunteered to join the End of Life Steering Group a number of years ago, as this had been an area of personal interest for him. He had been touched by the dedication and the conscientiousness of staff who went the extra mile for patients approaching the end of their life. The staff were to be commended for the recognition and honesty when mistakes had occurred and to know what good, quality care looked like. The lack of junior and senior medical staff on the steering group was noticeable and it was acknowledged that representatives from this staff group were important in order to raise awareness of the group throughout the different areas of the Trust.

Lisa Gardner enquired as to reasons for the lack of medical staff representation on the steering Group. Sean O'Kelly advised that Karen Forbes, End of Life Care Lead, attended the meeting but he was not certain of the constitution of the group. Alison Ryan reflected on a presentation given to the Quality and Outcomes committee by Professor Forbes, during which she had explained the difficulty in securing medical staff representation, as the medical profession predominantly perceived their role was to treat patients and the End of Life Care pathway was perceived to be an admission of failure. Sean O'Kelly advised that the Trust routinely collated morbidity data which was then fed back to the Divisions and the evidence was that the process raised awareness in Divisions of the end of life process, which would assist in generating interest from clinicians.

Alison Ryan asked Mr Houlihan his thoughts on how patients could be encouraged to engage in conversations with their families and clinicians with regard to end of life care. Mr Houlihan acknowledged the positive culture within the End of Life team towards both patients and their families, and explained that focus groups had taken place with patients to develop this further but stressed the importance in clinical staff engagement. Deborah Lee reported on an agreement that had been reached with commissioners to sponsor an initiative whereby six specialities would be identified where patients would be most likely to encounter end of life care. Each of the specialties would be required to identify an End of Life Care Champion from within the medical body whose remit would be to engage in the steering group and to also champion the cascading of the importance of End of Life Care planning.

Graham Briscoe advised that there were a number of active charities in Bristol in this genre and suggested a link be developed to those organisations in order to support the work ongoing within the Trust.

John Moore welcomed Mr Houlihan's comments with regard to his positive experience in the Emergency Department and enquired whether statistics were available on the typical wait time for patients. Deborah Lee confirmed this information could be made available.

Members of the Board expressed their thanks to Mr Houlihan for sharing his story. It was:

RESOLVED:

- **That the Board receive the Patient Experience Story for information**

134/11/15 Declarations of Interest

In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. No declarations of interest were received.

135/11/15 Minutes and Actions from Previous Meeting

The Board considered the minutes of the meeting held in public on 30 October 2015. It was:

RESOLVED:

- **That the minutes of the meeting held 30 October 2015 be agreed as an accurate record of proceedings.**

136/11/15 Matters Arising

Outstanding and completed actions were noted by the Board.

With regard to action 3, Robert Woolley confirmed that detailed plans had been put in place to meet the requirements of the Trust Development Agency and Monitor Consultation on Agency Staffing Caps for all staff groups. The consultation had concluded and the proposals had been received, with an expectation with regard to the trajectory by which the Trust would reduce the rates paid to agency staff. The Trust intended to use solely framework agencies and eliminate the use of non-framework procured agencies. A clinical exceptions process had been agreed which would allow the procurement of staff from non-framework agencies if a risk to patient safety had been identified. The expectation from Monitor would be that individual Boards would closely monitor agency staff usage, approve the exception process and review the usage of agency staff and rates of pay on an ongoing basis. Work continued to develop internal communications, development and implementation plans. Carolyn Mills confirmed that a weekly return would be provided to Monitor.

In response to a query from Emma Woollett with regard to services in Weston, Robert Woolley confirmed that the Trust continued to engage in discussions and provide support. The Sustainability Board had been established and continued to develop its short-term and long-term intentions. Discussions continued with regard to a sustainable recruitment strategy and the strategic future of the organisation. Deborah Lee advised that final discussions had taken place around the revised model of care for Emergency Gynaecology services in Weston which UH Bristol would provide in the New Year. The Board also noted

that Weston had commissioned an external review of the A&E services they currently provide in light of concerns raised related to junior doctor training.

Emma Woollett sought confirmation that the degree of urgency remained, due to the risk to UH Bristol until Weston had achieved a more sustainable position. Robert Woolley confirmed that the Trust Development Authority had appointed a Project Director and that the Sustainability Board met on a fortnightly basis to ensure momentum was monitored. UH Bristol remained aware of the risks of activity being transferred without adequate plans in place and continued to raise this as a concern.

137/11/15 Chief Executive's Report
The Board received a written report of the main business conducted by the Senior Leadership Team in November 2015.

Robert Woolley referred to the recent government spending review which provided a welcome commitment of £10bn for the NHS for the remainder of the life of the current parliament. In real terms, the funding equated to a 1% increase above inflation although it was noted that demands were in the region of 4% per annum. The requirement remained for efficiency savings and reductions to social care, public health and NHS England were expected. The announcement had been positively received but further details were awaited with regard to the commitments expected from NHS organisations, for example, progression of 7 day working.

Further to the Industrial Action planned for December, the British Medical Association and the Department of Health were to hold discussions with ACAS in a bid to avert the strike action that 98% of junior doctors voted in favour of. Plans were in place to manage the Industrial Action should it proceed as planned.

David Armstrong enquired whether the implications had been mandated for seven day working and the risks of non-compliance identified. Robert Woolley advised that a mandate had not yet been received but a baseline assessment around four individual standards had been submitted to NHS England. The Department of Health would confirm the expectations behind the implementation in 2016/17, which was expected to be phased through the remainder of the term of the current government.

Sue Silvey enquired as to the contingency plans in place to manage the Industrial Action. Robert Woolley explained that planned elective activity had been curtailed in order to focus all available resources to provide a full emergency service.

In response to a query from Graham Briscoe with regard to the use of military personnel, Robert Woolley advised this had not been discussed locally but noted that the Royal Army Medical Corps may be drafted in to assist but no details had been received. Should a major incident be declared during planned Industrial Action, all emergency services would be utilised. The British Medical Association had also stated their expectation that should a major incident be declared during a period of Industrial Action, the Industrial Action would end.

Clive Hamilton enquired as to the extent to which junior doctors were already required to work seven days a week. Robert Woolley confirmed this was already part of their contract and that the Industrial Action had been called due to a breakdown in the negotiations around the terms of the junior doctor's contract.

Robert Woolley informed the Board that the Care Quality Commission had commenced a thematic review of the care of older people in Bristol, which would apply to all partners involved in the provision of care for this patient group. The review would run until 10 December and be followed by a quality summit to discuss the findings. The review was part of the CQC's approach to assessment of "place-based care", whereby individual registered organisations were reviewed, as part of a regulatory requirement.

The Trust hosted a visit by the Chief Scientific Officer on 19 November to review the application submitted for the establishment of a Genomics Centre for the West of England, hosted by UH Bristol. An immense amount of detail had been provided and an announcement was expected on 16 December as to the outcome of the bid.

The Board noted that the Trust had received an HSJ award for 'Improving Environmental Sustainability' which had been led by Sam Willitts and 70 'Big Green' teams throughout the Trust. The award recognised the great work undertaken internally and in partnership with the Bristol Green Capital Project.

The Trust held its 'Recognising Success' awards evening on 27 November 2015 which showcased a vast range of positive work. The winners would shortly be announced on the Trust's internal website 'Connect'.

Robert Woolley advised the Board of the appointment process underway for the Clinical Chairs in each of the Clinical Divisions. A number of existing tenures would come to an end in the Spring and announcements would be made in due course.

Staff interviews had commenced as part of the Independent Review of Children's Congenital Heart Services in Bristol and would run at least until January. Sir Andrew Cash, Chief Executive of Sheffield Teaching Hospitals NHS Foundation Trust, had been appointed as the Chief Executive Advisor and the review intended to publish its report in the Spring. A number of parallel investigations continued. The Trust had also engaged in the national review of congenital heart services and a self-assessment had been submitted against the new standards.

Emma Woollett asked for an update on the transfer of the Cellular Pathology Service and Robert Woolley advised that discussions continued with the likelihood of the transfer being completed by late March / early April 2016. The final detail of the clinical models continued to be developed. In addition, the National Audit Office would conduct an update visit to the Trust in January in relation to the Histopathology Inquiry. It was agreed that a full account of the plans that had been put in place for the transfer would be reported to the Board in January.

In response to a query from Wendy Gregory with regard to the tender for provision of community child health and child and adolescent mental health services, Robert Woolley confirmed that commissioners had issued a tender for a 12 month contract to provide the service. UH Bristol had expressed its intention to be involved in the consortium comprised of Sirona, Bristol Community Health and Avon and Wiltshire Mental Health Partnership NHS Trust and to produce a collaborative response to the tender. Following the 12 month contract award, there would be an opportunity to bid for a five year contract. The Women's and Children's Division had expressed their enthusiasm for the opportunity to bid, due to the potential developments and interfaces that could follow. The Senior Leadership Team confirmed its intention to engage in the process and had the support of the Board.

It was:

RESOLVED:
- **That the Board receive the report from the Chief Executive to note**
- **That the Board receive the plans for the transfer of the Cellular Pathology Service**

138/11/15 Quality and Performance Report

Overall Performance

Deborah Lee introduced the monthly report which reviewed the Trust's performance in relation to Quality, Workforce and Access standards. Performance continued to improve and for the second consecutive month, the Trust achieved the 6 week diagnostic 99% national standard. With regard to Referral to Treatment times (RTT), the Trust had reached its most positive position since 2013 with fewer than 1000 patients waiting for surgery. Challenges remained with regard to the 62 Day GP Cancer standard but it had been positive to note that for the first time since early 2012, performance had equalled or bettered the national average. The challenges continued in Colorectal Cancer cases, which were due to capacity issues, and it was noted that if this percentage of patients had not been included in the reported figures, the standard would have been achieved in November.

A number of potential risks to the RTT standard had previously been identified, one of which related to the 'go live' of North Bristol Trust's Patient Administration System. The risk had not materialised as the implementation had been well managed and referral flows continued as expected. A further risk related to the closure of the Clinical Genetics service provided by Taunton and Somerset NHS Foundation Trust; discussions had taken place between interested parties in order to identify a solution. Closure of the service would result in a significant increase in referrals coming to UH Bristol and would have a significant impact on the Trust's RTT position.

In A&E, the standard had not been achieved in November but it had been positive to note a 2.5% increase compared to the same point in 2014, which was evidence of the continued progress. The Children's Hospital had experienced unprecedented levels of activity in November; emergency admissions had increased by 17% compared to the same period in 2014 and related to an excess in demand and not the anticipated seasonal admissions.

Deborah Lee commended the teamwork witnessed in the Children's Emergency Department during a particularly challenging period in November, and also the teams who provided support to their colleagues at that time. The key focus had been the safety of the department and its patients and no incidents occurred during the difficult period. A "Happy app" had been launched to take the temperature of staff morale and a significant difference in the comments made had been noted following the previous week's events in the Emergency Department.

Performance in the adult Emergency Department continued to disappoint. Analysis continued to ensure a culture had not developed whereby poor performance had become standard practice. However, it had been positive to note that the number of patients awaiting discharge was lower than expected at this time of year and had been positive to note. The Board also noted that the Emergency Department had treated more patients in less than four hours than previously reported.

Strong performance had been reported against the quality measures relating to the fundamentals of care, which indicated positive experiences for patients. Fewer falls and fewer

pressures ulcers had been reported, in addition to 100% compliance for completion of the WHO checklist.

In response to a query from David Armstrong about spontaneous awards for staff efforts, Deborah Lee confirmed an informal system was in place to recognise the efforts made by staff.

Lisa Gardner enquired about the absence of figures for cleanliness in October and Deborah Lee advised that she had met with Carolyn Mills to review the data and discuss concerns with regard to the rigour of responses to issues around poor cleanliness. It had been disappointing to note there were pockets of concern located within the new estate and the Board were given assurance that the senior team were sighted on this. Improvements had been made but further work was required to bring the levels of cleanliness to an appropriate standard.

Emma Woollett reflected on previous discussions with regard to cleanliness and echoed the disappointment that standards had not been maintained. Deborah Lee advised that there had been issues related to personnel identified within the department and the appropriate steps had been taken to manage this.

John Moore enquired whether a strategic review of the approach to fractured neck of femur standards had been considered in recognition of repeated failure to achieve the target. Alison Ryan explained that the Quality and Outcomes Committee had been very well sighted on this standard and that the 36 hours to theatre target should not be reviewed in isolation. Sean O'Kelly advised that there were a number of parameters to be considered in the management of fractured neck of femur and good performance had been reported against the majority of the indicators. It was acknowledged that a more holistic approach was needed to consider whether the deficit in performance with regard to length of time taken to go theatre necessitated a more fundamental review. Workforce pressures in the Ortho-Geriatric team had been recognised and it was noted that performance may deteriorate further in January with the departure of one of the locums. Despite the failure to achieve the time to theatre standard, good mortality and morbidity for patients had been reported in this area. Deborah Lee confirmed that fractured neck of femur treatment had been included in the ongoing strategic review and dialogue with North Bristol Trust would shortly commence regarding the provision of the service.

In response to a query from Julian Dennis about the timeliness of complaint responses, Carolyn Mills reported that a review of the pathways for allocation of complaint responses continued.

Emma Woollett noted the increased proportion of dissatisfaction with complaint responses and Carolyn Mills reported performance in this domain in Q2 had improved. There had been an increased level of national attention with regard to patient complaints which required the Board to focus its attention on this quality objective and it would be timely for the Board to understand the issues around management of dissatisfied complainants.

Clive Hamilton enquired as to the reason behind the low rating for food choice and quality in the Bristol Eye Hospital. Deborah Lee explained that as there were only eight beds in the eye hospital, food would only be provided occasionally to only a few people and scores would be significantly affected by poor responses.

It was:

RESOLVED:
- **That the Board receive the Quality and Performance Report for assurance**

139/11/15 Quality and Outcomes Committee Chair's Report
Alison Ryan presented the report for members of the Board on the business of the Quality and Outcomes Committee meeting held on 27 November 2015. Key issues included serious incidents and the abilities and competencies of agency staff. Safe staffing levels on wards were regularly questioned by the Committee in order for assurances to be provided with regard to adequate levels of supervision and local induction.

The Committee commended the improvement to the Referral to Treatment times and also the clarity of the detail provided in the report.
Clarification had also been provided with regard to detail around the nursing establishment.

The Committee had received a presentation on maternity services in response to the national maternity survey. The results for the Trust had been disappointing but a number of initiatives had commenced with regard to the improvement of expectations of new mothers and aspirations to achieve national levels.

Infection Prevention and Control, and hand hygiene in particular, had been discussed as it had been key factor in a Serious Incident and should be considered for inclusion in future quarterly reports.

Professor Karen Forbes, Consultant in Palliative Care, presented an update on End of Life Care and the Clinical Ethics Advisory Groups. The presentation echoed the comments made in the patient experience story about clinical engagement and involvement in End of Life care.

The Committee received assurance in relation to adherence to the policy for authorisation of medical staff annual leave.

Wendy Gregory referred to End of Life care and enquired whether links had been established with carer organisations and also asked about the number of complaints made by patients themselves, compared to complaints made by carers about the quality of information provided. Alison Ryan advised that this level of detail had not been discussed at the meeting but Carolyn Mills agreed to obtain the data to provide a response outside of the meeting. Following the presentation at the Quality and Outcomes Committee, there had been a about plans for end of life care plans which were very much focussed around the patient and their families.

Lisa Gardner enquired as to the percentage of Serious Incidents involving agency staff and Carolyn Mills notified the Board of two incidents. Alison Ryan advised that very rarely had agency staff involvement been the only factor but there had been a number of incidents whereby agency staff had been a contributory factor identified via the Root Cause Analysis undertaken.

John Moore noted the progress made with the outlier bed days and enquired how routinely patients were moved. Deborah Lee confirmed that patients were reviewed on a daily basis and moved appropriately into the right beds.

Mo Schiller, supported by Florene Jordan, referred to the whistleblowing concerns raised in Heygroves Theatres and expressed concerns that staff had contacted the CQC directly, rather than escalated concerns internally via the Trust's Speaking Out Policy. Robert Woolley explained that work continued with the Division to investigate the detail of the allegations, some of which could be addressed immediately, while others would take time to resolve. The Division had facilitated opportunities for individuals and groups to identify and address the cultural issues which had blocked the open discussions. A significant factor to note was the 29% vacancy rate in the theatre complex.

Flo Jordan thanked Deborah Lee for the gratitude shown to staff who worked under extreme pressure in the Children's Hospital. The Chairman echoed the comments made and asked that the Board's appreciation was also passed on to staff.

It was recognised that achievement of the RTT standards had provided the opportunity for formal recognition of the efforts made by staff and Deborah Lee would write to all staff to express the Board's appreciation. It was:

RESOLVED:
- **That the Board receive the Quality and Outcomes Committee Chair's Report for assurance**
- **That Carolyn Mills provide detail of the number of complaints made by patients and number of complaints by carers to Wendy Gregory, Carer Governor**

140/11/15 Quarterly Workforce Report

Alex Nestor introduced the quarterly report which provided a more detailed update than provided in the monthly reports. The report detailed the work underway to support the action plans and the forecast outturn for the end of the year. In addition, the report provided the Trust's current benchmarking position against other organisations. The Board noted the achievement of the Core Essential Training standard, due to efforts made by Divisions.

In terms of support provided to Divisions, work continued with regard to increased marketing for nurse recruitment and to reduce the length of time taken to get staff into post. Investment had been provided for training and development opportunities for staff to reduce turnover and improve retention and a pilot to manage self-certification for short-term absence had commenced in Medicines, Specialised Services and Facilities and Estates. The Chairman acknowledged the helpful benchmarking data.

Lisa Gardner queried the low percentage reported in New Deal compliance in Women & Children's. Alex Nestor advised that the Division operated a number of complex rotas but confirmed that compliance was continuously reviewed in every monthly performance meeting to ensure the Division remained on track. Sean O'Kelly advised that any gaps in a sub-speciality rota could result in a more adverse position, due to the small numbers in the teams. The Division had provided assurance of the progress made in a number of areas where low compliance had been reported and no underlying issues had been highlighted as a reason for the outliers. It was noted that the Division had experienced significant levels of stress and demand but this would not affect New Deal compliance which related solely to the complexity of the rotas in the Division.

Alison Ryan commended the team on the revised format of the paper and the ease of navigation.

John Moore welcomed the paper and reflected on the benchmarking data which highlighted the actions required to become an exemplar but also recognised the efforts that had been made and enquired whether the Trust had considered a training programme to develop management and leadership skills. Alex Nestor confirmed that approximately 800 managers and leaders had undertaken the Trust's 'people management' programme and following a discussion at the Executive Directors' meeting, it had been agreed that the content would be reviewed to ensure the programme covered all areas required and was appropriate. A more targeted approach would also be implemented with regard to future attendees of the revised training programme.

With regard to professional development for theatre and ITU nurses, Mo Schiller enquired whether there were opportunities for staff to work in different areas of the Trust. Alex Nestor advised that a proportion of the £200,000 provided for staff development had been solely for theatre staff and had been received positively. External training providers had been commissioned to provide further development opportunities. In addition, a 'transfer window' had been established to enable staff to transfer internally. It was:

RESOLVED:
- **That the Board receive the Quarterly Workforce Report for assurance**

141/11/15 Finance Report
Paul Mapson introduced the report which detailed an encouraging financial position at the end of October 2015 with a reported surplus of £0.309m, before technical items, and compared positively to the national picture. The adverse run rate in Divisions continued to be a cause for concern and non-recurring measures continued to be used to manage the position. With regard to the two major areas of concern previously reported, the nursing agency spend position remained unchanged but significant improvements had been made in the income position, which had been driven by the delivery of activity.

Surges of non-pay spend had been reported which required further investigation and related to individual pockets or trends. Whilst the Trust continued to forecast a breakeven position, there were a number of concerning trends within the Divisions to be addressed. The significant increase in emergency activity in October also had an impact.

Paul Mapson reported a reasonable cash position and the Board noted this would decline slightly in March, due to loan repayments and dividend payments. The Trust's current risk rating year to date was 3, in comparison to the forecast risk rating of 4 for the year end. It was:

RESOLVED:
- **That the Board receive the Finance Report for assurance**

142/11/15 Finance Committee Chair's Report
Lisa Gardner presented the report of the business discussed at the meeting of the Finance Committee on 24 November 2015. The focus of the meeting had been nursing agency staff spend and the committee had received a presentation from Carolyn Mills and Sue Donaldson. The presentation covered areas of over-establishment and the use of agency staff, to provide cover for sickness absence as an example. The committee also discussed training staff in the

proper procedure for utilising agency staff. The decision to commence recruitment of overseas nurses had also been discussed in detail.

Retention of staff had also been discussed by the Committee, in addition to communication between and accountability for agency staff.

The Finance Committee noted the breakeven forecast and the continued underlying spend. In terms of Divisions, Surgery, Head and Neck had been placed in special measures and a new Divisional Director had been appointed for the Division who would start in post on 4 January.

The substantially revised Standing Financial Instructions were discussed by the Committee and it was noted they would be presented to the Board once they had been approved by the Audit Committee. The team involved in the work to revise the SFIs were commended for the efforts made.

Emma Woollett referred to the cultural issues in the Cardiac Intensive Care Unit documented in the report and enquired about the scope for a cultural audit to be undertaken in order to ascertain the issues. Deborah Lee advised that there had been a number of areas where insights had indicated a less than positive culture and how this had developed. The 'Happy App' had been a particular benefit in mapping staff morale and the Board were asked reflect on how insights could be obtained earlier in areas where the culture affected the delivery of a good service and patient experience.

Clive Hamilton enquired about the overspend in Surgery, Head and Neck and the nature of the outsourcing costs. Deborah Lee explained that, as part of the development of the operating plan, an element of outsourcing had been expected for endoscopy and cataract treatment. The operating plans assumed successful recruitment for the two areas but recruitment had not been as timely as anticipated and the outsourcing continued. It was important to note that the outsourcing represented good value for money and there had been no additional costs for the Trust or the Division. A robust clinical governance framework had provided assurance that patients received the same high quality care as received within the Trust. It was:

RESOLVED:
- **That the Board receive the Finance Committee Chair's report for assurance**

143/11/15 Strategic Implementation Planning
Anita Randon presented the paper which provided an update on the implementation of the Trust's strategy and to provide assurance that the current position for delivery of the strategy was as expected. The paper also identified areas where progression had been slower than expected and provided a summary of the next steps in the delivery of the key strategic objectives. The Board were reminded of the business planning round undertaken each year and the work underway to ensure the planning process was as integrated as possible.

The Board's attention was drawn to the review of strategic choices in the five year strategy that had not progressed as intended. This had proceeded incrementally but a programme of work had not been formally structured. In order to review the implementation of the strategy, five further choices had been identified, without which other work would not progress as well. A detailed summary of the nine outstanding strategic choices had been provided on page 133 of the Board pack, along with the additional choices and a proposed

programme of work, which would require robust dialogue internally within the Trust and with strategic partners.

David Armstrong welcomed the helpful and insightful paper but felt further work would be required in order to understand how the strategy would be collectively developed, implemented and reviewed to provide assurance that the strategy had progressed. Robert Woolley agreed and suggested the Board use at a future Board Seminars to discuss further development of the areas identified. The Board were notified that a substantive Director of Strategy and Transformation would be appointed in December who would be charged with progression of the Board's requirements in this regard.

Emma Woollett referred to the previous Board Seminar which provided clarity around the strategy and expressed concern about the addition of further strategic choices. It was understood that the choices must be reviewed but concerns were raised that if the process were to be continually revisited, the choices would not be addressed and actioned. Robert Woolley explained the paper had identified that a number of elements of the strategic implementation plan were dependent on making the strategic choices required in order to create the plans for a one, three and five year implementation. Emma Woollett acknowledged the comments but expressed concerns at a delay of up to two years to address a number of the choices and felt a view should be agreed swiftly in order to provide guidance to the staff who would be required to implement it. Deborah Lee welcomed the discussion and explained that the challenge for the New Year would be to determine how to utilise the analysis to make appropriate strategic choices.
Julian Dennis complimented Anita Randon on the report and commented on the benefits of ensuring clarity around the term "innovation" and easy to understand language in future papers in this regard.

Alison Ryan welcomed the alignment of the enabling strategies and the divisional strategies and enquired as to the attendance at the Divisional workshops. Anita Randon advised that a separate detailed list of attendees could be provided and explained that attendance had been very broad and included clinical, diagnostic, workforce and finance colleagues to ensure the strategic areas were sufficiently represented to facilitate a rounded conversation.

David Armstrong suggested that an objective could be to articulate the choices in terms of success criteria and what good would look like for each of the strategic choices, as he did not feel this detail had not been included in the paper. It was:

RESOLVED:
- **That the Board receive the Strategic Implementation Plan for assurance**

144/11/15 Register of Seals
The report provided the Trust Board with details of all new applications of the Trust Seal to November 2015 since the previous report on 30 July 2015. The seal had been used more extensively in the period due to the consequential agreements following disposal of the Old Building and its subsequent developments.

In response to a query from Emma Woollett with regards to reference numbers 771 and 773, Debbie Henderson confirmed the absence of a witness was not significant as two signatories had witnessed the application of the seal.
It was:

RESOLVED:

- **That the Board receive the Register of Seals to note**

145/11/15 Governors' Log of Communications
The report provided the Trust Board with an update on governors' questions and responses from Executive Directors. There were no items outstanding.

In response to a query from Mo Schiller in respect of item 132 (Staff engagement), Robert Woolley advised this had been the subject of extensive discussions and that a new proposal for the management of executive walk rounds had been developed. The walk rounds would be divided into those required for safety and those solely to talk to and listen to staff and would commence in the New Year. Staff engagement workshops had been held throughout the year, the learning from which had been taken back to the Senior Leadership Team and one of the key themes identified had been the visibility of leaders, not just Board members but also divisional leaders, line managers and supervisors. A further piece of work was underway to develop staff with supervisory and line management responsibility.

Robert Woolley also reported that the staff survey had just closed and the results were expected in the New Year. The Executive Directors were hopeful that benefits from the work undertaken with staff and for staff would be reflected in the results. It was:

RESOLVED:

- **That the Board receive the Governors Log of Communications to note.**

146/11/15 Big Green Scheme Vision
The Board congratulated the Big Green Scheme team on their Health Service Journal Award in the Environment and Sustainability category.

Deborah Lee introduced the paper which highlighted the progress made throughout the Trust on recycling and improvements in staff who travelled to work by non-car based means. Despite a large footprint, the Trust had successfully reduced energy consumption but the most significant achievement had been the creation of 70 green champion teams who champion the agenda across the Trust. The refreshed strategy for 2015 – 2020 had set out a number of exciting and ambitious challenges across the next five years.

Julian Dennis welcomed the report but suggested the inclusion of a table which provided an estimate of the carbon savings made. Deborah Lee noted the suggestion.

Alison Ryan referred to the impact of technology and technological change which had not been explicitly referred to in the report and enquired about the impact of telehealth and the reduction of the number of patient journeys to the hospital. Deborah Lee advised that this had been evaluated as part of a service move into the community, whereby the carbon footprint had been mapped in association with the delivery of patient care in the community and the exercise demonstrated an increase in the carbon footprint due to the delivery of drugs. A methodology to map the carbon footprint had been implemented but it was not routinely measured. The Board were also advised that every new initiative or service development project was required to complete an assessment to consider the impact on the carbon footprint. It was:

RESOLVED:

- **That the Board receive the Big Green Scheme Vision update to note**

147/11/15 Any Other Business
Wendy Gregory enquired as to the recruitment procedure for hard to fill vacancies and said that it would be helpful to understand how the successes were evaluated. Alex Nestor would provide the recent evaluation of the recruitment process.

In response to a request from Wendy Gregory, it was agreed that Governors who attend the Board meeting would receive the Board pack printed in colour.

Flo Jordan reflected on a very positive meeting and acknowledged that staff concerns had been listened to and issues raised were being progressed.

Meeting close and Date and Time of Next Meeting
There being no other business, the Chair declared the meeting closed at 12.55
The next meeting of the Trust Board of Directors will take place on Friday 29 January 2016, 11.00am, the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

……………………………………..   ………………..2016
Chair   Date

Trust Board of Directors meeting held in Public 30th November 2015
Action tracker

No.	Minute reference	Detail of action required	Responsible officer	Completion date	Additional comments
Outstanding actions following meeting held 30th November 2015					
1.	**49/06/15**	A report to be provided on the detailed action plan arising from the Education, Learning and Development Strategic priorities	Director of Workforce & OD	February 2016	
Completed actions following meeting held 30th November 2015					
2.	**137/11/15**	**Cellular Pathology Services** An update to be provide to the Board of Directors on the transfer of the Cellular Pathology Service	Medical Director	January 2016	Completed: agenda item 14, 29 January 2016

Cover report to the Board of Directors meeting held in public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
06. Chief Executive's Report									
Sponsor and Author(s)									
Sponsor and author: Robert Woolley, Chief Executive									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team.

Key issues to note
The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in December 2015 and January 2016.

Recommendations

The Trust Board is recommended to note the key issues addressed by the Senior Leadership Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.

Impact Upon Board Assurance Framework

The Senior Leadership Team is the executive management group responsible for delivery of the Board's strategic objectives and approves reports of progress against the Board Assurance Framework on a regular basis.

Impact Upon Corporate Risk

The Senior Leadership Team oversees the Corporate Risk Register and approves changes to the Register prior to submission to the Trust Board.

Implications (Regulatory/Legal)

There are no regulatory or legal implications which are not described in other formal reports to the Board.

Equality & Patient Impact

There are no equality or patient impacts which are not addressed in other formal reports to the Board.

Resource Implications			
Finance	✓	Information Management & Technology	✓
Human Resources	✓	Buildings	✓

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JANUARY 2016

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in December 2015 and January 2016.

2. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the current position in respect of performance against Monitor's Risk Assessment Framework.

The group **supported** the recommendation to declare the standards failed in Quarter 3 to be, the Referral to Treatment Incomplete/Ongoing pathways standard (due to the failure in October only), the Accident and Emergency 4-hour standard, the 62-day GP and 62-day Screening cancer standards. It was also **supported** to recommend that the ongoing risks to achievement of the 62-day screening and 62-day GP cancer standards and the Accident and Emergency 4-hour standard be flagged as part of the narrative that accompanied the declaration.

The group **received** updates on the financial position for 2015/2016.

The group **noted** the quarter 3 update on achievement of the corporate quality objectives.

3. STRATEGY AND BUSINESS PLANNING

The group **approved** the Education Plan for 2016-2017, subject to any resource requirement going through the planning and resource approval process, and **agreed** further consideration be given about next steps for the education agenda, particularly embedding within Divisions.

The group **supported** a recommendation for the future strategic direction for the Cardiac Magnetic Resonance Imaging (MRI) Service and agreed that a detailed operational delivery and workforce plan be formulated.

The group **received** reports on the current position in respect of registered nursing vacancies and **supported** the need to run an overseas recruitment campaign to commence shortly, prioritising specialist nurses, particularly theatre and adult ITU nurses, subject to clarity on the costings and contract arrangements.

The group **supported** the recommendation to transfer the Clinical Genetics Services from the Division of Women's and Children's to the Division of Specialised Services, with the aim of concluding the transfer by 1 April 2016 subject to satisfactory due diligence.

The group **noted** the findings and recommendations of the Post Project Evaluation Report of the Centralisation of Specialist Paediatrics in Bristol, on its way to the Trust Board.

The group **noted** an update on the Community Child Health Partnership tender.

The group **noted** an update on the application by UH Bristol and University of Bristol for an NIHR Biomedical Research Centre.

4. RISK, FINANCE AND GOVERNANCE

The group **received** updates on the status of the transfer of Cellular Pathology to North Bristol Trust, noting the continued work on the clinical models for a small number of sub-specialties.

The group **received** a report setting out clear definitions and revised payments for additional hours worked by medical and dental staff and **agreed** an implementation date of 1 April 2016.

The group **endorsed** a process for the approval of booking agency requests above the agency price cap rules and the escalation sign-off process.

The group **noted** an update on the General Medical Council planned inspection in April.

The group **received** the Board Assurance Framework 2015/2016 Quarter 3 update prior to onward submission to the Trust Board.

The group **approved** the Corporate Risk Register report prior to onward submission to the Trust Board.

The group **approved** the quarter 2 complaints and patient experience reports for onward submission to the Trust Board.

The group received and **noted** the Quarter 3 2015/2016 Serious Incident Report.

The group **noted** three low impact Internal Audit Reports in relation to Leadership on Wards, Quality and Performance Management and Theatre Utilisation, and a medium impact Internal Audit Report in relation to a Care Quality Commission Action Plan. An update was noted on outstanding Internal Audit recommendations.

Reports from subsidiary management groups were **noted,** including updates on the Transforming Care Programme.

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

The group **received** Divisional Management Board minutes for information.

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
January 2016

Cover report to the Board of Directors meeting held in public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
07. Quality and Performance Report									
Sponsor and Author(s)									
Report sponsors: • Overview and Access – Deborah Lee, Chief Operating Officer / Deputy Chief Executive • Quality – Carolyn Mills, Chief Nurse and Sean O'Kelly, Medical Director • Workforce – Sue Donaldson, Director of Workforce & Organisational Development Report authors: • Xanthe Whittaker, Associate Director of Performance • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To review the Trust's performance on Quality, Workforce and Access standards.									
Recommendations									
The Board is recommended to receive the report for **assurance.**									
Impact Upon Board Assurance Framework									
Links to achievement of the standards in Monitor's Risk Assessment Framework.									
Impact Upon Corporate Risk									
As detailed in the individual exception reports.									
Implications (Regulatory/Legal)									
Links to achievement of the standards in Monitor's Risk Assessment Framework.									
Equality & Patient Impact									
As detailed in the individual exception reports.									
Resource Implications									
Finance		Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance	✓	For Approval		For Information			

Date the paper was presented to previous Committees				
Finance Committee	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Quality & Performance Report

January 2016

Executive Summary

Further progress was made this month in recovering performance against the access standards, with continued delivery of the 6-week diagnostic 99% national standard for a fourth consecutive month, ongoing achievement of target reductions in the total number of patients waiting over 18 weeks Referral to Treatment (RTT), and also achievement of the 0.8% national standard for the number of operations cancelled at last-minute for non-clinical reasons, for both the month and the quarter as a whole. The Trust also achieved its improvement trajectory for the 62-day GP referral to treatment cancer standard in each month of quarter 3, and is expecting to report achievement of the 85% national standard for the month of December. This is the first time the 85% standard has been met since June 2014. Further successes for the month are detailed on the Overview page of this report, alongside the priorities, risks and threats for the coming months.

Although the Trust remains on trajectory for recovery of performance against the national access standards, there continue to be risks that may slow the good progress made to date. In addition to the generic ongoing risk of high levels of referrals for outpatient appointments and diagnostic test, there remains the specific risk of future industrial action by junior doctors. Although the number of operations that had to be cancelled due to industrial action to date has been relatively low, the number of outpatient appointments cancelled has been more significant in volume terms. The impact this is going to have in lengthening the waits for patients on a non-admitted RTT pathway is not easy to determine, but is likely to be felt for several months. This will already have contributed to the small observed increase in the number of patients waiting over 18 weeks for treatment between December and January, along with the previously noted impact of patient choice to defer next steps of the pathway until after the Christmas/New Year period.

Levels of emergency admissions into the BRI increased in December relative to same period last year. The level of delayed discharges also remained above plan and those levels originally committed to by partner organisations though notable improvements have been seen in recent weeks as the issues relating to home care capacity begin to resolve. These factors in combination created further challenges for achievement of the A&E 4-hour trajectory for the month and the quarter as a whole. However, despite difficulties maintaining effective flow, the focus remained on delivering high quality care in the right setting, with the number of days patients spent outlying from their specialty ward remaining with target levels for a second consecutive month and the timely discharge standard also being met. Due to a number of the planning assumptions that underpin the 4-hour trajectory not being met for reasons outside of the Trust's control, NHS England has requested a revision to the 4-hour trajectory, which will be included in next month's report following ongoing discussions with commissioners and regulators. The Trust continues to flag system risks to Monitor and escalate issues to commissioners to engage primary care and partner organisations in mitigations to manage demand.

Performance against several of the headline quality metrics in the Trust's Summary Scorecard improved, with nine out of twelve of the quality metrics within the Safe, Caring and Effective domains of the Trust Summary Scorecard being green rated in the period. Within the context of high emergency demand performance also remains consistently strong against many of the core quality standards, such as the incidence of falls and pressure ulcers per 1,000 bed-days, timely nutritional reviews and measures of management of patients with dementia. Also of note this month is the achievement of the 90% standard for compliance with antibiotic prescribing policy.

System pressures continue to provide context to the current workforce challenges, especially bank and agency spend and considerable focus is being placed on the reasons and necessity for each band and agency shift. There remains a strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand ahead of the seasonal winter peaks. Importantly, within this backdrop of seasonal pressures and staff turn-over, the Trust has reported greater than 90% compliance with core essential training standards for a third consecutive month. We also continue to work in partnership with other organisations within the community to mitigate these system risks, and improve the responsiveness of the Trust's services.

Performance Overview

External views of the Trust

This section provides details of the ratings and scores published by the Care Quality Commission (CQC), NHS Choices website and Monitor. A breakdown of the currently published score is provided, along with details of the scoring system and any changes to the published scores from the previous reported period.

Care Quality Commission

Intelligence Monitoring Report (IMR)

This is a tool used by the CQC to assess risk within care services. It was developed to support the CQC's regulatory function. The scoring uses a set of indicators, 93 of which are applicable to the Trust, against which tests are run to determine the level of risk for each indicator. From this analysis trusts are assigned to one of six risk bands based upon a weighted sum of the number of 'risks' or 'elevated risks', with 'elevated risks' scoring double the value of 'risks'.

Band 6 represents the lowest risk band.

Overall risk score = 5 points (2.69%) – **band 5** (not published as recently inspected) – **the CQC will no longer be updating the IMR. Consideration will be given to what other external views can be provided.**

Previous risk score = 10 points (5.43%) – band 3 (not published as recently inspected)

Current scoring

Risks

Safe:	Never Event Incidence
Effective:	SSNAP Domain (Stroke) team-centred rating score
Responsive:	Referral to Treatment Time (composite indicator) Ratio of days delayed in transfer from hospital to total occupied beds (delayed discharges)
Well-led:	Monitor Governance Risk Rating(see next page)
Elevated risks:	None

NHS Choices

Website

The NHS Choices website has a 'Services Near You' page, which lists the nearest hospitals for a location you enter. This page has ratings for hospitals (rather than trusts) based upon a range of data sources.

Site	User ratings	Recommended by staff	Open and honest	Infection control	Mortality	Food choice & Quality
BCH	4.5 stars	OK	OK (✓)	Not avail	OK	✓ (OK)
STM	3.5 stars	OK	OK (✓)	Not avail	OK	✓ (OK)
BRI	4 stars	OK	OK (✓)	Not avail	OK	✓ (OK)
BDH	4 stars	OK	OK (✓)	Not avail	OK	Not avail
BEH	4 Stars	OK	OK (✓)	Not avail	OK	✓ (!)

Stars – maximum 5
OK = Within expected range
✓ = Among the best
! = Among the worst
Please refer to appendix 1 for our site abbreviations.
Last month's ratings shown in brackets where these have changed

Monitor's Risk Assessment Framework

For quarter 3 as a whole the Trust achieved all except four of the standards in Monitor's 2015/16 Risk Assessment Framework, as shown in the table below. The 62-day GP and 62-day screening cancer waiting times standards are scored as a single standard. Overall this gives the Trust a Service Performance Score of 3.0[1] against Monitor's Risk Assessment Framework. Monitor restored the Trust to a GREEN risk rating in quarter 1, following its review of actions being taken to recover performance against the RTT, Cancer 62-day GP and A&E 4-hour standards and an acceptance of the factors continuing to affect Trust performance, which are outside of its control.

Monitor's Risk Assessment Framework - dashboard

Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework: Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16*	Q3 Actual	Notes	Q3 Draft Risk Assessment Risk rating
1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	8	✓	✓	✓	✓	TBC**	✓	Limit to the end of Q3 = 34 cases	Achieved
2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.1%	✓	✓	✓	✓	99.3%	✓		Achieved
2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	96.6%	✓	✓	✓	✓	97.7%	✓		
2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	96.9%	✓	✓	✓	✓	97.2%	✓		
3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	79.7%	×	×	×	×	82.1%	×		Not achieved
3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	72.1%	×	×	×	×	51.9%	×		
4	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	90.9%	Not achieved	Not achieved	Not achieved	Not achieved	91.6%	×		Not achieved
5	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	97.3%	✓	✓	✓	✓	98.1%	✓		Achieved
6a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	95.9%	✓	✓	✓	✓	96.0%	✓		Achieved
6b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
7	A&E Total time in A&E 4 hours	1.0	95%	92.9%	×	×	×	×	90.2%	×		Not achieved
8	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
	CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
				Risk Rating	Triggers further investigation	GREEN	GREEN	GREEN	To be confirmed	Triggers further investigation		3.0 To be confirmed (see narrative)

Please note: If the same indicator is failed in three consecutive quarters, a trust will be put into escalation and Monitor will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur if the target is failed in two quarters in a twelve-month period and is then failed in the subsequent nine-month period or for the year as a whole.

*Q3 Cancer figures based upon confirmed figures for October and November, and draft figures for December.
** C. diff cases from October onwards still subject to commissioner review, but within limit

[1] **Please note** that in the newly revised Monitor Risk Assessment Framework (August 2015) performance against the admitted and non-admitted RTT standards are no longer scored.

Summary Scorecard

The following table shows the Trust's current performance against the chosen headline indicators within the Trust Summary Scorecard. The number of indicators changing RAG (RED, AMBER, GREEN) ratings from the previously reported period is also shown in the box to the right. Following on from this is a summary of key successes and challenges, and reports on the latest position for each of these headline indicators.

Key changes in indicators in the period:

RED to GREEN:
- Infection Control
- Safety Thermometer

AMBER to GREEN:
- Complaints response
- Cancelled operations
- Heart Reperfusion Times

AMBER to RED
- Outpatient appointments cancelled
- Sickness absence

GREEN to AMBER:
- Referral to Treatment Times

Overview

The following summarises the key successes in December 2015, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 4 2015/16

Successes	Priorities
• Antibiotic prescribing compliance has been restored to over 90% in December; • Number of patients with timely discharge (7am to 12 noon) has increased significantly to 1003 in December; • Essential training compliance exceeded the target of 90% for the third consecutive month; • Nursing agency use is at the lowest point for a year; agency staffing in December was 26% below the average year to date average; • Achievement of the 99% 6-week wait diagnostic standard for a fourth consecutive month; • Continued achievement of target reductions in the number of patients waiting over 18-weeks from Referral to Treatment and improvements in performance against the 62-day GP cancer standard; • Achievement of the 0.8% standard for the percentage of operations cancelled at last-minute for non clinical reasons.	• Improve time to theatre for fractured neck of femur patients in January; • Improve complaints response timescales in January; • Improve staff experience and staff retention: analysis of annual staff survey to indicate priorities for action; • Reduce sickness absence: self- certification for absences of 1-3 days implemented in all divisions January. Evaluation mid-February will inform next steps; • Delivery planned Referral to Treatment (RTT) clock stop activity in January in order to stay on track with RTT backlog reduction trajectory and achieve 92% standard; • Increase service capacity in the short-term for paediatric and cardiac MRI scanning if possible, in order to catch-up on routine requests and improve on forecast position against the 6-week wait diagnostic standard (i.e. failure of 99% standard).
Opportunities	**Risks & Threats**
• Revisit Venous thrombo-embolism Exemplar Centre criteria and consider further actions which could be taken to reduce the risk to patients; • Target improvements in omitted doses of critical medication to specific ward areas as this has increased slightly in December; • An overseas recruitment campaign has been agreed in principle by the Senior Leadership Team (SLT) for specialist areas such as Theatres, ITU, Haematology and Oncology. The associated costs of commissioning such a campaign are under consideration.	• Whilst falls incidence remains low, the number of falls with harm is creeping up again, although not all of these will be avoidable. We will continue to investigate and learn from all falls serious incidents; • Venous thrombo-embolism risk assessment performance has dropped below the internally set target of 98%, but remains above the national target of 95%; • Risk of not achieving annual turnover and sickness KPIs agreed during Operating Planning process; • Ongoing high levels of emergency admissions and delayed discharges impacting on patient flow and 4-hour performance; • Further Junior Doctor Industrial Action poses a risk to achievement of the 92% RTT Ongoing pathways standard and continued delivery against the improvement trajectory.

Description	Current Performance	Trend	Comments

Infection control

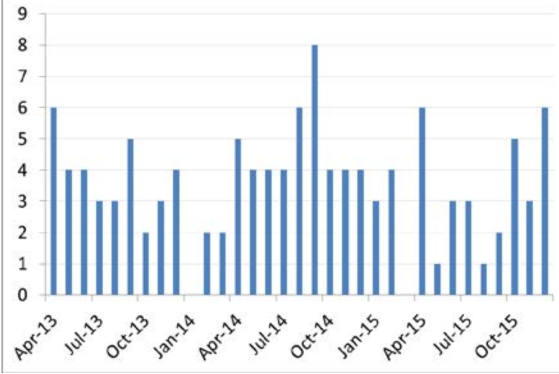
The number of hospital-apportioned cases of Clostridium difficile infections and the number of MRSA (Meticilin Resistant Staphylococcus aureus) bacteraemias. The Trust limit for 2015/16 is 45 avoidable cases of clostridium difficile and zero cases of MRSA.

Six cases of clostridium difficile (C. diff) were reported in December. These cases still need to be discussed with the Clinical Commissioning Group (CCG).

	C. diff	MRSA
Medicine	2	0
Surgery	3	0
Specialised Services	1	0
Women's & Children's	0	0

There were no cases of MRSA bacteraemia reported in December

Total number of C. diff cases



A total of 30 cases (unavoidable + avoidable) have been reported in the year to date (April to December).

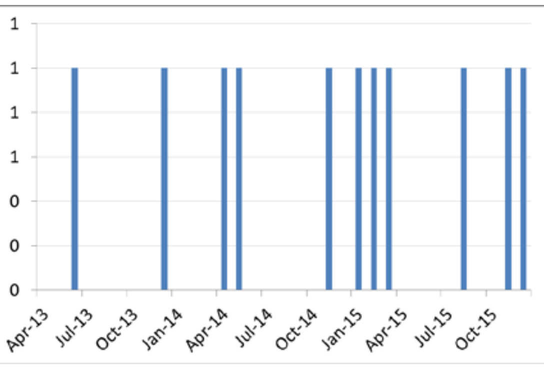
We remain within the limit for avoidable cases of C. diff with seven to date against a target of 45 for 2015/16 as a whole.

There are four cases of MRSA bacteraemia attributed to the Trust to date. The case from November is being challenged with Public Health England due to patient's clinical condition.

Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. There are currently 14 different categories of Never Events listed by NHS England.

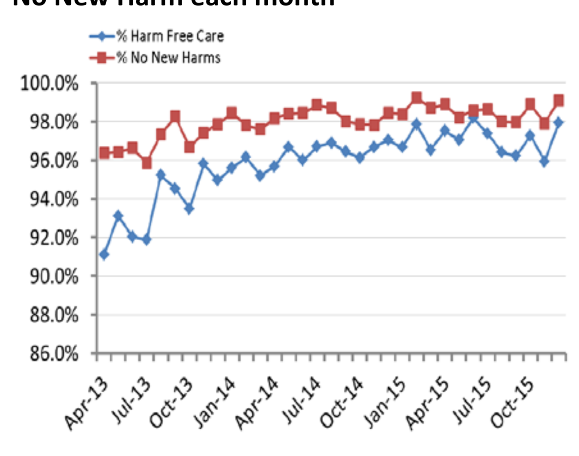
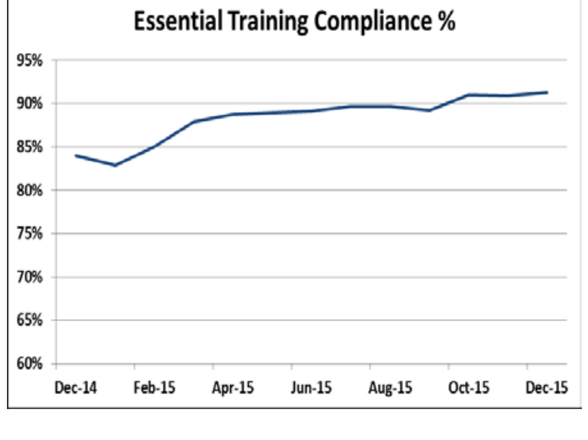
As reported last month there has been one never event reported in December in the category "wrong site surgery". Despite the implementation of control measures previously reported to the Quality & Outcomes Committee, a wrong tooth was extracted. The tooth has been re-implanted.

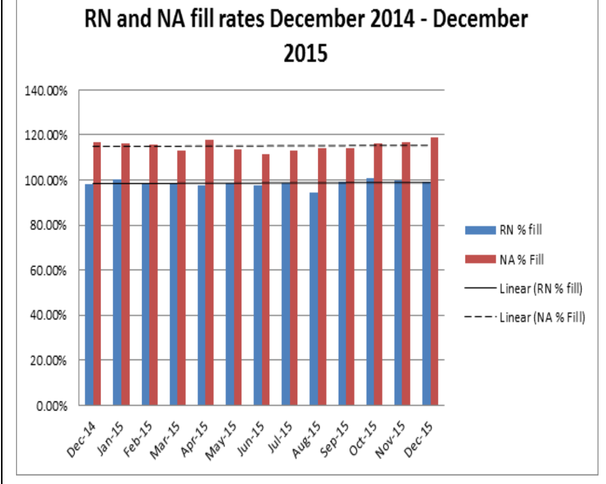
Number of never events per month



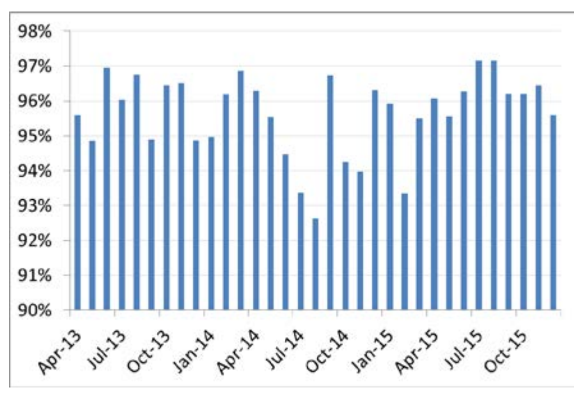
An investigation is underway (Action 1). Commissioners, Monitor and the Care Quality Commission have been informed.

The outcome of the investigation will be reported to the Quality & Outcomes Committee in due course.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.</td>
<td>In December 2015, the percentage of patients with no new harms was 99.1 %, against an upper quartile target of 98.26% (GREEN threshold) of the NHS England Patient Safety peer group of trusts, an improvement from 97.9% in November 2015.</td>
<td>The percentage of patients surveyed showing No New Harm each month

</td>
<td>The December safety thermometer point prevalence audit showed a reduction in new catheter associated new urinary tract infections from seven in November to two in December. Falls with harm and new pressure ulcers remained low with one and zero respectively. There were four incidences of new venous thrombo-emboli.</td>
</tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Compliance at the end of December was 91.3% against the 90% threshold for core Essential Training. Six out of 7 Divisions achieved the 90% target this month.
<table>
<tr><th>December 2015</th><th>Compliance Rate</th></tr>
<tr><td>UH Bristol</td><td>91.3%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>90.5%</td></tr>
<tr><td>Medicine</td><td>91.5%</td></tr>
<tr><td>Specialised Services</td><td>91.8%</td></tr>
<tr><td>Surgery Head & Neck</td><td>92.9%</td></tr>
<tr><td>Women's & Children's</td><td>88.5%</td></tr>
<tr><td>Trust Services</td><td>92.4%</td></tr>
<tr><td>Facilities And Estates</td><td>95.5%</td></tr>
</table></td>
<td>Core Essential Training Compliance

</td>
<td>Compliance exceeded the target of 90% for core essential training for the third consecutive month. The 90% standard was also achieved for induction, Safeguarding Adults Level 1 and Safeguarding Children Level 1 and Level 2. Other essential training data is included in appendix 2; these areas continue to be the focus off further actions to improve compliance levels (Action 2).</td>
</tr>
</table>

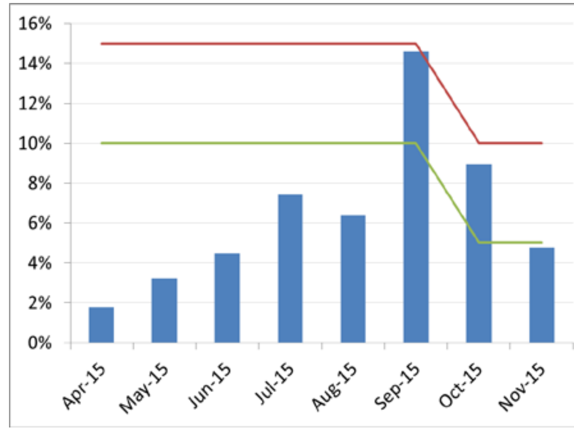
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in December the Trust had rostered 217,125 expected nursing hours, with the number of actual hours worked of 227,506. This gave an overall fill rate of 105%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>70,149</td><td>61,590</td><td>+8559</td></tr>
<tr><td>Specialised Services</td><td>39,109</td><td>40,167</td><td>-1058</td></tr>
<tr><td>Surgery Head & Neck</td><td>44,769</td><td>42,719</td><td>+2050</td></tr>
<tr><td>Women’s & Children’s</td><td>73,478</td><td>72,649</td><td>+830</td></tr>
<tr><td>Trust - overall</td><td>227,506</td><td>217,125</td><td>+10,381</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month


</td>
<td>Overall for the month of December, the Trust had 99% cover for Registered Nurses on both days and nights due to reduced activity over the Christmas period whilst the unregistered level of cover of 119% was again slightly above the usual Trust percentage of 114%. This was due to Nursing Assistant specialist assignments to safely care for confused or mentally unwell patients (Action 3). Recruitment continues at pace, however, the net turnover rate turned negative for the month due to the extended holidays in December.</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.</td>
<td>Performance for December 2015 was 95.6%. This metric combines Friends and Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services. A breakdown of the scores by division is shown below:
<table>
<tr><th></th><th colspan="2">2015/16</th></tr>
<tr><th></th><th>Quarter 2</th><th>Quarter 3</th></tr>
<tr><td>Medicine</td><td>94%</td><td>94%</td></tr>
<tr><td>Specialised Services</td><td>99%</td><td>97%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>98%</td><td>98%</td></tr>
<tr><td>Women's & Children's (excl. maternity)</td><td>96%</td><td>96%</td></tr>
<tr><td>Maternity wards</td><td>94%</td><td>94%</td></tr>
</table>
</td>
<td>Inpatient Friends & Family scores each month


</td>
<td>The overall Trust level scores for UH Bristol are in line with national norms of 96%, and a very high proportion of the Trust's patients would recommend the care that they received to their friends and family. These results are shared with ward staff and are displayed publically on the wards.</td>
</tr>
<tr>
<td>Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.</td>
<td>For the month of November 2015, performance was 4.8%, an improvement from 8.9% in October.

In November, we sent out 42 responses to complaints. By the 15th January we had received two responses back from complainants indicating they were dissatisfied with the Trust's response = 4.8%.

One of these cases relates to a response from the Division of Surgery Head & Neck and one from Trust Services Division.</td>
<td>Percentage of compliantaints dissatisfied with the complaint response each month


</td>
<td>Our performance for 2014/15 was 11.1%. Informal benchmarking with other NHS trusts suggests that rates of dissatisfied complainants are typically in the range of 8% to 10%. Improving the quality of written complaint responses is one of our quality objectives for 2015/16.

Actions continue as previously reported to the Board (Action 4).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments

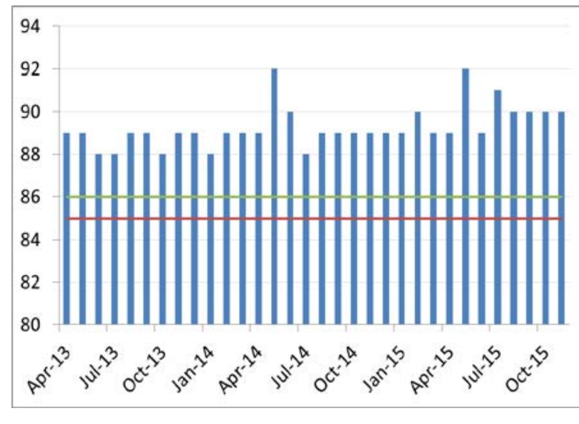
Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.

For the month of November 2015, the score was 90 out of a possible score of 100.

Divisional scores are broken down at the end of each quarter as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.

	Q 1	Q2
Trust	90	90
Division of Medicine	86	87
Division of Surgery, Head & Neck	91	90
Division of Specialised Services	90	91
Women's & Children's Division (Bristol Royal Hospital for Children)	91	91
Women's & Children's Division (Postnatal wards)	89	90

Inpatient patient experience scores (maximum score 100) each month



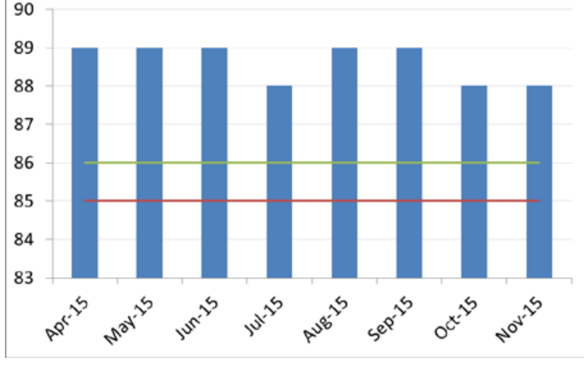
The Trust’s performance is in line with national norms in terms of patient-reported experience. For the year to date the score remains green rated. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.

Outpatient experience tracker comprises four scores from the Trust’s monthly survey of outpatients (or parents of 0-11 year olds):
1) Cleanliness
2) Being seen within 15 minutes of appointment time
3) Being treated with respect and dignity
4) Receiving understandable answers to questions.

This metric is derived from a new survey that the Trust introduced in April 2015. Quarter 3 data shows the Trust score to be 88 out of a possible 100, a slight change from 89 in Quarter 2. The divisional breakdown is shown below.

	2015/16	
	Quarter 2	Quarter 3
Trust	89	88
Medicine	88	89
Specialised Services	87	83
Surgery, Head & Neck	88	90
Women's & Children's (Bristol Royal Hospital for Children)	85	87
Diagnostics & Therapies	94	91

Outpatient Experience Scores (maximum score 100) each month



At a Trust level, this metric would turn red if outpatient experience at UH Bristol began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. For the year to date the Trust score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.

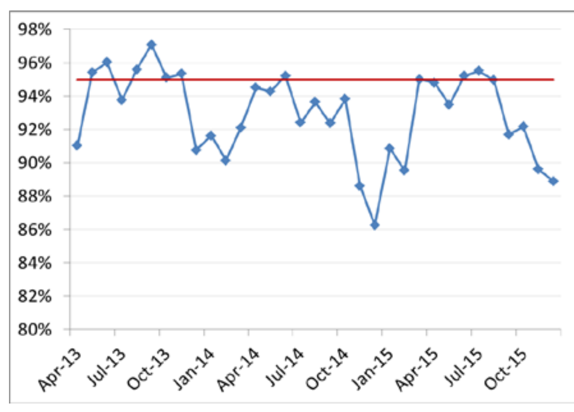
Description	Current Performance	Trend	Comments

A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.

The 95% national standard was not achieved in December, with performance for the Trust as a whole reported at 88.9%. Performance and activity levels for the BRI and BCH Emergency Departments are shown below.

BRI	Dec 2014	Nov 2015	Dec 2015
Attendances	5331	5450	5490
Emergency Admissions	1841	1831	1943
Patients managed < 4 hours	4401 82.6%	4874 89.4%	4767 86.8%
BCH	**Dec 2014**	**Nov 2015**	**Dec 2015**
Attendances	3491	3707	3444
Emergency Admissions	895	924	904
Patients managed < 4 hours	2999 85.9%	3150 85.0%	2986 86.7%

Performance against the A&E 4-hour standard



There was a slowing in the year-on-year growth in Emergency admissions into the Bristol Children's Hospital (BCH) in December. However, emergency admissions were 5.5% higher in the BRI than in December 2014. The number of delayed discharges reduced towards the second half of December, but has increased again in January and remains above plan. Actions continue to be taken to manage demand into the BCH and to reduce delayed discharges (Actions 5B and 5C).

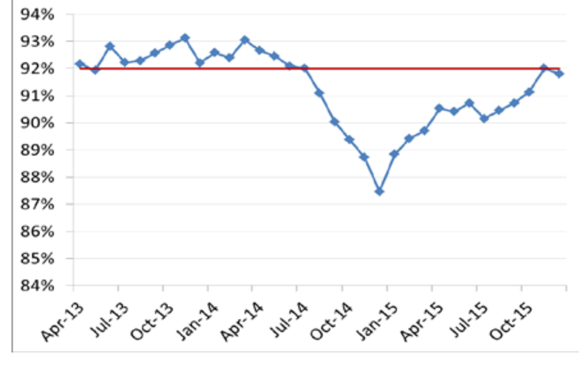
Referral to Treatment (RTT) is a measure of the length of wait from referral through to treatment. The target is for at least 92% of patients, who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), to be waiting less than 18 weeks at month-end.

Although the 92% national standard wasn't achieved at the end of December as expected due to patient choice to delay pathways, the total number of patients waiting over 18 weeks was lower than the revised backlog trajectory, for both the admitted and non-admitted pathways (see Appendix 3).

There was also a decrease in the number of patients waiting over 40 weeks RTT at month-end against the trajectory (zero). There were no over 52-week waiters at month-end.

	Oct	Nov	Dec
Numbers waiting > 40 weeks RTT	25	22	15
Numbers waiting > 52 weeks RTT	0	0	0

Percentage of patients waiting under 18 weeks RTT by month



Delivery of the revised trajectories is monitored weekly, with any significant variances from plan escalated to Divisional Director level. The weekly RTT Operational Group continues to oversee the management of waiting lists and booking of longest waiting patients (Action 6).

Description	Current Performance	Trend	Comments

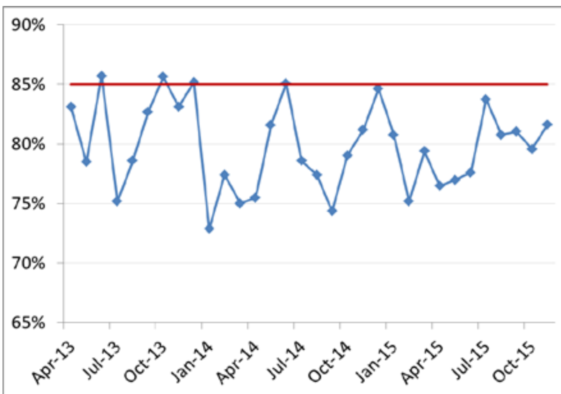
Cancer Waiting Times

Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.

Performance against the 85% 62-day GP standard was 81.6% in November, which was above the improvement target (78%) set for the month. Performance against the 90% 62-day screening standard was 71.4%. The main reasons for failure to achieve the 85% national 62-day GP standard are shown below.

Breach reason	Nov 15
Late referral by other provider	8.0
Medical deferral/clinical complexity	2.0
Insufficient surgical capacity	1.0
Delayed diagnostic (other provider)	1.0
Delayed outpatient appointment	1.0
Other (of which, patient choice 1.0)	3.0
TOTAL	**16.0**

Percentage of patients treated within 62 days of GP referral



The 2 x 62-day screening pathway breaches in November out of 7 treated. The breach reasons were: patient choice and delayed surgical diagnostic.

Performance for quarter 3 is forecast to be 82.1%, with the 85% standard achieved for December. The internal priority for improving performance is the implementation of ideal timescale pathways (Action 7). All remaining redesigned pathways went live at the end of December. A further meeting to agree timescales for tertiary referral as part of the 2016/17 CQUIN will be held in February. The above areas of focus are part of wide ranging action plan, as previously signed-off by the Board.

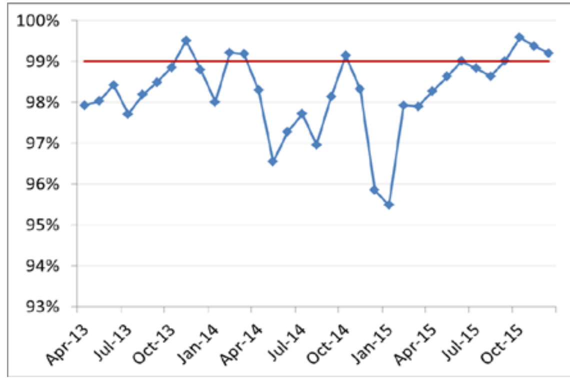
Diagnostic waits

Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.

The 99% national standard was achieved at the end of December, which is the fourth consecutive month of achievement. The number and percentage of over 6-week waiters at month-end, is shown in the table below:

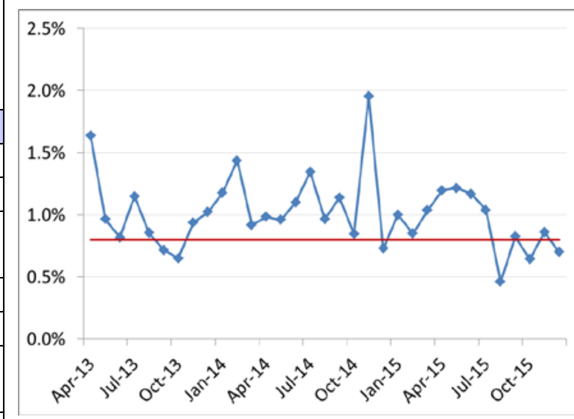
Diagnostic test	Oct	Nov	Dec
MRI	0	14	30
Ultrasound	0	1	5
Sleep	2	6	0
Endoscopies	22	17	14
Other	5	2	4
TOTAL	**29**	**40**	**53**
Percentage	**99.6%**	**99.4%**	**99.2%**
Trajectory	99.1%	99.4%	98.7%

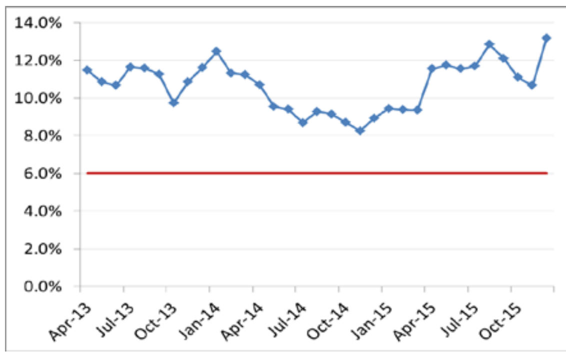
Percentage of patients waiting under 6 weeks at month-end



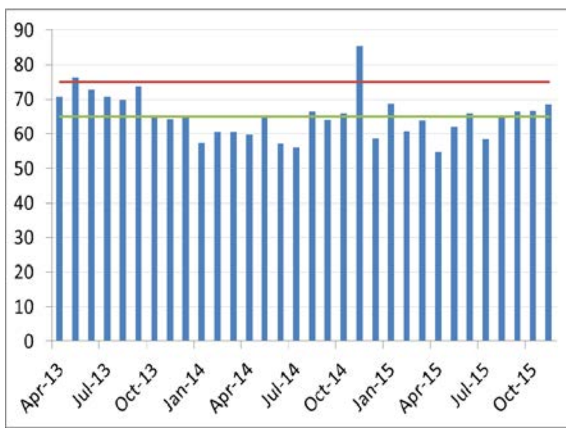
Trajectory/forecast for January = 98.4% (i.e. 99% standard not achieved).

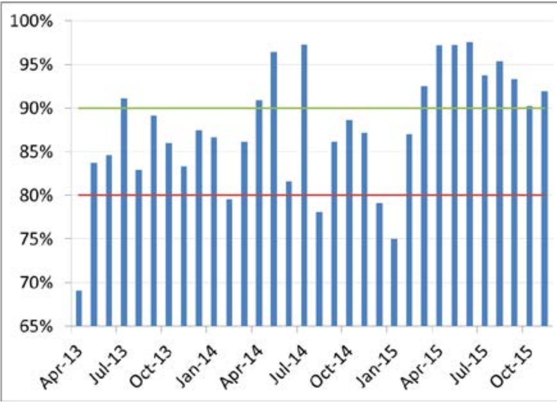
The number of patients currently waiting more than 6 weeks for a paediatric or cardiac MRI scan is above plan, and is likely to result in the 99% standard not being achieved at the end of January. This is mainly due to an increase in urgent requests, the loss of sessions due to winter pressures and annual leave (Action 8). Options for increasing service capacity to undertake more scans continue to be reviewed.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In December the Trust cancelled 39 (0.70%) operations at last-minute for non-clinical reasons. The 0.8% national standard was also achieved for the quarter. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number/%</th></tr>
<tr><td>Emergency patient prioritised</td><td>16 (41%)</td></tr>
<tr><td>Surgeon unavailable</td><td>7 (18%)</td></tr>
<tr><td>Lack of time (morning list ran over; other complicated patient in theatre)</td><td>5 (13%)</td></tr>
<tr><td>No theatre staff</td><td>4 (10%)</td></tr>
<tr><td>No ITU/HDU bed</td><td>3 (8%)</td></tr>
<tr><td>Other causes (3 different breach reasons - no themes)</td><td>4 (10%)</td></tr>
</table>
Two patients cancelled in November were readmitted outside of the required 28 days. This equates to 96.1% of cancellations being readmitted within 28 days.</td>
<td>Percentage of operations cancelled at last-minute

</td>
<td>Emergency pressures continued to be a main reason for the cancellation of routine operations in the period. A separate action plan to reduce elective cancellations continues to be implemented (Actions 9A and 9B). However, please also see actions detailed under A&E 4 hours (5A to 5C) and outlier bed-days (12A to 12C).</td>
</tr>
<tr>
<td>Outpatient appointments cancelled is a measure of the percentage of outpatient appointments that were cancelled by the hospital. This includes appointments cancelled to be brought forward, to enable us to see the patient more quickly.</td>
<td>In December 13.2% of outpatient appointments were cancelled by the hospital. This is significant increase on the level reported in November (10.7%), and reflects the necessary cancellations that took place as a result of the Junior Doctor Industrial Action in December. Analysis is being undertaken to provide an estimate of what the cancellation rate would be, with the impact of the Industrial Action excluded from the figures.

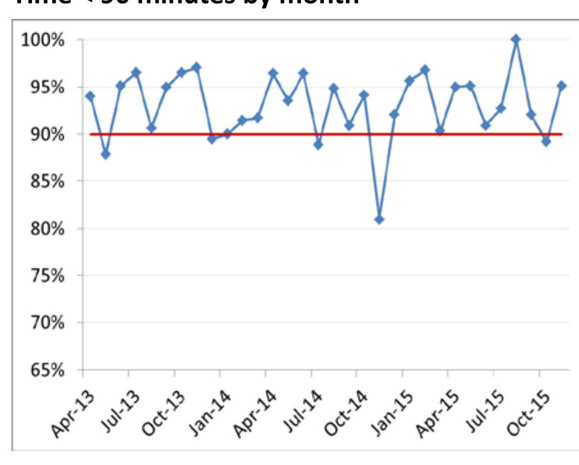
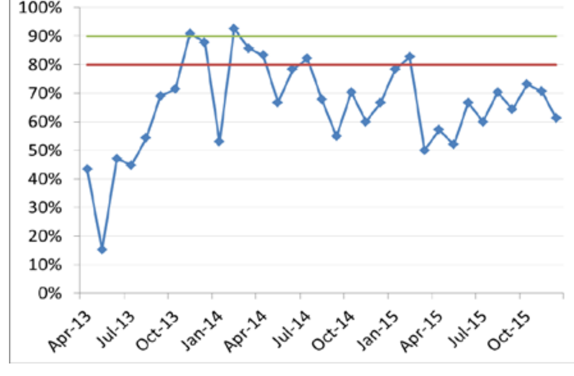
January's performance against this metric is also expected to be RED rated, due to the Industrial Action on the 12th January.</td>
<td>Percentage of outpatient appointments cancelled by the hospital

</td>
<td>Services will continue to plan for any future Industrial Action, to minimise the level of cancellations appointments (and admissions) and consequent disruption to patients. Ensuring outpatient capacity is effectively managed on a day-to-day basis is a core part of the improvement work overseen by the Outpatients Steering Group (Action 10).</td>
</tr>
</table>

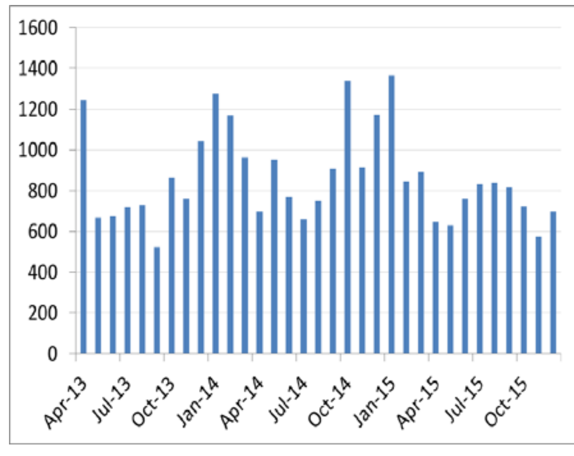
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Summary Hospital Mortality Indicator (in hospital deaths) is the ratio of the actual number of patients who died in hospital and the number that were ‘expected’ to die, calculated from the patient case-mix, age, gender, type of admission and other factors.</td>
<td>Summary Hospital Mortality Indicator for November 2015 was 68.4 against an internally set target of 65.

The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter (i.e. lower and upper confidence intervals greater than 100). No patterns of causes for concern have been identified.</td>
<td>Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month

</td>
<td>This is a high level indicator of the effectiveness of the care and treatment we provide. Although November’s performance is above our internally set GREEN threshold, our performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors.</td>
</tr>
<tr>
<td>Stroke care. This indicator is a measure of what percentage of a stroke patient’s stay was spent on a designated stroke unit. The target is for 90% of patients to spend at least 90% of their stay in hospital on a stroke unit, so that they receive the most appropriate care for their condition</td>
<td>Performance in November 2015 was 91.9% (latest data) against a target of 90%. There were 37 patients discharged in November, of which 34 had spent at least 90% of their stay on the stroke unit.

The year to date performance for this measure is 94.5% (293/310 patients) compared with 86.4% last year.</td>
<td>The percentage of stroke patients spending 90% of their stay on a stroke unit by month

</td>
<td>Reasons regarding the three patients for whom we did not achieve the target this month were:

Two patients were admitted to the Acute Medical Unit and Older Person’s Assessment Unit and discharged in less than 24 hours. One patient with a stroke was admitted to the Acute Medical Unit but needed to remain there initially as they required specialist care using Bi-PAP. They were transferred to the stroke unit promptly when this was no longer needed.</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Door to balloon times measures the percentage of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Heart Institute.</td>
<td>In November (latest data), 39 out of 41 patients (95.1%) were treated within 90 minutes of arrival in the hospital. Performance for the year to date (93.8%) remains well above the 90% standard.</td>
<td>Percentage of patients with a Door to Balloon Time < 90 minutes by month

</td>
<td>Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. The 90% standard continues to be met for the year as a whole.</td>
</tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In December we achieved 61.2% overall performance in Best Practice Tariff (BPT). There were 29 patients eligible for BPT; 11 patients' care did not meet all eight standards. Ten patients were not operated on within 36 hours. Three patients were not reviewed by an Ortho-geriatrician within 72 hours
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number</th></tr>
<tr><td>Not well enough for theatre</td><td>4</td></tr>
<tr><td>Fracture not visible on initial X-ray</td><td>1</td></tr>
<tr><td>Lack of theatre capacity</td><td>5</td></tr>
</table>
The average time to theatre for the 10 patients was 52.2 hours.</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.

</td>
<td>The patient whose fracture was not visible on initial x-ray was operated on within 36 hours of their second admission.
The reason for lack of Ortho-geriatrican review within 72 hours for three patients was sickness in the team.
The on-going actions shown in the improvement plan focus on improving access to theatres and improving the overall fractured neck of femur pathway (11A and 11B).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.	In December there were 697 outlier bed-days against a Q3 monthly target of 705. This is a deterioration from November of 132 outlier bed-days. But performance remains within the GREEN threshold.	**Number of days patients spent outlying from their specialty wards** 	The deterioration is almost entirely within the Division of Medicine and is reflective of the operational pressures on the hospital across December with higher levels of emergency medical admissions and periods of escalation resulting in more medical patients outlying in other divisions. Ongoing actions are shown in the action plan section of this report. (Actions 12A to 12C).

Outlier bed-days	Nov 2015
Medicine	461
Surgery, Head & Neck	125
Specialised Services	105
Women's & Children's Division	6
Other	0
Total	697

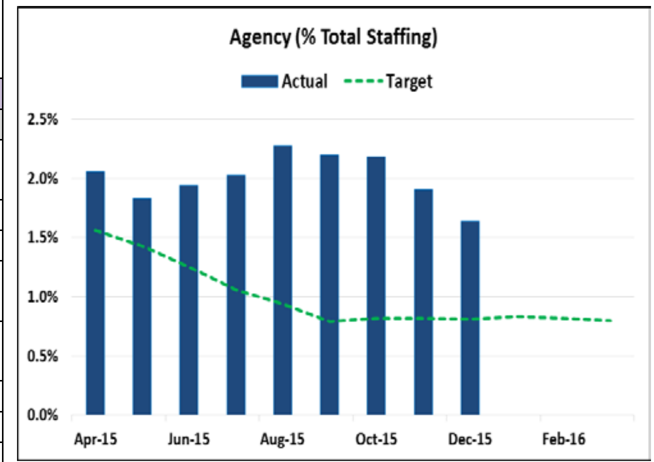
Description	Current Performance	Trend	Comments

Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.

Agency usage reduced by 22.1 FTE, with reductions across all Divisions. Nursing agency WTE reduced by 20% in month to 75.7FTE.

December 2015	FTE	Actual %	KPI
UH Bristol	**134.0**	**1.6%**	**0.8%**
Diagnostics & Therapies	3.4	0.4%	0.5%
Medicine	31.5	2.6%	0.8%
Specialised Services	17.0	2.0%	1.8%
Surgery, Head & Neck	23.8	1.4%	0.6%
Women's & Children's	24.6	1.3%	0.8%
Trust Services	15.7	2.3%	0.6%
Facilities & Estates	18.0	2.3%	0.9%

Agency usage as a percentage of total staffing by month



The agency action plans continue to be implemented and the headlines are in the improvement plan (Action 13).

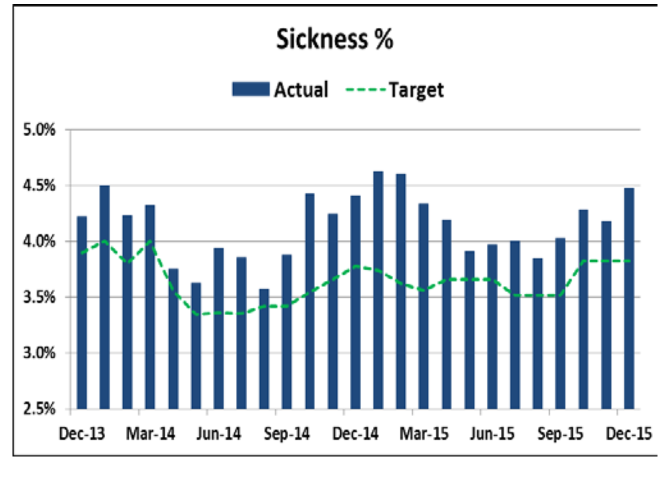
A summary of the Monitor submission in relation to compliance with the newly established agency caps is attached as an appendix.

Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.

Sickness absence has increased from 4.2% to 4.5% due to a 28% increase in cold and flu related absence, and 19% rise in gastro-intestinal. Absence increased in the month in all divisions except Medicine where there was no change.

December 2015	Actual	KPI
UH Bristol	**4.5%**	**3.8%**
Diagnostics & Therapies	3.2%	3.0%
Medicine	4.9%	4.2%
Specialised Services	4.3%	3.8%
Surgery, Head & Neck	4.5%	3.4%
Women's & Children's	4.3%	4.0%
Trust Services	3.9%	2.7%
Facilities & Estates	6.8%	6.0%

Sickness absence as a as a percentage of full time equivalents by month



Action 14 describes the ongoing programme of work to address sickness absence.

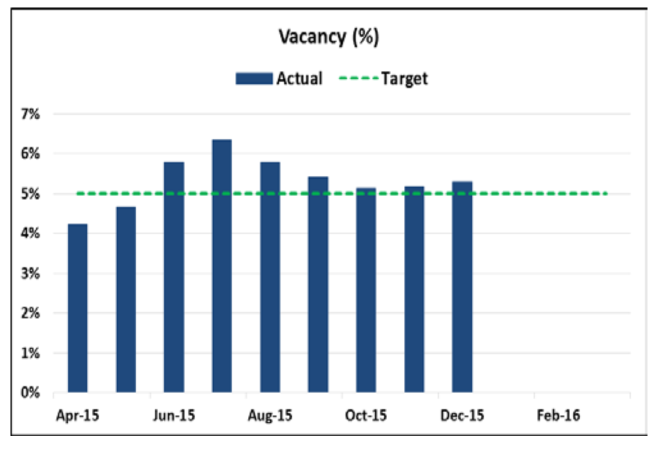
Description	Current Performance	Trend	Comments

Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.

Vacancies increased slightly from 5.2% to 5.3% (431 FTE) against a target of 5%. Registered Nursing vacancies rose by 14.6 FTE to 5.1% due to increases in Medicine and Specialised Services.

December 2015	Rate
UH Bristol	**5.3%**
Diagnostics & Therapies	4.5%
Medicine	7.7%
Specialised Services	5.2%
Surgery, Head & Neck	4.6%
Women's & Children's	1.9%
Trust Services	8.9%
Facilities & Estates	9.1%

Vacancies rate by month



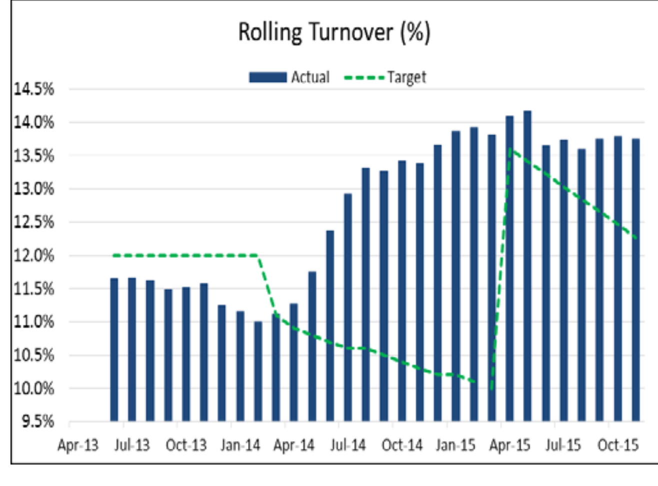
The programme of recruitment activities is summarised in Action 15.

Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 11.5% by the end of 2015/16. The red threshold is 10% above monthly trajectory.

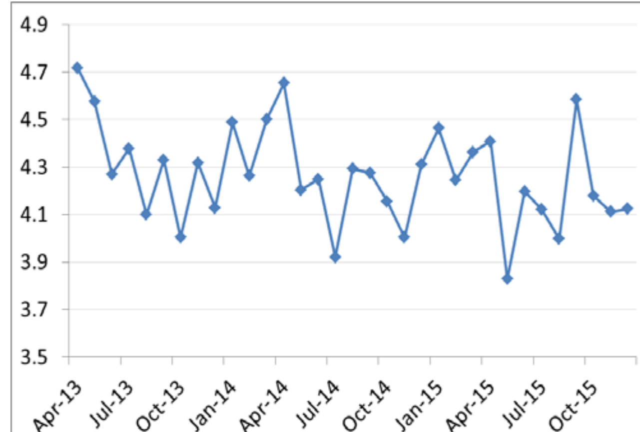
Turnover has dropped very slightly to 13.8% with small reductions in all Divisions except Facilities & Estates and Medicine. Registered nurse turnover reduced from 13.5% to 13.4%.

December 2015	Actual	Target
UH Bristol	**13.8%**	**12.1%**
Diagnostics & Therap.	13.2%	11.1%
Medicine	13.8%	12.9%
Specialised Services	15.4%	13.5%
Surgery, Head & Neck	14.6%	13.2%
Women's & Children's	11.7%	10.4%
Trust Services	15.2%	11.5%
Facilities & Estates	14.4%	12.9%

Staff turnover rate by month



Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 16).

Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In December the average length of stay for inpatients was 4.12 days. Length of Stay remains above plan, and for this reason is RED rated. However, Length of Stay for the last two months has been lower than the same period last winter. This appears to be due to a combination of a lower proportion of long stay patients (i.e. over 14 days) and a higher proportion of shorter stays (i.e. 3 to 6 days). At the end of December the number of delayed discharges was lower than the same period last year (34 versus 48). However, in January numbers of Delayed Discharges have risen again and still remains above the jointly agreed planning assumption of 30 patients.	**Average length of stay (days)** 	Although levels of BRI emergency admissions and delayed discharges remain above plan, the number of days patients spent as an outlier remained within the GREEN threshold for the period. Maintaining a lower level of outliers is an important for reducing length of stay as outlying patients usually have longer stays than patients in the correct specialty ward. Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide resilience plan and additional exceptional actions being taken (Actions 12A to 12C).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Never events	1	The Root Cause Analysis (RCA) will be completed and the report reviewed by the Trust Patient Safety Group, Clinical Quality Group and Quality & Outcomes Committee. The report will also be provided to commissioners and to the Care Quality Commission (CQC), Monitor and the patient's family if required.	April 2016	RCA and serious incident reports to the Quality & Outcomes Committee.	To aim for no never events.
Essential Training	2	Continue to drive compliance of core topics, including increasing e-learning Detailed plans focus on improving the compliance of Safeguarding and Resuscitation	Ongoing Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group Oversight of safeguarding training compliance by Safeguarding Board	Trajectory linked to action plans to sustain 90%.
Monthly Staffing levels	3	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls and action plan.	Action plan available on request
Caring					
Dissatisfied complainants	4	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the caseworker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality for	Ongoing	Senior Managers responsible for drafting and signing off response letters before they leave the Division are named on a Response Letter Checklist that is sent to the Executives with the letter. Any concerns over the quality of these	10% by October 2015, then 5% by March 2016.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Patient Experience & Clinical Effectiveness also checks a selection of response letters each week. All responses are then sent to the Executives for final approval and sign-off.		letters can then be discussed individually with the manager concerned and further training provided if necessary.	
Responsive					
A&E 4-hours	5A	Analysis of the causes of the unexpected rise in emergency admissions into the BCH. Work with commissioners to mitigate rise in emergency admissions.	Completed. Ongoing	Urgent Care Board	Achievement of Q4 revised recovery trajectory.
	5B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of Q4 revised recovery trajectory.
	5C	Working with partners to mitigate any impact of planned recommissioning of domiciliary care packages providers and bed closures in other acute trusts See also actions 14A to 14C relating to delayed discharges and flow.	Ongoing	Urgent Care Board	Achievement of Q4 revised recovery trajectory.
Referral to Treatment Time (RTT)	6	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting patients through RTT Operations Group	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Achievement of the RTT Incomplete/Ongoing pathways standard as per revised trajectories (remains on track for end of January).

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Cancer waiting times	7	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments (copy of plan provided to the Quality & Outcomes Committee as a separate paper in August; and Trust Board in September)	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Restore internal pathway performance to above 85% for quarter 3 (already achieved in Q2). Achieve 85% across shared and internal pathways combined by March 2016.
Diagnostic waits	8	Weekly monitoring of waiting list to inform capacity planning, with particular focus on cardiac stress echo, paediatric and adult gastrointestinal endoscopy long waiters.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Forecast for 99% standard to be restored from the end of September (achieved), although risks noted in the trajectory for December and January achievement of 99% (December achieved).
Last minute cancelled operations	9A	Continued focus on recruitment and retention of staff to enable all adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited but now in pipeline before starting.	Ongoing	Monthly Divisional Review Meetings;	Improvement to be evidenced by a reduction in cancellations for this reason (as seen since August). Ongoing achievement of quality objective on a quarterly basis, with achievement of national standard of 0.8% in quarter 4 2015/16.
	9B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.
Outpatient appointments cancelled by hospital	10	Reductions in cancellation rates to be realised through improvements in booking practices and	March	Oversight of programme of work, which this is a core part, by the Outpatients Steering	Green target level achieved.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		appointment slot management		Group.	
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	11A	Live flow tracker in situ across Division from June to increase visibility and support escalation standards.	January 2016 (revised from November 2015)	Inclusion of three new fields to include all trauma patients waiting without a plan, all fractured Neck of Femur (NOF) patients waiting, and all fractured NOF patients over 24 hours. IM&T needs to build a new system in order to be able to retrieve this information into the live tracker. Ongoing project in IM&T.	
	11B	Review of all Ward Processes on Trauma and Orthopaedic Wards. Project to review fractured neck of femur direct admission process and reduced length of stay.	February 2016 (revised from November 2015)	Updates to Divisional and Trust Board.	Improve in overall fractured neck of femur pathway
Ward Outliers	12A	Reduce demand on beds to support optimal occupancy. Range of initiatives in place to reduce demand for acute services including proposals to initiate hot clinics to target over 75 year olds, but with limited impact to date. Further significant initiative now being pursued – community acute virtual ward under discussion.	Ongoing Working to bring on line in Q4 (subject to reaching agreement with	Oversight in monthly Urgent Care Working Group Fortnightly Director-led escalation meeting established this month in response to lack of impact of ongoing initiatives	Maintain modelled occupancy of 90%.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
			provider)		
	12B	Weekly Patient Progress meeting continues to expedite early discharge with support of our partners, now escalated to Divisional Director attendance. Divisions reviewing long stay patients with additional (new) focus on those patients requiring one-to-one care.	Ongoing	Monitoring of Green to go list	Green to Go trajectory or no more than 30 patients
	12C	Ward processes work continues to roll-out and embed with evidence of success in increasing early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer.	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of BRI Discharge Lounge
Well led					
Agency Usage	13	Key actions driven corporately include the following.		Oversight by Savings Board (Nursing Agency) and Medical Efficiencies Group (Medical Agency)	Based on the mid year review, agency usage is anticipated to be around 1.7% compared with a KPI of 1% of total staffing at the end of March.
		All staff Newly established agency caps set by Monitor give an increasingly challenging maximum for the amount NHS Trusts may pay for an agency worker. Actions associated with this change include the following:	Full implementation from mid-December		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• Only agencies on approved Monitor frameworks will be used; • There will be a clear clinical and business exception approval process for all staff groups; • No changes will be made to clinical operating model to limit demand, pending assessment of impact of initial measures; • UH Bristol intends to only use agencies on approved frameworks. During 2016, reporting will be extended to cover all data. Currently reporting covers Temporary Staffing Bureau bookings only.			
		Nursing and midwifery • Close working with wards to maximise the functionality of Rosterpro to support booking and payment processes for bank staff.	January 2016		
		• A "real-time" staffing dashboard is being developed to enable cross-trust review of staffing levels. This will provide a 7 day real time overview for inpatient staffing, including bank and agency.	October – February 2016 2016		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• A direct booking process based at ward level for temporary staff, commencing September 2015 is being rolled out to all areas to allow greater control over staffing at ward level and maximise the availability to bank staff.	Ongoing		
		• A cross-community Group has been established to share and develop collaborative approaches to reducing agency spend.	Ongoing		
		• Internal and external local marketing to develop an increased pool of bank nurses.	Ongoing		
		Medical agency usage • "Envoy" texting system, advising doctors of available shifts, implemented in Division of Medicine, wider roll out planned for Surgical and Women`s & Children`s rotas.	March 2016		
		• There is a continued Divisional focus on filling vacancies and gaps, which are the main reasons for medical agency.	Ongoing		
Sickness Absence	14	The detailed plan with timescales for the work programmes agreed with Senior Leadership Team is provided below. • Pilot self certification for		Oversight by Workforce and OD Group via the Staff Health and Well Being Sub Group	The mid-year review indicates that the out turn for sickness absence will be amber rated at about 4.2% by March 2016.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		absences of 1-3 days implemented in all divisions January. Evaluation mid February will inform next steps.	November 2015 to end February 2016		
		• Audit and raising the profile of return to work interviews. • Contacting employees on the 1st, 3rd and 7th day of sickness absence, phased roll-out. • Managers in "hot spots" to receive coaching in consistent implementation of the policy.	November 2015 to February2016 December 2015 to June 2016 Ongoing		
		The Staff Health and Well Being action plan continues to be implemented, including the following.	October 2015 to end February 2016		
		Staff health and well being • Free on site health checks over the next 2 years with a target of reaching 2000 staff.	December 2017		
		Musculo-skeletal • Review of Occupational Health Physiotherapy pathway to improve the focus on prevention and keeping staff at work.	Ongoing		
		• Continued targeted intervention by Occupational Health Musculo-skeletal services, Physio direct, and Manual Handling Team.	Ongoing		
		Colds and flu • The seasonal flu vaccination			

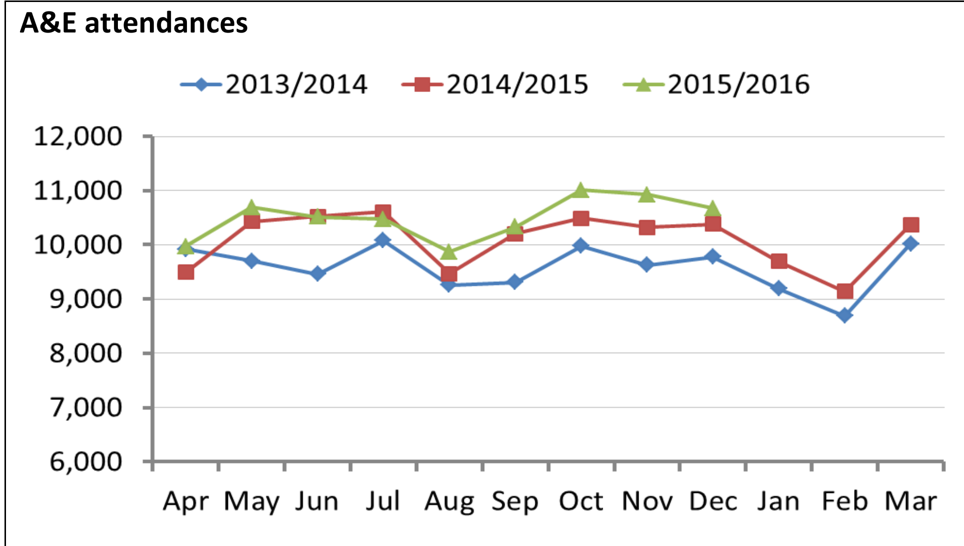
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		campaign for Trust staff commenced in October 2015. The Trust is aiming to achieve the 75% target set by NHS England. Current coverage is 45%. Recovery plan includes more staff to deliver vaccine, using a bleep system.	End February 2016	Flu Steering Group	
Vacancies	15	Recruitment action plan includes the following activities.		Oversight by Workforce and OD Group via the Recruitment Sub Group.	On the basis of the review of trajectories at the mid year review, out turn is expected to be around 5.9% compared with a target of 5%.
		• A schedule of advertising activity has been developed utilising the agreed funding for 2015/16 to target the national market for hard to fill posts including nursing and midwifery. Activity includes the use of local radio, Bristol buses and social media.	September 2015 to March 2016		
		• Service level agreements and KPIs for recruitment are being developed to measure performance and support improvement of conversion to hire rates and benefits realisation.	January 2016		
		An overseas recruitment campaign has been agreed in principle by the Senior Leadership Team (SLT) for specialist areas such as Theatres,			

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		ITU, Haematology and Oncology. The associated cost of commissioning such a campaign is under consideration.	To be agreed	Senior Leadership Team	
Turnover	16	Key corporate and divisional actions include the following.		Oversight of Staff Experience Programme by Transformation Board.	An out turn of 13% is anticipated on the basis of the mid year review.
		• Senior Leadership Team agreed divisional and corporate actions arising from the staff experience workshops, with progress against actions to be reported back in February.	November 2015 - March 2016.		
		• Pilot preceptorship programmes to support newly qualified nurses in their transition from student to registered nurses.	September 2015/ February 2016	Oversight by Workforce and Organisational Development Group	
		• Additional investment for divisional hot spots including innovative training and development.	September 2015 – March 2016	Senior Leadership Team/Workforce and Organisational Development Group /Divisional Boards	
		• Role competency and career frameworks to be embedded within the revised appraisal process to improve the quality and application of staff appraisals.	September 2016	Workforce and Organisational Development Group	
		• Staff Survey results published at the end of February, which will enable Divisions to develop action plans by the end of March.	End March	Workforce and Organisational Development Group	

Operational context

This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

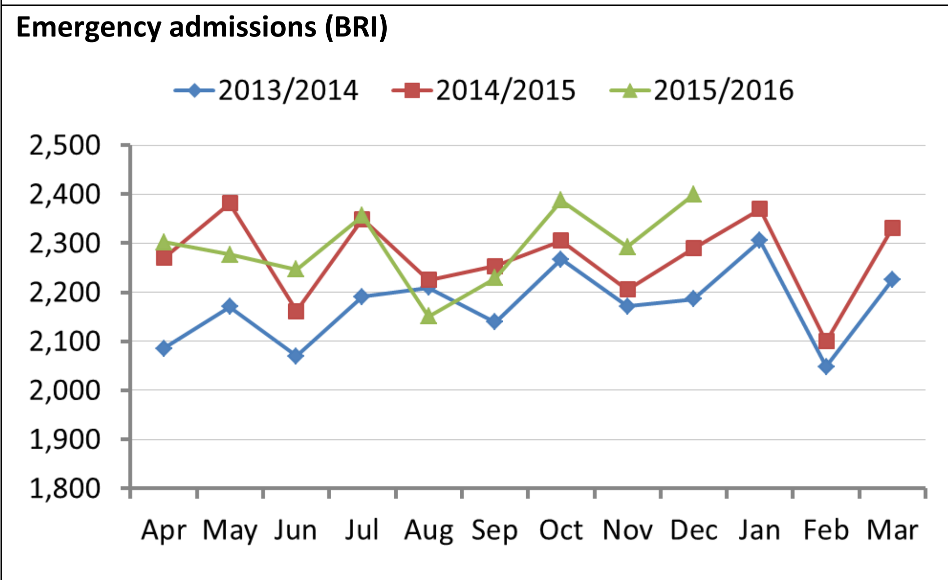
A&E attendances



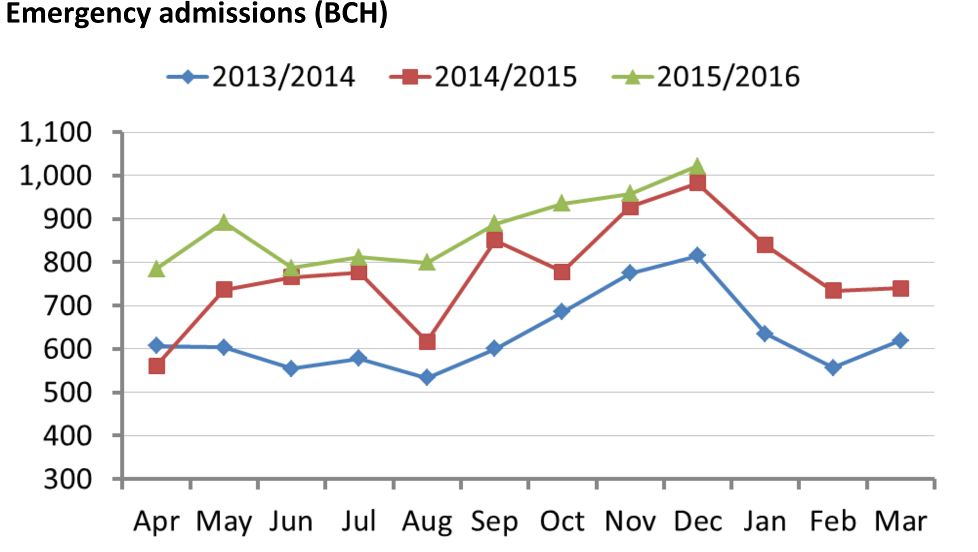
Summary points:

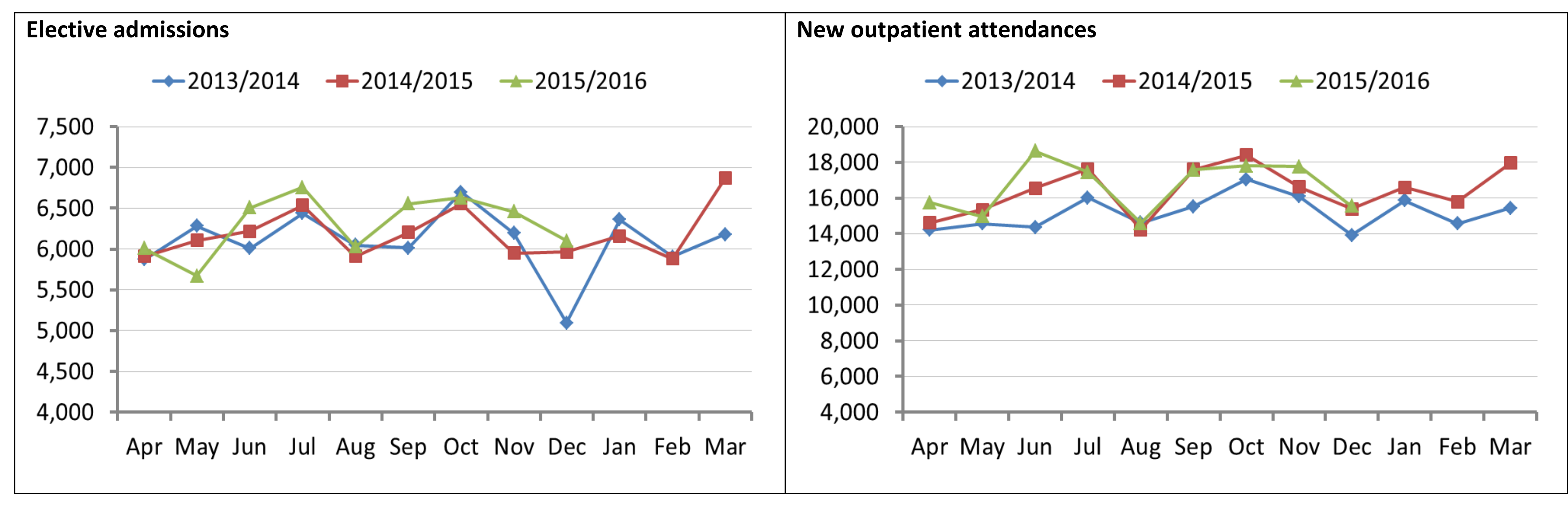
- Emergency activity remains high across all sites, although the main increase this month has been in the level of emergency admissions into the BRI, which is significantly above the same period last year;
- The number of elective admissions is similar to that of the same period last year (but slightly lower than planned, due to the Junior Doctor Industrial Action); as will be seen in the Assurance and Leading Indicators summary, consistent with this, the number of patients on elective waiting list has increased slightly;
- The number of new outpatient attendances is also similar to last year, but below plan for the same reason, resulting in a slight increase in the total number of patients on the outpatient waiting list, and the total number of patients waiting over 18 weeks Referral to Treatment.

Emergency admissions (BRI)



Emergency admissions (BCH)



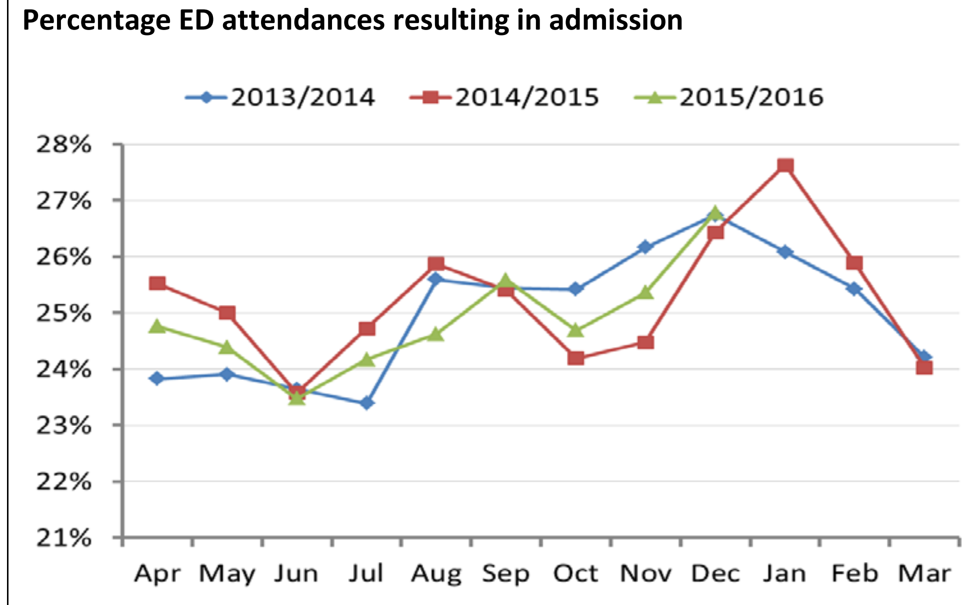


Elective admissions
2013/2014
2014/2015
2015/2016
7,500
7,000
6,500
6,000
5,500
5,000
4,500
4,000
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
New outpatient attendances
2013/2014
2014/2015
2015/2016
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Assurance and Leading Indicators

This section of the report looks at set of assurance and 'leading' indicators, which help to identify future risks and threats to achievement of standards.

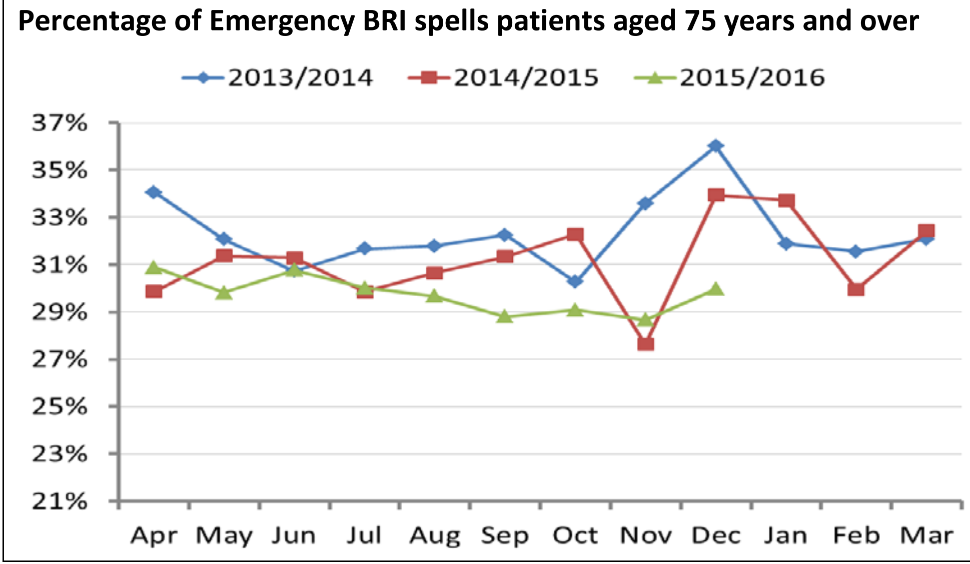
Percentage ED attendances resulting in admission



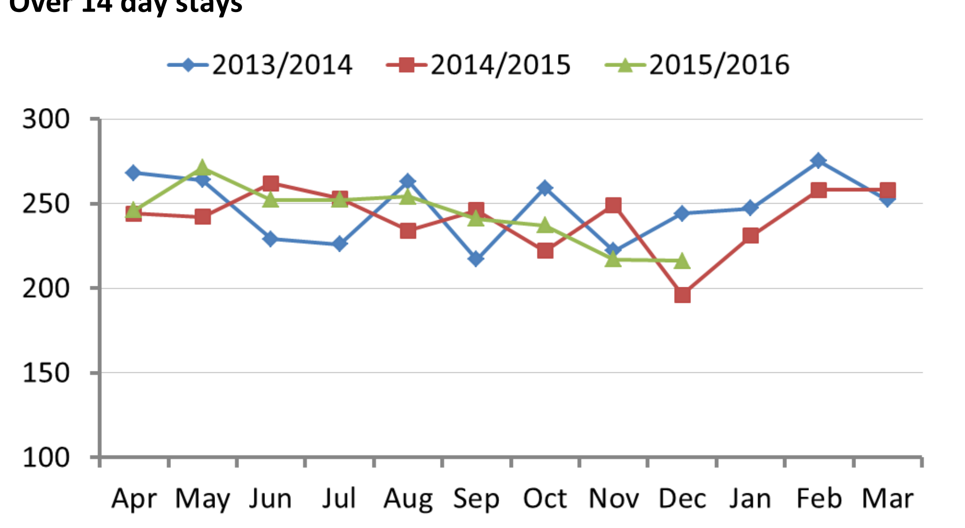
Summary points:

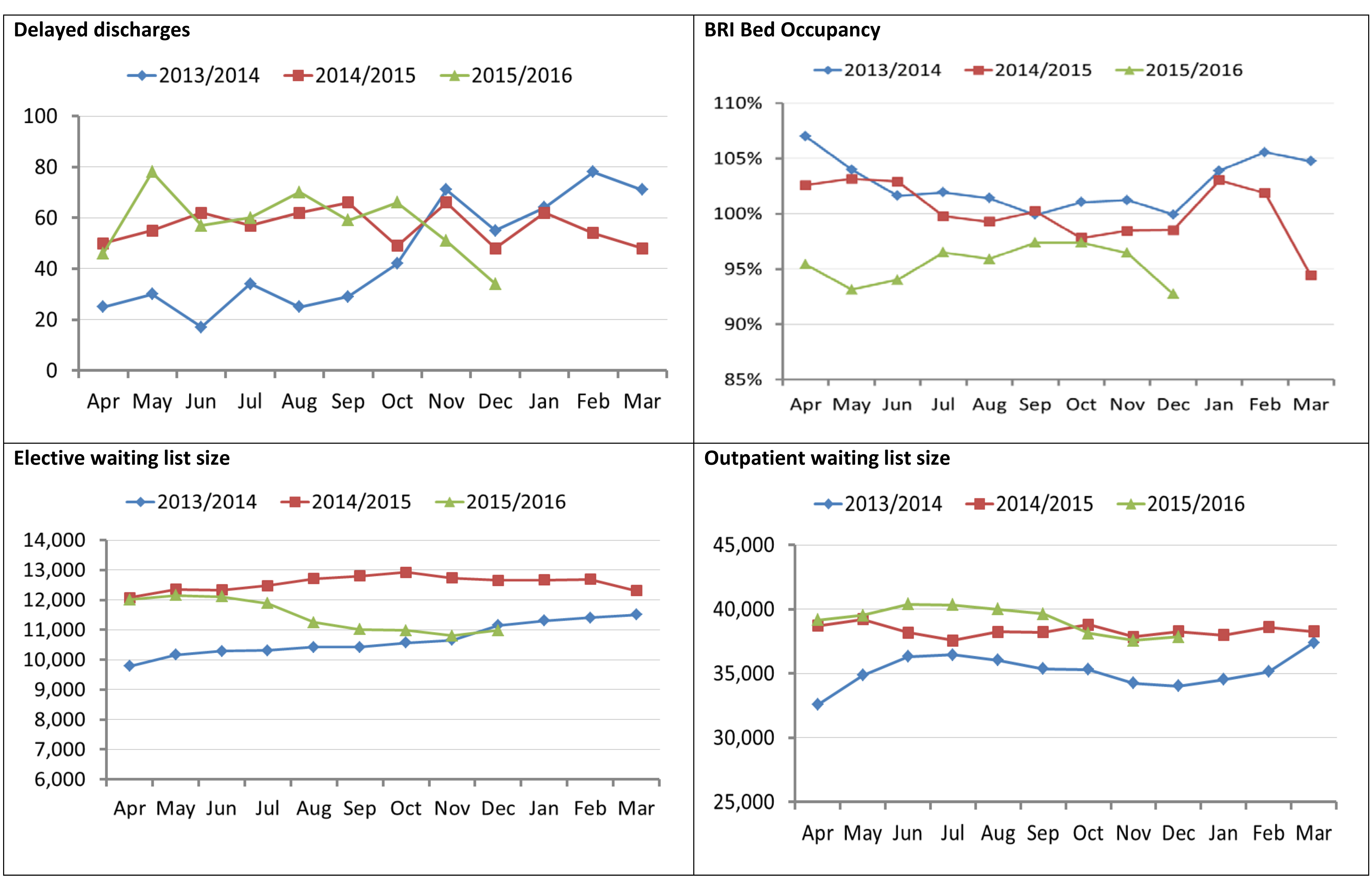
- The percentage of patients arriving in our Emergency Departments and converting to an admission was consistent with the seasonal norm in December; the percentage of patients admitted aged 75 years and over, was below both 2013/14 and 2014/15 levels;
- The number of delayed discharges showed a reduction in the period, and as a consequence BRI bed occupancy also reduced; however the overall number of 14 day stays is slightly above 2014/15 levels;
- The number of patients on both the outpatient and elective waiting lists increased slightly; consistent with this there were fewer 18 week clock (treatment) stops, due to the shorter working month and patient choice to delay pathways, which resulted in a small rise in the number of patients waiting over 18 weeks RTT (see Appendix 3);
- Numbers of patients referred by their GP with a suspected cancer has remained at the seasonal norm, which is starting to lead to a reduction in the number of patients treated on 62-day pathways.

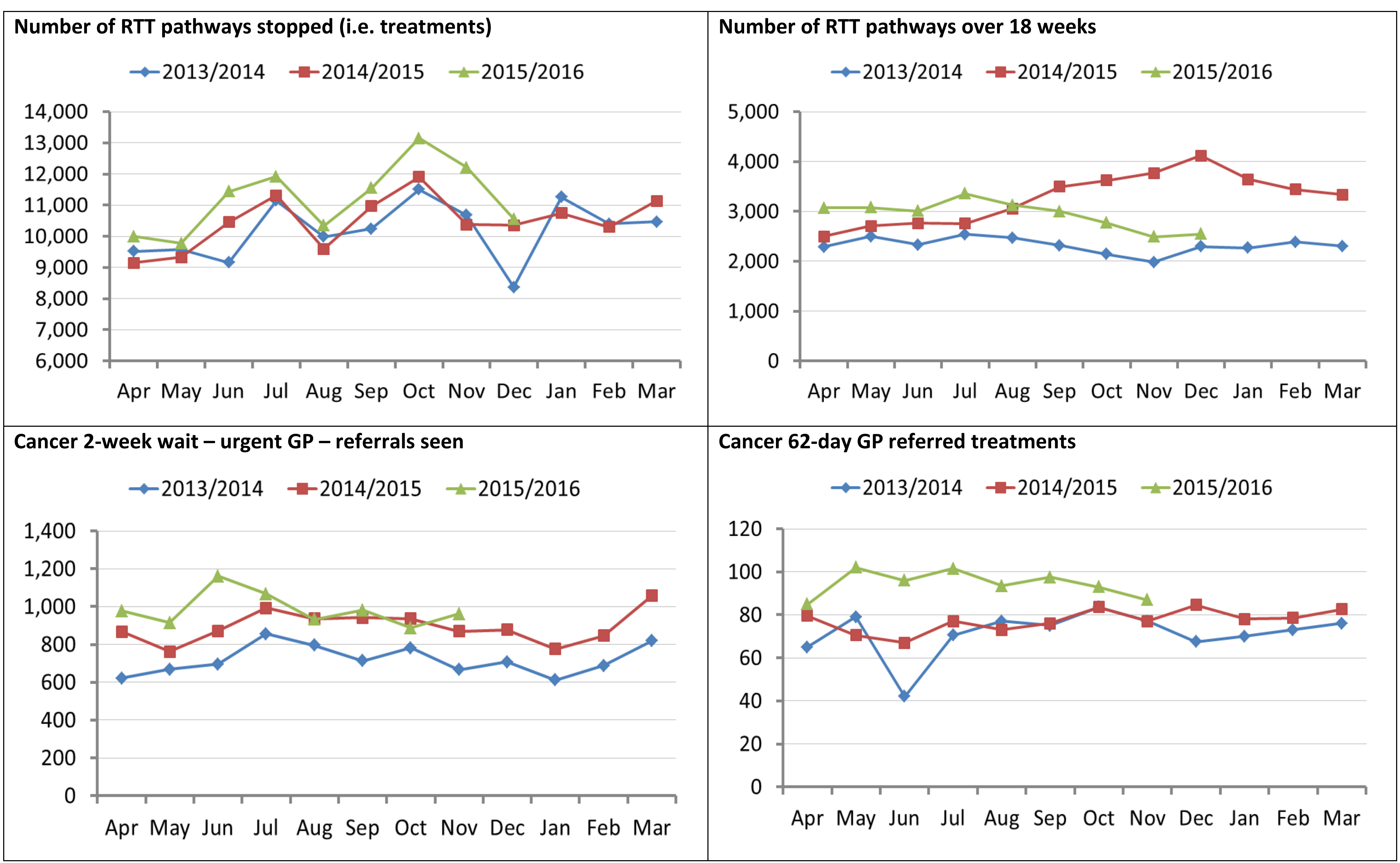
Percentage of Emergency BRI spells patients aged 75 years and over



Over 14 day stays




Delayed discharges
2013/2014
2014/2015
2015/2016
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
BRI Bed Occupancy
2013/2014
2014/2015
2015/2016
110%
105%
100%
95%
90%
85%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Elective waiting list size
2013/2014
2014/2015
2015/2016
14,000
13,000
12,000
11,000
10,000
9,000
8,000
7,000
6,000
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Outpatient waiting list size
2013/2014
2014/2015
2015/2016
45,000
40,000
35,000
30,000
25,000
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Number of RTT pathways stopped (i.e. treatments)
2013/2014
2014/2015
2015/2016
14,000
13,000
12,000
11,000
10,000
9,000
8,000
7,000
6,000
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Number of RTT pathways over 18 weeks
2013/2014
2014/2015
2015/2016
5,000
4,000
3,000
2,000
1,000
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Cancer 2-week wait – urgent GP – referrals seen
2013/2014
2014/2015
2015/2016
1,400
1,200
1,000
800
600
400
200
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Cancer 62-day GP referred treatments
2013/2014
2014/2015
2015/2016
120
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Trust Scorecards

QUALITY

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	14/15	15/16 YTD	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	5	4	4	5	5	1	1	2	2	3	3	3	4	4	5	2	3	4
	DA01	MRSA Bloodstream Cases - Monthly Totals	5	4	0	1	0	1	0	1	0	1	0	0	1	0	1	2	1	1
	DA03	C.Diff Cases - Monthly Totals	50	30	3	4	0	6	1	3	3	1	2	5	3	6	7	10	6	14
	DA02	MSSA Cases - Monthly Totals	33	23	3	2	4	4	1	4	2	3	2	3	2	2	9	9	7	7
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	7	8	8	2	2	3	4	5	5	-	-	-	8	3	5	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.2%	97.4%	97.1%	97.4%	97.6%	97%	96.7%	97.6%	97.7%	97.7%	97.9%	95.8%	98.1%	98.1%	97.4%	97.1%	97.8%	97.3%
	DB02	Antibiotic Compliance	89.3%	87.8%	90.6%	88.8%	88.8%	90.7%	90.9%	88.9%	88.3%	86.1%	82.3%	85.7%	86%	90.6%	89.4%	90.1%	85.7%	87.2%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	96%	96%	96%	95%	95%	93%	95%	93%	93%	94%	94%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	98%	98%	97%	96%	97%	96%	97%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	96%	96%	97%	97%	95%	94%	93%	94%	95%	95%	95%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	78	49	7	4	6	6	6	4	3	8	4	4	9	5	17	16	15	18
	S02a	Number of Confirmed Serious Incidents	71	27	5	4	6	5	3	3	3	8	1	3	1	-	15	11	12	4
	S02b	Number of Serious Incidents Still Open	2	19	2	0	0	0	2	1	0	0	2	1	8	5	2	3	2	14
	S03	Serious Incidents Reported Within 48 Hours	88.5%	77.6%	100%	100%	83.3%	100%	100%	25%	100%	62.5%	100%	100%	44.4%	100%	94.1%	81.3%	80%	72.2%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	73.3%	77.5%	80%	66.7%	100%	75%	85.7%	66.7%	100%	100%	75%	85.7%	66.7%	60%	76.2%	78.6%	87.5%	72.2%
Never Events	S01	Total Never Events	6	3	1	1	1	0	0	0	0	1	0	0	1	1	3	0	1	2
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	12712	9008	1017	1022	1124	1087	1139	1216	1023	1109	1143	1142	1149	-	3163	3442	3275	2291
	S06b	Patient Safety Incidents Per 1000 Beddays	41.32	43.73	37.64	41.85	43.14	42.65	43.43	47.3	39.07	42.88	45.48	43.86	45.33	-	40.81	44.46	42.43	44.59
	S07	Number of Patient Safety Incidents - Severe Harm	89	68	12	7	6	7	5	5	9	13	8	13	8	-	25	17	30	21
Patient Falls	AB01	Falls Per 1,000 Beddays	4.8	3.99	4.89	4.91	4.53	3.61	4.46	3.81	4.05	4.6	3.9	3.53	3.79	4.14	4.77	3.97	4.19	3.82
	AB06a	Total Number of Patient Falls Resulting in Harm	28	20	2	1	2	2	2	0	2	1	1	4	3	5	5	4	4	12
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.387	0.238	0.37	0.45	0.269	0.353	0.267	0.311	0.229	0.232	0.318	0.192	0.079	0.158	0.361	0.31	0.259	0.143
	DE02	Pressure Ulcers - Grade 2	110	49	9	10	5	9	7	7	5	4	7	4	2	4	24	23	16	10
	DE03	Pressure Ulcers - Grade 3	9	6	1	1	2	0	0	1	1	2	1	1	0	0	4	1	4	1
	DE04	Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.8%	98.8%	99.1%	99.4%	99.2%	99.1%	99.3%	99.1%	99.4%	99.3%	99%	98.4%	98.1%	97.4%	99.2%	99.2%	99.2%	98%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.4%	94.5%	92.4%	92.9%	96%	93.9%	93%	94.3%	96.6%	95.2%	95.1%	94%	93.5%	94%	93.8%	93.8%	95.7%	93.9%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	88.9%	90.4%	87.4%	88.4%	87.9%	86.8%	93%	92.3%	90.7%	86.6%	86.5%	91.5%	91.6%	93.2%	87.9%	90.9%	87.9%	92.1%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.9%	100%	100%	100%	100%	99.7%	100%	100%	100%	100%	100%	99.8%	100%	100%	99.9%	100%	99.9%

QUALITY (continued)

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Patient Safety																				
Medicines	WA01	Medication Errors Resulting in Harm	0.45%	0.07%	0%	0%	0.54%	0%	0.56%	0%	0%	0%	0%	0%	0%	-	0.21%	0.18%	0%	0%
Medicines	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.01%	0.85%	1.55%	1.54%	0.52%	0.63%	1.43%	0.96%	0.83%	0.73%	0.75%	0.78%	0.62%	1.03%	1.23%	0.96%	0.77%	0.8%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	96.6%	97.1%	96.7%	97.9%	96.5%	97.5%	97.1%	98.2%	97.4%	96.4%	96.2%	97.3%	95.9%	97.9%	97%	97.6%	96.7%	97.1%
Safety Thermometer	AK04	Safety Thermometer - No New Harms	98.4%	98.5%	98.4%	99.3%	98.7%	98.9%	98.2%	98.6%	98.6%	98%	98%	98.9%	97.9%	99.1%	98.8%	98.6%	98.2%	98.6%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	89%	92%	92%	96%	88%	90%	96%	91%	98%	90%	92%	92%	91%	90%	92%	92%	94%	91%
Out of Hours	TD05	Out of Hours Departures	10.4%	11%	10.7%	9%	10.4%	9%	11.7%	11.6%	10.1%	11.7%	11.7%	12.9%	11.1%	9.3%	10.1%	10.8%	11.2%	11.1%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	19.5%	19.6%	18.5%	22.3%	20.6%	20.4%	19%	18.6%	19.9%	17.8%	19.8%	18.9%	19.3%	22.3%	20.4%	19.3%	19.2%	20.2%
Timely Discharges	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9862	7615	809	877	873	845	838	789	879	738	844	845	834	1003	2559	2472	2461	2682
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	97.9%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CAS Alerts	CS03	Number of CAS Alerts Overdue At Month End	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.6%	102.7%	104.6%	103.4%	102.4%	100.4%	100.3%	101.8%	102.8%	100.5%	103.1%	105.8%	104.8%	104.8%	103.5%	100.8%	102.1%	105.1%
Clinical Effectiveness																				
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital Deat	64.1	63.4	68.6	60.8	63.9	54.8	62	66	58.4	65	66.6	66.7	68.4	-	64.8	60.9	63.3	67.5
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	96.5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mortality	X06	Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline	68.3	64.6	70.3	57.8	68.6	56.6	71.7	64.7	56.4	64	61.7	69.5	73.1	-	66.1	64	60.6	71.3
Readmissions	C01	Emergency Readmissions Percentage	2.83%	2.9%	3.12%	2.83%	2.96%	3.01%	3.55%	2.7%	2.75%	2.89%	2.77%	2.83%	2.77%	-	2.97%	3.08%	2.8%	2.8%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	61.5%	62.1%	60%	59.8%	57.9%	60.9%	63.4%	64.1%	57.3%	62.5%	62.4%	61.3%	63.9%	63.4%	59.3%	62.8%	60.7%	62.9%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	76%	75.1%	78.3%	89.7%	72.7%	71.4%	72%	66.7%	76%	81.5%	85.7%	80.8%	76.5%	66.7%	81.1%	70.2%	81.3%	74%
Fracture Neck of Femur	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	93.4%	83.1%	95.7%	93.1%	86.4%	77.1%	68%	91.7%	80%	85.2%	78.6%	92.3%	94.1%	86.7%	91.9%	78.6%	81.3%	90.4%
Fracture Neck of Femur	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	70.1%	63.60%	78.3%	82.8%	50%	57.1%	52%	66.7%	60%	70.4%	64.3%	73.1%	70.6%	61.2%	71.6%	58.3%	65%	68.1%
Fracture Neck of Femur	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	45.5	37	47.5	45.5	56.2	55.8	46.7	40.2	39.4	42.4	44.4	44.8	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	56.5%	60.4%	55%	66.7%	60%	68.6%	65.7%	56.1%	43.8%	67.4%	62.2%	57.5%	59.5%	-	61.2%	63.1%	59.2%	58.4%
Stroke Care	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	86.4%	94.5%	75%	87%	92.5%	97.1%	97.2%	97.6%	93.8%	95.3%	93.3%	90.2%	91.9%	-	85.1%	97.3%	94.2%	91%
Stroke Care	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.2%	62%	50%	57.1%	50%	69.2%	83.3%	30.8%	58.8%	100%	75%	54.5%	62.5%	47.1%	52.8%	60.5%	73.5%	52.8%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	65%	90.3%	78.3%	77.3%	81.6%	83.9%	88.4%	82.7%	83.3%	92.5%	91.1%	97.6%	97.2%	95%	79.3%	84.9%	88.8%	96.6%
Dementia	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	84.1%	95.7%	90.7%	88.5%	94.2%	98.6%	100%	92.8%	90%	92.3%	93.2%	98.4%	96.9%	98.4%	91.7%	97%	91.8%	97.9%
Dementia	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	58.5%	90.7%	82.4%	81.3%	90.5%	90%	92.3%	92.9%	80%	100%	88.9%	100%	83.3%	100%	85.2%	91.5%	88.9%	91.3%
Dementia	AC04	Percentage of Dementia Carers Feeling Supported	75.2%	86.5%	87.5%	81.8%	-	90.9%	100%	93.3%	92.3%	76.9%	70%	100%	72.7%	72.7%	85.2%	94.6%	80.6%	84.2%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	11260	6517	1364	847	889	647	629	760	833	839	815	722	575	697	3100	2036	2487	1994

QUALITY (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			14/15	15/16 YTD	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	89	90	89	89	92	89	91	90	90	90	90	-	89	90	90	90
	P01g	Patient Survey - Kindness and Understanding	-	-	93	93	93	94	96	93	93	95	94	94	95	-	93	94	94	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	-	-	-	89	89	89	88	89	89	88	88	-	-	89	89	88
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	38.7%	18.3%	37.9%	33.9%	59.3%	17.4%	19.7%	16.2%	20.5%	10.4%	19.8%	19.3%	20.4%	20.6%	44%	17.7%	17.1%	20.1%
	P03b	Friends and Family Test ED Coverage	20.8%	12.4%	17.3%	22.5%	37.1%	6.6%	6.7%	7%	12.3%	14.7%	17.8%	15.9%	16.4%	13.9%	26.1%	6.7%	14.9%	15.4%
	P03c	Friends and Family Test MAT Coverage	28.9%	22.1%	26.9%	22.5%	35%	23.9%	33.7%	20.1%	22.1%	18.3%	14.6%	25.3%	20.2%	20.3%	28.2%	26.1%	18.5%	21.8%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	94.9%	96.3%	95.9%	93.3%	95.5%	96.1%	95.5%	96.3%	97.2%	97.2%	96.2%	96.2%	96.5%	95.6%	95.1%	96%	96.8%	96.1%
	P04b	Friends and Family Test Score - ED	92.7%	75.7%	93.4%	89.9%	93.5%	80.7%	66.3%	70.4%	78.1%	77.3%	76.6%	72.2%	76.2%	80%	92.5%	72.2%	77.2%	75.9%
	P04c	Friends and Family Test Score - Maternity	94.2%	96.8%	97.1%	97.1%	91.5%	97.3%	93.3%	97.8%	98.7%	97.1%	96.3%	98.2%	96.9%	97.7%	94.9%	95.6%	97.6%	97.6%
Patient Complaints	T01	Number of Patient Complaints	1883	1465	165	171	181	158	147	154	207	168	185	182	148	116	517	459	560	446
	T01a	Patient Complaints as a Proportion of Activity	0.261%	0.257%	0.267%	0.291%	0.273%	0.266%	0.25%	0.231%	0.315%	0.302%	0.279%	0.267%	0.219%	0.19%	0.277%	0.249%	0.298%	0.227%
	T03a	Complaints Responded To Within Trust Timeframe	85.9%	75.4%	84.8%	83.7%	85.3%	89.5%	83.9%	82.1%	87%	80.9%	83.3%	60.7%	59.5%	50.8%	84.7%	84.9%	83.9%	56.5%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	91.1%	87.9%	81.4%	92.6%	93%	91.9%	94%	98.1%	93.6%	95.8%	80.4%	81%	90.5%	88.1%	93%	96%	84.5%
	T04c	Percentage of Responses where Complainant is Dissatisfied	-	6.24%	-	-	-	1.75%	3.23%	4.48%	7.41%	6.38%	14.58%	8.93%	4.76%	-	-	3.23%	9.4%	7.14%
Ward Moves	J06	Average Number of Ward Stays	2.32	2.25	2.24	2.28	2.24	2.31	2.18	2.19	2.25	2.28	2.28	2.23	2.25	2.27	2.25	2.22	2.27	2.25
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.08%	0.9%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.04%	0.46%	0.83%	0.64%	0.86%	0.7%	0.97%	1.19%	0.78%	0.73%
	F01a	Number of Last Minute Cancelled Operations	749	466	58	46	66	66	63	70	62	25	50	40	51	39	170	199	137	130

ACCESS

			Annual Target		Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	Green	Red	14/15	15/16 YTD	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Referral to Treatment (RTT)	A01	Referral To Treatment Admitted Under 18 Weeks	90%	90%	84.9%	82.4%	80.5%	80.4%	80.5%	79.9%	81%	80.4%	84.2%	85.1%	82.5%	83.1%	79.9%	85%	80.5%	80.4%	84%	82.6%
	A02	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	90.3%	89.5%	88.9%	89.3%	90%	90.2%	91.4%	90.7%	89.2%	88.9%	88.7%	89%	88.7%	89.3%	89.4%	90.8%	89%	89%
	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	90.4%	90.9%	88.8%	89.4%	89.7%	90.5%	90.4%	90.7%	90.2%	90.5%	90.7%	91.1%	92%	91.8%	89.3%	90.6%	90.4%	91.6%
Referral to Treatment (RTT) Ongoing Volumes	A03A	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3641	3440	3339	3069	3078	3010	3357	3128	3004	2772	2491	2544	-	-	-	-
	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	59	6	9	11	4	4	1	0	0	0	1	0	0	-	24	5	1	0
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	1842	416	160	161	119	116	89	38	45	38	28	25	22	15	440	243	111	62
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.5%	95.9%	94.3%	95.8%	93.1%	94.2%	94.9%	95.3%	97.3%	95.4%	96.8%	97.5%	95.8%	-	94.3%	94.8%	96.5%	96.6%
	E01b	Cancer - Breast Symptom Referrals Seen In Under 2 Weeks	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.9%	97.3%	97.9%	98.4%	97%	95.8%	99.5%	95.3%	96.7%	96.7%	97.3%	98.7%	98.1%	-	97.7%	96.9%	96.9%	98.4%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.6%	99.1%	99%	98.1%	100%	100%	97.8%	100%	99.1%	98.1%	98.6%	99.1%	100%	-	99%	99.3%	98.6%	99.5%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.9%	96.6%	95.6%	94.4%	95.9%	94.1%	97.4%	97.9%	89.1%	100%	97.6%	97.9%	100%	-	95.4%	96.4%	95.6%	98.8%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.6%	96.9%	96.5%	97.7%	97.2%	97.5%	98.1%	94.7%	96.1%	98.4%	96%	96.2%	98.1%	-	97.1%	96.7%	96.8%	97.1%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	79.7%	80.8%	75.2%	79.4%	76.5%	77%	77.6%	83.7%	80.7%	81%	79.6%	81.6%	-	78.5%	77%	81.9%	80.6%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	89%	72.1%	71.4%	60%	100%	100%	81.3%	62.5%	76.9%	70%	85.7%	14.3%	71.4%	-	80.6%	78.6%	78.4%	52.4%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	90.1%	88.7%	84.4%	94.4%	87.2%	100%	83.3%	76.9%	80.8%	86.7%	91.2%	93.6%	92.7%	-	88.8%	85.2%	87.6%	93.2%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	1.5%	1.08%	0.9%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.04%	0.46%	0.83%	0.64%	0.86%	0.7%	0.97%	1.19%	0.78%	0.73%
	F02c	Number of LMCs Not Re-admitted Within 28 Days	36	36	75	57	7	3	3	10	12	12	7	4	2	5	3	2	13	34	13	10
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	79.7%	77.6%	78.3%	87.1%	83.9%	77.5%	80.5%	86.4%	73.2%	76%	76%	75.7%	78%	-	82.4%	80.6%	74.7%	76.9%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	92.4%	93.8%	95.7%	96.8%	90.3%	95%	95.1%	90.9%	92.7%	100%	92%	89.2%	95.1%	-	94.4%	94.2%	94.5%	92.3%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.47%	98.95%	95.48%	97.92%	97.9%	98.27%	98.63%	99%	98.83%	98.63%	99.01%	99.59%	99.37%	99.2%	97.11%	98.64%	98.83%	99.39%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	9.2%	11.8%	9.4%	9.4%	9.4%	11.6%	11.7%	11.6%	11.7%	12.8%	12.1%	11.1%	10.7%	13.2%	9.4%	11.6%	12.2%	11.6%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	49	43	39	30	58	51	41	59	48	54	41	30	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	13	11	9	16	20	6	19	11	11	12	10	4	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.26	4.17	4.46	4.24	4.36	4.41	3.83	4.2	4.12	4	4.58	4.18	4.11	4.12	4.36	4.14	4.23	4.14

ACCESS (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 14/15	Annual 15/16 YTD	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Emergency Department Indicators																						
Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	92.23%	92.87%	90.87%	89.53%	95.01%	94.81%	93.47%	95.2%	95.51%	94.95%	91.69%	92.16%	89.6%	88.89%	91.92%	94.48%	94.04%	90.23%
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	10	0	10	0	0	0	0	0	0	0	0	0	0	0	10	0	0	0
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95%	95%	97.2%	87.9%	99.7%	99.8%	87.9%	87.9%	88.3%	89.3%	92.1%	92%	87.1%	87.6%	83.2%	84.9%	95.1%	88.5%	90.3%	85.2%
	B02a	ED Time to Initial Assessment - 95th Percentile	15	15	15	31	14	14	29	30	30	28	23	21	32	30	42	37	15	30	26	25
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	78.3%	93%	77.7%	76.1%	94.5%	93.2%	92.2%	92.3%	93.4%	91.6%	92.8%	93.2%	94.1%	93.8%	83%	92.6%	92.6%	93.7%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	55.4%	54.5%	60.6%	59.6%	56.3%	57.2%	53.5%	53.9%	57.5%	60.4%	53.2%	52.8%	49.8%	53.1%	58.8%	54.8%	57%	51.9%
	B03a	ED Time to Start of Treatment - Median	60	60	54	55	48	50	53	51	56	56	52	48	56	57	61	56	50	54	52	58
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	99.3%	99%	99.5%	99.5%	99.3%	99.3%	99.1%	98.5%	99.1%	99.2%	98.7%	98.8%	99%	98.9%	99.4%	99%	99%	98.9%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.3%	2.9%	2.7%	2.5%	2.5%	2.7%	3%	2.6%	2.9%	2.5%	2.9%	2.7%	3.1%	3.5%	2.6%	2.8%	2.8%	3.1%
	B05	ED Left Without Being Seen Rate	5%	5%	1.8%	2.3%	1.6%	1.5%	1.6%	1.9%	2.4%	2.9%	2.3%	2%	2.3%	2.4%	2.4%	2.2%	1.6%	2.4%	2.2%	2.3%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	1032	1032	1287	573	119	78	49	46	46	29	38	36	92	96	86	104	246	121	166	286

WORKFORCE

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Sickness	AF02	Sickness Rate	4.2%	4.2%	4.7%	4.6%	4.3%	4.2%	4%	4.1%	4.2%	3.9%	4.1%	4.3%	4.2%	4.5%	4.5%	4.1%	4.1%	4.3%
Staffing Numbers	AF08	Funded Establishment FTE	-	-	7927.2	7912.4	7958.8	7976.8	8011.6	8088.3	8096.3	8110.8	8128.9	8168.6	8197.6	8199.8	-	-	-	-
	AF09A	Actual Staff FTE (Including Bank & Agency)	-	-	8004.1	8088.6	8130.6	8080.5	8123.2	8114.4	8069.3	8149.2	8253.7	8280.5	8198	8180	-	-	-	-
	AF13	Percentage Over Funded Establishment	-	-	1%	2.2%	2.2%	1.3%	1.4%	0.3%	-0.3%	0.5%	1.5%	1.4%	0%	-0.2%	-	-	-	-
Bank Usage	AF04	Workforce Bank Usage	-	-	373.9	432.2	416.2	368.6	424.2	423.5	395	399.2	446.2	408.4	339.3	336.1	-	-	-	-
	AF11A	Percentage Bank Usage	-	-	4.7%	5.3%	5.1%	4.6%	5.2%	5.2%	4.9%	4.9%	5.4%	4.9%	4.1%	4.1%	-	-	-	-
Agency Usage	AF05	Workforce Agency Usage	-	-	138.9	157.3	170.3	165.8	148.3	157.3	163.5	185.2	193.1	180	156.1	134	-	-	-	-
	AF11B	Percentage Agency Usage	-	-	1.7%	1.9%	2.1%	2.1%	1.8%	1.9%	2%	2.3%	2.3%	2.2%	1.9%	1.6%	-	-	-	-
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	-	-	435.8	413.3	414.7	333.2	368.5	463.6	507.9	465.1	436	416.4	420.1	431.3	-	-	-	-
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	-	-	5.5%	5.2%	5.2%	4.2%	4.7%	5.8%	6.3%	5.8%	5.4%	5.1%	5.2%	5.3%	-	-	-	-
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	2415	1629	162	239	199	121	174	156	147	398	227	146	148	112	600	451	772	406
	AF10	Workforce Turnover Rate			13.7%	13.8%	13.9%	13.8%	14.1%	14.1%	13.7%	13.7%	13.6%	13.7%	13.9%	13.8%				
Training	AF20	Essential Training Compliance	-	-	83%	85%	88%	89%	89%	89%	90%	90%	89%	91%	91%	91%	-	-	-	-

Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive)

Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive)

Turnover is a rolling 12 months. It's number of permanent leavers over the 12 month period, divided by average staff in post over the same period. Average staff in post is staff in post at start PLUS stafff in post at end, divided by 2.

Appendix 1

Glossary of useful abbreviations, terms and standards

Abbreviation, term or standard	Definition
BCH	Bristol Children's Hospital – or full title, the Royal Bristol Hospital for Children
BDH	Bristol Dental Hospital
BEH	Bristol Eye Hospital
BHI	Bristol Heart Institute
BRI	Bristol Royal Infirmary
CQC	Care Quality Commission
DNA	Did Not Attend – a national term used in the NHS for a patient failing to attend for their appointment or admission
FFT	Friends & Family Test This is a national survey of whether patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. There is a similar survey for members of staff.
Fracture neck of femur Best Practice Tariff (BPT)	There are eight elements of the Fracture Neck of Femur Best Practice Tariff, which are as follows: 1. Surgery within 36 hours from admission to hospital 2. Multi-disciplinary Team rehabilitation led by an Ortho-geriatrician 3. Ortho-geriatric review within 72 hours of admission 4. Falls Assessment 5. Joint care of patients under Trauma & Orthopaedic and Ortho-geriatric Consultants 6. Bone Health Assessment 7. Completion of a Joint Assessment 8. Abbreviated Mental Test done on admission and pre-discharge
ICU / ITU	Intensive Care Unit / Intensive Therapy Unit

LMC	Last-Minute Cancellation of an operation for non-clinical reasons
NA	Nursing Assistant
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
RCA	Root Cause Analysis
RN	Registered Nurse
RTT	Referral to Treatment Time – which measures the number of weeks from referral through to start of treatment. This is a national measure of waiting times.
STM	St Michael's Hospital

Appendix 2

Other Essential Training Compliance Figures for December 2015

Safeguarding Adults:

Level 1: 91.8% (previous month 92.0%)
Level 2: 86.0% (previous month 84.8%)
Level 3: 35.4% (previous month 37.5%)

Safeguarding Children:

Level 1: 91.1% (previous month 91.7%)
Level 2: 90.7% (previous month 90.3%)
Level 3: 76.7% (core) (previous month 78.4%)
Level 3: 78.0% (specialist) (previous month 77.8%)

Resuscitation: 76.6% (previous month 74.7%)

Appendix 2 (continued)

Summary of Monitor submission showing performance against agency cap requirements 1st December to 31st December

Framework and price cap compliance

Number of shifts (Reported via Temporary Staffing Bureau)	(i) Exceeded price cap only	(ii) Non Framework but within price cap	(iii) Both framework and price cap exceeded
Nursing & Midwifery	335	16	230
Healthcare Assistant and other support	21	2	2
Medical and Dental	179	-	-

.

Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level for November 2015/16, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Breast†	100%	-	94.4%
Gynaecology	90.9%	85%	80.9%
Haematology (excluding acute leukaemia)	100%	85%	79.5%
Head and Neck	84.6%	79%	68.1%
Lower Gastrointestinal	36.4%	79%	76.4%
Lung	67.7%	79%	75.4%
Other*	100%	-	72.5%
Sarcoma*	100%	-	78.7%
Skin	95.8%	96%	95.2%
Upper Gastrointestinal	58.8%	79%	74.7%
Urology*	50.0%	-	79.0%
Total (all tumour sites)	**81.6%**	**85.0%**	**83.3%**
Monthly trajectory target	**78.0%**		

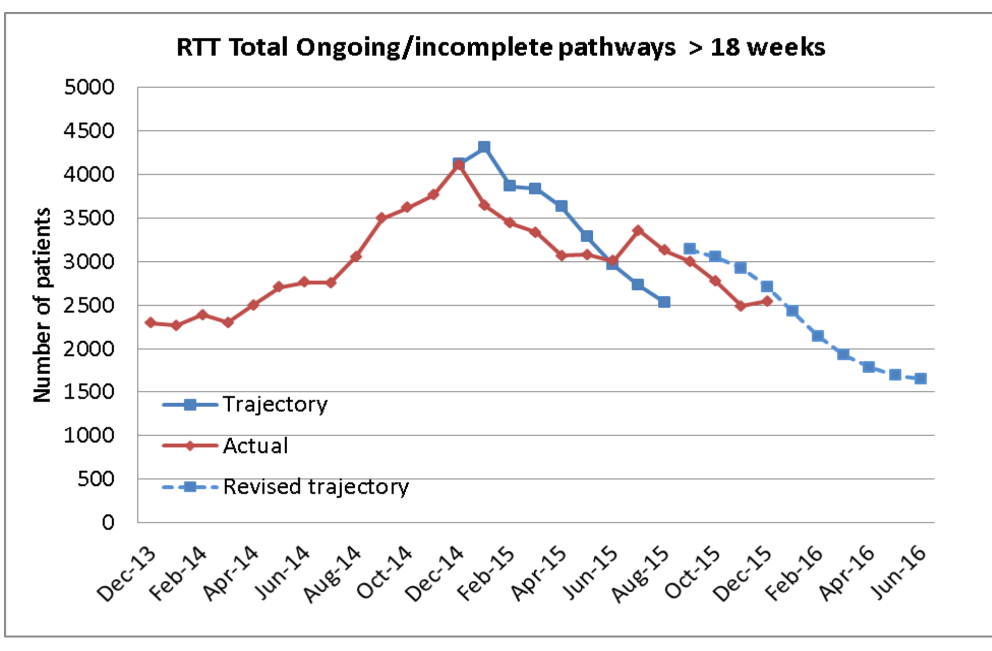
*3 or fewer patients treated in accountability terms
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

Appendix 3 (continued)

Access standards – further breakdown of figures

B) RTT Incomplete/Ongoing pathways standard – numbers and percentage waiting over 18 weeks by national RTT specialty in December 2015

RTT Specialty	Ongoing Pathways Over 18 weeks	Ongoing Pathways	Ongoing Performance
Cardiology	336	2,154	84.4%
Cardiothoracic Surgery	15	261	94.3%
Dermatology	44	1,634	97.3%
E.N.T.	67	2,191	96.9%
Gastroenterology	70	507	86.2%
General Medicine	0	42	100.0%
Geriatric Medicine	3	160	98.1%
Gynaecology	55	1,266	95.7%
Neurology	103	406	74.6%
Ophthalmology	168	4,100	95.9%
Oral Surgery	104	2,662	96.1%
Other	1,466	13,414	89.1%
Rheumatology	3	362	99.2%
Thoracic Medicine	5	768	99.3%
Trauma & Orthopaedics	103	1,103	90.7%
Urology	2	2	0.0%
Grand Total	2,544	31,032	91.8%



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Non-admitted pathways (target/actual)	1977/1963	1911/1725	1811/1634	1689/1632	1498	1313	1190
Admitted pathways (target/actual)	1165/1041	1143/1047	1130/857	1023/912	923	814	707
Total pathways (target/actual)	3142/3004	3054/2772	2923/2491	2710/2544			
Target % incomplete < 18 weeks	90.6%	90.9%	91.1%	91.7%	92.4%	93.2%	93.9%
Actual target % incomplete < 18 weeks	90.7%	91.1%	92.0%	91.8%			

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
09. Quarterly Complaints and Patient Experience Reports									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Authors**: Paul Lewis, Patient Experience Lead (surveys and evaluation); and Tanya Tofts, Patient Support & Complaints Manager									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Patient Experience

- The Trust continued to achieve "green" patient satisfaction ratings in the Trust Board Quality Dashboard: reflecting the provision of a generally high quality patient experience at UH Bristol.
- Negative outliers in respect of patient reported experience in this period include:
  - Waiting times in outpatient clinics at the Bristol Royal Hospital for Children.
  - Kindness and understanding ratings on postnatal wards (although these scores are in line with maternity service norms nationally).
  - Inpatient experience scores at the South Bristol Community Hospital.
  - Friends and Family Test survey scores for the Bristol Royal Hospital for Children and Bristol Royal Infirmary Emergency Departments.
  - Relatively low patient satisfaction on ward A900 (principally from patients receiving care for Cystic Fibrosis).

The report outlines the reasons for these findings and actions being taken in response to them.

Complaints

- 560 complaints were received in Quarter 2 of 2015/16 (Q2), representing 0.30% of activity, compared to 459 complaints (0.25%) in Quarter 1 (Q1).
- The Trust's performance in responding to complaints within the timescales agreed with complainants was 83.9% in Q2, compared to 84.9% in Q1. In Q2, 45.8% of these breaches were attributed to Divisions, compared to 85.7% in Q1.
- In Q2, complaints relating to appointments and admissions continued to account for over a third (36%) of the total complaints received by the Trust.
- Complaints about cancelled or delayed appointments and operations increased in Q2 to 151, compared with 124 in Q1.
- Complaints about failure to answer telephones decreased to 22 in Q2, after increasing for five consecutive quarters.
- Complaints about Bristol Eye Hospital decreased to 56 in Q2, compared with 71 in both of the previous Quarters.
- Complaints about outpatient services in the Bristol Heart Institute increased slightly from 21 in Q1 to 26 in Q2.
- Complaints about the Bristol Royal Infirmary Emergency Department increased from 18 in Q1 to 26 in Q2.

Links between complaints and survey data in Quarter 1

- The Bristol Royal Infirmary Emergency Department had a low Friends and Family Test (FFT) survey score in Quarter 2, and also saw a rise in complaints. However, the FFT score was attributable to the methodology used to collect the data and so this should not be viewed evidence of a correlation.
- Although the themes emerging from survey comments and complaints are not directly comparable, "waiting and delays" are consistent issues that patients raise via both complaint and survey channels.

Recommendations

The Committee is recommended to receive these reports for assurance

Impact Upon Board Assurance Framework

The complaints report supports achievement of the objective, "To establish an effective and sustainable complaints function to ensure patients receive timely and comprehensive responses to the concerns they raise and that learning from complaints inform service planning and day to day practice."

Impact Upon Corporate Risk

The complaints report provides assurances that the Trust's Patient Support & Complaints Team is continuing to respond to enquiries with appropriate timescales, i.e. with a sustained 'no backlog' position (previously a corporate risk).

Implications (Regulatory/Legal)

The complaints report supports compliance with the Care Quality Commission's Fundamental Standard for complaints, Regulation 16. The patient experience report provides assurance in relation to the Care Quality Commission's Fundamental Standard, Regulation 10: respect and dignity.

Equality & Patient Impact

A new addition to the quarterly Complaints report is data describing the known 'protected characteristics' of people who complaint about our services. Going forward, the intention is to develop and use this data to help make our complaints service more accessible to all patients.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
			x	Patient Experience Group

Complaints Report

Quarter 2, 2015/2016

(1 July to 30 September 2015)

Author: **Tanya Tofts, Patient Support and Complaints Manager**

1. Executive summary

- 560 complaints were received in Quarter 2 of 2015/16 (Q2), representing 0.30% of activity, compared to 459 complaints (0.25%) in Quarter 1 (Q1) and 517 (0.28%) in Quarter 4 of 2014/15 (Q4).
- In Q2, of the complaints received, 166 (30%) were dealt with through the formal complaints process, whilst 394 (70%) were resolved informally. This compares to 175 (38%) formal and 284 (62%) informal in Q1.
- The Trust's performance in responding to complaints within the timescales agreed with complainants was 83.9% in Q2 compared to 84.9% in Q1 and 84.7% in Q4. In Q2, 45.8% of breaches (11/24) were attributed to Divisions, compared to 85.7% (24/28) in Q1 and 63% (17/27) in Q4.
- The number of cases where the original response deadline was extended decreased to 35 in Q2, compared to 44 cases in Q1 (27 in Q4).
- The way in which the Trust reports the number of complainants who tell us that they are unhappy with our investigation of their concerns changed with effect from Q1. "Dissatisfied" cases are now reported as a percentage of the total number of responses sent out in a given month. At the time of finalising the data for this report (14th November 2015), performance for Q2 is 6.7% (i.e. by this date, of the 149 responses sent out during Q2, 10 complainants had told us that they were dissatisfied), compared to 3.2% in Q1.[1]
- In Q2, complaints relating to appointments and admissions continued to account for over a third (36%) of the total complaints received by the Trust, in line with each quarter of 2014/15 and Q1 of 2015/16.
- Complaints about cancelled or delayed appointments and operations increased again in Q2 to 151, compared with 124 in Q1.
- Complaints about failure to answer telephones decreased to 22 in Q2, after increasing for five consecutive quarters to 34 in Q1.
- Complaints about Bristol Eye Hospital decreased to 56 in Q2, compared with 71 in both Q1 of 2015/16 and Q4 of 2014/15.
- Complaints about outpatient services in the Bristol Heart Institute increased slightly from 21 in Q1 to 26 in Q2.
- Complaints about the Emergency Department (BRI) increased from 18 in Q1 to 26 in Q2.
- During Q2, the Trust has been advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in three new complaints.
- In Q2, the Patient Support and Complaints Team acknowledged 99.1% of verbal complaints within two days and 97.3% of written complaints within three days.

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

[1] For consistency, Q1 figure of 3.2% is as reported in the Q1 Complaints Report 2015/16.

2. Complaints performance – Trust overview

The Board 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 5 of this report provides a comprehensive 13 month overview of complaints performance including all three key indicators. The change to the way in which dissatisfied cases is recorded shown with effect from April 2015.

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. total inpatient admissions and outpatient attendances in a given month.

We received 560 complaints in Q2, which equates to 0.30% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[2]; the figures do not include concerns which may be raised by patients and dealt with immediately by front line staff. The volume of complaints received in Q2 represents an increase of approximately 22% compared to Q1 (459) and an 8% increase on the corresponding period a year ago.

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, or arrange a meeting to discuss, our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days.

The Trust's target is to respond to at least 95% of complainants within the agreed timescale . The end point is measured as the date when the Trust's response is posted to the complainant. In Q2, 83.9% of responses were posted within the agreed timescale, compared to 84.9% in Q1. This represents 24 breaches out of 149 formal complaints which were due to receive a response during Q2[3]. Figure 1 shows the Trust's performance in responding to complaints since June 2014.

[2] 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.
[3] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

Figure 1. Percentage of complaints responded to within agreed timescale

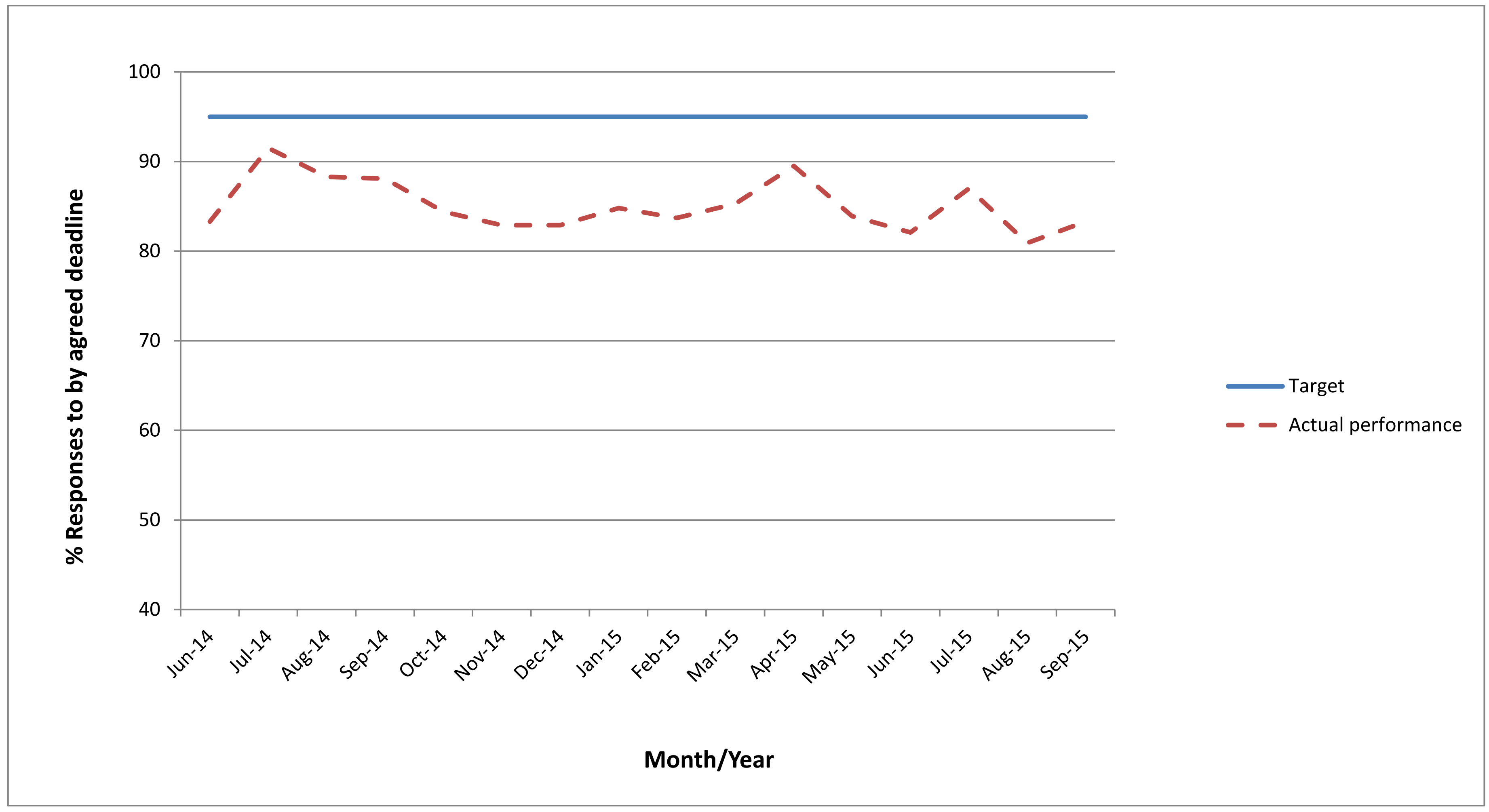


Table 1 – Complaints performance

Items in italics are reportable to the Trust Board.

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

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Total complaints received (inc. TS and F&E from April 2013)	170	148	14	133	165	171	181	158	147	154	207	168	185
Formal/Informal split	86/84	68/80	61/79	52/81	70/95	79/92	88/93	72/86	46/101	57/97	61/146	51/117	54/131
Number & % of complaints per patient attendance in the month	*0.27% 170 of 63,794*	*0.22% 148 of 66,104*	*0.25% 140 of 55,703*	*0.22% 133 of 59,487*	*0.27% 165 of 61,683*	*0.29% (171 of 58,687)*	*0.27% (181 of 66,317)*	*0.27% (158 of 59,419)*	*0.25% (147 of 58,716)*	*0.23% (154 of 66,548)*	*0.31% (207 of 65,810)*	*0.30% (168 of 55.657)*	*0.28% (185 of 66,285)*
% responded to within the agreed timescale (i.e. response posted to complainant)	*88.1% (52 of 59)*	*84.4% (65 of 77)*	*82.9% (58 of 70)*	*82.9% (58 of 70)*	*84.8% (56 of 66)*	*83.7% (36 of 43)*	*85.3% (58 of 68)*	*89.5% (51 of 57)*	*83.9% (52 of 62)*	*82.1% (55 of 67)*	*87.0% (47 of 54)*	*80.9% (38 of 47)*	*83.3% (40 of 48)*
% responded to by Division within required timescale for executive review	81.4% (48 of 59)	77.9% (60 of 77)	78.6% (55 of 70)	87.1% (61 of 70)	87.9% (58 of 66)	81.4% (35 of 43)	92.6% (63 of 68)	87.7% (50 of 57)	91.9% (57 of 62)	94.0% (63 of 67)	98.1% (53 of 54)	93.6% (44 of 47)	95.8% (46 of 48)
Number of breached cases where the breached deadline is attributable to the Division	6 of 7	6 of 12	6 of 12	1 of 12	7 of 10	2 of 7	8 of 10	3 of 6	9 of 10	12 of 12	6 of 7	3 of 9	2 of 8
Number of extensions to originally agreed timescale (formal investigation process only)	17	20	15	11	16	4	7	7	21	16	11	14	10
Percentage of Complainants Dissatisfied with Response								*1.8% (1 case)*	*1.6% (1 case)*	*1.5% (1 case)*	*1.9% (1 case)*	*4.3% (2 cases)*	*14.6% (7 cases)*

Figures 2 and 3 show the increase in the volume of complaints received in Q2 (2015/16) compared to Q1 (2015/16) and also when compared to the corresponding period last year.

Figure 2: Number of complaints received

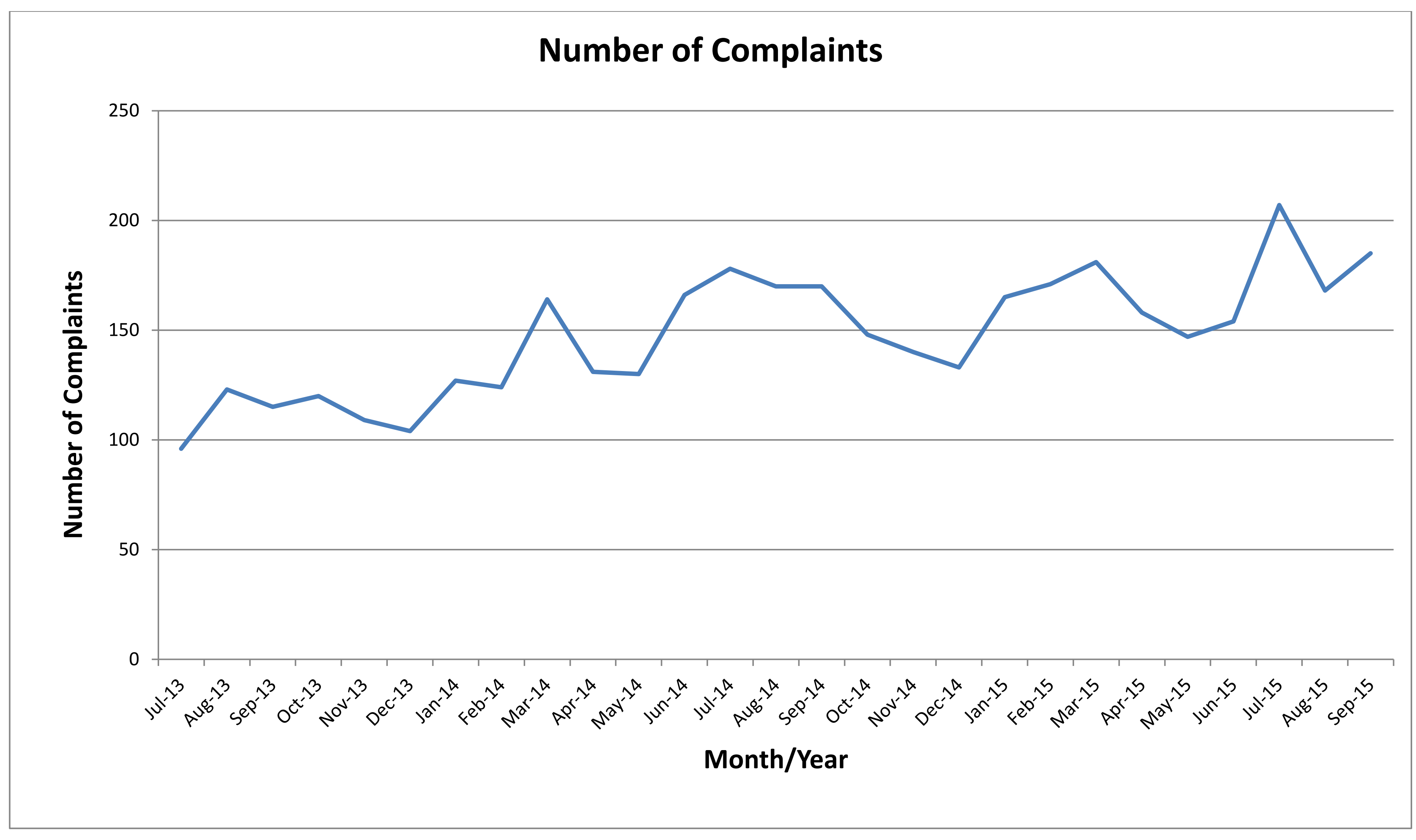
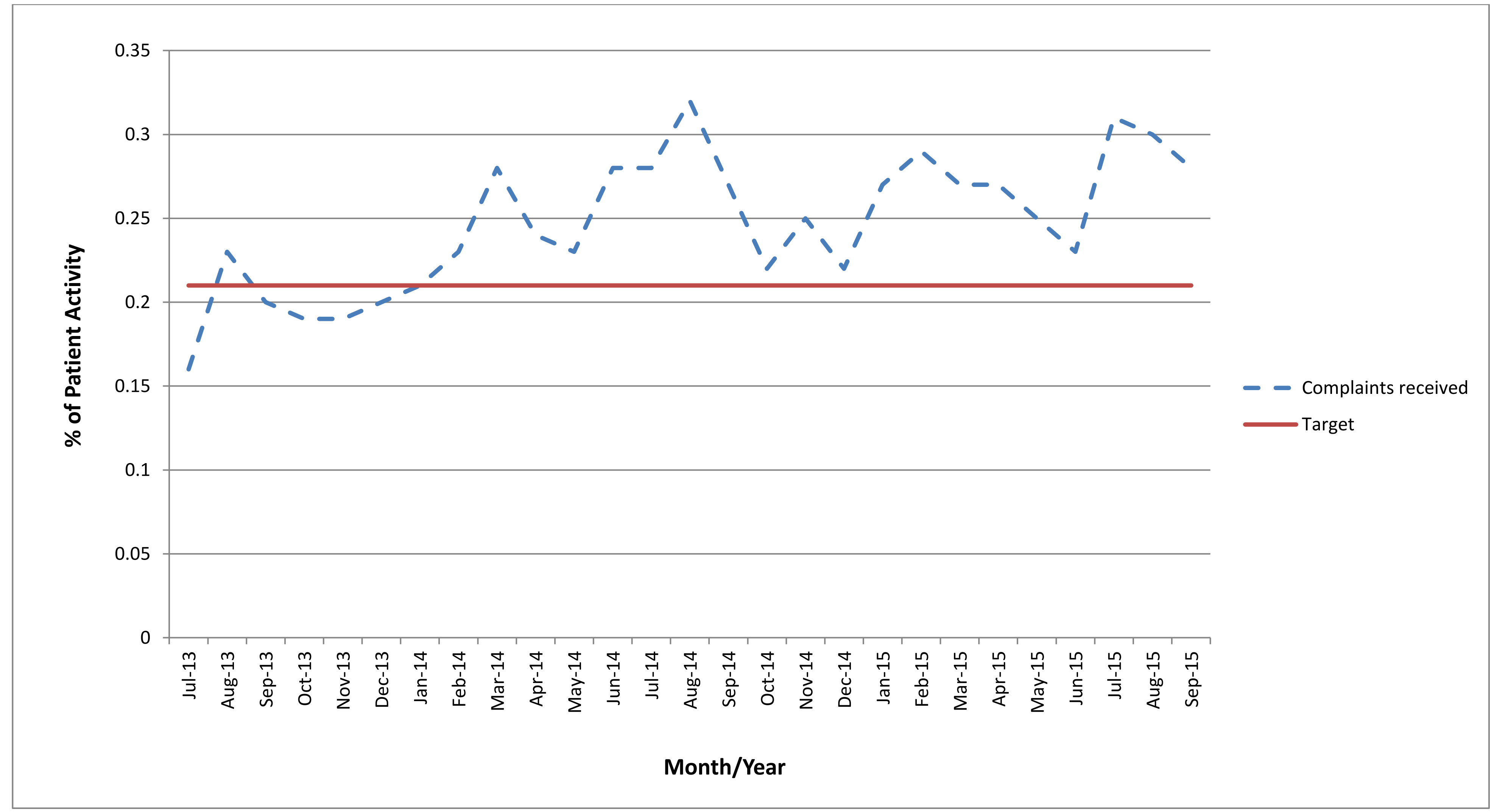


Figure 3: Complaints received, as a percentage of patient activity



2.3 Dissatisfied complainants

Reducing numbers of dissatisfied complainants is one of the Trust's nine corporate quality objectives for 2015/16. 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 do not 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. As noted earlier in section 2 of this report, the way in which dissatisfied cases are reported is now expressed as a percentage of the responses the Trust has sent out in any given month. In Q1 and Q2 of 2015/16, our target has been for less than 10% of complainants to be dissatisfied, reducing to less than 5% from Q3 onwards.

In Q2, a total of 149 responses were sent out. By the cut-off point of 12th November 2015 (the date on which the complaints data for September was finalised), 10 people had contacted us to say they were dissatisfied with our response. This represents 6.7% of the responses sent out.

This compares to six cases out of 186 responses (3.2%) in Q1 of 2015/16.

In each case where a complainant comes back to us to advise they are dissatisfied with our response, the case is reviewed by the Patient Support & Complaints Manager. This review leads to one of the following courses of action:

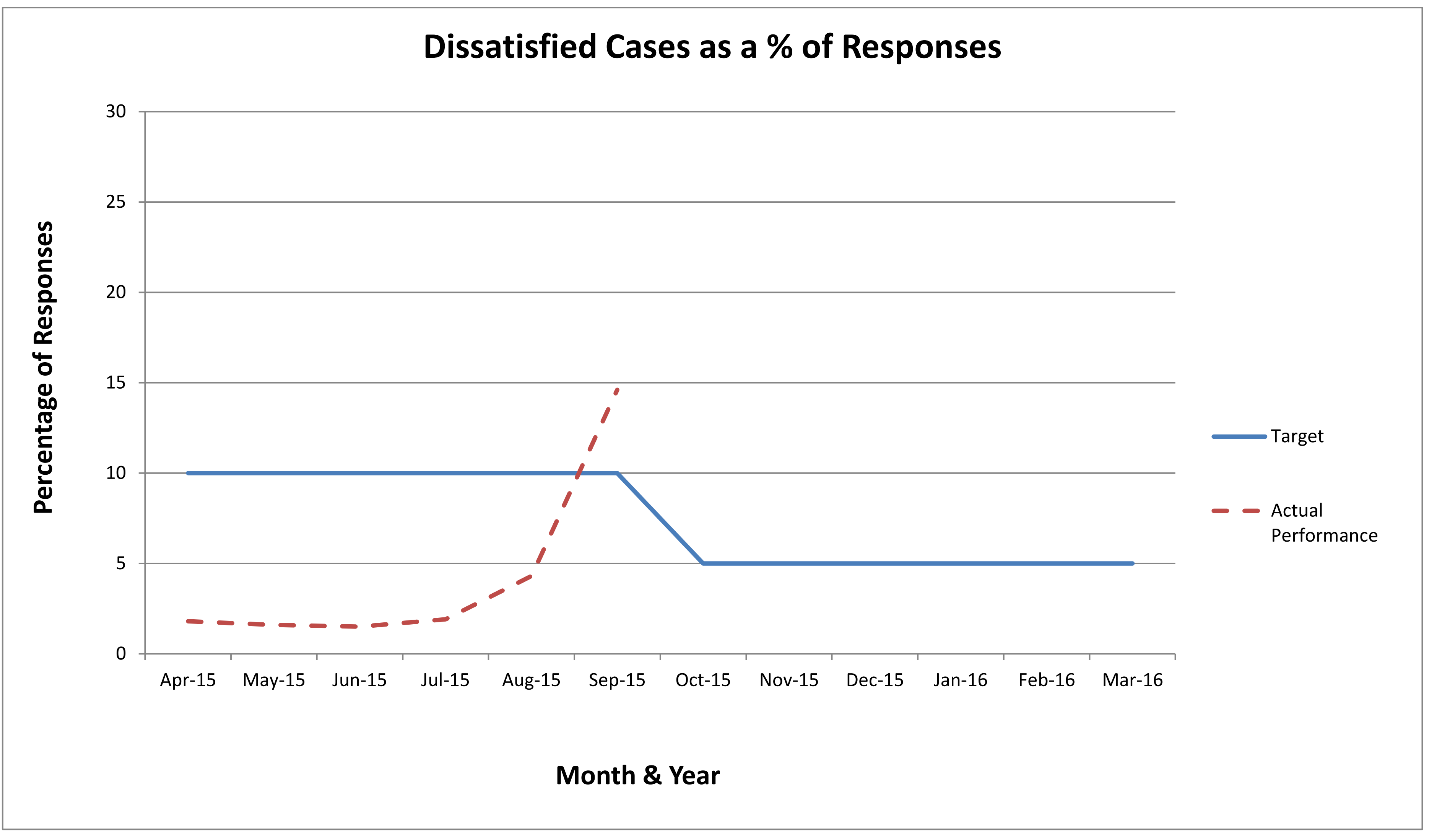
- The lead Division is asked to reinvestigate the outstanding concerns and send a further response letter to the complainant addressing these issues.
- The lead Division is asked to reinvestigate the outstanding concerns and arrange to meet with the complainant to address these issues.
- A letter is sent to the complainant advising that the Trust feels that it has already addressed all of the concerns raised and reminding the complainant that if they remain unhappy, they have the option of asking the PHSO to independently review their complaint.

In the event that it is not clear at this stage, a caseworker from the Patient Support & Complaints Team will contact the complainant for clarification of which issues remain unresolved and, where possible, collate some specific questions that the complainant wishes to be answered. Following this, the process noted above would then be followed.

In all cases where a further written response is produced, this response is reviewed by the Patient Support & Complaints Manager and by the Head of Quality (Patient Experience and Clinical Effectiveness) before sending it to the Executives for signing.

In the event that a complainant comes back to us again, having received two responses (whether in writing or by way of a meeting) the case will be escalated to the Chief Nurse for review.

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



2.4 Complaints themes – Trust overview

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

Category Type	Number of complaints received – Q2 2015/16	Number of complaints received – Q1 2015/16
Appointments & Admissions	202 (36% of total complaints) ↑	170 (37% of total complaints) ↓
Attitude & Communication	146 (26%) ↑	127 (28%) ↓
Clinical Care	112 (20%) ↓	118 (26%) ↓
Facilities & Environment	39 (7%) ↑	12 (3%) ↓
Access	16 (3%) ↑	8 (2%) ↓
Information & Support	45 (8%) ↑	24 (4%) ↓
Total	**560**	**459**

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 55% of the complaints received in Q2 (310/560).

Sub-category	Number of complaints received – Q2 2015/16	Q1 2015/16	Q4 2014/15	Q3 2014/15
Cancelled or delayed appointments and operations	151 ↑ (22% increase *compared to Q1*)	124	140	124
Clinical Care (Medical/Surgical)	48 ↓ (2% decrease)	49	78	58
Communication with patient/relative	31 ↓ (6% decrease)	33	26	28
Clinical Care (Nursing/Midwifery)	20 ↓ (17% decrease)	24	26	26
Attitude of Nursing/Midwifery	14 ↑ (40% increase)	10	10	14
Attitude of Medical Staff	24 ↑ (118% increase)	11	21	15
Failure to answer telephones	22 ↓ (35% decrease)	34	26	19

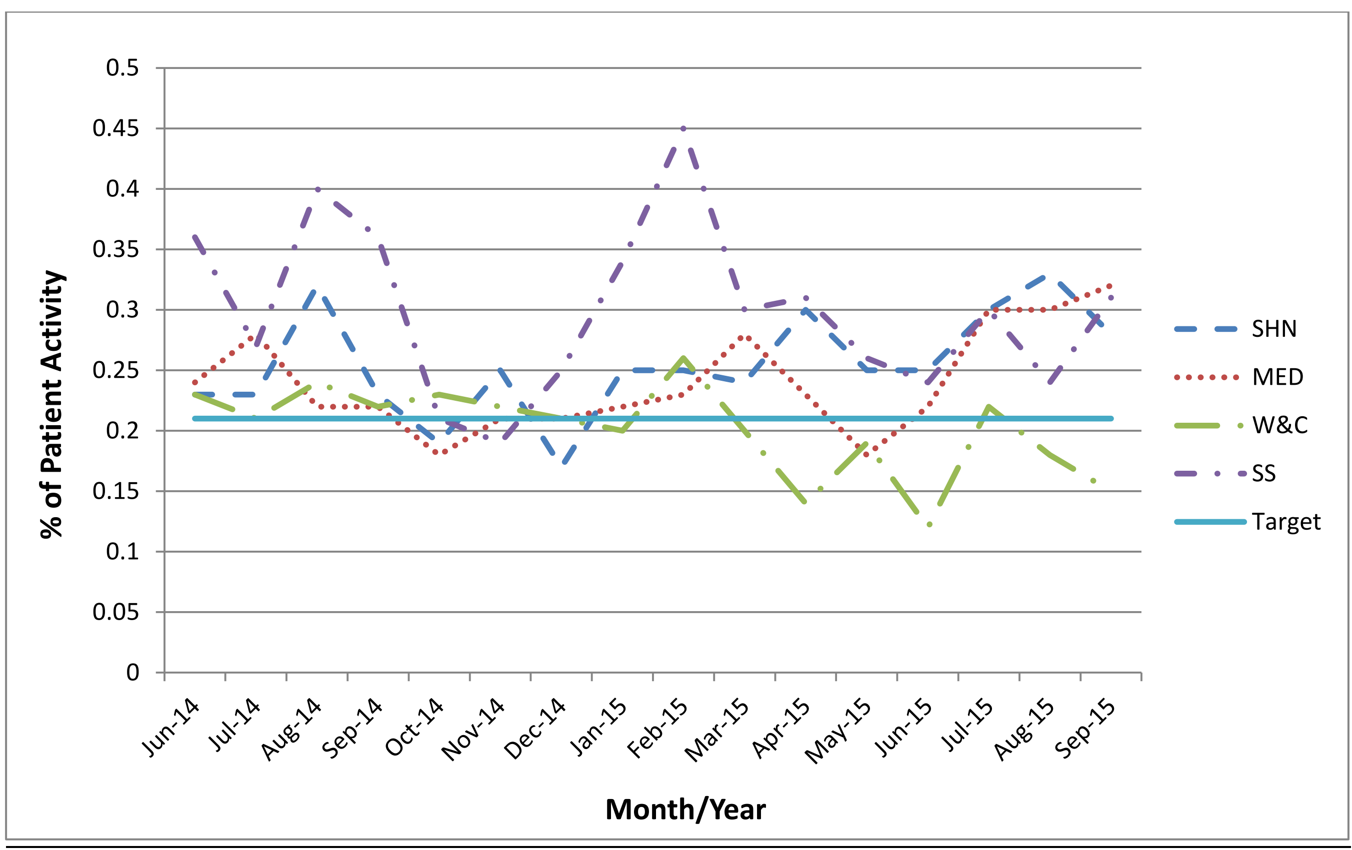
The issue of cancelled or delayed appointments and operations has seen a 22% increase in Q2, following an 11% decrease in the previous quarter. There have been significant increases in complaints about the attitude of both medical/surgical staff and nursing/midwifery staff. Complaints regarding the failure to answer telephones decreased by 35% in Q2, following consecutive increases in the previous the five quarters.

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 during Q2.

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



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

Table 2. Complaints received by Diagnostics and Therapies Division since October 2014

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of complaints received	7	7	8	7	5	11	2	5	7	10	4	4

3.2 Divisional analysis of complaints received

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

Table 3.

	Surgery Head and Neck	**Medicine**	**Specialised Services**	**Women and Children**	**Diagnostics and Therapies**
Total number of complaints received	236 (208) ↑	125 (85) ↑	69 (61) ↑	80 (65) ↑	18 (14) ↑
Total complaints received as a proportion of patient activity	0.30% (0.26%) ↑	0.31% (0.21%) ↑	0.27% (0.27%) =	0.18% (0.15%) ↑	N/A
Number of complaints about appointments and admissions	103 (101) ↑	37 (19) ↑	26 (26) =	30 (22) ↑	6 (3) ↑
Number of complaints about staff attitude and communication	64 (56) ↑	33 (25) ↑	22 (18) ↑	22 (16) ↑	5 (5) =
Number of complaints about clinical care	45 (45) =	27 (34) ↓	11 (14) ↓	22 (24) ↓	7 (2) ↑
Areas where the most complaints have been received in Q2	Bristol Dental Hospital – 41 (33) ↑ Ear Nose and Throat – 36 (25) ↑ Trauma & Orthopaedics – 24 (18) ↑ Queens Day Unit (Endoscopy) – 6 (5) ↑ Ward A800 – 6 (2) ↑ Bristol Eye Hospital – 57 (71) ↓ Upper GI – 8 (11) ↓	A&E – 27 (18) ↑ Gastroenterology & Hepatology – 12 (8) ↑ Ward A300 (MAU) – 6 (4) ↑ Diabetic Clinic – 7 (2) ↑ Dermatology – 9 (14) ↓	BHI Outpatients – 26 (21) ↑ GUCH Services – 5 (2) ↑ Chemo Day Unit / Outpatients – 15 (16) ↓ Ward C708 – 4 (6) ↓	Children's ED & Ward 39 - 10 (6) ↑ Paediatric Neurosurgical – 5 (1) ↑ ENT (Paediatric) – 9 (2) ↑ Clinical Genetics – 5 (1) ↑ Ward 71/74 – 4 (1) ↑ Paediatric Orthopaedics – 5 (9) ↓	Radiology – 6 (3) ↑ Orthotics – 3 (0) ↑ Adult Therapy – 3 (3) = Pharmacy – 2 (3) ↓

Notable deteriorations compared to Q1	Ear Nose & Throat – 36 (25) Trauma & Orthopaedics – 24 (18) Bristol Dental Hospital – 41 (33)	A&E – 27 (18) Gastroenterology & Hepatology – 12 (8)	BHI Outpatients – 26 (21)	Paediatric Neurosurgical – 5 (1) Clinical Genetics – 5 (1) ENT (Paediatric) – 9 (2)	Radiology – 6 (3) Orthotics – 3 (0)
Notable improvements compared to Q1	Bristol Eye Hospital – 57 (71)	Dermatology – 9 (14)	None	Paediatric Orthopaedics – 5 (9)	None

3.3 Areas where the most complaints were received in Q2 – additional analysis

3.3.1 Division of Surgery, Head & Neck

Complaints by category type[4]

Category Type	Number and % of complaints received – Q2 2015/16	Number and % of complaints received – Q1 2015/16
Access	6 (2.5% of total complaints)	1 (0.5% of total complaints)
Appointments & Admissions	103 (43.6%)	101 (48.6%)
Attitude & Communication	64 (27.1%)	56 (26.9%)
Clinical Care	45 (19.1%) =	45 (21.6%)
Facilities & Environment	6 (2.5%)	1 (0.5%)
Information & Support	12 (5.1%)	4 (1.9%)
Total	**236**	**208**

Top sub-categories

Sub-category	Number of complaints received – Q2 2015/16	Number of complaints received – Q1 2015/16
Cancelled or delayed appointments and operations	88 (11.4% increase compared to Q1)	79 (2.6% increase compared to Q4)
Clinical Care (Medical/Surgical)	14 (22.2% decrease)	18 (14.3% decrease)
Communication with patient/relative	12 (29.4% decrease)	17 (88.9% increase)
Attitude of Medical Staff	6 (500% increase)	1 (85.7% decrease)
Attitude of Nursing/Midwifery	8 (100% increase)	4 (20% decrease)
Clinical Care (Nursing/Midwifery)	9 (50% increase)	6 (33.3% decrease)
Failure to answer telephones	15 (11.8% decrease)	17 (54.5% increase)

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
There was a significant (44%) increase in complaints about the ENT outpatient service. Of the 36 complaints received, 17 were in respect of appointments and admissions and 15 came under the category of attitude and communication (with eight of these specifically for failure to answer the telephone)	The ENT administration team has experienced a period of significant long term sick leave particularly amongst the administrative staff. This has been compounded by vacancies in the department.	The ENT Performance and Operations Manager is working with the team to address the gaps in service in order to maximise staff availability. Recruitment is in progress to fill the vacancies, with staff expected to be in post within three months in line with Trust recruitment timescales
Complaints about Bristol Dental Hospital increased to 41 in Q2. 17 of these complaints were received by Adult Restorative Dentistry. 11 of the complaints related to appointments and admissions and six to attitude	The adult restorative team continues to be challenged with the availability of appointments due to large numbers of vacancies; recruitment has been extremely challenging with one consultant post having	The two new consultants take up their positions in January 2016. One new consultant was able to start in September and has been extremely flexible in providing additional sessions. Plans are also in place to fill the gaps resulting from maternity leave, with a small reduction in

[4] Arrows in Q2 column denote increase or decrease compared to Q1. Arrows in Q4 column denote increase or decrease compared to Q3. Increases and decreases refer to actual numbers rather than to proportion of total complaints received.

and communication.	been vacant for well over a year whilst active recruitment has been ongoing. A second post became vacant in July 2015; both consultant posts were appointed to in July but, due to difficulties in being released from their university contracts, these staff will take up their positions in January 2016. In addition to these vacancies, there have been gaps in the junior staff rotas due to maternity leave.	capacity anticipated. We have had a small number of patients who have complained about a change in the treatment plan they were expecting; this is particularly in relation to implants. Unfortunately, a number of patients were offered implants by a former clinician, who had a different threshold for offering implants than the remainder of the restorative team. As a result, the offer of treatment has been withdrawn. Although the rationale for this decision has been explained to the patients concerned, they are of course disappointed and in some cases have raised formal complaints. The hospital matron continues to provide training for each cohort of junior doctors and for all prospective consultants about the most common causes of complaints and how to improve patient experience. An action plan is being developed following Delivering Best Care in Outpatients week in November 2015, and will be presented to divisional board in early January.
There was an increase in Trauma and Orthopaedic complaints from 18 in Q1 to 24 in Q2. Seven of these complaints fell under the category of cancelled and delayed appointments, with the remainder split across a range of categories, including attitude of staff and waiting time in clinic.		This report has been fed back to the team via the clinical executive meeting and through the monthly performance meetings with the departmental sister, matron and Head of Nursing. The team has been asked to consider influencing factors and to come up with actions to help reduce this level of complaints. This will be monitored through the aforementioned meetings and fed back through the divisional governance meeting. The recent Delivering Best Care audit week has highlighted some relevant issues which will be addressed via an action plan (as per above).

3.3.2 Division of Medicine

Complaints by category type

Category Type	Number and % of complaints received – Q2 2015/16	Number and % of complaints received – Q1 2015/16
Access	2 (1.6% of total complaints) ↑	0 (0% of total complaints) ↓
Appointments & Admissions	37 (29.6%) ↑	19 (22.4%) ↓
Attitude & Communication	33 (26.4%) ↑	25 (29.4%) ↓
Clinical Care	27 (21.6%) ↓	34 (40%) ↑
Facilities & Environment	15 (12%) ↑	2 (2.4%) ↓
Information & Support	11 (8.8%) ↑	5 (5.8%) ↓
Total	**125**	**85**

Top sub-categories

Category	Number of complaints received – Q2 2015/16	Number of complaints received – Q1 2015/16
Cancelled or delayed appointments and operations	22 (144.4% increase compared to Q1) ↑	9 (18.2% decrease compared to Q4) ↓
Clinical Care (Medical/Surgical)	7 (41.7% decrease) ↓	12 (9.1% increase) ↑
Communication with patient/relative	9 (12.5% increase) ↑	8 (33.3% increase) ↑
Attitude of Medical Staff	5 (25% increase) ↑	4 (42.9% decrease) ↓
Attitude of Nursing/Midwifery	4 (100% increase) ↑	2 =
Clinical Care (Nursing/Midwifery)	6 (57.1% decrease) ↓	14 (133.3% increase) ↑
Failure to answer telephones	2 (50% decrease) ↓	4 (33.3% decrease) ↓

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
Complaints received about the Emergency Department increased to 24 in Q2, a 33% increase on Q1. Of these 24 complaints, nine were in respect of attitude and communication, eight related to clinical care and five complaints were made in respect of the facilities and environment.	Attitude/Communication: The majority of these relate to patients feeling that staff are being dismissive or disrespectful or staff being overheard talking about patients or situations in an unprofessional manner. Some patients feel that staff do not care or are flippant and do not attend to them as they feel they should be. Clinical care: One complaint related to a patient not being given an ambulance to transport them home (not appropriate or needed) in circumstances where the South West Ambulance service had indicated to the patient that ambulance transport home was provided routinely.	For all complaints, the staff involved have either written individual reflective pieces as part of their personal learning, or conversations have been had with members of staff to enable them to reflect upon what they would do differently in future. Learning from complaints in ED is further reinforced via weekly safety briefings which each member of the team has to read and sign to say that they have read, understood and will implement the briefing. The Supervisory Sister and Matron for ED has met with the staff concerned to discuss

	Complaints about patients and relatives not being kept up to date with their journey or not being told the plan of action/care. Relatives not being informed of incidents that happen, patients going missing off ward or staff not passing on messages relating to medications. Facilities/ Environment: These complaints relate to patients not being offered food and drink, or lack of communication that they are Nil By Mouth (NBM) or their NBM status not being reviewed in a timely manner. One complaint related to a patient being disturbed at night by noisy relatives visiting a dying patient, and one to patients reporting a breach of privacy and dignity on the ward. There were two complaints where patients reported theft of valuables and one where a set of dentures were lost in the laundry.	their recollection of events and what they would do in future if faced with similar scenarios. The Shine checklist has been implemented (a patient safety checklist for patients in ED which ensures that all elements of care are delivered even when the department is under extreme pressure) which is completed hourly should address the main issues around communication and keeping the patient and their relatives up to date and the offering of food and drinks.
The department of Gastroenterology and Hepatology saw an increase to 12 complaints in Q2. Half of these complaints were in respect of cancelled and delayed appointments and four were related to attitude and communication.	Some informal complaints relate to patients on the partial booking list contacting the department for an update rather than to complain about their care. Partial booking letters had been sent out but then clinic cancellation requests were submitted prior to the patient calling back to book their appointment, causing further delays in offering an appointment.	The department will be introducing a letter to inform patients that they are still on the partial booking follow up list. By the end of December Consultants are happy to see general Inflammatory Bowel Disease (IBD) patients in each other's clinics, which will assist with reducing the partial booking list. New Clinics being added for IBD nurses in January A new IBD nurse has been appointed, which will also assist with reducing waiting times for suitable patients as there will be two additional

	The clinic co-ordinator had sent out the incorrect letter to a couple of patients, resulting in them attending SBCH for their appointments instead of the BRI.	clinics from January 2016. The issue has been highlighted to the clinic co-ordinator and careful checking of letters is being carried out. Clinic Coordinator checking correct letter selected. Letter project to streamline letters available for each clinic to be carried out in January/February 2016 which will reduce the risk of incorrect letters being sent.
There was a sharp rise in the number of complaints received by the Diabetic Clinic, with seven complaints received, compared to just two in Q1. Three of these complaints were about delayed appointments, one related to a referral error, one was about a failure to book hospital transport and two were in respect of administrative communication.	Two patients wished to be seen sooner (although appointments had been booked for them within 11 weeks, which is the accepted timeframe within the Trust). Two complaints related to a delay in clinic letters being sent out. One complaint was about transport issues One patient was incorrectly referred to us instead of North Bristol NHS Trust (NBT). One complaint was formal and concerned referral processes between UH Bristol and NBT.	Appointments were brought forward as a gesture of goodwill to the complainants. Sickness absence in the secretarial team had led to a typing delay. The backlog has now been cleared and additional staff are going to be helping the team going forward. It appears that all usual processes were followed correctly by UH Bristol; currently awaiting statements from NBT.

3.3.3 Division of Specialised Services

Complaints by category type

Category Type	Number and % of complaints received – Q2 2015/16	Number and % of complaints received – Q1 2015/16
Access	1 (1.4% of total complaints) ↑	0 (0% of total complaints) ↓
Appointments & Admissions	26 (37.7%) =	26 (42.6%) ↓
Attitude & Communication	22 (31.9%) ↑	18 (29.5%) ↓
Clinical Care	11 (15.9%) ↓	14 (23%) ↑
Facilities & Environment	3 (4.3%) ↑	2 (3.3%) ↓
Information & Support	6 (8.7%) ↑	1 (1.6%) ↓
Total	**69**	**61**

Top sub-categories

Category	Number of complaints received – Q2 2015/16	Number of complaints received – Q1 2015/16
Cancelled or delayed appointments and operations	19 (5.6% increase compared to Q1) ↑	18 (30.8% decrease compared to Q4) ↓
Clinical Care (Medical/Surgical)	7 (16.7% increase) ↑	6 (14.3% decrease) ↓
Communication with patient/relative	1 (75% decrease) ↓	4 (=)
Attitude of Medical Staff	5 (400% increase) ↑	1
Attitude of Nursing/Midwifery	0 (100% decrease) ↓	1 (50% decrease) ↓
Clinical Care (Nursing/Midwifery)	1 ↑	0 =
Failure to answer telephones	7 (22.2% decrease) ↓	9 =

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
The Division has worked very hard to reduce complaints received by the Outpatients Department at Bristol Heart Institute (previously from 41 in Q4 2014/15 to 21 in Q1 2015.16). There has been a light increase in Q2 to 26 complaints. 14 of these complaints were in respect of appointments and admissions (mainly delayed appointments); and seven fell under the category of attitude and communication – all of these being specifically about a failure to answer telephones or respond to enquiries.	The Division has been experiencing a number of pressures in relation to maintaining the flow of patients through their required surgical procedures, which at times has led to miscommunication. In addition, there is a high turnover of staff in administration and clerical roles, including the Bristol Heart Institute Outpatients Department. The Division has developed a specific e-mail address for the bookings and outpatient team to improve communication with patients. Emails sent to this address are actively monitored	Since November, the waiting list office has taken action to reduce the number of telephone calls by contacting patients to agree admission dates (whereas previously they were contacted by letter). Appointments are now only booked six weeks in advance to reduce the numbers of cancellations and delays.

	and responded to on a daily basis. The Division has also funded a temporary post to focus upon answering telephones and responding to messages.	
Cardiology GUCH services saw an increase in complaints from just two in Q1 to 5 in Q2. Four of these complaints were in respect of cancelled or delayed procedures.	There has been an increase in the numbers of emergency cases which has in turn effected elective admissions. There have been some communication issues around the process of cancellation when staff have been unable to contact patients at short notice, as many patients travel long distances to access these services.	The Division has developed a more robust communication process which involves handing over the communication for cancellations to the day case team. If the booking office team have not been able to contact the patient during office hours, this is communicated by a formal handover.
Complaints received by BHOC Outpatients remained high at 15 complaints. Six of these complaints came under the category of attitude and communication and five related to appointments and admissions.	The BHOC Outpatient Department includes the Chemotherapy Day Unit (CDU). The Division identified that the CDU is an area which required a review of the way appointments and admissions are booked; this has formed part of the Division's quality objectives for 2015/16. Concerns raised by patients include delays in treatment or admission to CDU, messages not being returned, and staff not following up patients' queries.	The Transformation team is currently supporting the Division in reviewing the processes and systems currently in place across CDU and the bookings and admissions teams. This is a long term piece of work which commenced in the summer of 2015 and will continue into 2016.

3.3.4 Division of Women & Children

Complaints by category type

Category Type	**Number and % of complaints received – Q2 2015/16**	**Number and % of complaints received – Q1 2015/16**
Access	1 (1.25% of total complaints) =	1 (1.5% of total complaints) ↓
Appointments & Admissions	30 (37.5%) ↑	22 (33.9%) ↓
Attitude & Communication	21 (26.3%) ↑	16 (24.6%) ↓
Clinical Care	21 (26.3%) ↓	24 (37%) ↓
Facilities & Environment	2 (2.5%) ↑	1 (1.5%) ↑
Information & Support	5 (6.3%) ↑	1 (1.5%) ↓
Total	**80**	**65**

Top sub-categories

Category	Number of complaints received – Q2 2015/16	Number of complaints received – Q1 2015/16
Cancelled or delayed appointments and operations	25 (38.9% increase compared to Q1) ↑	18 (25% decrease compared to Q4) ↓
Clinical Care (Medical/Surgical)	11 (15.4% decrease) ↓	13 (23.5% decrease) ↓
Communication with patient/relative	7 (133.3% increase) ↑	3 (50% decrease) ↓
Attitude of Medical Staff	6 (20% increase) ↑	5 (28.6% decrease) ↓
Attitude of Nursing/Midwifery	3 =	3 =
Clinical Care (Nursing/Midwifery)	5 (25% increase) ↑	4 (66.7% decrease) ↓
Failure to answer telephones	0 =	0 =

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
There were five complaints received by the Paediatric Neurosurgical Department at Bristol Royal Hospital for Children, compared to just one in Q1. Three of these complaints related to delayed appointments; one related to clinical care and one was in respect of delayed test results.	Most of these complaints were compounded by communication issues, both between hospital teams and then each team communicating these decisions to the families. Communication needed to be timely and manage parent/relative expectations in terms of the length of wait for tests, results or appointments.	We are currently working on reducing our backlog of patients, both admitted and non-admitted, with an RTT trajectory to bring us back in line with the RTT standards, which will help to alleviate the length of wait for outpatient appointments and surgery dates. Work is ongoing regarding the practice of bringing in neurology patients for observation and then to see which tests are needed. The plan is to ensure that at least two tests are booked before any patients are admitted. The Neurology team has met and agreed a plan for timely communications with families in circumstances where appointments are delayed.
Clinical Genetics saw a sharp rise in complaints in Q2, with five complaints, compared to just one in Q1. Three of these complaints related to delayed appointments, with the remaining two being in respect of communication with patients.	The Genetics Department has had a number of temporary staff employed to support some backlogs, including typing and the management of appointments. Some of these staff needed further support to ensure they were meeting Trust expectations regarding appropriate communication on the telephone.	Substantive appointments have been advertised and partly recruited to in order to reduce the reliance on temporary staff. Departmental support has been given internally to ensure all staff communicate appropriately with patients.
The ENT (Paediatric) Department received nine complaints in Q2, compared	The majority of these have been due to a delay in admission for patients on the elective waiting	Clearance of the backlog is on track with additional SPIRE activity and waiting list initiatives; a new ENT

with just two in Q1. Seven of the nine complaints were in respect of delayed appointments or treatment.	list.	consultant has been appointed and commences in January 2016.
There was an increase in the number of complaints received by the Children's ED & Ward 39, from six in Q1 to 10 in Q2. These complaints were a mixture of complaints about waiting times and attitude and communication of staff.	A variety of complaints were received by Children's ED, with no single theme emerging. The department has continued to experience an unusually high level of attendances in Q2 (12% more patients than for the same period last year).	Actions taken which should address these concerns include: additional support for families waiting to be seen by a doctor by having a Nurse Assistant based in the waiting area during peak times of activity; an increase in Registered nurse presence overnight; and information given to parents about how they can escalate their concerns to a more senior medical team member if they need to.

3.3.5 Division of Diagnostics & Therapies

Complaints by category type

Category Type	Number and % of complaints received – Q2 2015/16	Number and % of complaints received – Q1 2015/16
Access	0 (0% of total complaints)	2 (14.3% of total complaints) =
Appointments & Admissions	6 (33.3%)	3 (21.4%)
Attitude & Communication	5 (27.8%) =	5 (35.7%)
Clinical Care	7 (38.9%)	2 (14.3%)
Facilities & Environment	0 =	0
Information & Support	0	2 (14.3%)
Total	**18**	**14**

Top sub-categories

Category	Number of complaints received – Q2 2015/16	Number of complaints received – Q1 2015/16
Cancelled or delayed appointments and operations	6	5 =
Clinical Care (Medical/Surgical)	4	2
Communication with patient/relative	2	4 (33.3% increase)
Attitude of Medical Staff	2	1
Attitude of Nursing/Midwifery	0	0 =
Clinical Care (Nursing/Midwifery)	0	0 =
Failure to answer telephones	0	0 (100% decrease)

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
Radiology services saw an increase in complaints from three in Q1 to six in Q2. Three of these complaints related to attitude and communication (one each in Paediatric x-ray and two in Bristol Dental Hospital).	The first complaint regarding attitude and communication related to a letter being sent to the wrong address and subsequently being opened, photographed and sent to the patient's father via the internet.	GPs usually advise the department of patients' up to date address details when they notice they are incorrect on the ICE system. Unfortunately, on this occasion the department was not alerted, and consequently the appointment letter for the patient was sent to the wrong address. Confirmation was sent to the complainant to advise that all of our hospitals systems were updated with the correct address on 2nd September.
	The second complaint regarding attitude and communication related to the carers of a patient with learning difficulties being unhappy with the manner in which a Radiographer in the Dental Hospital communicated with, and handled the patient.	The complaint was discussed with the Radiographer involved who asked for their apologies to be passed on to the patient. An incident form was raised at the time and the case was discussed with Bristol City Council (in line with section 42 of the Care Act of 2014), who confirmed that the matter would not be pursued as a safeguarding issue. The department is working with the Learning Disability Specialist Nurse to develop a learning disabilities training package to be rolled out for radiology dental department staff by the end of December 2015.
	The third complaint regarding attitude and communication related to a patient who was unhappy with the treatment she received when being examined by a clinician in the Dental Hospital.	The complaint was discussed with the Consultant and the Dental Nurse who had been present during the consultation with the patient, and in the response letter the Consultant apologised for any discomfort the patient suffered during the consultation, and for unintentionally giving the patient the impression that their concerns were unimportant and being dismissed.
One complaint related to a missed diagnosis at South Bristol Community Hospital (SBCH), one was about delayed MRI results (Bristol Heart Institute) and one was in respect of a delayed	The complaint regarding clinical care related to a missed diagnosis of the patient's broken ankle at SBCH.	The Clinical Director for Radiology (Consultant Radiologist) reviewed the X-rays the patient had whilst under the care of the Trust, including the X-rays taken at SBCH. The review confirmed that the fracture was visible in the X-ray

appointment at the Bristol Royal Hospital for Children.		taken on 27th October, and an apology was offered to the patient that it was missed at that time. It is part of the Radiology Department's practice to hold 'discrepancy' meetings where the Radiology Consultants review any missed diagnoses. When it was found that the fracture had been missed, the scans were discussed in that forum to ensure that the learning was taken from this case.
	The informal complaint related to delayed Cardiac MRI results at the BHI.	The Consultant Cardiologist rang the patient to explain the timescales around their report and the reasons for the delay in their referrer receiving them. It was primarily down to a communication error between an internal referring Consultant, and the Consultant Cardiologist, whereby an email sent by the referring Consultant was missed by the Consultant Cardiologist, and in addition, a letter sent by them by referrer was never received.
	The informal complaint regarding appointment and admissions related to concerns expressed by South West Commissioning Support Unit about delays in referrals being received and actioned by UH Bristol from Weston General Hospital, specifically relating to children's MRI.	The Radiology Department confirmed that the referral was received on 23rd April and that an appointment was offered to the family for 9th June, which was cancelled by the family due to other commitments. The appointment subsequently took place on 24th June.
The Orthotics Team received three complaints in Q2, although no trends were identified. One complaint related to clinical care, one was in respect of communication with the patient and the third was about a referral error.	The informal complaint regarding clinical care related to the clinician not being helpful and being dismissive of the patient's concerns.	Apologies were made regarding the clinician's manner and lack of clarity about the patient's treatment plan. A further appointment with one of the Orthotists was made, and the GP practice was contacted to add details of the current plan to the patient's medical record.
	The informal complaint regarding attitude and communication related to a patient having to pay for a sling without prior knowledge of	Apologies were made to the complainant, as a new member of staff had mistaken two different types of sling. Arrangements were made to reimburse the patient for

	charges. The informal complaint regarding appointments and admissions related to referral difficulties.	the charges made. The department arranged for the patient to be booked into an urgent appointment with one of the Orthotists to reassess the patient's footwear provision. Feedback was given to the administration team to ensure that all patient enquiries are appropriately triaged by the clinical staff prior to patients being discharged from the service.

3.4 Complaints by hospital site

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

Hospital/Site	Number and % of complaints received – Q2 2015/16	Number and % of complaints received – Q1 2015/16
Bristol Royal Infirmary (BRI)	225 (40.2% of total complaints) ↑	183 (39.9% of total complaints) ↓
Bristol Eye Hospital (BEH)	57 (10.2%) ↓	71 (15.5%) =
Bristol Dental Hospital BDH)	41 (7.3%) ↑	33 (7.2%) ↓
St Michael's Hospital (STMH)	66 (11.8%) ↑	46 (10%) ↓
Bristol Heart Institute (BHI)	52 (9.3%) ↑	43 (9.4%) ↓
Bristol Haematology & Oncology Centre (BHOC)	29 (5.2%) ↑	28 (6.1%) ↑
Bristol Royal Hospital for Children (BRHC)	64 (11.4%) ↑	44 (9.5%) ↓
South Bristol Community Hospital (SBCH)	26 (4.6%) ↑	11 (2.4%) ↑
Total	**560**	**459**

The table below 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, in Q2, Bristol Children's Hospital accounted for 15.5% of the total attendances and received 11.4% of all complaints

Site	No. of complaints	No. of attendances	Complaints rate	Proportion of all attendances	Proportion of all complaints
BRI	225	58,279	0.39%	31.3%	40.2%
BEH	57	30,564	0.19%	16.4%	10.2%
BDH	41	18,531	0.22%	9.9%	7.3%
STMH	66	19,654	0.34%	10.5%	11.8%
BHI	52	5,042	1.03%	2.7%	9.3%
BHOC	28	18,150	0.15%	9.7%	5.0%
BRHC	64	28,857	0.22%	15.5%	11.4%
SBCH	26	7,365	0.35%	4.0%	4.6%
TOTAL	**560**	**186,442**	**0.30%**		

This analysis shows that the Bristol Royal Infirmary and Bristol Heart Institute receive the highest rates of complaints and that the BHI receives a disproportionately high volume of complaints compared to its shares of patient activity.

3.5 Complaints responded to within agreed timescale

All of the clinical Divisions reported breaches in Quarter 2, totalling 23 breaches, which represents a decrease on the 28 reported in Q1. There was also one breach by the Division of Facilities & Estates, which is not included in the table below.

	Q2 2015/16	Q1 2015/16	Q4 2014/15	Q3 2014/15
Surgery Head and Neck	12 (22.6%)	9 (12.9%)	8 (11.6%)	12 (14.6%)
Medicine	3 (8.8%)	9 (20%)	5 (14.7%)	10 (23.8%)
Specialised Services	6 (30%)	2 (11.1%)	1 (5.6%)	4 (15.4%)
Women and Children	2 (5.1%)	7 (17.1%)	11 (23.9%)	6 (12.5%)
Diagnostics & Therapies	0 (0%)	1 (10%)	0 (0%)	0 (0%)
All	**23 breaches**	**28 breaches**	**25 breaches**	**32 breaches**

(So, as an example, there were six breaches of timescale in the Division of Specialised Services in Q2, which constituted 30% *of the complaints responses that had been due in that Division in Q2*.)

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 during the sign-off process itself. Sources of delay are shown in the table below. The column indicating 'other' breaches relates to delays in other organisations providing their input to the Trust's response.

	Source of delays (Q2, 2015/2016)			**Totals**
	Division	**Patient Support and Complaints Team**	**Executive sign-off**	
Surgery Head and Neck	6	2	4	**12**
Medicine	1	0	2	**3**
Specialised Services	4	1	1	**6**
Women and Children	0	0	2	**2**
Diagnostics & Therapies	0	0	0	**0**
All	11 breaches	3 breaches	9 breaches	**23**

The majority of divisional delays have resulted from increased scrutiny of draft responses. The vast majority of responses were prepared by Divisions within the agreed timescale (143 out of 149 responses or 96%), however the need for significant changes/improvements following executive review led to 23 cases breaching the deadline by which they were sent to the complainant.

For the first time, this quarterly report includes information about the length of time by which each breached case exceeded its due date and whether any of those cases had been extended but still breached the deadline. The following table provides this information in respect of the 23 cases which breached the agreed deadline in Q2. The number of days is shown as total days, rather than working days, as this is the delay that the complainant will have experienced.

Date originally agreed with complainant	Date deadline extended to	Date response posted to complainant	Number of days deadline breached by
25/06/2015	23/07/2015	28/07/2015	5
01/07/2015	N/A	02/07/2015	1
03/07/2015	N/A	09/07/2015	6
21/07/2015	N/A	23/07/2015	2
24/07/2015	N/A	28/07/2015	4
29/07/2015	N/A	06/08/2015	8
29/07/2015	N/A	03/08/2015	5
31/07/2015	N/A	14/08/2015	14
03/08/2015	N/A	10/08/2015	7
04/08/2015	07/08/2015	10/08/2015	3
05/08/2015	N/A	06/08/2015	1
05/08/2015	21/08/2015 and 07/09/2015	14/09/2015	7
06/08/2015	N/A	10/08/2015	4
12/08/2015	N/A	17/08/2015	5
14/08/2015	N/A	26/08/2015	12
14/08/2015	N/A	17/08/2015	3
08/09/2015	N/A	15/09/2015	7
08/09/2015	15/09/2015	18/09/2015	3
10/09/2015	N/A	14/09/2015	4
10/09/2015	24/09/2015	29/09/2015	5
14/09/2015	N/A	18/09/2015	4
21/09/2015	N/A	29/09/2015	8
22/09/2015	N/A	25/09/2015	3

The average (mean) delay was 5.3 days, the median was 5 days and the range was 1-14 days.

Ongoing actions previously agreed via Patient Experience Group:

- The Patient Support and Complaints Team continue to monitor response letters to ensure that all aspects of each complaint have been fully.
- All response letters, as well as being checked by the individual caseworker, are now also checked by the Patient Support & Complaints Manager, prior to being sent to the Executives for final sign-off.
- A random selection of two or three draft responses per week are also sent to the Head of Quality (Patient Experience and Clinical Effectiveness) for an additional level of checking prior to Executive sign-off.
- 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 investigating complaints and writing response letters has been delivered to at least one group from each Division. The training delivered so far has been well received, with positive feedback from attendees. Improvements have been made to the training based on feedback received.
- The Patient Support & Complaints Manager is in the process of reviewing the process around the checking and signing off of response letters and, as part of this review, will draft a new Standard Operating Procedure (SOP) to cover this process. The review will look at timescales for the various parts of the process, along with a review of the practical steps involved in the checking and signing of the response letters.

3.6 Number of dissatisfied complainants

As reported in Section 1 of this report, the way in which the Trust reports the number of complainants telling us that they were unhappy with our investigation of their concerns changed with effect from Q1. In Q2, a total of 149 responses were sent out. By the cut-off point of 14th November 2015 (the date on which the complaints data for September was finalised) 10 people had contacted us to say that they were dissatisfied with our response. This represents 6.7% of the responses issued during that period, compared to 3.2% in Q1.

Training on investigating complaints and writing response letters has now been delivered to at least one group of senior staff/management from all Divisions. Dates have been confirmed for further sessions for other staff requesting the training in each Division. The training delivered so far has been well received, with positive feedback from attendees.

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 Q2, the team dealt with 138 such enquiries, compared to 171 in Q1. These enquiries can be categorised as:

- 74 requests for advice and information (100 in Q1)
- 57 compliments (65 in Q1)
- 7 requests for support (6 in Q1)

The table below shows a breakdown of the 81 requests for advice, information and support dealt with by the team in Q2.

Category	Number of Enquiries
Hospital Information Request	15
Information about Patient	11
Medical Records Enquiries	8
Bereavement Support	6
Clinical Information Request	5
Appointment Enquiries	5
Wayfinding	5
Complaints Handling	4
Car Parking	3
Emotional Support	3
Freedom of Information Request	3
Signposting	3
Travel Arrangements	3
Personal Property	2
Medical Equipment	2
Expenses Claim	2
Accommodation Enquiry	1
Total	**81**

5. Acknowledgement of complaints by the Patient Support & Complaints Team

One of the Key Performance Indicators (KPIs) that the Patient Support & Complaints Team is measured against is the length of time between receipt of a complaint and sending an acknowledgement.

The Complaints and Concerns Policy states that when the Patient Support & Complaints Team reviews a complaint following receipt: a risk assessment will be carried out; agreement will be reached with the complainant about how we will proceed with their complaint and a timescale for doing so; the appropriate paperwork will be produced and sent to the Divisional Complaints Co-ordinator for investigation; an acknowledgment letter confirming how the complaint will be managed will be sent to the complainant. In line with the NHS Complaints Procedure (2009), the Trust's policy states that this review will take place within three working days of receipt of written complaints (including emails), or within two working days of receipt of verbal complaints (including PSCT voicemail).

In Q2, 232 complaints were received verbally and 328 were received in writing. Of the 232 verbal complaints, 230 (99.1%) were acknowledged within two working days. The remaining two cases were acknowledged within three working days. In both cases, the team had attempted to contact the enquirer within two working days but had not managed to speak to them, although voicemail messages were left for the enquirers.

Of the 328 written complaints, 319 (97.3%) were acknowledged within three working days. All of the remaining nine cases were acknowledged within four working days. In one case, the caseworker had made some telephone calls trying to resolve the issue before contacting the enquirer, in another case the enquirer had not provided full contact details and in one case there was a delay in the case being logged by the team's administrators; the remaining six delays were due to team workload/capacity.

6. PHSO cases

During Q2, the Trust has been advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in three new complaints (compared to three in Q1 and four in Q4) as follows:

<table>
<tr><th>Case Number</th><th>Complainant (patient unless stated)</th><th>On behalf of (patient)</th><th>Date original complaint received</th><th>Site</th><th>Department</th><th>Division</th></tr>
<tr><td>17584</td><td>LT</td><td>CT</td><td>19/12/2014</td><td>BRI</td><td>Trauma & Orthopaedics</td><td>Surgery, Head & Neck</td></tr>
<tr><td colspan="7">Contacted by PHSO in July 2015. Copy of complaints file, medical records and Division's comments sent to PHSO, who have since advised that they anticipate providing their draft report for comment by January 2016.</td></tr>
<tr><td>16474</td><td></td><td>CM</td><td>05/08/2014</td><td>BRI</td><td>Ward A604</td><td>Surgery, Head & Neck</td></tr>
<tr><td colspan="7">Contacted by PHSO in July 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from PHSO regarding their investigation.</td></tr>
<tr><td>17173</td><td>DF</td><td>DJ</td><td>29/10/2014</td><td>BDH</td><td>Adult Restorative Dentistry</td><td>Surgery, Head & Neck</td></tr>
<tr><td colspan="7">Contacted by PHSO in September 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from PHSO regarding their investigation.</td></tr>
</table>

The following cases are currently the subject of ongoing investigations with the PHSO:

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
15213	WE	VE	10/03/2014	BHOC	Chemotherapy Outpatients	Specialised Services
Copy of complaint file, correspondence and medical records sent to PHSO. Received further request from PHSO for patient's oncology records, which were sent to them in August 2015. Trust's comments on PHSO's draft report sent 19/11/2015.						
12124 & 11500		SM	21/11/2012 & 13/08/2012	BRI & BHI	Urology & Cardiology (GUCH)	Surgery, Head & Neck & Specialised Services
Copy of complaints file and medical records sent to PHSO in May 2015. Further contact from PHSO received in July advising that they now have all the information they require and will contact us in due course with their provisional report and findings. Further documentation requested by and sent to PHSO in October 2015. Currently awaiting further contact from the PHSO.						
16120	CL	LW	30/06/2014	BHI	Coronary Care Unit (CCU)	Specialised Services
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Contacted by PHSO November 2015 to advise unlikely they will uphold complaint but requested some further information from the Trust. At the time of writing this report, this request was with the Division and will be sent to the PHSO shortly.						
17608	JR	AH	19/12/2014	BRI	Ward A604	Surgery, Head & Neck
Received PHSO's final report 26/11/2015 – complaint not upheld.						
15952	KH	JH	09/06/2014	BRI	Ward 11	Medicine
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Advised PHSO that some issues complainant raised with them had not previously been raised with the Trust. PHSO advised Trust in July 2015 that the case is currently waiting to be allocated to an investigator. Advised by PHSO on 06/11/2015 that they have now allocated the case to an investigator. Currently awaiting further contact from the PHSO.						

One case was closed during Q2 and was partly upheld by the PHSO:

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
12548		CM	05/02/2013	BRI	Upper GI	Surgery, Head & Neck
PHSO's final report received 16/10/2015 – complaint partially upheld and recommendations made that the Trust apologises to the patient, pays the patient the sum of £200 and advise the PHSO of actions taken in respect of the failings identified.						

7. Protected Characteristics

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, gender, religion and civil status.

The Patient Support and Complaints Team continues to work hard to ensure that as much of this information as possible is gathered from patients, in order to reduce the numbers reported in each category as "unknown".

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

7.1 Age

Age Group	**Number of Complaints Received – Q2 2015/16**
0-15	90
16-24	37
25-29	18
30-34	22
35-39	18
40-44	30
45-49	29
50-54	34
55-59	38
60-64	43
65+	201
Total Complaints	**560**

7.2 Ethnic Group

Ethnic Group	**Number of Complaints Received – Q2 2015/16**
Asian or British Asian	6
Bangladeshi or British Bangladeshi	1
Black Or Black British - African	1
Black Or Black British - Caribbean	2
Indian or British Indian	1
Mixed - Any Other Mixed Background	1
Mixed - White And Black African	1
Mixed - White And Black Caribbean	6
Pakistani or British Pakistani	4
White - British	355
White – Irish	3
White - Any Other White Background	11
Any Other Ethnic Group	23
Not Collected At This Time	66
Not Stated/Given	79
Total Complaints	**560**

7.3 Religion

Religion	(Christian denomination)	Number of Complaints Received – Q2 2015/16
Christian	Anglican	2
	Baptist	4
	'Christian'	26
	Church of England	199
	Methodist	12
	Protestant	4
	Roman Catholic	27
	United Reform	2
	(Total Christian)	*(276)*
Atheist		6
Buddhist		4
Muslim		9
No Religious Affiliation		127
Sikh		3
Unknown		135
Total Complaints		**560**

7.4 Civil Status

Civil Status	Number of Complaints Received – Q2 2015/16
Co-habiting	22
Divorced/Dissolved Civil Partnership	26
Married/Civil Partnership	218
Separated	4
Single	154
Widowed/Surviving Civil Partner	32
Unknown	104
Total Complaints	**560**

7.5 Gender

Of the 560 complaints received in Q2 2015/16, 307 (55%) of the patients involved were female and 253 (45%) were male.

Patient Experience Report

Quarter 2, 2015/16

(1 July to 30 September 2015)

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

1. Patient experience at UH Bristol: Quarter 2 summary and update

This report presents quality assurance data from the UH Bristol patient experience survey programme, principally: the Friends and Family Test, the monthly postal surveys, and the national patient surveys. The key headlines from Quarter 2 (July–September 2015) are:

- The Trust continued to achieve "green" patient satisfaction ratings in the Trust Board Quality Dashboard: reflecting the provision of a high quality patient experience at UH Bristol (see Appendix C and D for a description of the surveys and scoring mechanisms used in this report).
- Praise for UH Bristol staff continues to be the most frequent form of written comment received via the Trust's corporate patient experience surveys - easily exceeding the top five negative themes combined. The negative themes that emerge most frequently are around communication, waiting / delays, food, and negative experiences with staff.
- The Trust commenced a new monthly survey of outpatients in April 2015. The data from this survey indicates that a generally high quality outpatient experience is being provided by the Trust. The lowest score in our aggregate "outpatient experience tracker" measure is around waiting times in clinic (although 71% of patients say that they were seen on time or within 15 minutes): improving this aspect of outpatient services is a Trust Quality Objective for 2015/16.
- UH Bristol performs in line with national norms in most of the national patient experience surveys. The exception here is the national cancer survey, where a series of low scores have been achieved by the Trust since this survey commenced in 2011. A significant programme of patient engagement has been undertaken to better understand these results and a summary of the outcomes was presented to the Trust Board in September 2015. A comprehensive action plan has been developed in response to this information, with progress being overseen by the Trust's Cancer Steering Group. The 2015 survey is currently taking place (as at December 2015), with results expected in the summer of 2016.
- In Quarter 2, UH Bristol received results from the Care Quality Commission's National Paediatric Survey. Most of the Trust's scores were in line with the national average (one was better, none were worse), and a generally positive set of scores was attained relative to other large acute Trusts. The results and action plan were reviewed by the Trust Board in November 2015.
- Achieving high response rates in the Emergency Department Friends and Family Test (FFT ED) survey has been a significant challenge for trusts, including UH Bristol. To support data collection in this context, in Quarter 1 UH Bristol introduced touchscreens into the EDs which patients can use to complete the FFT (previously an FFT "postcard" was provided to patients at discharge). The screens have enabled us to meet our response rate targets, but they have also produced much lower FFT scores[1] – principally because patients can now give feedback at any stage of their "journey", rather than just at the end. We are currently identifying the optimal positioning of the screens, along with the appropriate level of data collection that is maintained via "FFT postcards" at discharge: the aim is to continue to maximise opportunities for people to give feedback, but also to ensure this is done in a way that better reflects their overall experience. (All other FFT scores for UH Bristol are positive and in line with national norms.)
- For the first time in the current report, we have included data that summarises feedback that patients have left on the NHS Choices website. This isn't a robust measurement of patient experience, particularly as the number of comments is relatively low, but is presented "for interest". The comments themselves (which aren't presented here) largely re-enforce the idea that ratings websites tend to attract polarised views, but the net result is an average rating score for UH Bristol of 3.8 out of 5 in the six months to September 2015 – suggesting that there are more positive than negative comments.

[1] The touchscreens went in consecutively to our two main EDs, and each time the score immediately declined. The Bristol Eye Hospital ED is still principally using a card based approach, and the score achieved there has remained consistent.

2. Trust-level patient experience data

Charts 1 to 6 (over) show the six headline metrics used by the Trust Board to monitor patient satisfaction 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 would turn "amber" or "red" if they fell significantly, alerting the senior management team to the deterioration. For the first time in this report we have also provided the ratings the Trust received via the NHS Choices website (Chart 7) – our use of this data is "in development" and is presented here as a potential way of capturing the impression of the Trust a member of the public might take away with them from the feedback left on this website.

A new UH Bristol outpatient survey started in April 2015. This is sent by post to approximately 500 patients (or parents of 0-11 year olds) per month. From this data an "outpatient tracker score" is now provided to the Trust Board (Chart 3) [4]. This metric is an aggregate of four survey scores that relate to cleanliness, treating patients with respect and dignity, waiting times in clinic, and communication. Among this group of four questions, waiting times in clinic achieved the lowest (i.e. worst) score in Quarter 2 – although it should be noted that the majority of respondents (71%) reported that they were seen on time or within fifteen minutes of their appointment time. Reducing delays in clinic is currently one of UH Bristol's corporate Quality Objectives and so is a major focus of improvement activity at the Trust in 2015/16.

The Friends and Family Test (FFT) scores continue to indicate that a high quality patient experience is provided to patients: consistently around 95% state that they would recommend the care to their friends and family. However, one of the benefits of the Trust's postal survey programme is that we are able to explore patient experiences across a wider range of topics and, because it is done away from hospital, respondents to this survey tend to give a more insightful and constructively critical account of their stay. Whilst the feedback about inpatient care via the postal surveys is still very positive (overall satisfaction being around 98%), a number of improvement themes emerge in the written comments relating to delays, communication and staff behaviour (see Section 5 of this report). We can also see that it is challenging to *consistently* provide people with the highest quality of care during their time in hospital: the negative comments about staff behaviour are often single instances in an otherwise very positive experience, and fewer than half (45%) of our postal survey respondents give us top marks on every one of the five key metrics that make up our inpatient experience tracker (communication, cleanliness, involvement in decisions, and respect and dignity)[5]. In other words: at a population-level the Trust provides a positive experience that is at least in line with (if not slightly better than) national norms. At an individual patient-level there is an opportunity to better ensure that patients consistently receive the highest quality experience. This focus on "responsiveness" will be a major theme in the Trust's new Patient Experience and Involvement Strategy, which is currently in development.

---

[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. The outpatient tracker is made up of four questions relating to respect and dignity, cleanliness, communication and waiting time in clinic.

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

[4] Trust Board data from the outpatient survey is provided as a "rolling three monthly score". So for example, in July the Trust Board received the combined survey score for April, May, and June; in August the Board will receive combined data for May, June and July. This is to ensure that the sample sizes are sufficiently large to generate an accurate score. This approach will be reviewed for the 2016/17 Trust Board Quality Dashboard, as there will be enough survey data at that point to test whether reliable discrete monthly data can be generated.

[5] Conversely, in Q2 no patient gave the Trust the worst possible score on every one of these five survey questions.

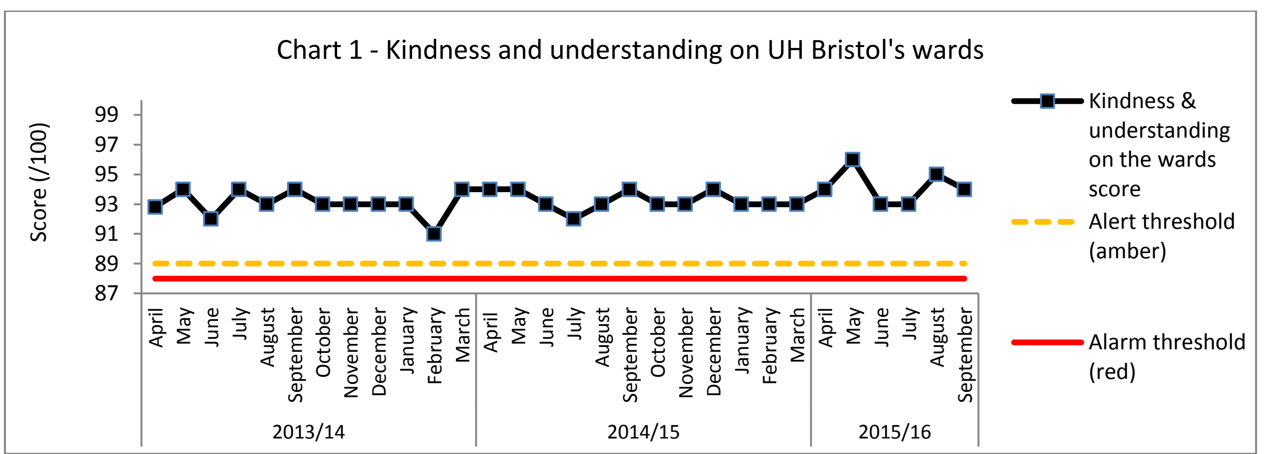


Chart 1 - Kindness and understanding on UH Bristol's wards
Score (/100)
99
97
95
93
91
89
87
April
May
June
July
August
September
October
November
December
January
February
March
2013/14
2014/15
2015/16
Kindness & understanding on the wards score
Alert threshold (amber)
Alarm threshold (red)

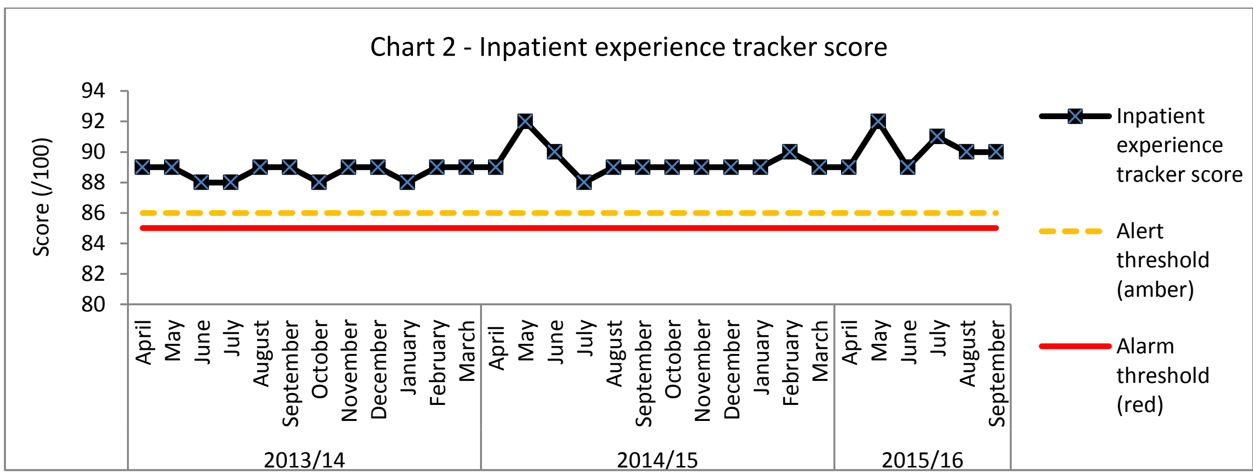


Chart 2 - Inpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
July
August
September
October
November
December
January
February
March
2013/14
2014/15
2015/16
Inpatient experience tracker score
Alert threshold (amber)
Alarm threshold (red)

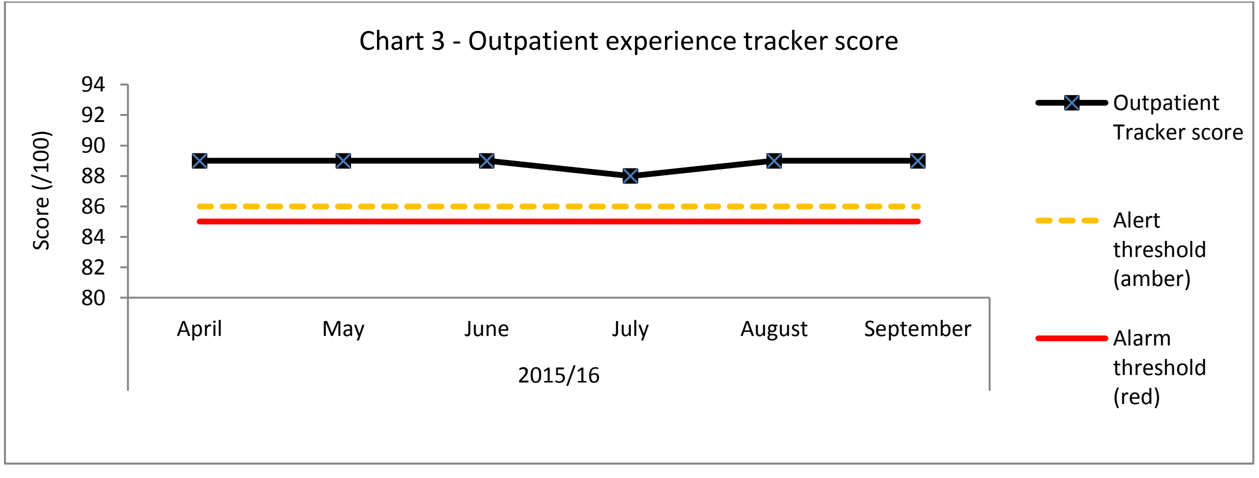


Chart 3 - Outpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
July
August
September
2015/16
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

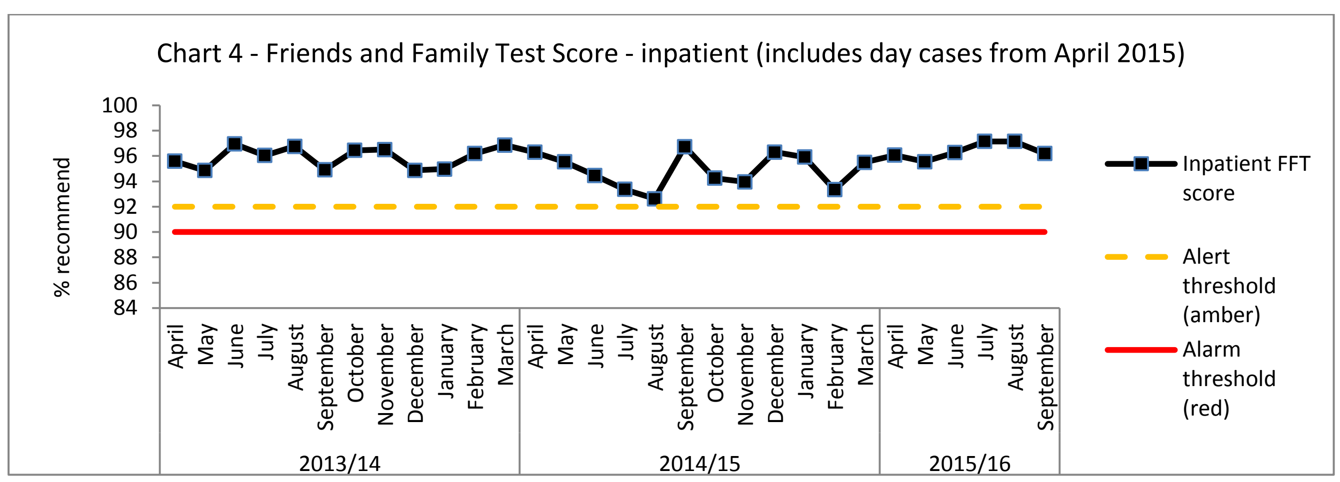


Chart 4 - Friends and Family Test Score - inpatient (includes day cases from April 2015)
% recommend
100
98
96
94
92
90
88
86
84
April
May
June
July
August
September
October
November
December
January
February
March
2013/14
2014/15
2015/16
Inpatient FFT score
Alert threshold (amber)
Alarm threshold (red)

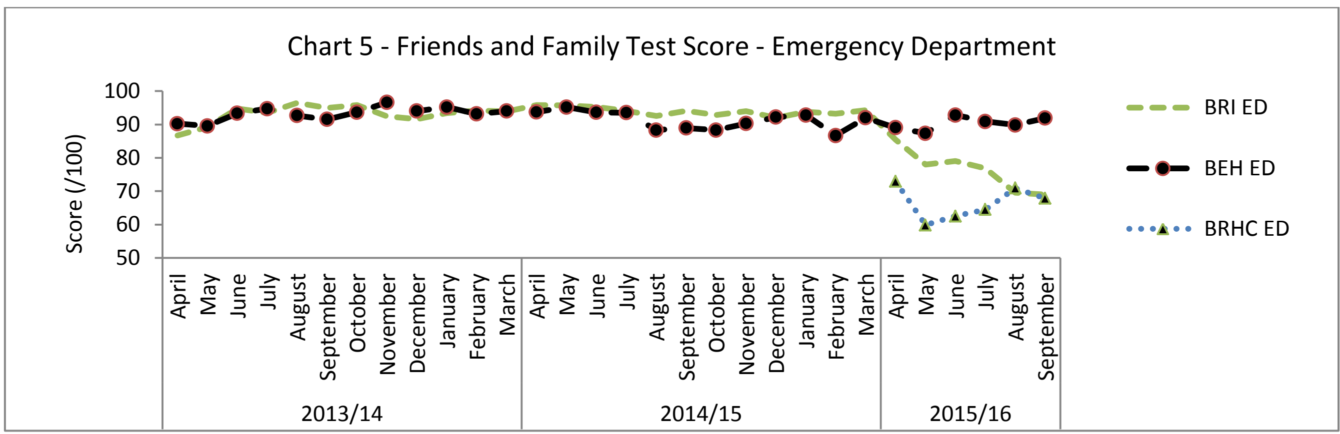


Chart 5 - Friends and Family Test Score - Emergency Department
Score (/100)
100
90
80
70
60
50
2013/14
2014/15
2015/16
BRI ED
BEH ED
BRHC ED

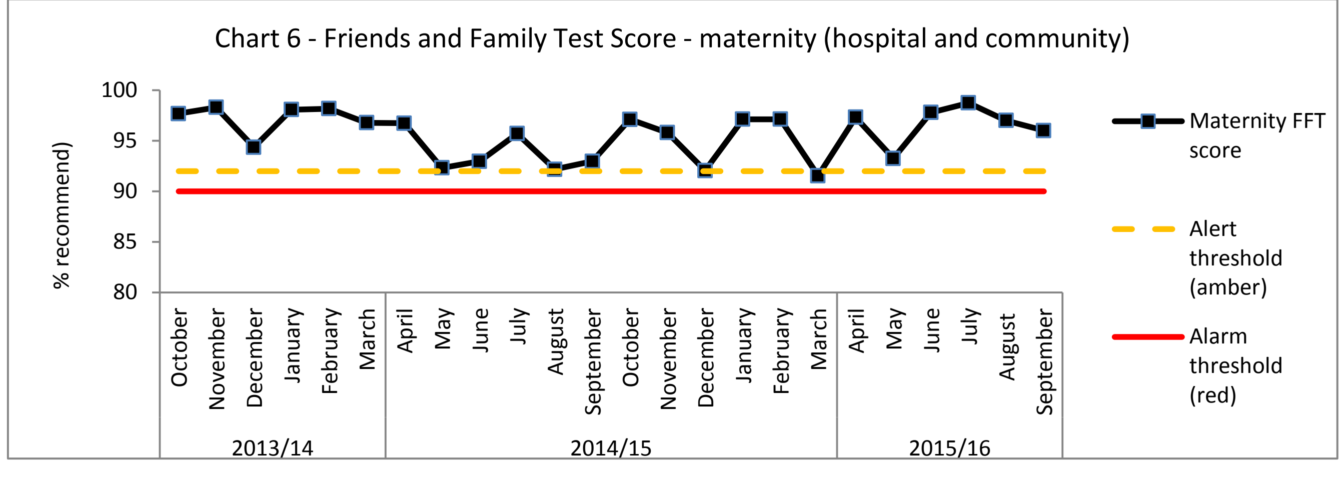


Chart 6 - Friends and Family Test Score - maternity (hospital and community)
% recommend)
100
95
90
85
80
2013/14
2014/15
2015/16
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

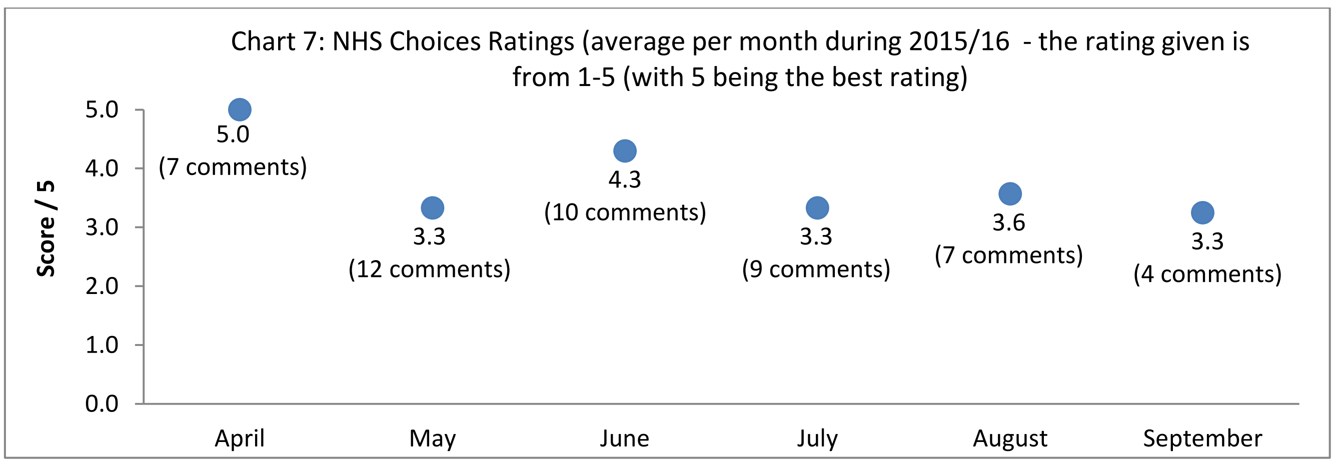


Chart 7: NHS Choices Ratings (average per month during 2015/16 - the rating given is from 1-5 (with 5 being the best rating)
Score / 5
5.0
4.0
3.0
2.0
1.0
0.0
5.0
(7 comments)
3.3
(12 comments)
4.3
(10 comments)
3.3
(9 comments)
3.6
(7 comments)
3.3
(4 comments)
April
May
June
July
August
September

3. Divisional and hospital-level patient experience data

Charts 8 to 16 (pages 7-9) show the headline patient experience metrics by UH Bristol Division and hospital site. The "alarm threshold" is shown in these charts, but this is a guide only - caution is needed in applying this threshold because there is a higher margin of error in the scores at this level. Table 1 provides an overview of the hospital-level results and indicates how many times each site has received scores below the target threshold.

Table 1: summary of hospital-level survey scores for the last four quarters. An "amber" rating is given if any quarterly scores in this period were below the Trust-level target, and a "red" rating is given over half fell into this category.

	Kindness and understanding	Inpatient tracker	Inpatient and Day case FFT	Outpatient tracker
Bristol Royal Hospital for Children				*Red*
Bristol Eye Hospital				*Amber*
Bristol Haematology & Oncology Centre				*Amber*
Bristol Royal Infirmary				
Bristol Heart Institute				
South Bristol Community Hospital	*Amber*	*Red*		
St. Michael's Hospital (excluding maternity)				
Postnatal wards	*Red*		*Red*	(Not applicable)
Bristol Dental Hospital	*(Not applicable)*		(Not applicable)	

Postnatal wards tend to attract lower survey ratings for kindness and understanding and in the Friends and Family Test. Directly comparing these scores with other inpatient wards is problematic because the demographics of respondents from maternity services are different to the rest of the Trust. It is important to note that the Trust's maternity scores are in line with and, in a number of respects, better than their national benchmarks (see section 6 of this report). It is however recognised by the management team that there is scope to improve service-user experience, and an update of ongoing initiatives to improve this aspect of care was received by the Quality and Outcomes Committee of the Trust Board in November 2015. There were encouraging increases in all of the maternity metrics in Quarter 2.

It can be seen in Table 1 that the inpatient tracker for South Bristol Community Hospital (SBCH) was rated "red", having been consistently below the Trust-level minimum target score. Two elements of the "inpatient tracker" bring down the overall score on this metric (Chart 13): involvement in care decisions and patients receiving understandable answers to their questions from doctors and nurses. The management team at SBCH are aware of these scores and are constantly striving to improve the service provided to patients and their carers / families, but as a large proportion of inpatients at SBCH are elderly with long-term medical / care needs (e.g. rehabilitation from stroke), these lower "communication" scores are in many ways a realistic reflection of the challenges in caring for this group of patients. This is a trend seen at both national-level[6] and within UH Bristol's own survey data. The hospital also had a low "kindness and understanding" score in Quarter 2 – the management team has been alerted to this and the score will be monitored closely, but given the small sample sizes for this hospital the most likely explanation is a (temporary) "statistical blip". If a more consistent trend emerges then a formal action plan will be put in place.

For the two Quarters that the Trust's outpatient survey has been running, the Bristol Royal Hospital for Children has received relatively lower survey scores on our headline "outpatient experience tracker". As this is a relatively new survey, this is the first consistent trend to emerge. A more detailed analysis of this data will be shared with the management team and an update will be provided in the next Quarterly Patient Experience report.

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

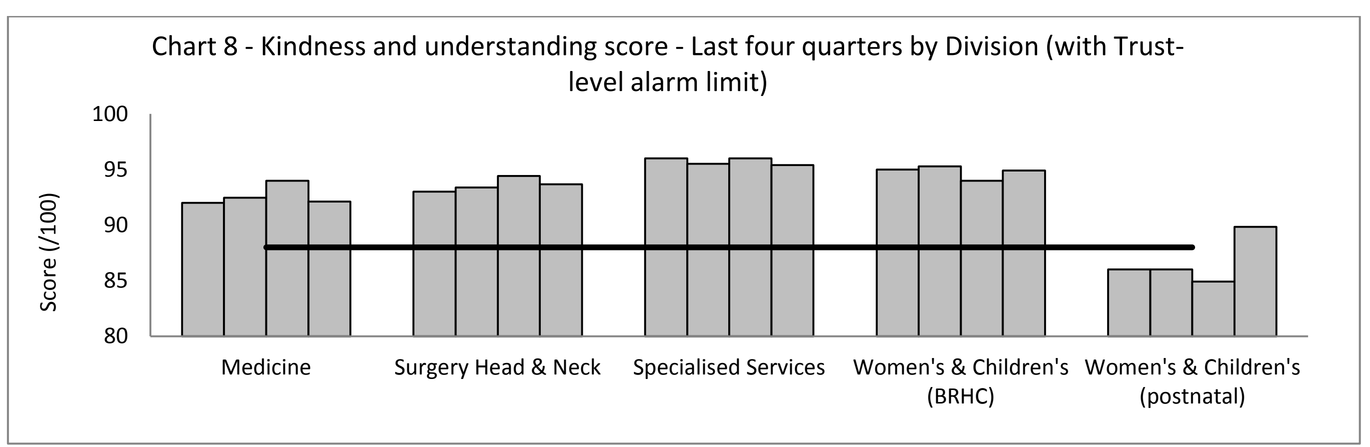


Chart 8 - Kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)
Score (/100)
100
95
90
85
80
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Women's & Children's (postnatal)

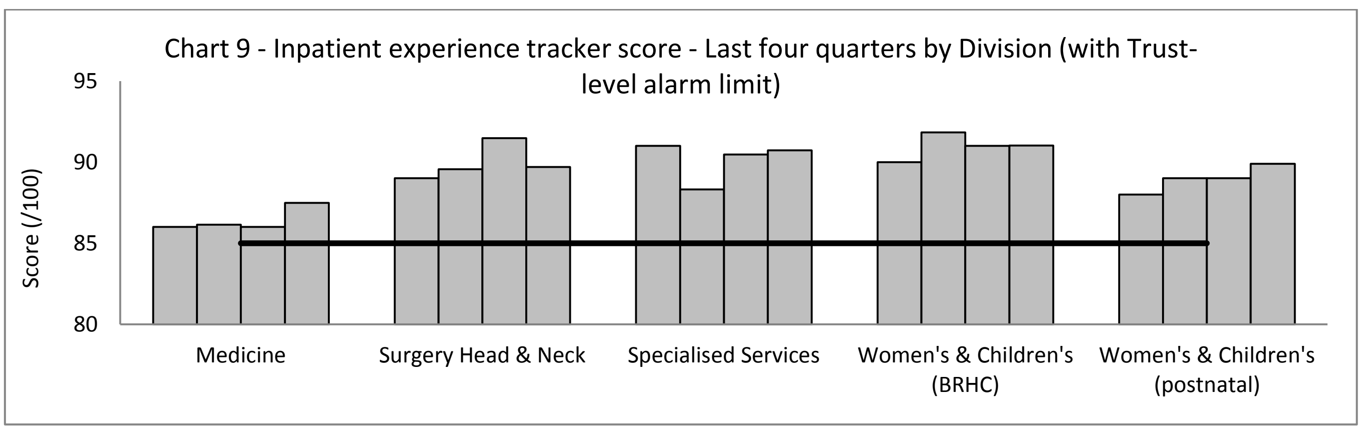


Chart 9 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)
Score (/100)
95
90
85
80
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Women's & Children's (postnatal)

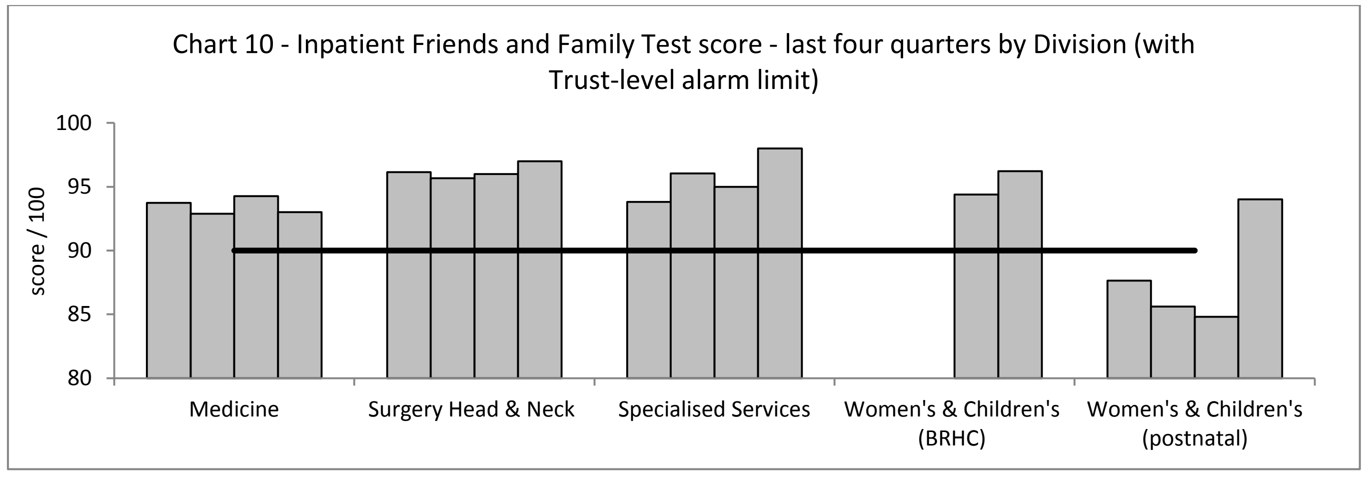


Chart 10 - Inpatient Friends and Family Test score - last four quarters by Division (with Trust-level alarm limit)
score / 100
100
95
90
85
80
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Women's & Children's (postnatal)

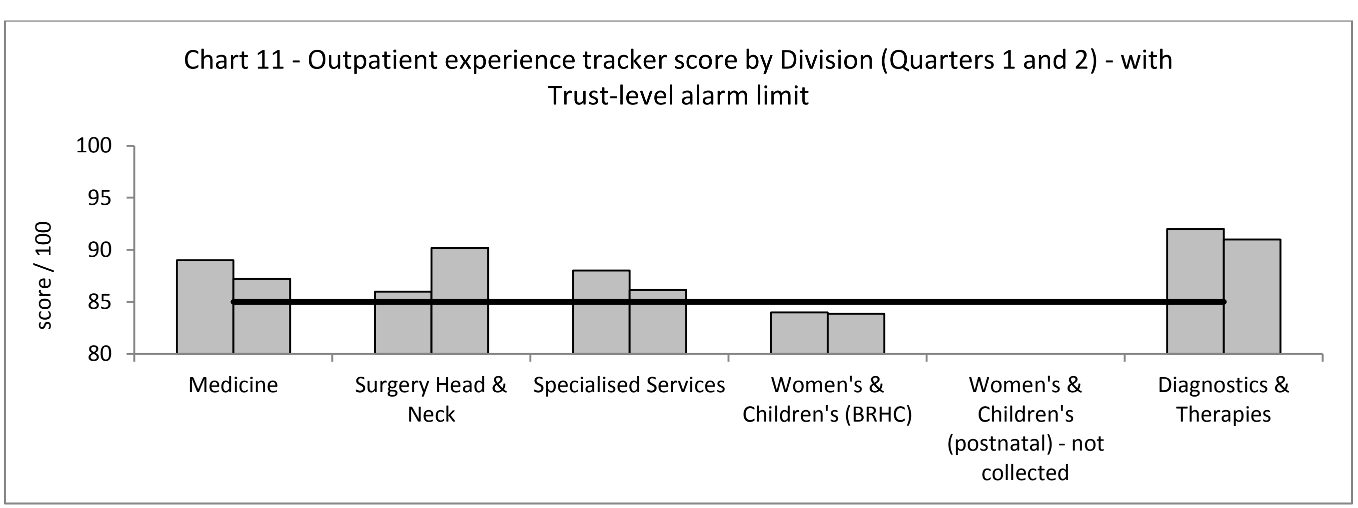


Chart 11 - Outpatient experience tracker score by Division (Quarters 1 and 2) - with Trust-level alarm limit
score / 100
100
95
90
85
80
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Women's & Children's (postnatal) - not collected
Diagnostics & Therapies

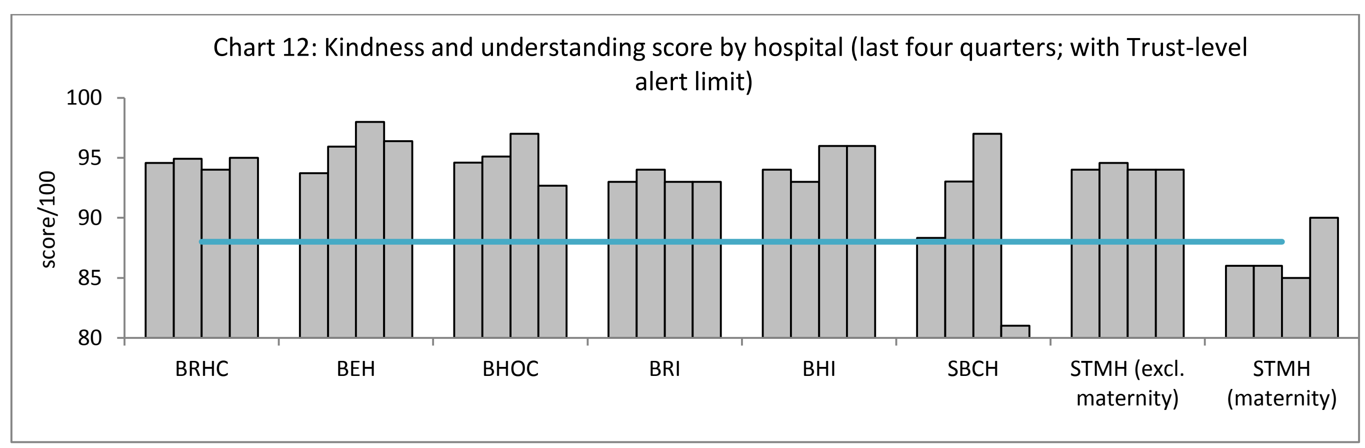


Chart 12: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)
score/100
100
95
90
85
80
BRHC
BEH
BHOC
BRI
BHI
SBCH
STMH (excl. maternity)
STMH (maternity)

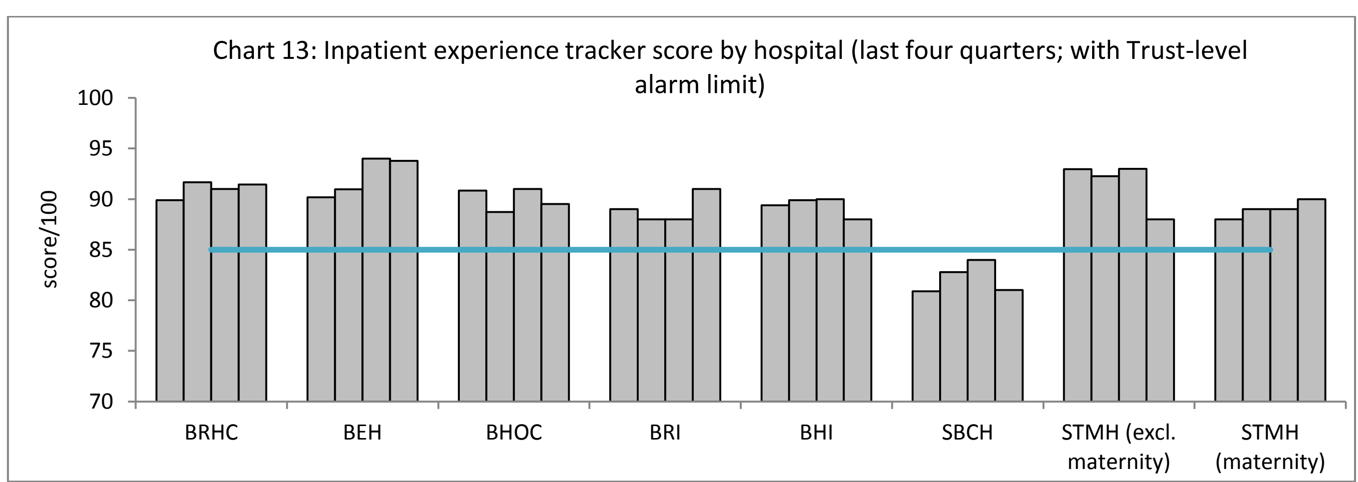


Chart 13: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)
score/100
100
95
90
85
80
75
70
BRHC
BEH
BHOC
BRI
BHI
SBCH
STMH (excl. maternity)
STMH (maternity)

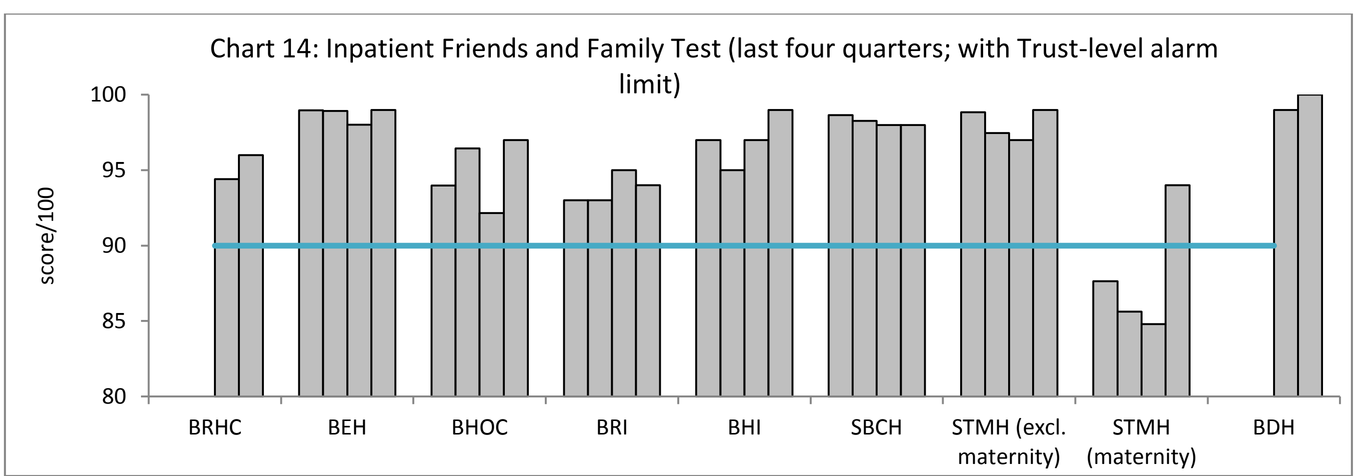
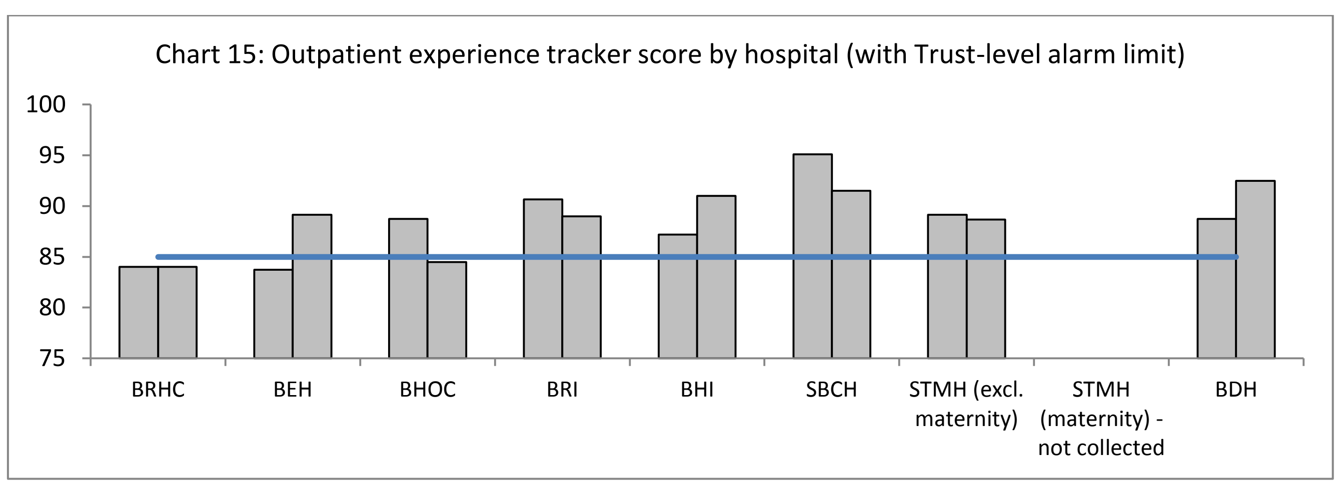
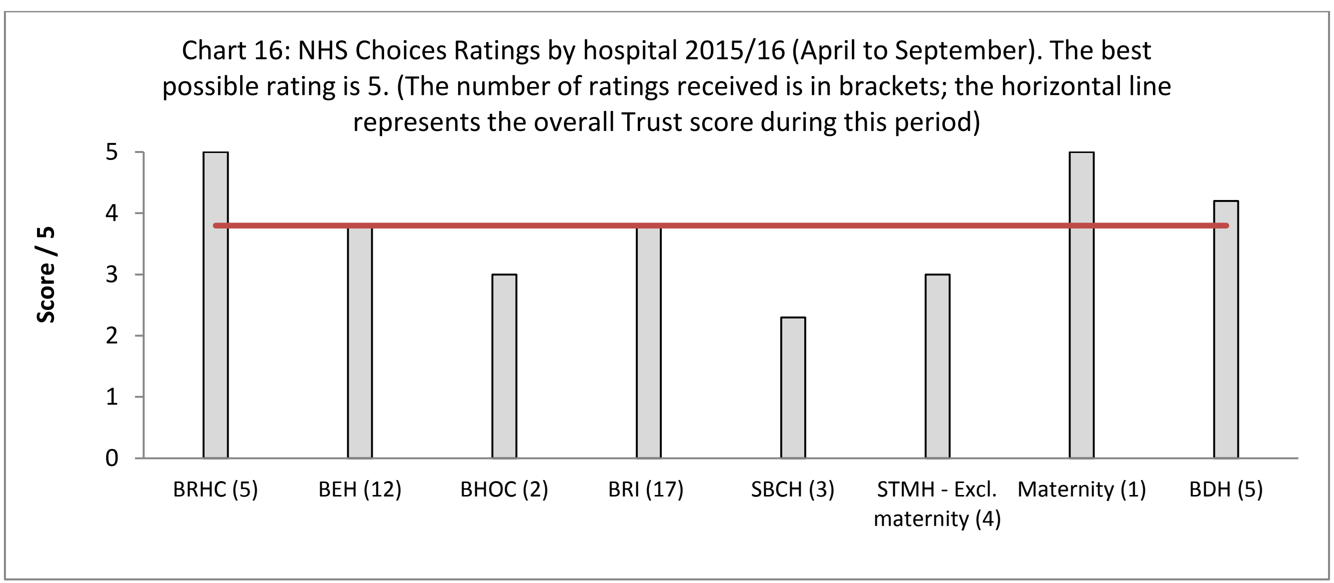


Chart 14: Inpatient Friends and Family Test (last four quarters; with Trust-level alarm limit)
score/100
100
95
90
85
80
BRHC
BEH
BHOC
BRI
BHI
SBCH
STMH (excl. maternity)
STMH (maternity)
BDH





Key: BRHC (Bristol Royal Hospital for Children); BEH (Bristol Eye Hospital); BHOC (Bristol Haematology and Oncology Centre); BRI (Bristol Royal Infirmary); BHI (Bristol Heart Institute); SBCH (South Bristol Community Hospital); STMH (St Michael's Hospital); BDH (Bristol Dental Hospital)

4. Ward-level data

Ward-level inpatient survey and Friends and Family Test data is presented in charts 17 to 19 (over)[7]. In order to increase the accuracy of this data, a six month timeframe is used (i.e. the scores are Quarters 1 and 2 combined). Even so, data at a ward-level should be used with caution, particularly as the data has been affected by the ward moves occurring within the Bristol Royal Infirmary. At a ward-level therefore, it is important to look for consistent trends across the various surveys (particularly given the issues described above) and to draw on wider quality data /research to help interpret the results. The postnatal wards (71,74, and 76) and South Bristol Community Hospital (100 and 200) have already been discussed in the previous section of this report.

The remaining consistent outlier in the ward data is ward A900, which had the lowest "kindness and understanding" rating and was among the lowest scores on the inpatient tracker. Ward A900 is a new ward at the Bristol Royal Infirmary that provides specialist care for patients admitted with gastro and respiratory problems. It also houses the inpatient beds for the Bristol Adult Cystic Fibrosis Centre, which is an adult specialist

[7] Wards with less than ten survey responses have not been included in this analysis.

centre providing multidisciplinary care to adults with Cystic Fibrosis (CF) in the region. Whilst in general the patient feedback is positive about the ward, a number of CF patients in particular have expressed concerns about their care since moving to this new area. Patient interviews have been carried out by the Trust's *Face2Face* volunteer interview team. They found that patients were broadly positive about the new physical environment, but having established long-term relationships with staff in the previous ward, it was clear that confidence and trust needs to be established with the new care team. Other issues were raised around food provision, staffing levels and staff understanding of CF care. The feedback from this exercise, along with a wider review of quality metrics and staffing on the ward, has been undertaken by the Division of Medicine. Improving experience on Ward 900 is now a key priority for the Division, and a number of actions are currently underway that should positively impact on patient experience. The survey scores will continue to be monitored and an update will be provided in the next edition of this report. The *Face2Face* interviewers will return to the ward in February 2016 to discuss the impact of these changes with patients.

Ward A602 had the lowest Friends and Family Test score in Quarter 2 (Chart 19). Although it is important not to draw firm conclusions based on this particular survey, it is a dataset that is available publically (albeit not in a readily accessible form at ward-level), and the Trust's Commissioners take a close interest in the scores. This was an unusual result for A602, and for Quarter 3 (to date) the ward is back above the minimum target threshold: in other words, Quarter 2 seems to have been a statistical blip in the data. (The ward-level FFT data is circulated to Divisions each month, enabling close monitoring of these scores to take place.)

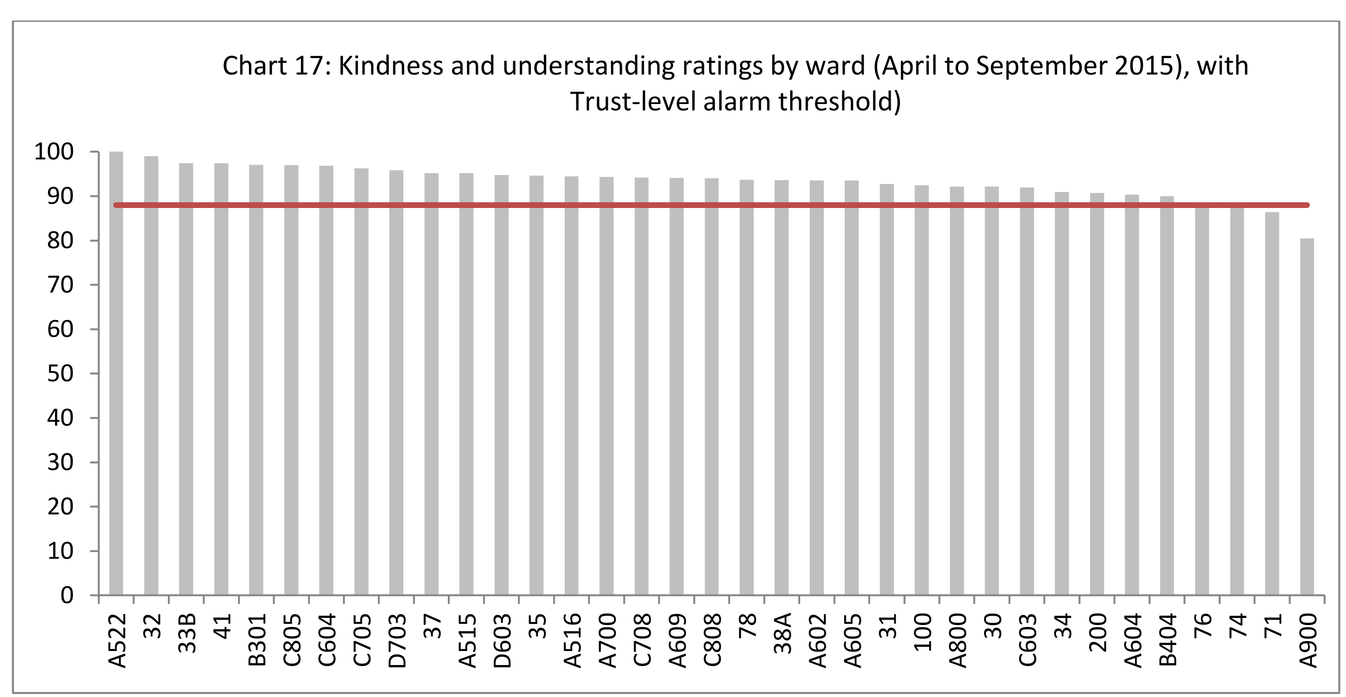


Chart 17: Kindness and understanding ratings by ward (April to September 2015), with Trust-level alarm threshold)
100
90
80
70
60
50
40
30
20
10
0
A522
32
33B
41
B301
C805
C604
C705
D703
37
A515
D603
35
A516
A700
C708
A609
C808
78
38A
A602
A605
31
100
A800
30
C603
34
200
A604
B404
76
74
71
A900

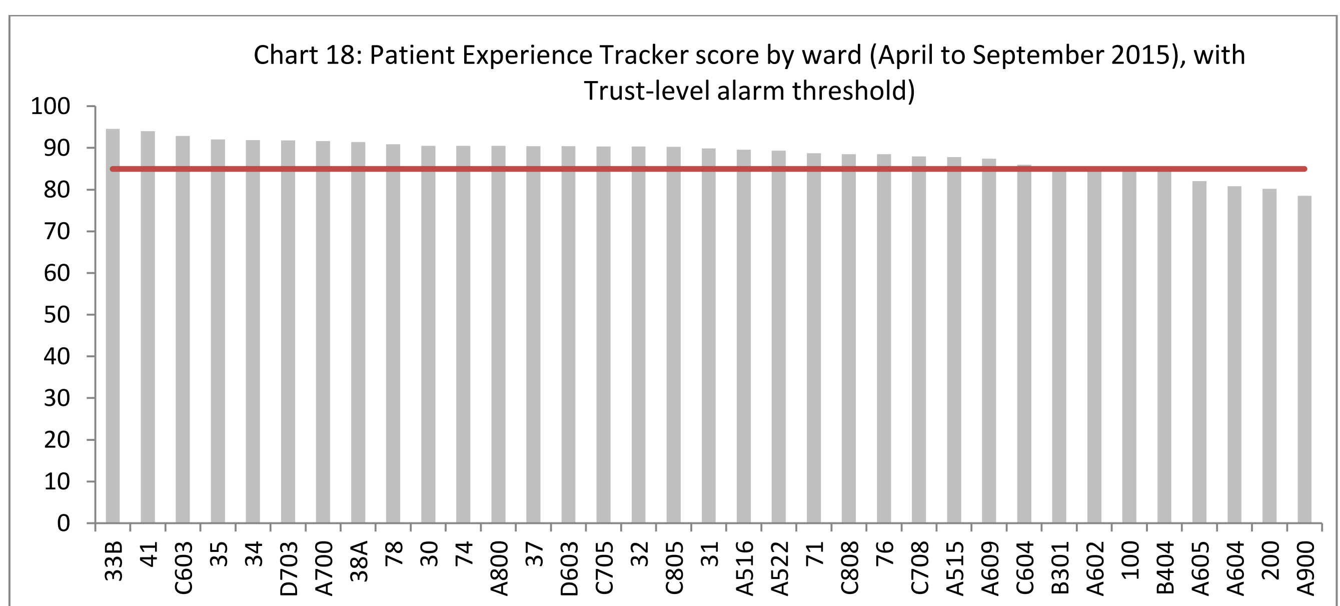


Chart 18: Patient Experience Tracker score by ward (April to September 2015), with Trust-level alarm threshold)
100
90
80
70
60
50
40
30
20
10
0
33B
41
C603
35
34
D703
A700
38A
78
30
74
A800
37
D603
C705
32
C805
31
A516
A522
71
C808
76
C708
A515
A609
C604
B301
A602
100
B404
A605
A604
200
A900

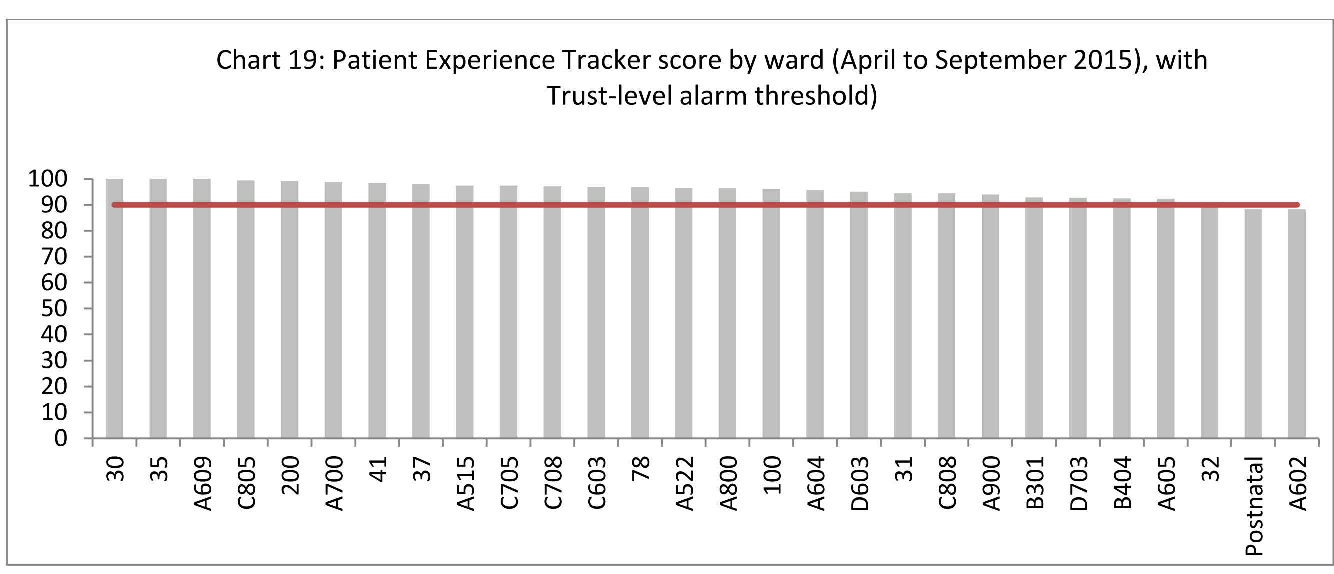


Chart 19: Patient Experience Tracker score by ward (April to September 2015), with Trust-level alarm threshold)
100
90
80
70
60
50
40
30
20
10
0
30
35
A609
C805
200
A700
41
37
A515
C705
C708
C603
78
A522
A800
100
A604
D603
31
C808
A900
B301
D703
B404
A605
32
Postnatal
A602

5. 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 categorised, reviewed by the relevant Heads of Nursing, and shared with ward staff for wider learning. 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 inpatient /parent comments (excluding maternity)

Theme	Valence	% of comments[8]
Staff	Positive	66%
Waiting/delays	Negative	9%
Staff	Negative	8%
Food/catering	Negative	8%
Communication	Negative	7%

66% of the comments received contained praise for UH Bristol staff. Improvement themes centre on communication, staff, waiting/delays, and food. "Food" generates strong feelings, but the majority of patients (69%) rate it as "very good" or "good"

Division of Medicine

Theme	Valence	% of comments
Staff	Positive	60%
Staff	Negative	11%
Food/catering	Negative	11%

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	66%
Waiting/delays	Negative	10%
Communication	Negative	7%

Negative comments about staff also often relate to a one-off negative experience with a single member of staff, showing how important each individual can be in shaping a patient's experience of care.

Division of Surgery, Head and Neck

Theme	Valence	% of comments
Staff	Positive	67%
Waiting/delays	Negative	9%
Information	Negative	9%

Communication is a key issue, but it is a very broad theme which includes ease of contacting the trust, patient information, clinic letters, and face-to-face discussions with individual staff.

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

Theme	Valence	% of comments
Staff	Positive	68%
Staff	Negative	9%
Communication	Negative	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	65%
Staff	Negative	11%
Staffing levels	Negative	9%

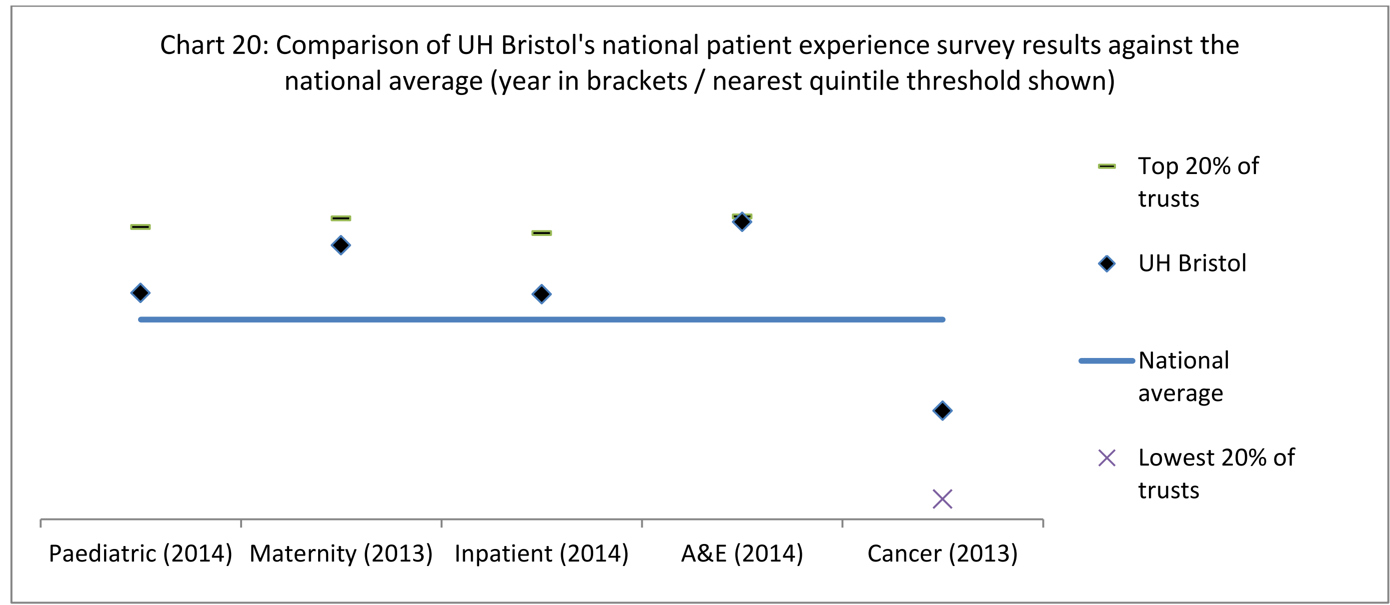
For maternity services, the two most common themes relate to praise for staff and praise for care during labour and birth.

[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).

6. National patient survey programme - overview

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 20 below[9] and Appendix A. It can be seen that UH Bristol broadly performs among the mid-performing trusts nationally. The main exception is the 2014 national Accident and Emergency survey, 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, despite a large number of service improvement actions at the Trust to try and redress this. A comprehensive engagement programme with patients receiving cancer services at UH Bristol has been carried out, in collaboration with the Patient's Association. In addition, the Trust is participating in an NHS England programme which involves working closely with a peer Trust that performs consistently well in the NCS. These activities have formed the development of a service-improvement plan which was approved by the Trust's Cancer Steering Group in Quarter 2.

In Quarter 2 the Trust also received the results of the 2014 national paediatric survey. The survey was completed by parents and also their children if they were aged 7-15 years old. This was, in effect, a survey of the experience of parents and patients at the Bristol Royal Hospital for Children (BRHC): although it is not a comprehensive view as the survey only covered patients aged 16 years or under (the BRHC treats patients aged over 16 years old), and it should also be noted that a proportion of the sample were from the Bristol Dental Hospital (around 10%). All but one of UH Bristol's scores in this survey was in line with the national average. One score was better than this benchmark – whether hospital staff told the parent what would happen to their child in hospital. UH Bristol scored relatively well compared to similar large, acute trusts. A number of improvement actions were identified, particularly around information provision, communication and parental facilities / accommodation. The analysis and action plan for this survey was received by the Trust Board in November 2015, and will be monitored by the Divisional Governance group with regular updates provided to the Trust's Patient Experience Group.



[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.

Appendix A: summary of national patient survey results and key actions arising for UH Bristol (action plans are reviewed by the Patient Experience Group)

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan review*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2014 National Inpatient Survey	57/60 scores were in line with the national average. One score was below (availability of hand gels) and two were above (explaining risks and benefits and discharge planning)	July 2015	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Explaining potential medication side effects to patients at discharge	May 2016
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
2015 National Paediatric Survey	All scores in line with the national average, except one which was better than this benchmark	November 2015	Six-monthly	• Information provision • Communication • Facilities / accommodation for parents	Not known
2011 National Outpatient Survey	All scores in line with the national average	March 2012	n/a	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments	Not known

Appendix B: Full quarterly Divisional-level inpatient survey dataset (Quarter 2 2015/16)

The following table contains a full update of the inpatient and parent data for July to September 2015. Where equivalent data is also collected in the maternity survey, this is presented also. All scores are out of 100 (see Appendix D), 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 16 for the key to the column headings.

	MDC	SHN	SPS	WAC (excl. maternity)	Maternity	Trust
Were you / your child given enough privacy when discussing your condition or treatment?	89	93	94	93	n/a	92
How would you rate the hospital food you / your child received?	62	64	63	64	57	63
Did you / your child get enough help from staff to eat meals?	78	87	89	72	n/a	82
In your opinion, how clean was the hospital room or ward you (or your child) were in?	94	94	96	94	91	95
How clean were the toilets and bathrooms that you / your child used on the ward?	91	93	93	91	82	92
Were you / your child ever bothered by noise at night from hospital staff?	77	88	83	86	n/a	84
Do you feel you / your child was treated with respect and dignity on the ward?	95	96	96	95	92	96
Were you / your child treated with kindness and understanding on the ward?	92	94	95	95	90	94
How would you rate the care you / your child received on the ward?	85	89	88	88	85	87
When you had important questions to ask a doctor, did you get answers you could understand?	85	87	89	88	85	87
When you had important questions to ask a nurse, did you get answers you could understand?	85	89	88	90	91	88
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	74	73	74	77	78	74
If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so?	82	84	86	88	91	85
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	79	83	84	89	90	83
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	84	87	88	86	n/a	86
Did you / your child find someone to talk to about your worries and fears?	68	72	75	81	83	74

	MDC	SHN	SPS	WAC (excl. maternity)	Maternity	Trust
Staff explained why you needed these test(s) in a way you could understand?	84	86	85	91	n/a	86
Staff tell you when you would find out the results of your test(s)?	71	71	71	76	n/a	72
Staff explain the results of the test(s) in a way you could understand?	73	79	75	83	n/a	77
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	82	91	91	95	n/a	91
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	76	78	75	84	n/a	78
Staff were respectful any decisions you made about your / your child's care and treatement	89	93	93	94	n/a	92
During your hospital stay, were you asked to give your views on the quality of your care?	22	21	24	28	31	23
Do you feel you were kept well informed about your / your child's expected date of discharge?	84	89	88	92	n/a	88
On the day you / your child left hospital, was your / their discharge delayed for any reason?	67	64	57	70	62	65
% of patients delayed for more than four hours at discharge	18	17	14	18	23	17
Did a member of staff tell you what medication side effects to watch for when you went home?	55	64	60	67	n/a	61
Total responses	412	457	355	336	246	1806

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	Before leaving hospital, all adult inpatients, day case, 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. A new monthly outpatient survey commenced in April 2015, which is sent to around 500 patients / parents per month.
	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 inpatient and day case Friends and Family Test (FFT) is a card 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 score is calculated as the percentage of patients who tick “extremely likely” or “likely”.

The Emergency Department (A&E) FFT is similar in terms of the recommend question and scoring mechanism, but at present UH Bristol operates a mixed card and touchscreen approach to data collection.

Cover report to the Board of Directors meeting held in public to be held on Friday 29 January 2016 at 11.00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
11. Strategic Partnerships Report									
Sponsor and Author(s)									
Sponsor & Author: Anita Randon, Interim Director of Strategy & Transformation									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

In 2006 the Trust agreed a framework for partnership working that sought to achieve the following objectives, to:

- identify those relationships which qualify as key partnerships
- identify the purpose of those partnerships
- identify how each partnership should be best supported and its status monitored
- ensure that formal arrangements are in place where appropriate, which may, depending on the nature of the partnership, include written agreements, quality standards and arbitration measures

Purpose: The ambition behind these objectives remains very much at the forefront of our thinking. That said, our world has changed in the last 10 years. The focus is increasingly on the wider system, shared accountabilities and defined outcomes and accountabilities.

Ambition: Our key partners are welcoming of a more fundamental approach to partnering, to not only consider where and how we work together to achieve our own ambitions or our shared ambitions, but to consider how we can support our partners in the furtherance of their ambitions to the benefit of the wider system. Specifically the University of Bristol and Bristol Community Health are eager to develop such an approach, collaboratively with us.

Recommendations

The Board are asked to agree the recommendations listed below:

1. That we adopt a series of established stakeholder management and partnering 'tools' to structure and drive value through these relationships. A high level summary of how we intend to develop this further is enclosed, with UoB and BCH being identified, as two partnerships that are eager to pilot a new approach with us; and
2. That we refine our current approach to the partnership report to focus on the original ambitions of our partnering framework, and segment our relationships:
    a) Strategic Partners. We will pilot this for the next report (April).
    b) Delivery partners. Approach to be developed (August)
    c) Network 'partners' – currently reported through the partnering report, in future to be reported into existing groups and sub-committees (changes from April)
    d) Key stakeholders (approach to be agreed, to include NHSE, Monitor, CCGs etc.) (August).

The partnering approach is not intended to cover all stakeholder relationships, but it will seek to signpost how and where accountability will lie for these.

Impact Upon Board Assurance Framework
Not applicable.

Impact Upon Corporate Risk
Not applicable.

Implications (Regulatory/Legal)
Not applicable.

Equality & Patient Impact
Not applicable.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	✓	For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
				20/01/2016	

Partnerships Report

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Avon Partnership NHS Plus Occupational Health Service	To manage Occupational Health and Wellbeing			Sue Donaldson	Barry Lane		18/01/2016

Update from last review:

Strategic Planning Framework - Market-based approach to business planning is on-going.

Representation of key Stakeholders, including the public, community groups etc in partnership processes and decision making - The Partnerships Trust, as key stakeholders, are represented on the Partnership Board.

Action plans to deliver local and national targets - Coordinating various staff Health and Wellbeing initiatives. Negotiating with other Trusts regarding possible extension of the Partnership.

Flexible use of resources - Integrated IT infrastructure and operations and Advice lines onto a single site. Currently implementing self-service web portal.

Monitoring systems to measure the progress of plans, using common targets and indicators - Quarterly monitoring is in place. More detailed/ in-depth reports currently being developed to support updated SLA.

Transparent and effective management of the partnership, especially communication and feedback loops - Scrutiny and feedback at regular 1:1 performance reviews between HRD and APOHS Business Manager.
A radical service review is currently near completion, which will update SLA, KPIs and the Partnership Agreement Framework. This is anticipated to be completed by 1st April 2016.

Current Partnership Agreement allows partners to 'walk away' with the only redress being arbitration. However, this is currently unlikely. Review of Partnership SLA and agreement underway to be completed on 1st April 2016.

Identified risk: **Low**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Bristol Against Violence and Abuse	Strategic partnership to develop a consistent approach to domestic abuse	Police, NBT, PCT,BCC, Victims Support, Social Services, Volunteer Organisations	Bristol Partnership Vulnerable Adults. Bristol Safeguarding Children Board	Carolyn Mills	Philippa Lloyd	Training	18/01/2016

Update from last review:

Shared vision and common priorities - Joitn Strategy.
Representation of key stakeholders, including the public, community groups etc, in partnership processes and decision making - Lay membership.

Action plans to deliver local and national targets - strategy.
Flexible use of resources - staff, money, time facilities - joint training.

Compliant on all arrangements, noting that there are no common data sources.

21/10/15 meeting attended by UHB. Safer Bristol - Bristol Domestic and Sexual Abuse Strategy Group, minutes not yet received.

Identified risk: Low

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Bristol City Council	Social Care	Social Care Team	Urgent Care working Group/Operational Delivery Group	Deborah Lee	Rowena Green	Implications regarding DTOCs/	18/01/2016

Update from last review:

Strategic Planning Framework - RG on Better Care Bristol Design group. SC on Better Care Fund Board.

Champions and leaders at strategic and operational levels - As above. RG meets at least weekly with operational leads.

Common data sources - Joint reporting in place.

Action plans to deliver local and national targets - System wide unscheduled care delivery plan monitored at fortnightly multi organisation tactical group. BCC attend weekly patient progress meeting.

Flexible use of resources - Integrated discharge hub.

Coordinated approach to mainstreaming initiatives - Several joint projects i.e. Discharge 2 Assess.

Monitoring systems to measure the progress of plans, using common targets and indicators - System wide cluster KPI's and weekly reporting against BCC targets.

Identified risk: Medium

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Bristol Community Health	Key partner in delivery of Integrated Care and SBCH specifically.	BNSSG Cluster		Deborah Lee	Rowena Green		18/01/2016

Update from last review:

BCH played a key role in the delivery of a system wide unscheduled care delivery plan. Active participation on OPAU.

Regular weekly and fortnightly meetings.

Access to BCH data systems and connecting care.

Leading on new rehab pathway.

Champions and leaders at strategic and operational levels - Regular weekly and fortnightly meetings.

Common data sources - Access to BCH data systems and connecting care.

Flexible use of resources - Integrated discharge Hub.

Monitoring systems to measure the progress of plans, using common targets and indicators - System wide cluster KPI's and project monitoring at unscheduled steering group.

Joint learning and staff development arrangements - Further work on joint learning with the development of community ward.

Identified risk: **Low**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Bristol Dementia Board	The Bristol Dementia Board exists to provide a forum for joint decision-making, strategic leadership, engagement and consultation across the health and social care agenda for dementia care in Bristol	BCC,NBT,PCT, Social Care	Bristol Dementia Strategy	Carolyn Mills	Helen Morgan		18/01/2016

Update from last review:

Compliant on all arrangements, except:

There are no funded resources for Flexible use of resources – staff, money, time, facilities

Terms of Reference to be finalised at April 15 meeting to reflect new format and membership of the group, now called Dementia HIT Management Group. The last meeting was held in October 2015 and minutes are available.

Proposals to Change the Structure and Form of the Dementia Meetings in Bristol and South Gloucestershire is being taken to the Joint Dementia Board on July 22nd.

Identified risk: **Low**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Bristol Health Partners and CLARHC				Robert Woolley	Diana Benton		18/01/2016

Update from last review: Shared vision and common priorities - Director of BHP sits in UH Bristol, this creates improved synergy.

Compliant on all other arrangements, except joint learning and staff development arrangements - HITs now being supported by the CLAHRC to develop evidence and bring research into practice.

Identified risk: Low

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Bristol Safeguarding Adults Board	Strategic alliance of key organisations working together ensuring the safeguard of adults in the community.	BCC, BPCT, AWP, Police, NBT, Independent Provider Forum, Voluntary Sector	Bristol Safeguarding Adults Partnership Board	Carolyn Mills	Philippa Lloyd		18/01/2016

Update from last review: Compliant on all arrangements, noting that there are no funded resources for this partnership. Request has been made to the Trust for funding. Notes from meeting held on 28th October 2015 are available.

Identified risk: Low

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Bristol Safeguarding Children Board/South Gloucestershire Safeguarding Children's Board/North Somerset Safeguarding Children's Board	Strategic partnership to safeguard children across all agencies	Local Authority, Health, Education, Police, Voluntary Sector	Statutory requirement. NSF. Change for Children. Carolyn Mills attends Safeguarding Children Board meetings.	Carolyn Mills	Carol Sawkins	UH Bristol provide funding	18/01/2016

Update from last review: Compliant on arrangements. No change from previous review.

The financial contribution required from UH Bristol is currently being reviewed and an increase in contributions is anticipated.

Identified risk: Low

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Bristol, North Somerset and South Gloucestershire Health Community	Strategic development programme for BNSSG	NBT, WAHT, Bristol CCG, SG CCG, NS CCG, SWAST, BCC, BCH, Sirona, SGCC, NSCC	System Leadership Group	Robert Woolley	Anita Randon	Pooled programme manageme	05/08/2015

Update from last review: New chair in place and progress towards common CCG strategic vision and priorities and renewed commitment to partnership for sustainable system change.

Identified risk: **Medium**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Charitable Partners	To raise funds to support Trust priorities that cannot be core funded	Above and Beyond, The Grand Appeal, Friends of BHOC and Teenage Cancer Trust	Mixture of formal and informal updates with charitable partners.	Anita Randon	Anita Randon	None. Above staff time	05/08/2015

Update from last review: Productive partnerships continue with all charitable partners. The Grand Appeal wishing to support expansion of Cots for Tots house and land transaction to facilitate underway. Above & Beyond considering their status following changes to legislation for the constitutional arrangements for NHS affiliated charities.

Identified risk: **Low**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Clinical Commissioning Groups (CCGs)	Clinical Commissioning Group are responsible for commissioning approximately 50% of the Trust's services.		Regular meetings through ICQPM	Anita Randon	Janet Burrows	Staff time	18/01/2016

Update from last review: The Commissioning Support Unit fronts relationship with CCGs. At this level, the relationship is primarily transactional - responding on issues as they arise. However, there are some strategic projects/initiatives where we are more proactive, e.g. SBCH, and where we are working collaboratively with CCGs, e.g. the Bristol CCG GP engagement event in November.

Identified risk: **Medium**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
NHS England South West	To ensure effective partnership working between the two organisations for the benefit of a co-ordinated whole system approach	Clinical Commissioning Group and Commissioning Support unit.		Robert Woolley	Anita Randon	Senior staff time	18/01/2016

Update from last review: Generally positive relationships with NHSE commissioners; however, a number of senior changes in the local team may change the nature of that relationship. Coupled with a significantly worsening financial position for NHSE South West, it is anticipated that the 2016/17 contracting round will present come challenges.

Identified risk: **Medium**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
North Bristol NHS Trust	To ensure effective partnership working across the two organisations for the benefit of our patients and staff with the aim of supporting the success of both organisations	Local Area Teams; Clinical Commissioning Groups	Partnership Board meetings Exec to Exec meetings	Robert Woolley	Anita Randon	Senior Staff time	05/08/2015

Update from last review: Partnership Programme Board and Executive meetings continue. A number of service strategy issues under discussion but not yet in train. Delays to histopathology transfer remain a concern.

Identified risk: **Medium**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
South Western Ambulance Service Trust	To ensure delivery of effective urgent and emergency care pathways through effective joint working	Bristol CCG / GPs / BCH		Deborah Lee	Rowena Green	Staff time	18/01/2016

Update from last review:

Strategic Planning Framework - Executive attendance at SRG.

Champions and leaders at strategic and operational levels - SWAST/BRI monthly liaison meeting.

Common data sources - Ambulance screens. Handover breach joint validation process.

Action plans to deliver local and national targets - Monitored at monthly Liaison meeting. Contribute to overarching recovery plan.

Monitoring systems to measure the progress of plans, using common targets - Monthly Liaison meetings and indicator's - UCWG.

Identified risk: **Medium**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
University of Bristol				David Wynick	Diana Benton		18/01/2016

Update from last review:

AHSN now established; shared vision will be strengthened.

Each organisation follows own protocols. High level strategic arrangements in place to strengthen partnership working.

There is no common data sources. Close partnership working facilitates sharing of data. Memorandum of understanding has been drafted and is being taken to the Board in February.

Each specialty group has relevant terms of reference.

Common data sources - Close partnership working facilities sharing of data.

Coordinated approach to mainstreaming initiatives - ASHN now established.

Joint learning and staff development arrangements - HR subgroup has been initiated.

Identified risk: **Low**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
University of the West of England				Sue Donaldson	Kay Collings		10/08/2015

Update from last review:

Focus on improving understanding and communication of joint priorities in order to maximize efficiency. This is being supported by an organizational review of Teaching and Learning, expected to conclude in quarter 3 2015/16.

High level strategic arrangements in place to strengthen partnership working.

Appropriate data sharing in place.

Identified risk: **Low**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
Urgent Care Working Group	Address Urgent Care flow	Bristol CCG, Bristol City council, SWAST, BrsDoc 111, AWP	Reports to SRG	Deborah Lee	Rowena Green	Meeting attendance	18/01/2016

Update from last review:

Delivery of ED 4 hour target. Admission avoidance.

Accountable to SRG.

Executive attendance to SRG. Senior managers of all partner organisations meet weekly and fortnightly and report into UCWG.

Representation of key stakeholders - Regular attendance at all meetings including weekly patient progress meeting at BRI.

Action plans to deliver local and national targets - System wide unscheduled care delivery plan.

Agreement on the contribution of each organisation to the delivery of joint targets/action plans - as above.

Flexible use of resources - Daily input into OPAU. Social worker in ED. Key members of discharge hub.

Monitoring systems to measure the progress of plans, using common targets and indicators - Fortnightly attendance at Tactical operational group. Scorecard and joint KPI's.

Joint learning and staff development arrangements - Community ward project.

Identified risk: **Medium**

Partnership:	Nature/purpose:	External partners:	Link/working arrangements:	Exec sponsor:	Operational Lead:	Resource implications:	Last review:
West of England Academic Health Science Network				Robert Woolley	Sean O'Kelly		09/04/2015

Update from last review: AHSN now established. UH Bristol CEO represents Clinical Research Network Board on Board and will act as Chief Executive sponsor of AHSN Academy for cross-organisation capacity and capability development programme in quality improvement, patient safety, innovation and informatics. UH Bristol has representatives on AHSN Patient Safety Collaborative Board and in its Enterprise and Translation Team. Wide range of programmes in place, including support for Genomics Partnership, Enterprise, Informatics, Patient Safety and Quality Improvement.

Identified risk: **Low**

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
12. Monthly Report on Staffing Levels, Adult Inpatient Wards including Midwifery and Bristol Children's Hospital , January 2016									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Authors**: Helen Morgan, Deputy Chief Nurse									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									

Purpose

There is a requirement, post the publication of the Francis Report 2013 and the new nursing vision, Compassion in Practice, that all NHS organisations will take a six monthly report to their public Trust Board on staffing capacity and capability which has involved the use of an evidence-based tool.

The purpose of this six monthly report is to provide the Board with assurance on progress and activity regarding nurse staffing, demonstrating that capacity and capability in the Trust is sufficient to deliver safe and effective care.

Key issues to note

The report demonstrates a continued commitment in UH Bristol to ensure that we have the right number of staff in place with the right skills.

The Trust level quality performance dashboard for the last six months indicates that overall the standard of patient care during this period was of good quality (safety/clinically effective/patient experience).

The report contains an update on previous actions. There are two key actions highlighted for the next six months which are:

- Progress the procurement of an e-rostering system, which incorporates a real time acuity and dependency scoring
- Review staff skill mix in medical wards following ward moves in November/December

Recommendations
The Board is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
Links to reference no 2. National Quality Safe Staffing Expectation for Trust Boards. Currently green on the Board Assurance Framework.
Impact Upon Corporate Risk
None

Implications (Regulatory/Legal)
National Quality Board Safe Staffing Expectation for Trust Boards.
Equality & Patient Impact
The Trust level quality performance dashboard for the six months June 2015 – November 2015 indicates that overall the standard of patient care was of good quality (safety/clinically effective/patient experience).

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination**	**Senior Leadership Team**	**Other (specify)**

6 Monthly (June – November 2015) Report on Staffing Levels for UHBristol Adult Inpatient Wards, Midwifery and Bristol Children's Hospital.
January 2016 Trust Board

1.0 Introduction & background

There is a requirement, post the publication of the Francis Report 2013 and the Compassion in Practice publication that all NHS organizations will take a six monthly report to their public Board Boards on staffing capacity and capability which has involved the use of an evidence-based tool.

This report must:

- Draw on expert professional opinion and insight into local clinical need and context
- Make recommendations to the Board which are considered and discussed
- Be presented to and discussed at the public Board meeting
- Prompt agreement of actions which are recorded and followed up on
- Be posted on the Trust's public website along with all the other public Board papers.

In June 2014 the Board of Directors received the first report from the Chief Nurse in line with new NHS guidance detailing staffing levels for UH Bristol adult inpatient wards, including Midwifery and Bristol Children's Hospital. In 2014, following the last nursing and midwifery staffing paper they also received an adhoc report detailing the principles for setting safe staffing levels in other professional groups. The Board receives detailed quarterly workforce reports and monthly safe staffing reports are received at the Quality and Outcomes Committee (Board subcommittee).

This report details:

a) An update on next steps as detailed in the June 2015 Board paper
b) What are the significant changes in the last 6 months for nursing staffing levels at UHBristol adult inpatient wards, including Midwifery and Bristol Royal Children's Hospital
c) How the Trust knows the wards have been safely staffed over the last 6 months

This report demonstrates a continued commitment in UHBristol to ensure that we have the right number of staff in place with the right skills.

2.0 Update on Next Step Actions from June 2015

- Action 1: Include the use of red flags, in line with national safe staffing guidance for inpatient and maternity in the new Datix reporting system.
- **Update: Red flag alerts are in place on Datix for adult inpatients and will be in place for midwifery areas by February 2016. . These will be reported on within the monthly staffing report presented to Quality and Outcomes Committee.**
- Action 2: undertake a review of nurse staffing in the Children's Emergency Department.
- **Update: Review completed with some recommendations actioned. Other recommendations are being considered as part of the divisional operating planning processes.**
- Action 3: Review the roles and responsibilities of band 4 Assistant Practitioners in inpatient areas across the Trust.
- **Update: Completed in all divisions**

3.0 Changes to nursing staffing levels in the last 6 months

3.1 Adult inpatient areas

The Trust continues to monitor the acuity of our patients using the 'Safer Nursing Care Acuity Tool'. For adult inpatient areas this tool is now on a web based system and the acuity and dependency of patients is monitored and recorded daily. This information supports both daily decisions and more strategic decisions regard staffing levels, skill mix and establishment .The current nurse rostering system contract up for renewal in 2016. The specification for tendering will include a requirement for an electronic real time acuity and dependency scoring system.

Maternity continues to use birth rate plus as the tool to benchmark their establishment and skill mix. Maternity, are not currently undertaking acuity and dependency scoring on a daily basis but will be have an opportunity to do this with an electronic system acuity and dependency scoring system. BRCH continues to record acuity and dependency via 6 monthly snap shot audits.

3.2 Adjustments in staffing

As described previously under the Standard Operating procedure (SOP) for setting Safe Nurse Establishments, there are a number of triggers that indicate when a staffing review is required (appendix 1). Below are detailed any changes to the nursing skill mix and establishment made in the last 6 months.

Specialised Services Division

- The annual staffing review was held in June 2015.
- Since the last report no significant changes to staffing establishment have been made.

Women's Services

- The annual staffing review was held in August 2015,
- There have been 10 extra whole time equivalent midwives put into the establishment, these have been recruited into in the last 6 months

Bristol Royal Hospital for Children (BRHC)

- The annual nurse staffing review was held in November 2015.
- Ward 34 - post the transfer of adult BMT patients to the Bristol Oncology Centre and the amalgamation of BMT/Ward 34, a review of nurse staffing supported an additional increase to the funded establishment of 2.65 wte Band 5 nurses.
- Children's Emergency Department (CED) – recurring operational resilience winter funding supported an increase in establishment of 1.24 wte Band 5 nurses and 0.5 wte Emergency Nurse Practitioners. Non-recurring operational resilience winter funding supported 3 wte Band 5's to cover the winter period.
- Clinical Site/Outreach Team - recurring operational resilience winter funding supported an increase in establishment of 2.15 wte to cover the winter period

Medicine Division

- All ward moves within the Division of Medicine have now taken place. A review of staffing has been undertaken before each move to ensure the appropriate skill mix is in place for the new ward environments. This will be fully reviewed at Medicine's annual staffing review in February 16, with a further review planned in 3-6 months to ensure the skill mix is appropriate and effective.

Surgery Head and Neck Division

- Five 5 additional band 2 staff have been employed within a pool SH&N to provide enhanced observation when required, primarily with trauma and orthopaedic wards, though the staff will used flexibly across the division.
- The Ophthalmic in-patient and day case ward, Gloucester ward, has seen an increase in throughput of over 2000 cases per annum, as a result additional funding was placed in the budget to support an increased skill mix.

4.0 CQC inspection Sept 2014 – update on outstanding actions

The CQC review identified that under the regulated activity of diagnostic and screening procedures, treatment of disease, disorder or injury, Surgical Procedures, the Trust had failed to consistently safeguard the health, safety and welfare of service users because the Trust did not ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activity. Specifically that there were not always sufficient numbers of suitably qualified, skilled and experienced staff employed on surgical wards and theatres. The Trust committed to undertake a number of actions. The following is an update on the remaining 2 actions:

- Action: Embark upon international recruitment venture for hard to recruit posts, commencing with theatres.
- **Update**: **An agency has been selected following a tendering process. A paper regarding Trust overseas recruitment plans went to Senior Leadership Team in December with approval given, pending approval of a business case, to proceed with international recruitment for adult theatre and critical care areas.**
- Action: Undertake work to better understand reasons for high turnover in some areas, notably theatres and Ward 700, and develop actions to address, where possible.
- **Update**: Work completed to understand reasons for high turnover, key theme was the challenge of two very diverse specialties being located in the same ward, SHN are reviewing ward configurations/speciality base. **Whilst attrition rates on ward 700 have settled, the ward continues to hold vacancies;**

CQC requests for further information on staffing establishment and skill mix

Two whistle-blowing incidents were reported to the CQC regarding adult theatre staffing. Staffing within all theatre environments has been reviewed and confirmation given by the Division/Trust to the CQC that theatres are staffed in line with The Association for Perioperative Practice guidance for staffing an operating theatre

5.0 Review and update against NICE Safe Staffing Guidance

The Nice guideline for Safe Midwifery staffing was published in February 2015. A baseline assessment has been completed against the published standards. The Trust meets the standards with the implementation of the red flag alerts in Datix.

NICE is no longer leading any further development of safe staffing guidance. This work is now being led by NHS England as part of a wider programme of service improvement. Revised inpatient ward safe staffing guidance are to be published in March/April 2016. Urgent and emergency care safe staffing guidance to be published in June/July 2016.

It is anticipated that Lord Carter's review will have some specific recommendations on the use of care hours per patient per day, which will include nursing/nursing assistant hours.

6.0 How the Trust knows the wards have been safe over the last 6 months

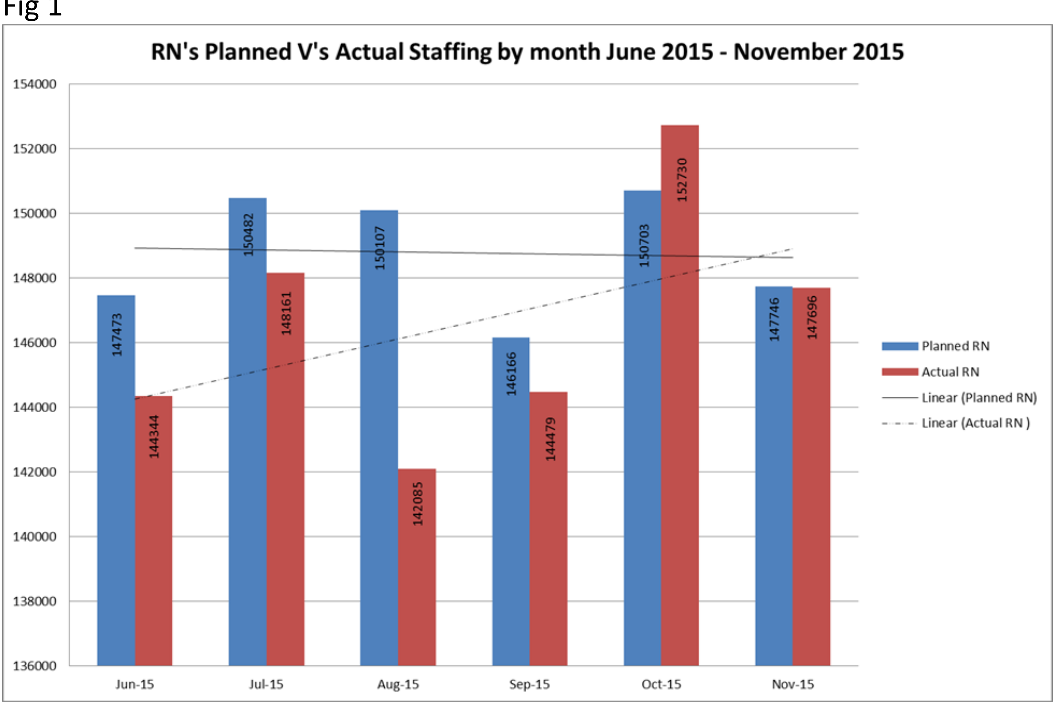
6.1. Monthly Staffing Reports to Quality and Outcomes Committee.
The Trust continues to submit monthly returns of the Department of Health via the NHS national staffing return. This return details the overall Trust position on actual hours worked versus expected hours worked for all inpatient areas, the percentage fill rate for Registered Nurses (RN) and Nursing Assistants (NA) for day and night shifts, together with the overall Trust percentage fill rate.

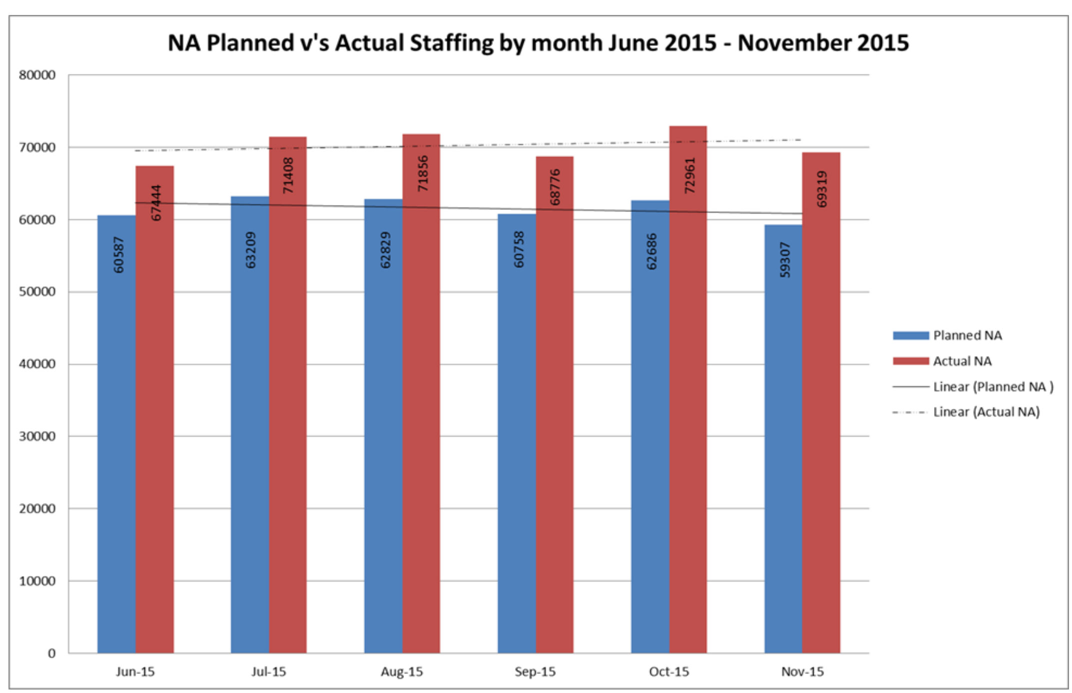
A monthly detailed report is received and reviewed at the monthly at the Quality and Outcomes Committee a Non-Executive sub-committee of the Board. This report gives a detailed breakdown of any variances by Division. A review of Trust wide data over the last six months for planned versus actual nursing hour's, which included RN's and Nursing Assistants, shows that in every month the overall actual nursing hours were above plan.

The Trust wide fill rate for planned RN hours (days and nights) continued to be slightly below actual hours for the first 4 months but saw a slight change in the last 2 months where RN actual hours were either above or at planned levels**.** The Trust wide fill rate for planned NA hours over last six months (days and nights) continues to be over actual hours (see fig 1).

Where there is variance within specific areas there is a flexible approach to staffing, with wards providing cross cover where possible to support any shortfall in RN or NA staffing.   Bank and agency staff are used as required to cover shifts and to ensure patient safety if cross cover is not possible. All divisions have a daily and robust review of staffing in place and decisions to move or use temporary staff to fill gaps are made on a risk assessment of the staff skill mix, the number of beds open and the acuity and dependency of the patients.

There are no corporate risks on the risk register related to nurse staffing.
Fig 1



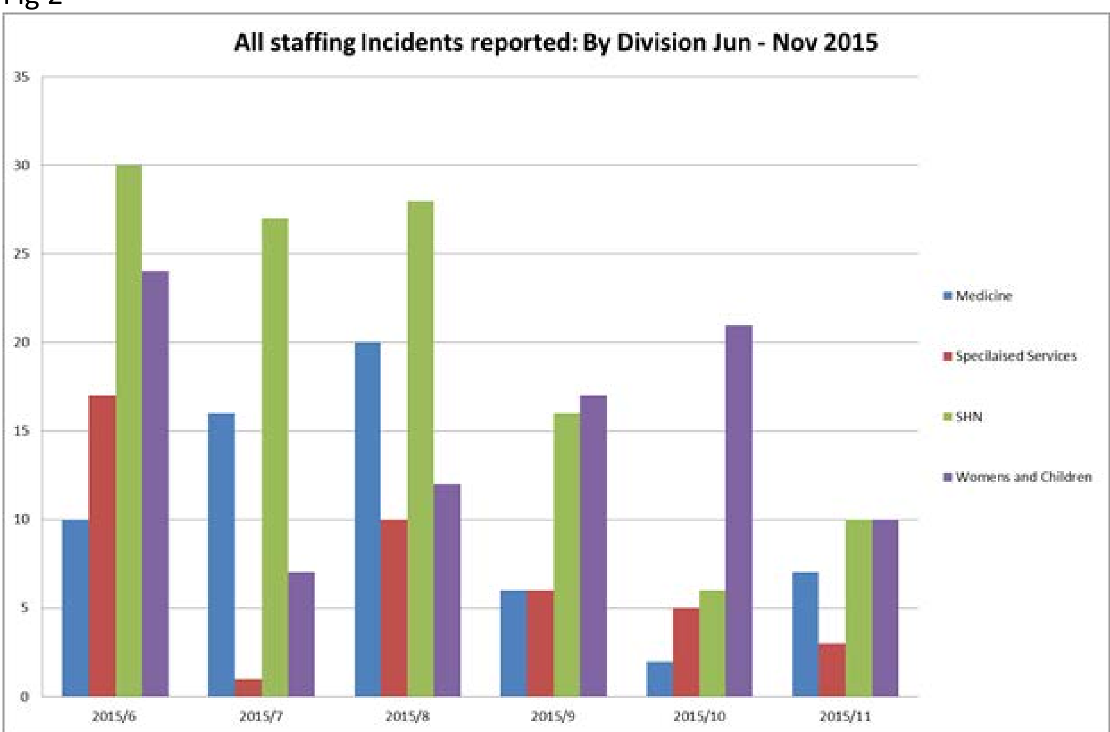


6.2 Quality metrics
The Trust level quality performance dashboard for the last six months indicates that overall the standard of patient care during this period was of good quality (safety/clinically effective/patient experience), with a decrease in the overall numbers of falls and pressure ulcers per 1000 bed days.

The number of falls with harm and hospital acquired grade 3 pressure ulcers over the last 6 months, has remained static. Reviews of RCAs to identify good practice, themes and areas requiring improvement continue to be undertaken for both falls and hospital acquired grade 3 pressure ulcers with actions incorporated into the trust work plans for 15/16 and 16/17.

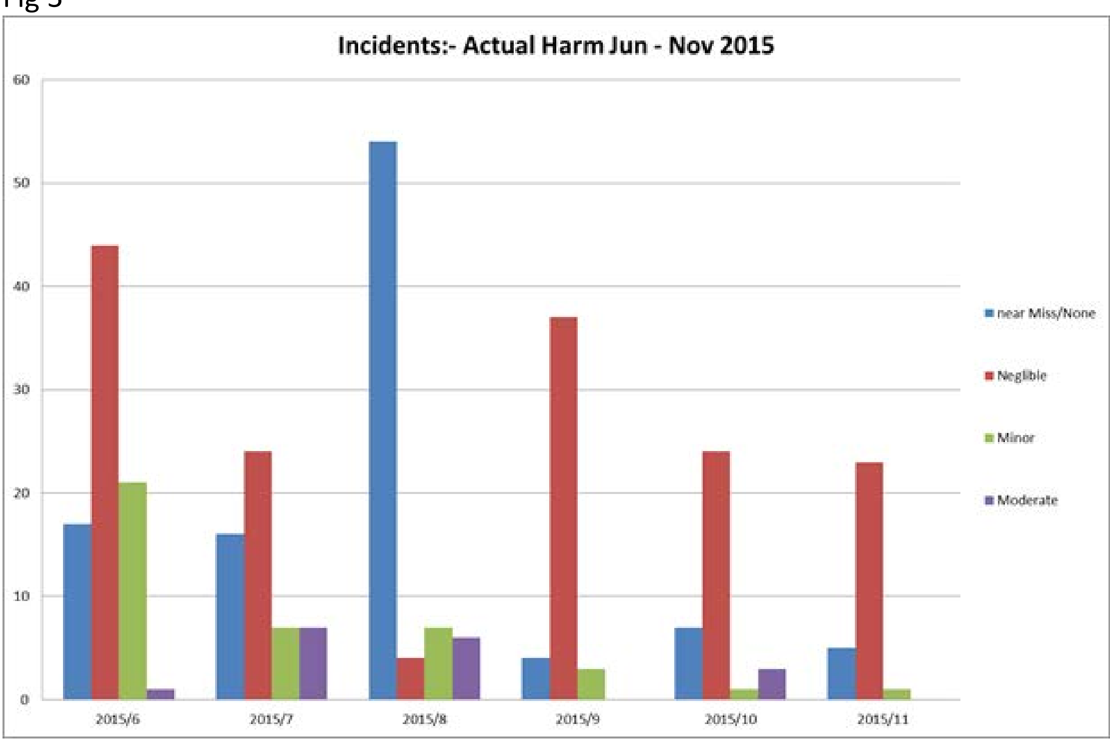
6.3 Staffing incidents
The number, content and any themes arising staffing incidents related to staffing levels are reviewed and discussed monthly and quarterly via Divisional Performance and Ops Reviews. The average number of incidents compared to the previous last 6 months has remained static, however the data shows a decrease in the number of incidents reported from September onwards (see fig 2).

Fig 2



It is interesting to note that where the level of risk assessed in most divisions is moderate to very high; the actual harm continues to be assessed as near miss to minor (see fig 3).

Fig 3



6.4 Update on national developments

- National Nursing Research Unit report on 12 hour shifts – due Dec 2014. **The report has still not been published. No communication has been received regarding its future publication date. The Trust conducted its own review on 12 hour shifts with findings and recommendations presented to the Workforce and OD Group in July 2015.**

Recommended actions were:

- Review the e–rostering rules to ensure that the necessary controls are in place to avoid rostering of more than two consecutive long days/nights and an adequate time off is rostered. (unless this is a personal request) – this should reduce fatigue. **Complete**
- There is a re-communication that there is an option available for staff to work half twelve hours shifts. (NB this is only possible if two members of staff want to work shorter shifts in one area so may necessitate staff moving area to accommodate these requirements) **Complete**
- The importance of taking allocated breaks is re-enforced with all staff and managers. **Complete**
- Review options to identify and flag staff working excess hours using e-roster so that impact on these staff can be assessed. **Complete**

- Safer Care Nursing Tool for Paediatric inpatient settings – **due to have published in June 2015 but delayed by transfer of leadership to NHS England. Work is ongoing and being led by the CN of Birmingham Children's Hospital.**
- NICE Safe Staffing for Nursing in A & E Departments – Due to be published June/July 2016
- National Research being commissioned – impact of supervisory ward sister role, links between staff numbers and outcomes, more in-depth research on 12hr shifts – impact on staff and patients. To yet be published.
- In November 2015 the Price Cap for agency staff: rules was published and came into force on 23 November. The Trust is committed to complying with the rules set out in the paper. Detailed compliance reports are submitted to NHS England on a weekly basis. The Trust has clear processes and authorization guidance in place for nursing staff.

7.0 Next Steps

- Progress the procurement of an e-rostering system, which incorporates a real time acuity and dependency scoring.
- Review staff skill mix in medical wards following ward moves in November/December.

8.0 Conclusion

In the last six months, the Chief Nurse and Divisional Teams have continued to review and monitor staffing levels to ensure they are staffed safely. Ward Sisters and
Charge Nurses have an understanding of their funded workforce resource, and are aware that if required this will be adjusted to reflect the acuity and dependency of patients admitted and changes to ward environments.

This paper can assure the Board of Directors that UHBristol has safe staffing levels. However there is no element of complacency and there is a need to stabilise the workforce with an effective UK and international recruitment campaign and to ensure if the service model changes that staffing can be adjusted accordingly.

UHBristol's principles for initiating a staffing review (2014)

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

OR when there is:

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

Principles of Safe Staffing for General Inpatient Wards

Ratio of registered to unregistered professionals

Within UHB adult inpatient areas, the Trust set staffing levels based on a principle of 60:40 ratio of registered nurse to nursing assistant in general inpatient areas. This will be higher in some specialist ward areas due to the increasing complexity of care, for example medication regimes and the number of intravenous drugs now given and increased dependency and complexity of elderly patients being admitted.

Ratio of number of patients per nurse

In setting wards establishment and skill mix UHB use the principles of one registered nurse per 6 patients on a day shift and one registered nurse to 8 patients on a night shift.

In adult critical care areas, the ratio is one nurse per patient adult intensive care (level 3 patient) day and night and one nurse per two patients in adult high dependency (level 2 patients) day and night

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
13. Quarterly Research and Innovation Update									
Sponsor and Author(s)									
Sponsor: Sean O'Kelly, Medical Director **Author**: David Wynick, Director of Research									
Intended Audience									
Board	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose The purpose of this report is to provide an update on performance and governance for the Board. Key issues to note See executive summary.									
Recommendations									
The Board is recommended to receive the report for **assurance.**									
Impact Upon Board Assurance Framework									
None									
Impact Upon Corporate Risk									
None									
Implications (Regulatory/Legal)									
None									
Equality & Patient Impact									
None									

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination**	**Senior Leadership Team**	**Other (specify)**

Overview

<table>
<tr><th>Successes</th><th>Priorities</th></tr>
<tr><td>Review of infrastructure within the division of Medicine completed and implementation of recommendations is under way
Additional post to support sponsor financial and regulatory oversight within the R&I team has been agreed; recruitment in progress
Performance in initiating and delivering research has been maintained over the previous successive 2 quarters
Successful NIHR grant applications are increasing year on year
Investment in non-malignant haematology resource by the LCRN is expected to increase capacity to take on trials in that area, maintaining the region’s position as highest national recruiter per 100,000 population</td><td>Agree appropriate KPIs with divisional leadership teams in order to optimise recruitment into trials and make research available to more patients
Formulate credible bid as part of Biomedical Research Centre call to sustain and build on research infrastructure built during the past 5 years
Embed new standard operating procedures for research into routine practice for researchers; work with teaching and learning to ensure mandatory requirements are incorporated into trust systems</td></tr>
<tr><th>Opportunities</th><th>Risks and Threats</th></tr>
<tr><td>Closer partnership working with UoB to present seamless pathway for researchers setting up trials led here
Develop research activity in under-represented areas, such as medical specialties, planning to build on new or developed services where appropriate
Consider options for increasing commercial research activity in areas where there is potential for growth
RCF income is expected to remain steady next year; however, any increase would allow more investment in research & counteract expected small network funding decrease
In line with national changes to research approvals, opportunity for streamlining departmental processes and enabling more efficient research set up.</td><td>Flat cash/reduction (of up to 5%) likely to be awarded by research network due to decrease in recruitment into clinical trials in current financial year. Impact of this will have to be absorbed through other research funding schemes as required.
Changing regulatory landscape for research is unclear, leading to uncertainties in the short to medium term regarding resourcing within the R&I team
Staff turnover/sickness in small core R&I team impact on research management metrics
If NIHR BRC bid is unsuccessful this will affect RCF long term.</td></tr>
</table>

Executive Summary

Performance: *Research has shown a strong performance during 2015 in a number of key areas, which include performance under the NIHR contract in initiating and delivering research (PID), and success in drawing in NIHR grant income. Two large NIHR grants totalling £2.8m have been awarded since July 2015 and a further five applications were submitted (see graphs below).*

Both weighted recruitment and actual recruitment have been significantly lower than in previous years. This is due to a number of factors which include: availability of large interventional trials on the portfolio, burden of follow up to large interventional trials which have finished recruitment, delays by sponsors in opening new trials here. The delivery funding that we receive from the Local Clinical Research Network is not fully tied to our recruitment activity, with a collar and cap being implemented, so we expect to receive a reduction in delivery funding of no more than 5%, despite the large drop in activity.

Whilst it is important for us to generate delivery income for UHBristol and the network region to sustain our capacity, we are also actively seeking to increase research activity in our medical specialties so that we can develop capacity and offer trials to a wider range of our patients; this will underpin the research network's high level objectives, contribute to regional and local activity and increase sustainability. Two large interventional trials have now commenced, and total and weighted recruitment is expected to increase in 2016 (calendar year) over 2015. Within the division of Medicine a review of workforce and workload and opportunities for increasing commercial research has taken place and next steps are being agreed. In the clinical divisions, research KPIs are currently in development; this will increase local ownership, supporting better activity planning and, importantly, recruiting to target in the studies that we open. Recognising the renewed focus by the NIHR on delivering research to time and target, projects are underway to improve data accuracy and performance.

Partnerships: *The call to bid for Biomedical Research infrastructure funding was announced shortly on the heels of the comprehensive spending review; funding for Biomedical Research Units and Centres has been rolled into a single call to which we are responding, working closely with the University of Bristol as our key partner for the bid. The national budget for Biomedical Research Centres has been protected. The deadline for the preliminary qualifying questionnaire is in mid February, following which shortlisting of themes will take place, with the full application deadline in June.*

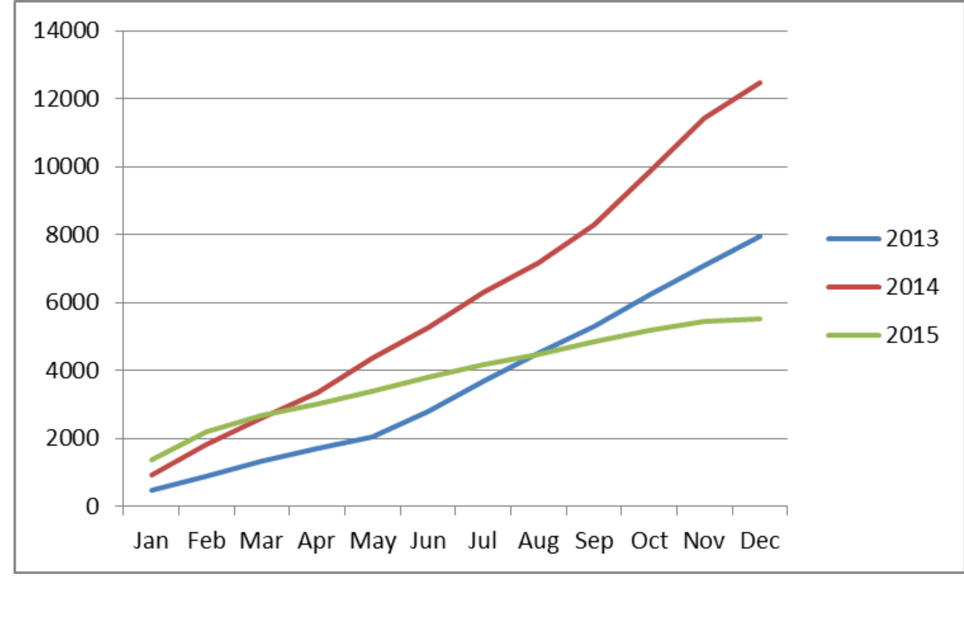
Governance and training: *The second quarterly submission of progress against actions following the MHRA inspection was submitted on 29th January 2016. Implementation of actions is to plan, including developing and approving a suite of standard operating procedures to better control and more formally describe the activities already ongoing within the trust, particularly in relation to clinical trials of investigational medicinal products (CTIMP). Targeted investigator oversight training has taken place for 100% of our CTIMP chief investigators and 63% of our principal investigators; this training is ongoing. Alongside this, 72 (86%) non-medical research staff who receive consent have received face to face training in receiving valid informed consent for research.*

Impact of research: *NHS England published an Interim clinical commissioning policy on the use of adalimumab for children with severe refractory uveitis, recommending its use for patients who meet the clinical criteria it sets out. The policy will benefit children for whom uveitis threatens their sight, and for whom other treatments have proven ineffective. A policy on this indication was held over from the 2015/16 specialised commissioning prioritisation round pending further evidence from the 'Sycamore' clinical trial, shared with NHS England in confidence and in advance of its publication. UHBristol is the sponsor of 'Sycamore'.*

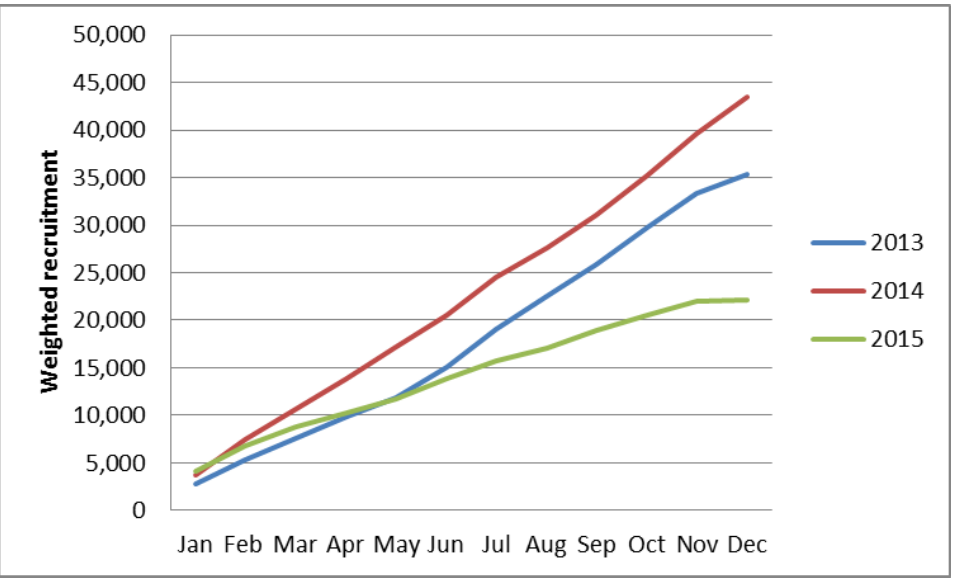
Performance Overview

This section provides information about performance against key performance indicators. All KPIs are financial or drive the income we receive.

a) Cumulative number of patients recruited into NIHR portfolio studies in 2015. NB. There is a 6 week lag of data from the portfolio.



b) Cumulative weighted recruitment into NIHR portfolio studies in 2015. NB. There is a 6 week lag of data from the portfolio.



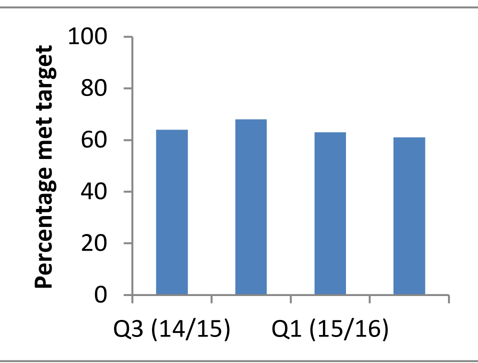
c) Our performance of meeting the 70 day first patient first visit benchmark adjusted by NIHR in comparison to other Trusts

NIHR PID report- latest received Q2 15/16

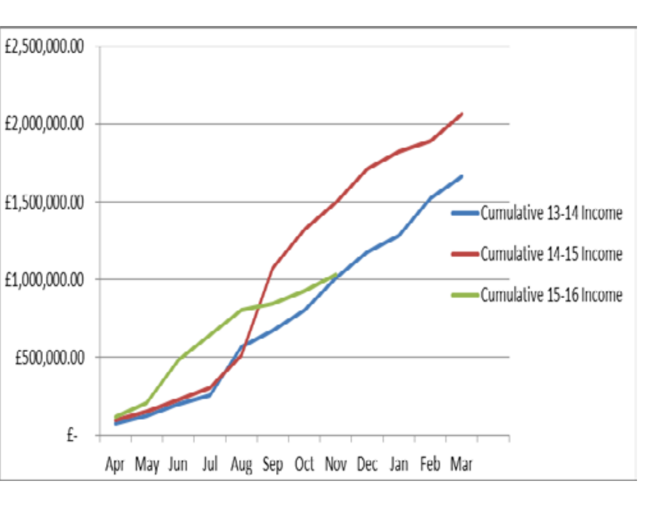
Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
86%	78%	95%	87%

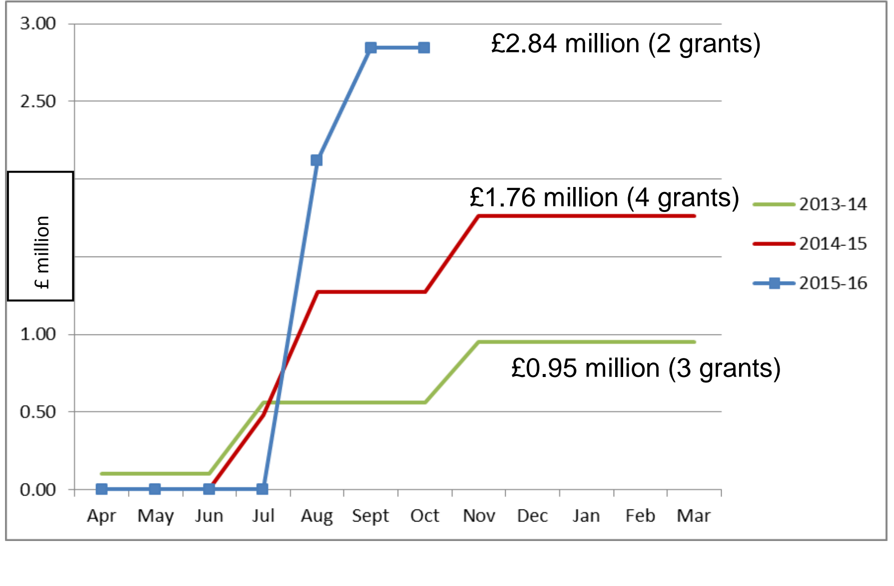
Green: >81.4% (Upper Quartile)
Red: <70.7% (Median)

d) Percentage of commercial studies recruiting to time and target

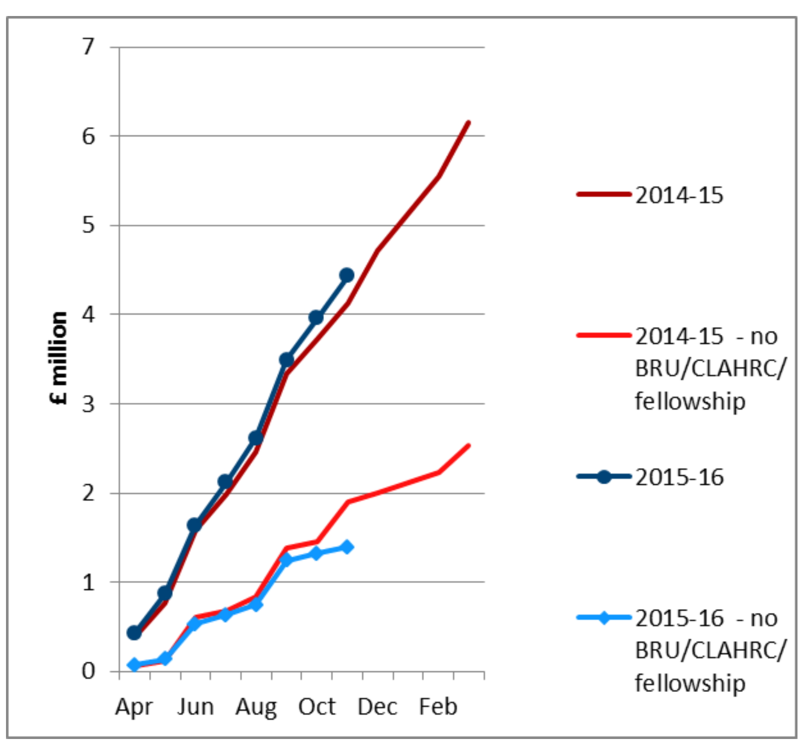


e) Monthly commercial income





Monthly NIHR grant income – drives research capability funding



Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
14. Cellular Pathology Service Transfer Update									
Sponsor and Author(s)									
Sponsor: Sean O'Kelly, Medical Director **Author**: Fiona Jones, Divisional Director, Division of Diagnostics & Therapies									
Intended Audience									
Board	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose The purpose of this report is provide a status update on the transfer of the Cellular Pathology Service to North Bristol NHS Trust, highlighting the governance around the project, current risks, and mitigation being taken. Key issues to note The transfer of services is dependent on the new Pathology building and integrated Laboratory Information Management System (LIMS) being completed on schedule.									
Recommendations									
The Board is recommended to receive the report for **assurance.**									
Impact Upon Board Assurance Framework									
None									
Impact Upon Corporate Risk									
None									
Implications (Regulatory/Legal)									
None									
Equality & Patient Impact									
None									
Resource Implications									
Finance		Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance	✓	For Approval		For Information			

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination**	**Senior Leadership Team**	**Other (specify)**

Cellular Pathology Service Transfer Update

Background

The report of the *'Independent Inquiry into Histopathology [Cellular Pathology] Services in Bristol'* published in 2010 made a series of recommendations to improve patient safety and enhance the performance of cellular pathology services across the city. The majority of the recommendations made by this Inquiry have been implemented with the exception of creating a single Cellular Pathology service. It has always been recognised that a single Cellular Pathology service for Bristol had a number of pre-requisites including suitable single accommodation, a single integrated IT system and a suitable logistics solution to operate a cross city service.

In December 2014, the Trust Boards of North Bristol NHS Trust (NBT) and University Hospitals Bristol NHS Foundation Trust (UHBristol) approved the business case for the transfer of Cellular Pathology Services from UHBristol to NBT, to enable the final outstanding action from the Inquiry to be met.

The Cellular Pathology Transfer Project Board was established and meets monthly, originally chaired by Dr Rob Pitcher, and from May 2015, chaired by Dr Chris Burton, Medical Director at NBT. There is senior clinical and managerial representation on this Project Board. Dr Rob Pitcher, the Joint Clinical Lead for Cellular Pathology for UHBristol and NBT retired in August 2015. At present the Joint Clinical Lead post is vacant, and the new Clinical Director for UHBristol Cellular Pathology is Dr Newton Wong. The progress of the Cellular Pathology project is led by the Division of Diagnostics & Therapies, with input from all Divisions who are impacted by the transfer of services. A formal written report is provided to the Senior Leadership Team (SLT) on a monthly basis, updating progress, milestones, risks and actions required by SLT.

NBT recently provided a written update to the South Gloucestershire Health Overview Scrutiny Committee, and the Executive Summary is attached as Appendix 1

Timescales

The original transfer date was set to be 1st July 2015. Due to delays to the building of the new Pathology Services building at NBT, and the integrated IT Laboratory Information System (LIMS), this date slipped to 1st September 2015. Further delays resulted in a revised date of 1st April 2016. However due to further construction delays, the working date has been set as mid-April.

Building

The new Pathology Services Building will house the combined Cellular Pathology service and the Public Health England (PHE) Microbiology service. The construction work has now been completed (excepting the Category 3 Laboratory, part of the PHE service) and on 15th January 2016 NBT took partial possession of the building which will allow them to start their 12 week commissioning and snagging resolution

programme. It is anticipated that the Category 3 Laboratory work will be completed by mid-April. It will then be possible for clinical occupation of the rest of the building, whilst the Category 3 lab is commissioned.

Integrated Computer System (Laboratory Information Management System – LIMS)

The LIMS project is being managed by NBT, and the original implementation date was April 2015, however due to a number of delays, the revised date is currently 29th February 2016. The system is currently in the UAT (User Acceptance Testing) phase, and a Go/No Go date is being established. The integrated LIMS had previously been a pre-requisite for the transfer of Cellular Pathology, however, due to the implementation of a new tracking system, it may be possible for the service to transfer on the current computer system, and transition to the new system at a later date. If this is the case, should there be any further delays to the LIMS implementation, this may not impact on the Cellular Pathology Transfer.

Clinical models

Significant work has been undertaken to ensure that the pathology service models provide the necessary support to the relevant clinical teams at UHBristol. The majority of the models, developed by pathologists with input from the clinical services, have been agreed by the clinical services. The two that currently require resolution are: haematopathology and gynaepathology. In December, Dr Chris Burton chaired a joint meeting with representatives from both Trusts to discuss and develop the gynaepathology model, and a further meeting chaired by him is planned at the end of January. The same is being planned for haematopathology.

Impact of delay

It is recognised that the original date for transfer was April 2015 and that this has been postponed several times and is now expected to be May/June 2016. Inevitably, this has affected staff morale. The appointment of Dr Newton Wong as the UHBristol Clinical Director has improved the support for staff, along with the continued leadership for the Biomedical Scientist staff from Mark Orrell, Head of Service for Cellular Pathology, who will hold the role of Operations Manager for Cellular Pathology in the new service. Organisational Development (OD) initiatives are also being organised by NBT to assist in the transfer of staff and services.

The delay in the transfer has also impacted on the Trust Capital Plans. The relocation of all office accommodation from the Old Building site requires vacant possession of Level 8 and 9 of the Queens Building. The original proposed transfer date would have enabled the construction work in the Queens Building to be complete by the date that the Trust is contractually required to move out of the Old Building (1st October 2016).

The late possession of the Queens Building has required temporary alternative arrangements for office accommodation, utilising the old site village at the rear of the Bristol Haematology & Oncology Centre (BHOC) car park.

The subsequent further delays to gaining possession of levels 8 & 9 of Queens will require rephrasing of construction works to ensure that there is the minimum delay in completing the works; this may require paying a premium for the work to be completed on a fast track programme.

Fiona Jones
Divisional Director, Division of Diagnostics & Therapies
20th January 2016

Appendix 1: Executive Summary of paper presented to South Gloucestershire Health Overview Scrutiny Committee, January 2016

Appendix 1: Executive Summary of paper presented to South Gloucestershire HOSC, January 2016

Report to:	Health Overview Scrutiny Committee	**Agenda item:**	**12.** Update on Severn Pathology
Date of Meeting:	6th January 2016		

Report Title:	Severn Pathology Update			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	David Gibbs, Pathology Services Director			
Executive Sponsor:	Chris Burton, Medical Director, NBT			

Executive Summary:

Pathology service redesign has made significant progress since the last report on the subject to the local authorities in January 2015. The aim of changes that have been supported by the local authorities is creation of high quality and resilient pathology services that can meet the challenges of the future that include significant pace of change in services that are significantly driven by new technologies.

The first priority for pathology teams is continued delivery of high quality in services that underpin high quality of clinical care in both hospitals and General Practice. During the year, Cellular Pathology, Clinical Chemistry, Haematology and Immunology laboratories at North Bristol NHS Trust have been amongst the first in the UK to be granted ISO 15189, the new international quality standard for clinical laboratories. All the laboratories remain accredited with the Clinical Pathology Accreditation scheme. The laboratories are working to achieve the new Royal College of Pathologists standards.

Pathology infrastructure is nearing completion with the phase 2 pathology building on the Southmead site due for handover on the 11th January 2016. The new single laboratory IT system for North Bristol NHS Trust (NBT), University Hospitals Bristol NHS Foundation Trust (UHB), Weston Area Health NHS Trust (WAHT) and Public Health England Southwest (PHE) is due to go-live on all sites February/March 2016.

The integration of the cellular pathology services from NBT and UHBristol is on track for a combined service to launch in April 2016.

The Bristol Genetics Laboratory (BGL) team has been praised for their contribution to the creation of a West of England Genomics Medicine Centre. The team is well placed to become a regional genomics hub laboratory in the upcoming NHS England tendering process. The

integration of the BGL with other pathology services will establish a molecular hub that will enable cellular pathology to use molecular techniques, especially in cancer diagnosis putting them at the forefront of new technologies. Furthermore the links with microbiology will enable rapid uptake of new methods in infection sciences that could revolutionize the detection and treatment on infectious agents in the coming years.

Links with Public Health England have been agreed and will create the largest and broadest infection sciences service in the UK.

Working with many different organisations and requiring significant infrastructure development makes this a challenging agenda. North Bristol NHS Trust with partner organisations is committed to completing the necessary work to ensure pathology services fit for future requirements is available to the populations of Bristol and South Gloucestershire.

Appendix 1: Executive Summary of paper presented to South Gloucestershire HOSC, January 2016

Report to:	Health Overview Scrutiny Committee	**Agenda item:**	**12.** Update on Severn Pathology
Date of Meeting:	6th January 2016		

Report Title:	Severn Pathology Update			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	David Gibbs, Pathology Services Director			
Executive Sponsor:	Chris Burton, Medical Director, NBT			

Executive Summary:
Pathology service redesign has made significant progress since the last report on the subject to the local authorities in January 2015. The aim of changes that have been supported by the local authorities is creation of high quality and resilient pathology services that can meet the challenges of the future that include significant pace of change in services that are significantly driven by new technologies. The first priority for pathology teams is continued delivery of high quality in services that underpin high quality of clinical care in both hospitals and General Practice. During the year, Cellular Pathology, Clinical Chemistry, Haematology and Immunology laboratories at North Bristol NHS Trust have been amongst the first in the UK to be granted ISO 15189, the new international quality standard for clinical laboratories. All the laboratories remain accredited with the Clinical Pathology Accreditation scheme. The laboratories are working to achieve the new Royal College of Pathologists standards. Pathology infrastructure is nearing completion with the phase 2 pathology building on the Southmead site due for handover on the 11th January 2016. The new single laboratory IT system for North Bristol NHS Trust (NBT), University Hospitals Bristol NHS Foundation Trust (UHB), Weston Area Health NHS Trust (WAHT) and Public Health England Southwest (PHE) is due to go-live on all sites February/March 2016. The integration of the cellular pathology services from NBT and UHBristol is on track for a combined service to launch in April 2016. The Bristol Genetics Laboratory (BGL) team has been praised for their contribution to the creation of a West of England Genomics Medicine Centre. The team is well placed to become a regional genomics hub laboratory in the upcoming NHS England tendering process. The

integration of the BGL with other pathology services will establish a molecular hub that will enable cellular pathology to use molecular techniques, especially in cancer diagnosis putting them at the forefront of new technologies. Furthermore the links with microbiology will enable rapid uptake of new methods in infection sciences that could revolutionize the detection and treatment on infectious agents in the coming years.

Links with Public Health England have been agreed and will create the largest and broadest infection sciences service in the UK.

Working with many different organisations and requiring significant infrastructure development makes this a challenging agenda. North Bristol NHS Trust with partner organisations is committed to completing the necessary work to ensure pathology services fit for future requirements is available to the populations of Bristol and South Gloucestershire.

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
15. Post-Project Review of the Transfer of Specialist Paediatrics

Sponsor and Author(s)
Sponsor: Deborah Lee, Chief Operating Officer / Deputy Chief Executive **Author**:

Intended Audience									
Board	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The purpose of this report is to present the Post-project Review of the transfer of specialist paediatric services from Frenchay Hospital to the Bristol Royal Hospital for Children. Historically, this review would have formed part of the final Gateway Review but unfortunately the Gateway Team has been disbanded and as a result this review has been undertaken in-house.

Key issues to note

- The CSP transfer reflected one of the largest and most complex service transfers to have been undertaken by an NHS Trust in recent times.
- The transfer fulfilled one of the key recommendations arising from Sir Ian Kennedy's Report following the Bristol Heart Inquiry.
- The transfer was affected safely, with no resulting clinical incidents.
- Whilst there are clear opportunities for learning, the vast majority of stakeholders have described the transfer as a success.
- The involvement of a third party trust and specialised commissioners, in a building and service project of this scale and complexity, added a significant degree of complexity and challenge to the project.
- The report includes areas of notable practice and makes 11 recommendations to the Trust for future projects of this scale. These will be incorporated into a Project Design Checklist which will allow the (soon to be established) Strategic Development Board to hold design oversight of future projects to ensure this learning is not lost.

Recommendations
The Board is recommended to receive the report as **assurance** that the learning from this project has been considered and will inform the design and implementation of future projects.

Impact Upon Board Assurance Framework
N/A

Impact Upon Corporate Risk
N/A

Implications (Regulatory/Legal)
N/A

<table>
<tr><th colspan="8">Equality & Patient Impact</th></tr>
<tr><td colspan="8">N/A</td></tr>
<tr><th colspan="8">Resource Implications</th></tr>
<tr><td colspan="3">Finance</td><td>X</td><td colspan="3">Information Management & Technology</td><td></td></tr>
<tr><td colspan="3">Human Resources</td><td>X</td><td colspan="3">Buildings</td><td>X</td></tr>
<tr><th colspan="8">Action/Decision Required</th></tr>
<tr><td>For Decision</td><td></td><td>For Assurance</td><td>✓</td><td>For Approval</td><td></td><td>For Information</td><td></td></tr>
<tr><th colspan="8">Date the paper was presented to previous Committees</th></tr>
</table>

Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination**	**Senior Leadership Team**	**Other (specify)**
				20/01/2016	

Post Project Evaluation For Centralisation of Specialist Paediatrics

Contents

Executive Summary

1. Introduction
2. Evaluation Methodology
3. Scheme Objectives
4. Project Structure and Governance
5. Project Communications
6. Gateway Reviews
7. P21 Contract Administration
8. Financial Assessment
9. Survey
10. Benefits Realisation
11. Integrated Models of Care
12. Workforce Planning
13. Safe and Sustainable Services
14. Risk Management
15. Environment
16. The Grand Appeal
17. Conclusions
18. Recommendations for future projects

Appendices

Appendix 1 – Initial Post project Evaluation report

Appendix 2 – Project Governance Structures and Terms of Reference

Appendix 3 – Survey Responses

Appendix 4 – BREEAM Certificate

Tables

Table 5.1 - Recent gateway reviews summary

Table 7.1 - Revenue – Nov ’13 update

Table 7.2 - Revenue – CSP related services 2015/2016 updates

Table 7.3 - Capital

Table 9.1 - Benefits Realisation

Table 13.1 - Summary of final medium & high rated risks

Table 14.1 - Energy Consumption

Executive Summary

1. Introduction

This report sets out the approach and result of the final post project evaluation for the Centralisation of Specialist Paediatrics scheme and uses the outcomes to recommend a number of actions and points of notable practice that will assist the successful delivery of future schemes. It should be noted that this project represented the biggest and most complex service transfer between two healthcare provider organisations in the city, and has been considered a resounding success, with all of the scheme objectives and benefits met in full.

The scheme was designed to deliver the transfer of a range of specialist paediatric services from Frenchay Hospital to the Bristol Royal Hospital for Children (BRHC), resulting in a single site for specialist paediatric services in Bristol, thus fulfilling a key recommendation by Sir Ian Kennedy, following the Bristol Heart Inquiry. This scheme was one of the Trust's key investment priorities, and was critical for the long term viability of the Children's Hospital.

The first phase of the centralisation process was completed in April 2007 with the transfer of general paediatrics from Southmead Hospital to a new extension at the BRHC.

The main aims of the second phase were:-

- Transfer specialist children's inpatient and day-case services from Frenchay Hospital to the BRHC
- Provide a fully integrated children's service through integrating new and existing services and developing new models of care: and
- Deliver the development no later than the closure of Frenchay Hospital acute services in order to contribute to the wider objectives of the Bristol Health Services Plan, now governed by the Healthy Futures Programme.

The Outline Business Case for this project was approved in July 2007 by the Trust Board, with the Full Business Case (FBC) being approved in February 2011. A further review of the FBC was conducted between April-November 2013, as part of a business case "refresh" to ensure the financial implications of the scheme were robust.

The Centralisation of Specialist Paediatrics Project (CSP) relied partially on the space provision delivered through the BRI Redevelopment scheme, which dedicated one floor of the new ward block for Children's day-case services and was designed to form an extension to the original footprint of the Children's Hospital. A series of complex planning phases and internal departmental and ward moves enabled the successful completion of the build project with no loss or reduction in operational function of the Children's Hospital. This in itself was a real achievement, and testament to staff who worked under some challenging conditions as well as patients and their families and visitors who at times had to manage through periods of noisy building work. The project was enhanced by the completion of the air ambulance access facility, with dedicated helipad access

routes planned for paediatric patients requiring immediacy of access to the children's Emergency Department, the Burns assessment unit, or the children's theatre suite.

Ultimately the project delivered the following additions and enhancements;

- New Children's hearing department in St Michaels Hospital
- New 8 bedded observation unit for Children's Emergency Department
- Latest technology CT scanner
- Shell space for future 1.5T MRI scanner(now installed)
- Enhanced Pharmacy
- New Outpatients Department
- New School Facilities
- Hybrid interventional cardiology/neurosurgical catheter laboratory
- Dedicated Burns Theatre
- Neuro/Scoliosis theatre with Intra-operative 3T MRI facility
- Extended Recovery including high dependency recovery
- Neurosciences ward
- New Burns ward
- Burns Outpatients department
- 6 bedded high dependency unit (4 beds commissioned at the time of transfer)
- Larger EEG department
- New 6 bed Clinical Investigation Unit
- New 18 bed short stay ward and dedicated twin day case theatres
- Extended Medical Records and Hotel Services Accommodation
- New Adolescents Ward
- Enhanced BMT and Oncology Facilities
- New therapies space for physiotherapy and speech and language assessment

.

2. Evaluation Methodology

The Full Business Case outlined the approach to the evaluation and identified the key lines of inquiry as;

- Measuring the success of the project in achieving its planned objectives
- Monitoring the progress of benefits realisation
- Identifying the reasons for any problems which arose
- Assessing the management of risk
- Identifying any necessary remedial action
- Recording the lessons learned in order to improve the performance of subsequent projects
- Disseminating the lessons learned from the project
- Ongoing dialogue with the lead commissioners in order to ensure achievement of specific agreed objectives

An initial project evaluation event was conducted by the transformation team in partnership with the Division of Women and Children's Services in December 2014, six months following the transfer. This event included stakeholders from both UH Bristol and North Bristol NHS Trust. Attendees represented all levels of the project structure ranging from Project Board to Operational Delivery and Core Transfer Group. The outcome of this initial evaluation was then reported to the Women and Children's Divisional Board in the following January. This report is included at Appendix 1 and the outcomes updated as part of this final review

The project has previously used the external review process provided by Gateway to review key programme stages and the outcomes of those reviews is shown later in the report. As the Gateway function is no longer available from the Department an internal evaluation of the project has been undertaken through a technical assessment of the project in terms of its delivery through the P21 procurement and via a feedback questionnaire of the key individuals involved in the delivery of the project.

A full review of the Benefits realisation has been undertaken by the Division and is summarised in Section 9.

3. Scheme Objectives

The Full Business Case identified the scheme objectives as;

- Responding to the national strategic commissioning agenda to designate transferring specialist services.
- Implementing the outcome of the Future Organisation of Neurosciences Services in Bristol Report.
- National drivers for designation of neurosurgery, burn, scoliosis and trauma.
- Assessing the potential impact of future specialist services designation i:e cardiac surgery.
- Developing an integrated model of care to improve the patient experience, increase operational efficiency and to ensure performance targets are met.
- Anticipating commissioner demand management targets especially in relation to emergency department and outpatient provision.
- Improving efficiency to assist with divisional financial targets.
- Delivering a paediatric service that meets the Commissioning Safe and Sustainable services agenda.
- Planning for future economic environment.
- Delivering environmental targets through reducing carbon footprint and energy consumption.

As assessment of the achievement of the objectives as stated are contained throughout the report.

4. Project Structure and Governance

The project was governed through a Project Board, supported by a Project Team and latterly by an Operational Delivery Group. The structure of each group and its terms of reference are included at Appendix 2. Deborah Lee, Director of Strategic Development, was the Senior Responsible officer for the project from planning through to delivery.

Both the Project Board and Operational Delivery Group included membership from North Bristol Trust and met monthly with formal minutes and action logs issued. An active risk register was maintained for the entirety of the project.

The function of the Operational Delivery Group (ODG) was to ensure models of care were developed from the Full Business Case into Operational Policy's that enabled services to transfer according to the timeline agreed between the respective organisations. The leads for these groups, supported by the project team, escalated issues to ODG, which then reported and escalated issues to the Project Board for cross organisational senior discussion and resolution if required.

The governance structure was reviewed mid-point and revised to create a tighter core of members for the Board to address issues relating to ownership, direction and decision making. The operational group was established to ensure the involvement of key members and clinicians in particular was focussed on live operational issues, but outside of the Board.

The SRO coming from the Executive Team was considered a benefit in respect of resolving and escalating significant issues and membership of the Board by the SRO was considered to be a positive feature.

Engagement of NBT staff in the operational groups was difficult at times, and there were a number of challenges resulting from competing clinical commitments amongst all of the clinical teams attending the relevant meetings, and ensuring the work was done to meet the various deadlines throughout the duration of the project, despite project team support.

Notable Point

Project governance for schemes of this scale should reflect the requirements for both strategic and operational business to be executed but recognise that these issues are likely to warrant different memberships and approaches. In this instance, the interface between the project board and the ODG achieved this.

Notable Point

Careful consideration should be given to the balance between divisional ownership and corporate support and leadership, when deciding the Senior Responsible Officer arrangements. In this instance, the Divisional Director was the Chair of the ODG and a member of the Project Board. This ensured that corporate support and leadership flowed through the project structure from the SRO, but first line responsibility and ownership for the management of the detailed work sat with the project team and Division.

Recommendation 1

Thought should be given to ensuring project arrangements reflect the needs of all stakeholders, particularly when projects are pan-Trust to ensure meetings are accessible to all, and that clinical commitments are regularly assessed and backfilled to enable project deadlines to be met.

5. Project Communications

Project communications was one of the mixed fortunes of the CSP Transfer, and developing a communications strategy that effectively met the needs of the diversity of the transferring staff groups, in addition to family's and charitable partners, was a real challenge. There were some very notable successes. The CSP Newsletter which was produced on a regular basis throughout the project was hailed a huge success by those that read it but it became apparent that not all staff accessed it, for a variety of reasons.

Face to face group meetings were arranged frequently and both formally and informally (i.e. drop in basis) but were often poorly attended, particularly those held at NBT and as a result some staff groups reported they felt disconnected from the project. A dedicated communications manager was appointed partway through the project, and this was a huge benefit to the project both in respect of dedicated capacity but also continuity of contact and knowledge.

Despite the success of the project, which represented one of the largest services transfers of its kind, little positive media coverage was secured either during the build up to the transfer, or at the point of the transfer itself.

Recommendation 2

Future projects should ensure

- Detailed planning of project communications should take full account of the differing needs of staff groups with respect to the nature and format of communication
- Dedicated communications resource should be identified for major projects of this type
- Opportunities to positively promote the reputation of the Trust through local and national media should be taken

6. Gateway Reviews

Gateway reviews formed a key part of the on-going project review process with reviews arranged at the key decision making points in the project programme. Gateway reviews are undertaken by independent professionals and report to the Project Senior Responsible Officer with a series of recommendations to assist the project to a successful delivery.

In 2006, a Gate 1 (Business Justification) review was undertaken when the proposed delivery route for the project was a PFI project combined with the BRI redevelopment scheme. This review was considered as Red and recommended a comprehensive review of the project, in particular the project governance.

Following the recommended comprehensive project review, the project was revised to a self-funded scheme with revised project governance.

The more recent gateway reviews are summarised below.

Table 1

Gateway Review stage	Assessment	Recommendations
Combined healthcheck with BRI Redevelopment 2011	Amber/Green (successful delivery appears likely)	The project team and clinical areas should develop a Benefits Realisation Plan, clearly identifying metrics and assigning ownership and timeline. Complete workforce plan and secure TEG sign-off. Ensure adequate clinical, operational and project input to the programme. In particular, this should include the relevant Heads of Division, and also that the skills within the project office are appropriate for the next phase of the development Jointly develop a transition roadmap.
Gate 3 – Investment Decision July 2011	Green- Successful delivery appears highly likely	The review recognised the progress the project had made and offered no recommendations.
Gate 4- Readiness for service Feb 2014	Amber/Green (successful delivery appears likely)	The SRO to ensure that there is careful monitoring of the activity which transfers from NBT to ensure that Board is sighted on any emerging financial risk. The Programme Director to ensure that communications activity is more detailed and focused. The Programme Director to resolve and mitigate the long standing risks.

		The Programme Director to address staff concerns with respect to car parking and consider transitional arrangements. The SRO to ensure that clear guidance is provided on the minimum level of detail required for pre-transition MoCs, working with clinical leads and UHB Medical Director The SRO to establish a breakthrough process to identify then resolve those issues critical for transition.

A Gate 5 (operational review) is normally undertaken 1 year after the transition to the new facility, however due to the changes to the central Gateway team this is no longer available.

7. P21 Contract Administration

This project was delivered under the Procure 21 (P21) framework with Laing O'Rourke (LOR) as the Trust principal supply chain partner (PCSP). The framework was entered into in 2004 and delivered a number of schemes prior to the CSP scheme, the Bristol Heart Institute, for example, as well as the BRI redevelopment scheme

- Programme

  The contract completion date was set as 9th May 2014 with possession granted to the construction partner on the first phase of works on 23rd May 2011.

  Over the 3 year construction period over 50 department moves and sectional completions were undertaken to achieve the final scheme design and objectives.

  The key deliverable for this project was the achievement of the transfer of Burns and Neurosciences services from the Frenchay hospital site in a timescale that met the requirements of North Bristol Trust's major development of Southmead Hospital site and the planned closure of the Frenchay site. The final transfer date was 6 & 7th May 2014 which was two weeks later than originally planned following a project risk assessment carried out in the preceding March where both Trust agreed a revised date to accommodate slippage in the construction programme was acceptable.

- Capital Cost

  A Guaranteed Maximum Price (GMP) was agreed with LOR for the sum of £15.1m rising to a final cost of £15.9m once all compensation events had been taken into account.

  The full capital cost assessment is reported in the following section.

The Project Team's reflection was that the partnership with LOR had been a successful. Stability in the LOR and UH Bristol teams enabled positive, trusting relationships to be developed. This was identified as a key success criteria within the project, both in the contract negotiation phase and delivery phase.

Notable point
LORs willingness to work with the project team to deliver the scheme with full recognition of the need to ensure clinical services were maintained.

Recommendation 3
Contractor selection criteria, for strategic schemes, should include an evaluation of the contractor's ability to be a "positive partner" as well as more traditional criteria regarding cost and quality of build.

8. Financial Assessment

Recurring Revenue – FBC refresh

The Trust Board approved the Centralisation of Specialist Paediatrics (CSP) Full Business Case (FBC) refresh in November 2013.

The approved recurrent revenue position was a break-even position consisting of recurrent income and expenditure of £17.1 million as follows:

Table 1 Revenue – November 2013 update

At 2013/14 prices		Approved FBC Refresh £M
Income:	Inpatient, day cases & outpatients	12.6
	Critical care	1.2
	Emergency Dept. attendances	0.9
	Other	2.1
	Income - non patient related	0.3
	Total Income	**17.1**
Operating Expenses:	Pay	(10.8)
	Direct non pay	(2.9)
	Indirect non pay:	(1.3)
	Total Operating Expenses	**(15.0)**
Sub-total - EBITDA		**2.1**
Non-operating expenses	Depreciation and financing costs	(2.1)
Net Surplus / (Deficit)		**0.0**

Revenue – FBC Post Project Update

The CSP scheme included new discrete services such as neurosurgery and burns/plastics, however, many existing services were simply expanded as a result of the scheme, for example, the emergency department, orthopaedics, neurology, critical care, anaesthesia and theatres. Recurrent funding was allocated to the Women's & Children's Division, Diagnostic & Therapies Division and Trust Services at the start of the 2014/15 financial year in line with the approved FBC refresh.

However, during 2014/15, the Division faced a number of operational challenges, particularly recruitment into key roles such as junior doctor roles, paediatric critical care and paediatric theatre nursing roles which in term resulted in an adverse impact on the financial performance of the

transferring and existing specialties. Therefore, the financial assessment of the CSP transfer reviews 2015/16 performance as a more reliable measure of the CSP transfer financial performance.

A number of components and services of the CSP transfer were integrated into the existing services and hence the income and expenditure cannot be accurately identified. Therefore, for CSP related services, the financial assessment compares the 2015/16 forecast outturn with the aggregate of the 2013/14 outturn and 2014/15 CSP plan at 2015/16 prices to form a 2015/16 baseline and provide an indicative assessment.

The revenue position for 2015/16 shows forecast outturn income of £28.0 million, a favourable variance of £0.5 million. This is primarily due to greater than planned high dependency care for burns and neurosurgery patients. Operating expenditure is £0.9 million adverse and is primarily due to the requirement for savings since the transfer of £0.7 million and higher than expected equipment maintenance costs. Depreciation and financing reports a favourable variance of £0.2 million due to the higher than expected impairment of capital costs. The overall net position is an adverse variance of £0.2 million. The position is summarised below:

Table 2 Revenue – CSP related services 2015/16 update

At 2015/16 prices		Approved FBC Refresh A £M	Existing CSP related services B £M	2015/16 Baseline C=A+B £M	2015/16 Forecast Outturn D £M	Variance Favourable / (Adverse) E=D-C £M
Income:	Inpatient, day cases & outpatients	12.7	7.8	20.5	20.5	0.0
	Critical care	1.2	0.0	1.2	1.6	0.4
	Emergency Dept. attendances	0.9	2.5	3.4	3.5	0.1
	Other	2.1	0.0	2.1	2.2	0.1
	Income - non patient related	0.3	0.0	0.3	0.2	(0.1)
	Total Income	**17.2**	**10.3**	**27.5**	**28.0**	**0.5**
Operating Expenses:	Pay	(10.9)	(27.0)	(37.9)	(38.2)	(0.3)
	Direct non pay	(2.9)	(4.5)	(7.4)	(8.1)	(0.7)
	Indirect non pay:	(1.3)	0.0	(1.3)	(1.2)	0.1
	Total Operating Expenses	**(15.1)**	**(31.5)**	**(46.6)**	**(47.5)**	**(0.9)**
EBITDA		**2.1**	**(21.2)**	**(19.1)**	**(19.5)**	**(0.4)**
Non-operating expenses	Depreciation and financing costs	(2.1)	0.0	(2.1)	(1.9)	0.2
Net Surplus/(Deficit)		**0.0**	**(21.2)**	**(21.2)**	**(21.4)**	**(0.2)**

Recommendation 4

Better delivery of data requirements when requested to enable timely information to support business case development. It must be noted that this issue is very particular to the scheme, due to the requirement to transfer services across organisations.

Capital

The 2013 refresh approved the capital cost of the scheme at £31.3 million mainly relating to works costs of £18.8 million and equipment of £10.0 million. The scheme was supported by charitable funding of £4.8 million from The Grand Appeal.

The Trust's Capital Programme Steering Group (CPSG) approved a number of funding changes to the approved capital cost during 2014/15, for example, a transfer of funding of £0.5 million relating to IM&T works offset by an increase in funding of £0.3 million to support the purchase of a volumetric CT scanner. Therefore, the capital cost of the scheme approved in the 2015/16 Resources Book in May 2015 was £31.1 million. In July 2015, a further transfer of £0.1 million was approved bringing the final sum to £31.0 million.

In addition, in recognition of the CSP transfer and the additional requirement placed upon the Trust's Sterile Services Department, capital funding of £0.5 million was approved in 2013 for additional paediatric surgical instruments. As the requirements for instrumentation became clear, additional funding of £0.4 million was approved by CPSG in February 2014. A further sum of £0.3 million was agreed in July 2014.

The main scheme completed in 2014 at a total cost of £30.9 million against funding of £31.0 million, an under-spend of £0.1million. However, it should be noted that the final outturn remains subject to confirmation of the final settlement of VAT recovery with HM's Revenue & Customs. Capital expenditure relating to the Sterile Services component was in line with the increased funding at £1.1 million. The position is summarised in the table below.

Table 3 Capital

	Main scheme £M	Sterile Services £M	Total £M
FBC refresh	**31.3**	**0.5**	**31.8**
Transfer out – IM&T	(0.5)	0.0	(0.5)
Addition funding – CT scanner & surgical instruments	0.3	0.6	0.9
2015/16 Resources Book	**31.1**	**1.1**	**32.2**
Transfer out –MRI chiller works	(0.1)	0.0	(0.1)
Final approved funding	**31.0**	**1.1**	**32.1**
Outturn expenditure	(30.9)	(1.1)	(32.0)
Underspend	**0.1**	**0.0**	**0.1**

CSP related services will shortly end their first full year of operation. The revenue position of the CSP related services represents an excellent result particularly given the scale and complexity of the transfer.

Notable Point
The CSP scheme was delivered within the capital funding made available

Recommendation 5
Better transparency and reporting on equipment budgets where it forms a major part of the overall project cost.

9. Survey

Members of the Project Board and the Operational Delivery Group were invited to respond to an on line survey looking at various aspects of the management and outcomes of the project.

The survey was compiled in conjunction with the Trusts Patient experience team and issued following sign off from the Senior Responsible Officer. The full survey and responses are included at Appendix 3, for information.

The results of the survey are summarised by section;

Design (Q1-10)

Over two thirds of the respondents agreed that the project had the right structure, ensuring that each department was involved in the detailed design process and agreed that each division had sufficient time to conduct the final sign off process. Almost 75% of respondents were pleased with the sign off process and over two thirds were happy with the way changes to the final design were managed. Encouragingly, over 91% believe that the new building/ department is completely or largely how they expected and 75% agreed that it improves the experience for patients.

Notable Point *"To have undertaken such a complex build within the confines of a live hospital environment, and to have completed with such a successful outcome whilst maintaining all services is a significant achievement".*

Delivery/Commissioning & Equipping (Q11-20)

Everyone who responded to the project evaluation survey strongly agreed or agreed that the Operational Delivery Group had the right membership and over 92% believe that the structure of the ODG and working groups helped the delivery of the project. 69% agreed that the commissioning period was well planned, that the induction process worked well and the transition from the old department to the new worked well. *"Once good engagement was established between both UHB and NBT teams, the process worked well".*

The equipping aspect of the project saw less agreement from survey respondents. 41% disagreed that the equipping schedule was well developed and believe that the actual cost against budget was not clearly reported by the Equipment Project Manager. *"This part of the process felt chaotic and negatively impacted the engagement and relationships between the project and clinical teams".*

Overall, over 91% of respondents agreed that the project Board and ODG met the needs of the project. *"This was a very complex scheme that required good cooperation with the BRHC which was very effective.*

Recommendation 6

Review the approach taken to scoping and management of all equipment requirements for future projects.

10. Benefits Realisation

The following table summarises the progress made to date on the benefits the project was designed to deliver as defined within the full business case.

Table 1

Desired Benefit	Stakeholders Impacted	Enablers required to realise benefit	Outcomes displayed if benefit realised	Current baseline measurement	Who is responsible	Target Date	Benefit Met
To achieve the transfer of specialist burn and neuro by mid-2014	• NBT Staff • BRHC Staff • Project Team	• Funding contracts. • Charitable funding.	Project completion date achieved and transfers complete.	Construction yet to commence.	Project SRO and Director.	Mid 2014	**Yes** Services transferred as scheduled, May 2014
To fully integrate transferring service.	All clinical and management staff associated with BRHC.	• Communica tions. • Job Planning. • Induction.	• Seamless transfer. • Unified workforce.	• Split site working. • Different job plans at each Trust.	BRHC Management.	By Transfer date	**Yes** Building design, workforce planning and supported effective integration.
To achieve designation status for burn & neurosciences.	Lead Clinician for specialities and management.	• Facilities and environment to erect specified standards. • Delivery of clinical standards.	Designation status achieved.	• Temporary designation for Burn Centre. • No designation for Neuroscienc es	Lead Clinicians & BRHC Management.	Determined by national process	**Yes** Epilepsy surgery designation achieved as a joint submission prior to transfer. Major trauma designation enabled by transfer, burns services re-designated following transfer.
To achieve transfer of same outpatients and rehab to community or closer to home settings.	Lead Clinicians & Management.	Development of Models of Care with Clinicians and SCG.	Outpatient clinics in community settings. Rehabilitation closer to home	Majority of outpatient and all rehabilitation delivered in Acute settings.	Lead Clinicians & BRHC Management.	Mid 2014	**Yes** Outpatient services transferred, peripheral/closer to home outpatients delivered where possible and appropriate
To achieve efficiencies through monitoring revenue cost against Full Business Case.	BRHC Management and Divisional FinanceManag ers.	• Service line reporting for specialities. • Tariff and top ups confirmed.	Income exceeds expenditure.	Service Line Reporting (SLR).	BRHC Management and Trust finance team.	Ongoing	**Yes**SLR reports surplus I&E positions for paediatric neurosurgery and burns.
Improve patient experience.	All staff and patients.	PPI Involvement in design process communication s.	Patient survey outcomes.	Patient Survey Outcomes.	BRHC Management.	Post 2014	**Yes** Positive impact of BCH clinical adjacencies for children Ongoing feedback captured through routine BCH processes

Notable Point

All the benefits as defined in the full business case were met.

11. Integrated Models of Care

Integrated care brings together delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion, and is a means to improve services in relation to access, quality, patient/family satisfaction and efficiency. The advantage of having all Paediatric Specialised Services delivered from a single site and delivered through integrated models of care was a key driver for the project, as was the development of a service model based on principles that underpin the Trust's corporate strategy to deliver safe, high-quality, patient-focused paediatric care, integrating additional specialist paediatric services into the heart of the Children's Hospital

The CSP project involved the disaggregation of the paediatric element of specialist care from a number of different clinical directorates at NBT in order to facilitate the transfer. This disaggregation, whilst bringing the care of children altogether on one site, also required the development of new, cross city rotas within some specialities, to enable the appropriate speciality care to be delivered across two separate sites, i.e. adults (at the new Southmead Hospital) and paediatrics at the Children's Hospital..

Whilst the burns and neurosurgical services were delivered exceptionally at NBT, the advantages of clinical adjacencies with all other paediatric services based at the Children's Hospital was well recognised. Dedicated work with the clinical teams throughout the lifespan of the project meant that the services were integrated at the point of transfer. The appropriate configuration and utilisation of inpatient facilities was fundamental to the delivery of care at the Children's Hospital, and by optimising the specialist facilities required by the specific services transferring from NBT, the benefits of integration with the existing specialist, acute and support services were identified. The resulting models of care as determined in the business case, were fully implemented.

The challenge to teams across both organisations was not to simply view how their existing service was going to carry on from a new location, but to consider the development of new models of care as an opportunity to undertake a service review, this approach was easier to influence within UHB specialities.

As a clinical example of the successful integration of the new models of care, 3 months after the transfer, a catastrophically injured child following a major burn was admitted. According to the transferring Burns service lead, the child's care was delivered to an exceptional quality. The medical, nursing and therapy staff from the anaesthetic department, PICU, theatre staff, burns surgeons, paediatric surgeons, ENT, ophthalmology and the wider burns team worked together throughout, and in her view, the multidisciplinary care that this child received could not have been provided at a higher level anywhere else.

Due to the challenges in relation to reaching clinical consensus in the development of some of the models of care, across clinical teams from UH Bristol and North Bristol NHS Trust, there was little emphasis given to reviewing the opportunities to work differently with community services and drive integration between health and other sectors such as social care.

Notable Points

At the point of transfer there were a number of good examples of how the new integrated models of care supported the delivery of excellent clinical care.

Recommendation 7

Future projects, should create capacity to ensure that opportunities to transform services and drive further integration between health and social care are not lost in the complexity of service transfers.

12. Workforce Planning

Workforce planning was delivered through a number of different forums, and the process overall was led by HR. There were real challenges in planning the workforce required to deliver paediatric elements of whole (combined adult and paediatric) services at NBT. These challenges spanned the full range of staff groups including Consultants, junior doctors, admin staff, nurses and AHP's

Disaggregation of services did not take place at NBT until the transfer in May 2014, so an element of risk remained associated with this, and this was monitored through the Operational Delivery Group and the Project Board.

Once staff were identified who met TUPE criteria, full staff consultations took place, supported by joint NBT/UHB senior managers with staff side representation, and staff were supported through formal 1:1's, drop in sessions, regular tours of the new build/Children's Hospital, and a bespoke induction package.

A dedicated Matron at the Children's Hospital worked on the Barbara Russell Unit to support nursing staff prior to transfer, align clinical guidelines and provide leadership support to the nursing leads at NBT.

Recruitment for all vacancies related to the transferring services at NBT within six months of the transfer date was managed by UHB, with newly appointed staff working at NBT prior to the transfer.

There were a significant number of nursing vacancies leading up to the transfer date, which meant that NBT were not able to consistently operate the full bed base on the children's ward at NBT. Whilst the focus was on recruitment, there was an operational impact on various services access targets and waiting times which only became truly apparent following the transfer.

Very close to transfer, the original expectations regarding the numbers of theatre nurses expected to transfer changed significantly. As a result, a significant national recruitment campaign was undertaken to achieve theatre recruitment for the transferring specialities, which was largely successful. In the year following transfer there was considerable staff turnover within the theatre complex which challenged the ability to deliver the full range of surgical services then offered by the Children's Hospital.

Notable Point Nursing staff in particular felt very supported by the input from having a dedicated Children's Hospital Matron working with the transferring nursing teams on the Barbara Russell Children's Unit

Recommendation 8 Thought should be given as to how turnover, following significant change projects, can be mitigated

given the potential scale of impact.

One of the most significant challenges was the delay in securing an agreed list of personnel eligible for transfer. This issue was predominantly confined to theatres at NBT, where staff regularly worked across both adult and paediatric lists, with no clear delineation which would have then been supported by the TUPE process. There were various mixed messages from NBT at the time regarding the staff required to run the dedicated adult services at the new Southmead Hospital, and some staff who had previously indicated their desire to come and work at the Children's Hospital where incentivised to stay at NBT. This led to difficulties in assessing the revenue cost of the transfer but more concerning resulted in a number of key personnel not transferring and some key vacancies being present at the time of transfer.

Recommendation 9

Cross organisational agreements are required in future to ensure that services for both organisations are not affected through competitive recruitment strategies.

13. Developing Sustainable Services

Both UHB and NBT were jointly designated to provide Epilepsy Surgery as part of a national process, and as part of ongoing safe and sustainable planning for neurosurgery. The designation was contingent on the transfer taking place, as without the move to the Children's Hospital, some of the core standards for epilepsy surgery would not have been met. There was significant UHB management support to the running of the epilepsy programme at NBT in the year following designation and prior to the service transfer, and whilst this was positive, there was at times a limited sphere of influence.

NBT were a designated centre for paediatric burns prior to the transfer. Significant design work was done to ensure that the designation standards would be fully met following the transfer to the Children's Hospital, and the burns team were exceptional in their approach to developing the new models of care for the service. Burns services were re-designated following the transfer, and the Children's Hospital is now part of the designated paediatric burns centre network.

An evaluation visit from the Severn trauma network took place in January 2014, 4 months prior to the service transfer. The outcome of this review was extremely positive, and following the move of specialist paediatric services from Frenchay in May 2014, and a very successful peer review, the Children's Hospital was formally designated as a major trauma centre.

Prior to the move, there was considerable dialogue regarding specific recognition for dedicated neuro-rehabilitation facilities. Whilst the whole paediatric service transferred as originally planned, it was clinically recognised that advances in paediatric intensive care have significantly improved survival rates both locally and nationally among children who sustain acquired brain injury (ABI) and acquired spinal injury (ASI). Such children frequently have complex neurological disability and require prolonged neuro-rehabilitation therapy to help them achieve their potential. Recent research suggests that even some patients in an apparent minimally conscious state (MCS) may have retained awareness and benefit from active rehabilitation. A proposal was developed following the move to use an area adjacent to the new neurosciences ward to open a dedicated rehabilitation ward. Following some minor estates alterations, this unit opened six months following the transfer, and cares for a number of children whose care needs are focussed on rehabilitation rather than on acute care.

Part of the new build design included a new interventional hybrid catheter lab. This has supported the development of both interventional neuroradiology and cardiology techniques, and demonstrated ongoing commitment to service growth and development including the cardiac designation process.

Planning for the transfer of services took account of future growth where possible, through both the development of models of care, and in terms of design. For example the new high dependency unit

had additional beds built that were not required to be commissioned at the point of transfer, but could be when future growth deemed it necessary.

Notable Point

There was extensive work done through both design and model of care development to ensure that services met designation standards where required, and were able to respond to a variety of ongoing developments.

14. Risk Management

A robust approach to risk management was adopted throughout the project. The full business case set out the proposed approach which was entirely in accordance with the Trust risk management policy. Critical risks were identified at full business case stage with the risk register being developed and monitored by the Project Board monthly as the scheme progressed. Any high level risks where subsequently escalated to the Trust risk register as deemed appropriate by the Project Board and Senior Responsible Officer.

Any residual risks at project close were transferred to the Divisional risk register. A summary of the final medium and high rated risks reviewed by the Project Board are shown below;

Table 1

S1	Models of care and operational policies for transferring services are now closed.
S3	The model for interventional neuro-radiology for adults and children to be completed this week. Soon to be closed.
S4	The planning assumptions that may have underestimated ED activity becomes a divisional risk.
S7	All data is now transferred and operational and the issues of notes transfer is now resolved.
S9	PS reported that two anaesthetists were now in place and the system was operating well.
WF1	Two paediatric posts will settle here with Jon leading of the recharging of staffing overall. This will be picked up in the Quarterly Review cycle.
WF2	Availability of trained theatre staff remains as a risk for the Divisional Register. DL recommended Theatre Staff morale also be recorded on the Divisional Risk Register.
WF4	No longer relevant.
WF5	Split site working to be recorded on the Divisional Risk Register moving forward. It is also important to include a Recruitment review of the locum recruitment to include in job planning. Plastic Juniors are still to be reviewed by Chris' team.

Only WF5 remained as a high rated risk, which has subsequently been resolved.

The approach to risk management was effective and a key element to the successful delivery of the project.

15. Environment

The environmental impact of the project has been assessed by looking at the energy consumption in relation to the changed floor area resulting from the new build elements of the project. Additionally the agreed target on the building was to achieve a BREEAM rating of GOOD and this has now been confirmed and certified by external assessors. The certificate is shown at appendix 4.

The table below shows the energy impact of the project.

This follows a similar pattern to other new buildings, where there is small increase in electricity KW/m2 , but a greater decrease in steam KW/m2 resulting from improved thermal performance of the building materials and better efficiency of major engineering plant , resulting in an overall reduction of energy consumption.

Table 1

	Unit	**2011-12 RA723 BRHC**	**2014-15 RA723 BRHC**
Gross Internal Area	m2	15726	17730
Gross Internal Occupied Area	m2	15726	17730
Site Heated Volume	m3	63583	71685
Average ceiling height	M	4.043	4.043

		RA723	RA723
Performance Indicators		BRHC	BRHC
based on Occupied Floor Area			
Imported Electricity consumption	kW/m2	163.35	203.32
Local Electricity Consumption	kW/m2	39.61	25.98
Renewable Electricity Consumption	kW/m2	18.15	22.59
Total Electricity consumption	kW/m2	221.11	251.89
Local Steam consumption	kW/m2	215.82	160.37
Total Energy consumption	kW/m2	436.93	412.27
Total Energy consumption	kW/100m3	10806.66	10196.65

16. The Grand Appeal

The Grand Appeal was pleased to continue its commitment to the Bristol Children's Hospital with a contribution of £5 million towards the Hospital's recent expansion.

Whilst the Charity understands that there will always be uncertainties during planning phases, they would appreciate as much notice as possible where such a large capital contribution is requested. Whilst they raised the £5 million in a couple of years, they had a limited notice and therefore little time to plan their campaign strategy.

The charity were pleased that they were able to negotiate and ring fence all children's hospital fundraising through the Grand Appeal – this provides clarity of message that the general public and grant-making institutions expect to ensure that fundraising is efficient and is cause-led.

The Grand Appeal is now looking forward to extending their provision of family accommodation at Cots for Tots House for the Neonatal Intensive Care Unit and to create additional family accommodation to support the children's hospital Paediatric Intensive Care Unit and other departments.

Recommendation 10

Early engagement with supporting charities with clearly defined elements against which they can plan fund raising activities.

17. Conclusions

This was a complex project to undertake in a live hospital environment, with a large number of services moves required to facilitate the works. The project required and received a high level of commitment, management drive and support from the Divisional management team to enable the construction works to take place and this was largely achieved with the minimum amount of impact on operational services.

The project, uniquely, also required close co-operation across UHB and North Bristol Trust as services and staff were transferring between organisations. The project has delivered against the defined objectives in particular those resulting from the wider healthcare system reviews for Neurosciences and the requirement for centralised and designated specialist services.

The implementation of fully integrated models of care supported by the required workforce has met the objectives for delivering designated specialist services that are managing the forecast demand on services with elements of future proofing services where appropriate, recognising that considerable has been made to fill key vacancies. The Safe and Sustainable services agenda has also been fully met.

Financially, the scheme completed within the capital envelope, recognising that budget adjustments had to be made during the life of the project to accommodate such issue as equipment cost pressures, particularly in connection with theatre instrumentation.

A break even revenue position is forecast for 2015/16 in line with the approved refresh of the Full Business Case.

The project structure and governance has been effective as has the approach to risk management.

The use of the external Gateway review process has assisted in providing confidence that project was on track to deliver its objectives.

Whilst a full assessment of the effectiveness of the project communications has not been conducted a recurring theme form both Gateway reviews, surveys and the initial evaluation exercise, is that the communication plan could have been improved recognising that it had to meet the need of both Trusts and heavily relied on information being cascaded from management and board/group members.

Scheme benefits were identified at full business case stage and these have been fully met.

The delivery of the construction element worked well using the P21 Framework and work was completed with the minimum of interruption to operational services, noting that this required a high level of logistics planning between the project management team, contractor and the division.

The final building design achieved a Good BREEAM rating and an overall reduction in energy consumption.

The project benefitted from support from The Grand appeal however, it is noted that earlier engagement with the charity could have improved their fund raising potential.

The overall assessment is that this was a complex project both in terms of the design and construction and also from an organisational / service design perspective involving a multitude of stakeholders, which was well managed and delivered all the objectives and benefits identified within the approved Business case.

There are a number of notable points of success which should be recognised in future projects, as well as some recommendations derived from the evaluation and these are summarised in the final section of this report.

18. Recommendations for Future Projects

These are summarised;

R1 -.Thought should be given to ensuring project arrangements reflect the needs of all stakeholders, particularly when projects are pan-Trust to ensure meetings are accessible to all, and that clinical commitments are regularly assessed and backfilled to enable project deadlines to be met

R2 - Future projects should ensure

- Detailed planning of project communications should take full account of the differing needs of staff groups with respect to the nature and format of communication
- Dedicated communications resource should be identified for major projects of this type
- Opportunities to positively promote the reputation of the Trust through local and national media should be taken

R3 -Contractor selection criteria, for strategic schemes, should include an evaluation of the contractor's ability to be a "positive partner" as well as more traditional criteria regarding cost and quality of build.

R4 -Better delivery of data requirements when requested to enable timely information to support business case development. It must be noted that this issue is very particular to the scheme, due to the requirement to transfer services across organisations.

R5-Better transparency and reporting on equipment budgets where it forms a major part of the overall project cost.

R6 - Review the approach taken to scoping and management of all equipment requirements for future projects.

R7 - Future projects, should create capacity to ensure that opportunities to transform services and drive further integration between health and social care are not lost in the complexity of service transfers

R8 - Thought should be given as to how turnover, following significant change projects, can be mitigated given the potential scale of impact

R9 - Cross organisational agreements are required in future to ensure that services for both organisations are not affected through competitive recruitment strategies.

R10 - Early engagement with supporting charities with clearly defined elements against which they can plan fund raising activities

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
16. Finance Report									
Sponsor and Author(s)									
Sponsor: Paul Mapson, Director of Finance & Information									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To report to the Board on the Trust's financial position and related financial matters which require the Board's review. Key issues to note The summary income and expenditure statement shows a surplus of £1.666m (before technical items) for the first nine months of the financial year. After technical items, the surplus increases to £10.580m.									
Recommendations									
The Board is recommended to receive the report for **assurance.**									
Impact Upon Board Assurance Framework									
None									
Impact Upon Corporate Risk									
None									
Implications (Regulatory/Legal)									
None									
Equality & Patient Impact									
None									

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

REPORT OF THE FINANCE DIRECTOR

1. Year to date position overview

The summary income and expenditure statement shows a surplus of £1.666m (before technical items) for the first nine months of the financial year. After technical items the surplus increases to £10.580m.

The run-rate overspend in Divisions slowed again in December. The adverse variance was £0.651m, reduced from £0.765m in November and £0.850m in October. The year to date overspend is now £6.688m compared to the operating plan target of £1.889m.

The year to date position for owned depreciation and PDC has changed to reflect the forecast outturn position. The changes reflect the slippage on the capital programme, the associated increases in surplus cash balances and the revised year end forecast surplus. The depreciation underspend increased by £0.210m in the month and PDC by £0.393m. The forecast year end underspend on Financing is likely to be £3m.

The favourable variance against plan for technical items increased by £7.458m in December. The accounting treatment of the disposal of the old building has been revised. Originally the transactions reflected the revaluation of the building by the District Valuer prior to sale. Following further consideration, including seeking external advice, the value at the point of decision to sell has now been used. This has resulted in a significant favourable variance in the month of £9.154m on profit on sale of assets offset by an adverse variance of £4.804m in the month on reversal of impairments. Impairments showed a favourable variance in the month of £3.072m as expected impairments relating to the façade and phase 4 schemes slipped.

The position re nursing spend in December is very encouraging. The major overspend on non-pay requires further explanation and may be due partly to stocking-up over the Christmas / New Year period.

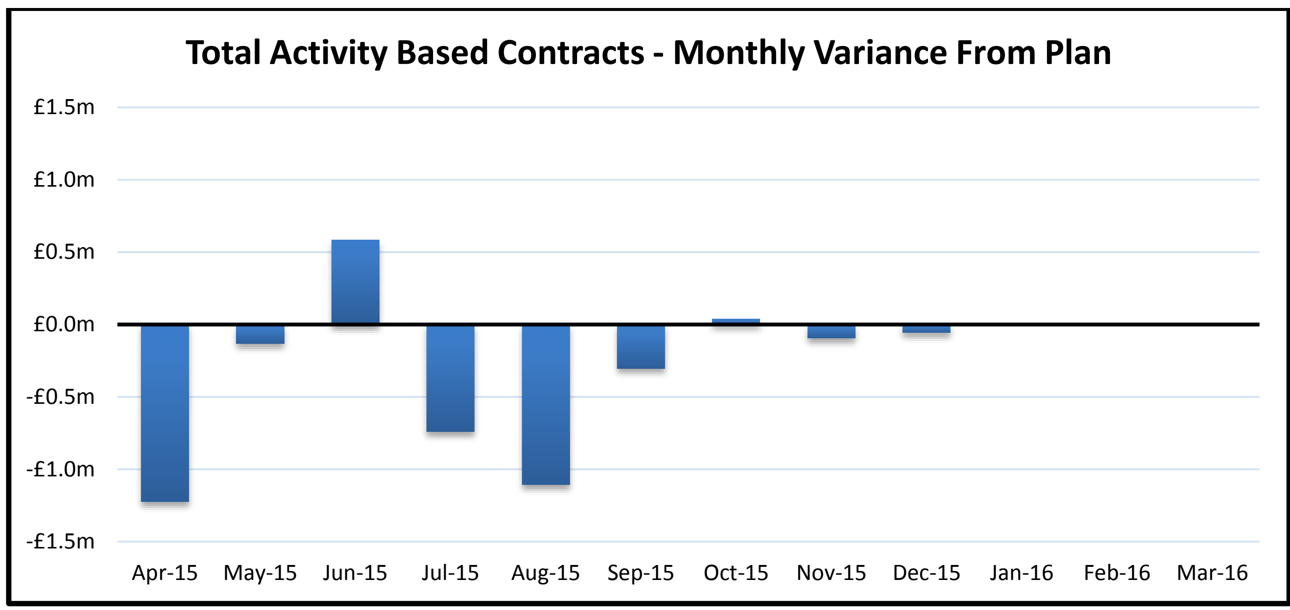
The analysis is shown below:

(Adverse)/Favourable	December £m	November £m	October £m	Year to date £m
Nursing pay	(0.011)	(0.476)	(0.497)	(2.486)
Medical staff pay	(0.024)	(0.178)	(0.074)	(0.697)
Other pay	(0.096)	0.238	0.058	0.576
Non-pay	(0.523)	(0.313)	(0.410)	(1.690)
Income	0.003	(0.036)	0.073	(2.391)
Total	**(0.651)**	**(0.765)**	**(0.850)**	**(6.688)**

The savings programme performance shows a shortfall of £2.839m to date. The forecast outturn shortfall has improved by £0.182m to £3.306m.

The following tables show how two key financial drivers are changing during the year:

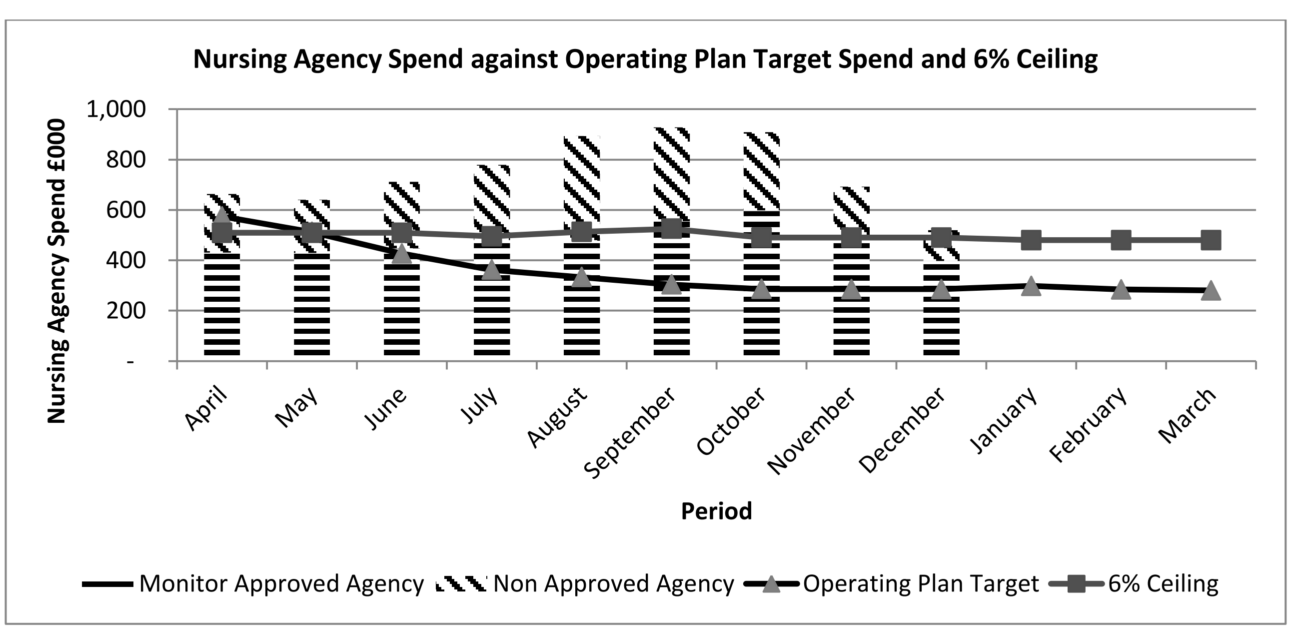
- Clinical Activity – the position in December has marginally deteriorated by £0.06m. The net SLA underperformance is £3.03m for the year to date. The graph below shows the total activity position (monthly financial variance from plan). The position is encouraging.



- Nursing Agency Spend – as can be seen there has been a substantial reduction in nursing agency expenditure in the month, reducing by 25%. The Trust also saw an increase in the use of monitor approved framework agencies, with the percentage increasing from 70% to 77%. The year to date position remains of concern – specifically:

  - The year to date spend is £6.737m compared to the Operating Plan of £3.368m
  - The agency spend is 6.2% of total registered nursing spend in December compared to the Monitor cap of 6% and the submitted trajectory of 5.2% for months 7 to 12.

However the nursing spend position broadly broke-even in December which is an excellent result.



2. Financial Outturn Assessment

The previous forecast outturn for the Trust based on results up to Month 6 (Quarter 2) showed a break-even position before technical items which was in line with plan. The position for the NHS as a whole has become considerably more acute with the necessity of ensuring the NHS vote overall is not breached being continually emphasised. In fact, if the vote is breached, then funding for 2016/17 will be reduced accordingly. UH Bristol must play its part in this challenge.

To deliver the NHS vote the maximum provider sector deficit which can be accommodated is £1.8 billion (offset by equivalent capital underspends and non-provider underspends). The quarter 2 forecast out-turn was a £2.2 billion deficit, with trends suggesting this could be as high as £2.5 billion. Hence a significant improvement is required. It is in this context that the UH Bristol forecast out-turn is assessed and described in this report.

To contribute to the national position, UH Bristol has already spent c. £15m less on capital than planned and delivered a £13m capital receipt in respect of the sale of the Old BRI. The income and expenditure position is now expected to improve also by £2m. However the way these results are reported by Monitor needs to be understood. This is shown below:

	Original Plan £m	Forecast at Quarter 2 £m	Forecast at Quarter 3 £m
Income and expenditure surplus/(deficit)	-	-	2.000
Donated asset income	4.558	3.103	3.115
Donated asset depreciation	(1.472)	(1.511)	(1.518)
Monitor reported surplus/(deficit)	**3.086**	**1.592**	**3.597**
Other technical items not included in Monitor reported surplus/(deficit)	(4.219)	(0.700)	4.756
Surplus/(deficit)	**(1.133)**	**0.892**	**8.353**

For UH Bristol reporting the forecast outturn has moved from a break-even plan to a £2m surplus (this is described below). For Monitor reporting the forecast out-turn has moved from a £3.086m surplus plan to a forecast £3.597m surplus. This is due to the re-phasing of donations into 2016/17 as well as the revised forecast outturn.

The forecast out-turn assessment is based on the following knowledge and judgements. The optimistic and pessimistic columns included in Quarter 2 have been removed as these estimates have firmed up during the year:

Surplus/(deficit)	Original Operating Plan £'m	Forecast Out-turn at Quarter 2 £'m	Forecast Out-turn at Quarter 3 £'m
Divisions	(2.000)	(7.000)	(8.630)
Corporate Income (fines/rewards etc.)	-	(1.000)	(0.500)
Financing costs (mainly Capital Charges)	2.000	2.000	3.000
Reserves		6.000	8.130
Income & Expenditure surplus/(deficit)	**-**	**-**	**2.000**
Net Donations (income less depreciation)	3.086	1.592	1.597
Monitor reported surplus/(deficit)	**3.086**	**1.592**	**3.597**

The Reserves balances are shown below:

Surplus/(deficit)	Forecast Out-turn at Quarter 2 £'000	Forecast Out-turn at Quarter 3 £'000
Inflation – incremental drift	1,500	1,500
Other	800	950
MPET – transition funding	750	750
Other slippage	450	400
Histopathology slippage	500	500
Non-recurring provisions	700	700
Contingency reserve	300	500
Pay provisions	1,000	1,000
Slippage in developments / cost pressures		1,030
Transfer to Capital		200
Technical items		600
Total	**6,000**	**8,130**

The change in reserve balances relate to the level of slippage in cost pressures/developments funded in the 2015/16 plan along with a single technical item related to historic pharmacy stock accruals.

3. Divisional Financial Position

In total, the Clinical Divisions and Corporate Services overspend against budget increased by £0.651m in December to £6.688m cumulatively. The most concerning in month deterioration was within the Divisions of Surgery, Head and Neck and Women's and Children's. The table below summarises the financial performance in December for each of the Trust's management divisions against the budget and against their December operating plan target. Further analysis of the variances against budget by pay, non-pay and income categories is given at Appendix 2.

	Budget Variance to 30 Nov	Dec Budget Variance	Budget Variance to 31 Dec	Dec Operating Plan Target	Operating Plan Variance
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Diagnostic & Therapies	74	114	188	(26)	214
Medicine	(1,021)	(65)	(1,266)	(25)	(1,241)
Specialised Services	(815)	52	(763)	105	(868)
Surgery, Head & Neck	(3,592)	(456)	(4,048)	(1,374)	(2,674)
Women's & Children's	(919)	(290)	(1,209)	(559)	(650)
Estates & Facilities	40	21	61	(10)	71
Trust Services	10	(23)	(13)	-	(13)
Other corporate services	366	(4)	362	-	362
Totals	**(6,037)**	**(651)**	**(6,688)**	**(1,889)**	**(4,799)**

Variance to Budget:

The table below shows the Clinical Divisions and Corporate Services budget variances against the four main income and expenditure headings.

Divisional Variances	Variance to 30 Nov	Dec Variance	Variance to 31 Dec
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(2,118)	(182)	(2,300)
Non Pay	858	(551)	307
Operating Income	320	(15)	305
Income from Activities	(2,262)	101	(2,161)
Sub Totals	(3,202)	(647)	(3,849)
Savings Programme	(2,835)	(4)	(2,839)
Totals	**(6,037)**	**(651)**	**(6,688)**

Pay budgets have an adverse variance of £0.182m in the month increasing the cumulative adverse variance to £2.300m. The significant adverse movements in the month were in Medicine (£0.176m) and Women's and Children's (£0.173m). Cumulative adverse variances are within Women's and Children's (£1.540m), Specialised Services (£0.732m), Surgery, Head and Neck (£0.345m) and Medicine (£0.709m) offset by favourable variances in Diagnostic & Therapies (£0.570m) and Trust Services (£0.364m). For the Trust as a whole, agency spend is £11.158m to date, an increase of £1.159m in the month. The average monthly spend of £1.240m compares with £0.967m for 2014/15. Agency spend to date is £2.514m in Medicine, £2.409m in Women's and Children's, £2.249m in Surgery, Head and Neck and £1.963m in Specialised Services. Waiting list initiatives costs increased by £0.294m in the month to £2.566m to date, of which £1.165m is within Surgery, Head and Neck, £0.577m in Women's and Children's and £0.425m in Specialised Services.

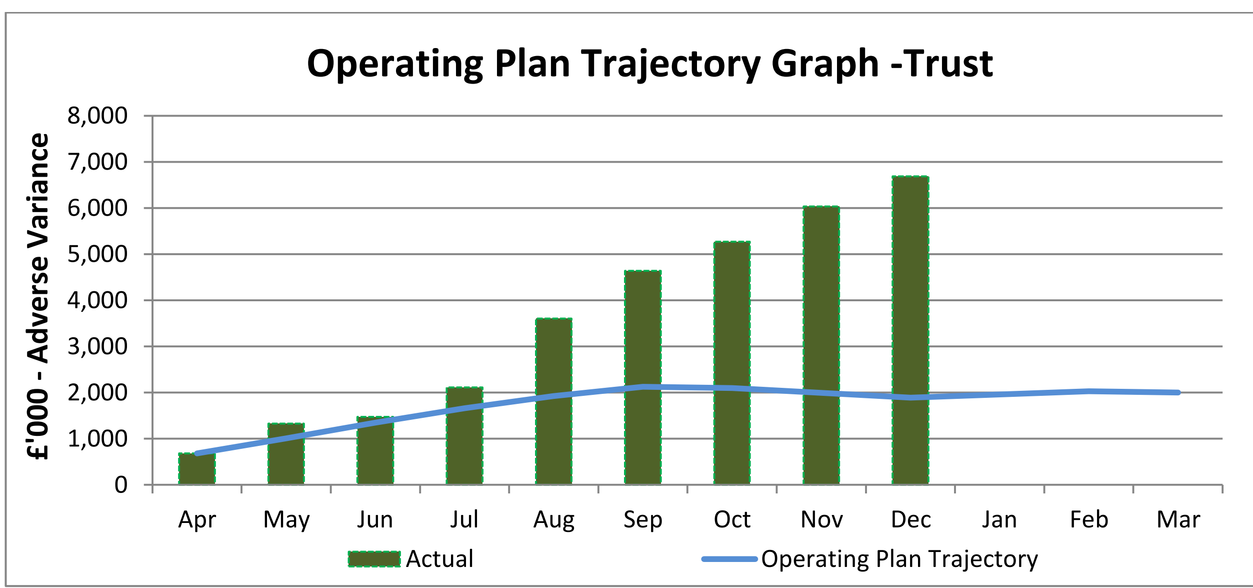
Non-pay budgets have an adverse variance of £0.551m in the month reducing the cumulative favourable variance to £0.307m. The significant adverse movements in the month were in Medicine (£0.148m) and Surgery, Head and Neck (£0.372m).

Operating Income budgets have an adverse variance of £0.015m for the month to give a cumulative favourable variance of £0.305m.

Income from Activities budgets have a favourable variance of £0.101m in the month to give a cumulative adverse position of £2.161m, reflecting continued improvements in activity run rate. The principal areas of under achievement to date are within Surgery, Head and Neck (£0.592m), Medicine (£0.541m), Specialised Services (£0.926m) and Diagnostics and Therapies (£0.179m) offset by an over achievement in Women's and Children's (£0.037m). Within the month, Women's and Children's under achieved against their income target by £0.094m. Surgery, Head and Neck over achieved by £0.056m and Medicine by £0.093m. The difference between the in month deterioration reported here and that reported in section 6 (SLA income) is accounted for by variances relating to private patients, other non SLA income from activities, including RTA income, and differences with the reporting of CIP delivery.

Variance to Operating Plan:

Clinical Divisions and Corporate Services have an adverse variance of £6.688m against a combined operating plan trajectory of £1.889m. The December position is £4.799m above trajectory as shown in the graph below.



Further detail is given under agenda item 5.3 in the Finance Committee papers.

Savings Programme

The savings requirement for 2015/16 is £19.879m. This is net of the £4.476m provided non-recurringly to support the delivery of Divisional operating plans. Savings of £12.070m have been realised to date, a shortfall of £2.871m against divisional plans. The shortfall is a combination of the adverse variance for unidentified schemes of £2.651m and a further £0.220m for scheme slippage. The 1/12th phasing adjustment reduces the shortfall to date by £0.032m.

The year-end forecast outturn is a shortfall of £3.306m, (an improvement of £0.182m from last month's forecast shortfall of £3.488m), which represents delivery of 83%.

A summary of progress against the Savings Programme for 2015/16 is summarised below. A more detailed report is given under item 5.4 on this month's agenda.

	Savings Programme to 31st Dec 2015			1/12ths Phasing Adj Fav / (Adv) £'000	Total Variance Fav / (Adv) £'000
	Plan £'000	Actual £'000	Variance Fav / (Adv) £'000		
Diagnostics and Therapies	1,580	1,339	(241)	(28)	(269)
Medicine	1,642	1,821	179	(26)	153
Specialised Services	1,225	1,430	205	36	241
Surgery, Head and Neck	4,495	2,277	(2,218)	70	(2,148)
Women's and Children's	3,291	2,269	(1,022)	81	(941)
Estates and Facilities	812	849	37	(7)	30
Trust HQ	329	489	160	(72)	88
Other Services	1,567	1,596	29	(22)	7
Totals	**14,941**	**12,070**	**(2,871)**	**32**	**(2,839)**

4. Divisional Reports

The following is intended to provide a brief update on the divisional positions including reasons for variance and actions being taken to address adverse positions. As requested at the previous Finance Committee, the divisional reports at item 5.3 provide further detail on the impact of actions being taken and new actions having been introduced since the last report.

Four Divisions are red rated for their financial performance for the year to date:

Division of Medicine

The Division reports an adverse variance to month 9 of £1.266m; this represents a deterioration in the month of £0.065m almost the same deterioration as the previous month. The Division is £1.241m adverse to its operating plan target to date. The Division is reporting a savings programme year to date favourable variance of £0.153m and a revised savings programme forecast outturn favourable variance of £0.539m.

The key reasons for the adverse variance against budget and operating plan to date are:

- An adverse variance on SLA income of £0.541m (although a favourable variance in month of £0.027m) due to the following factors:

  i) A c.2% adverse financial variance (£0.4m gross) driven by a 2% under-performance against SLA in volume of emergency admissions. Admissions were however 8% higher than SLA in December.
  ii) 1% fewer attendances to the Emergency Department (ED) than at the same time in 2014/15. This, in part, reflects the fact that up to 8 'GP expected' patients per day are now admitted directly to the Acute Medical Unit (AMU) and bypass the Emergency Department completely which was not accounted for in the planned activity. Attendances were higher however in December.
  iii) An adjustment to patient volumes in the Port CF database given changes to bandings and deaths within the regional Cystic Fibrosis service, c. £0.187m. This was an unplanned adjustment and the full year impact must be absorbed within the 2015/16 financial plan;
  iv) New outpatient attendances are c.3% below SLA (£0.2m gross) but this largely reflects capacity issues in quarters 1 and 2 across specialties with sizable growth incorporated in the 2015/16 contract. Similarly, follow-up attendances are c.3% below SLA (£0.1m gross.
  v) A pay adverse variance of £0.709m due to costs associated with agency nursing and medical staffing. However despite activity being higher than contracted, absolute pay expenditure decreased by £0.108m in December and for the third successive month also agency nursing expenditure decreased significantly with fewer shifts booked to cover sickness and fewer shifts booked to cover staff vacancies.

- The savings programme is now reporting a favourable variance of £0.153m.

Actions being taken and mitigation to restore performance include:

- A proposal to move to single sex wards within Care of the Elderly is being pursued and will likely take place in January; the likely consequence of which will be a significant reduction in one to one agency shifts as duplication across wards is reduced.
- Continuation of an intensive nurse recruitment programme (using divisional matron resource) and additional resource from Employee Services to address and improve sickness absence rates.

- The division continues to scrutinise all requests for agency shifts through regular meetings with ward managers.
- Improved approach to absence management involving additional resource in employee services.
- The Division is also proposing to undertake formal communication and negotiation with regards to funding and undertaking procurement for, a community bed placement service. Upon investigation it has been ascertained that many commissioners (as opposed to provider hospitals) fund and procure such services. The number of placements made by the existing service, Care Home Selection, continues to be high and supports the push for accelerated discharge.

Key risks to delivery of the operating plan include:

- Failure of the recruitment strategy to deliver the required number of posts and hence the planned level of agency expenditure reductions are not achieved.
- Failure to adequately control nursing expenditure.
- The risk that activity does not pick up in the later months of the year.
- Potential adverse financial impact of the change to the cystic Fibrosis patient co-hort and the impact of the year of care tariff.

Division of Specialised Services

The Division reports an adverse variance to month 9 of £0.763m, which represents an improvement from month 8 of £0.052m. The Division is £0.868m adverse to the operating plan target to date.

Pay budgets show an adverse variance of £0.732m. Income from activities is showing an adverse variance of £0.926m although much of this stems from very low activity in the early part of the year. The savings programme is showing a favourable variance of £0.241m to date and the non pay budgets are reporting a favourable variance of £0.511m due to the year to date share of support funding and unallocated contract transfer funding as well as a small favourable variance on blood.

The key reasons for the adverse variance against budget and operating plan to date are:

- Cardiac Surgery activity – Year to date at Month 9 the division completed 129 cases fewer than required (90%) of contract resulting in an inpatient under performance of £0.635m.
- Cardiology activity is overachieving year to date by £0.254m and over-performed in the month by £0.079m.
- Cardiac Critical Care activity has underperformed year to date by £0.244m.
- Adult BMT – Year to date contract underperformance of £0.377m, with allograft volumes down 20.9% below contracted levels.
- Radiotherapy Activity – Year to date contract underperformance of £0.76m. However a new consultant has started which has had the impact of increasing activity volumes.
- Haematology activity has over-performed year to date by £0.234m. There was an over performance in month of £0.042m. Demand is expected to grow over the rest of the year.
- Private Patients Income is over performing against target by £0.014m.
- Nursing – There has been high agency usage within CICU caused by sickness supernumerary time and vacancies as well as significant hour’s requirements for one to one nursing across wards resulting in a £0.556m adverse variance.
- Medical pay budgets show an adverse variance of £0.291m mainly due to agency and waiting list costs.
- Non recurring savings support funding has benefited the position by £0.369m.
- The Cost Improvement Programme reports an over achievement of £0.241m.

- Operating income reports a favourable variance of £0.143m.

Actions being taken and mitigation to restore performance: Further information on the progress with current actions and new actions developed are included in the main divisional report.

- Delivery of Cardiac Surgery activity- Activity volumes have been improved over recent periods predominantly due to improved patient flow through the CICU. A greater focus has been taken to look to minimise blockages due to avoidable patient scheduling issues. Moving into the winter it is essential that every effort is made to keep flow through CICU and the wards to enable sufficient volumes to be delivered.
- A number of actions have been identified within nursing to maintain a continued focus on this area. These include, the development of a critical care bank, recruitment and retention programme led by the divisional matron, continued review of lost time including annual leave, review of CICU staffing levels all of which are aimed at addressing and reducing agency expenditure.
- Perfusion expenditure on agency has been stopped following successful training of internal staff to take on senior roles.
- Clinical fellows have been appointed to replace junior doctor's agency staff in Cardiac Surgery.
- Recruitment of specialty doctors in BHOC will drive improved activity and financial performance in this area.
- Additional SLA income opportunities may be possible throughout the year in the areas of Cardiology and Haematology following strong performance year to date. Opportunities with Gamma Knife are also probable in the final quarter of the year.
- The Division is attempting to source new referrals for BMT's within the region including working with Swindon to look at referrals that are currently going to London.
- Continuing to deliver savings programmes identified and developing new schemes.
- Maintaining controls on non-pay expenditure.

Key risks to delivery of the operating plan include:

- Further loses of Cardiac Surgery activity due to shortages of staff, high acuity of patients or bed pressures during the winter period.
- An inability to recruit to vacant posts in nursing resulting in continued agency expenditure;
- Non recruitment into medical vacancies within the BHOC, particularly for Radiotherapy.
- Continued charges for unused chemotherapy drugs.
- Non delivery of expected savings
- Any further reduction in referrals for BMTs

Division of Surgery, Head and Neck

The Division reports an adverse variance to month 9 of £4.047m; deterioration from month 8 of £0.455m. The Division is £2.673m adverse to its operating plan target to date. It should be noted that the adverse variance on income from activities reduced by £0.056m this month which reflects the planned improvement forecast in the division's recovery plan.

The key reasons for the adverse variance against budget to date are:

- Underachievement of income from activities of £0.592m due to lower than expected activity primarily in outpatient areas (oral surgery, ophthalmology and ENT) and emergency/ unplanned work in upper GI surgery and T&O. A significant element of this is a share of the underperformance on cardiac surgery within Specialised Services (£0.248m).

- An adverse variance to date on non-pay of £1.182m which is an in month deterioration of £0.387m. This is due to the ongoing divisional deficit offset by divisional non recurring support £0.608m plus adverse variances on drugs £0.155m and non clinical supplies/other non-pay £0.447m. The reasons for the latter remain poorly understood.
- An underachievement of the savings programme, resulting in an adverse variance to date of £2.148m. The majority of which relates to unidentified plans of £2.079m with the balance mainly due to shortfalls on income related schemes. The most significant being income from the national Bowel Screening Programme (flexible sigmoidoscopy) which has been slowed down by the national programme and as such is not recoverable this year.

The key reasons for the adverse variance against operating plan are:

- Underachievement of activity (including the share of cardiac surgery), £0.879m.
- Higher than planned nursing spend £0.690m.
- Higher than planned waiting list payments £0.112m.
- Higher than planned spend on medical and dental agency offset by BEH vacancies £0.242m.
- Higher than planned spend on drugs £0.242m
- Higher than planned expenditure on outsourcing £0.177m.
- Slippage on CIP delivery.

Actions being taken and mitigation to restore performance: Further information on the progress with current actions and new actions developed are included in the main divisional report.

- Implementing a revised operating model to improve utilisation rates within theatres, reducing the number of waiting list initiatives (WLI) required;
- Recruitment of locum posts in endoscopy and anaesthesia to reduce spend on WLI
- Review of classification of critical care patients to ensure staffing skill mix is appropriate, and not higher than required;
- Review of data re nurse rostering to ensure that substantive staff are delivering substantively funded shifts and sharing of good practice, delivery of auto roster across the wards is on the work plan of the ward managers and Human Resources Business Partner.
- Work being carried out to clarify what is driving increased staffing need in ITU.
- Review carried out of levels of work outsourced, to CESP and GLANSO, in terms of required capacity to meet demand, and the capacity that is available in house.
- Review of controls especially within theatres to support improved control of spend on consumables in line with Trust Wide aim to reduce stock levels. A case to evaluate the benefits of a Trust wide Managed Inventory System is being developed.
- Oral Surgery/Dentistry – scheduling of additional high volume sessions in both outpatients and day case settings. Increased capacity delivered as theatre nursing and Consultant/Dentist staffing will soon be up to required levels. Further detailed work under way to improve productivity at SBCH by establishing clinical criteria of patients who can transfer.
- Oral Surgery/Dentistry – review of clinics at NBT that are not efficient due to environmental difficulties that NBT are not resolving. Possible relocation to SBCH or the Dental Hospital
- Ophthalmology; planned increase in clinical activity at South Bristol for the Glaucoma service. Scheduling of additional sessions evening and weekends to deliver volumes. Review of all clinic templates to ensure productivity maximised.
- Increasing capacity at South Bristol Hospital including the scheduling of additional sessions in the evenings and at weekends.

Key risks to delivery of the operating plan include:

- Continuing high usage of agency nursing if the recruitment strategy fails to deliver.
- Failure to address and recover the underperformance on activity to date.
- Failure to better control non-pay expenditure

The Division of Women's and Children's Services

The Division reports an adverse variance to month 9 of £1.209m; this represents deterioration from month 8 of £0.290m. The Division is £0.650m adverse to the operating plan target to date.

The key reasons for the adverse variance against budget to date are:

- An adverse variance on pay of £1.540m due to higher than planned agency costs within medical staff (NICU cover) and nursing (including one to one care. The nursing and midwifery adverse variance improved against the trend of the last few months, overall staff in post was down by 17 wte although it remains 11 wte above funded establishment. Non clinical staff has an adverse variance of £0.245m driven by requirements such as validating waiting lists, completion of missing outcomes, administrative spend in clinical genetics, vacancies for medical secretaries and increased staffing in the governance team.
- An underperformance on the saving programme, resulting in an adverse variance to date of £0.941m. The majority of which relates to the level of unidentified savings in the plan £0.680m, most of the balance being shortfalls in income related schemes.
- An overachievement on SLA income of £0.37m including favourable variances in paediatric medical specialties £0.273m, St Michaels specialties £0.301m and paediatric, cardiac & PICU £0.050m offset by an adverse performance on paediatric surgical specialties £0.511m and on private patients and overseas visitors of £0.107m.
- These adverse variances are offset by a significant favourable variance on non-pay £1.247m which includes the year to date share of support funding, CQUIN funding and a capacity reserve held within the division.

Actions being taken and mitigation to restore performance. Further information on the progress with current actions and new actions developed are included in the main divisional report.

In order to return the Division's financial position to within its operating plan control envelope it is now clear that more financial recovery actions are required as the pace of cost reduction in nursing is insufficient in itself. The monthly Finance Performance meetings are to be used to develop a recovery action plan which will need to include:

- Raising awareness about the financial position and increasing emphasis of controls and reduction in any discretionary spend
- Ensuring that elective operating is continuing as much as possible whilst winter emergency work is managed safely and efficiently.
- The other key actions have been the implementation of nursing pay controls, alongside managing Monitors agency cap rules. This has been focussed on reconciling ward funded establishments, Rosterpro and DoH staff staffing returns; escalating controls and exception reporting for authorising agency staff; and creating governance structure for reviewing ward nursing KPIs routinely. Annual Nurse Staffing Review was considered by Children's Governing Executive Committee also.
- Emergency demand has settled down since about mid-December and patient flow is improving in the Children's Hospital which should increase the ability to deliver elective income over the remainder of the year.

Key risks to delivery of the operating plan include:

- Maintaining elective income though the winter months, whilst containing winter emergency pressure costs within the operational resilience funding envelope. Cardiac Surgery activity may well be reduced but plans are being developed to increase Neurosurgery activity which is less dependent on PIC bed availability.
- Ensuring nurse agency costs reduce significantly in line with recruitment of 107 new starters this autumn.
- If the usage of off-framework agency staff is stopped immediately it is likely to have a knock on effect in the short term which could potentially reduce income.

The remaining three Divisions are rated green.

Diagnostic and Therapies Division

The Division reports a favourable variance to month 9 of £0.188m, which represents and improvement from month 8 of £0.114m. The Division is £0.214m favourable compared to the operating plan target to date.

The key reasons for the variance against budget to date are:

- A favourable variance on pay of £0.570m which is primarily the result of vacancies in clinical staff.
- An adverse variance on non-pay of £0.68m which includes a recurrent adverse variance on Radiology maintenance contracts of £0.180m and the Microbiology Public Health England contract of £0.240m. The year to date adverse variance also includes LIMS double running costs of £0.185m which is being challenged with NBT. There has also been non-recurrent cost pressures year to date for the Laboratory server of £0.050m. These adverse variances are off-set by non-recurring support funding of £0.298m and divisional reserves.
- An adverse variance on income from activities (mainly SLA income) of £0.179m year to date £0.013m favourable on D&T hosted services off-set by £0.322m adverse on services hosted by other divisions), £0.120m non-recurring CQUIN benefit, off-set by underachievement on private patient income of £0.077m.
- The savings programme is adverse to requirement by £0.269m year to date, of which £0.251m was unidentified in the operating plan.
- A favourable variance on Operating Income of £0.134m this is across a number of areas including research and innovation, MEMO external contracts and pharmacy income.

Actions being taken and mitigation to restore performance: Further information on the progress with current actions and new actions developed are included in the main divisional report.

- Developing the savings programme to address the shortfall.
- Challenging the dual running LIMS costs with NBT.
- Review of radiology outsourcing costs.

Key risks to delivery of the operating plan include:

- Other Division's under-performance on contracted activity.
- The ability to continue with high levels of vacancies and any potential impact this might have on service delivery.
- Non-delivery or under-delivery of savings schemes currently forecast to achieve, such as those linked to the extension of the Roche Managed equipment service for laboratory medicine.

- Employing high cost agency and or locum staff into hard to recruit to posts to ensure delivery of key performance targets and resilience in services such as Radiology and Laboratory Medicine.

The Facilities and Estates Division

The Division reports a favourable variance to month 9 of £0.061m, which represents an improvement from month 8 of £0.021m. The Division is now £0.071m favourable to the operating plan target to date.

Trust Headquarters

The Division reports an adverse variance to month 9 of £0.013m, this represents a deterioration from month 8 of £0.023m; the Division is £0.013m adverse to the operating plan target to date.

5. Income

Contract income was £0.16m higher than plan in December bringing the year to date position to £0.12m lower than plan. Pass through payments were favourable against plan in the month whilst contract penalties and contract activity were lower than plan. The table below summarises the overall position which is described in more detail under agenda item 5.2.

Clinical Income by Worktype	**In Month Variance** Fav/(Adv)	**Year to Date Plan**	**Year to Date Actual**	**Year to Date Variance** Fav/(Adv)
	£'m	£'m	£'m	£'m
Activity Based				
Accident & Emergency	(0.01)	11.07	11.29	0.21
Emergency Inpatients	0.42	54.58	56.27	1.70
Day Cases	0.13	28.20	27.92	(0.29)
Elective Inpatients	(0.22)	39.72	37.35	(2.37)
Non-Elective Inpatients	0.00	11.91	11.64	(0.27)
Excess Bed days	(0.17)	5.22	5.56	0.34
Outpatients	(0.14)	59.36	58.50	(0.86)
Bone Marrow Transplants	(0.21)	7.06	6.01	(1.05)
Critical Care Bed days	0.16	31.51	31.84	0.33
Other	(0.02)	69.84	69.06	(0.78)
Sub Totals	**(0.06)**	**318.46**	**315.43**	**(3.03)**
Contract Penalties	(0.09)	(4.57)	(3.89)	0.68
Contract Rewards	(0.23)	6.01	5.59	(0.42)
Pass through payments	0.22	60.16	62.82	2.66
Totals	**(0.16)**	**380.06**	**379.94**	**(0.12)**

Significant activity underperformance continues within elective inpatients, outpatients and bone marrow transplants. Key areas for the elective inpatient underperformance of £2.37m are cardiac surgery (£0.63m), upper gastrointestinal surgery (£0.68m) and paediatrics (£0.66m). There was a small improvement in cardiac surgery this month of £0.03m and it is expected that activity will remain close to plan for the remainder of the year. Ophthalmology outpatient activity is £0.70m lower than plan arising from reduced capacity due to staff recruitment. Bone marrow transplants for adult services were £0.73m below plan this month.

Emergency inpatients over performance increased by £0.43m to £1.70m to date, with the over performance to date within the Children's Hospital accounting for £1.08m and adult cardiology £0.56m.

Contract penalties are £0.68m better than plan. The main driver for this is the specialised services marginal tariff adjustment which is better than expected at £0.85m. Further detail is given at 2.3 in the contract income report.

Contract rewards underperformance increased this month by £0.23m to £0.42m behind plan. The forecast year-end delivery of CQUINs is 76.8%. "Dementia: Case finding" and "Organisational Patient Safety Culture" CQUINs continue to have a ≤50% predicted delivery in whole or part but "Neonatal Unit Admissions" is also now in this category due to delays in the availability of required information from community midwives. All CQUINs are monitored closely through the Clinical Quality Group, with relevant SLT sponsors accountable to SLT for delivery.

Pass through payments are £2.66m higher than planned to date within devices £2.72m higher than plan.

Performance at Clinical Divisional level is shown at appendix 4a. Activity based contract performance is summarised as follows:

Divisional Variances	**In Month Variance** Fav/(Adv)	**Year to Date Plan**	**Year to Date Actual**	**Year to Date Variance** Fav/(Adv)
	£'m	£'m	£'m	£'m
Diagnostic & Therapies	0.06	28.89	28.58	(0.31)
Medicine	0.10	36.62	36.33	(0.29)
Specialised Services	0.03	40.85	39.66	(1.19)
Surgery, Head and Neck	0.00	56.92	56.22	(0.70)
Women's and Children's	(0.25)	74.98	75.08	0.20
Facilities and Estates	0.00	2.91	2.87	(0.04)
Corporate	0.00	77.39	76.69	(0.70)
Totals	**(0.06)**	**318.46**	**315.43**	**(3.03)**

6. Risk Rating

The following table shows performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the nine month period to 31st December 2015, the Trust's achieved an overall FSRR of 4 (actual 3.5 rounded up) against a plan of 3 (3.25 rounded down).

A low risk going forward is the adverse EBITDA performance against plan and the impact upon the FSRR. Within the FSRR, the EBITDA performance impacts on the "capital servicing capacity" metric. The headroom available until this metric scores a rating of 1 has decreased to £7.8 million from £8.5 million last month. Should any of the four metrics score a metric rating of 1, Monitor will apply an "over-ride" resulting in an overall FSRR capped at 2 for the Trust and potential investigation. A summary of the position is provided in the table below.

	Weighting	30 November 2015 Plan	30 November 2015 Actual	31st December 2015 Plan	31st December 2015 Actual	31st March 2016 Plan	31st March 2016 Forecast
Liquidity							
Metric Result – days		12.12	12.95	8.57	12.18	7.20	8.32
Metric Rating	25%	4	4	4	4	4	4
Capital Servicing Capacity							
Metric Result – times		2.01	2.03	1.68	1.80	1.83	1.97
Metric Rating	25%	3	3	2	3	3	3
Income & expenditure margin							
Metric Result		0.49%	0.53%	0.40%	0.69%	0.52%	0.60%
Metric Rating	25%	3	3	3	3	3	3
Variance in I&E margin							
Metric Result		0.00%	0.04%	0.00%	0.29%	0.00%	0.08%
Metric Rating	25%	4	4	4	4	4	4
Overall FSRR		**3.5**	**3.5**	**3.25**	**3.5**	**3.5**	**3.5**
Overall FSRR (rounded up)		**4**	**4**	**3**	**4**	**4**	**4**

7. Capital Programme

A summary of income and expenditure for the nine months ending 31 December is given in the table below. Expenditure for the period is £16.639m against a revised plan of £17.285m.

Original Monitor Annual Plan	Revised Annual Plan	Subjective heading	Month ended 31st December 2015 Plan	Month ended 31st December 2015 Actual	Month ended 31st December 2015 Variance	Forecast Outturn	Forecast Slippage
£m	£m		£m	£m	£m	£m	£m
		Sources of Funding					
4.558	4.805	Donations	2.632	2.432	(0.200)	3.115	(1.690)
1.100	14.025	Disposals	14.025	14.025	-	14.025	-
0.954	1.130	Grants/Contributions	0.954	1.040	0.086	1.216	0.086
		Cash:					
20.814	20.814	Depreciation	15.486	15.553	0.067	20.771	(0.043)
7.043	(0.912)	Cash balances	(15.812)	(16.411)	(0.599)	(14.645)	(13.733)
34.469	**39.862**	**Total Funding**	**17.285**	**16.639**	**(0.646)**	**24.482**	**(15.380)**
		Expenditure					
(15.862)	(15.994)	Strategic Schemes	(7.577)	(7.505)	0.072	(10.612)	5.382
(4.287)	(7.393)	Medical Equipment	(3.027)	(3.038)	(0.011)	(5.008)	2.385
(3.171)	(3.265)	Information Technology	(1.468)	(1.448)	0.020	(2.729)	0.536
(2.177)	(2.259)	Estates Replacement	(1.450)	(1.576)	(0.126)	(2.588)	(0.329)
(8.972)	(10.951)	Operational Capital	(3.763)	(3.072)	0.691	(5.545)	5.406
(34.469)	**(39.862)**	**Gross Expenditure**	**(17.285)**	**(16.639)**	**0.646**	**(26.482)**	**13.380**
-	-	Planned Slippage				2.000	2.000
(34.469)	**(39.862)**	**Net Expenditure**	**(17.285)**	**(16.639)**	**0.646**	**(24.482)**	**15.380**

Following a re-assessment of the capital programme, the Trust's forecast outturn has reduced from £30.269m last month to £24.482m. This represents 71% of the original Monitor Annual Plan, 88%

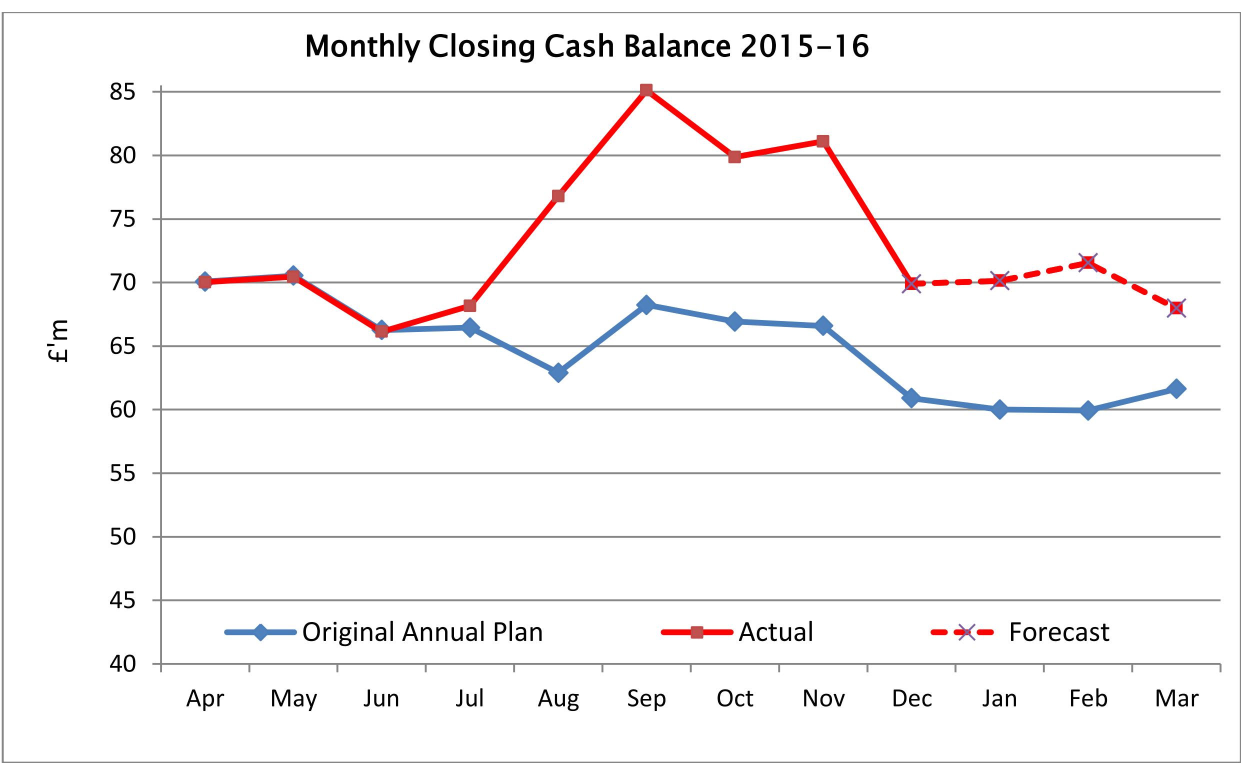
of the revised plan submitted at quarter 2. The Finance Committee is provided with further information under agenda item 6.1.

9. Statement of Financial Position and Cashflow

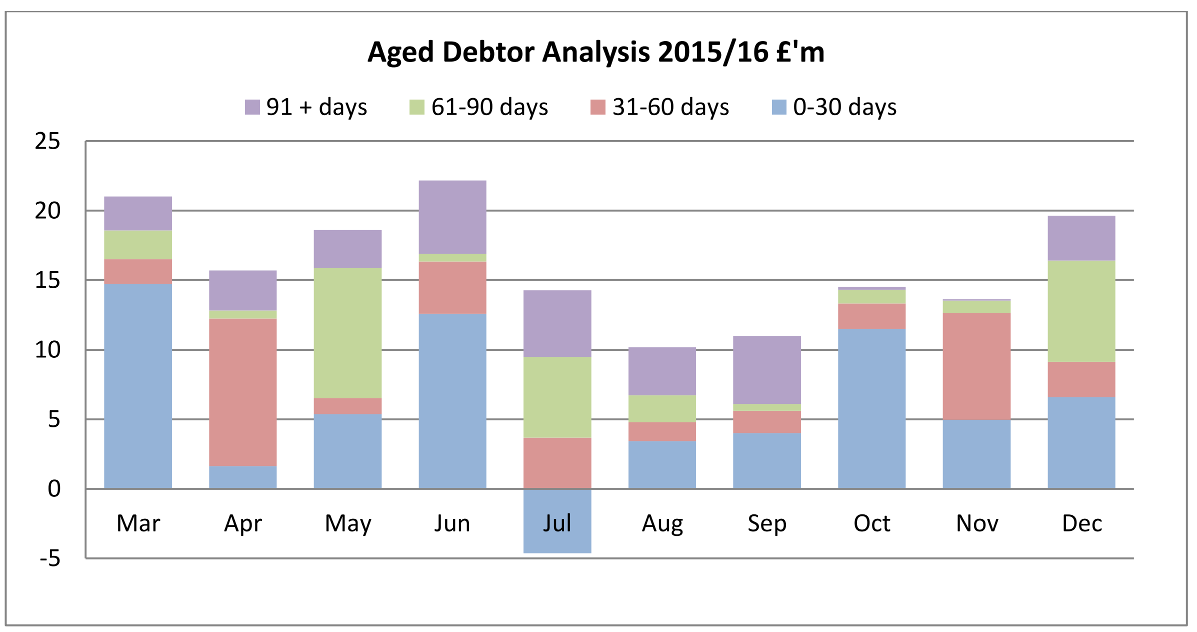
Overall, the Trust has a strong statement of financial position with net current assets of £30.458m as at 31st December 2015. This is £6.906m above the Monitor plan, primarily reflecting the capital slippage.

Cash - The Trust held cash and cash equivalents of £69.948m, a decrease of £11.145m from last month and £9.043m above the Monitor plan. The reduction in month reflects the increased payments to suppliers and the credit notes taken by NHS Commissioners. The forecast year end closing cash balance is £67.975m, an increase of £5.164m from last month reflecting the increased forecast capital slippage.

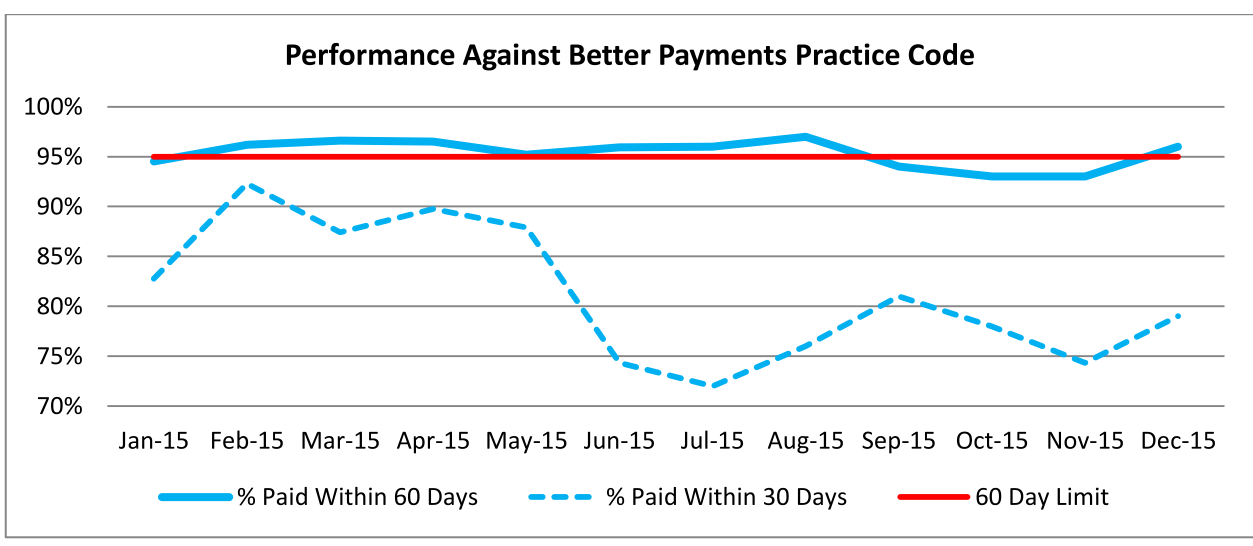
The graph below shows the forecast cash balance trajectory for the remainder of the financial year.



Receivables - The total value of debtors increased by £6.011m to £19.628m in December. SLA debtors increased by £3.107m and non SLA debtors increased by £2.904m. The total value of debtors over 60 days old increased by £9.529m, predominantly reflecting NHS England taking their overdue credit note of £3.186m and an outstanding invoice to Bristol CCG of £5.9m for quarter 2 activity. Bristol CCG had a number of queries which have been resolved and payment is due imminently. Further details are provided in agenda item 7.1.



Accounts Payable Payments – In December, performance for payment of invoices within 60 days increased to 96% compared with the Prompt Payments Code target of 95%. The number of invoices paid within 30 days increased to 79%. A summary of performance is provided below.



Attachments	*Appendix 1 – Summary Income and Expenditure Statement*
	Appendix 2 – Divisional Income and Expenditure Statement
	Appendix 3 – Financial Sustainability Risk Rating
	Appendix 4a – Key Financial Metrics
	Appendix 4b – Key Workforce Metrics
	Appendix 5 – Financial Risk Matrix
	Appendix 6 – Monthly Analysis of Pay Expenditure 2015/16
	Appendix 7 - Release of Reserves

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report December 2015– Summary Income & Expenditure Statement

Approved Budget / Plan 2015/16	Heading	Position as at 31st December Plan	Actual	Variance Fav / (Adv)	Actual to 30th November	Forecast Outturn Month 9
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
508,313	From Activities	383,503	380,629	(2,874)	338,495	508,242
91,702	Other Operating Income	68,636	68,611	(25)	60,705	93,353
600,015	**Sub totals income**	**452,139**	**449,240**	**(2,899)**	**399,200**	**601,595**
	Expenditure					
(349,353)	Staffing	(262,391)	(264,996)	(2,605)	(235,282)	(354,437)
(208,136)	Supplies and Services	(157,455)	(158,920)	(1,465)	(142,062)	(213,623)
(557,489)	**Sub totals expenditure**	**(419,846)**	**(423,916)**	**(4,070)**	**(377,344)**	**(568,060)**
(8,075)	Reserves	(6,150)	–	6,150	–	–
34,451	**EBITDA**	**26,143**	**25,324**	**(819)**	**21,856**	**33,535**
5.74	**EBITDA Margin – %**		**5.64**		**5.47**	**5.57**
	Financing					
(23,054)	Depreciation & Amortisation – Owned	(17,258)	(15,557)	1,701	(13,740)	(20,771)
269	Interest Receivable	208	229	21	203	308
(315)	Interest Payable on Leases	(236)	(240)	(4)	(213)	(320)
(3,167)	Interest Payable on Loans	(2,402)	(2,343)	59	(2,086)	(3,089)
(8,184)	PDC Dividend	(6,138)	(5,747)	391	(5,458)	(7,663)
(34,451)	**Sub totals financing**	**(25,826)**	**(23,658)**	**2,168**	**(21,287)**	**(31,535)**
0	**NET SURPLUS / (DEFICIT) before Technical Items**	**317**	**1,666**	**1,349**	**569**	**2,000**
	Technical Items					
–	Profit/(Loss) on Sale of Asset	–	9,161	9,161	7	9,161
4,558	Donations & Grants (PPE/Intangible Assets)	2,579	2,575	(4)	2,556	3,115
(4,719)	Impairments	(4,558)	(1,695)	2,863	(1,695)	(4,886)
500	Reversal of Impairments	–	–	–	4,804	481
(1,472)	Depreciation & Amortisation – Donated	(1,104)	(1,127)	(23)	(1,001)	(1,518)
(1,133)	**SURPLUS / (DEFICIT) after Technical Items**	**(2,766)**	**10,580**	**13,346**	**5,233**	**8,353**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 2015– Divisional Income & Expenditure Statement

Approved Budget / Plan 2015/16	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 30th November	Forecast Outturn Variance Month 9	Operating Plan Target Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP					
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income												
504,328	Contract Income	380,058	380,058	–	–	–	–	–	–	–	–	–	–
(151)	Overheads, Fines & Rewards	(113)	(394)	–	227	(27)	(481)	–	(281)	45	(500)	–	–
39,139	NHSE Income	29,119	29,119	–	–	–	–	–	–	–	–	–	–
543,316	**Sub Total Corporate Income**	**409,064**	**408,783**	**–**	**227**	**(27)**	**(481)**	**–**	**(281)**	**45**	**(500)**	**–**	**–**
	Clinical Divisions												
(51,193)	Diagnostic & Therapies	(38,444)	(38,256)	570	(68)	134	(179)	(269)	188	74	200	(26)	214
(72,374)	Medicine	(54,355)	(55,621)	(709)	(263)	94	(541)	153	(1,266)	(1,201)	(1,580)	(25)	(1,241)
(94,473)	Specialised Services	(70,765)	(71,528)	(732)	511	143	(926)	241	(763)	(815)	(1,163)	105	(868)
(100,187)	Surgery Head & Neck	(75,440)	(79,488)	(345)	(1,182)	219	(592)	(2,148)	(4,048)	(3,592)	(5,042)	(1,374)	(2,674)
(117,041)	Women's & Children's	(87,698)	(88,907)	(1,540)	1,247	(12)	37	(941)	(1,209)	(919)	(1,550)	(559)	(650)
(435,268)	**Sub Total – Clinical Divisions**	**(326,702)**	**(333,800)**	**(2,756)**	**245**	**578**	**(2,201)**	**(2,964)**	**(7,098)**	**(6,453)**	**(9,135)**	**(1,879)**	**(5,219)**
	Corporate Services												
(36,240)	Facilities And Estates	(27,761)	(27,700)	17	(152)	101	65	30	61	40	75	(10)	71
(25,054)	Trust Services	(18,704)	(18,717)	364	(473)	(50)	58	88	(13)	10	(30)	–	(13)
(4,228)	Other	(3,604)	(3,242)	75	687	(324)	(83)	7	362	366	460	–	362
(65,522)	**Sub Totals – Corporate Services**	**(50,069)**	**(49,659)**	**456**	**62**	**(273)**	**40**	**125**	**410**	**416**	**505**	**(10)**	**420**
(500,790)	**Sub Total (Clinical Divisions & Corporate Services)**	**(376,771)**	**(383,459)**	**(2,300)**	**307**	**305**	**(2,161)**	**(2,839)**	**(6,688)**	**(6,037)**	**(8,630)**	**(1,889)**	**(4,799)**
(8,075)	Reserves	(6,150)	–	–	6,150	–	–	–	6,150	4,671	8,214	–	–
(8,075)	**Sub Total Reserves**	**(6,150)**	**–**	**–**	**6,150**	**–**	**–**	**–**	**6,150**	**4,671**	**8,214**	**–**	**–**
34,451	**Trust Totals Unprofiled**	**26,143**	**25,324**	**(2,300)**	**6,684**	**278**	**(2,642)**	**(2,839)**	**(819)**	**(1,321)**	**(916)**	**(1,889)**	**(4,799)**
	Financing												
(23,054)	Depreciation & Amortisation – Owned	(17,258)	(15,557)	–	1,701	–	–	–	1,701	1,491	2,283	–	–
269	Interest Receivable	208	229	–	21	–	–	–	21	15	39	–	–
(315)	Interest Payable on Leases	(236)	(240)	–	(4)	–	–	–	(4)	(4)	(5)	–	–
(3,167)	Interest Payable on Loans	(2,402)	(2,343)	–	59	–	–	–	59	52	78	–	–
(8,184)	PDC Dividend	(6,138)	(5,747)	–	391	–	–	–	391	(2)	521	–	–
(34,451)	**Sub Total Financing**	**(25,826)**	**(23,658)**	**–**	**2,168**	**–**	**–**	**–**	**2,168**	**1,559**	**2,916**	**–**	**–**
0	**NET SURPLUS / (DEFICIT) before Technical Items**	**317**	**1,666**	**(2,300)**	**8,852**	**278**	**(2,642)**	**(2,839)**	**1,349**	**238**	**2,000**	**(1,889)**	**(4,799)**
	Technical Items												
–	Profit/(Loss) on Sale of Asset	–	9,161	–	9,161	–	–	–	9,161	7	9,161	–	–
4,558	Donations & Grants (PPE/Intangible Assets)	2,579	2,575	–	–	(4)	–	–	(4)	(43)	(1,443)	–	–
(4,719)	Impairments	(4,558)	(1,695)	–	2,863	–	–	–	2,863	(209)	(167)	–	–
500	Reversal of Impairments	–	–	–	–	–	–	–	–	4,804	(19)	–	–
(1,472)	Depreciation & Amortisation – Donated	(1,104)	(1,127)	–	(23)	–	–	–	(23)	(20)	(46)	–	–
(1,133)	**Sub Total Technical Items**	**(3,083)**	**8,914**	**–**	**12,001**	**(4)**	**–**	**–**	**11,997**	**4,532**	**7,486**	**–**	**–**
(1,133)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**(2,766)**	**10,580**	**(2,300)**	**20,853**	**274**	**(2,642)**	**(2,839)**	**13,346**	**4,770**	**9,486**	**(1,889)**	**(4,799)**

University Hospitals Bristol NHS
NHS Foundation Trust

Finance Committee
25th January 2016
Appendix 3

Financial Sustainability Risk Rating – December 2015 Performance

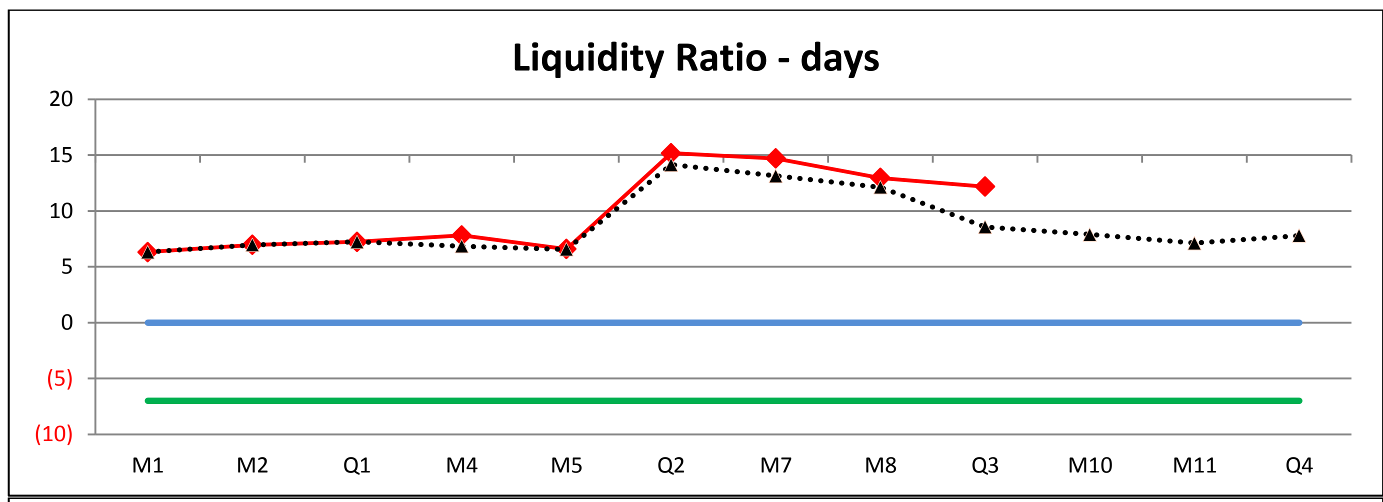
The following graphs show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the eight month period to 31st December 2015, the Trust's achieved an overall FSRR of 4 (actual 3.5) against a plan of 3 (3.25 rounded down).

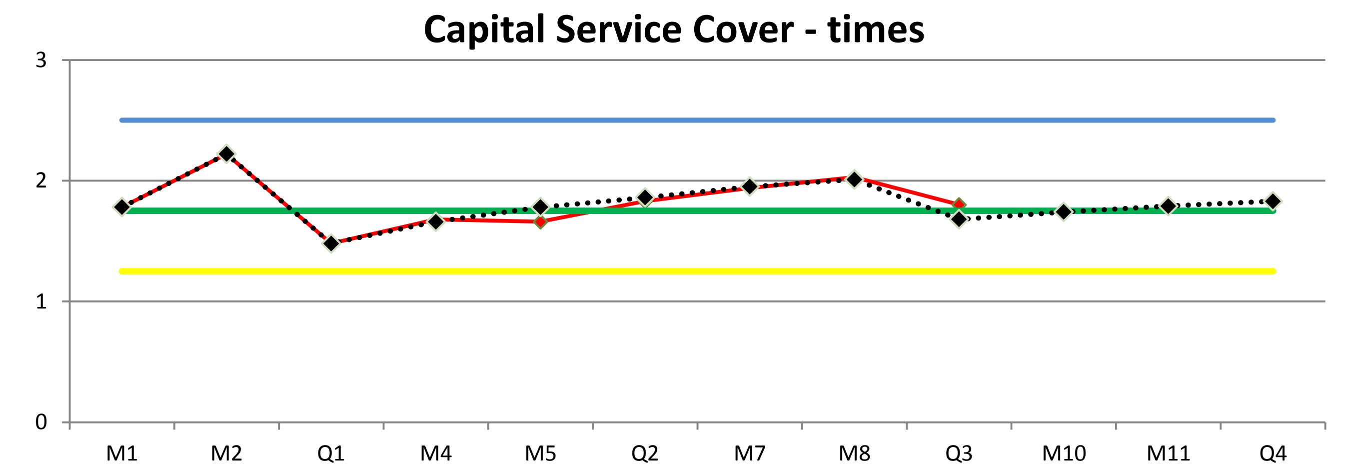
A low risk going forward is the adverse EBITDA performance against plan and the impact upon the FSRR. Within the FSRR, the EBITDA performance impacts on the "capital servicing capacity" metric. The headroom available until this metric scores a rating of 1 has decreased to £7.8 million from £8.5 million last month. Should any of the four metrics score a metric rating of 1, Monitor will apply an "over-ride" resulting in an overall FSRR capped at 2 for the Trust and potential investigation.

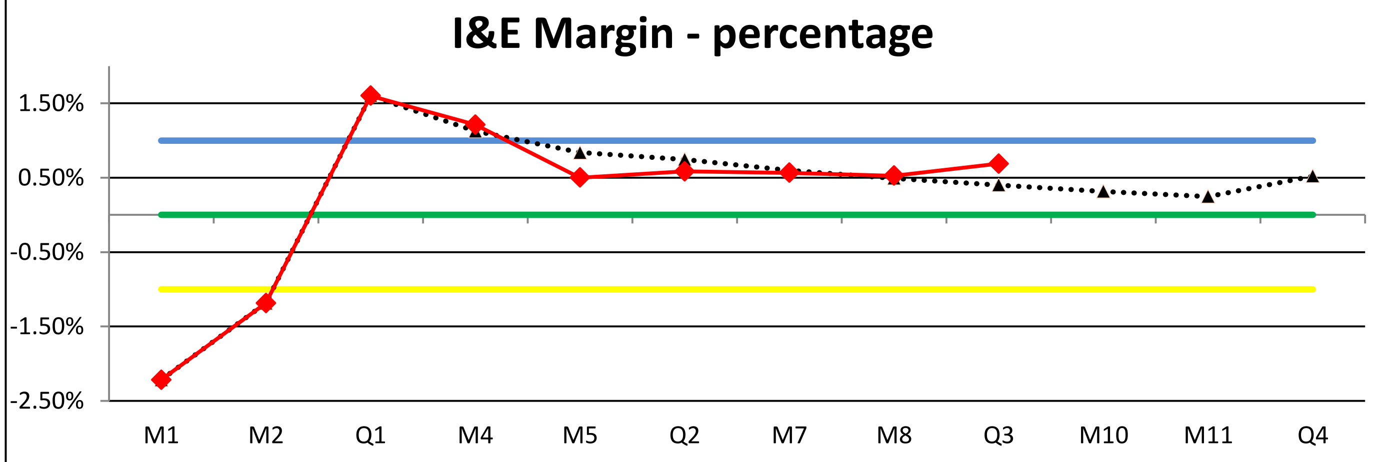
A summary of the position is provided in the table below.

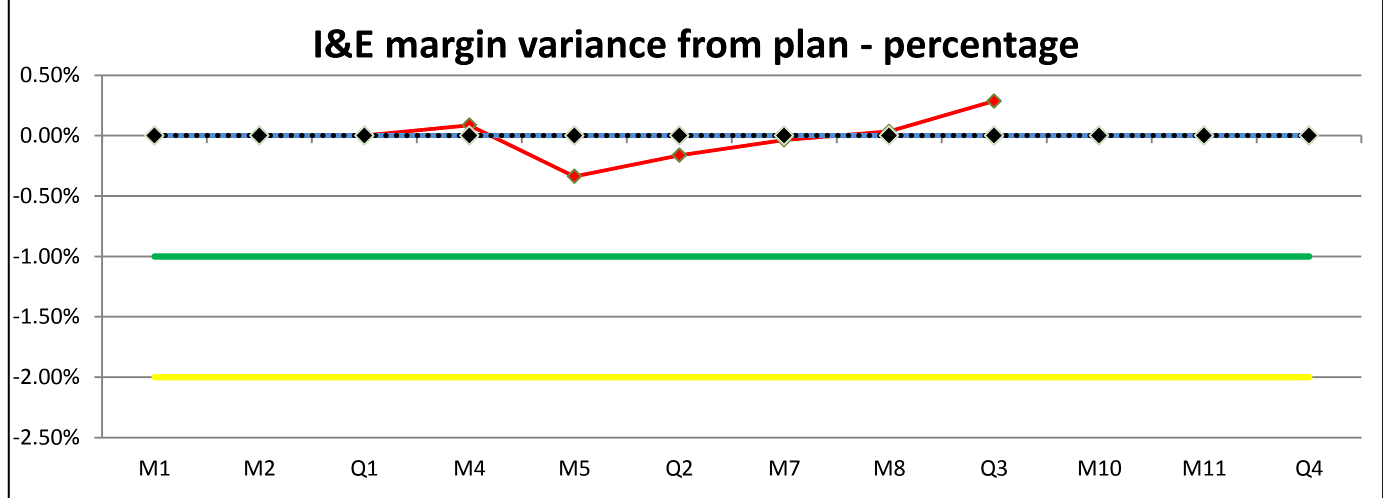
		30 November 2015		31st December 2015		31st March 2016	
	Weighting	Plan	Actual	Plan	Actual	Plan	Forecast
Liquidity							
Metric Result – days		12.12	12.95	8.57	12.18	7.20	8.32
Metric Rating	25%	4	4	4	4	4	4
Capital Servicing Capacity							
Metric Result – times		2.01	2.03	1.68	1.80	1.83	1.97
Metric Rating	25%	3	3	2	3	3	3
Income & expenditure margin							
Metric Result		0.49%	0.53%	0.40%	0.69%	0.52%	0.60%
Metric Rating	25%	3	3	3	3	3	3
Variance in I&E margin							
Metric Result		0.00%	0.04%	0.00%	0.29%	0.00%	0.08%
Metric Rating	25%	4	4	4	4	4	4
Overall FSRR		**3.5**	**3.5**	**3.25**	**3.5**	**3.5**	**3.5**
Overall FSRR (rounded up)		**4**	**4**	**3**	**4**	**4**	**4**

The charts presented overleaf show the trajectories for each of the four metrics. The 2015/16 revised Annual Plan submitted to Monitor on 31st July 2015 is shown as the black dotted line against which actual performance is plotted in red. The metric ratings are shown for **4 (blue line)**; **3 (green line)** and **2 (yellow line)**.


Liquidity Ratio - days
20
15
10
5
0
(5)
(10)
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


Capital Service Cover - times
3
2
1
0
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E Margin - percentage
1.50%
0.50%
-0.50%
-1.50%
-2.50%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E margin variance from plan - percentage
0.50%
0.00%
-0.50%
-1.00%
-1.50%
-2.00%
-2.50%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4

Key Financial Metrics

Appendix 4a

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contract Income - Activity Based									
Current Month									
Budget	3,151	4,041	4,427	6,167	8,402	319		8,420	34,927
Actual	3,210	4,146	4,459	6,170	8,149	317		8,419	34,870
Variance Fav / (Adv)	59	105	32	3	(253)	(2)	0	(1)	(57)
Year to date									
Budget	28,891	36,625	40,850	56,918	74,883	2,907		77,385	318,459
Actual	28,581	36,332	39,660	56,216	75,075	2,869		76,694	315,427
Variance Fav / (Adv)	(310)	(293)	(1,190)	(702)	192	(38)	0	(691)	(3,032)

Information shows the financial performance against the planned level of activity based service level agreements with Commissioners as per agenda item 5.2

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
Contract Income - Penalties									
Current Month									
Plan		(29)	(4)	(11)	(3)			(468)	(515)
Actual		(36)	18	(13)	(5)			(571)	(607)
Variance Fav / (Adv)	-	(7)	22	(2)	(2)	-	-	(103)	(92)
Year to date									
Plan		(260)	(33)	(102)	(27)			(4,149)	(4,571)
Actual		(256)	(39)	(128)	(40)			(3,430)	(3,893)
Variance Fav / (Adv)	-	4	(6)	(26)	(13)	-	-	719	678

Information shows the financial performance against the planned penalties as per agenda item 5.2

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
Contract Income - Rewards									
Current Month									
Plan								678	678
Actual								445	445
Variance Fav / (Adv)	-	-	-	-	-	-	-	(233)	(233)
Year to date									
Plan								6,012	6,012
Actual								5,588	5,588
Variance Fav / (Adv)	-	-	-	-	-	-	-	(424)	(424)

Information shows the financial performance against the planned rewards as per agenda item 5.2

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
Cost Improvement Programme									
Current Month									
Plan	185	194	120	476	345	94	69	174	1,657
Actual	269	324	175	275	272	98	63	176	1,652
Variance Fav / (Adv)	84	130	55	(201)	(73)	4	(6)	2	(5)
Year to date									
Plan	1,580	1,642	1,225	4,495	3,291	812	329	1,567	14,941
Actual	1,339	1,821	1,430	2,277	2,269	849	489	1,596	12,070
Variance Fav / (Adv)	(241)	179	205	(2,218)	(1,022)	37	160	29	(2,871)

Key Workforce Metrics **Appendix 4b**

Diagnostic & Therapies

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	952	728	106	115	155	116	74	53	48	66	72				805	- 77
Nursing agency expenditure (£'000)	29	22	13	1	1	-	1	0	-16	0	0				-	22
Overall																
Sickness (%)	3.00		3.00	2.70	3.10	2.80	2.50	2.60	3.00	2.70	3.20				2.84	
Turnover (%)	11.00		11.80	11.70	12.20	12.00	12.40	12.60	12.90	13.40	13.20				13.20	
Establishment (wte)			968.01	978.45	978.94	981.34	982.24	976.50	975.47	985.42	990.39					
In post (wte)			948.03	943.08	940.05	942.47	961.81	967.64	947.27	958.59	960.26					
Under/(over) establishment (wte)			19.98	35.37	38.89	38.87	20.43	8.86	28.20	26.83	30.13					
Nursing:																
Sickness - registered (%)			0.20	1.90	2.80	4.60	0.20	2.90	8.80	12.20	15.40				5.44	
Sickness - unregistered (%)																
Turnover - registered (%)	15.00		15.70	12.60	11.40	11.00	11.00	10.60	10.60	17.40	17.40				13.08	
Turnover - unregistered (%)																
Starters (wte)			-	-	-	-	-	-	-	-	1.00				1.00	
Leavers (wte)			0.59	-	1.00	-	-	-	-	1.00	1.00				3.59	
Net starters (wte)			(0.59)	0.00	(1.00)	0	0	0	0	(1.00)	0.00				(2.59)	
Establishment (wte)			16.33	16.33	17.29	17.29	17.88	17.88	17.88	18.00	17.70					
In post - Employed (wte)			16.25	16.42	16.66	15.66	15.57	15.57	15.57	15.57	16.57					
In post - Bank (wte)			1.35	0.42	0.52	0.41	2.10	0.85	0.85	0.20	1.90					
In post - Agency (wte)			2.10	-	-	-	0.70	-	-	-	-					
In post - total (wte)			19.70	16.84	17.18	16.07	18.37	16.42	16.42	15.77	18.47					
Under/(over) establishment (wte)			(3.37)	(0.51)	0.11	1.22	(0.49)	1.46	1.46	2.23	- 0.77					

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro and where appropriate backdated adjustments applied. In month 8 a backdated change was made to month 7 to better reflect staff utilisation.

Key Workforce Metrics

Medicine

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,732	1,473	324	248	254	226	269	380	373	243	198				2,515	(1,042)
Nursing agency expenditure (£'000)	1,343	1,129	279	186	154	184	234	314	307	179	144				1,981	(852)
Overall																
Sickness (%)	4.10		5.10	5.70	5.90	5.50	5.20	5.40	5.30	4.90	4.90				5.32	
Turnover (%)	12.70		13.40	13.50	13.80	12.40	12.50	12.60	13.20	13.20	13.80				13.80	
Establishment (wte)			1,233.42	1,233.54	1,238.01	1,211.24	1,217.72	1,221.40	1,203.55	1,208.43	1,188.76					
In post (wte)			1,267.74	1,282.71	1,255.17	1,233.82	1,254.14	1,275.14	1,263.80	1,228.06	1,223.14					
Under/(over) establishment (wte)			(34.32)	(49.17)	(17.16)	(22.58)	(36.42)	(53.74)	(60.25)	(19.63)	(34.38)					
Nursing:																
Sickness - registered (%)			4.80	5.30	6.20	6.00	5.10	4.70	3.90	3.80	3.10				4.77	
Sickness - unregistered (%)			9.60	10.80	10.40	9.20	11.00	10.70	10.90	10.00	9.40				10.22	
Turnover - registered (%)	13.50		13.00	13.60	14.20	13.30	14.20	14.60	14.60	14.50	15.00				14.11	
Turnover - unregistered (%)	18.50		22.20	21.40	20.40	16.50	16.30	15.50	17.90	17.90	18.20				18.48	
Starters (wte)			18.22	9.24	8.00	7.36	10.07	20.64	10.00	14.88	4.10				102.51	
Leavers (wte)			7.25	10.79	10.54	4.17	17.89	14.90	10.37	11.77	6.56				94.24	
Net starters (wte)			10.97	(1.55)	(2.54)	3.19	(7.82)	5.74	(0.37)	3.11	(2.46)				8.27	
Establishment (wte)			789.28	780.39	776.57	758.75	769.84	762.66	757.68	761.26	742.92					
In post - Employed (wte)			674.67	685.88	682.90	677.10	678.05	676.58	675.40	669.82	662.39					
In post - Bank (wte)			100.97	118.33	99.23	94.67	93.31	107.88	99.83	91.74	101.90					
In post - Agency (wte)			47.40	33.86	27.25	31.51	40.08	49.02	48.92	31.87	27.10					
In post - total (wte)			823.04	838.07	809.38	803.28	811.44	833.48	824.15	793.43	791.39					
Under/(over) establishment (wte)			(33.76)	(57.68)	(32.81)	(44.53)	(41.60)	(70.82)	(66.47)	(32.17)	(48.47)					

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.

Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.

The annual target for sickness is the average of the previous 12 months as at March 2016.

The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.

The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro and where appropriate backdated adjustments applied. In month 8 a backdated change was made to month 7 to better reflect staff utilisation.

Key Workforce Metrics **Appendix 4b**

Specialised Services

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	2,136	1,707	205	219	247	236	185	289	216	180	185				1,962	(255)
Nursing agency expenditure (£'000)	633	460	87	121	113	93	68	145	146	104	73				950	(490)
Overall																
Sickness (%)	3.70		3.80	3.50	3.50	3.80	3.70	4.10	3.60	3.30	4.30				3.73	
Turnover (%)	12.40		16.00	16.80	16.40	16.80	16.70	16.20	17.10	16.90	15.40				15.40	
Establishment (wte)			834.39	825.38	851.88	858.86	860.19	859.26	860.16	865.52	867.79					
In post (wte)			870.20	888.79	874.75	873.03	856.07	877.70	879.30	878.34	868.15					
Under/(over) establishment (wte)			(35.81)	(63.41)	(22.87)	(14.17)	4.12	(18.44)	(19.14)	(12.82)	(0.36)					
Nursing:																
Sickness - registered (%)			3.40	3.00	3.80	3.20	3.60	4.30	3.90	3.90	5.00				3.79	
Sickness - unregistered (%)			8.40	6.40	6.20	7.70	9.10	8.20	9.40	7.30	9.20				7.99	
Turnover - registered (%)	14.00		16.20	17.00	17.30	17.10	16.90	16.00	17.70	18.40	17.30				17.10	
Turnover - unregistered (%)	16.20		22.00	20.90	19.00	20.60	17.80	17.50	19.70	18.50	16.50				19.17	
Starters (wte)			4.60	3.46	8.64	1.80	8.00	8.60	11.00	6.60	-				52.70	
Leavers (wte)			4.96	10.70	6.94	7.14	6.67	4.87	11.04	5.97	3.60				61.89	
Net starters (wte)			(0.36)	(7.24)	1.70	(5.34)	1.33	3.73	(0.04)	0.63	(3.60)				(9.19)	
Establishment (wte)			453.58	449.36	460.69	463.54	463.26	463.26	463.26	465.36	465.36					
In post - Employed (wte)			439.48	439.02	432.60	433.82	427.33	436.39	444.96	441.30	437.91					
In post - Bank (wte)			32.04	37.61	43.55	35.07	32.69	42.42	35.22	36.36	39.56					
In post - Agency (wte)			11.33	13.13	13.01	11.02	9.77	16.08	17.58	12.75	9.16					
In post - total (wte)			482.85	489.76	489.16	479.91	469.79	494.89	497.76	490.41	486.63					
Under/(over) establishment (wte)			(29.27)	(40.40)	(28.47)	(16.37)	(6.53)	(31.63)	(34.50)	(25.05)	(21.27)					

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.

Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.

The annual target for sickness is the average of the previous 12 months as at March 2016.

The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.

The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro and where appropriate backdated adjustments applied. In month 8 a backdated change was made to month 7 to better reflect staff utilisation.

Surgery, Head and Neck

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,387	1,119	172	190	241	281	320	308	283	244	211				2,250	(1,131)
Nursing agency expenditure (£'000)	1,019	852	144	144	167	242	276	222	195	160	131				1,681	(829)
Overall																
Sickness (%)	3.50		4.00	3.40	3.60	4.10	4.10	3.90	4.20	4.30	4.50				4.01	
Turnover (%)	12.60		15.40	15.90	16.10	14.60	14.50	14.40	14.40	14.70	14.60				14.60	
Establishment (wte)			1,698.59	1,716.16	1,735.10	1,752.82	1,753.62	1,760.25	1,776.76	1,779.36	1,773.69					
In post (wte)			1,737.89	1,752.24	1,754.64	1,762.71	1,786.37	1,782.40	1,765.18	1,764.20	1,758.16					
Under/(over) establishment (wte)			(39.30)	(36.08)	(19.54)	(9.89)	(32.75)	(22.15)	11.58	15.16	15.53					
Nursing:																
Sickness - registered (%)			4.70	3.40	3.60	4.50	4.60	4.90	4.10	4.20	5.20				4.36	
Sickness - unregistered (%)			7.40	6.20	6.80	7.40	7.90	5.30	6.10	6.80	6.20				6.68	
Turnover - registered (%)	13.00		15.10	16.40	16.80	14.90	15.60	15.40	15.10	15.90	16.30				15.72	
Turnover - unregistered (%)	20.10		28.70	27.30	26.90	23.70	22.60	22.20	23.10	21.20	19.60				23.92	
Starters (wte)			10.61	4.00	5.63	1.00	9.00	21.40	13.00	20.57	5.40				90.61	
Leavers (wte)			9.52	8.33	10.64	5.51	23.40	10.97	7.80	11.41	9.87				97.45	
Net starters (wte)			1.09	(4.33)	(5.01)	(4.51)	(14.40)	10.43	5.20	9.16	(4.47)				(6.84)	
Establishment (wte)			677.18	680.98	689.06	694.06	701.12	701.15	702.30	703.60	696.79					
In post - Employed (wte)			644.20	646.24	650.41	642.90	648.68	636.91	645.27	650.04	649.36					
In post - Bank (wte)			45.02	51.89	55.40	59.14	62.43	64.34	48.09	42.73	39.56					
In post - Agency (wte)			20.66	19.59	27.45	31.41	35.91	29.47	25.05	21.90	16.80					
In post - total (wte)			709.88	717.72	733.26	733.45	747.02	730.72	718.41	714.67	705.72					
Under/(over) establishment (wte)			(32.70)	(36.74)	(44.20)	(39.39)	(45.90)	(29.57)	(16.11)	(11.07)	(8.93)					

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.

Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.

The annual target for sickness is the average of the previous 12 months as at March 2016.

The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.

The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro and where appropriate backdated adjustments applied. In month 8 a backdated change was made to month 7 to better reflect staff utilisation.

Key Workforce Metrics

Appendix 4b

Women's and Children's

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,228	634	189	230	284	305	171	365	308	300	257				2,409	(1,775)
Nursing agency expenditure (£'000)	978	467	116	178	225	235	182	248	298	268	205				1,955	(1,488)
Overall																
Sickness (%)	3.90		4.00	3.50	3.40	3.40	3.30	3.60	3.60	4.00	4.30				3.68	
Turnover (%)	9.80		12.30	12.30	12.20	12.30	12.40	11.50	11.60	11.70	11.70				11.70	
Establishment (wte)			1,814.32	1,825.58	1,828.38	1,835.19	1,841.46	1,847.70	1,878.60	1,874.87	1,887.66					
In post (wte)			1,808.92	1,808.69	1,832.69	1,812.60	1,821.97	1,873.24	1,946.37	1,917.60	1,902.50					
Under/(over) establishment (wte)			5.40	16.89	(4.31)	22.59	19.49	(25.54)	(67.77)	(42.73)	(14.84)					
Nursing:																
Sickness - registered (%)			4.60	3.90	4.00	3.80	3.80	4.60	4.40	4.30	4.90				4.26	
Sickness - unregistered (%)			5.80	5.40	4.60	4.70	3.60	2.90	3.60	5.30	6.80				4.74	
Turnover - registered (%)	10.00		11.50	11.30	11.00	10.90	10.50	9.60	9.80	9.90	9.70				10.47	
Turnover - unregistered (%)	20.00		22.70	24.60	23.80	23.00	23.60	17.90	17.20	15.40	16.30				20.50	
Starters (wte)			6.94	5.00	6.88	9.23	19.36	59.77	44.64	21.55	0.80				174.17	
Leavers (wte)			13.40	8.23	9.95	10.14	17.03	9.73	9.57	9.67	7.75				95.46	
Net starters (wte)			(6.46)	(3.23)	(3.06)	(0.91)	2.33	50.04	35.07	11.88	(6.95)				78.71	
Establishment (wte)			1,081.96	1,091.14	1,089.27	1,092.66	1,095.48	1,099.99	1,133.19	1,124.25	1,132.05					
In post - Employed (wte)			1,024.80	1,016.21	1,014.22	1,005.18	1,005.84	1,034.16	1,098.34	1,097.15	1,093.03					
In post - Bank (wte)			39.82	41.71	41.03	36.24	42.60	43.30	40.47	35.55	27.68					
In post - Agency (wte)			15.95	19.81	25.19	24.60	24.19	26.96	27.74	27.63	22.64					
In post - total (wte)			1,080.57	1,077.73	1,080.44	1,066.02	1,072.63	1,104.42	1,166.55	1,160.33	1,143.35					
Under/(over) establishment (wte)			1.39	13.41	8.83	26.64	22.85	(4.43)	(33.36)	(36.08)	(11.30)					

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro and where appropriate backdated adjustments applied. In month 8 a backdated change was made to month 7 to better reflect staff utilisation.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 2015 - Risk Matrix

Datix Risk Register Ref.	Description of Risk	Inherent Risk (if no action taken)		Action to be taken to mitigate risk	Lead	Current Risk Score & Level	Target Risk	
		Risk Score & Level	Financial Value				Risk Score & Level	Financial Value
959	Risk that Trust does not deliver future years financial plan due to under delivery of recurrent savings in year. Only around 80% of the required savings have been identified and delivered however, the impact on the financial plan has reduced due to other compensatory factors.	16 - Very High	£7.0m	Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes. Trust is working to develop savings plans to meet 2016/17 target.	DL	12 - High	4 - Moderate	£4.0m
416	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	9 - High	-	Maintenance of long term financial model and in year monitoring on financial performance through monthly divisional operating reviews and Finance Committee and Trust Board.	PM	9 - High	9 - High	-
951	Risk of national contract mandates financial penalties on under-performance against key indicators.	9 - High	£4.0m	Contract signed with NHS England. Trust has also agreed heads of terms with main Commissioners.	DL	9 - High	1 - Low	£3.0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3.0m	The Trust has strong controls of the SLA management arrangements.	PM	6 - Moderate	6 - Moderate	£2.0m
408	Risk to UH Bristol of fraudulent activity.	3 - Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	3 - Low	3 - Low	-

Analysis of pay spend 2014/15 and 2015/16

Division		2014/15							2015/16									2013/14	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Q1 £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	10,162	10,066	10,037	10,206	40,471	3,373		10,357	10,483	3,494	3,483	3,456	10,432	31,273	3,475		3,294	
	Bank	64	91	86	74	315	26	0.8%	82	109	26	31	36	93	284	32	0.9%	26	0.8%
	Agency	79	184	387	395	1,045	87	2.6%	377	242	48	66	72	186	804	89	2.6%	28	0.9%
	Waiting List initiative	45	46	65	113	269	22	0.7%	98	54	13	49	33	95	247	27	0.8%	19	0.6%
	Overtime	101	94	111	99	405	34	1.0%	147	94	36	35	29	100	340	38	1.1%	26	0.8%
	Other pay	9,772	9,435	9,675	9,492	38,375	3,198	95.0%	9,572	9,648	3,296	3,239	3,252	9,788	29,007	3,223	94.5%	3,179	97.0%
	Total Pay expenditure	10,062	9,850	10,324	10,173	40,409	3,367	100.0%	10,276	10,146	3,419	3,420	3,422	10,261	30,682	3,409	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	100	216	(287)	33	62	5		82	337	75	63	34	172	591	66		16	
Medicine	Pay budget	11,591	11,880	12,506	13,320	49,297	4,108		12,841	12,458	4,137	4,191	4,072	12,400	37,699	4,189		3,679	
	Bank	805	870	1,019	872	3,566	297	7.1%	897	935	271	308	325	905	2,736	304	7.1%	275	6.9%
	Agency	451	630	1,058	1,356	3,495	291	7.0%	826	875	373	243	198	814	2,514	279	6.5%	196	4.9%
	Waiting List initiative	26	39	34	94	193	16	0.4%	51	45	15	15	26	56	152	17	0.4%	13	0.3%
	Overtime	36	19	16	20	91	8	0.2%	16	21	17	9	9	35	72	8	0.2%	16	0.4%
	Other pay	10,704	10,399	10,587	11,130	42,820	3,568	85.4%	11,212	10,941	3,646	3,714	3,623	10,982	33,135	3,682	85.8%	3,479	87.4%
	Total Pay expenditure	12,022	11,957	12,715	13,471	50,165	4,180	100.0%	13,002	12,817	4,322	4,289	4,181	12,792	38,611	4,290	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(431)	(77)	(209)	(152)	(868)	(72)		(161)	(359)	(185)	(98)	(109)	(391)	(912)	(101)		(300)	
Specialised Services	Pay budget	9,577	9,653	9,727	10,232	39,189	3,266		10,130	10,250	3,410	3,471	3,461	10,342	30,722	3,414		3,060	
	Bank	309	335	357	292	1,293	108	3.2%	402	404	116	145	91	352	1,158	129	3.7%	99	3.1%
	Agency	509	664	677	885	2,735	228	6.7%	671	710	216	180	185	582	1,963	218	6.2%	157	5.0%
	Waiting List initiative	91	90	133	194	508	42	1.3%	125	144	53	55	48	156	425	47	1.4%	32	1.0%
	Overtime	55	40	22	30	147	12	0.4%	29	29	12	10	8	30	88	10	0.3%	15	0.5%
	Other pay	8,813	8,894	9,028	9,211	35,946	2,995	88.5%	9,189	9,222	3,084	3,172	3,140	9,395	27,806	3,090	88.4%	2,840	90.4%
	Total Pay expenditure	9,777	10,022	10,215	10,613	40,627	3,386	100.0%	10,415	10,510	3,481	3,562	3,473	10,516	31,440	3,493	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(200)	(369)	(488)	(381)	(1,438)	(120)		(285)	(260)	(71)	(91)	(12)	(174)	(718)	(80)		(82)	
Surgery Head and Neck	Pay budget	17,951	18,025	18,188	18,190	72,354	6,030		19,366	19,669	6,626	6,539	6,543	19,708	58,743	6,527		5,911	
	Bank	463	511	587	463	2,024	169	2.7%	559	683	166	173	149	488	1,730	192	2.9%	155	2.5%
	Agency	226	327	275	448	1,276	106	1.7%	603	908	283	244	211	738	2,249	250	3.8%	67	1.1%
	Waiting List initiative	366	456	446	395	1,663	139	2.2%	407	387	123	137	111	371	1,165	129	2.0%	116	1.9%
	Overtime	184	114	39	43	380	32	0.5%	38	47	17	17	11	45	130	14	0.2%	40	0.7%
	Other pay	17,464	17,399	17,639	17,809	70,313	5,859	92.9%	17,853	17,860	6,130	6,037	6,034	18,200	53,913	5,990	91.1%	5,766	93.8%
	Total Pay expenditure	18,703	18,808	18,988	19,157	75,656	6,305	100.0%	19,461	19,885	6,719	6,608	6,517	19,844	59,187	6,576	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(752)	(783)	(800)	(967)	(3,302)	(275)		(95)	(215)	(93)	(69)	26	(136)	(444)	(49)		(235)	

Analysis of pay spend 2014/15 and 2015/16

Division		2014/15							2015/16									2013/14	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Q1 £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	20,433	21,521	21,945	22,234	86,133	7,178		22,562	22,828	7,692	7,803	7,796	23,290	68,681	7,631		6,123	
	Bank	530	485	631	528	2,174	181	2.5%	533	582	174	186	127	487	1,602	178	2.3%	151	2.5%
	Agency	384	397	411	650	1,842	154	2.1%	703	840	308	300	257	866	2,409	268	3.4%	117	1.9%
	Waiting List initiative	88	87	76	139	390	33	0.5%	205	169	59	68	76	203	577	64	0.8%	30	0.5%
	Overtime	82	79	95	99	355	30	0.4%	23	19	7	10	9	26	67	7	0.1%	19	0.3%
	Other pay	19,455	20,428	20,875	20,758	81,516	6,793	94.5%	21,492	21,695	7,371	7,529	7,509	22,409	65,595	7,288	93.4%	5,843	94.9%
	Total Pay expenditure	20,539	21,476	22,088	22,174	86,277	7,190	100.0%	22,956	23,305	7,919	8,093	7,978	23,991	70,251	7,806	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(106)	45	(144)	60	(144)	(12)		(393)	(477)	(229)	(290)	(182)	(701)	(1,570)	(174)		(36)	
Facilities & Estates	Pay budget	4,638	4,916	4,931	4,936	19,421	1,618		5,057	5,113	1,668	1,675	1,799	5,142	15,312	1,701		1,536	
	Bank	227	316	271	251	1,065	89	5.5%	296	320	100	80	98	278	894	99	5.8%	46	3.0%
	Agency	80	115	133	174	502	42	2.6%	145	189	88	90	71	249	584	65	3.8%	29	1.9%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	244	255	273	193	965	80	5.0%	225	244	68	76	64	207	676	75	4.4%	75	4.9%
	Other pay	4,109	4,129	4,274	4,218	16,729	1,394	86.9%	4,406	4,373	1,426	1,443	1,502	4,371	13,150	1,461	85.9%	1,366	90.1%
	Total Pay expenditure	4,660	4,815	4,951	4,835	19,261	1,605	100.0%	5,072	5,126	1,682	1,689	1,735	5,106	15,304	1,700	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	(23)	101	(20)	101	161	13		(16)	(12)	(14)	(14)	64	36	7	1		20	
(Including R&I and	Pay budget	6,524	6,903	7,257	9,053	29,738	2,478		6,487	6,496	2,207	2,312	2,458	6,977	19,961	2,218		2,458	
(Incl R&I and Support Services)	Bank	165	154	189	178	686	57	2.4%	179	211	71	61	99	232	622	69	3.2%	57	2.4%
	Agency	135	139	154	280	707	59	2.5%	69	177	129	97	164	390	635	71	3.3%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	31	27	33	19	110	9	0.4%	22	23	9	6	5	20	65	7	0.3%	9	0.4%
	Other pay	6,061	6,433	6,362	7,822	26,678	2,223	94.7%	6,029	5,967	1,997	2,063	2,141	6,201	18,197	2,022	93.2%	2,285	95.9%
	Total Pay expenditure	6,392	6,754	6,737	8,298	28,180	2,348	100.0%	6,299	6,378	2,206	2,229	2,409	6,843	19,520	2,169	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	132	149	520	755	1,557	130		188	118	1	83	49	134	441	49		75	
Trust Total	Pay budget	80,876	82,964	84,592	88,172	336,604	28,050		86,800	87,298	29,233	29,474	29,585	88,292	262,391	29,155		26,060	
	Bank	2,564	2,762	3,140	2,657	11,124	927	3.3%	2,949	3,244	924	984	925	2,834	9,027	1,003	3.4%	809	3.0%
	Agency	1,865	2,455	3,096	4,187	11,603	967	3.4%	3,393	3,941	1,444	1,221	1,159	3,824	11,158	1,240	4.2%	625	2.4%
	Waiting List initiative	616	718	754	935	3,023	252	0.9%	886	799	263	324	294	881	2,566	285	1.0%	210	0.8%
	Overtime	734	628	589	503	2,454	204	0.7%	499	478	165	164	135	463	1,440	160	0.5%	201	0.8%
	Other pay	76,378	77,117	78,440	80,436	312,370	26,031	91.7%	79,752	79,705	26,950	27,197	27,201	81,348	240,805	26,756	90.9%	24,759	93.1%
	Total Pay expenditure	82,157	83,680	86,019	88,718	340,574	28,381	100.0%	87,480	88,166	29,747	29,890	29,714	89,352	264,996	29,444	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(1,281)	(716)	(1,427)	(546)	(3,970)	(331)		(680)	(868)	(514)	(416)	(129)	(1,058)	(2,605)	(289)		(543)	

NOTE: Other Pay includes all employer's oncosts.
In Month 6 a review of central provisions held within support services resulted in a movement of credits between agency and employed staff - this is reflected in this report appropriately in prior months.

Release of Reserves 2015/16 **Appendix 7**

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other including income	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Resources Book	1,000	5,111	40,114	(268)	11,131	6,050	63,138									
April movements	(220)	(2,511)	(29,556)	-	(4,872)	(1,047)	(38,206)	4,075	5,792	4,807	9,850	7,758	967	4,922	35	38,206
May movements	(30)	288	(5,225)	312	(2,481)	(3,500)	(10,636)	(219)	2,155	193	89	106	17	153	8,142	10,636
June movements	(89)	(26)	(529)	-	(334)	(117)	(1,095)	30	162	50	164	320	142	169	58	1,095
July movements	43	(26)	(94)	-	(182)	(7)	(266)	31	26	14	23	14	27	15	116	266
August Movements	44	(26)	(447)		(638)	(11)	(1,078)	165	102	69	196	130	34	656	(274)	1,078
September movements	89	(202)	(206)		(85)	(31)	(435)	17	90	61	70	341	45	15	(204)	435
October movements	(76)	(26)	(758)	-	238	(27)	(649)	13	37	15	21	745	33	125	(340)	649
November movements	(55)	(26)	(116)		167	(49)	(79)	29	67	46	34	129	46	(107)	(165)	79
December Movements																
Service developments			(442)				(442)	12				430				442
EWTD					(124)		(124)	9	26	16	21	49	1	2		124
MPET funding					(90)		(90)								90	90
SIFT					(91)		(91)								91	91
Support for recruitment and retention	(30)					(46)	(76)		32	8		6		30		76
Redevelopment costs						(19)	(19)		5				7	7		19
MARS						(63)	(63)							63		63
Other	(35)	(26)	(45)		7		(99)						26	39	34	99
Month 9 balances	641	2,530	2,696	44	2,646	1,133	9,690	4,162	8,494	5,279	10,468	10,028	1,345	6,089	7,583	53,448

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
18. Standing Financial Instructions and Scheme of Delegation									
Sponsor and Author(s)									
Sponsor: Paul Mapson, Director of Finance and Information **Author**: Kate Parraman, Deputy Director of Finance									
Intended Audience									
Committee members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
<u>Purpose</u> To inform the Trust Board of the proposed changes to the Trust's Standing Financial Instructions and Scheme of Delegation and request approval. <u>Key issues to note</u> The attached report and appendix 1 explains the proposed changes to the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD). The Finance Committee considered and approved the proposed changes to the Standing Financial Instructions, the revised scheme of delegation and the revised order of the sections in the SFIs at their meeting on the 24th November 2015 for approval by the Trust Board. This report has also been presented to the Audit Committee to give assurance that the controls work previously reported there has been reflected in the revised SFIs. The report includes a copy of the SFIs showing the proposed changes, highlighting additions in yellow and striking through words to be removed. The original and revised SoD have been included for comparison.									
Recommendations									
The Trust Board is asked to **consider** and **approve** the proposed changes to the Standing Financial Instructions, the revised scheme of delegation and the revised order of the sections in the SFIs.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									

Equality & Patient Impact			
N/A			
Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	✓	For Information	

Date report submitted to other sub-committee				
Finance Committee	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
24th November 2015				Audit Committee 9th December 2015

Standing Financial Instructions and Scheme of Delegation

1. Introduction

The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) are required to be reviewed on an annual basis. Any changes must be considered by the Finance Committee before being recommended for approval at the Trust Board.

The Trust Board last reviewed the Standing Financial Instructions in June 2014. It was felt appropriate to delay the annual review until November 2015 for the completion of the purchase to pay controls work to be incorporated and also to move a significant annual piece of work away from the time when focus is on the submission of the annual accounts and report.

The purpose of this report is to inform the Trust Board of proposed changes to the SFIs and SoD following the annual review process and seek their approval of those changes. It was presented to the Finance Committee at their meeting on the 24th November 2015 who considered and agreed the changes for ratification at the Trust Board. Given the significant controls work that has been undertaken and reported to the Audit Committee, it was considered appropriate that the Committee had the opportunity to provide comment and feedback to ensure this was properly reflected in the final document. The Audit Committee considered and agreed with the proposed changes at their meeting on the 9th December 2015.

The revised SFIs and supporting scheme of delegation are attached as a separate document. To enable the committee to review the changes within the SFIs, additions are highlighted in yellow and words being removed are crossed through. The original scheme of delegation and proposed revised version are presented.

2. Proposed Changes to the SFIs

The opportunity has been taken to clarify and strengthen the Standing Financial instructions and to incorporate new processes and controls. In particular sections 8 and 13 incorporate the work of the purchase to pay controls group and the report received by the Audit Committee in September 2015, there is a new section on Research and Innovation and section 23 (acceptance of gifts and hospitality) has been strengthened. Section 23 has been agreed with the Trust Secretary who is reviewing the supporting policy in line with the changes made.

Appendix 1 summarises the changes made and the reasoning for them, where appropriate. It does not detail where words have been changed to aid understanding without changing the meaning of the SFIs, although these are visible within the document. Significant changes are highlighted in yellow on appendix 1.

It is proposed to change the order of the sections of the SFIs to flow from reporting and planning, through income and expenditure, security of assets and other sections. References to sections and paragraphs will be reviewed and amended appropriately and the contents page will be made clearer. The following table shows the current and proposed ordering of the sections.

Current Title and Order	Proposed Title and Order
Introduction	Introduction
Business Plans, Budgets and Budgetary Control	Planning, Budgets and Budgetary Control
Service Agreement for the Provision of Healthcare Services	Annual Accounts and Reports
Annual Accounts and Reports	Research and Innovation
Banking, Cash and the Investment of Cash Surpluses	Service Agreement for the Provision of Healthcare Services
External Borrowing and Public Dividend Capital	Banking and Cash Management
Payment of Trust Employees and Contractors	Income
Payment for Goods and Services Received	Payment of Trust Employees and Contractors
Security of Cash, Cheques and Other Negotiable Instruments	Procurement of Goods and Services
Income	Tendering Procedure
Patients' Property	Payment for Goods and Services Received
Stores and Receipt of Goods	Stores and Receipt of Goods
Procurement of Goods and Services	Fixed Asset Register and Security of Assets, Disposal and Account of Assets
Tendering Procedure	Security of Cash, Cheques and Other Negotiable Instruments
Losses and Special Payments	Patients' Property
Funds Held in Trust	Losses and Special Payments
Audit and Counter Fraud	External Borrowing and Public Dividend Capital
Information Management and Technology	Capital Investment and Private Financing
Capital Investment and Private Financing	Risk Management and Insurance
Fixed Asset Register and Security of Assets, Disposal and Account of Assets	Audit and Counter Fraud
Retention of Documents	Information Management and Technology
Risk Management and Insurance	Acceptance of Gifts by Staff and Other Standards of Business Conduct
Acceptance of Gifts by Staff and Other Standards of Business Conduct	Funds Held in Trust
	Retention of Documents

3. Proposed Changes to the Scheme of Delegation

The opportunity has been taken to bring greater clarity to the Scheme of Delegation by expanding it to include matters referred to in the SFIs but previously not brought out in the SoD (colour coded green) and giving greater granularity or a clearer explanation (colour coded yellow).

The original SoD has been amended so that the final column refers to where it is covered within the new, to give assurance that the revised SoD covers the relevant matters.

The changes highlighted yellow are described below.

Section 3b

Virements are all checked and approved by the Senior Management Accountant for reasonableness so greater delegation given to budget managers. Reference to not exceeding specific budgets removed as by definition this can't happen.

Section 5

Reference was made within section 13 previously but not clearly, the revised detail gives greater definition of responsibilities.

Section 8

f Line managers can authorise staff changes within national terms and conditions, incremental credit is outside of these and requires HR BP approval.

g Previous scheme referred to re-grading, for which there is due process if the post is deemed to be a higher band. To assess a post for re-banding requires Divisional approval and the adherence to the Trust's review process. This is now described.

r Relocation expenses framework is approved by the Director of Finance which gives delegated responsibilities as part of the Trust Pay Assurance Group.

s This has been rewritten to distinguish between consultancy services, filling a post 'off payroll' and using bank/agency and locum. The delegated limits have been redefined, particularly in the light of 'off payroll' DH requirements. The responsibilities for bank/agency and locum are blank, awaiting discussion re implementing controls resulting from the introduction of the cap.

Section 9

This new section describes responsibilities for agreeing charges and signing contracts/agreements for providing goods and services to other bodies, excluding healthcare services which are defined in section 5. These represent new limits and delegations which had not been previously defined. 9a requires the approval of fees and charges to be levied. 9b defines who is responsible for agreeing/signing contracts to provide services to other bodies. There are more categories in 9b than 9a as some of the types of service provision are not associated with fees, but their proper costing and recharging schedules will form part of the agreement.

Section 10

This section has incorporated elements of the old scheme but procuring, signing of contracts to agree the purchase, ordering and receipting is presented separately. This supports the revised procurement process.

All goods and services need to be procured in line with 10a, with the authorisation of single tender actions delegated under 10b and with only the Chief Executive able to waive these processes under 10c, which requires reporting to the Audit Committee. All items available for ordering via EROS will have complied with this process as they will not be available on the system otherwise. Any non-EROS procurement process requires, as discussed at the Audit Committee, the process under 10a to 10c to be complied with and demonstrated.

The delegated authority for approving the awarding of the contract following the evaluation of the tenders or quotes is now explicitly defined. This is the decision to commit the Trust to expenditure. The general delegation is described in (i) with specific exceptions described in (ii) to (viii).

Ordering then becomes delegated to a person with authorised designation to do so.

The control is clearly defined at the decision to procure. This reflects both the EROS and non-EROS purchase to pay processes.

Section 13

Has been written to give greater clarity to write offs of bad debts, ex-gratia claims for direct reimbursement and maladministration and distress payments.

Section 17

Delegated responsibilities included as per the Trust's Capital Investment Policy for both high risk and other capital investment business cases.

Section 18

Gives clear responsibility for the Director of Finance to approve capital schemes within the annual capital programme approved and managed by CPSG by the Director of Finance. For estates based schemes, it clearly defines the contracting delegated responsibilities for procuring both main contractor and enabling works, and that the medium term contractor should only be used for enabling works below £25k without obtaining quotes. It also requires feasibility fees to be specifically approved. This requires discussion with the Director of Estates and Facilities but is considered to meet the requirements of the internal audit report.

Section 22

Sets out responsibilities within the more detailed standing financial instructions for this area as discussed and agreed with the Trust Secretary, improving the information available to staff.

Section 23

Reflects the new R&D section in the SFIs.

Section 24

All delegated matters that were in the original scheme that have not been identified to an earlier section in the revised scheme or have not been removed have been put into section 24. It is proposed to identify which should remain in the SFIs given that they do not all have a financial consequence or implication.

4. Recommendation:

The Trust Board is asked to **consider** and **approve**

- the proposed changes to the SFIs
- the revised scheme of delegation and additional matrix
- the revised order of the sections

5. Next Steps:

Following approval by the Trust Board the SFIs and SoD will be updated on Finweb and communicated across the Trust. This will include:

- presentation at all Divisional Boards within the context of controls
- specific training within Estates to understand how their processes comply
- updating the 'budget managers guide to SFIs' which provides an easy reference
- updating the training on controls part of the monthly course for budget managers
- newsbeat article
- finance staff discussing at their regular meetings with budget managers

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

NOVEMBER 2015

Approved at Finance Committee: 26th November 2015
Approved at Trust Board: 29th January 2016

Contents

1. Introduction ... 4
1.1 Purpose and Content ... 4
1.2 Responsibilities and Delegation ... 5

2. Business Plans, Budgets and Budgetary Control ... 8
2.1 Objective ... 8
2.3 Budgetary Delegation ... 9
2.4 Budgetary Control and Reporting ... 9
2.5 Capital Expenditure ... 11
2.6 Research and Innovation ... 11

3. Service Agreements for the Provision of Healthcare Services ... 13
3.1 Objective ... 13
3.2 Service Agreements ... 13
3.3 Service Agreement Monitoring and Reporting ... 14

4. Annual Accounts and Reports ... 15
4.1 Objective ... 15
4.2 General ... 15

5. Banking, Cash and the Investment of Cash Surpluses ... 16
5.1 Objective: ... 16
5.2 General ... 16
5.3 Banking Arrangements ... 16
5.4 Cash Management ... 17
5.5 Investment of Temporary Cash Surpluses ... 18

6. External Borrowing and Public Dividend Capital ... 19
6.1 Objective: ... 19
6.2 General: ... 19

7. Payment of Trust Employees and Contractors ... 20
7.1 Objective ... 20
7.2 Remuneration and Terms of Service of Directors ... 20
7.3 Other Staff Remuneration and Appointments ... 21
7.4 Notification of Information to Payroll ... 21
7.5 Processing Of Staff Payments ... 22
7.6 Use of Management Consultants and Other Contractors ... 23
7.7 Travel and Subsistence ... 24

8. Payment for Goods and Services Received ... 25
8.1 Objective ... 25
8.2 General ... 25
8.3 Requisitioning ... 25
8.4 Verification and Payment ... 26
8.5 Prepayments ... 26
8.6 Duties of Managers and Officers ... 27
8.7 Imprests ... 28
8.8 Negotiation with Suppliers ... 28

9. Security of Cash, Cheques and Other Negotiable Instruments ... 29
9.1 Objective ... 29
9.2 Cash ... 29
9.3 Cash Expenditure ... 29
9.4 Cash Income ... 30
9.5 Security of Cash ... 30
9.6 Unofficial Funds ... 30
9.7 Controlled Stationery ... 30
9.8 Cheques ... 30
9.9 Movement of Cash ... 31
9.10 Transfer of Responsibilities for Cash, Cheques and Controlled Stationery ... 31

10. Income ... 32
10.1 Objective ... 32
10.2 Income Due ... 32
10.3 Income Received ... 33

11. Patients' Property ... 34
11.1 Objective ... 34
11.2 Responsibilities ... 34
11.3 Deceased Patients ... 34

12. Stores and Receipt of Goods ... 36
12.1 Objective ... 36
12.2 Control of Stores ... 36
12.3 Stocktaking ... 36
12.4 Losses and Slow-Moving Items ... 36

13. Procurement of Goods and Services ... 38
13.1 Objective ... 38
13.2 General ... 38
13.3 EU Directives, Legislation and Guidance ... 38
13.4 Financial Limits ... 38
13.5 Other ... 39

14. Tendering Procedure ... 41
14.1 Objective ... 41
14.2 Requirement to Tender ... 41
14.3 EU Directives, Legislation and Guidance ... 42
14.4 Selection of Suitable Firms to Invite to Tender ... 42
14.5 Health Care Services ... 42
14.6 Pre-Qualification Questionnaire ... 42
14.8 Invitation to Tender ... 43
14.9 Receipt and Safe Custody of Tenders and Records ... 44
14.10 Opening Tenders ... 44
14.11 Admissibility and Acceptance of Tenders within Prescribed Limits in Section 14.10 ... 45
14.12 Form of Contract ... 46
14.13 Payments to Contractors by Instalments ... 46
14.14 Variations ... 46
14.15 Final Certificates and Accounts ... 46
14.16 Competitive Tendering of Support Services ... 47

15. Losses and Special Payments ... 48
15.1 Objective ... 48
15.2 General ... 48
15.3 Losses ... 48
15.4 Write-Offs and Special Payments ... 49
15.5 Ex-Gratia Payments ... 49
15.6 Insurance ... 50
15.7 Severance Payments ... 50
15.8 Maladministration and Distress Payments ... 51
15.9 Bankruptcy and Liquidation ... 51

16. Funds Held in Trust ... 52
16.1 Objective ... 52
16.2 General ... 52

17. Audit and Counter Fraud ... 53
17.1 Objective ... 53
17.2 Audit Committee ... 53
17.3 Responsibilities of the Director of Finance ... 54
17.4 Internal Audit ... 54

17.5 External Audit ... 56
17.6 Fraud and Corruption ... 57
17.7 Security Management ... 57

18. Information Management and Technology ... 58
18.1 Objective ... 58
18.2 Responsibilities and Duties of the Director of Finance ... 58
18.3 Responsibilities and Duties of Other Directors in Relation to Computer Systems of a General Application ... 59
18.4 Contracts for Computer Services with NHS Bodies or Outside Agencies ... 59
18.5 Risk Assessment ... 59

19. Capital Investment and Private Financing ... 60
19.1 Objective ... 60
19.2 Capital Investment ... 60
19.3 Commercial/Private Finance ... 61

20. Fixed Asset Register and Security of Assets, Disposal and Accounting of Assets ... 62
20.1 Objective ... 62
20.2 Asset Register ... 62
20.4 Protected Property ... 63
20.5 Disposal of Assets ... 64
20.6 Condemnations ... 64

21. Retention of Documents ... 65
21.1 Objective ... 65
21.2 General ... 65

22. Risk Management and Insurance ... 66
22.1 Objective ... 66
22.2 Risk Management ... 66
22.3 Insurance ... 66

23. Acceptance of Gifts by Staff and Other Standards of Business Conduct ... 68
23.1 Objective ... 68
23.2 General ... 68

1. Introduction

1.1 Purpose and Content

1.1.1 These Standing Financial Instructions (SFIs) regulate the conduct of the Trust, its members, employees and agents ~~Directors and Officers~~ in relation to all financial matters.

1.1.2 These Standing Financial Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law, the requirements of the Independent Regulator and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way the Trust manages public resources. They should be used in conjunction with the Standing Orders, Schedule of Matters Reserved to the Trust Board (appendix 1) and the Scheme of Delegation (appendix 2) adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to **everyone** working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice and should be read in conjunction with the relevant departmental guidance and the financial procedure notes (available on the intranet or via the Finance Department). All detailed financial procedures must be approved by the Director of Finance.

1.1.4 These Standing Financial Instructions do not include applicable Regulator's guidance, the current version of all relevant guidance should be consulted. They also do not contain every legal obligation applicable to the Trust.

1.1.5 Each section in the Standing Financial Instructions clearly sets out its objectives and the financial responsibilities, policies and procedures relevant to it which must be complied with. When situations arise which are not specifically covered by this document, staff and Trust Board members are required to act in accordance with the spirit of the instructions as set out in the objectives.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.7 These Standing Financial Instructions have been reviewed by the Trust's Finance Committee and approved by the Trust Board. It is expected that all staff employed by the Trust will comply with these instructions at all times. **The failure to comply with the Trust's standing financial instructions and standing orders could result in disciplinary action up to and including dismissal**. Should any other guidance or departmental policies appear to conflict with these instructions, these Standing Financial Instructions will prevail. Any apparent conflict should be brought to the attention of the Director of Finance.

1.1.8 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the Director of Finance. ~~next formal meeting of the Audit Committee for referring action or ratification.~~ All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible. The Director of Finance shall investigate and decide on the appropriate action to be taken. This will be reported to the next formal meeting of the Audit Committee for consideration.

1.1.9 These Standing Financial Instructions and associated scheme of delegation should be reviewed annually.

1.1.10 All references to Monitor refer to the Independent Regulator of Foundation Trusts as established under the National Health Service Act 2006.

1.2 Responsibilities and Delegation

1.2.1 The Trust Board

1.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Matters Reserved to the Trust Board at Appendix 1. Those aside, all executive powers are invested in the Chief Executive, who is the Accounting Officer.

The Board as a whole, and each member of the Board, is accountable for the financial performance of the Trust.

~~1.2.3 The Scheme of Delegation, at Appendix 2, contains all delegated powers. Should responsible officers delegate any of these powers to other individuals within their organisational control, a full record should be maintained with evidence of authorisation.~~

~~1.2.4 **The Trust Board**~~

~~The Trust Board exercises financial supervision and control by:~~

~~(a) formulating the Trust's financial strategy,~~

~~(b) approving the Trust's budgets, ensuring they are within approved allocation/income limits;~~

~~(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);~~

~~(d) approving specific responsibilities placed on members of the Board and employees as set out in the Scheme of Delegation.~~

1.2.4 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Wherever the title Chief Executive or Director of Finance is used in these instructions, it is deemed to include the deputies where they have been duly authorised by them to represent them.

The Chief Executive

The Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State and ~~Independent Regulator~~ Monitor, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall

executive responsibility for the Trust's activities, is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is ~~a duty~~ the responsibility of the Chief Executive to ensure that all staff ~~members of the Board and employees~~, are notified of and are required to understand their responsibilities within these instructions.

The Director of Finance

The Director of Finance is responsible for the implementation and monitoring of the Trust's financial policies and for ensuring any corrective action necessary to further these policies. In particular they will:

- provide financial advice to the Board, managers and other employees of the Trust
- design, implement and supervise systems of financial control
- prepare and maintain such accounts, certificates, financial estimates, records and reports as the Trust may require for the purpose of carrying out its statutory and other duties
- ensure that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time

The Director of Finance requires that any officer who carries out a financial function does so in a manner and maintains records in a form that meets with their requirements.

The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of segregation of duties an internal checks. These procedures should be read as forming part of the Standing Financial Instructions.

~~(a) implementing the Trust's financial policies, and coordinating any corrective action necessary to further these policies;~~

~~(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;~~

~~(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:~~

~~(i) the provision of financial advice to other members of the Board and employees;~~

~~(ii) the design, implementation and supervision of systems of internal financial control;~~

(iii) ~~the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.~~

1.2.5 **All Trust Employees**

All Trust Employees ~~have a responsibility for ensuring probity and accountability in all of their work for the Trust. In particular they are severally and collectively~~ are responsible for:

(a) the security of the property of the Trust.

(b) avoiding loss.

(c) ~~exercising~~ ensuring economy, ~~and~~ efficiency and value for money in the use of public resources.

~~(d) Conforming~~ Complying with ~~to the requirements of~~ the Trust's Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation ~~with regard to the Constitution and NHS Provider Licence.~~

The scheme of delegation at appendix 2 contains all delegated authorities to nominated officers. Whilst these officers remain responsible for these authorities, should they delegate matters to other individuals within their organisational control, evidence should be maintained of this ensuring the understanding by the delegated officer of their associated responsibilities. This must be regularly reviewed.

All references in these instructions to 'employee' or 'officer' shall be deemed to include all salaried staff or those under contract to the Trust. This includes staff supplied using agency contracts even though the terms of supply may be covered in an agreement with the supplying organisation. ~~to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions~~

It is the responsibility of managers to ensure that both existing staff and new appointees within their management area know and understand their responsibility to comply with these instructions.

~~For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must meet the requirements of the Director of Finance.~~

~~1.2.6 **Contractors and their Employees**~~

~~Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.~~

1.2.6 Hosting Arrangements

Where the Trust hosts an organisation with a separate management board, the financial transactions supporting the day to day business of the organisation shall be strictly in accordance with the Trust's Standing Financial Instruction, policies and procedures. Responsibility for decision making, planning and reporting will be delegated in accordance with the hosting agreement or as specified in the scheme of delegation.

2. ~~Business Plans~~ Planning, Budgets and Budgetary Control

2.1 Objective

2.1.1 **To ensure the Trust Board is provided with the information required regarding the planning and development of the Trust's activities and finances to enable the Trust's Directors to fulfil their responsibilities. To provide assurance that the Trust exercises proper control of income and expenditure throughout the year. To inform budget managers of their delegated responsibilities**

2.2 Preparation and Approval of Annual Plans and Budgets

2.2.1 The Chief Executive will, with the assistance of ~~the Director of Finance~~, other Directors, compile and submit to the Trust Board an annual ~~financial~~ plan, strategic and operational plans required to support their accountability for the financial performance of the Trust. As a minimum this will meet the requirements laid down by Monitor. ~~taking into account financial targets and forecast income and service developments.~~ The annual plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan.

2.2.2 The Chief Executive will, with the assistance of the Director of Finance, compile and submit to the ~~Independent Regulator of Foundation Trusts (~~Monitor~~)~~ all strategic and operational plans required by them in accordance with their guidance and submission dates. This information will be prepared by the Trust's Officers who must have regard to the views of the Council of Governors.

2.2.3 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit a~~n~~ ~~annual revenue budget~~ financial plan supporting the annual plan for approval by the Board. This will include:

- the expected level of income and the sources of that income
- the planned level of surplus or deficit planned
- how expenditure is to be managed in order to achieve the planned surplus or deficit
- the effect on the Monitor Financial Risk Ratios
- the impact on the Trust's Statement of Position
- cash flow and levels of borrowing
- the cost pressures faced by the Trust
- savings plans which need to be achieved
- potential risks which may affect the financial position of the Trust

The financial plan will

- be in accordance with the aims and objectives set out in the Trust's annual business plan
- accord with capacity and workforce plans
- be produced in accordance with principles agreed with the Senior Leadership Team as advised by the Director of Finance
- ~~be prepared within the limits of available resources~~
- ~~identify potential risks~~

2.2.4 The Director of Finance is responsible for the ~~co-ordination and~~ preparation of the overall Trust budget within the total income receivable by the Trust, and in accordance with its agreed strategies and policies. Operational budgets shall be set at the beginning of each financial year by financial and operational managers in line with the Trust's approved budget.

2.2.5 Operational plans shall be compiled for each Division by the Clinical Chairs and Divisional Directors and for each corporate service area by the Head of Service. These plans should reflect the Trust's annual business plan and the budget and will be approved by the Chief Executive.

2.2.6 Appropriate Trust employees shall provide the Directors with all financial, statistical and other relevant information, as required, in order to enable the compilation of plans and budgets. ~~Officers must provide financial, statistical and any other relevant information as required by the Director of Finance for the compilation of business plans and budgets~~.

2.3 Budgetary Delegation

2.3.1 The Chief Executive may delegate the management of budgets for defined services to the Clinical Chairs/Divisional Directors or Heads of Corporate Services responsible for the management of those services. Delegation and associated responsibilities must be clearly communicated. Control of budgets shall be exercised in accordance with these Standing Financial Instructions and supplementary guidance issued by the Director of Finance.

2.3.2 Clinical Chairs, Divisional Directors and Heads of Corporate Service with budgetary responsibility must ensure that their budgets are structured appropriately to ensure effective budgetary control. Whilst accountable for the overall budget management, Clinical Chairs, Divisional Directors and Heads of Corporate Service are authorised to delegate the management of specific budgets to named budget managers. Delegation and associated responsibilities must be clearly communicated to these budget managers. It is the responsibility of the Head of Division/Corporate Service to ensure the budget structure and delegation to budget managers is maintained in line with organisational and staff changes.

2.3.3 The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Trust Board, except as specified below:

(a) The Chief Executive may vary the budgetary limit of a Division or Service within the Trust's total budgetary limit.

(b) Clinical Chairs, Divisional Directors and Heads of Corporate Service are permitted to authorise expenditure over the budget on individual budgets within their delegated areas provided this does not cause their delegated budget area to overspend or to exceed the financial limit set by (a) above.

2.3.4 Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purposes shall transfer to the Trust's reserves, unless covered by the delegated powers of virement. ~~Budgets shall only be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement~~.

2.3.5 Non-recurring budgets must not be used to finance recurring expenditure unless authorised by the Director of Finance.

2.3.6 Expenditure for which there is no provision in an approved budget and is not subject to funding under the delegated powers of virement, or approved procedures for new funding obtained during the year, may only be incurred if authorised by the Chief Executive.

2.3.7 Budget limits, individual and group responsibilities for the control of expenditure, exercise of virement, and achievement of planned levels of income and expenditure, shall be set out annually in a Resources Book approved by the Trust Board.

2.4 Budgetary Control and Reporting

2.4.1 The ~~Chief Executive shall require the~~ Director of Finance is responsible for ~~ensure~~ maintaining an effective system of budgetary control. All Trust staff responsible for the management of a budget or for

incurring expenditure or collecting or generating income on behalf of the Trust must comply with these controls.

2.4.2 The Director of Finance is responsible for providing ~~budgetary~~ financial information and advice to enable the Board, Chief Executive and other officers to carry out their budgetary responsibilities. This includes:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date against plan and forecast year-end position,

(ii) the statement of financial position, changes in working capital and other material balances,

(iii) monthly cash flow monitoring of actual against plan and forecast year-end position,

(iv) capital expenditure against plan and forecast year-end position,

(v) achievement against the savings programme

(vi) explanations of any material variances from plan,

(vii) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation,

(viii) performance against ~~the Independent Regulator's~~ Monitor's Risk Assessment Framework.

(b) ~~The issue~~ providing ~~of~~ timely, accurate and comprehensible advice and financial information to all budget holders, covering the areas for which they are responsible,

(c) ~~The~~ providing clear financial processes and procedures governing the operation of budgets,

(d) training and support to budget holders to allow them to undertake their financial responsibilities,

(e) investigation and reporting of variances from financial, activity and workforce budgets,

(f) monitoring of management action to correct variances,

(g) arrangements for the authorisation of budget transfers.

2.4.3 The Director of Finance shall keep the Chief Executive and Board informed of the financial consequences to the Trust of changes in government policy, pay, terms and conditions, accounting standards and any other events affecting the current or future financial plans of the Trust.

2.4.4 All delegated budget managers are responsible for ensuring that:

(a) they check and validate all monthly budget statements,

(b) they fully understand their financial responsibilities and have received the required training and support to understand the financial information presented to them to fulfil these responsibilities,

(c) any likely overspending or reduction of income, which cannot be met by virement, is not incurred without the prior consent of the Head of Division/Service as per 2.3.3 (b) above,

(d) their delegated budget is only used in whole or in part for the purpose it was provided for, subject to the rules of virements,

(e) no permanent employees are appointed without the required approval as set out in section 7.3.2 and are provided for within the available resources and workforce establishment as approved by the Board,

(f) savings programmes and income generation initiatives are implemented to achieve a balanced budget,

(g) all expenditure is approved and authorised in advance of commitment in line with these standing financial instructions and financial processes and procedures issued by the Director of Finance.

2.4.5 The Chief Executive is responsible for authorising the implementation of ~~cost improvements, cost~~ savings programmes and income generation initiatives in accordance with the requirements of the Annual Business Plan to secure a balanced budget.

2.5 Capital Expenditure

2.5.1 The Director of Finance is responsible for compiling and submitting to the Board for approval an annual capital programme, ensuring that the planned expenditure is in line with available resources. Performance against the capital programme, forecast out-turn, and changes in capital allocation must be reported to the Board monthly.

2.5.2 The Director of Finance is responsible for submitting to ~~the Independent Regulator~~ Monitor all capital programme information required by them in line with their requirements and timescales.

2.5.3 The general rules applying to delegation, control and reporting above shall also apply to capital expenditure, (see section 19 for details relating to capital investment).

~~**2.6 Research and Innovation**~~

~~2.6.1 All applications for research and innovation funding require approval from the Director of Finance or a designated deputy. This applies to applications to NHS institutions such as grant requests to the National Institute for Health Research, and to applications to non-NHS organisations, such as charitable bodies and research councils.~~

~~2.6.2 All other documents (including commercial research and innovation contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments) relating to research & innovation, require approval from the Director of Research & Innovation or a designated deputy, ensuring all the necessary checks have been carried out, including finance checks where applicable.~~

~~2.6.3 The general rules applying to delegation, control and reporting above shall also apply to research and innovation projects.~~

X Research and Innovation

x.1 Objective

x.1.1 To provide specific instructions relating to research and innovation and reference to general financial instructions and processes governing this area.

x.2 General

x.2.1 The undertaking of research or clinical trials by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research governance and shall be subject to approval accordingly.

x.2.2 The Standing Financial Instructions apply equally when undertaking externally funded research activity within the Trust, particularly;

- Section 2 - Business Plans, Budgets and Budgetary Control
- Section 7 - Payments of Trust Employees and Contractors
- Section 8 - Payment of Goods and Services Received
- Section 12 - Stores and Receipt of Goods
- Section 13 - Procurement of Goods and Services
- Section 14 – Tendering Procedure
- Section 21 – Retention of Documents
- Section 22 – Risk Management and Insurance
- Section 23 – Acceptance of Gifts by Staff and Other Standards of Business Conduct

x.2.3 The principles governing probity and public accountability shall apply equally to work undertaken through externally funded research or clinical trials.

x.3 Research & Innovation Applications

x.3.1 All applications for research and innovation funding require approval from the Director of Finance or a designated deputy. This applies to applications to both NHS funders, such the National Institute for Health Research, and to non-NHS organisations, such as charitable bodies and research councils.

x.3.2 All other documents* relating to Research & Innovation will require approval from the Director of Research & Innovation or a designated deputy, once all the necessary checks have been carried out, including finance checks where applicable.

**other documents include research contracts with funding bodies, collaboration agreements, commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendment*s.

x.4 Intellectual Property

x.4.1 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

3. Service Agreements for the Provision of Healthcare Services

3.1 Objective

3.1.1 **To ensure that the Trust's service agreements for the provision of healthcare services are properly planned and controlled and that all income relating to these agreements is properly accounted for.**

3.2 Service Agreements

3.2.1 The Chief Executive~~, as the Accounting Officer,~~ is responsible for ensuring the Trust enters into suitable legally binding contracts with service commissioners for the provision of NHS services. Appropriate legal advice identifying the Trust's liabilities within the terms of the contract should be considered. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services; and
- any model contracts issued by the Department of Health.

Where the Trust makes arrangements for the provision of services by non-NHS providers, the Chief Executive is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided.

3.2.2 In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

- costing and pricing of services, including contract currencies;
- payment terms and conditions;
- amendments to contracts and extra-contractual arrangements;
- payment by results.

3.2.3 Agreements should be devised as to minimise risk whilst maximising the Trust's opportunity to generate income. The Trust will use the National Tariff where appropriate and, for services not covered by the National Tariff, a local tariff agreed with the Commissioners.

3.2.4 All agreements should aim to implement the agreed priorities contained within the annual plan. National guidance on arrangements for contracting should be taken into account.

3.2.5 The Chief Executive ~~is responsible for ensuring the Trust has the required internal processes in place to support the production of the proposed agreements and negotiation with NHS Commissioners. All Trust staff involved with these processes must ensure that they comply with these processes and provide information in support of these processes as required~~ shall ensure the contracting process is administered effectively and that appropriate service, quality, safety, clinical and financial input is provided.

3.2.6 The Director of Finance is responsible for agreeing the financial details contained in service contracts.

3.2.7 NHS Contracts with commissioners for the provision of healthcare services can only be signed by the Chief Executive, Director of Finance or Chief Operating Officer, without financial limit.

Service changes and developments initiated within the Divisions must be with the agreement of the Chief Executive or the Chief Operating Officer. The Finance Director must be informed to ensure appropriate financial scrutiny.

3.3 Service Agreement Monitoring and Reporting

3.3.1 The Director of Finance is responsible for ensuring that systems and processes are in place to record patient activity, invoice and collect monies due under the agreements for the provision of healthcare services.

3.3.2 The Director of Finance is responsible for reporting to the Board the Trust's actual contract activity and income due against the agreed contracts with an assessment of the financial impact of any contract under/over achievement.

3.3.3 The Director of Finance is responsible for providing information to Clinical Chairs, Divisional Directors and Heads of Corporate Service for the actual contract activity and income due against the agreed contracts and the associated financial consequences for their service areas to facilitate financial management.

3.3.4 The Director of Finance is responsible for ensuring training and support to the Clinical Chairs, Divisional Directors and Heads of Corporate Service to be able to understand the contracts for their service areas and the information relating to activity and financial performance.

3.3.5 All Clinical Chairs, Divisional Directors and Heads of Corporate Service responsible for the management of service agreement income must ensure they understand and use the contract monitoring information for the financial management of their service areas.

4. Annual Accounts and Reports

4.1 Objective

4.1.1 **To ensure the production of the Trust's Annual Accounts and Report in accordance with statutory requirements**

4.2 General

4.2.1 The Director of Finance, on behalf of the Trust, is responsible for the preparation and submission of financial reports and returns as required by ~~the Independent Regulator~~ Monitor and other Government Departments in such form as they require and in accordance with their timetable.

4.2.2 The Director of Finance, on behalf of the Trust, is responsible for the preparation and submission of the Trust's annual accounts as required by ~~the Independent Regulator~~ Monitor, in such form as they require and in accordance with their timetable.

4.2.3 The Trust's financial returns and annual accounts will be prepared in accordance with the accounting policies and guidance issued by Monitor, ~~with the approval of HM Treasury~~, the Trust's accounting policies, International Financial Reporting Standards and other accounting standards applicable at the time. The Director of Finance is responsible for ensuring the Trust's accounting policies are reviewed annually, updated as required and approved by the Audit Committee.

4.2.4 The Trust's annual accounts must be audited and certified by an independent external auditor (see section 17) and the Director of Finance is responsible for ensuring this happens in accordance with Monitor's timetable.

4.2.5 The Trust's Company Secretary, on behalf of the Trust, is responsible for the preparation and submission of the Trust's Annual Report to Monitor in such form as they require and in accordance with their timetable.

4.2.6 The Director of Nursing, on behalf of the Trust, is responsible for the preparation and submission of the Trust's Quality Report to Monitor in such form as they require and in accordance with their timetable.

4.2.7 The Trust's annual report (including the quality report) must be audited and certified by an independent external auditor (see section 17) and the Company Secretary is responsible for ensuring this happens in accordance with Monitor's timetable.

4.2.8 The Trust's annual report and statutory accounts must be presented to the Trust Board for approval. They must be laid before Parliament, after which they cannot be changed. They must be made available for inspection by the public. The annual report and accounts and the auditor's report must be presented at a meeting of the Council of Governors in accordance with the Monitor's timetable

5. Banking and Cash Management ~~and the Investment of Cash Surpluses~~

5.1 Objective:

5.1.1 **To ensure the effective management of the Trust's cash and to ensure it is properly controlled and safeguarded from loss and fraud.**

5.2 General

5.2.1 The Director of Finance is responsible for producing a Treasury Management Policy, in accordance with any relevant guidance from Monitor, for Trust Board approval.

5.2.2 The Director of Finance is responsible for the operation of the commercial bank and Government Banking Service ~~Citi Bank~~ accounts and for the management of accounts receivable, cash flow forecasting and investment of surplus funds. The Director of Finance will ensure that these functions are properly managed and that information is provided to the Trust Board to support this.

5.3 Banking Arrangements

5.3.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of bank accounts. This advice will take into account guidance/directions issued by Monitor and Treasury requirements for NHS banking.

5.3.2 The Director of Finance is solely authorised to open, operate and control any bank account where Trust funds are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any officer of the Trust outside of the organisational control of the Director of Finance to operate such an account with a Trust name or from a Trust address.

5.3.3 All income relating to Trust business must be paid into the Trust's bank account This includes all income from the sale of goods and services, disposal of items, vending machines and courses/lectures/other outside work undertaken in paid Trust time.

5.3.4 ~~Any Trust Officer wishing to manage non Trust funds such as ward funds or funds from~~ Donations are required to be managed via accounts operated by the Trust's charitable body. Such accounts must not be opened by employees. Any donations received must be managed in accordance with section X.. ~~do so through the Charitable Trustees who will operate the accounts on their behalf. It is not permissible for such an account to be held in the name of a Trust Officer as it can create a lack of transparency and allow the officer's integrity to be questioned.~~

5.3.5 If a member of staff wishes to set up a bank account with reference to the Trust and/or Trust address for a purpose other than that which has been explicitly prohibited in the sections above, they must write to the Director of Finance for approval.

5.3.6 The Director of Finance shall ~~prepare~~ establish and approve procedural instructions on the operation of all commercial bank accounts, investment accounts and Government Banking Service. ~~Citi Bank for the approval by the Finance Committee.~~

5.3.7 The Finance Committee shall ensure proper safeguards are in place for security of the Trust's funds by:

(a) approving the Trust's commercial bankers, selected by competitive tender.
(b) approving a list of permitted 'relationship' banks and investment institutions.
(c) setting investment limits for each permitted investment institution.
(d) approving permitted types of investments /instruments.

(e) approving the establishment of new/ changes to existing bank accounts.

5.3.8 The Director of Finance is responsible for ensuring approved bank mandates are in place for all accounts and that these are updated regularly for any changes in signatories and authorised limits.

~~5.3.9 The Trust's Commercial Bankers shall be selected by competitive tenders and formally approved by the Finance Committee. Competitive tenders shall be sought at least every 5 years~~.

5.3.9 The Director of Finance will review the banking needs of the Trust at regular intervals to ensure that they reflect current business patterns and represent value for money. Following such reviews, the Director of Finance shall determine whether or not re-tendering for services is necessary.
The Director of Finance shall be responsible for organising and evaluating bank tendering processes. The Director of Finance shall report the outcome of any tendering exercise for approval by the Finance Committee.

5.3.10 The Director of Finance, on behalf of the Finance Committee, shall advise the Trust's commercial and relationship bankers in writing of the conditions under which each account shall be operated, the limits to be applied to any overdraft, the limitation on single signatory payments and the officers authorised to release money from and draw cheques or other payable orders on each account. This must contain the Chief Executive and Director of Finance. The cancellation of any such authorisation shall be notified promptly to the bank.

5.3.11 Where a new banking relationship is suggested this must be pre-approved by the Director of Finance before a proposal is made to the Finance Committee. The Finance Committee will consider the need for and potential benefit of the new relationship and sanction or reject the proposal. The Trust's bankers shall be notified by the Director of Finance, on behalf of the Finance Committee of any alterations in the conditions of operation of the Trust's accounts that may be required by the Finance Committee.

5.3.12 ~~The Director of Finance must approve any may enter into a formal agreement with the Trust's bankers or other agents, as appropriate, for payments to be made directly from the Trust's bank accounts on behalf of the University Hospitals Bristol NHS Foundation Trust by electronic funds transfer (e.g. The Bankers Automated Clearing Services or Direct Debit). Where such an agreement is entered into, the Director of Finance shall ensure that appropriate security procedures are observed in relation to the Trust's bank accounts.~~ The Director of Finance is required to approve any direct debit or standing order payment arrangements. The Director of Finance is responsible for the effective control of payments made from the Trust's bank account through bank transfers, cheques and payments by Bank Automated Credits (BACS).

5.3.13 The Director of Finance may operate ~~a~~ credit/purchasing cards on behalf of the Trust. They~~is credit card~~ must be used in accordance with a written policy approved by the Finance Committee.

5.4 Cash Management

5.4.1 The Director of Finance is responsible for managing and monitoring the cash flow of the Trust and ensuring that it has enough cash balances to meet all its commitments.

5.4.2 Any member of Trust staff aware of significant and unexpected delays in the receipt of cash or of significant unexpected or early payments that will have an effect on the Trust's cashflow position must inform the Director of Finance or other Senior Finance Manager.

5.4.3 The Director of Finance is responsible for providing assurance to the Trust Board and Finance Committee on the management of the Trust's cash position through monthly reporting.

5.5 Investment of Temporary Cash Surpluses

5.5.1 Temporary cash surpluses shall be invested in line with the Treasury Management Policy, subject to the overall cash flow position and in line with any relevant guidance from Monitor or HM Treasury.

5.5.2 The Director of Finance is responsible for advising the Finance Committee on investments and shall report monthly to the Finance Committee concerning the performance of investments held.

5.5.3 The operation of investment accounts and the records maintained must be in accordance with detailed procedural instructions issued by the Director of Finance and approved by the Finance Committee.

5.5.4 The Finance Committee shall:

(a) approve a list of permitted investments institutions.
(b) set investment limits for permitted investment institutions.
(c) approve a schedule of permitted types of investments and financial instruments

5.5.4 Investments for purely speculative purposes are strictly prohibited.

6. External Borrowing and Public Dividend Capital

6.1 Objective:

6.1.1 To ensure that borrowings are properly authorised and controlled and that interest and principal is repaid in accordance with agreed timescales

6.2 External Borrowings:

6.2.1 ~~As a foundation trust, the Trust has the freedom to borrow externally subject to constraints:-~~
- ~~a) prohibition on the use of Commissioner Requested Services (CRS) relevant assets as security for borrowing; and,~~
- ~~b) any additional financial and non-financial covenants with financial institutions.~~

6.2.2 The Trust can obtain a working capital facility from the commercial banking sector. All ~~such~~ short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, comply with the Trust's Treasury Management Policy and all guidance issued by Monitor.

6.2.3 The Director of Finance shall be responsible for advising the Trust Board regarding the Trust's ability to repay public dividend capital (PDC) and long-term loan principal together with the payment of dividends on PDC and interest on such borrowings. The Director of Finance shall also be responsible for reporting periodically to the Trust Board concerning the PDC debt and all loans or short term borrowings. ~~working capital facility~~.

6.2.4 Any application for a loan or ~~working capital facility~~ short term borrowing will only be made by the Director of Finance or an officer designated for this purpose following approval by the Finance Committee, and in accordance with the Scheme of Delegation as appropriate.

6.2.5 The Director of Finance shall maintain a schedule of employees (including specimens of their signatories) approved by the Finance Committee who are authorised to make short term borrowings ~~(within the limits specified in the current Annual Plan)~~ on behalf of the Finance Committee. This must include the Chief Executive and Director of Finance.

6.2.6 Any short-term borrowing must be with the authority of two employees identified in 6.2.5 ~~members of an authorised panel~~, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowing at the next meeting.

6.2.7 The Director of Finance will advise the Trust Board on the need for longer term borrowing. Following resolution of the Board the Director of Finance will make appropriate arrangements with the Foundation Trust Financing Facility or other lender depending on the commercial arrangements available. All long term borrowing in respect of Strategic Capital Schemes must be consistent with the plans outlined in the current Medium Term Capital Programme approved by the Finance Committee.

6.2.8 The Director of Finance must ensure that any loan application is made in accordance ~~Prepare detailed procedural instructions concerning applications~~ ~~for new borrowing and on~~ ~~for the form of records to be maintained, which comply~~ with the instructions issued by the lender and Monitor ~~from time to time~~, Records must be maintained and all interest and loan principal must be repaid in accordance with the lender's loan agreements.

6.2.9 Assets defined as Commissioner Requested Services (CRS) relevant assets shall not be used or allocated for borrowing; non-CRS relevant assets will be eligible as security for loans.

6.2.10 ~~All short term borrowings must be kept to the minimum period of time consistent with the overall cash flow position, represent good value for money, comply with the Trust's Treasury Management Policy and all guidance issued by the Independent Regulator~~.

~~6.2.11 Long term borrowings will only be used to finance longer term capital or investment programmes.~~

7. Payment of Trust Employees and Contractors

7.1 Objective

7.1.1 **To ensure proper control over the appointment and payment of Trust employees and contractors.**

7.2 Remuneration and Terms of Service of Directors

7.2.1 In accordance with Standing Orders and the 2006 Act, the Board shall establish a Remuneration and Terms of Service Committee consisting of Non-Executive Directors to decide the remuneration and allowances and other terms of office of the Executive Directors, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

7.2.2 The Committee will:

(a) Advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors employed by the Trust ~~and other senior employees~~ including:

(i) All aspects of salary (including any performance-related elements/bonuses);

(ii) Provisions for other benefits, including pensions and cars;

(iii) Arrangements for termination of employment and other contractual terms;

(b) Make such recommendations to the Board on the remuneration and terms of service of Executive Directors of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) Monitor and evaluate the performance of individual Executive Directors (and other senior employees);

(d) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

7.2.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

7.2.4 The Council of Governors will decide the remuneration and allowances and other terms of office of the Chair and Non-Executive Directors.

7.2.5 The Trust will pay allowances to the Chairman and Non-Executive Directors in accordance with all relevant guidance.

7.3 Other Staff Remuneration and Appointments

7.3.1 The implementation of national pay directives relating to the remuneration of staff will be approved by the Chief Executive. Any variation from these or implementation requiring local interpretation or negotiation will be approved by the Chief Executive.

7.3.2 All Trust officers responsible for the engagement, re-engagement and regrading of employees, either on a permanent or temporary contract, or for hiring agency staff or contractors, or agreeing to changes in any aspect of remuneration must comply with the scheme of delegation and act in accordance with the processes designated by the Director of Workforce and Organisational Development. In particular such actions must be within the limit of their approved budget and funded establishment.

7.3.3 The Board shall delegate responsibility to the Director of Workforce and Organisational Development for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) ensuring processes are in place for dealing with variations to, or termination of, contracts of employment.

7.3.4 The Director of Finance and Director of Workforce and Organisational development must be informed when a reward (monetary and non-monetary) is being proposed for staff in recognition of their work for the Trust which will not be processed through the payroll. This is to ensure consistency and that appropriate legislation is being complied with. It should be noted that such rewards may constitute a taxable benefit.

7.4 Notification of Information to Payroll

7.4.1 All Trust Officers responsible for the engagement and management of staff must inform the Director of Finance's Payroll Department promptly and in the agreed form of full details in respect of:-

(a) Commencement of employment.

(b) Change to terms and conditions of employment or circumstance.

(c) Termination of employment.

7.4.2 On appointment, a properly authorised appointment form for Direct Hires or an e-Starter form for all staff recruited through ESR and such documents as required by the Director of Finance and/or Director of Workforce and Organisational Development shall be submitted to the Payroll Department immediately.

7.4.3 A properly authorised change of conditions e-form shall be submitted to the Payroll Department immediately a change in status of employment or personal circumstances of an employee is known.

7.4.4 A properly authorised termination of employment e-form and other relevant information shall be submitted to the Payroll Department immediately the effective date of an employee's resignation, retirement or termination is known. Where an employee fails to report for duty in circumstances which suggest that they have left without notice, the Payroll Department shall be informed immediately.

7.4.5 All absence due to sickness and other reasons as required shall be notified to the Payroll Department ~~on a weekly basis~~ in the required form and timescales.

7.4.6 All documents used for payroll purposes such as time sheets and payment sheets must be in a form approved by the Director of Finance and must be properly authorised.

7.5 Processing Of Staff Payments

7.5.1 The Director of Finance is responsible for:

(a) specifying timetables for the submission to the Payroll Department of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

7.5.2 The Director of Finance will issue instructions regarding:

(a) Verification and documentation of data.

(b) The timetable for receipt of data, preparation of payroll and the payment of staff.

(c) Maintenance of subsidiary records for superannuation, income tax, national insurance, social security and other authorised deductions from pay.

(d) Security and confidentiality of payroll information.

(e) Checks to be applied to completed payroll before and after payment.

(f) Authority to release payroll data under the provisions of the Data Protection Act.

(g) Methods of payment for ALL staff by BACS.

(h) Procedures for payment of BACS and in an emergency cheques, or cash to staff.

(i) Procedures for recall of BACS.

(j) Pay advances and their recovery.

(k) Separation of the duties of initiating and making payments.

(l) A system to ensure the recovery from leavers of sums due by them to the Trust.

(m) Maintenance and regular reconciliation of adequate control accounts with appropriate internal check procedures.

7.5.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting properly authorised time records, and other notifications to the Payroll Department in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

7.5.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.5.5 The Director of Finance shall pay salaries and wages on the currently agreed dates but may vary these when necessary due to special circumstances (e.g. Christmas and other bank holidays). Payments shall not normally be made in advance of the authorised normal pay date.

7.6 'Off Payroll' Arrangements ~~Use of Management Consultants and Other Contractors~~

7.6.1 Off payroll arrangements relate to the payment of individuals for work undertaken on behalf of the Trust which is paid on receipt of invoice rather than through the payroll. It does not include staff employed via employment agencies or those staff being seconded to the Trust, paid by another organisation which then recharges the Trust.

7.6.2 All senior staff must be on the payroll unless there are exceptional temporary circumstances, which will require the Chief Executive's approval. This includes all Trust Board members, members of Divisional Boards and staff with significant financial responsibility.

7.6.3 All other staff engaged to fill a specific role 'off payroll' require the approval of the Director of Workforce and Organisational Development who may delegate authority in accordance with the scheme of delegation.

7.6.4 All 'off payroll' engagements are required to comply with the relevant requirements of this section of the Standing Financial Instructions and with section x, recognising that payment is not via the payroll. In particular:

- all staff are required to be issued with a Contract of Employment which complies with employment legislation
- the terms of remunerations should be in line with national pay directives or locally Trust agreed variations. Payment outside of these terms requires Divisional Director and Human Resources approval.

7.6.5 The engagement of ~~management consultants and other contractors, including retired NHS officers, to provide services to the Trust~~ staff 'off payroll', gives rise to tax, national insurance and pension implications. It is the responsibility of Trust managers engaging the provision of such staff ~~services~~ to ensure that the arrangements comply with the requirements of HM Revenue and Customs.

7.6.6 The Director of Finance is responsible for ensuring there are detailed procedures in place ~~for ensuring that~~ to assist employing managers ~~are able~~ to assess and select the correct form of contractual relationship required (payable gross on invoice or subject to statutory deductions through PAYE) to comply with HM Revenue and Custom requirements.

7.6.7 ~~The Trust must ensure that arrangements for using management consultants or other contractors do not contravene IR 35. The aim of this legislation being to eliminate the avoidance of tax and national~~

~~insurance contributions through the use of intermediaries, such as service companies or partnerships, in circumstances where an individual worker would otherwise:~~

- ~~for tax purposes, be regarded as an employee of the client; and~~
- ~~for national insurance contribution purposes, be regarded as employed by the client.~~

7.6.8 All Trust officers responsible for procuring the provision of services by individuals not directly employed by the Trust must ensure that they comply with relevant Trust procedures and should seek guidance if required.

7.7 Travel and Subsistence

7.7.1 Payment of travel and subsistence costs incurred by staff on Trust business ~~to officers~~, shall be made by the Payroll Department in accordance with the current regulations, subject to verification of claim details, upon receipt of the prescribed form, properly completed and authorised by an officer with delegated authorisation for this purpose.

8. Payment for Goods and Services Received

8.1 Objective

8.1.1 To ensure that:

(a) Payments are only made for goods and services which have been ordered and received in accordance with these instructions, and are of the appropriate quality and quantity.

(b) Payments are only made once an invoice has been properly checked and authorised by a person with delegated responsibility.

(c) Contract invoices are paid in accordance with contract terms or otherwise in accordance with National Guidance.

(d) Invoices and other valid claims are paid promptly.

8.2 General

8.2.1 The Director of Finance is responsible for the payment of all properly authorised invoices and claims.

8.2.2 The Director of Finance is responsible for establishing procedures regarding the prompt notification of all monies payable by the Trust arising from transactions initiated by Trust officers. All Trust employees are responsible for complying with these procedures.

8.2.3 The Director of Finance shall ensure there are procedures covering the provision of professional advice regarding the supply of goods and services, including the tendering of goods and services.

8.3 Requisitioning

8.3.1 The Director of Finance is responsible for establishing procedures regarding the requisitioning of goods and services on behalf of the Trust. This will include a list of managers authorised to requisition goods and services, including levels of authorisation. See also section 13.

8.3.2 Requisitioners should ensure that they comply with the Trust's procedures in the procurement of goods and services. They should always seek to obtain best value for money for the Trust and ensure that there are no conflicts of interest. In doing this the advice of the procurement department should be sought.

8.3.2 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

8.3.3 Requisitioning is required to be placed using the Trust's electronic requisitioning and ordering system EROS. It is recognised that the nature of some goods and services means EROS is not suitable. These cases have been clearly defined within the non-EROS purchase to pay process must be followed. Only the goods and services defined within this policy are able to be procured outside of EROS and the prescribed process must be followed.

8.4 Verification and Payment

8.4.1 The Director of Finance is responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by the Trust.

This system shall provide by certification or by compliance with an authorised computer system that:-

(a) Goods and services have been ordered in accordance with Section 13.

(b) Goods have been duly received, are in accordance with specification and order and that prices are correct;

(c) Services have been satisfactorily executed in accordance with the order and that the charges are correct;

(d) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time records, that the rates of labour are in accordance with the appropriate rates, that the materials have been checked as regards quantity, quality and price, and that the charges for the use of vehicles, plant and machinery and other expenses have been examined and are reasonable;

(e) The invoice is arithmetically correct;

(f) The account has not been previously passed for payment or paid;

(g) The account is in order for payment.

8.4.2 ~~A list~~ The Trust will maintain an Authorised Signatory List of budget holders and officers delegated by them ~~will be maintained of Trust employees (including specimens of their signatures)~~ who are authorised to certify invoices. All changes to this list must be notified to the ~~Director of Finance~~ finance department through the designated process.

8.4.3 The Director of Finance shall ensure that all invoices and accounts are paid promptly having regard to:

(a) The Trust's cash flow

(b) The possibility of receiving a discount for early payment.

(c) Current Department of Health guidance on prompt payment.

8.4.4 Where an employee ~~certifying accounts~~ authorising invoices for payment relies upon other employees to do preliminary checking they shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

8.4.5 In the case of contracts for building or engineering works which require payment to be made on account during the progress of the work, the Director of Finance shall make payment on receipt of a certificate from the appropriate technical consultant or officer. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subjected to financial and general examination by the person responsible to the Trust as Project Manager before the final certificate is issued.

8.5 Prepayments

8.5.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages,

(b) The appropriate employee must provide in writing, the case for a prepayment, setting out all relevant circumstances of the purchase. This must include the effect on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered.

8.6 Duties of Managers and Officers

8.6.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance for approval in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement. See also section 13;

(c) ~~where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;~~ Where consultancy advice is being obtained or where supply of staff is being sought via an agency, the procurement of such skills must be in accordance with the latest guidance issued by the NHS Executive, the Department of Health and the independent regulator and in line with section 7.6;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive branded seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with section 23. ~~Standing Order No. 7 and the principles outlined in the national guidance contained in HSG 93(5) and Register of Interests Policy (2006) "Standards of Business Conduct for NHS Staff");~~

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except ~~works and services executed in accordance with a contract and~~ purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds laid out in section 13;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the Trust's Authorised Signatory List of budget holders and officers delegated by them ~~list of employees and officers~~ authorised to certify invoices are notified to the ~~Director of Finance~~ finance department through the designated process;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance;

(m) orders should be placed using either the Trust's electronic requisitioning and ordering system EROS or the Trust's non EROS purchase to pay process as described in the applicable Trust policy.

8.6.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice and guidance issued by the Department of Health and Monitor. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.

8.7 Imprests

8.7.1 The Director of Finance may authorise advances on the imprest system for petty cash and other purposes as required. Individual payments from such imprests must not exceed an amount authorised by the Director of Finance and must be properly reconciled to petty cash sheets, which are supported by vouchers showing details of the transaction (see Section 9).

8.8 Negotiation with Suppliers

8.8.1 Where there are ongoing disputes with suppliers that require compromise arrangements to resolve, these will be considered and approved as follows:

- £0 - £1,000 – the ~~Head of Finance~~ Deputy Director of Finance
- £1,001 - £25,000 – the Director of Finance
- Over £25,000 – the Finance Committee

9. Security of Cash, Cheques and Other Negotiable Instruments

9.1 Objective

9.1.1 (a) To ensure that cash, cheques, ~~payable orders~~ and similar documents of value are kept securely and properly controlled.

(b) To design and securely control all controlled stationery e.g. receipt books, agreement forms, income books.

9.2 Cash

9.2.1 Cash handling represents an area of high risk, therefore it should be kept to a minimum with banking facilities used whenever possible. All staff responsible for ~~cash handling~~ collecting or holding cash must ~~ensure that they~~ comply with these standing financial instructions and all detailed procedures ~~applicable to their work~~, issued by the Director of Finance, in order to protect themselves and prevent their integrity from being called into question.

9.2.2 The Director of Finance is responsible for establishing systems and procedures ~~for the handling of~~ relating to cash within the Trust.

9.2.3 The Senior Manager responsible for an area where cash is handled must ensure that all staff:

- ~~obtain written confirmation from all members of staff involved with the handling of cash that they~~ are aware of their duty to comply with Standing Financial Instructions and ~~with any supplementary~~ the procedures issued by the Director of Finance.

- comply with ~~Be satisfied by inspection or otherwise, that~~ the provisions of this section of the Standing Financial Instructions and ~~any supplementary~~ cash handling procedures ~~are strictly observed~~. ~~Procedures for ward staff shall incorporate the requirements of this section as well as sections 10, 11 and 16~~.

9.2.4 On every occasion when cash is transferred from the custody of one person to another it shall be the duty of the recipient to check it and of the other to obtain a written acknowledgement. Where this is not possible due to the cash being in sealed packets, the packets shall be counted and acknowledged unopened.

9.2.5 Cash handling procedures should always demonstrate segregation of duties. Where this is not possible, a Senior Manager must oversee the process including conducting regular checks to provide assurance.

9.3 Cash Expenditure

9.3.1 If a Manager considers it necessary for a member of staff to use cash to purchase goods or services on behalf of the Trust, where cheque payment or bank transfer is impractical, they must comply with the 'petty cash' conditions and procedures established by the Director of Finance.

9.3.2 The Trust's money shall not, under any circumstances, be used for the encashment of private cheques or be used for private purposes.

9.3.3 Staff responsible for administering petty cash imprests must ensure that payments are only made in line with the petty cash procedure established by the Director of Finance. Every payment must be recorded and authorised in accordance with these procedures ~~established by the Director of Finance~~ with evidence supporting the transaction.

9.3.4 It is the responsibility of all staff authorised to hold cash to reconcile, at least once a week, the record of transactions with the amount actually in hand, in line with Trust procedures. It is the responsibility

of their manager to review and make appropriate checks in line with Trust procedures. Any discrepancy or concerns must be reported to senior management and the Director of Finance without delay.

9.4 Cash Income

9.4.1 Income received shall be handled and accounted for in accordance with the requirements of Sections 5.3 and 10.

9.5 Security of Cash

9.5.1 Staff involved in the handling of cash and their managers are responsible for ensuring that cash is kept securely and in accordance with instructions issued by the Director of Finance. They must ensure that they have notified the finance department of the cash handling within their area.

9.5.2 Safes and/or lockable cash boxes shall be provided for the custody of cash in all places where it is necessary for cash to be held. Coin-operated machines shall wherever possible be fitted with separately lockable compartments for cash.

9.5.3 Cash boxes holding cash shall not be left unattended at any time and shall be kept in a safe when not in use.

9.5.4 The loss of cash, cash boxes, safes or keys should be notified to the finance department immediately.

9.5.5 ~~Cash held in a safe overnight shall be limited to the amount as approved by the Director of Finance.~~

9.5.6 ~~The inspection of the cashier's safe shall be included in security patrol duties.~~

9.5.7 ~~Only the Trust employee responsible for the custody of the contents of a safe or cash box or for collection from a coin-operated machine shall hold its key. The key shall be carried on the person. The loss of any key shall be reported to the Director of Finance by the responsible officer immediately its loss is discovered~~.

9.5.8 ~~Duplicate keys shall be kept in accordance with the arrangements which the Director of Finance shall prescribe.~~

9.6 Unofficial Funds

9.6.1 The Trust shall not be liable in any circumstances for the loss of unofficial funds (funds not arising from Trust business). The holder of the key of a safe provided for the custody of official cash shall not accept unofficial funds for safe keeping except in identifiable sealed packages or locked containers. When such deposits are made, a written indemnity shall be obtained from the person or organisation concerned absolving the Trust from responsibility for any loss.

9.7 Controlled Stationery

9.7.1 The Director of Finance is responsible for approving the design of, and ordering, all controlled stationery such as receipt books, agreement forms, invoices or other means of recording monies received or receivable

9.7.2 All controlled stationery shall be issued and kept securely in accordance with procedures established by the Director of Finance. Any loss of controlled stationery must be reported to the Director of Finance immediately.

9.8 Cheques

9.8.1 All blank cheques or other orders for payment shall be ordered only on the authority of the Director of Finance, who shall make proper arrangements for their safe custody. They shall be subject to the same security precautions as are applied to cash. Any loss of cheques shall be reported to the Director of Finance immediately.

9.8.2 Cheques will only be drawn to "cash" with the specific, written authority of the Director of Finance. All cheques drawn to "cash" must have a second authorised signature.

9.9 Movement of Cash

9.9.1 The Director of Finance shall prescribe the system for the transporting of cash and shall be responsible for making all arrangements with any security company operating under a contract with the Trust. Cash in transit (including cash moved from one office or building to another on Trust premises) and the making up and paying out of cash payments shall be suitably safeguarded. When substantial amounts have to be moved, special security arrangements shall be made.

9.9.2 Any employee who has any indication that the safe custody of cash on the Trust's premises or in transit to or between premises may be at risk shall immediately notify the Director of Finance and the Security Officer confidentially of the circumstances.

9.10 Transfer of Responsibilities for Cash, Cheques and Controlled Stationery

9.10.1 When an employee, whose duties include the holding of cash, cheques or controlled stationery hands over responsibility prior to leave or termination of appointment, both the outgoing and the incoming officer shall sign a handing over certificate stating:-

(a) The composition of the cash;

(b) The consecutive numbers of the cheques or controlled stationery;

(c) Particulars of keys handed over;

(d) Particulars of anything else being held for safekeeping.

9.10.2 In the unavoidable absence of the outgoing employee, one or more other employee shall be appointed to carry out the hand-over to the incoming officer.

9.10.3 Where the responsibility for an imprest changes permanently, this fact shall be notified to the Director of Finance. Hand-over certificates evidencing the change in responsibility should be retained within the area for future reference.

9.10.4 During any absence of the substantive holder of the key to a safe or cash box, the officer or officers appointed to act temporarily shall be fully accountable for the performance of such duties and shall be subject to these Standing Financial Instructions as though they were the substantive key holder.

.

10. Income

10.1 Objective

10.1.1 To ensure that:

(a) Income due is promptly assessed and collected; and

(b) Income received is promptly banked and fully accounted for.

10.2 Income Due

10.2.1 The Director of Finance is responsible for designing and maintaining systems for the proper recording, invoicing and collection of all income. ~~monies due~~, ~~including income due under contracts or extra-contractual arrangements for the provision of healthcare services~~, together with systems for financial coding.

10.2.2 The Director of Finance is ~~also~~ responsible for the prompt banking of all monies received.

10.2.3 The Director of Finance is responsible for the design and ordering of all receipt books, tickets, agreement forms, or other means of officially acknowledging or recording amounts received or receivable. They will be issued and controlled according to procedures established by the Director of Finance and will be subject to the same ~~precautions~~ controls as are applied to cash (Section 9).

10.2.4 Cash payment for charges made by the Trust, for the provision of any goods or services, must not normally be accepted where the value of any single transaction is in excess of £10,000. ~~€15,000 (£10k)~~. ~~In the unlikely event of this occurring, the transaction must be notified by Finance to HM Revenue and Customs.~~ Should this occur, the Head of Treasury Management must be notified immediately to ensure the Trust complies with HM Revenue and Customs regulations.

10.2.5 A contract or agreement must be in place for all income due to the Trust for the provision of goods or services to a third party. The nature of the contract or agreement will depend on the goods or services being provided. The Director of Finance is responsible for signing all contracts and agreements with delegated responsibilities given within the scheme of delegation (appendix 2) and supporting financial limits matrix.

10.2.6 Employees responsible for agreeing the prices of goods and services provided by the Trust should ensure that they cover all costs, including overheads. Support should be sought from the finance department as required. Appropriate, independent professional advice shall be taken on matters of valuation. Prices and charges shall be reviewed at least annually. This paragraph applies equally to:

- tenders for the sale of goods and services;
- quotations for support to commercial research trials and projects; and
- pricing of service agreements with other NHS bodies.

10.2.7 The Trust's price tariff for private patient treatment is set by the Director of Finance. The pricing structure ensures that prices are at least equal to those charged to NHS Commissioners and ensures that public funds are not used to subsidise private patient activity. Any proposed variations to the Private Patient Tariff prices must be approved by the Director of Finance before patients are advised of the cost of their treatment.

10.2.8 All Trust employees shall promptly inform the Director of Finance of money due to the Trust arising from transactions which they initiate including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

10.2.9 The notification of income due shall be as prescribed by procedures established by the Director of Finance, ensuring sufficient details are included to enable the prompt payment by the debtor.

10.2.10 The Director of Finance shall ensure that debtors are invoiced promptly on receipt of the advice of income due.

10.2.11 There must be clear separation of duties so that officers responsible for raising invoices or accounting for amounts due to the Trust shall not handle cash or cheques received by the Trust.

10.2.12 The Director of Finance shall take appropriate recovery action on all outstanding debts and no claims shall be abandoned except as in accordance with Section 15 - Losses and Special Payments.

10.2.13 Income from the disposal of assets, scrap material and items surplus to requirements shall be dealt with in accordance with Section 20 of these Instructions.

10.3 Income Received

10.3.1 All income received into the Trust must be collected, receipted and accounted for in accordance with the procedures established by the Director of Finance. It is the responsibility of all Trust employees responsible for these duties to ensure they comply with these procedures. It is the responsibility of the Senior Managers responsible for areas where income is received to ensure that their staff are complying with these procedures.

10.3.2 All cheques, postal orders, cash, etc shall be banked intact promptly in accordance with the Director of Finance's instructions. Disbursements shall not be made from cash received. Payment by debit or credit card may only be accepted by staff designated by the Director of Finance. All transactions must be processed in accordance with the instructions approved by the Director of Finance.

10.3.3 The opening of incoming post must be undertaken by officers working in pairs and all cash, cheques, postal orders and other forms of payment shall be entered immediately in an approved form of register and certified by both officers.

10.3.4 Every employee authorised to receive remittances in cash or other forms must keep up to date a record of the amounts received in accordance with procedures approved by the Director of Finance. This record must be reconciled with the amount held in accordance with these instructions. Any discrepancy shall be reported immediately to their senior manager and the Director of Finance.

10.3.5 Official receipts shall be issued in all cases involving cash and only where especially requested by the payer for cheques, debit card etc.

10.3.6 All cash received, if not paid directly into the bank, shall be locked as soon as possible in the safe or cash box provided for the purpose, which shall be safeguarded as specified in Section 9.

10.3.7 Collections from cash tills, telephone and other coin boxes and from night safes shall be made at such intervals as shall be prescribed by or with the approval of the Director of Finance. The opening of each such box or safe and the counting and recording of the contents shall be undertaken by two employees together. Both shall sign the record and the keys shall, at other times, be separately held by a senior officer.

10.3.8 The Director of Finance shall ensure that all income received into the Trust's bank accounts is accounted for promptly – as per section 5.

11. Patients' Property

11.1 Objective

11.1.1 **To ensure that property of patients is properly safeguarded and fully accounted for.**

11.2 Responsibilities

11.2.1 The Trust has a responsibility to provide safe custody for money or other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital, or dead on arrival.

11.2.2 Staff shall be informed on appointment in writing by the appropriate departmental head or senior officers of their responsibilities and duties for the administration of the property of patients.

11.2.3 The Chief Executive shall be responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' monies and personal property brought into the Trust's premises, unless it is handed in for safe custody and a copy of the patients' property record is obtained as the official receipt.

11.2.4 Where possible patients should be advised to make their own arrangements for the safe custody of their property - outside of the hospital.

These matters shall be drawn to patients' attention by means of:-

(a) Notices and information booklets;

(b) Hospital admission documents and property records; and

(c) The verbal advice of administrative and nursing staff responsible for admissions.

11.2.5 The Director of Finance must provide detailed written instructions on the collection, custody, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises) for all staff whose duty it is to administer in any way the property of patients.

11.2.6 Every employee of the Trust into whose personal custody any money or other property of a patient is received must comply with the requirements of these instructions. Valuable items shall be dealt with in the same way as cash and therefore instructions in sections 9 and 10 will apply.

11.2.7 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements specified by the Director of Finance. Monies deposited in excess of the patients' needs shall be invested in accordance with guidance from the Secretary of State and in accordance with arrangements specified by the Director of Finance.

11.2.8 Except as provided below in Section 11.3, refunds of property handed in for safe custody shall be returned to the patient, as required, by the employee who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate, and witnessed.

11.3 Deceased Patients

11.3.1 The disposal of property of deceased patients shall be effected by the Director of Finance and in accordance with Department of Health and Treasury guidance. Disposal to relatives shall be dependent on clarification of the lawful kin or other such person entitled to the possessions in question.

11.3.2 In all cases where property, including cash and valuables of a deceased patient is of a total value of more than £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments Act 1965), the production of a Grant of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be obtained.

11.3.2 In respect of a deceased patient's property, if there is no will and no lawful kin, the property vests with the Crown, and particulars shall, therefore, be notified to the Treasury Solicitor, or to the Duchies of Lancaster and Cornwall, as appropriate.

11.3.3 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any cash of the estate held by the Trust shall be appropriated towards funeral expenses. No other expenses or debts shall be discharged out of the estate of a deceased patient.

12. Stores and Receipt of Goods (Stock Control)

12.1 Objective

12.1.1 **To ensure that all stockholdings of significant value are properly safeguarded and accounted for.**

12.2 Control of Stores

12.2.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

12.2.2 Subject to the responsibility of the Director of Finance for the systems of control, the overall control of stores shall be the responsibility of the ~~relevant~~ appropriate Divisional Manager/Head of Trust Services function. This ~~day to day~~ responsibility may be further delegated to a ~~Trust employee such as a departmental~~ service manager or ~~storekeeper~~ staff member provided this is clearly documented.

12.2.3 The Director of Pharmacy is responsible for the control of pharmaceutical stocks.

12.2.4 The Director of Estates is responsible for the control of fuel stocks (oil and coal).

12.2.5 The Director of Finance shall establish procedures and systems regarding the control of stores including receipting, issues, returns and losses. All staff responsible for the control of stores must comply with these procedures.

12.2.6 The responsibility for security arrangements and the custody of keys for all stores locations shall be clearly defined in writing by the designated employees and agreed with the Director of Finance. Wherever practicable, stocks shall be marked as Trust property.

12.2.7 The Director of Finance shall be informed of any variations in policy that are likely to result in any significant variation in overall stock levels.

12.3 Stocktaking

12.3.1 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the designated responsible officer. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check.

12.3.2 Any surpluses or deficiencies revealed on stocktaking shall be reported to the responsible officer for investigation. Evidence of such investigation shall be recorded and all confirmed surpluses or deficiencies shall be reported immediately to the Director of Finance.

12.3.3 All responsible employees shall comply with the arrangements made by the Director of Finance to certify stock values at the 31st March each year.

12.4 Losses and Slow-Moving Items

12.4.1 The responsible employee shall maintain a system approved by the Director of Finance for reviewing slow moving and obsolete items at least annually and for the condemnation, disposal and

replacement of all unserviceable items. They shall formally report to the Director of Finance any evidence of significant overstocking and of negligence or malpractice.

12.4.2 Breakages, deteriorations due to overstocking and other losses of goods in stores shall be recorded as they occur, and a summary should be presented to the Director of Finance at quarterly intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, such as certain foodstuffs and natural deterioration of certain goods.

12.4.3 It is a duty of employees responsible for the custody and control of stores to notify all losses including those due to theft, fraud and arson, in accordance with Section 15 and 20 of these instructions.

13. Procurement of Goods and Services

13.1 Objective

13.1.1 To ensure that proper control is exercised and value for money is obtained in the procurement of all goods and services on behalf of the Trust.

13.2 General

13.2.1 The Trust Board may enter into contracts on behalf of the Trust within the statutory powers delegated to it. The procedure for making all contracts shall comply with these powers and Standing Financial Instructions. A contract or agreement must be in place for all goods and services procured by the Trust. The nature of the contract or agreement will depend on the goods or services being provided. The Director of Finance is responsible for signing all contracts and agreements with delegated responsibilities given within the scheme of delegation (appendix 2).~~Delegated powers of authorisation are granted to Trust officers according to the Scheme of Delegation~~.

13.2.2 All contracts made shall endeavour to obtain best value for money by using the Trust's procurement department and processes established by the Director of Finance. The Chief Executive shall nominate a Trust officer ~~an employee~~ who shall be responsible for overseeing and managing each contract on behalf of the Trust.

13.2.3 Goods, services and works shall only be ordered in line with the controls and systems established and approved by the Director of Finance, which must comply with the financial limits and other principles set out in this section. These controls and systems cover all goods and services procured both within and outside of the Trust's Electronic Requisitioning and Ordering System (EROS).

13.2.4 All employees must comply with the processes, systems and controls for procuring all goods and services established by the Director of Finance which are available from the finance department, as well as these Standing Financial Instructions and Scheme of Delegation.

13.3 EU Directives, Legislation and Guidance

13.3.1 The Trust shall comply with all European Union and Government Directives regarding public sector procurement ~~purchasing~~ and prescribed procedures for awarding all forms of contracts.

13.3.2 The Trust shall comply as far as is practicable with all guidance and advice issued by the Department of Health and the independent regulator in respect of procurement, capital investment, estate and property transactions and management consultancy contracts.

13.3.3 No order shall be issued to any firm which has made an offer of gifts or rewards to Directors or employees, ~~The Trust Standing Orders set out the Standards of Business Conduct which apply at all times –~~ in line with Section 21.

13.4 Financial Limits

13.4.1 A minimum of three ~~four~~ competitive tenders shall be invited in accordance with the requirements of Section 14 for any purchase of goods or services over £25,000 (excluding VAT) including:

(a) a specification for equipment, goods, service contract, construction contract or other project;

(b) a period standing order, call-off contract, framework agreement or other purchase of goods or services where the aggregate value exceeds £25,000 in any year.

13.4.2 Where such purchases exceed £5,000 but are less than £25,000 a minimum of three competitive quotations in writing shall be obtained.

13.4.3 Where such purchases do not exceed £5,000, non-competitive quotations in writing may be obtained with value for money being demonstrated on all occasions. Best practice should be a minimum of three such quotations.

13.4.4 Before placing an order for goods or services, potential suppliers and the cost should be adequately investigated and evaluated. This should include consultation with the procurement department.

13.4.5 Orders shall not be placed in a manner devised to avoid the financial thresholds specified by the Trust Board.

13.4.6 If the procurement department is asked to issue orders outside these thresholds, they will refer the request back to the budget holder. ~~or to the Director of Finance.~~ The ordering of goods or services above £5,000 without competitive quotes or £25,000 without competitive tendering will not be allowed but if the budget holder believes there is an exceptional case for doing so, that case must be submitted to the Director of Purchasing and Supply ~~Finance~~ for consideration of approval as a Single Tender Action via the Trust's Single Tender Action procedure.

All ~~When~~ orders above £5,000 ~~between £5,000 and £25,000~~ that are not supported by competitive quotations, the case for proceeding must be submitted to the applicable authorising officers shown below ~~to the Divisional Manager~~ to decide whether to approve as a Single Tender Action.

Value of Contract Per Annum	Authorising Officer
£5,000 to £24,999	Divisional Director and the Director of Purchasing and Supply
£25,000 to £100,000	As above, plus the Director of Finance
Above £100,000	As above, plus the Chief Executive/Trust Board

13.4.7 For any ~~none standard~~ procurement that takes place outside of the Trust's purchasing department and/or the Trust's electronic requisitioning and ordering system EROS, the processes referred to in 13.2.3 should be followed and the limits in 13.4.6 shall apply. The Trust's non EROS purchase to pay process must be followed.

13.5 Other

13.5.1 No requisition or order shall be placed for items for which there is no provision in an authorised budget.

13.5.2 Access to the ~~requisitioning/ordering system~~ Trust's electronic requisitioning and ordering system EROS shall only be granted ~~to~~ by budget holders and officers delegated by them though the Trust's Authorised Signatory list.

13.5.3 Information regarding every order shall be notified to the ~~Director of Finance~~ finance department in an agreed format immediately after the order is issued via either the Trust's electronic requisitioning and ordering system EROS or the Trust's non EROS purchase to pay process.

13.5.4 Official orders shall be consecutively numbered, in a form approved by the Director of Finance, and shall include such information concerning prices, discounts, and other conditions of trade as they may require. The order shall incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations, etc.

13.5.5 Orders requisitioned through the Trust's electronic requisitioning and ordering system EROS are required to be independently authorised by a second person. The receipt of the goods can therefore be carried out by one of these officers. All orders requisitioned outside of EROS must be certified by a separate person via the Trust's non EROS purchase to pay process.

13.5.6 All contracts, leases, tenancy agreements and other commitments, which may result in a long-term liability, must be notified to the Director of Finance for approval in advance of any commitment being made. The Director of Finance shall nominate a Trust officer who shall be responsible for overseeing and managing each commitment based contract on behalf of the Trust.

13.5.7 Where consultancy advice is being obtained or where supply of staff is being sought via an agency, the procurement of such skills must be in accordance with the latest guidance issued by the NHS Executive, the Department of Health and the Monitor.

14. Tendering Procedure

14.1 Objective

14.1.1 To ensure that major purchases are tendered in a manner which can be demonstrated to ensure fair competition and value for money and to comply with legislation. The Trust shall ensure that competitive tenders are invited for:

- **the supply of goods, materials and manufactured articles;**
- **the ~~tendering~~ provision of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);**
- **For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.**

14.2 Requirement to Tender

14.2.1 The following instructions shall apply to any purchase over £25,000 as required by Section 13.4. The principles in this instruction apply equally to the separate tendering procedures operated by the Estates Department (for capital contracts) and the Procurement Department. Formal tendering procedures may be waived by the Chief Executive, where the supply is proposed under special arrangements negotiated by the DH, in which event the said special arrangements must be complied with.

14.2.2 Formal tendering procedures **may** be waived by the Chief Executive in the following circumstances:

(a) in very exceptional circumstances where it is decided that formal tendering procedures would not be practicable and the circumstances are detailed in an appropriate Trust record
(b) where the requirement is covered by an existing contract
(c) where national NHS agreements are in place
(d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) where specialist expertise is required and is available from only one source;
(f) when the task is essential to complete a project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(g) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

14.2.3 Where the tendering procedures are waived under (a) above this must be reported and approved by the Trust Board before being actioned.

14.3 EU Directives, Legislation, ~~and~~ Guidance and Public Contract Regulations

14.3.1 EU procurement directives and UK procurement legislation governing procedures for awarding contracts by an NHS body shall have effect as if incorporated in these Standing Financial Instructions.

14.3.2 Contracts above specified thresholds must be advertised and awarded in accordance with EU and other directives and Government legislation. The Procurement Department will advise on these requirements.

14.3.3 The Trust should never enter into a contract which involves a contractor assessing and carrying out work on behalf of the Trust.

14.4 Selection of Suitable Firms to Invite to Tender

14.4.1 The Procurement Department shall ensure that they source suitable ~~maintain information on~~ suppliers ~~suitable~~ to be invited to provide tenders or quotations for the supply of goods or services to the Trust. Suitability will include the technical and financial competence of the supplier.

14.4.2 The Estates Department will refer to the Government Register of Contractors in considering suppliers suitable to be invited to provide tenders or quotations for their requirements.

14.4.3 All suppliers deemed suitable to be invited to submit quotations or tenders should comply with the Equality Act 2010, the Health and Safety at Work Act, procurement sustainability, fair and equitable trade policy and all other legislation concerning employment and the health, safety and welfare of workers and other persons. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

14.4.4 The Director of Finance may make or institute any enquiries deemed appropriate concerning the financial standing and financial suitability of approved contractors. The Directors with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

14.5 Health Care Services

14.5.1 ~~Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure~~. The tendering limits and processes in these standing financial instructions apply equally to the supply of healthcare services.

14.6 Pre-Qualification Questionnaire

14.6.1 Statutory guidance states that the Trust may not include a pre-qualification stage in any procurement where the value of the goods and services is below the EU threshold, thus restricting the use of Prequalification Questionnaires (PQQs). However the Trust should ensure they ask ‘suitability assessment questions’ relating to a potential supplier making certain that the questions are relevant to the subject matter of the procurement and proportionate.

For procurements above the EU threshold, the standardised set of pre-qualification questions should be followed as per the Crown Commercial Service guidance.

~~Expressions of interest from potential suppliers are subject to a process of pre-qualification. Potential suppliers must demonstrate their financial, commercial and technical capabilities to fully meet the~~

~~contractual requirements under tender by completing a Prequalification Questionnaire (PQQ). It takes account of a company's past performance and experience with reference to contracts of a similar nature, both with the Trust and other organisations. It seeks clear demonstration of their commitment to corporate social responsibility, equal opportunities, environmental issues, ethical trading and health and safety where appropriate.~~

14.6.2 Where appropriate supplier self-declarations should be used with only the winning bidder submitting the various certificates and documents to prove their status. The statutory guidance provides a number of grounds for excluding a supplier based on evidence of unsuitability, some of which are mandatory. Those suppliers not excluded must then be assessed on the basis of the economic and financial standing, and on their technical capacity and ability.

~~The decision to use a Pre-Qualification Questionnaire as part of the tendering process depends on the complexity and value of the requirement and the market conditions. Pre-Qualification Questionnaires should be used for all procurements that are above the EU threshold and procurements below the EU Threshold that are subject to sealed bid tendering.~~

14.7 Invitation to Tender

14.7.1 The Trust shall ensure that:

(a) invitations to tender are sent to a sufficient number of firms to provide fair and adequate competition, unless this can be evidenced otherwise. ~~and~~ In all cases ~~that~~ a minimum of either
(i) three ~~four~~ firms shall be invited to tender ~~in all cases~~ or
(ii) the most the market permits

(b) ~~(~~the firms invited to tender are deemed suitable as described above, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

(c) the firms invited to tender area subject to the pre-qualification questionnaire described above

(d) invitations to tender shall clearly state the date and time as being the latest time for the receipt of tenders.

(e) invitations to tender shall state that no tender will be accepted unless it meets the submission requirements of the Trust's e-tendering process or for manual tendering unless:

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) by the latest date and time for the receipt of such tender and addressed to the Chief Executive or nominated manager

(ii) the tender envelopes/ packages are free from any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

14.7.2 Before inviting tenders the appropriate officers shall compile a formal estimate of the probable expense of meeting the specification. Such estimates must quote the value of the relative item in the capital and/or revenue budget for the year approved by the Trust Board.

14.7.3 Every tender for goods, services or disposals shall include such of the NHS Standard Contract Conditions as are applicable.

14.7.4 Every tender for building, engineering works, land and property transactions shall comply with the industry standards for such contracts.

14.7.5 In the case of IT procurements the requirements of relevant industry standards shall be followed.

14.8 Receipt and Safe Custody of Tenders and Records

14.8.1 Tenders received via the e-tendering system will be subject to the controls ~~regarding the~~ built into the system regarding the receipt and safe keeping of all tenders and records.

14.8.2 The date and time of receipt of each manual tender shall be endorsed on each unopened tender envelope/package.

14.8.3 The nominated employee shall be responsible for the receipt, endorsement and safe custody of manual tenders received until the time appointed for their opening, and of records maintained in accordance with Section 14.10.

14.9 Opening Tenders

14.9.1 Manual Tenders

(a) Within three working days after the date and time stated as being the latest time for the receipt of tenders, they shall be opened in the presence of persons specified in the separate procedures for Capital and Procurement. In the case of J C T tenders, for capital projects, they shall be opened by:

- Executive members of the Trust Board
- Head of Finance
- Deputy Director of Operations
- Head of Human Resources

(b) Every tender received shall be stamped with the date of opening and initialled by the persons in Section 13.18(a) above, who witnessed the opening.

Every envelope shall be referenced to the tenderer and shall be retained with the tender documents.

(c) All pages of the tender documents containing the tender prices or making specific reference to terms and conditions stipulated by the tenderer shall be stamped in the presence of the persons witnessing the opening, with a uniquely identifiable stamp, which shall be held securely in the charge of a nominated officer.

(d) A record shall be maintained by the Nominated employee for each set of competitive tender invitations despatched, which shall be initialled by the witnesses to the opening of tenders. The register shall contain the following information:-

(i) The names of all the firms invited;

(ii) In the case of building and engineering contracts, the estimate of the probable cost in accordance with Section 13.13

(iii) The names and the number of firms from which tenders have been received and the amount of each tender where applicable;

(iv) The date the tenders were opened;

(v) The persons present at the opening and their signatures;

(vi) Particulars of any anomalies in accordance with Section 13.19(a), 13.19(d) and 13.19(f).

(e) Every price alteration appearing on the tender shall be initialled by two of those present at the opening.

(f) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

14.9.2 E-Tenders

Within three working days after the date and time stated as being the latest time for the receipt of tenders, they shall be unlocked and opened in the e-tendering system by two officers within the Procurement Department. ~~The system shall ensure that the controls and recording described in 14.10.1 above are adhered to.~~

14.10 Admissibility, Evaluation and Acceptance of Tenders ~~within Prescribed Limits in Section 14.10~~

14.10.1 Admissibility

(a) If for any reason it appears that the tendering process ~~tenders received are~~ has not been carried out on a strictly competitive basis; no contract shall be awarded without the approval of the Chief Executive.

(b) ~~Tenders received after the due date, but prior to the opening date may be considered.~~ Tenders received after the opening may not be considered unless it is agreed by the Chief Executive that there is adequate reason for the late arrival and that it is in the interest of the Trust so to do and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

If none of the tenders that were received in time is economically or in other ways acceptable, re-tendering to a new date shall be invited.

While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

14.10.2 Evaluation

(a) Tender evaluation reports will be approved in accordance with the scheme of delegation.

(b) Necessary discussion and consultation with a tenderer to clarify the tender before the award of a contract need not disqualify. However, if such discussions result in clarifications of the specification, which result in a tender price being reduced below what were previously lower prices of other tenderers, a contract shall not be awarded unless all the other tenderers have been given the benefit of any clarification to the specification that has resulted from the discussions, and an opportunity to re-tender if they wish. This is with the exception of a negotiated and competitive dialogue or innovation partnership procedure.

14.10.3 Acceptance

(a) The ~~lowest~~ most economically advantageous tender ~~if payment is to be made, or the highest if payment is to be received,~~ shall be accepted unless, for good and sufficient reasons which must be formally recorded, the Chief Executive decides otherwise. This is with the exception of a negotiated and competitive dialogue or innovation partnership procedure.

(b) No tender shall be accepted until the professional officer concerned has formally agreed that it is technically satisfactory.

(c) No tender for building works which is in excess of the budget sum under 14.8.2 by more than 10% or £5,000, whichever is the greater, should be accepted without the approval of the Chief Executive.

(d) All tenders shall be treated as confidential and should be retained for inspection.

14.11 Form of Contract

14.11.1 (a) Every contract including those for building and engineering works shall embody or be in the same terms and conditions of contract as those on the basis of which tenders were invited.

(b) Every contract for building and engineering works, which exceeds the sum of £150,000, shall be executed under the common seal of the Trust (except those executed under the JCT form of contract for minor works). The use of the common seal of the Trust shall be in accordance with Section 16p of the Scheme of Delegation.

14.12 Payments to Contractors by Instalments

14.12.1 (a) Where contractors provide for payment to be made by instalments, the Director of Finance shall keep a contract register to show the state of account on each contract, between the Trust and the contractor, together with any other payments and the related professional fees.

(b) Payment to contractors on account shall be made only on a certificate issued by the appropriate Works Officer, Private Architect or other consultant nominated as Contract Administrator.

14.13 Variations

14.13.1 (a) Subject to the provision of the contract in each case, no extra or variation shall be authorised except in writing by the appropriate employees as in Section 14.13.1(b) above. Such variation or instruction orders must be issued prior to the commencement of the work in question, excepting in the case of emergency when it must be issued on the next working day. All such orders must be priced within one month from the date of issue.

(b) A report to the Chief Executive must be made when 66% of the contingency sum has been expended and a further report if the contingency sum is 90% expended.

(c) Any extensions to contracts should be made in writing in accordance with the Trust's scheme of delegation.

(d) Any variation should not fundamentally change the scope of the procurement or increase the value to over fifty percent of the original contract.

14.14 Final Certificates and Accounts

14.14.1 (a) The final payment certificate of any contract shall not be issued until the appropriate Contract Administrator, as in Section 14.12.1(b), has certified the accuracy and completeness of the value of the final account submitted by the contractor.

Any final account that is agreed at a figure in excess of the approved sum in the contract shall be reported to:-

(i) The Chief Executive if in excess of 5%;
(ii) The Trust Board if in excess of 10%.

(b) The Director of Finance may examine final accounts for contracts and may make all such enquiries and receive such information and explanations as may be required in order to be satisfied of the accuracy of the accounts.

14.15 Competitive Tendering of Support Services

14.15.1 The costs of support services may be tested by competitive tendering in accordance with appropriate legislation.

14.15.2 For each tendering exercise the following groups shall be set up:-

(a) Specification group, comprising a nominee of the Chief Executive and a specialist technical officer who will obtain such support from Management Services as is required.

(b) In-house tender group, comprising a nominee of the Chief Executive with technical support as necessary.

(c) Evaluation team, comprising specialist support from the procurement ~~Purchasing~~ department and a Director of Finance's representative.

14.15.3 All groups should work independently of each other. Individual officers may be members of more than one group, although no member of the in-house tender group may participate in evaluation of tenders.

14.15.4 The evaluation team shall make recommendations on the award of contracts to the Trust Board.

14.15.5 The price at which a tender is accepted becomes the new budget for the service and shall not be varied except for:-

(a) Subsequent changes in specification authorised by the Chief Executive (being a different person to the in-house contract manager) at prices to be negotiated by the Divisional Director ~~of the NHS Supplies Authority~~.

(b) Price variations allowed for in the contract.

14.15.6 Monitoring of performance against the contract shall be the responsibility of the in-line senior manager utilising such advice as is appropriate.

14.15.7 The provisions of this section relating to tendering and contracting shall also be observed in competitive tendering ~~for support services~~.

15. Losses, Write Offs and Special Payments

15.1 Objective

15.1.1 To ensure that losses and special payments are properly controlled and fully accounted for.

15.2 General

15.2.1 The Director of Finance is responsible for establishing procedures for the recording of and accounting for losses and special payments.

15.2.3 The Director of Finance shall maintain a losses and special payments register. in which all losses shall be recorded without delay. Appropriate officers must undertake a review of systems and processes to reduce the risk of similar losses arising in the future and seek advice where they believe a particular case raises a point of principle

15.2.3 For any loss the Director of Finance shall consider whether any claim can be made against insurers and ensure this is pursued if appropriate

15.3 Losses

15.3.1 Any employee discovering or suspecting a loss of any kind must immediately inform their Head of Department, who must ensure that their Divisional Manager (or Head of Service in the case of Trust Services) is informed.

The Divisional Manager or Head of Service must appropriately inform the Chief Executive, Director of Finance or Chief Internal Auditor. Employees may also report suspicions directly to the Chief Internal Auditor. Where a criminal offence (i.e. theft or arson) or loss due to fraud or corruption is suspected, the Chief Executive, Director of Finance or Chief Internal Auditor ~~shall notify the police~~ must be informed immediately.

15.3.2 The Director of Finance is responsible for ensuring the Trust has a 'Counter Fraud Plan' setting out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. Where loss due to fraud or corruption is suspected ~~For initial suspicions of fraud~~, the Trust's countering fraud and bribery policy should be referred to. ~~Director of Finance will discuss the particular circumstances with the NHS Local Counter Fraud Unit. If the case involves suspicion of fraud, and it is suspected that a criminal offence has been committed the Director of Finance will discuss the particular circumstances of the case with the NHS Regional Counter Fraud Operational Service in deciding how to proceed.~~

15.3.3 ~~For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance shall notify:~~

~~(a) The Trust Board and~~

~~(b) The Statutory Auditor.~~

~~15.3.4 The Director of Finance must also prepare a 'Counter Fraud Plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.~~

15.3.3 Losses arising from accidental breakages, deteriorations due to overstocking and other losses of goods in stores should be recorded and notified as described in section 12.

15.3.4 All losses are required to be reported to the Audit Committee on a quarterly basis.

15.4 Write-Offs ~~and Special Payments~~

15.4.1 The Trust Board shall approve a scheme of delegation for the approval and authorisation of ~~the~~ write-offs ~~of losses and making of special payments~~ within the limits of delegation granted to the Trust by ~~the Independent Regulator~~ Monitor. Write offs includes the abandonments of claims and the charging of fruitless payments. ~~In this context the "write-off of loss" means also:-~~

~~(a) the abandonment of claims;~~

~~(b) the charging of fruitless payments; and~~

~~(c) the making of compensation and ex-gratia payments.~~

15.4.2 ~~For any loss the Director of Finance shall consider whether any claim can be made against insurers and ensure this is pursued if appropriate~~.

15.4.3 ~~The Director of Finance shall maintain a losses and special payments register in which all losses shall be recorded without delay. Appropriate officers must undertake a review of systems and processes to reduce the risk of similar losses arising in the future and seek advice where they believe a particular case raises a point of principle~~.

15.4.4 The Director of Finance shall report to the Audit Committee a summary of ~~losses~~ write offs each quarter with details of all cases for which the Trust Board's specific approval is required.

15.5 ~~Ex-Gratia~~ Special Payments

15.5.1 Special Payments and are defined by the Foundation Trusts ARM and include:

- Ex-gratia payments
- Compensation payments made under legal obligation
- Extra statutory or extra regulatory payments
- Extra contractual payments to contractors

15.5.2 Ex gratia payments compensate ~~In summary, the powers to make ex-gratia payments including payments to~~ patients, visitors and staff for the loss of personal effects or for incurring unnecessary expense in exceptional circumstances. The authority to make ex-gratia payments and the process for doing so is included in the procedures referred to in section 15.2.1. Key points can be summarised as: ~~of costs are as follows~~:

- Ex-gratia payments for loss or damage to employees' or patients' personal effects should only be paid if there has been negligence on the part of the Trust or of any of its employees. Divisional Managers/Heads of Service must confirm that the loss occurred on Trust property and that there was negligence on the Trust's part which contributed to the loss. Reference should be made to Section x, patient property.

- Accidental damage to an employee's clothes, etc., where no other person is involved does not qualify for compensation unless caused by defects in equipment or conditions which are the responsibility of the Trust and which could not reasonably have been foreseen or avoided by the employee. Accidental damage to staff's personal effects caused by a patient should be dealt with on the merits of the case.

- Reimbursement of unnecessary costs incurred, such as those associated with attending for treatment which is subsequently cancelled, will only be considered in exceptional circumstances and only reasonable expenses as defined in the policy will be considered.

- Ex-gratia payments are only made once properly authorised and reimbursement is limited to actual costs incurred. Receipts are required to support all claims, although reimbursement for amounts below £50 can be made without a receipt at the discretion of the Director of Finance. ~~can and gareedto cover actual over the value of £50 must be supported by a receipt for the replacement items which are actually subject to the loss. Such payments may be approved in accordance with the delegated limits as shown below~~.

- Recommendations for ex-gratia payments should be made to the Director of Finance in accordance with Trust procedures. Only the Director of Finance or delegated deputy can authorise such payments.

- Ex-gratia payments are authorised in accordance with the following delegated limits: (~~excluding Personal Injury and Clinical Negligence Cases~~)

  – Up to £1,000 ~~- Approval by an Executive~~ Director of Finance
  – £1,001 - £50,000 ~~- Approval by the~~ Chief Executive
  – Over £50,000 ~~- Approval by the~~ Trust Board

15.5.3 Personal Injury cases will be dealt with in the following manner:

Over £10,000 – decided in conjunction with the NHS Litigation Authority.
Up to £10,000 – may be settled without legal advice with the approval of the Chief Executive or Director of Finance or the Director of Workforce and Organisational Development

15.5.4 Public Liability cases will be dealt with in the following manner:

Over £3,000 – decided in conjunction with the NHS Litigation Authority.
Up to £3,000 – may be settled without legal advice with the approval of the Appropriate Divisional/Corporate Services Manager ~~or~~ and the Chief Executive or Director of Finance.

15.5.4 All Clinical Negligence Cases are handled and decided by the NHS Litigation Authority (NHSLA) on behalf of the Trust. Whilst the NHSLA are administratively and financially responsible for all clinical negligence cases the legal liability remains with the Trust.

~~15.6 Insurance~~

~~15.6.1 There is a scheme available, administered by the NHS Litigation Authority, through which the Trust insures. A small number of specified risks are not insurable through the NHS scheme and these may be insured commercially. See section 22. The Director of Finance shall establish procedures so that claims are made for all insured losses that are reported.~~

15.5.5 Severance payments ~~All proposals for individual severance payments~~ or voluntary severance schemes require a supporting business case for submission to the Trust's relationship manager at Monitor. ~~Subject to the quality of the business case~~ Monitor will then forward to HM Treasury for approval.

15.5.6 Special severance payments to staff outside contractual or statutory entitlements (including settlement of employment tribunal claims) in order to terminate employment need to be approved by

HM Treasury before settlement is offered. There are no delegated limits for special severance payments, and all cases need to go to HM Treasury.

15.5.7 All applications for severance payments must be approved by the Director of Workforce and Organisational Development and submitted by the Director of Finance according to Trust procedures and in the appropriate form required by HM Treasury.

15.5.8 The Trust is required to obtain approval for time limited voluntary severance schemes, which obviates the need to make a submission for each individual non contractual or non-statutory payment made under the scheme.

~~15.8 Maladministration and Distress Payments~~

15.5.9 All proposals for payment for maladministration and distress shall be dealt with in accordance with the Trust's policy '~~Guidelines for Managers on receipt of a request for financial remedy relating to the local resolution of a complaint~~'. Divisional Managers shall sign off all payment requests for approval.

15.5.10 The delegated limits for approving ~~such cases~~ maladministration and distress payments are as follows:

Up to £1,000	Director of Finance ~~or Head of Finance~~,
£1,001 - £50,000	Chief Executive,
Over £50,000	Trust Board.

15.5.11 All extra contractual payments to contractors must be approved by the Director of Finance. All payments relating to construction contracts must first be approved by the Director of Estates.

15.5.12 All special payments are required to be reported to the Audit Committee on a quarterly basis.

15.6 Insurance

15.6.1 There is a scheme available, administered by the NHS Litigation Authority, through which the Trust insures. A small number of specified risks are not insurable through the NHS scheme and these may be insured commercially. See section 22. The Director of Finance shall establish procedures so that claims are made for all insured losses that are reported.

15.9 Bankruptcy and Liquidation

15.9.1 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16. Charitable Funds ~~Held in Trust~~

16.1 Objective

16.1.1 To ensure that the Trust's charitable funds ~~held in trust~~ are properly safeguarded and used for the benefit intended.

16.2 General

16.2.1 'Charitable funds ~~held in trust~~" are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the NHS, the objects of which are for the benefit of the NHS in England.

16.2.2 The charitable trusts for the University Hospitals Bristol NHS Foundation Trust are administered by the Trustees of Above & Beyond (hereafter called the Trustees). The Trustees have their own systems of accounting and financial control and operate separate bank accounts to the Trust. Charitable funds should not be confused with those operated by the Trust for its exchequer funds.

16.2.3 All gifts, donations and proceeds of fund-raising activities which are intended for the Trust's benefit shall be handed immediately to either the Trustees or to the Trust's cashier who will bank the money and transfer to the Trustees. Any charitable funds paid in through the Trust's cashier must be clearly identified as such to ensure it is separated from the Trust's exchequer funds. However the funds are passed to the Trustees, there must be clear instruction regarding the donor's intentions or the area to benefit.

16.2.4 The Director of Finance shall be required to advise the Trust Board on the financial implications of any proposal for fund-raising activities which the Trust may initiate, sponsor or approve.

16.2.5 The Trustees will designate a fund advisor for each fund held who must comply with the written procedures issued by the Trustees regarding the use of these funds.

16.2.6 Expenditure of any funds held in trust shall be conditional upon:-

(a) the expenditure being within the terms of the appropriate fund

(b) meeting the delegated limits which are:

<£1,000 approved by the designated fund advisor
>£1,000 approved by the Trustees in accordance with their scheme of delegation

equipment >£5,000 also requires approval~~ed~~ in the first instance by the Trust's Capital Programme Steering Group ~~and then the Trustees~~

Expenditure can only be as prescribed by the approval given and can't exceed the value approved.

(c) the prior approval of the Trust's Capital Programme Steering Group being obtained for items falling within the capital definition;

(d) being authorised by the fund advisor in writing, or by a person to whom the fund advisor has delegated authority having advised the Trustees in writing.

17. Audit and Counter Fraud

17.1 Objective

17.1 **To ensure a systematic and effective review of the Trust's financial and management controls to give assurance that resources are used efficiently and safeguarded against misuse or fraud.**

17.2 Audit Committee

17.2.1 In accordance with Standing Orders, the NHS Act 2006 and the NHS Foundation Trust Code of Governance as developed by Monitor, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and membership consistent with relevant guidance issued by Regulators or the Department of Health, including the NHS Audit Committee Handbook.

17.2.2 The role of the Audit Committee is to provide assurance to the Board on the suitability and efficacy of the Trust's governance, risk management and internal control by obtaining an independent and objective view of the Trust's financial systems, financial information, management controls and compliance with relevant laws and guidance. This will be achieved by:

(a) Monitoring and reviewing the effectiveness of the Trust's Internal and External Audit function, including involvement in the selection process when there is a proposal to review the provision of their services;

(b) Monitoring the integrity of the Trust's financial statements, reviewing significant financial reporting judgements contained in them;

(c) Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) Monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) Reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly;

(g) Reporting to the Council of Governors.

17.2.3 Where the Audit Committee considers there is evidence of ultra-vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to ~~the Independent Regulator~~ Monitor via the Director of Finance in the first instance.

17.3 Responsibilities of the Director of Finance

17.3.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function.

(b) ensuring that the Internal Audit is effective and meets the NHS mandatory audit standards and any directions given by the Independent Regulator.

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover*:*

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

17.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employees of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and

(d) explanations concerning any matter under investigation.

17.4 Internal Audit

17.4.1 Internal Audit primarily provides an independent and objective opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust’s objectives. Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability and reliability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
   (i) fraud and other offences;
   (ii) waste, extravagance, inefficient administration;
   (iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and/or ~~the Independent Regulator~~ Monitor.

17.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property of the Trust or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

17.4.3 The Chief Internal Auditor will normally attend the Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

17.4.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

17.4.5 The Chief Internal Auditor is responsible for developing and maintaining an Internal Audit Strategy to provide an objective evaluation of, and opinion on, the effectiveness of the organisation's risk management, control and governance arrangements. The Chief Internal Auditor's opinion is a key element of the framework of assurance the Chief Executive needs to inform the completion of the Annual Statement on Internal Control. The delivery of this strategy will be realised through the delivery of considered and approved annual plans which will systematically review and evaluate risk management, control and governance of all the Trust's operations, resources, services and responsibilities for other bodies.

17.4.6 The Chief Internal Auditor will co-ordinate Internal Audit Plans and activities with line managers, external audit and other review agencies to ensure effective audit coverage is achieved and duplication of effort is minimised.

17.4.7 Internal Audit have the right to access all records, assets, personnel and premises of the Trust in the pursuit of information necessary to fulfil its responsibilities. In any instances of conflict this will be referred for resolution to the Director of Finance, Chief Executive or Chair of Audit Committee as appropriate.

17.4.8 If the Chief Internal Auditor, Chief Executive, Director of Finance or the Audit Committee consider that the level of Internal Audit resources or the terms of reference in any way limit the scope of Internal Audit, or prejudice the ability of Internal Audit to deliver a service consistent with the definition of internal auditing, they should advise the Board accordingly.

17.4.9 Internal Audit provides an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance. The service applies the professional skills of Internal Audit through a systematic and disciplined evaluation of the policies, procedures and operations that management put in place to ensure the achievement of the

organisation's objectives, and through recommendations for improvement. Such consultancy work contributes to the opinion, which Internal Audit provides on risk management, control and governance.

17.4.10 Internal Audit must be sufficiently independent of the activities which it audits to enable auditors to perform their duties in a manner, which facilitates impartial and effective professional judgements and recommendations. Internal Audit will have no Executive responsibilities.

17.4.11 Internal Auditors must have an impartial, unbiased attitude, characterised by integrity and an objective approach to work, and should avoid conflicts of interest. Internal Auditors must declare any conflicts of interest to the Chief Internal Auditor. Any conflicts of interest encountered by the Chief Internal Auditor must be declared to the Director of Finance.

17.4.12 The Director of Finance is responsible for ensuring the Chief Internal Auditor is of sufficient status to facilitate the effective discussion and negotiations of the results of Internal Audit work with senior management.

17.4.13 Appointment at all levels within the Internal Audit team must endeavour to fulfil the four main principles of the code of ethics for Internal Auditor's Audit, integrity, objectivity, competency (i.e. professional qualifications, skills and experience) and confidentiality.

17.4.14 Within the parameters of the contract for the Internal Audit Service, the Chief Internal Auditor is responsible for ensuring the team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience to deliver the Internal Audit Plan in line with the NHS Internal Audit Standards. The team will undertake regular assessments of professional competence through an on-going appraisal and development programme (Personal Development Plans and Continuing Professional Development) with training provided where necessary.

17.5 External Audit

17.5.1 The External Auditor is appointed by the Council of Governors Representative at a general meeting of the Council of Member Representatives and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and reported to the Audit Committee and Council of Governors Representatives.

17.5.2 The Trust will ensure that the external auditor complies with the Audit Code for NHS Foundation Trusts at the date of appointment and on and on-going basis throughout the term of appointments.

17.5.3 The Council of Governors shall determine the terms of the contract for the provision of the External Audit.

17.5.4 The Audit Committee will receive and agree the External Auditor's annual plan.

17.6 Fraud and Corruption

17.6.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with relevant directions and guidance on countering fraud and corruption within the NHS.

17.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud and Corruption Manual and relevant directions and guidance.

17.6.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in ~~the NHS Counter Fraud and Security Management Services (CFSMS)~~ NHS Protect in accordance with the NHS Fraud and Corruption Manual.

17.6.4 The Local Counter Fraud Specialist will provide a written report to the Audit Committee, at least annually, on counter fraud work within the Trust.

17.7 Security Management

17.7.1 The Chief Executive is responsible for ensuring compliance with directions issued by the Department of Health relating to NHS security management.

17.7.2 The Trust shall nominate a director at Board level who will have delegated responsibility for security management as required by the Department of Health guidance on NHS security management.

17.7.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

18. Information Management and Technology

18.1 Objective

18.1.1 To define responsibilities for the management of the Trust's Information Management and Technology Systems.

18.2 Responsibilities and Duties of the Director of Finance

18.2.1 The Director of Finance is responsible for the accuracy and security of the computerised financial data of the Trust and as such is responsible for:

(a) devising and implementing any necessary procedures to ensure appropriate protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensuring that appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensuring that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensuring that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are carried out.

(e) ensuring procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

18.2.2 The Director of Finance is responsible for ensuring that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

18.2.3 Where computer systems have an impact on corporate financial systems, the Director of Finance shall seek assurance that

(a) systems acquisition, development and maintenance are in line with corporate policies including the Clinical Systems Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that there is an audit trail;

(c) Director of Finance staff has access to such data;

(d) appropriate computer audit reviews are undertaken.

18.3 Responsibilities and Duties of Other Directors in Relation to Computer Systems of a General Application

18.3.1 The Legal Services Department (with support from the Head of Information Management and Technology) shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. This describes the information regarding the Trust that is made publicly available.

18.3.2 For the implementation, upgrade or changes to computer systems used generally within the Trust, the responsible manager for the system will present a business case to the Information Management and Technology Committee for approval.

18.4 Contracts for Computer Services with NHS Bodies or Outside Agencies

18.4.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another NHS body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

18.4.2 Where another NHS body or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

18.5 Risk Assessment

18.5.1 The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

19. Capital Investment and Private Financing

19.1 Objective

19.1.1 **To ensure that capital investments are properly planned, approved and controlled.**

19.2 Capital Investment

19.2.1 The Trust Board shall approve the funding contained within the Trust's Medium Term Capital Programme as part of the annual budget approval process and any subsequent updates.

19.2.2 The Director of Finance shall ensure that the Trust produces a Capital Investment Policy and this is reviewed annually and approved by the Trust Board. All capital investment must be approved in line with the Trust's Capital Investment Policy.

19.2.3 The Chief Executive

(a) shall ensure that there is an adequate appraisal and approval process in place in line with the Trust's Capital Investment Policy**,** for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the ensuring the effective management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including, the servicing of loan interest and loan principal repayment capital charges and potential impairment losses.

19.2.4 For every capital expenditure proposal the Chief Executive shall ensure;

(a) that a business case is produced in line with guidance issued by the DoH or Independent Regulator and the Trust's Capital Investment Policy which sets out:

i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to cost

ii) the involvement of appropriate Trust personnel and external agencies

iii) appropriate project management and governance arrangements.

(b) that the Director of Finance has validated the capital costs and revenue consequences detailed in the business case.

(c) approval of each business case in line with the Trust's Capital Investment Policy prior to tender

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with appropriate guidance and the Trust's Standing Orders.

19.2.5 For capital schemes requiring stage payments, the Director of Finance shall issue procedures on their management.

19.2.6 The Director of Finance shall ensure that all capital schemes are accounted for in accordance with HM Revenue and Custom guidance.

19.2.7 The Director of Finance is responsible for ~~shall issue procedures for~~ the regular reporting of donations, expenditure and commitments against the Trust's approved Medium Term Capital Programme via the Trust's Capital Programme Steering Group.

19.2.8 The approval of a Medium Term Capital Programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall ensure that there are procedures in place identifying managers responsible for each scheme, specifying:

(a) levels of authority to commit expenditure;

(b) authority to proceed to tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Trust's Standing Orders.

19.2.9 Schemes must be tendered and managed in accordance with the requirements of Section 14.

19.2.10 Donations received from charitable parties for the purposes of capital investment will require submission to and the approval of the Capital Programme Steering Group. Any associated legal agreement containing obligations on the part of the Trust requires signature by the Director of Finance or Director of Strategic Development.

19.2.11 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

19.3 Commercial/Private Finance

19.3.1 The Trust should give consideration to private finance when considering material capital procurement. When the Trust proposes to use private finance the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of commercial/private finance represents a balance of value for money compared with using the Trust's own finance and where appropriate, genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Trust Board.

19.3.2 The Director of Strategic Development is responsible for ensuring that:

(a) a programme of service delivery inspections is in place to ensure contract terms are monitored;

(b) payments to the commercial partners are authorised in accordance with the contracted availability and performance factors;

(c) clearly established dispute resolution procedures are in operation;

(d) effective procedures for agreement of changes to service delivery; and

(e) the service is market tested in line with the contract.

19.4 Leases

19.4.1 All proposals for finance or operating leases must be submitted to the Director of Finance for advice and approval. Leasing proposals must demonstrate value for money. The Director of Finance must sign all leases.

20. Fixed Asset Register and Security of Assets, Disposal and Accounting of Assets

20.1 Objective

20.1.1 To ensure that assets are properly safeguarded and accounted for.

20.2 Asset Register

20.2.1 The Director of Finance is responsible for the maintenance of the Trust's register of assets and for arranging for a physical check of assets against the asset register to be conducted ~~once every two years~~ on a rolling three year programme.

20.2.2 The Director of Finance must ensure the Trust maintains an asset register recording all fixed assets in accordance with the requirements of the Independent Regulator.

20.2.3 Additions to the fixed asset register must be clearly identified to an appropriate officer and be validated by reference to

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

The Trust shall maintain ~~a publicly available property~~ an asset register of every relevant asset used for the provision of Commissioner Requested Services ~~recording protected property~~ in accordance with the guidance issued by the Independent Regulator.

20.2.4 If Monitor has given notice about the ability of the Trust to carry on as a going concern the Trust ~~may not dispose of any protected property assets without the approval~~ shall not dispose of, or relinquish control over any relevant asset without consent in writing of Monitor. This includes the disposal of part of the property or granting an interest in it.

20.2.5 Where capital assets are sold, scrapped, lost or otherwise disposed of, the responsible officer must notify the Director of Finance, who will ensure that their value is removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

20.2.6 Assets that are leased by the Trust must not be disposed of.

20.2.7 The Director of Finance shall approve procedures for reconciling the fixed asset balances in the financial ledger with the balances on the fixed asset register.

20.2.8 The value of each asset shall be ~~re-valued at least annually to fair values~~ maintained in accordance with the Trust's agreed accounting policies.

20.2.9 The value of each asset shall be depreciated over its expected asset life in accordance with the appropriate accounting standards and any guidance issued by ~~the Independent Regulator~~ Monitor.

20.3 Security of Fixed Assets

20.3.1 The Chief Executive is responsible for the overall control of the Trust's fixed assets.

20.3.2 Asset control procedures (including fixed assets, ~~including~~ donated assets, cash, cheques and negotiable instruments) must be approved by the Director of Finance. These procedures shall make provision for

(a) recording the managerial responsibility for each asset;
(b) the identification of additions and disposals;
(c) the identification of all repairs and maintenance expenses;
(d) the physical security of assets;
(e) the periodic verification of the existence of, condition of and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset; and
(g) reporting, recording and safekeeping of cash, cheques and negotiable instruments.

20.3.3 All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Director of Finance.

20.3.4 Each employee has a responsibility for the security of the Trust's property and should ensure that equipment and property is secured when not attended and should report suspicious incidents and losses to their appropriate manager. It is the responsibility of Directors and senior managers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported to the Chief Executive.

20.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported in accordance with the procedure for reporting losses in section 15.

20.3.6 Where practical, purchased or donated assets should be marked as Trust property.

20.3.7 Where assets are loaned or leased to the Trust, responsible officers should ensure these are notified to the Director of Finance in accordance with prescribed procedures. These assets must be clearly identified and must not be scrapped or otherwise disposed of. An inventory of such assets will be maintained but will not form part of the fixed asset register.

20.4 ~~Protected Property~~ Restrictions on the disposal of assets

20.4.1 A register of ~~Protected Property~~ every relevant asset for the provision of Commissioner Requested Services is required to be maintained in accordance with requirements issued by the Independent Regulator. ~~The property referred to in the NHS Provider Licence which is to be protected is limited to land and buildings owned or leased by the Foundation Trust~~.

20.4.2 If Monitor has given notice to the Trust that it is concerned about the ability of the Trust to carry on as a going concern then the following shall apply.

(a) The Trust shall not dispose of the whole or any part of, or relinquish control over, any relevant asset except with the consent in writing of Monitor,
(b) The Trust shall inform Monitor of any proposals to dispose of, or relinquish control over, any relevant asset
(c) Written consent from the Monitor shall not prevent the Trust from disposing of, or relinquishing control over, any relevant asset where:
    i. Monitor has issued a general consent, or
    ii. The Trust is required by the Care Quality Commission to dispose of a relevant asset.

~~20.4.2 No Protected Property may be disposed of (including disposing of part of it or granting and interest in it) without the approval of the Independent Regulator.~~

~~20.4.3 The Annual Plan will include proposed changes in the treatment, disposal and acquisitions of protected assets~~.

~~20.4.4 The Trust is required to notify relevant bodies of the publication date of such plans in 20.4.3 to allow objection to be lodged. Twenty one days is allowed before the plans are then approved~~.

~~20.4.5 The Asset Register must be updated for any such changes. The relevant bodies should then be notified that an updated Asset Register is available~~.

20.5 Disposal of Assets

20.5.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to Managers.

20.5.2 When a Department decides to dispose of a Trust asset, the Head of Department, or authorised deputy must comply with the Trust's procedures. In particular by:

(a) establishing whether it is needed elsewhere in the Trust; and if not

(b) determining and advising the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

20.5.3 In the event of a private sale (e.g. to a member of staff) the Head of Department should first follow the procedure in Section 20.5.2. If the private sale is more beneficial the Divisional Manager should be notified of the course of action. Advice should be sought from the Finance Department regarding the VAT liability of the proposed sale.

20.6 Condemnations

20.6.1 All unserviceable articles can only be condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance and in accordance with Trust procedures. In particular the condemnation must be appropriately recorded in line with these procedures identifying whether the articles are to be converted, destroyed or otherwise disposed of. All records shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

20.6.2 The officer condemning the item shall establish whether or not there is evidence of negligence in use and shall report such evidence to the Director of Finance who will take appropriate action.

21. Retention of Documents

21.1 Objective

21.1.1 To ensure the Trust has appropriate arrangements for retaining documents to comply with legal responsibilities and to enable the effective operation of the Trust.

21.2 General

21.2.1 The Chief Executive shall be responsible for maintaining archives for all records, including electronic records, required to be retained in accordance with Department of Health guidelines.

21.2.2 The documents held in archives shall be capable of retrieval by authorised persons.

21.2.3 Documents held in accordance with Department of Health guidelines shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

22. Risk Management and Insurance

22.1 Objective

22.1.1 To define the Trust's requirements for risk management and insurance.

22.2 Risk Management

22.2.1 The Chief Executive shall ensure that the Trust has robust risk management arrangements, in accordance with any requirements of ~~the Independent Regulator~~ Monitor which must be approved and monitored by the Board.

22.2.2 The programme of risk management arrangements shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the ~~control~~ management of risk;

(c) governance ~~management~~ processes to ensure all significant risks and potential liabilities are identified, managed ~~addressed~~ including identifying responsibility, effective systems of internal control, action/mitigation, cost effective insurance cover, and decisions on the acceptable level of mitigated ~~retained~~ risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(a) a clear indication of which risks shall be insured;

(g) regular review of the Trust's risk management arrangements.

22.2.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by Monitor ~~the Independent Regulator~~.

22.3 Insurance

22.3.1 The Chief Executive, in conjunction with the Director of Finance, is responsible for ensuring that adequate insurance cover is held in line with the Trust's risk management policy approved by the Board. This will include insuring through the risk pooling schemes administered by the NHS Litigation Authority, self-insuring for some or all of the risks covered by the risk pooling schemes and purchasing insurance from commercial insurers. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

22.3.2 Trust Officers are required to notify the Director of Finance of all new risks or property which may require to be insured and of any changes that may affect risk or existing insurance.

22.3.3 All insurance policies must be approved by the Director of Finance

22.3.4 The Trust may purchase commercial insurance policies for risks not provided for under the Property Expenses Scheme (PES) and Liabilities to Third Parties Scheme (LTPS). This includes:

- Additional cover over and above the Trust's delegated limit under PES i.e. property (to the full reinstatement value of the property), contract works, fidelity, and business interruptions.
- Providing cover for specific activities outside the LTPS i.e. non-clinical professional indemnity, charitable trustees' liability, and Directors and Officers liability.
- All such insurance policies must be approved by the Director of Finance.

22.3.5 Arrangements to be followed in agreeing insurance cover

a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

c) All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

23. ~~Acceptance of~~ Gifts, Hospitality and Commercial Sponsorship ~~by Staff and Other Standards of Business Conduct~~

23.1 Objective

To ensure that Trust staff comply with required standards of behaviour when using public funds.

23.2 General

23.2.1 The Chief Executive is responsible for ensuring that the Trust has policies in respect of conflicts of interest and the acceptance of gifts or other benefits in kind conferring an advantage to a member of staff. These policies should be consistent with the Standards of Business Conduct for NHS Staff.

23.2.2 The Chief Executive shall ensure that all Trust employees are aware of these Trust policies and the restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage that could be considered to be bribes under the Bribery Act 2010.

23.2.3 The Trust Secretary shall hold and maintain a register of gifts, hospitality and sponsorship. ~~Trust shall maintain a Register of Interests and Hospitality~~ It is the responsibility of all Trust employees to comply with the procedures regarding the disclosure of such ~~interests~~ gifts, hospitality and sponsorship as well as the policies referred to in 23.2.2.

23.3 Gifts

23.3.1 Casual gifts offered by contractors or others may be construed to be connected with the performance of duties so as to constitute an offence under the Bribery Act 2010 and therefore all such gifts should be declined. Business articles with little intrinsic value (of less than £25 per gift) such as diaries, calendars, pens etc need not be refused, nor small tokens of gratitude from patients or their relatives.

23.3.2 Any gift accepted of value greater than £25 should be declared in writing to the Trust Secretary. If several small gifts worth a total of over £100 are received by an individual from the same or closely related source in a twelve month period, these should also be declared to the Trust Secretary.

23.3.3 Gifts offered to an individual where the value exceeds £40 should be declined. In exceptional circumstances and with the agreement of the line manager, the matter may be referred to the Trust Secretary for a decision as to whether the gift can be accepted.

23.3.4 Gifts of cash made to a ward or department are deemed to be charitable donations and should be dealt with as described in section X. No further declaration is required.

23.4 Hospitality

23.4.1 Suppliers must not attempt to influence business decision making by offering hospitality to trust staff. Modest hospitality provided it is normal and reasonable in the circumstances may be accepted (e.g. lunches in the course of a working visit). If in doubt, advice should be sought from the employee's line manager or relevant Director.

23.4.2 Any offers of inappropriate hospitality should be notified to the Trust secretary for appropriate action.

23.5 Sponsorship

23.5.1 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks approval in advance from their line manager. Approval must depend on whether acceptance will, or could be believed to, compromise current or future purchasing decisions in any way.

23.5.2 The sponsorship of Trust events by existing suppliers to the Trust is acceptable subject to informing the Trust Board Secretary of the agreement for recording the details in the Register of Gifts, Hospitality and Sponsorship. Where the sponsor does not have a contract for supplies or services with the Trust, the Procurement Department should be consulted. The Trust Board Secretary should be informed. In all such cases there must be no favouritism shown to any one supplier in a way that could later be challenged by a competitor. Where this could be the case the same opportunity to sponsor events should be offered to the other interested parties.

23.5.3 Some suppliers offer training as a part of supplying equipment and this should be fully reflected through the contract entered into with the relevant organisation. In such cases no disclosure to the Trust Board Secretary is necessary.

23.5.4 The Trust shall not enter into commercial or charitable sponsorship arrangements which link such sponsorship to the supply of goods or services from any particular source.

23.5.5 Employees must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to concessionary agreements negotiated with companies by the Trust, or the NHS, or by recognised staff interests, on behalf of all staff for example, staff benefit schemes.

Change Control Summary

Appendix 1

Para	Change	Supporting Information
1.1.8	Explicitly requires non-compliance with SFIs to be reported to the DoF for investigation and action before reporting to the Audit Committee	Reporting to the Audit Committee remains but there is a clearer prescribed course of action for investigation.
1.1.10	Described references to Monitor	Can remove explanation in the SFIs every time Monitor is referred to.
1.2.3	Moved description of scheme of delegation to 1.2.5	To improve the flow of the document
1.2.4 (old)	Removed details of how Trust Board exercises financial control and inserted description of general responsibility of Board	Appendix 1 describes Board's control, unnecessary duplication.
1.2.4 (new)	Explicitly defines the ability for the CEO and DoF to define deputies to represent them within the SFIs.	Ensures clarity when deputies are required
1.2.4 (new)	DoF responsibilities, presented differently	To make it easier to read
1.2.5	Employee responsibilities presented differently, including information on the scheme of delegation.	Makes it easier to read and puts information about the scheme of delegation into the section for employees where it is most relevant.
1.2.6 (old)	Removed and included in 1.2.5	To improve the flow of the document
1.2.6 (new)	New section on hosted arrangements	Requires transactions to be in line with Trust policies and procedures, but allows for management and decision making to be delegated to the hosted organisation board, e.g. WCLRN
2.2.1	Describes the annual plan , with the financial plan elements moved to 2.2.3	To improve the flow of the document
2.2.3	Presented differently, incorporating elements removed from 2.2.1	To make it easier to read
2.2.6	Widens requirements of staff to support all Directors with the plans, not just the financial elements.	Explicit guidance for staff
2.6	Remove and replace with separate R&I section	Significant part of UHB requiring clear section for reference by relevant staff
X	New section on R&I	R&I leads sometimes consider that as their projects are externally funded they are able to use the funding in a way that is not supported by Trust policies and procedures. This section removes any ambiguity.
3.2.6 -7	New clarification on contract signing and service developments	Strengthen SFIs in relation to contract signing and service developments
4.2.6	New reference to the quality report	Strengthen SFIs in relation to the quality report
5.3	The order of the paragraphs have been rearranged to flow better	To improve the flow of the document
5.3.3-5	Explicit guidance on the operation of Trust bank accounts and the banking of income through Trust activity or donations.	In response to bank accounts being operated by individuals and wards relating to Trust business – now closed.

Change Control Summary

Para	Change	Supporting Information
5.3.6	Removal of need for Finance Committee to approve procedures on operating the bank accounts	Considered too detailed for Committee approval, Finance committee responsibilities detailed in 5.3.7
5.3.9	Replace the need to formally tender with the need for the DoF to keep under consideration the banking arrangements and whether a retender should be held.	The need to review the costs and service provided by commercial banking providers should be balanced with the need to develop sound relationships, processes, systems and technologies which can be costly to regularly change.
5.3.13	Includes purchasing cards but with the requirement for Finance Committee approval of the policy for operation.	Allows better purchasing arrangements with appropriate controls for the future.
6.1.1	Removed as it's details of facts rather than instructions	No requirement for such information in the SFIs
6.2.2	Expanded to incorporate 6.2.10 which has been removed	To improve the flow of the document
6.2.11	Removed and replaced by details in section 6.2.7	To improve the flow of the document
7.3.4	Requirement to seek approval for rewarding staff over and above their pay	To ensure compliance with tax requirements and equity
7.6.1	Added definition of off payroll arrangements	Improves clarity in classifying such arrangements
7.6.2	Added new requirement from Dept of Health	Ensures compliance with DoH regulations
7.6.3-4	Improved control of off payroll contracts	Explicit guidance for staff
7.6.7	Removed detail contained in the procedures referred to under 7.6.2	Remove duplication
8.1.1	(b) added to explicitly describe the checking and authorisation required	Explicit guidance for staff
8.3.3	Explicitly requires procurement through EROS unless specifically allowed for within the Trust's non-EROS purchase to pay policy	This ensures compliance with the process considered and approved by the Audit Committee
8.4.2	Updates the SFIs with the authorised signatory list and process established this year	Strengthens SFIs in line with new controls introduced
8.6.1 (c)	Updates in line with section 7.6	Ensures compliance with DoH regulations
9.2.5	Explicit reference to segregation of duties added	Explicit guidance for staff
9.5.5 - 8	Removed detail contained in the cash handling procedure	Information is too detailed for SFIs
10.2.4	Requirement to notify significant cash payments before acceptance	Gives clearer advice in this situation
10.2.5	Requires contract/agreement for providing goods and services with delegated limits for signing the contract	Explicit guidance for staff
13.2.1	Requires contract/agreement for procuring goods and services with delegated limits for signing the contract	Explicit guidance for staff
13.2.3 - 4	Explicitly refers to both EROS and non EROS procurement and the need for SFIs and processes to be followed in both cases	Strengthens SFIs in line with non EROS purchase to pay process

Change Control Summary

Para	Change	Supporting Information
13.4.1	Reduced requirement to three competitive tenders to be sought, in line with procurement advice	To provide consistency with other sections of SFIs and Trust policy where three competitive quotes are to be sought
13.4.6 - 7	Improves description of single tender action process and authorisation requirements.	Does not change the STA process, but better defines it
14.5	Clarifies that the supply of healthcare is covered by the SFIs	Under new EU regulations, these services are no longer exempt from competition.
14.6	Updates the SFIs to the latest EU legislation and statutory guidance around Prequalification Questionnaires, in line with procurement advice	Ensures compliance with EU legislation and statutory guidance
14.10	Separates out the admissibility, evaluation and approval of tenders and refers to new delegated responsibilities for approving contracts	
15.3.2 – 4 (old)	Referred to counter fraud plan and countering fraud and bribery policy and removed detail	Ensure consistency and compliance
15.3.3 - 4	Added in a requirement for other losses	Ensures comprehensive guidance for all losses
15.4	Separated write offs from special payments	Reflecting their different definitions
15.5	Increased instructions for special payments, including definition	To strengthen guidelines and remove any ambiguity
15.5.2	Greater clarity on ex-gratia payments	To strengthen guidelines and remove any ambiguity
15.5.4	Requires public liability cases to be authorised by divisions and Executive	To ensure Director of Finance is aware of all cases for reporting purposes
15.6.1 (old)	Moved to later in the section	To improve the flow of the document
15.5.7	Requirement for all severance payments to be approved by the Director of Workforce and Organisational Development	In practice their deputy ensures this
15.5.11	Requires extra contractual payments to contractors to be approved by the Director of Finance, with construction contracts to also be approved by the Director of Estates	Strengthens control over such payments and ensures appropriate reporting
16	Change Trust funds to Charitable Funds in line with trust terminology	Ensure consistency
19	Reference to the Trust's Capital Investment Policy	Ensure consistency and compliance
20.2.1	Asset Register check changed to a rolling three year programme	To improve operational working practices
20.4	Restrictions on the disposal of assets updated in accordance with the Monitor provider license	Ensures compliance with monitor regulations
23	Expanded to include Hospitality and Commercial Sponsorship and gives greater clarity rather than just referring to the policy.	This has been agreed with the Trust Secretary. It is an area that staff often require guidance and support on, rather than pointing them to a further policy, it was felt important to include in the SFIs

Revised

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST - SCHEME OF DELEGATION

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
Where the title 'Executive' is used it is deemed to include their nominated deputy where they have been duly authorised by them to represent them			
1. OVERALL RESPONSIBILITIES AND DELEGATION			
1a	Financial framework, policies and internal financial control systems. Maintain and update Trust's financial procedures.	Director of Finance	SFIs section 1.2.4
1b	Requirement for all staff to be notified of and understand these instructions	Chief Executive, delegated to all managers	SFIs section 1.2.4
	Complying with the Trust's Standing Financial Instructions, Scheme of Delegation and financial procedures	All staff under contract to the Trust	SFIs section 1.2.5
2. PLANNING AND BUDGETS AND BUDGETARY CONTROL			
2a	Strategic and annual business plans	Chief Executive	SFIs section 2.2.1
	Annual (and longer term) financial plan and budget	Director of Finance	SFIs section 2.2.3
	Divisional/Corporate Service operational plans and budgets	Clinical Chairs/Divisional Directors/Corporate Service Director	SFIs section 2.2.5
3. BUDGET MANAGEMENT			
3a	Budget Management Responsibility		SFIs sections 2.3
	i. at individual cost centre level	Budget Manager or nominated deputy	
	ii. at departmental level	Departmental Manager or nominated deputy	
	iii. at divisional level	Clinical Chair / members of the Divisional Board as authorised by the Clinical Chair.	
	iv. at corporate service level	Director of Facilities and Estates or delegated deputy Director of Information Management Technology or delegated deputy Corporate Director or delegated deputy	
3b	Budget Virement/Transfer	Virements must be supported by appropriate paperwork and approved by the Senior Management Accountant	SFIs section 2.3
	i. Within a cost centre	Budget Manager and Department Manager	
	ii. Within a department/specialty between cost centres	Department Manager	
	iii. Between specialties/departments	Both department managers	
	iv. Between Divisions/Corporate Services below £5k	Both department managers	
	v. Between Divisions/Corporate Services above £5k	Divisional Director / Director of Facilities and Estates / Director of Information Management Technology / Corporate Director by joint agreement	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	vi. To and from Trust reserves	Director of Finance or nominated deputy	
4. ANNUAL ACCOUNTS AND REPORTS			
4a	Preparation of annual accounts and associated financial returns for Board approval	Director of Finance	SFIs section 4.2.1 - 2
4b	Preparation of Annual Report for Board approval	Trust Secretary	SFIs section 4.2.5
4c	Preparation of Quality Report for Board approval	Director of Nursing	SFIs section 4.2.6
5. SERVICE AGREEMENTS FOR THE PROVISION OF HEALTHCARE SERVICES			
5a	Agreeing and signing NHS contracts for the provisions of healthcare services to NHS commissioners, other NHS providers or private organisations	Chief Executive, Deputy Chief Executive or Director of Finance	SFIs section 3.2.7
5b	Agreeing changes and developments within existing contracts for healthcare services	Chief Executive, Deputy Chief Executive or Chief operating Officer with Director of Finance agreement	SFIs section 3.2.8
5c	Service agreement monitoring and reporting	Director of Finance	SFIs section 3.3.2
5d	Service agreement operational management	Clinical Chairs	SFIs section 3.3.5
6. BANKING AND CASH MANAGEMENT			
6a	Opening, operating and controlling all bank accounts referencing the Trust's name of Trust address.	Director of Finance	SFIs section 5.3.2
6b	Day to day operational management of the Trust's bank accounts	Deputy Director of Finance	SFIs section 5.3.6
6c	Determining when to subject commercial banking services to competitive tendering. Organising and evaluating the tender process.	Director of Finance	SFIs section 5.3.9
6d	Approval of bank signatories	Chief Executive or Director of Finance or nominated Senior Finance Manager	
6e	Approval of direct debit or standing order payment arrangements	Director of Finance	SFIs section 5.3.12
6f	Operation of Trust credit/purchasing cards	Director of Finance	SFIs section 5.3.13
6g	Investment of temporary cash surpluses	Director of Finance	SFIs section 5.5
7. EXTERNAL BORROWING AND PDC			
7a	Approval of short term borrowing	Finance Committee	SFIs section 6.2.4
7b	Approval of long term borrowing	Trust Board	SFIs section 6.2.7

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
7c	Application for borrowing	Director of Finance	SFIs sections 6.2.4 and 6.2.8
8. WORKFORCE AND PAYROLL			
8a	Remuneration and terms of service for Directors	Remuneration Committee	SFIs section 7.2.1
8b	Remuneration and allowances of Chair and Non-Executive Directors	Council of Governors	SFIs section 7.2.4
8c	Approval of implementation of national pay directives and local variations	Director of Workforce and Organisational Development and Director of Finance	SFIs section 7.3.1
8d	Approval of non-payroll rewards to staff	Director of Workforce and Organisational Development and Director of Finance	SFIs section 7.3.4
8e	Appointment of permanent staff (subject to any vacancy control process in place) or extension of fixed term contract		
	i. to funded established post	Budget holder or nominated deputy and divisional finance manager and HR advisor	
	ii. to post not within formal establishment	Divisional Director or nominated deputy and divisional finance manager and HR advisor	
8f	Granting of additional increments to staff outside of national terms and conditions	HR Business Partner	
8g	Banding of new posts or re-banding of existing posts	Divisional/Corporate Director with Trust review panel scrutiny	
8h	Authorisation and notification to payroll of all starters, leavers and changes of conditions for staff	Budget holder or nominated deputy	SFIs section 7.4.1 - 4
8i	Authorisation of all timesheets, overtime, unsocial, oncall, bank shifts and any other approved form to vary pay	Budget holder or nominated deputy	SFIs section 7.5.3
8j	Authorisation and notification to payroll of all absences from work including sickness, special leave, maternity leave, paternity leave, time off in lieu,	Line manager in accordance with agreed policies and processes	SFIs section 7.5.3
8k	Authorisation of medical staff leave of absence	Clinical Chair/Medical Director	SFIs section 7.5.3
8l	Approve annual leave applications and carry forwards to next year		
	i. within national or local Trust approved limits	Line manager	SFIs section 7.5.3
	ii. outside of the limits above	Divisional/Corporate/Executive Director	SFIs section 7.5.3
8m	Approve staff departure		
	i. under compromise agreement	Director of Workforce and Organisational Development and the Director of Finance	SFIs section 15.5.7

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	ii. under redundancy scheme	Divisional/Corporate/Executive Director and Director of Finance	
8n	Early retirements in furtherance of efficiency or on ill health grounds.	Director of Workforce and Organisational Development and the Director of Finance	
8p	Authorise benefits in kind	In accordance with Trust policies:	
	i. new or changes to authorised car users	Budget Manager or nominated deputy	
	ii. mobile phones/land lines	Divisional/Corporate/Executive Director	
8q	Authorisation of travel and subsistence claims	Line Manager	SFIs section 7.7.1
8r	Authorisation of relocation expenses	Director of Finance	SFIs section 7.7.1
8s	Engaging staff to undertake work outside of the payroll (subject to contracting/procurement rules):		
	i. for consultancy work (excluding strategic capital projects)	Below £25k gross commitment – Divisional/Corporate Director Above £25k gross commitment – Chief Operating Officer or Corporate Executive Director Over £500k gross commitment – Chief Executive	SFIs section
	ii. to fill a defined post using self-employed, limited company or umbrella professional services agency	For posts on the Trust Board, Divisional Board or those with significant financial responsibility – Chief Executive Other posts over £20 per day and/or over 6 months - Director of Workforce and Organisational Development Other posts below £220 per day and less than 6 months – HR Business Partner	SFIs section 7.6.2 - 3
	iii. using agency or locum staff		
9 CONTRACTING TO PROVIDE GOODS AND SERVICES EXCLUDING SERVICE AGREEMENTS FOR HEALTHCARE SERVICES (SEE SECTION 5)			
9a	Setting of fees and charges		SFIs Section 10.2.6
	i. Private Patients	Director of Finance or nominated deputy	SFIs Section 10.2.7
	ii. Overseas Visitors	Director of Finance or nominated deputy	SFIs Section
	iii. Property rental (excluding residences)	Director of Estates and Facilities	SFIs Section
	iv. Residences	Director of Estates and Facilities	SFIs Section
	v. Trading services	Divisional/Corporate Director or nominated deputy	SFIs Section
	vi. Other income generation	Divisional/Corporate Director or nominated deputy	SFIs Section

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
9b	Agreeing/signing agreement/contract	All require Divisional Finance Manager agreement	SFIs Section 10.2.5
	i. Hosting arrangements	Director of Finance or nominated deputy	
	ii. Research and other grant applications	Director of Finance or nominated deputy	
	iii. Staff secondments	Service Manager	
	iv. Leases	Director of Finance or nominated deputy	
	v. Property rentals (excluding residences)	Below £5k per annum, Service Manager Above £5k and below £100k per annum, Director of Estates and Facilities or nominated deputy Over £100k per annum, Director of Finance or nominated deputy	
	vi. Residences	Residences Manager	
	vii. Peripheral clinics and provider to provider arrangements	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
	viii. Trading Services	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
	ix. Other income generation	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
10 PROCUREMENT OF GOODS AND SERVICES INCLUDING CAPITAL SCHEMES (financial limits exclude VAT and the whole order/contract should be considered) **All capital schemes must have been approved as per section 17 before orders/tenders are made)** **Goods/services will only be available for ordering via EROS once matters referred to under 10a to 10d have been followed – therefore staff requisitioning via EROS need only comply with 10e and 10f**			
10a	Obtaining quotes/tendering for the provision of Goods and Services		
	i. Below £5k, best value to be demonstrated	Budget holder	SFI section 13.4.3
	ii. Between £5k and £25k, minimum three quotes to be obtained	Budget holder	SFI section 13.4.2
	iii. Over £25k and upto £1m, minimum three tenders to be obtained	Divisional/Corporate Director	SFI section 13.4.1
	iv. Over £1m, three tenders to be obtained	Trust Board	
10b	Single tender actions – best value to be demonstrated		SFI section 13.4.6
	i. Between £5k and £25k	Divisional/Corporate Director and the Director of Purchasing and Supply	
	ii. Between £25k and £100k	As above plus Director of Finance	
	iii. Over £100k	As above plus Chief Executive	
10c	Waiving of tendering and single tender action procedures	Chief Executive, reported to Audit Committee	SFI section 14.2.2

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
10d	Signing of contract evaluations/contracts/agreements to procure good/services on behalf of the Trust	Following procurement processes described in 10a to 10c above	SFI section 13.2.1
	i. Contract evaluations/contracts/agreements following tendering process above unless specifically referred to below:	Below £25k, service manager Above £25k and below £100k, Divisional Director/Director of Purchasing and Supply Over £100k, Chief Operating Officer/Director of Finance	
	ii. for purchase of healthcare	Below £100k, Divisional Director Over £100k, Chief Operating Officer	
	iii. for property leases	Director of Finance	
	iv. for leases – non property	Director of Finance	
	v. for outsourcing services	Below £100k, Divisional Director Over £100k, Chief Operating Officer and Director of Finance	
	vi. facilities contracts	Director of Estates and Facilities or nominated deputy	
	vii. estates maintenance contracts	Director of Estates and Facilities or nominated deputy	
	viii. capital estates based contracts	Director of Estates and Facilities or nominated deputy, following approval as per section19	
10e	Requisitioning/ordering after procurement and contract/ agreement is in place:	Authorised requisitioner, ensuring segregation of duties from procuring and receipting	
10f	Receipting	Authorised receiptor, ensuring segregation of duties from procuring and ordering	
11 PAYMENT FOR GOODS AND SERVICES (FOLLOWING APPROPRIATE PROCUREMENTPROCESSES)			
11a	Authorisation of invoices for goods and services procured	(applies to all procurement methods, not just EROS)	SFIs section 8.4.1
	i. Where invoice price = order/quote	Budget holder or authorised signatory for the cost centre with regard to segregation of duties between ordering and approving in line with Trust procedures	
	ii. Where invoice price exceeds order/quote upto the lesser of 10% or £5,000	Budget holder	
	iii. Where invoice price exceeds order/quote over 10% or between £5,000 and £25,000	Divisional/Corporate Services Director	
	iv. Where invoice price exceeds order/quote over 10% or over £25,000	Director of Finance	
11b	Prepayments	Director of Finance or nominated deputy	SFIs section 8.5.1
11c	Receipting of goods and services procured via EROS	Budget holder or authorised receiptor for the cost centre, with regard to segregation of duties between ordering and approving in line with Trust procedures.	SFIs section 8.4.1
11c	Maintaining the Trust's authorised signature list	Budget holder to review and advise Deputy Director of Finance to update	SFIs section 8.4.2
11d	Authorisation of expenditure reimbursement via petty cash in line with the Trust's policy.	Below £50 budget holder or nominated deputy Over £50, Divisional Manager	SFIs section 8.7, 9.3.3

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
11e	Agreeing compromise arrangements with suppliers	Below £1k, Deputy Director of Finance Above £1k and below £25k, Director of Finance Above £25k, Finance Committee	SFIs section 8.8
12 STORES AND STOCKS			
12a	System of stock control, receipting, issues, returns and losses	Director of Finance	SFIs section 12.2.5
12b	Control of stores		
	i. Pharmaceutical	Director of Pharmacy	SFIs section 12.2.3
	ii. Fuel stores	Director of Estates and Facilities	SFIs section 12.2.4
	iii. All other stores	Relevant Divisional/Corporate Services Manager	SFIs section 12.2.2
12c	Condemning and disposal of goods (excluding fixed assets – see section x)	All losses must be reported to the Director of Finance in accordance with section 14	
	i. Pharmaceutical Items	Director of Pharmacy	SFIs section 12.2.3
	ii. X-ray films	Head of Radiology	SFIs section 12.2.4
	iii. Computer equipment	Director of Information Management and Technology	
	iv. All other goods with a current/estimate purchase price up to £1k	Relevant Divisional/Corporate Services Manager	SFIs section 12.2.2
	v. All other goods with a current/estimate purchase price between £1k and £25k	Divisional/Corporate Director or nominated deputy	
	vi. All other goods with a current/estimate purchase price over £25k	Director of Finance	
13 LOSSES WRITE OFFS AND SPECIAL PAYMENTS (to be reported to the Audit Committee on a quarterly basis)			
13a	Maintenance of losses and special payments register	Director of Finance	SFIs section 15.2.3
13b	Loss/damage due to theft, fraud, corruption or criminal activity	Chief Executive or Director of Finance	SFIs section 15.2.3
13c	Write off of bad debts, abandoned claims and fruitless payments	Below £1k – Deputy Director of Finance Above £1k and below £50k – Chief Executive Over £50k – Trust Board	SFIs section 15.4.1
13d	Ex-gratia payments to compensate for loss or damage to personal effects or for out of pocket expenses	Below £1k – Deputy Director of Finance Above £1k and below £50k – Chief Executive Over £50k – Trust Board	SFIs section 15.5.2
13e	Personal Injury Claims		SFIs section 15.5.3

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	• Up to £10,000	Director of Workforce and Organisational Development or Chief Executive or Director of Finance – without legal advisor	
	• Over £10,000	Director of Workforce and Organisational Development or Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	
13f	Public Liability Claims		SFIs section 15.5.4
	• Up to £3,000	Divisional/Corporate Director or Chief Executive or Director of Finance – without legal advice	
	• Over £3,000	Divisional/Corporate Director and Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	
13e	Compensation (no limit) payments made under legal obligation	Chief Executive and Director of Finance	
13f	Maladministration and distress payments where there was no financial loss by the claimant. • Remedy up to £1,000; • Remedy between the value of £1,001 and £50,000; • Remedy over the value of £50,000.	Director of Finance or Deputy Director of Finance Chief Executive Trust Board	SFIs section 15.5.10
13g	Cancellation of NHS debts • Up to £5,000 • Over £5,000	Deputy Director of Finance or Divisional Financial Manager Director of Finance or nominated deputy	
13h	Extra-contractual payments to contractors • Up to £25,000 • Between £25,000 and £100,000 • Over £100,000	Director of Finance or Deputy Director of Finance Chief Executive Trust Board	SFIs section 15.5.11
14 CHARITABLE FUNDS/DONATIONS			
14a	Administration of Trust charitable funds	Above and Beyond	SFIs section 16.2.2
14b	Acceptance of donations of goods or cash from charitable bodies relating to capital defined expenditure	Trust's Capital programme Steering Group	SFIs section 16.2.6
15 AUDIT			
15a	Establishment of an internal audit function	Director of Finance	SFIs section 17.3.1
15b	Appointment of External Auditors	Council of Governors	SFIs section 17.5.2
15c	Implementation of agreed internal and external audit recommendations	Divisional/Corporate Directors	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
16 INFORMATION MANAGEMENT AND TECHNOLOGY			
16a	Security and accuracy of Trust computerised financial data	Director of Finance	SFIs section 18.2.1
16b	Implementation of new and amendments to existing financial IT systems and approval of any Trust systems with an impact on financial transactions	Director of Finance	SFIs section 18.2.3
16c	Compliance with Freedom of Information Act	Trust solicitor	SFIs section 18.3.1
16d	Implementation, upgrades or changes to general computer systems	Information Management and Technology Committee	SFIs section 18.3.2
17 CAPITAL INVESTMENT AND PRIVATE FINANCING			
17a	Approval of the Trust's Capital Investment Policy annually.	Trust Board	SFIs section 19.2.2
17b	Business case approval – high risk schemes		Capital Investment Policy
	i. >1% of Trust turnover (£5.87m)	Outline and Full business case to be approved by Trust Board and Council of Governors	
	ii. Between 0.25% and 1% of Trust turnover (between £1.47m and £5.87m)	Comprehensive business case to be approved by Trust Board and Council of Governors	
	iii. Less than 0.25% of Trust turnover (less than £1.47m)	Short form business case to be approved by Trust Board and Council of Governors	
17c	Business case approval – other schemes outside of high risk and less than 1% of trust turnover (£5.87m)		Capital Investment Policy
	i. > 0.5% of Trust turnover (between £2.94m and £5.87m)	Comprehensive business case to be approved by Finance Committee	
	ii. Between 0.25% and 0.5% of Trust turnover (between £1.47m and £2.94m)	Comprehensive business case to be approved by Senior Leadership Team	
	iii. Less than 0.25% of Trust turnover (less than £1.47m)	Short form business case to be approved by Capital Programme Steering Group	
17d	Approval of Trust's Medium Term Capital Programme	Trust Board	
17e	Approval of all finance and operating leases	Director of Finance	SFIs Section 19.3.3
17f	Private Finance Initiative	Trust Board	
18 CAPITAL EXPENDITURE – supported by section 10 re procurement			
18a	Approval of Trust's annual capital programme	Trust Board	
18b	Management of the Trust's annual capital programme	Capital Programme Steering Group	
18c	Approval of procurement based schemes within the annual capital programme	Director of Finance	

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
18d	Approval of estates based schemes within the annual capital programme	Director of Finance	
18e	Variations to approved capital schemes		
	i. Upto £250k	Capital programme steering Group	
	ii. Between £250k and £500k,	Senior leadership Team	
	iii. Over £500k	Trust Board	
18f	Procurement of main contractors for estates based capital schemes		
	iv. Below £5k, best value to be demonstrated	Requisitioner	
	v. Between £5k and £25k, three quotes to be obtained	Estates Manager	
	vi. Over £25k and upto £1m, three tenders to be obtained	Director of Estates and Facilities	
	vii. Over £1m	Capital Programme Steering Group	
18g	Enabling works for capital schemes		
	Below £5k, best value to be demonstrated	Requisitioner	
	ii. Between £5k and £25k, three quotes to be obtained or medium term contractor can be used	Estates Manager	
	iii. Over £25k and upto £1m, three tenders to be obtained	Director of Estates and Facilities	
	iv. Over £1m	Capital Programme Steering Group	
18h	Feasibility fees given compliance with 10a and 10b	Director of Estates and Facilities	
19 TRUST ASSETS			
19a	Maintenance of a fixed asset register	Director of Finance	SFIs section 20.2.1
19b	Authority to dispose of (sell or transfer to another organisation or scrap) a fixed asset	Director of Finance	SFIs section 20.5
19c	Security of fixed assets and notification of loss or transfer to another department	Service Manager	SFIs section 20.3
20 RETENTION OF DOCUMENTS			
20a	Retention of records and documents	Relevant Divisional/Corporate Director	
21 RISK MANAGEMENT AND INSURANCE			
21a	Risk management arrangements	Chief Executive	SFIs section 22.2.1
21b	Insurance Policies		
	i. Arranging and ensuring adequate cover	Director of Finance	SFIs section 22.3

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	ii. Notifying Director of Finance of new or changed risks	All staff	SFIs section 22.3.2
22 GIFTS HOSPITALITY AND SPONSORSHIP			
22a	Maintaining a register of gifts, hospitality and sponsorship	Trust Secretary	SFIs section 23.2.3
22b	Acceptance of gifts		SFIs section 23.3
	i. Business articles less than £25 per gift	Receiving member of staff may accept with no requirement to register	SFIs section 23.3.1
	ii. Gifts over £25 but below £40 per gift or several small gifts of a value over £100 from same source over 12 month period	Receiving member of staff may accept with if declared and registered	SFIs section 23.3.2
	iii. Gifts over £40 per gift	Receiving member of staff should decline or seek Trust Secretary advice	SFIs section 23.3.3
22c	Acceptance of hospitality		SFIs section 23.4
	i. Modest hospitality if normal and reasonable in the circumstances	Receiving member of staff may accept but should refer to line manager or relevant Director if in doubt	SFIs section 23.4.1
	ii. Inappropriate hospitality offers	Member of staff should notify Trust Secretary.	SFIs section 23.4.2
22d	Sponsorship		SFIs section 23.5
	i. Commercial sponsorship for attendance at conference or course	Approval from line manager	SFIs section 23.5.1
	ii. Sponsorship of Trust events	Approval by Trust secretary, contractual agreement signed by Director of Finance	SFIs section 23.5.2
22e	Acceptance of preferential rates or benefits in kind for private transactions with companies with which there have been or could be dealings with on Trust business	Not permissible by any member of staff unless a concessionary agreement negotiated by the Trust or NHS on behalf of all staff.	SFIs section 23.5.5
23 Research and Development			
23a	Authorisation or research funding applications	Director of Finance or designated deputy for funding applications	
23b	Authorisation of commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.	Director of Research & Innovation or designated deputy	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
23c	The West of England Clinical Research Network (CRN:WoE) Decision to provide additional funding to an NHS partner of the CRN:WoE following a request for financial support; Of £50,000 or below In excess of £50,000	 Senior Leadership Team Senior Leadership team	
24 Other			
24a	Reporting of incidents to the police	Chief Executive, Director of Finance, Chief Internal Auditor	SFIs Section 15.3.2 & 17.3.1c
	▪ general	Appropriate departmental manager – need to inform Divisional Director or relevant Corporate Director as soon as possible. Also inform Local Security Management Specialist	
	▪ where a fraud is involved	Director of Finance or Local Counter Fraud Specialist	Counter Fraud Policy
24b	Compliance with Freedom of Information Act	Trust ~~Solicitor~~ Secretary	Freedom of Information Policy – December 2009
24c	Grievance procedure/appeals board procedures	Director of Workforce and Organisational Development	Disciplinary Policy Managing Performance Policy Grievance Policy
24d	Dismissal	See Matrix	Disciplinary Policy and Procedure
24e	Authorisation of new drugs or significant change of use of existing drugs	Medicines Advisory Group– see specific guidelines and terms of reference of this committee	
	▪ Request for new drugs require authorisation before purchase	Senior Pharmacy Manager	
	▪ Orders placed to suppliers over £5,000 to be signed	Director of Pharmacy or Pharmacy Purchasing Manager	
	▪ Pharmacy Payment Lists to be authorised ▪ Copy invoices over £10,000 and invoices from NHS bodies to be sent with the Payments Lists to Creditor Payments	Director of Pharmacy or Pharmacy Purchasing Manager or Senior Pharmacy Clerical Officer	
	▪ Pricing agreements and quotations should be authorised	Director of Pharmacy and Pharmacy Purchasing Manager	
	▪ Authorisation of coding slips for invoices and credits requirement payment to be carried out	Senior Clerical Officer	
24g	Patients' & Relatives' Complaints :		
	▪ Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Nurse	

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ Responsibility for ensuring complaints relating to a division are investigated thoroughly	Divisional Director and Head of Nursing / Midwifery	
	▪ Legal Complaints - Co-ordination of their management	Trust Solicitor	
24h	Relationship with the media	Head of Communications who reports to the Chief Executive	
24i	Infection Control and Prevention • Corporate Policy • Divisional and Clinical Delivery	Director of Infection Control and Prevention / Chief Nurse /Clinical Chairs	Standing Orders section 2.10
24j	Governance and Assurance Systems Corporate Risk Register Divisional Risk Registers Quarterly review of Risk Registers Reports on the Risk Registers quarterly Maintenance of the Assurance Framework Quarterly review of Assurance Framework Exception Reports on the Assurance Framework (1/4ly)	 Relevant Executive Directors Divisional Directors and Divisional Managers Risk Management Group Senior Leadership Team Trust Company Secretary Senior Leadership Team Audit Committee	SFIs Section 22
24k	All proposed changes in bed allocation	Chief Operating Officer	
24l	Review of Fire Precautions	Fire Safety Manager	Fire Safety Policy and Fire Standards Procedures and Guidelines
	Review of all statutory compliance: legislation and Health and Safety requirements including control of substances hazardous to health regulations	Director of Estates and Facilities / Health and Safety Advisor	Control of Substances Hazardous to Health (COSHH) Policy
24m	Review of compliance with environmental regulations for example those relating to clean air and waste disposal	Director of Estates and Facilities	Operational Policy for Handling Disposal of Waste – August 2005
24n	Review of Trust's compliance with Data Protection Act	Director of Information Management and Technology	Health Records Policy
24o	Review the Trust's compliance with the Access to Records Act	Director of Information Management and Technology	Health Records Policy
24p	Allocation of sealing in accordance with standing orders	Trust Company Secretary on behalf of the Chief Executive	
24q	The keeping of a Register of Sealing	Trust Company Secretary on behalf of the Chief Executive	Section 8 Standing Orders
24r	Affixing the Seal	Chief Executive (or, should the Chief Executive not be available, another Executive Director not from the contract's originating department) and Director of Finance or Head of Finance	
24s	Clinical Audit	Medical Director	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
24t	Human Rights Act Compliance	Trust Solicitor	
24u	Equality and Diversity Schemes	Director of Workforce and Organisational Development	
24v	Child Protection	Chief Nurse	Section 2.10 Standing Orders

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST - SCHEME OF DELEGATION

	DELEGATED MATTER	AUTHORITY DELEGATED TO	Change Control
1. BUDGETS			
1a	Financial control, budgetary management	Chief Executive and Director of Finance	1a
	Financial policies and internal financial control systems	Director of Finance	1a
	Maintenance and review of Trust's financial procedures	Director of Finance	1a
1b	Annual planning and budgets	Chief Executive and Director of Finance	2a
	Divisional/Corporate Service operational plans	Clinical Chairs/Divisional Directors/Corporate Service Director	
1c	Budget delegation		
	▪ individual cost centre level	Budget holder or nominated deputy	3a
	▪ department level	Departmental manager or nominated deputy	
	▪ divisional level	Clinical Chair / members of the Divisional Board as authorised by the Clinical Chair. The Divisional Board may consist of: a. Divisional Director b. Divisional Manager c. Head of Nursing d. Divisional Financial Manager e. HR Business Partner	
	▪ corporate service level	Director of Facilities and Estates Director of Information Management Technology Corporate Director or delegated deputy	
1d	Virements A virement is described as a transfer of funding between budget lines whether within or between departments. All virements require consultation with and the approval of the Divisional Financial Manager		3b but simplified
	▪ Between pay budget lines within a department.	Budget holder with one of the following:	
	Virement not to exceed overall department pay budget value.	Head of nursing/modern matron Divisional Director/Manager or Assistant Departmental Head Director of Facilities and Estates Director of Information Management Technology	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ Between non-pay budget lines within a department: Virement not to exceed overall department non-pay budget value	Budget holder	3b
	▪ Between Divisional/Department Up to £5,000 Over £5,000 Virements must be supported by appropriate paperwork maintained by the Finance department • Between Divisions	 Budget holder for both Departments / Divisions Budget holder and Divisional Manager/Director of Facilities and Estates/Director of Information Management Technology or appropriate Deputy of both Departments/Divisionals Divisional Director / Director of Facilities and Estates / Director of Information Management Technology by joint agreement	3b
	All virements from reserves Virements must be supported by appropriate paperwork maintained by the Finance department	Director of Finance or nominated Deputy	3b

2. BANK ACCOUNTS AND INVESTMENTS			
2a	Maintenance and operation of bank accounts Overall control of Trust bank accounts	Director of Finance Director of Finance	6a
2b	Maintenance of operating procedures and instructions	Director of Finance	6a
2c	Opening of bank accounts	Director of Finance	6a
2d	Approved cheque (and other payable order) signatories encompassing approval requirements • Cheque payments over single signatory limits • Cheque drawn to cash	 Chief Executive or Director of Finance or nominated Senior Finance Manager Director of Finance	6d 6d 6d
2e	Approved bank transfer signatories	Chief Executive or Director of Finance or nominated Senior Finance Manager	6d
2f	Investment of surplus cash	Director of Finance or nominated Senior Finance Manager	6g
2g	Application for loan or working capital facility	Director of Finance	7c

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
3	**Non-pay revenue and capital expenditure\requisitioning\ordering\payment of goods and services.** Financial thresholds in this section mirror the procurement limits and as such exclude VAT Where there is an order/contract for more than one financial year, the total cost must be included not just the 12 months element.		
3a	Ordering ▪ up to £5,000 ▪ £5,000 to £25,000 ▪ £25,000 to EU Threshold ▪ EU Threshold to £1m ▪ Over £1m	Requisitioner as specifically designated by budget holder Budget holder or authorised deputy Divisional Director / Director of Facilities and Estates / Director of Information Management Technology / relevant Corporate Director or authorised deputy Director of Estates and Facilities to authorise all Estates and Facilities services orders, Relevant Corporate Director or authorised deputy for all other services Chief Executive, after approval by Trust Board	10a and 10e EU threshold taken out as delegated responsibility doesn't change with it Split out procuring (10a) and ordering (10e) as decision to procure is key and requires controls, placing orders once procurement has been approved doesn't require same level of control.
3b	Capital expenditure and investment Subject to the above tendering and quotation limits and in accordance with the Capital Investment Policy, the following will apply. • Equal to or less 0.25% of turnover including VAT, a short form business case is required for approval. It must justify the investment, demonstrate value for money and identify the recurring revenue consequences. • Greater than 0.25% of turnover and less than or equal to 0.5% of turnover – a comprehensive business case is required for approval. • Greater than 0.5% of turnover and less than or equal to 1.0% of turnover a comprehensive business case is required for approval.	Capital Programme Steering Group Senior Leadership Team Finance Committee	17b and c Mirrors capital investment policy and splits between high and low risk

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	• Greater than 1.0% of turnover, an Outline Business Case is required for approval followed by a Full Business Case for approval.	Trust Board	
	Capital Expenditure – variations to approved business case. • Up to £250,000 • Over £250,000 to £500,000 • Over £500,000	 Capital Programme Steering Group Senior Leadership Team Trust Board	18e
	Selection of architects, quantity surveyors, consultant engineers and other professional advisors within European Union regulations.	Director of Facilities and Estates and/or Strategic Development Programme Director	Removed as requires same tendering process as all other services
	Financial Monitoring and reporting on all capital scheme expenditure	Director of Finance or nominated Deputy	18b but changed to CPSG
3c	Payment for goods and services • Certified invoices • Pre-payments	 Budget holder or authorised signatory for cost centre Director of Finance	11a – greater clarity 11b
3d	Negotiations with suppliers • Up to £1,000 • Over £1,000 to £25,000 • Over £25,000	 Head of Finance Director of Finance Finance Committee	11e
3e	Approving expenditure greater than tendered or quoted price by the lesser of 10% or £100: ▪ Up to £5,000 ▪ £5,000 to £25,000 ▪ Over £25,000	 Budget Holder or nominated deputy Divisional Director / Director of Facilities and Estates / Director of Information Management Technology Director of Finance	11a

4	**Capital Investment**		
4a	Approval of the Trust's Capital Investment Policy annually.	Trust Board	18a
4b	Approval of procurement strategy	Director of Strategic Development and Director of Finance	Removed – procurement in normal manner
4c	Selection of advisors	Director of Strategic Development and/or Strategic Development Programme Director	Removed – normal tendering
4e	Signing of contracts	Chief Executive	10d ix

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
4f	Changes to project management infrastructure	Director of Strategic Development	Removed – not SFI
4g	Sign off of projects	Director of Strategic Development	18d – changed to Director of Finance as part of CPSG
4h	Financial monitoring of major capital scheme expenditure	Director of Finance and Director of Facilities and Estates and / or Strategic Development Programme Director	18b – changed to CPSG
4i	Private Finance • Approval of Business Case	 Trust Board	17f
4.j	Leasing • Approval of Lease Proposals	 Director of Finance	 17e
5	**Quotation, Tendering and Contract Procedures Value of supplies or services are defined as the total cost over the period of the contact. All thresholds in this section exclude VAT**		
5a	Supplies and Services ▪ Up to £5,000 – best value to be demonstrated non competitive quotations in writing may be obtained ▪ £5,000 to £25,000 Minimum of 3 competitive quotations shall be obtained in writing ▪ £25,000 and over Minimum 4 competitive quotations shall be obtained in writing ▪ Over £1,000,000 minimum of 4 competitive quotations shall be obtained in writing	 Requisitioner Budget holder Divisional Director / Director of Facilities and Estates / Director of Information Management Technology / Corporate Director Trust Board	10a
5b	Wavering or variations of tendering or quotation requirements ▪ £5,000 to £25,000 ▪ £25,001 and above All breaches of these provisions shall be reported to the Audit Committee through the Chief Executive	 Divisional Director may approve single tender quotation, with Head of Procurement sign off Director of Finance may approve single tender quotation, with Head of Procurement sign off	10b
6	**Setting of Fees and Charges**		9a – greater clarity
6a	Private Patients, overseas visitors, income generation and other patient related services	Director of Finance or nominated deputy	9a
6b	Service Agreements ▪ Under £1m ▪ Over £1m	 Director of Finance or nominated deputy in consultation with Director of Strategic Development Chief Executive and Director of Finance in consultation with the with Director of Strategic Development	9a – changed authorised levels
7	**Expenditure of Charitable Funds**	Managed by the Charitable Trust of the University Hospitals Bristol NHS Foundation Trust	14a
8	**Condemning & Disposal**		

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
8a	Items obsolete, redundant, irreparable or cannot be repaired cost effectively. ▪ with a current or estimated purchase price up to £1,000. ▪ with a current purchase price of £1,000 - £25,000	 Divisional Manager Divisional Director or nominated deputy	 12c iv 12c v
	▪ with a current purchase price over £25,000.	Director of Finance	12c vi
8b	Disposal of x-ray films	Radiology Departmental Manager / Divisional Director / Divisional Manager	12c ii
8c	Disposal of mechanical engineering plant.	Director of Facilities and Estates	Removed – considered in with 8a
9	**Losses, write off and compensation payments.**	**These should be reported to the Audit Committee on a quarterly basis.**	13 – all covered but clearer
9a	All losses in any of the categories below up to £1,000 (subject to reporting the loss) All losses over £1,000 up to £50,000 All losses over £50,000	Executive Director Chief Executive or Director of Finance Trust Board	13c
9b	Losses of cash due to theft, fraud, overpayment of salaries and others.	Chief Executive, Director of Finance (or nominated Deputy re overpayment of salaries)	13b
9c	Fruitless payments including abandoned capital schemes.	Chief Executive and Director of Finance	13c
9d	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors and Others	Chief Executive and Director of Finance or nominated Deputy	13c
9e	Damage to buildings, fittings, furniture and equipment and property in stores and in use due to culpable cause (fraud, theft, arson).	Chief Executive and Director of Finance	13b
9f	Compensation (no limit) payments made under legal obligation	Chief Executive and Director of Finance	13g
9g	Extra contractual payments to contractors up to £50,000	Chief Executive and Director of Finance	13j
9h	Personal Injury Claims • Up to £10,000 • Over £10,000	 Director of Workforce and Organisational Development or Chief Executive or Director of Finance – without legal advisor Director of Workforce and Organisational Development or Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	13e
9i	Public Liability Claims • Up to £3,000 • Over £3,000	 Divisional Director or Chief Executive or Director of Finance – without legal advice Divisional Director or Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	13f

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
9j	Other, except cases of, maladministration where there was no financial loss by the claimant. • Remedy up to £1,000; • Remedy between the value of £1,001 and £50,000; • Remedy over the value of £50,000.	Director of Finance or Head of Finance Chief Executive Trust Board	13h
9k	Ex-gratia payments patients and staff for loss of personal effects ▪ Up to £1,000	Director of Finance or nominated deputy	13d
	▪ between £1,001 and £50,000 ▪ Over £50,000	Chief Executive Trust Board	
9l	Cancellation of NHS debts • Up to £5,000 • Over £5,000	Head of Finance or Divisional Financial Manager Director of Finance or nominated deputy	13i
9m	Maladministration and distress payments • Remedy up to £1,000; • Remedy between the value of £1,001 and £50,000; • Remedy over the value of £50,000.	Director of Finance or Head of Finance Chief Executive Trust Board	13h

10	**Petty Cash Disbursements**		11d
	▪ expenditure up to £50 per item with the exception of wage advances ▪ expenditure over £50 per item	Budget holder or nominated deputy Divisional Manager	

11	**Hospitality**		22 – greater detail
11a	Receiving hospitality for individual and collective hospitality receipt items in excess of £25 per item received	Receiving member of staff required to declare hospitality has been received.	
11b	The keeping of the Hospitality Register and Register of Interests	For Corporate Divisions – Corporate Directors All other Divisions – held by Divisional Director	

12	**Implementation of internal and external audit recommendations.**	Divisional Directors and Corporate Directors	15c

13	**Contracts and SLAs**	Chief Executive or Director of Finance in consultation with the Director of Strategic Development	Greater clarity on healthcare services – section 5 and other provision of goods and services – section 9

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
13a	Agreements/Licences		9a and 9b
	Preparation and signature of all tenancy agreements/licences for all staff subject to Trust policy on accommodation	Director of Estates and Facilities or nominated deputy	9b
	▪ form of tenancy agreements	Director of Estates and Facilities or nominated deputy	
	▪ signature of individual tenancy agreements	Residences Manager	
	Extensions to existing agreements	Residences Manager	9b
	Letting of premises to outside organisations	Director of Estates and Facilities or nominated deputy	9b
	Approval of rent based on professional assessment	Director of Finance	9b
13b	SLA monitoring and reporting	Director of Finance or nominated deputy in conjunction with the Chief Operating Officer and relevant Corporate Directors	5c
13c	SLA management	Director of Finance or nominated deputy in conjunction with the Director of Strategic Development and relevant Corporate Directors and Divisional Directors	5c and 5d
13d	Monitor proposals for contractual arrangements between the Trust and outside bodies.	Delegated lead as defined in the framework document	removed
13e	Review of the Trusts Compliance Code of Practice for handling confidential information in the contracting environment.	Medical Director	removed
14	**Legal**		
14a	Reporting of incidents to the police	Chief Executive, Director of Finance, Chief Internal Auditor	24a
	▪ general	Appropriate departmental manager – need to inform Divisional Director or relevant Corporate Director as soon as possible. Also inform Local Security Management Specialist	
	▪ where a fraud is involved	Director of Finance or Local Counter Fraud Specialist	
14b	Compliance with Freedom of Information Act	Trust Solicitor	24b
15	**Personnel and Pay**		
15a	Authority to fill funded post on the establishment with permanent staff	Budget holder or nominated deputy (subject to any vacancy review policy in place)	8e i
15b	Authority to appoint staff to post not on the formal establishment	Head of Division or Executive Director with Head of Human Resources and Director of Finance	8e ii
15c	The granting of additional increments to staff within the defined payscale for the post held	Within terms & conditions Human Resources Business Partner	8f
15d	Upgrading and re-grading	Head of Division for Divisions Corporate Directors for corporate teams Director of Estates and Facilities for Estates and Facilities Director of Information Management Technology for Information Management Technology	8g
15e	Establishments		
	▪ additional staff to the agreed establishment within specifically allocated finance	Divisional Manager with appropriate Human Resource advice	Removed as considered duplicate of 15a

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ additional staff to the agreed establishment without specifically allocated finance	Head of Division or Executive Director with Head of Human Resources and Director of Finance	Removed as considered duplicate of 15b
15f	Pay Authority to complete standing data forms effecting pay, new starters, variations and leavers Authority to complete and authorise positive reporting forms Authority to authorise overtime Authority to authorise travel and subsistence expenses Approval of performance related pay	 Budget holder or nominated deputy Budget holder or nominated deputy Budget holder or nominated deputy Budget holder or nominated deputy Remuneration Committee	8h, 8i, 8j,
15g	Leave Approval of annual leave Annual leave carried forward up to Trust agreed limit Annual leave carried forward in excess of Trust agreed limit Any special leave Medical staff leave of absence Time off in lieu Maternity leave paid and unpaid Sick Leave Extension of sick leave after half pay completed Return to work part time on full pay to assist recovery Extension of sick leave on full pay	 Line manager Line manager Divisional Director or Corporate Director Line manager, in accordance with agreed Human Resource policies Clinical Chair/Medical Director Line manager Line manager Line manager Divisional Managers and senior corporate managers after discussion with Head of Human Resources Divisional Managers or Corporate Director in conjunction with Head of Human Resources Divisional Director or Corporate Director in conjunction with Head of Human Resources	8k, 8l
15h	Removal Expenses ▪ up to £8,000 • above £8,000	 Divisional Human Resource Business Partner in conjunction with Payroll Manager Head of Human Resources and Director of Finance	8r changed to Director of Finance
15i	Grievance procedure/appeals board procedures	Director of Workforce and Organisational Development	24c
15j	Authorised car users ▪ requests for new post to be authorised as car users ▪ authorised car users – request for extension	 Divisional Manager or Corporate Director Divisional Manager or Corporate Director	8p
15k	Authorised mobile phone users - requests for new phones to be authorised within Trust policy	Divisional Manager or Corporate Director	8p
15l	A renewal of fixed term contracts	Budget holder or nominated deputy	8e
15m	Staff retirement policy extension of contract beyond normal retirement age in exceptional circumstances Early retirement in furtherance of efficiency	Divisional Director Director of Workforce and OD and Director of Finance	8n

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
15n	Redundancy	If payment is up to the value of the annual salary – Director of Workforce and Organisational Development If payment is beyond annual salary – Director of Workforce and Organisational Development and Director of Finance. If employee over minimum early retirement age – Director of Workforce and Organisational Development and Director of Finance	8m
15o	Dismissal	See Matrix	24d
15p	Engagement of staff not on the establishment Non Medical consultancy staff • Where the aggregate commitment is up to £100,000 • £100,000 to £500,000 • Over £500,000	 Divisional Director or relevant Corporate Director – in line with tendering procedures Director of Finance Chief Executive	8s but changed – see report
	Engagement of Trust Solicitors	For specific Human Resource related issues: Head of Human Resources For property issues – Director of Estates and Facilities All other matters – Director of Finance or Chief Executive	removed
	Booking of Bank\Locum\Agency Staff ▪ Nursing ▪ Clerical/support services ▪ Medical	 Budget holder or nominated deputy Budget holder or nominated deputy Clinical Chair/some or all of the Divisional Board as authorised by the Clinical Chair. Divisional Board may consist of: a. Divisional Director b. Divisional Managers c. Head of Nursing d. Divisional HR Business Partner	
	Consultancy Services (outside major strategic capital projects) Up to £1,000 Over £1,000 - £5,000 Over £5,000	 Divisional Manager or Corporate Director Corporate Director or Divisional Director Chief Executive	

16. GENERAL			
16a	Authorisation of new drugs or significant change of use of existing drugs	Medicines Advisory Group-- see specific guidelines and terms of reference of this committee	24e

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	▪ Request for new drugs require authorisation before purchase ▪ Orders placed to suppliers over £5,000 to be signed	Senior Pharmacy Manager Director of Pharmacy or Pharmacy Purchasing Manager	24e 24e
	▪ Pharmacy Payment Lists to be authorised ▪ Copy invoices over £10,000 and invoices from NHS bodies to be sent with the Payments Lists to Creditor Payments	Director of Pharmacy or Pharmacy Purchasing Manager or Senior Pharmacy Clerical Officer	24e
	▪ Pricing agreements and quotations should be authorised	Director of Pharmacy and Pharmacy Purchasing Manager	24e
	▪ Authorisation of coding slips for invoices and credits requirement payment to be carried out	Senior Clerical Officer	24e
16b	Authorisation of sponsorship deals ▪ all deals to be vetted for potential legal and other conflicts plus: ▪ up to £15,000 ▪ £15,000 to £50,000 ▪ over £50,000	 Trust Solicitor Divisional Director Director of Finance Chief Executive	22d ii
16c	Authorisation of commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.	Director of Finance or designated deputy for funding applications Director of Research & Innovation or designated deputy for all other Research & Innovation documents	25a
16d	Insurance Policies	Director of Finance	21b
16e	Patients' & Relatives' Complaints :		24g
	▪ Overall responsibility for ensuring that all complaints are dealt with effectively ▪ Responsibility for ensuring complaints relating to a division are investigated thoroughly ▪ Legal Complaints - Co-ordination of their management	Chief Nurse Divisional Director and Head of Nursing / Midwifery Trust Solicitor	
16f	Relationship with the media	Head of Communications who reports to the Chief Executive	24h
16g	Infection Control and Prevention • Corporate Policy • Divisional and Clinical Delivery	Director of Infection Control and Prevention / Chief Nurse /Clinical Chairs	24i
16h	Governance and Assurance Systems Corporate Risk Register Divisional Risk Registers	 Relevant Executive Directors Divisional Directors and Divisional Managers	24j

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	Quarterly review of Risk Registers Reports on the Risk Registers quarterly Maintenance of the Assurance Framework Quarterly review of Assurance Framework Exception Reports on the Assurance Framework (1/4ly)	Risk Management Group Senior Leadership Team Trust Company Secretary Senior Leadership Team Audit Committee	
16i	All proposed changes in bed allocation	Chief Operating Officer	24k
16j	Review of Fire Precautions	Fire Safety Manager	24l
	Review of all statutory compliance: legislation and Health and Safety requirements including control of substances hazardous to health regulations	Director of Estates and Facilities / Health and Safety Advisor	24l
16k	Review of compliance with environmental regulations for example those relating to clean air and waste disposal	Director of Estates and Facilities	24m
16l	Review of Trust's compliance with Data Protection Act	Director of Information Management and Technology	24n
16m	Review the Trust's compliance with the Access to Records Act	Director of Information Management and Technology	24o
16n	Allocation of sealing in accordance with standing orders	Trust Company Secretary on behalf of the Chief Executive	24p
16o	The keeping of a Register of Sealing	Trust Company Secretary on behalf of the Chief Executive	24q
16p	Affixing the Seal	Chief Executive (or, should the Chief Executive not be available, another Executive Director not from the contract's originating department) and Director of Finance or Head of Finance	24r
16q	Retention of Records	Relevant Corporate Directors	20a
16r	Clinical Audit	Medical Director	24s
16s	Human Rights Act Compliance	Trust Solicitor	24t
16t	Equality and Diversity Schemes	Director of Workforce and Organisational Development	24u
16u	Child Protection	Chief Nurse	24v
16v	The West of England Clinical Research Network (CRN:WoE) Decision to provide additional funding to an NHS partner of the CRN:WoE following a request for financial support; Of £50,000 or below In excess of £50,000	 West of England Clinical Research Network Executive Group West of England Clinical Research Network Partnership Group	25b

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
19. Quarterly Capital Projects Status Report									
Sponsor and Author(s)									
Sponsor: Deborah Lee, Chief Operating Officer / Deputy Chief Executive **Author**: Andy Headdon, Strategic Development Programme Director									
Intended Audience									
Committee members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose The purpose of this report is to update the Board on the progress, issues and risks' arising from the Trust's remaining major capital developments which are governed through the Strategic Development Department and associated programme infrastructure. Key issues to note • All phase 4 ward moves are now complete and have been occupied. • Works to remodel and refurbish King Edward Building have now commenced. • Due to earlier delays in tendering the contract and unavoidable delays in wards moves, the KEB programme timeline is very tight but is deliverable if no unforeseen issues are encountered and no other slippage occurs. Penalties for programme delays have been incorporated into the contract.
Recommendations
The Board is asked to receive this update for **assurance** that the strategic development is on track and being effectively governed.
Impact Upon Board Assurance Framework
Central to delivery of strategic objective 2.1
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
N/A
Resource Implications

Finance	X	Information Management & Technology	
Human Resources		Buildings	X

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date report submitted to other sub-committee				
Finance Committee	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Quarter 3
29th January 2016 Trust Board

1. Introduction

This status report provides a summary update for Quarter 3 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. Project Updates

Bristol Royal Infirmary Redevelopment Phase 3, Centralisation of Specialist Paediatrics and the Bristol Haematology and Oncology Centre have all completed, with final accounts settled and final submissions in progress with HMRC to finalise VAT recovery amounts.

BRISTOL ROYAL INFIRMARY Phase 4 and Queens Facade		
1	**Decisions required**	None
2	**Progress**	**Old Building** Decommissioning of the Old Building is progressing in line with the programme to vacate departments. The scheme to disconnect all services by the vacant possession date of Oct 2106 has been tendered and the contractor appointed. **Contractors Site Village/ Office accommodation** Work continues to develop the site village for temporary office accommodation. A final plan has not yet been agreed due to restricted disabled access but a number of solutions are being evaluated. All solutions remain contingent on Public Health England and histopathology services relocating to Southmead Hospital. A provisional date of 11th April has been agreed for the commencement of this move. Unite have decided to only part demolish the Old Building site, using the original structure to host their own headquarters and the medical school. They have requested early access to the courtyard area to commence demolition of the redundant estate; the team are working closely with them to facilitate this in line with the requirements of the sale agreement. **BRI Phase 4** The ward refurbishment programme for the Queens building is now fully complete with Ward A522 successfully occupied prior the Christmas. Refurbishment of King Edward Building is now fully contracted in terms of cost and programme and progress is being made in all areas. A final department sign off process is just completing to ensure the final design solution meets end user requirements. The agreed contract programme delivers the new departments by early September 2016, which only just allows vacation of the Old Building site by

		the agreed date of 1st October. This will require very careful management to ensure there is no slippage to the contract programme. Penalties for failing to deliver vacant possession apply from 1st November 2016. **Queens Façade** 97% of external windows are now installed and 85% of internal window reveals completed. The remainder of the external windows will be completed imminently as the access system is removed. The internal work to level 6 has been delayed to meet the operational needs of the ward and will be completed as soon as access can be agreed. The final design details of the free standing screen element are now finalised and the submission made to planners for the final planning condition to be discharged. Site visits by the planners to view sample panels was conducted on the 15th January and a final sign off is expected shortly. The lighting installation has commenced and is 50% complete. The works remain on programme to complete by the contract date of June 2016. A submission has been made to planners for the proposed external signage.
3	**Budget**	A total capital allocation for Phase4 and the Façade of £32.68m is in the capital programme which includes funding for façade and assumes charitable funding support of £2m. The final account has been settled on the major strategic schemes and final submissions made to HMRC to agree VAT recovery amounts for CSP and BRI, BHOC has now been fully concluded with HMRC. The programme remains within budget.
4	**Programme**	The phase 4 programme remains on programme to achieve the required vacation date of the Old Building however the slippage on wards A524, 525, 528 and the consequent effect on the KEB scheme has created some programme pressure in that all programme contingency has now been exhausted and further delays are likely to impact on vacant possession and thus attract financial penalties. Mitigations to avoid this are in place and contract penalties within the Wilmot Dixon contract will offset any penalties, in some part 40k per month against a 105k per month sanction from Unite.

		Risk	Mitigation Actions
5	**Risks**	Projects in train slip and programme is not delivered on time with resulting operational impacts.	Additional external project management support has been retained to oversee the largest projects to strengthen project management arrangements. Additionally the Strategic Development Programme Director has temporarily taken over management responsibility for all capital works to support the Director of Facilities and Estates.

3. Conclusion

The Trust Board is requested to receive this report for information, noting the risks that have been identified and the mitigation/contingency plans that have been developed though it should be noted that risks, out with the control of the Trust, have manifested in period and impacted upon cost and programme.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 14.01.2016

Cover report to the Board of Directors meeting to be held in public on Friday 29 January 2016 at 11:00am in the Board Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
20. Monitor Q3 Risk Assessment Framework Declaration									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Authors:** Deborah Lee, Chief Operating Officer / Deputy Chief Executive; Paul Mapson, Director of Finance and Information; Xanthe Whittaker, Associate Director of Performance									
Intended Audience									
Board members	✓	Regulators	✓	Governors		Staff		Public	
Executive Summary									

Purpose

All NHS Foundation Trusts require a licence from Monitor stipulating specific conditions that they must meet to operate including financial sustainability and governance requirements. The 'Risk Assessment Framework' constitutes Monitor's approach and their use of the framework to assess individual FT compliance with two specific aspects of their work: the Continuity of Services and Governance conditions in their provider licences.

The purpose of a Monitor assessment under the framework is to highlight when there is a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or poor governance.

It is important to note that concerns do not automatically indicate a breach of the licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk.

Key issues to note

This report provides an analysis of governance risk (Appendix A) and finance risk (Appendix B). Following making the necessary enquiries, the Senior Leadership Team confirmed that it is not aware of any matters arising during the quarter requiring an exception report to Monitor which have not previously been reported.

The recommendation to the Board is to declare the standards failed in quarter 3 to be, the RTT Incomplete/Ongoing pathways standard, the A&E 4-hour standard, the 62-day GP and 62-day Screening cancer standards. It is also recommended that the ongoing risks to achievement of the 62-day screening and 62-day GP cancer standards, and the A&E 4-hour standard, are flagged as part of the narrative that accompanies the declaration.

Recommendations

The Board of Directors are asked to approve the following Quarter 3 declaration for submission to Monitor on 29th January 2016:

- A submission against the 'Governance Rating' reflecting the standards failed in quarter 3 to be the RTT Incomplete/Ongoing pathways standard, the A&E 4-hour standard, the 62-day GP and 62-day Screening cancer standards;
- The recommendation that the planned ongoing failure of these standards, with the exception of RTT Incomplete/Ongoing Pathways standard, continues to be flagged to Monitor, as part of the narrative that accompanies the declaration;
- Acknowledgement of the receipt of the Regulation 28 Report following a recent Inquest;
- Confirmation that the Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months; and
- Confirmation that the Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the forecast in the financial return

Impact Upon Board Assurance Framework

This report does not result in any changes to the Board Assurance Framework.

Impact Upon Corporate Risk

This report does not result in any changes to the Corporate Risk Register.

Implications (Regulatory/Legal)

None.

Equality & Patient Impact

N/A

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	✓	For Information	

Date report submitted to other sub-committee

Finance Committee	Quality & Outcomes Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
	27/1/16		20/1/16	

Monitor Quarter 3 declaration against the 2015/16 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 3 declaration of compliance with the 2015/16 Monitor Risk Assessment Framework by the 31st January 2016.

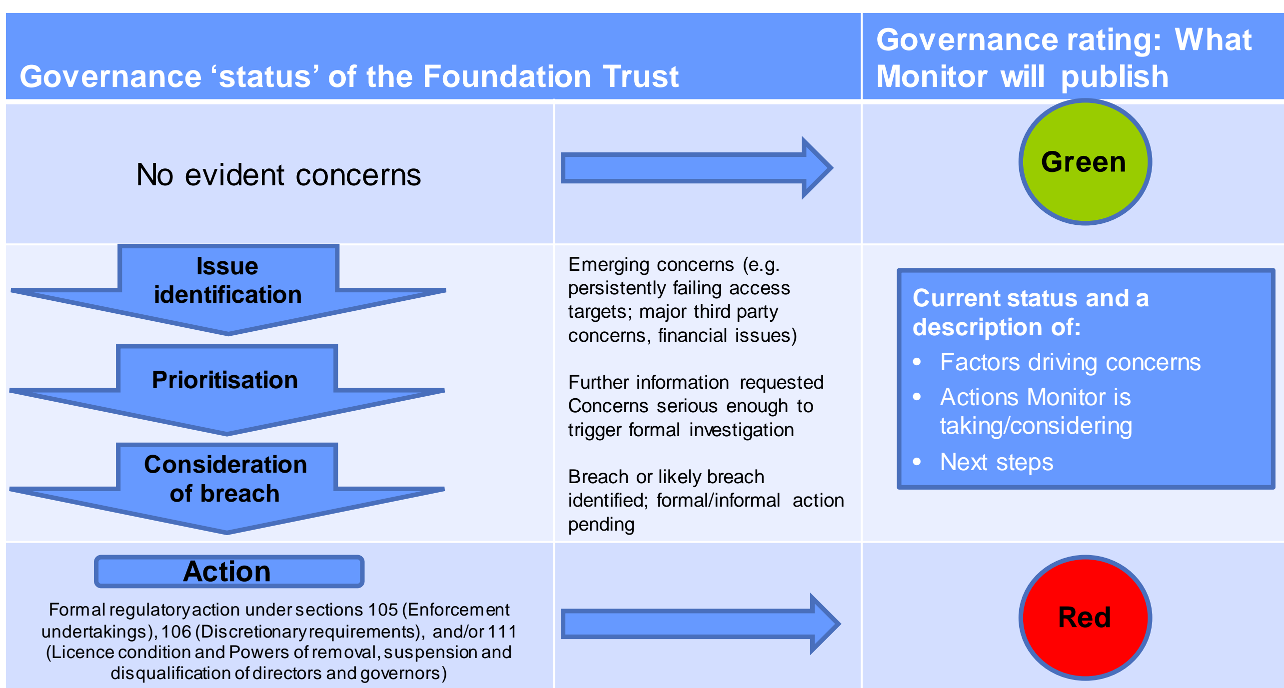
The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 3, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

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

Monitor also uses other information to signal potential Governance Concerns, using patient and staff metrics such as satisfaction rates, turn-over rates, levels of temporary staffing and other information from third party organisations.

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

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



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

Monitor compares the quarterly declarations a trust makes with its Annual Plan risk assessment. If a trust declares a standard as not met as part of its quarterly declaration, which it did not declare at risk in the annual plan risk assessment, the trust may be required to commission an independent review of its self-certification and associated processes. In the 2015/16 Monitor Annual Plan the Trust declared standards to be at risk of failure in quarter 3 and quarter 4 to be as follows:

	Quarter 3	Quarter 4
Standards not forecast to be met	RTT Non-admitted* RTT Admitted* 62-day GP cancer 62-day Screening cancer	RTT Admitted* A&E 4-hours 62-day GP cancer 62-day Screening cancer
Score	**3.0**	**3.0**

*Please note: these standards are no longer scored under the Risk Assessment Framework

2. Performance in the period

Table 2 shows the performance in quarter 3 against each of the standards in Monitor's Risk Assessment Framework. The following standards were not achieved in the quarter:

- A&E 4-hour standard (1.0)
- 62-day GP and 62-day Screening cancer standards (combined score of 1.0)
- Referral to Treatment (RTT) Incomplete/Ongoing pathways standard (score 1.0)

The A&E 4-hour standard was not achieved in the quarter, but was not declared as being at risk in the period, as part of the Annual Plan declaration.

Overall the Trust scores 3.0 against the Risk Assessment Framework, although under the rules set-out within the Risk Assessment Framework, the failure of the RTT standards, 62-day GP standard and the A&E 4-hour standards in quarter 3 would trigger Governance Concerns for repeated failures of the same standard. However, Monitor has recently restored the Trust to a GREEN rating but will continue to monitor progress with achievement of recovery trajectories.

Please note that performance against the cancer standards is still subject to final national reporting at the beginning of February and therefore the position shown in Table 2 remains draft.

Quarter 3 2015/16 risk assessment

The risk assessment detailed in Table 2 sets-out the performance against each standard in Monitor's 2015/16 Risk Assessment Framework in quarter 3, along with the key risks to target achievement for quarter 4 2015/16. The mitigating actions that are being taken are also provided, along with the residual risk.

The RTT recovery trajectories were met in each month in quarter 3. In addition, the 92% national Incomplete/Ongoing pathways standard was achieved from the end of November, two months ahead of the revised trajectory. This is the first time the RTT Incomplete pathways standard has been met since July 2014. The number of patients waiting over 18 weeks for admitted treatment is the lowest it has been since the end of November 2013. The RTT backlog reduction trajectories were revised in September, to reflect the impact of growth in demand into outpatients and additional clinical staff not coming into post when expected. These revised trajectories were signed-off by the Trust Board and by commissioners, and sent to Monitor. The failure of the admitted and non-admitted RTT standards (but not the Incomplete/Ongoing pathways standard) in Quarter 3 was declared in the Monitor Annual Plan.

The A&E 4-hour 95% standard failed to be achieved in the period. The deterioration in performance, which started in September, was associated with the rise in delayed discharges on the BRI site, resulting from new providers of domiciliary care packages not being up to full

capacity, and an acute shortage of social workers. In addition, the Children's Hospital has experienced a 7% increase in emergency admissions in quarter 3, above levels seen in the same period last year. Whilst the levels of delayed discharges decreased during December system risks, especially high levels of paediatric emergency admissions and longer than 4 hour waits at other providers, continue to be at play in quarter 4.

There continues to be the potential for failure of the 62-day Screening standard, following the transfer out of the Avon Breast Screening service. This is because the bowel screening pathway is now the highest volume reported pathway, but is a difficult one to complete within 62-days due to a high proportion of breaches resulting from patient choice and other causes outside of the Trust's control. A total of seven patients (6.5 breaches in accountability terms) were not treated within 62 days of referral in quarter 3. The reasons for the breaches were: patient choice (4 patients), delayed surgical diagnostic (2 patients), and medical deferral (1 patient). The capacity problems experienced within the colorectal service during quarter 2 also impacted, but to a lesser extent, in quarter 3. Additional theatre sessions have been established on a temporary basis prior to a substantive appointment being made in quarter 4. As noted in previous quarters, although it is expected the 90% standard will be achieved in some quarters, it is unlikely to be achieved every quarter. It is therefore recommended that the high risk of failure of this standard continues to be flagged to Monitor for quarter 4, and future quarters.

The 62-day GP cancer standard continued to be failed in quarter 3. However, the improvement trajectory was met each month, and overall performance was above that reported in quarter 2. It is recommended that the potential risk to failure of the 62-day GP cancer standard that our case-mix and late tertiary referrals brings, continues to be flagged to Monitor as part of the narrative that accompanies the declaration, along with the likely failure of the A&E 4-hour standard.

One standard is flagged as having a moderate residual risk of failure, in addition to the RTT Incomplete pathways standard, which is the 31-day subsequent surgery cancer standard. This standard along with all those at risk remain under close scrutiny through the Service Delivery Group (SDG) and the Senior Leadership Team (SLT).

3. Recommendation

The recommendation to the Senior Leadership Team is to declare the standards failed in quarter 3 2015/16 as being the RTT Incomplete/Ongoing pathways standard, the 62-day GP cancer standard, the 62-day Screening cancer standard and the A&E 4-hour standard. It is also recommended that the narrative that accompanies the declaration should flag the specified potential risks to failure against the A&E 4-hour standard, 62-day GP and 62-day screening standard, for the reasons set-out in section 3 above.

Table 2 Summary of performance in quarter 3 2015/16, and the risks to quarter 4 compliance

Indicator	Score	Achieved in Q3 2015/16?	New risks to Q4 2015/16?	Risks/Issues	Steps being taken to mitigate risks	Original risk rating	Residual risk rating[1]
18-weeks Referral to Treatment for incomplete pathways	1.0	No – 92% standard failed in October and December	No – ongoing risk of high levels of demand continuing from Q2	- Non admitted RTT treatments difficult to plan because an RTT clock may or may not stop at each outpatient attendance; - Longer than planned waits for first outpatient appointments in dental specialties in particular, due to recruitment challenges and loss of capacity; - Ongoing growth in outpatient demand above planning assumptions; - Higher than predicted paediatric emergency admissions which may result in elective cancellations in Q4; - Additional new outpatient appointments put in place to shorten waiting times for non-admitted pathways, will continue to create a 'bulge' in the elective (admitted pathways) waiting list in the short-term.	- Revised trajectories developed and being implemented, to reflect rising demand and clinician appointments not being made as planned; additional activity being delivered in quarter 4 in line with these trajectories; - Validation of long waiters to improve data quality and waiting list management; - Robust monitoring and escalation to optimise the number of long waiters booked each month; - Planned move to direct reporting from Medway (Patient Administration System) in Q1 16/17, which will enable real time reporting and as a result improve pathway management capabilities; - RTT steering group overseeing the recovery plans.	High	Moderate

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

A&E Maximum waiting time 4 hours	1.0	No	No – Ongoing risks from Q3	- Delayed Discharges rose sharply during quarters 2 and 3 due to previously flagged risk related to changes in providers of domiciliary care packages and also an acute shortage of social workers, although have now reduced - Levels of emergency admissions via the Emergency Department into the Bristol Children's Hospital have remained significantly higher that the same period last year (7%) and materially above plan; - Other local providers reporting a high proportion of over 4-hour waits, increasing the potential for ambulance diverts and high levels of variation in demand; - Performance trajectory based upon impact of system-wide actions not forecasting achievement of 95% standard in Q4.	- Escalation of risks relating to delayed discharges to partner organisation Execs; - Continued implementation of wide ranging system-wide Resilience Plan, supported by additional funding; - Further Transformation efforts focused on discharges earlier in the day, and improving flow within the Children's Hospital;	High	High
Cancer: 62-day wait for first treatment – GP Referred	1.0	No – although performance improved from Q2 and improvement trajectory met	No	- High levels of late tertiary referrals continuing to be main cause of breaches - High levels of medical deferral, patient choice, and clinical complexity (none of	- Cancer Performance Improvement Group overseeing action plan, which includes development and implementation of 'ideal timescale' pathways and offering	High	High

				which can be accounted for in waiting times and are difficult to mitigate) - Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard - Intensive Therapy Unit (ITU) / High Dependency Unit (HDU) bed related cancellations - Awareness raising campaigns likely to continue to increase demand	patients a first appointment within 7 days, wherever possible; - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work; - Patients on the cancer patient tracking list continue to be actively managed, with oversight of the waiting list through divisional and Trust-wide weekly meetings, and any delays escalated to Divisional Directors and Chief Operating Officer; - Further focus on staff recruitment and retention of nurses in order to maximise number of adult ITU/HDU beds that can be kept open in situations of high patient acuity.		
Cancer: 62-day wait for first treatment – Screening Referred		No – performance below 90% (69% of breaches outside of the control of the Trust)	No	- Following the transfer of the Avon Breast Screening Service in quarter 2 2014/15, the majority of the Breast Screening pathways will no longer be reported under this standard; breast pathways normally completed in under 62 days, unlike bowel which nationally performs well below the 90% standard; - All bowel screening	- Specialist practitioner and colonoscopy waiting times remain short and continue to be closely monitored; - Any patients on shared pathways continue to be actively tracked via our Cancer Register until treated at other providers; - Need for additional elective capacity for colorectal surgery continuously reviewed; - All CT colon scanning and reporting delays escalated, and	High	High

				pathways originate at the Trust, and capacity constraints at other providers will have a knock-on impact on performance for shared pathways; - Patient choice in bowel screening pathway; - Numbers of cases reported under this standard are now low, due to the loss of the breast pathways, so small numbers of breaches may have a large impact.	further work has been undertaken to reduce delays; - Patient choice and medical deferral related breaches cannot be fully mitigated, and for this reason the residual risk remains high; - Capacity and demand review undertaken for colorectal service, with approval to now appoint to additional consultant post, whilst additional sessions are put in place in the short-term to meet demand.		
Cancer: 31-day wait for subsequent treatment - subsequent surgery	1.0	Yes	No	- Cancellations of surgery due to emergency pressures (mainly ITU/HDU beds) - Having enough surgical capacity to meet peaks in demand, especially for the colorectal and hepatobiliary services - Unpredictably high volume of delays due to medical deferrals in some quarters.	- Book dates for surgery at least 7 days before the breach date whenever possible, to enable the patient to be re-booked if cancelled on the day for unavoidable reasons; - Ongoing proactive management of cancer patient tracking list, to identify bulges in demand as early as possible; - See also action under 62-day GP regarding ITU/HDU bed capacity.	High	Moderate
Cancer: 31-day wait for subsequent treatment - subsequent drug therapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for subsequent		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low

treatment - subsequent radiotherapy							
Cancer: 31-day wait for first definitive treatment	1.0	Yes	No	- Peaks in demand from emergencies for ITU/HDU beds, resulting in cancellations of surgery - Current shortfall in colorectal surgical capacity, in the process of being addressed	- Book dates for surgery at least 7 days before the breach date to enable the patient to be re-booked if cancelled on the day for unavoidable reasons; - Divisions to continue to pro-actively manage patients on the Cancer patient tracking list; - See also action under 62-day GP regarding ITU/HDU bed capacity.	Moderate	Low
Cancer: Two-week wait - urgent GP referral seen within 2 weeks	1.0	Yes	No	- The Trust's skin cancer clinic capacity is limited at Weston, but patient demand relatively high, with patients choosing to wait over 14 days; - Very high levels of demand now being experienced in some months, for reasons not well understood.	- Patients referred with a query skin cancer being offered an earlier appointment at the BRI first, before being offered an appointment at Weston; - Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Clostridium difficile	1.0	Yes, although still awaiting confirmation of the number of cases deemed by the commissioners to be potentially avoidable.	No	- Flat profiling of annual target continues to be imposed by Monitor; - Bristol community is an outlier for antibiotic prescribing	- Procalcitonin testing of high risk patients in the Elderly Assessment Unit (EAU) and Medical Assessment Unit (MAU) continues, to reduce the use of un-necessary antibiotics - An antibiotic prescribing phone application has been implemented - Use of Fidaxomicin to treat patients at high risk of C. diff recurrence or relapse	Low	Low

					- Awareness sessions for GPs and Nursing Home Managers - Rigorous Root Cause Analysis of cases to continue to enable any C. diff cases not resulting from a lapse in quality of care to be demonstrated to the commissioners.		
Certification against compliance with requirements regarding access to healthcare for patients with a learning disability	1.0	Yes	No	- No significant risks	See the standard set-out in Appendix 1, which the Trust is declaring compliance with.	Low	Low

Appendix 1 – Learning Disability Access Criteria

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

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

Appendix 2 – Draft declaration

Click to go to index

Declaration of risks against healthcare targets and indicators for 201516 by University Hospitals Bristol NHS Foundation Trust

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key:
must complete
may need to complete

Target or Indicator (per Risk Assessment Framework)		Threshold or target YTD	Scoring Per Risk Assessment Framework	Annual Plan: Risk declared	Annual Plan: Scoring Per Risk Assessment Framework	Quarter 3: Performance	Quarter 3: Declaration	Quarter 3: Comments / explanations	Quarter 3: Scoring Per Risk Assessment Framework
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	i	92%	1.0	Yes	1	91.1%	Not met	Average for Q3 = 91.6%	1
A&E Clinical Quality - Total Time in A&E under 4 hours	i	95%	1.0	Yes	1	90.2%	Not met		1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	i	85%	1.0	Yes	1	82.1%	Not met	Subject to national reporting	1
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	i	90%	1.0	Yes		51.9%	Not met	Subject to national reporting	
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation	i					82.1%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation	i					51.9%			
Cancer 31 day wait for second or subsequent treatment - surgery	i	94%	1.0	No	0	97.7%	Achieved	Subject to national reporting	0
Cancer 31 day wait for second or subsequent treatment - drug treatments	i	98%	1.0	No		99.3%	Achieved	Subject to national reporting	
Cancer 31 day wait for second or subsequent treatment - radiotherapy	i	94%	1.0	No		97.2%	Achieved	Subject to national reporting	
Cancer 31 day wait from diagnosis to first treatment	i	96%	1.0	No	0	98.1%	Achieved	Subject to national reporting	0
Cancer 2 week (all cancers)	i	93%	1.0	No	0	96.0%	Achieved	Subject to national reporting	0
Cancer 2 week (breast symptoms)	i	93%	1.0	N/A		0.0%	Not relevant		
C.Diff due to lapses in care (YTD)	i	33.75	1.0	No	0	8	Achieved	Limit for Q3 = 34	0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)	i					30			
C.Diff cases under review	i					14			
Compliance with requirements regarding access to healthcare for people with a learning disability	i	N/A	1.0	No	0	N/A	Achieved		0
Risk of, or actual, failure to deliver Commissioner Requested Services		N/A	Report by Exception	N/A			No		
Date of last CQC inspection	i	N/A		N/A			08/09/2014		
CQC compliance action outstanding (as at time of submission)		N/A		N/A			No		
CQC enforcement action within last 12 months (as at time of submission)		N/A		N/A			No		
CQC enforcement action (including notices) currently in effect (as at time of submission)		N/A		N/A			No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A		N/A			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A		N/A			No		
Overall rating from CQC inspection (as at time of submission)	i	N/A		N/A			Requires improvement		
CQC recommendation to place trust into Special Measures (as at time of submission)		N/A		N/A			No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration		N/A		N/A			No		
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)		N/A		N/A			N/A		

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

A There are three targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 3. These are: the A&E 4-hour standard, the RTT Incomplete pathways standards, and the combined 62-day GP and 62-day screening cancer standards.

The Trust performed at 90.2% against the A&E 4-hour standard in the period, against the recovery trajectory for the quarter of 93.1%. Two factors affected performance against the standard in the quarter. These were 1) the increase in emergency admissions into the Children's Hospital in the period, at 6.7% above the same quarter last year, which is above the baseline level of activity with the Centralisation of Specialist Paediatrics transfer accounted for, 2) the increase in delayed discharges from 40 at the end of April peaking at 70 during the period, as a result of insufficient domiciliary care packages and an acute shortage of social workers. The risks associated with the re-commissioning of domiciliary care packages within the community, from 51 to 4 providers, was flagged to Monitor earlier in the year, and in routinely monthly reporting. The Trust is continuing to mitigate system risks through an action plan with partner organisations which was put in place during the latter half of quarter 2 2014/15, with additional actions being taken to address delayed discharges and improve the ability of partner organisations to respond to demand.

B Due to the transfer of Head & Neck services from North Bristol NHS Trust and the associated transfer of a large number of patients with extended waits, the Trust declared in its 2013/14 Annual Plan significant risks to the Trust's achievement of the non-admitted RTT standard. A decision was taken during quarter 2 2014/15, following the national request for a failure of the admitted and non-admitted standards to support backlog clearance, to have a planned failure of the three RTT standards during 2014/15. During quarter 3 2014/15, the Trust undertook detailed capacity and demand modelling, supported by the Interim Management and Support (IMAS) team, and established delivery plans to meet the required level of both recurrent and non-recurrent capacity. Recovery trajectories for reducing the over 18-week backlogs were developed, and the activity required to deliver these agreed with commissioners. The Trust continued to implement its backlog reduction plans, with trajectories having been revised in September 2015 to take account of unexpected delays in clinical appointments and heightened growth in outpatient referrals. Good progress continued to be made in Q3 in reducing the number of patients waiting over 18 weeks for treatment, and the Trust is now expecting to report compliance against the 92% standard from the end of January onwards, although noting the risks associated with the loss in activity as a consequence of industrial action by junior doctors.
The 62-day GP cancer standard has been failed since quarter 4 2013/14, primarily due to high levels of unavoidable breaches (late referrals, medical deferrals/clinical complexity and patient choice) and tumour site case-mix. (cont'd below)

C Cancer pathway improvement work continues, focusing on both further minimising internal causes of breaches, through reductions in waits for the 2-week wait step, and implementation of ideal timescale pathways, but also on working with other providers to reduce late referrals. The case mix of patients treated (typically having a -3.5% impact on performance) and late referrals into the Trust continues to make achievement of the 62-day GP standard challenging. However, the Trust continues to meet its improvement trajectory. During quarter 2 of 2014/15 the Avon Breast Screening service transferred to North Bristol Trust. As a result performance against the screening standard is largely based on a relatively small number of bowel screening treatments, which nationally performs well below 90%. In quarter 3 15/16, 7 patients (6.5 breaches in accountability terms) were not treated within 62 days of referral in quarter 3. Breach analysis demonstrates 5 of the 7 screening breaches were for reasons outside of the control of the Trust (i.e. patient choice and medical deferral). There were also breaches attributable to an unforeseen increase in demand, in association with a period of extended unplanned leave by one of the clinicians. A capacity and demand review has been undertaken and service capacity is being increased in the short-term, but also on a substantive basis from April 2016.

The Trust is in receipt of the Regulation 28 Report following a recent Inquest.

Cover report to the Board of Directors meeting to be held in public on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
21. Board Assurance Framework Report – Quarter 3 Update									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author:** Debbie Henderson, Trust Secretary									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									

Purpose

To provide assurance that the organisation is on track to achieve its strategic and annual objectives for the current year. Importantly, the BAF describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

The BAF now includes reference to the Corporate and Divisional Risk Registers where appropriate, and reference to Internal Audits in order to provide assurance that the Trust's principle objectives and risks are considered as part of the Internal Audit planning process and internal control.

The BAF provides detail on: key activities underway to achieving each annual objective; progress as it currently stands in-year; risks to achieving objectives; actions and controls in place to mitigate those risks; and internal and external sources of assurance to ensure the risks are being mitigated appropriately.

The BAF also details the residual risk to achieving annual objectives. This is a RAG rating as Red (expectation that the annual objective is unlikely to be achieved at the year-end), Amber (expectation that the annual objective is likely to be partially achieved at the end year-end) and Green (expectation that the annual objective will be fully achieved at the year-end).

Key issues to note:

Of the 36 annual objectives, as at 30th December 2015, there are 20 objectives where delivery is forecast with a residual rating of GREEN (20 in Q2), 15 Amber rated objectives (15 in Q2) and 1 Red rated objective (1 in Q2). The Red rated objective relates to 2.2. Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audit have been implemented. The risk relates to the adequacy of documentation and policies currently in place and work is ongoing to mitigate this risk.

Other changes to the BAF from the previous quarter are as follows:

Strategic Objective	**Annual Objective**	**Progress towards achievement of annual objective %) ↑↓**	**Residual Risk to achieving the annual objective ↑↓**
1. High quality care	1.2 Compliance with service specification requirements.	↑	*Unchanged*
	1.4 Reputation	↑	*Unchanged*
	1.5 Reducing avoidable harm	↑	↑
2. Estate and	2.1 Completion of Phase 4 BRI	↑	*Unchanged*

environment	redevelopment		
	2.2 Emergency Planning Processes	*Unchanged*	↓
	2.3 Future direction of estate	↑	↓
3. Workforce	3.1 Leadership and management capability	↑	*Unchanged*
	3.2 Staff Engagement	↑	*Unchanged*
	3.3 Recruiting and retaining the best	↑	*Unchanged*
	3.4 Reward and performance management	↑	*Unchanged*
	3.5 Education, Learning and Development	↑	*Unchanged*
4. Research, innovation and transformation	4.3 Maintenance of NIHR grant applications	↑	*Unchanged*
	4.4 Demonstrate the value of research	↑	*Unchanged*
5. System leadership	5.1 System leadership to achieve timely patient flow	↑	↑
	5.2 Effective hosting of networks	↑	*Unchanged*
	5.3 Work with partners on R&I development	↑	*Unchanged*
	5.4 Effective hosting of networks	↑	*Unchanged*
6. Financial sustainability	6.1 Deliver agreed financial plan	↑	*Unchanged*
	6.4 Deliver Cost Improvement Plan	↑	*Unchanged*
	6.5 Address risks to sustainability	↑	↓
	6.6 Evaluate strategic choices	↑	*Unchanged*
	6.7 Development of private patient offer	↑	*Unchanged*
7. Sound governance and regulatory compliance	7.1 Maintain a Continuity of Services Risk Rating of 3 or above	↑	*Unchanged*
	7.2 Governance Risk Rating of GREEN	↑	↑
	7.3 Good governance and regulatory compliance	↑	*Unchanged*
	7.5 Achieve performance recovery plans	↑	↑

Recommendations

The Board is asked to approve the Quarter 3 Board Assurance Framework and note the changes to progress towards achievement of the Trust's strategic and annual objectives.

Impact Upon Board Assurance Framework

N/A

Impact Upon Corporate Risk

Corporate Risks contained within the Corporate Risk Register are included in the Board Assurance Framework, where applicable, to provide further assurance as to the actions taken to mitigate risks.

Implications (Regulatory/Legal)

N/A

Equality & Patient Impact

N/A

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	✓	For Information	

Finance Committee	**Audit Committee**	**Quality and Outcomes Committee**	**Senior Leadership Team**	**Risk Management Group**
		27/1/16	20/1/16	13/1/16

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date last reviewed at Monitoring Group
1	We will consistently deliver high quality individual care, delivered with compassion.	**1.1.** To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit. We will achieve this by delivering the agreed changes to our Operating Model and our work with system partners.	Focus the improving early discharge (time of day) and reducing delayed discharges integrated discharge processes, team and hub. Undertake a review of the need for, and nature of, further additional out of hospital capacity and notably "discharge to assess" capacity. Introduce changes in the unscheduled care pathways which improve flow and promote prompt discharge including roll out of Ward Processes to all wards. Maintain and further develop the Planned Care model across surgical areas to improve throughput, efficiency and patient and staff experience. Deliver an agreed programme across surgical services in the Bristol Royal Hospital for Children (BRHC) to improve efficiency and throughput and align capacity and demand. Review adult critical care provision across the organisation with the aim of eliminating cancelled operations due to access to critical care. Plan and deliver Breaking the Cycle Together events to further embed the SAFER bundle across the Trust and support improvements introduced by the Operating Model projects.	25-50%	Integrated discharge hub established and embedded but further opportunities exist and review being established. Progress is being monitored on related Quality Objectives, though rated AMBER due to ongoing risks. Discharge to assess capacity established in very limited capacity due to issues with domicilary care supply. Flow transformation project ongoing, with evidence of impact. Ward Processes bundle delivering early benefit and roll out underway in Surgery Head and Neck division and Bristol Heart Institute (BHI). Terms of Reference for review of critical care in development paused to allow for impact of a fully recruited unit to be felt. Breaking the Cycle concluded and a further Emergency Department Perfect week undertaken.	Risk that system partners do not sustain their focus on UH Bristol pathways and flow. Risk of a reduction in bed base of NBT, RUH and Clevedon. Risk relating to the recommissioning of large volume of homecare providers and significant shortfall in hospital based social work.	Urgent Care Working Group actively managing risks and developing mitigation plans. Weekly operational meetings with system partners to enable early escalation of emerging issues. Daily Alamac calls to enable cross partner discussion regarding flow and operational issues.	UCWG holds Bristol system risk register, and SRG holds BNSSG wide risk oversight. UH Bristol Executive Directors represented on both groups. Internal Audit: 28-14 Theatre Utilisation; 06-15 Discharge Planning; and 28-16 Urgent Care Recovery Plan	A	Corporate Risk Register Reference: 423; 801, 961 and 1366; Divisional Risk Register Reference: 1145	Chief Operating Officer	Senior Leadership Team (SLT)	Unschedule Care & Discharge Group January 2016
		1.2. To ensure patients receive evidence based care by achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners	Deliver action plan to achieve compliance with all areas where derogation has not been agreed, in line with timescales set by commissioners and mitigate any risks associated with on-going non-compliance.	50% - 75%	2015/16 contract has been agreed with the following ongoing derogations: - Paediatric Medicine; Gastroenterology; Heptology; and Nutrition. - Specialised Endocrinology - Paediatric Intensive Care Retrieval (Transport). This has been strengthened further in-year by joint South West and Wales 'WATCH' service. Paediatric Congenital Heart Disease - compliance required with new service specification from April 2013. Three main areas of focus are internal Standard Operating Procedures and processes (SOPs), recruitment of key staff, and establishment of a formal network. SOPs to be in place, new posts currently raised through external expressions of interest process as part of the 2016/17 comissioning round, and network to be established by April 2016 (posts currently being recruited to, including Lead Manager). Five other services raised to Commissioners through external expressions of interest process requiring potential investment to strengthen position against service specifications (although not required to meet key requirements). To be discussed through 2016/17 contract process.	Paediatric Congenital Heart Disease - Risk that the number of centres being proposed for Congenital Heart Disease acts as a barrier to any individual centre to achieve required compliance. Risk that external expressions of interest will not be agreed by commissioners for investment in required staff to meet standards from April 2016.	Specific standard relating to number of cases derogated for three years until April 2019. Discussions regarding external expressions of interest to manage through 2016/17 contract round. Specifically highlighted as a risk to service specification compliance.	NHS England Commissioning Planning Group Internal Audit: 01-14 Quality Accounts review; 01-15 Quality Accounts; and 23-15 Management of Commissioning Contracts	G	Corporate Risk Register reference 856 Divisional Risk Register Reference: 872	Director of Strategy & Transformation	SLT via Clinical Strategy Group (CSG)	23/09/2015
		1.3. To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.	Delivery the quality improvements as per the 2015/16 CQUIN schedule. Deliver all annual quality objectives described in the Trust's quality report To ensure services are compliant with national quality standards including compliance with the draft standards for paediatric cardiac services	25% - 50%	Progress towards achievement remains ongoing and is monitored monthly by the Clinical Quality Group (CQG). Any areas of risk are escalated to the identified Senior Leadership Team/ Operational Lead. The Trust identified nine corporate quality objectives for 2015-16. Based on progress and performance year to date (end of August 2015), three objectives are 'green' rated (improving how the Trust communicates with patients; improving the quality of written complaint responses; and improving experience of cancer patients), three are amber rated (reducing appointment delays in outpatients and keep patients better informed about delays; reducing cancelled operations; and improving the management of Sepsis) and three are red-rated (minimising inappropriate patient moves between wards; improving patient discharge; and ensuring patients are treated on the right ward for their clinical condition). National Standards for Paediatric Cardiac Services were received from NHS England in Q3. The Trust have commenced a review against the standards and are not aware at the current time of any services which are not compliant with accepted national standards.	Risk of non-acheivement of the CQUIN quality improvements. Risk of non-acheivement of the Trust's Corporate Quality Objectives by year-end. Current prediction is that objectives relating to minimising inappropriate patient moves between wards, and improving patient discharge, will not be achieved. Risk of non-compliance with National Standards for Paediatric Cardiac Services.	Cancelled operations performance continues to be monitored through divisional performance reporting; patient moves performance continues to be monitored through the emergency access steering group; and patient discharge performance continues to be monitored through the Transformation Board. Arrangements in place for the ongoing review of compliance against national standards to be reported via the Quality and Outcomes Committee initially and the Clinical Quality Group thereafter.	Divisional performance reporting; Emergency Access Steering Group; Transformation Board; reporting via QoC/Board; CQUIN reports to CQG; reviews of standards of care by CQG; and Commissioners quality meeting. Internal Audit: 19-13 Clinical Audit of Histopathology; 21-13 SI & Incident Process; 10-14 MRSA Screening; 16-14 Consent from Vulnerable Adults/Speaking out over concerns of treatment of children; 24-14 Removing Health Inequalities; 25-14 Prescribing; 26-14 ED Performance Indicators; 31-14 Q&P CQUINS; 03-15 Operation of WHO Checklist; 15-15 Cleanliness Monitoring & Actions; 21-15 Meeting Nutritional Needs; 24-15 Q&P Management; 25-15 Patient Experience – Dementia; 15-16 Child Death Review Process; and 28-16 Urgent Care Recovery Plan	A	Corporate Risk Register Reference: 919 and 991	Medical Director/ Chief Nurse	SLT and CQG for CQUINs CQG for Quality Objectives; Quality and Outcomes Committee (QoC) and CQG for National Paediatric Cardiac Standards	SLT 20/1/16 CQG 7/1/16 CQC and QoC for National Standards to be confirmed following review
			Subject to resources, review and redevelop the Trust website to promote the Trust to as wide a group of stakeholders as possible.		Preparatory work done to make recommendations on how website could be redeveloped. Development stalled, pending agreement of funding. Media work is fully on track. Working with a range of media to acheive short,	Risk of funding not being achieved. Media work - negative events are extensively reported in the media - risk that we cannot maintain the same level of proactive work.	Substantial maintenance being done on current website to ensure it remains functional. Media - maintaining good relationships with the local media to maintain	All media coverage is monitored and classified (positive/negative/neutral). Monthly Comms report to		Divisional Risk Register Reference: 869	Deputy CEO	Senior Leadership Team	16/12/2015

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date last reviewed at Monitoring Group
		1.4. To ensure the Trust's reputation reflects the quality of the services it provides	Work proactively with media and other key stakeholders to actively promote positive coverage of the Trust's activities.	50% - 75%	medium and longer term results. Social Media Policy developed and agreed by Senior Leadership Team in November. BRHC testing new platform.		balanced reporting of negative events. Looking at longer term coverage that would not be as affected by short term negative events. Recent adverse coverage by national media in relation to BRHC but balancing coverage also acheived.	SLT. Internal Audit: 08-14 Clinical Audit Governance; 19-14 Learning from Complaints; 27-14 Friends & Family Test; and 15-16 Child Death Review Process.	A				
		1.5. Reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.	Successful programme management of Trust Patient Safety Improvement Programme - deliver on process improvement measures and outcomes.	50 - 75%	The launch of Trust's Patient Safety Improvement Programme took place in July 2015, with the initial meeting of the Patient Safety Programme Board held on 24/11/2015. Work streams have been established and progress will report to the Quality and Outcomes Committee on a quarterly basis from January 2016, following deferral of the initial update in December. Precise measures for all programme work streams have been developed. Mortality outcomes to be measured by SHMI and avoidable harm to be measured by adverse event rate.	Risk of a reduced momentum due to lack of recources in the central patient safety team. Risk of the failure to identify and implement effective actions and reduce harm. Risk of a lack of focus on, and understanding of, reduction on 'avoidable' deaths	Ongoing fixed term resource in place to support the Patient Safety Programme. Robust processes are in place to identify causes of harm including the Serious Incident and Root Cause Analysis process. Increase understanding of 'avoidable' deaths.	Patient Safety Programme reports to the Patient Safety Group (PSG) and QoC.	G	Not currently applicable	Medical Director	Patient Safety Group Quality and Outcomes Committee	22/07/2015 QoC 27/1/16
2		**2.1.** To successfully complete phase 4 of the BRI Redevelopment	Complete the ward re-furbishments in Queens Building. Complete the refurbishment of the outpatient departments in the King Edward Building. Staff Restaurant opened Q1. Identify and implement solution for office accommodation, aligned to vacation of Old Building. Successfully deliver Queen's Building Façade Project.	50% - 75%	Refurbishment of all wards in the Queens Building now complete and occupied, thus vacating all areas of the King Edward Building. Willmott Dixon appointed as contracter for the refurbishment of the King Edward Building, enabling works and demolitions have commenced under a pre order. Final contract price and programme agreed and contracts signed on 22nd Dec 15. De-commissioning of Old Building currently on track as a result of mobilising contingency plan to address delayed service transfers. Office planning exercise concluded which confirms adequate space for reprovision, though significant work to do to achieve appropriate co-locations. Façade due to be completed by Q1 2016/17.	Risk of failure to successfully mobilise contingency plan for clearing Old Building of all services. Risk of further delay to service transfers. Risk of the failure to address budget constraints associated with KEB work programme.	Redevelopment Board (RB) continues to have oversight of all Phase 4 risks, and is responsible for developing actions to adequately mitigate risks.	Project Risk Register presented to RB on monthly basis. External Gateway Review GREEN rated, providing assurance re approach to project and risk management. Internal Audit: 07-16 Redevelopment Projects	G	Not currently applicable	Chief Operating Officer	BRI Redevelopment Group	21/12/2015
	We will ensure a safe, friendly and modern environment for our patients and our staff	**2.2.** Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audit have been implemented	Review and restructure as appropriate the Civil Contingencies Committee and its sub groups (Major Incident Planning, Business Continuity and Communicable Disease). Embed and test for revised Major Incident Plan.	25% - 50%	Folloiwng changes to the leadership and team, signifcant work is in train to strengthen and develop the function. Notably the documentation and evidence, to secure external assurance.	Risk of a lack of input from divisions and clinical teams during periods of operational pressure.	New resilience Manager in post work programme agreed. Development of overarching Emergency Preparedness Resilience and Response strategy (EPRR) to bring together all aspects of this agenda. EPRR self-assessment submitted and response demonstrates signifcant non-compliance in some areas, largely in respect of paperwork. Work in hand to address non-compliance with first milestone end of Q4. EPRR self-assessment and review with NHS E complete and gaps identified relating primarily to out of date plans, or lack of training and exercising of plans.	Internal Audit: 03-14 Emergency Planning & Business Continuity. NHSE External Assessment confirms gaps in compliance.	R	TBC - Risk entry pending	Chief Operating Officer	Senior Leadership Team	CCSG January 2016
		2.3. Set out the future direction for the Trust's Estate	Agree and implement approach to future of Old Building Site.	75% - 100%	Sale agreed and completed with all funds received. Vacant possession date agreed as 1st October 2016.	Risk of inability to secure a transaction that reflects best value or development partner not able to be identified in timeline to support current decommissioning timeline.	External advisers (HTC) and District Valuer (DV) engaged to provide advice to capital team. Pre-application discussions with planners established. Governance structure and terms of reference in place to monitor and review progress.	DV and HTC have provided 3rd party assurance regarding Trust approach and value expectations. Capital Programme Steering Group. Internal Audit: 07-15 Estates Management Service; and 12-15 Business Planning & Capital Prioritisation.	A	Not currently applicable	Chief Operating Officer	Senior Leadership Team	16/12/2015
			Scope future priorities for refurbishment of remaining estate post BRI Redevelopment and incorporate into forward strategic capital programme - Campus Phase V.	25% - 50%	Process for Phase V evaluation being developed but programme on hold pending clarification of available capital. Multi-storey car park outline business case approved.								
			Agree and implement revised governance arrangements for forward capital programme.	25% - 50%	Draft governance structure has been developed. Terms of Reference for new structure developed.								
3		**3.1.** Developing Leadership and Management Capability: Deliver a comprehensive approach to leadership and management training and development. The immediate focus will be front line supervisory and managerial roles across the Trust.	Roll-out new internal Leadership Programme for front line managers and supervisors following on from pilot. Launch monthly Leadership masterclasses based on the leadership healthcare competency model. These workshops encourage leaders to 'make leadership real in practice' and work as a community/action learning set to develop and consolidate skills. Use the Teaching and Learning system to record appraisals and support individuals with their learning records. Develop a 'development centre' approach for managers and leaders to enable them to understand and map their competencies and enable them to plan their development to support the Trusts priorities.	50% - 75%	The programme for supervisors and team leaders has been developed in partnership with our stakeholders and goes live in January 2016. We have two full cohorts of 20 in each group going through a modular programme. The Leadership Masterclasses continue to run monthly and have been evaluated and are receiving excellent feedback. These will continue throughout 2016. The appraisal improvement project has been approved at Transformation Board and stakeholder events commenced on 21st December 2015.	Risk that we do not improve the capability of front line leaders as approach not targetted effectively.	A review of approach to leadership development is underway focussing on ensuring we are clear about capability gaps. Stakeholder meetings are underway and improvements have been introduced including a new website to target leadership groups and self-service leadership development.	Risks are managed through the Workforce & OD group and Transformation Board. Internal Audit: 10-15 Leadership on Wards.	A	Not currently applicable	Director of Workforce & OD	Senior Leadership Team 23/9/15 and Executive Team meeting 12/11/2015	Transformation Board 3/8/15, Staff Enagement & Leadership sub-group 26/8/15, Workforce & OD Group 25/9/15

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date last reviewed at Monitoring Group
	We will strive to employ the best and help all our staff fulfil their individual potential.	**3.2.** Staff Engagement: Improve two way communication, including a programme of listening events	a) Ensure the programme of listening events are responding to local actions to support staff survey outcomes. b) Develop with divisions other interactions that support listening opportunities for staff. c) Achieve a better understanding of staff concerns/issues by drilling down from themes of the Staff Survey. d) Undertake more regular pulse checks and ensure actions are fully and accurately reflected in Divisional Plans.	50% - 75%	Divisions have their own engagement and Staff Survey action plans. These include 'fix-it' boxes, smaller surveys, engagement events relating to the operating plans, focus groups on specific issues, the findings from which are translated into impactful actions. Four staff engagement events have been held to date with more planned at various locations. The themes from these events have been extracted and worked upon by SLT sub-group. In September, a full census survey was distributed across the Trust. Quarter 3 FFT response has shown a slight improvement in staff engagement scores.	Risk that staff engagement does not improve as listening events not prioritised and/or not well attended. Failture to act on feedback.	Staff Experience/ Leadership Development Group debating the management of risk to the agenda. Recommendations are under consideration and will be shared with Workforce and OD group/SLT.	National Staff Survey findings. Staff Experience and Leadership Development Sub-Group, Workforce and OD group and Transformation Board	A	Corporate Risk Register Reference: 793	Director of Workforce & OD	SLT strategy session 4/11/2015	Workforce & OD Group September 2015 Staff Engagement Leadership Group 22/12/2015
			Conducted a full census staff survey. Carry out more regular pulse checks and ensure actions are fully and accurately reflected in Divisional plans.										
		3.3. Recruiting and retaining the best. Key priority; develop a structured marketing approach which is tailored to target staff groups, improve the speed of recruitment application to appointment	Identify and implement improvements within the end to end recruitment process, focussing particularly on the known areas of inefficiency.	50% - 75%	Areas for improvement to create efficiency were identified through the rapid improvement programme - optimising the speed of staff recruitment. The new recruitment system went live at the end of June 2015. Over 300 appointing managers have been trained. Work remains ongoing to roll out the 'vacancy authorisation end' of the system across all divisions. Work continues to identify improvements in processes and systems within the Temporary Staffing Bureau (TSB). Benchmarking is underway, evaluating results from a recent survey on staff benefits, the outcomes of which will ensure the framework is responsive and improves retention. A retention plan included funding of £200,000 for divisions to bid against development opportunities. Innovative marketing has continued both nationally and locally for nursing, raising the profile of the Trust and both permanent and temporary opportunities.	Risk that the Trust fails to recruit and retain staff to key staff groups due to national shortages; timeliness of recruitment and failing to address high turnover. The risk appears greater around the turnover KPI than the Trust's vacancy KPI.	Recruitment group overseeing detailed plan to ensure we achieve staff numbers with OPP. WFOD Group overseeing retention/staff engagement plan. The WFOD Group escalated to SLT given the level of risk.	The Recruitment Sub-group of the Workforce and OD Group and the Workforce and OD Group. Internal Audit: 09-15 Recruitment Processes; and 14-15 Divisional Vacancy Control Process.	A	Corporate Risk Register Reference: 674	Director of Workforce & OD	Senior Leadership Team 16/12/2015	Recruitment sub-group 15/12/15, Workforce & OD Group 10/12/15
			Procure and implement a recruitment management system which delivers the required efficiencies within the recruitment process and deliver improved management information and performance monitoring.										
			Review processes, systems and practice within the Temporary Staffing Bureau to ensure a fit for purpose and efficient service delivery in order to meet the increasing demands of the Trust's temporary workforce.										
			For existing staff, develop retention and reward initiatives, informed by the exit data, Friends and Family Test (FFT) and staff survey, including mobilisation of staff engagement plans.										
			Improve exit data to understand key reasons for leaving.										
			Develop a strong identity through innovative branded advertising solutions.										
		3.4 Reward and Performance Management: Improve the quality and application of staff appraisal	Clarify role, responsibilities and objectives for all individuals and teams.	50% - 75%	The Trust is working with Kallidus (IT system provider) to understand the capacity to record appraisal information including objectives and scoring; initial draft appraisal paperwork completed to inform IT design; Staff Health appraisals included in Ward Health and Safety Audits. Competencies developed for nursing roles bands 5 - 7. All of these activities will shape the work required to ensure that all staff have clarity of their role, responsibilities and clear objectives. Staff engagement events commenced on 21st December 2015 for one month and will inform how we redesign our approach to appraisals.	Risk that a reduction in the quality of appraisals are not increased due to the lack of engagement/messaging that appraisal is a continuous process, not a one-off event.	Develop better understanding of the new appraisal approach including IT capability, targetting training and coaching resources to have maximum impact.	Risks reviewed by the Workforce & OD group. Internal Audit: 08-15 Doctors Revalidation; and 30-15 Medical Staff Appraisals.	A	Not currently applicable	Director of Workforce & OD	Senior Leadership Team 23/9/15	Staff Engagement and Leadership Group 22/12/2015 Pay and Rewards to Reward and Performance Group 1/12/2015
			Clearly identified competences and training to enable staff to deliver against objectives.										
			To include staff health appraisal process with 100% of appraisals conducted, which will change immunisation status, physical and emotional health and promote health and well being.										
			Regular recognition for achievement and holding to account where performance falls short of required levels.										
			Develop a better understanding of what constitutes a 'high performing team' including productivity of measures /KPIs derived from best practise benchmarking.	25% - 50%	Aston pilot on effective team working (including team objectives) underway. Two cohorts received training on team coaching and are currently working with teams across the Trust. High performing teams which have completed Aston will see an increase in the quality and effectiveness of care, improved inter-professional team working, increased well being of team members, and reduced turnover and sickness. Two Divisional Boards have commenced their Aston journey and this will be evaluated in March 2016.								
			Develop a pay and reward framework which supports the development of high performing individuals and teams.	50% - 75%	Benefits framework drafted and proceeding through governance routes, initially being reviewed by the Reward and Performance Group. It is anticipated that this work will support and improve retention. Reward and Performance Group have drafted and agreed objectives for 2016/17 to support recruitment and retention.								
		3.5. Education, Learning and Development: Provide high quality training and development programmes to support a diverse, flexible workforce	Develop an appropriate infrastructure and strategy to deliver high quality training and development, including strengthening partnerships with other organisations.	50% - 75%	Strategy approved by Senior Leadership Team and Trust Board. New governance via Education Group and Learning & Development group in place. Work commenced to strengthen partnerships with Health Education South West (HESW), University of Bristol and University of the West of England (UWE).	Risk of limited external places for learners will impact on delivery of the Education Strategy	Engaged with HESW to ensure allocation of UH Bristol places for learners is increased for future intakes.	Risks reviewed by the Education Group and the Workforce & OD Group. Internal Audit: 09-14 Training Information Systems review.	A	Not currently applicable	Director of Workforce & OD	Senior Leadership Team 23/9/15	Education Group 16/12/15
			Work with Divisions to scope priorities for training to deliver service and organisational requirements and to ensure safe and effective patient care to develop a trust wide plan.	50% - 75%	An activity template has been developed and completed by divisions in partnership with education, learning and development. Further work with the divisions to prioritise training against organisational requirements will be introduced as part of the business planning round for 2016/17. Divisions were able to bid against £200,000 to support development activities in clinical areas. On 16th December the Education Group held a workshop and invited Clinical Chairs and other education leads/stakeholders to further develop the delivery plan.								

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date last reviewed at Monitoring Group
			Monitor and evaluate equity of opportunity, consistency of approach and a measureable return on investment, highlighting gaps and implementing appropriate measures to respond.	50% - 75%	A quality assurance framework is embedded within learning and development and will be extended to cover all aspects of this strategy. We will review the approach to ensure equity of access during 2016/17. A review of existing funding across the Trust and divisions is underway.								
		3.6. Strategic Workforce Planning: 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	Develop Trust wide workforce planning capability to ensure that key managers have the necessary skills to plan and develop their staffing needs. Support divisions to assess any hard to recruit staff groups or specialties impacted by age profiles and enable them to develop different ways of staffing their services where appropriate.	50% - 75%	Building on training from early 2015, a Masterclass on Workforce planning methodologies for senior nurses took place in December 2015. Improved templates/tools for supporting operating plans for 2016/17 have been developed for the planning process commencing in January 2016, including a joint Finance/HR template. Additional tools and benchmarking sources have been added to the HR intranet webpage. Age profiles/trajectories within Divisions highlighting gaps within groups/specialist areas have been provided to HR Business Partners, to support development of operating plans. Mid-year review in October has identified the Divisions and KPIs most at risk.	Risk to developing inadequate workforce KPIs for vacancy, turnover and agency due to national nursing recruitment challenges.	Mitigations including agency action plans, being led by the Chief Nurse, and recruitment action plans, being overseen by the Workforce & OD Group.	Risks reviewed by Workforce & OD Group and Risk Management Group. Finance Committee and Quality and Outcomes Committee. Internal Audit: 20-14 Medical Staff Job Planning; and 19-15 Workforce Planning.	A	Divisional Risk Register Reference: 922; and 737	Director of Workforce & OD	Workforce & OD Group / Risk Management Group	Workforce & OD Group 11/11/2015 (as part of mid-year review)
4	We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**4.1.** We will continue to deliver 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.	Continue/commence implementation: UPACS, Electronic Document Management, Critical Care Information System, Laboratory Information Management System, Clinical Task Management & Communication, Electronic Prescribing, Connecting Care - Stage 2 and replace VPLS. Also introduce a number of Medway related projects i.e. Patient self check-in and clinical noting functionality. Start to work up and agree CSIP plans for the next phase.	75%-100%	Various projects within the programme remain on track and will be implemented by the year end, with the next phase being ongoing progress of development. Phase 3 will be scoped and agreed in Q4.	Risk to IT implementations are inherently high but adequate mitigation of all risks are in place and are reported to the Information Management and Technology Group and Risk Management Group on a quarterly basis.	Robust programme monitoring and management processes will manage the risks through the various Project Boards, IM&T Committee and CSIP Committee.	IM&T Committee and CSIP Committee. Internal Audit: 16-13 Back-ups Arrangements; 14-14 IT Technical Infrastructure; 18-14 Data Quality; 05-15 Medway Access Controls; 36-15 Data Storage; 03-16 Electronic Document Management; and 16-16 Wireless Networks	G	Not currently applicable	Director of Finance	Information Management and Technology Group	2/9/2015
		4.2. 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 National Institute of Health Research (NIHR) and maintain our performance in initiating research). Remain the top recruiting trust within the West of England Clinical Research Network (LCRN) and within the top 10% of Trusts nationally (published annually by NIHR)	(a) Develop and initiate project(s) within the 'delivering research' work stream to identify the opportunities to improve our performance to time and target for non commercial trials. (b) Following (a), make changes to the way we manage our research to increase the rate of delivery to time and target for non commercial research. (c) Support the Division of Medicine in developing a sustainable staffing model to deliver research by the end of 2015/16.	25% - 50%	Priority is towards effective delivery of open studies and using staffing efficiently: (a/b) Working with North Bristol Trust Research and Innovation Department to develop coherent plan and share best practice in improving recruitment to time target; focusing on optimising data quality for non-commercial research. (c) Plan of work is ongoing: report has been presented to the division of Medicine, and decision made about preferred option. Implementation now planned for Q2 2016/17 due to timelines required for HR processes.	(a) (b) Risk of competing priorities for fixed resource. R&I staffing currently under pressure due to sickness and leavers. (c) Risk of a lack of high levels of expert resource required to support implementation of change, with strong buy-in from divisional management team. Absence/lack of this of this will put implementation at risk/delay plan.	(a) & (b) Plan adjusted to account for reduction in staffing. Focus on areas likely to give best return quickly in the first instance. (c) Close engagement with divisional management staff ensuring awareness of timelines of the plan and when input and leadership will be required. Monitoring of progress against the plan. Extensive oversight of Clinical Research Network (CRN) performance on a monthly basis via the Medical Director and Director of Finance.	Trust Research Group; CRN Annual Plan and Annual Report, reported to the Board of Directors; via the NIHR - review the performance of the CRN and feedback on any issues and concerns. Internal Audit: 22-16 R&D Governance.	G	Not currently applicable	Medical Director	Trust Research Group	Nov-15
		4.3. We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR)	(a) Improve systems and processes for setting up NIHR grants within UH Bristol and across Bristol Health Partners, increasing the rate of meeting planned timelines for grant setup, and thereby optimising NIHR grant income. (b) Work with our partners in Bristol in developing strong bids for the expected NIHR biomedical research centre/unit call in 2016, to maintain the infrastructure already in place to support cardiovascular and nutrition research.	50% - 75%	(a) Timelines for grant set-up continue to show incremental improvements. (b) Ongoing engagement between University of Bristol and UH Bristol in developing shape of bid; intelligence gained since comprehensive spending review indicates streamlining of bid process is likely.	(a) Risk that NIHR reduces the Research Capability funding. (b) Risk that BRU/BRC call is not in the form or scale expected, particularly following comprehensive spending review.	(a) (I) Engagement with BHP Director ongoing; group self monitors progress against plan; for UHBristol, regular updates to head of R&I by UHBristol team member (grants manager); (ii) Contributors to group from organisations are appropriate and can contribute to change. (b) Agile and flexible bid team will develop alternative strategies in parallel. Use of key contacts to develop intelligence.	Trust Research Group; CRN Annual Plan and Annual Report, reported to the Board of Directors; via the NIHR - review the performance of the CRN and feedback on any issues and concerns. Internal Audit: 22-16 R&D Governance.	G	Not currently applicable	Medical Director	Trust Research Group	Nov-15
		4.4. We will demonstrate the value of research to decision makers within and outside the trust	(a) Routinely identify recently completed grants and collate information about the outputs and potential impact. (b) Identify clinical areas where the conduct of research has had a defined impact on the service delivery. (c) Disseminate information to relevant stakeholders (internal and external).	50% - 75%	(a) Ongoing. No further update to report. (b) Ongoing. No further update to report. (c) Map process for effective research implementation in UH Bristol with wide range of stakeholders. Ongoing activities on case by case basis to support commissioning discussions.	(a) Risk that completion rates of locally led grants is low, making momentum difficult to maintain. Staffing issues draw activity to other areas. (b) Risk that the tangible benefit difficult to quantify, reducing the likelihood of impacts being identified and reported. (c) Risk of low throughput so routine standard systems for dissemination may not be effective.	(a) Incorporation into routine checklists within Research & Innovation for grants and contracts facilitator. Collaboration with library services. (b) Continual engagement with research staff via research matron and other routes. (c) Develop tailored approach as required. Ensure all relevant stakeholders are engaged in discussions around implementation. Reporting to Board and stakeholders via the Annual Quality Report.	Trust Research Group; CRN Annual Plan and Annual Report, reported to the Board of Directors; via the NIHR - review the performance of the CRN and feedback on any issues and concerns. Internal Audit: 22-16 R&D Governance.	G	Not currently applicable	Medical Director	Trust Research Group	Nov-15

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date last reviewed at Monitoring Group
		4.5. We will develop transformation priorities to deliver improved patient pathways and adopt innovation.	Support the objectives identified in the Operating Model initiatives. Review objectives for 2015/16 to further improve Trust wide efficiency. Deliver a theatre transformation programme to drive more efficient use of theatres, better patient and staff experience.	25-50%	Our Operating Model programmes have established new ways of working across our hospitals; In unscheduled care we have established the Integrated Discharge hub and designed new Discharge to Asses pathways with our partners. In Planned Care we have extended the new scheduling processes and in the BHI and BRHC, and designed new pathways for emergency surgical patients to help all surgical patients get treated in the right location. We are working with IM&T colleagues to get real time data visible in clinical areas to be progressed further in 2016/17. Package of work implemented throughout the Medicine Division with clinical teams on wards to establish best practice ward processes in day to day routines - initial results are very positive. Roll-out of package of work is underway across all divisions. The focus of work is ensuring we derive measurable improvement from these changes. Partnership working ongoing in relation to the Better Care Bristol Programme, with current focus on Urgent Care Programme. The Theatres programme has engaged teams in each suite to make improvement within a Trust wide set of standards which has led to changes such as new portering arrangements and automatic patient sending to reduce start of day delays, and projects to reduce turnaround times between procedures. Focus on sustaining short term improvements through consistent and standardised leadership roles. Refresh of Transformation objectives and priorities to be undertaken in January 2016, in light of output of Strategic Implementation Planning Process and 2016/17 planning guidance.	Risk of not fully understanding and evidencing the underlying causes and issues which require addressing. Risk of operational demands causing progress to drift. Risk of operational demands adversly affecting staff engagement and therefore improved performance is not sustained.	Structured review by Transformation Board. Detailed benefits realisation plans and performance tracking. Strong engagement of clinical teams at all levels.	Progress updates to Trust Board. Internal Audit: 28-14 Theatre Utilisation.	G	Not currently applicable	Director of Strategy & Transformation	Transformation Board	Transformation Board 07/12/2015
5	We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**5.1.** We will play an active roll in the urgent system with the aim of consistently achieving timely flow through our hospitals	Participate in the Better Care Fund (BCF) governance to ensure programmes and projects are impacting as predicted. Work with community partners to reduce delayed transfers of care by 50% over two years (Jan 15 - Dec 16).	50% - 75%	Urgent Care Working Group (UCWG) currently reviewing and refreshing System Emergency Access Recovery Plan. Internal Emergency Access Steering Group reviewed and format and focus revised to address minors performance. Insufficient progress on reduction in delayed discharge due to issues of supply of social work and community based social care over much of the reporting period but significant reductions in December 2015.	Risk that community partners do not engage with objectives of BCF programme. Risk of insufficient capacity in community to support 50% reduction in delayed discharges. Risk that these are complex problems to resolve (e.g. revised front door model) and will not deliver in year solutions.	Multiple actions are in place to mitigate the impact of any single initiative failing. The collective impact of individual actions exceeds that required in total.	UCWG , BCFB and SRG all retain oversight of progress and internal group reports directly to Trust Service Delivery Group, whilst Divisional actions are scrutinised through the Divisional review framework. Recent external review of the system in respect of delayed transfers of care - draft report received and under review. A number of recommendations have been received.	A	Not currently applicable	Chief Operating Officer	Senior Leadership Team	December 2015 - Unscheduled Care and Discharge Group
		5.2. We will effectively host the Operational Delivery Networks that we are responsible for.	Establish governance arrangements for both Critical Care Networks.	75% - 100%	The Medical Director is a member of established Governing Body. Trust acts as host of two Operational Delivery Networks. Medical Director is a member of the NHS England Governing Body. Governance arrangements are fully embedded.	Risk to maintaining robust governance arrangements.	Governance arrangements in place and continually monitored. Governance arrangements for organisations hosted by the Trust was reported to the Audit Committee in September 2014. A further review and update will be submitted to the Audit Committee in March 2016.	Report to NHS England Governing Body. Report and assurance regarding hosting arrangements to be reported via the Audit Committee	G	Not currently applicable	Medical Director	Senior Leadership Team	22/07/2015
		5.3. We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners (BHP), West of England Academic Health Science Network (WEAHSN) and Collaboration for Leadership and Applied Research and Care (CLAHRC).	Fully engage with BHP agenda and ensure strong governance arrangements. Fully engage with WEAHSN governance and assist with strategic planning.	75% - 100%	Chief Executive is a member of Bristol Health Partners and WEAHSN Boards.	Risk of failure to effectively engage with partners.	Full engagement in place. The Chief Executive and Medical Director are members of the BHP Board Chief Executive is a member of the WEAHSN Board. Quarterly reports on the work of the WEAHSN are submitted to the Board of Directors.	Regular reporting to SLT and Board of Directors WEAHSN quarterly reports to the Board	G	Not currently applicable	Medical Director	Senior Leadership Team	21/10/2015
		5.4. We will be an effective host to the networks we are responsible for including the CLAHRC and Clinical Research Network (CRN)	Establish robust internal governance including Board reporting for the CRN and CLARHC	75% - 100%	CRN Governance and Exec group established. Trust Secretary working with West of England Clinical Research Network (LCRN) to undertake a review of governance arrangements between the Trust, as host, and LCRN. Expected completion date end of March 2016.	Risk to maintaining robust governance arrangements.	Governance arrangements in place and continually reviewed. Governance arrangements for organisations hosted by the Trust was reported to the Audit Committee in September 2014. A further review and update will be submitted to the Audit Committee in March 2016.	Report and assurance regarding hosting arrangements to be reported via the Audit Committee. Internal Audit: 22-16 R&D Governance	G	Not currently applicable	Medical Director	Senior Leadership Team	21/10/15

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date last reviewed at Monitoring Group
6	We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal	**6.1.** Deliver agreed financial plan	Achieve positive contract settlement with Clinical Commissioning Group and NHS England commissioners.	100%	Service Level Agreement signed in line with Heads of Terms. The Trusts net surplus (before technical items) to the end of December 2015 is £0.569m, £0.238 ahead of plan.	Risk of failure of under performance of activity Risk of under delivery of CIPS Risk of failure to deliver performance Risk of failure to recruit and retain staff, manage staff absence resulting in high agency expenditure	Monthly Operational and Finance reviews with divisions. Monthly reporting to the Finance Committee and Board of Directors.	Oversight by operational planning core group, monthly operational and finance reviews with divisions. Internal Audit: 02-14 Procurement ; 13-14 Financial Reporting & Budgetary Control; 21-14 Main Accounting; 22-14 Payroll review; 23-14 Contract Income; 02-15 Non-Purchase Order Procurement; 04-15 Capital Accounting; 27-15 Main Accounting; 28-15 Payroll; and 31-15 Accounts Payable	G	Corporate Risk Register Referece: 959 Divisional Risk Register Reference: 80, 872 and 951	Director of Finance	Finance Committee	21/12/2015
		6.2. Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas.	Service Line Reporting development. Use of result to inform strategic and business planning.	50% - 75%	Quarter 4 - 2014/15 position published 5th October 2015.	Risk of failure to retain of staff.	Finance Department staff development and succession planning.	Director of Finance oversight	G	Not currently applicable	Director of Finance	Finance Committee	21/12/2015
		6.3. Deliver minimum cash balance	Maintain a liquidity metric of at least 0 days thus achieving Monitor's Risk Assessment Framework liquidity metric of rating of 4. Maintain a cash balance of no less than £15 million.	100%	Cash balance as at 30th November 2015 was £81.2 million. The forecast year end cash balance as at 31st March 2016 is £63 million.	Risk of failing to deliver financial plan.	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Monthly reporting to Monitor. Internal Audit: 06-14 Treasury Management; and 31-15 Accounts Payable.	G	Not currently applicable	Director of Finance	Finance Committee	21/12/2015
		6.4. Deliver the annual Cost Improvement Plan (CIP) programme in line with the Long Term Financial Plan (LTFP) requirements	Ensure robust in year oversight of Divisional CIPs through monthly Finance and Operations Review. Develop robust CIP plans to ensure annual CIP is delivered in 15/16 in addition to carry forward shortfalls from 14/15 and ensure plans for 16/17 are developed in a timely way.	50% - 75%	Focus of work programme reviewed and Savings Board being 'reinvigorated'. Savings Board format reviewed and revised; use of scenarios to prompt identification of more savings. Workstream Terms of Reference clarified. Renewed focus on CIP pipeline at Divisional level on an ongoing basis.	Risk that further opportunities to reduce costs cannot be identified and / or planned CIP schemes are delayed or do not materialise.	Savings Board supports identification of CIP opportunities, including commissioning of work looking at RCI and service opportunities there in. Monthly Divisional CIP Review meetings to monitor progress of current plan and ensure recovery actions if required.	Monthly Reports to Savings Board and Finance Committee. External benchmarking to provide assurance on Trust approach taken. Internal Audit: 12-14 Financial Planning Efficiency Review; and 26-15 Financial Sustainability & CIPs	A	Corporate Risk Register Reference: 959	Chief Operating Officer	Savings Board	18/12/2015
		6.5. Ensure 2015-16 Operating Plans addresses risks to sustainability	Ensure 15/16 Operating Plans are robust and subsequently reviewed at Quarterly Reviews where risks are identifed at an early stage and plans to mitigate and/or recover developed.	50% - 75%	Monthly and Quarterly Divisional review format, function, and paperwork recently revised, changes evaluating well. Significant financial risks have manifested in most Divisions relating to both underperformance of activity and income as well as expenditure above plan. Key areas of overspends is temporary staffing, notably nursing.	Risk that plans are unable to be implemented due to factors outside Trust control such as failure to recruit.	Monthly and quarterly operational and finance reviews flag early warning to risks to delivery, which in turn require recovery plans to be developed for review and implementation.	Well Led Governance Review provided external assurance. Internal Audit: 12-15 Business Planning & Capital Prioritisation. Reports to monthly operational and finance reviews.	A	Corporate Risk Register Reference: 674	Chief Operating Officer	Senior Leadership Team	Q2 reviews October 2015
		6.6. Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decision as they arise.	Appraise the risks and benefits associated with forthcoming major, strategic choices and decision e.g. South Bristol Community Hospital (SBCH) and Community Child Health (CCH) and ensure the Board is adequately briefed and supported to make choices.	50% - 75%	Well Led Governance review task and finish activity defined and in train to ensure effective strategy governance. Phased programme of strategic activity progressing. Strategic Implementation Plan activity with divisions concluded and approved at Board of Directors in November 2015. Clear actions identified to be implemented by April 2016. Individual strategic initiatives/opportunities being evaluated, with revised tender processes currently being completed. Clinical Strategy Group re-launched to cover full scope of the Trust's strategy, with current focus on scenario planning.	Risk of lack of capacity across the Bristol Health and Well Being System to collaborate in strategic activity for the benefit of Bristol patients.	Review our partnership activity as part of routine monitoring and reporting; proposals in development to increase the impact of this work.	Regular reporting to Senior Leadership Team. Internal Audit: 12-15 Business Planning & Capital Prioritisation.	G	Corporate Risk Register Reference: 949	Director of Strategy & Transformation	Senior Leadership Team	18/11/2015

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date last reviewed at Monitoring Group
		6.7. Continue to develop private patient offer for the Trust	Develop robust systems and controls for private and overseas patients, working closely with finance function. Develop a co-ordinated Trust-wide programme of private patient activity.	50% - 75%	Joint project underway with Finance Team to review controls around overseas and private patients. PP post held pending outcome of review.	Risk of a lack of resilience in this area until review completed and post recruited into.	Development of post which is attractive to potential candidates.	Review of Overseas and PP processes complete and will report to SDG in January 2016. Internal Audit: 14-16 Private Patients.	A	Not currently applicable	Chief Operating Officer	Senior Leadership Team	SDG January 2016
7		**7.1.** Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above.	Achieve Liquidity, Capital Servicing Capacity, Income and Expenditure margin, and variance in income and expenditure margin metrics in line with the 2015/16 revised plan.	100%	Financial Sustainability Risk Rating (FSRR) at 30th November 2015 is 4. The current forecast outturn for 2015/16 is a FSRR of 4.	Risk of not succeeding in the delivery of CIP plans, a reduction in premium cost services. Improvement in workforce retention, recruitment and management of absence is a pre-requisite to delivering a reduction in agency expenditure and delivering contracted clinical activity to secure income in line with Commissioners SLAs and the Trust's 2015/16 planned income.	Monthly Operational and Financial Reviews chaired by Chief Operating Officer with Executive Director support. Monthly FSRR performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Monthly reporting to Monitor via Finance Committee and Trust Board.	G	Divisional Risk Register Reference: 50 and 872	Director of Finance	Finance Committee	21/12/2015
		7.2. Restore Trust's Monitor governance rating to GREEN and maintain throughout 2015/16.	Delivery of recovery plans in areas of A&E, cancer services and Referral To Treatment Time targets. Develop response and implement agreed actions arising from Well Led Review. Develop and implement RTT Reporting Migration Plan in line with agreed timescale.	50% - 75%	A&E trajectory not achieved in Q1, Q2 or Q3 mainly due to Green to Go numbers and levels of paediatric emergency admissions being above planning assumptions. 62 day cancer standard remains at risk, but performance is improving by quarter and improvement trajectory is being met each month. Internal performance is above 85% for Q2 and Q3, with the Q3 performance expected to be above the national average. RTT over 18 week backlogs continue to reduce in line with the revised recovery trajectories, with the 92% national standard achieved at the end of November 2015) ahead of plan. RTT Medway migration plan being actively managed, although recent refresh to timeline for implementation due to scale of task to update historic pathways and need for further enhancement to Medway to facilitate RTT pathway management. RTT medway migration plan being actively managed, although recent refresh to timeline for implementation due to scale of task to update historic pathways and need for further enhancement to Medway to facilitate RTT pathway management.	Risk that activity exceeds plans and partners do not deliver benefits in flow as predicted, recruitment is delayed or unsuccessful.	Performance Improvement "architecture" established for all three areas and reporting to SLT. Divisional actions closely monitored through monthly review mechanism. System oversight achieved through UCWG.	Monthly reports to Quality & Outcome Committee and Trust Board. Quarterly Reporting to Monitor via QOC and Trust Board. Oversight by Urgent Care Working Group (UCWG)	G	Corporate Risk Register Reference: 801	Chief Operating Officer	Senior Leadership Team	16/12/2015
		7.3. Establish an effective Trust Secretariat to ensure all principles of good governance are embedded in practice and policy	Conclude the Well Led Governance Review and ensure action is taken to remedy any identified short-comings in Trust Governance and push forward on exemplar practice.	50% - 75%	Report outlining progress against actions to address recommendations submitted to Board in November with significant progress having been made. Two of the seven themed task and finish groups have now been disbanded with outstanding work feeding into others. A further report will be submitted to Board in January with a final report in March 2016 identifying Pan-Governance issues and where these will be incorporated into the existing strengthened governance structure. Regular reporting is also provided to the Executive Team to ensure momentum.	Risk of a lack of commitment due to other priorities to push forward trust wide change and improvement. Risk of a lack of resource to support the required actions. Risk that Pan-Governance issues are not addressed and picked up via the wider governance structure.	Continuation of the task and finish groups led by NEDs and Execs, with support from senior managers. Implementation of actions and accountability at the lowest level of possible to ensure resource is effective. Regular monitoring of progress at both Executive Team and Board of Directors.	Regular updates to Executive Team and Trust Board. Internal Audit: 15-14 IG Toolkit Review.	A	Divisional Risk Register Reference: 895 and 177	Deputy CEO	Executive Team and Board of Directors for Well Led Review oversight Risk Management Group for DMS oversight	Board 30/11/15 Exec Team 22/12/15 Risk Management Group 13/1/16 and meeting with Trust Secretary, Head of IT and COO 5/1/16
			To agree direction of travel for Trust Document Management System (DMS) and agree plan for forward approach.	50% - 75%	Options appraisal undertaken for the development of a new fit for purpose DMS, which addresses shortcomings in current system. Requirements agreed by Trust Secretary and CSIP Director. Project scheduled for full completion in Q2 2016/17.	Risk that the infrastructure for the new Document Management System and Procedural Document Framework remains not fit for purpose, or is not complete before the end of the year.	DMS Administrator undertaken significant work to address housekeeping issues and review of all documentation prior to transfer. Regular reporting to Risk Management Group. Cost provision made in 2015/16 Trust Services Operating Plan to support the development. Agreement with Internal Audit to re-audit the system before and following implementation to ensure all risks have been mitigated.	Quarterly Updates to Risk Management Group. Internal Audit: 17-14 Policy Management.					
	We will ensure we are soundly governed and are compliant with the requirements of our regulators	**7.4.** To achieve regulatory compliance against CQC fundamental standards.	Deliver all aspects of CQC action plans: - Must do's -Should do's - System wide (UH Bristol objectives) Implement the revised CQC compliance assurance process and ensure ongoing compliance.	75% - 100%	Inspection plans have been closed with agreement of Senior Leadership Team and Quality and Outcomes Committee. Remaining actions have been subsumed into 'business as usual' (for UH Bristol and for Bristol Urgent Care Working Group) and will be reviewed in March 2016. An internal audit of the process of monitoring these plans has returned an Amber rating. Further evidence of completion was required for four 'must do' actions, which will be addressed in the March 2016 update. Clinical Quality Group is routinely monitoring compliance with CQC fundamental standards; each month, the group receives a detailed report on one standard and exception reports for all others. Delivering Best Care in Outpatients week took place in November and tested key areas of compliance - Divisional action plans to be reported to CQG in February 2016. The Trust continues to monitor and follow up any concerns raised to the Trust by the CQC.	Risks that assurances which led to the closure of inspection action plans were not sufficiently robust. Risk that governance arrangements are not robust to facilitate adequate oversight of ongoing compliance. Risk that the Trust does not achieve regulatory compliance.	Fundamental standards assurance is monitored monthly by Clinical Quality Group. Any concerns raised by the CQC are followed up and monitored via the appropriate process and reviewed monthly by the Clinical Quality Group and on an ad hoc basis by the Quality and Outcomes Committee.	Fundamental standards assurance is monitored monthly by Clinical Quality Group and annually by the Board of Directors. Internal Audit: 02-13 Outcome 13 (Staffing); 11-14 Outcome 21 (Outpatient Medical Records); 21-15 Meeting Nutritional Needs; 04-16 Management of Resuscitation Equipment; 10-16 Management of CQC Action Plan; and 05-16 Fire Safety.	G	Not currently applicable	Chief Nurse	Clinical Quality Group Quality & Outcomes Committee	Clinical Quality Group 3/12/15 Quality and Outcomes Committee 18/12/15

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date last reviewed at Monitoring Group
		7.5. Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways	To achieve compliance with the national RTT standard of 92% of patients on an on-going pathway waiting less than 18 weeks, from January 2016 and maintain thereafter.	75% - 100%	At the end of the November 2015 the number of patients waiting over 18 weeks had reduced to 2491, with the 92% national standard achieved two months ahead of plan (January 2016).	Risk of continued increase in outpatient referrals, as recently evidenced. Difficulties in sustaining the required level of capacity in dental specialties, and also potential risk to elective flow at the BCH due to higher than expected levels of emergencies. Neurology service also below capacity due to challenges in recruitment.	Divisions review options for increasing/restoring capacity, which has fed into the recent review of trajectories. Issues escalated to monthly Divisional Reviews. Weekly reporting of progress against RTT trajectories, with opportunities for over-performing in some areas to compensate for delivery risks, explored.	Weekly RTT Ops Group reviews management of longest waiters and backlog management more generally at a patient level. Monthly RTT Steering Group, overseeing progress with backlog reductions and implementation of the wider RTT plan. Internal Audit: 28-16 Urgent Care Recovery Plan; and 25-16 Data Quality.	G	Divisional Risk Register Reference: 888	Chief Operating Officer	Senior Leadership Team	16/12/2015
		7.6. Improve cancer performance to ensure delivery of all key cancer targets	Delivery of Internal milestones within the Cancer Improvement Plan and Trust recovery trajectory for performance. To work through the Tripartite to agree and implement a pan-BNSSG Cancer Performance Improvement Plan.	50% - 75%	Action plan in place and on track. Performance continues to be ahead of trajectory.	Risk of late referrals from other providers remains the leading cause of breaches in the 62 day GP standard. Medical deferral and clinical complexity are also increasing and result in a high proportion of breaches. Critical care capacity and temporary shortfalls in operating capacity also impact on performance.	Leading on work to redesign cancer pathways, sharing this with other providers to support agreement of timely referral milestones. The BNSSG Cancer Working Group is in place and meets regularly. The Trust is well represented and an active member. Plan to improve critical care recruitment and retention in place. Actions also being taken to identify co-morbidites earlier in the pathway.	Weekly cancer performance assurance meeting chaired by the Associate Director of Performance. Performance Improvement Plan managed through Cancer Performance Improvement Group (CPIG) with escalation to the Cancer Steering Group and SLT. IMAS review completed in early December, with no material areas of concern identified.	G	Corporate Risk Register Reference: 932	Chief Operating Officer	Senior Leadership Team	16/12/2015

Rating	Definition
RED	Expectation that the annual objective is unlikely to be achieved at the year-end
AMBER	Expectation that the annual objective is likely to be partially achieved at the year-end
GREEN	Expectation that the annual objective will be fully achieved at the year-end

KEY TO TABLE STRUCTURE	
Key activities	key activities which underway to achieving the annual objective (and associated progress toward achieving the strategic objective
Progress towards achieving the annual objective	progress in percentage terms and a narrative of achievement of the annual objective as it currently stands
Current risks and mitigation of risks	risks to achieving the annual objective, and actions and controls currently in place to mitigate these risks.
Source of Assurance	including internal and external to ensure the risks are being mitigated appropriately.
Residual risk to achieving annual objective	RAG rated as Red, Amber and Green (definitions are provided to the left).

Cover report to the Board of Directors meeting held in public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
22. Corporate Risk Register									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author**: Debbie Henderson, Trust Secretary and Sarah Wright, Risk Manager									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									

Purpose

The Corporate Risk Register (CRR) contains risks identified as having a potential impact on corporate objectives, including risks identified in and escalated from divisions. The CRR contains all risks which attract a current risk score of 12 or greater. The risks reflect Divisional risks which continue to attract a score of 12 or greater, following reassessment in a corporate context.

Risks are formally approved for inclusion on, and removal from, the Corporate Risk Register by the Senior Leadership Team.

Key issues to note

There are 14 risks on the Corporate Risk Register.

New risks added to the Corporate Risk Register during Q3:

- 856 – Risk that the emotional and mental health needs of children and young people are not being fully met
- 869 – Risk of reputational damage arising from adverse media coverage of Trust activities.
- 949 – Risk of not having access to a designated community perinatal mental health service.
- 1366 – Risk of drain blockages leading to unavailability of bed spaces and the need to move patients.

Risks which have been de-escalated to Divisional risk registers during Q3:

- 421 – Risk to staff safety and patient safety and care due to limited availability on site of bariatric equipment. This risk was escalated to the CRR during the quarter and has now been de-escalated as equipment has now been purchased to reduce this risk to a more acceptable level.
- 872 – Risk of non-delivery of contracted levels of clinical activity. The risk has been reduced to reflect the increase in monthly run rate of activity in Q3.
- 888 – Risk of failure to deliver the agreed recovery trajectories for all RTT standards. The risk has been reduced due to the positive impact on the controls in place to mitigate the risk.
- 1145 – Risk that patients' requiring domiciliary care may have a delay in their discharge due to reduced service capacity. The risk has been reduced due to improvements in home care capacity and numbers delayed have reduced significantly.

Risks Closed

- None

Amendments to Corporate Risks

- 964 Risk of non-compliance with Department of Health Safety Alert related to window restriction - Assurance of compliance to be received at February Senior Leadership Team meeting.

Recommendations

The Board of Directors is asked to receive the Corporate Risk Register for assurance.

Impact Upon Board Assurance Framework

Corporate Risks are identified, where appropriate on the Board Assurance Framework

Impact Upon Corporate Risk

N/A

Implications (Regulatory/Legal)

N/A

Equality & Patient Impact

There are no equality or patient experience implications as a result of this report.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Risk Management Group
27/1/16				20/01/2016	13/01/2016

Corporate Risk Register 21/01/2016								Inherent				Controls		Current				Actions Summary	Target				Review
ID	Division	Risk Domain		Manager	Executive Lead	Title	Description	C	L	S	Risk level	Controls in place	Adequacy	C	L	S	Risk level	Action	C	L	S	Risk level	Review date
423	Trust Services	Quality	**1.1**. To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model and our work with system partners.	Lee, Deborah	Chief Operating Officer	Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy	Risk that length of stay does not reduce in line with plans resulting in increased occupancy that impacts on flow, ED performance, staff workload and patient experience. Links to following risks: 766 - Delays in discharge or transfer to community services; 759 - Redevelopment Programme not to time; 2168 - CSP; 1798 - Emergency admissions above bed capacity.	Major	Likely	16	Very High Risk	-Constant work with system partners to support timely discharge of patients who are medically fit for discharge. -Transformation programme to support effective and timely discharge -Board rounds, enhanced recovery, day of admission initiatives, improved day surgery rates, accelerated discharge, TTAs, access to pathology, order comms, review of ED rota, review of medical model of care for general medicine take. Whole system approach to be developed through Urgent Care Board. Drive to reduce Length of Stay and improve bed efficiency. Weekly system wide operational group, Acute Services Transfers - city wide group, Daily monitoring of activity levels throughout the Frenchay move (using SPC charting)	Inadequate	Moderate	Likely	12	High Risk	-Continue to work with partners to improve timeliness of discharge from hospital (complete) -Work with partners through the Urgent Care Group on an agreed integrated action plan to deliver system wide improvement. Within this, deliver the internal Unscheduled Care Operating Model project scope to improve flow through our wards.	Moderate	Unlikely	6	Moderate Risk	31/03/2016
674	Trust Services	Workforce	**3.3**. Recruiting and retaining the best. Key priority; develop a structured marketing approach which is tailored to target staff groups, improve the speed of recruitment application to appointment **6.5**. Ensure 2015-16 Operating Plans addresses risks to sustainability	Donaldson, Sue	Director of Workforce & Organisational Development	Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff	A risk of increased costs for recruitment, agency and bank cover, low staff morale and staffing levels due to an increase in turnover and inability to fill vacancies without staffing gap. Turnover is considerably above the benchmark and are continuing to increase and recruitment into many areas is challenging.	Moderate	Likely	12	High Risk	-Review at Workforce and OD Group, Divisional Reviews, QOC, Trust Board. -Identification of reasons for leaving through exit process. -Engagement Action Plan. -Retention Action Plan.	Adequate	Moderate	Likely	12	High Risk	-Understanding reasons for leaving.Improved exit interview and questionnaire process. Progress is included in the quarterly Workforce & OD report which goes to Workforce & OD, QOC and Board (complete). -Develop a range of retention incentives as part of an overall work programme. Additional money (£200k) allocated for training and development across the Trust. Reward and Benefits paper at Workforce & OD on 11th November. Retention update paper at Workforce & OD on 11th November, including further development and appraisal workstream. Additional money (£200k) allocated for trainiing and development across the Trust (complete). -Preceptorship - preceptorship role has been appointed to, and first cohort has run, second cohort in February 2016. Review of turnover of newly qualified due in early 2016 (complete). -Career Progression for nursing roles through competence development and intranet site to showcase nursing.Job description template completed and agreed. All core nursing job descriptions have been revised and updated to ensure standardisation and consistency. Core nursing role education, development and learning plans are being developed for completion Jan/Feb 2016 (complete).	Minor	Possible	6	Moderate Risk	29/01/2016
793	Trust Services	Health & Safety	**3.2.** Staff Engagement: Improve two way communication, including a programme of listening events	Donaldson, Sue	Director of Workforce & Organisational Development	Risk of work related stress affecting staff across the organisation	Our staff are at risk of work related stress with evidence from staff surveys and occupational health information that this is affecting a wide range of different staff. Impact is on both individual and service, when staff are not able to work fully or at all.	Moderate	Almost certain	15	Very High Risk	-Annual audits are conducted to check that each ward or dept. has conducted the stress check list and proceeded to a risk assessment as required by law. -All dept. managers where stress is recognised as a risk are advised to implement the HSE management standards and proceed to the HSE questionnaire process, facilitated by the Safety Dept. -The annually completed Staff attitude survey looks at 10% of the workforce and includes work related stress as part of the question set. -An action plan is then formulated at Trust and Divisional level, Conflict resolution training is delivered to all clinical staff described in the NHS protect target audience and offered to those that are non clinical dependant on role/ location.	Inadequate	Moderate	Likely	12	High Risk	Safety dept team facilitate the HSE process throughout the trust. Requests to complete the HSE process, come from a wide range of sources including hot spot areas for stress related absence identified by Divisions, at the request of Divisional leads where change management occuring for example during the change from three shift system to two in nursing, as an action following stress risk assessments being undertaken to mitigate the risk of stress at work. -Resilience building utilising two extended modules from the 5 module Lighten up programme, namely Making changes and Identifying and managing stress being rolled out to a maximum of 300 staff - 150 places per module. This will be followed by full evaluation and consideration of further opportunity to deliver in the next financial year (complete) -Mapping of all wellbeing activity that could impact on staff health in progress, plus monthly calender of events that can be accessed (complete).	Moderate	Possible	9	High Risk	30/04/2016
801	Trust Services	Statutory	**1.1**. To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model and our work with system partners.	Lee, Deborah	Deputy Chief Executive	Risk that the Trust does not mainain a GREEN Monitor Governance Rating	Prolonged failure of one of the following performance indicators, or concurrent failure of 4 or more indicators leading to loss of green status in Monitor Governance risk rating: Referral to Treatment Time Standards Cancer Standards ED Standards (A&E 4-hours) Healthcare Acquired Infections	Major	Likely	16	Very High Risk	-RTT Steering Group (monthly and weekly), Cancer Steering Group, Project plans for new Operating Model 2014/15 being overseen via the Senior Leadership Team (SLT). -Weekly reporting against performance indicators and escalation to Steering Groups, Service Delivery Group and Senior Leadership Team as appropriate. -Oversight of A&E performance and recovery within Emergency Care Access Steering Group.	Inadequate	Major	Possible	12	High Risk	-Work commenced with Interim Management & Support (IMAS) team, with an internal review scheduled as agreed with NHS England and Monitor. Review and develop action plan in response to recommendations of IMAS team. -Develop action plan from Deloitte Well Led Governance Review and submit to Monitor. -Undertake Monthly monitoring calls with Monitor.	Major	Rare	4	Moderate Risk	20/01/2016
856	Womens & Childrens	Quality	**1.2**. To ensure patients receive evidence based care by achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners	Marnell, Caitlin		Risk that the emotional & Mental Health needs of children and young people are not being fully met	Risk that the emotional & Mental Health needs of children and young people admitted to the Children's Hospital for mental health reasons only are not fully met due to the BHRC not being a provider of mental health services. The outcome is children with mental health needs admitted to the Children's Hospital do not receive the standards of care that they would receive if they were being cared for in a specialist mental health service.	Moderate	Likely	12	High Risk	-Use of CAMHS services for appropriate patients. -Use of new, small liaison psychiatry resource in post at BRHC. -Involvement of multiple specialities to gain additional knowledge and input. -Use of psychology service to support emerging situation, but this is limited to certain specialities. -Can pursue Individual Funding Request to commissioners, if CAMHS have capacity in their team to provide the input. However this can create delays, and there is no commissioned resource.	Inadequate	Moderate	Likely	12	High Risk	-Ongoing reporting to commissioners of any related admissions/incidents. -Complete scoping exercise working with BRHC staff to understand and define need for further service. Create business case based on this work and propose model. Once signed off by children's mental health operational group, submit EOI to commissioners for 2016/17. (complete) -Recruit to Liason roles -NICE guidance for self-harm, for depression with a chronic physical illness NICE quality framework.National documentation (No Health without Mental Health). Review National standards and undertake gap analysis against recommendations. (complete)	Moderate	Unlikely	6	Moderate Risk	31/03/2016
869	Trust Services	Reputational	**1.4** To ensure the Trust's reputation reflects the quality of the services it provides.	Lee, Deborah	Chief Operating Officer	Risk of reputational damage arising From adverse media coverage of trust activities	Risk of reputational damage arising from adverse media coverage of Trust actiivties and notably coverage of paediatric cardiac issues old and new.	Moderate	Possible	9	High Risk	Pro-active monitoring of forthcoming inquests, robust inquest preparation including pro-active & reactive communication and media management as considered appropriate.	Adequate	Moderate	Likely	12	High Risk	Identify Trust actiivties at risk of attracting adverse media and ensure proactive management and mitigation of these risks and associated supporting communications	Minor	Rare	2	Low Risk	29/01/2016

Corporate Risk Register 21/01/2016								Inherent				Controls		Current				Actions Summary	Target				Review
ID	Division	Risk Domain		Manager	Executive Lead	Title	Description	C	L	S	Risk level	Controls in place	Adequacy	C	L	S	Risk level	Action	C	L	S	Risk level	Review date
919	Trust Services	Quality	**1.3**. To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.	Lee, Deborah	Chief Operating Officer	Risk that the Trust does not meet the national standard for cancelled operations	Risk that the Trust does not meet the national standard for cancelled operations resulting in poor patient and staff experience, adverse impact on access standaards and contractual penalties.Risk of cancelled operations arisies from multiple sources including lack of ward beds, critical care beds, booking errors, theatre over runs.	Moderate	Likely	12	High Risk	-Twice monthly monitoring at the EA-PIG and the SDG meeting monthly. Reported monthly to the Trust Board and reviewed at monthly performance monitoring meetings. -Three times daily patient flow meetings supporting proactive management of cancellations with review of all elective admissions on a daily basis. -Weekly operational meetings to validate cancellations and review action plan. -Productive theatre initiative successfulyl brings on additional controls over theatre utlisation increaidng capacity and reducing cancllations, Protocol for use of intensive care between cardiac and surgical teams resulting in immediate reduction of cancllaations of cases due to shortage of bed. -Protocol agreed with medical director for priority use of ITU beds and embedded from 23/12/2010, Additional ITU capacity planed for 2011 with interim capaity in 2010, Programme of work to improve patient flow in the Trust will reduce the risk of cancellations due to lack of beds. -Paper presented to Service Development Group on cancelled ops and all divisions developing a plan to tackle. -All Division have implemented a new escalation process such that LMCs can only be approved by a DM, HoD or HoN.	Inadequate	Moderate	Likely	12	High Risk	-Children's Flow Programme to improve planning, communication and decision making to reduce LMCs (complete).	Minor	Rare	2	Low Risk	30/01/2016
932	Trust Services	Quality	**7.6**. Improve cancer performance to ensure delivery of all key cancer targets	Whittaker, Xanthe	Chief Operating Officer	Risk of failure to deliver care that meets National Cancer Waiting Time Standards	Failure to meet Cancer Targets, specifically 2-week, 31-day and 62-day target, resulting in poor patent experience, reputational and regulatory issues. Clincial risks as a result of delayed pathways are covered by separate risks when applicable.	Major	Almost certain	20	Very High Risk	-Weekly meetings held with all Divisions to review cancer patient tracking. -Performance reviewed every two weeks at the Service Delivery Group and at the Trust Management Executive via SDG. -Performance reported to Cancer Board at every meeting. -Cancer performance action plan in place and reviewed at fortnightly Cancer Performance Improvement Group, with new actions identified and added regularly. -Ongoing efforts to engage other providers and commissioners in performance improvement.	Inadequate	Major	Likely	16	Very High Risk	-Manage response to new NICE guidance together with BNSSG colleagues. -Use of ongoing cancer performance target action plan to manage specific actions to improve performance e.g. pathway redesign. Actions identified via monthly breach reviews and weekly PTLs. Action plan updated fortnightly and reviewed by Service Delivery Group. -Ongoing close patient level management of cancer PTL, including a weekly cross-divisional review meeting.	Major	Unlikely	8	High Risk	31/03/2016
949	Womens & Childrens	Quality	**6.6.** Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decision as they arise.	Windfeld, Sarah	Medical Director	Risk of not having access to a designated community perinatal mental health service	Risk that patients receive inadequate service/ treatment in relation to perinatal mental health due to non-compliance with NICE Guidelines CG192, as no provider is currently commissioned to provide a community specialist service. The consequence of not being able to access treatment could have an adverse effect on mothers and their infants.	Catastrophic	Possible	15	Very High Risk	- The obstetric consultant lead for perinatal mental health now has a psychiatric nurse who works alongside the antenatal clinic three days per week. -The psychiatric nurse has access to RIO which allows them to checking past mental health history and involvement with services. -Psychiatric nurse and midwife triaging patients screened to be 'at risk'. - There is no input from New Horizon's for specialist advice for antenatal patients with mental health diagnosis. This is a reduction in the service previously provided.	Inadequate	Major	Possible	12	High Risk	-To support the antenatal clinic at St Michael's with provision of mental health expertise and access to mental health records to enable a cohesive approach to patient care and treatment during the course of a pregnancy. -To ensure that healthcare professionals working in St Michaels Hospital check the main Medway patient information system. This will enable them to able to interrogate the system for previous interventions in relation to patients presenting with mental health concerns (complete). -To revise the guidelines on breastfeeding to include the information regarding guidance on taking anti-psychotic medication when breast feeding (complete). -Mental Health services within Maternity services to be put into BNSSG strategy by commissioners (complete). -The process for triaging patient with mental health problems appears to be working well. The new guideline has been introduced which signposts women to the appropriate level of care. Work with commissions on -going. Awaiting NICE guidance Regulation 28 served on Commissioners by Coroner awaiting action by Commissioners. Mental health nurse in post working alongside Maternity Services (complete). -Plan to appoint to extra midwifery time (2 days) which will also enhance risks identification and allow for co-ordination of care within maternity services (complete). -Commissioners have been requested to consider commissioning a community perinatal mental health service by HM Coroner and UH Bristol.	Minor	Possible	6	Moderate Risk	29/01/2016
959	Trust Services	Financial	**6.1** Deliver agreed financial plan	Lee, Deborah	Director of Finance	Risk that Trust does not deliver 2016/17 financial plan due to Divisions not achieving their current year savings target.	Risk that Trust does not deliver future years financial plan due to under delivery of recurrent savings in year. Only around 80% of the required savings havebeen idenitfed and delivered however, the impact on the financial plan has reduced due to other compensatory factors.	Major	Likely	16	Very High Risk	-Monthly Divisional CIP reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CIP Programme Steering Group, monthly updated at a glance reports, Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed, Divisional control of vacancies and procurement monitored at monthly performance meetings. -Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery. -Regular Reporting to the Finance Committee and Trust Board, Risk is partially mitigated by slippage on reserves.	Adequate	Major	Possible	12	High Risk	Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes. Trust is working to develop savings plans to meet 2015/16 target.	Minor	Unlikely	4	Moderate Risk	23/03/2016

Corporate Risk Register 21/01/2016								Inherent				Controls		Current				Actions Summary	Target				Review
ID	**Division**	**Risk Domain**		**Manager**	**Executive Lead**	**Title**	**Description**	**C**	**L**	**S**	**Risk level**	**Controls in place**	**Adequacy**	**C**	**L**	**S**	**Risk level**	**Action**	**C**	**L**	**S**	**Risk level**	**Review date**
961	Medicine	Patient Safety	**1.1**. To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model and our work with system partners.	Green, Rowena	Chief Operating Officer	Risk of harm to patients awaiting discharge, once medically fit	There is evidence of harm to patients who are awaiting discharge - classified as Green To Go Patients - this includes functional deterioration with mobility leading to falls potentially resulting in fracture, pressure ulcers and hospital acquired infection. These have occurred on at least a monthly basis.	Major	Likely	16	Very High Risk	-Enhanced Observation of patients at risk in place across all wards. -Standard Operating Procedure in place and compliance regularly monitored. -All incidents investigated and any learning, to prevent future incidents, acted upon. -Weekly Patient Progress Meetings with partners . -Fortnightly Unscheduled Care and Discharge Steering Group. -Three month project in which there is an enhanced REACT service which will cover OPAU and MAU in addition to the Emergency Department. -A Social care Practitioner has been seconded to the team to assist in the rapid turnaround of appropriate patients. -A clinical alert system is established to alert the Hospital Discharge Team when identified patients re-present in the emergency department. -New Fast Track nurse assessor posts are now in place facilitating earlier discharge for end of life patients. -The two orthopaedic wards have been identified as having the majority of delayed patients in the Division SHN and they are now routinely involved in the weekly Progress Meeting. -Discharge to Assess pathways all operational. Monitoring and further development continues in conjunction with the CCG and BCC. -New DToC codes introduced in December 2015. -Agreed standards for Social care are included and reported weekly. -Choice policy implemented including workshops for ward staff. -Checklist for Choice policy on medway for audit purposes.	Inadequate	Major	Possible	12	High Risk	-Discharge to Assess Pathways to be agreed and delivered (complete). -Develop weekly Patient Progress meeting to provide a seperate meeting for Surgery (complete). -Integrated Discharge Project actions in progress following workshops held in July 2014. Monitored weekly and reporting to the Unscheduled care and Discharge Steering Group. This project is being overseen by the Transformation Team at UHB with individual projects led by senior staff from UHB, Bristol CCG and Bristol city Council. -Monitor performance standards for Social Services (complete). -Pathways required for bariatric patients. Audit new Choice policy being implemented in Adult wards across the Trust. To continue workshops for ward staff around Choice policy.	Moderate	Possible	9	High Risk	28/01/2016
964	Trust Services	Statutory	N/A	Donaldson, Sue	Director of Workforce & Organisational Development	Risk of non-compliance with Department of Health Safety Alert related to window restriction	Not all window restrictors are compliant with national guidance and as such may be inadequate in preventing a determined effort to force a window open beyond the 100mm restriction as per guidance on the installation, use and maintenance of window restrictors, e.g. HTM 55 and advice from HSE.	Major	Possible	12	High Risk	-There is a rolling programme to address and to date there have been NO incidents as a result of this non-compliance. -Monthly checks by wards and departments. -Regular inspections by estates/facilities/modern matrons/H&S adviser. -Site inspections by Specialist Advisers includes checking of circulation routes for window restrictors, Door closures - swipe card access two way wherever possible. -Audits undertaken 2011, 2013, 2014.	Adequate	Major	Possible	12	High Risk	-Annual audit as a reminder for monthly checks to take place has shown increased coverage, report taken to Risk Management Group and Health & Safety Committee re other trust where lessons can be learnt (complete). -Estates contracted out a window survey which looks at glazing specification and window restrictors throughout patient facing areas in the trust (complete).	Negligible	Rare	1	Low Risk	29/01/2016
991	Womens & Childrens	Quality	**1.3** To address existing shortcommings in the quality of care and exceed national standards in areas where the Trust is performing well.	Hernandez, Judith	Chief Operating Officer	Risk to quality of care, due to failure of pneumatic chute	This risk occurs on a daily basis, and relates to the failure to meet the internal turnaround standard of one hour for urgent bloods - which has the potential to cause harm, though the occasions when it does are infrequent (as evidenced by incident reporting).	Moderate	Almost certain	15	Very High Risk	-Samples and blood and blood products can be transported by staff member, taxi or NICU ambulance transport staff, when tube is out of service. -Discussion with laboratory to expedite analysis (when tube has delayed transport) or inform clinical teams that repeat samples are needed.	Inadequate	Moderate	Almost certain	15	Very High Risk	-Improve transportation chute on site in NICU and delivery suite all blood samples sent to the lab by chutes robust alternative when chute down e.g. dedicated Porter to walk to and from the BRI. Review staffing in the laboratory 24/7 to ensure that urgent specimens sent from high risk areas - theatres, CDS, HDU, NICU are prioritised and delay with a timely fashion. Develop audit standards for the analysis of blood test and the release of results. Sufficient WTE MLA lab staff to deal with workload (2 vacant posts at present. Review of chute system to identify reason for the raised temperature within the system which is damaging the specimens (complete). -Following meeting in October 2014 agreed to look at trial of having a dedicated driver for STMH to transport samples directly to the laboratory in BRI without the need for taxis. It is hoped to carry out the trial whilst further work on the chute is carried out. This would be a spend to save project based on current taxi usage (complete). -Business case for new chute (complete). -Duplicate(complete). -New Estates project to fix the long term issues that prevent the chute from working are now in progress. Testing of robustness of pod delivery is underway with further work to be done under this scheme to review the ventilation in order to prevent samples from overheating en route. -Planning for new chute (complete). -Audit number of days/times the chute is unavailable due to technical errors, to assure divisional board that the chute is able to reliably transport samples.	Minor	Unlikely	4	Low Risk	31/01/2016
1366	Trust Services	Business	**1.1**. To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model and our work with system partners.	Mistry, Jeenash	Chief Operating Officer	Risk of drain blockages leading to unavailability of bed spaces and the need to move patients	The Risk is that any of the older drainage systems could become blocked at any time. There has been an increasing occurance of weekly drainage blockages in the older areas of the estate. This is becoming more critical to patient flow as the Trust bed base is becoming more tightly managed. Camera surveys have discovered that problematic areas are wide spread and therefore it is difficult to identify hotspots. The outcomes of blockages impact on length of stay and patient experience due to the need to move patients as a result of an incident.	Moderate	Almost certain	15	Very High Risk	To monitor and review emerging hotspots and prioritise limited funding accordinaly to descale and create more reactive rodding points.	Inadequate	Moderate	Likely	12	High Risk	Progress capital bid to upgrade and replace drainage on a prioritisation basis Obtain data and review to inform the prioritisation process Submit Capital Bid for Trustwide Drainage Replacement & Upgrade	Moderate	Unlikely	6	Moderate Risk	16/03/2016

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
23. Audit Committee Chair's Report									
Sponsor and Author(s)									
Sponsor & Author: John Moore, Non-Executive Director and Chair of Audit Committee									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose This report provides a summary of the business discussed at the meeting of the Audit Committee held on 9 December 2015. Key issues to note The report includes an overview of the key issues discussed, areas of challenge and scrutiny and assurance provided by the Executive, Trust representatives, Internal Audit and External Audit. Board members are also asked to note the review of the Committee Terms of Reference. The Committee were provided with the proposed Terms of Reference, the previous Terms of Reference and a summary of amendments proposed. The Terms of Reference were discussed at length and the Committee would reassure the Board that appropriate scrutiny has been applied.									
Recommendations									
The Board of Directors are asked to: - Receive the Audit Committee Chair's report of business conducted at the meeting held 9th December 2015; and - Approve the proposed Audit Committee Terms of Reference									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									

<table>
<tr><th colspan="8">Equality & Patient Impact</th></tr>
<tr><td colspan="8">None</td></tr>
<tr><th colspan="8">Resource Implications</th></tr>
<tr><td colspan="3">Finance</td><td></td><td colspan="3">Information Management & Technology</td><td></td></tr>
<tr><td colspan="3">Human Resources</td><td></td><td colspan="3">Buildings</td><td></td></tr>
<tr><th colspan="8">Action/Decision Required</th></tr>
<tr><td>For Decision</td><td></td><td>For Assurance</td><td>✓</td><td>For Approval</td><td>✓</td><td>For Information</td><td></td></tr>
<tr><th colspan="8">Date report submitted to other sub-committee</th></tr>
</table>

Finance Committee	Quality and Outcomes Committee	Remuneration & Nomination Committee	Senior Leadership Team	Audit Committee
				9/12/15

Report to the Board of Directors meeting 19th January 2016

From Audit Committee Chair John Moore, Non-Executive Director

This report describes the business conducted at the Audit Committee held 9th December 2015, indicating the challenges made and the assurances received.

Item	Key Points	Challenges	Assurance
Matters Arising from Minutes	Workforce Planning Internal Audit – Green rating query	At the previous meeting members of the Committee queried the Green rating given to Workforce Planning Internal Audit.	Assurance was provided by Internal Audit that the Green rating for Workforce Planning was appropriate for the scope of the audit. However, a further audit with a broader scope will be undertaken within the next programme of work.
		Members of the Committee required additional assurance in relation to recording of appraisal dates for Medical Staff.	Internal Audit agreed to circulate a narrative prior to the March meeting.
		Improvements required to the report providing assurance regarding governance arrangements for hosted organisations.	The Annual Report on governance arrangements will be submitted to the March meeting and will include further information on risk to UHB based on performance levels of the hosted organisations.

Item	Key Points	Challenges	Assurance
Local Counter Fraud Status Report	The regular report was received summarising the work of the counter fraud service during the period. New legislation regarding 'false or misleading information offences'. The Trust's Anti-Fraud and Bribery Policy was submitted to the Committee review and approval.	There were no specific challenges in relation to the report.	A full briefing on the new legislation will be provided to Contract Managers.
Internal Audit Progress Report	The Committee received the report and noted the amendments to the IA Annual Plan. Ward Leadership Audit (reflected an assessment as opposed to an audit therefore a grading was not applicable).	Committee members noted the value of the report and requested that the report be submitted to the Quality and Outcomes Committee (QoC) for further discussion.	The report is scheduled for discussion at the January meeting of QoC.
	Care Quality Commission action plans.	There were no specific challenges in relation to this report.	Confirmed that a progress report would be presented to QoC for assurance in February including review of outstanding actions.
	Cleanliness Monitoring and Actions	Committee members requested clarification with regard to the Green rating in light of recent concerns raised regarding compliance with cleanliness levels at QoC. Committee members sought clarity on governance arrangements to monitor cleanliness.	Confirmation was given that the audit had reviewed the controls and monitoring in place and work continues to understand the issues impacting on current levels of cleanliness. This will continued to be monitored via QoC. A review of the infrastructure of the Decontamination Committee demonstrated that it remains fit for purpose.

Item	Key Points	Challenges	Assurance
	Quality and Performance Management	Although the report received a Green rating, the Committee recommended in future, Internal Audit attend a meeting of QoC as an observer. A query was made observing that the report did not review the completeness and escalation of Q&P management issues. Committee noted that reference to the Women's and Children's Division was made in the report and noted that the division had also been highlighted at other forums including Finance Committee and QoC, particularly in relation to HR processes.	It was noted that individual audit Terms of Reference be considered further during next year's planning process including the use of risk profiles to allocate audit resource appropriately. It was noted that governance templates had been standardised across divisions, but W&C division were unique due to the complex nature of the services delivered. The Executive Team continue to support the Division.
	Estates Management.	Committee members noted their frustration at the length of time taken to respond to the report, however acknowledged to challenges in terms of culture and process.	Significant assurance was provided by the Chief Operating Officer with regard to progress to addressing actions and recommendations from the report. A systems analysis would be undertaken to ascertain if new practices could be embedded within a revised IT system. A review would also be undertaken to look at resources to support the risk, health and safety and governance function within the division.
External Audit Progress Report	The report was received for information.	Members sought clarification with regard to methodology for 'testing of key controls'.	External Audit confirmed that this related to reliance on controls and the methodology for collating standard audit evidence. Controls

Item	Key Points	Challenges	Assurance
			were tested using evidence to ensure assurance was obtained in the most effective way depending on each particular item.
Standing Financial Instructions and Scheme of Delegation Review	The report provided detail of the proposed changes to the Trust's Standing Financial Instructions and Scheme of Delegation.	Members of the Committee requested the inclusion of a definition of 'senior manager'.	A definition of senior manager to be included in the version to be submitted to the Board for approval in January.
		Given the complexity of the document, Committee members queried the dissemination process and the mechanism to ensure training and compliance.	A budget managers guide would be produced and the disseminated alongside the SFIs via: FinWeb (Intranet), Divisional Boards, and managers with budgetary responsibility. A formal sign off process is in place at local induction and attendance at the monthly budget manager training sessions is recorded.
Losses and Compensation Report	The report was received for information.	There were no areas where challenge was required.	The report provided adequate assurance.
Single Tender Actions	The report was received for information.	There were no areas where challenge was required.	The report provided adequate assurance.
Risk Management Group Summary Report	The report was provided for assurance to the Committee.	The improved format of the report was acknowledged as providing clarity on the business discussed, actions taken, assurance provided, and actions outstanding. Committee members referred to the newly implemented Trust wide Risk Management and Incident Reporting	The Trust Secretary will arrange a demonstration of Datix for Non-Executive Directors.

Item	Key Points	Challenges	Assurance
		System, Datix and requested an opportunity for a demonstration.	
Board Assurance Framework	The BAF was received for review and outlined the Trust's strategic objectives, annual objectives, progress on achieving these and the associated risks and mitigation plans.	There were no areas where challenge was required however; members of the Committee were provided with an update on the Red rated objective. The Committee suggested including a cultural, value based objective into the 2016/17 BAF.	BAF reference 5.1 - We will play an active role in the urgent system with the aim of consistently achieving timely. It was noted that this referred to the current challenges relating to discharge into community. The BAF will be reviewed in line with the Trust strategic and operational review in Q4. The revised BAF will be submitted to the Committee and Board for approval in March.
Clinical Audit Quarterly Report 2015/16	The report provided the Committee with an update on progress against the plan for clinical audit activity for 2015/16.	Committee members queried if complaints responses were being used to drive the clinical audit plan going forward.	A meeting will take place to explore options to link the work of clinical audit with Datix. Committee members were advised that clinical audit was only one of the resources available to help address issues of clinical practice. The Clinical Audit Team will provide a report to the March meeting with regard to the role of Clinical Audit as a quality tool to help ensure strong clinical practice, although it was acknowledged that the purpose of Clinical Audit is on process as opposed to outcomes.

Item	Key Points	Challenges	Assurance
Reports were received from the Quality and Outcomes Committee and Finance Committee Chairs	The report was provided for assurance to the Committee.	There were no areas where challenge was required.	The report provided adequate assurance.
Audit Committee Annual Self-Assessment	The report was provided for discussion to the Committee. Areas for further development were highlighted for further discussion.	There were no areas where challenge was required.	Committee members received the report and agreed to a proposal to allocate additional time to the March meeting to discuss and agree an action plan to enhance the effectiveness of the Audit Committee for 2016/17.
Audit Committee Terms of Reference and Forward Planner	The Terms and Reference were submitted for agreement following the annual review.	The Committee requested some monitor amendments to the Terms of Reference prior to submission to the Board for final approval.	The Trust Secretary will ensure the amendments are reflected in the final Terms of Reference for submission to the Board in January. It was agreed to discuss and finalise the forward planner in conjunction with the development of the Audit Committee effectiveness action plan in March in preparation for the business cycle for 2016/17.

Terms of Reference – Audit Committee

Document Data	
Corporate Entity	Audit Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Trust Secretary
Document Owner	Trust Secretary
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	01/12/2016

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
16/02/2011	1	Trust Secretary	Draft	Draft for consideration by the members of the Audit and Assurance Committee
08/03/2011	2	Trust Secretary	Draft	Draft for consideration by the Audit and Assurance Committee
04/05/2011	3	Trust Secretary	Draft	Draft for consideration by the Audit Committee on 09 May 2011
09/05/2011	4	Trust Secretary	Draft	Revisions by Audit Committee
26/05/2011	5	Trust Secretary	Draft	For Approval by Trust Board of Directors
26/05/2011	6	Trust Secretary	Approved version	Approved by the Trust Board of Directors
01/09/2015	7	Trust Secretary	Major	Revised terms of reference for consideration by the Audit Committee 9th September 2015

Table of Contents

		Page No
1.	Constitution of the Committee	4
2.	Purpose and function	4
3.	Authority	4
4.	Membership	4
5.	Quorum	5
6.	Duties	5
7.	Reporting and Accountability	9
8.	Administration	9
9.	Frequency of Meetings	10
10.	Review of Terms of Reference	10

1. Constitution of the Committee

The Audit Committee is a statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for Governance, Risk Management and Internal Control.

2. Purpose and function

The purpose and function of the Committee is to:

2.1 Monitor the integrity of the financial statements of the Trust, any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them;

2.2 Assist the Board of Directors with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy of the processes for governance, assurance, and risk management, and where appropriate, facilitate and support through its independence, the attainment of effective processes;

2.3 Review the effectiveness of the Trust's internal audit and external audit function; and

2.4 In discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards, and affairs are managed to secure economic, efficient and effective use of resource with particular regard to value for money.

3. Authority

The Committee is:

3.1 Authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any officer of the Trust and to call any employee to be questioned at a meeting of the Committee as and when required;

3.2 Authorised to obtain whatever professional advice it requires (as advised by the Trust Secretary); and

3.3 A Non-executive Committee of the Trust Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

4. Membership and attendance

4.1 Members of the Committee shall be appointed by the Board of Directors and shall be made up of at least four members. All members of the Committee shall be independent Non-executive Directors at least one of whom shall have recent and relevant financial experience.

4.2 The chairman of the Board of Directors shall not be a member of the Committee.

4.3 Only members of the Committee have the right to attend Committee meetings.

4.4 The chair of the Committee shall not be the Chairman, or Senior Independent Director of the Board of Directors.

4.5 In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

4.6 External Audit and Internal Audit representatives shall be invited to attend meetings of the Committee on a regular basis. At least once a year the Committee should meet privately with the External and Internal Auditors.

4.7 The Director of Finance shall attend all meetings. In the absence of the Director of Finance, the Deputy Director of Finance may be invited to attend in their place.

4.8 The Chief Executive should be required to attend, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

4.9 The Chief Executive and other Executive Directors will be expected to attend as appropriate.

5. Quorum

5.1 The quorum necessary for the transaction of business shall be three members, all of whom must be independent Non-executive Directors.

5.2 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6. Duties

The Committee shall undertake the duties detailed in the NHS Audit Committee Handbook and shall have regard to the Audit Code for NHS Foundation Trusts. The Committee should carry out the duties below for the Foundation Trust and major subsidiary undertakings as a whole, as appropriate. These duties shall include:

6.1 Financial Reporting

The Committee shall:

6.1.1 Monitor the integrity of the annual report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements which they contain;

6.1.2 Review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement;

6.1.3 Review the consistency of, and changes to, accounting policies both on a year on year basis and across the Trust and its subsidiary undertakings;

6.1.4 Review the methods used to account for significant or unusual transactions where

different approaches are possible (including unadjusted mis-statements in the financial statements);

6.1.5 Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor; and

6.1.6 Review the clarity of disclosure in the Trust's financial reports and the context in which statements are made.

6.2 Governance, Risk Management and Internal Control

The Committee shall

6.2.1 Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

6.2.2 Review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

6.2.3 Review the Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

6.2.4 Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security as required by NHS Protect;

6.2.5 Receive assurance from Internal Audit, External Audit, directors and managers, but will not be limited to these audit functions, including evidence of compliance with systems of governance, risk management and internal control, together with indicators of their effectiveness.

6.3 Internal Audit and Counter Fraud

The Committee shall:

6.3.1 Ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards 2013* and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors;

6.3.2 Consider and approve the Internal Audit strategy and annual plan and ensure it has adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee shall also ensure the function has adequate standing and is free from management or other restrictions;

6.3.3 Review promptly all reports on the Trust from the Internal and External Auditors,

review and monitor the Executive Management's responsiveness to the findings and recommendations of reports, and ensure coordination between Internal and External Auditors to optimise use of audit resource;

6.3.4 Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee;

6.3.5 Conduct a review of the effectiveness of Internal Audit and Counter Fraud services once every five years; and

6.3.6 Satisfy itself that the Trust has adequate arrangements in place for counter fraud and security that meets the *NHS Protect* standards and shall review the outcomes of work in these areas.

6.4 External Audit

The Committee shall:

6.4.1 Consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

6.4.2 Work with the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors;

6.4.3 Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts;

6.4.4 Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

6.4.5 Agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

6.4.6 Review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

6.4.7 Meet the external auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

6.4.8 Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, as set out in the annual plan;

6.4.9 Discuss with the External Auditors their evaluation of audit risks and assessment of the Trust, and the impact on the audit fee; and

6.4.10 Review all External Audit reports, including the report to those charged with

governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;

6.5 Other Board Assurance Functions

6.5.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators, and professional bodies with responsibility for the performance of staff or functions.

6.5.2 The Committee shall review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework, including the Quality and Outcomes Committee and the Finance Committee; and

6.5.3 The Committee shall review the governance arrangements with regard to Hosted Organisations.

6.6 Annual Report and Annual Members Meeting

6.6.1 The annual report should include a statement referring to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;

6.6.2 The annual report should include details of the full auditor appointment process, and where the Council of Governors decide not to accept the recommendations of the Committee, a statement setting out those reasons.

6.6.3 Where the external auditor's contract is terminated in disputed circumstances, the annual report should include detail on the removal process and the underlying reasons for removal.

6.6.4 The Committee chair shall attend the Annual Members Meeting/Annual General Meeting and prepared to respond to any stakeholder questions on the Committee's activities.

6.7 Clinical Audit

6.7.1 The Committee shall review issues around clinical risk management and satisfy itself on the assurance that can be gained from the Clinical Audit function including development of the Clinical Audit Strategy.

6.7.2 The Committee will receive the Clinical Audit Annual Plan and Annual Report and receive regular updates on progress made by clinical audit throughout the year.

6.8 Speaking Out Policy

6.8.1 The Committee shall monitor and receive assurance on compliance with the Trust's Speaking Out Policy, and ensure that the policy allows for proportionate and independent investigation of such matters and appropriate follow-up action.

7. Reporting and Accountability

7.1 The Committee chairman shall report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, and make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

7.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Governance Statement.

7.3 The Committee shall make necessary recommendations to the Council of Governors on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement as it deems appropriate.

7.4 The chair of the Committee shall write to the Independent Regulator of NHS Foundation Trusts (Monitor) in those instances where the services of the External Auditor are terminated in disputed circumstances.

7.5 Where exceptional, serious and improper activities have been revealed by the Committee, the chair shall write to Monitor, if insufficient action has been taken by the Board of Directors after being informed of the situation.

7.6 The Committee shall produce a statement to be included in the Trust's Annual Report which describes how the Committee has fulfilled its terms of reference and discharged its responsibilities throughout the previous year.

7.7 Outside of the written reporting mechanism, the Committee chair should attend the Annual Members Meeting and be prepared to respond to any questions on the Committee's area of responsibility.

8. Administration

8.1 The Trust Secretary shall provide secretariat services to the Committee and shall provide appropriate support to the Chair and Committee members as required.

8.2 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider it necessary.

8.3 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting. Supporting papers shall be made available no later than three working days before the date of the meeting.

8.4 The secretary shall minute the proceedings of all Committee meetings, and draft minutes of Committee meetings shall be made available promptly to all members of the Committee.

8.5 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

9. Frequency of Meetings

9.1 The Committee shall meet a minimum of four times a year and at such other times as the Chair of the Committee shall require to allow the Committee to discharge all of its responsibilities.

10. Review of Terms of Reference

10.1 The Committee shall, at least once a year, review its own performance to ensure it is operating at maximum effectiveness. The Committee shall use the Audit Committee Self-assessment Checklist for this purpose.

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
24. Acute Trust Mass Casualty Response Planning
Sponsor and Author(s)
Sponsor & Author: Deborah Lee, Chief Operating Officer / Deputy Chief Executive
Intended Audience

Committee members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose Following the tragic events in Paris, NHS England and the Department of Health requested elements of assurance from NHS Trusts regarding their capacity and capability to respond to a similar type of incident. This requirement included the need to present this statement of assurance at a public board meeting. Key issues to note The Trust does not currently have a standalone mass casualty plan, however information pertaining to a mass casualty response is contained within the Trust Major Incident Plan. A standalone plan is now being developed. The Trust has recently undertaken a self-assessment and NHSE Peer Review of its emergency planning systems and processes, which has highlighted and a number of areas for further improvement and plans to address these shortcomings, with associated timelines, have been agreed with NHSE. The key areas of concern relate the adequacy of documentation.
Recommendations
Impact Upon Board Assurance Framework
Strategic Objective 2.2 relating to emergency planning is currently RED rated due to the issues described above.
Impact Upon Corporate Risk
A risk is pending on the Trust Services Risk Register to reflect the issues described above.
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
N/A
Resource Implications

Finance		Information Management & Technology	
Human Resources	✓	Buildings	

<table>
<tr><th colspan="8">Action/Decision Required</th></tr>
<tr><td>For Decision</td><td></td><td>For Assurance</td><td>✓</td><td>For Approval</td><td></td><td>For Information</td><td></td></tr>
</table>

Date report submitted to other sub-committee				
Finance Committee	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
			20/01/2016	Service Delivery Group 11 January 2016

Appendix A

Emergency Planning and Resilience Assurance Return
Accountable Executive officer: Deborah Lee - Chief Operating Officer and Deputy Chief Executive Officer

Date: 21st January 2016

Assurance	Statement of assurance
You have reviewed and tested your internal cascade systems to ensure that you can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss the primary communications system;	The Trust Cascade system is initiated via the 24 hour switchboard and has been recently tested and confirmed to work. In the event of the loss of the primary communication system i.e. communication by landline, then the Trust has access to mobile, Wi-Fi and analogue telephone systems. This would inevitably, however, be a less timely means of contacting staff.
You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency;	University Hospitals Bristol is a city centre hospital, as such a large proportion of staff live in the immediate surroundings and are therefore less dependent on transport links than out of town and rural hospital sites. A significant proportion of staff travel to work by cycle or foot. The Trust has its own transport department, who have plans in place to bring staff into the workplace during times of travel disruption and these have been deployed in recent years to deal with adverse weather impacts. In addition, business continuity plans support continued operation of critical activities (only) in times of extremis to enable the redeployment of staff from less critical areas to address staff shortages and preserve all emergency services. This model has been recently tested through the recent junior doctors' industrial action.

Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care;	Critical care surge capacity would follow the same model deployed in response to pandemic flu. . The key constraints to mobilising additional capacity are access to trained workforce and critical equipment such as ventilators.
The Trust has given due consideration as to how specialist advice can be gained in relation to the management of a significant number of patients with traumatic blast and ballistic injuries.	The Trust has formalised access to specialist trauma, blast and ballistic injuries advice from University Hospital Birmingham, for both adults and paediatrics.
Date of public Board meeting to present statement of readiness:	29th January 2016

Publications Gateway Reference No.04494

Dame Barbara Hakin
National Director: Commissioning Operations
NHS England
Skipton House
80 London Road
London
SE1 6LH

E-mail: england.eprr@nhs.net

To:
NHS Trust Chief Executives
NHS Trust Medical Directors
Accountable Emergency Officers

9 December 2015

Dear Colleague

RE: NHS preparedness for a major incident

In light of the recent tragic events in Paris, NHS England together with the Department of Health and other national agencies are reviewing and learning from the incidents that occurred and will ensure that this is then reflected fully in our established Emergency Preparedness Resilience and Response procedures. We have already undertaken significant work on the clinical implications and expect to communicate with you on this shortly. In the meantime, I am writing to request your support in continuing to ensure that the NHS remains in a position to respond appropriately to any threat.

It is important to be clear that the threat level remains unchanged since 29 August 2014. The threat assessment to the UK from international terrorism in the UK remains SEVERE. SEVERE means an attack is highly likely.

We appreciate that you will currently be in the process of undertaking the annual EPRR assurance process, in line with the recently refreshed NHS England Assurance Framework, available at: https://www.england.nhs.uk/ourwork/eprr/gf/. In addition, it will be important that all trusts review the following immediately and that you are able to provide assurance that:

- You have reviewed and tested your cascade systems to ensure that they can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss the primary communications system;
- You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency;

- Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care; and

- You have given due consideration as to how the trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistic injuries.

Ambulance trusts should also assure themselves that they:

- Ensure that the Marauding Terrorism and Firearms, Hazardous Area Response Team, Chemical, Biological, Radiological and Nuclear capacity and capability is declared live in Proclus and updated a minimum of every 12 hours.

Please could you ensure that your responses to the above form part of a statement of readiness at a public board meeting in the very near future as part of the normal assurance process.

Both my team and I appreciate your continuing support in ensuring that the NHS is in a position to respond to a range of threats and hazards at any time.

Yours faithfully

Dame Barbara Hakin
National Director: Commissioning Operations

Cc.
Prof. Sir Bruce Keogh – National Medical Director – NHS England
Prof. Keith Willett – NHS England – Director for Acute Care
Dr Bob Winter – NHS England – National Clinical Director EPRR
Richard Barker – NHS England - North
Paul Watson – NHS England – Midlands & East
Anne Rainsberry – NHS England – London
Andrew Ridley– NHS England – South
Hugo Mascie-Taylor - Monitor
Helen Buckingham – Monitor
Dr K McLean – NHS Trust Development Authority
Peter Blythin – NHS Trust Development Authority
National on Call Duty Officers NHS England
NHS England Heads of EPRR
NHS England Medical Directors

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
25. Monitor Q2 Risk Assessment Framework Feedback									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author**: Debbie Henderson, Trust Secretary									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The purpose of this report is to inform the Board of Directors of Monitor's analysis of the Trust's Quarter 2 submission against the requirements of Monitors Risk Assessment Framework. Monitor's analysis of the quarter 2 submission is based on the Trust's risk ratings relating to Continuity of Services and Governance, which the Trust submission as follows:

- Financial Sustainability Risk Rating – 3
- Governance Risk Rating – Green

Key issues to note:

The ratings were published on Monitor's website in December reflecting the Trust's failure to meet the following targets:

- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge target since Q3 2013/14;
- Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway target since Q2 2014/15;
- All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer target since Q4 2013/14; and
- All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral target since Q3 2014/15

Recommendations

The Board are asked to receive Monitor's feedback correspondence for information.

Impact Upon Board Assurance Framework

This report does result in any changes to the Board Assurance Framework.

Impact Upon Corporate Risk							
This report does not result in any changes to the Corporate Risk Register.							
Implications (Regulatory/Legal)							
None.							
Equality & Patient Impact							
N/A							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

Date report submitted to other sub-committee				
Finance Committee	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

1 December 2015

Mr Robert Woolley
Chief Executive
University Hospitals Bristol NHS Foundation Trust
Trust HQ
Marlborough Street
Bristol
BS1 3NU

Making the health sector
work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.gov.uk/ monitor

Dear Robert

Q2 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q2 submissions is now complete. Based on this work, the trust's current ratings are:

- Financial sustainability risk rating: 3
- Governance rating: Green

These ratings will be published on Monitor's website later in December.

The trust has failed to meet the following targets:

- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge target since Q3 2013/14;
- Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway target since Q2 2014/15;
- All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer target since Q4 2013/14; and
- All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral target since Q3 2014/15.

These failures have individually and collectively triggered consideration for further regulatory action.

Monitor uses the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the Health and Social Care Act 2012, taking into account, as

appropriate, its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

We expect the trust, in partnership with system stakeholders where appropriate, to address the issues leading to the target failures and achieve sustainable compliance with the targets promptly.

Monitor has decided not to open an investigation to assess whether the trust could be in breach of its licence at this stage. The trust's governance rating has been reflected as Green. Should any other relevant circumstances arise, Monitor will consider what, if any, further regulatory action may be appropriate.

A report on the FT sector aggregate performance from Q2 2015/16 is now available on our website[3] which I hope you will find of interest.

We have also issued a press release[4] setting out a summary of the key findings across the FT sector from the Q2 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0192 or by email (Justin.Collings@Monitor.gov.uk).

Yours sincerely

Justin Collings
Senior Regional Manager

cc: Mr John Savage, Chairman
Mr Paul Mapson, Finance Director

---

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf
[3] https://www.gov.uk/government/publications/nhs-providers-quarterly-performance-report-quarter-2-201516
[4] https://www.gov.uk/government/news/challenging-environment-for-nhs-providers

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
26. Governor's Log of Communications									
Sponsor and Author(s)									
Sponsor: John Savage, Chairman **Author**: Amanda Saunders, Head of Membership & Governance									
Intended Audience									
Board members	✓	Regulators		Governors	✓	Staff	✓	Public	✓
Executive Summary									
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 and subsequent responses added or modified since the previous Board. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. The log is distributed to all Board members, including Non-Executive Directors when new items are received and when new responses have been provided. Key issues to note: Since the last report was submitted to Board in November there have been two new queries added to the Governors' Log (140 & 141). One query is now outstanding (140), but a response is expected in advance of the Board meeting and will be circulated by email to Board members and governors.									
Recommendations									
The Board is asked to receive this report to note.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									
Equality & Patient Impact									
N/A									
Resource Implications									
Finance		Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	✓		

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
					Executive Directors

ID	Governor Name		
141	Chairman and NEDs Counsel	***Theme:*** Cardiac Surgery	***Source:*** Chairman's Counsel

Query **18/12/2015**

Following a point made at the Governors Counsel, it would be helpful if we could be briefed on:
1. Level of cancelled operations in cardiac surgery
2. Method for prioritising use of theatres by surgeons
3. Method of prioritising who is put on each list
4. Whether any of the above is impacted on by the private practice being carried out at the weekends.

(Query logged by Alison Ryan, Non-exectutive Director on behalf of Governors)

Division: Specialised Services ***Executive Lead:*** *Medical Director* ***Response requested:*** 18/12/2015

Response **29/01/2016**

1) The level of cancellations in cardiac surgery has been very high in recent weeks ranging between 25 and 36% over the last 4 weeks. This has led to a high level of poor patient experiences and is primarily a direct consequence of the acute pressures facing the hospital. Excel files with a detailed breakdown on a weekly basis of the cancellations and the reasons for these are kept. The files contain patient specific information and therefore inappropriate to share. The specific figures for the last few weeks have been W/c 14/12 28% cancellations, w/c 7/12 36%, w/c 30/11 25%, w/c 23/11 26% . The commonest causes for cancellation are currently
i) Shortage of theatre staff
ii) Lack of Hospital bed for admission
iii) Lack of CICU bed for admission
Although these causes will vary depending on the pressure on the service.
2) There is a matrix for scheduling as part of the SOP. This creates a balance to ensure that elective and urgent priority patients are balanced. There is always an opportunity to alter this based on clinical priority. This can never be perfect and but offers a practical way of organising the service. Given the multiprofessional environment in which we work on occasion it might be open to criticism from some.
3) The exact scheduling is a complex process based on taking into account the clinical priority of urgent patients but also ensuring that elective patients are treated within appropriate RTT timescales and also taking into account the available surgical expertise as well as issues like numbers of cancellations. This is outlined in the SOP also
4) There is currently no private practice being undertaken in cardiac surgery at the weekend. There are some waiting list initiative lists being undertaken on a Saturday when the acute pressures allow this . The idea of these is to utilise the theatre time at weekends when the level of acute pressure may be less on a Saturday. The idea is that doing these cases deals with some urgent cases and keeps us within RTT. Whether these cases impact on 1-3 is unlikely and would be hard to quantify objectively.

Status: *Awaiting Governor Response*

ID	Governor Name		
140	Florene Jordan	***Theme:***	***Source:*** Governor Direct

Query **22/12/2015**

In relation to the Centralisation of Specialist Paediatrics, what process was put in place to ensure adequate training of all operating theatre staff and recovery staff? What training took place prior to the transfer and during the early stages post transfer, and what measures were put in place to ensure that this training was adequate?

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 22/12/2015

Response

Response pending.

Status: *Assigned to Executive Lead*

ID	Governor Name		
139	Clive Hamilton	***Theme:*** Patient Experience	***Source:*** Council of Governors

Query **09/11/2015**

The Quarter 1 Patient Experience Report outlines that for inpatient surveys of Maternity services, 30% of respondents noted a delay of more than four hours at discharge. Please can further detail be provided with regards to the possible cause of this and any work being undertaken to address the matter. (Reference page 82 of the Council of Governors Meeting pack, 30th Oct 2015.)

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 10/11/2015

Response **20/11/2015**

There are a large number of discharges from the maternity wards (sometimes up to 20 per day), which represents a large amount of discharge paperwork / process for the staff to work through. A proportion of these women will also have to be reviewed by an Obstetrician before they can be discharged - a high caseload in itself, but particularly because the doctors have to prioritise patients on the delivery suite. In order to improve the review process, a junior doctor is now assigned to the wards each day.

Waiting for medications is also an issue for some women who are ready to leave. This is mainly at the weekend because there is no pharmacy open at St. Michaels at that time (medications therefore have to be obtained from the BRI and prescription charts have to go by transport). The wards are working with the Pharmacy Department to have more ward dispensed medication ("TTA") packs, and are identifying ways of better anticipating the medications will be required at the weekends so that they can be obtained in advance.

Tony Watkin , Jenny Ford Matron and Sneha Basude, Consultant Obstetrician are starting a piece of Co Design work on the post-natal wards to further improve the patient experience which will include evaluating and focusing on the discharge process.

Status: *Awaiting Governor Response*

138	Philip Mackie	***Theme:*** Parking	***Source:*** Council of Governors

Query **30/10/2015**

When will the THQ disabled parking spaces be restored given the works behind the current hoarding appeared to have ceased?

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 30/10/2015

Response **02/11/2015**

The original constructors site village, located behind the hoarding adjacent to THQ, was used by the appointed contractor undertaking the work in the King Edward Building (KEB) on the Surgical Assessment Suit. This work ended in late August with a plan to redeploy the site village to the appointed (different) contractor for the final KEB works. There has been a delay in appointing this contractor, hence the period of 'nil activity' behind the hoarding, but the contractor is due to commence on site this month. The current plan entails the continued use of this site, with resulting impact on disabled parking until September 2016. Options for the site village location are limited due to the required adjacency to KEB, however, work is in hand to scope whether there are any alternative locations which would enable the disabled parking facility to be restored ahead of the current schedule.

Status: *Awaiting Governor Response*

137	Mo Schiller	***Theme:*** Dermatology Services	***Source:*** Governor Direct

Query **22/10/2015**

I understand that Weston dermatology has now transferred to UHB. In view of the increase in numbers of skin cancers coming to us now from there are the trust considering setting up nurse led PDT [photodynamic therapy] centre at UHB.This is proven treatment without surgical excision. The nearest centres for patients to access this are Cardiff and Bath.

Division: Medicine ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 22/10/2015

Response **27/10/2015**

Photodynamic therapy is a treatment for superficial skin cancers and pre-cancers which entails use of a cream to make the area sensitive to a specific wave length of light and then to irradiate the area with that light. In the UK it is licensed for the treatment of superficial basal cell carcinoma, in situ squamous cell carcinoma (pre-invasive) and actinic keratosis which are seen in sun damage as a preliminary to skin cancer. Basal cell cancer is the most common cancer in the UK. The treatment is preferable to surgery in some cases where the disease or field of disease is large, making surgery a significant undertaking. This most applies most to elderly patients with multiple co-morbidities and widespread disease. The Trust's dermatology service has now recruited staff with the skills and experience to develop a PDT service and a proposal will be submitted to commissioners in this business planning round, with a view to establishing the service from April subject to securing the required approvals and capital equipment.

Status: *Closed*

Cover report to the Board of Directors meeting held in Public to be held on Friday 29 January 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
27. West of England Academic Health Science Network Mid-Year Report									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive									
Intended Audience									
Board members	✓	Regulators		Governors	✓	Staff	✓	Public	✓
Executive Summary									
Purpose To update the Board of the West of England Academic Health Science Network of the decisions, discussion and activities as detailed in their mid-year report. Key issues to note There are no key issues to note.									
Recommendations									
The Board is asked to receive this report to note.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									
Equality & Patient Impact									
N/A									

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)

2015 mid-year report for University Hospitals Bristol NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust is an important member of the West of England Academic Health Science Network (AHSN). The role of the Network is to deliver positive healthcare outcomes locally and nationally by driving the development and adoption of new innovations and making a meaningful contribution to the economy. This mid-year report highlights some of the key areas of our work the Trust has been involved in so far this financial year.

Annual conference

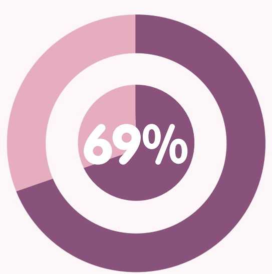
Representatives from the Trust joined more than 400 professionals from the region's health and social care sectors at our annual conference at Cheltenham Race Course. Find out more here.

Feedback from members

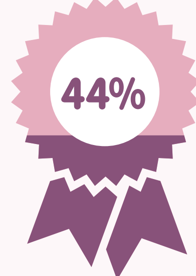
In our recent stakeholder survey, members gave the West of England AHSN their vote of confidence. 78% of respondents said they are confident the Network will deliver its plans and priorities and 69% reported the Network is helping member organisations achieve their own objectives.

The West of England AHSN is working hard to bring individuals and organisations together to focus on innovative solutions to shared problems, and so it is encouraging to hear that 85% of respondents feel we are effectively building a culture of partnership and collaboration. See the full survey results.

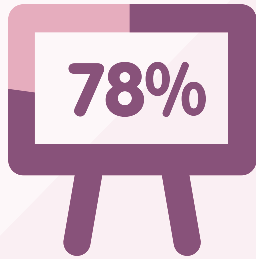
Creating confidence



feel we have helped towards achieving their objectives



feel we are achieving more than expected



have confidence we will deliver our plans and priorities

www.weahsn.net

How has the Trust been working with the West of England AHSN?

Bringing innovation into practice

The Trust has been actively involved in various Enterprise programmes, including clinical testing of two SBRI funded companies, and we have carried out a bespoke funding search for the Trust through our Funding Finder.

Two members of Trust staff participated in our three-day Healthcare Innovation Programme.

David Wynick is Link Director working closely with our Enterprise team.

Enhancing patient safety

The Trust is involved in a number of Patient Safety work programmes, including Emergency Laparotomy and Medicines Optimisation. It is also supporting our work on Sepsis and the adoption of the National Early Warning Scores, which will replace the Bristol adapted score.

The Trust has been supported in its scaling up bid and roll out of the ED Checklist. Dr Emma Redfern is the clinical lead for this, in addition to being the Associate Clinical Director for our Patient Safety Collaborative.

Ann Reader has been selected as one of the founding cohort of the Health Foundation Q Initiative participants to design and test Q in 2015.

Creating a more joined up health service

Steve Gray, Clinical Systems Programme Director, is actively involved in the Network's Connecting Care project and Test Bed development.

Taking an evidence-informed approach to healthcare improvement

The Obstetric Unit has been active in the Network's programme to reduce Cerebral Palsy in pre-term births (the PReCePT project). 664 staff have been trained as part of PReCePT across the West of England, including 89 from the Trust.

The Trust and the AHSN have worked together to support the West of England Genomics Partnership.

Training and events

The West of England Academy now underpins all the learning and development activities we organise and deliver. The Academy aims to continually increase the number of healthcare professionals across the region with the skills and knowledge to deliver long-term, sustainable improvements in patient care.

Chief Executive, Robert Woolley is Chair of the Academy programme steering group and a board member of the West of England AHSN.

At least **36** Trust staff attended West of England AHSN events in the last six months, including...

10 Safer Care Through Early Warning Scores

1 Dementia Masterclass

1 Medical Directors Workshop

15 Annual Conference

More information on the Network's continuing programme of work is on our website www.weahsn.net and in our Business Plan 2015/16.