University Hospitals Bristol NHS Foundation Trust

PUBLIC TRUST BOARD

Meeting to be held on Friday 28th July 2017, 11:00 am - 1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Preliminary Business				
1.	Apologies for absence	Information	*Chairman*	**Verbal**
2.	Declarations of Interest	Information	*Chairman*	**Verbal**
3.	Patient Experience Story and Chaplaincy Annual Report 2016/17	Information/ Approval	*Chief Nurse*	**Verbal** /3
4.	Minutes of the last meeting	Approval	*Chairman*	16
5.	Matters arising and Action Log	Approval	*Chairman*	30
6.	Chief Executives Report	Information	*Chief Executive*	31
7.	Board Assurance Framework 2017/18 (quarter 1)	Assurance	*Chief Executive*	35
8.	Research and Innovation Quarterly Report	Assurance	*Medical Director*	56
Care and Quality				
9.	Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Assurance	*Chief Operating Officer and Deputy Chief Executive*	63
10.	Quality and Outcomes Committee Chair's Report	Assurance	*Quality & Outcomes Committee Chair*	**To be tabled**
11.	Independent Review of Children's Cardiac Services final report	Assurance	*Chief Nurse*	126
12.	Equality and Diversity Annual Report 2016/17	Assurance	*Acting Director of Workforce and OD*	155
13.	National Staff Survey Results 2016	Assurance	*Acting Director of Workforce and OD*	215
14.	Speaking Up Annual Report 2016/17	Assurance	*Trust Secretary*	244

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
15.	Medical Revalidation Annual Report 2016/17	Assurance	*Medical Director*	253
16.	Safeguarding Annual Report 2016/17	Assurance	*Chief Nurse*	268
17.	Infection Control Annual Report 2016/17	Approval	*Chief Nurse*	301
Research and Innovation				
18.	Education and Development Annual Report 2016/17	Assurance	*Acting Director of Workforce*	332
Financial Performance				
19.	Finance Report	Assurance	*Director of Finance & Information*	408
20.	Finance Committee Chair's Report	Assurance	*Finance Committee Chair*	**To be tabled**
Governance				
21.	Audit Committee Chair's Report	Assurance	*Chair Audit Committee*	428
22.	Risk Management Strategy	Approval	*Chief Executive*	431
23.	Transforming Care Report	Assurance	*Chief Executive*	445
24.	Congenital Heart Disease Network Annual Report	Assurance	*Medical Director*	453
25.	Clinical Research Network Annual Report	Assurance	*Medical Director*	471
Items for Information				
26.	Changes to UH Bristol Constitution	Approval	Trust Secretary	474
27.	Governors Log of Communication	Information	Chairman	477
Concluding Business				
28.	Any Other Urgent Business	Information	*Chairman*	**Verbal**
29.	Date and time of next meeting **Friday 29th September 2017, 11:00am -1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**		*Chairman*	**Verbal**

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 29 June 2017
Report Title	Patient Story and Chaplaincy Annual Report 2016-17		
Author	Brenda Dowie Chaplaincy Team Leader		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary

<u>Purpose</u>

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 this patient and for Board members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.

Key issues to note

This story recognises and reflects the importance of the treatment of spiritual pain. The story draws on an encounter between a UH Bristol Chaplain and a war veteran who had lived with an unresolved issue for many years.

The story recognises that, in the face of illness, patients may find the need to resolve long held and unaddressed issues and may use the privacy a hospital affords them to do so. It underlines how compassion, hope, understanding and relationships are crucial elements of the healing process and work hand in glove with more technical aspects of care.

This agenda item includes the Chaplaincy annual report for 2016-17.

Recommendations

Members are asked to:

- **Note** the patient story

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☒	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
				Patient Experience Group, 25/5/17

University Hospitals Bristol
NHS Foundation Trust

Annual report for the Department of Spiritual and Pastoral Care (Chaplaincy) and Patient Affairs 2016/17

Reverend Brenda Dowie, Chaplaincy Team Leader

1. Introduction

The Department of Spiritual and Pastoral Care (Chaplaincy) provides Spiritual, Religious and Pastoral Care to the patients, staff, relatives and carers with whom we come in contact at our Trust.

With colleagues from North Bristol NHS Trust (NBT) and the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), UH Bristol's chaplains are part of a city wide chaplaincy agreement providing continuity of care across the city's hospitals twenty four hours a day, three hundred and sixty five days a year.

The Patient Affairs Team provides the Trust with the expertise to manage the legal and practical requirements following a death in hospital. They work closely with doctors, the wards and the mortuary; they manage the release of the deceased from the hospital to the appropriate care in the community.

2. The move to the new Chaplaincy Centre and Patient Affairs Office, level 4, King Edward Building

On 14th December, the Chaplaincy Team vacated the Bristol Royal Infirmary (BRI) Old Building and moved across the road to our new offices in the Kind Edward Building (KEB), adjacent to the new BRI Sanctuary space.

The New Sanctuary

Members of the Chaplaincy Team have been involved in the BRI redevelopment project for over four years, and became intimately involved with phase 2, with the moving of their offices to the KEB. The wider Chaplaincy Team, including Chaplains from NBT as well as our Muslim and honorary Hindu Chaplains engaged with Bronwen Gwillim from Willis Newson to develop a concept that could be presented to the architects O'Leary Goss and artists tendering for the artworks. It was deemed that "The Sanctuary should be a place of quiet, a place which is safe, a place which is beautiful, a place which is flexible and a place which will permit religious action".

A theme of Sea, Sky, Forest and Sun was developed, and five artists were asked to present portfolios. Following discussions with Bronwen, and members of the UH Bristol team, Ptolemy Mann, a colourist and weaver was asked to put forward a plan for the Sanctuary which would include screens to allow the space to be divided, particularly for Muslim Friday prayers. She developed the theme using woven panels, which would be suspended from the ceiling, which as well as allowing the artworks to be shown to advantage would allow the space to be divided into smaller more intimate spaces. The theme of the panels has been replicated in the corridor outside the Sanctuary providing a welcome to the space introducing it as "A place of refuge, of shelter, of protection, where nature and the world of spirit meet, a place safe to use, to come and go, to bring and leave or to wait and be". During development, the plans were shared with as wide a group of service users as possible.

On 5th April the first of two opening events in the Sanctuary welcomed staff, volunteers, sponsors and Ptolemy to a reflective gathering using music and poetry. The screens were used as part of the reflections to great effect. A second opening event on 12th April welcomed members of faith communities from across Bristol representing Buddhist, Hindu, Baha'i, Christian, Muslim, Jewish, and Sikh communities, many of whom had been involved in the consultation process during the development of the artworks. They each prayed and brought with them as a gift for the Sanctuary an item which their faith community would like to find there. Both events were sponsored by Above and Beyond who have been instrumental in raising the money to pay for the artworks in the space. The Chaplains are looking forward to continuing to develop the Sanctuary for the benefit of patients, relatives and staff, from all faith communities and none, as a place where they can come to get away from the difficulties of hospital life and find peace.

3. Changes to the Department of Spiritual and Pastoral Care in 2016/17

In August 2016 Revd Graham Reaper-Brow retired and the Revd Ana Hansell joined the team.

As of 31st March 2017, our chaplaincy team staffing was as follows:

- Rev Brenda Dowie Spiritual and Pastoral Care Team Leader (0.5 WTE)
- Rev Steve Oram, Team Chaplain with particular responsibility for Children's and Women's Services (1.0 WTE)
- Rev Ana Hansell, Team Chaplain with particular responsibility for Oncology and Palliative Care (1.0 WTE)
- Fr Cavan McElligott, Team Chaplain with particular responsibility for Roman Catholic Patients (0.5 WTE)
- Rev Jillianne Norman, Team Chaplain with particular responsibility for second stage care and care of the older person (0.5 WTE)
- Imam Rafiqul Alam, Team Chaplain (0.1 WTE) with particular responsibility for Muslim Patients (funding is provided by Above and Beyond for this post).
- Supplementary team chaplain bank hours (0.2 WTE)

This team provides cover across all of UH Bristol's services, including South Bristol Community Hospital.

We also enjoy the services of a small group of Chaplains, who provide occasional additional chaplaincy support via the Temporary Staffing Bureau ('Bank'), to cover periods of sickness or general short staffing. There are also Honorary Chaplains who work on a voluntary basis.

4. Chaplaincy Volunteer Training Course

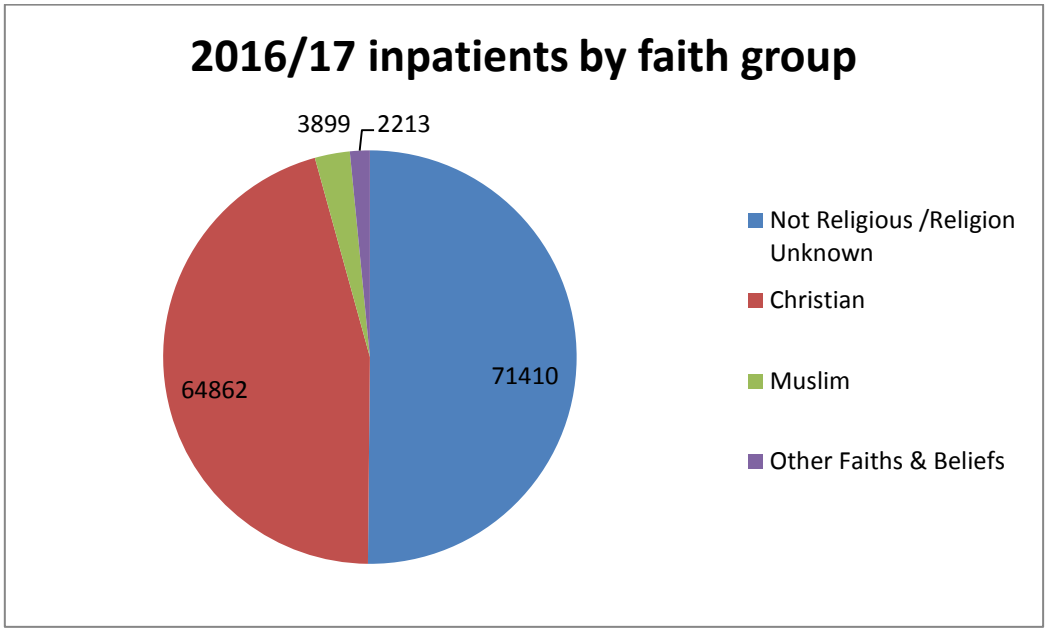
In February and March 2017 a group of 12 new chaplaincy volunteers gathered for the specialist chaplaincy training course. Led by Rev Tom Douglas and Rev Jillianne Norman, the course covered key aspects of pastoral and spiritual care and also examined multi-faith issues. The course itself was then followed by three sessions of shadowing either with an experienced volunteer or a team member and finally by a post training interview undertaken by Rev Stephen Bentley and Rev Steve Oram.

5. Chaplaincy activity

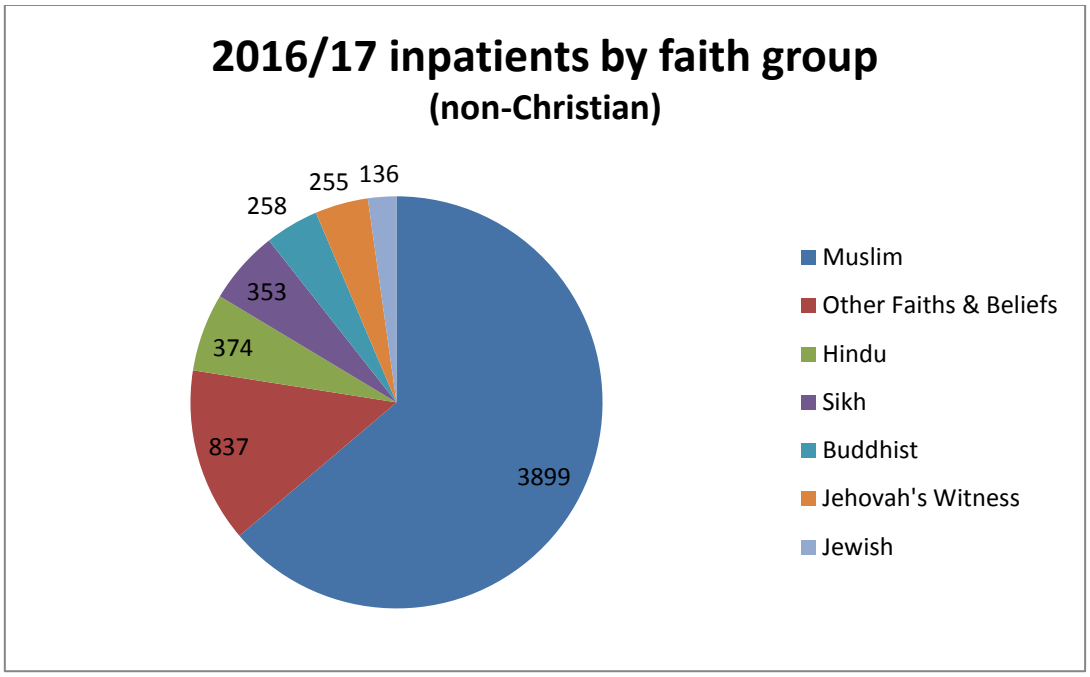
Chaplains at UH Bristol record the visits they make on the Medway system. This information sits within the patient profile and is accessible to any member of staff who uses the system. The information recorded provides a factual record of when the visit took place and any religious rites performed.

5.1 Chaplaincy visits

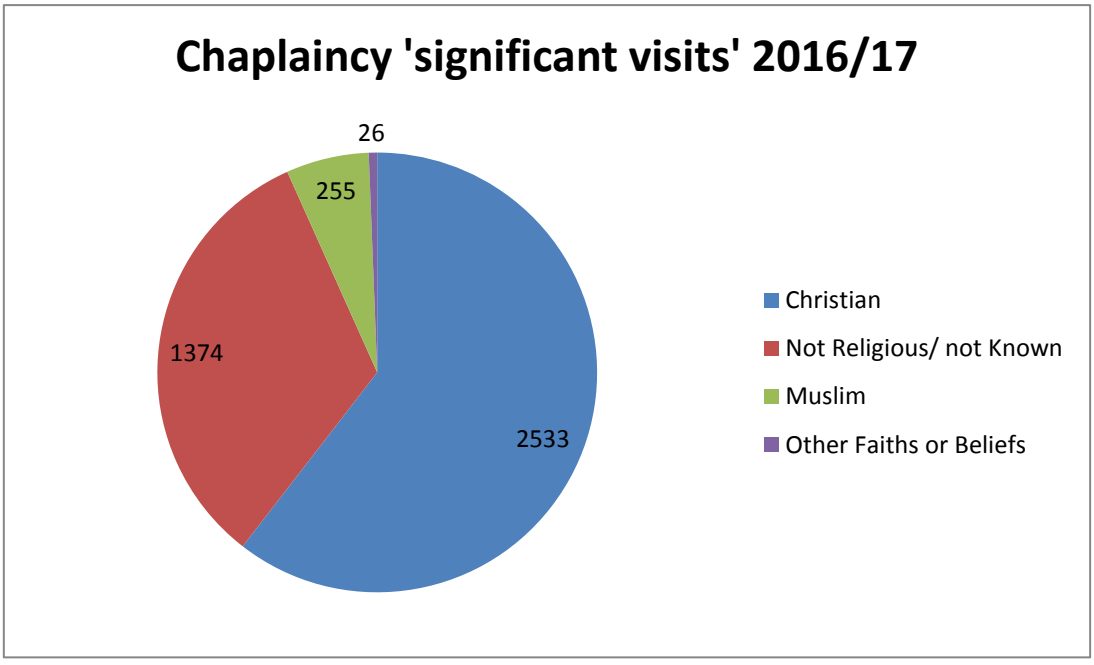
Medway data indicates that the Trust received 142,384 inpatients in 2016/17. Almost exactly a half of these patients are recorded as having a religious belief, as follows:



Christians constituted 91.4% of patients who are recorded as having a faith/belief. Muslim patients constitute the largest group of patients from other faiths.



During 2016/17, the chaplaincy team recorded 4,188 'significant visits' with patients across all hospitals in the Trust. A 'significant visit' is one where either the conversation itself was a long one and/or the conversation itself was a particularly important one for the patient (the decision to record or not is made by the chaplain or volunteer on a case by case basis). It is noteworthy that many of the visits carried out were to patients for whom the Medway system does not record a religious affiliation.

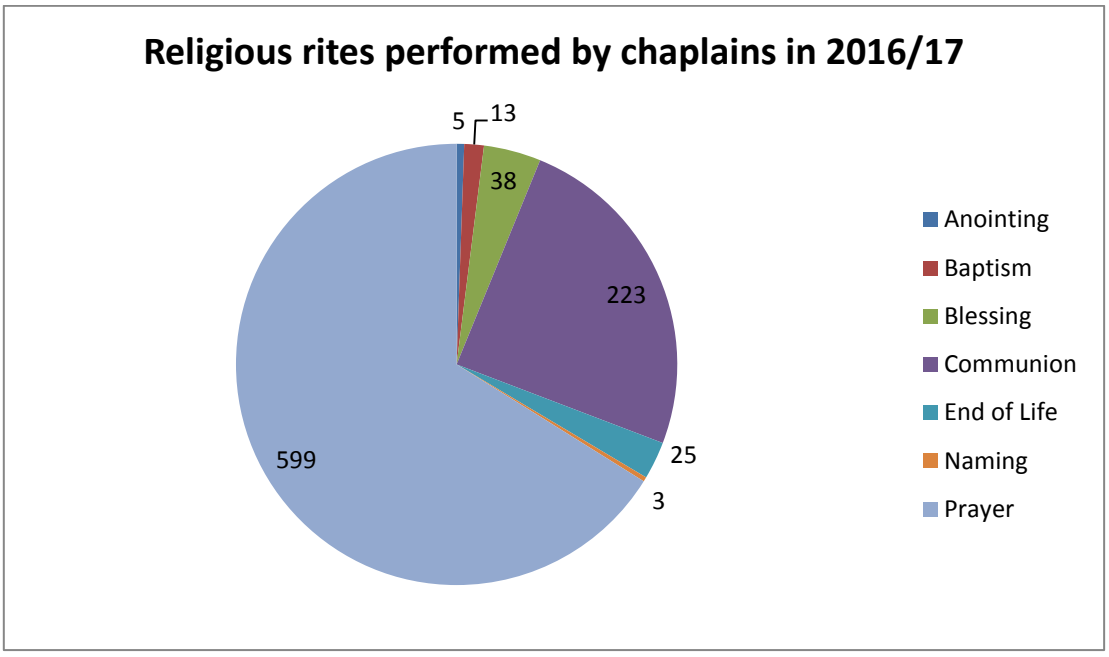


A proportion of the work carried out by chaplains involves visits to patients in palliative care situations. This includes not only patients in the Bristol Haematology and Oncology Centre, but also those in the four Continuing Health Care funded beds at South Bristol Community Hospital as well as elsewhere around the Trust. Records on the Medway system show 195 recorded visits with this group of patients during 2016/17.

Although chaplains currently have no means of recording the encounters they have with staff, chaplains spend a significant proportion of their time supporting staff through both private traumas and difficulties which arise as a result of the challenging jobs they do.

5.2 Rites performed

During 'significant visits', there were 906 occasions in 2016/17 when patients requested a variety of Christian religious rites which the chaplains carried out with them. In other words, only one fifth of significant visits resulted in a religious rite being performed, underlining the fact that chaplains are not just visiting people who want religious rites, but are mostly visiting those who simply want trained pastoral support in a time of crisis. It is also interesting to note that many of those receiving religious rites had no known faith affiliation recorded in Medway.



During the year, there have been five baptisms across the Trust. There were also 13 blessings of babies, undertaken at the request of their parents. The most frequent religious rite was prayer.

5.3 Baby Funerals

Chaplains undertake funerals for the majority of the stillbirths and non-viable foetuses born in St Michael's Hospital, as well as babies who die on the Neonatal Intensive Care Unit (NICU) without ever having gone home. In the past year, 82 funerals were undertaken. Funerals are tailored to the needs of the parents, whether they are of a particular faith or none. Most of these services were attended by parents, and many by members of the wider family.

In addition, chaplains undertake the disposal of the products of conception, of which there were 800 in the period 2016/17. These are cremated communally. Parents are told when these services take place, but do not attend.

5.4 On-call

In the period 2016/17, the chaplains were called to emergencies on 233 occasions.

6. <u>The wider contribution of Chaplains</u>

6.1 Trust committees and working groups

- **Equality and Diversity** – The Chaplaincy Team Leader is a member of the Equality and Diversity Group, bringing a religious, spiritual and cultural perspective.
- **End of Life –** The Chaplaincy Team Leader is a member of the End of Life Steering Group, which meets every two months, offering insights from the pastoral support that chaplains offering End of Life care provide to patients and seeking to bring a spiritual and religious perspective to discussions.
- **Patient Experience Group –** The Chaplaincy Team Leader produces is a member of this committee, for which an annual report is prepared.
- **Voluntary Services Strategy Group**

6.2 Multi-Disciplinary Team Meetings

Chaplains routinely attend a number of multidisciplinary team meetings. Their presence at the meetings allows them to be aware of any ongoing medical or social issues which are affecting the care of patients they are visiting. It may also inform the way in which they approach visiting and can give chaplains a forum which enables them to feed back to the multidisciplinary team any insights which they have gained from their visits. These include:

- **Oncology and Palliative Care** - Rev Ana Hansell attends the weekly MDT meeting.
- **PICU -** Rev Steve Oram attends meetings as trust chaplain with special responsibility to the children's hospital.
- **Bereavement Forum for St. Michael's Hospital** – Rev Steve Oram attends.
- **Integrated Care Round** – Steve Oram attends Tuesday morning meetings in the Neonatal Intensive Care Unit (NICU) at St Michael's Hospital.

6.3 Preceptorship Training

The chaplaincy team leader has begun to teach a session on Spiritual Care on this training course. The first sessions have been well received.

6.4 Nurse Assistant Training

The chaplaincy team contributes to the monthly teaching sessions as part of Essential Care training, introducing the department to Nurse Assistants in training. The session is designed to help staff think about how they can help provide spiritual and pastoral care for their patients.

6.5 Students

When requested, the team will provide placements for chaplaincy students. In particular, the chaplaincy provides week-long placements for students who are in the final year of training at Trinity College, Bristol. There have been five theological placements during 2016/17.

7. Chaplaincy Volunteers

At the end of 2016/17, UH Bristol had a total of 40 registered chaplaincy volunteers working in a variety of capacities.

8. Patient Affairs

In 2016/17, Patient Affairs dealt with 1,648 adult deaths. In the same period, 800 products of conception were cremated through 16 collective ceremonies conducted by our chaplains at South Bristol Crematorium. Parents are notified of the dates of the cremation, but do not attend the service which precedes it.

92 funerals were organised and taken by the chaplains for Stillbirths, Non-Viable Foetuses and babies who died on the Neonatal Intensive Care Unit (NICU).

On 15th December 2016, Patient Affairs moved to a new purpose-built office situated in the centre of the BRI on level 4 (A409) of the Queen's Building.

Patient Affairs continues to actively support a variety of other associated research / review projects within UH Bristol namely:

1. Mortality Review – this review has been in place for two years, involving the review of all adult deaths at UH Bristol.
2. Support for the Butterfly Project which is seeking to improve the service provided to inpatients diagnosed with dementia.
3. NHSBT – during 2016 UH Bristol became an Alliance hospital meaning that all adult deaths are now referred to the blood and transplant service. We continue to work closely with key staff to ensure improve take up of the scheme and to develop best practices.
4. Assisting the Palliative Care Team with quarterly reviews of our 'end of life' systems and associated documentation.

9. 2017/18 Plans

Several important staffing changes have happened since the end of the year.

Firstly a decision has been taken to end the shared arrangement for chaplaincy management which has been in place between UH Bristol and North Bristol NHS Trust since 2005. After the end of September 2017, Rev Brenda Dowie will continue to be employed by NBT, whilst UH Bristol will be seeking to appoint its own full-time chaplaincy team leader. The two trusts remain committed to collaboration on training and development for chaplains and also maintaining a viable cross-city on-call chaplaincy rota.

At the beginning of 2017/18, Father Cavan Mcelligott retired and Rev Steve Oram reduced his hours to three days a week. Father Cavan's post will be recruited to, whilst Rev Oram's reduction in hours will enable the recruitment of a full-time team leader.

In light of Rev Dowie's departure, the development of a new strategy for Spiritual and Pastoral Care for UH Bristol will be delayed until 2018, however the groundwork for this strategy will continue to be laid,

including a series of focus groups with staff to explore the place of spiritual and pastoral care within our hospitals.

Elsewhere, we will continue to seek to develop new ways of using the new BRI sanctuary space. We will also continue to monitor and respond to national developments for proposed Medical Examiners offices, currently scheduled for implementation in 2019.

Rev Brenda Dowie, Chaplaincy Team Leader
May 2017

University Hospitals Bristol
NHS Foundation Trust

Minutes of the Public Trust Board Meeting

Held on Thursday 29th June 2017, 11:00am-1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol,BS1 3NU

Present
Board Members

Member Name	Job Title/Position
John Savage	Chairman
Emma Woollett	Non-Executive Director / Vice- Chair
Julian Dennis	Non-Executive Director
Alison Ryan	Non-Executive Director
Guy Orpen	Non-Executive Director
Lisa Gardner	Non-Executive Director
David Armstrong	Non-Executive Director
John Moore	Non-Executive Director
Robert Woolley	Chief Executive
Carolyn Mills	Chief Nurse
Mark Smith	Chief Operating Officer/ Deputy Chief Executive
Alex Nestor	Acting Director of Workforce and Organisational Development
Sean O'Kelly	Medical Director
Paul Mapson	Director of Finance and Information

In Attendance

Name	Job Title/Position
Pam Wenger	Trust Secretary
Tony Watkin	Patient and Public Involvement Lead (for Item 3)
Mikie	Patient (for Item 3)
Josie	Patient Experience Story (for Item 3)
Chris Swonnell	Head of Quality (Patient Experience and Clinical Effectiveness), Patient Experience and Clinical Effectiveness (for item 13)
Judith Reed	Voluntary Services Manager (for item 13)
Alastair Johnstone	Consultant, Guardian of Safe Working Hours (for item 14)
Fiona Reid	Head of Communications
Penny Parsons	Public Governor
Mary Whittington	Public Governor
Ray Phipps	Patient Governor
Tony Tanner	Patient Governor
Clive Hamilton	Member of the Public
Jo Roberts	Staff Governor
John Chablo	Patient Carer Governor
Jane Westhead	Staff Governor
Rashid Joomun	Patient Governor
Florene Jordan	Staff Governor
Garry Williams	Patient Carer Governor

Kathy Baxter	Patient Governor
Alastair Darby	Member of Public
Simon Evans	Member of the Public

Minutes:

Zainab Gill	Corporate Governance & FOI Administrator

The Chair opened the Meeting at 11:00am

Minute Ref	Item Number	Action
100/06/17	**1. Welcome and Introductions**	
	The Chairman welcomed everyone to the meeting. Apologies for absence were noted from Paula Clarke and Jill Youds.	
101/06/17	**2. Declarations of Interest**	
	There were no declarations of interest.	
102/06/17	**3. Patient Experience Story**	
	The meeting began with a patient story, introduced by Carolyn Mills Chief Nurse. In this story the Board heard from Mikie, a young adult, who had been monitored by the dental hospital since he was a child, and had a carefully planned operation to realign his jaw in November 2016 at the BRI. Mikie was joined by his sister, and together they reflected on an exceptionally well-coordinated procedure between several different teams at the dental hospital and the BRI, orthodontics and maxiofacial team. Mikie explained how he had always been spoken to about his jaw in an age appropriate way, with professionalism and kindness, how he was fitted with braces on his top and bottom teeth (a process that had taken two years), so that his teeth could be moved into the correct position for the jaw surgery and how both he and his family had been well looked after throughout this long period of time. The Board were pleased with the care Mikie had received and thanked him for attending. The Board discussed Mikie's story and his experience and were pleased to note how successful his treatment and care had been.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the patient story.	
103/06/17	**4. Minutes of the last meeting**	
	The minutes of the meetings held on the 26th May 2017 were agreed as a true and accurate record. **Members RESOLVED to:** • **Approve** the minutes as a true and accurate record from the meeting held on 26th May 2017.	
104/06/17	**5. Matters arising and Action Log**	
	Members received and reviewed the action log. The progress against completed actions was noted, there were no outstanding actions to review in this meeting. **Members RESOLVED to:** • **Note** the update against the action log.	
105/06/17	**6. Chief Executive's Report**	
	Robert Woolley, Chief Executive, discussed the highlights from the Chief Executive's report and updated the Board on several further matters which were not covered in the report: <u>Hospital Cladding</u> Robert Woolley informed the Board that NHS Improvement asked Trusts to detail what type of cladding is used on all buildings on their estates and if any risk assessment has been carried out in the last year. Robert Woolley confirmed to the Board that all hospitals on the estate with cladding had been reviewed, as well as the specification of materials used, and all materials had been rated as non-combustible. He further confirmed that for absolute assurance, the Trust would be seeking an external contractor to test the cladding directly, the results of which would be reported back to the Board in due course. <u>Outcome of the Care Quality Commission (CQC) inspection at Weston Area Health NHS Trust</u> Robert Woolley reported to the Board that following the recent CQC inspection at Weston Area Hospital, there would be a closure of their Accident &Emergency Department overnight between the hours of 10pm and 8am from the 4th of July 2017. The Board were assured that the Trust had been fully collaborating in the system wide plan to	

Minute Ref	Item Number	Action
	manage how emergency patients would be transferred across the system during closure. He further confirmed that there was an internal contingency plan in place in response to the closure. The Board were reassured that the Trust believed that the impact of the Accident and Emergency Department closure at Weston Area Hospital would be manageable and that they would continue to monitor this throughout the length of closure. CQC 'Driving improvement' Publication Members noted that the CQC had published a document report called 'Driving Improvement' which included 8 case studies of Trusts and how they had become well led according to the CQC. Robert Woolley confirmed that UHBristol was one of the 8 Trusts featured, following its 'Outstanding' rating from the CQC earlier this year. Thank you letter to NHS Staff Robert Woolley reported to the Board that the Secretary of State had issued a thank you letter to all NHS staff acknowledging the increased pressures they faced, and responding to particular events across the region. Unity Sexual Health Service Robert Woolley reminded the Board that the Trust had partnered with 7 other organisations to deliver a new sexual health service for people living in Bristol, North Somerset and South Gloucestershire. This new service, had recently progressed to providing a service offering the option to order testing kits for sexually transmitted infections online, and a confidential results service. **Members RESOLVED to:** • **Receive** the Chief Executive report for information.	
106/06/17	**7. Quality and Performance Report** Members agreed to take item 7 and 8 together.	
	Mark Smith, Chief Operating Officer and Deputy Chief Executive presented this report. It was noted that progress in restoring performance against the national access standards had continued to be variable this month. Performance against the A&E 4-hour standard improved to above trajectory and for this reason is now Amber-rated, but remained well below the national 95% standard. Although the recovery trajectory for the Referral to Treatment (RTT) time standard was not met in the month, performance remained the same in percentage terms as that reported in March 2017 and April 2017. The	

Minute Ref	Item Number	Action
	Board noted that the Urgent Care Plan developed in response to increasing pressures by the Trust's urgent care steering group, was presented at the recent Quality Outcomes Committee meeting and progress against the plan would be reported back to the Board in due course. *Members noted:* • Performance against the 62-day GP cancer standard deteriorated in the month due to critical care bed pressures and elective capacity constraints. • There was a further reduction in the number of Sleep Studies over 6 week waiters, which in addition to a reduction in demand for Cardiac CT scan led to an improvement in performance to 98.8% against the 99% national standard. • The number of patients seen for new outpatient appointments rose in the month, well above the seasonal norm. This offset a 9% rise in new outpatient referrals relative to the same period last year, which would otherwise have resulted in an increase in the size of the outpatient waiting list • There were ongoing risks to restoring achievement of the 6-week wait for a diagnostic test, due to the high demand for Cardiac CT scans, for which a sustainable capacity solution will be piloted in July. Recent national publicity of Sleep Studies testing may lead to increased demand. • The overall level of emergency admissions into the Bristol Children's Hospital (BCH) increased by 5% in May relative to the same period last year. • There was an improvement in 4-hour performance at the BRI of just less than 5% relative to the previous month. This improvement in performance was despite a further rise in bed occupancy. • The Safety Thermometer measure of No New Harms and the Non-purposeful Omitted doses of Critical Medication was Amber rated for the first time following more than a year of being Green rated. • Noteworthy improvements in performance against Quality metrics included a further month of the NEWS deteriorating patient indicator being Green rated and performance against the metric for patients who have sustained a fractured neck of femur going to theatre within 36 hours, improving to 87% against the 90% national standard. • The improvements seen in some of the workforce metrics in recent months have been maintained, including a continued Green rating for agency levels and turnover rates being maintained at the lower levels seen since October 2016.	

Minute Ref	Item Number	Action
	Sean O'Kelly reported to the Board that there had been 3 never events reported in this quarter and that all would be investigated appropriately and were from different areas in the Trust. The Board were pleased to hear that there had been a slight improvement in the performance target relating to fracture neck of femur and that the Trust was getting closer to achieving the target. **Members RESOLVED to**: • **Receive** the Quality and Performance Report for assurance.	
107/06/17	**8. a) Quality and Outcomes Committee Chair's Report** **b) Quality and Outcomes Committee Terms of Reference** Members agreed to take item 7 and 8 together.	
	Members received a written report following the meeting of the Quality and Outcomes Committee held on the 27th June 2017. Members also received a verbal account of the meeting held on the 27th June 2017 from Alison Ryan, Non-executive Director and Chair of the Quality and Outcomes Committee (QoC), covering the following key areas: • The Committee received a report summarising the key actions being taken to improve urgent care performance at UH Bristol • The Committee had welcomed the results of the National Inpatient Survey and it was pleasing to note that UH Bristol inpatients' overall rating of their experience in hospital was the best of any general acute trust in the country. • The Committee had received an update on progress of the 17/18 outpatient improvement programme including the future work programme for 2017/18. The Committee were provided with assurance in terms of team resources to implement changes and carry forward actions. • The Committee had reviewed 6 serious incidents, 3 relating to patient falls, one relating to a pressure ulcer, one relating to loss of heating and hot water and the one relating to a delayed diagnosis. • The Committee had received a detailed report on the results of the staff survey and the key findings for the Trust. There was a discussion around the increase in emergency admissions.	

Minute Ref	Item Number	Action
	The Board noted that it was difficult to understand or identify any trends in these as they were so variable, and also that the increase in emergency admissions was a national issue. There was a discussion around improving access to ITU/HDU Beds, Mark Smith explained that Cardiac Surgery was working hard to achieve their plan and Cardiac Surgeons had implemented actions to help ensure that patients who undergo surgery have a bed waiting for from, once surgery is complete. Lisa Gardner asked a question in relation to training and induction where numbers around completion seemed to be low, Alex Nestor explained that there was an increased focus from divisions on training and that the fire and safety update was a yearly update which was due in April 2017, when this report had been processed, which was partly the reason for the spike in this training. She went on to clarify that the induction was not the Trust's induction but related to local inductions in divisions. Robert Woolley advised that the move to e-appraisals would help the Trust to target individuals rather than the divisions as a whole. **b) Quality and Outcomes Committee Terms of Reference** The Board were asked to approve the terms of reference for the Quality and Outcomes Committee in line with the delegated authority from the Trust Board of Directors. The Board noted that the terms of reference for the Quality and Outcomes Committee had been reviewed at the Committee meeting on 23 May 2017, and that there was only one minor amendment relating to the deletion of the risk assessment framework which had now been replaced by the Single Oversight Framework. **Members RESOLVED to**: • **Receive** the Quality and Outcomes Committee Chair's Report for assurance. • **Approve** Quality and Outcomes Committee Terms of Reference.	

Minute Ref	Item Number	Action
108/06/17	**9. Independent Review of Children's Cardiac Services progress report**	
	The Board received a progress report relating to the recommendations from the Independent Review of Children's Cardiac Services and a CQC expert review of clinical outcomes of the service published on 30 June 2016. The key highlights from the report were that the June 2017 Steering Group approved the closure of three further recommendations. There were three remaining recommendations to close, it was anticipated that these would be closed or transferred to the paediatric cardiac network work plan following the July 26th meeting. The Board would receive a final report on the delivery of the recommendations at the September meeting of the Trust Board. This will detail ongoing assurance work planned. Members noted that Internal audit have been commissioned to undertake two audits to provide additional assurance to Trust Board members, on the robustness of the sign off process of completed recommendations and in 6 months the completion of ongoing follow up/audit actions. **Members RESOLVED to:** • **Receive** the Independent Review of Children's Cardiac Services progress report.	
109/06/17	**10. Annual National Inpatient Survey**	
	The Board welcomed the results of the National Inpatient Survey and were pleased to note that UH Bristol inpatients' overall rating of their experience in hospital was the best of any general acute trust in the country. The Board noted that areas for focus and improvement were around signage and ensuring that this is communicated clearly and ensuring high customer service is provided at all times. John Moore commented on the success of the overall rating the Trust had received and asked why there was a delay in the publication of the results. Carolyn Mill's explained that this was a national survey which was done through the CQC and that the timelines are set nationally. . **Members RESOLVED to:** • **Receive** the Annual National Inpatient Survey report.	
110/06/17	**11. Annual Complaint Report**	

Minute Ref	Item Number	Action
	The Board received the report, which was presented to fulfil a statutory requirement for the Trust to publish a summary of complaints received during the year. The Board had previously reviewed the data included in the report via detailed quarterly reports, and in summary form via the Trust's Annual Quality Report (Account). Robert Woolley asked a question in relation to the increased number of dissatisfied complainants and whether the new executive oversight panel would help to address this, Carolyn Mill's explained that the annual executive review related to engagement and divisions; however there were now monthly reviews with feedback to divisions, which were proving to be effective in understanding complaints. **Members RESOLVED to:** • **Receiv**e the Annual Complaints Report for assurance.	
111/06/17	**12. a) Quarterly Complaints Report** **b) Quarterly Patient Experience Report**	
	The Board received the Quarterly Complaints Report for assurance. Carolyn Mills advised that the report contained feedback from the final quarter of 2016/17. Improvements in Quarter 4 included: • The total number of complaints received in Quarter was 11% more than in Quarter 3, but this was significantly less than in Quarter 2, and 8% less than the corresponding quarter one year previously. • In Quarter 4, complaints about cancelled/delayed appointments and operations fell to a historical low of 54. The Trust had also received only 66 complaints in quarter 3; this was the first time the quarterly total for this reporting theme had fallen below 100 since the third quarter of 2013/14. • Complaints about failure to answer telephones fell for a third consecutive quarter, returning to its lowest, (and best), point since the third quarter of 2015/16. • Complaints about Trauma and Orthopaedics fell significantly to 14 in quarter 4 compared to 37 in quarter 3. • No formal complaints were received by the Diagnostics and Therapies division in February and March 2017. • No cases referred to the Ombudsman were upheld against the Trust in quarter 4. **b) Quarterly Patient Experience Report** The Board received the Patient Experience and Involvement Report for	

Minute Ref	Item Number	Action
	assurance. Members noted the following highlights from the report: • All of the UH Bristol's Trust-level patient survey measures remained above target - demonstrating the continued provision of a high quality patient experience. • UH Bristol has a contractual obligation with the Bristol Clinical Commissioning Group to meet specified Friends and Family Test response rate targets. In Quarter 4 the Trust continued to meet these targets. There was an improvement in the response rate for the inpatient and day case element of this survey during Quarter 4, having only just been meeting the 30% target in Quarter 3. • Ward C808 (care of the elderly) had the lowest score across the headline survey measures. It has been a consistent feature of the survey data that care of the elderly areas tend to attract lower patient experience scores. This has led to additional analysis and exploration of the data, which suggests that the scores are a realistic reflection of the challenges of caring for patients (and being a patient / carer) in this setting - rather than a reflection of the quality of care being provided. To further test this theory, in Quarter 1 the Patient Experience and Involvement Team have been carrying out a range of activities on care of the elderly wards. • Ward A602 (trauma and orthopaedics) had a relatively low survey score on two key survey measures. This was an unusual result for this ward, further analysis did not identify any specific improvement issues, and the number of complaints actually fell over this period. The most likely explanation at present is that this was a statistical "blip", but the ward Sister has been alerted to the result and the score will continue to be monitored to look for any consistent trend. **Members RESOLVED to:** • **Receive** the Quarterly Complaints Report and the Quarterly Patient Experience Report for assurance.	
112/06/17	**13. Volunteering Strategy**	
	Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness), and Judith Reed, Voluntary Services Manager, attended the Board meeting to present this item. Chris Swonnell explained that the purpose of the strategy was to set out the Trust's ambitions for developing and growing the contribution of volunteering to the organisation over the next three years. The Board noted the ambitions for the next year, which were:	

Minute Ref	Item Number	Action

	• Our ambitions for 2017-2020 can be summarised as:
	  ○ Consolidating existing core volunteer roles and developing a defined number of new core roles which will deliver the greatest benefit for patient experience
	  ○ Making our volunteer 'offer' attractive and opening it up to a diverse range of people
	  ○ Maintaining a continuous focus on best practice in volunteer management
	• New plans include lowering the minimum age for volunteering to 16, as part of a two year initiative funded by the Pears Foundation via Above and Beyond to significantly increase in-hospital volunteering opportunities for people aged 16-25 (pending final confirmation of funding support at the time of writing)
	• Governance arrangements for volunteering at UH Bristol are already strong and robust and must continue to be so
	• We are committed to listening to our volunteers and constantly improving the volunteer experience
	• Our numbers of volunteers are significantly lower than many of our peer trusts – a potentially missed opportunity which we want to address through this strategy.
	
	The Board noted that these key themes had previously been discussed and supported by the Governors Quality Focus Group and the Quality and Outcomes Committee of the Board.
	
	David Armstrong asked for clarity around governance, and where actions are reviewed, Chris Swonnell explained that there would be regular reviews at the volunteering strategy group, which was chaired by Carolyn Mills, Chief Nurse and reported through to the Clinical Quality Group.
	
	Alison Ryan spoke about how integral volunteers are and commented on the need to ensure that staff are trained on the role of volunteers and that investment in this area would help to increase the success of volunteering.
	
	Robert Wooley asked if there was a plan illustrating how the work would be taken forward, Carolyn Mills confirmed that there was and that this would go to the Quality Outcomes Committee for assurance.
	
	Members RESOLVED to:
	• **Approve** the Volunteering strategy	

Minute Ref	Item Number	Action
113/06/17	**14. Guardian of Safe Working Hours Annual Report**	
	Alastair Johnstone, Guardian of Safe Working Hours, attended the meeting to present this item. Sean O'Kelly explained that the Guardian of Safe Working is a new post mandated by the introduction of the 2016 Junior Doctors Contract. Part of the responsibility of this post is to produce regular reports for the Trust Board to ensure that issues around junior doctor staffing are visible at a high level across the organisation. These reports are intended to be publicly available and the annual report (or a link to it) will form part of the Trust Annual Quality report.. This report follows the national format suggested by NHS employers and focusses on "rota gaps" and provides a summary of the actions taken by the Trust. Alastair Johnstone explained that the 2016 junior doctors' contract was gradually being introduced at University Hospitals Bristol. The new contract introduced stricter safe working limits and reduced the maximum number of sequential shifts that a junior doctor can work necessitating significant rota redesign in some areas. Whilst there was a national implementation timetable the Trust had chosen to depart from this where divisions had been unable to provide assurance that safe levels of medical cover could be provided under the new terms and conditions. Emma Woollett asked how Junior Doctors were feeling in relation to the implementation of the new contract. Alastair Johnstone explained that morale nationally for Junior Doctors was low, and that it did not relate directly to this Trust, however was due to the increased pressures to cover short terms gaps on the rotas due to absence and sickness. **Members RESOLVED to:** • **Receive** the Guardian of Safe Working Hours Annual Report for assurance.	
114/06/17	**15. Finance Report** **(The Board agreed to take questions for item 10 and 11 together.)**	
	Paul Mapson, Finance Director presented the Finance Report. It was noted that the Trust is reporting a deficit of £1.400m (before technical items) at the end of May. The Operational Plan is a deficit of £1.028m and therefore the Trust is £0.373m below plan. This position includes £0.932m sustainability and transformation (S&T) funding but is £0.399m behind the planned receipt of £1.331m. Therefore the Trust is reporting a surplus of £0.027m excluding S&T funding. However the	

Minute Ref	Item Number	Action
	divisional position is an overspend of £1.230m after only two months which is of serious concern and risks delivery of the 2017/18 Control Total. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
115/06/17	**16. Finance Committee Chair's Report** **(The Board agreed to take questions for item 15 and 16 together.)**	
	Members received reports from the meetings of the Finance Committee held on 26th June 2017. Members also received a verbal account of the meeting held on the 26th June 2017 from Lisa Gardner, Non-executive Director covering the following key areas: - The Divisional Financial Reports were received and it was noted that the Clinical Divisions and Corporate Services are £1.230m adverse to plan. - The Committee had received an update on the progress towards delivering the Trust's Cost Improvement Target for 2016/17. For month ending 31st May 2017, the Trust has achieved savings of £1.491m against a plan of £1.947m, leaving a shortfall of £0.456m. With the exception of two Divisions, the Cost Improvement Plans are being met. - The Committee had received an update in relation to the Trust's contract and activity income and noted that the contract income was £0.93m higher than plan in May. - The Committee had received an update on the capital programme and noted that capital expenditure totals £2.478m up to 31st May 2017. - The Committee had noted the Trust has a strong statement of financial position at 31 May 2017, with net current assets of £36.989m, £3.291m higher than the Operational Plan. Julian Dennis asked a question in relation to performance against CQUINs, Paul Mapson explained that CQUINs had been made more difficult nationally and that they were now largely relating to the control total which the Trust was forecasting currently as unlikely to achieve. He confirmed that the Trust was looking into renegotiating the CQUINs into something that was more appropriate and achievable. It was	

Minute Ref	Item Number	Action
	agreed that it would be helpful to have a session on CQUINS at a Board Seminar. John Moore asked a question for assurance in relation to procurement and actions being taken place to help deliver positive results. Paul Mapson explained that the implementation and adoption of new products had caused delays, which was now being speed up and the procurement team were looking into ways to increase productivity. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance; and • **Schedule** a session on CQUINS at a Board Seminar.	
116/06/17	**17. Corporate Governance Statement Self-Assessment Certification**	
	Robert Woolley introduced the report which provided the necessary assurance for the Board to enable approval of the proposed Corporate Governance Statement for submission to NHS Improvement on 30 June 2017. He explained that the requirements changed slightly each year and asked the Board to agree that the assurances described in the paper were sufficient to certify each statement. The Board approved the statements with no amendments. **Members RESOLVED to:** • **Confirm** self-certification against the requirements of General Condition 4 of the Licence.	
117/06/17	**18. Governors' Log of Communications**	
	The report provided the Board with an update on governors' questions and responses from Executive Directors. **Members RESOLVED to:** • **Note** the Governors' Log of Communications.	
113/06/17	**19. Any Other Business**	
	The Board had no other urgent Business to be discussed.	
114/06/17	**20. Date of Next Meeting**	
	28th July 2017, 11:00am-1:00pm, Conference Room, Trust HQ, Marlborough Street, Bristol, BS1 3NU.	

Chair's Signature: ..... Date: .....

University Hospitals Bristol
NHS Foundation Trust

Trust Board of Directors meeting held in Public June 2017
Action tracker

Outstanding actions following meeting held in June 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	**91/05/17**	**Independent Review of Children's Cardiac Services progress report** **Receive** the closure report in September 2017 and invite the Divisional Director and the families to the meeting.	Chief Nurse	October 2017	**Work in Progress.** The final report will not be available until October, therefore added to the agenda plan for October 2017.
2.	**115/06/17**	**Finance Chairs Report** Schedule a session on CQUINS at a Board Seminar.	Trust Secretary	September 2017	**Work in Progress.** To be added to the Board Development Programme.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Chief Executive Report		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

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 July 2017.

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. Members are asked to: • **Note** the report.

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees

Audit Committee	Finance Committee	Quality and Outcomes Committee	Remuneration & Nomination Committee	Other (specify)

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JULY 2017

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in July 2017.

2. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the current position in respect of performance against NHS Improvement's Oversight Framework.

The group **received** the quarterly benchmarking report on key national access and quality standards.

The group **received** an update on the financial position for 2017/2018.

3. STRATEGY AND BUSINESS PLANNING

The group **approved** sign-off of the Division of Medicine's Operating Plan.

The group **received** an update on the work being undertaken to develop a Reward Strategy and **noted** the strategic principles developed. The group **agreed** that further work and clarification was required in regards to long service, financial information and coordination.

The group **approved** the revised Trust Sustainable Development Policy.

The group **received** an update on progress and key issues associated with the creating capacity and out of hospital work.

4. RISK, FINANCE AND GOVERNANCE

The group **received** a review of corporate meetings, with a request for further review and comment from Executive Directors, prior to consideration being given as to any proposed changes.

The group **approved** the Quarter 1 Board Assurance Framework on its way to Trust Board.

The group **approved** the Corporate Risk Register on its way to Trust Board.

The group **received** a proposal to develop a performance management framework and **approved** the approach presented.

The group **approved** the Risk Management Policy and Strategy.

The group **approved** the annual reports for Risk Management and Equality and Diversity on their way to Trust Board.

The group **received** the staff survey results for 2016 and **supported** the priorities for the local divisional and trust wide plans.

The group **received** the Quarter 1 Corporate Quality Objectives.

The group **received** the Quarter 1 Serious Incident Quarterly report.

The group **approved** the closure of Risk 1530 due to it being superseded by risk 2063. The group **rejected** risk 1640 from being downgraded due to deterioration in performance in recent months.

Reports from subsidiary management groups were **noted,** including updates on the current position following the transfer of Cellular Pathology to North Bristol NHS Trust and on the Transforming Care Programme.

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.

Mark Smith
Deputy Chief Executive
July 2017

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 09.00 -12.00 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Board Assurance Framework 2017-18 (Quarter 1)		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 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.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose
To receive the Board Assurance Framework for 2017/18 and note progress at the end of quarter 1.

Key issues
This reports provides assurance that the organisation is on track to achieve its strategic and annual objectives for the current year. Importantly, the Board Assurance Framework 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 Board Assurance Framework (BAF) forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks. 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.

Key Changes

STRATEGIC PRIORITY 1:
We will consistently deliver high quality individual care, delivered with compassion
Principal Risk 1 - Failure to maintain the quality of patient services.

- Second line of assurance robust forms of assurance, some gaps in controls around business continuity arrangements.
- Action Plan to address the issues around business continuity is ongoing.
- Further development has been made to the Quality Impact Assessment process to cover and support changes to service provision and the stopping of services.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 11 associated Corporate Risks -

STRATEGIC PRIORITY 2:
We will ensure a safe, friendly and modern environment for our patients and our staff
Principal Risk 2 - Failure to develop and maintain the Trust estate.

- Second line level of assurance in relation to Health and safety issues, third line in respect of Internal Audit work programme.
- Gaps in assurance around roof and drain maintenance being addressed via operational and capital work programme, the impact of roof and drain issues on bed capacity and flow remains low.
- Previous Risk Rating 8, Current Risk Rating 8, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 3:
We will strive to employ the best staff and help all our staff fulfil their individual potential
Principal Risk 3 - Failure to recruit, train and sustain an engaged and effective workforce.

- First & second line assurance around reporting arrangements and agency action plan now in place.
- Metrics continue to highlight risk around staff retention, although improving (see corporate risk 674).
- Previous Risk Rating 12, Current Risk Rating 12, static trajectory.
- 4 associated Corporate Risks.

STRATEGIC PRIORITY 4:
We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
Principal Risk 4 - Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.

- Second line assurance in place but gaps identified Trust wide around supporting innovation and improvement, to be addressed by implementation of Innovation Strategy.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 5:
We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.
Principal Risk 5 - Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.

- Second line assurance currently in place with potential for feedback via STP from BNSSG.
- Bid for research funding from NIHR successful.
- Partnership meetings now in place with NBT, UoB, UWE and memorandum of understanding in place with UoB.
- Senior staff involvement in North Somerset sustainability board programme
- Previous Risk Rating 6, Current Risk Rating 6, static trajectory.
- 2 associated Corporate Risks.

STRATEGIC PRIORITY 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.

Principal Risk 6 - Failure to sustain financial sustainability

- Second line assurance in place via internal reporting and divisional reporting arrangements, weak controls and gaps in assurance identified.
- Previous Risk Rating 9, Current Risk Rating 9 static trajectory.
- 3 associated Corporate Risks

STRATEGIC PRIORITY 7:
We will ensure we are soundly governed and are compliant with the requirements of our regulators

Principal Risk 7 - Failure to comply with targets, statutory duties and functions

- Robust second level assurance in place and third level in respect of NHS Improvement returns and CQC inspections.
- No significant gaps identified in either controls or assurance,
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 3 associated corporate risks.

Summary

The current scores for principal risks are summarised in the following heat map - there has been no movement in Q1.

	Likelihood				
Impact	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic					
4 Major					
3 Moderate			1, 3, 5, 7, 8	4	
2 Minor			6	2	
1 Negligible					

Recommendations
Members are asked to: • **Receive** and **review** the Board Assurance Framework for quarter 1

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☒
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☒	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☒
Failure to maintain financial sustainability.	☒	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☒	Legal	☒	Workforce	☒

Impact Upon Corporate Risk
None identified.

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☒	Information Management & Technology	☒
Human Resources	☒	Buildings	☒

Date papers were previously submitted to other committees				
Executive Director Meeting	**Risk Management Group**	**Audit Committee**	**Senior Leadership Team**	**Quality and Outcomes Committee**
25/05/2017	04/7/2017	11/07/2017	19/07/2017	26/07/2017

University Hospitals Bristol NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

Q1 2017-18

Board Assurance Framework (BAF) for the delivery of the Trusts Strategic Objectives.

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process.

The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

1. The Trust Strategic Plan

As an organisation, our key challenge is to maintain and develop the quality of our services, whilst managing within the finite resources available. We are also clear that we operate as part of a wider health and care community and our strategic intent sets out our position with regard to the key choices that we and others face.

Our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services.

We are committed to addressing the aspects of care that matter most to our patients and the sustainability of our key clinical service areas is crucial to delivering our strategic intent.

Our strategy outlines nine key clinical service areas:

1. Children's services;
2. Accident and Emergency (and urgent care);
3. Older people's care;
4. Cancer services;
5. Cardiac services;
6. Maternity services;
7. Planned care and long term conditions;
8. Diagnostics and therapies; and
9. Critical Care.

Our 2014-19 five year Strategic Plan outlines ***seven strategic priorities,*** structured according to the characteristic of our Trust Vision outlined above. Our strategic priorities are:

1. We will consistently deliver high quality individual care, delivered with compassion;
2. We will ensure a safe, friendly and modern environment for our patients and our staff;
3. We will strive to employ the best staff and help all our staff fulfil their individual potential;
4. We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation;
5. We will provide leadership to the networks we are part of, for the benefit of the region and people we serve;
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; and
7. We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

2. The Trusts Operational Plan 2017-19

The focus of strategic and operational plans over the next two year period will be the following:

3.1 Care and Quality and Health and Wellbeing

3.1.1 Delivery of our quality objectives as agreed in our new quality strategy, including delivery against requirements outlined in the nine 'must dos' and NHS mandate to close our identified gaps in care and quality. For our organisation; this will include a specific focus on;

- Ensuring timely access to services
- Delivering safe and reliable care
- Improving patient and staff experience
- Improving outcomes and reducing mortality

3.1.2 Independent Children's Cardiac Review

- Full delivery of the recommendations

3.1.3 Staff strategic engagement and retention strategy,

- Focus on staff engagement and wellbeing,
- Supported by real-time feedback, using innovative approaches such as the 'Happy App' (2016 HSJ winner) and;
- The on-going development of leadership capacity and capability.

3.1.4 Access standards

- Improving performance and delivery of our performance trajectories in the four core standards.

3.2 Finance and Efficiency

3.2.1 Operational and financial sustainability

- with a specific focus on internal specialty level productivity and the efficient delivery of activity aligned to our capacity modelling,
- along with the implementation of Carter recommendations,
- including a system view of corporate overheads, estates and pathology.

3.2.2 Maximising the impact from partnership system working

- service redesign and strategic partnerships within region
- development of shared leadership and associated opportunities to improve system and service level productivity.

3.2.3 Estates and capital strategy for 2017-19

- continue to align the modernisation and development of our estate to our evolving clinical strategy and
- support delivery of the emerging strategic planning new model of care.

3.2.4 Maximising workforce productivity

- including controlling agency and locum costs.

3.3 Strategy, Transformation, Innovation and Technology

3.3.1 Refresh our existing Trust Strategy

- to reflect the need to respond to local and national changes to our operating environment and
- with a specific focus on developing our clinical strategy

3.3.2 Exploring options to continue to develop our specialist portfolio

- in the context of potential changes to Specialised Commissioning approaches across the south

3.3.3 Maximise our opportunity to continue to develop our research capacity and capability

- associated with the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.

3.3.4 Development of an Innovation and Improvement Strategy for the organisation

- including maximising the opportunities for innovation and transformational change associated with our successful appointment as a National Digital Exemplar site,
- with clear alignment to organisational and STP digital priorities / local digital roadmap.

3.3.5 Continued development and delivery of our Transforming Care Programme

- focussing on transforming the way in which we deliver care through service and workforce redesign,
- with a focus over the next two years on real time internal processes to support patient flow alongside engaging in and supporting STP processes to develop effective system care pathways and patient flow.

3. Principal Risks

- **Risk to SP 1**: Risk that the Trust will be unable to maintain the quality of patient services
- **Risk to SP 2**: Risk that the Trust will be unable to develop and maintain the Trust estate
- **Risk to SP 3:** Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.
- **Risk to SP 4:** Risk that the Trust will not be able to support transformation and innovation and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Risk to SP 5:** Risk of failing to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
- **Risk to SP 6:** Risk of being unable to deliver the 2017/18 financial plan.
- **Risk to SP 7:** Risk of failing to comply with targets, statutory duties and functions

4. Approach to Risk Assessment - Risk scoring = consequence x likelihood

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 -12	High risk
15 - 25	Very High risk

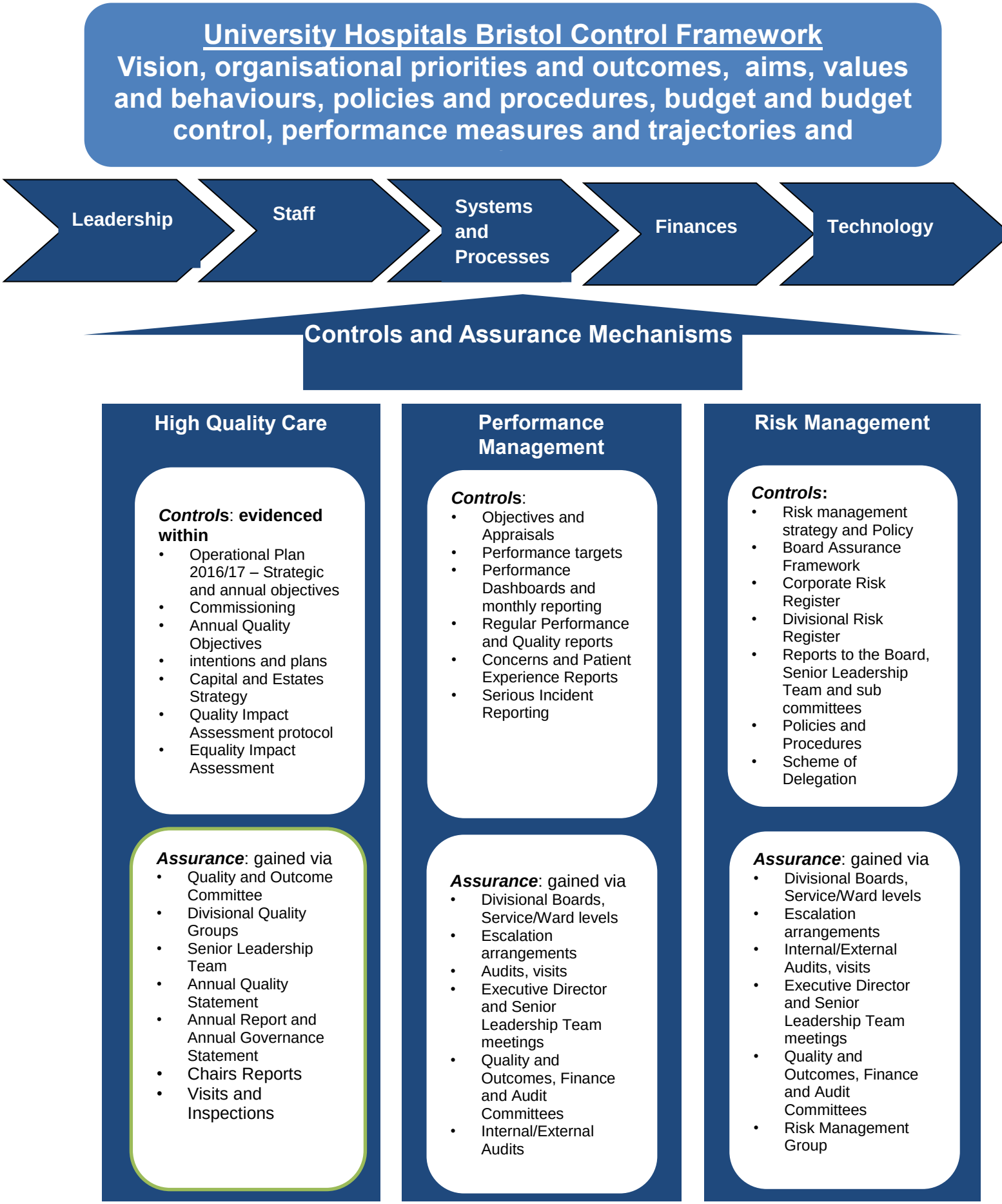
The current scores for principal risks are summarised in the following heat map.

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic					
4 Major		2	3		
3 Moderate		5	1, 4, 6, 7		
2 Minor					
1 Negligible					

The progress summary of the principal risks are as follows.

Principal Risk	April 17	July 17	October 17	December 17
1. Risk that the Trust will be unable to maintain the quality of patient services.	Possible x Moderate **= 9**	Possible x Moderate **= 9**		
2. Risk that the Trust will be unable to develop and maintain the Trust estate	Unlikely x Major **= 8**	Unlikely x Major **= 8**		
3. Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.	Possible x Major **= 12**	Possible x Major **= 12**		
4. Risk that the Trust will not be able to support transformation and innovation and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	Possible x Moderate **= 9**	Possible x Moderate **= 9**		
5. Risk of failing to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**		
6. Risk of being unable to deliver the 2017/18 financial plan	Possible x Moderate **= 9**	Possible x Moderate **= 9**		
7. Risk of failing to comply with targets, statutory duties and functions	Possible x Moderate **= 9**	Possible x Moderate **= 9**		

5. Controls Framework



Q1 2017/18

6. Risk Assurance

Levels of Assurance

VISION AND CORPORATE PRIORITIES

First Line
Operational

- Organisational structures – evidence of delegation of responsibility through line Management arrangements
- Compliance with appraisal process
- Compliance with Policies and Procedures
- Incident reporting and thematic reviews
- Compliance with Risk Management processes and systems
- Performance Reports, Complaints and Patient Experience Reports, Workforce Reports, Staff Nursing Report, Finance Reports

Second Line
Risk and Compliance

Reports to Assurance and Oversight Committees

- Audit Committee
- Finance Committee
- Quality and Outcomes Committee
- Remuneration Committee
- Risk Management Group, Clinical Quality Group, Health and Safety Groups etc

Findings and/or reports from inspections, Friends and Family Test, Annual Reporting through to Committees, Self-Certification NHS Improvement

Third Line
Independent

- Internal Audit Plan
- External Audits (eg. Annual Accounts and Annual Report)
- CQC Inspections
- NHS Improvement Inspections
- Visits by Royal Colleges
- External visits and accreditations
- Independent Reviews
- Well Led Governance Review

REGULATORS

EXTERNAL AUDIT

7. Risk Appetite

Risk Domain	Definition	Risk Appetite	Risk Rating
Safety	Impact on the safety of patients, staff or public	Low	
Quality	Impact on the quality of our services. Includes complaints and audits.	Moderate	
Workforce	Impact upon our human resources (not safety), organisational development, staffing levels and competence and training.	Moderate	
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.	Low	
Reputation	Impact upon our reputation through adverse publicity.	High	
Business	Impact upon our business and project objectives. Service and business interruption.	Moderate	
Finance	Impact upon our finances.	Moderate	
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.	Moderate	

8. Key

The Assurance Framework has the following headings:

Principal Risk	What could prevent the objective from being achieved?
Key Controls	The systems/processes/strategies that we have in place to assist secure delivery of the objective
Gaps in Controls	Gaps in the effectiveness of controls in place
Form of Assurance	Evidence of how the controls are monitored e.g. reporting mechanism

Gaps in assurance	Gaps in the evidence required to provide assurance or failure of the monitoring/reporting process
Level of Assurance	Robustness of the assurance which is being relied on - 1st line, 2nd line, 3rd line.
Actions Agreed for any gaps in controls or assurance	Plans to address the gaps in control and / or assurance and reference to any related risks.
Current Risk Rating	Assessment of the principal risk taking into account the strength of the controls currently in place to manage the risk
Direction of travel	Are the controls and assurances improving? ↑ ↓ ↔

STRATEGIC PRIORITY 1 : We will consistently deliver high quality individual care, delivered with compassion

Operational Plan 2017/19 Focus	**3.1.1 - Delivery of our quality objectives as agreed in our new quality strategy**, including delivery against requirements outlined in the nine 'must dos' and NHS mandate to close our identified gaps in care and quality. For our organisation; this will include a specific focus on; ➢ Ensuring timely access to services ➢ Delivering safe and reliable care ➢ Improving patient and staff experience ➢ Improving outcomes and reducing mortality	**3.1.2 -** Full delivery of the recommendations from the **Independent Children's Cardiac Review**. **3.3.1** - **Refresh our existing Trust Strategy** to reflect the need to respond to local and national changes to our operating environment and with a specific focus on developing our clinical strategy.

Executive Lead - Chief Nurse & Chief Operating Officer **Assuring Committee -** Quality and Outcomes Committee & Service Delivery Group

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to maintain the quality of patient services.	Trust wide Risk Management arrangements including incident reporting and investigation processes to identify areas of failure and implement corrective actions. Patient Safety Strategy and delivery of Patient Safety Improvement Programmes, including Sign Up to Safety initiative Implementation and monitoring of Quality Strategy objectives and metrics. And implementation of updated Volunteers Strategy UH Bristol survey programme to measure and monitor the quality of service-user reported experience. This programme will be further developed in 2017/18 with the procurement of a real-time patient feedback system. Clinical Audit Programme, including process for the self -assessment against NICE guidance Productive theatre initiative to reduce the number of cancelled Operations. Whole system approach being delivered through the Urgent Care Network and development of an internal Urgent Care Plan which will be overseen by the newly created Urgent Care Steering Group Professional Standards and Code of Practice/Clinical Supervision. Quality Impact Assessment (QIA) process for savings schemes meeting specific criteria. Monitoring of RTT Performance via: • Emergency Access Performance • Divisional Access performance scorecards • Divisional Monthly Reviews with Executive Team Business Continuity and Emergency planning arrangements Roll out of Evolve to provide ready availability of electronic patient records	Annual Governance Statement providing assurance on the strength of internal control regarding risk management processes, review and effectiveness Corporate reporting structure to Trust Board and Quality and Outcomes Committee via Clinical Quality Group. Quality metrics demonstrate that despite operational pressures, our patients are receiving good quality care despite delays in their discharge. Reports to SLT & Audit Committee/ via Clinical Quality Group/Clinical Audit Group/ Clinical Effectiveness Group, Patient Experience Group. Reporting functions in place to SDG, SLT Trust Board, via: • RTT Operations Group • RTT Steering Group • Cancer PTL Meetings • Cancer Performance Improvement Group • Cancer Steering Group • Urgent Care Steering Group External - EPRR assessment (NHSE) and Internal - self assessment.	Internal performance reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Audit Committee • Quality & Outcomes Committee • Risk Management Group • Service Delivery Group • Clinical Quality Group • Patient Experience Group Form second line assurance External audit/review forms third line assurance.	Although some of the patient feedback collected corporately is made available directly to inpatient wards (e.g. via posters and circulation of spread sheets), there is an opportunity to make this more rapidly available and more accessible to ward staff. QIA Process requires development.	Emergency Preparedness, Resilience and Response *(EPRR)* externally assessed as partially compliant	Procurement of a real-time patient feedback system. Further development of the QIA process to cover /support changes to service provision/stopping of services There is a work programme in place to achieve full EPRR compliance. This will next be assessed in September 2017 by the CCG and NHS England where we expect to reach full compliance.	**Possible x Moderate 9**	↔

STRATEGIC PRIORITY 2 : We will ensure a safe, friendly and modern environment for our patients and our staff

Operational Plan 2017/19 Focus	**3.2.3 - Estates and capital strategy for 2017-19** • continue to align the modernisation and development of our estate to our evolving clinical strategy and • Support delivery of the emerging strategic planning new model of care.

Executive Lead - Chief Operating Officer **Assuring Committee -** Service Delivery Group

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to develop and maintain the Trust estate	Incident reporting and risk assessments at Divisional and Departmental level. Regular inspections and maintenance Internal Audit work programme. Implementation of Operational and Capital work Programme. Recent PLACE (Patient-led assessments of the care environment) inspection reports did not surface any key risks. Trust Capital Group Chaired by COO, receives monthly status reports on Capital Projects from Divisions and Director of Estates	Reports to Audit Committee, Risk Management Group, Divisional Boards and Health and Safety Groups Findings from inspections are included in reports to assurance committees. External audit of the Trust's Annual Accounts and Annual Report. Findings from independent assessments are included in reports to assurance committees. Reports from Trust Capital Group to Capital Programme Steering Group. Chairs reports from Capital Programme Steering Group to Finance Committee.	Regular inspections form first line assurance. Reports to: • Trust Board • Audit Committee • Finance Committee • Capital Programme Steering Group • Divisional Boards Form second line assurance External assessment and audit forms third line assurance.	Incident reporting in relation to aspects of estate, reveal limited assurance in respect of drain blockages and roofs. Capacity within Estates Department to undertake required work.	No significant gaps.	Operational and capital works programme for provides resources to address issues in relation to drains and roofs (both to improve controls and mitigate future risks). Procurement process to build a Multi Storey Car Park. Capacity assessment of Estates Department to be undertaken alongside a review of how work is prioritised.	**Major x Unlikely 8**	↔

STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential

Operational Plan 2017/19 Focus	**3.1.4 Staff strategic engagement and retention strategy**, • Focus on staff engagement and wellbeing, • Supported by real-time feedback, using innovative approaches such as the 'Happy App' (2016 HSJ winner) and; • The on-going development of leadership capacity and capability.	**3.2.4 Maximising workforce productivity** • Including controlling agency and locum costs.

Executive Lead - Director of Workforce and Organisational Development **Assuring Committee -** Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.	Delivery of the Workforce and Organisational Development Strategy Corporate and Local Induction Quality objective on staff engagement HR Policies and Procedures support a framework for clear accountability at Divisional level for staff engagement. Monthly compliance reports on Essential Training are sent to Divisions and include trajectories to achieve compliance and divisional Reviews include performance against workforce plans and HR KPI's to improve staff experience Appraisal Process/Personal Development Plan moving towards E-Appraisal in May 2017 in order to measure quality and support comprehensive development plans at Divisional and trust wide level. Workplace Health and Wellbeing Framework delivery plan to include the NHS Staff Health and Wellbeing CQUIN National Staff Survey Regular staff workshops are held to gather feedback and views from staff members in an informal setting. The Staff Friends and Family Test. Other, local or more specific surveys/focus groups also take place sickness and turnover). Happy App available in clinical areas Introduction of Leadership Behaviours	Metrics in relation to key controls are reviewed by the Senior Leadership Team, QOC and Trust Board: Annual learning and development report. Weekly returns agency staffing. Agency action plan. Reports from new E-Appraisal system in place August 2017 Reports to Agency Controls Group. Health & Safety Reports to Trust Health, Safety and Fire Committee and Risk Management Group. Externally accredited Health & Safety audit and Workplace Wellbeing Charter. Reporting of results on achievement of staff wellbeing CQUIN Reporting of Occupational Health KPI's Reporting on results of Staff survey/ friends and family tests. This will now be in a targeted department approach in response to the heat map data Divisional improving staff experience plans in place focusing on hotspot areas in response to the divisional heat maps Developed by Trust leaders and approved at SLT for roll out in August 2017	Regular internal reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Quality Outcome Committee • Risk Management Group • Workforce and OD • Health, Safety & Fire Committee Form second line assurance External audit/review forms third line assurance.	Workplace Wellbeing Framework requires a shared strategic vision with a view to establishing a Board Wellbeing Champion Workplace wellbeing and Health & Safety to be more explicitly determined within the Workforce and Organisational Development Strategy. Happy App not available in all areas.	Limited assurance primarily around achieving compliance with essential training rates. Limited assurance around levels of staff retention.	Identification of a Board Wellbeing Champion Refresh of the Workforce and OD Strategy. Mid-year review of workforce KPIs to understand forecast out turn. Staff Recognition Awards and rewards framework being developed Roll out Happy App across whole organisation.	**Major x Possible 12**	↔

STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.									
Operational Plan 2017/19 Focus	**3.3.2 Exploring options to continue to develop our specialist portfolio** • in the context of potential changes to Specialised Commissioning approaches across the south **3.3.3 Maximise our opportunity to continue to develop our research capacity and capability** associated with the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.			**3.3.4 Development of an Innovation and Improvement Strategy for the organisation** • including maximising the opportunities for innovation and transformational change associated with our successful appointment as a National Digital Exemplar site, • with clear alignment to organisational and STP digital priorities / local digital roadmap.					
Executive Lead - Medical Director & Director of Strategic Development & Transformation			**Assuring Committee -** Trust Board						
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Current Risk Rating**	**Direction of travel**	
Risk that the Trust will not be able to support transformation and innovation. and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	Memorandum of agreement with University of Bristol. Joint Posts and Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Key Performance Indicators at divisional level (bed holding only) finalised for regular divisional review. Staff engagement embedded in planning service improvement and transformation work. Transformation and other service improvement leads networked across the divisions – role includes identifying and supporting local innovation. Partnership with the Academic Health Science Network to train a cohort of improvement coaches to add capacity to this support network. During 16/17 review of approach to supporting innovation across the Trust completed and Innovation & Improvement strategy developed Quality Improvement Academy established 2017 Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans NIHR award £21m over 5 years for Biomedical Research Centre to Trust and UoB partnership. Trust chosen as Global Digital Exemplar, securing the opportunity to progress our Digital Transformation plans at pace	Reporting structures for divisional research committees/groups to Trust Research Group. Regular reports to the Board on KPI reviews (trust wide & divisional) Education and Training Annual Report Project steering groups /reporting to Transformation Board & Senior Leadership Team. Regular reports to the Trust Board. Evidence of wide range of innovation and improvement programmes completed/underway including good response to programmes such as Bright Ideas, Trust Recognising Success awards etc. Audit and inspections. Digital Strategy presented to Trust Board, Including updated objectives and additional functional scope. Clinical Systems Board (incorporating GDE programme components) providing overall governance on digital delivery projects reporting to Trust Board and Senior Leadership Team Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group.	Regular reviews and departmental programme management forms first line assurance. Reports to: • Trust Board, • Transformation Board • Senior Leadership Team • IT Management Group • Divisional Groups • Transformation Board • NHS Digital for GDE and Tech-funded project boards Form second line assurance Internal/External Audit/inspections forms third line assurance.	No significant gaps.	Clear mechanism for protecting time for non-medical PIs who do not hold funded research role recruiting to National Institute of Health Research portfolio trials not in place. Evidence that Improvement & Innovation Strategy approach further promotes and encourages innovation and improvement, in order that staff with good ideas can bring them to life for the benefit of patients, staff, the Trust and the wider NHS There is currently lack of evidence that the use of digital technology renders direct benefits. The proposed direct reporting of benefits realization will address this gap.	Very low numbers of non-medical PIs not supported by research funding. Address on a case by case basis. Work in progress to address the divisional research committee's gaps. Implementation of plan for supporting Innovation & Improvement in line with action plan agreed by Transformation Board and supported by SLT with focus on three aims: 1. To support and connect people with our structured programmes 2. To provide support to staff with good ideas outside these programmes 3. To build capability to support staff to lead improvement independently of these programmes Full implementation of Digital Transformation, including Global Digital initiatives and embedding as an integral part of the Trust's business	**Moderate x Possible 9**	↔	

STRATEGIC PRIORITY 5:	**We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.**	
Operational Plan 2017/19 Focus	**3.2.2 Maximising the impact from partnership system working** • service redesign and system wide re-configuration, with • Development of shared leadership and associated opportunities to improve system and service level productivity.	**3.3.5 Continued development and delivery of our Transforming Care Programme** • focussing on transforming the way in which we deliver care through service and workforce redesign, • with a focus over the next two years on real time internal processes to support patient flow alongside engaging in and supporting STP processes to develop effective system care pathways and patient flow.
Executive Lead - Director of Strategy and Transformation	**Assuring Committee -** Trust Board	

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk of failing to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	Formal Partnership Agreement with Weston Area Health NHS Trust (WAHT) to increase joint working between the two Trusts. Formal Partnership Agreement with North Bristol NHS Trust (NBT) to increase joint working between the two Trusts. Programme Partnership Boards in place and regular reporting through to the Trust Board. 4 way Partnership meeting with NBT, UoB, UWE Chief Executive agreed as local system leader for regional joint working/collaboration planning with other Executives playing lead roles Range of senior staff involvement in NS Sustainability Board programme Staff involved in wide range of external activities e.g. Bristol Health Partners, Better Care Bristol, CLAHRC West, BNSSG System Leadership Group. Implementation of new Strategic Governance Process Development of new internal STP Leads meeting to improve visibility of staff engagement in external activities, reporting into Strategy Steering Group	Reports to the Trust Board following each of the Partnership Board Meetings. Staff survey feedback. Appraisal process KPI. Tender Framework and business case templates in place from April 2016 explicitly addressing partnership opportunities. Evidence in recent tenders that Trust is a sought after partner - Children's Community Services; Sexual Health No indication in current self-assessment within STP of adverse perceptions. National feedback on Sustainability and Transformation Plan processes and leadership. Bristol NIHR Biomedical Research Centre successful partnership bid for funding 2016.	Internal reviews and monitoring of KPI's form first line assurance. Reports to: • Trust Board, Form second line assurance	Complete visibility of scope of staff engagement in external activities challenging and not necessarily always required.	Ability to harness soft information. Ensuring forums are established to co-ordinate Trust approach into, and secure communication output from key system groups	Co-ordinated approach to key system processes overseen by Executive Directors – to include new internal urgent care steering group and action to target input into CEP/savings control centres.	**Moderate x Unlikely 6**	↔

STRATEGIC PRIORITY 6 : We will ensure we are financially sustainable to safeguard the quality of our services for the future								
Operational Plan 2017/19 Focus	**3.2.1 Operational and financial sustainability** • with a specific focus on internal specialty level productivity and the efficient delivery of activity aligned to our capacity modelling, • along with the implementation of Carter recommendations, • Including a system view of corporate overheads, estates and pathology.							
Executive Lead - Director of Finance **Assuring Committee -** Finance Committee								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Current Risk Rating**	**Direction of travel**
Risk of being unable to deliver the 2017/18 financial plan.	Budgetary control systems in place. Scheme of delegation and agreed budget holders. Financial Control Procedures. Standing Financial Instructions. Monthly Divisional CIP reviews. Monthly Finance & Operational Divisional Performance reviews. Divisional Board monthly scrutiny of operational and financial performance. Monthly review of financial performance with Divisional budget holders. Monthly Divisional contract income and activity reviews, savings reviews. Monthly savings work stream reviews. Monthly review by Savings Board Divisional control of vacancies and procurement monitored at monthly performance meetings. Income and Expenditure performance, capital expenditure, the statement of financial position and cash flow statement scrutiny at the Finance Committee.	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital. Regular Reporting to the Finance Committee and Trust Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Strong statement of financial position. Liquidity metric of 1 (highest) and Use of Resources Rating of 1 (highest rating) for 2016/17 year to date.	Capital expenditure for year to date at 85% within the 85% to 115% tolerance specified by the Regulator. Regular divisional board scrutiny and reviews form first line assurance. Reports to: • Trust Board, • Finance Committee • NHSI Form second line assurance External review of financial position forms third line assurance.	Evidence that staffing controls are weak in some areas Evidence that income and activity performance controls are weak e.g. inpatient activity planning and delivery performance.	Lack of assurance that pay expenditure controls are fully effective. Lack of assurance that activity capacity planning and income performance controls are fully effective. Lack of assurance that new savings ideas will be developed. Lack of assurance that capital expenditure controls for operational capital and major medical equipment are fully effective Limited assurance that all controls are effective in light of continued spend above plan in some areas e.g. agency spend. Weak assurance in Divisions given adverse positions to Operating Plans largely due to income underperformance, shortfall in savings delivery and high levels of nursing and medical expenditure.	Prioritised Executive review at Divisional Reviews Transformation Board and productivity review process via Savings Board to identify further savings. Trust Capital Group has been established to scrutinise delivery of capital plans and has met since November 2016.	**Moderate x Possible 9**	↔

STRATEGIC PRIORITY 7 : We will ensure we are soundly governed and are compliant with the requirements of our regulators								
Operational Plan 2017/19 Focus	**3.1.4 Access standards** • Improving performance and delivery of our performance trajectories in the four core standards.							
Executive Lead - Chief Executive	**Assuring Committee - Trust Board**							
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Current Risk Rating**	**Direction of travel**
Risk of failing to comply with targets, statutory duties and functions	Trust Board and all committees have an annual forward plan aligned to their terms of reference, Trust's Standing Orders and Standing Financial Instructions to ensure appropriate annual reporting against plans is in place. Monitoring of CQC inspection action plans via Clinical Quality Group, Senior Leadership Team, QOC.	Annual Report, Annual Governance Statement, and Annual Quality Report, Annual Account submitted to Trust Board. Regular reporting to NHS Improvement following Board approval. NHS Improvement returns signed off by the Trust Board. Internal Audit Reports on Governance, risk management and financial accounts reported to Audit Committee. Self-assessment. Monthly Board Reports. Performance and Finance Reports at each Board Meeting. Committee Reports at each Board Meeting. Independent reports from CQC on Inspection Visits.	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Audit Committee • Risk Management Group Form second line assurance CQC Inspection Report provides third level assurance into areas inspected.	No significant gaps	Partial assurance of effectiveness of controls, in light of on-going failure of some standards.	None.	**Moderate x Possible 9**	↔

Appendix 2: Links to the Corporate Risk Register

Strategic Objective	Principal Risk	Corporate Risk Register	Current Risk Rating
STRATEGIC PRIORITY 1: We will consistently deliver high quality individual care, delivered with compassion.	**Risk that the Trust will be unable to maintain the quality of patient services.**	**423 -** Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy. **856 -** Risk that the emotional & Mental Health needs of children and young people are not being fully met. **888** - Risk of failure to deliver the agreed recovery trajectories for all RTT standards **910** - Risk to the provision of timely and efficient care and patient experience due to being held in the ambulance queue **919 -** Risk that the Trust does not meet the national standard for cancelled operations. **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards. **949 -** Risk that perinatal mental health services are not adequate to the needs of those requiring to access the service. **961 -** Risk of harm to patients awaiting discharge, once medically fit **1595 -** Risk that patients detained under s136 may be brought to ED due to lack of capacity in community provision **1598 -** Risk of Patients Falls Resulting in Harm. **2063** - Risk of closure of Weston ED for a sustained period leading to additional demand on UHB services	**9**
STRATEGIC PRIORITY 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	**Risk that the Trust will be unable to develop and maintain the Trust estate**	No corporate risks identified	**8**
STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential**.**	**Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.**	**674-** Risk of increased agency spend due to significant non-compliance with national agency caps. **793 -** Risk of work related stress affecting staff across the organisation. **921 -** Risk of not achieving 90% compliance for Essential Training for all Trust staff. **737** - Risk that continuity of service due to inability to recruit sufficient numbers of substantive staff	**12**
STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**Risk that the Trust will not be able to support transformation and innovation. and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.**	No corporate risks identified	**9**
STRATEGIC PRIORITY 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**Risk of failing to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.**	**1497 -** Risk of Delays in transfer of North Somerset patients due to temporary closure of Clevedon Hospital. **1640 -** Risk of poorer quality service for patients due to delays with reporting of histology samples following service transfer.	**6**
STRATEGIC PRIORITY 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	**Risk of being unable to deliver the 2017/18 financial plan.**	**951** - Risk financial penalties in excess of planned position, due to greater under-performance against key indicators **959 -**Risk that Trust does not Deliver 2016/17 financial plan due to Divisions not achieving their current year savings target **1843** - Trust's 2016/17 Operational Plan Control Total surplus of £15.9m	**9**
STRATEGIC PRIORITY 7: We will ensure we are soundly governed and are compliant with the requirements of our regulators.	**Risk of failing to comply with targets, statutory duties and functions**	**801 -** Risk that the Trust does not maintain a GREEN Monitor Governance Rating **869 -** Risk of Reputational Damage Arising From Adverse Media Coverage of Trust Activities **970 -** Potential risk of non-compliance with some of Monitor's core 4-hour Wait Clinical Indicator	**9**

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	8
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Research and Innovation Report		
Author	David Wynick, Director of Research		
Executive Lead	Sean O'Kelly, Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

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 in report.

Recommendations
Members are asked to: • **Note** the report.

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☒	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Executive Summary

Performance:

Following on our focussed efforts to increase performance of our trials recruiting patients to time and target we have seen a further improvement of our closed commercial trials achieving 55% (from 47% previous quarter).

Performance in achieving the 70 day benchmark (time from valid application to first patient recruited) as set by the NIHR has decreased this quarter following the introduction of HRA approval instead of NHS permission. We have been in a transition period for the last 6 months. The Q4 report excluded studies that received NHS permission, reducing the studies submitted from 46 to 24. The effect of the reduction in the size of the denominator by just one study results in a swing of approximately 10% in our performance in the benchmark. We expect that it will take between 6 and 9 months for all 'NHS permission' studies to make their way out of the system, with a consequent improvement in our published metrics. Most other research active trusts are similarly affected by these changes.

We have modelled our predicted weighted recruitment for 2017/18 financial year. Weighted recruitment drives our delivery income. Estimates are that we will achieve approximately 21,600, which is lower than the two previous years. Studies are increasing in complexity and the target numbers are generally lower, so the resources used to achieve the same level of recruitment is greater. We will monitor this estimate through the year and mitigate where possible.

Partnerships and Governance:

Setup of the NIHR Biomedical Research Centre is proceeding as planned, with management posts all appointed and milestones around contracting arrangements on track. We have been advised that funding for the current NIHR CLAHRC has been extended by 9 months to September 2018, and we expect a call in Spring 2018 for the next funding round.

Benchmarking:

Measure	***Value/number***	***Value/number (previous)***	***Place (current)***	***Place (previous)***	***Frequency of update***	***Source***
Research capability funding, 2017 vs 2016	***£1,691,941***	***£1,615,303***	***12***	***15***	***Annual***	***NIHR***
Infrastructure funding (BRC/U), 2017 vs 2012	***£20,892,445***	***11,470,180***	***11/20***	***15/22***	***Every 5 years***	***NIHR***
Number of patients recruited, 2016/17 vs 2016/15	***5,357***	***4,429***	***N/A***	***N/A***	***Every year***	***Quality account***

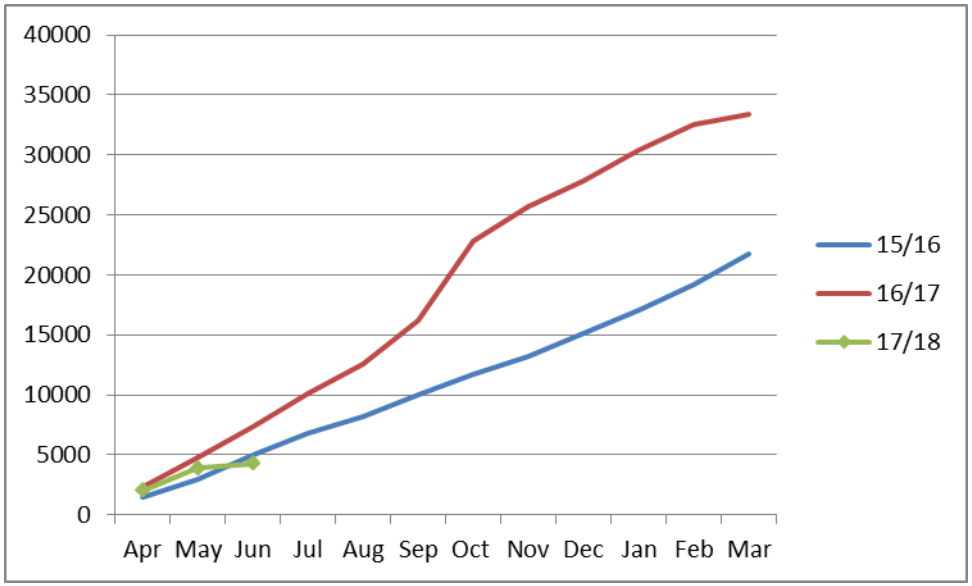
Overview

Successes	Priorities
• All outstanding vacancies in R&I have been appointed to, and from 25th July the department will have a full complement of staff. This will increase resource available to focus on project work that is targeted at improving performance and patient recruitment. • Performance in delivering commercial research continues to improve each quarter. • We have been awarded CTAP status (Clinical Trials Accelerator Platform) for cystic fibrosis research in adults and children. The expected impact is an increase in the number of commercial trials we can make available to our CF patients, widening their access to research.	• Focus attention on optimising our performance in delivering research to time and target, for both commercial and non-commercial trials.
Opportunities	**Risks and Threats**
• We are working with the Local Clinical Research Network to improve ways of working across the region and increase opportunities for our patients to take part in research. The LCRN is currently prioritising diabetes research. • We are exploring opportunities to work with charities to provide infrastructure for rare diseases research, for example in Duchenne Muscular Dystrophy.	• Estimates are that we will achieve lower weighted recruitment than the two previous years. Studies are increasing in complexity and the target numbers are generally lower, so resource use for achieving the same level of recruitment is increasing. Weighted recruitment performance affects delivery income therefore a drop in performance could result in reduced funding for 18/19.

Performance Overview

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

a) Cumulative weighted recruitment into NIHR portfolio studies 17-18. [NB. There is a 6 week lag in recruitment data becoming visible on the system.]



b) Performance in meeting the 70 day first patient first visit benchmark adjusted by NIHR in comparison to other Trusts

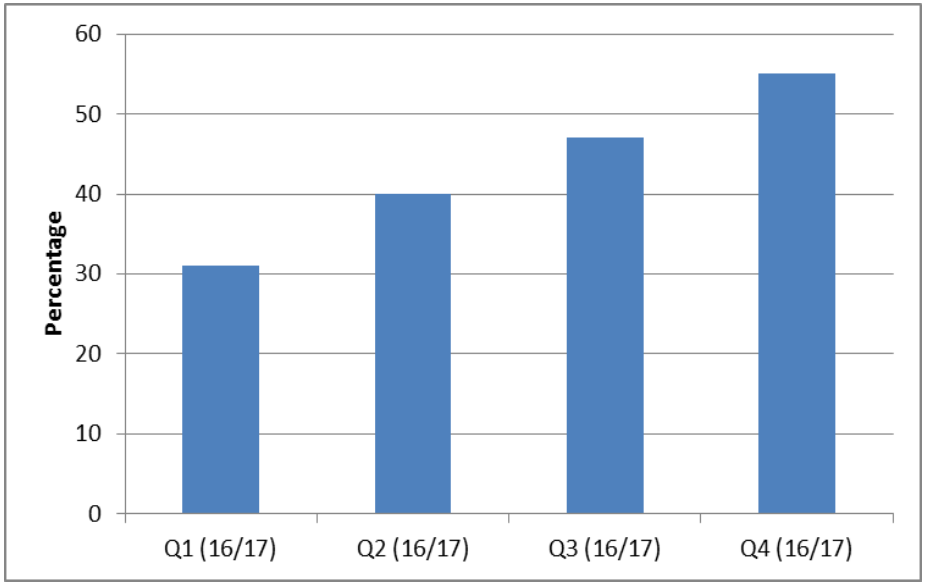
NIHR PID report- latest received Q4 16/17

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
88%	84%	88%	64%

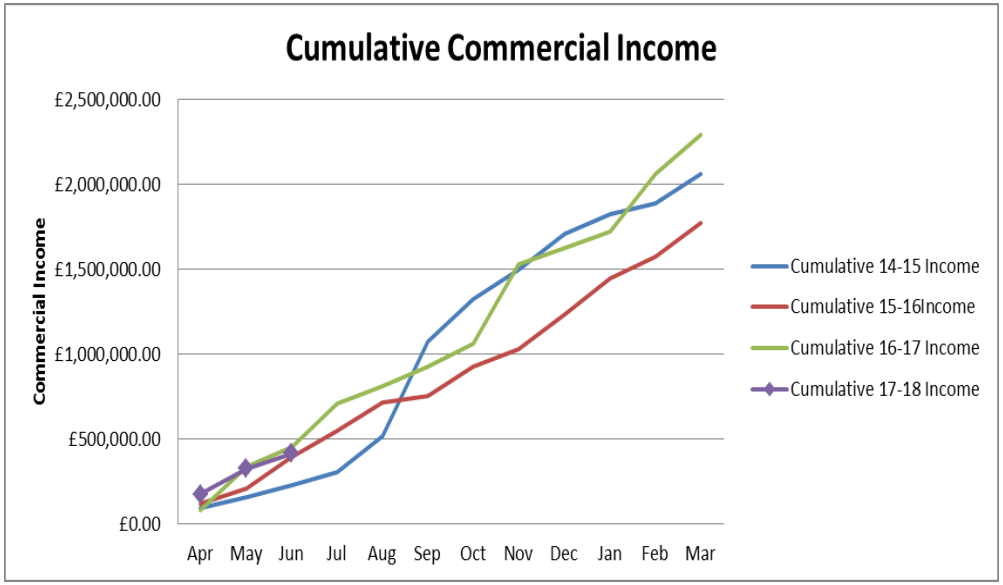
Green: >81.4% (Upper Quartile)
Red: <70.7% (Median)

Please note, in Q4 the NIHR changed the way they analyse the data to exclude any studies that received NHS permission under the old approval system. Sample size reduced from 46 studies submitted to only 11 analysed thus affecting performance data outcome.

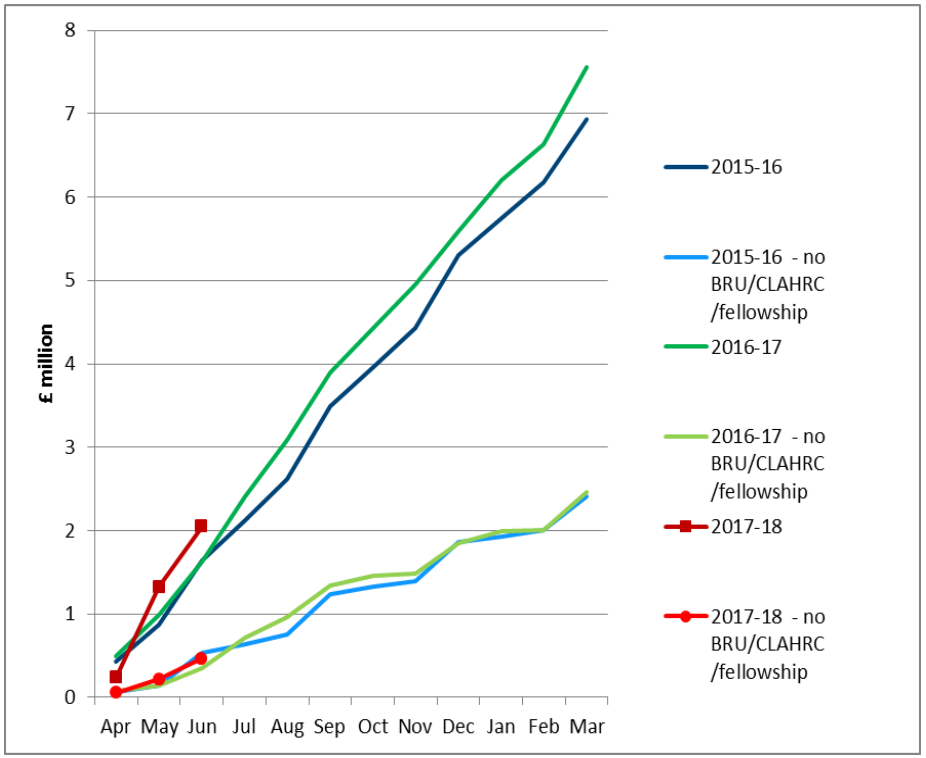
c) Percentage of closed commercial studies recruiting to time and target



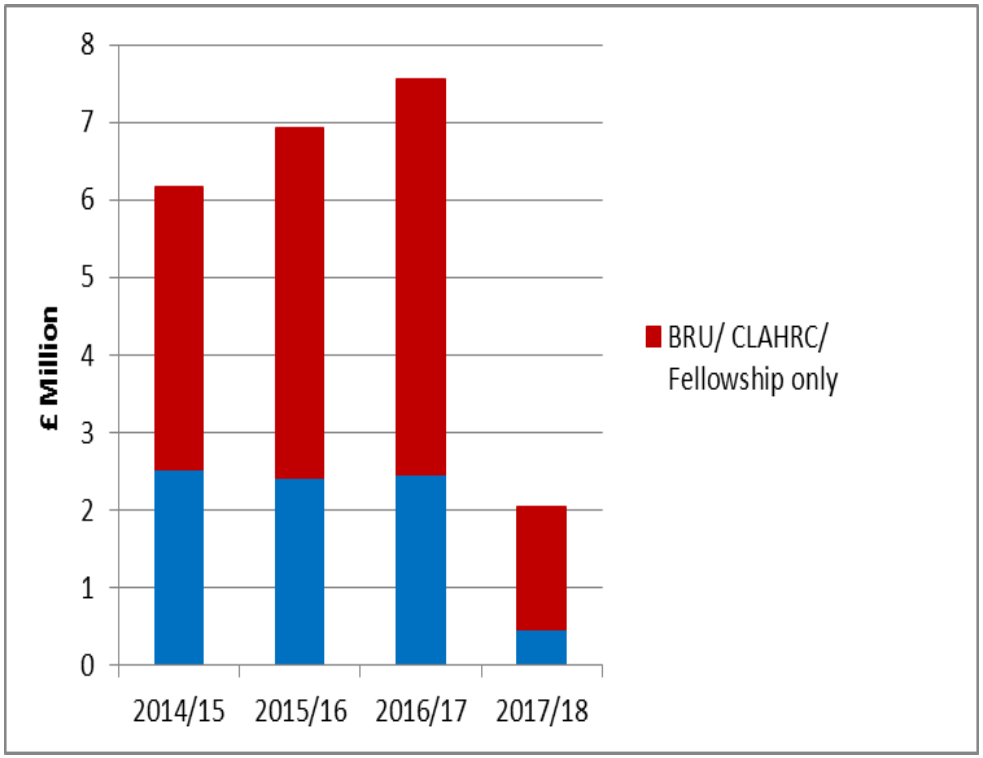
d) Monthly commercial income



NIHR monthly grant income – year on year comparison



NIHR grant income – drives research capability funding.



Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Quality and Performance Report		
Author	• Xanthe Whittaker, Associate Director of Performance • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning		
Executive Lead	Mark Smith, Chief Operating Officer/Deputy Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary
Purpose To review the Trust's performance on Quality, Workforce and Access standards. Key issues to note Please refer to the Executive Summary in the report.
Recommendations
Members are asked to: • **Note** report for Assurance

Intended Audience (please select any which are relevant to this paper)								
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public ☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		26th July 2017		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

July 2017

Executive Summary

Challenges remain in restoring performance against the national access standards due to high levels of demand across a range of services. However, performance against the A&E 4-hour standard continued to improve and remained above the Trust's recovery trajectory. Although the recovery trajectory for the Referral to Treatment (RTT) time standard continued to not be met in the month, the number of over 18 week waiters reduced in the period, as did the total number of ongoing RTT pathways. Performance against the 62-day GP cancer standard remained below the 81% trajectory for the quarter, due to the continuing critical care bed pressures and elective capacity constraints. Performance is expected to be confirmed at circa 81% for June upon final validation and reporting. Although there was a small deterioration in performance against the diagnostic 6-week wait standard, the Trust performed above the recovery trajectory and is on track to report a further improvement in performance next month. The Overview page of this report provides further details of the priorities, risks and threats for the coming months, to access, quality and workforce standards, along with noteworthy successes in the period.

The number of patients seen for a new outpatient appointment remained above last year's levels. However, this was not sufficient to offset a 16% increase in new outpatient referrals received in June, relative to the same period last year. As a result, for the first time since May 2016, there was a significant rise in the size of the outpatient waiting list. In contrast, the size of the elective waiting list showed the normal seasonal decrease, although remains significantly above the same period last year. Despite this, the number of patients on ongoing RTT pathways decreased in the month, as did the number of patients waiting over 18 weeks for treatment. The current size of the outpatient and elective waiting lists continues to pose a risk to prompt recovery of the 92% RTT standard. There are also ongoing risks to restoring achievement of the 6-week wait for a diagnostic test, due to the high demand for Cardiac CT scans, for which a sustainable capacity solution is being piloted in July, and recent national publicity over Sleep Studies testing which may lead to increased demand.

The overall level of emergency admissions into the Bristol Children's Hospital (BCH) in June was similar to the same period last year. The BCH performed well above the national A&E 4-hour 95% standard, at 97.1%. The number of emergency admissions into the BRI was 15.3% higher than June last year, and 4.6% above the levels reported last month. However, there was a further 5% improvement in 4-hour performance at the BRI relative to May. This improvement in performance was despite bed occupancy remaining high. The number of over 14 day stays in hospital at month-end continued to fall, even though the proportion of patients discharged in the month who had stayed 14 days or more was low in June. The percentage of emergency admissions for patients aged 75 years and over, which is a proxy for patient acuity, continued to be below the level seen last year. This should lead to a continued fall in length of stay, and as a result, bed occupancy, both of which fell in the month. This may help to mitigate in part the impact of the overnight closure of Weston's Emergency Department in July, which has lead to an increase in emergency admissions into the BRI and more variable performance against the 4-hour standard.

There were improvements in a number of the headline measures of quality that sit within the Trust Summary Scorecard in the month, reversing the deteriorations seen last month. This included the Safety Thermometer measure of No New Harms and the Non-purposeful Omitted doses of Critical Medication being restored to a Green rating. Other noteworthy improvements in performance against Quality metrics included the highest reported performance against the WHO Surgical Checklist since October 2016. The improved performance against the metric for patients who have sustained

a fractured neck of femur going to theatre within 36 hours was maintained, with performance reported at 85% against the 90% national standard. The Trust's Performance against the fracture neck of femur metrics continues to be the focus of significant attention.

Challenges also remain in maintaining the improvements seen in some of the workforce metrics in recent months. The headline changes in workforce metrics this month include the rise in agency usage, which reflects the rises in sickness and vacancies rates. However, turn-over rates are being sustained at the lower levels seen since October 2016. We continue to work in partnership with other organisations within the community to mitigate system risks which impact on patient flow, workforce indicators and 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

Ratings for the main University Hospitals Bristol NHS Foundation Trust sites
(March 2017)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Medicine	Good	Outstanding	Good	Requires improvement	Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Outstanding	Good	Outstanding	Outstanding
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity & Family Planning	Good	Good	Good	Good	Outstanding	Good
Services for children and young people	Good	Outstanding	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Outstanding	Good	Requires improvement	Outstanding	**Outstanding**

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	Mortality rate (within 30 days)	Food choice & Quality
BCH	5 stars	OK	OK	✓ 98.5%
STM	4.5 stars	OK	OK	✓ 98.4%
BRI	3.5 stars	OK	OK	✓ 96.5%
BDH	3 stars	OK	OK	Not avail
BEH	4.5 Stars	OK	OK	✓ 91.7%

Stars – maximum 5
OK = Within expected range
✓ = Among the best (top 20%)
! = Among the worst
Please refer to appendix 1 for our site abbreviations.
Last month's ratings shown in brackets where these have changed

NHS Improvement Single Oversight Framework

For the latest month reported (i.e. June for A&E, RTT and 6-weeks, and May for 62-day GP) the Trust failed to achieve all four standards in the Single Oversight Framework (SOF). Although the national standards were not met for A&E 4 hours and 6-week diagnostics, the recovery trajectories were achieved for the month. The 92% Referral to Treatment (RTT) standard failed to be achieved, with reported performance below trajectory at 91.0%. Performance against the 85% national standard for 62-day GP cancer remained below trajectory in May, mainly due to critical care bed and surgical capacity pressures.

The Trust has been off trajectory with all four standards for greater than two consecutive months. Under the rules of the SOF this means that NHS Improvement (NHSI) may consider providing additional support to the Trust to recover performance. NHSI recently undertook a further visit to the Trust in relation to emergency access, for which the Trust received a written report. The recommendations made in this report have informed the latest revision of the Trust's urgent care plan.

Access Key Performance Indicator		Quarter 3 2016/17			Quarter 4 2016/17			Quarter 1 2017/18		
		Oct 16	Nov 16	Jan 17	Feb 17	Mar 17	Dec 16	Apr 17	May 17	Jun 17
A&E 4-hours	Actual	82.9%	78.5%	79.6%	80.4%	80.7%	83.3%	82.3%	84.2%	87.9%
	STF trajectory	93.3%	90.0%	89.3%	88.5%	87.4%	91.0%	82.5%	83.5%	85.0%
62-day GP cancer	Actual	79.5%	85.2%	81.5%	84.3%	78.8%	81.2%	76.7%	78.0%	
	STF trajectory	85.0%	85.1%	86.9%	83.6%	85.7%	85.9%	81.0%	81.0%	81.0%
Referral to Treatment Time (RTT)	Actual	91.2%	92.0%	92.0%	92.2%	92.0%	91.1%	91.1%	91.1%	91.0%
	STF trajectory*	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%	92.0%	92.0%	92.0%
6-week wait diagnostic	Actual	98.9%	99.0%	98.2%	98.4%	98.7%	98.7%	98.6%	98.8%	98.6%
	STF trajectory*	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.0%	99.0%	99.0%

*minimum requirement for securing Sustainability & Transformation Funds (STF) is achievement of the national standard

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory and/or recovery trajectory (where agreed) achieved
RED rating = national standard not achieved, the STF trajectory not achieved, and the recovery trajectory (where agreed) not achieved

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 AMBER:
- Diagnostic waits

RED to GREEN:
- Length of Stay

GREEN to AMBER:
- Deteriorating patient
- Sickness absence

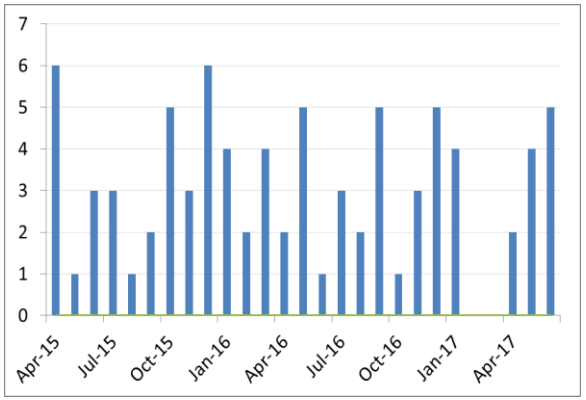
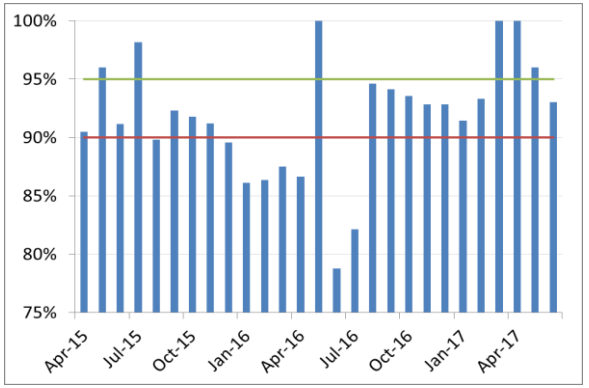
GREEN to RED
- Agency

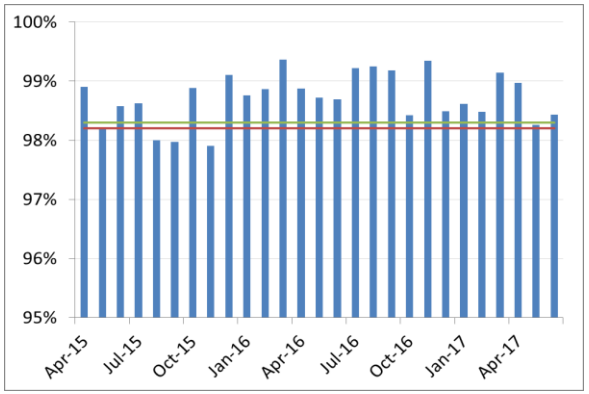
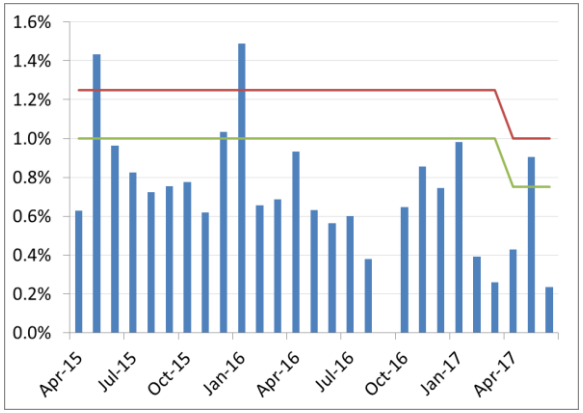
AMBER to GREEN
- Safety Thermometer
- Medication errors

Overview

The following summarises the key successes in June 2017, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 2 2017/18.

Successes	Priorities
• Significant reduction in outlier bed days. The target for June (815) was achieved by 330 bed days; • This month has seen a continued improvement in compliance in the WHO surgical checklist. The figure of 99.8% was achieved against a set target of 100%. This is the highest reported figure since September 2016; • Significant improvement in non-purposeful omitted doses of listed critical medicines: in June 0.24% of patients reviewed (2 out of 851) had one or more omitted critical medications in the past three days, against a target of no more than 0.75%; • The Trust has recruited its first in-take of apprentices with nine applicants commencing as Healthcare Support Worker (Nursing Assistant) apprenticeship programme; • Achievement of the 28-day readmission standard and a significant reduction in last-minute cancellations in the period.	• The focus on the reduction of turnover, agency usage and sickness absence continues to be an ongoing priority in the operating plans for 2017/18; • Reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), by delivering additional activity in July and August; • Restore performance against the 62-day GP cancer waiting times standard to above the national average during quarter 2; • Recovery of performance against the 6-week diagnostic waiting times standard by the end of September, with achievement of the recovery trajectory each month; • Further improvements in A&E 4-hour performance against trajectory.
Opportunities	**Risks & Threats**
• Levels of dissatisfied complaints remain above target, however all dissatisfied cases are now retrospectively reviewed for learning; the Patients Association have recently carried out telephone interviews on behalf of the Trust to better understand the experience of dissatisfied complainants – learning from this review will be discussed by Patient Experience Group in August; • Improvements in HR Reporting systems include junior doctor rotations on TRAC, e-reporting of preceptorships, e-appraisal and a new process for exit interviews.	• The workforce targets agreed as part of the 2017/18 operating planning cycle will be challenging to achieve; • The size of the current elective and outpatient waiting lists could make recovery of the 92% RTT national waiting times standard challenging; • Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard; • The number of over 6-week waiters for Cardiac CT scans is expected to remain high and above current capacity due to the refreshed NICE guidelines; • Sleep Studies referrals are expected to rise following national publicity about the availability of testing on the NHS, which could impact on 6-week diagnostic wait performance; • Overnight closure of Weston's Emergency Demand will lead to an increase in emergency admissions which could worsen 4-hour performance.

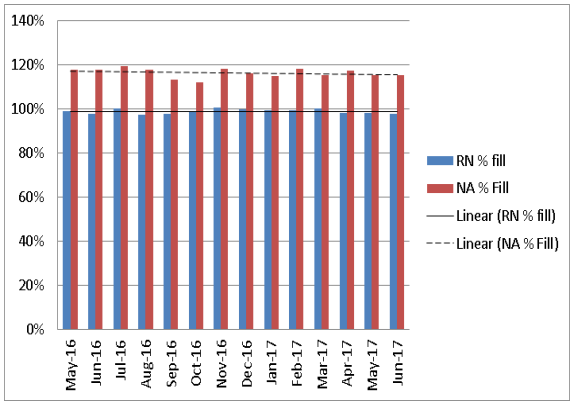
Description	Current Performance	Trend	Comments
Infection control The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).	There were five cases of *Clostridium difficile* (C. diff) attributed to the Trust in June 2017.	**Total number of C. diff cases**  A total of 11 cases (unavoidable + avoidable) have been reported in the year against a limit of 45 for April 2017 to March 2018.	The annual limit for the Trust for 2017/18 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group. At the end of June, the Trust had five cases of *Clostridium difficile* awaiting assessment by the Clinical Commissioning Group.
Deteriorating patient National early warning scores (NEWS) acted upon in accordance with the escalation protocol (excluding paediatrics). This is an area of focus for our Sign up to Safety Patient Safety Improvement Programme. Our three year goal is sustained improvement above 95%.	Performance in June was 93% (three breaches) against a three-year improvement goal of 95%. This is a slight deterioration from May's position of 96% (one breach). All three breaches occurred within the Division of Medicine. One breach was due to a patient with a NEWS score of 3 in one parameter not being escalated to a registered nurse by a Nurse Assistant. The second breach was due to a patient with a NEWS score of 5 having no documented medical review. We are unable to evidence the final breach because the matron who completed the information in relation to the breach is currently on sick leave. The Division of Medicine has given assurance that this information will be held centrally by the Division in the future.	**Deteriorating patient: percentage of early warning scores acted upon** 	This indicator is measured by a monthly point prevalence audit. Work continues in the deteriorating patient work stream of our Patient Safety Improvement Programme and is reported in detail to the Programme Board. Details of the actions being taken are described in the actions section (Actions 1A to 1G).

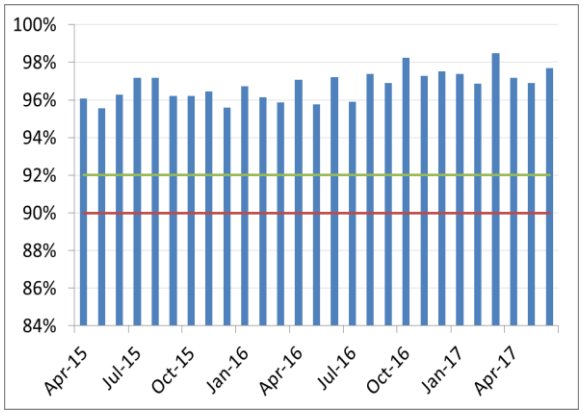
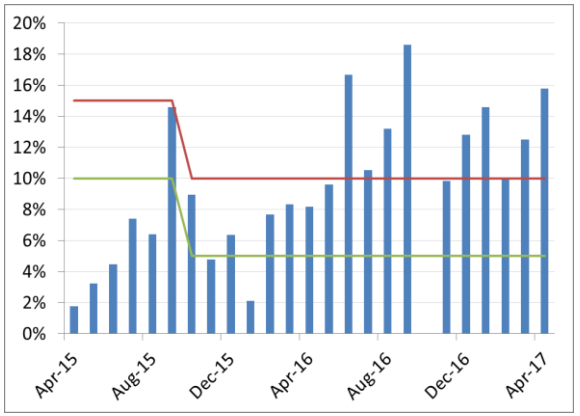
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In June 2017, the percentage of patients with no new harms was 98.4% (12 patients had new harms), against an upper quartile target of 98.3% (GREEN threshold) of the NHS Improvement patient safety peer group of Trusts.	**The percentage of patients surveyed showing No New Harm each month** 	The June 2017 the Safety Thermometer point prevalence audit showed four new catheter associated urinary tract infections, no falls with harm, three new pressure ulcer and five new venous thrombo-emboli.
Non-purposeful omitted doses of listed critical medicines Monthly audits by pharmacy incorporate a review of administration of critical medicines: insulin, anti-coagulants, Parkinson's medicines, injected anti—infectives, anti-convulsants, short acting bronchodilators and 'stat' doses.	In June 2017, 0.24% of patients reviewed (2 out of 851) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 0.75%. The 0.24% for June 2017 is a significant improvement from the May 2017 figure of 0.90% (8 out of 851).	**Percentage of omitted doses of listed critical medicines** 	The target for omitted doses in 2017/2018 has been revised and is now set at 0.75% (previous target was 1%). Actions being taken are described in the actions section (Actions 2A and 2B)

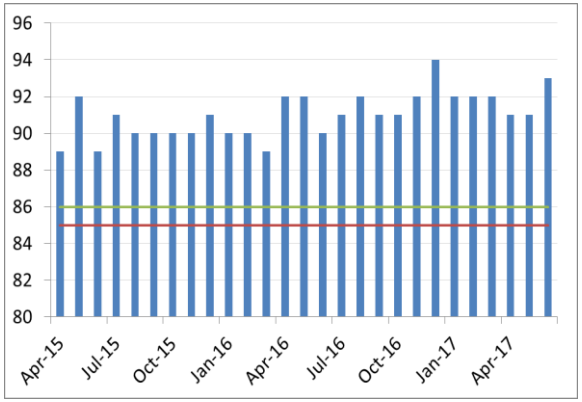
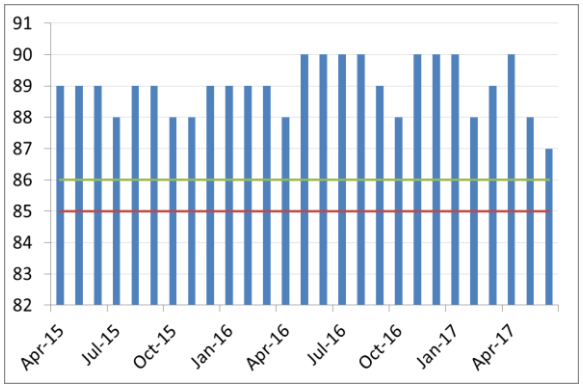
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Overall Essential Training compliance is 89% (excluding Child Protection Level 3). Compliance with each of the reporting categories is provided below
<table>
<tr><th>June 2017</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>89%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>89%</td></tr>
<tr><td>Annual (Fire)</td><td>84%</td></tr>
<tr><td>Annual (IG)</td><td>75%</td></tr>
<tr><td>Induction & Orientation</td><td>98%</td></tr>
<tr><td>Doctors induction</td><td>72%</td></tr>
<tr><td>Resuscitation</td><td>71%</td></tr>
<tr><td>Safeguarding</td><td>90%</td></tr>
</table>
</td>
<td>Performance against target for Fire and Information Governance is included in Appendix 2.

Target audiences for Dementia Awareness Training will be agreed at the end of July.</td>
<td>Compliance is reviewed at Divisional quarterly Performance Review meetings.

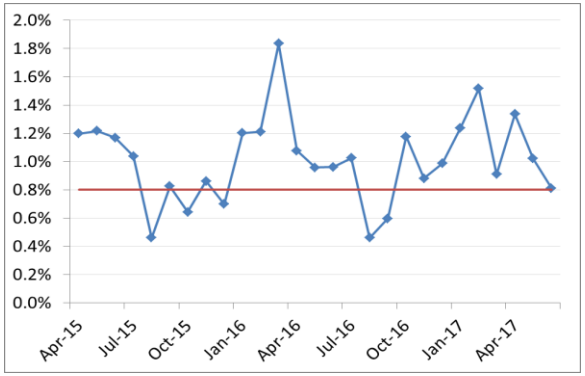
Divisional HR Business Partners are being asked to provide recovery plans for all non-compliant staff.

Automated reminders for non-compliant staff are to be increased to monthly from 60 days prior to subject expiry.</td>
</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 June 2017 the Trust had rostered 218,891 expected nursing hours, with the number of actual hours worked of 224,051. This gave a fill rate of 102.4%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>64,105</td><td>59,408</td><td>+4,697</td></tr>
<tr><td>Specialised Services</td><td>40,767</td><td>39,488</td><td>+1279</td></tr>
<tr><td>Surgery</td><td>43,994</td><td>41,252,</td><td>+2,742</td></tr>
<tr><td>Women’s & Children’s</td><td>75,185</td><td>78,743</td><td>-3558</td></tr>
<tr><td>Trust</td><td>224,051</td><td>218,891</td><td>+5,160</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month
 
</td>
<td>Overall for the month of June 2017, the Trust had 97% cover for Registered Nurses (RN) on days and 98% RN cover for nights. The unregistered level of 111% for days and 120% for nights reflects the activity seen in June 2017. This was due primarily to Nurse Assistant specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night. Close monitoring continues (Action 4).</td>
</tr>
</table>

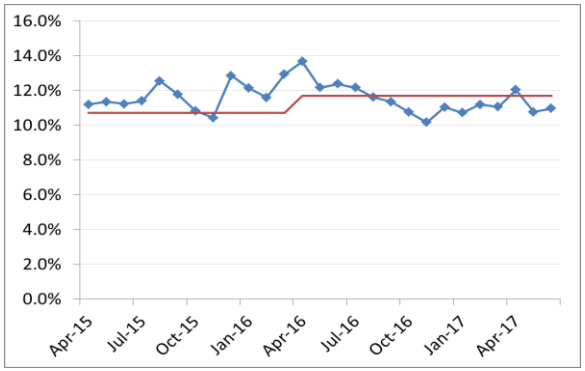
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for June 2017 was 97.7%. This metric combines Friends & Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services. Division and hospital-level data is provided to the Trust Board on a quarterly basis in the quarterly Patient Experience and Involvement report	**Inpatient Friends & Family scores each month** 	The scores for the Trust are in line with national norms. A very high proportion of the Trust's patients would recommend the care that they receive to their friends and family. These results are shared with ward staff and are displayed publically on the wards. Division and hospital-level data is provided to the Trust Board and is explored within the Quarterly Patient Experience report.
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.	Dissatisfied cases are now measured as a proportion of complaints sent out in any given month and are reported two months in arrears. This means that the latest data in the board dashboard is for the month of April 2017. As of 17th July 2017, 6 of the 38 responses sent out in April had resulted in dissatisfied replies (15.8% against a target of 5%).	**Percentage of compliantaints dissatisfied with the complaint response each month** 	In 2016/17, 65 complainants expressed dissatisfaction with one or more aspects of our response to their formal complaint, compared to 59 in 2015/16 (as published in our annual quality reports). Informal Benchmarking with other NHS Trusts suggests typical dissatisfied rates of 8% to 12%. The Patients Association has recently conducted telephone interviews with dissatisfied complainants – learning will be discussed at Patient Experience Group in August. Other actions continue as previously reported to the Board (Actions 5A to 5E).

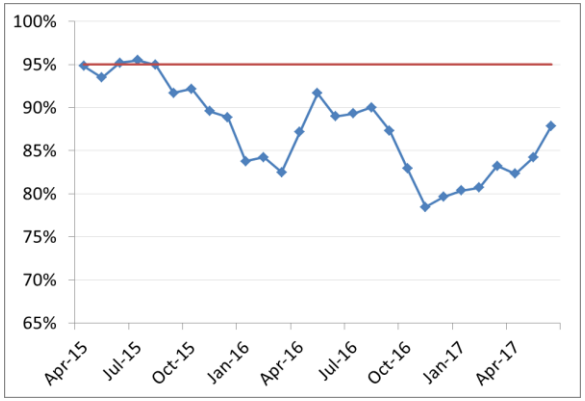
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of June 2017, the score was 93 out of a possible score of 100, and 91 for Q1 as a whole. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable.
<table>
<tr><th></th><th>Q4 2016/2017</th><th>Q1 2017/2018</th></tr>
<tr><td>Trust</td><td>91</td><td>91</td></tr>
<tr><td>Medicine</td><td>90</td><td>87</td></tr>
<tr><td>Surgery</td><td>91</td><td>93</td></tr>
<tr><td>Specialised Services</td><td>92</td><td>92</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>92</td><td>92</td></tr>
<tr><td>Women's & Children's Division (Postnatal wards)</td><td>91</td><td>92</td></tr>
</table>
</td>
<td>Inpatient patient experience scores (maximum score 100) each month
 
</td>
<td>UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if patient experience at the Trust began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the 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.</td>
</tr>
<tr>
<td>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.</td>
<td>The score for the Trust as whole was 87 in June 2017 (out of score of 100). Divisional scores for quarter 1 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.
<table>
<tr><th></th><th>Q4 2016/2017</th><th>Q1 2017/2018</th></tr>
<tr><td>Trust</td><td>89</td><td>88</td></tr>
<tr><td>Medicine</td><td>90</td><td>89</td></tr>
<tr><td>Specialised Services</td><td>86</td><td>87</td></tr>
<tr><td>Surgery</td><td>89</td><td>88</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>87</td><td>87</td></tr>
<tr><td>Diagnostics & Therapies</td><td>93</td><td>92</td></tr>
</table>
</td>
<td>Outpatient Experience Scores (maximum score 100) each month
 
</td>
<td>The Trust’s performance is in line with national norms in terms of patient-reported experience.

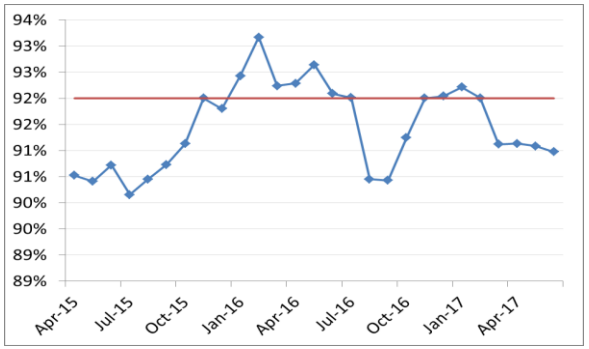
This metric would turn red if outpatient experience at UH Bristol began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the Trust score remains green. Divisional scores are examined in detail in the Trust’s Quarterly Patient Experience Report.</td>
</tr>
</table>

<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 June the Trust cancelled 54 (0.81% of) operations at last-minute for non-clinical reasons. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number</th></tr>
<tr><td>No HDU/ITU/CICU bed available</td><td>10 (19%)</td></tr>
<tr><td>Emergency patient prioritised</td><td>10 (19%)</td></tr>
<tr><td>Surgeon/anaesthetist unavailable</td><td>8 (15%)</td></tr>
<tr><td>Lack of time (over-run)</td><td>5 (9%)</td></tr>
<tr><td>No ward staff</td><td>5 (9%)</td></tr>
<tr><td>Other causes (8 reasons)</td><td>16 (30%)</td></tr>
</table>
Two patients cancelled in May were readmitted outside of 28 days. This equates to 97.0% of cancellations being readmitted within 28 days, which is above the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 

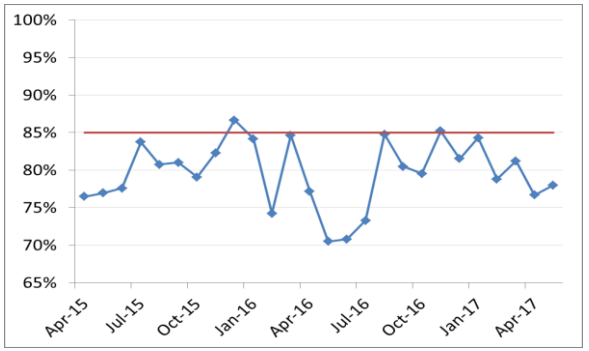
The national 0.8% standard is currently not forecast to be met in July due to continued high bed occupancy levels.</td>
<td>The national 0.8% standard was narrowly missed in June, despite the level of emergency admission being un-seasonally high. Emergency pressures continued to be the predominant cause of cancellations, with critical care bed availability, and emergency patients needing to be prioritised, making-up 38% of all cancellations. An action plan to reduce elective cancellations continues to be implemented (Actions 6A and 6B). However, please also see actions detailed under A&E 4 hours (8A to 8I) and outlier bed-days (13).</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 June 11.0% of outpatient appointments were cancelled by the hospital, which is below the revised Red threshold of 11.7%. This is a similar level of performance to last month. The level of cancellation remains lower than the same period last year.

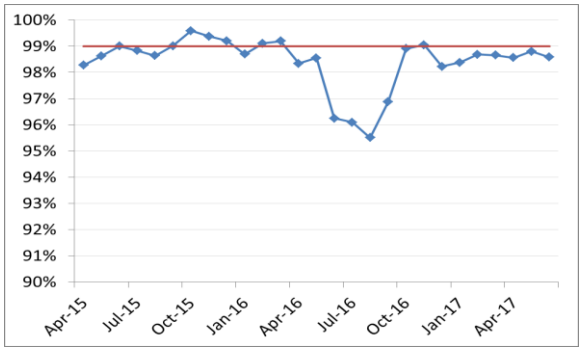
Please note: the RED and GREEN thresholds have been revised for 2017/18, with the Green threshold representing a 2% improvement on 2015/16, and the RED threshold being the same average performance in 2015/16 of 11.7%.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Ensuring 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. The improvement plan for this key performance indicator has been refreshed for 2017/18, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital. These actions are based upon our current analysis of the causes of cancellations (Actions 7A to 7D).</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>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%.</td>
<td>The 95% national standard was not achieved in June. However, Trust-level performance improved to 87.9%, and was above the in-month trajectory (85.0%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Jun 2016</th><th>May 2017</th><th>Jun 2017</th></tr>
<tr><td>Attendances</td><td>5,571</td><td>5,812</td><td>5,568</td></tr>
<tr><td>Emergency Admissions</td><td>1,794</td><td>1,910</td><td>1,966</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4557
81.8%</td><td>4287
73.8%</td><td>4399
79.0%</td></tr>
<tr><th>BCH</th><th>Jun 2016</th><th>May 2017</th><th>Jun 2017</th></tr>
<tr><td>Attendances</td><td>3,250</td><td>3,646</td><td>3,283</td></tr>
<tr><td>Emergency Admissions</td><td>803</td><td>836</td><td>732</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3091
95.1%</td><td>3429
94.0%</td><td>3189
97.1%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

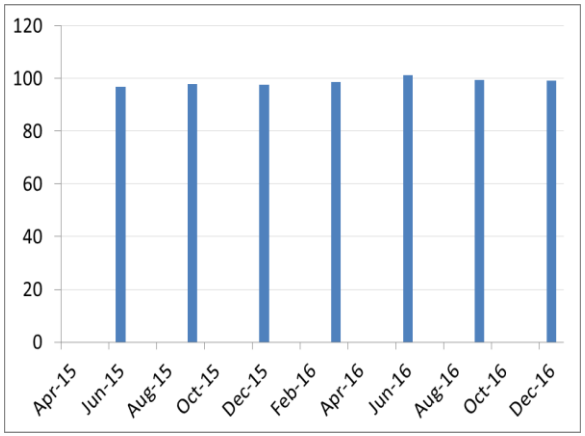
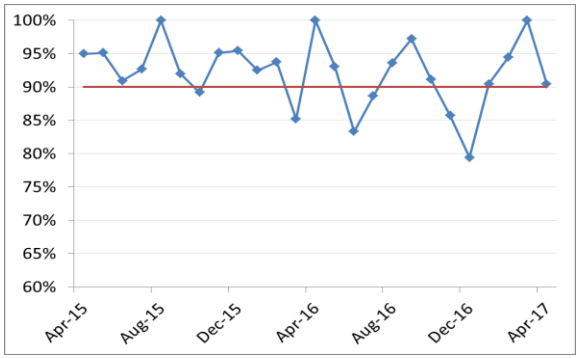
The trajectory of 90% is not currently forecast to be met in July due to the imapct of the Weston ED overnight closure.</td>
<td>Total emergency admissions into the BRI were 15% up on last June's levels. Bed occupancy has reduced, helped by the decrease in 14 day stays and an ongoing lower level of admissions for patients aged 75 years, and but remains un-seasonally high. The current low level of outlier bed-days, combined with lower patient acuity, should help to further reduce length of stay. However, the overnight closure of Weston's ED has increased demand in July. Actions continue to be taken to reduce length of stay (Actions 8A to 8I).</td>
</tr>
<tr>
<td>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.</td>
<td>The 92% national standard was not met at the end of June, with performance reported at 91.0%. This is below the recovery trajectory of 91.8% (see Appendix 3). The number of patients waiting over 52 weeks RTT has increased due to capacity pressures in Women's & Children's and re-validation of some RTT pathways within the Dental Hospital following errors having been identified.
<table>
<tr><th></th><th>Apr</th><th>May</th><th>Jun</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>153</td><td>165</td><td>193</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>5</td><td>11</td><td>46</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

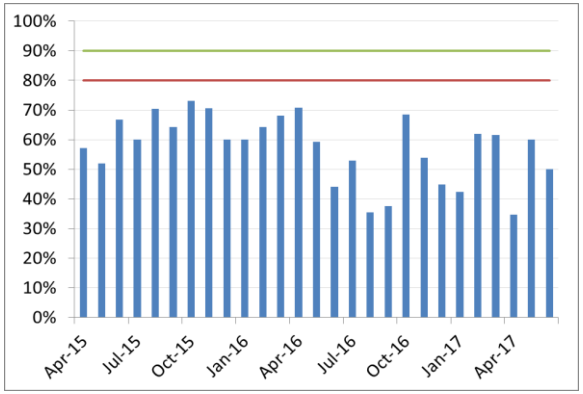
Forecast performance for July will continue to be below the 92% standard, due to rising demand.</td>
<td>Performance against the RTT standard remained similar to that of the last three months, despite rising demand. The total number of patients on an incomplete RTT pathway decreased, as did the number of patients waiting over 18 weeks. The size of the elective waiting list remains high, which in combination with the now rising outpatient waiting list, poses risks to recovery of the 92% standard. See the actions which continue to be taken to restore performance (Action 9A to 9H).</td>
</tr>
</table>

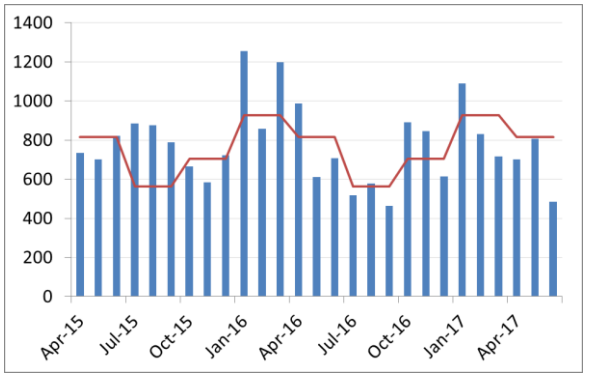
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.</td>
<td>May’s performance was 78.0% against the 85% 62-day GP standard, and a trajectory of 81.0%. The 85% standard was not met for internally managed pathways with performance at 83.8%. May’s 62-day GP breach reasons are:
<table>
<tr><th>Breach reason</th><th>May 17</th></tr>
<tr><td>Late referral by/delays at other provider</td><td>5.0</td></tr>
<tr><td>Medical deferral/clinical complexity</td><td>4.5</td></tr>
<tr><td>Delayed histology</td><td>2.0</td></tr>
<tr><td>Delayed diagnostic</td><td>2.0</td></tr>
<tr><td>Delayed outpatient appointment</td><td>2.5</td></tr>
<tr><td>Insufficient surgical capacity/cancellation</td><td>3.0</td></tr>
<tr><td>Other causes (four reasons)</td><td>5.0</td></tr>
<tr><td>TOTAL</td><td>24.0</td></tr>
</table>
There were 2.5 breaches of the 62-day screening standard, 1.5 due to patient choice and 1.0 due to a delayed surgery diagnostic.</td>
<td>Percentage of patients treated within 62 days of GP referral
 

The 31-day subsequent surgery standard was failed in May, due to critical care bed capacity constraints. The 31-day subsequent drug standard was also failed in the month, but will be achieved for the quarter as a whole.</td>
<td>May’s performance continued to be impacted by surgical capacity issues and elective cancellations due to critical care bed capacity constraints. Performance also continued to be heavily impacted by factors outside of the Trust’s control. A CQUIN came into effect on the 1st October, along with a national policy for ‘automatic’ breach reallocation of late referrals. However, adjusted performance based upon these rules was 76.3%. The existing Trust Cancer Performance Improvement Plan is being refreshed (Action 10A to 10F).</td>
</tr>
<tr>
<td>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.</td>
<td>Performance was 98.6% in June, which is below the 99% national standard, but above the recovery trajectory for the month of 98.3%. The number and percentage of over 6-week waiters at month-end, is shown below:
<table>
<tr><th>Diagnostic test</th><th>Apr</th><th>May</th><th>Jun</th></tr>
<tr><td>MRI</td><td>9</td><td>15</td><td>13</td></tr>
<tr><td>Sleep</td><td>11</td><td>2</td><td>10</td></tr>
<tr><td>Endoscopies</td><td>30</td><td>23</td><td>28</td></tr>
<tr><td>CT</td><td>72</td><td>59</td><td>64</td></tr>
<tr><td>Echo</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Other</td><td>1</td><td>3</td><td>4</td></tr>
<tr><td>TOTAL</td><td>123</td><td>102</td><td>119</td></tr>
<tr><td>Percentage</td><td>98.6%</td><td>98.8%</td><td>98.6%</td></tr>
<tr><td>Recovery trajectory</td><td>99.0%</td><td>99.0%</td><td>98.3%</td></tr>
</table></td>
<td>Percentage of patients waiting under 6 weeks at month-end
 

The recovery trajectory of 97.9% is on track to be met at the end of July.</td>
<td>Demand for Cardiac CT remains high, following the significant increase earlier in the year as a result of implementation of November 2016 refresh of the NICE guidelines. A pilot commenced in July, which should increase the throughput on Cardiac CT scanners. If successful, the backlog of routine over six week waiters should be cleared in August and September. An increase in sleep studies over six week waiters is forecast for the end of July (Actions 11A and 11B).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for December 2016 was 99.1 This statistical approach estimates that there were 15 fewer actual deaths than 'expected' deaths in the 12-month period up to December 2016.	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	Our overall performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter. We will continue to track Hospital Standardised Mortality Indicator monthly to give earlier warning of a potential concern.
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.	In April (latest data), 38 out of 42 patients (90.5%) were treated within 90 minutes of arrival in the hospital. Performance for 2016/17 as a whole ended above the 90% standard at 91.7%.	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. There were no emerging themes in April.

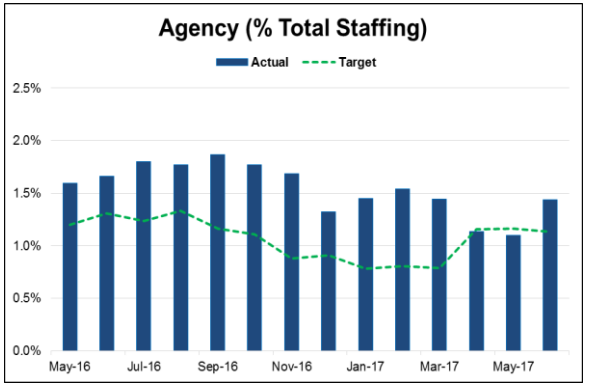
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In June 2017 we achieved 50% (10/20 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 85% (17/20 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Procedure delayed due to lack of theatre capacity.</td><td>3</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.


</td>
<td>Eight patients did not receive any ortho-geriatrician review due to sickness and the clinician having to cover the Older Person Assessment Unit.
Actions are being taken to establish a future service model across Trauma & Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12D).</td>
</tr>
<tr>
<td>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.</td>
<td>In June 2017 there were 485 outlier bed-days against a target of 815.
Performance showed a continued improvement despite ongoing operational pressure on the hospital. There was a significant improvement of 322 bed days compared with May (807).
<table>
<tr><th>Outlier bed-days</th><th>June 2017</th></tr>
<tr><td>Medicine</td><td>187</td></tr>
<tr><td>Surgery</td><td>162</td></tr>
<tr><td>Specialised Services</td><td>126</td></tr>
<tr><td>Women's & Children's Division</td><td>8</td></tr>
<tr><td>Diagnostics and Therapies</td><td>2</td></tr>
<tr><td>Total</td><td>485</td></tr>
</table>
</td>
<td>Number of days patients spent outlying from their specialty wards


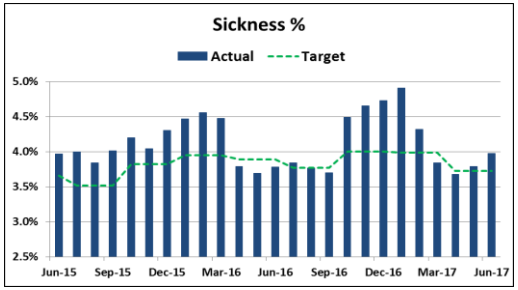
</td>
<td>The quarter one target has been set at 815 bed-days per month and this was achieved in June 2017 by 330 bed days.
Ongoing actions are shown in the action plan section of this report. (Action 13).</td>
</tr>
</table>

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 increased by 29.3 FTE, with increases in all staff groups. Nursing & Midwifery usage increased by 10.1 FTE in the month, with increased bookings largely due to sickness and vacancies.	**Agency usage as a percentage of total staffing by month**	A summary of compliance with agency caps is attached in Appendix 2. See action 14 for a summary of key actions to target agency use.
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 rose from 3.8% to 4.0%, with increases in all Divisions except Trust Services and Surgery Division. Reductions in colds/flu and psychological related absence were offset by increases in a range of smaller reasons such as endocrinology and pregnancy related.	**Sickness absence as a percentage of full time equivalents by month**	See action 15 for the sickness absence action plan.

June 2017	FTE	Actual %	KPI
UH Bristol	**123.4**	**1.4%**	**1.1%**
Diagnostics & Therapies	13.0	1.3%	0.7%
Medicine	32.5	2.6%	1.4%
Specialised Services	17.5	1.7%	1.8%
Surgery	18.4	1.0%	1.0%
Women's & Children's	22.4	1.2%	0.5%
Trust Services	11.4	1.4%	2.1%
Facilities & Estates	8.2	1.0%	1.3%



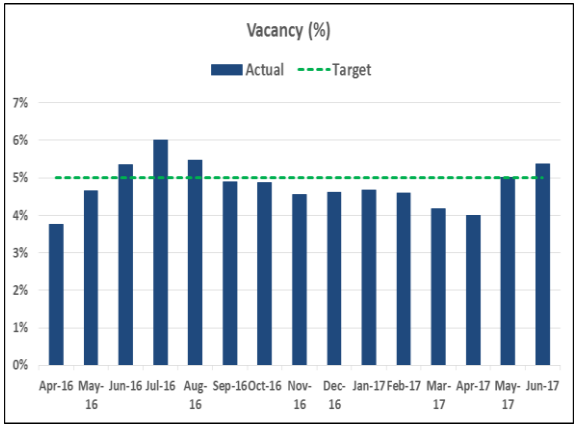
June 2017	Actual	KPI
UH Bristol	**4.0%**	**3.7%**
Diagnostics & Therapies	3.3%	2.5%
Medicine	4.1%	4.7%
Specialised Services	4.1%	3.5%
Surgery	3.9%	3.6%
Women's & Children's	3.9%	3.4%
Trust Services	2.7%	3.1%
Facilities & Estates	6.2%	5.8%



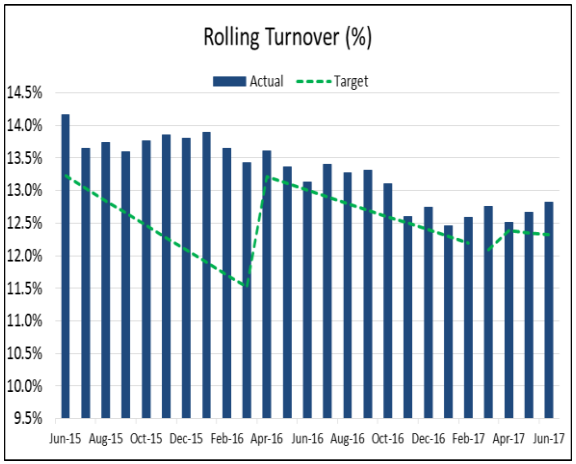
Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data is consistent with the Trust's final submission for national publication.

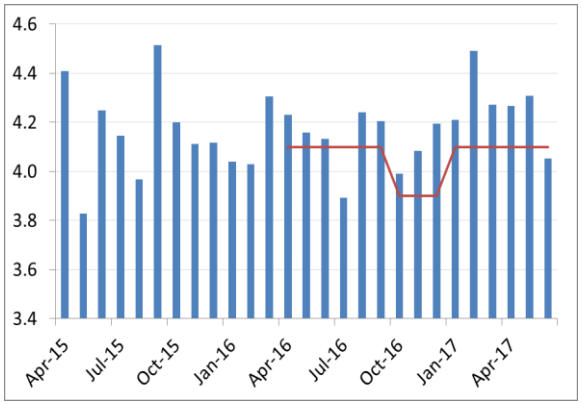
Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Overall vacancies increased from 5.0% to 5.4%. Nursing vacancies rose by 20.95 FTE in month to 206.9 (6.8%), due to increases in Women's & Children's and Surgery Divisions.	**Vacancies rate by month**	See Action 16 for further details of the plans that continue to be implemented to reduce the vacancy rate.
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 12.1% by the end of 2016/17. The red threshold is 10% above monthly trajectory.	Turnover increased from 12.7% to 12.8%, rising in month in all Divisions except Women's & Children's and Facilities & Estates.	**Staff turnover rate by month**	See Action 17 for further details of the plans that continue to be implemented to reduce turn-over.

June 2017	Rate
UH Bristol	**5.4%**
Diagnostics & Therapies	7.2%
Medicine	9.3%
Specialised Services	5.0%
Surgery	4.2%
Women's & Children's	2.6%
Trust Services	5.3%
Facilities & Estates	6.9%



June 2017	Actual	KPI
UH Bristol	**12.8%**	**12.3%**
Diagnostics & Therapies	11.6%	11.7%
Medicine	14.3%	14.5%
Specialised Services	13.3%	12.1%
Surgery	12.5%	11.6%
Women's & Children's	12.1%	11.1%
Trust Services	12.4%	12.5%
Facilities & Estates	14.6%	14.4%



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 June the average length of stay for inpatients was 4.05 days, which is below the quarter 1 RED threshold of 4.1 days. The percentage of patients discharged in the month who were long-stay stay patients (14 day plus stays) was the lowest since November 2016. However, despite this low rate of discharge of long stay patients, there was a further decrease in the number of long stay patients in hospital at month-end, down from 240 at the end of May, to 227 at the end of June. This is the lowest level of in-hospital 14-day plus stays since July 2016.	**Average length of stay (days)**  Length of stay is forecast to remain above the RED threshold in July.	The total number of Green to Go (delayed discharge) patients in hospital remains just less than double the jointly agreed planning assumption of 30 patients. The number of 14-day stays has reduced, but remains above the level required to maintain effective flow and meet the 95% standard for A&E 4-hour waits. Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide plan (Actions 8A to 8I and 13).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Deteriorating patient Early warning scores for acted upon.	1A	Further targeted teaching for areas where NEWS incidents have occurred.	On-going	Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality and Outcomes Committee	Sustained improvement to 95% by 2018.
	1B	Accessing doctor education opportunities to assist with resetting triggers safely.	On-going	As above	Sustained improvement to 95% by 2018.
	1C	Conduct 1:1 debriefs to further understand the reasons why nurses and doctors are unable to escalate or respond to escalation and address these accordingly. Also please see 1E below.	Completed. Actions in response to thematic analysis now under consideration.	As above	Sustained improvement to 95% by 2018.
	1D	Spreading point of care simulation training in adult general ward areas to address human factors elements of escalating deteriorating patients and use of structured communication.	On-going	As above	Sustained improvement to 95% by 2018.
	1E	Additional time allocated for patient safety in doctors' induction to train new appointees on resetting triggers safely and	Ongoing	As above	Sustained improvement to 95% by 2018.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		human factors awareness of escalation conversations.			
	1F	Review and response to outputs of mapping exercise of coverage of responders to escalation calls out of hours actions.	May 2017 review completed. Actions being fed into Urgent Care Group.	As above	Sustained improvement to 95% by 2018.
	1G	Procurement of e observations system to enable automatic calculation of NEWS and notification of elevated NEWS to responder.	To be confirmed.	As above	Sustained improvement to 95% by 2018.
Non-purposeful omitted doses of critical medication	2A	Datix dashboard being developed to capture omitted doses, to allow detailed thematic analysis.	Commenced February 2017 and ongoing	Improvement under development	Maintain current improvement and sustain performance below 0.75%
	2B	Teaching session to be run for new Pharmacists on data collection and background	Commenced February 2017 and ongoing	Teaching session under development	Maintain current improvement and sustain performance below 0.75%
Essential Training	3	Continue to drive 90% compliance in all subjects including increasing e-learning functionality. Compliance reviewed at Divisional quarterly Performance Review meetings. Divisional HRBPs are being asked to provide recovery plans for all non-compliant staff with escalation to Divisional Boards. Automated reminders for non-	December 2017 July 2017 December 2017	Oversight of training compliance by the Education Group. Monthly and quarterly Divisional Performance Review meetings. Oversight of training compliance by the Education Group.	Performance against target for Fire and Information Governance are included in Appendix 2. Target audiences for Dementia Awareness Training will be agreed at the end of July by subject matter expert.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		compliant staff to be increased to monthly from 60 days prior to subject expiry.			
Monthly Staffing levels	4	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls and action plan.	Action plan available on request.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Caring					
Dissatisfied complainants	5A	Response writing training continues to be rolled-out to Divisions	Ongoing	Completion of training signed-off by Patient Support & Complaints Team and Divisions.	Achieve and maintain a green RAG rating for this indicator.
	5B	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the case-worker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality for 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.	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 letters can then be discussed individually with the manager concerned and further training provided if necessary.	Achieve and maintain a green RAG rating for this indicator
	5C	Dissatisfied responses are now routinely checked by the Head of Quality (Patient Experience & Clinical Effectiveness) to identify learning where appropriate. All cases where a complaint is dissatisfied for a second time are escalated to and reviewed by the Chief Nurse.	Implemented September 2015 and ongoing		Achieve and maintain a green RAG rating for this indicator
	5D	In January 2017, the Head of Quality (Patient Experience and	Ongoing.	From June 2017 (reviewing March cases), all dissatisfied	Achieve and maintain a green RAG rating for this indicator

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Clinical Effectiveness) and Acting Patient Support and Complaints Manager undertook a detailed review of all dissatisfied cases from August and September 2016.		cases are now retrospectively reviewed on a monthly basis for learning by the Head of Quality (Patient Experience and Clinical Effectiveness) and Patient Support and Complaints Manager. Findings are reported to the Patient Experience Group and Divisional Management Teams.	
	5E	The Trust will be establishing a new complaints review panel in 2017.	Terms of Reference established March 2017	Evidence that the panel is in place and learning identified and shared with Divisions	Achieve and maintain a green RAG rating for this indicator
Last minute cancelled operations	6A	Continued focus on recruitment and retention of staff to enable all adult BRI HDU/ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post. Development and implementation of a strategy for managing ITU/HDU beds across general adult and cardiac units, to improve ability to manage peaks in demand.	Ongoing End August	Monthly Divisional Review Meetings; Senior Leadership Team sign-off	Sustained reduction in critical care related cancellations in 2017/18. As above.
	6B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Outpatient appointments cancelled by hospital	7A	Explore option of increasing required notice of annual leave from six to eight weeks to reduce the number of cancelled clinics	Agreed in principle but process of how to communicate this out and enact it being worked through	Senior Leadership Team	Amber threshold expected to be achieved again by the end of September.
	7B	Full service-level review of the electronic Referral Service (eRS) Directory of Services, to limit the number of required re-bookings	Complete - full improvement plan in place around ERS to comply with the CQUIN and NHSE Paper Less initiative; Milestones across each quarter	Outpatient Steering Group	
	7C	Implement changes to the way capacity is managed to support eRS appointment bookings and limit cancellations.	Working through as part of the ERS plan. NHS Digital to undertake one capacity review on one service for us by September	Outpatient Steering Group	
	7D	eRS Improvement Plan to be developed, following review by NHS Digital, to help improve eRS access for patients and reduce un-necessary re-arrangement of outpatient appointments.	Complete.	Outpatient Steering Group	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Responsive					
A&E 4-hours	8A	Extended escalation capacity (A518) likely to end of quarter 4, and continued use of ORLA. Escalation capacity has remained open during quarter 4 and agreement has been given for this to be included in Medicine's substantive bed base. Orla Healthcare went into administration at the end of April 2017 and no longer provide a service to UH Bristol. Options for replacement of this service are being developed.	Ward A518 has remained open as extreme escalation capacity during quarter 1 and a decision has been made following the closure of the Orla Healthcare service to include the ward as part of the Medicine Division's substantive bed base. This change was implemented with effect from 3rd July 2017 with the ward being managed in the future by the respiratory team pending successful nursing and consultant recruitment.	Monitoring of expected improvement in relevant KPI through the Emergency Access Improvement Group (EAPIG)	Achievement of recovery trajectory in each month of Q1 2017/18.
	8B	Flexible use of community beds via system partners: Integrated Discharge Service (IDS) continues to pursue flexible use of available care home and reablement capacity to facilitate	Improvement in discharge processes are being made through the Integrated Discharge Service	Progress monitored through daily ALAMAC calls. Actions expected to reduce and/or smooth demand. Monitoring of expected	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		discharge on a daily basis. Work is being undertaken within the IDS to improve and optimise internal processes with the service being part of the Flow Coaching Programme supported by the West of England Academic Health Science Network (AHSN) which is being formally launched on 23 Mat 2017.	Development Programme with the focus being on the implementation of a revised Managing Expectations policy and Single Referral Form planned during quarter 2 2017.	improvement in relevant KPI through the Emergency Access Improvement Group (AEPIG)	
	8C	Additional GP Support Unit and Urgent care capacity: Future requirements for GPSU will be incorporated into the proposed model for Front-Door Primary Care Streaming which has to be operational by October 2017 at the latest. The UCSG will undertake a further review of all direct access admission pathways during quarter 2 2017/18 to ensure that these are as effective as possible and reduce the reliance on the Emergency Department (ED) as a gateway for all admissions. The pilot for medically expected patients to be admitted via Ambulatory Care Unit has been extended.	The review of direct admission pathways is being undertaken by Divisional teams with progress being monitored through the UCSG. The Medicine Division are piloting a medical assessment area for ambulant patients within the AMU which is also available for patients who self-present in the Emergency Department with the aim of preventing overnight		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
			admissions and ensuring an earlier senior review of medical patients.		
	8D	Proposals for a different Urgent and Emergency Care staffing model is being developed for presentation to the UCSG and SLT in July 2017.	Business case for an enhanced ED consultant staffing model has been developed and is currently in final draft stage prior to presentation at UCSG and SLT.		
	8E	Commissioning of Pulse to provide domiciliary care packages, to support early supported discharge: Pulse commissioned and operational from 20th February 2017 and has reduced the number of patients delayed waiting for a package of care. Formal evaluation to be presented to SLT in July for decision about continuation of the initiative.	The Pulse initiative has continued with 47 patients having an earlier discharge from hospital as at 30 June 2017, this has released 559 bed days which is the equivalent of 4.3 beds. The initial evaluation of the project was presented to SLT in July 2017 with a proposal to request that the service is continued but financially supported by	Contract monitoring	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
			system partners.		
	8F	Review of formal feedback from NHS Improvement Critical Friend Visit, to feed into refresh of the action plan. Formal feedback reviewed and has been incorporated into the Urgent Care Steering Group (UCSG) action plan which will be presented to the May 2017 meeting.	The UCSG Improvement Plan has been developed and signed off by the UCSG and at SLT. The plan contains 10 high priority actions which are expected to have the greatest impact on performance and these are being prioritised during quarter 2 2017.	Review and monitoring of agreed actions by EAPIG.	
	8G	Division of Medicine to embed new medical model of Acute Physicians and develop clear strategy of medical admissions flow from ED, learning from their first two weeks in post. Acute physicians are now in post and early indications are that there has been an increase in the 0-2 day length of stay and a reduction in overall length of stay. The Medicine Division is developing an urgent and emergency care strategy which will now look to develop the acute medicine model further for	Vacant 3rd acute physician post has been recruited with an estimated start date at the end of August 2017. Revised model for the assessment of ambulant patient on the AMU is being piloted (8C above) and this development will inform the development of the future model for	Review and monitoring of agreed actions by EAPIG.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		presentation to the UCSG and SLT in July 2017.	Acute Medicine.		
	8H	ED to pilot escalation of delayed speciality review of patients in ED to Silver (operational meetings) for respective divisions (Surgery and Specialised Services) using ipods. This is Monday to Friday with the purpose of capturing in real-time what the issues are, and looking for innovative ways to improve access to speciality review. Contributes to implementation of refreshed professional standards. Professional standards approved at April UCSG and will be taken to June SLT for formal sign off.	Professional standard approved by SLT and were launched across UH Bristol at the start of July 2017.		
	8I	Consideration of strategic solutions to potential bed capacity shortfalls for 2017/18, including ways of increasing early supported discharge. Paper detailing the next steps for out of hospital care options presented to SLT in April. Detailed analysis and work with system partners is now been undertaken to develop potential future models of care which are formally costed and assessed.	Task and Finish group established with representation from Bristol Community Health to develop proposals for out of hospital services with the aim of having a proposal developed for an IVT at home service for discussion at SLT in August 2017.	Review of options to be considered at Senior Leadership Team	Achievement of STF trajectory in 2017/18

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Referral to Treatment Time (RTT)	9A	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 92% standard from the end of July onwards.
	9B	Implementation of RTT Sustainability Plan for the first half of 2017/18, which focuses on areas of recent growth and those specialties whose backlogs are still above sustainable levels	Ongoing	Fortnightly meetings between Divisions and Associate Director of Performance, and Access Improvement Manager	
	9C	Refresh of IMAS Capacity and Demand modelling for key specialties (including Clinical Genetics, Paediatric Cardiology and Sleep Studies).	Complete except for Clinical Genetics (now end of July)	Modelling to be reviewed by Associate Director of Performance	
	9D	Chronological booking report to be developed to challenge inefficient booking practices for outpatients and elective procedures.	End July	Sign-off of report by Chief Operating Officer	
	9E	Implementation of chronological booking report.	End August	Divisional PTL meetings making use of this report	
	9F	Dental administrative management improvement plan to be developed.	Complete	Sign-off of plan by Associate Director of Performance	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	9G	Support for the implementation of the Dental administrative management improvement plan to be secured.	End August	Level of support agreed by Chief Operating Officer and Surgery Divisional Director	
	9H	Real-time RTT reporting to be developed and fully tested	End August	Validation of rules; RTT business rules to be signed-off by Intensive Support Team	
Cancer waiting times	10A	Cancer Performance Improvement Plan to be refreshed.	End August	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Achieve 85% for internally managed pathways and 85% with application of CQUIN. Sustain performance above national average each quarter.
	10B	Ring-fencing of step-down beds to reduce Critical Care related cancellations of cancer surgery.	Complete	Cancer Steering Group	Achievement of 85% standard by the end of 2017/18
	10C	Completion of transfer from Taunton & Somerset Trust of skin cancer service.	End March 2018	Cancer Steering Group	As above.
	10D	Explore options relating to the re-provisioning / re-commissioning of cancer 62-day GP pathways, in order to reduce inter-provider transfer delays.	End October	Cancer Steering Group	As above.
	10E	Strategic case for more effective management of critical care bed capacity across adult and cardiac units.	End August	Sign-off by Senior Management Team	As above.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	10F	IMAS capacity and demand modelling of thoracic and hepatobiliary cancer surgery and outpatient appointments to determine whether there is a shortfall.	End August	Sign-off by Surgery Deputy Divisional Director	As above.
Diagnostic waits	11A	Additional Sleep Studies waiting list sessions to be established to minimise residual backlog of long waiters.	End September	Weekly monitoring by Associate Director of Performance, with escalation to monthly Divisional Review meetings as required.	Achievement of 99% standard again for this diagnostic modality by the end of September.
	11B	Changes to be made to Cardiac CT scanning sessions to improve utilisation. Pilot to be run in the first instance to determine impact.	End July	Weekly monitoring by Associate Director of Performance, with escalation to monthly Divisional Review meetings as required.	Achievement of 99% standard again for this diagnostic modality by the end of September.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	12A	**Middle grade orthogeriatric support** – to submit a proposal to establish a dedicated middle grade orthogeriatric role (ST3+) to provide additional support to the orthogeriatric consultants and wards. This post will also contribute to improvements in cross-cover.	Pending approval and further discussion with executive colleagues	Proposal for investment included in BOA business case. Recruitment lead time difficult to determine as this may be a difficult role to recruit to	Successful funding bid and subsequent recruitment to post
	12B	**Consultant orthogeriatric consultant cover** – to support a return to work for the consultant that has been on extended long term sick.	To be confirmed	Reduction in variability in cross-cover arrangements. The current shortfall of 3.5 Care of the Elderly consultant posts is having a significant adverse impact on ortho-geriatric capacity.	Improvements in time to review by an orthogeriatrician.
	12C	**Establishment of an elderly trauma and hip fracture ward** – to cohort frail elderly trauma patients on A604. To facilitate direct admission from ED to ring-fenced fractured neck of femurs beds.	This is contingent upon amending care pathways and admission protocols.	There also needs to be sufficient capacity to maintain ring fenced admission beds and medical ward capacity to accommodate step down patients	Improvements to the quality and coordination of patient care.
	12D	**Physiotherapy the day after surgery** – to ensure that there is physiotherapy support available to the orthopaedic wards on Sundays	To be incorporated in revised costings for the business case following discussions with D&T Division.	There are potential benefits associated with reduction in patient length of stay with earlier mobilisation.	Improvements against the new quality standard measure of therapy review the day after surgery.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	12E	**Time to surgery** – to improve trauma throughput and to expedite the surgery of fractured neck of femurs patients within 36 hours.	Ongoing	The number of patients that do not meet this standard is relatively small. There is work being undertaken to refine the process for escalation of patients that are not anticipated to meet the standard to ensure that proactive steps are taken	Improvements against time to theatre standard
Outlier bed-days	13	Ward processes to increase early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer. See also actions 8A to 8J.	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Efficient					
Agency Usage	14	**Effective rostering**: • "Healthroster" – implemented and KPIs agreed in place.	Ongoing	KPI Performance monitored through Nursing Controls Group. Nursing agency: oversight by Savings Board. Medical agency: oversight through the Medical Efficiencies Group.	A KPI has been agreed for 2017/18 of 1% through the Divisional Operating Planning. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. Marketing activity now being actively deployed.
		Controls and efficiency: • New agency rules in place for Nursing from April • Nurse agency suppliers still under consideration through the wider BNSSG group. • Operating plan agency trajectories monitored by divisional reviews.	Ongoing Ongoing Monthly/quarterly reviews		
		Enhancing bank provision: • Recruitment and marketing plan for all staff groups in place for 2017/18. • Staff able to book shifts from home on Healthroster. • Extended Temporary Staffing Bureau opening hours.	Ongoing From end June 2017 From end June 2017		
Sickness Absence	15	**Supporting Attendance Policy:** Draft Policy to Policy Group in May 2017. Final draft to group in July. Proposed implementation	September 2017	Oversight by Workforce and Organisational Development (OD) Group via the Staff Health and Well Being Sub	A KPI has been agreed for 2017/18 of 3.8% Divisional Operating Planning Process.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		September 2017		Group	Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. Where divisions are above target an extensive deep-dive into the data is provided and a recovery plan is produced.
		Supporting Attendance Surgeries: To expedite cases where possible.	Ongoing		
		Musculo-skeletal: Interventions by Occupational Health, Physio Direct, and Manual Handling Team.	Ongoing	Workplace Wellbeing Steering Group (quarterly) /CQUIN Delivery Group	
		Mental health: Draft Stress management strategy framework.	Senior Leadership October 2017		
		Staff Health and Well Being: Trust review of model for well-being including healthy food and beverages.	January 2016 to March 2019		
Vacancies	16	**Recruitment Performance:** • Divisional Performance and Operational Review Meetings monitor vacancies and performance against KPI of 45 days to recruit.	Reviewed quarterly	Workforce and OD Group /Recruitment Sub Group.	The target for vacancies continues to be 5% in 2017/18. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
		Marketing and advertising: • Recruitment and marketing plan for nursing in place for 2016/17. • Marketing for Radiology in	Ongoing Ongoing	Divisional Performance and Operational Review Meetings.	

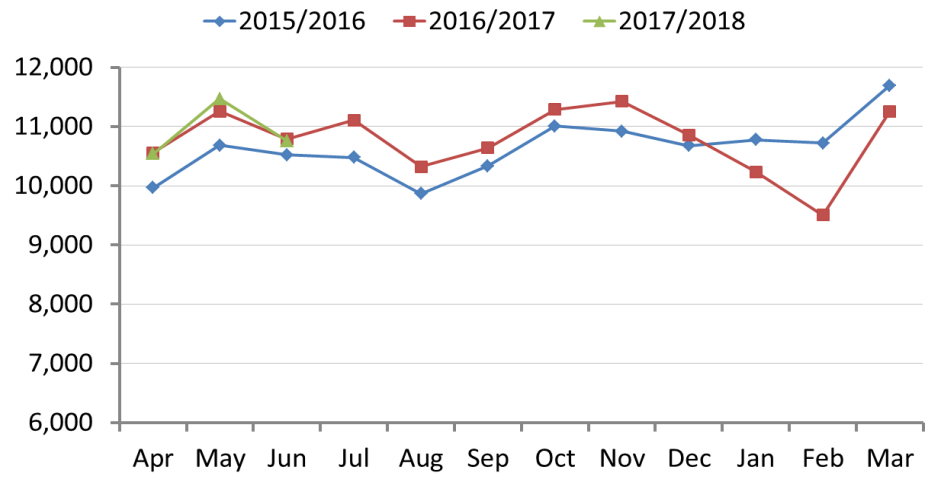
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		place 2016/17 maximising new recruitment website. • Divisional Nurse Recruitment Leads in bed-holding divisions. • "Head-hunter" agency approach has been extended to hard to fill areas e.g. Sonography, Trauma & Orthopaedics and Care of the Elderly nursing.	April 2017-18 From April 2017		
Turnover	17	**Complete review of appraisal:** Phase 1, including E-appraisal and updated policy now complete. Phase 2 of the E-Appraisal programme commences in August and includes a 360 feedback to support the embedding of the leadership behaviours in the future.	From May 2017	Transformation Board.	A KPI has been agreed for 2017/18 of 12% through the Divisional Operating Planning Process. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance reviews meetings.
		Transformational Engagement and Retention: rolling out 'Leadership Behaviours' led by Executive Directors and Senior Leaders across the Trust in August with follow up events in September and October	Commencing August 2017	Senior Leadership Team/Board.	
		Engagement (Staff Survey): HR BPs developed Improving Staff Experience Plans for 2017/2018	2017/18	Divisional Boards/ Senior Leadership Team/Workforce and OD Group.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		to target hot spots. Interventions in progress to support these plans.			

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.

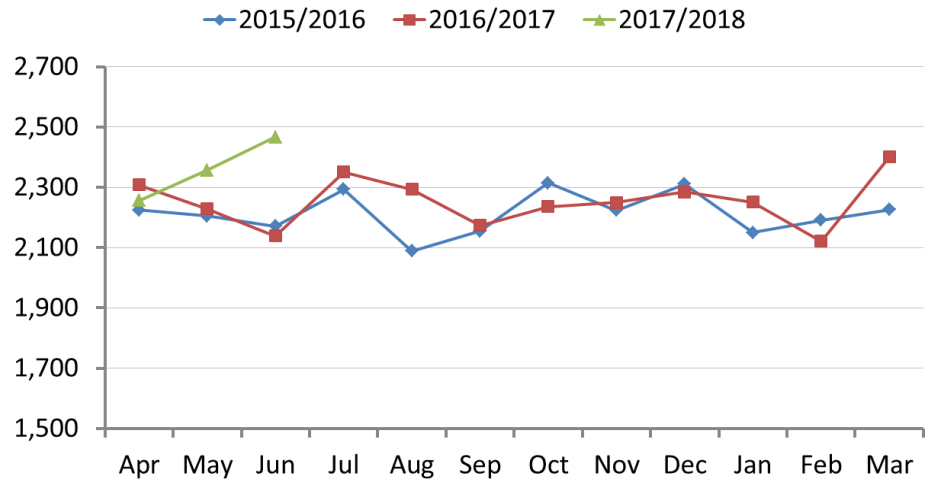
Emergency Department (ED) attendances



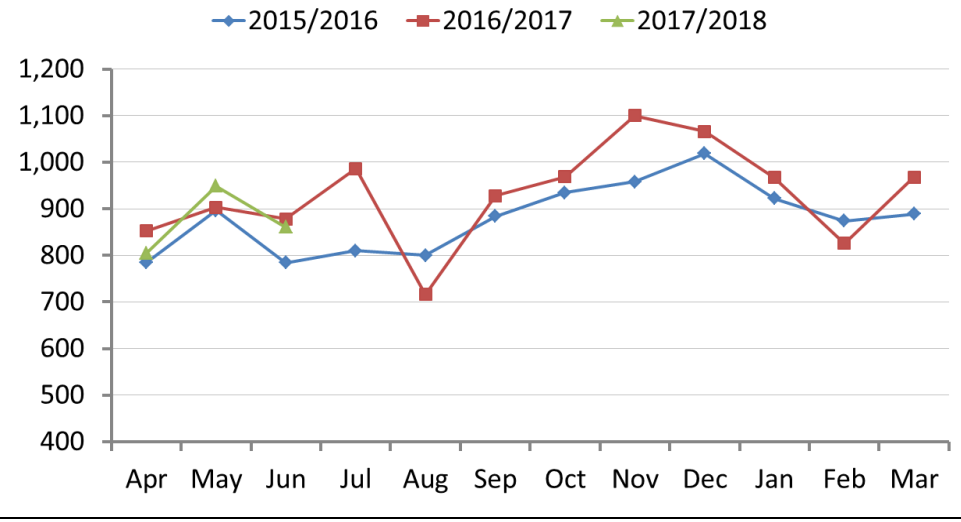
Summary points:

- Emergency Department attendances are similar to last year's levels; in contrast the total number of emergency admissions into the BRI significantly above the seasonal norm;
- The number of new outpatient attendances has remained at a high level, but despite this there has been a significant increase in the size of the outpatient waiting list, likely due to a 16% growth in referrals relative to the same period last year;
- The number of elective admissions remains above the seasonal norm;
- The number of patients waiting over 18 weeks for treatment has decreased, as has the total number of pathways; the size of the elective remains high, which in conjunction with a rising outpatient waiting list means there are multiple 'bulges' in the RTT waiting list that will need to be met to prevent an increase in over 18 week waiters in future months (see Assurance and Leading Indicators section).

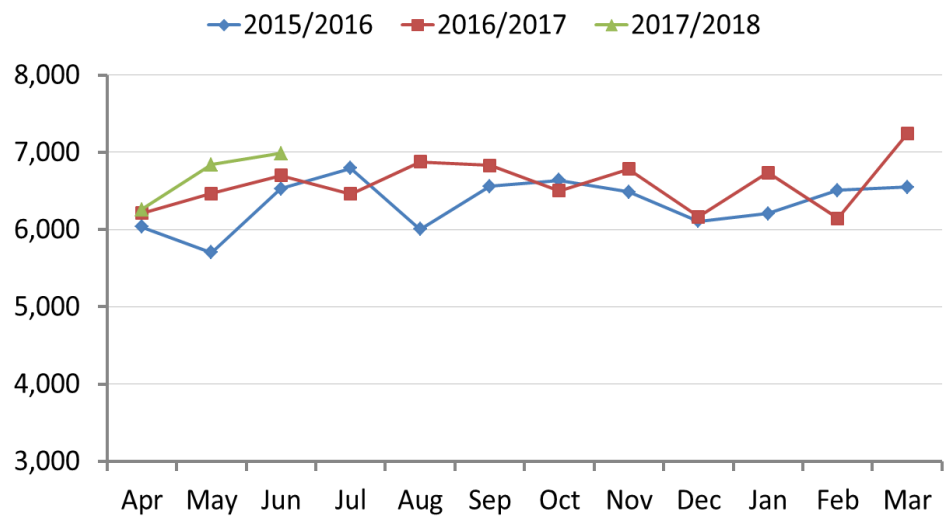
Emergency admissions (BRI)



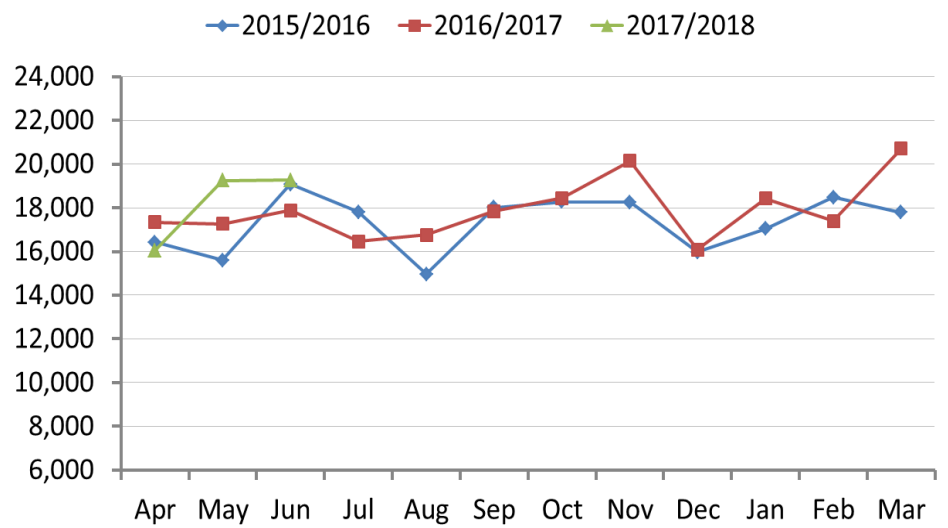
Emergency admissions (BCH)



Elective admissions



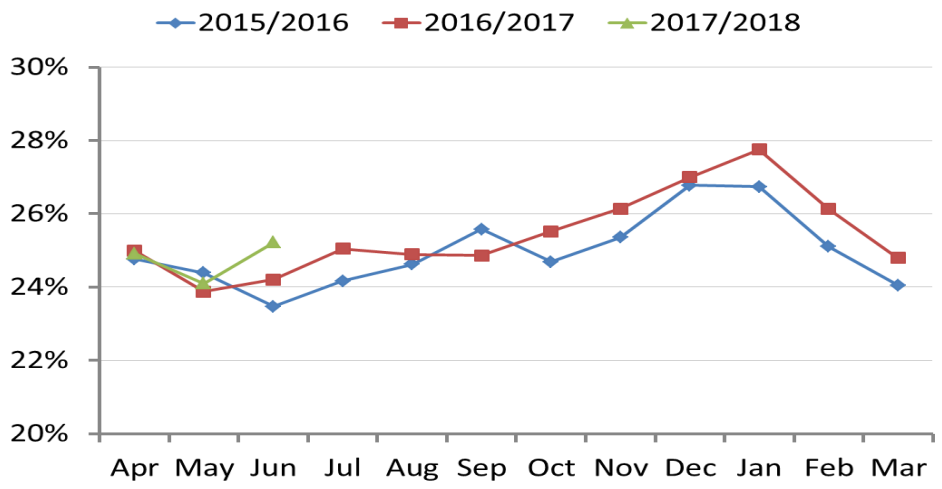
New outpatient attendances



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.

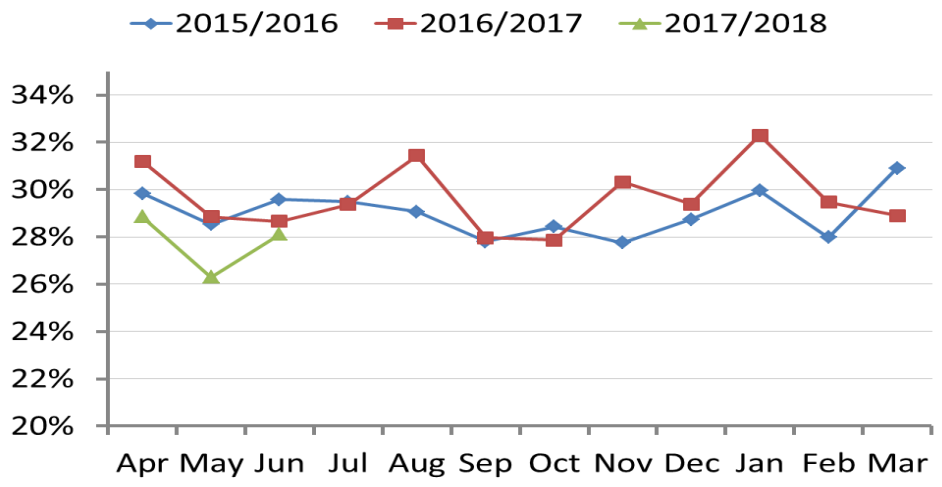
Percentage ED attendances resulting in admission



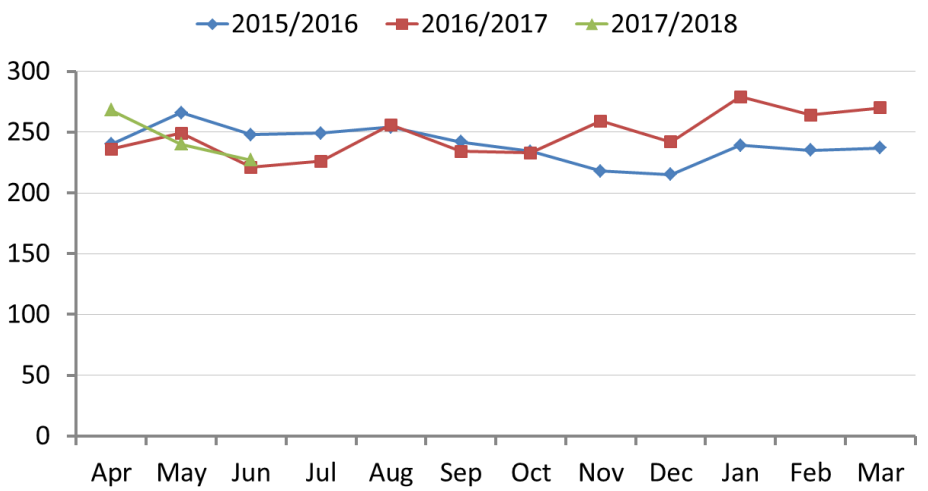
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission is significantly above the seasonal norm; the percentage of patients admitted aged 75 years and over continues, however, to be below the levels seen in the last two years;
- The number of over 14 days stays has continued to fall, and is now similar to last year's levels; the BRI bed occupancy level has fallen, despite the sharp rise in emergency admissions;
- The number of patients on the outpatient waiting list has started to rise, but remains below last year's levels; the elective waiting list has started to show the typical seasonal fall in size, but remains much higher than the levels seen in 2016/17, when the 92% standard was achieved;
- The number of patients referred by their GP with a suspected cancer (2-week waits) remains above the seasonal norm, as does the number of 62-day GP cancer treatments.

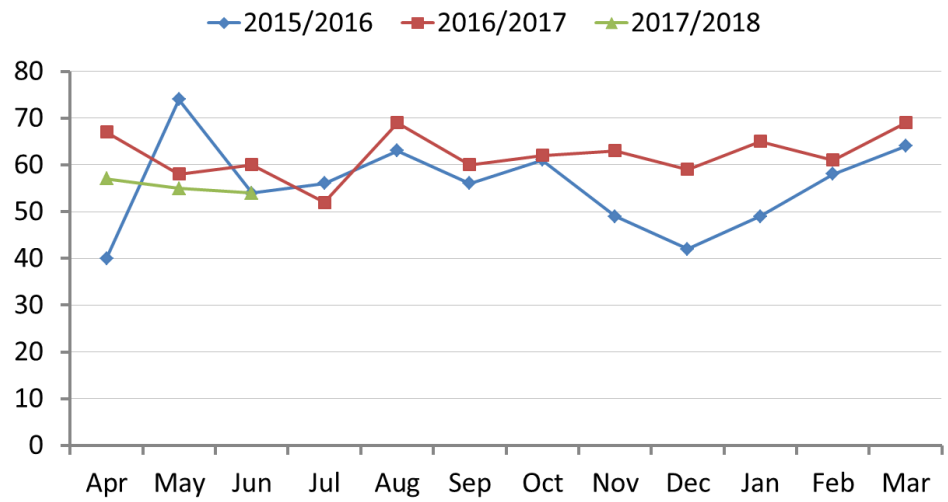
Percentage of Emergency BRI spells patients aged 75 years and over



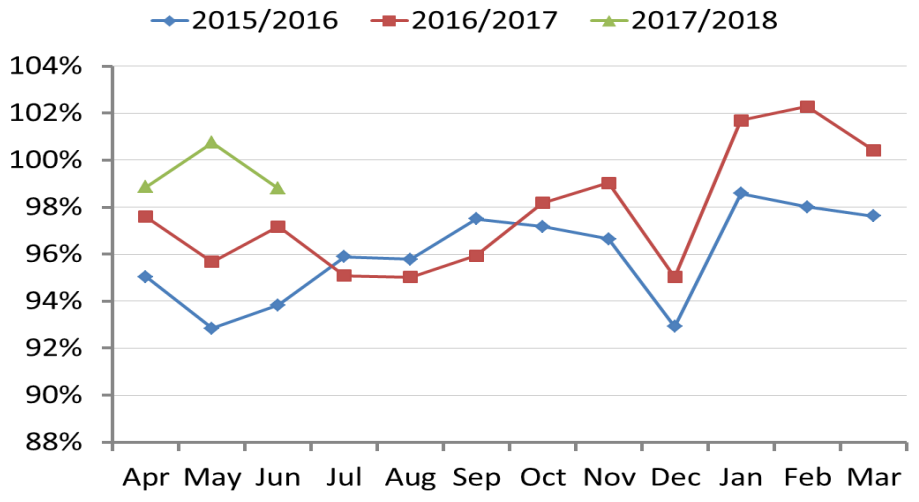
Over 14 day stays



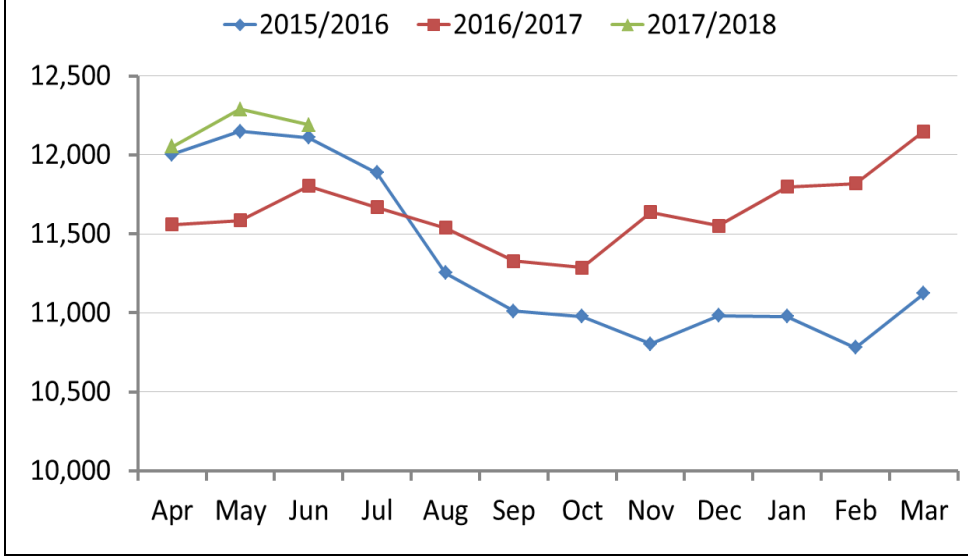
Delayed discharges (Green to Go)



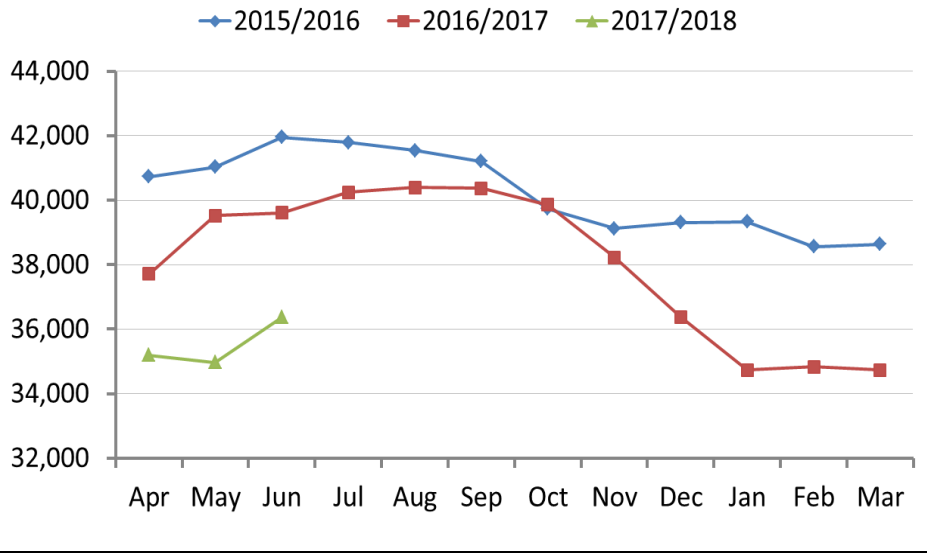
BRI Bed Occupancy



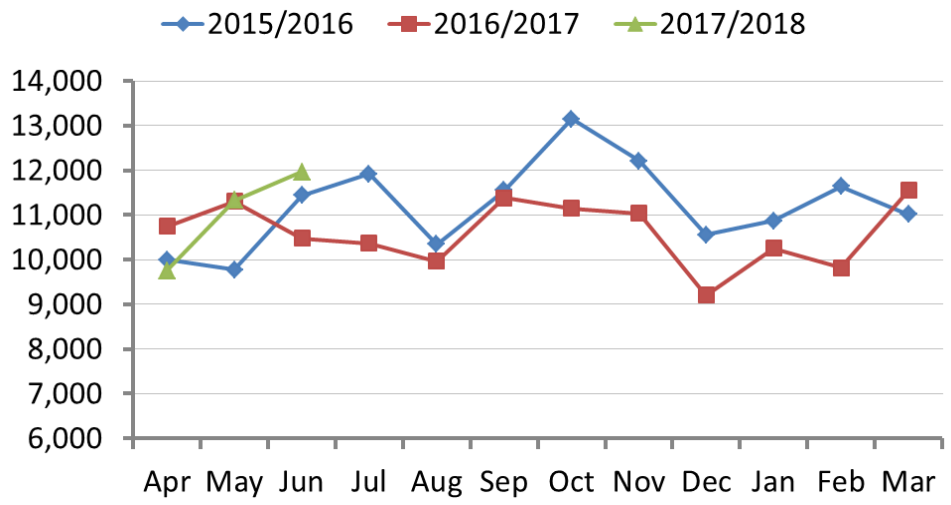
Elective waiting list size



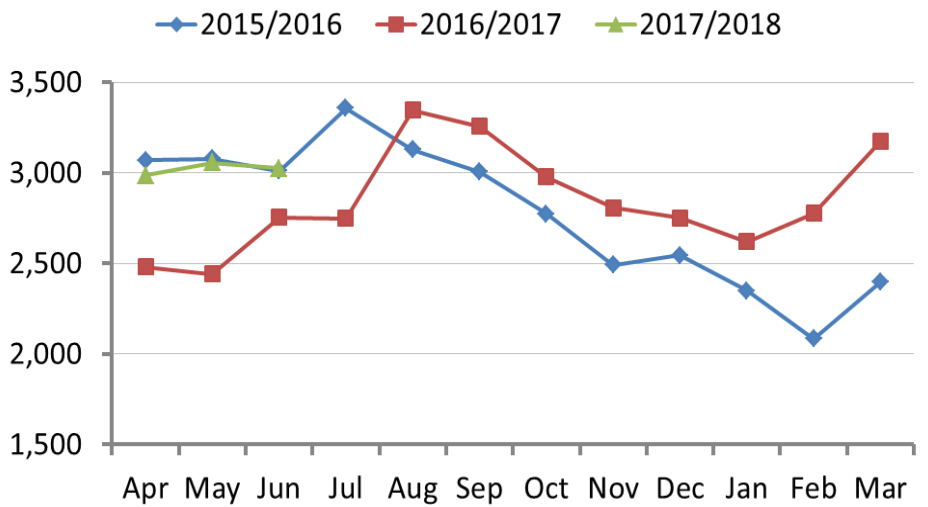
Outpatient waiting list size



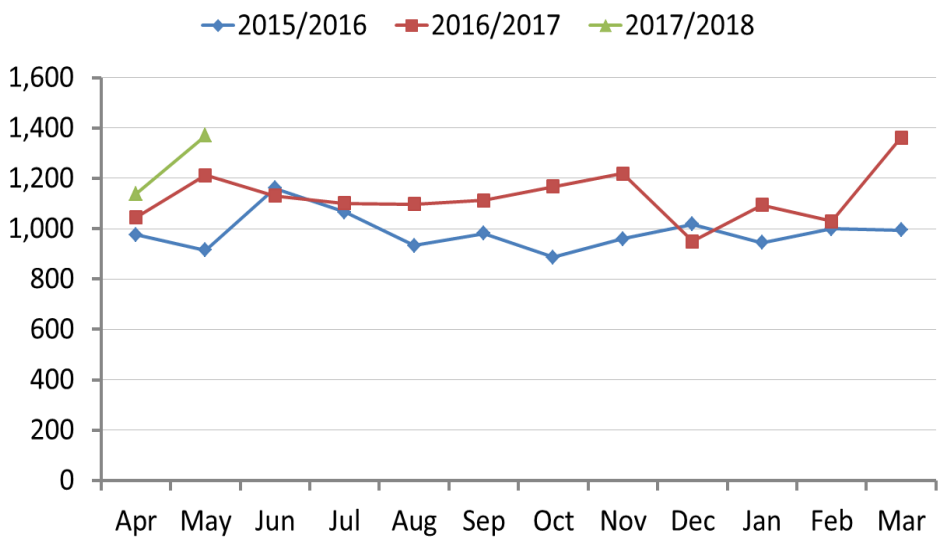
Number of RTT pathways stopped (i.e. treatments)



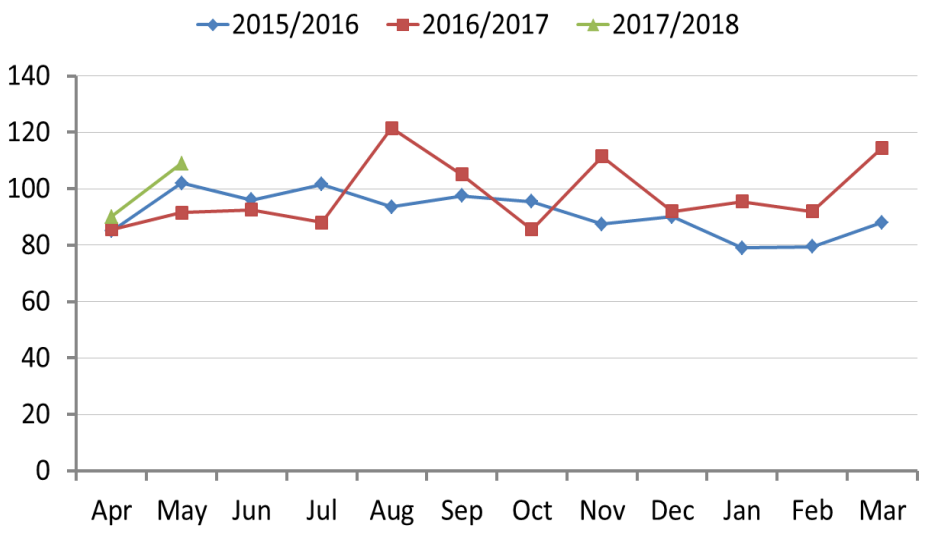
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	0	0	0	0	1	1	1	1	1	0	0	1	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	1	1	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0	1
	DA03	C.Diff Cases - Monthly Totals	31	11	3	2	5	1	3	5	4	0	0	2	4	5	10	9	4	11
	DA02	MSSA Cases - Monthly Totals	37	4	7	4	2	0	6	2	3	3	2	0	1	3	13	8	8	4
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	3	4	5	5	8	9	10	10	10	-	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	96.6%	98.2%	96.9%	98.4%	94.9%	97%	96.5%	95.7%	95.5%	95.4%	97%	98.4%	98.1%	-	96.8%	96.4%	96%	98.2%
	DB02	Antibiotic Compliance	88.3%	88.3%	88.2%	86.5%	86.8%	90.9%	90.3%	91.2%	91.7%	92%	88.1%	87.7%	89.6%	87.4%	87.4%	90.8%	90.8%	88.3%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	96%	97%	95%	95%	96%	96%	96%	94%	95%	96%	96%	96%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	97%	97%	97%	98%	97%	97%	98%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	97%	97%	96%	96%	97%	96%	96%	95%	96%	96%	97%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	52	15	6	8	1	4	5	3	5	2	5	2	7	6	15	12	12	15
	S02a	Number of Confirmed Serious Incidents	49	1	5	7	1	4	5	3	5	2	5	1	-	-	13	12	12	1
	S02b	Number of Serious Incidents Still Open	-	14	-	-	-	-	-	-	-	-	-	1	7	6	-	-	-	14
	S03	Serious Incidents Reported Within 48 Hours	94.2%	100%	83.3%	87.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86.7%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	90.4%	93.3%	100%	87.5%	100%	75%	80%	66.7%	100%	100%	100%	100%	100%	83.3%	93.3%	75%	100%	93.3%
	S04	Serious Incident Investigations Completed Within Timescale	98%	91.7%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	75%	100%	100%	93.3%	100%	91.7%
	S04a	Overdue Exec Commissioned Non-SI Investigations	-	5	-	-	-	-	-	-	-	-	-	1	2	2	-	-	-	5
Never Events	S01	Total Never Events	2	3	1	0	0	1	0	0	0	0	0	0	1	2	1	1	0	3
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	14866	2518	1173	1139	1263	1220	1389	1185	1335	1211	1332	1203	1315	-	3575	3794	3878	2518
	S06b	Patient Safety Incidents Per 1000 Beddays	47.82	48.5	45.32	44.67	50.77	45.61	52.93	46.21	48.94	48.67	48.47	47.02	49.94	-	46.88	48.25	48.69	48.5
	S07	Number of Patient Safety Incidents - Severe Harm	95	18	10	10	2	10	12	10	10	7	5	7	11	-	22	32	22	18
Patient Falls	AB01	Falls Per 1,000 Beddays	4.23	4.55	4.6	3.84	4.42	4.86	4.04	3.74	3.74	4.9	3.89	4.85	3.91	4.91	4.29	4.22	4.16	4.55
	AB06a	Total Number of Patient Falls Resulting in Harm	36	9	3	3	3	2	2	4	3	3	5	2	3	4	9	8	11	9
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.148	0.118	0.077	0.196	0.161	0.075	0.114	0.195	0.11	0.201	0.182	0.078	0.076	0.203	0.144	0.127	0.163	0.118
	DE02	Pressure Ulcers - Grade 2	40	7	2	5	4	1	3	5	3	3	3	1	1	5	11	9	9	7
	DE04A	Pressure Ulcers - Grade 3 or 4	6	2	0	0	0	1	0	0	0	2	2	1	1	0	0	1	4	2
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	99.1%	98.8%	99.1%	99.1%	99%	99%	99.4%	99%	99.1%	98.9%	99.1%	98.9%	98.9%	98.7%	99.1%	99.1%	99%	98.8%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	96.4%	96.3%	97.3%	95.7%	94.1%	97%	96.5%	97%	97.8%	98%	96.6%	94.5%	97.6%	97%	95.8%	96.8%	97.4%	96.3%
	N04	Number of Hospital Associated VTEs	63	8	5	5	5	2	9	7	11	3	2	5	3	-	15	18	16	8
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	7	0	0	0	1	1	0	1	2	0	0	0	0	-	1	2	2	0
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	13	6	0	1	1	0	4	2	3	1	0	6	0	-	2	6	4	6
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	89.6%	89.7%	89.4%	89.8%	89.7%	86.5%	87.1%	94.3%	92.7%	89.1%	90.2%	89.9%	87.7%	91.5%	89.6%	89.4%	90.6%	89.7%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	86.9%	92.2%	-	-	88%	-	-	91.2%	-	-	87.9%	-	-	92.2%	88%	91.2%	87.9%	92.2%
Safety	Y01	WHO Surgical Checklist Compliance	99.1%	99.7%	99.6%	99.9%	100%	99.6%	-	97.7%	98.4%	98%	97.8%	99.5%	99.7%	99.8%	99.9%	98.7%	98.1%	99.7%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.37%	0.69%	0.55%	0%	1.01%	0.55%	1.19%	0%	0%	0.53%	0%	0.98%	0.44%	-	0.51%	0.64%	0.16%	0.69%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.59%	0.53%	0.6%	0.38%	0%	0.65%	0.86%	0.74%	0.98%	0.39%	0.26%	0.43%	0.9%	0.24%	0.33%	0.75%	0.52%	0.53%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	97.7%	98.4%	98.6%	98.6%	97.6%	97.5%	97.4%	98%	97.3%	98.3%	97.9%	97.3%	97.9%	98.6%	97.5%	97.9%	97.7%
	AK04	Safety Thermometer - No New Harms	98.9%	98.6%	99.2%	99.2%	99.2%	98.4%	99.3%	98.5%	98.6%	98.5%	99.1%	99%	98.3%	98.4%	99.2%	98.7%	98.7%	98.6%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	92%	96%	82%	95%	94%	94%	93%	93%	91%	93%	100%	100%	96%	93%	90%	93%	95%	96%
Out of Hours	TD05	Out of Hours Departures	7.8%	8.2%	7.9%	8.8%	7.4%	7.2%	7.8%	8.1%	8.4%	9.2%	6.5%	8.5%	8.2%	7.9%	8%	7.7%	8%	8.2%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.1%	22.5%	23.1%	21%	22.1%	21.8%	22.3%	22.1%	21.6%	21.4%	21.1%	22%	22.3%	23%	22.1%	22.1%	21.3%	22.5%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11293	2818	1006	907	932	974	970	935	905	816	934	885	971	962	2845	2879	2655	2818
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.7%	103.7%	104.3%	102.7%	101.9%	102.6%	105.3%	104.2%	103.6%	104.5%	104.1%	107.1%	102.6%	102.4%	103%	104%	104%	103.7%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	99.9	-	-	-	99.4	-	-	99.1	-	-	-	-	-	-	99.4	99.1	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	91.3	-	100.4	88	81.2	91.3	110.4	92.2	87.2	90.9	91.1	-	-	-	89.9	97.9	89.6	-
Mortality Review	tbc	Number of Deaths																		
	tbc	Number of Deaths Subject to Casenote Review																		
	tbc	Number of Deaths Reviewed Under Serious Incident Framework																		
	tbc	Number of Deaths With More Than 50:50 Chance of Being Avoidable																		
Readmissions	C01	Emergency Readmissions Percentage	1.77%	2.09%	1.76%	2%	2.29%	1.48%	1.7%	1.93%	1.75%	1.84%	1.47%	1.71%	2.44%	-	2.01%	1.7%	1.68%	2.09%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	21.6%	38.1%	7.1%	11.1%	16.7%	20%	21.7%	27.3%	27.8%	28.6%	41.7%	38.5%	37.5%	38.1%	12%	22%	31.8%	38.1%
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatien	65.7%	71.4%	33.3%	80%	33.3%	66.7%	85.7%	71.4%	100%	50%	42.9%	100%	50%	62.5%	54.5%	73.9%	68%	71.4%
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	74.4%	80%	30%	50%	100%	60%	80%	80%	90%	80%	100%	85.7%	76.9%	78.3%	60%	73.3%	90%	80%
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	56.3%	76.7%	30%	60%	90%	40%	50%	60%	77.8%	70%	25%	85.7%	63.6%	77.8%	60%	50%	59.3%	76.7%
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	94.3%	100%	100%	100%	100%	100%	100%	70%	100%	100%	100%	100%	100%	100%	100%	84.2%	100%	100%
Maternity	G01	Percentage of Low Weight Babies	2.7%	2.2%	3.3%	2.3%	2.6%	3.1%	3.3%	2.3%	2.4%	3.9%	3.3%	2.3%	3.5%	0.5%	2.7%	2.9%	3.2%	2.2%
	G01A	Number of Low Weight Babies	137	26	14	10	11	14	13	9	10	14	14	9	15	2	35	36	38	26

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 16/17	Annual 17/18 YTD	Monthly Totals Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Quarterly Totals 16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Patient Safety																				
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	70.5%	76.3%	73.5%	61.3%	58.3%	73.7%	69.2%	51.7%	69.2%	81%	80.8%	57.7%	86.7%	85%	65.2%	63.5%	76.7%	76.3%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	74%	69.7%	79.4%	64.5%	58.3%	89.5%	69.2%	86.2%	61.5%	71.4%	73.1%	73.1%	73.3%	60%	68.5%	81.1%	68.5%	69.7%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.9%	48.7%	52.9%	35.5%	37.5%	68.4%	53.8%	44.8%	42.3%	61.9%	61.5%	34.6%	60%	50%	42.7%	54.1%	54.8%	48.7%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	44.4	72.2	53.5	49.4	51.7	53.2	48.8	43.3	37.3	67.4	38	37.1	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	58.6%	55.7%	59%	51.4%	63.4%	56.8%	61.8%	35.3%	52.4%	50%	64.3%	61.5%	51.4%	-	58.3%	51.4%	55.5%	55.7%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90.2%	85.5%	92.3%	85.7%	92.7%	97.3%	88.2%	94.1%	90.5%	84.1%	88.6%	90.9%	80.6%	-	90.4%	93.3%	87.7%	85.5%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.8%	62.5%	76.5%	71.4%	80%	60%	65.2%	81.8%	51.7%	72.2%	61.5%	56.3%	50%	77.3%	76.5%	68.2%	60%	62.5%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	90.4%	88.3%	98%	96.3%	93.2%	93.1%	88.9%	89.1%	80.8%	80.1%	84%	87.2%	88.3%	89.4%	96%	90.2%	81.6%	88.3%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	97.2%	98.3%	98.1%	97.8%	100%	96.8%	94.1%	97.6%	97.6%	88.9%	100%	97.3%	97.6%	100%	98.6%	96.3%	96.2%	98.3%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	94.7%	88.9%	100%	100%	85.7%	100%	100%	71.4%	100%	100%	100%	100%	66.7%	100%	92.3%	88.2%	100%	88.9%
	AC04	Percentage of Dementia Carers Feeling Supported	75%	100%	-	-	-	-	-	-	-	-	-	-	-	100%	-	-	-	100%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	8854	1994	517	578	464	892	847	614	1089	830	717	702	807	485	1559	2353	2636	1994
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	91	92	91	91	92	94	92	92	92	91	91	93	91	92	91	91
	P01g	Patient Survey - Kindness and Understanding	-	-	93	96	96	95	96	97	96	95	96	96	95	97	95	95	95	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	90	90	89	88	90	90	90	88	89	90	88	87	90	90	89	88
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.5%	36.8%	36.5%	36.8%	30.7%	33.7%	35.9%	30.6%	31.7%	34.8%	36.8%	34.6%	38.3%	37.4%	34.6%	33.5%	34.5%	36.8%
	P03b	Friends and Family Test ED Coverage	16.4%	17.6%	12%	16.8%	15.5%	17.3%	18.9%	15.4%	21.2%	17.7%	18.4%	15.9%	16.1%	20.9%	14.7%	17.2%	19.1%	17.6%
	P03c	Friends and Family Test MAT Coverage	22.5%	20.7%	24.4%	20.4%	21.1%	22.6%	22.1%	19.8%	24.6%	29.7%	25.3%	23.6%	17.1%	21.8%	21.9%	21.6%	26.4%	20.7%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.2%	97.3%	95.9%	97.4%	96.9%	98.2%	97.3%	97.5%	97.4%	96.9%	98.5%	97.2%	96.9%	97.7%	96.7%	97.7%	97.6%	97.3%
	P04b	Friends and Family Test Score - ED	78.2%	81.7%	71.8%	79.6%	78.6%	79.3%	78.9%	74.1%	80.8%	79.6%	80.2%	83.2%	77%	84.4%	77.1%	77.6%	80.2%	81.7%
	P04c	Friends and Family Test Score - Maternity	96.8%	96.6%	96.2%	97.8%	97.3%	97.7%	94.3%	94.5%	98.2%	96.2%	97.4%	96.9%	95.8%	96.9%	97%	95.6%	97.3%	96.6%
Patient Complaints	T01	Number of Patient Complaints	1875	555	200	155	162	140	139	118	129	144	168	247	158	150	517	397	441	555
	T01a	Patient Complaints as a Proportion of Activity	0.232%	0.402%	0.315%	0.246%	0.24%	0.204%	0.19%	0.19%	0.186%	0.222%	0.22%	0.402%	-	-	0.266%	0.195%	0.21%	0.402%
	T03a	Complaints Responded To Within Trust Timeframe	86.1%	80.2%	86.8%	90.6%	86%	92.3%	93.4%	97.4%	87.5%	87.5%	83.3%	76.3%	83%	80.4%	88.1%	94.2%	86%	80.2%
	T03b	Complaints Responded To Within Divisional Timeframe	86.6%	78.6%	89.5%	94.3%	81.4%	92.3%	85.2%	76.9%	85.4%	85%	72.9%	76.3%	83%	76.1%	88.8%	84.9%	80.9%	78.6%
	T04c	Percentage of Responses where Complainant is Dissatisfied	11.41%	4.58%	10.53%	13.21%	18.61%	0%	9.84%	12.82%	14.58%	10%	12.5%	15.79%	-	-	14.18%	7.91%	12.5%	4.58%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.98%	1.05%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	1.02%	0.81%	0.69%	1.01%	1.2%	1.05%
	F01a	Number of Last Minute Cancelled Operations	734	201	63	30	39	73	57	58	79	89	63	80	67	54	132	188	231	201

RESPONSIVE

			Annual Target		Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	Green	Red	16/17	17/18 YTD	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.7%	91.1%	92%	90.5%	90.4%	91.2%	92%	92%	92.2%	92%	91.1%	91.1%	91.1%	91%	91%	91.8%	91.8%	91.1%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2749	3344	3256	2978	2805	2751	2619	2777	3171	2985	3056	3023	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	11	62	0	0	1	0	1	1	3	3	2	5	11	46	1	2	8	62
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	696	511	27	33	27	53	78	93	86	106	133	153	165	193	87	224	325	511
New Outpatient Wait List	L02L	New Outpatient List (RTT Specialties) - Numbers Waiting 12+ Weeks	-	-	-	-	8735	9283	9562	9295	7986	8521	7372	7068	6307	6723	7105	7586	-	-	-	-
	L02M	New Outpatient List (RTT Specialties) - Percentage Waiting 12+ Weeks	-	-	-	-	32.3%	33.9%	35.5%	33.7%	29.8%	32.3%	28.5%	28.9%	27.5%	27.6%	28.7%	28.3%	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.8%	95.3%	95.4%	93.7%	91.6%	94.3%	96.2%	96%	95.9%	95.5%	96.3%	95.1%	95.6%	-	93.6%	95.5%	95.9%	95.3%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	68.4%	54.1%	67.6%	68.4%	67%	55.1%	71%	60.8%	75.3%	76%	79.7%	52.7%	55.2%	-	67.6%	62.4%	77.2%	54.1%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.7%	94.1%	99.1%	96.5%	97.4%	97.8%	98.3%	96.1%	96.5%	96.8%	97.4%	91.2%	96.5%	-	97.6%	97.4%	96.9%	94.1%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.7%	98.2%	97.5%	97.7%	99.1%	97.5%	100%	99.1%	100%	100%	98.4%	99.1%	97.4%	-	98.1%	98.9%	99.5%	98.2%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.4%	87.5%	97.1%	92.6%	98.4%	96.4%	98%	95.9%	93.8%	92.3%	96.5%	82.6%	92%	-	96.1%	96.8%	94.3%	87.5%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.6%	97.3%	96.7%	95.2%	92%	95.4%	98.1%	98.2%	96.9%	97.6%	96.7%	98.1%	96.6%	-	94.5%	97.3%	97%	97.3%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	77.4%	73.3%	84.8%	80.5%	79.5%	85.2%	81.5%	84.3%	78.8%	81.2%	76.7%	78%	-	80.1%	82.4%	81.5%	77.4%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	69.4%	53.3%	66.7%	55.6%	44.4%	100%	83.3%	100%	57.1%	100%	83.3%	66.7%	44.4%	-	55.6%	94.3%	77.8%	53.3%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	87.9%	85.5%	89.3%	91.1%	92.5%	88%	90.1%	82.1%	93.2%	77.8%	88.4%	93.1%	78.8%	-	90.8%	86.5%	86.8%	85.5%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	62	9	3	2.5	5	4	6.5	4	5.5	4.5	7.5	4	5	-	10.5	14.5	17.5	9
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	0.98%	1.05%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	1.02%	0.81%	0.69%	1.01%	1.2%	1.05%
	F01a	Number of Last Minute Cancelled Operations	-	-	734	201	63	30	39	73	57	58	79	89	63	80	67	54	132	188	231	201
	F02c	Number of LMCs Not Re-admitted Within 28 Days	10	10	72	12	4	3	0	3	6	4	4	6	15	4	6	2	7	13	25	12
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.36%	1.59%	1.5%	1.12%	1.33%	2.11%	1.61%	1.38%	0.67%	1.16%	1.13%	1.05%	1.86%	1.82%	1.31%	1.7%	0.99%	1.59%
	F07a	Number of Admissions Cancelled Day Before	-	-	1020	306	92	73	87	131	104	81	43	68	78	63	122	121	252	316	189	306
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	72.4%	81.1%	70.5%	76.6%	75%	73.5%	57.1%	64.7%	69%	86.1%	83.3%	83.3%	78.1%	-	74%	65%	79.2%	81.1%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	91.7%	91.9%	88.6%	93.6%	97.2%	91.2%	85.7%	79.4%	90.5%	94.4%	100%	90.5%	93.8%	-	92.9%	85.4%	95%	91.9%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.79%	98.65%	96.09%	95.51%	96.88%	98.91%	99.05%	98.23%	98.38%	98.69%	98.65%	98.56%	98.8%	98.58%	96.17%	98.74%	98.58%	98.65%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	11.5%	11.2%	12.2%	11.6%	11.4%	10.7%	10.2%	11%	10.7%	11.2%	11.1%	12%	10.8%	11%	11.7%	10.6%	11%	11.2%
	R05	Outpatient DNA Rate	5%	10%	7.3%	7.3%	8%	7.1%	7.9%	7.7%	6.9%	7.8%	7.3%	6.9%	6.9%	7.1%	7.2%	7.5%	7.7%	7.4%	7%	7.3%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.24	2.23	2.23	2.22	2.25	2.17	2.17	2.2	2.29	2.3	2.27	2.2	2.25	2.23	2.24	2.18	2.28	2.23
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	31%	23.4%	39.2%	41.1%	35.8%	21.6%	25.3%	34.3%	26.1%	25.2%	26.4%	24.4%	24%	21.7%	38.6%	26.2%	25.9%	23.4%

RESPONSIVE (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	Monthly Totals Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Quarterly Totals 16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	29	31	25	30	28	28	29	29	29	19	24	30	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	5	6	5	4	2	3	4	2	16	8	6	6	-	-	-	-
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	10232	1836	776	963	889	927	802	834	891	750	809	655	604	577	2628	2563	2450	1836
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	2167	710	183	193	184	233	138	131	106	183	252	306	145	259	560	502	541	710
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	43	56	44	55	54	51	59	52	47	43	42	43	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	9	13	16	6	8	8	6	9	22	14	13	11	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1563	1679	1505	1706	1864	1691	1937	1575	1716	1400	1371	1403	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	343	344	396	372	249	270	189	334	450	503	383	419	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.17	4.21	3.89	4.24	4.2	3.99	4.08	4.19	4.21	4.49	4.27	4.27	4.31	4.05	4.11	4.09	4.32	4.21
	J04D	Percentage Length of Stay 14+ Days	-	-	7%	7.2%	6.5%	6.7%	7%	6.3%	6.6%	7.2%	6.9%	7.9%	7.4%	7.3%	7.8%	6.6%	6.7%	6.7%	7.4%	7.2%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	226	256	234	233	259	242	279	264	270	268	240	227	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	3.5%	6.2%	5.1%	6.2%	4.8%	5.6%	2.8%	2.8%	2.2%	4.1%	1.4%	3.9%	5.2%	5.8%	4.4%	3.1%	3.5%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39%	49.4%	29.2%	25%	37.2%	30.3%	52.6%	33.3%	55%	57.1%	44.1%	63.6%	61.3%	37.2%	30.5%	40.2%	50%	49.4%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	85.01%	84.81%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	84.21%	87.89%	88.89%	80.35%	81.53%	84.81%
	This is measured against the national standard of 95%																					
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	85.01%	84.81%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	84.21%	87.89%	88.89%	80.35%	81.53%	84.81%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	77.42%	73.99%	83.73%	83.71%	80.78%	73.39%	71.69%	73.47%	68.86%	68.15%	73.89%	69.16%	73.76%	79.01%	82.77%	72.85%	70.4%	73.99%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	89.89%	95.93%	93.58%	97.29%	91.57%	90.65%	78.6%	79.38%	90.19%	92.11%	88.92%	96.83%	94.05%	97.14%	93.94%	82.63%	90.28%	95.93%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	98.97%	97%	98.65%	98.61%	99.26%	98.06%	99.06%	99.15%	98.56%	99%	99.18%	96.52%	96.57%	97.9%	98.84%	98.74%	98.93%	97%
	This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																					
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	40	0	0	0	1	2	1	11	19	5	0	0	0	0	1	14	24	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.6%	97.8%	97%	97.9%	97.3%	98.3%	97.9%	97.9%	98%	98.5%	98.8%	98.9%	96.3%	98.3%	97.4%	98%	98.4%	97.8%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	92.8%	92.1%	91.7%	91.8%	91.2%	91.8%	92.7%	93.7%	93.6%	94.1%	93.9%	92.1%	91.6%	92.8%	91.6%	92.7%	93.8%	92.1%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.6%	52%	51.1%	56.5%	55.2%	52.8%	48.2%	50.5%	53.3%	54.3%	51%	50.8%	52.3%	52.8%	54.2%	50.5%	52.8%	52%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.5%	97.4%	98.3%	98.9%	98.5%	98%	98.5%	98.3%	98.7%	98.1%	98.1%	97.8%	97.2%	97.1%	98.6%	98.3%	98.3%	97.4%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.6%	2.6%	2.2%	2.2%	2.3%	2.4%	2.5%	3.3%	2.5%	3.1%	2.5%	2.6%	2.6%	2.7%	2.3%	2.7%	2.7%	2.6%
	B05	ED Left Without Being Seen Rate	5%	5%	2.2%	2.6%	2.9%	1.8%	2.2%	2.6%	2.2%	2.4%	1.4%	1.8%	2%	2.8%	2.6%	2.5%	2.3%	2.4%	1.8%	2.6%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1216	277	77	125	140	161	119	114	138	83	11	111	82	84	342	394	232	277
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	3.5%	6.2%	5.1%	6.2%	4.8%	5.6%	2.8%	2.8%	2.2%	4.1%	1.4%	3.9%	5.2%	5.8%	4.4%	3.1%	3.5%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39%	49.4%	29.2%	25%	37.2%	30.3%	52.6%	33.3%	55%	57.1%	44.1%	63.6%	61.3%	37.2%	30.5%	40.2%	50%	49.4%

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Sickness	AF02	Sickness Rate	3.9%	3.8%	3.8%	3.8%	3.7%	4.5%	4.7%	4.7%	5%	4.4%	3.9%	3.7%	3.8%	4%	3.7%	4.7%	3.9%	4%
		For 2017/18, the Trust average for the year is 3.8%. Divisional targets are: 2.7% (DAT), 5.7% (FAE), 4.5% (MDC), 3.6% (SPS), 3.6% (SHN), 3.7% (WAC), 3.1% (THQ). Different targets were in place in previous years.																		
		There is an amber threshold of 0.5 percentage points above the target. These annual targets vary by quarter.																		
Staffing Numbers	AF08	Funded Establishment FTE	8446.1	8491.6	8334.2	8364.5	8364.5	8393.1	8402.2	8407.6	8434.2	8436	8446.1	8367.1	8479.3	8491.6	8364.5	8407.6	8446.1	8491.6
	AF09A	Actual Staff FTE (Including Bank & Agency)	8566.5	8584.7	8322.1	8398.3	8436.4	8427.7	8468.8	8412.7	8458.1	8496.4	8566.5	8510.5	8546.3	8584.7	8436.4	8412.7	8566.5	8584.7
	AF13	Percentage Over Funded Establishment	1.4%	1.1%	-0.1%	0.4%	0.9%	0.4%	0.8%	0.1%	0.3%	0.7%	1.4%	1.7%	0.8%	1.1%	0.9%	0.1%	1.4%	1.1%
		Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																		
Bank Usage	AF04	Workforce Bank Usage	427.9	501.8	429.9	437.9	410.7	376.3	387	358.5	378.3	398.9	427.9	446.7	476.6	501.8	410.7	358.5	427.9	501.8
	AF11A	Percentage Bank Usage	5%	5.8%	5.2%	5.2%	4.9%	4.5%	4.6%	4.3%	4.5%	4.7%	5%	5.2%	5.6%	5.8%	4.9%	4.3%	5%	5.8%
		Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive). Trust annual average for 17/18 is 3.9% with separate divisional averages.																		
Agency Usage	AF05	Workforce Agency Usage	123.7	123.4	149.8	148.5	157.4	149.1	142.7	111.5	122.5	131	123.7	96.7	94.1	123.4	157.4	111.5	123.7	123.4
	AF11B	Percentage Agency Usage	1.4%	1.4%	1.8%	1.8%	1.9%	1.8%	1.7%	1.3%	1.4%	1.5%	1.4%	1.1%	1.1%	1.4%	1.9%	1.3%	1.4%	1.4%
		Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive). Trust annual average for 17/18 is 1.0% with separate divisional averages.																		
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	349.8	451	494.8	452.7	404.5	404.5	379.6	383.7	389.4	384	349.8	331.4	420.4	451	404.5	383.7	349.8	451
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.2%	5.4%	6%	5.5%	4.9%	4.9%	4.6%	4.6%	4.7%	4.6%	4.2%	4%	5%	5.4%	4.9%	4.6%	4.2%	5.4%
		Vacancy is Funded Establishment minus Staff as a percentage of Funded Establishment. Before Apr-15, this was all Funded Establishment; from Apr-15 it was substantive staff only. Green is < 5% with Red >= 5%																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	146	136	169	367	205	128	109	133	165	111	146	173	172	136	205	133	146	136
	AF10	Workforce Turnover Rate	12.8%	12.8%	13.4%	13.3%	13.3%	13.1%	12.6%	12.7%	12.5%	12.6%	12.8%	12.5%	12.7%	12.8%	13.3%	12.7%	12.8%	12.8%
		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.																		
Essential Training 2016/17	AF21a	Core Essential Training (Three Yearly)	85%	89%	88%	85%	88%	88%	88%	89%	89%	89%	85%	85%	89%	89%	88%	89%	85%	89%
	AF21b	Essential Training Compliance - Annual Training (Fire & IG)	-	-	66%	67%	73%	75%	-	-	-	-	-	-	-	-	73%	-	-	-
	AF21f	Essential Training Compliance - Fire Safety	83%	84%	-	-	-	-	80%	81%	82%	82%	83%	82%	84%	84%	-	81%	83%	84%
	AF21g	Essential Training Compliance - Information Governance	76%	75%	-	-	-	-	76%	76%	76%	77%	76%	75%	75%	75%	-	76%	76%	75%
	AF21c	Essential Training Compliance - Induction	97%	98%	96%	94%	96%	96%	96%	96%	96%	97%	97%	98%	98%	98%	96%	96%	97%	98%
	AF21d	Essential Training Compliance - Resuscitation Training	75%	71%	79%	77%	81%	81%	81%	83%	85%	85%	75%	75%	71%	71%	81%	83%	75%	71%
	AF21e	Essential Training Compliance - Safeguarding Training	91%	90%	89%	86%	88%	89%	90%	90%	90%	90%	91%	90%	90%	90%	88%	90%	91%	90%
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		

Appendix 1

Glossary of useful abbreviations, terms and standards

Abbreviation, term or standard	Definition
AHP	Allied Health Professional
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
BOA	British Orthopaedic Association
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
DVLA	Driver and Vehicle Licensing Agency
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
GI	Gastrointestinal – often used as an abbreviation in the form of Upper GI or Lower GI as a specialty or tumour site relating to that part of the gastrointestinal tract
ICU / ITU	Intensive Care Unit / Intensive Therapy Unit
LMC	Last-Minute Cancellation of an operation for non-clinical reasons
NA	Nursing Assistant
NBT	North Bristol Trust
NICU	Neonatal Intensive Care Unit
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
PICU	Paediatric Intensive Care Unit
RAG	Red, Amber Green – the different ratings applied to categorise performance for a Key Performance Indicator
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

Breakdown of Essential Training Compliance for June 2017:

All Essential Training

	UH Bristol	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgical	Trust Services	Women's & Children's
Three Yearly	89%	89%	86%	91%	90%	91%	86%	86%
Annual Fire	84%	82%	84%	82%	87%	87%	82%	82%
Annual IG	75%	77%	66%	72%	78%	82%	79%	72%
Induction & Orientation	98%	99%	99%	98%	97%	98%	98%	97%
Medical Induction	72%	67%	N/A	88%	60%	65%	N/A	77%
Resuscitation	71%	64%	N/A	77%	76%	74%	59%	68%
Safeguarding	90%	92%	86%	93%	89%	89%	90%	88%

Timeline of Trust Essential Training Compliance:

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	June-17
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Compliance	85%	86%	87%	85%	86%	87%	88%	88%	89%	87%	87%	89%	89%

Safeguarding Adults and Children

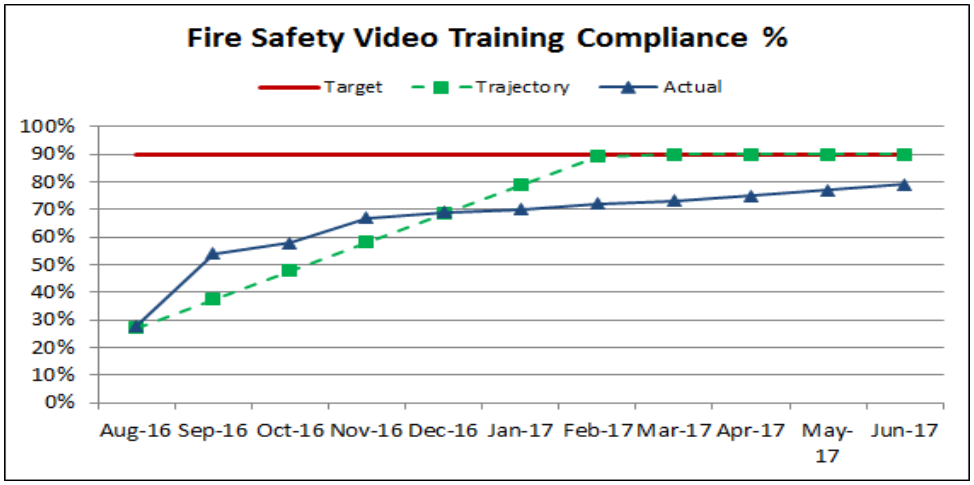
	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgical	Trust Services	Women's & Children's
Safeguarding Adults L1	**89%**	93%	88%	89%	88%	85%	90%	92%
Safeguarding Adults L2	**90%**	93%	79%	95%	91%	91%	88%	87%
Safeguarding Adults L3	**81%**	50%	N/A	82%	100%	80%	88%	58%
Safeguarding Children L1	**90%**	94%	85%	91%	92%	88%	93%	N/A
Safeguarding Children L2	**89%**	89%	87%	92%	86%	89%	82%	96%

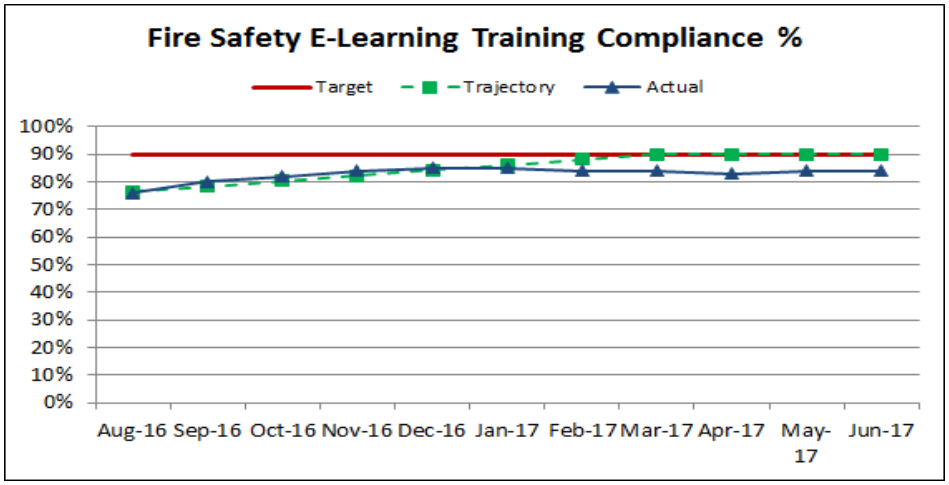
Child Protection Level 3

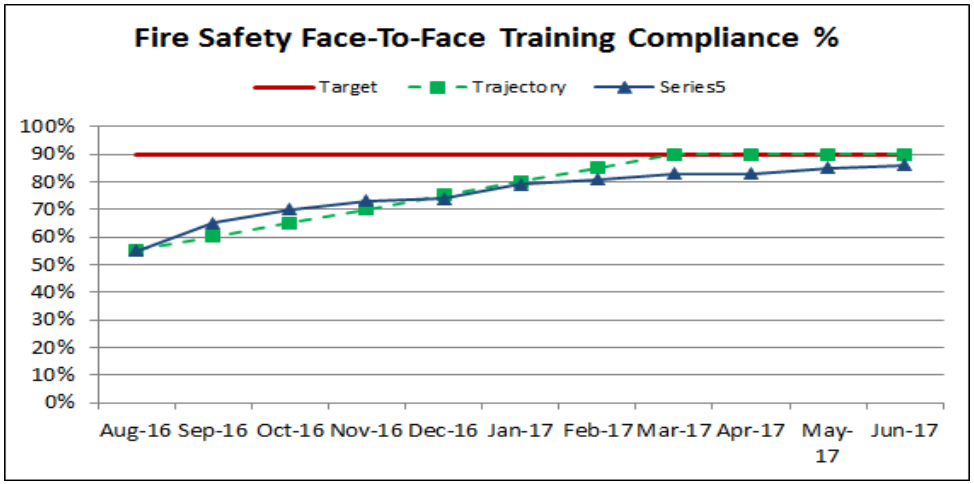
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgical	Trust Services	Women`s & Children`s
Core	**76%**	77%	63%	96%	88%	100%	77%
Specialist	**72%**	N/A	N/A	N/A	N/A	100%	71%

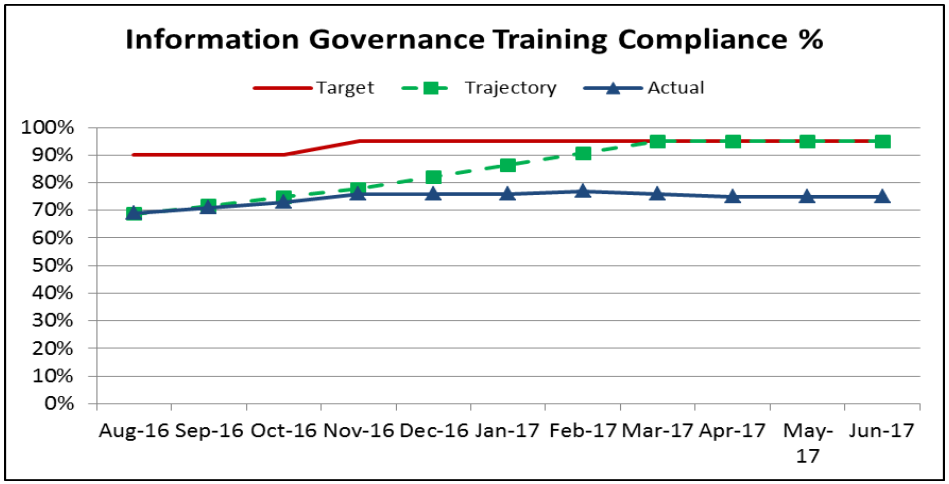
Appendix 2 (continued)

Performance against Target for Fire and Information Governance









Note: there are two types of fire training represented in these graphs, two yearly and annual, with different target audiences. In addition, there are a number of staff who require an additional training video under the previous fire training requirements. The agreed Trust target for all essential training continues to be 90%, except Information Governance, which has a national target of 95%.

Appendix 2 (continued)

Agency shifts by staff group for 29th May to 25th June 2017

This report provides the Trust with an opportunity to do a retrospective submission to NHS Improvement of all our agency activity for the preceding four calendar week period, confirming over-rides with agency rates, worker wage rates and frameworks.

Staff Group	Within framework and price cap	Exceeds price cap	Exceeds wage cap	Non framework and above both price and wage cap	Exceeds price and wage cap	Total
Nursing and Midwifery	0	31	0	201	822	1054
Health Care Assistant & other Support	39	10	8	6	0	63
Medical & Dental	0		5		92	97
Scientific, therapeutic / technical Allied Health Professional (AHP) & Healthcare Science						0
Administrative & Clerical and Estates	1357					1357

Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level for May 2017, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Brain*	100%	-	90.9%
Breast†	100%	-	93.2%
Gynaecology	81.8%	85%	78.1%
Haematology (excluding acute leukaemia)	77.8%	85%	78.8%
Head and Neck	66.7%	79%	65.4%
Lower Gastrointestinal	65.0%	79%	68.4%
Lung	48.3%	79%	72.2%
Other*	100%	-	77.3%
Sarcoma*	100%		66.3%
Skin	97.6%	96%	96.1%
Upper Gastrointestinal	50.0%	79%	72.6%
Urology*†	0%	-	75.2%
Total (all tumour sites)	**78.0%**	**85.0%**	**80.8%**
Improvement trajectory	**81.0%**		
Performance for internally managed pathways	**83.8%**		
Performance for shared care pathways	**62.1%**		
Performance with breach reallocation applied	**76.3%**		

*3 or fewer patients treated in accountability terms

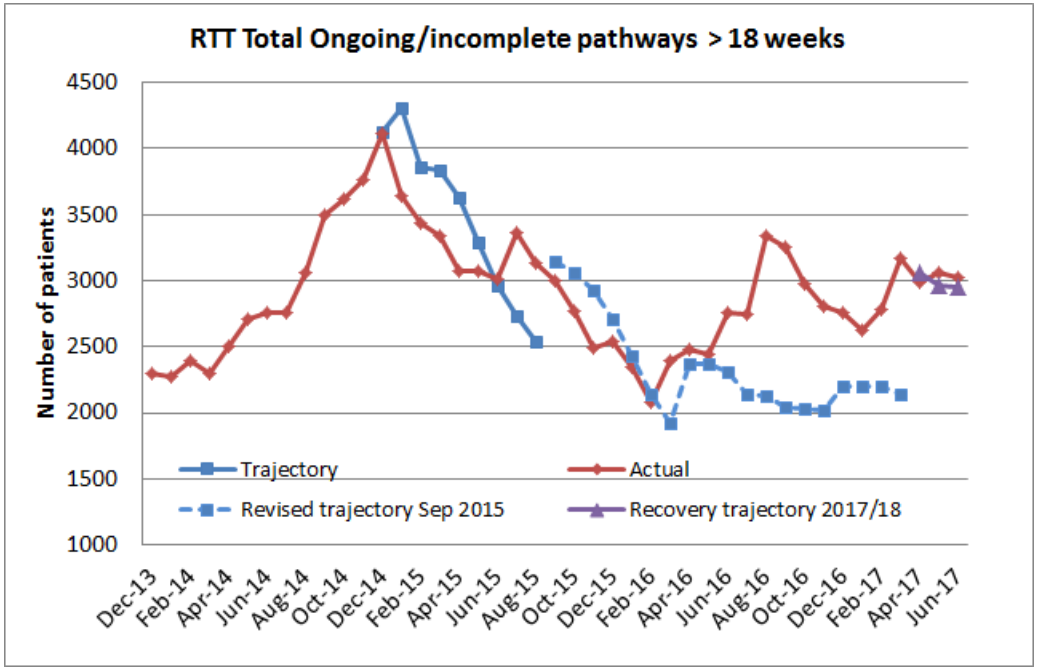
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

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 June 2017

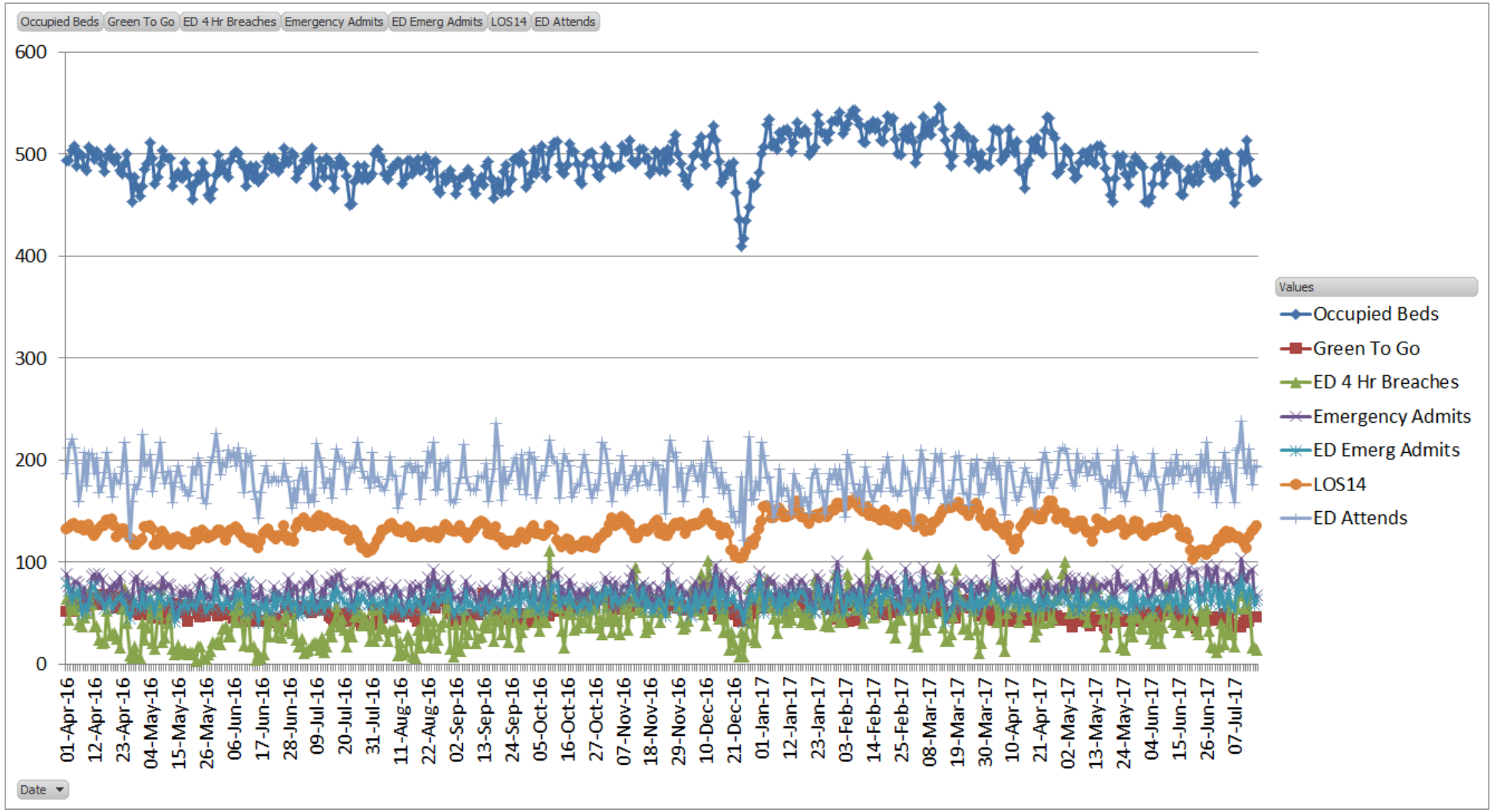
RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	336	2,204	84.8%
Cardiothoracic Surgery	20	328	93.9%
Dermatology	63	2,346	97.3%
E.N.T.	57	2,145	97.3%
Gastroenterology	32	423	92.4%
General Medicine	0	57	100.0%
Geriatric Medicine	0	172	100.0%
Gynaecology	89	1,350	93.4%
Neurology	56	421	86.7%
Ophthalmology	246	4,727	94.8%
Oral Surgery	178	1,841	90.3%
Other	1,850	15,105	87.8%
Rheumatology	8	553	98.6%
Thoracic Medicine	9	978	99.1%
Trauma & Orthopaedics	79	853	90.7%
Grand Total	**3,023**	**33,503**	**91.0%**



	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17
Non-admitted pathways > 18 weeks	1594	1528	1592	1826	1705	1744	1750		
Admitted pathways > 18 weeks	1157	1091	1185	1345	1280	1312	1273		
Total pathways > 18 weeks	2751	2619	2777	3171	2895	3056	3023		
Actual target % incomplete < 18 weeks	92.0%	92.2%	92.0%	91.1%	91.1%	91.1%	91.0%		
Recovery forecast	91.6%	92.0%	92.0%	92.0%	90.9%	91.4%	91.8%	92.0%	92.0%

Appendix 3 (continued)

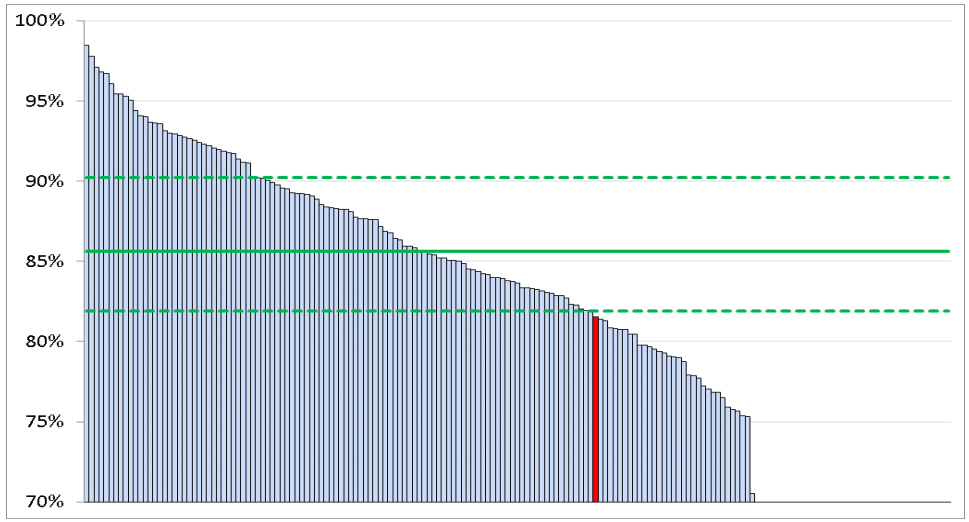
BRI Flow metrics



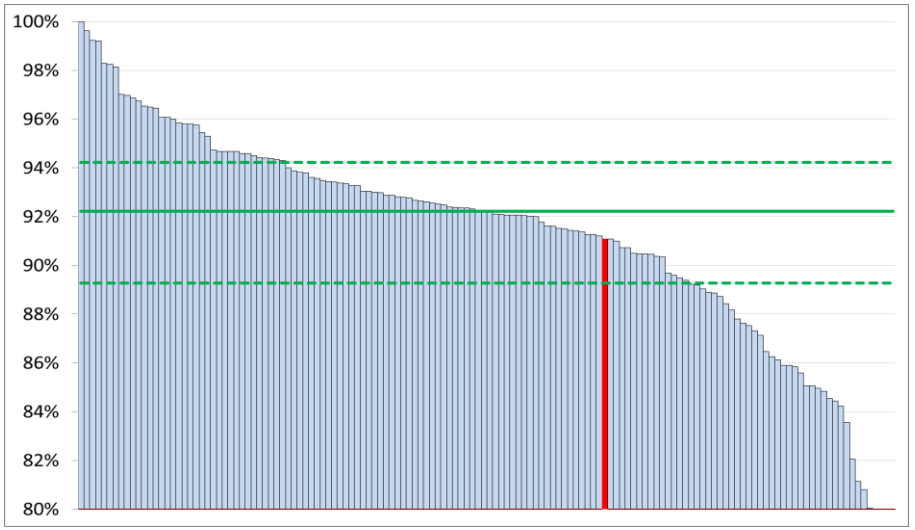
Appendix 4

Benchmarking Reports

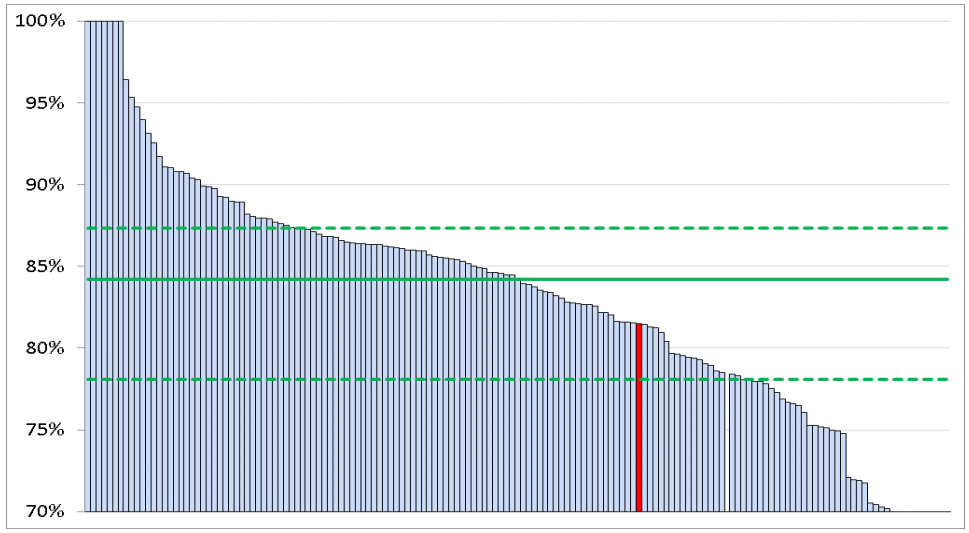
A&E 4-hours (Quarter 4 2016/17)



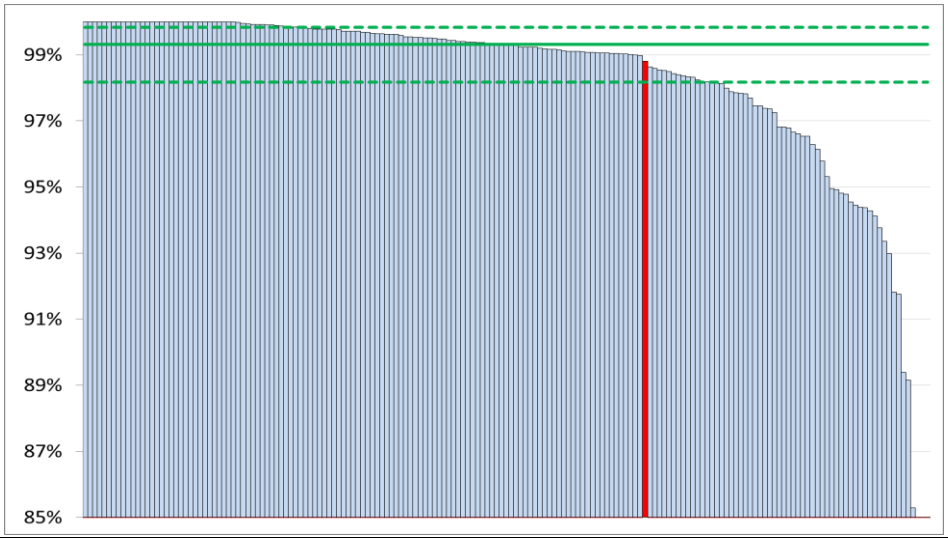
Referral to Treatment Time (May 2017)



62-day GP cancer (Quarter 4 2016/17)



6-week diagnostic (May 2017)

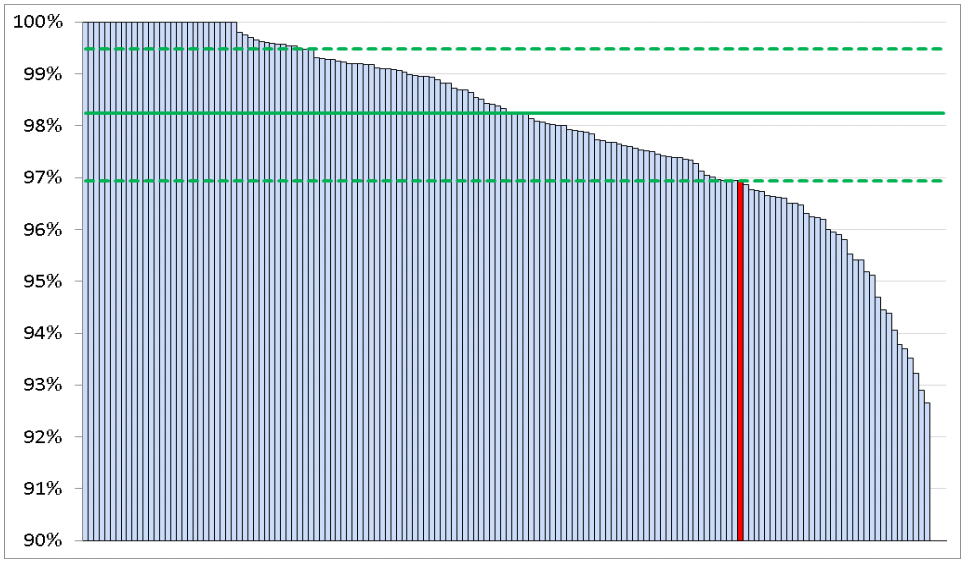


Appendix 4 (continued)

Benchmarking Reports

2-Week wait (Quarter 4 2016/17)

31-day first definitive cancer (Quarter 4 2016/17)



In the above graphs the Trust is shown by the Red bar, with other trusts being shown as pale blue bars. For the A&E 4-hour benchmarking graph, only those trust reporting type 1 (major) level activity are shown.

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	11
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Independent Review of Children's Cardiac Services Progress Report		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

This paper provides an update to Board members on the delivery of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan.

Key issues to note

Three recommendations remain to be completed. It is anticipated that one will be closed at the meeting on the 26th of July.

The two outstanding recommendations are:

Recommendation 7 – (Management of follow up appointments) All actions to deliver the recommendation have been completed as has the validation of the outpatient backlog and the development of a recovery trajectory to address the backlog. The recommendation was not supported for closure by the delivery group as the actions in the plan to address the backlog had not yet all commenced. The risk relating to the potential impact on delivery of the recommendation remains on the risk register rated a 6. This recommendation will be further reviewed at the delivery group meeting on 18th July 2017 and if supported for closure will be presented to the July steering group meeting for approval; should the recommendation not be supported for closure an action and monitoring plan will be submitted to the steering group in July to provide assurance of ongoing actions to address the issues.

Recommendation 18 – (risk assessment of cancellations) discussed at the June delivery group meeting however the delivery group did not receive assurance that the action to review data weekly at the designated meeting was embedded in practice. This recommendation will be further reviewed at the delivery group meeting on 18th July 2017 and if supported for closure will be presented to the July steering group meeting for approval; should the recommendation not be supported for closure an action and monitoring plan will be submitted to the steering group in July to provide assurance of ongoing actions to address the issues.

Recommendations

Members are asked to:

- **Note** the report for assurance

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☒	Information Management & Technology	☐
Human Resources	☒	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
				Nil

Independent Review of Children's Cardiac Services at the Bristol Royal Hospital for Children (BRCH)

1.0 Introduction

This paper provides an update to Board members on development of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan.

2.0 Programme management

The tables below details a high level progress update of delivery against the agreed programme plan for the three delivery groups. The plan shows the progress of the work that is ongoing to deliver the actions to support the closure of the recommendations. It also shows where delivery of the actions is not within the initially set timescales.

Of note the Trust wide steering group meeting is due to meet on Wednesday 26th July 2017 where it is anticipated that one further recommendations will be approved for closure.

Please see below update:

Table 1: Status Women's & Children's Delivery Group (total= 18)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	13	1	4	0	0 of 32
Oct '16	0	0	15	3	0	0	0 of 32
Nov'16	0	3	9	6	0	0	0 of 32
Dec'16	0	3	9	6	0	0	2 of 32
Jan'17	0	9	3	6	0	0	5 of 32
Feb'17	6	3	3	6	0	0	5 of 32
Mar'17	3	2	2	11	0	0	11 of 32
Apr'17	3	2	2	11	0	0	11 0f 32
May'17	2	1	0	15	0	0	13 of 32
Jun'17	2	1	0	15	0	0	13 of 32
Jul'17	0	0	0	18	0	0	15 of 32

Table 2: Consent Delivery Group (total= 5)

	Actions in Progress	RECOMMENDATIONS CLOSED BY

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	STEERING GROUP
Sept '16	0	0	1	0	1	3	**0 of 32**
Oct '16	0	0	5	0	0	0	**0 of 32**
Nov'16	0	0	5	0	0	0	**0 of 32**
Dec'16	0	0	5	0	0	0	**0 of 32**
Jan'17	0	4	1	0	0	0	**0 of 32**
Feb'17	4	0	1	0	0	0	**0 of 32**
Mar'17	0	0	1	4	0	0	**4 of 32**
Apr'17	0	0	1	4	0	0	**4 of 32**
May'17	0	0	0	5	0	0	**5 of 32**

Table 4: Status Incident and Complaints Delivery Group (total= 5)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	1	0	4	0	**0 of 32**
Oct '16	0	0	5	0	0	0	**0 of 32**
Nov'16	0	2	3	0	0	0	**0 of 32**
Dec'16	0	2	3	0	0	0	**0 of 32**
Jan'17	0	3	2	0	0	0	**0 of 32**
Feb'17	1	2	2	0	0	0	**0 of 32**
Mar'17	0	2	1	2	0	0	**2 of 32**
Apr'17	1	1	1	2	0	0	**2 of 32**
May'17	1	0	0	4	0	0	**4 of 32**
Jun'17	0	0	0	5	0	0	**5 of 32**

Table 5: Status Other Actions governed by Steering Group (total=4)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	1	0	2	1	**0 of 32**
Oct '16	0	0	1	2	1	0	**0 of 32**
Nov'16	0	0	2	2	0	0	**0 of 32**

Dec'16	0	0	2	2	0	0	**0 of 32**
Jan'17	0	2	0	2	0	0	**0 of 32**
Feb'17	1	0	0	3	0	0	**3 of 32**
Mar'17	1	0	0	3	0	0	**3 of 32**
Apr'17	1	0	0	3	0	0	**3 of 32**
May'17	0	0	0	4	0	0	**4 of 32**

Exception report- Red actions

Recommendation 7 – (Management of follow up appointments) All actions to deliver the recommendation have been completed as has the validation of the outpatient backlog and the development of a recovery trajectory to address the backlog. The recommendation was not supported for closure by the delivery group as the actions in the plan to address the backlog had not yet all commenced. The risk relating to the potential impact on delivery of the recommendation remains on the risk register rated a 6. This recommendation will be further reviewed at the delivery group meeting on 18th July 2017 and if supported for closure will be presented to the July steering group meeting for approval; should the recommendation not be supported for closure an action and monitoring plan will be submitted to the steering group in July to provide assurance of ongoing actions to address the issues.

Recommendation 18 – (risk assessment of cancellations) discussed at the June delivery group meeting however the delivery group did not receive assurance that the action to review data weekly at the designated meeting was embedded in practice. This recommendation will be further reviewed at the delivery group meeting on 18th July 2017 and if supported for closure will be presented to the July steering group meeting for approval; should the recommendation not be supported for closure an action and monitoring plan will be submitted to the steering group in July to provide assurance of ongoing actions to address the issues.

Exception report – Amber actions

Recommendation 4 - Support for women accessing fetal services between Wales and Bristol; this recommendation was accepted for closure by the June delivery group and will be presented to the July steering group for approval. The fetal survey results have been received and are being reviewed; in view of vacancies in the cardiac fetal service on both sites it is expected that some elements of the work required will transfer into the Network work plan for completion.

3.0 Risks to Delivery

No further risks to delivery were added to the project risk register.

Risk ICR1: risk of commitment to changes required for ensure closer working with UHBristol and University Hospital Wales (UHW) and relevant commission organisations was reduced from a risk rating of 12 to 4 as a result of funding being agreed to support additional consultant sessions in UHW.

Risk ICR2: risk of delivery to fetal cardiology service in UHW due to lack of substantive/vacant consultant positions was reduced from a risk rating of 12 to 8 following an agreement on the operational requirements to meet the service need. The rating was not reduced further as the positions have not yet been recruited to.

Both risks are being recommended for closure at the July steering group meeting, the Congenital Cardiac Network will discuss at their next board meeting whether outstanding elements relating to work and communications between UHBristol and UHWales necessitates an entry on the network held risk register.

Risk ICR5: Risk to completion of recommendation within agreed timescales due to validation work required to establish status of outpatient waiting list to provide full assurance on timing of follow up appointments.

Risk remains at current rating due as no formalised plan has been finalised with the clinical team to address the backlog. The division of Women's and Children's have an established risk on the risk register relating to Cardiac/Cardiology performance; this will be updated in light of the actions taken and will provide ongoing monitoring of the risk within the division once the project has closed..

4.0 Family involvement update

All actions have been completed in relation to IDR recommendations and actions, work continues with family members as noted below

Work in progress includes:

- Listening event in collaboration with the Welsh commissioners and service providers – planning for a September 2017 date
- Young Persons event in August 2017 in collaboration with NHS England event
- Families who have contributed to the independent review work have been invited to continue to be part of a virtual reference group that we hope to grow to incorporate families who have experience of other specialities.

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – 18th July 2017 Delivery Group update

1. Women's and Children's Delivery Group Action Plan

W&C Recommendation's delivery timeframe

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
Recommendations	**8-** Outpatients experience **Approved as closed by Steering Group (09/01/17)**	18- Cancelled Operations risk assessment - timescale change request to Feb'17 Change req to Mar'17 Final SOP and new Next steps SOP with transformation team. March'17 delivery group felt unable to sign off recommendation; all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly; request for a further delay to May 17 to enable the demonstration of embedding in practice. April'17 Process in place to record all cancelled patients, presented to cardiac clinicians weekly at JCC meeting. All discussions when patients are cancelled are captured here. Further work to provide assurance that the meeting oversees the record of cancelled patients. RT to ensure that all clinicians are aware of the importance of reviewing the list. Reviewing JCC attendance to ensure appropriate oversight. May Delivery – need more data to demonstrate sustained commitment to holding and recording the discussion on risk. Jun'17 Process established, record of discussion x 1, further discussion around appropriatness of JCC for discussion; agreement sought from chair of JCC, commitment from clinical leads of PIC and Cardiology to establish process	16- communication with families about team working/ involvement of other operators timescale change request to Feb'17 Change request to Mar'17 Intervention leaflet amendment & printing as a trial pending additions Mar'17 information booklets complete and approved through the divisional assurance process; some FI comments to include and then print, trial and evaluate; RTC supported by delivery group. Subject to steering group sign off an official launch date will be established and communicated to all staff. **Approved as closed by Steering group 4/4/17**	**7-** periodic audit of follow up care timescale change request to Feb'17 Change request to May'17 in view of numbers of outpatients and inpatients requiring validation to establish risk – added to RR Mar'17 initial validation of data completed; next steps to return to April mtg to consider alternative accommodation for additional clinics and associated costs and equipment requirements before rtc in May '17 April'17 Significant work undertaken to identify capacity gap (backlog and ongoing), locum advert going out, outpatient space being identified, additional clinics being planned. Trajectory of the outcome of this work for May delivery mtg with a view to closing recommendation. May 17 plan devised to address backlog, elements still requiring work before confidence to sign off, return to June delivery Jun'17 update business case made for Paediatrician with expertise in cardiology to support backlog		**21-** (Commissioner) - provision of a comprehensive service of Psychological support, Trust-Expression of Interest submission **(green-provider actions)** Mar'17 RTC supported by the delivery group in view of successful recruitment **Approved as closed by Steering group 4/4/17**	**2-** NCHDA data team staffing Mar'17 recommendation added to IR risk register (is also on divisional risk register) as no current solution in place to provide additional resource to the data collection team. Mar'17 EOI unsuccessful, plan outstanding final actions at present, to review current resource and finalise a plan for April '17 mtg- added to risk register in view of no plan Apr'17 current paediatric resource reviewed, additional resource added into fetal service already so the team are able to absorb this additional workload with minimal additional support from paediatric team. Original bid reviewed and agreement received to fund additional paediatric admin and nursing time on a fixed term basis from within the division to allow for a full review of all data teams to establish whether any further economies or efficiencies can be identified. Data team have approved that this will be sufficient for the current workload and supporting the fetal team. Commitment from management team to review the team resource on a quarterly basis and external review pending Sept'17. Further sign off received at joint cardiac board (26/04/17) to ensure no impact on adult services. Sign off by lead consultant for cardiac data confirmed additional input is sufficient for current requirements with ongoing review required. RTC agreed by delivery group. May steering group accepted for closure		

		formally. Work with admin team to ensure discussion appropriately captured and documented. Jul'17		management; CRIC clinic space case written including costs and availability; Nursing and cardiac physiologist additional requirements established and costed. Jul'17					
		20- End of life care and bereavement support **(approved as closed by Steering group 07/02/17)**	23- reporting and grading of patient safety issues **(approved as closed by Steering group 07/02/17)**	**9 &11-** Benchmarking exercise (gaps/actions/implement plan) timescale change request to Feb'17 Change request Mar'17 – benchmarking almost complete – action plan to be devised Mar'17 feedback provided to support the RTC of recommendations with the caveat that, as the action plan is a work in progress it would be held and progressed by the cardiac business meeting. **Approved as closed by Steering group 4/4/17**			**3 & CQC 5-** review access to information – diagnosis and pathway of care Mar'17 rec. 3 progressing to plan CQC 5 supported for closure in view of the production of information sheets to support over 33 different operations; FI comments to be incorporated and then print, trial and evaluate **Rec 5 Approved as closed by Steering group 4/4/17** April'17 template front sheets presented to group; have been to listening events and cardiac governance for review and comment which have been incorporated. To go back to governance on Friday 28th for final approval and agreement on a go live date, location on website (BRHC or Network or both). Links added to patient letters to guide families to website. Patient information leaflets updated and in circulation. RTC approved by delivery group pending governance sign off for visual pathways and caveats as above. May steering group accepted for closure		
		CQC 3- Pain and comfort scores **Approved as closed by Steering Group (06/12/16)**	CQC 4 CNS recording of discussions with families in notes timescale change request to Feb'17 Change request to Apr 17 to allow for additional training Mar17 delivery group supported RTC in view of provision of medway communications page in use and accessible to all appropriate staff; plan to audit quality of records and return to delivery group. **Approved as closed by Steering group 4/4/17**	**CQC 6-** Discharge planning to include AHP advice **(approved as closed by Steering group 07/02/17)**			**4-** Support for women accessing fetal services between Wales and Bristol – *timescale change request to Jun '17* Mar'17 update, FI review of questionnaire complete. April'17 letter sent to all families, questionnaire going out to respondees by end April. Improvements will be identified and planned and are anticipated to be sufficient to sign off recommendation by June however both sites have fetal vacancies and therefore this will impact on the timescale for the delivery of the total plan. May'17 on track for June closure, fetal survey results received. June'17 Accepted for closure by delivery group awaiting Steering sign off on 25th July 2017		

		CQC 2 Formal ECHO report during surgery – *timescale* change request to Mar'17 to allow re-audit Mar'17 re-audit shows an improvement in the use of the echo forms however they are still not in use 100% of times. Request to amend delivery date to May'17 to allow for reaudit. Apr'17 Further audit in May to come to delivery group end of May. RT to highlight to cardiologists and IJ to highlight to intensivists. May'17 request to close supported forJune steering – Jun'17 steering supported closure					**5-** Improved pathways of care paed. cardiology services between Wales and Bristol – timescale change request to May '17 April '17 improvements identified, corresponding with Wales re implementation, awaiting a response. Recommendation on target to close at May delivery meeting May'17 request to close supported for June steering. Jun'17 steering supported closure		

	Progress overview						**Detailed actions**				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
2	That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data.	Deputy Divisional Director	Apr '17	**Green-complete**	None		Review of staffing	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green-complete**	Staffing review report
							Results and recommendations reported at Women's and Children's Delivery Group in Sept. '16.	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green-complete**	Women's and Children's Delivery Group Agenda and minutes 20.09.16
							Requirement for additional staff will feed into business round 2016-17	Assistant General Manager for Paediatric Cardiac	Apr' 17	**Green-complete**	Expression of interest form and Women's and Children's Operating Plan

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
								Services			Feb Meeting – review of current resources (FU/VM) Mar'17 added to IR RR in view of concerns over ability to meet recommendation requirements due to lack of support for additional resource Apr'17 review complete, additional resource funded by division, RTC submitted
3	That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.	Specialist Clinical Psychologist	Apr '17	**Green-complete**			Information given to families at the point of diagnosis reviewed by the clinical team and the cardiac families – remaining information for Catheter Procedures and Discharge leaflet. Website and leaflets updated to reflect improvements	Clinical Team & Cardiac Families	Jan' 16	**Green-complete**	Revised patient information leaflets
							Links to access relevant information to be added to the bottom of clinic letters for patients.	Specialist Clinical Psychologist	Dec '16	**Green - Complete**	Clinic letter with links (examples Feb mtg docs)
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Green - Complete**	Revised Catheter and Discharge leaflet Feb mtg – this may replicate work in recomm 16 CNS team to check (JH/ST)
							Enhance existing information with a visual diagram displaying pathways of care (FI).	Specialist Clinical Psychologist	Apr' 17	**Green-complete**	Pathways of Care devised – update to come to Mar'17 mtg re opportunities to link with Network website to enable

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											interactive functionality VG/LS to discuss timescales to share with Virtual group Mar'17 visual pathways shared at listening event – supportive of structure and content; charitable funding secured; designer commissioned with a timescale of draft drawings by April 17 mtg for RTC April'17 visual pathway designs received, RTC approved caveated by sign off by cardiac governance meeting
							Website proposal to be written for new Children's website including cardiac information similar to Evelina to improve accessibility of our information. *This will be additional and not essential for delivery of the recommendation* (FI).	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Started**	
							Smart phone App proposal to be written for Cardiac Services to enable patient/families to access information electronically (FI). *This will be additional and not essential for delivery of the recommendation*	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Not started**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
4	That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth	CHD Network Clinical Director	Apr '17	**Green - complete**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that operational challenges in delivery of the fetal cardiology service in UHW prevent focus on the achievement of this recommendation business plan	Jun 17 due to delay in engagement with UHW and the operational challenges in their fetal cardiology service	Meeting arranged for 18th November with English and Welsh commissioners as well as Bristol and Cardiff trusts to establish: 1. Commissioner oversight of network 2. Commissioner support for IR actions (4,5 &11) 3. Establishment of working group(s) to address the specific changes in practices required	CHD Network Clinical Director and Network Manager	Nov '16	**Green - complete**	Agreed pathway of care in line with new CHD standards and in line with patient feedback Update from May delivery group – significant work completed, survey complete and results returned. Pt counselling and CNS cover addressed. Offer in place for families to visit Bristol when antenatal diagnosis made. Vacancies in both main sites will mean that the full extent of the work planned in this area will move to the Network work plan going forward. Plan to request closure in June 2017 June'17 Network agreed to accept ongoing work into network work plan, network management team to formalise inclusion into work plan in order to provide assurance.

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							Ahead of the meeting: define specifics of recommendation (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); CHD standards that relate to this recommendation; examples of practice from other centres	CHD Network Clinical Director and Network Manager	Nov '16	**Green-complete**	
							University Hospital Wales to define how additional foetal sessions will be delivered and who from foetal cardiology will lead the recommendation implementation and collaborate with Bristol to set up working group in January	Clinical Director for Acute Child Health, university hospital wales	~~Dec '16~~ Revised to Mar '17. UHW have appointed lead, but have not yet resolved operational issues	**Green - Complete**	Feb mtg – outline plan for foetal sessions, process to manage referral through acceptance criteria in short term Jun'17 3 additional fetal sessions established, 1 further required to address requirement – plan in progress to achieve, network to monitor.
							Foetal working group to define changes / new pathways, taking account of patient feedback	Working group	~~Jan '17~~ Revised to Feb '17. Working group established, but struggling to coordinate diaries for meeting	**Green - complete**	Feb mtg - Changes defined; joint review of approach to counselling; establishment of joint service review meeting Outstanding – patient feedback; survey complete ready to go to QIS group before circulation Mar'17 foetal survey being sent out having been

	Progress overview						Detailed actions				
No.	Recommendation	Lead Officer	Completion date	Status	Delivery Risks	Revised timescale & reason	Actions to deliver recommendations	By	When	Status	Evidence
											for FI feedback which has been incorporated. April'17 letter sent to all identified families to pre-warn and request agreement to receive survey, survey out this week. On target for June closure June'17 Fetal survey complete, results did not demonstrate disconnect between UHW and UHB however further work to do on fetal pathway once fetal psychologist is in post in Sept'17; awaiting fetal recruitment on both sites to support final delivery of requirements to support fetal pathway – Network to hold final actions as part of their work plan!
							Undertake patient survey and focus groups (FI).	CHD Network Manager	~~Jan '17~~ Revised to Jun 17due to delay in engagement with UHW and the operational challeng	**Green - complete**	As above

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
									es in their fetal service		
							Co-design the offer with patient representatives for women whose fetus has been diagnosed with cardiac anomaly and deliver agreed model.	CHD Network Manager	Apr 17	**Green - complete**	Feb mtg -Focus group to come from survey results Mar'17 as above Jun'17 update as above
							New pathways in place	CHD Network Clinical Director and Network Manager	~~Apr '17~~ Revised to Jun 17	**Green - complete**	Feb mtg - Summary paper showing previous and new ways of working, detailing an assessment of the benefits; Pathways to follow completion of actions above Jun'17 update as above
5	The South West and Wales Network should regard it as a priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.	CHD Network Clinical Director	Apr '17	**Green - complete**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that lack of paediatric cardiology	Final completion delayed to May 17 due to initial delay getting engagement from UHW	Network Manager and Network Clinical Director to contact Welsh Commissioners and University of Hospital of Wales to meet to discuss and agree process including method of monitoring its implementation	CHD Network Manager	Nov 16	**Green-complete**	
							Set up joint working group set up with Network Team facilitating. UHB, UHW and commissioners to deliver the relevant actions and improvements required for service.	CHD Network Manager	Dec 16	**Green-complete**	Minutes of meeting and action plan
							To define the opportunities for improvement in coordination and the actions to achieve this	CHD Network Manager	Dec 16	**Green-complete**	Action plan
							To undertake a patient engagement exercise (e.g. focus group, survey, online reference group) to test the proposed options for improvement	CHD Network Manager	Jan 17	**Green - complete**	Feb mtg - Proposal sent to virtual ref group, 1 response to date which will be incorporated into plans; any further

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
					lead in UHW delays the ability to undertake actions						feedback received will be incorporated
							Deliver actions to improve coordination	CHD Network Manager	May 17	**Green - complete**	Feb mtg - improved in-pt transfer process; joint audit and training; improved IT for sharing images; standardised patient information; further changes required to meet recommendation April'17 work ongoing, improvements identified, awaiting contact from UHW on target for May closure May'17 RTC presented and approved by delivery group; work plan for network devised and approved by network board; reviewed quarterly by trust board and annually by commissioners. Welsh cons now have JCC in their job plans to support attendance. Review of process at JCC req to

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											ensure that appropriate clinicians are present for discussions. CNS work plan being reviewed to support peripheral services. Commitment to provide CNS cover for all additional outpatient services at UHW
7	The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up appointments.	Deputy Divisional Director	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	None	Timescale change request to Feb'17 to provide assurance about backlog validation Timescale change request to May 17 in view of requirement to validate backlog to establish risk – item added to risk register	Audit proposal submitted to the audit facilitator for inclusion on the Children's annual audit plan	Patient Safety Manager	Aug '16	**Green-complete**	Audit proposal
							Conduct 1st annual audit into follow up care for cardiac patients as per recommendation	Patient Safety Manager	Nov '16	**Green-complete**	Audit report
							Report findings of the audit	Patient Safety Manager	Jan '17	**Green-complete**	Audit presentation and W&C delivery group Agenda and minutes November meeting
							System developed for the regular reporting and review of follow up waiting lists at monthly Cardiac Business meeting.	Assistant General Manager for Paediatric Cardiac Services	Aug '16	**Green-complete**	Follow up backlog report, Cardiac Monthly Business meeting standard agenda Feb mtg – validation work ongoing; added to RR (VM/FU) action can be RTC once complete and any risks established Mar'17 validation

	Progress overview						Detailed actions				
No.	Recommendation	Lead Officer	Completion date	Status	Delivery Risks	Revised timescale & reason	Actions to deliver recommendations	By	When	Status	Evidence
											complete; options for delivering additional activity being scoped as described above. April'17 validation ongoing, capacity gap identified, locum advert, space being identified. Trajectory will be in place for May closure. May'17 RTC presented to group. Clear trajectory presented for what is required to happen to address the backlog and also recurrent capacity gaps. RTC rejected on the basis of the requirement for more progress on the proposed plans to address the backlog in view of remaining risks re: funding; clinic space; clinician agreement to undertake WLI. To return to June mtg when there will be more clarity on these elements.

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
8	The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective.	Nurse Project Lead	Oct '16	**Approved as closed by Steering Group (09/01/17)** **22/11/16- approved for closure by W&C delivery group**			Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed)	Outpatients Experience working group	Aug '16	**Green- complete**	1.Outpatients and Clinical Investigations Unit Service Delivery Terms of Reference 2. Outpatients and Clinical Investigations Unit Service Delivery Group Agenda(3.10.16) 3. Outpatients and Clinical Investigations Unit Service Delivery minutes of meeting (3.10.16) 4. OPD Patient Experience Report (October 2016) 5. Paediatric Cardiology – Non-Admitted RTT Recovery (Appendix 1) 6. Cardiology Follow-Up backlog update (Appendix 7. Project on a
							Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatient's completed	Outpatients Experience working group	Sept '16	**Green- complete**	
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '16	**Green- complete**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											Page: Outpatient Productivity at BRHC (Appendix 7)
9	In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.	Divisional Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Risk that other sites are unable to share data required to complete a comprehensive benchmarking exercise Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.	Request to delay to Feb '17 due to late return of benchmarking Request to delay to Mar'17 as some benchmarking data received late; analysis ongoing with visits to be planned by Mar'17	Undertake benchmarking exercise with other CHD Networks, reviewing a defined list of criteria including aspects such as: job planning, IT and imaging links, information governance. To include site visits as appropriate	CHD Network Manager	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Feb mtg - Benchmarking data collection analysis ongoing Site visits dates to be agreed for Mar mtg (JD) Mar'17 RTC supported by delivery group with the caveat that the action plan is held by the cardiac business meeting for completion
							Identification of actions required to address the gaps	CHD Network Manager	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Gaps to be identified from completion of analysis; action held by Cardiac business group (JD)

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							Progress to implementing any changes in practice that are deemed necessary	CHD Network Manager and Divisional Director	Jan '17 Revised to Feb '17. Delayed responses from other centres	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	As above, change implementation plan to be devised following gap analysis (JD)
11	That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC	CHD Network Clinical Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Linked to recommendation no.9. Actions detailed under recommendation no. 9 will also achieve recommendation no. 11. Risks to delivery, timescales, progress against delivery and evidence will be the same as per recommendation no. 9 Mar'17 benchmarking complete; RTC supported by delivery group						

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	(Links to recommendation no. 5)										
16	As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other operators or team members.	Clinical Lead for Cardiac Services and Consultant Paediatric Cardiac Surgeon	Dec '16	**Red – second revision of timescales**		Request delay to Feb'17 to allow update of catheter leaflets in line with surgery ones Request delay to Mar'17 to allow completion of intervention leaflet and consideration for any others requiring this information to be included.	Enhance existing guidance to describe team working and in particular the involvement of other operators and team members in patient care. Review by the Trust wide consent group and Cardiac Clinical Governance for approval and then implement.	Consultant Paediatric Surgeon and Specialist Clinical Psychologist	Dec '16	**Green-complete**	Revised 'Preparing for Surgery' leaflet and email to surgeons about new guidance VG/LS to add updated leaflets to website Consider revision of ward 32's leaflet to replicate changes made (ST) Complete changes to interventional leaflet (AP) and produce in draft as a trial for use with patients (ST). Mar'17 Booklets produced and formatted; shared widely for family input; signed off by business meeting with all comments incorporated prior to printing, trial and evaluation – RTC supported by delivery group

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
18	That steps be taken by the Trust to review the adequacy of the procedures for assessing risk in in relation to reviewing cancellations and the timing of re-scheduled procedures within paediatric cardiac services.	Deputy Divisional Director	Nov '16	**Red – second revision of timescales**		Request delay to Feb'17 to allow implementation of new cancellation policy Request delay to Mar'17 to allow development of next steps SOP to support process Request to delay to May '17 to enable the demonstration of the implementation of the process to risk assess patients adequately	Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure	Cardiac Review Programme Manager	Aug '16	**Green-complete**	Current process review report
							Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented	Consultant Paediatric Surgeon and Cardiac Review Programme Manager	Nov '16	**Green-complete**	JCC performance review meeting agenda and cancelled operations report Sops for cancellation and next steps being reviewed/devised for presentation at Mar'17 mtg (ST) March'17 delivery group felt unable to sign off recommendation; all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly April'17 process in place to risk assessment cancelled patients, assurance process during May with a view to closing at May mtg. May'17 not

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											presented for closure as process in place and being documented however only 2 weeks documentation available to support closure and therefore agreement to defer to June mtg to ensure sufficient evidence to support process embedded in practice. Consider incorporating some of the processes used at the Evelina re cancellation and performance oversight (VM/RT)
20	That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.	Deputy Divisional Director	Nov '16	**Green-complete**	None		End-of-life care and bereavement support pathway developed (FI)	Deputy Divisional Director	Sept '16	**Green-complete**	End-of-life and bereavement support pathway
							Implementation and roll out of new pathway	Deputy Divisional Director	Nov '16	**Green-complete**	Communication and presentations to roll out
21	Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological	Commissioners		**Green-complete (provider actions)**			Previous submission to commissioners for psychological support updated	Head of Psychology Services	Sept '16	**Green-complete**	Submission to Commissions
							Expression of Interest for increased resource to be submitted as part of business planning	Head of Psychology Services / Deputy Divisional	Mar'17	**Green-complete**	Expression of interest and W&C Business plan Mar 17 update Recruitment

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	support							Director			completed RTC supported by delivery group
23	That the BRHC confirm, by audit or other suitable means of review, that effective action has been taken to ensure that staff possess a shared understanding of the nature of patient safety incidents and how they should be ranked.	Deputy Divisional Director	Dec '16	**Green-complete**	None		Review results of Trust wide Manchester Patient Safety (MAPSAF) to understand current baseline for both team level and divisional staff views on patient safety incident reporting and management	Deputy Divisional Director	Sept '16	**Green-complete**	
							Annual programme- Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff	Deputy Divisional Director	Dec '16	**Green-complete**	Training plan and log of attendance
CQ C.2	Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	Clinical Lead for Cardiac Services	Nov '16	**Red – second revision of timescales**		Mar '17 Delayed to allow audit to demonstrate improvement Mar'17 Request to delay to May '17 to enable the demonstration of robust and consistent implementation	ECHO form for reporting in theatres implemented	Consultant Paediatric Cardiologist	Aug '16	**Green-complete**	
							Audit to assess implementation (Nov'16) and request to Steering Group to close	Patient Safety Manager	~~Nov '16 Revised to Mar 17~~ Revised to May 17	**Red – second revision of timescales**	Repeat audit results expected at Mar'17 delivery group with a view to proposing closure of recommendation (JM/BS) Mar'17 audit shows improvement however not 100% compliance at present therefore further communication to clinicians and reaudit prior to closure April'17 reaudit planned for May 17 with a view to closure at May

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											delivery group; comms going out to all teams re the importance of these records and location on electronic patient record system May'17 RTC presented in view of further audit; approved for closure in view of significant improvement in completion of forms, use of correct forms, consistent filing position on Evolve. 100% compliance for the small cohort of patients able to be audited since the previous audit. Plan to reaudit in Aug 17 to ensure process embedded in practice. Jul'17 reaudit expedited with 100% compliance reported
CQ C. 3	Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	Ward 32 Manager	Aug '16	**Green-complete** **22/11/16-approved for closure by W&C delivery group**			Documentation developed to record pain scores more easily	Ward 32 Manager	Jan'16	**Green-complete**	Nursing documentation
							Complete an audit on existing practise and report findings	Ward 32 Manager	Aug '16	**Green-complete**	Audit of nursing documentation

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
CQ C. 4	Ensuring all discussions with parents are recorded to avoid inconsistency in communication. This includes communications with the Cardiac Liaison Nurses, who should record contacts with families in the patient records (links with review recommendation 12)	Head of Nursing	Dec '16	**Amber- behind target**		Request delay to Feb'17 to ensure process is robust Request delay to Apr'17 in view of potential training needs for staff	Work with Cardiac Nurse Specialists to improve recording communication in the patients' medical records and review option of Medway proforma's to support recording in notes	Head of Nursing	~~Dec '16~~ Feb 17 revised timescale for wider issue	**Green- complete**	Examples of stickers in notes and Heartsuite entries Audit of compliance to be undertaken by MG/VG pre Mar mtg Process to provide consistent recording in accessible patient records to be established (ST) Mar'17 Medway record in place and in use; RTC supported by delivery group subject to audit of quality of records to return to delivery group April 17 (MG/VG)
CQ C. 5	Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3)	Clinical Lead for Cardiac Services	Apr '17	**Blue- on target**	Linked to recommendation no. 3. Actions detailed under recommendation no. 3 will also achieve CQC recommendation no. 5 Mar'17 Information sheets produced and formatted; shared widely for family input; signed off by governance meeting with all comments incorporated prior to printing, trial and evaluation; RTC supported by delivery group.						
CQ C.6	Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan '17	**Green- complete**		Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services	Assessment of current Allied Health Professionals input into discharge planning for Cardiac Services Audit completed and results to be formulated 27th October 2016.	Head of Allied Health Professionals	Oct '16	**Green- complete**	Assessment documentation
							Agree with Cardiac Services Team an effective mechanism for including Allied Health Professionals into discharge planning for Cardiac Services. Meeting setup for 4th November.	Head of Allied Health Professionals and Clinical Lead	Nov'16	**Green- complete**	Agreed mechanism for including AHP advice into discharge

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
								for Cardiac Services			planning for children within Cardiac Services
							Implement agreed mechanism for including Allied Health Professionals into discharging planning for Cardiac Services	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan 17	**Blue – on target**	Implementation plan delivery report

Key	
R	Red - Milestone behind plan, requirement to revise delivery date on more than one occasion; impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, delivery date revised on one occasion
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Equality and Diversity Annual Report 2016/17		
Author	Teresa Sullivan, Equality & Diversity Officer		
Executive Lead	Alex Nestor, Acting Director of Workforce and Organisational Development		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

The Annual Report forms part of the Trust's compliance with the Public Sector Equality Duty. It provides an update on progress against achievement of the Trust's Strategic Equality & Diversity Objectives for 2016-2019, progress in relation to regulatory requirements and demographic information about staff and patients.

Key issues to note

To improve access to services for our local communities

- Progress towards implementation of the Accessible Information Standard *(ensuring that the individual communication needs of patients with disabilities are identified so that the care they receive is appropriately adjusted).* Included in the Trust's 2016/2017 Quality Objectives and reported as Green in the 2017/18. Significant progress has been made

to enable the Trust to become compliant with Accessible Information Standard. Further work will be taken forward into 2017/18 to embed the consistent and effective use of Medway flags to alert staff to the existence of a communication need.

- The increasing range of involvement activities with patients and public from local communities.

To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust

- Recruitment – inclusion of unconscious bias awareness in Recruiting the Best training.
- South West Audit report into Equality in Recruitment, delivered in September 2016, concluded that the processes and guidance in place enable compliance with the Equality Act in recruitment. Recommendations to improve guarding against bias during the recruitment process are being implemented and monitored by the Equality & Diversity Group.

- Opportunities for progression – Improved year-on-year responses to the Staff Survey question regarding equal opportunities for career progression (BME staff: 63% in 2014, 73% in 2015, 77% in 2016). This is also a measure reported in the Workforce Race Equality Standard – progress monitored by the E&D Group, Trust Board and NHS England annually.

To work towards a more inclusive and supportive working environment for all of our staff.

- Key measures of experience for staff members from protected groups are taken from the National Staff Survey responses. BAME staff are more highly motivated and more likely to recommend the Trust as a place to work or receive treatment than staff from other protected groups.
- Staff Survey results relating to bullying and harassment are showing a year on year improvement in staff experience BUT the experience reported by disabled, Black Asian and Minority Ethnic (BAME) and Lesbian, Gay, Bisexual and Transgender (LGBT) staff is still worse than the Trust's overall score.
- Self-assessment of the Representative & Supported Workforce EDS2 Goal – carried out by the Education and Development Group demonstrates that the Trust is either Achieving or Developing each of the objectives within the Goal. (Appendix E.)
- The three Staff Forums (BAME, LGBT & LAWDII) are building their membership and raising their profiles with the Trust.

Delivery of actions to support all of these Objectives is monitored by the Trust's Equality & Diversity Group and reported by exception to the Improving Staff Experience Group and senior groups through this annual report and the Workforce Race Equality Standard (WRES) progress report.

Recommendations

Members are asked to:

- **Note** the report. **(**For assurance of compliance with the Trust's regulatory duties under the Equality Act.)

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☒	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☒	Legal	☐	Workforce	☒

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		26th July 2017		Equality & Diversity Group – 23/05/2017 Improving Staff Experience Group – 31/05/2017 WF&OD Group 28/06/2017 Senior Leadership Team – 19/07/2017

University Hospitals Bristol
NHS Foundation Trust

Equality and Diversity Annual Report

2016 - 2017

1. INTRODUCTION

"We aspire to be an organisation that treats people differently: in the sense that there is something special about how we care for people – whether they are patients or members of staff – and also because we treat people as valued individuals, rather than as sets of presenting symptoms, diagnoses or as job titles."

(UH Bristol Quality Strategy, 2016 – 2020)

With its emphasis on treating people as valued individuals, this message encapsulates what the Trust is committed to achieve through its work on equality, diversity and inclusion.

This Annual Report will focus on the progress being made towards achievement of our Equality & Diversity Strategic Objectives for 2016-2019, including our performance in regulatory areas, and show how we are proud to care – for patients, service users, and our staff.

2. BACKGROUND

University Hospitals Bristol NHS Foundation Trust provides services to the socially and ethnically diverse population of Bristol, as well as to service users from our neighbouring counties, and specialist services for the wider south-west.

Each of our patients and members of staff is a unique individual with different needs and aspirations. The Trust aims to recognise and celebrate these differences by providing an environment which is inclusive for patients, carers, visitors and staff.

The Trust is fully committed to adherence to the Equality Act 2010, and undertaking action under the Public Sector Equality Duties (PSED) as defined within the Act.

Equality Act 2010 and the Public Sector Equality Duty (PSED)

The Equality Act 2010 gives the NHS and its organisations responsibilities to work towards eliminating discrimination and reducing inequalities in care. The Public Sector Equality Duty applies to public bodies and others carrying out public functions, and requires these organisations to publish information to show their compliance with the Equality Duty. The information (including strategic Equality & Diversity objectives) must show that the organisation has had due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between people who share a protected characteristic and people who do not;
- foster good relations between people who share a protected characteristic and people who do not share it

Other key areas of our regulatory obligations are described in Appendix A, and included in the narrative of this report.

3. EQUALITY OBJECTIVES

The 2015-2016 Annual report included our newly-agreed strategic objectives for the next four years:

To improve access to services for our local communities;
To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust;
To work towards a more inclusive and supportive working environment for all of our staff.

These were developed by the Trust's Equality & Diversity Group, informed by key priorities from a range of sources including the Workforce Race Equality Standard, the National Staff Survey results and the EDS2. They can be read in full at Appendix B.

When the Equality Objectives were agreed, it made sense to review the existing action plan to make sure that the actions would lead to achievement of the Objectives. At the same time, actions in the Workforce Race Equality Standard report were included. This integrated action plan to support delivery of the objectives is included at Appendix C.

The format of this year's report will, for each objective, take you through progress against the measures outlined in last year's report, include additional success stories and initiatives, and say what we plan to do next.

To improve access to services for our local communities.

The first measure of our progress is achievement of one of the Trust's Quality Objectives for 2016/17:
"To fully implement the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted."

The Trust seconded an experienced sister to become the dedicated Accessible Information Standard (AIS) implementation lead and convened a steering group chaired by the Trust's Deputy Chief Operating Officer to assess the detailed actions and resources needed to systematically identify, record and respond to patients' communication needs. The AIS steering group has met monthly to oversee the delivery of the implementation plan, which has incorporated a number of standards contained within the Bristol Deaf Charter. Work with the Trust's Medway (patient administration system) team is ongoing to improve the management of alerts on the system. The alerts bring staff's attention to the existence of a communication need, so this is a key component of our approach. Standard operating procedures have been implemented to govern the processes by which communication needs are identified and recorded and have been incorporated into the Trust's outpatient standards.

A 'sister' project is underway to offer patients the opportunity to receive their Medway generated letters by email. This will provide the Trust with an alternative solution to written material but more work is underway to investigate technical solutions to deliver information in an accessible format.

In two of the clinical Divisions, outpatient letters have been rewritten in line with the Accessible Information Standard and will be made available when they have been approved.

Significant progress has been made to enable the Trust to become compliant with the Accessible Information Standard. Further work will be done during 2017/18 to embed the

consistent and effective use of Medway flags to alert staff to the existence of a communication need.

Success stories and initiatives

We know that a huge amount of work which is difficult to measure goes on throughout the Trust to improve the experience of patients and service users. Here are just a few examples.

Bristol teams work together to tackle TB in homeless communities

Throughout 2015 and 2016 the Bristol TB medical and nursing team noticed an increasing number of their patients were homeless, or had problems with misuse of drugs and alcohol. In February 2017, to coincide with Bristol Homelessness Awareness Week, Public Health England staff, the TB nurses at Bristol Community Health and the TB team at BRI worked together with the Find & Treat team, to try to evaluate the amount of "hidden" TB in this population.

Over two days the mobile X-ray unit visited 5 locations, and screened over 200 people. Each person was given their X-ray result immediately, and was then offered flu vaccine, and instant screening for hepatitis C. On the spot liver scans were available for people testing positive for hepatitis C, and everyone who had a chest X-ray suspicious for TB was seen by the TB specialists at BRI within 2 days.

Translating and Interpreting Services

The Patient Experience, Involvement and Complaints Team have continued to engage with representatives from the deaf community and the Trust's provider of British Sign Language interpreting services (sign Solutions Ltd). This includes attending quarterly meetings with a range of stakeholders to discuss service quality and improvements.

In December 2016 there was a meeting with representatives from the Trust's Quality Team, UH Bristol's lead on the Accessible information standard, Head of Audiology, Healthwatch, and Bristol City Council to discuss the outcomes of the April 2016 Healthwatch report "Accessing health & social care services by the deaf, deafened and hard of hearing communities in Bristol and South Gloucestershire". Following this meeting, a joint action plan was agreed in response to issues raised in the report.

Patient Stories at Trust Board

Each month the Trust Board hear a "patient story" – usually presented by the person themselves. 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 and the patient experience. Here are some of the stories from 2016/2017.

In January 2017, the deaf health promotion officer for Bristol City Council, together with the parent of a patient, spoke about the communication and information needs of people when they are in our hospitals and how this can have an impact on the quality of care they receive. This includes the experiences of deaf British Sign Language users, deaf people who speak/lip read, hard of hearing and Deafblind people.

Bristol Black Carers supports carers and those whom they care for to access healthcare. In November 2016, their Manager reflected on the experiences of carers who have supported patients at UH Bristol, the perceptions the local community have of our hospitals, and how the organisation is developing a voice in the Trust through the Involvement Network.

In October 2016 the Board heard a story charting the experience of a long-standing patient of the UH Bristol Rheumatology service. The story described a journey that started in 1996 and explored how the quality of care at the Trust has improved over twenty years and how

developments in research have impacted on the care provided. It considered the implications of living with a long term condition and the importance that continuity of care offers patients.

Patient and Public Involvement

The Trust's Involvement Network continues to grow so that representatives from diverse backgrounds can engage in conversations about how we can improve what we do.

We teamed up with North Bristol Trust and Bristol Community Health to recruit a diverse group of 16 people to our patient and community leadership programme. As Healthcare Change Makers they bring a unique perspective to health care planning and include representatives from the D/deaf[1], disabled and visually impaired community.

In the Adult Congenital Heart Disease clinical nurse specialist service, a dedicated volunteer interviewer was assigned to talk to patients about their experience of care. Conversations took place over several weeks as patients attended appointments. A relatively high proportion of patients in this service have a learning disability, so the volunteer interviewer was trained specifically for this task. The feedback received from patients is being collated at the time of writing, but was generally very positive. Insight from this work will also inform the Trust's response to the national Congenital Heart Disease public consultation planned for early 2017.

In conjunction with the Trust's Transformation Team and the Bristol Clinical Commissioning Group, members of the *Face2Face* interview team talked to inpatients in the Trust's care who were homeless or vulnerably housed. This proved to be a challenging task for the team, particularly because the patients had often left the Trust's care by the time the interviewer arrived to talk to them, and on some occasions it wasn't appropriate for the volunteer to interview the patient. Although limited feedback was elicited from this work, it was a useful learning experience in terms of the *Face2Face* programme itself. The Trust will continue to work with its partners in this project to find ways of engaging with our patients who are homeless or vulnerably housed.

At the invitation of the Trust, Healthwatch Bristol carried out an "enter and view" of inpatient areas at South Bristol Community Hospital in October 2016. These wards are primarily for "rehabilitation" and have a relatively high proportion of elderly patients. In general very positive feedback was received:
"Inpatient wards 100 and 200 at South Bristol Community Hospital are to be commended for providing a friendly, caring, clean and functional environment for stroke and rehab' patients to recover in. It was clear that the staff team were happy in their work, treated well by UHB and dedicated to aiding patient recovery. Patients and visitors said very complimentary things about the staff team."
Several improvement opportunities were identified by Healthwatch, primarily related to non-clinical aspects of care (e.g. access to magazines and the hospital café). The Trust has identified a number of actions to take forward in response to this feedback.

A quarterly report incorporating Patient and Public Involvement activities is published on the Trust's website: What patients tell us about UH Bristol. The Patient Experience Team has also provided a demographic analysis of patient surveys for 2016-2017. This is included at Appendix D.

[1] Big D deaf people are those who are born deaf or experience hearing loss before spoken language is acquired and regard their deafness as part of their identity and culture rather than as a disability. They form the Deaf Community and are predominantly British Sign Language (BSL) users.
Small d deaf people are those who have become deafened or hard of hearing in later life, after they have acquired a spoken language and so identify themselves with the hearing community. Small d deaf people are more likely to use hearing aids and develop lipreading skills. *(ageUK)*

Bristol Royal Hospital for Children - Disabled Children's Working Group

This Group is co-ordinated by the LIAISE Family Support Team Manager and includes a representative from Bristol Parent Carers. It has an extensive programme of work to support children with disabilities and complex needs, and their parents and carers, and welcomes input about how their hospital experience can be improved.

Homeless Support Project Pilot

The Homeless Support Project Pilot, run jointly with the Clinical Commissioning Group and led by a clinical co-ordinator, has been running since January 2017. The principal aims of the pilot are to support homeless patients with their discharge from hospital, reduce Emergency Department attendances and provide outreach work to support them outside hospital. Since 14th February this year, when the service went live, the team has had a total of eighty-nine referrals.

Dementia Support Cafes

Providing informal support for people concerned about their memory, and the relatives and carers of patients with dementia in our hospitals, the well-established drop-in sessions at the BRI have now been augmented by a session each month at South Bristol Community Hospital.

Measures of achievement so far

Much of the technical groundwork is in place to ensure compliance with the Accessible Information Standard.

Continually increasing and evolving engagement with our patients and service users is giving us a better understanding of their needs.

Next steps

As our local communities change and grow, the Trust will continue to work with them and local health partners to discover and meet their needs.

Compiling a record of the myriad activities being undertaken across the Trust to support service users with specific needs – whether physical, emotional or cultural – is a daunting task. However, it will help us to complete the EDS2 self-assessment goals related to Better Health Outcomes and Improved Patient Access & Experience, providing evidence of good practice and identifying areas for improvement. The self-assessment of these EDS2 goals will be a major piece of work for the forthcoming year.

We need to know about our patients and service users to make sure that the services we provide fulfil the needs of the local communities. A review of the processes for collecting and reporting patient monitoring data will seek to understand the barriers to both requesting and recording patient information for all protected characteristics.

Some of this work will come under the aegis of a new Group dedicated to support and develop the diversity and inclusion aspect of patient experience and involvement.

Please keep an eye on the Patient Experience and Involvement pages of the Trust's website for further developments.

To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust

Bristol is a diverse community and we mustn't miss out on the talent available on our doorstep. We said that we will focus on two areas in particular, one regarding local recruitment, encouraging people from all backgrounds to view the Trust as an employer of choice, and the other supporting equality of access to development for existing staff.

Recruitment

During the last year, members of the Trust's Recruitment team have been working with JobCentrePlus through fortnightly direct engagement sessions. These sessions include interviewing and offering posts to candidates who may struggle with conventional recruitment processes (for example, ex-offenders or candidates with a history of mental health issues), and who are supported by JobCentrePlus case workers.

The Trust also promotes health sector roles at careers fairs throughout the local community. A particular area of focus at the moment is South Bristol. Recent events include an open day at South Bristol Community Hospital and a careers fair at the City of Bristol College in South Bristol. Forthcoming events include one targetting youth into work for those struggling to gain employment which will showcase apprenticeship opportunities.

Attending recruitment fairs provides an opportunity to meet a wide range of people from varied backgrounds, and having an 'open door' approach can help to create a more personalised recruitment experience for potential candidates. It also gives the team a chance to raise more awareness that the Trust is a Disability Confident Employer (the scheme which has replaced the Double Tick scheme), and welcomes people from all backgrounds.

Recruitment materials have been tailored to show that the Trust is also Age Positive and a Mindful Employer. These two schemes emphasise our commitment to providing equal opportunities in employment and by using their logos on all material we can communicate this clearly to potential employees.

The Head of Midwifery has been asked to represent UHBristol working with UWE and other health partners to improve the experience of students from BME backgrounds and also encourage more applicants from these backgrounds.

The Trust has been piloting a new recruitment process for administrative staff. This is in line with the process already adopted for Nursing Assistants. Candidates are interviewed through centres where various assessments are undertaken, and is a more positive and supportive way for candidates to take part in the recruitment process.

Once we've attracted applicants from all backgrounds, we need to make sure that the recruitment process gives everyone the best opportunity.

One of the ways we said we would measure progress towards equality of opportunity in recruitment was through t*he outcomes and recommendations from reviews of the Trust's recruitment processes for potential unconscious bias, and the criteria for appointments - including ensuring executive search agencies are committed to diversity in their processes.*

South West Audit delivered their findings into Equality in Recruitment in September 2016. The report concluded that there are clear processes in place and guidance available to staff to comply with the Equality Act during recruitment. Whilst no obvious bias during the recruitment process was identified, some improvements were recommended.

The regular audit of recruitment files carried out by the Resourcing Team will include a check to identify any potential bias at the interview stage by monitoring interview notes. The outcomes will be reported quarterly to the Trust's Equality & Diversity Group.

It's almost inevitable that we each have a set of preconceptions. To encourage recruiting managers to look and think beyond first impressions, the Recruiting the Best training for managers has included a section on stereotyping since November 2016.

One way in which the Workforce Race Equality Standard encourages us to think about how our preconceptions might play into the recruitment process is through *the relative likelihood of shortlisted applicants from BME (Black and Minority Ethnic) groups being appointed, compared with White applicants.* Figures for our 2016 WRES report showed that White staff were 1.54 times more likely to be appointed from shortlisting than BME staff during the 2015 calendar year. (At the time of writing, the data for 2016 is being collated and analysed.)

Opportunities for Development

It goes without saying that, once we have recruited, we want to retain talented staff and encourage their progression within the Trust. Another way we said we would measure the success of this objective is by the d*evelopment and implementation of a succession planning framework which supports equality of access to continuing professional development for all protected groups.*

An ongoing concern for the NHS is to ensure that there is a steady supply of individuals with the skills and knowledge to fill the many different roles which make up the workforce. As people retire or move on it is important that plans are in place to ensure that there is a pool of talent from which potential successors can be identified, and talent management has been shown to be integral to this process.

Whilst offering opportunities for development is key to encouraging and retaining those who wish to progress within the Trust, it is equally important to recognise that many employees find their current roles satisfying and fulfilling. So, talent management will not be intended solely for those with ambition to progress, but will also nurture the skills and talents of members of staff who wish to continue with their existing role in the Trust.

We know from the Staff Survey that people from some protected groups believe that opportunities for progression are not equally available, so it is vital that that the succession planning framework being developed ensures equity of access to all.

Success stories and initiatives

Recruiting the Best Training

Managers from across the Trust are invited to undertake this training so that they can gain a better understanding of how to recruit people successfully. Consistency in all aspects of recruitment – from advertising to shortlisting to interviewing – ensures that candidates from all backgrounds are provided with the same recruitment experience.

Testimonials from new recruits

We are offering new recruits the opportunity to tell us about their experience of the recruitment process. We're asking what we could do better to help us ensure that our service is continually improving to meet the needs of people from all backgrounds.

Support for ex-services personnel

The Trust is also establishing contact with ex-services personnel, including those who may have suffered mental or physical trauma, through local open days and use of the Career

Transition Partnership which advertises to those looking for work after duties in the armed forces.

Diversity Advantage Programme

The introduction of the Workforce Race Equality Standard was, in part, driven by the publication of Roger Kline's report into the Snowy White Peaks of the NHS. This highlighted the very low numbers of Executives and Board members from BME backgrounds compared to the overall workforce in NHS organisations. When an invitation was extended to the Trust for a Board member to take part in the Diversity Advantage Programme, our Chair, John Savage, was delighted to participate.

The programme was designed to offer fresh perspectives through the placement of an aspiring Non-Executive Director and to support, through mentoring, the mutual learning of participants on the programme.

Learning and Development

As a teaching trust, UH Bristol has a mission to equip its staff with the knowledge and skills needed to perform the wide variety of roles in the Trust. In addition to these essential skills, training is a way of providing staff with the knowledge to support them to live the Trust's values, and to provide insight into the Trust's approach to equality, diversity and inclusion.

Within the last year, a new Equality, Diversity & Human Rights e-learning package has been finalised and made available to all staff. Building on the background given to all starters at Corporate Induction, it helps staff to know more about equality, diversity and human rights in the workspace and why it is important; to understand what is expected of the Trust and its staff and each individual's responsibilities; and to promote understanding of what informs our attitudes to others and know what support is available to help deal with unacceptable behaviours. From later this year, Equality, Diversity & Human Rights e-learning will become part of the Essential Training update required of all staff every three years.

Continuing development for existing managers, supervisors and leaders is provided in a suite of leadership courses which staff can book themselves onto. The courses include information about career development and awareness of cultural and other differences in teams.

Bespoke interactive sessions discussing what the Trust Values mean in action are being offered and taken up by a wide variety of staff from different staff groups.

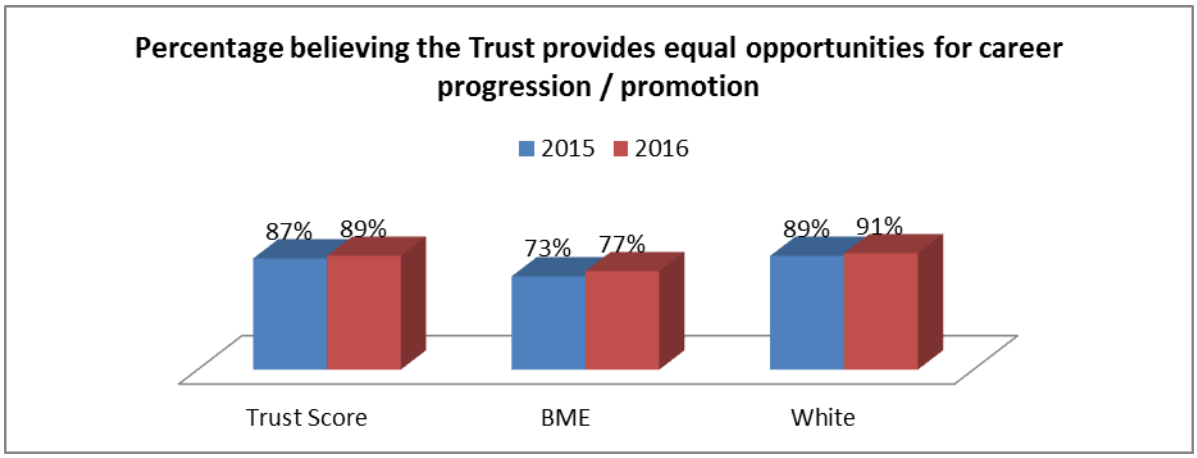
The handbook which new starters work through with their line managers as part of their Local Induction now includes a prompt for managers to discuss whether any reasonable adjustments might be needed to support the new employee in their role, and a prompt to complete the equality, diversity and human rights online training

Introduction of e-appraisal on 15th May 2017 will encourage an opportunity for more informed discussions between line managers and staff, including about personal development, and improve the quality of appraisals.

Measures of achievement so far

The real measure of whether our planned actions are having a positive effect is what our staff say about their experience of working for the Trust. Therefore, *the response from BME staff to the Staff Survey question regarding equal opportunities for career progression – as reported in the Workforce Race Equality Standard* – is vital to our understanding.

This was one of the findings in the Staff Survey in which the Trust as a whole showed the greatest improvement since 2015, going from 87% to 89% and appearing in the best 20% of acute trusts. Although the responses from BME staff also show an improvement (and a significant improvement on the 2014 response of 63%), there is still a greater belief among BME staff that there are barriers to progression within the Trust.



It is key to the Trust's ability to retain highly motivated staff that the Trust understands what these barriers are and works towards their removal. These findings have been discussed with members of the Trust's Black, Asian and Minority Ethnic Workers Forum and will be included in the 2017 Workforce Race Equality Standard report, together with any extra actions which have been identified as supporting equal opportunities for progression.

Another key measure of equalities performance is the EDS2 (Equality Delivery System), so completion of the EDS2 self-assessment – Representative and Supported Workforce Goal, will provide evidence of good practice and identify areas for improvement.

Based on the evidence presented to them, the Equality & Diversity Group carried out a self-assessment of the six Outcomes included in this Goal in February 2017 and recommended an initial grading for each outcome. (The potential gradings are Undeveloped, Developing, Achieving and Excelling.) For each outcome, the group was also asked to consider whether staff from protected groups fare well.

The Group's recommended initial grading for the outcome related to recruitment – "Fair NHS recruitment and selection processes lead to a more representative workforce at all levels" – was 'Developing'.
This reflects the under-representation of some protected groups at higher levels in the Trust. The Group also considered that, whilst it is possible to indicate the protected characteristics which fare well, it should be explained in the evidence that it is difficult to identify evidence for all protected groups and that none fare badly.

The Workforce & Organisational Development Group have signed off the findings for all six Outcomes of this Goal, which can be found at Appendix E, together with a link to the evidence templates. This information has been added to both the staff intranet and the Trust's external website with an invitation for comment from stakeholders.

Next steps

Until we have an accurate picture of the staff who are taking part in non-essential training and continuing professional development, we will not know to what extent staff from different protected groups are or are not participating. Considerable progress is being made towards capturing information about participants in the voluntary Leadership training courses, but

there are still many areas of study which are not being recorded systematically. It is therefore a priority to make sure that we are reporting and analysing all staff training data.

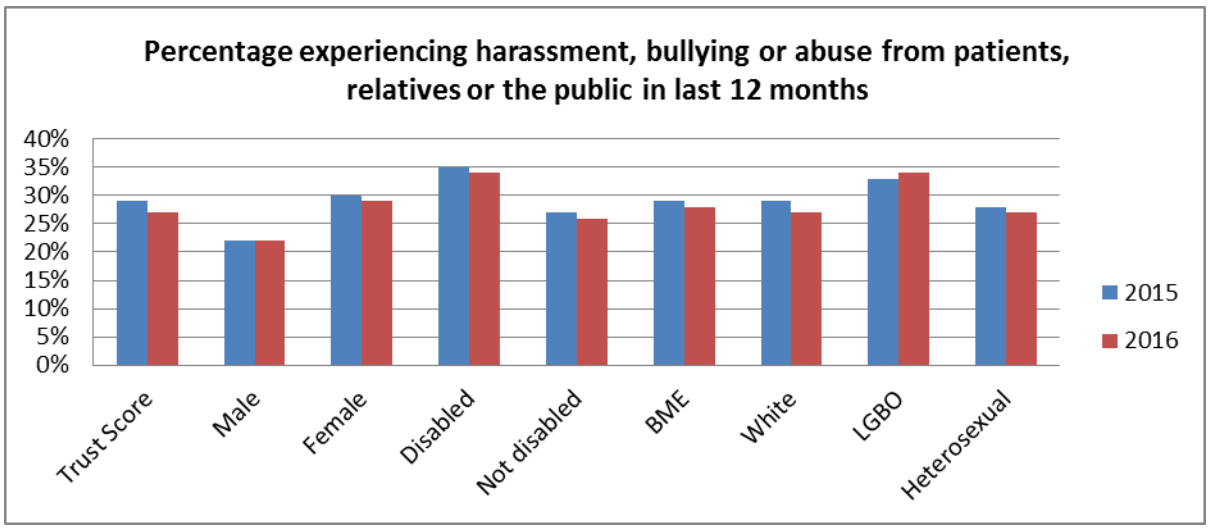
As part of Phase 2 (starting in 2018) of the e-appraisal project, Development Centres will be introduced as a way to provide the opportunity for staff to be assessed to identify skills and knowledge which will inform their future development plans. As all members of staff have to be appraised annually, this should enable staff from all protected groups to have greater access to training and development.

The Trust's Black, Asian and Minority Ethnic Workers Forum is taking an active part in developing the next steps towards demonstrating progress in workforce race equality performance. Planned actions in the Trust's 2017 WRES report will include suggestions from the Forum who will follow their progress throughout the year.

To work towards a more inclusive and supportive working environment for all of our staff.

We said we would place an emphasis on providing an environment free from harassment, bullying or abuse from colleagues or service users as one of the ways of achieving this objective, and that we will measure this by *the results of the National Staff Survey, with particular reference to the experience of staff from protected groups. Also, the experience of staff from BME (Black & Minority Ethnic) groups as measured by the Workforce Race Equality Standard*.

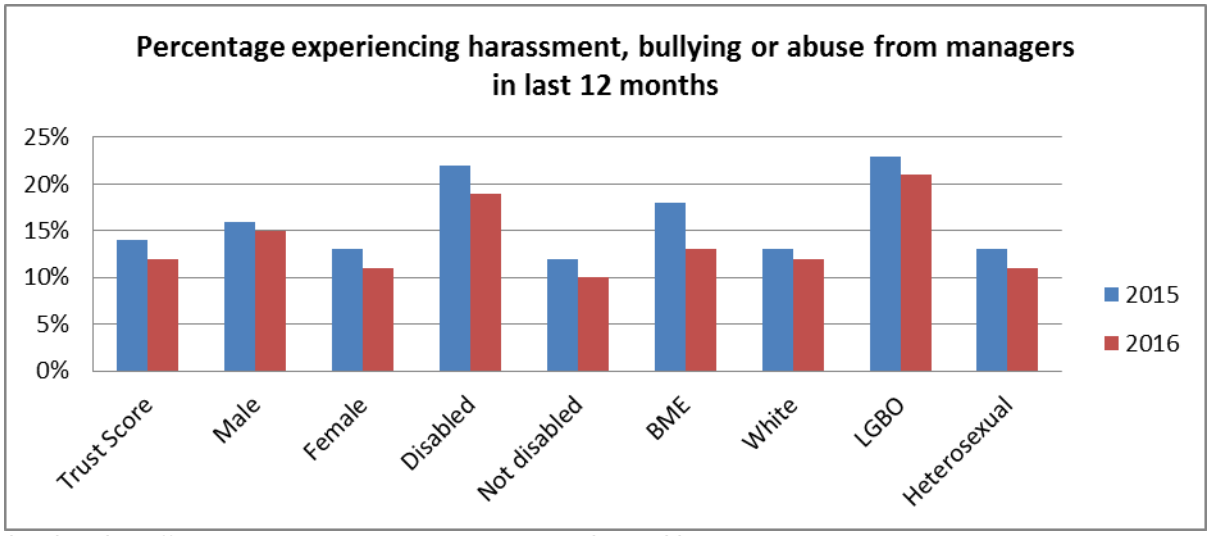
Like many healthcare organisations, UH Bristol has a policy and processes in place to enable staff to report and receive support to resolve issues of harassment, bullying or abuse. The Trust is also very clear that it will not tolerate behaviour contrary to the Trust Values or discriminatory behaviour.



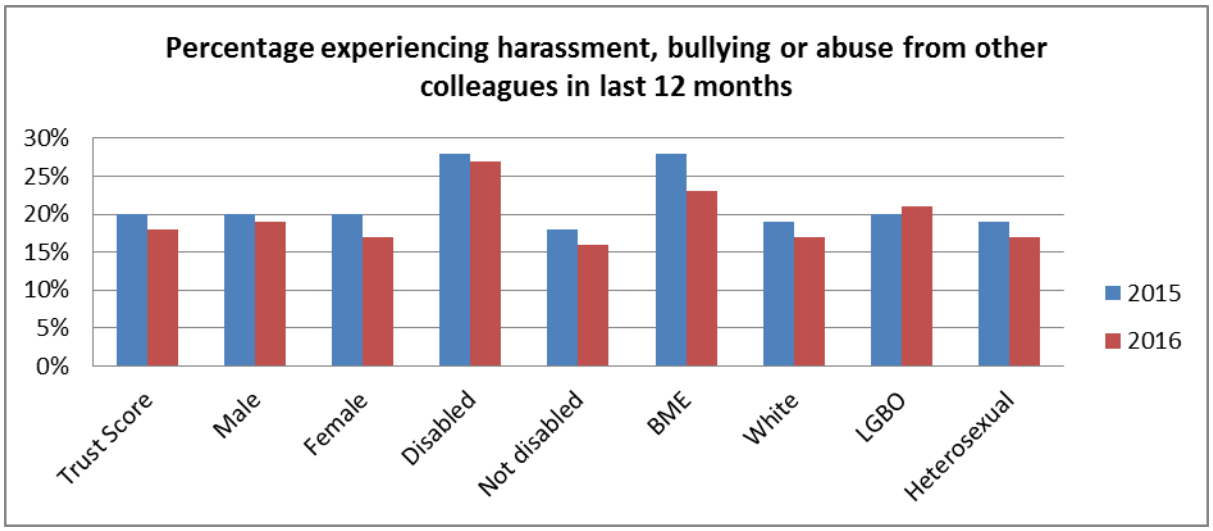
(National Staff Survey 2016 – responses to Question 15a)
(Note: Transgender is not given as an option for identifying in the staff survey returns, hence LGBO (Lesbian, Gay, Bisexual, Other)

There is a widely-used process for reporting incidents of physical violence and verbal abuse from patients, relatives and the public which includes the recording of how an incident was resolved. Analysis of this information should make it possible to identify wards and departments where it is necessary to re-emphasise to service users that the Trust will not tolerate harassment, bullying or abuse of its staff.

The incidence of complaints against colleagues being brought to the attention of Human Resources is very low (as reported in Appendix F) and yet the experience of staff as reported through the Staff Survey (in the graphs below) tells a different story.



(National Staff Survey 2016 – responses to Question 15b)



(National Staff Survey 2016 – responses to Question 15c)

Through the work on Leadership Behaviours and the development of a Dignity at Work Policy, the Trust is restating its aim of ensuring that all staff are treated with the dignity and respect due to them. The Policy is being developed in partnership with staff side, and will set out behaviours expected of staff and the support available for them if they feel that they are being bullied or harassed. Whilst encouraging informal resolutions to issues raised, it will also seek to reassure staff that complaints about unacceptable behaviours are treated seriously, and set out the formal process if an informal resolution has not been possible.

The Trust's Staff Forums are also involved in discussions about what other steps can be taken to promote a culture in which unacceptable behaviour towards colleagues because of a protected characteristic is not tolerated.

Where the Staff Survey has identified problems in particular working areas, specific actions to resolve them are being developed for inclusion in Divisional Staff Engagement Plans. In the future, their progress will be reported to the Improving Staff Experience Group on a regular basis.

Success stories and initiatives

Spiritual and Pastoral Care (Chaplaincy)

The Trust's Chaplaincy team provides a listening point for staff of any faith or none in need of support on a daily basis, as well as being part of staff debriefs after difficult incidents. The team also regularly teaches on the healthcare assistants and preceptorship courses.

The Trust has five sacred spaces open to patients, visitors and staff which provide a spiritual place for reflection. The Chaplaincy team is seeking to hold a series of events in the new Sanctuary in the King Edward building, and are reviewing the prayer space in the Children's Hospital in consultation with staff. Alongside a small team a refurbishment project is being undertaken.

Confidential Harassment and Bullying Advisors Service

The Trust has a team of trained advisors who can provide support and advice to colleagues who may be experiencing harassment or bullying at work. The Advisors can be contacted on a confidential helpline and, from April 2017, through a dedicated email address. During January and February face to face confidential appointments were also offered to members of staff who wished to talk through any issues of bullying or harassment.

Workplace Health & Wellbeing

The Trust seeks to foster a workplace culture which promotes, encourages and supports inclusion, equality and diversity within all functions. This is evident in the staff health and wellbeing agenda where schemes are developed with consideration of potential differences among the entire workforce, as well as the characteristics protected by law.

Over the past year, we have taken advice from staff side on effective communication, and took steps to ensure both online and hard copy information channels are used across the organisation. This maximises opportunities to engage with colleagues; measure the impact of wellbeing initiatives and to raise awareness of local and national campaigns that focus on the principles of inclusion.

Workplace Wellbeing Charter

The national Workplace Wellbeing Charter provides easy and clear guidance on how to make the workplace a supportive and productive environment in which colleagues can flourish; it also acts as a platform for ongoing improvement. In May 2016, the Trust welcomed the opportunity to audit and benchmark itself against an established and independent set of standards which form the charter – identifying what the Trust already had in place and any gaps to be addressed. Issues of equality, diversity and inclusive employment practices are embedded throughout the charter standards. The Trust achieved accreditation of 8 standards at varying levels and will be re-accredited again next year.

Physical Activity Challenge 2016

In the summer, we presented our first physical activity challenge whereby colleagues were invited to plan and review their level of daily activity over a three-week period. This challenge was designed to enable all members to participate, regardless of impairment, disability or fitness level as the emphasis was on building on what an individual can already achieve. This incentive, along with a buzzer challenge to tackle sedentary behaviour, assisted the Trust in winning the Sport and Physical Activity @Work Bronze award in recognition of its holistic approach to being active. The Physical Activity challenge will be repeated in 2017.

Psychological and Emotional Wellbeing

Our wider Workplace Wellbeing team are responsible for identifying and reviewing current health and wellbeing issues, priorities and objectives, and for responding to emerging and evolving workplace issues. The psychological and emotional wellbeing of staff was of

primary importance to the Trust last year with the introduction of a range of pre-emptive and counteractive initiatives being made available to support individual colleagues and teams. The adoption of a holistic approach to tackle issues such as work-related stress and programmes to enhance emotional resilience not only ensured accessibility and inclusivity to our diverse workforce but also recognised links between wellbeing themes - for instance, the effect of physical health on mental wellbeing.

The Trust will continue to demonstrate its commitment to equality, diversity and inclusion as it undertakes a review of its Workplace Wellbeing Strategic Framework and associated delivery plan for 2017-18.

STAFF FORUMS

The Trust currently has three Staff Forums. The Lead for each Forum is a member of the Trust's Equality & Diversity Group, and they have contributed to this report.

Lesbian, Gay, Bisexual & Transgender (LGBT) Forum 2016-17

The forum is for Lesbian, Gay, Bisexual and Transgender members of Trust staff and supporters within UHBristol. We are a safe space for staff to discuss issues and assist in advising HR on staff policy relating to LGBT issues within the organisation.

Within the last year the LGBT Forum has being working to increase attendance at our meetings. We have organised events with a local LGBT History charity (OutStories Bristol) including two events during LGBT History Month in February, when OutStories Bristol kindly set up their 'Revealing Stories' travelling exhibition in the Education Centre.

As part of the Forum's aim of working towards a greater understanding of the issues faced by LGBT patients by assisting our staff though training, two representatives from the Forum gave a presentation to the first Bristol Palliative Care Nurses forum. The presentation highlighted some of the areas where a better understanding would make a big difference to the experience of LGBT patients. For example, it's better to use the term 'partner' instead of assume 'husband' or 'wife'. Issues for transgender patients include using the correct personal pronoun, presenting gender, and the appropriate use of gendered clothing. And the importance of understanding that the people who matter to the patient may be a partner of the same sex or a previous partner who may have 'come out' later in life.

This year has seen the production of the first joint poster advertising all of the staff forums, and over the next year we will be continuing to build the forum and working with the BAME/LAWDII forums to increase participation.

Black, Asian & Minority Ethnic Workers (BAMEW) Forum 2016 -2017

The Black, Asian and Minority Ethnic Workers Forum (BAMEWF) is a network of UH Bristol staff from multi-disciplinary backgrounds across the Trust. It endeavours to support, involve and develop its members from diverse cultural backgrounds and to act as a unified voice and advocate for BAME staff with their stakeholders. The forum is open to all Black, Asian and Minority Ethnic workers within UH Bristol.

Following an open session for BAME staff held during their visit in November 2016, the CQC encouraged the development of the Forum as an important voice within the Trust. The current Chair has now established himself in the role and started the process of building a strong team to take the Forum forward. The Forum now has a dedicated and keen Core Group who are outlining initiatives to build membership and engagement with BME staff, beginning with a recruitment drive in July 2017.

At the heart of the Forum's objectives for 2017-2018 is their ambition to encourage participation, provide tailored support by identifying BAME needs, to raise the profile of the Forum both internally and externally and to work collaboratively with other forums and organisations to develop best practice and share experiences.

The Forum will continue to have three meetings per year that are open to all BAME staff and supporters, and an AGM. In addition the Core Group will meet monthly to steer and provide momentum. The new Core Group has started the year by revising the Terms of Reference and the Forum leaflet, developing the BAMEWF Workspace, and connecting with the other staff forums and the NHS BME Network (a national independent body) with a view to collaboration.

Living & Working with Disability, Illness or Impairment (LAWDII) 2016 – 2017

The Trust LAWDII Forum (Living and Working with Disability, Illness or Impairment) is a group of UH Bristol staff with visible and non-visible disabilities and impairments.

The Group enables staff and volunteers with physical, sensory or mental impairments to raise awareness of any issues they may have encountered at work. We play a key part with problem solving and resolving concerns around any forms of discrimination; physical access problems; barriers to communication and any lack of consideration or understanding from other staff.

The network is about sharing best practice and the empowerment of staff members, supporting non-disabled staff and managers by raising awareness of issues relating to disability, illness and injury, ensuring that the Trust benefits from disabled employees' experience and improves policy and practice as a result.

This year we are focussing on Mental Health and in the group we have looked at supporting staff to talk and share their experiences. We agreed to hold our meetings in one area for ease of access this has enabled wider participation. The theme of mental wellbeing will be expanded on during the coming year to provide additional support for colleagues dealing with anxiety and stress.

Measures of achievement so far

The Staff Survey results relating to bullying and harassment are showing a year on year improvement, although we are very aware that much more needs to be done to ensure that none of our staff are subjected to unacceptable behaviours, especially from colleagues.

Wellbeing initiatives have a high profile within the Trust to provide a supportive working environment for all staff.

The self-assessment of the Representative and Supported Workforce EDS2 Goal shows that the Trust is either Achieving or Developing each of the objectives within the Goal. (See Appendix E.)

The Staff Forums are building their membership and raising their profiles within the Trust.

Next steps

The Trust Board has requested an update on our progress against the WRES, which will be delivered in June/September 2017.

With a more robust way of tracking the actions to improve staff engagement in Divisions, we should be able to use the next Staff Survey to find out what has worked, and spread this good practice.

Self-assessment of the EDS2 Inclusive Leadership Goal will show how the Trust's leaders and managers are committed to promoting equality within and beyond the organisation.

In response to a series of workshops, a set of Leadership Behaviours has been developed and will be rolled out in 2017.

The Dignity at Work Policy being developed in partnership with staff side will be submitted for approval in summer 2017. Events held later in the year to coincide with national anti-bullying week will be used to promote the positive behaviours advocated in the policy, and its approach to resolving problems associated with unacceptable behaviours.

An ongoing piece of work is to develop the Equality & Diversity pages on the staff intranet so that they are as complete a resource as possible for staff and managers.

4. OTHER STAFF EXPERIENCE MEASURES

Staff Survey Results – Other Key Staff Experience Findings

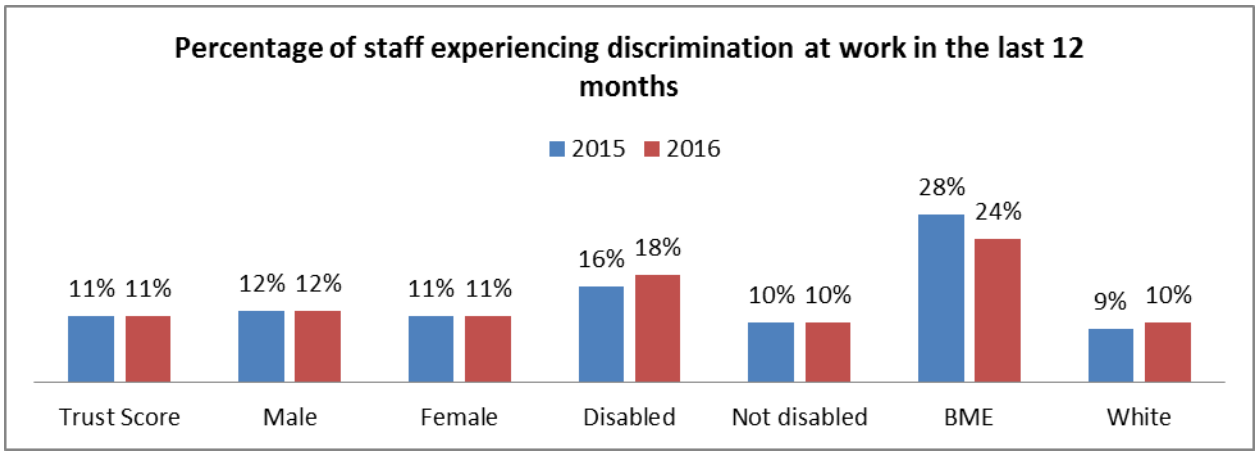
Each year, NHS organisations are given the opportunity to ask all of their staff about what it's like to work for that organisation. The results of the annual National Staff Survey are regarded as a good indicator of overall staff experience and also provide an insight into the experience of staff from some of the protected groups.

The 2016 National Staff Survey questionnaires were sent to all substantively employed staff across University Hospitals Bristol NHS Foundation Trust and 3,597 staff completed and returned the survey – a response rate of 42%.

Because the results of the Staff Survey are used as an important measure of staff experience, it is helpful to know how the demographic make-up of staff who responded to the Staff Survey compares to the make-up of the workforce as a whole. You can find this information at Appendix G.

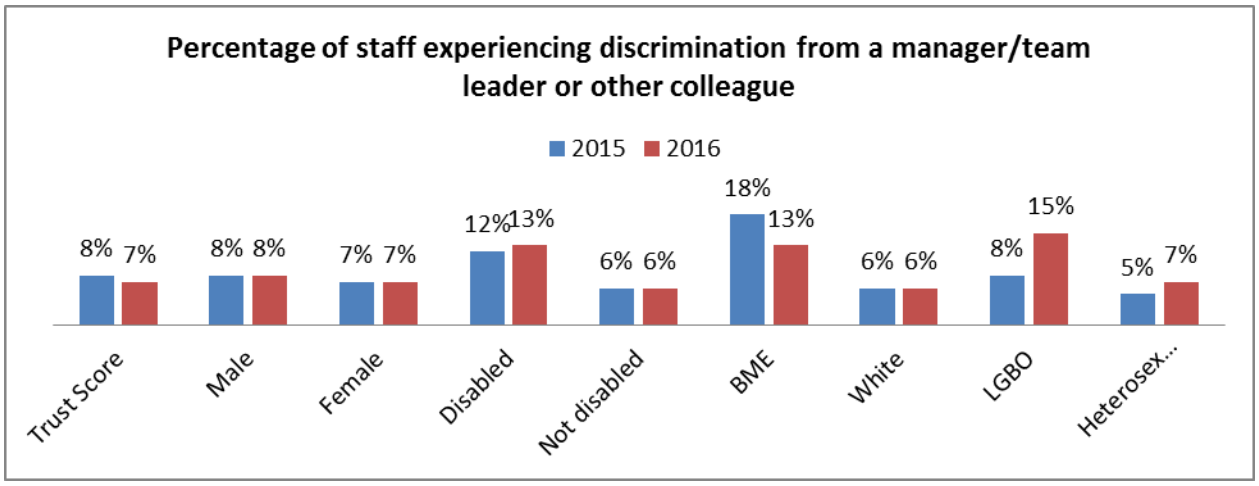
The Staff Survey includes two Key Findings specifically relating to Equality and Diversity: The percentage of staff experiencing discrimination at work in the last 12 months (from patients, service users, managers and colleagues), and the percentage believing the organisation provides equal opportunities for career progression/promotion.

The graph below shows the results for the first of these findings, comparing 2016 and 2015 results.



(The national average score for acute trusts in 2016 was 11%. The best score was 5%.)

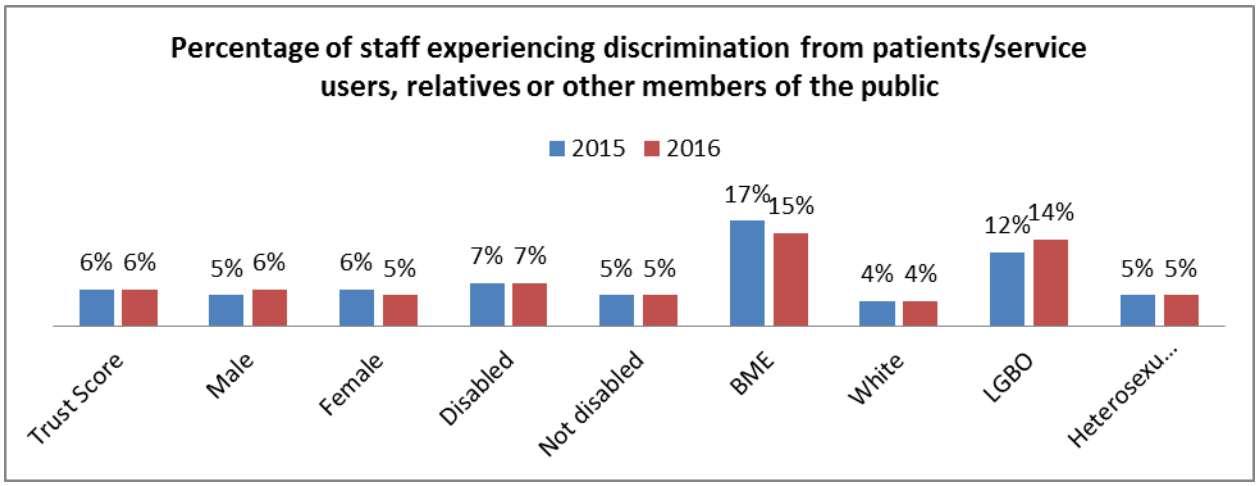
Experience of discrimination from colleagues is highlighted by the response to another staff survey question – one which is also used as part of the Workforce Race Equality Standard. This graph shows the percentage of different groups which answered "Yes" to the question "In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?"



(National Staff Survey 2016 – responses to Question 17b)

This comparison between 2015 and 2016 responses shows that, although the experience of BME staff has improved to a certain extent, we need to find out why the experience of disabled and LGBO staff has worsened.

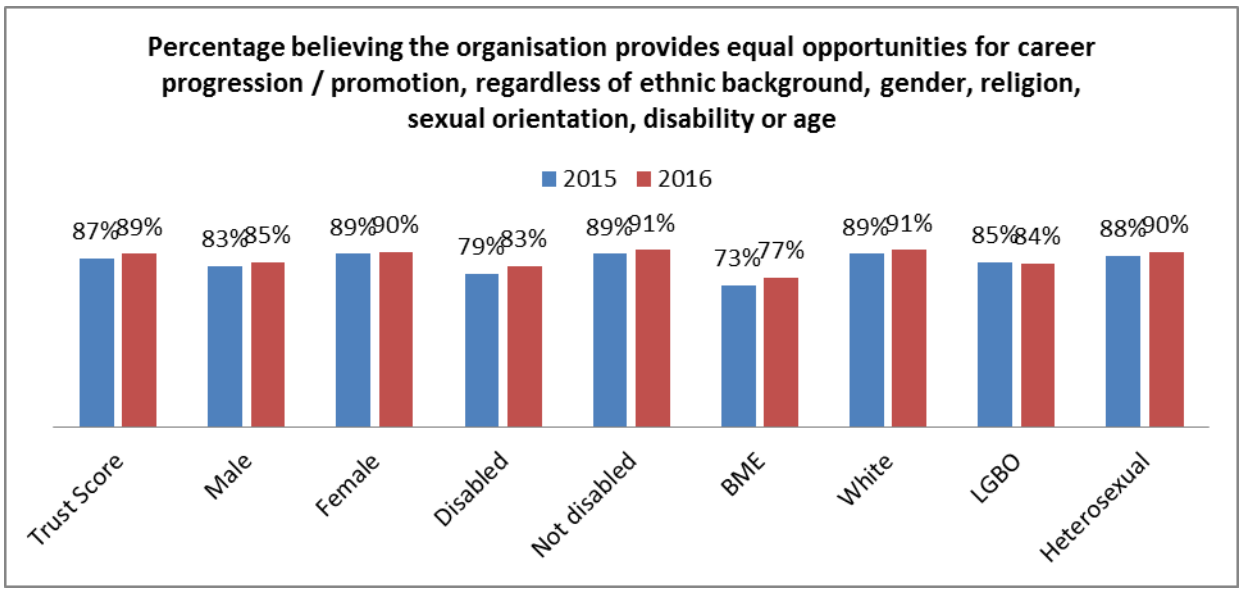
The Survey questionnaires were completed between September and December 2016 - in the wake of the vote to leave the EU – so a further breakdown of this key finding has been done to establish whether staff experienced more discrimination from the public or from colleagues:



(National Staff Survey 2016 – responses to Question 17a)

These responses indicate that, with the exception of BME staff, colleagues from protected groups say that they experience more discrimination from people they work with than from members of the public.

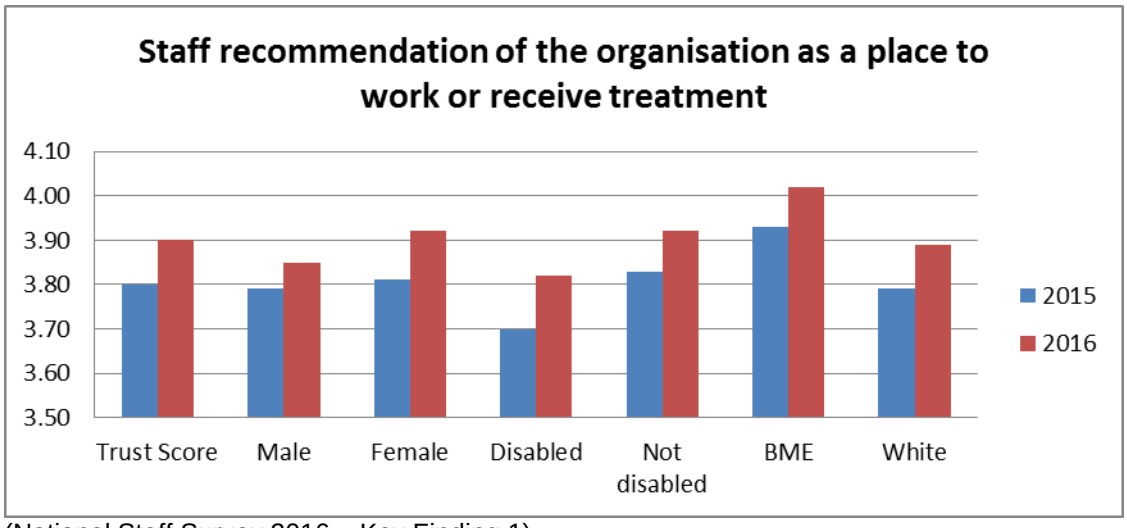
The comparison between White and BME staff who believe that the organisation provides equal opportunities for career progression or promotion is also a measure for the Workforce Race Equality Standard. This key finding was explored for staff in other protected characteristics:



(National Staff Survey 2016 – responses to Question 16)

This highlights the differing experiences of disabled staff, who also perceive that there are barriers to progression. The work on succession planning and mentoring described above should support staff from all protected groups, and input from the Trust's BAMEW Forum – based on lived experience – will inform the 2017 WRES action plan.

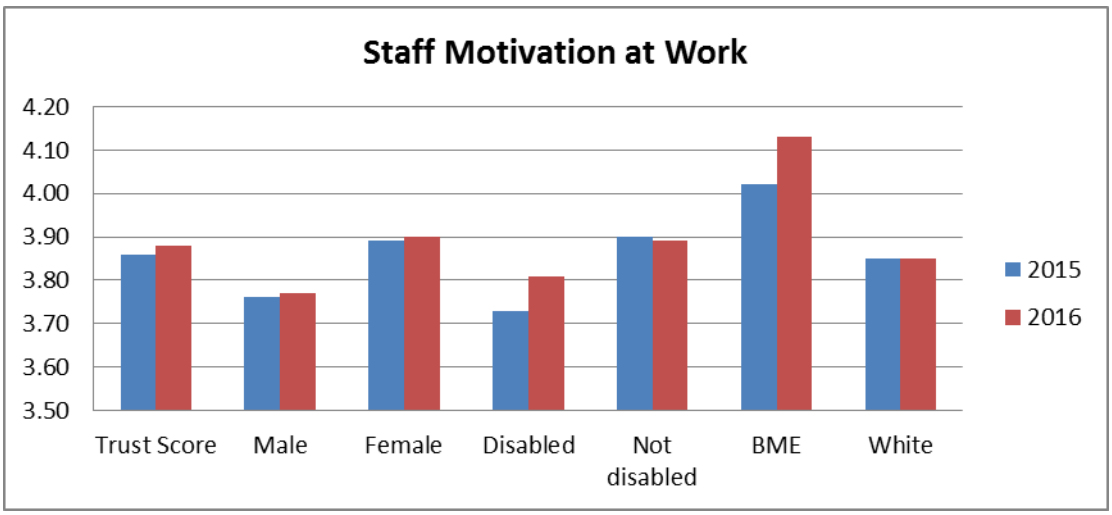
The Trust improved its overall staff engagement score in 2016. Two of the elements contributing to that score are staff recommendation of the organisation as a place to work or receive treatment, and staff motivation at work. Responses to these two elements are particularly interesting when compared with poor experiences as highlighted above reported by staff from some protected groups.



(National Staff Survey 2016 – Key Finding 1)

National findings also indicate that Asian and BME staff are more likely to recommend their employer as a good place to work than white staff, but are still under-represented at senior management levels and report higher levels of discrimination.

And yet, staff from BME backgrounds are more highly motivated than their white colleagues. This must provide further impetus to ensure that BME staff are at the forefront of our talent management and succession planning programmes.



(National Staff Survey 2016 – Key Finding 4)

Workforce Race Equality Standard (WRES) – 2016 Report

There are nine WRES indicators which are used to highlight any differences between the experiences of White staff and Black & Minority Ethnic staff in the NHS. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on Boards.
NHS organisations are required to submit and publish their data in August of each year, together with their action plans outlining the practical approach needed to continuously improve their respective organisation with regard to workforce race equality.

The Trust has now successfully reported against all but one of the required metrics in July 2015 and August 2016. (The 2016 report and action plan, including progress against the actions, is included at Appendix H).
Although non-mandatory training is recorded locally it needs to be added to the central Learning Management System to enable extraction and reporting against protected characteristics. Until this has been completed it will not be possible to assess whether BME and White staff access non-mandatory training equally - and therefore whether steps are needed to address inequity of access. This means that reporting in the preferred format for Indicator 4 was not possible again in 2016, although it might be argued that the Staff Survey findings more accurately reflect staff experience of access to non-mandatory training.

Workforce Race Equality Standard (WRES) – 2017 Report

Work is in progress to collate and report on the data for this year's report against the nine metrics which are indicators of workforce equality, in preparation for reporting in August 2017.

The information already available shows little change in the make-up of the Trust's workforce. The experience of BME staff as measured by the Staff Survey results which are included in the WRES is showing a year on year improvement, but we are very aware that there is still much to be done to ensure an equally positive experience for all.

PLANS FOR THE FUTURE

Our Strategic Equality & Diversity Objectives are only one year old, so are still a major part of our plans for the future. We will continue to follow the plans mapped out, and encourage other initiatives which support their delivery and promote inclusion for staff and patients from

all protected groups. We're also aware of other regulatory requirements which are on the horizon:

The Workforce Disability Equality Standard is likely to be mandated for reporting from 2018, so we are looking forward to the focus and profile this will bring to the experiences of disabled colleagues. We already know that staff with disabilities do not always tell us that they are disabled (2.8% of the staff in post as reported via the Electronic Staff Record system, compared with 15% of the staff survey respondents). We need to find out why, and investigate ways of encouraging self-reporting, so that as a Trust we can make sure that our systems and our people fully support these colleagues.

Public sector organisations need to provide a Gender Pay Gap report by March 2018. In the draft Order – the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 – public authorities are required to report on various differences in pay between male and female employees. Work is in progress nationally to allow this reporting through the Electronic Staff Record (ESR) system and, whilst the legislation focusses on Gender, it is intended that the ESR reporting solution will enable Pay Gap Analysis across a range of other protected characteristics including age, disability, religion or belief, and sexual orientation.

CONCLUSION

The Trust continues to be committed to the equality, diversity and inclusion agenda and this past year has made significant progress against objectives both regulatory and organisationally.

The wide range of activities being undertaken to involve members of our local communities in the decisions which affect their experience of using our services show that we are Proud to Care for all of them, and know that we need to keep talking to them to understand how we can continue to improve the care we provide.

In order to strive for continued improvement, governance has been strengthened and local equality and diversity leads have been supported to better understand their roles with support from the Workforce Equality & Diversity Officer.

We have learnt from the results of the 2016 Staff Survey and the Workforce Race Equality Standard reporting that not all of our staff have an equally positive experience of working for the Trust. This is something which we will continue to work to improve, with equality and diversity an integrated strand of our Improving Staff Experience plans.

We are working with Human Resources Business Partners and Divisions on the improving Staff Experience plans, and working collaboratively to support solutions in the coming months to see an improvement in the experience of our staff as measured through the staff survey later in the year.

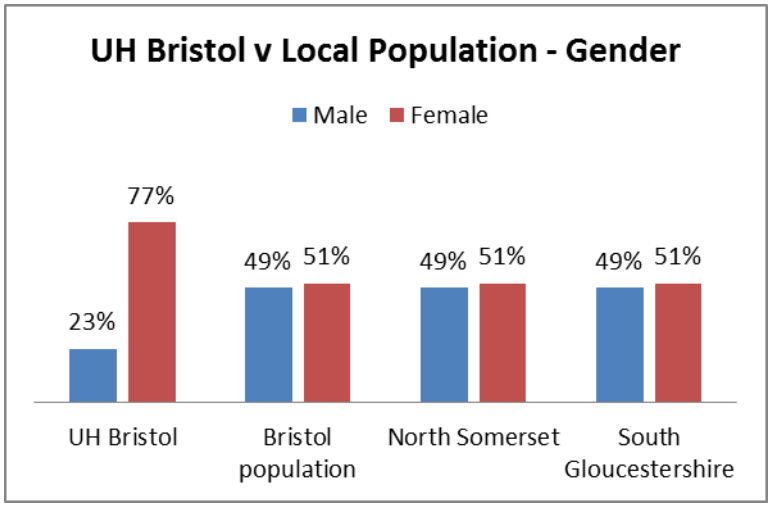
We remain confident that the work towards achievement of the strategic Equality & Diversity Objectives, underpinned by the Integrated Equality & Diversity Action Plan, will enable the Trust to ensure it continues to improve patient care and experience and to work towards a more inclusive and supported working environment for all of its staff.

Local Population, Workforce, and Patients – a snapshot

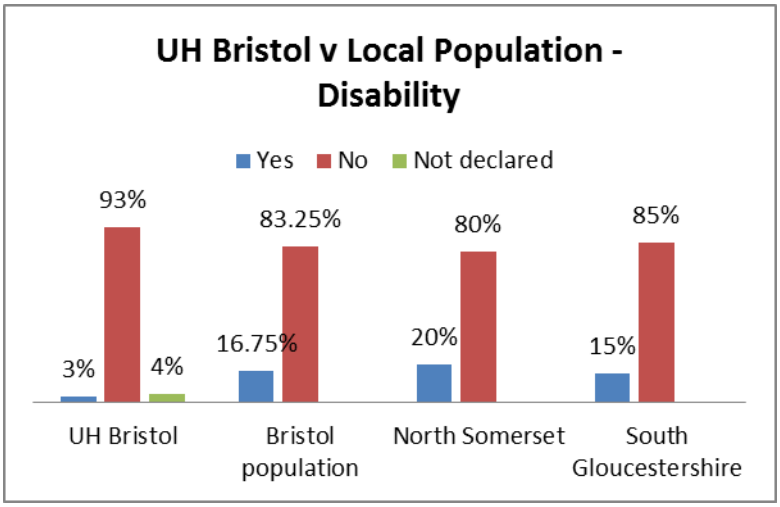
More detailed demographic breakdowns are included at Appendix F

Local Population

Sex: 77% of UH Bristol staff are female, compared with 51% of the local population (but note that it is usual for NHS organisations to have a higher proportion of female staff)

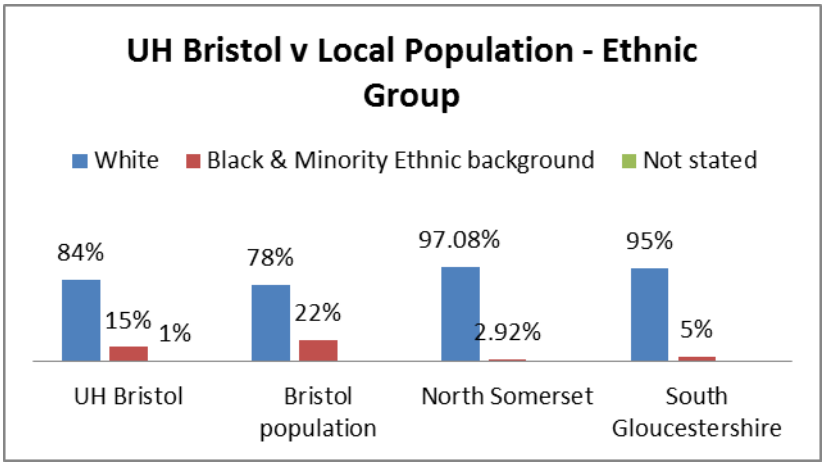


Disability: 3% of UH Bristol staff compared with 15 – 20% of local population

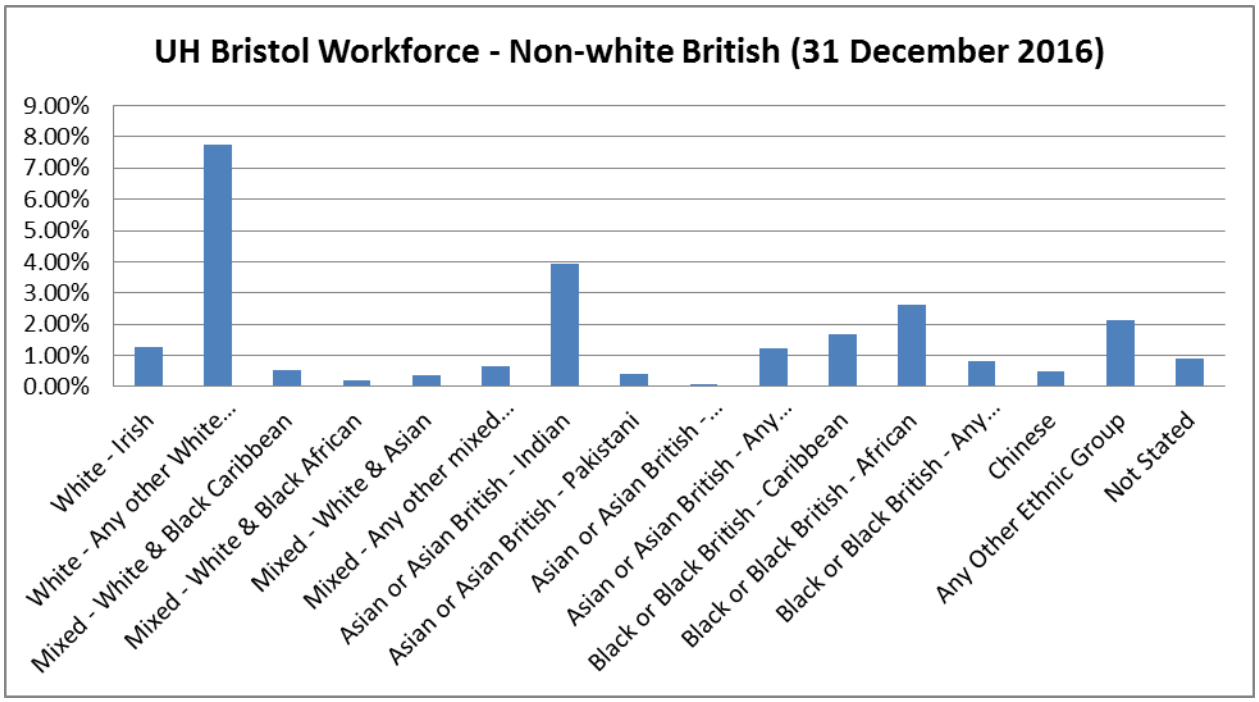


Race: 15% of UH Bristol staff are from a BME background, compared with 22% of the Bristol population

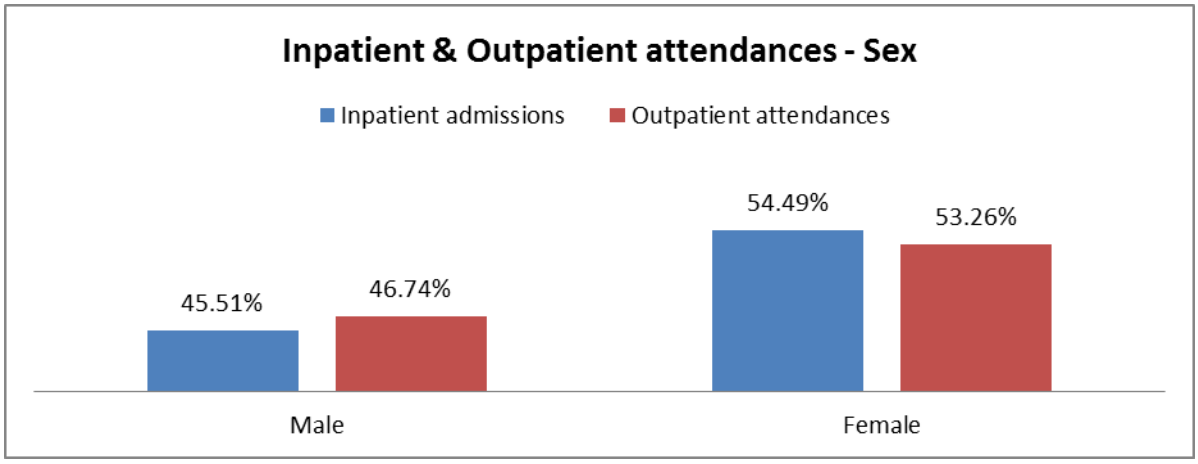
(76% of UH Bristol staff declare as White British)

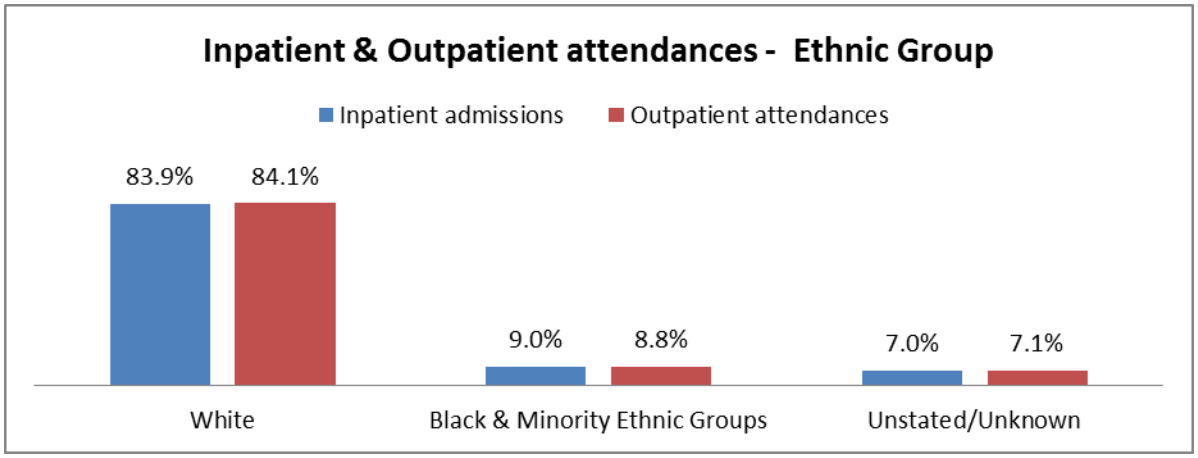


Our Workforce – Non-White British



Our patients and service users (data from January to December 2016)





Appendices

Appendix A Regulatory Requirements Background

Appendix B Equality & Diversity Strategic Objectives 2016 - 2019

Appendix C Integrated Equality & Diversity Action Plan

Appendix D Demographic Analysis of Patient Surveys 2016-2017

Appendix E EDS2 Goal – A Representative & Supported Workforce – Recommended grades

Appendix F Some workforce Diversity data (including Employee Relations cases)

Appendix G Staff Survey Respondents v Workforce demographics

Appendix H WRES Report 2016

Acknowledgements

With thanks to colleagues across the Trust who have contributed to this report.

APPENDIX A

Regulatory Requirements Background

Protected Characteristics

The protected characteristics covered by the Equality Act and PSED are:
Age
Disability
Gender reassignment
Marriage and civil partnership
Pregnancy and maternity
Race (including ethnic or national origins, colour or nationality
Religion or belief (including lack of belief)
Sex
Sexual orientation

The Trust's information in relation to its members of staff and its service users is published on the UH Bristol Website, and is included at Appendix B of this report.

Measures to improve equality

The Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard requires organisations to publish information against a number of indicators of workforce equality, and to demonstrate progress against them. The WRES highlights any differences between the experience and treatment of White staff and Black & Minority Ethnic (BME) staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
The Trust published its results in July 2015 and August 2016, which are available on the Trust's website.

The Equality Delivery System (EDS2)

The EDS2 is a toolkit which aims to help organisation improve the services they provide for their local communities and provide better working environments for all groups. There are four goals within the EDS2:

Goal 1 – Better Health Outcomes
Goal 2 – Improved Patient Access and Experience
Goal 3 – A Representative & Supported Workforce
Goal 4 – Inclusive Leadership

The goals are divided into eighteen outcomes. For most of these outcomes, the key question is "How well do people from protected groups fare, compared with people overall?"

The Trust is continuing with the extensive piece of work required to grade its performance against these goals and outcomes (and to have the self-assessment commented on by internal and external stakeholders.)

The Accessible Information Standard

The Accessible Information Standard (SCCI1605 NHS England, 2015) places a mandatory requirement on NHS and Adult Health and Social Care providers to develop a standardised

approach to identify, record, flag, meet and share information relating to patients and their information and/or communication needs, where those needs relate to a disability, cognitive impairment or sensory loss.

The Equality Act (2010) strengthened existing legislation which protected specific groups including disability. However, the reality is that many service users receive information from their healthcare providers in a format that they are unable to read and do not always receive communication support.

There is a legal requirement for all Trust staff, volunteers and others representing University Hospitals Bristol NHS Foundation Trust to provide every possible reasonable adjustment with regards to communication and information support when related to disability, impairment or sensory loss.

Those with information and/or communication support needs should not be put at disadvantage as compared to those who do not have any information or communication support needs.

APPENDIX B

OUR EQUALITY & DIVERSITY STRATEGIC OBJECTIVES

The Trust's Strategic Equality & Diversity Objectives for 2016 – 2019 have been developed by the Trust's Equality & Diversity Group, informed by key priorities from a range of sources including the Workforce Race Equality Standard, the National Staff Survey results and the EDS2 self-assessment, and supported by the Equality & Diversity Action Plan.

It is vital that the objectives have an impact on the Trust's continuing commitment to improve both patient and staff experience. They must also be underpinned by deliverable action plans and be supported by the Senior Leadership of the Trust.

What are our objectives for 2016 – 2019?

To improve access to services for our local communities

This will be measured by:

Achievement of one of the Trust's Quality Objectives for 2016/17:
"To fully implement the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted."

Completion of the EDS2 self-assessment. In particular the Better Health Outcomes and Improved Patient Access & Experience Goals, which will provide evidence of good practice and identify areas for improvement.

Completion of a review of the processes for patient monitoring data, seeking to reduce numbers of not declared/not known, and increase information collected for all protected characteristics. (Increased information will better able to Trust to provide services aligned to the needs of the local communities.)

To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.

In particular:
Increase recruitment activities to engage with local talent, encouraging people from all backgrounds to view the Trust as an employer of choice

Make full use of the Succession Planning element of the 5 Year Teaching and Learning Framework to facilitate and encourage the progress of staff from BME backgrounds

This will be measured by:

The outcomes and recommendations from reviews of the Trust's recruitment processes for potential unconscious bias, and the criteria for appointments - including ensuring executive search agencies are committed to diversity in their processes.

The relative likelihood of shortlisted applicants from BME (Black and Minority Ethnic) groups being appointed, compared with White applicants – as reported in the Workforce Race Equality Standard.

The response from BME staff to the Staff Survey question regarding equal opportunities for career progression – as reported in the Workforce Race Equality Standard

Benchmarking against other Trusts – learning from, and sharing, best practice where succession planning and development programmes are in place to support an equal playing field for potential future applicants for senior manager and Board positions from diverse backgrounds.

Reporting and analysing all staff training data.

Completion of the EDS2 self-assessment – Representative and Supported Workforce Goal, which will provide evidence of good practice and identify areas for improvement

To work towards a more inclusive and supportive working environment for all of our staff.

With an emphasis on providing an environment free from harassment, bullying or abuse from colleagues or service users

This will be measured by:

The results of the National Staff Survey, with particular reference to the experience of staff from protected groups.

The experience of staff from BME (Black & Minority Ethnic) groups as measured by the Workforce Race Equality Standard.

Actions on recruitment and training information as above.

Completion of the EDS2 self-assessment – Representative and Supported Workforce Goal, which will provide evidence of good practice and identify areas for improvement.

Actions from Staff Engagement Action Plans – Trust-wide & Divisional, and the Workforce Race Equality Standard Action Plan.

Development of a resource pack on Equality & Diversity for managers and leaders to access via HR Web.

Progress against all of the objectives will be reported to the Trust's Equality & Diversity Group and onwards to the Trust's Workforce & OD Group. Progress during 2016/17 will be reported in next year's Annual Report.

APPENDIX C
Integrated Equality & Diversity Action Plan

Planned actions	Planned Completion Date/Frequency	Supports Objective/EDS2 Goal/WRES	RAG rating
TRAINING			
Training and briefings/seminars for and Trust Board on 'Unconscious Bias' completed	Trust Board Seminar July 2016.	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels WRES Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts	
Introduction of training to raise awareness of unconscious bias/stereotyping – specifically inclusion in Recruiting the Best training for recruiting managers	End of November 2016	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** WRES Indicator 1 (Percentage of BME staff in Bands 1 - 9 and VSM) and 7 (Percentage of BME staff believing the Trust provides equal opportunities for career progression/promotion)	
Resource pack on Equality and Diversity available for all staff to access via HR Web	Ongoing (as information is provided/becomes available)	**To work towards a more inclusive and supportive working environment for all of our staff**. EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	
Implementation of a robust Trust wide system for reporting on centrally-held diversity data on essential and non mandatory training (where held on LMS)	End of May 2017	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff.** EDS2 Outcome 3.3 Training and development opportunities are taken up and positively evaluated by	

		all staff WRES Indicator 4 (Relative likelihood of staff accessing non-mandatory training and CPD) and 7 (Percentage believing the Trust provides equal opportunities for career progression/promotion	
Training and briefings/seminars for the Senior Leadership Team to be implemented	End of December 2017 (and ongoing as appropriate)	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels EDS2 Goal 4: Inclusive Leadership WRES Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts	
Equality & Diversity online training in place for all staff	End of May 2017	**To work towards a more inclusive and supportive working environment for all of our staff**. EDS2 Outcome 3.6 Staff report positive experiences of their membership of the workforce. WRES Indicators 6 & 8 re experience of harassment, bullying, discrimination from staff	On-line training added to all staff portfolios 24th Feb 17. Inclusion in 3-yearly Corporate Updates approved by ETSG April 2017.
STAFF EXPERIENCE			
Review the Trust's recruitment processes for potential unconscious bias, as per the recommendations in the South West Audit report into Equality in Recruitment.	End of December 2016	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust** EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Assurance received from Head of Resourcing that actions are either in place or planned. Original deadline of end December for review of Recruitment Policy now March 2017 due to process mapping.
Implement a review of agencies used for the recruitment	Timescale for	**To improve the opportunities for members of our**	

of senior staff and executives, to provide assurance that they have fair selection processes with no barriers to employment of people from protected groups.	implementation to be confirmed.	**diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff.** EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels. WRES Indicator 1 (Percentage of BME staff in Bands 1 - 9 and VSM) and 9 (Percentage difference between the organisation's Board voting membership and its overall workforce)	
Implement, where appropriate, recommendations from the 2015 report into disciplinary outcomes that additional training and support should be given to managers and supervisors in the application of the Disciplinary Policy. Data now being prepared for WRES report based on 2016/2017 data. Data comparisons to be made in respect of numbers of disciplinary cases and outcomes to establish whether there is equity in application of the process.	End of September 2017	**To work towards a more inclusive and supportive working environment for all of our staff** WRES Indicator 3 - Relative likelihood of staff entering the formal disciplinary process	
Implement a divisional plan to increase staff awareness that clinical incident reporting must be used to report incidents of harassment, bullying, abuse or discrimination by patients, relatives and the general public. Reports from Datix to be presented to E&D Group from July 2017 for discussion if additional actions needed in Divisions	From July 2017	**To work towards a more inclusive and supportive working environment for all of our staff.** EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source. WRES Indicators 5, 6 and 8 re experience of harassment, bullying and discrimination	
Develop and implement a succession planning framework which supports equality of access to continuing professional development for all protected groups. (To consider the inclusion of Reverse Mentoring)	End of October 2017	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust** WRES Indicator 1 (Percentage of BME staff in Bands 1 - 9 and VSM), 4 (Relative likelihood of staff accessing non-mandatory training and CPD)and 7 (Percentage of	

		BME staff believing the Trust provides equal opportunities for career progression/promotion)	
Support the introduction of a 'Dignity at Work Policy'		**To work towards a more inclusive and supportive working environment for all of our staff.** EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source, and 3.6 Staff report positive experiences of their membership of the workforce WRES Indicators 5, 6 and 8 re experience of harassment, bullying and discrimination	
PATIENT EXPERIENCE			
To enable equalities reporting for patients in line with the Public Sector Equality duty (PSED)	End of June 2017	**To improve access to services for our local communities** EDS2 Goals: Better health outcomes Improved patient access and experience	
EQUALITY DELIVERY SYSTEM (EDS2)			
Completion of the EDS2 self-assessment (Representative & supported workforce)	End of December 2016	**To improve access to services for our local communities** **To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff.** And all EDS2 Goals & Outcomes: Better health outcomes Improved patient access and experience A representative and supported workforce Inclusive leadership	Completed April 2017
Completion of external assessment (Representative & supported workforce)	End of September 2017		
Completion of EDS2 self-assessments for two pilot areas (Maternity Services and Radiology)	End of November 2017		
Completion of external assessment & publication for two pilot areas	End of January 2018		
Develop training and additional support for managers to enable collation of information for self-assessment across other areas of the Trust.	End of September 2017		
Develop and implement timeframe for roll-out of EDS2 self-assessment across the Trust	End of March 2018		
GOVERNANCE			

Review and refresh the Equality Objectives for the Trust to give us a clear, measurable framework for our activities.	Completed and published August 2016	**Public Sector Equality Duty**	
Completion of a review of the Trust's processes for undertaking and completing equality analysis, and introduction of a refreshed process.	End of June 2017	**To improve access to services for our local communities** **To work towards a more inclusive and supportive working environment for all of our staff** EDS2 Outcome 4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Draft approved by E&D Group. Submission to Improving Staff Experience Group and Senior Leadership Team Summer 2017
To support the Trust in fulfilling its obligation under the PSED, by annual reporting on and publishing of equalities data for workforce and service users, by production of an annual Equality & Diversity report, including progress against the Trust's Equality Objectives and by compliance with the reporting requirements of the WRES, EDS2, AIS and other regulatory requirements.	Annually (July/August) and as required.	**All Trust E&D Strategic Objectives** All EDS2 Goals & Outcomes All WRES Indicators and outcomes	
MONITORING & ASSURANCE			
Completion of Equal Pay Audit across all staff groups		**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** EDS2 Outcome: 3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Audit report delivered Feb 2017. Management response submitted. Actions to be confirmed to action leads.
Provide quarterly assurance that the outcomes/recommendations of the South West Audit report into equality in recruitment have been implemented	Quarterly as of July 2017	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust** EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels WRES Indicator 1 (Percentage of staff in each of the AfC	

		Bands and VSM) & 7 (Percentage believing that Trust provides equal opportunities for career progression or promotion**)**	
Ensure equalities information is recorded for all starters.	End of December 2017	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** WRES Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts.	
Provide quarterly assurance that the succession planning framework supports an equal playing field for potential future applicants for Senior Manager and Board positions from diverse backgrounds.	End of December 2017	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** WRES Indicator 1 (Percentage of BME staff in Bands 1 - 9 and VSM) and 9 (Percentage difference between the organisation's Board voting membership and its overall workforce) Indicators 1 and 9	
Provide quarterly assurance of the monitoring of issues of harassment, bullying or abuse highlighted in the Staff Survey and included in divisional engagement plans	As of January 2017	**To work towards a more inclusive and supportive working environment for all of our staff** EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source, and 3.6 Staff report positive experiences of their membership of the workforce WRES Indicators 5, 6 and 8 re experience of harassment, bullying and discrimination	

Demographic analysis of UH Bristol's monthly inpatient postal survey (2016-17)

1. Purpose of this report

This report presents a breakdown of overall patient-reported care ratings by the demographic variables collected via UH Bristol's monthly inpatient postal survey (age, sex, ethnicity, sexuality, religion, and disability). The analysis aims to identify trends in the data to generate further discussion about equality and diversity issues in the delivery of care at UH Bristol. Due to the complexity of the issues being considered in this report, and the fact that it draws on data from a survey that is not designed to measure these factors, the report cannot be used to *prove* whether differences exist between demographic groups or provide insight on why any differences are occurring.

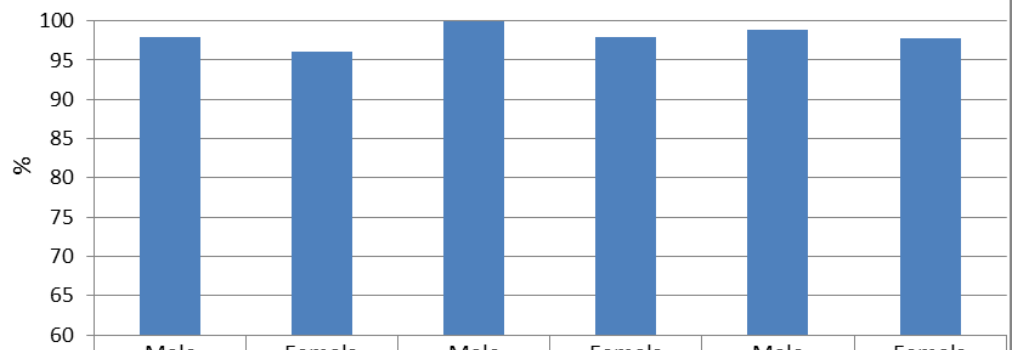
Please note that whilst comparisons are provided to previous years, a change in the methodology for 16/17 generally led to slightly higher satisfaction scores for that year[2]. Margins of error in the data mean that scores fluctuate naturally over time and between groups. Unless otherwise stated in the report, it should be assumed that differences in scores are not statistically significant.

2. Overall inpatient care ratings by demographic group

Sex

Females tend to be slightly less satisfied with their hospital experience than males. This is in line with trends seen at a national level. The reasons for this are unclear and it could be linked to a number of other factors (e.g. women tend to live longer and experience different hospital services).

Chart 1: overall care rating by sex (all data are percentages)



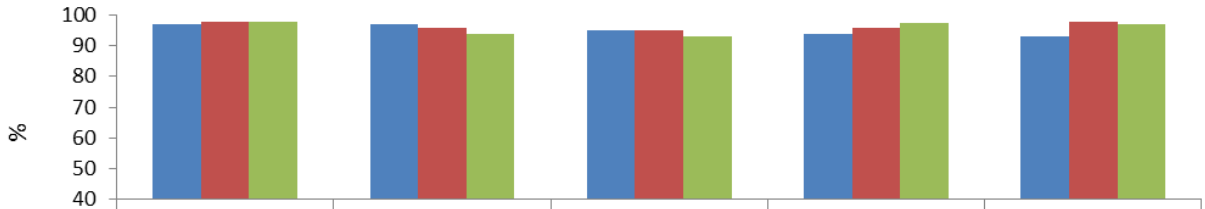
	Male	Female	Male	Female	Male	Female
	2014-15		2015-16		2016-17	
% Excellent, very good, good	98	96	100	98	99	98

[2] We dropped the reminder letter from the survey process – reducing the response rate but allowing more rapid access to the survey results. To reduce the variability in comparing with previous years, in this report we have presented aggregate scores (percentage rating the care as excellent, very good, or good) - rather than rely on a single response category (e.g. excellent).

Ethnicity

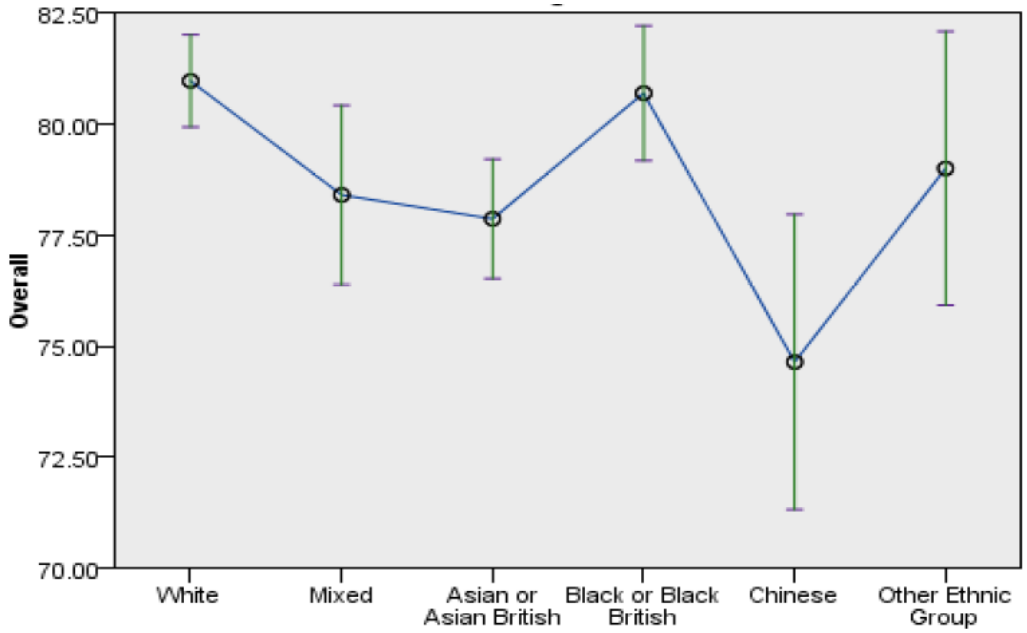
None of the differences shown in Chart 2 reach statistical significance, therefore any variations seen should be considered a result of chance fluctuation in the data. However, over the last three years the Trust has received slightly lower overall satisfaction ratings from our Asian / Asian British patients, compared to our White patients. The reasons cannot be determined from this survey – but it is in line with general trends seen nationally (Chart 3).

Chart 2: Inpatients rating their care as excellent, very good or good by ethnic group



	White	Mixed	Asian or Asian British	Black or Black British	Other Ethnic Groups
2014-15	97	97	95	94	93
2015-16	98	96	95	96	98
2016-17	98	94	93	98	97

Chart 3: National-level patient satisfaction by ethnic group



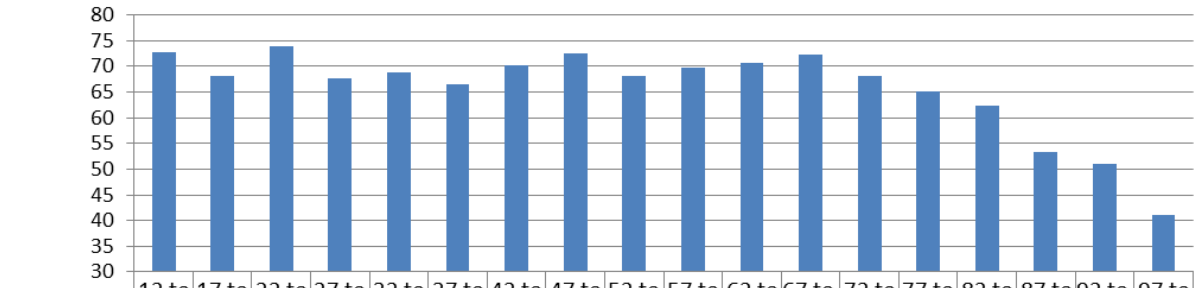
Source: Picker Institute Europe (please note that the scoring system is not directly comparable to the one used in Chart 2 and Table 1. Also, there are insufficient responses in the UH Bristol survey to break the data down in to all of the groups shown in the Picker data)

Age

The care ratings shown in Chart 4 broadly correspond to trends seen at a national level (Chart 5) - with scores steadily increasing with age and then dipping back again for the very oldest patients. Interestingly our data suggests that our younger patients buck the national trend, with

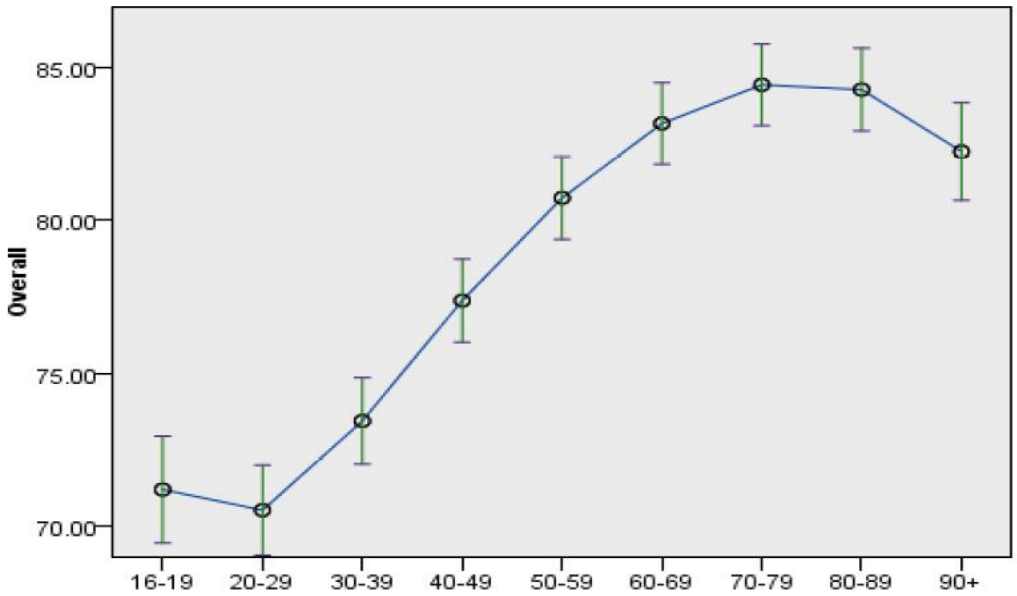
relatively high satisfaction ratings for UH Bristol amongst 12-21 years. Conversely, the fall-off in satisfaction in the oldest age groups is more marked at UH Bristol than nationally.

Chart 4: % rating the care as excellent (by age category)



	12 to 16	17 to 21	22 to 26	27 to 31	32 to 36	37 to 41	42 to 46	47 to 51	52 to 56	57 to 61	62 to 66	67 to 71	72 to 76	77 to 81	82 to 86	87 to 91	92 to 96	97 to 101
% excellent	73	68	74	68	69	66	70	72	68	70	71	72	68	65	62	53	51	41

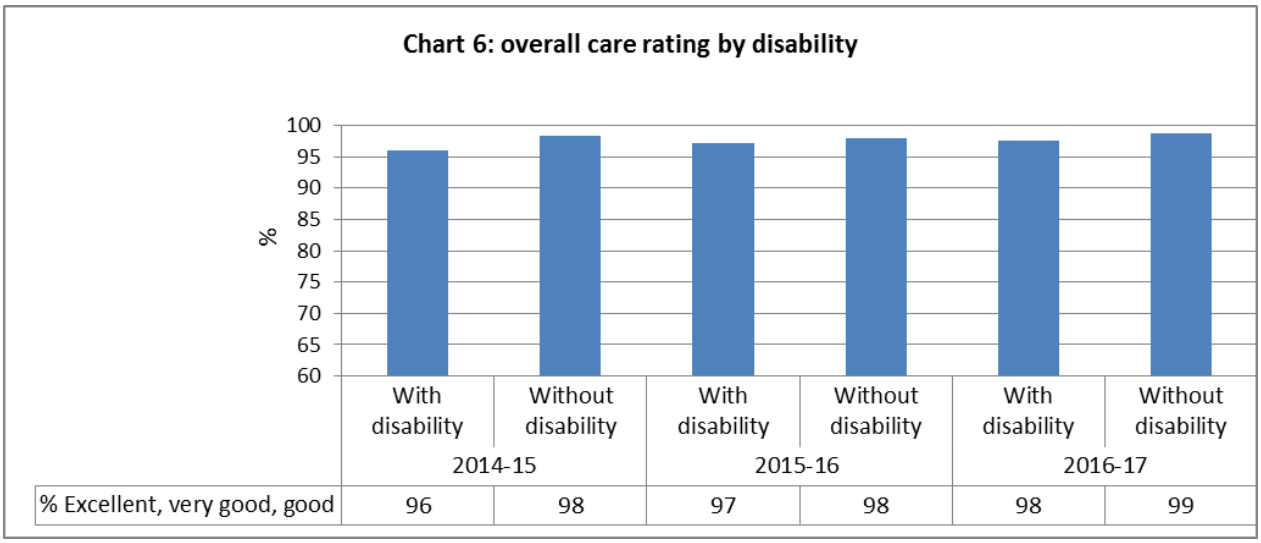
Chart 5: National-level patient satisfaction by age group



Source: Picker Institute Europe (please note that the scoring system is not directly comparable to the one used in Chart4. Also, it can be seen that the age categories used are different between Charts 4 and 5 – although the general trend can still be compared)

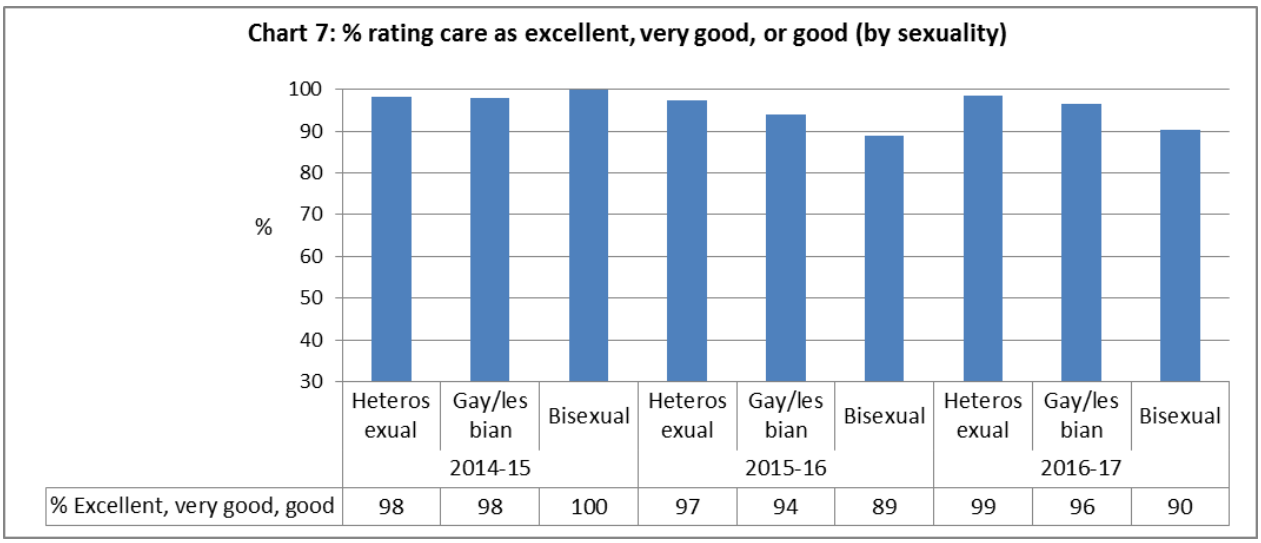
Disability

In our questionnaire, patients are asked to state whether they consider themselves to have a disability. It can be seen in Chart 6 that patients with a disability are slightly less likely to rate their care as excellent, very good, or good. However, it is again not possible to be sure that this is related to the disability *per se,* or what the reasons behind this might be.



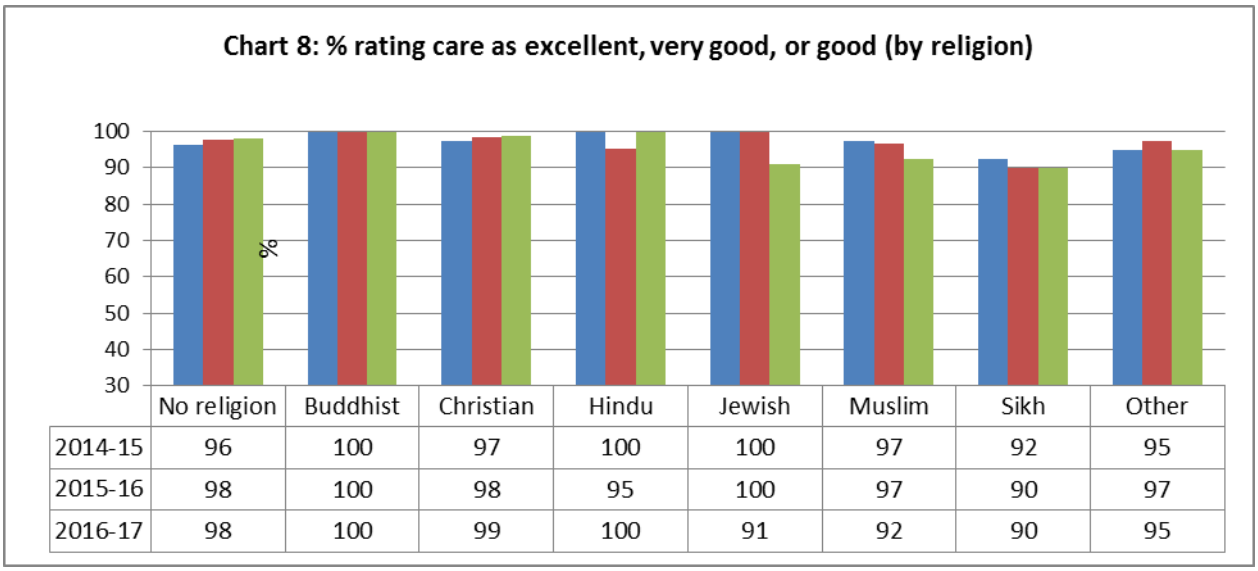
Sexuality

The sample sizes for the gay and bi-sexual groups are very small in Chart 7 and so we can see quite large fluctuations in the data. The differences do not reach statistical significance however.



Religion

Again the sample sizes are very low for some of the groups shown in Chart 8 and there is no statistically significant difference evident.



	No religion	Buddhist	Christian	Hindu	Jewish	Muslim	Sikh	Other
2014-15	96	100	97	100	100	97	92	95
2015-16	98	100	98	95	100	97	90	97
2016-17	98	100	99	100	91	92	90	95

3. Conclusions

The data presented in this report does not in itself provide evidence of an "equalities and diversities" bias in the delivery of UH Bristol's inpatient care. Even where a difference is identified between demographic groups in this analysis, it is impossible to isolate the various factors that may be influencing the outcome, and therefore to identify where to target improvements. Nevertheless, the Patient Experience Group can consider the key findings of this report and identify potential opportunities to improve care.

Paul Lewis, Patient Experience and Involvement Team Manager, UH Bristol.

APPENDIX E

EDS2 – Initial Self-Assessment Grading for Goal 3 – Representative & Supported Workforce

The Equality & Diversity Group carried out a self-assessment of the six Outcomes included in the EDS2 Goal – A Representative & Supported Workforce on 28th February 2017.

Based on the evidence presented, the Group recommended an initial grading for each outcome. (The potential gradings are Undeveloped, Developing, Achieving and Excelling.) For each outcome, the group was also asked to consider whether staff from protected groups fare well. The Group's recommended initial gradings and rationale are given below.

3.1 – Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.
The Trust's Head of Resourcing contributed to the evidence included for this outcome. The Recruitment Policy is being reviewed at the moment and will include the changes recommended in the SW Audit report referred to in the template.
The Group recommended that the initial grading should be Developing.
This reflects the under-representation of some protected groups at higher levels in the Trust. The Group also considered that, whilst it is possible to indicate the protected characteristics which fare well, it should be explained in the evidence that it is difficult to identify evidence for all protected groups and that none fare badly.

3.2 – The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their obligations.
The Group suggested that the inclusion of information about equal opportunities for career progression was not strictly necessary (although this had been included in the remit of the Audit South West report into Equal Pay).
The Group recommended that the initial grading should be Achieving.
This is based on the use of Agenda for Change and the completion of the equal pay audit. However, the Group also recommended that the grading should be qualified as the audit had not extended to all of the protected groups.

3.3 – Training and development opportunities are taken up and positively evaluated by all staff
The Group discussed whether this should be measured on take-up of the training required for all staff to be able to do their jobs (Essential Training), or the additional opportunities for development available and taken up. It was felt that although training opportunities are there, access to them is dependent on where you are in the organisation and how well the opportunities are communicated.
The Group therefore recommended two components to the initial grading:
Achieving where validated compliance evidence is available
Developing for non-mandatory training

3.4 – When at work staff are free from abuse, harassment, bullying and violence from any source
The Group recommended that the initial grading should be Developing.
This is based on consistent information about staff experience from the National Staff Survey, employee relations cases and anecdotal evidence, and Divisional and other plans to address the ongoing issues.

3.5 – Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives.
It was acknowledged that the Trust has flexible working policies and options. However, these opportunities are not necessarily made available to all staff and there is inconsistency in some areas in the application of the processes.

The Group therefore recommended an initial grading of Developing.
The Group also recommended that there should be a focus in the coming year on consistency of application of process supported by training for managers.

3.6 – Staff report positive experiences of their membership of the workforce.
The evidence for this outcome is predominantly based on responses to the National Staff Survey.
The Group recommended an initial grading of Developing.

The Workforce & Organisational Group approved these recommended gradings in April 2017. The evidence templates can be viewed on the Trust's website at Equality & Diversity - Measures to Improve Equality, where members of the public are invited to comment.

APPENDIX F

BACKGROUND EQUALITY DATA 2016

Equality legislation requires us to collect a range of pre and post-employment information, and information relating to patients accessing our services. The information below is an extract from the data which is available on the Trust's website. It is for the calendar years 1st January to 31st December 2015 and 1st January to 31st December 2016 unless otherwise stated.

Staff in post (all substantive staff)

Age band	Headcount 31 December 2015	Proportion of Headcount December 2015
16 – 20	94	1.1%
21 – 25	861	9.7%
26 – 30	1,284	14.4%
31 – 35	1,289	14.5%
36 – 40	1,172	13.2%
41 – 45	1,054	11.8%
46 – 50	989	11.1%
51 – 55	1,028	11.5%
56 – 60	761	8.5%
61 – 65	295	3.3%
66 - 70	62	0.7%
71 - 77	18	0.2%
Grand Total	**8,907**	**100.0%**

Age band	Headcount 31 December 2016	Proportion of Headcount December 2016
16 – 20	87	0.9%
21 – 25	847	9.2%
26 – 30	1,389	15.1%
31 – 35	1,354	14.7%
36 – 40	1,204	13.1%
41 – 45	1,069	11.6%
46 – 50	1,007	10.9%
51 – 55	1,023	11.1%
56 – 60	804	8.7%
61 – 65	345	3.7%
66 - 70	74	0.8%
71 - 77	21	0.2%
Grand Total	**9,224**	**100.0%**

Disability	Headcount December 2015	Proportion of Headcount December 2015
No	8,291	93.1%
Not Declared	363	4.1%
Yes	253	2.8%
Grand Total	**8,907**	**100.0%**

Disability	Headcount December 2016	Proportion of Headcount December 2016
No	8,667	94.0%
Not Declared	296	3.2%
Yes	261	2.8%
Grand Total	**9,224**	**100.0%**

Gender	Headcount December 2015	Proportion of Headcount December 2015
Female	6,896	77.4%
Male	2,011	22.6%
Grand Total	**8,907**	**100.0%**

Gender	Headcount December 2016	Proportion of Headcount December 2016
Female	7,113	77.1%
Male	2,111	22.9%
Grand Total	**9,224**	**100.0%**

Ethnicity	Headcount December 2015	Proportion of Headcount December 2015
White	7,476	83.9%
Black & Minority Ethnic Groups	1,322	14.8%
Not Stated	109	1.2%
Grand Total	**8,907**	

Ethnicity	Headcount December 2016	Proportion of Headcount December 2016
White	7,746	84.0%
Black & Minority Ethnic Groups	1,397	15.1%
Not Stated	80	0.9%
Grand Total	**9,224**	**100.0%**

Religious Belief	Headcount December 2015	Proportion of Headcount December 2015
Atheism	1,088	12.2%
Buddhism	47	0.5%
Christianity	3,542	39.8%
Hinduism	102	1.1%
Islam	155	1.7%
Jainism	3	0.0%
Judaism	6	0.1%
Sikhism	18	0.2%
Other	523	5.9%
I do not wish to disclose my religion/belief	3,391	38.1%
Undefined	32	0.4%
Grand Total	**8,907**	**100.0%**

Religious Belief	Headcount December 2016	Proportion of Headcount December 2016
Atheism	1,213	13.2%
Buddhism	54	0.6%
Christianity	3,705	40.2%
Hinduism	113	1.2%
Islam	190	2.1%
Jainism	2	0.0%
Judaism	9	0.1%
Sikhism	13	0.1%
Other	588	6.4%
I do not wish to disclose my religion/belief	3,312	35.9%
Undefined	24	0.3%
Grand Total	**9,224**	**100.0%**

Sexual Orientation	Headcount December 2015	Proportion of Headcount December 2015
Bisexual	37	0.4%
Gay	54	0.6%
Heterosexual	5.981	67.1%
Lesbian	35	0.4%
I do not wish to disclose my sexual orientation	2,770	31.1%
Undefined	30	0.3%
Grand Total	**8,907**	**1.00.0%**

Sexual Orientation	Headcount December 2016	Proportion of Headcount December 2016
Bisexual	45	0.5%
Gay	61	0.7%
Heterosexual	6,408	69.5%
Lesbian	38	0.4%
I do not wish to disclose my sexual orientation	2,649	28.7%
Undefined	23	0.2%
Grand Total	**9,224**	**100.0%**

Employee Relations Cases – as recorded on the Trust's Case Management System

(In line with reporting requirements for the Workforce Race Equality Standard, the reporting period is 1st April – 31st March for each year. The numbers include all cases live during those periods.)

Harassment & Bullying Cases (recorded under the Trust policy)

Diversity data for both Harassment & Bullying and Grievance cases refers to the person making the complaint.

Gender	Number of cases 1 April 2015 – 31 March 20116	Proportion of cases 2015/2016
Female	15	71.4%
Male	4	19.0%
Group	1	4.8%
Not reported	1	4.8%
Grand Total	**21**	**100.0%**

Gender	Number of cases 1 April 2016 – 31 March 2017	Proportion of cases 2016/2017
Female	16	64.0%
Male	7	28.0%
Group	1	4.0%
Not reported	1	4.0%
Grand Total	**25**	**100.0%**

Disability	Number of cases 1 April 2015 – 31 March 2016	Proportion of cases 2015/2016
Yes	0	
No	19	90.5%
Group	1	4.8%
Not declared/reported	1	4.8%
Grand Total	**21**	

Disability	Number of cases 1 April 2016 – 31 March 2017	Proportion of cases 2016/2017
Yes	1	4.0%
No	22	88.0%
Group	1	4.0%
Not declared/reported	1	4.0%
Grand Total	**25**	

Ethnic Background	Number of cases 1 April 2015 – 31 March 2016	Proportion of cases 2015/2016
White	16	76.2%
Black & Minority Ethnic Groups	3	14.3%
Not Stated / not reported	2	9.5%
Grand Total	**21**	

Ethnic Background	Number of cases 1 April 2016 – 31 March 2017	Proportion of cases 2016/2017
White	16	64.0%
Black & Minority Ethnic Groups	7	28.0%
Not Stated / not reported	2	8.0%
Grand Total	**25**	

Grievance Cases (recorded under the Trust policy)
Diversity data for both Harassment & Bullying and Grievance cases refers to the person making the complaint.

Gender	Number of cases 1st April 2015 – 31st March 2016	Proportion of cases 2015/2016
Female	12	60.0%
Male	7	35.0%
Group	1	5.0%
Not reported		
Grand Total	**20**	

Gender	Number of cases 1st April 2016 – 31st March 2017	Proportion of cases 2016/2017
Female	17	63.0%
Male	8	29.6%
Group	1	3.7%
Not reported	1	3.7%
Grand Total	**27**	

Disability	Number of cases 1st April 2015 – 31st March 2016	Proportion of cases 2015/2016
Yes	1	5.0%
No	17	85.0%
Group	1	5.0%
Not declared/reported	1	5.0%
Grand Total	**20**	

Disability	Number of cases 1st April 2016 – 31st March 2017	Proportion of cases 2016/2017
Yes	0	
No	23	85.2%
Group	1	3.7%
Not declared/reported	3	11.1%
Grand Total	**27**	

Ethnic Background	Number of cases 1st April 2015 – 31st March 2016	Proportion of cases 2015/2016
White	13	65.0%
Black & Minority Ethnic Groups	6	30.0%
Not Stated / not reported	1	5.0%
Grand Total	**20**	

Ethnic Background	Number of cases 1st April 2016 – 31st March 2017	Proportion of cases 2016/2017
White	20	74.1%
Black & Minority Ethnic Groups	5	18.5%
Not Stated / not reported	2	7.4%
Grand Total	**27**	

Disciplinary Cases (recorded under the Trust policy)

Gender	Number of cases 1st April 2015 – 31st March 2016	Proportion of cases 2015/2016
Female	54	54.5%
Male	45	45.5%
Grand Total	**99**	**100.0%**

Gender	Number of cases 1st April 2016 – 31st March 2017	Proportion of cases 2016/2017
Female	50	54.9%
Male	41	45.1%
Grand Total	**91**	**100.0%**

Disability	Number of cases 1st April 2015 – 31st March 2016	Proportion of cases 2015/2016
Yes	2	2.0%
No	93	93.9%
Not declared/reported	4	4.0%
Grand Total	**99**	**99.0%**

Disability	Number of cases 1st April 2016 – 31st March 2017	Proportion of cases 2016/2017
Yes	3	3.3%
No	85	93.4%
Not declared/reported	3	3.3%
Grand Total	**91**	**100.0%**

Ethnic Background	Number of cases 1st April 2015 – 31st March 2016	Proportion of cases 2015/2016
White	64	64.6%
Black & Minority Ethnic Groups	34	34.3%
Not Stated / not reported	1	1.0%
Grand Total	**99**	**99.0%**

Ethnic Background	Number of cases 1st April 2016 – 31st March 2017	Proportion of cases 2016/2017
White	60	65.9%
Black & Minority Ethnic Groups	30	33.0%
Not Stated / not reported	1	1.1%
Grand Total	**91**	**100.0%**

APPENDIX G

Staff Survey Respondents v Workforce Demographics

Staff in Post as at 31st December 2016

Staff Survey 2016 (42% returns)

Gender	Headcount	% of Total	Number returned	Percentage of survey respondents
Female	7113	77.1%	2,721	78%
Male	2111	22.9%	759	22%
Did not specify			117	
Grand Total	9224	100.0%	3597	100%

Disabled	Headcount	% of Total	Number returned	Percentage of survey respondents
Yes	261	2.8%	512	15%
No	8667	94.0%	2942	85%
Not Declared/Did not specify	296	3.2%	143	
Grand Total	9224	100.0%	3597	100%

Ethnic Group	Headcount	% of Total	Number returned	Percentage of survey respondents
White	7746	84.0%	3136	90%
Black & Minority Ethnic background	1397	15.1%	365	10%
Not stated / did not specify	81	0.9%	96	
TOTAL	9224	100.0%	3597	100%

Age Range	Headcount	% of Total	Number returned	Percentage of survey respondents
16 - 20	87	0.9%		
21 - 25	847	9.2%		
26 - 30	1389	15.1%	659	19%
31 - 35	1354	14.7%		
36 - 40	1204	13.1%	818	23%
41 - 45	1069	11.6%		
46 - 50	1007	10.9%	830	24%
51 - 55	1023	11.1%		
56 - 60	804	8.7%		
61 - 65	345	3.7%		
66 - 70	74	0.8%		
71 - 76	21	0.2%	1214	34%
Did not specify			76	
Grand Total	9224	100.0%	3597	100%

Sexual Orientation	Headcount	% of Total	Number returned	Percentage of survey respondents
Heterosexual	6408	69.5%	3185	98%
LGBO	144	1.6%	120	3%
Not stated / did not specify	2672	29.0%	292	8%
TOTAL	9224	100.0%	3597	100%

APPENDIX H

Workforce Race Equality Standard Indicators July 2016

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

For each of these four workforce indicators, compare the data for White and BME staff.

1 — **Percentage of staff in each of the AfC Bands 1 – 9 and VSM (including executive Board members and senior medical staff) compared with the percentage of staff in the overall workforce. (Organisations should undertake this calculation separately for non-clinical & for clinical staff)**

Data for reporting year (2016)

Overall workforce = 84% White and 15% BME

Non-Clinical Staff

	White	BME
Band 1	51.0%	49.0%
Band 2	87.3%	12.7%
Band 3	91.6%	8.4%
Band 4	95.2%	4.8%
Band 5	94.4%	5.6%
Band 6	90.7%	9.3%
Band 7	97.3%	2.7%
Band 8A	91.3%	8.7%
Band 8B	100.0%	0.0%
Band 8C	91.7%	8.3%
Band 8D	100.0%	0.0%
Band 9	100.0%	0.0%
VSM	100.0%	0.0%

Data for previous year (2015)

Overall workforce = 85% White and 15% BME

Non-Clinical Staff

	White	BME
Band 1	55.3%	44.7%
Band 2	88.6%	11.4%
Band 3	92.1%	7.9%
Band 4	95.0%	5.0%
Band 5	95.4%	4.6%
Band 6	90.2%	9.8%
Band 7	98.1%	1.9%
Band 8A	91.7%	8.3%
Band 8B	97.6%	2.4%
Band 8C	100.0%	0.0%
Band 8D	100.0%	0.0%
Band 9	100.0%	0.0%
VSM	100.0%	0.0%

Narrative

Data is as at 31st March 2015 and 31st March 2016, as submitted via UNIFY2.

The percentage shown is for each pay band.
Whilst the percentage of BME staff in the lowest band (Band 1) is much higher than that in the overall workforce, BME staff are under-represented in other Agenda for Change pay bands, especially at senior levels.

The exception is Band 5 non-medical clinical staff – typically from the Nursing & Midwifery staff group.

Non-clinical staff on Band 1 would typically be from the

Action taken and planned

Actions taken:
July 2016: the Trust Board received presentations from Yvonne Coghill, NHS England Director, WRES, outlining the priorities of WRES, and on unconscious bias.

As part of the Equality & Diversity Action Plan, an Audit Southwest review of recruitment processes was commissioned and delivered in July 2016.

Planned actions:
Roll out training to raise awareness of unconscious bias/stereotyping – specifically inclusion in Recruiting the Best training for recruiting managers.
Consider how and who to

Clinical Staff - *Non-Medical*

	White	BME
Band 1	70.2%	29.8%
Band 2	81.4%	18.6%
Band 3	89.9%	10.1%
Band 4	92.7%	7.3%
Band 5	78.9%	21.1%
Band 6	91.0%	9.0%
Band 7	95.8%	4.2%
Band 8A	94.4%	5.6%
Band 8B	97.8%	2.2%
Band 8C	97.1%	2.9%
Band 8D	100.0%	0.0%
Band 9	100.0%	0.0%
VSM	100.0%	0.0%

Clinical Staff - *Medical & Dental*

	White	BME
Consultants (including Senior Medical Staff)	83.7%	16.3%
Non-consultant career grades	71.4%	28.6%
Trainee grades	81.7%	18.3%
Other	33.3%	66.7%

Clinical Staff - *Non-Medical*

	White	BME
Band 1	72.2%	27.8%
Band 2	81.9%	18.1%
Band 3	89.6%	10.4%
Band 4	94.7%	5.3%
Band 5	77.6%	22.4%
Band 6	91.5%	8.5%
Band 7	96.3%	3.7%
Band 8A	94.0%	6.0%
Band 8B	97.8%	2.2%
Band 8C	94.1%	5.9%
Band 8D	100.0%	0.0%
Band 9	100.0%	0.0%
VSM	100.0%	0.0%

Clinical Staff - *Medical & Dental*

	White	BME
Consultants (including Senior Medical Staff)	84.9%	15.1%
Non-consultant career grades	75.8%	24.2%
Trainee grades	80.0%	20.0%
Other	33.3%	66.7%

Estates & Ancillary staff group.

Clinical Staff on Medical & Dental pay grades more closely align with the ethnic make-up of the overall workforce

implement recommendations from the Audit SouthWest report – specifically carrying out regular sample checks of interview notes for unsuccessful candidates to identify any potential bias at interview stage.

Scrutiny of the succession planning element of the 5 year Teaching & Learning Framework, to include Reverse Mentoring and ensuring access to Continuing Professional Development.

Exploration of how disparities can be taken into consideration as part of Retention and Appraisal plans, Workforce and Divisional Business Continuity plans, as recommended by the Equality and Diversity Group and included in the E&D Action Plan.

Links to the revised Equality & Diversity Strategic Objective for 2016 – 2019:
To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.

2	**Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts**			
	Data for reporting year (2016)	*Data for previous year (2015)*	*Narrative*	*Action taken and planned*
	White staff 1.54 times more likely to be appointed from shortlisting than BME staff.	White staff 1.86 times more likely to be appointed from shortlisting than BME staff.	Data is for the calendar years 2014 and 2015, as submitted via UNIFY 2. All data for 2014 taken from NHS Jobs. For unavoidable reasons, two different systems have been used to provide the data for 2015. The figures for staff appointed who have not disclosed of not stated their ethnicity is much higher than would be expected.	*Actions taken:* *As for Indicator 1, above.* *Planned actions:* *Actions relating to Recruitment as for Indicator 1, above.* *Discover and remedy the large number of starters with unreported ethnicity.* *Links to the Strategic Objective as cited for Indicator 1, above.*

3	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**			
	Data for reporting year (2016)	*Data for previous year (2015)*	*Narrative*	*Action taken and planned*
	Relative likelihood of BME staff entering the formal disciplinary process is 2.49 times greater than White staff	Relative likelihood of BME staff entering the formal disciplinary process is 3.55 times greater than White staff	2015 data is for cases live between 1st April 2014 and 31st March 2015. 2016 data is for cases live between 1st April 2015 and 31st March 2016, excluding ongoing cases live during the previous reporting period. Both as submitted via UNIFY2.	*Actions taken:* *As part of the Equality & Diversity Action Plan, a report was completed in April 2016 benchmarking the Trust's outcome for this indicator in 2015 against other AUKUH trusts. The report also scrutinised the outcomes for different staff groups and was presented, with recommendations, to the Equality & Diversity Group in May 2016 and the WF&OD Group in July 2016.* *Planned Actions:* *Further examine the actions recommended in the*

				report and follow up as appropriate. *Carry out a comparison with the data for 2016 to identify any differences and follow up with remedial actions as appropriate.* *Examine the 2016 data for the likelihood of entering the disciplinary process by pay band, and compare with the ethnic make-up of each pay band.* *Links to the revised Equality & Diversity Strategic Objective for 2016 – 2019:* **To work towards a more inclusive and supportive working environment for all of our staff.**

<table>
<tr><td>4</td><td colspan="3">Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff</td></tr>
<tr><td></td><td>Data for reporting year (2016)</td><td>Data for previous year (2015)</td><td>Narrative</td><td>Action taken and planned</td></tr>
<tr><td></td><td>Data not available</td><td>Data not available</td><td>This data cannot be extracted from current reporting on training. As an alternative, the relative likelihood based on responses to the 2015 National Staff Survey (carried out on a full census basis) is given below.

<table>
<tr><th>Descriptor</th><th>BME 2015</th><th>White 2015</th></tr>
<tr><td>Number of staff responding to National Staff Survey 2015</td><td>402</td><td>3,128</td></tr>
<tr><td>Number of staff who stated they had received training, learning or development in the last 12 months (not including mandatory training)</td><td>283</td><td>2,269</td></tr>
<tr><td>Likelihood of receiving such training</td><td>0.70</td><td>0.725</td></tr>
</table>
</td><td>The recording and reporting of non-Mandatory training data was included in the WRES action plan for 2015.
Development of a Trust wide system for the collection of essential and non-essential training ha been delayed due to other key essential training priorities being implemented.

This is therefore a priority action for 2016, and is also included in the Equality & Diversity Action Plan.</td></tr>
</table>

			Relative likelihood - *Number of staff responding: White = 3,128; BME = 402* *Number of staff receiving non-mandatory training: White = 2,269 ; BME = 283* *Likelihood of White staff accessing training is 2,269/3,128 = 0.725* *Likelihood of BME staff accessing training is 283/402 = 0.70* ***Relative likelihood of White staff accessing non-mandatory training compared to BME staff = (0.725/0.70) 1.03 times greater.***	*Scrutiny of the succession planning element of the 5 year Teaching & Learning Framework, to include Reverse Mentoring and ensuring access to Continuing Professional Development.* *Links to the revised Equality & Diversity Strategic Objectives for 2016 – 2019:* **To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff.**

National NHS Staff Survey indicators. For each of the four staff survey indicators, compare the outcomes of the responses for White and BME Staff

5	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**			
	Data for reporting year (2016)	*Data for previous year (2015)*	*Narrative*	*Action taken and planned*
	White 28.12% BME 30.36%	White 29.70% BME 31.46%	Full census surveys were carried out in both 2014 and 2015. Data is based on these returns, as submitted via UNIFY2.	*Actions taken:* *Recruitment campaign for additional H&B Advisors carried out autumn 2015.* *Revised Policy approved February 2016. To be reviewed within one year to ensure shift of focus towards values-based behaviours.* *Actions planned:* *Increase staff awareness that clinical incident reporting*

				must be used to report incidents of harassment, bullying, abuse or discrimination by patients, relatives and the general public. *Through the Equality & Diversity Group, explore how best to communicate our expectations of the behaviours associated with the Trust Value of Respecting Everyone to both staff and patients and service users.* *Links to the revised Equality & Diversity Strategic Objective for 2016 – 2019:* **To work towards a more inclusive and supportive working environment for all of our staff.**

6	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**			
	Data for reporting year (2016)	*Data for previous year (2015)*	*Narrative*	*Action taken and planned*
	White 25.06% BME 33.76%	White 25.60% BME 39.95%	Full census surveys were carried out in both 2014 and 2015. Data is based on these returns, as submitted via UNIFY2.	*Actions taken:* *Recruitment campaign for additional H&B Advisors carried out autumn 2015.* *Revised Policy approved February 2016. To be reviewed within one year to ensure shift of focus towards values-based behaviours.* *Proposal to introduce a 'Dignity at Work Policy' presented to WF&OD Group June 2016 describing the benefits of moving to a culture which goes beyond policies of managing harassment and bullying to a culture of dignity and respect at work* *Actions planned:* *Divisional plans to address issues of harassment, bullying or abuse highlighted by 2015 Staff Survey to be monitored with a view to sharing best practice.* *Timeline for introduction and launch of Dignity at Work*

				Policy to be confirmed. *Introduction of refreshed Equality & Diversity training included in Equality & Diversity Action Plan* *Links to the revised Equality & Diversity Strategic Objective for 2016 – 2019:* **To work towards a more inclusive and supportive working environment for all of our staff.**

7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**			
	Data for reporting year (2016)	*Data for previous year (2015)*	*Narrative*	*Action taken and planned*
	White 89.42% BME 73.26%	White 89.72% BME 62.82%	Full census surveys were carried out in both 2014 and 2015. Data is based on these returns, as submitted via UNIFY2.	*Actions taken:* *July 2016: the Trust Board received presentations from Yvonne Coghill, NHS England Director, WRES, outlining the priorities of WRES, and on unconscious bias.* *As part of the Equality & Diversity Action Plan, an Audit Southwest review of recruitment processes was commissioned and delivered in July 2016.* *Planned actions:* *Roll out training to raise awareness of unconscious bias/stereotyping – specifically inclusion in Recruiting the Best training for recruiting managers.* *Consider how and who to implement recommendations from the Audit SouthWest report – specifically carrying out regular sample checks of interview notes for unsuccessful candidates to identify any potential bias at interview stage.* *Scrutiny of the succession planning element of the 5 year Teaching & Learning Framework, to include Reverse Mentoring and ensuring access to Continuing Professional*

				Development. *Exploration of how this can be taken into consideration as part of Retention and Appraisal plans, Workforce and Divisional Business Continuity plans, as recommended by the Equality and Diversity Group and included in the E&D Action Plan.* *The recording and reporting of non-Mandatory training data was included in the WRES action plan for 2015. Development of a Trust wide system for the collection of essential and non-essential training has been delayed due to other key essential training priorities being implemented.* *This is therefore a priority action for 2016, and is also included in the Equality & Diversity Action Plan.* *Links to the revised Equality & Diversity Strategic Objectives for 2016 – 2019:* **To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff**.

8	**Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**			
	Data for reporting year (2016)	*Data for previous year (2015)*	*Narrative*	*Action taken and planned*
	White 6.08% BME 17.36%	White 6.72% BME 21.41%	Full census surveys were carried out in both 2014 and 2015. Data is based on these returns, as submitted via UNIFY2.	*Actions taken:* *Reviewed Equality, Diversity & Human Rights Policy published February 2016.*

				Recruitment campaign for additional H&B Advisors carried out autumn 2015. *Revised Tackling Harassment & Bullying at Work Policy approved February 2016. To be reviewed within one year to ensure shift of focus towards values-based behaviours.* *Proposal to introduce a 'Dignity at Work Policy' presented to WF&OD Group June 2016 describing the benefits of moving to a culture which goes beyond policies of managing harassment and bullying to a culture of dignity and respect at work* *Actions planned:* *Through the Equality & Diversity Group, explore how best to communicate our expectations of the behaviours associated with the Trust Value of Respecting Everyone to both staff and patients and service users.* *Divisional plans to address issues of harassment, bullying or abuse highlighted by 2015 Staff Survey to be monitored with a view to sharing best practice.* *Timeline for introduction and launch of Dignity at Work Policy to be confirmed.* *Introduction of refreshed Equality & Diversity training included in Equality & Diversity Action Plan* *Links to the revised Equality & Diversity Strategic Objective for 2016 – 2019:* **To work towards a more inclusive and supportive working environment for all of our staff.**

Board Representation Indicator. For this indicator, compare the difference for White and BME staff.

9	**Percentage difference between the organisations' Board voting membership and its overall workforce**			
	Data for reporting year (2016)	*Data for previous year (2015)*	*Narrative*	*Action taken and planned*
	100% of Voting Board Members – White 0% of Voting Board Members – BME Overall workforce BME – 15.07% Percentage difference between Voting Board Membership = -15.07%	100% of Voting Board Members – White 0% of Voting Board Members – BME Overall workforce BME – 14.92% Percentage difference between Voting Board Membership = -14.92%	Data as submitted via UNIFY2.	*A review of the criteria for appointments, ensuring executive search agencies are committed to diversity, was included in the 2015 WRES Action Plan, and the Equality & Diversity Action Plan.* *The following remedial actions were agreed by the Equality & Diversity Group in June 2016:* *Engage senior colleagues involved in Recruitment in the discussion, so that there is greater understanding of the challenges* *Discuss revised timeframe with Head of Service Centre* *Also included in the 2015 WRES action plan was a review of the diversity of Governors in partnership with the Membership Office.* *These actions are still considered appropriate to address the apparent disparity between Board membership and the overall workforce, even though the Board Representation indicator is different from 2015.* *Links to the revised Equality & Diversity Strategic Objectives for 2016 – 2019:* **To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff.**

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	National Staff Survey Results 2016		
Author	Samantha Chapman, Head of OD		
Executive Lead	Alex Nestor, Acting Director of Workforce and Organisational Development		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary

The purpose of this paper is to formally share the results of the 2016 staff survey and highlights a number of key areas as set out below:

- it provides a summary of the Staff Survey Results 2016 against both the National and Acute average
- Highlights the key improvements made from 2015
- Presents the top 5 improvement areas and bottom 5 ranked scores
- Key Priorities for 17/18

The report is attached for assurance.

Recommendations
Members are asked to: Board are asked to note the report and support plans to further improve staff experience.

Intended Audience (please select any which are relevant to this paper)								
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☒	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☒

Impact Upon Corporate Risk
Impact to retention and attraction of a skilled workforce to deliver safe patient care

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☒	Information Management & Technology	☒
Human Resources	☒	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		27/06/17		Senior Leadership Team, 19/07/17

Trust Staff Survey Results 2016

1. Background

The purpose of this paper is to formally share the results of the 2016 staff survey (Appendix 1). The Executive summary pulls out a number of key areas from the staff survey results, in the context of our programme of work to date. The report is attached for information.

The response rate for 2016 was 3,597 which represents 42% of the workforce and is a marginal decrease from 2015 which was 44% response rate. The National average response rate was 44% with the AUKUH average response rate being 40%.

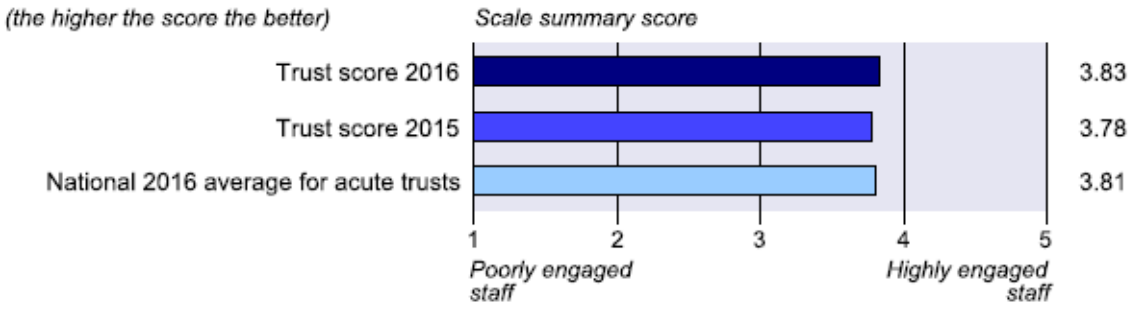
The Trust has improved on 83 questions (95%) and decreased in 4 questions.

The all-staff Friends and Family Test scores (measured in the first quarter of the year) have also improved:

- In 2016/17, 70% of staff said that they would recommend UH Bristol as a place to work, compared to 62% in 2015/16.
- In 2016/17, 86% of staff said that they would recommend UH Bristol as a place to receive treatment, compared to 85% in 2015/16.

2. Key issues to note

It is hugely positive and encouraging to see that staff engagement has improved from last year's figure and is also ahead of the NHS national average for acute Trusts.



As an organisation the staff engagement score has consistently increased over the past 3 years, the increase has been significant in terms of comparison to the national staff engagement position of which the Trust is now ahead; and is also encouraging given the quality objective to improve the engagement score to 4.0 by 2020.

Year	Trust Staff Engagement Score	National Staff Engagement Score
2014	3.69	3.71
2015	3.78	3.78
2016	3.83	3.79

2.1. Five fey findings where staff experience has improved since 2015 Staff Survey

The key areas which we have improved locally since the last Staff Survey 2015 are:

- Percentage of staff experiencing physical violence from staff in the last 12 months has decreased.
- Percentage of staff agreeing that there role that their role makes a difference to patients and service users.
- Effective team working.
- Percentage of staff satisfied with the opportunities for flexible working patterns.
- Recognition and value of staff by managers and the organisation.

2.2. Staff Survey Top Ranking Scores

Top ranking scores for the Trust are:

- Percentage of staff believing that the organisation provides equal opportunities for career progression.
- Staff recommendation of the organisation as a place to work or receive treatment.
- Organisation and management interest in and action on health and wellbeing.
- Fairness and effectiveness of procedures for reporting errors near misses and incidents.
- Percentage of staff/colleagues reporting errors near misses or incidents witnessed in the last month.

The Trust has improved in all areas of the top 5 ranking scores year on year 2015 to 2016. The Trust is also ahead on all of these measures when compared against the National NHS survey.

2.3. Staff Survey Bottom Ranking Scores

Bottom ranking scores for the Trust are:

- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves.
- Staff motivation at work.
- Staff satisfaction with the quality of work and care they are able to deliver.
- Staff confidence and security in reporting unsafe clinical practice.
- Percentage of staff/colleagues reporting most recent experience of violence.

The Trust is behind the National NHS survey results in these measures however; it is important to note that whilst the measures represent the bottom ranking scores that each measure has improved from the previous year.

2.4. AUKUH Benchmarking

The Trust has improved on 95% of its measures. Results from the AUKUH benchmarking place the Trust as 5th out of 44 AUKUH organisations in terms of improvement during 2016. The Trust is also 5th in its number of significantly improved scores from 2015- 2016. The strategic ambition is to be in the Top 20 University Hospitals Trusts therefore continued focus on this agenda is critical to sustain this position.

3. Divisional Highlights from 2016

Significant work has been undertaken at Divisional and local level to improve the overall Staff Survey scores including:

- Staff focus groups to improve two way communication between staff and management.
- Team interventions and team building/ development programmes.
- Recognition events and team building.
- A full review of the Trust's appraisal process.
- Continued training programme for leaders and managers.
- Team development programmes.
- Health and wellbeing initiatives, with a specific focus on stress related illness, and improving resilience.

The Divisional highlight summary can be found at Appendix 1

4. Next Steps

4.1. Local Divisional Plans

All Divisions have received a high level overview of their survey results at Divisional Boards and have developed local Improving Staff Experience plans based on the information received from local heat maps.

In order to respond to the findings in a more strategic way plans reflect 5 key themes:

- **Building Capability**- including E-Appraisal and Leadership Behaviours.
- **Equality and Diversity**- Improving how staff from the protected characteristics experience work.
- **Leadership and Management Development**- including coaching, mentoring and action learning.

- **Staff Engagement**- including Happy App, Health and well-being.
- **Teamwork**- including away days, focus groups and bespoke team development solutions

4.2. Trust wide plan

The key priorities are:

1. **Leadership Behaviours**

   Development of Leadership behaviours in response to the feedback and a subsequent roll-out/immersion programme for Leaders in the organisation.

2. **Appraisal Improvement Programme**

   Following on from the launch in May 2017 commence Phase 2 of the programme to include Leadership Behaviours, 360 degree feedback, and Talent Management.

3. **Recognition Framework**

   To develop a Trust wide Framework to support the application of consistent local reward and recognition principles for all staff. The Framework will provide assurance of equity and opportunity to be recognised for individual staff contribution.

4. **Equality and Diversity**

   To roll-out Equality and Diversity Training for all staff and to further embed the strategic objectives from the Equality and Diversity plan.

5. **Bullying and Harassment**

   To develop a revised 'Dignity at work policy' to support staff who are experiencing bullying and/or harassment at work. To champion the National 'Anti-Bullying' week in November through a roadshow of events to support staff and teams.

The Trust Board are asked to note the report and support plans to further improve staff experience.

Samantha Chapman
Head of OD
July 2017

2016 National NHS staff survey

Brief summary of results from University Hospitals Bristol NHS Foundation Trust

Table of Contents

1: Introduction to this report 3

2: Overall indicator of staff engagement for University Hospitals Bristol NHS Foundation Trust 5

3: Summary of 2016 Key Findings for University Hospitals Bristol NHS Foundation Trust 6

4: Full description of 2016 Key Findings for University Hospitals Bristol NHS Foundation Trust (including comparisons with the trust's 2015 survey and with other acute trusts) 15

1. Introduction to this report

This report presents the findings of the 2016 national NHS staff survey conducted in University Hospitals Bristol NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2016 survey results for University Hospitals Bristol NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

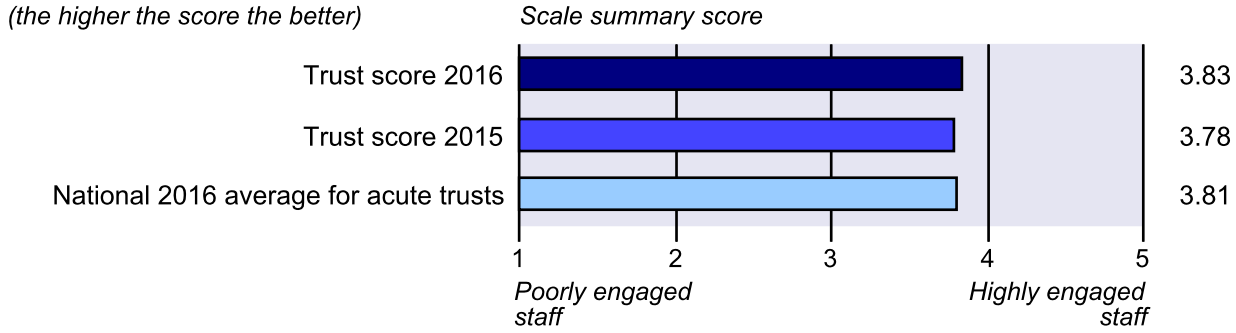
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	80%	76%	77%
Q21b	"My organisation acts on concerns raised by patients / service users"	75%	74%	72%
Q21c	"I would recommend my organisation as a place to work"	67%	62%	61%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	81%	70%	77%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.90	3.77	3.81

2. Overall indicator of staff engagement for University Hospitals Bristol NHS Foundation Trust

The figure below shows how University Hospitals Bristol NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.83 was above (better than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how University Hospitals Bristol NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2015 survey.

	Change since 2015 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	✓ Increase (better than 15)	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	✓ Increase (better than 15)	✓ Above (better than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	! Lowest (worst) 20%
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	• Average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2016 Key Findings for University Hospitals Bristol NHS Foundation Trust

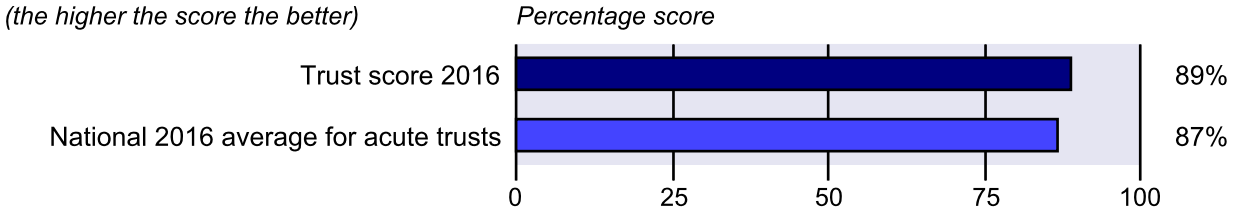
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which University Hospitals Bristol NHS Foundation Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

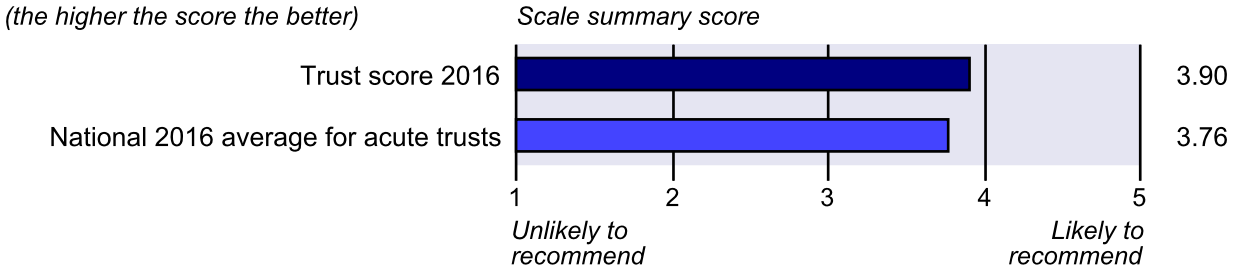
✓KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

(the higher the score the better)



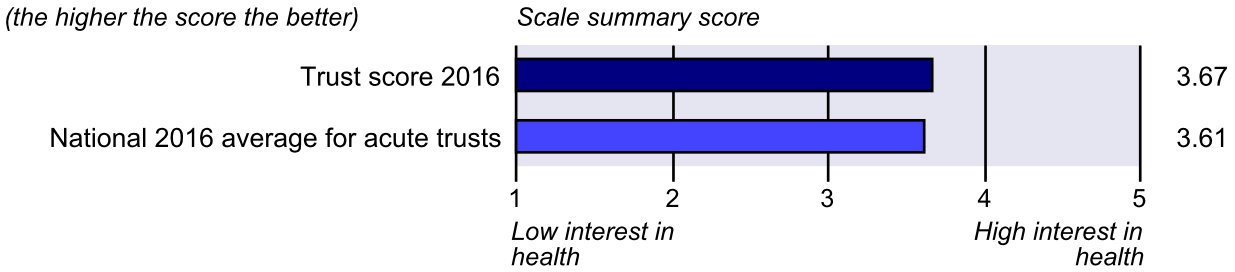
✓KF1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



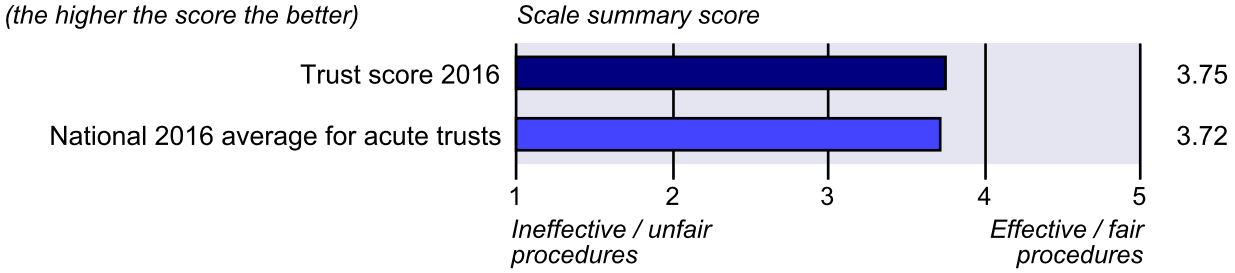
✓KF19. Organisation and management interest in and action on health and wellbeing

(the higher the score the better)



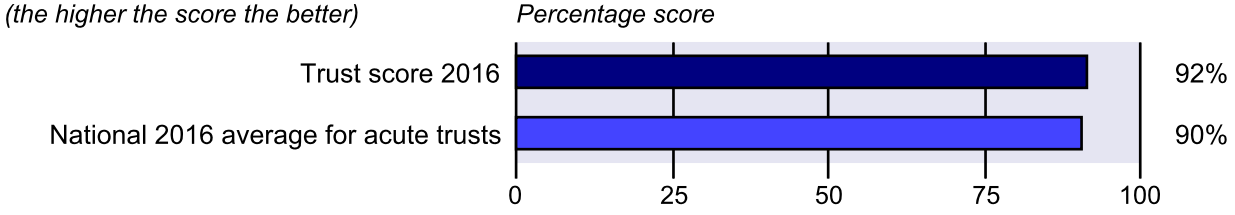
✓KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



✓KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)

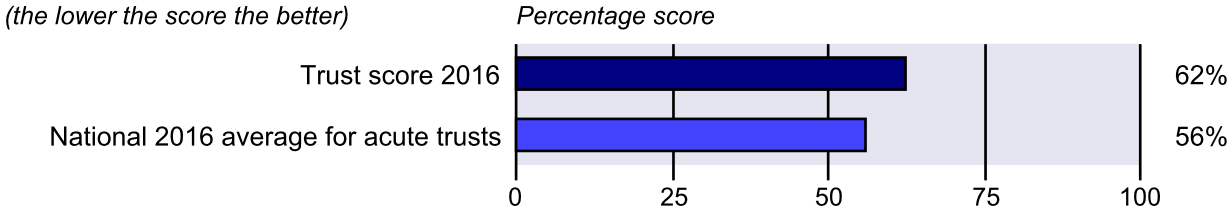


This page highlights the five Key Findings for which University Hospitals Bristol NHS Foundation Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

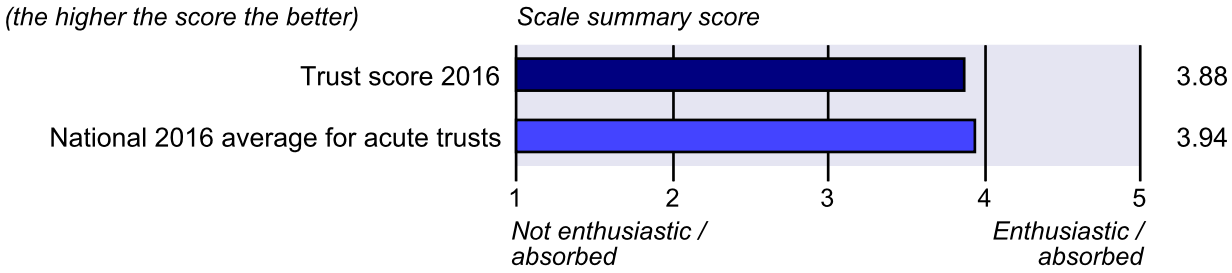
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



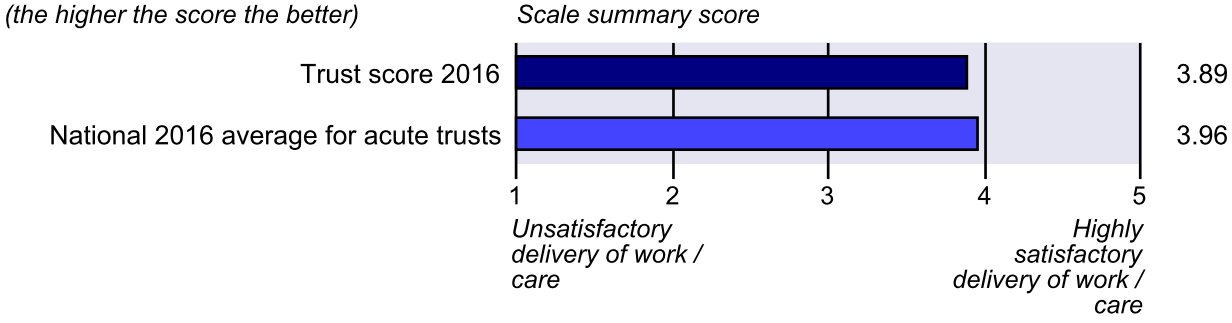
! KF4. Staff motivation at work

(the higher the score the better)



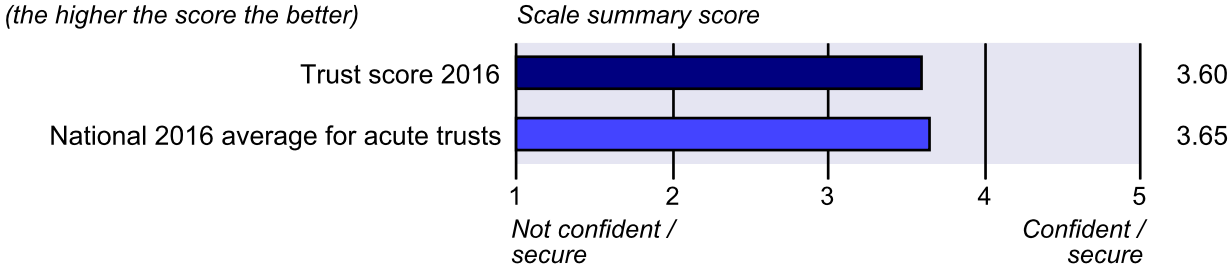
! KF2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



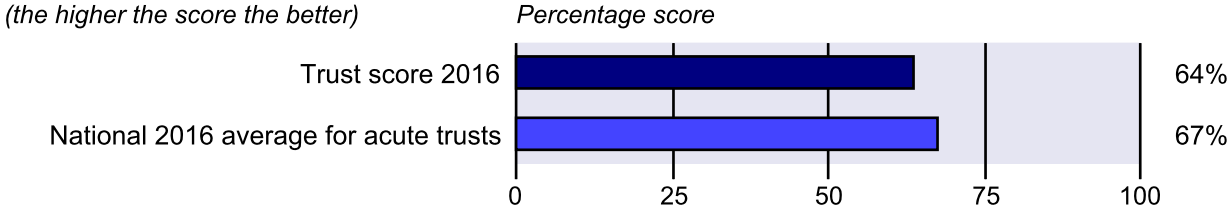
! KF31. Staff confidence and security in reporting unsafe clinical practice

(the higher the score the better)



! KF24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 98 (the bottom ranking score). University Hospitals Bristol NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 98. Further details about this can be found in the document ***Making sense of your staff survey data***.

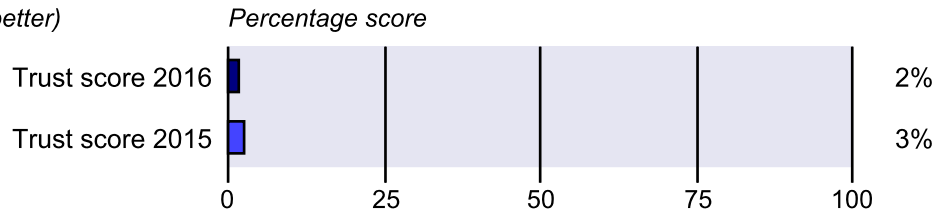
3.2 Largest Local Changes since the 2015 Survey

This page highlights the five Key Findings where staff experiences have improved at University Hospitals Bristol NHS Foundation Trust since the 2015 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other acute trusts in England, the score for Key finding KF15 is worse than average).

WHERE STAFF EXPERIENCE HAS IMPROVED

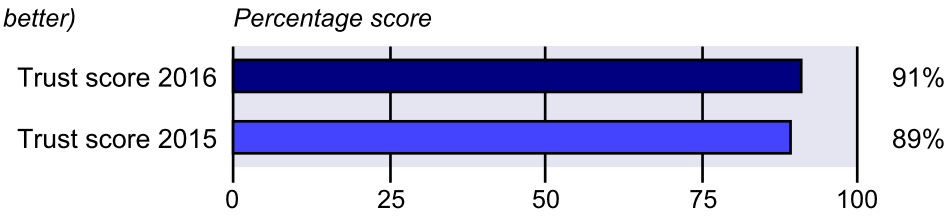
✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



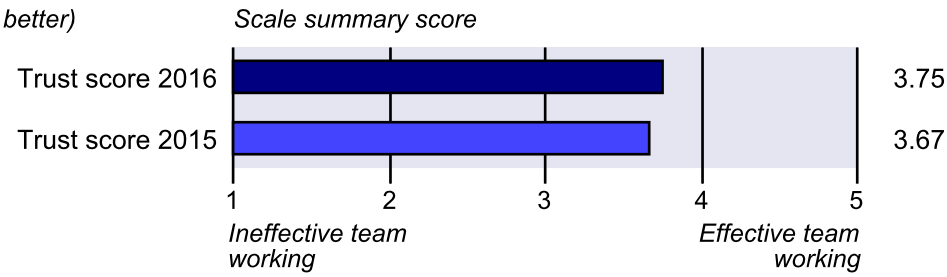
✓KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



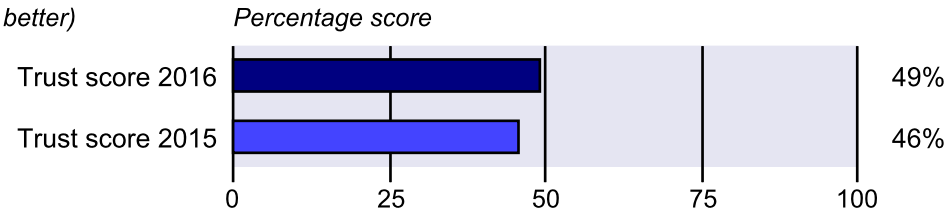
✓KF9. Effective team working

(the higher the score the better)



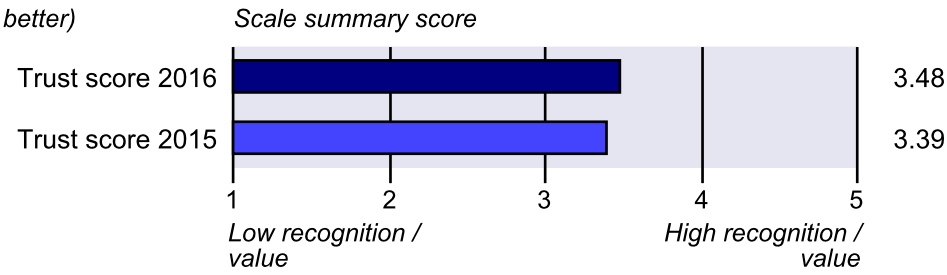
✓KF15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



✓KF5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



3.2. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust

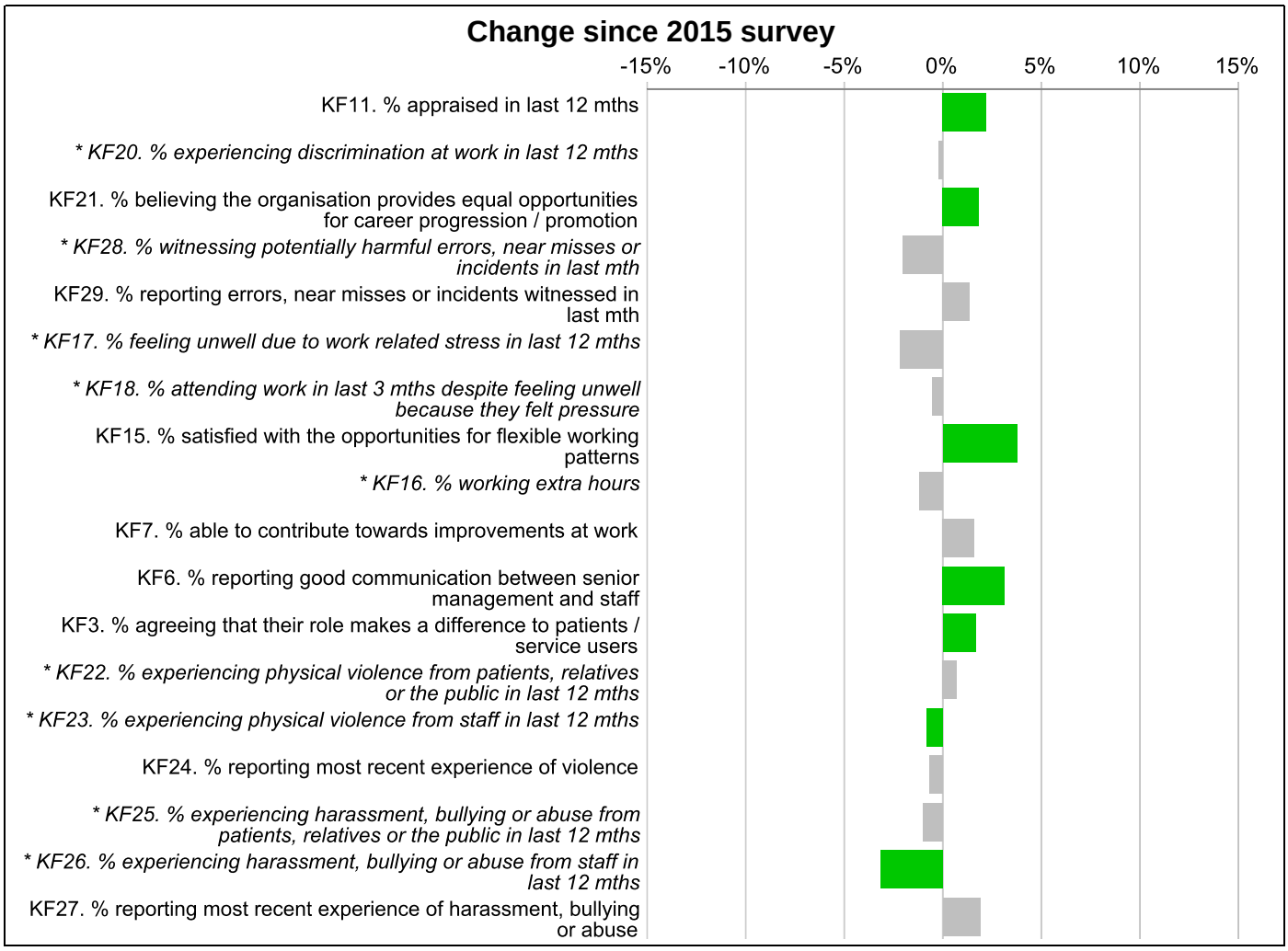
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2015 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2015 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust

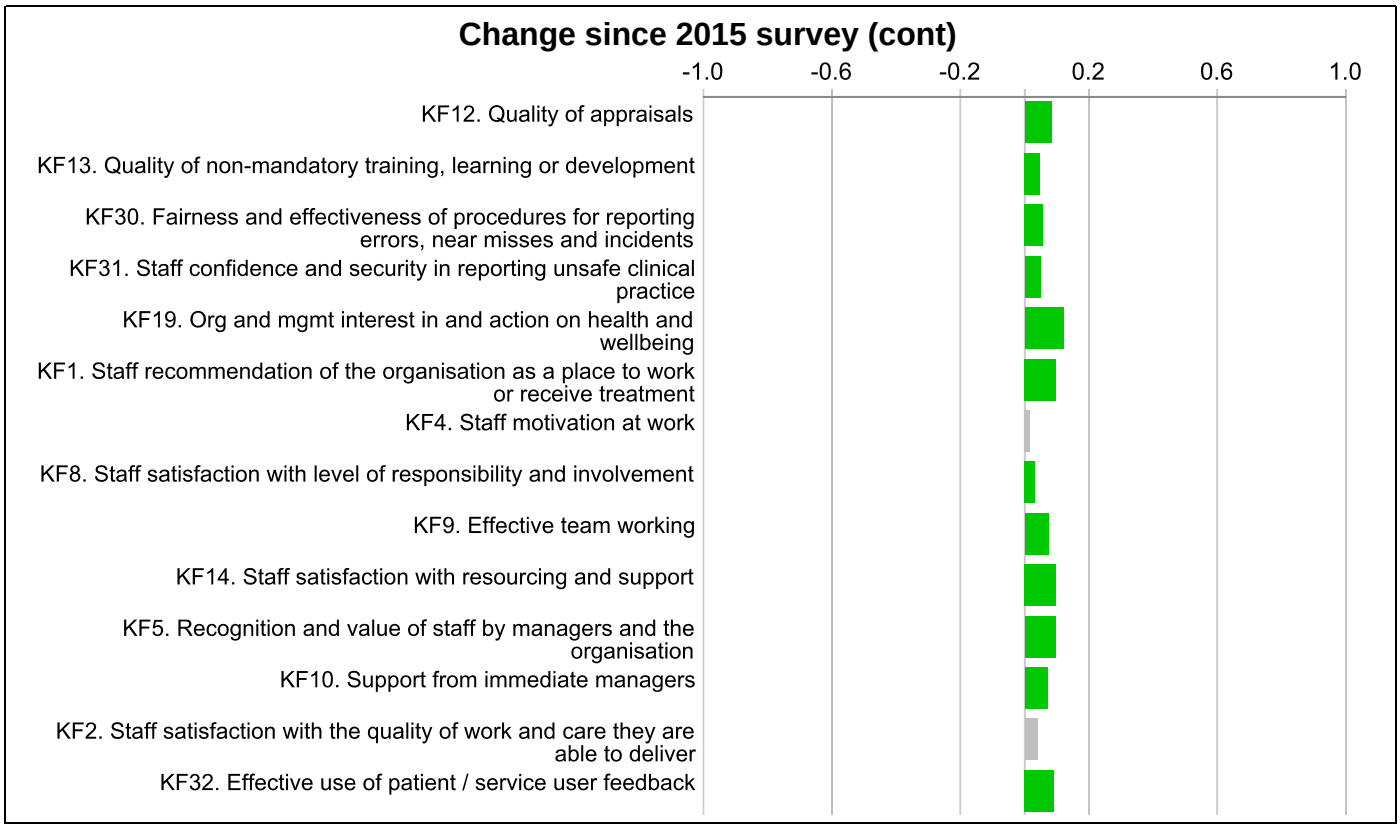
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2015 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2015 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust

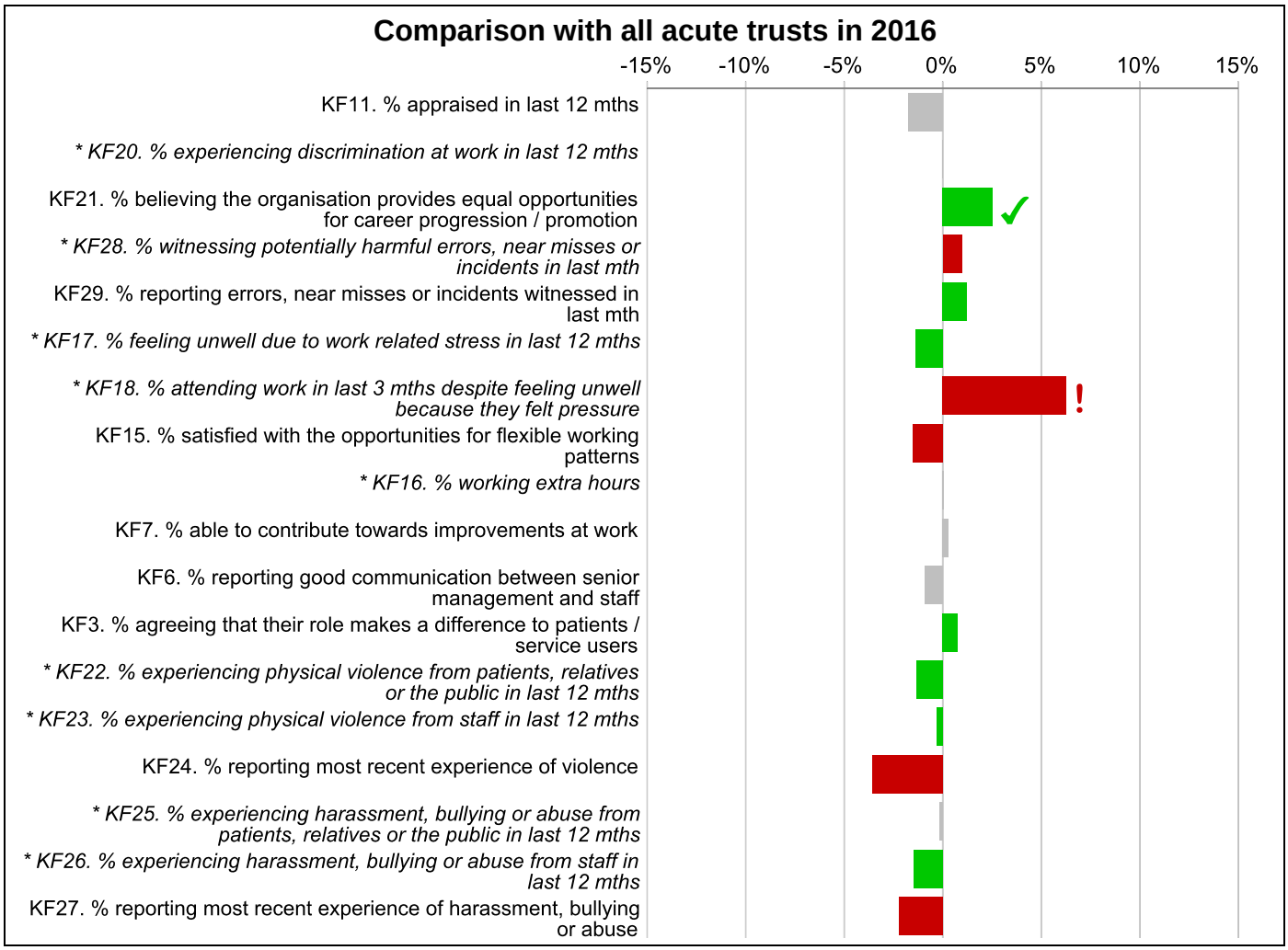
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust

KEY

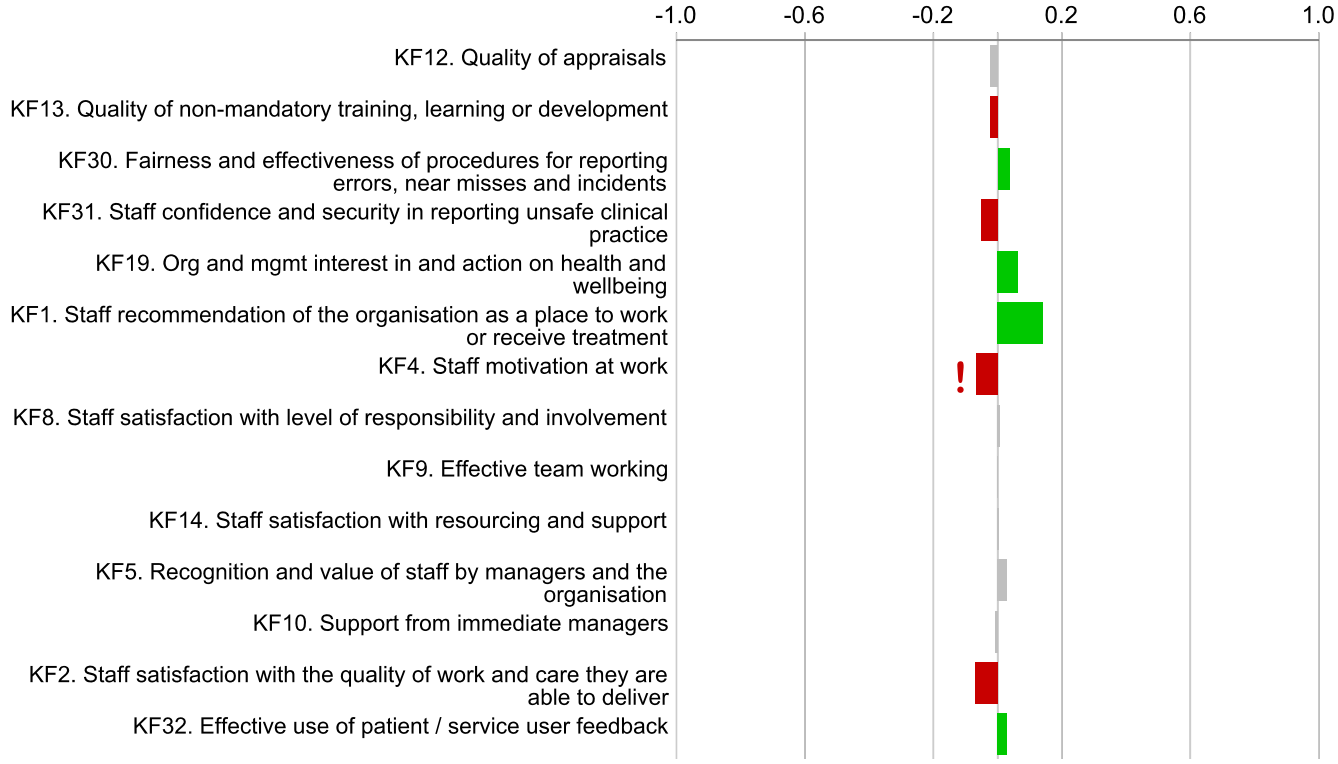
Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all acute trusts in 2016 (cont)



3.3. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2015.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2015.

'Change since 2015 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2015 survey.

-- No comparison to the 2015 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Appraisals & support for development		
KF11. % appraised in last 12 mths	✓ Increase (better than 15)	• Average
KF12. Quality of appraisals	✓ Increase (better than 15)	• Average
KF13. Quality of non-mandatory training, learning or development	✓ Increase (better than 15)	! Below (worse than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	• Average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	✓ Increase (better than 15)	✓ Highest (best) 20%
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Above (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓ Above (better than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	✓ Increase (better than 15)	✓ Above (better than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	✓ Increase (better than 15)	! Below (worse than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	! Highest (worst) 20%
KF19. Org and mgmt interest in and action on health and wellbeing	✓ Increase (better than 15)	✓ Above (better than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	✓ Increase (better than 15)	! Below (worse than) average
* *KF16. % working extra hours*	• No change	• Average

3.3. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust (cont)

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	✓ Increase (better than 15)	✓ Above (better than) average
KF4. Staff motivation at work	• No change	! Lowest (worst) 20%
KF7. % able to contribute towards improvements at work	• No change	• Average
KF8. Staff satisfaction with level of responsibility and involvement	✓ Increase (better than 15)	• Average
KF9. Effective team working	✓ Increase (better than 15)	• Average
KF14. Staff satisfaction with resourcing and support	✓ Increase (better than 15)	• Average
Managers		
KF5. Recognition and value of staff by managers and the organisation	✓ Increase (better than 15)	• Average
KF6. % reporting good communication between senior management and staff	✓ Increase (better than 15)	• Average
KF10. Support from immediate managers	✓ Increase (better than 15)	• Average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	! Below (worse than) average
KF3. % agreeing that their role makes a difference to patients / service users	✓ Increase (better than 15)	✓ Above (better than) average
KF32. Effective use of patient / service user feedback	✓ Increase (better than 15)	✓ Above (better than) average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	✓ Decrease (better than 15)	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	! Below (worse than) average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	✓ Decrease (better than 15)	✓ Below (better than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	! Below (worse than) average

4. Key Findings for University Hospitals Bristol NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust had 3597 staff take part in this survey. This is a response rate of 42%[1] which is average for acute trusts in England, and compares with a response rate of 44% in this trust in the 2015 survey.

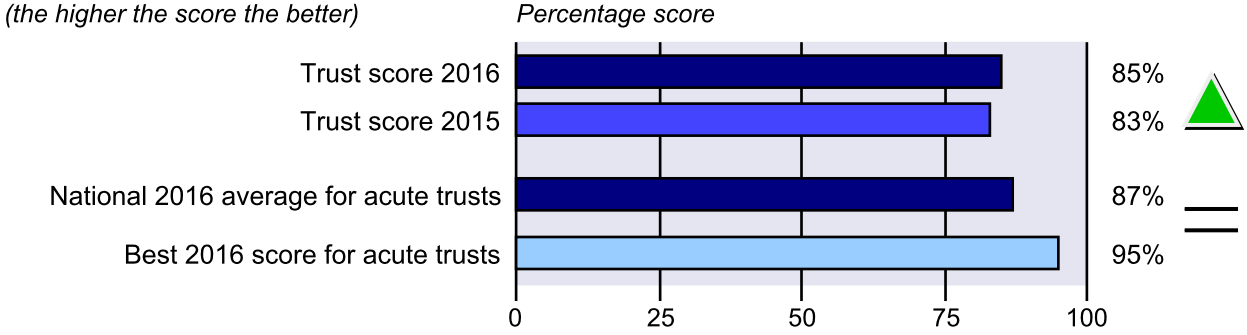
This section presents each of the 32 Key Findings, using data from the trust's 2016 survey, and compares these to other acute trusts in England and to the trust's performance in the 2015 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2015). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2015). An equals sign indicates that there has been no change.

Appraisals & support for development

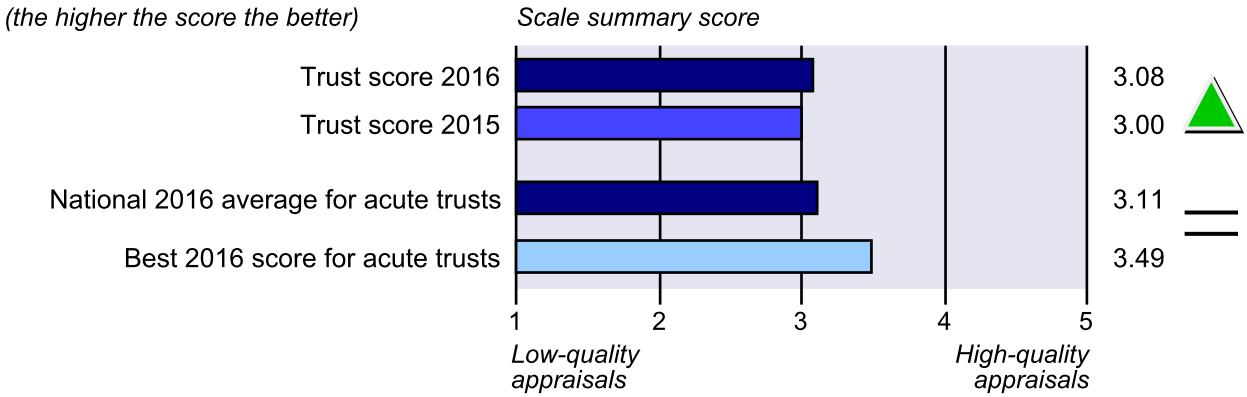
KEY FINDING 11. Percentage of staff appraised in last 12 months

(the higher the score the better)



KEY FINDING 12. Quality of appraisals

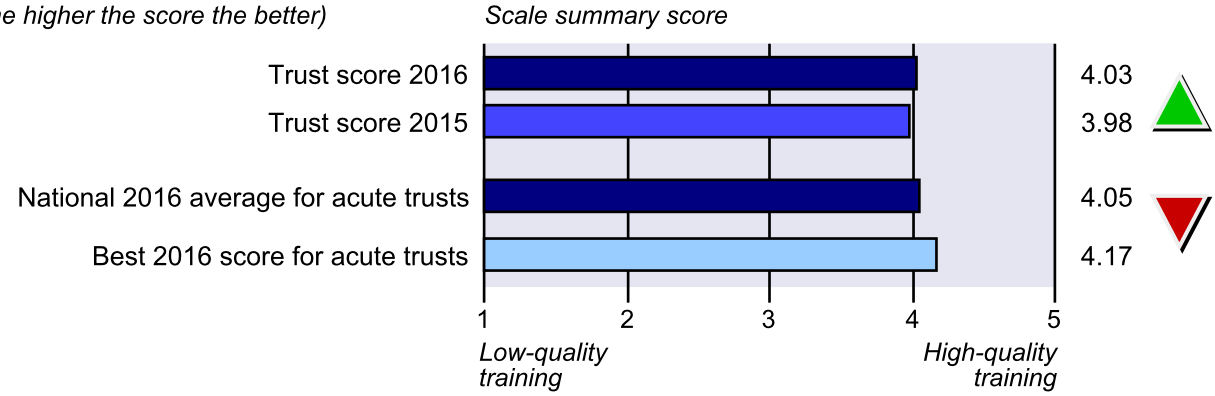
(the higher the score the better)



[1]Questionnaires were sent to all 8541 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

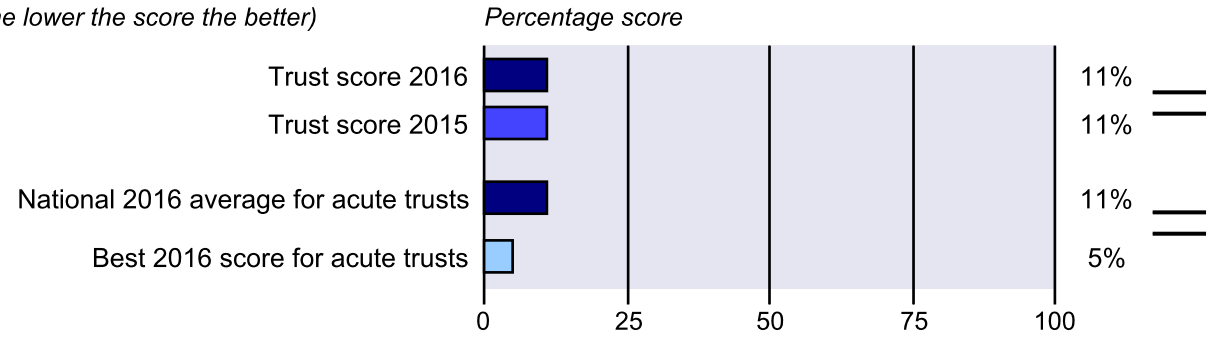
(the higher the score the better)



Equality & diversity

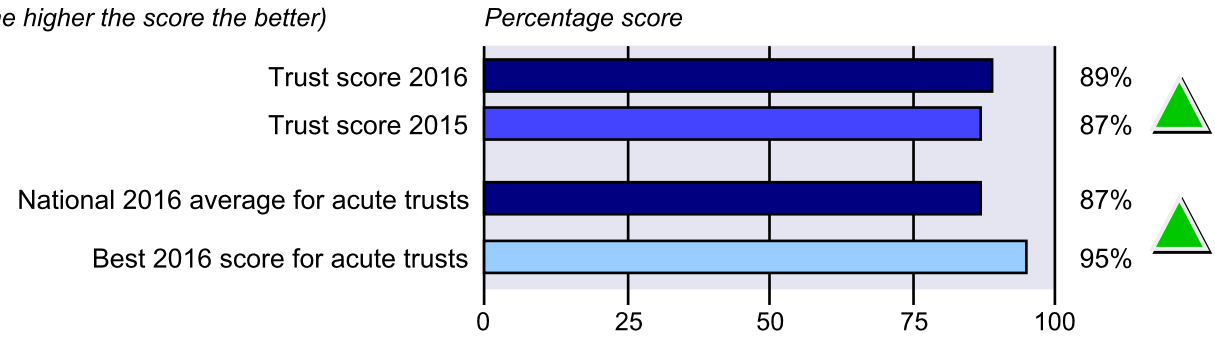
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

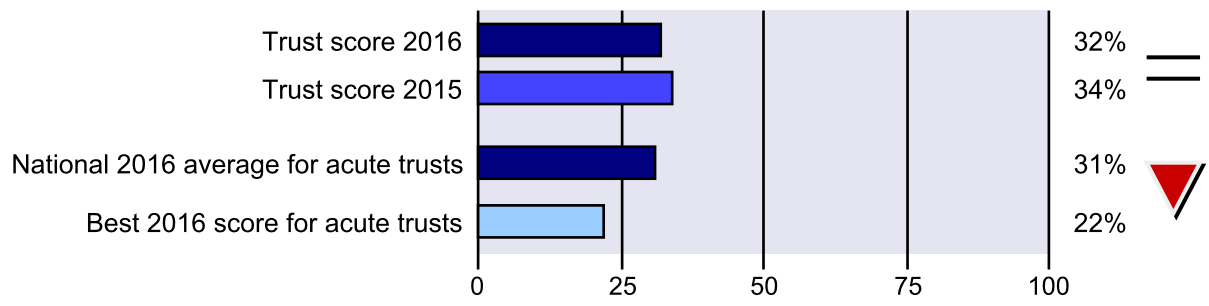
(the higher the score the better)



Errors & incidents

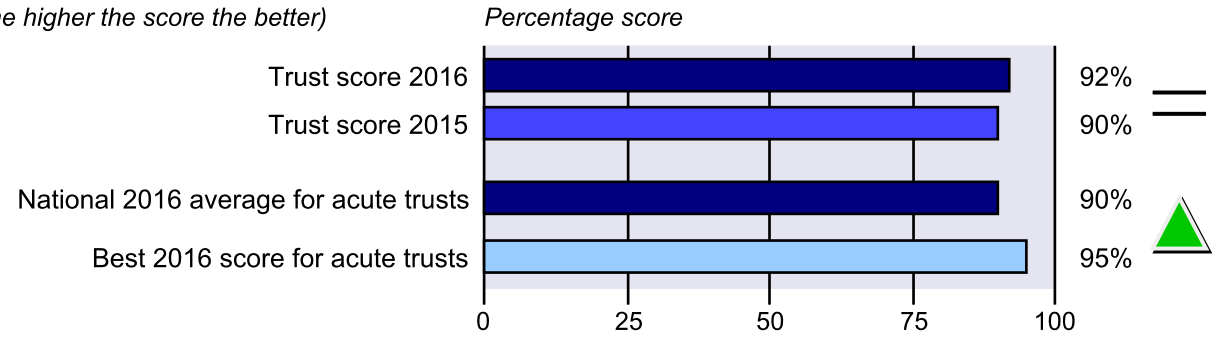
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



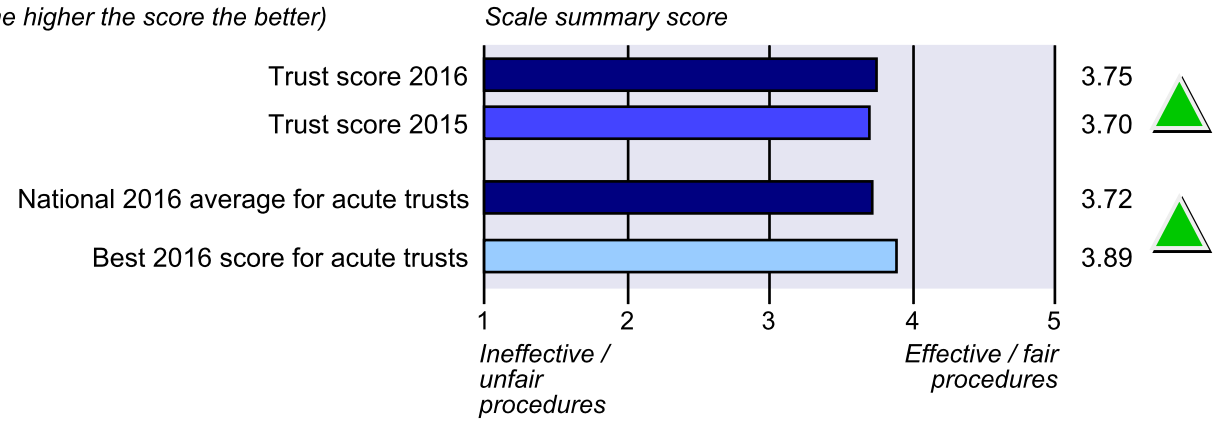
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



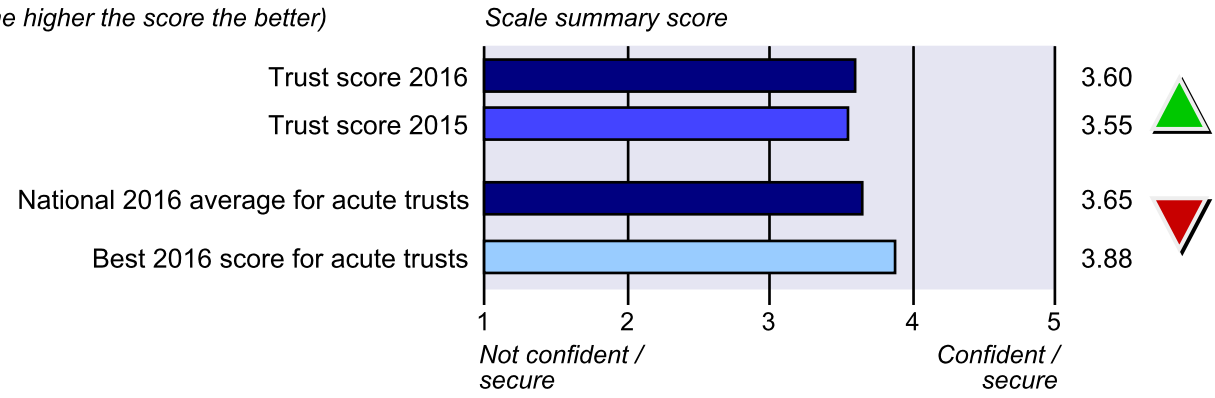
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

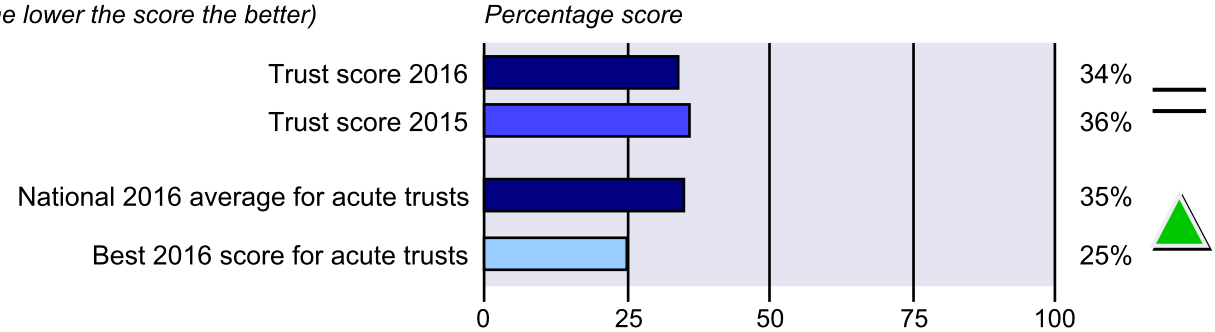
(the higher the score the better)



Health and wellbeing

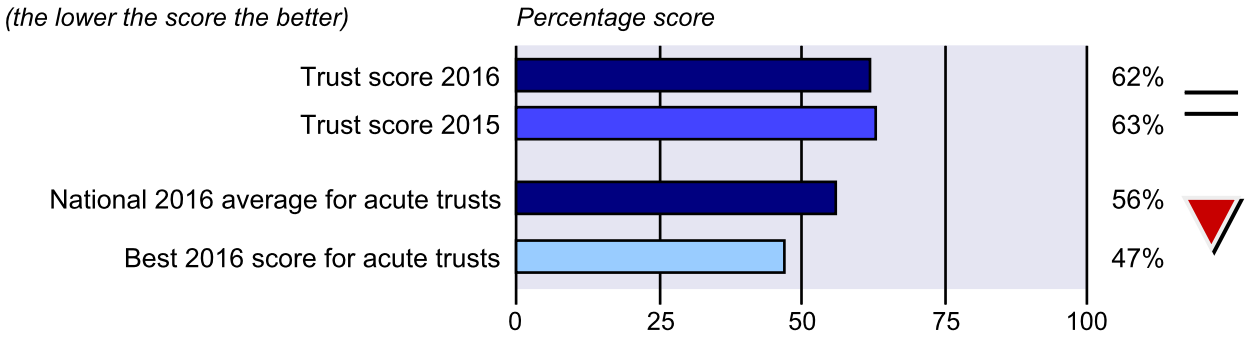
KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



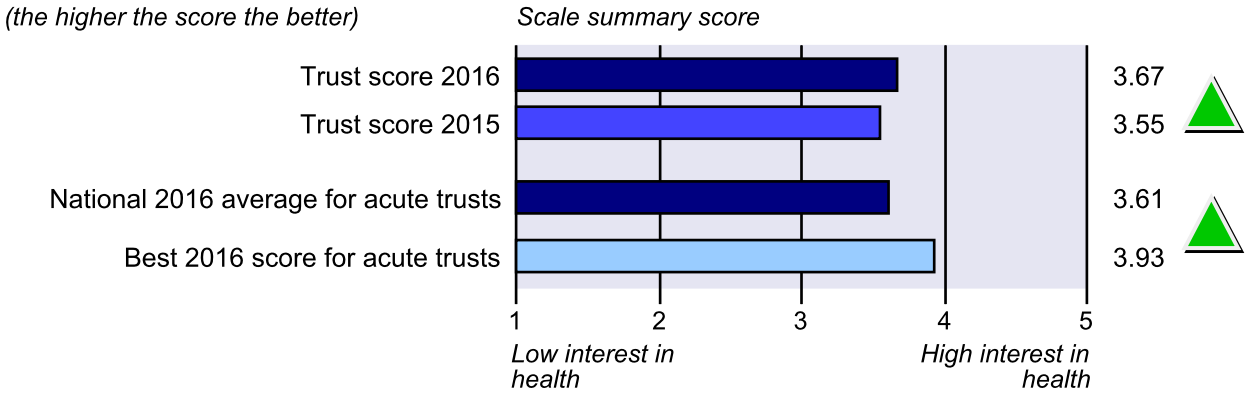
KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

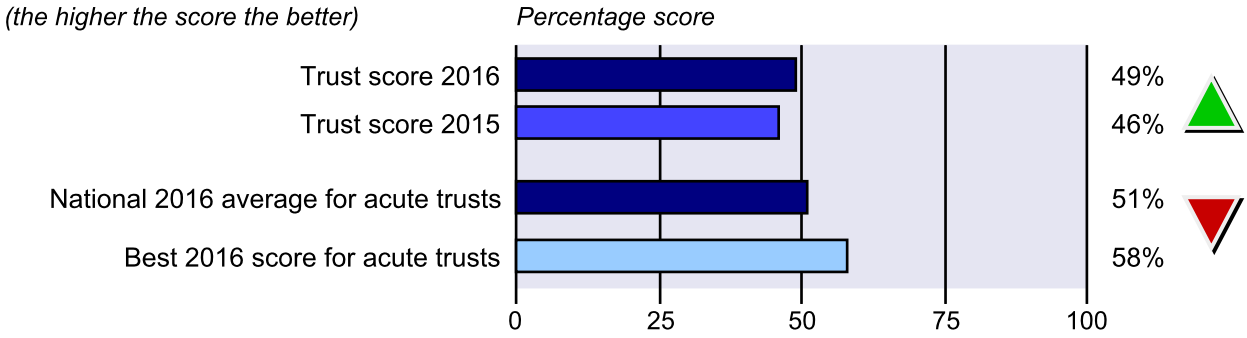
(the higher the score the better)



Working patterns

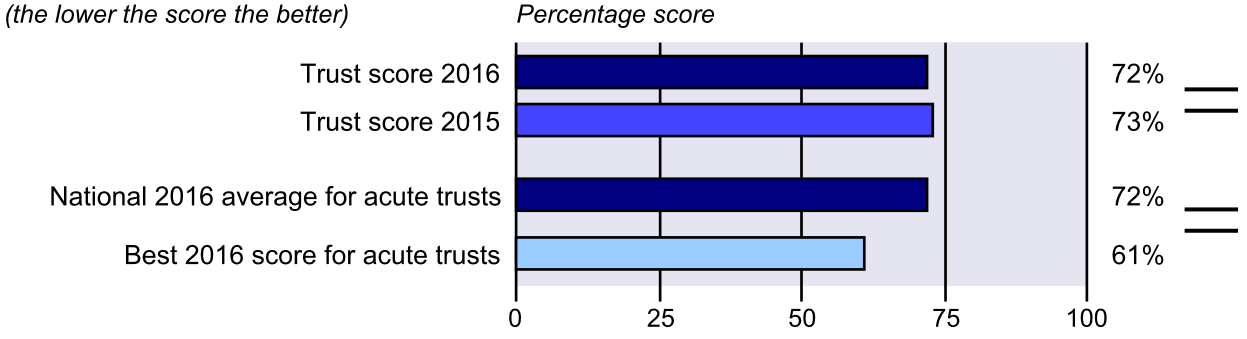
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



KEY FINDING 16. Percentage of staff working extra hours

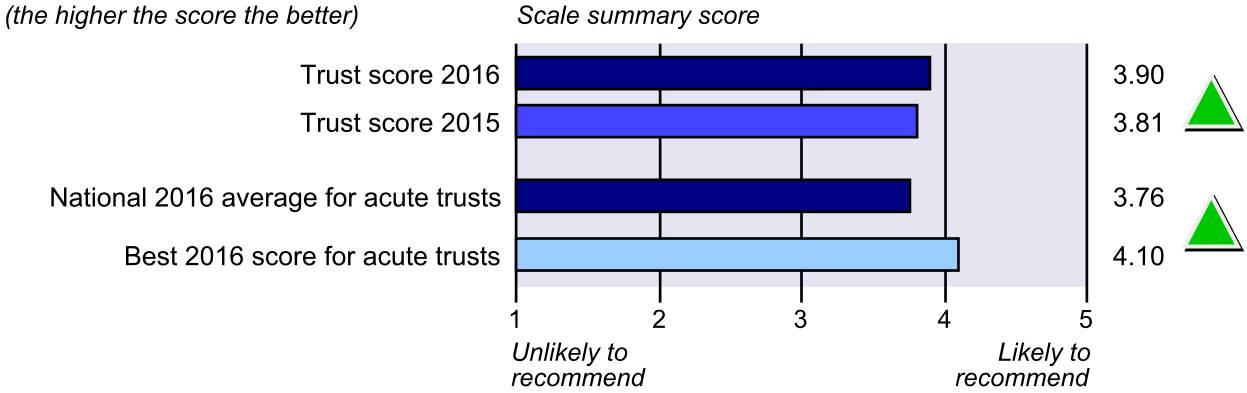
(the lower the score the better)



Job satisfaction

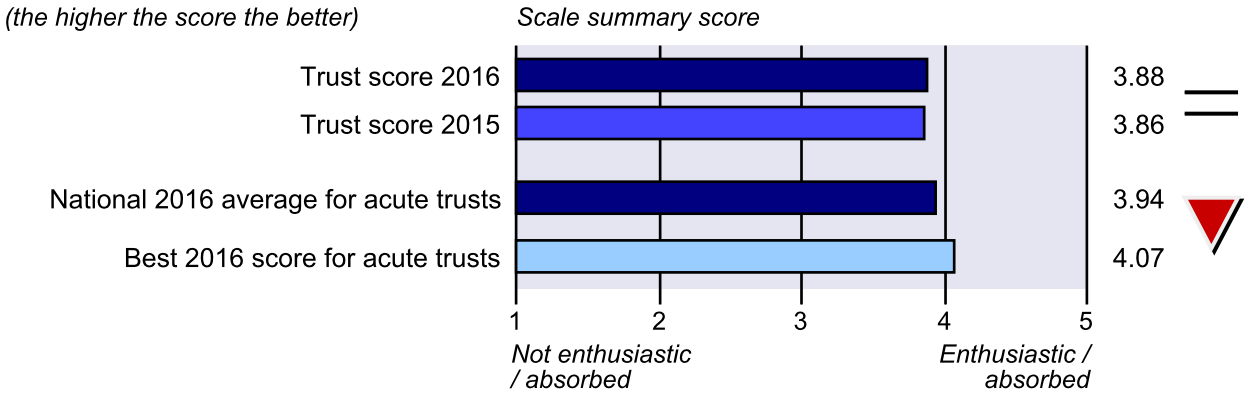
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



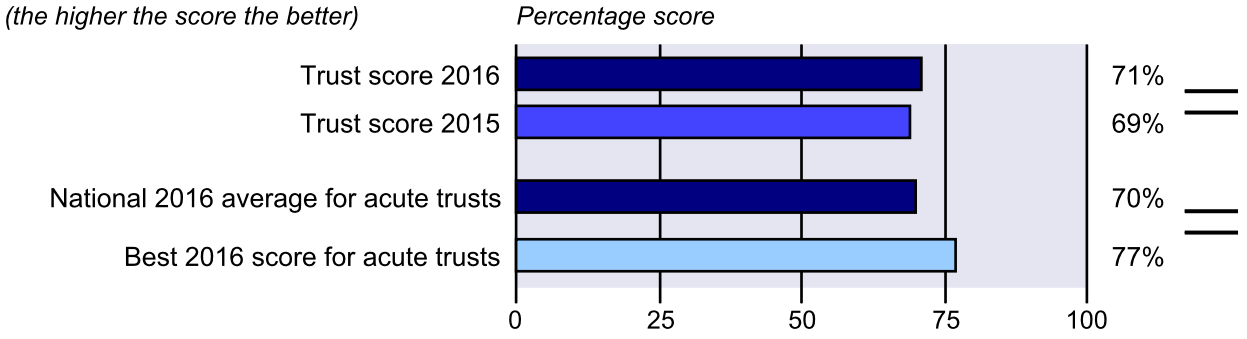
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



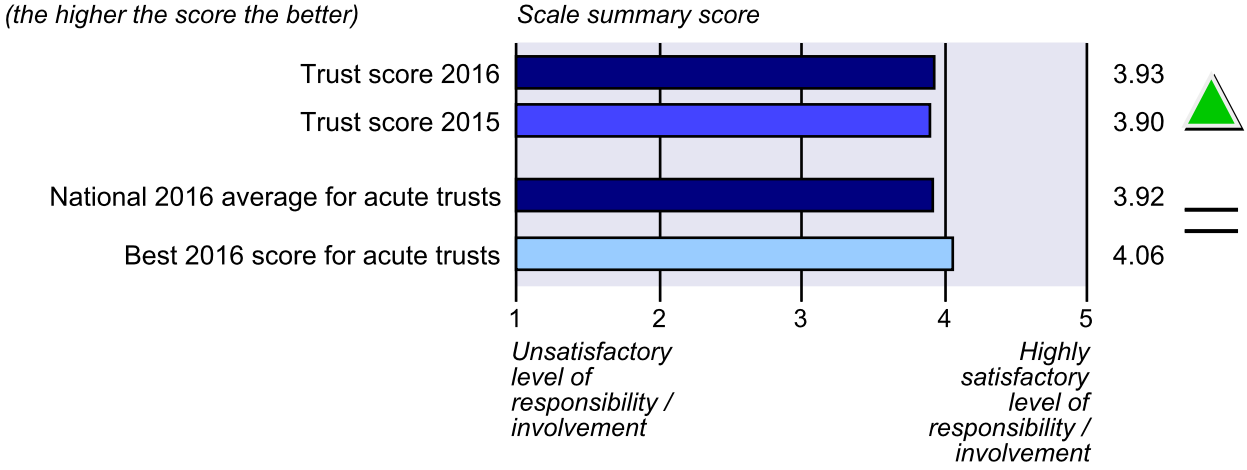
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)

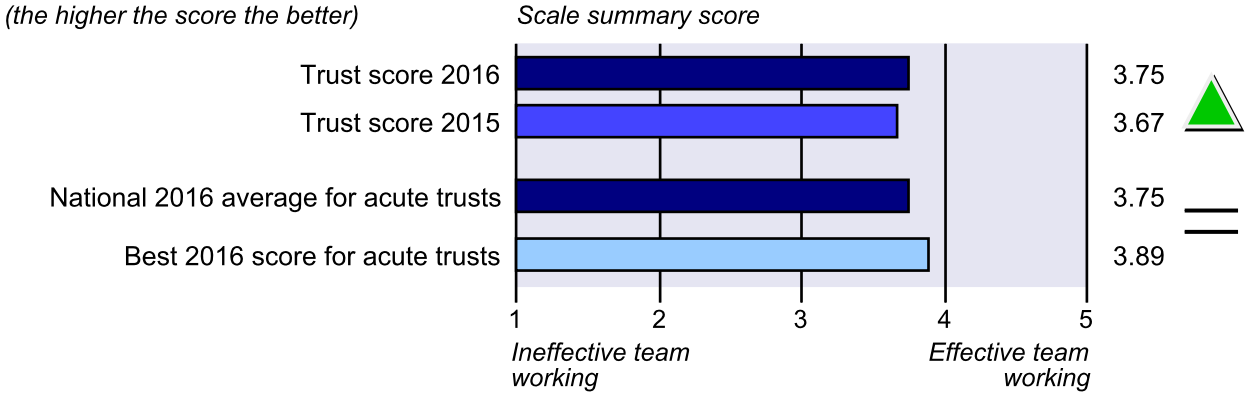


KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

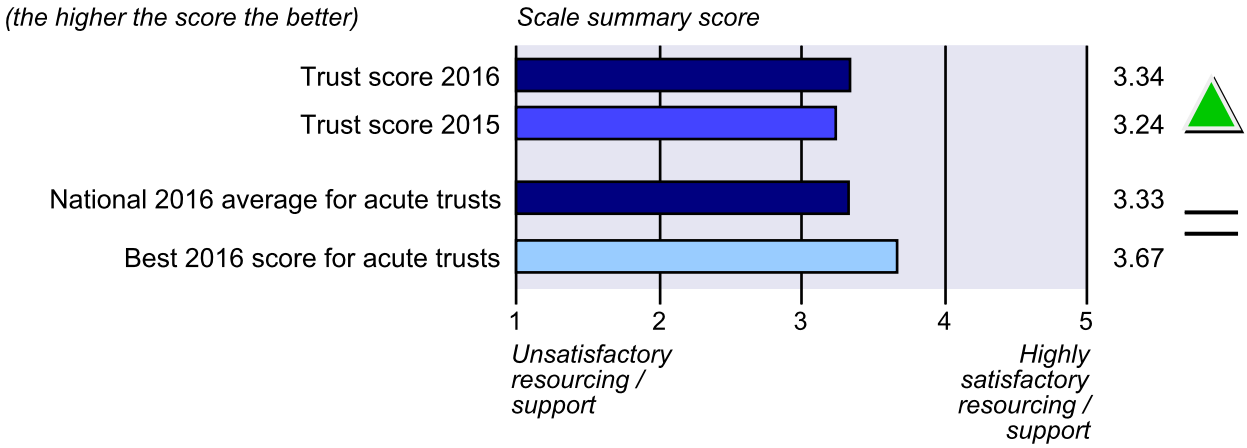
(the higher the score the better)



KEY FINDING 9. Effective team working

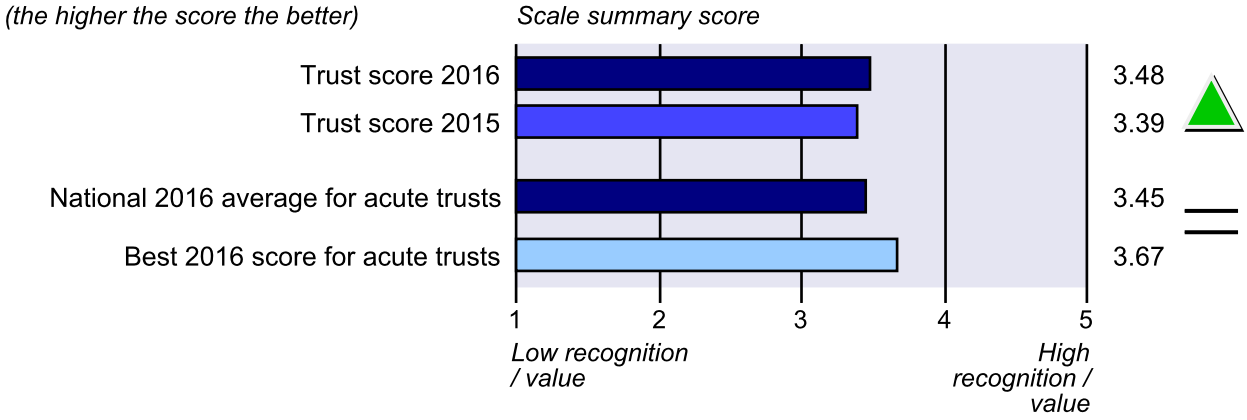


KEY FINDING 14. Staff satisfaction with resourcing and support

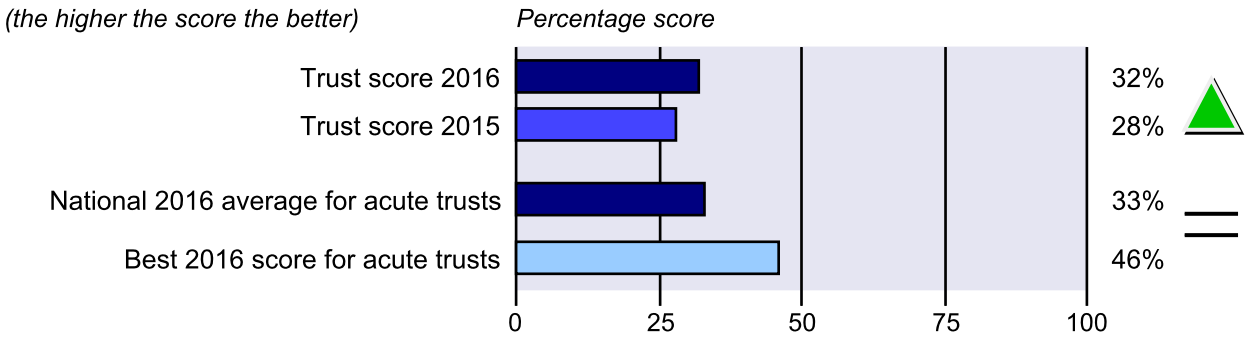


Managers

KEY FINDING 5. Recognition and value of staff by managers and the organisation

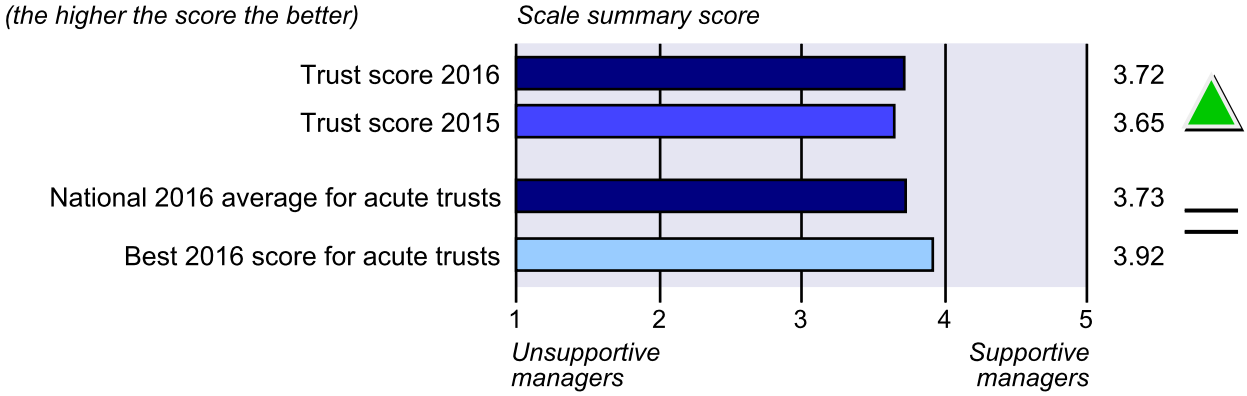


KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff



KEY FINDING 10. Support from immediate managers

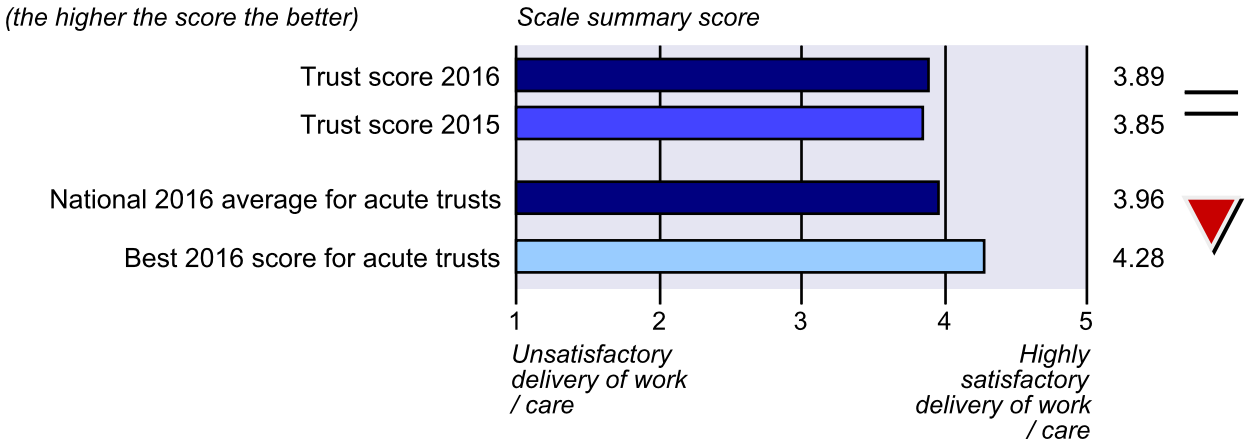
(the higher the score the better)



Patient care & experience

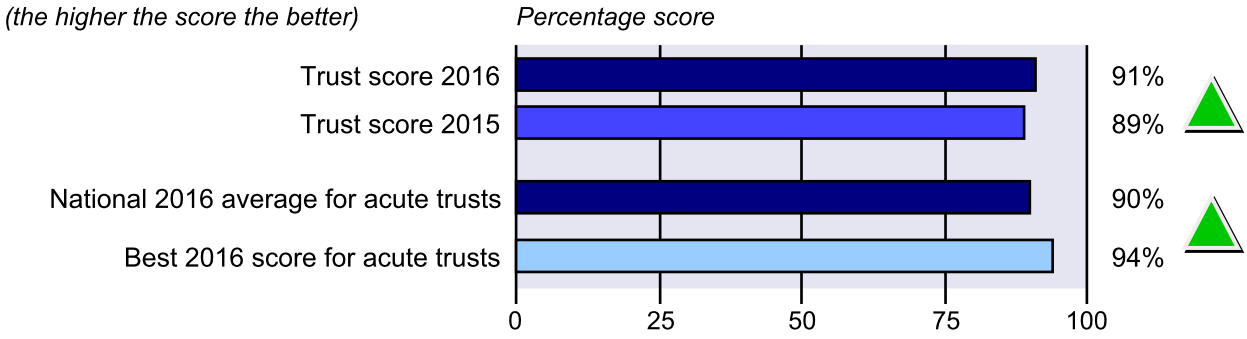
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



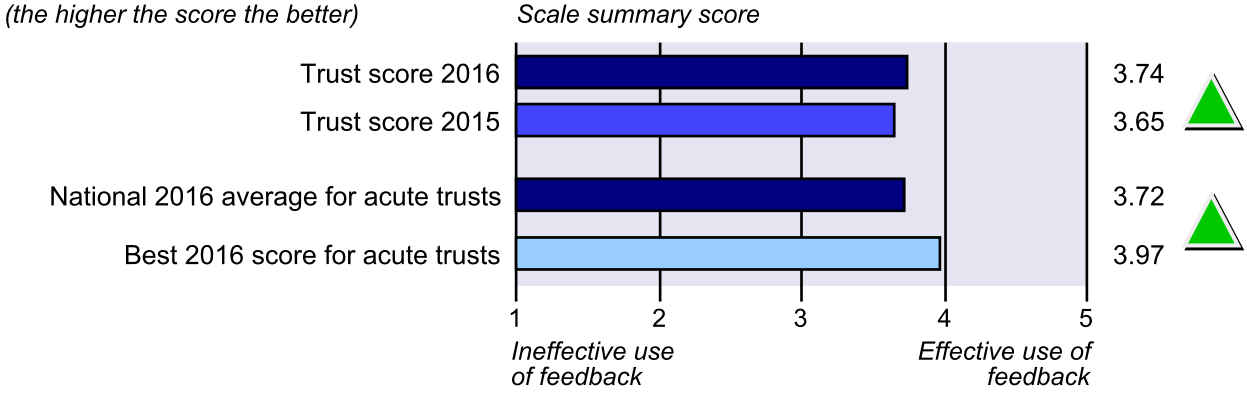
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

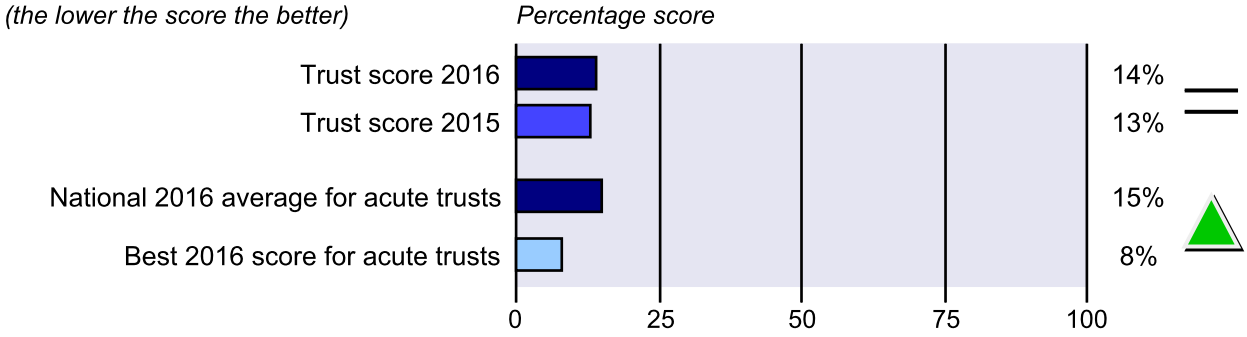
(the higher the score the better)



Violence, harassment & bullying

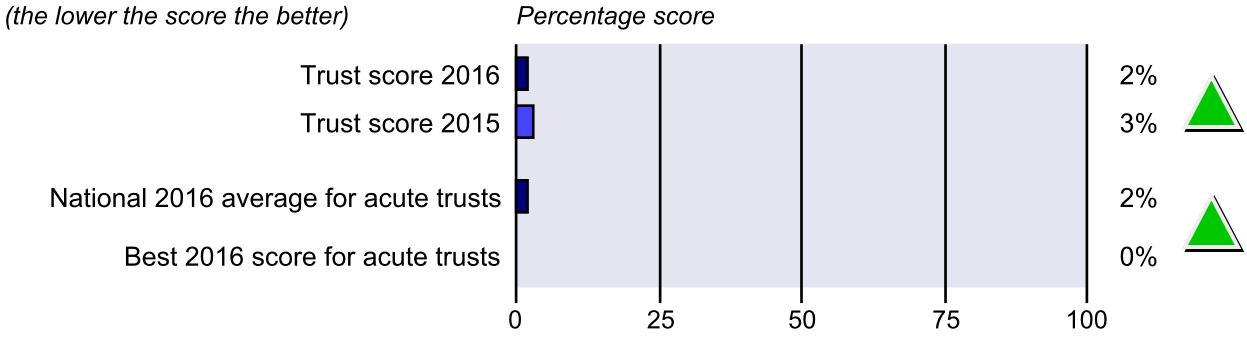
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



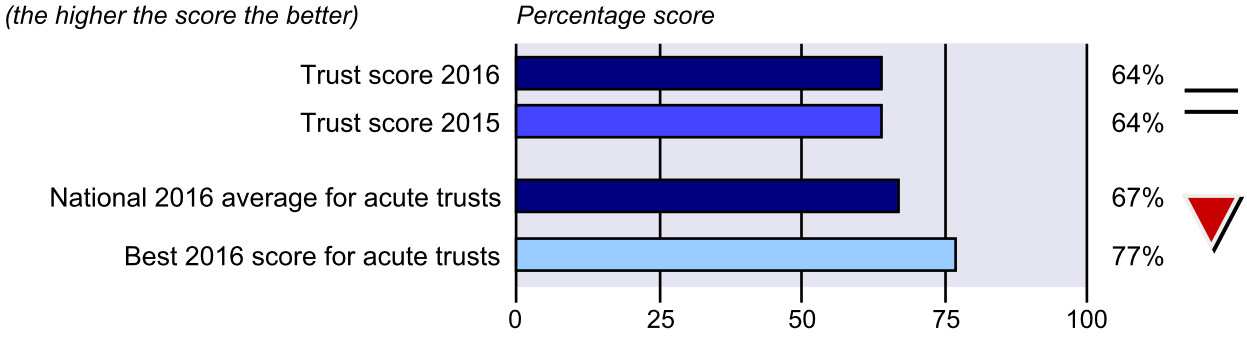
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



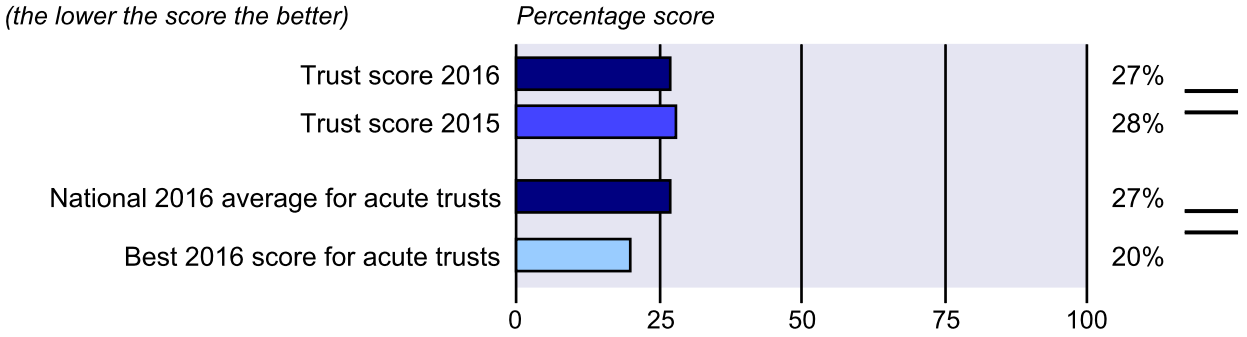
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



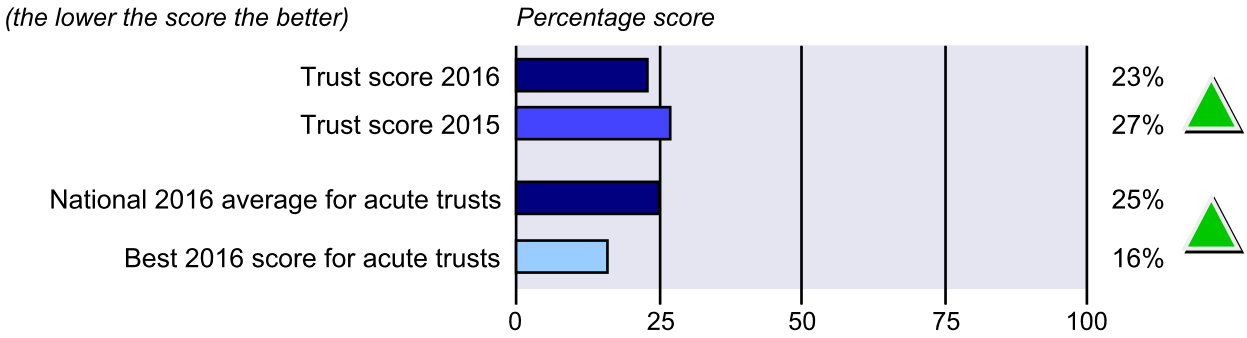
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



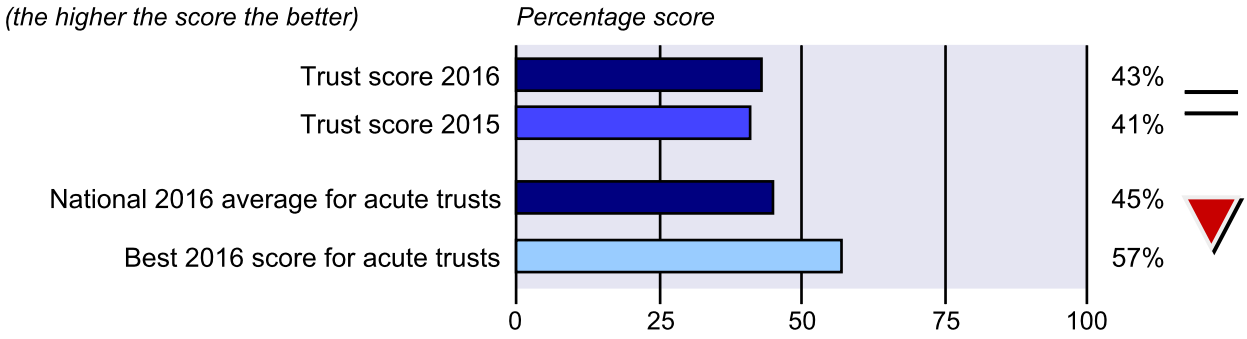
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	14
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Speaking Up Annual Report 2016/17		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Pam Wenger, Trust Secretary		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

This report will provide a brief summary on the context of the Freedom to Speak Up Guardian as a backdrop to this initial report which is intended to be presented on an annual basis.

This report aims to identify the progression and awareness around Speaking Up within the NHS; the introduction of the Freedom to Speak Up Guardian role and national requirements in relation to Board reporting; and how the Trust has responded and continues to develop.

Key issues to note

Freedom to Speak Up Guardian role

The Trust appointed Pam Wenger as the Local Freedom to Speak Up Guardian in October 2017 for the interim period to set up the processes and systems in the Trust.

Activity undertaken in the last 6 months include:

- Attendance at national events including the National Conference;
- Participation in the Regional Network which has included hosting the meetings at UH

Bristol;
- Establishment of the reporting system on DATIX for Speaking Up;
- Agreed the reporting mechanism through the Audit Committee;
- Reporting to the Senior Leadership Team including the establishment of Speaking Up Staff Advocates. This will be implemented in the next 3 months.
- Regular discussions with the Senior Independent Director; and
- Dealing with concerns raised under the Trust's Speaking Out Policy and Procedure.

The recorded cases within 2016/17 totals 10. Of the 10, 9 have been investigated and closed. All cases were investigated, feedback provided and appropriate actions put in place.

Of the 10 cases, 7 were dealt informally or via withdrawn in accordance with the most appropriate HR policy such as the grievance procedure.

Themes raised within the 7 cases include:
- Staff morale/team working
- Communication
- Bullying/Harassment
- Culture

Recommendations

Members are asked to:
- **Note** this report for assurance.

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
None identified.

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
11/07/2017	Click here to enter a date.	26/07/2017	Click here to enter a date.	

FREEDOM TO SPEAK UP ANNUAL REPORT 2016/17

1. INTRODUCTION

In February 2015, Sir Robert Francis published his final report which made a number of key recommendations under five overarching themes with actions for NHS organisations and professional and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern. Two key elements include the appointment of a local Freedom to Speak Up (FTSU) guardian in each Trust and a national guardian for the NHS.

This report will provide a brief summary on the context of the Freedom to Speak Up Guardian as a backdrop to this initial report which is intended to be presented on an annual basis. The Trust Board is requested to reflect on the contents of this first annual report and consider if this fulfils the reporting obligation requesting any relevant amendments to future editions and/or requesting supplementary or alternative information.

This report aims to identify the progression and awareness around Speaking Up within the NHS; the introduction of the Freedom to Speak Up Guardian role and national requirements in relation to Board reporting; and how the Trust has responded and continues to develop.

2. PROGRESS

Policy Review

NHS Improvement on 1 April 2016 published a standard integrated *Freedom to speak up: raising concerns (whistleblowing) policy* for NHS organisations in England to adopt as a minimum standard to help normalise the raising of public interest concerns. The Policy is currently under review and planned for implementation in 2017/18/

Freedom to Speak Up Guardian role

The Trust appointed Pam Wenger as the Local Freedom to Speak Up Guardian in October 2017 for the interim period to set up the processes and systems in the Trust.

Activity undertaken in the last 6 months include:

- Attendance at national events including the National Conference;
- Participation in the Regional Network which has included hosting the meetings at UH Bristol;
- Establishment of the reporting system on DATIX for Speaking Up;
- Agreed the reporting mechanism through the Audit Committee;
- Reporting to the Senior Leadership Team including the establishment of Speaking Up Staff Advocates. This will be implemented in the next 3 months.
- Regular discussions with the Senior Independent Director; and
- Dealing with concerns raised under the Trust's Speaking Out Policy and Procedure.

3. RAISING CONCERNS IN THE TRUST

There are a number of ways in which staff can raise concerns in the Trust. The Trust *Speaking Out Policy* is currently under review and will be re-focused to take into account the minimum content as required by the National Speaking Up Guardian.

During the year work has been progressed to provide clarity in relation to the reporting arrangements, attached at annex (i), the Trust flowchart for raising concerns.

The 2016 staff survey results are positive in most areas and the overall engagement score has improved year on year. The results indicate that staff feel more engaged and are more actively involved and up-to-date on what happens within their team, department and the Trust. On the whole; staff feel the Trust is a great place to work and receive treatment and that care of our patients and our staff is the Trust's top priority. Staff in the Trust feel they have the opportunity to progress that they are able to continue develop their skills through our training opportunities and appraisal.

4. LINKS WITH THE STAFF SURVEY

The Staff Survey 2016 took place between September and December 2016. The Trust results were published early March 2017. Key issues which are relevant to speaking up include:

- **Management**

  All of the questions show at least a small percentage improvement since 2015, and there are three scores around senior managers that have improved by around 5%. One of the most improved scores was staff disagreeing that senior managers act on staff feedback (down from 32% last year, to 27% this year) and this is now better than other Acute Trusts (30%).

  Staff disagreeing that senior managers involve staff in important decisions has also improved (down from 39% last year, to 34% this year).

- **Bullying, Harassment and Whistleblowing**

  The scores for the number of staff reporting harassment, bullying and abuse has improved slightly and the scores for the number of staff not reporting physical violence has worsened. The scores around reporting are all slightly worse than other Acute Trusts : staff not knowing how to report concerns about unsafe clinical practice (8% compared to 6% sector); staff and/or colleagues not reporting physical violence (31% compared to 29% sector) and staff and/or colleagues not reporting bullying, harassment and abuse (53% compared to 52% sector).

	Raising concerns about unsafe clinical practice	2014/15	2015/16	2016/17	Average Acute Trust
Q13a	% saying if they were concerned about unsafe clinical practice they would know how to report it	91`	92	92	95
	% agreeing / strongly agreeing with the following statements:				
Q13b	"I would feel secure raising concerns about unsafe clinical practice"	66	64	66	69
Q13c	"I am confident that the organisation would address my concern"	54	52	56	57

Improving Staff Experience Plans

The Organisational Development Team and Divisional HR Business partners have been working together to develop a robust approach to the plans for 2017/18 in response to the findings from the staff survey, both in terms of building on the successes and improving the lowest scoring areas. In order to respond to the findings in a more strategic way plans will reflect 5 key themes:

- **Building Capability**- including E-Appraisal and Leadership Behaviours
- **Equality and Diversity**- Improving how staff from the protected characteristics experience work
- **Leadership and Management Development**- including coaching, mentoring and action learning
- **Staff Engagement**- including Happy App, Health and well-being
- **Teamwork**- including away days, focus groups, bespoke team development solutions

The Freedom to Speak Up Guardian and Staff Advocates will play a key role in raising the profile of Speaking Up across the organisation and supporting the delivery of these as appropriate.

5. REPORTED CASES (April 2016 – March 2017)

The recorded cases within 2016/17 totals 10. These matters are considered as formally raised issues. Within the stages of the Speaking Out Policy and Procedure there is the opportunity for individuals to raise matters informally initially. This informal process has been promoted with the Trust's open culture however in terms of capturing data we currently are unable to report the number of concerns that are raised and resolved informally, at source, via line management or another route such as staffside, HR or the FTSU Guardian.

Within the year being reported, 10 Freedom to Speak Up cases were received. Of the 10, 9 have been completed and closed. All cases were investigated, feedback provided and appropriate actions put in place.

Of the 10 cases, 7 were dealt informally or withdrawn in accordance with the most appropriate HR policy such as the grievance procedure.

Themes raised within the 7 cases include:

- Staff morale/team working
- Communication
- Bullying/Harassment
- Culture

It should be noted that the majority of the cases reported involved more than one issue. The Trust agreed that the reporting route for Freedom to Speak Up as the Audit Committee and to receive 6 monthly updates and an annual report to the Board of Directors.

The Freedom to Speak Up Guardian maintains a secure system via DATIX which includes details of the cases, investigations and outcomes ensuring the Trust policy is adhered too. Progress against the cases are discussed regularly with the Chief Executive.

6. FORWARD LOOK 2017/18

The Board of Directors agreed that the Trust Secretary would take on the role of Guardian in October 2016. Due to the capacity to fully deliver the agenda it is accepted that limited progress has been made in setting up systems and processes.

Work continues to develop the Trust's Raising Concerns Policy and procedure to encourage staff to raise matters and for this to become part of everyday practice. The low resulting number in formal concerns may suggest that staff feel comfortable to raise matters and that informal resolution is achieved in most cases. However, it is recognised that there further work to do as identified in the staff survey to raise awareness of the processes around raising concerns.

It is important to remain focused on feedback from individuals who have raised concerns and relevant stakeholders within the process to ensure the current policy captures the spirit of the Trust's values and staff feel they can raise concerns or issues without fear of victimisation, blame or reprisal.

The next year will focus on putting in place the communication plan and mechanism to raise awareness. Specifically this will include:

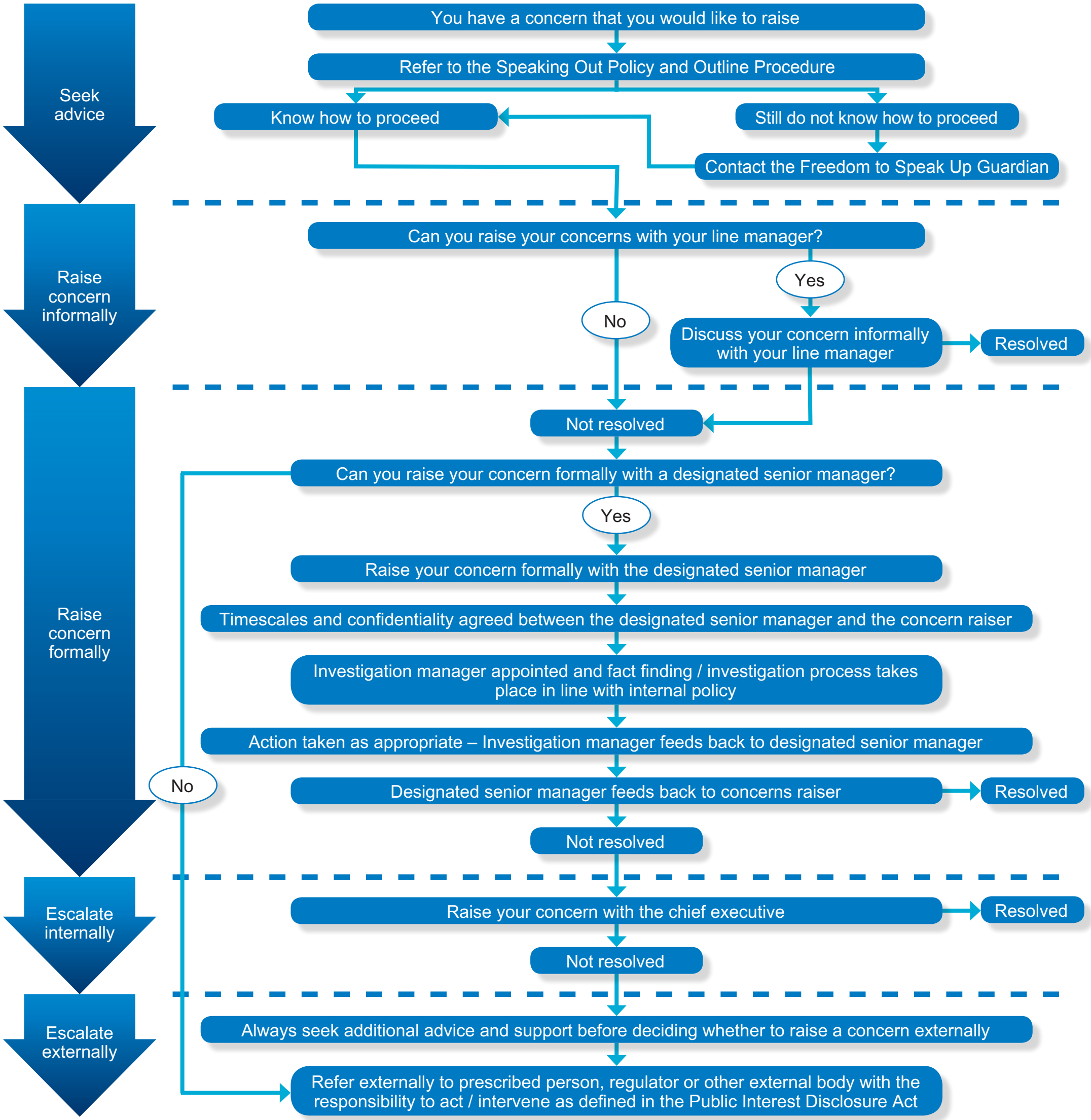
- Launch of the Network of Staff Advocates;
- Work with the Divisions to support the implementation of their Staff Experience Plans;

- Integrate Speaking Up in existing training programmes including; Leading for Managers, Corporate Induction and Equality and Diversity; and
- Continue to work with the National Guardian's Office

Flowchart for raising concerns

NHS
University Hospitals Bristol
NHS Foundation Trust

You should seek to highlight your concern within the Trust informally where possible.
Advice and support is available throughout this process. You can contact your trade union, HR, professional regulator, professional body or, alternatively, independent advice can be sought through the National Whistleblowing Helpline on 0800 072 4725.



Raising a public interest (whistleblowing) concern.

A public interest concern may include where:

- someone's health and / or safety has been put in danger because of an action or inaction;
- damage has been caused to the environment;
- a criminal offence has been committed;
- an employer fails to obey the law (such as not having appropriate insurance);
- a malpractice or wrong-doing has been covered up.

Contact the Freedom to Speak Up Guardian at raisingconcerns@uhbristol.nhs.uk or 0117 3421577

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	15
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Medical Revalidation Annual Report 2016/17		
Author	Frances Forrest, AMD Revalidation		
Executive Lead	Sean O'Kelly, Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

<u>Purpose</u>

The purpose of this report is to inform the Board of Directors that Medical Revalidation processes are operating satisfactorily.

<u>Key issues to note</u>

- Revalidation of a doctors' licence to practice has now been operational for four years and 486 Doctors have been revalidated in that period.
- 31 recommendations of revalidation were made in 2016/2017. 6 doctors were deferred. No doctors were considered to have non-engagement with the revalidation process. One doctor continues to be "on hold" with the GMC for ongoing investigation and is not currently working in the hospital.
- The reasons for deferral are outlined in the full report.

- 1 is related to ongoing processes complicated by sickness
- 5 were due to lack of sufficient evidence submitted.

Deferral appears to be more common in the Clinical Fellow group. This group appear to be less familiar with their responsibilities for Revalidation

- ❖ NHSE performed a Higher Level Responsible Officer Quality Review (HLROQR) in April 2016 which was deemed favourable and an action plan was agreed and implemented.
- ❖ The contract with Premier IT for the e-portfolio system (PReP) for appraisal was extended through a single tender action for 2 years at a cost saving of £6300 for 2016/2017 and £12600 for 2017/2018. In early 2018 UHBristol will go out to tender for renewal of the e-portfolio system.
- ❖ A new Assistant Medical Director in Revalidation (Dr Frances Forrest) was appointed and took up post from Dr P Weir on 1st June 2016

Recommendations
Members are asked to: • **Receive** the report for assurance.

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Annual Quality Assurance Report for Appraisal and Revalidation

University Hospitals Bristol NHS Foundation Trust 2016-2017

Responsible Officer:	**Dr Sean O'Kelly, Medical Director**
Associate Medical Director for Revalidation:	**Dr Frances Forrest**
Report produced by:	**Dr Frances Forrest**
Time period covered in report:	**1st April 2016 – 31st March 2017 (Year 4 of the first 5 year Revalidation cycle)**

Introduction

Since April 2013 all medical practitioners are required to revalidate their licence to practice with the General Medical Council (GMC) every five years. Each medical practitioner is formally linked to a Designated Body by the GMC, such as the Trust at which they are employed, and revalidate by engagement with governance processes operated by the designated body for this purpose. Revalidation is achieved through successful annual appraisal and review of patient feedback information and requires the Trust Responsible Officer (RO) to make a positive revalidation recommendation to the GMC when all professional practice information is taken into account. This report summarises the activity related to Medical Revalidation and appraisal for the year 16/17 and also highlights current issues in the process that are the focus of work for the Revalidation office.

Activity Levels 2016/17

Revalidation

The table below summarises the numbers of positive recommendations, deferrals and notices of non-engagement to the General Medical Council made by the Trust's Responsible Officer since the initiation of the GMC medical revalidation process in April 2013.

	Year 4: **April 16-Mar 17**	**Year 3:** **April 15 –Mar 16**	**Year 2:** **April 14 –Mar 15**	**Year 1:** **April 13 – Mar 14**
Number of doctors for whom UHBristol is Designated Body on 31/3/2017	**668**	**665**	556	503
Number of positive recommendations for revalidation	**31**	**187**	194	74
Number of deferments	**6**	**23**	24	4
Number of notices on non engagement	**0**	**0**	0	1

The number of recommendations for this year is significantly lower than for 2015/2016. This is a result of the manner in which revalidation was introduced nationally whereby all medical practitioners were required to Revalidate within the first three years of its introduction (April 2012 – April 2015). Consequently, the number of doctors revalidating was much higher in the first three years than has been seen in 2016/2017. An increase in numbers is anticipated again next year (2017/2018) as previously revalidated doctors approach the end of the first five year cycle.

Appraisal rates

The figure below shows 16/17 appraisal rates by grade of medical practitioner.

Grade of practitioner	Total numbers	Appraisals in year	% of doctors undertaking appraisal by grade. 2015/2016 data in ()
Consultant	516	415	82% (92.7%)
SAS doctor	44	33	78.5% (47%)
Clinical Fellows	108	68	63% (36%)
Total	668	516	77% (81.5%)

Quarterly appraisal reports are submitted by the Trust's Revalidation office to NHS England. These reports contain detailed information on appraisal rates for doctors of different grades. In summer 2016 NHSE clarified that it would in future monitor appraisal compliance on a strict 12 monthly basis. This shift in compliance tolerance is important going into the second cycle of revalidation to ensure that doctors undertake a total of five annual appraisals within the five year revalidation cycle. Previous reports to NHSE have been made on 14 month compliance and it is these figures have been included in previous UHBristol Board reports. As a consequence of this change in reporting process there is a noticeable drop in our appraisal rate at consultant grade from 92.7% to 82%. Since autumn 2016 the Associate Medical Director for Revalidation has developed a programme of work to address this.

Additionally, an issue with timely connection and disconnection to a Designated Body has been identified nationally. At UHBristol this is particularly noticeable within the Clinical Fellow grade. This results in two issues for the Trust as a Designated Body.

1) Failure to connect to the Trust when clinical fellows start employment, meaning they do not appear on our Designated Body list and may not get timely information from the revalidation office regarding their individual responsibilities for appraisal.

2) Failure to disconnect from the Trust as their Designated Body on leaving employment, meaning they appear within Trust audit figures reported to NHSE when they are no longer the Trust's responsibility.

Activity Levels 2016/17

Exception reporting

1: Deferred Recommendations

The table below lists the reasons for deferral of a revalidation recommendation for each of the six practitioners deferred in 16/17

Doctor	Grade	Date of deferral	Reason for deferral	New revalidation date	Outcome
1	Consultant	13/4/2016	Insufficient evidence	25/1/2017	Revalidated
2	Clinical Fellow	11/7/2017	Insufficient evidence	11/1/2017	Revalidated
3	Clinical Fellow	19/5/2016	Insufficient evidence	19/8/2016	Revalidated
4	SAS doctor	4/11/2017	On going processes Complicated by sickness	4/8/2017	Pending
5	Clinical Fellow	10/1/2017	Insufficient evidence. Maternity leave and change of specialty	15/9/2017	Pending
6	Consultant	15/2/2017	Insufficient evidence May not return to work	15/3/2018	Pending

Note: “insufficient evidence” is a GMC defined category chosen by the RO when it is not possible to make a recommendation for Revalidation based on the evidence the individual has submitted to the Revalidation Office. In most instances it is expected that the individual will go on to revalidate within a period of 6-12 months and it is not usually associated with concerns about the individual doctor. Common reasons for insufficient evidence are doctors being new to UK practice and not having appraised before, or doctors having significant absences from work (e.g. maternity leave) and then returning to a non-training post such as a clinical fellow role.

2: Non Engagement

No reports of non-engagement in year 2016/2017

Management of the appraisal process

E-portfolio system

Doctors on permanent contracts use an e-portfolio system for collection of their appraisal information. Currently the Trust’s contract is with a company called PReP. Those on non-permanent contracts use a MAG (Medical Appraisal Guide) form which is an electronic form recognised by UK Designated bodies and “transportable” between hospitals.

The contract for PReP started in 2013 and was extended for two years under single tender action in early 2017. This made a saving of £18,900 over 2 years and allowed continuity and support for the process of appraisal that underpins Revalidation. The Revalidation office will go out to tender for a new contract for an e-portfolio system in early 2018.

Governance and Quality Assurance

Governance

The Medical Director’s Team maintains a list of potential low level Governance concerns. This is reviewed regularly for revalidation purposes. Doctors for whom the concern may cause doubt about the RO’s ability to make a recommendation for revalidation are invited to discuss the issues with the RO and AMD. Further escalation of concerns to the GMC can be made if necessary. No referrals were made to the GMC through this route in 16/17.

Quality Assurance

NHS England Framework of Quality Assurance independent verification process: A review visit by this team took place on 22nd April 2016. A report on this was included in the 2015/2016 Board Revalidation report.

The action plan however, post-dates that report. The original action plan and reviewed progress on that action plan are included in the appendix.

Summary of fourth Year of Revalidation at UHBristol

UHBristol has a strong tradition of consultant appraisal and of employing high performing and highly motivated doctors. This continues to be reflected in the high quality of evidence submitted for revalidation.

A change to the time frame over which compliance with appraisal is monitored has been manifest in a perceived drop in appraisal rates. A programme of work has been started to address this.

The administrative workload to monitor appraisal is rising. This is a refection of an increase in the number of doctors employed at UHBristol who are not in training. This increase is most notable at Clinical Fellow Grade and will continue to increase as we address gaps in the junior rotas secondary to introduction of the new junior doctor's contracts.

The majority of permanent doctors at UHBristol have now been revalidated. The numbers for revalidation are relatively small this year and this trend will continue for the final year of this cycle.

ACTION PLAN TEMPLATE

Higher Level Responsible Officer Quality Review (HLROQR)

Designated Body:	University Hospitals Bristol NHS Foundation Trust	**Date of HLROQR:**	22nd April 2016	Status update January 2017	Status update July 2017
Responsible Officer:	Dr Sean O'Kelly	**Revalidation Lead (Ass. Med. Dir.) : Frances Forrest**			
Area for development identified at HLROQR	**Action**	**Responsibility**	**Timescale**	**Status**	**Status**
Consider how processes can be made more robust, with managerial/ administrative support, to ensure correct prescribed connections, appraisal and supply of supporting information for clinical fellows in particular.	Honorary contracted staff to be added to the pay linked ESR (Electronic Staff Records) system strengthening our oversight of the lists of all doctors working with the Trust, including Clinical Fellows on short term contracts.	Medical HR	April 2016 – September 2016	**Complete**	Issues with accuracy on ESR continue to be monitored and fed back to HR. Hand checking of data is identified as administrative burden
	AMD training in ESR	AMD	June- July 2016	**Complete** – ESR now also supplies bespoke data for AOA returns and closer monitoring of new starters'	
	Review information/induction processes to CFs and	AMD &Medical HR	June – September 2016	**Complete** – new elements to induction being introduced – comprehensive leaflet	New issues highlighted at the end of year report to NHSE (31/3/2017)

	newly recruited Doctors			designed and produced for new starters and mentor support offered where appropriate.	with connection and disconnection to UHBristol as a Designated Body to be raised with HR in meeting planned 31/7/2017
Achieved: AMD basic ESR training and access completed. Meeting with HR (Abigail Bishop and Alison Price) with explanation of issues and requirements. Work continues on CF database with emails sent from Revalidation office to CF's. Update of appraisal dates sent to Alison Price for accuracy and maintenance on ESR database. ESR now used as database for AO returns. Continues to need refining.					
As the success of the RO regulations in improving patient safety depends to some extent on each designated body liaising with, learning from and sharing with others, more extensive representation from UHB at the local RO and Appraisal lead networks would be positive.	RO and AMD booked to attend July and October local Appraisal Lead network meetings. (Note: Revalidation Administrator in discussion with other SW Trusts regarding set up of local administrator network.)	RO / AMD	Actioned May 10th	**Complete** - RO attended July meeting and presented. AMD continues to attend	AMD attends Taunton meetings 3 monthly
Consider use of an appraisal Quality Assurance tool as part of the assurance process of appraisal. Options for use include more experienced appraisers using the tool to benchmark good practice and/or use as a development tool in appraiser training days. Alternatively a risk-based approach to quality assurance of appraisals e.g. a check on one appraisal portfolio for each appraiser each year plus more extensive monitoring of new appraisers and those with	1) Full review of current appraiser/appraisee training offered within UHB. 2) CPD Feedback Survey to UHB appraisers as part of training review. 3) Review use of 'buddy' system of appraisal: specifically in relation to development of new appraisers/on- going CPD for established appraisers/for doctors in difficulty.	AMD AMD AMD	June to December 2016 June to December 2016 June to December 2016	**Complete** - Feedback reviewed from training by both providers **Complete** Ongoing: buddy system concept to be incorporated into appraiser training update discussions in 2017- starts Feb 1st 2017	Following 2 appraiser update sessions (Feb and May) no appetite from appraiser community to undertake this. More interest in cross divisional appraisal. AMD to

poorer quality summaries. This could feed in to a more formalised performance review of the appraiser role including feedback from appraises.	4) Review QA tools for appraisal portfolios.	AMD	June to December 2016	**Complete**	champion more cross divisional appraisal going forward
	5) Produce revised QA framework plan	AMD	June to December 2016	Ongoing: trialling AMD review using Wessex deanery tool "progress QA" of sample appraisals at time of review for recommendations for re-licensing. Using that information to inform and educate appraisers at updates.	"Progress 1 and 2 " QA tool trialled. Not ideal for our use. AMD to set programme of work relating to QA of appraisals for august 2017-Feb 2018
	6) Using data from 1-5 to produce recommendations for appraiser and appraisee training going forward and roll out 'buddy' system.	AMD	June to December 2016	Ongoing into 2017. To incorporate into appraiser updates and Consultant Away day updates. Dates confirmed in 2017	See above. Change in strategy to increasing cross divisional appraisal
	7) To work closely with training provider to create bespoke UH Bristol appraiser training package	AMD	December to June 2017	Ongoing- first update for appraisers being run 1st Feb by AMD with a plan for two to three more in 2017.	Appraiser update session complete and ongoing training sessions booked Plan 2017-2018 to consider in house new appraiser training as quality stable/improvement and cost saving measure

	8) To develop links with Umbrella Collaboration (particularly Camera group in Plymouth) to develop best practice and benchmark.	AMD	December to June 2017 (commenced April 2016)	Completed interviews with UHB.	**Completed programme of work**
To further develop reflection at appraisal there is a reflective workbook attached as a possible resource.	Review reflective workbook for use by consultants and SAS staff Edgecumbe 360 reflective workbook already in use and available to Drs – review communications to highlight availability and advantages  Edgecumbe reflective workbook f	RA RA	July 2016 May 2016	To make available the Frimley Health workbook in addition to Edgecumbe on Connect intranet site- permissions to be confirmed. Website update partially complete	
The trust have already identified a priority to do further work on identifying and acting supportively where doctors are under stress	Ensure appraisers / appraisees are aware of Staff Wellbeing project and the support available to doctors under stress Post message to all appraisers on PReP to highlight resources for doctors under stress with link to wellbeing site Ensure Stress Awareness training links to appraisal	AMD RA AMD/ HR Wellbeing lead/Occ	July - December 2016 May/June 2016 June/July 2016	Included in Revalidation updates for Consultant Away Days and appraiser updates going forward in 2017 AMD strengthened links to wellbeing project. Including	**Complete** Continues in CAD's and appraiser updates **Complete:** revalidation newsletter

	processes and make Stress awareness training priority CPD for appraisers Ensure links to staff wellbeing intranet sites on mentoring and appraisal pages Consultant's Resilience workshop to be scheduled for autumn 2016	Health Lead AMD / RA/ HR Wellbeing lead RA	 June 2016 October 2016	updates in revalidation letter and appraiser updates Website update partially complete 2016 workshop **complete** – next resilience workshop scheduled for sept 2017	 **Complete** Website updated **Complete**
Some organisations are developing IT capability to automatically feed complaints and incidents into appraisal portfolios which can reduce the preparation for appraisal and ensure the topics are covered at appraisal. This could prevent low level concerns developing into more serious ones by bringing them out earlier.	NOTE: Complaints and incidents are automatically flagged as part of PReP appraisal process for a reflection in writing and discussion at the appraisal meeting. RO is given awareness of doctors named in complaints directly via complaints teams. Low level concerns invited via quarterly communications to clinical team leaders and divisional HR leads followed up by RA (all divisions must submit a return). Chief Clinical Information Officer to be appointed September 2016, to be discussed as part of review of systems.	AMD	September 2016	**Complete**	AMD and Guardian of safe working identified common information streams that are required. Initial meetings planned to look at streamlining this process electronically with HR

Consider processes for exchanging information about new and existing doctors, both in a new starter situation and where there are concerns, in which HR can play a supporting role,	Review TIR / TOI / MPIT information flows and processes for doctors joining and leaving the Trust.	RA / AMD/Medical HR	August 2016 – February 2017	**Complete**	
The Trust intend supporting and developing case investigators more in future. Examples of Case investigator calibration and skills development meetings exist and further work in developing good practice in this area is being planned. If UHB would like to be part of a small cross region working group on this please let the regional team have a nominee.	To be discussed with Medical Director Team Professional Standards Lead and respond.	AMD / DMD Prof Standards	June 2016	Led by DMD JL	
There could be opportunities to prevent reoccurrence of the language issues that have arisen by ensuring all new recruits have a brief test. This could be applied across all recruitment, complying with equality and diversity legislation. An example of the approach of one trust is provided.	Review and discuss requirements for IELTS / PLAB tests for all EAL doctors with Medical HR Review language testing policy supplied by NHSE with Medical HR / Recruitment	AMD & Medical HR AMD & Medical HR	July 2016 July 2016	HR policies unchanged for language assessment. IELTS/PLAB reviewed. AMD d/w Director of Medical Education language testing policy.	AMD needs to revisit with HR following recent updates from NHSE (5/7/2017) on guidance for good practice on induction of short term locums and pre-employment checks of medical staff
There are many ways in which patients and the public can be involved in appraisal and revalidation to retain the focus on patient safety and include	Review materials supplied by NHSE with Patient Involvement Lead	AMD & Patient Involvement Lead (TW)	April 2016	Meeting held. No current in house project opportunity, PIL to update on results of LTP in early 2017	

the patient voice	Draft action plan with Patient Involvement Lead as part of the Leading Together Programme to extend public involvement in the revalidation process (initial discussions held April 13th 2016)	AMD & Patient Involvement Lead	June 2016	Happy App project for potential live patient feedback in clinic areas – being pursued by AMD for trial in Division of SH&N as part of actions to look at alternative ways of gathering patient feedback	2 in house projects started in conjunction with TW. Review of potential patient experience training with Oxford "leading together programme". Scoping meeting undertaken May 26th 2017. Costings requested and ready for review. Sept 7th planned patient and appraiser interface workshop to review role of patients in local revalidation processes AMD awaiting response on request to pursue Happy App
I confirm that the action plan above has been discussed and agreed with my Board or equivalent		*Responsible officer - Signature & Date*  *Dr Sean O'Kelly, Responsible Officer* *27th May 2016*		*Status update completed 19/1/2017 Frances Forrest*	*Status update completed July 19th 2017*

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	16
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Safeguarding Annual Report 2016/17		
Author	Carol Sawkins, Safeguarding Strategic Lead Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

The purpose of this annual report is to provide both assurance and evidence that the Trust is fulfilling its statutory responsibilities to safeguard adults, children and young people.

The annual report provides an overview of key activity, achievements, risks and the mitigations in place, across all areas of service delivery, for safeguarding adults, children and young people. This report reviews the Trust's progress on meeting national and local priorities.

Key issues to note

- The increase in safeguarding activity continues, particularly in relation to children's safeguarding and Deprivation of Liberty Safeguards applications for adults.

- The Trust's safeguarding governance arrangements are robust, led by the Safeguarding Steering Group chaired by the Chief Nurse, underpinned by Operational Groups for both adults and children, and supported by the newly combined adults and children's team of safeguarding professionals.

- There are six risks in relation to safeguarding adults and children on the Trust Risk Register, each are monitored by the Safeguarding Steering and Operational Groups, with clearly defined controls and action plans in place to mitigate risk rating (where possible).

- Objectives to support activities and outline further improvements in safeguarding of adults, children and young people within the Trust, are detailed in the Safeguarding work and audit plans for 2017/18 (available on request from CN).

Recommendations

Members are asked to:

- **Note** the report.

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
Supports CQC regulation no: 13 ' Safeguarding Service users from abuse'

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		17/02/2017		Safeguarding Children and Adult Board

University Hospitals Bristol NHS
NHS Foundation Trust

Safeguarding Annual Report

(Adults & Children)

April 2016 – March 2017

Index

Subject	Page number
1. Introduction	4
2. Brief Update of National and Local Safeguarding Context	4
3. Summary of current arrangements for Safeguarding within University Hospitals Bristol NHS Foundation Trust (UHBristol)	4
4. Safeguarding Assurance including Performance Monitoring and Audit	5
4.1 Safeguarding and Care Quality Commission (CQC) Regulation 13	5
4.2 Safeguarding Risks	6
5. Safeguarding Children Activity Data	8
5.1 Safeguarding Children Referrals	9
5.2 Safeguarding and Bristol Sexual Health	11
5.3. Safeguarding, Midwifery and the Unborn Baby	12
5.4 Emergency Department referrals and notifications	13
5.5 Child Abduction Policy	14
6 Safeguarding Advice and Supervision (adults and children)	14
7. Safeguarding Adults Activity Data	15
7.1 Safeguarding Adults at risk	15
7.2. Internal Safeguarding Alerts	17
7.3 Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)	19
8. Safeguarding Children and Adult Training	20
8.1 Level 1 and 2 Training Compliance	20
8.2 Level 3 Core and Specialist Training (Children)	20
8.3 Level 3 Safeguarding Training Compliance (Adult)	21
9. Prevent	22
10. Female Genital Mutilation (FGM)	23

11. Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews	23
12. Child Sexual Exploitation (CSE)	24
13. Safeguarding and Domestic Violence	24
13.1 Multi-Agency Risk Assessment Conferences (MARAC)	25
13.2 Independent Domestic and Sexual Violence Advisor (IDSVA) Service	25
14. Safeguarding Resourcing Group	26
14.1 Key Activity in the last twelve months	26
14.2 Programme of work for 2017/18	27
15. Learning Disabilities (Adults)	27
15.1 Key Activity in the last twelve months	28
15.2 Key Risk in 2016/17	28
15.3 Programme of work for 2017/18	28
16. Mental Health Operational Groups (Adults & Children)	28
16.1 Key Activity in the last twelve months	29
17. Dementia Care	29
17.1 Programme of work for 2017/18	30
18. Report Summary and objectives for 2017/18	30

1. Introduction

Welcome to the Safeguarding Children and Adults Annual Report. This annual report aims to provide University Hospitals Bristol Trust Board, Bristol Clinical Commissioning Group and Local Safeguarding Boards with an overview of safeguarding activity and performance for both children and adults for April 2016 to March 2017.

The report will review key safeguarding activity, achievements and risks and provide evidence that the Trust has continued to fulfil its statutory responsibilities to safeguard the welfare of children and adults across all areas of service delivery. The report will also provide an outline of significant national and local issues which have impacted on the Trust safeguarding agenda during this reporting period.

The Trust safeguarding agenda continues to be underpinned by the Trust values aiming to ensure that a culture exists where safeguarding is everyone's business and areas for learning and improvement are continually identified. The summary and conclusion of this report describes the key priorities and areas identified for development in relation to safeguarding activity for implementation during 2017-2018.

2. Brief Update of National and Local Safeguarding Context

- This reporting period has seen a significant change in the Trust approach to safeguarding with transition from the historical model of a separate safeguarding team for adults and children into a combined safeguarding team. This is an approach which has been replicated in many areas within health and social care, locally and nationally.
- The joined up approach promotes a robust and cohesive strategy to support a range of significant emerging national issues which affect both adults and children. This includes the risks posed by Modern Slavery and Human Trafficking, as well as existing areas of challenge such as Female Genital Mutilation. This reiterates the overall Trust approach to safeguarding, through a robust 'Think Family' model reflected through this year's safeguarding achievements.
- All NHS Trusts have been contacted during this reporting period by the Independent Inquiry into Child Sexual Abuse (IICSA). The Inquiry was established as a result of the Crime Survey (2015/16) which found that 7% of adults aged between 16 and 59 reported being a victim and survivor of child sexual abuse. The Inquiry will be the largest public inquiry in the UK and aims to investigate whether public bodies and other organisations have fulfilled their responsibilities to protect children. Information may potentially be required from historical patient records.

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

The UHBristol Trust Board holds ultimate accountability for ensuring that safeguarding responsibilities for both children and adults are met, led by the Chief Nurse as Executive Lead for Safeguarding. Day to day safeguarding activities are undertaken by staff providing services, supported by well-established and experienced safeguarding professionals, who provide expert advice, support and supervision to practitioners across all areas of the Trust.

The Trust's safeguarding activity and arrangements, for both children and adults, are robustly monitored internally by the Trust Safeguarding Steering Group. The Steering Group is chaired by the Chief Nurse and includes senior representation from all Divisions. The Steering Group reports to the Clinical Quality Group which in turn reports to the Quality and Outcomes Committee, the quality sub-committee of the Trust Board.

Two internal operational groups: one for Children's Safeguarding and one for Adult Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, meet bi-monthly and report to the Safeguarding Steering Group. The Operational Groups have the responsibility for completion of actions in the Trust Safeguarding Work and Audit plans, monitoring activity, actions from local Serious Case Reviews, receiving assurance from the divisions regarding safeguarding activity, monitoring training and the dissemination of learning and information through Divisions to all staff.

4. Safeguarding Assurance including Performance Monitoring and Audit

The Trust has a robust performance management framework in place through which safeguarding activities for both adults and children are monitored. This framework provides assurance both internally to the Trust Board and externally to Local Safeguarding Boards and Clinical Commissioning Groups that the Trust continues to meet its contractual safeguarding requirements.

During this reporting period the Trust's safeguarding arrangements and activities for both children and adults have continued to be safe and effective with areas of risk clearly identified and reviewed regularly (detailed in 4.2 overleaf).

Key safeguarding assurance evidence includes:

- Minutes from the Safeguarding Steering Groups and both Operational Groups providing detail of on-going quality assurance, completed actions and monitoring of activity.
- Quantitative safeguarding children data reported quarterly to Bristol and South Gloucestershire Local Safeguarding Children Boards and NHS Bristol as part of contractual requirements specified within the 'Safeguarding Children: Standards for providers of health services' (2016/17).
- Monitoring of allegations, complaints, risks and clinical incidents by the safeguarding teams for further actions to be taken. This enables recognition of possible patterns and trends, which in turn informs supervision practice and teaching content.
- Overview of annual audit plans, safeguarding children and adults, which are monitored quarterly through the Trust safeguarding steering groups.

4.1 Safeguarding and Care Quality Commission (CQC) Regulation 13

The Trust must maintain compliance with Regulation 13 'Protecting Service users from abuse' in order to maintain Care Quality Commission registration. Ensuring that those who use the Trust services are safeguarded and that staff are suitably skilled and supported, demonstrating safeguarding leadership and commitment at all levels of the organisation and being fully engaged in local accountability and assurance structures.

Compliance with Regulation 13 is regularly monitored by both Operational Groups which in turn informs the monthly exception reports made to the Clinical Quality Group (CQG). During this reporting

period a detailed review of Regulation 13 compliance was submitted to the CQG, in January 2017. This report included an overview of all corporate risks (See 4.2 below) associated with safeguarding for both adults and children.

The Trust's safeguarding arrangements for both adults and children were considered as part of the Care Quality Commission inspection of the Trust in November 2016. The inspection included a review of the Emergency Department, medical wards including older peoples care, Sexual Health Services, Surgery and Outpatients. The inspection highlighted that staff understood their safeguarding responsibilities, were aware of local procedures and knew what to do if they had a concern.

4.2 Safeguarding Risks

The Safeguarding Steering Group and the Operational Groups for both children and adults maintain oversight of all safeguarding corporate risks entered onto Datix. In order to provide a greater level of assurance, a detailed review of all risks linked to safeguarding (adults and children), directly or indirectly, at a Corporate, Divisional or Departmental level, was undertaken this year and will be undertaken six monthly.

During this reporting period the following safeguarding Corporate risks, have been identified or monitored, summarised in table one below.

Table 1: Summary of Corporate Safeguarding Risks

Risk No	Summary of Risk	Current Risk Rating & Controls	Key mitigating actions	Owners of Risk / Monitoring Group
921	Risk of not achieving 90% compliance for all Essential Training, which includes safeguarding training.	Risk Rating 12 Controls Adequate / High Risk	Whilst compliance with Level 1 & 2 training has been achieved and maintained, the 90% minimum compliance target for children's safeguarding level 3 training (Core and Specialist) continues to not be achieved. A detailed breakdown of the training data has highlighted lower rates of compliance in particular staff groups, including medical staff and healthcare scientists. A number of new actions are being taken to address this risk which has been on the risk register for three years. Key new actions are: • More flexible provision level 3 training • Monitoring of compliance and follow up of non - compliance by the Clinical Chair, Head of Nursing and Consultant Governance Lead for Women's & Children's Division. • Review of level three target audience • Review of alternative options for delivering level three training • Learning and benchmarking with other Trusts with a children's hospital that achieve 90% compliance with level three training	Executive Lead - Director of Workforce & Organisational Development. Safeguarding Steering
949	Risk that perinatal mental health services are	Risk Rating 12 Controls	This risk primarily relates to a lack of community perinatal mental health provision which has the potential to negatively impact on the care of women under the obstetric care of UHBristol.	Women's Divisional Governance

	not providing an adequate level of service. There is also a lack of specialist commissioned community service. Related to a serious case review	Inadequate / High Risk	A number of internal actions have been taken to mitigate this risk in the last year including; • provision of psychiatric nurse support at the antenatal clinic, led by the obstetric consultant • introduction of a mental health midwifery 'champion' role supported by additional training. • improved information sharing and assessment of risk, resulting from access to mental health records held within another Trust. A new community perinatal mental health team has been established by AWP mental health trust. The risk will remain on the Trust risk register until referral pathways are in place, thresholds for accepting referrals are finalised and the community perinatal mental health service is fully up and running (pending recruitment)	Group, Safeguarding Steering Group.
856	Risk that the emotional and Mental Health needs of children and young people admitted to the Children's Hospital (for mental health reasons only), may not be fully met as the Hospital is not a provider of mental health services.	Risk Rating 12 Controls Inadequate / High Risk	This is an ongoing risk with a number of children and young people being admitted to the BRCH as a place of safety who do not require treatment for any physical health reasons. Actions to mitigate this risk taken in the last year include: • Provision of some liaison psychiatry resource for the BRCH via AWP mental health trust, • BRCH psychology service providing additional support in specific situations, • Establishment of an improved system for collecting mental health activity data in the Children's ED. Further investment in the AWP mental health trust paediatric liaison service has been agreed for 2017/18, allowing the service to develop and expand provision for inpatients. Commissioning of mental health services for children is being reviewed by NHS England. It is anticipated that the risk score will reduce in the next reporting period when the new mitigating actions are complete.	Children's Governance & Mental Health Operational Group, Safeguarding Steering Group.
1595	Risk that if patients suffering from mental health disorders spend prolonged time in the ED their condition could deteriorate. Patients affected are those detained under S 136 (Mental Health	Risk Rating 16 Controls Inadequate / Very High Risk	This continues to be a risk with adults with mental health needs having a prolonged stay in ED and on sometimes having to be admitted to an inpatient bed due to the lack of available facilities locally and nationally for adults. There are ongoing controls in place and good partnership working with AWP colleagues. The key action ongoing action is: A project with partner agencies led by AWP mental health trust and Bristol CCG to review Section 136 provision across the city and agree a sustainable model to meet currently unmet demand.	Mental Health Operational Group adults. Safeguarding Steering Group

	Act)			
690	Risk of non – compliance with the Deprivation of Liberty Safeguards (DoLS)	Risk Rating 10 - Controls Adequate/ High Risk	Since 2014 the Trust has been partially non-compliant with the DoLS legislation following a change in the interpretation of the law. This resulted in a significant increase in the number of DoLS applications which the Local Authority DoLS team does not have sufficient capacity to process in a timely manner. There are controls in place to ensure that priority is given to patients who are most vulnerable patients. Concerns that the legislation is overly technical and not meaningful have resulted in a review of the Mental Capacity Act and DoLS by the Law Commission. The report published at the end of this reporting period, recommends significant amendments to the legislation. Changes to the legislative process are likely to take a number of years.	Safeguarding Adults Operational Group. Safeguarding Steering Group
1560	Risk of potential or inappropriate documentation relating to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions. Concerns about the quality of documentation around DNACPR decisions for adults with a Learning Disability	Risk Rating 12 Controls In Adequate / High Risk	A number of actions have been taken in the last year to mitigate this risk: • specific training for medical staff undertaking DNACPR assessments • regular monitoring and audit of completed DNACPR forms There has been a national review of the DNACPR documentation which has recently resulted in a new document 'RESPECT' which will result in further actions.	Resuscitation Group Medical Director

5. Safeguarding Children Activity Data

The significant year on year increase in the number of contacts to the Safeguarding Team for advice and support has continued, whilst the number of onward referrals to Children's Social Care has remained relatively stable. The continuing increase in contacts to the Safeguarding Team from practitioners across the Trust reflects the well-established positive safeguarding culture which is underpinned through the provision of robust high quality training.

5.1 Safeguarding Children Referrals

Safeguarding referrals are sent to the Safeguarding Team prior to being sent to Children's Social Care. This allows for quality assurance of all referrals and provides support to the front line practitioner to enable them to clearly articulate safeguarding risks. This system allows safeguarding activity data to be monitored and evaluated robustly by the Child Protection Operational Group (CPOG) to identify patterns, trends or areas of concern.

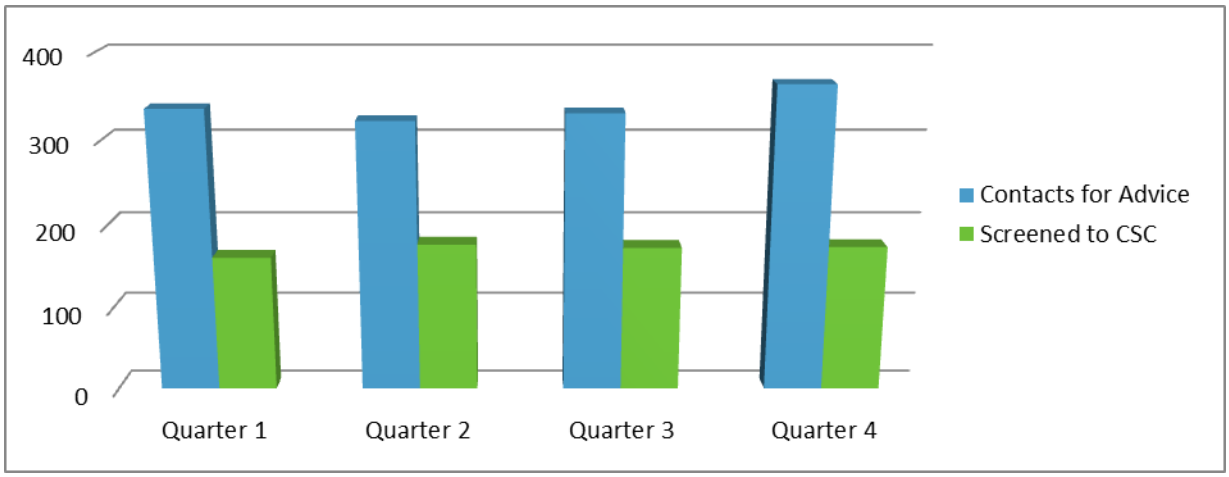
The activity data reflects a year on year increase in the number of the contacts to the Safeguarding Team, for advice and support (See table two below).

Table 2: Number of contacts to the Safeguarding Team (Children)

	2013/14	2014/15	2015/16	2016/17	% Increase
Total	602	795	1147	1353	18

The quality assurance process results in many contacts being 'screened out' following further information gathering and analysis by the Safeguarding Team (See table three below). This approach is in line with the aims of the Bristol Safeguarding Children Board (BSCB) that referrals should be made in accordance with the BSCB Thresholds Guidance.

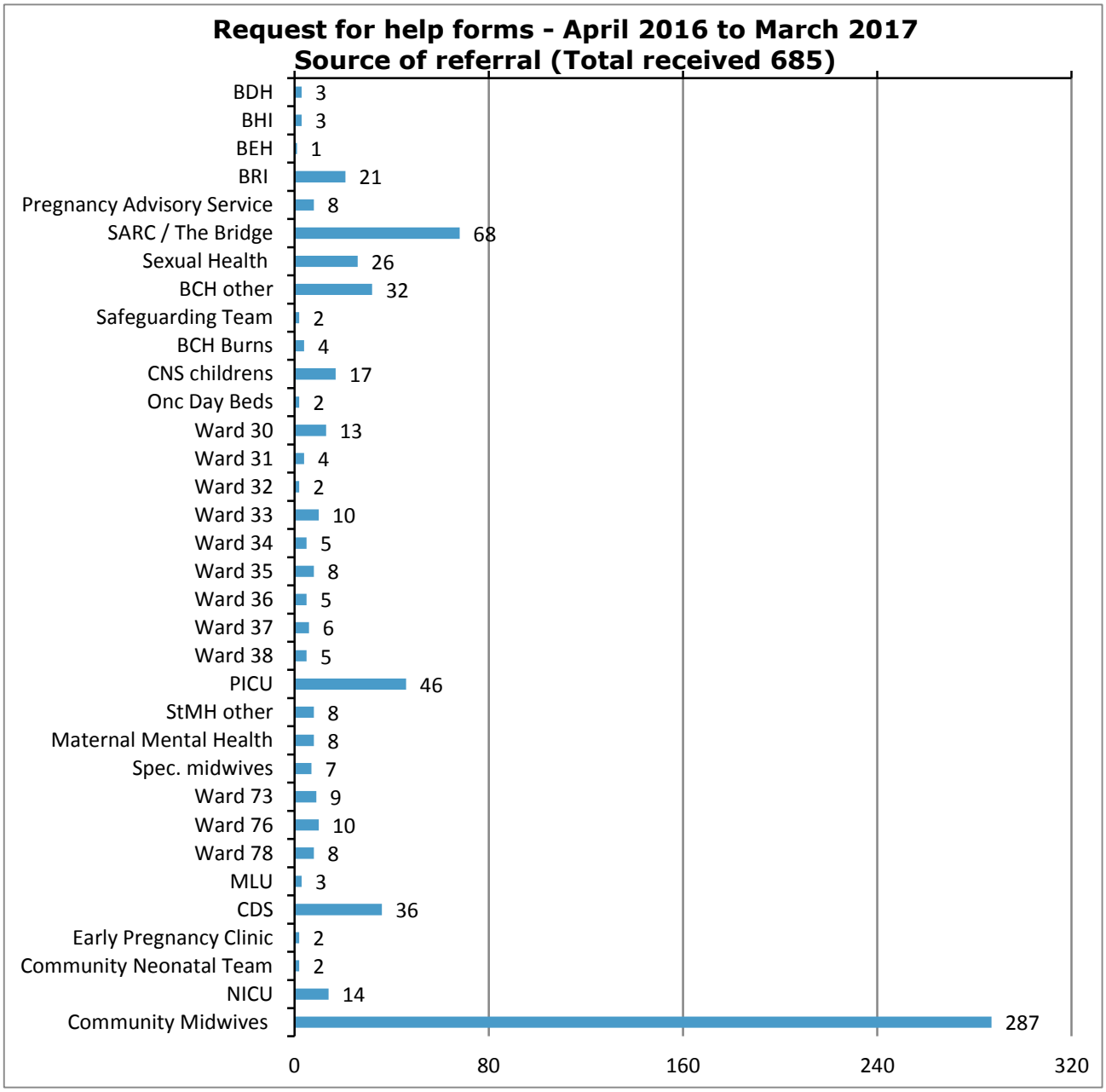
Table 3: Number of referrals screened prior to sending to Children's Social Care by quarter



Contacts and referrals 'screened out' are highlighted to the child's Primary Health Care Team for ongoing support and monitoring. During this reporting period 49% of contacts to the Safeguarding Team did not result in an onward referral to Children's Social Care. The total number of referrals (685) remains in line with the previous year's data (708).

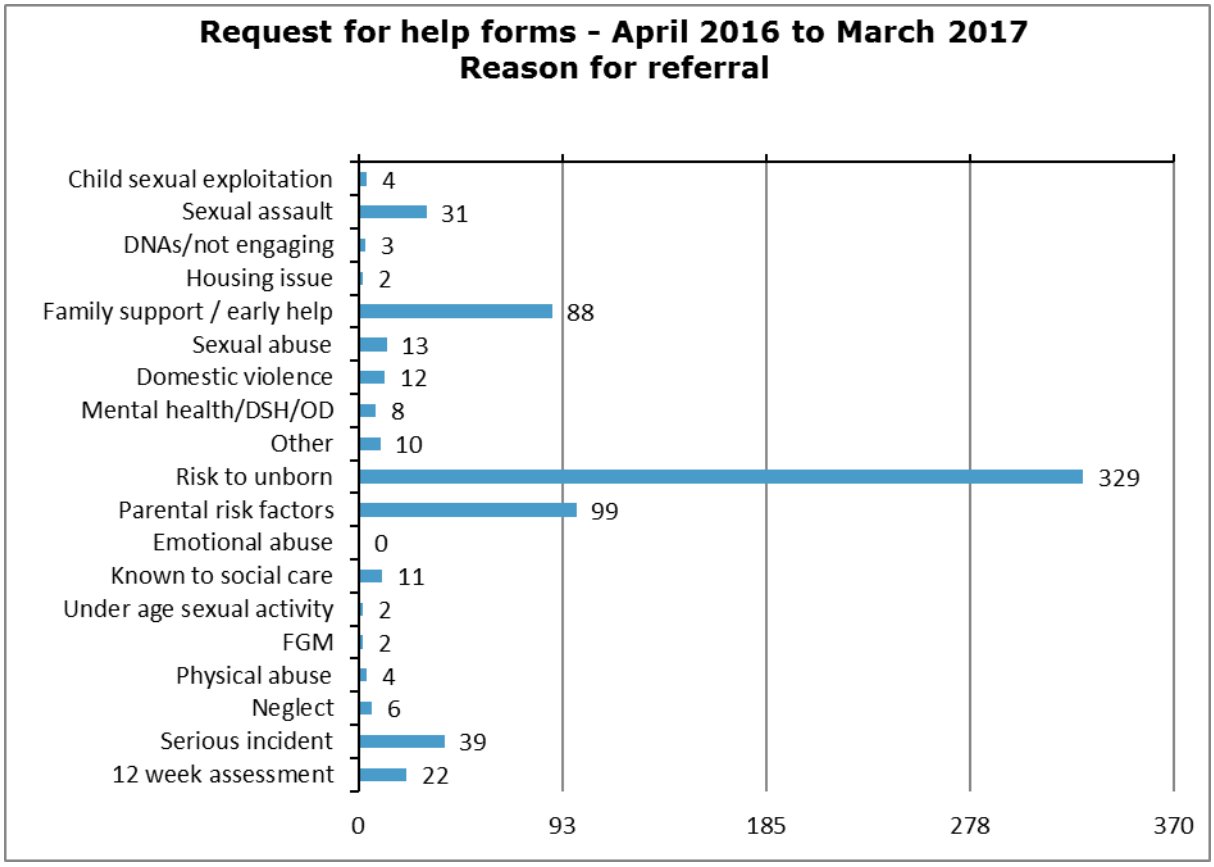
Safeguarding Children referrals continue to be made from a wide range of areas within the Trust as reflected in table four, overleaf.

Table 4: Safeguarding Referrals to Children's Social Care / Source of safeguarding referral



The majority of the referrals, as expected, continue to be made by the Community Midwifery Team. Additional resources to support the midwifery safeguarding remit are due to be considered in the next reporting period.

Table 5: Reason for safeguarding referral



The range of concerns or reasons for the referrals being completed remains broadly in line with previous reports.

5.2 Safeguarding and Bristol Sexual Health

Bristol Sexual Health services continue to see a year on year increase in safeguarding activity, detailed below:

- 2014/15 - 14 referrals
- 2015/16 - 87 referrals
- 2016/17 - 94 referrals

This reflects the heightened level of awareness by Bristol Sexual Health of the risk of Child Sexual Exploitation (CSE). There are robust safeguarding processes in place within Sexual Health Services. Specialist Risk Assessments are in place, supported by multi-agency working, and a quality assurance review of the records of children presenting to the service by the Lead Sexual Health Consultant.

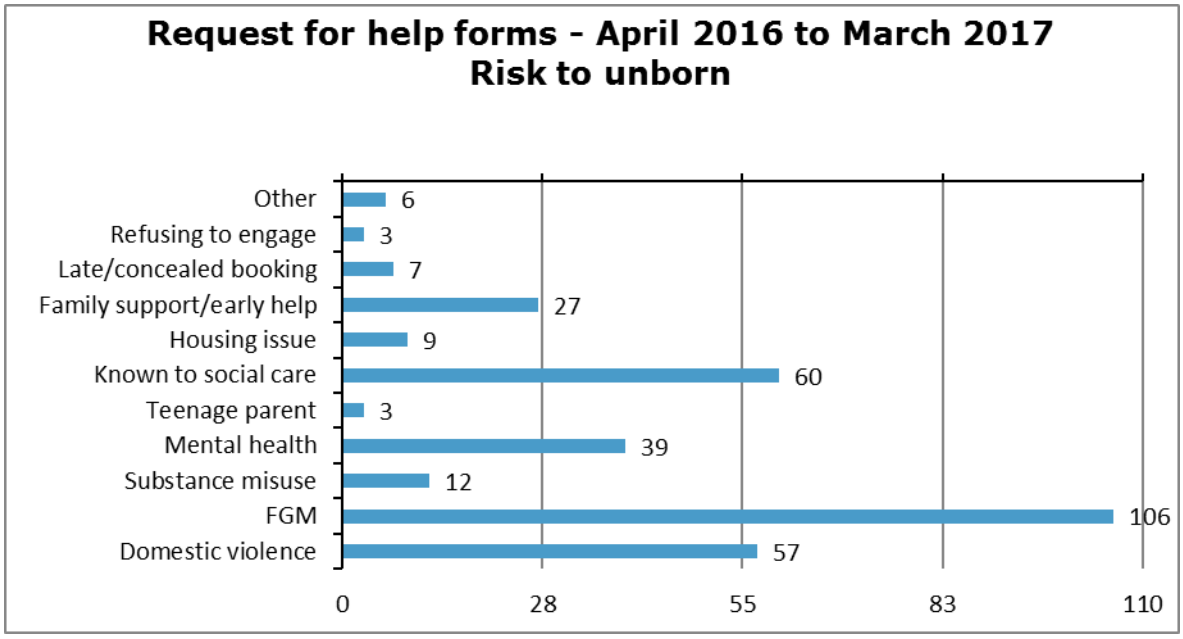
During this reporting period UHBristol has been awarded a five year contract to provide BNSSG Integrated Sexual Health Services. The new services will be known as Unity Sexual Health and will commence on 1st April 2017. Consideration of the safeguarding arrangements has been key to the new commissioning arrangements, including plans for the promotion of information sharing across all of the six provider organisations.

Unity Sexual Health will include a strategic group, 'The Senate' to oversee safeguarding activity, supported by a number of sub groups, including a safeguarding group. These safeguarding arrangements will be closely aligned to the overall Trust safeguarding arrangements, through interface with the safeguarding work and audit plans. Further support will be provided, initially on a secondment basis, through the appointment of a Unity Safeguarding Nurse who will work closely with the Safeguarding Team.

5.3. Safeguarding, Midwifery and the Unborn Baby

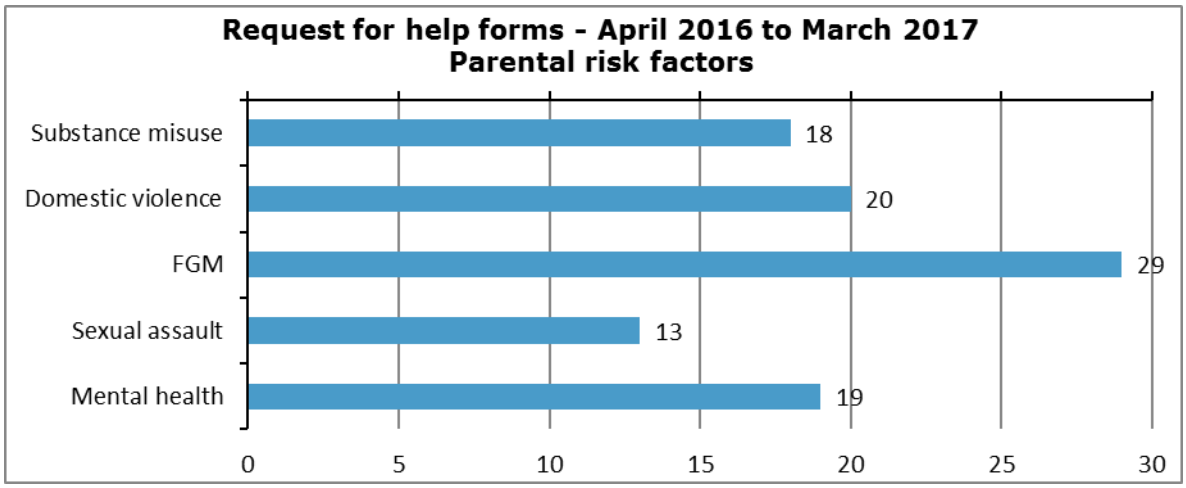
Midwifery Services continue to deal with challenging and complex cases, resulting in a significant number of referrals. The reasons for referrals are detailed in table six below.

Table 6: Reason for safeguarding referral for unborn babies



Referrals for unborn babies are made due to concerns about potential parental risk factors, (incorporated into table six above), which may result in occasions where babies have to be removed from their mothers following a multi- agency safeguarding process.

Table 7: Breakdown of referrals for parental risk factors/ think family



There has been an increase in the number of referrals made following concerns about parental mental health, 5 referrals in 2015/16 compared to 19 in this reporting period. This increase is likely to be associated with an increased level of awareness and concern following the high profile Bristol Serious Case Review (SCR). In 2014 a mother left the maternity hospital carrying her baby and subsequently took her own life and that of her baby.

This case was widely reported in the media both locally and nationally and has generated a number of further actions, including the requirement for NHS England to review the commissioning of perinatal mental health provision. Maternity Services continue to work with local NHS commissioners to introduce a new peri- natal mental health service for women.

Whilst the final SCR report is not due to be published until the beginning of the next reporting period, much of the learning from the report is already being considered within the multi- agency safeguarding process within the city. Within the Trust the risk that mothers may receive inadequate service/treatment in relation to perinatal mental health is reflected in Datix Risk number 949 (See section 4.2)

5.4 Emergency Department referrals and notifications

The number of information sharing notifications and referrals made by the Emergency Departments to Children's Social Care remains in line with previous years (Detailed in table eight below)

Table 8: Emergency Department Safeguarding Referrals / Information Sharing

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
BCH ED	1041	1172	885	1275	1362	1494	1326
BRI ED	330	514	462	488	593	486	616

A significant percentage of the forms continue to be for the purpose of sharing information with Children's Social Care, for example, a child might present with an appropriate medical attendance and noted to have a social worker or are a subject of a Child Protection Plan.

There continues to be a large number of notification/ referrals completed for children and young people who have self- harmed / taken an intentional overdose. This pattern mirrors the local and national picture of increasing concern about the emotional health and well-being of children and young people. An issue considered through the Children's Mental Health Operational Group (MHOG) as well as by the Bristol Safeguarding Children Board Health Sub Group.

5.5 Child Abduction Policy

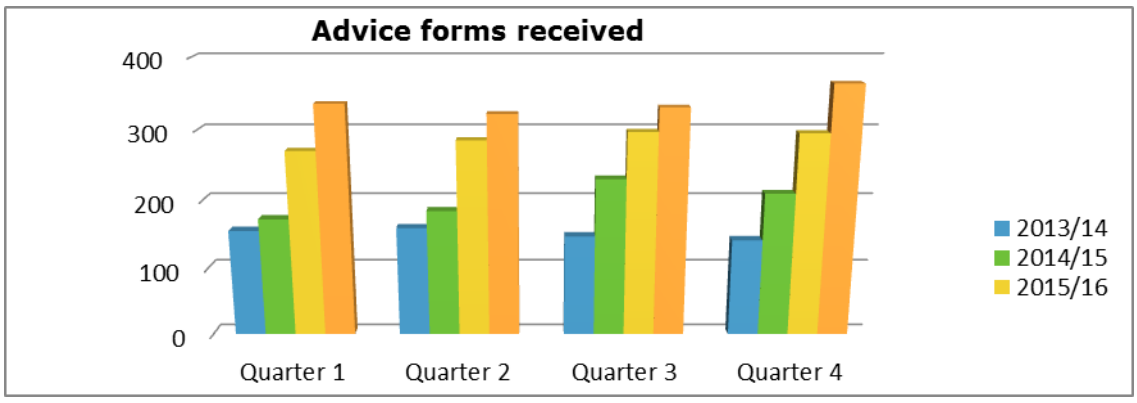
An assurance exercise was performed in relation to the Child Abduction Policy within this reporting period. This involved a child abduction simulation in a clinical area. Staff were not aware that the exercise was a simulation and their actions were observed in line with the process set out in the policy. The simulation highlighted an immediate risk involving an exit from the Children's Hospital. This was converted to swipe exit to reduce the risk.

The simulation will be repeated annually to ensure that the learning from the previous simulation has been incorporated into practice.

6 Safeguarding Advice and Supervision (adults and children)

The Safeguarding Supervision Policy has been reviewed during this reporting period and supports staff in accessing the model of supervision most appropriate to their role and responsibility. Local Serious Case Reviews have frequently highlighted the importance of safeguarding supervision and advice, to enable staff to articulate risks clearly in their referrals.

Table 9: Safeguarding Advice / Case Supervision



The Safeguarding Team provides supervision to a range of practitioners who are responsible for their own caseloads and a range of potential high risk clinical areas such as the Bristol Sexual Health Services, and the Intensive Care Unit. Safeguarding Midwifery Supervision has also been regularly provided to the Community Midwives.

Data for a complete twelve month period is included for the first time in table ten below. There has been a marked increase both in the number of cases discussed and the number of supervision sessions delivered.

Table 10: Safeguarding Supervision Data

	Children's services	Midwifery services
Number of areas engaging	15	11
Sessions delivered	24	34
Cases discussed	98	228

The majority of the cases discussed in supervision were raised by the Community Midwifery Teams, reflecting an effective model of supervision within these teams.

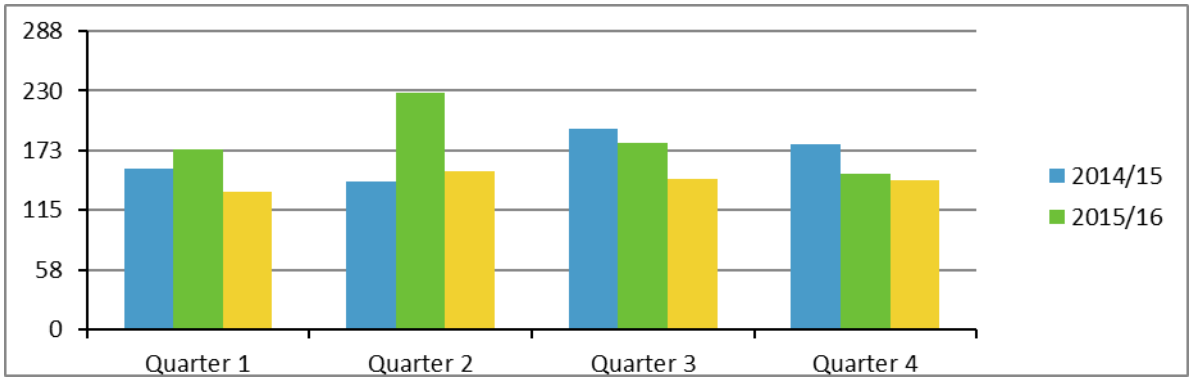
7. Safeguarding Adults Activity Data

The safeguarding adults' activity data, in the main, has remained consistent with previous reports.

7.1 Safeguarding Adults at risk

The total number of concerns raised for safeguarding adults has decreased overall (see table twelve below).

Table 12: Number of Referrals Received per quarter per year



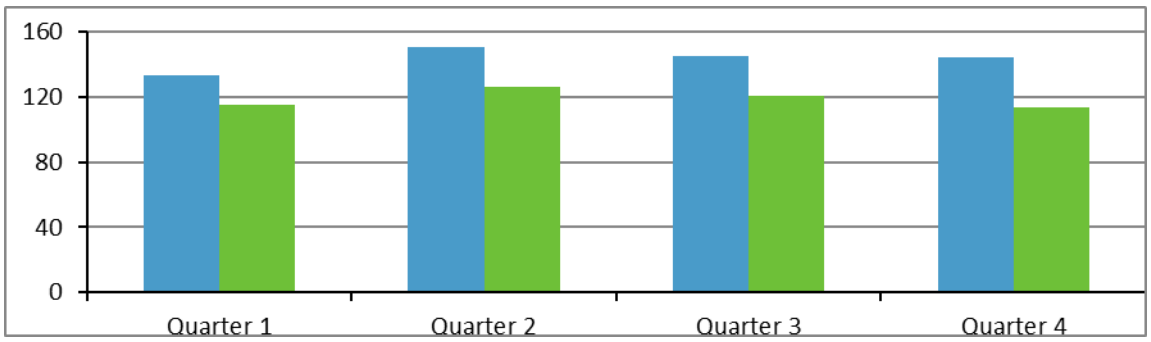
The recent inconsistencies in referrals demonstrated in table twelve may be the result of a number of contributory factors, including the previous impact of high profile public inquiries such as Winterbourne View and Mid Staffordshire and the subsequent Francis report.

The key messages from the new legislation are fully incorporated into training and embedded in practice; the multi-agency understanding and interpretation of the Care Act has become clearer. This has included a greater understanding of the prerequisite criteria and the thresholds for intervention which may in turn have caused the number of referrals to decrease.

The Safeguarding Team ensures that the appropriate threshold has been reached before the referral is submitted and a number of referrals are 'screened out' as detailed in table thirteen below. This has

involved a quality assurance of the referrals to ensure adherence to the guidance within the Care Act 2014 underpinned by the Bristol Safeguarding Adults Board Threshold document.

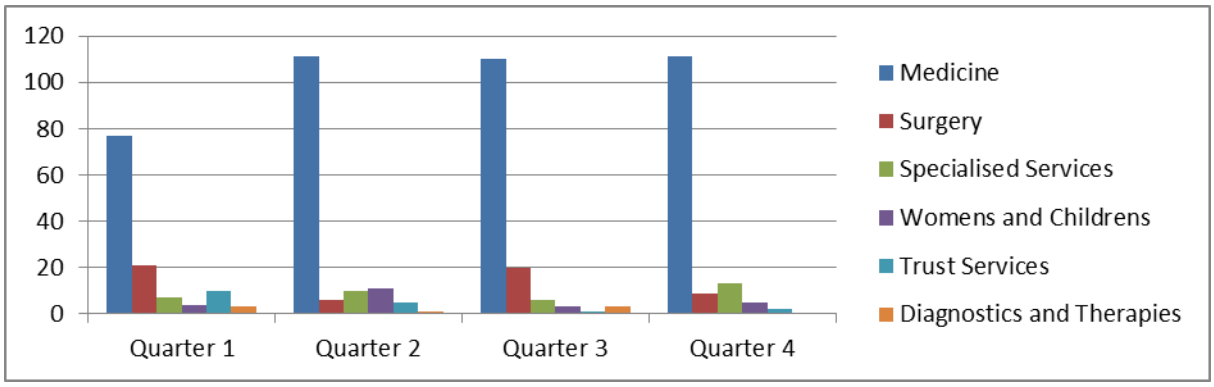
Table 13: Number of Referrals screened prior to sending to Local Authority



Approximately 17% of referrals are 'screened out', in line with previous reporting periods. The majority of these referrals are then signposted to other services, such as Domestic Abuse support services rather than the Local Authority.

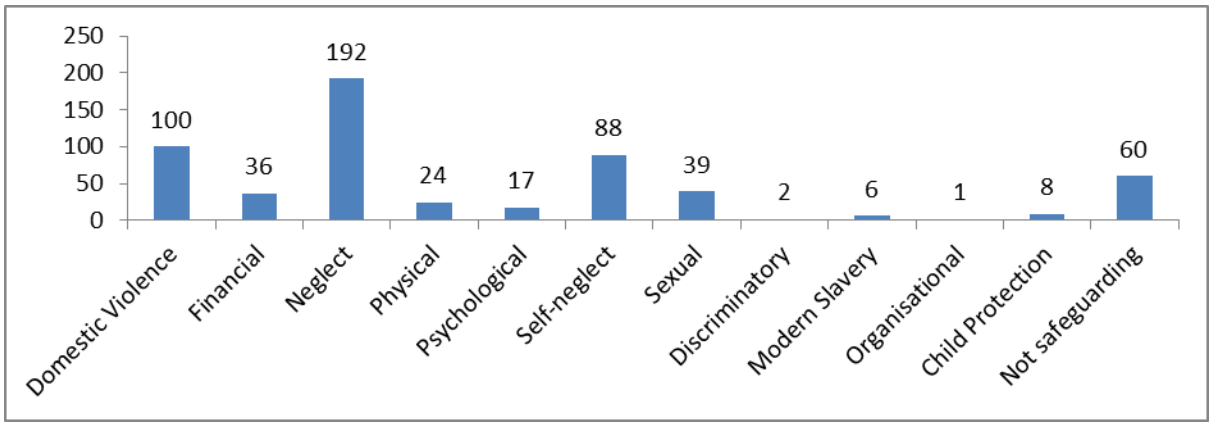
The majority of the referrals continue to be received from the Division of Medicine, as expected and is a picture which is echoed nationally (See table fourteen below).

Table 14: Safeguarding Referrals by Division



Activity data recording now fully reflects the categories of abuse outlined in the Care Act 2014, including Modern Slavery, Self-Neglect and Domestic Abuse as detailed in table fifteen below.

Table 15: Category of referrals



The Trust has made six referrals under the category of Modern Slavery, in comparison to two the previous year. This is likely to be a reflection of the inclusion of Modern Slavery into all levels of safeguarding adults training as well as being highlighted locally and nationally through the media.

The number of referrals made under the category of sexual abuse has also increased, 39 referrals compared to 13 in the previous report. This pattern of abuse may also be reflected in an increasing number of referrals for adults in the lower age range (See table sixteen below). The increase in the number of referrals made under the new category of self-neglect is a picture that was reflected nationally.

There were 145 referrals made for adults aged between 18-37 years of age (representing 25% of the total number of referrals) compared to 119 (16% of the total number of referrals) in the previous year. A significant number of these referrals were generated by the Bristol Sexual Health Service, mirroring the increase in referrals for sexual abuse within the data for children's safeguarding.

Table 16: Age of referrals

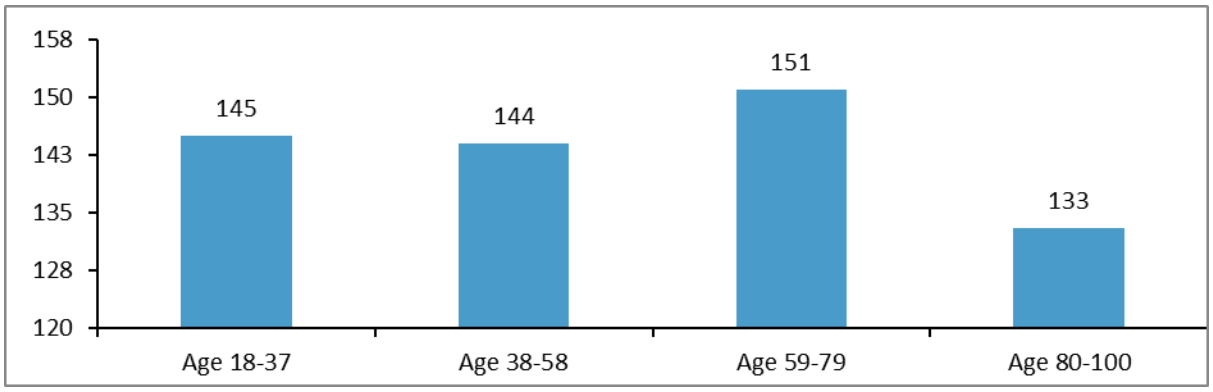


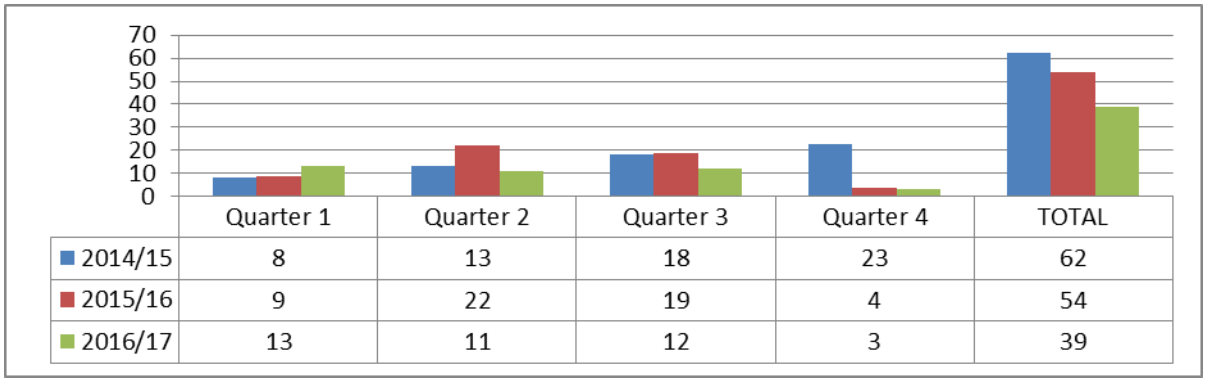
Table sixteen demonstrates the overall change in the demographic age profile of referrals, with an increase in the percentage of referrals for adults in the lower age ranges in comparison with the older age groups, as referenced above. There were 133 referrals made for patients aged between 80-100 years of age, representing 23% of the total number, in comparison to 37% in the previous report.

The reason behind the changing picture in the age referral profile is as yet unclear. The impact of the new categories of abuse, including Self Neglect and Domestic Abuse, may account for this changing picture.

7.2. Internal Safeguarding Alerts

A Safeguarding Internal Alert is raised if it is thought that the Trust may have caused harm through the omission or provision of care to a patient. This is underpinned by the Trust's values and wish to be open and transparent in line with the Duty of Candor. Alerts may be raised by practitioners within the Trust or by other agencies or individuals who may have a concern about the care a patient has received.

Table 17: Internal Safeguarding Alerts Received Per Quarter



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2014/15	8	13	18	23	62
2015/16	9	22	19	4	54
2016/17	13	11	12	3	39

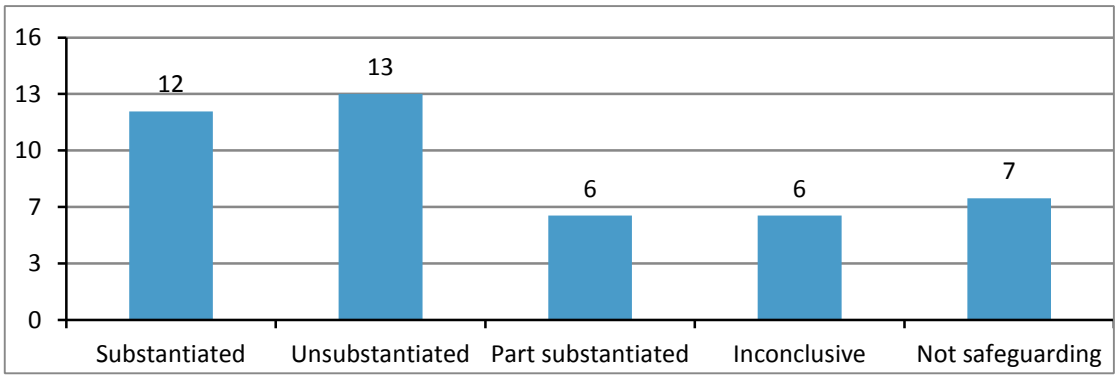
Table seventeen demonstrates a continuation of the year on year downward trend in the total number of internal alerts for the third consecutive year.

This trend is likely to be as a result of the robust process of screening and review by the Safeguarding Team, which includes reviewing a range of additional information, such as 72 hour and Root Cause Analysis (RCA) reports. In many cases the outcome from these reports will provide sufficient assurance that there is no safeguarding concern.

The numbers of internal alerts, outcomes, emerging themes or concerns, are monitored closely by the Safeguarding Team, Divisional Patient Safety Teams and the Adult Operational Group with regular reports submitted to the Safeguarding Steering Group. Learning outcomes are incorporated into staff training updates.

The process of reporting concerns, completing actions, disseminating the learning and changing practice is viewed by our partner agencies including Bristol Local Authority and the Clinical Commissioning Group as a positive indicator of continued transparency and willingness to learn lessons when appropriate.

Table 18: Outcome of internal Safeguarding investigations



Of the internal cases this year, 12 were closed as Substantiated, in comparison to 3 in the previous reporting period. Some of the outcomes relate to internal alerts raised during 2015/16 so further comparison between reporting periods is not meaningful. Of the 12 cases substantiated:

- 4 patients were discharged from hospital with a cannula in situ.
- 2 cases related to the failure to share information about pressure ulcers to the new care providers after discharge.

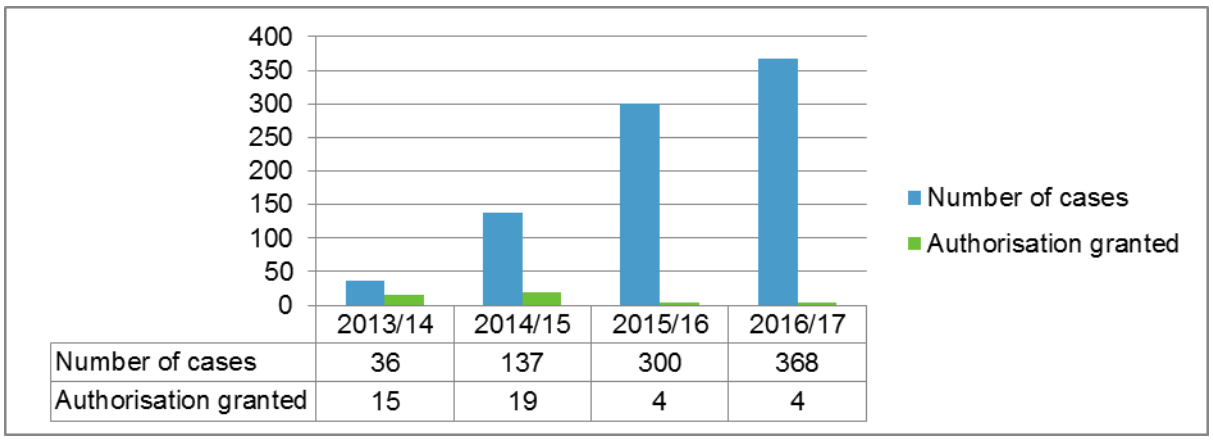
- 1 patient was discharged after urinary catheter removal without further evaluation afterwards. The patient subsequently required re-catheterisation in the community.
- 2 patients developed grade 3 pressure ulcers as the result of nasal prongs (one case behind the ear and one case at the base of the nose).
- 2 cases related to ward moves affecting continuity of care resulting in harm caused by a delay in missing essential medication.
- 1 case in which a patient fell and sustained a fractured neck of femur, there was inadequate assessment and communication afterwards, resulting in a delay in noticing the patient's deterioration.

For each of these cases, learning has occurred, supported by changes in practice and widely disseminated through the Trust governance structure across all the divisions. This has included the establishment of a short life working group to consider all incidents and complaints relating to the discharge process and a review of the guidance relating to transferring patients between wards.

7.3 Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS), within the Mental Capacity Act, provides a protective legal framework for those vulnerable / at risk people who are deprived of their liberty. The Supreme Court judgment in March 2014 continues to have a significant impact on frontline practice and the increase in the number of DoLS applications (See table nineteen below).

Table 19: Deprivation of Liberty Safeguards (DoLS)



	2013/14	2014/15	2015/16	2016/17
Number of cases	36	137	300	368
Authorisation granted	15	19	4	4

Of the 368 DoLS applications made to the Local Authority, only 4 were authorised (see Datix no 690). The Trust continues to care for and detain these patients, as it is in their best interests to do so, following the least restrictive option. This stance mirrors the current position of NHS Trusts both locally and nationally.

The concerns that the DoLS process is overly technical, legalised and not meaningful has resulted in a review of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) by the Law Commission, published at the end of this reporting period, which recommends significant amendments. Changes to the current legislation, are unlikely to be made for a number of years.

8. Safeguarding Children and Adult Training

The provision and delivery of both children and adults safeguarding training remains a key priority, ensuring that all staff are provided with the appropriate training for their role and responsibilities. Ensuring that all staff are aware of how to recognise abuse and know what to do, as a minimum requirement. All Divisions have continued to prioritise safeguarding training and significant numbers of staff have completed safeguarding training.

The Bristol Clinical Commissioning Group (CCG) requires 90% compliance with all levels of safeguarding training. This is specified within the Safeguarding Standards which are monitored both on a quarterly and annual basis.

8.1 Level 1 and 2 Training Compliance

Safeguarding Level 1 and 2 training for both children and adults is incorporated into corporate clinical and non-clinical induction and update training. Compliance with the specified target has been achieved and maintained, for both Level 1 and 2.

Table 20: Level 1 and 2 Safeguarding Training Compliance

	March 2015	March 2016	March 2017
Level 1 Safeguarding Adults	84%	91%	90%
Level 1 Safeguarding Children	81%	89%	91%
Level 2 Safeguarding Adults	68%	86%	91%
Level 2 Safeguarding Children	82%	89%	90%

8.2 Level 3 Core and Specialist Training (Children)

A high level of concern remains that the required Level 3 safeguarding children's training compliance target has not been achieved.

Non-compliance with the training target remains on the Trust Corporate Risk Register (Datix Number 921) monitored robustly through the Trust's governance arrangements including the Safeguarding Steering Groups and both Operational Groups.

Table 21: Level 3 Safeguarding Children Training Compliance (Primarily BRCH)

	March 2015	March 2016	March 2017
Level 3 Safeguarding Children (Core)	73%	78%	78%
Level 3 Safeguarding Children (Specialist)	64%	72%	74%

A number of factors have been considered, during this reporting period, as part of the assurance in relation to Level 3 safeguarding children training, summarised as follows:

- The majority of staff who require level 3 Core Safeguarding Children training and employed on permanent contracts, demonstrate compliance with the required 90% target. For example, nursing staff based within the specialist children's environment are approximately 95% compliant with training requirements.
- The Level 3 Core target audience includes a large number of rotating junior medical staff and the reporting system is not able to segregate those employed temporarily on training rotations from those permanently employed. A 'one-off' sampling analysis demonstrates that inclusion of doctors in training posts results in a drop in overall Level 3 Core training compliance of approximately 6%.
- Medical staff training compliance compared with other staff groups within the Women's and Children's Division is detailed in table twenty-two below. A similar picture of compliance is reflected through the Level 3 Specialist training data.

Table 22: Level 3 (Core) Training compliance by staff group.

	Sep-16	Nov-16	Jan-17	Mar-17	May-17
Nursing and Midwifery Registered	84%	84%	88%	88%	88%
Medical and Dental	49%	40%	48%	45%	47%
Additional Clinical Services	78%	69%	71%	71%	72%
Allied Health Professionals	68%	57%	75%	71%	74%
Healthcare Scientists	85%	54%	70%	73%	56%
Add Prof Scientific and Technic	68%	73%	80%	80%	77%
Administrative and Clerical	36%	62%	71%	79%	82%
TOTAL	**77%**	**73%**	**78%**	**78%**	**78%**

- Actions to address compliance with Level 3 Core and Specialist training are being undertaken as a priority, including oversight of staff compliance by the Clinical Chair, Head of Nursing and Consultant Governance Lead for Women's and Children's. This will continue in the next reporting period with a particular focus on medical staff (Datix no 921).
- By ensuring that a robust level 2 training package is delivered at induction, all clinical staff have sufficient knowledge to provide safe and appropriate safeguarding practice, allowing time for individual practitioners to book and achieve their level 3 training.

8.3 Level 3 Safeguarding Training Compliance (Adult)

Whilst unlike the training requirements for safeguarding children that are underpinned by the competencies specified within the Intercollegiate Documents (2014), the requirements for safeguarding adults training are less well defined. A new intercollegiate document to support adults training is due to be ratified in the next reporting period.

To comply with the anticipated training requirements a level 3 Safeguarding Adults training study day has been developed and introduced. The current Level 3 target audience includes 98 members of staff, mostly senior and on call managers, a significant number of whom have already completed the training (see table twenty three below).

Table 23: Level 3 Safeguarding Adult Training Compliance

	March 2015	March 2016	March 2017
Level 3 Safeguarding Adults	N/A	42%*	78%

* The 90% compliance target does not currently apply to Safeguarding Adults Level 3 training however, compliance is in line with the trajectory to achieve compliance in the next reporting period.

Further work will be required in the next reporting period to ensure that the Level 3 Safeguarding Adults target audience is in line with the requirements of the new Intercollegiate Document, which may initially, adversely affect the compliance data in the next reporting period.

9. Prevent

The Counter-Terrorism and Security Act requires that specified bodies, including health, have a legal duty to, "have due regard to the need to prevent people from being drawn into terrorism". As part of these statutory requirements, underpinned by the NHS Commissioning Standards, the Trust is required to train staff so they know what PREVENT is and how to escalate concerns regarding people who may be at risk of radicalisation.

Safeguarding training has been amended to ensure staff receive training to a level appropriate to their role and level of responsibility. Compliance is now reported as part of the Trust monthly Essential Training report. Compliance for both Prevent and WRAP training is currently on track with the Bristol Clinical Commissioning Group required trajectory target, which is to achieve 90% by 2018.

Table 22: Prevent/ WRAP Training Compliance

	Total number of staff who require training*	Total number of staff who require training*	Percentage Compliance*
Basic Prevent Awareness Training	8808	5714	65%
WRAP training	2061	960	47%

The Trust is required to have a dedicated PREVENT lead, which has been incorporated within the remit of the Safeguarding Lead Nurse. The Trust did not make any referrals under the PREVENT agenda during this reporting period.

10. Female Genital Mutilation (FGM)

The requirements introduced in 2015 in relation to FGM are now embedded into safeguarding practice, including the mandatory reporting requirements of the Serious Crime Act**.** Whenever a health professional identifies that a girl under the age of 18 has had FGM, or if the girl discloses this herself, the professional must make a report to the police. No reports to the police have been made in relation to girls under the age of 18 years during this reporting period.

The enhanced FGM dataset submitted to the Health and Social Care Information Centre (HSCIC) captures the following:

- If a patient has had FGM
- If there is a family history of FGM
- If an FGM related procedure has been carried out on a woman (de-infibulation)

During this reporting period, data relating to 248 women who have been victims of FGM has been reported to the HSCIC**.** The majority of the FGM data continues to be reported by Midwifery Services as FGM forms part of a wider mandatory question that all women are asked at their first booking appointment. This information is also reflected in the number of Request for Help forms sent to Children's Social Care to 'flag' potential risks to the unborn baby.

11. Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews

Serious Case Reviews (SCR) for children and Serious Adult Reviews (SAR) are undertaken as part of a statutory multi-agency investigation process:

- following the death or serious harm of a child or an adult (with care and support needs),
- as the result of abuse or neglect,
- and there have been concerns about the way in which agencies have worked together and lessons can be learnt.

Domestic Homicide Reviews (DHR), are conducted following the death of an individual over the age of 16 years of age as a result of violence within a relationship, either from a partner of another member of the household they live in.

During this reporting period the Trust has been asked to contribute to six case reviews for children and three for adults, incorporating a wide range of different circumstances with a range of associated multi-agency learning. Some of the cases have been widely reported in the media both locally and nationally.

Learning from Case Reviews is considered through the Steering and Operational Groups and incorporated into safeguarding training. Actions applicable to the Trust are added into the work and audit plans. Key actions during this reporting period have included:

- a review of supervision arrangements and activity, focusing on promoting the engagement of paediatric practitioners who manage their own case load and high risk front line areas.
- participation in a multi- agency audit reviewing the quality of safeguarding referrals, including practitioner's ability to clearly articulate the level of risk in relation to the threshold guidance. Key

learning from the audit has been incorporated into training and feedback given to specific staff groups, including midwifery.

- safeguarding training has been updated to reflect the latest guidance and best practice for Female Genital Mutilation, Child Sexual Exploitation, Self- Neglect and the Mental Capacity Act for adults.
- Child Sexual Exploitation (CSE) short life working group was established, a new assessment tool has been developed incorporating key risk factors. A pilot of the tool in front line areas has been completed with ongoing actions incorporated into the work plan for 2017/18. A system has been established to support electronic flagging of children at risk of CSE.
- Safeguarding Awareness week was held in November 2016 to raise the profile of the combined safeguarding team and to inform staff of topical safeguarding issues, including the 'Think Family' approach, CSE and the Mental Capacity Act. A large number of frontline staff were contacted in a wide range of areas across the Trust.
- key messages from case reviews have been incorporated into staff update leaflet to be published in the next reporting period.

12. Child Sexual Exploitation (CSE)

Child Sexual Exploitation (CSE) continues to receive a significant amount of media coverage both nationally and locally. The Bristol Safeguarding Children Board CSE sub group, attended by a lead Consultant from Bristol Sexual Health, continues to develop a multi-agency strategy to address CSE locally.

The CSE Task and Finish Group has reviewed and adapted an assessment tool specifically for adolescents called HEADSSS (Home and Environment, Education and Employment, Activities, Drugs, Sexuality, Suicide / Depression and Safety). An implementation plan is in place to introduce the tool to key front line areas across the Trust. The tool has been implemented in the Trust Emergency Departments and Ward 35 (the adolescent ward).

A robust process has been established to support the identification of children who are thought to be at risk of CSE, the use of an electronic alert within the Medway system will be implemented going forward, for any child considered to be at risk of CSE following a multi-agency strategy discussion. The process of information sharing and triggering CSE alerts will also be considered by Unity, the new Integrated Sexual Health Services.

13. Safeguarding and Domestic Violence

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

A self-assessment of the Trust position against the new NICE Domestic Abuse guidance has been completed by the Domestic Abuse Steering Group and the Independent Domestic and Sexual Abuse Advisors (IDSVAs). Actions arising from this will be monitored by the Group with reports to the Safeguarding Steering Group.

The Independent Domestic & Sexual Violence Advisor (IDSVA) service continues to assess the safety of domestic abuse victims presenting within the Emergency Department (ED) and Trust-wide. The IDSVA's support victims of domestic violence and abuse, working from the point of crisis with complex, high-risk cases in which the individual is at high risk of serious harm and domestic homicide.

13.1 Multi-Agency Risk Assessment Conferences (MARAC)

The Trust continues to engage with the process of Multi-Agency Risk Assessment Conferences (MARAC) which shares information about the risk of serious harm or homicide to people experiencing domestic abuse and their children. Following the expansion of the Safeguarding Team, facilitated by Bristol Public Health funding, a dedicated MARAC nurse has been in post since July 2013. Attendance both at the North and South Bristol MARAC continues.

During this reporting period confirmation has been received that the funding provided by Public Health will be discontinued from the beginning of the next reporting period. As a result some changes to the level of input to the MARAC steering group will be implemented from April 2017.

This situation will be monitored going forward including a review of any risks of areas of concerns raised by any MARAC partner agencies and any emerging risks.

13.2 Independent Domestic and Sexual Violence Advisor (IDSVA) Service

The Bristol Royal Infirmary is one of twenty five hospitals in the UK to have a team of IDSVAs. The Independent Domestic and Sexual Violence Advisor (IDSVA) service is now in its sixth year of operation focusing on the safety of domestic abuse victims, and their children, presenting within the Emergency Department (ED) and Trust-wide. This includes violence from intimate partners, ex partners and family members.

The IDSVA's support victims of domestic from the point of crisis, providing expert advice, advocacy and support (typically for a short to medium term) and compiles individual structure safety plans to manage risk. Victims presenting to the ED's are often complex, cases in which the individual is at high risk of serious harm and domestic homicide. If a patient is deemed to be at high risk, there is a provision for admission in hospital overnight, to ensure that they are not sent home to an unsafe environment.

The objectives for the IDSVA service are specified within the Bristol City Council Public Health agreement and activity data relating to these specifications is summarised in table twenty four, overleaf.

Table 24: Key Activity in the last twelve months

Service/Activity	Public Health Targets for the year	Actual activity data for 2016/17
Number of patients aged 16 and above referred following disclosure of DVA	300 from ED	240 victims in ED 25 from elsewhere in hospital
Numbers of patients referred who receive advice and safety planning from an adviser	75 %	(72%) 175 victims engaged with the IDSVA service
Number of patients referred who are not high risk on DASH Risk assessment	50%	58% not high risk

Of the 240 victims seen during this reporting period:

- 46 were admitted into hospital as inpatients.
- 110 children were identified as living in violent households (25 already living out of mother's care), resulting in 102 safeguarding referrals.
- 25 victims were identified as at risk due to being pregnant.
- 99 of the victims were considered to be high risk and were referred and discussed at the MARAC (see 13.1 on page 25).

Education to front line staff across the Trust to recognise high risk presentations and indicators such as, strangulation, sexual violence or recent separation from the perpetrator remains a key part of the work of the IDSVAs.

14. Safeguarding Resourcing Group

The purpose of the **Safeguarding Resourcing Group** is to ensure that the Trust's safeguarding duties for both adults and children relating to all resourcing matters are fully considered. The group reports to the Safeguarding Steering Group.

14.1 Key Activity in the last twelve months

- The level of criminal record check required for the different types of substantive roles within the Trust was reviewed and signed off.

- Volunteer compliance with safeguarding training continues to be formally reported to the Safeguarding Lead via the Group. There have been no concerns reported. More rigorous reporting has been established for the compliance with safeguarding training for Bank-only staff.
- Review of the NSPCC paper *'Towards Safer Organisations'* was undertaken. A working group is being established to look at values/behavioural based recruitment for Consultants.
- Changes have been made to the Trust's protocol for approving appointments where there is an adverse disclosure to ensure ongoing rigour, consistency and governance.
- A review of the Trust's guidelines on the '*Supervision in the absence of a Disclosure and Barring Service (DBS) check at recruitment'* was undertaken to ensure it remains fit for purpose. Recording of the volume of starters working under supervision is now maintained by the recruitment teams, by way of creating evidential information to escalate concerns with either the process or an increase in starters working under supervision.
- A review of the national mandatory NHS Employment Check Standards was undertaken to ensure that they are applied appropriately by the recruitment teams.
- An audit against the DBS Code of Practice was undertaken by the Resourcing team to ensure that the appropriate compliance is in place with aspects such as safe handling/storage of data, identity verification, eligibility and the DBS application process.
- Significant work has been undertaken to create rigour and compliance in the process of setting up honorary contracts in the Trust.

14.2 Programme of work for 2017/18

- Induction for agency staff and staff working in the Trust through an honorary contract.
- An audit of the Trust's agency suppliers is to be undertaken to test the content of safeguarding training that agency workers receive before they work in the Trust. This is to cover all staff groups.
- A formal policy on the process and procedure for Disclosure and Barring (DBS) checks is to be written.
- Review of the eligibility criteria for non-clinical staff working on the Bank to ensure that there is no over-checking of such staff groups.
- Review of the level of criminal record check required for the different types of volunteer roles continues with an anticipated sign off in June 2017.

15. Learning Disabilities (Adults)

The Trust has specialist nurses to support People with a Learning Disability and their families or carers. The nurses work closely with community partners to ensure that People with a Learning Disability have equal access to acute services. The activities undertaken to support patients is reviewed and assured through the adult protection operational group.

15.1 Key activity in the last twelve months:

- DNA rate has seen a further decrease, currently standing at 5.4%. A decrease year on year from 10.2% in 2012/13.
- During this period there has been a 16.2% increase in patients attending out-patient departments.
- The referral process, risk assessment and reasonable adjustment documentation has been integrated into the Medway system. Allowing for better visibility of patient specific needs on presentation to the Trust.
- Collaborative working with the children's hospital to ensure an effective and smooth transition into adult services.

15.2 Key Risk in 2016/17:

- There is one risk on the risk register in relation to supporting patients with Learning Disabilities (LD) and Autism Spectrum Condition (ASC). Completion of risk assessment and articulating reasonable adjustments within 48 hours of admission for patients target has not been met. Improvements were made with the introduction of the electronic referral process which needs to be built on this coming year.

15.3 Programme of work for 2017/18:

- Learning Disabilities Core Skills Education and Training Framework (2016) was published. The Trust will apply the recommendations in 2017 / 2018.
- The Learning Disabilities Mortality Review (LeDeR) process for reviewing all deaths of patients with LD and ASC will be launched in the region this year. For an interim period all patient deaths will be subject to a structured judgement review as described in National Guidance on Learning from Deaths (2017).

16. Mental Health Operational Groups (Adults & Children)

The Trust has in place two operational groups that meet regularly to review mental health activity in relation to adults, children and adolescents. Membership of the group includes key front line professionals, safeguarding and representation from neighbouring Trusts.

The Groups review relevant clinical incident forms, and associated risks (detailed in section 4.2, see page 6) as well as local mental health service processes and procedures, escalating areas of concern to the Safeguarding Steering Group.

16.1 Key Activity in the last twelve months:

- Monitoring of all relevant Datix incidents, including reports of episodes of clinical holding, including chemical restraint. The children's operational group also reviews incidents in which patients under the age of 18 years have been reported as having absconded from hospital.
- A new Operational Escalation Pathway for Children and Young People with Mental Health Difficulties requiring a Specialist CAMHS bed has been developed. The pathway was developed in response to the number of reported incidents in which staff had difficulty finding a specialist Tier 4 bed. Above and Beyond have agreed to support the development of a safe consulting space within the Children's Emergency Department (Datix risk 856).
- Ongoing monitoring of the impact of Section 136 of the Mental Health Act (MHA), on both the Children's and Adult Emergency Departments when used as a 'place of safety'. A multi-agency, city wide approach to considering the challenges resulting from a lack of Section 136 Provision has been on going during this reporting period, led by the Chief Nurse as Executive Lead (Datix risk1595).

17. Dementia Care

Dementia Awareness is recognised as an essential requirement for clinical staff and training is incorporated into Trust induction for all staff. Dementia training is delivered via a bespoke e-learning programme, which went live in March 2017.

To support staff in making appropriate referrals for patients, an electronic Medway dementia referral service was set up in November 2016, enabling staff to refer for help and support with patients or carers.

Activity engagement has also been a key aspiration for the year, with many wards now using activity boxes with patients. Two wards have been piloting the use of IPads with patients, with a plan to rolling out across the divisions in 2017/18.

Providing support for carers is an area of high priority, within the national dementia agenda, and the Trust aims to support carers locally through a dementia café both at the Bristol Royal Infirmary and South Bristol Community Hospital. Attendance is growing, with patients attending with ward staff or their carers'. Both cafes continue to be supported by a Carer Liaison Worker and a Navigator from the Bristol Dementia Well-Being service. Feedback from patients and carers is consistently positive, both about their time at the café and the subsequent support from the team.

The team has developed strong networks with external agencies to improve communication and the pathways between the hospital and community for patients with a dementia diagnosis; particularly with the Bristol Dementia Well-Being Service. The Trust participated in the National Audit of Dementia; the results are yet to be published. Any actions resulting from findings of the audit will be added to the dementia work plan for 2017/18.

17.1 Programme of work for 2017/18

- To review outcomes from national audit and implement an action plan, as necessary.
- To improve compliance and use of the Abbey pain scale.
- To increase knowledge and awareness of delirium, within in-patient areas.
- Development of a dementia friendly garden in the Bristol Heart Institute.

18. Report summary and objectives for 2017/18

The safeguarding agenda for both children and adults is constantly changing and it is essential that the Trust continues to develop a proactive approach to ensure that safeguarding practice remains up to date and in line with new guidance and best practice.

Safeguarding remains a key priority for the Trust and this annual report summarises the key safeguarding activities, developments and achievements in this reporting period. The report aims to provide a level of assurance that the Trust is fulfilling its statutory safeguarding duties and responsibilities and is thereby fulfilling its contractual duty to safeguard children and adults.

Whilst there have been many achievements over the last twelve months there are also many areas in which further work is required. Key objectives for the next twelve months include focusing on improving compliance with Level 3 Safeguarding Children's Training and continuing to raise awareness of the risks from Child Sexual Exploitation. For adult safeguarding, key areas of focus will continue to include the Mental Capacity Act and ensuring that front line practice is in line with major legislative changes. This will be particularly important in relation to the anticipated changes in the Deprivation of Liberty Safeguards Legislation.

A number of joint areas of work such as safeguarding supervision for both adults and children front line practitioners, and promotion of the 'Think Family' agenda, will continue during the next reporting period. Full details of the aims and objectives of both safeguarding teams going forward are detailed in the work plan for 2017/18.

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	17
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Infection Control Annual Report 2016/17		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

The report outlines progress against compliance with the hygiene code. The annual infection control programme was predominantly achieved with actions being rolled over onto the infection control programme for 2017/18. We have also:

- Reported and investigated cases and outbreaks of healthcare associated infection as mandated.
- Reduce further the incidence of infections, specifically *Clostridium difficile* and MRSA bacteraemia.
- Maintained a clean and appropriate environment.
- Continued to monitor antibiotic stewardship.
- Set up and rolled out the start of the surgical site infection surveillance programme.
- Achievement of 100% local CQUIN.

Key issues to note
Achievement of local CQUIN and the roll out of the start of the Surgical Site Infection Surveillance Programme.
Recommendations
Members are asked to: • **Approve** the Infection Control Annual Report 2016/17

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
None identified.

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	

University Hospitals Bristol NHS
NHS Foundation Trust

INFECTION CONTROL ANNUAL REPORT 2016 – 2017

STATEMENT FROM THE CHIEF NURSE

High standards of infection control are crucial to ensure prevention of infection in healthcare facilities. The organisation has a statutory responsibility under the Health and Social Care Act, 2008 (the Hygiene Code) to produce and publish an infection control annual report.

This report summarises the key infection prevention and control activities carried out on behalf of University Hospitals Bristol NHS Foundation Trust from April 1st 2016 to March 31st 2017 and provides an overview of all infection prevention and control activities in the past year, highlighting service achievements and progress made against national and local priorities related to infection control.

Our focus on working to reduce the incidence of hospital acquired infections is continuous. I would personally like to thank all staff for their efforts and support in this important area of clinical care.

Carolyn Mills
Chief Nurse

CONTENTS

SECTION		AUTHOR	PAGE
1	**INTRODUCTION**	Joanna Hamilton-Davies *Deputy Director of Infection Prevention and Control/Lead Nurse Infection Prevention and Nurse*	**4**
2	**OVERVIEW OF PROGRESS 2016/17**	Dr Martin Williams *Director of Infection Prevention and Control* Joanna Hamilton-Davies *Deputy Director of Infection Prevention and Control/Lead Nurse Infection Prevention and Control.*	**4**
3	**COMPLIANCE TO THE HYGIENE CODE**	Dr Martin Williams *Director of Infection Prevention and Control* *Joanna* Hamilton-Davies *Deputy Director of Infection Prevention and Control/Lead Nurse Infection Prevention and Control.*	**6**
4	**STATUTORY AND NATIONAL REQUIREMENTS**	Dr Martin Williams *Director of Infection Prevention and Control* Joanna Hamilton-Davies *Deputy Director of Infection Prevention and Control/Lead Nurse Infection Prevention and Control.*	**12**
5	**ANTIBIOTIC PRESCRIBING REPORT**	Sue Taylor *Antimicrobial Pharmacist*	**19**
6	**DECONTAMINATION**	Annette Giles *Trust Decontamination Manager*	**21**
7	**CLEANLINESS REPORT**	Dena Ponsford *General Manager Facilities*	**24**
8	**NEXT STEPS**	Dr Martin Williams *Director of Infection Prevention and Control* Joanna Hamilton-Davies *Deputy Director of Infection Prevention and Control/Lead Nurse Infection Prevention and Control.*	**27**
9	**APPENDIX A**		**28**
10	**APPENDIX B**		**29**

1. INTRODUCTION

The purpose of the report is to inform patients, public, staff, Trust board members and Bristol Clinical Commissioning Group of the infection prevention and control activities undertaken in 2016/17 within University Hospitals Bristol NHS Foundation Trust and to demonstrate progress against performance targets. The report corresponds with requirements set out in the Health and Social Care Act 2008.

Healthcare associated infections remain an important priority for the patients, public and staff. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources, therefore investment in infection prevention and control is necessary and cost effective. The resources committed to infection prevention and control by University Hospitals Bristol NHS Foundation Trust is visible in the content of this report.

The authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on decontamination, cleanliness, antimicrobial prescribing and vascular access.

2. OVERVIEW FOR 2016/17

The Infection Prevention & Control Teams' goal in 2016/17 was to continue to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of acquiring an infection, as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection. To achieve this, the following objectives were identified:

1. Compliance with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code).
2. Report, investigate and learn from cases and outbreaks of healthcare-associated infection as mandated.
3. Reduce the incidence of infections; specifically Meticillin-resistant *Staphylococcus aureus* (MRSA) and Meticillin-sensitive *Staphylococcus aureus* (MSSA) blood stream infections and *Clostridium difficile*.
4. Continue to develop and drive the surgical site infection surveillance programme – there needs to be more surgical site infection surveillance in the Trust as this influences our MRSA and MSSA limits.
5. Implement a rolling annual programme for aseptic non-touch technique (ANTT) workshops across all Divisions.
6. Develop working and supportive relationships with our community partners, as well as industry colleagues, via the South West and Wales IV Forum.
7. Research the possibility of developing of a Trust-wide Vascular Access Team.

   The progress and actions taken for each objective will be detailed in the following report.

Infection Prevention & Control performance and assurance review, 21 and 22 September 2016

- The Head of Infection Prevention and Control (South) NHS Improvement was invited to review the Infection Prevention Control (IPC) performance and assurance at the Trust by the Chief Nurse; prior to the visit several documents were requested and provided by the Trust.
- Clinical staff including Matrons and Heads of Nursing were invited to focus groups to discuss the Infection prevention and Control service.
- Ward visits were undertaken
- Discussions with the Infection Prevention and Control team, Chief Nurse, Director Infection prevention and Control and Deputy Director Infection Prevention and Control were undertaken.
- The review showed that Infection Prevention and Control was well embedded in the Trust.
- A risk was raised due to the age profile of the team however restructuring will occur due to retirement and staff moving on during 2016/17.
- The Head of Infection prevention and Control (South) NHS Improvement finished her report with a statement that it had been a pleasure to visit the Trust and had been impressed with what had been seen.
- A full report is available.

3. COMPLIANCE TO THE HYGIENE CODE (2008)

3.1 Have systems in place to manage and monitor the prevention and control of infection, using risk assessment to consider individual and environmental risks.

- We have a fully established Infection Prevention and Control Team (IPCT) that consists of an Infection Control Doctor (ICD), seven Infection Control Nurses (ICN) (which includes the deputy Director of Infection Prevention & Control), and an Intravenous Access Co-ordinator, an antimicrobial pharmacist, an analyst and administrative support.
- The Director of Infection Prevention and Control (DIPC) leads the team and reports directly to the Chief Nurse and Medical Director in regard to infection prevention and control issues.
- The Chief Nurse is the executive lead and chairs the Infection Control Group (ICG), which has met bi-monthly in 2016/17 and includes partner organisation representatives.
- The Trust Board has received monthly infection control exception reports within the quality report for key performance indicators related to infection.
- The Quality Outcomes Committee (Board sub-committee) has received quarterly infection control update reports.
- As part of the Hygiene Code, the IPCT works to an Infection Control Annual Programme, the delivery of which is monitored by the ICG. The programme includes audits of the environment and clinical practice. All results are fed back to clinical areas and an action plan is developed if necessary.
- The ICG has reviewed and monitored all relevant risks at each bi-monthly meeting.

There are five risks that have been monitored by ICG, which are:

1. Norovirus and the impact on the Trust if wards are closed. Due to the increase in isolation room capacity the Trust is able to isolate more patients with symptoms of diarrhoea and vomiting. The Trust manages patients in accordance with the National Norovirus Tool Kit. Guidelines are in place for staff that are also affected. Due to the actions that are in place, this is designated as a LOW risk on the register.
2. Infection Prevention and Control training. The Trust target for infection prevention and control training is 90% compliance. At the end of March 2016 compliance was at 92%, an increase of 3% from the previous year. The team teach on the Trust induction, and clinical and non-clinical essential training days. All infection prevention and control training is reviewed regularly and all staff has access to E-learning packages.
3. Due to available and unfulfilled posts for consultant medical microbiologists there may be a decrease in availability of senior cover and guidance for a period of time until the vacancies have been filled. There is a risk that the DIPC and the Infection Control Team may not be proactive during the period of reduced microbiology cover due to DIPC being a microbiology consultant and his commitments to the delivery of the clinical service. This is mitigated by a locum and colleagues from NBT filling slots until two new appointments start later in the year. The

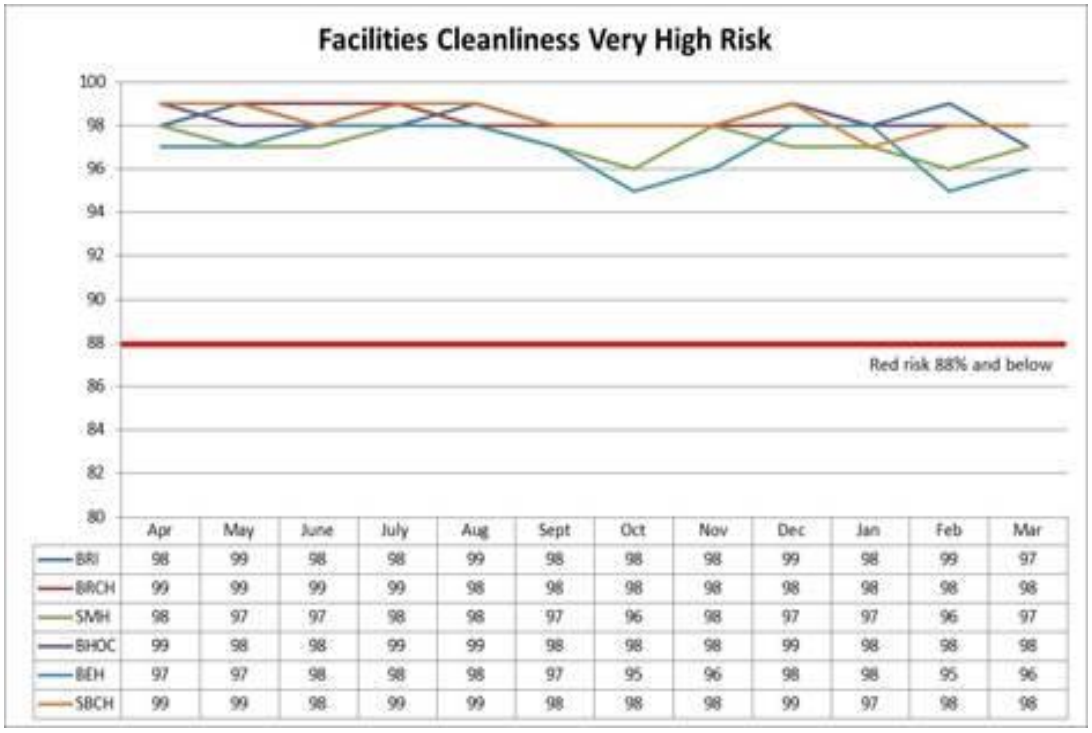
decontamination aspects of the Trust do not currently have a dedicated microbiologist, although acute issues are managed appropriately.

4. Due to the low numbers of trainee medical microbiologists across Bristol, there is a risk to the day-to-day and out-of-hours service being under resourced until August 2017. This may add to the pressure of the microbiology consultants who are under resourced. This is mitigated by the trainees being moved across two sites and two trainees appointed to start in August 2017.

3.2 Provide and maintain a clean and appropriate environment:

- There is a designated operational lead in the Trust for cleanliness (Deputy General Manager, Facilities).
- The methodology for cleanliness auditing is in line with National Specifications for Cleanliness and approved by Facilities, Chief Nurse, Heads of Nursing, Infection Control, and the Head of Performance Reporting.
- Trust wide cleanliness audits are completed on a monthly basis for very high- and high risk areas. For significant risk areas, audits are completed quarterly. A bespoke software package is used for completing cleanliness audits.
- The green risk ratings across the Trust are 98% for very high risk areas, 95% for high risk areas and 85% for significant risk areas. If scores fall below 98% in the very high risk area, further audits are completed within that month. For all areas, remedial action plans are implemented by staff in the relevant area (Facilities, Clinical).
- The methodology for reporting is in line with the National Specifications for Cleanliness and in partnership with the Head of Performance. Reports are presented to the ICG and other management groups. The scores includes: A, Functional Area Score: The functional score is the total of the individual elements; B, Hospital Score: Each hospital has a cleanliness score and will contribute to the Trust score; C, Trust Score: The Trust score combines all the hospital scores and will be weighted by functional areas. By using this weighting method, all hospitals contribute to the Trust score; D, Trust Target: The Trust target will be weighted by functional areas to ensure consistency.
- The monthly scores are distributed in two formats: by Hospital and Division.
- The scores are shared with the Ward Sisters, Matrons, Heads of Nursing, Service Leads, and Estates, Infection Control, Facilities Hotel Services Managers and members of the Trust Executive Team.
- There is a Cleaning Policy outlining clinical and non-clinical cleaning responsibilities and frequency.
- A comprehensive training programme for Facilities Hotel Services staff is in place.

Figure 1: *University Hospital's Bristol – component hospitals with their cleanliness score within very high risk areas (e.g. theatres) have been monitored since July 2014 in the following format: The Trust RAG rating for Very High category areas is 98% for Green, 90-97% for Amber and 89% or below for Red. The graph below demonstrates cleaning scores from April 2016 – March 2017.*



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
BRI	98	99	98	98	99	98	98	98	99	98	99	97
BRCH	99	99	99	99	98	98	98	98	98	98	98	98
SMH	98	97	97	98	98	97	96	98	97	97	96	97
BHOC	99	98	98	99	99	98	98	98	99	98	98	98
BEH	97	97	98	98	98	97	95	96	98	98	95	96
SBCH	99	99	98	99	99	98	98	98	99	97	98	98

Figure 2**:** *University Hospital's Bristol – component hospitals with their cleanliness score within high risk areas (e.g. wards) have been monitored since July 2014 in the following format: The RAG rating for High Risk category areas is 95% for Green, 80-94% for Amber and 79% or below of Red. The graph below demonstrates cleaning scores from April 2016– March 2017.*

3.3 Provide suitable and accurate information on infections to service users and their visitors.

- All patient and visitor Infection Prevention and Control (IPC) information leaflets are updated as necessary. New leaflets are developed when required.
- Large banners are placed at the entrance to all the hospital with information regarding norovirus and what visitors are required to do if they are unwell and want to visit patients.
- A telephone message plays when members of the public ring the hospital with information regarding norovirus throughout the year.
- Attendance and sharing of information at the Clinical Commissioning Group monthly Healthcare Associated Infection meeting, by the deputy DIPC.

3.4 Provide suitable and accurate information on infections to any person concerned with further support including nursing/ medical care in a timely manner.

- Adult and paediatric patients that have been discharged and have been found to be colonised/ infected with MRSA or *C.difficile* are informed by letter of their result. Their general practitioners are also informed.
- All infection prevention and control policies/ guidelines are available on the Trust's Document Management System and the Infection Prevention and Control Team's Connect site.
- Medical microbiologists undertake Trust-wide ward rounds to support clinical staff with antimicrobial prescribing and infection control advice.

3.5 Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care.

- An assessment for risk of infection is carried out for all patients when they are admitted.
- The IPCT ensure the clinical teams are informed of any significant positive results.
- Patients with infection are 'alerted' via the Medway system.
- The IPCT visit the wards when patients who are MRSA positive or *C.* colonised are admitted as well as patients who are diagnosed with any multi-drug resistant organisms, ensuring appropriate management and treatment is commenced.
- Management of the adult cubicle tracker by the IPCT and Clinical Site Team ensures patients are isolated appropriately.
- Patients are screened for MRSA in line with the national guidance.

3.6 Ensure all staff are fully involved in the process of preventing and controlling infection.

- All bed holding Divisions have leadership for infection control through the Heads of Nursing, a designated Medical Lead and Matrons. All Divisions have a link practitioner system in place.
- All induction, mandatory and update infection prevention and control training has been reviewed – this has been reviewed quarterly to reflect mandatory limit requirements and any achievements. E-Learning packages have been developed

and all clinical updates (including paediatrics) are now being delivered through this route. Non-clinical staff will have a mixture of E-Learning and face-to-face sessions. Medical staff has an E-Learning package which has been developed specifically for medical staff.

- The IPCT are involved in *ad hoc* training.

3.7 Provide adequate isolation facilities

- The Trust has a number of negative-pressure rooms and specialist ventilation rooms which allow the management of patients with infections such as multi-drug resistant (MDR) *Mycobacterium tuberculosis* (TB).

3.8 Secure adequate access to laboratory facilities

- Microbiology laboratory services are provided by Public Health England laboratory in line with the contract. The microbiology laboratory services have recently been centralised within Severn Pathology. They are based at North Bristol Trust.

3.9 Have and adhere to policies that will prevent and control infection.

- All IPC policies have been monitored and updated in line with national guidance and up-to-date evidence, as required.
- The IPCT have undertaken quality assurance audits to ensure the Personal Protective Equipment (PPE) and isolation of patient's protocols are being followed. Results are fed back to Ward Staff, Heads of Nursing and Matrons, at the bi-monthly ICG.
- Hand hygiene compliance is measured monthly. The standard achieved at the end of year was 96.6% against a target of 95%.
- The annual audit of sharps management has been completed by Daniels Healthcare Ltd, the company that supply the sharps bins to the Trust. The results are broken down into department and ward area and fed back to Divisions, along with any recommendations. Departments and ward areas devise an action plan where appropriate. A summary of results are below:

    - A total of 1085 sharps containers were audited across 134 areas The majority of containers (99.9%) were manufactured and supplied by Daniels Healthcare Ltd, in line the with Trusts sharps policy. A single container was found which was supplied by Amcor/Synergie. All sharps audited complied with the relevant BS & UN standards.
    - Of the departments audited, sixty two (46%) were rated as wholly compliant, a further forty four (33%) were largely compliant but required some remedial work, and eighteen departments (13%) failed to achieve the requisite score and were marked as non-compliant. Ten departments (8%) were either inaccessible or had no sharps containers in use.

- Environmental and equipment audits have been carried out by the IPCT trust-wide. Results and recommendations are fed back to each ward area. Action plans are developed by the ward staff.

- An annual audit was undertaken to assess whether compliance with the current UH Bristol MRSA screening document in all clinical specialties was being met. The screening protocol was radically changed to comply with the national screening guidance.

3.9 Ensure that healthcare workers are free of and protected from exposure to infections and that all staff are suitably educated in the prevention of cross infection. To develop a system in conjunction with Occupational Health and Human Resources for identifying members of staff who have been visiting (on annual leave/secondment) a high risk Pulmonary Tuberculosis country for more than 3 months or who have worked and lived with Pulmonary Tuberculosis patients for more than one month.

- All staff are screened for infection when they begin work at the Trust and are offered appropriate vaccinations against infectious diseases. All vaccination appointments are e-mailed and then a text message sent one week and two days prior to appointment.
- Bookings for the vaccination clinics for all new starters are sent through induction lists.
- There is a portal system for all new starters. When Occupational Health receives the portal health at work form, it is processed by Occupational Health staff. The turnaround time has been 48 hours for 75% of new starters.
- Staff referrals for appointments includes: letters being sent and then a text message at one week and two days prior to appointment.
- Staff immunisation status is included in staff appraisals.
- Employee Services track the status of a staff members' health clearance'. Occupational Health receives a list of new starters on a regular basis and text messages are sent to respective individuals with a date and time to attend the department for an immunisation review.
- Occupational Health has achieved accreditation under the ISO 9001, Investors in people and Safe, Effective, Quality Occupational Health Service (SEQOHS) schemes. This must be achieved to enable the Occupational health team to offer a high standard of services.
- Additional health screening continues for staff members that spend long periods in specific countries abroad, for either work or personal reasons.
- The BCG vaccine is currently unavailable for health care worker immunisations. Public Health England does not foresee availability for HCWs in the forthcoming months. All new starters are made aware of the risk and letters available for managers if there are concerns. The Trust awaits guidance on how this issue will be dealt with in the future.

4. STATUTORY AND NATIONAL REQUIREMENTS

4.1. Further reduce the incidence of infections, specifically MRSA and MSSA blood stream infections and *Clostridium difficile* infection (CDI).

Clostridium difficile

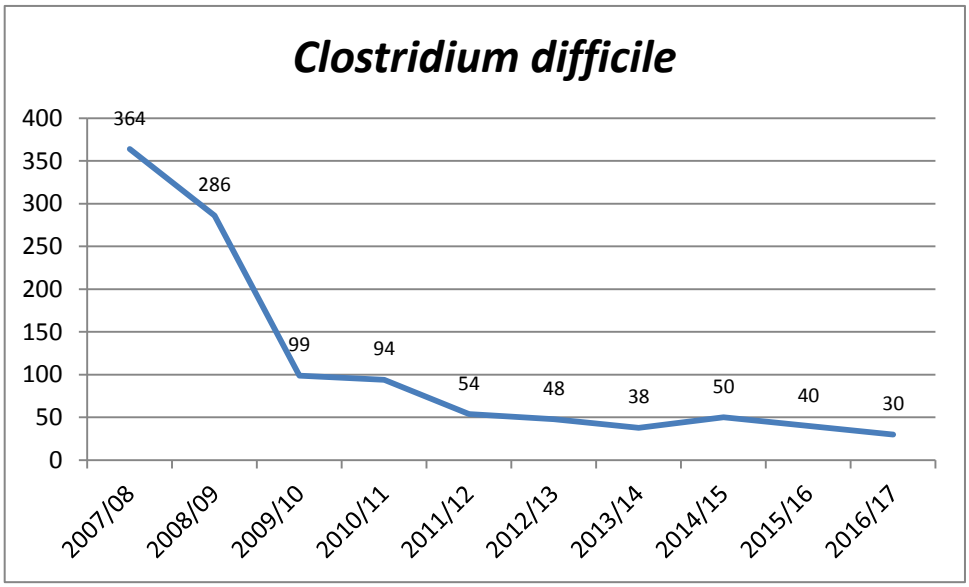
The National process continues to assess whether the patient's acquisition of *C.difficile* was "avoidable" or "unavoidable". The standard is measured by patients who are in hospital for 3 days or more. The Bristol Clinical Commissioning Group is also required to assess in conjunction with the IPCT that they agree with the assessment of each case. The IPCT meet the Bristol Clinical Commissioning Group on a monthly basis to discuss each case. The limit assigned to the Trust for 2016/17 was forty five "avoidable" cases; the Trust reported ten cases of avoidable CDI at the end of 2016/17. This is a reduction from the previous year.

Overall, the Trust has experienced a decrease in the number of CDI cases. In 2016/17; the total cases was 30, (see figure 3) compared to 40 in 2015/16.

We continue to manage the patient's on a case-by-case basis.

- All patients are visited on the next working day of the positive result by an infection control nurse, medical microbiologist and anti-infective pharmacist. They assess whether the Trust protocols have been followed and if the case is "avoidable" or "unavoidable".
- Post Infection Reviews (PIR) are completed on all patients. Any issues highlighted in the PIR are discussed with the ward staff. Action plans are developed if required and reported to the bi-monthly Infection Control Group.
- Antimicrobial prescribing is monitored on a monthly basis. Reported to the bi-monthly ICG.

Figure 3: *Total Trust attributable C.difficile infection cases since 2007*



Source: South West Public Health England Centre healthcare associated infection data

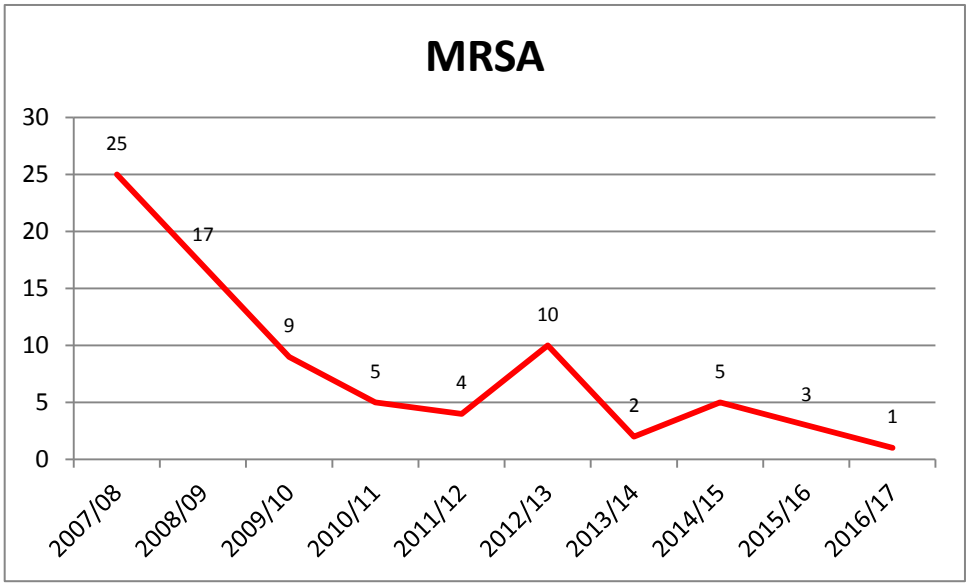
MRSA Bacteraemia

Number of cases

The standard for Trust attributable cases is measured by patients in hospital for more than 2 days. The limit for 2016/17 was zero tolerance to avoidable MRSA bacteraemia. The limit has no financial penalties but does contribute to MONITOR's compliance framework. By the end of March 2017 there was one MRSA bacteraemia attributed to University Hospitals Bristol NHS Foundation Trust.

- Mandatory reports are made to Public Health England on a case-by-case basis.
- The Public Health England investigation process was completed for the single bacteraemia attributed to the Trust.
- A multidisciplinary meeting was held and the case was discussed. An action plan has been instigated as per Trust and National protocols.
- Cases are discussed at the bi-monthly Infection Control Group.

Figure 4: *Numbers of Trust attributed Meticillin resistant* Staphylococcus aureus *blood stream infections since 2007.*



Source: South West Public Health England Centre healthcare associated infection data

MSSA

The standard for Trust attributable cases is measured by patients in hospital for more than 2 days. The Trust limit was no more than 25 cases in the year. This limit has no financial penalties and does not contribute to MONITOR's compliance framework. The Trust reported 37 cases. Eleven of the cases were related to vascular access, the majority being of an unknown source of infection. A Post Infection Review was undertaken for each case. An action plan was developed with the clinical teams and is monitored by the Intravenous Access coordinator. Hand hygiene and ANTT workshops are continuing throughout the Trust and the Surgical Site Infection Surveillance programme continues for another year and will expand into other surgical specialities.

The actions to reduce MSSA are the same as for MRSA; both organisms are responsible for intravascular access and surgical site infections.

E. coli

There is no target set for *E. coli* bacteraemia. We continue to report these blood stream infections to Public Health England, which remains a national requirement. However for 2017/18 the Secretary of State for Health has announced an ambition to reduce multi-resistant organisms across the whole Healthcare economy, including *E. coli,* by 50% by March 2021.

- It has been acknowledged that this is different from the challenges surrounding the management and control of MRSA and *C.difficile,* although we can learn from some of the actions that came out of those issues. There will be no prescriptive way of dealing with *E.coli* bacteraemia cases but a national resource will be available to help the Healthcare economy reduce infections and increase patient safety.
- The Clinical Commissioning Groups are leading on achieving the Quality Premium (from April 2017, for a 2 year period)
- With an ambition of a 10% reduction in all *E. coli* blood stream infections in Year 1 an action plan is being developed across the whole healthcare economy, which includes North Bristol Trust, Weston, UH Bristol and the commissioners.

4.2. Report and investigate cases of healthcare associated infection and outbreaks

Multi-resistant *Klebsiella pneumoniae*

Three patients with chronic pancreatitis each developed an infection caused by the same strain of multi-drug resistant *K.pneumoniae* (ESBL-producing) between April 14th 2016 and May 2nd 2016. The three patients were under the same surgical speciality team. The patients had a similar diagnosis and underwent similar procedures using various endoscopes and spent time on the same ward. Patients who had had any contact with these patients from March 1st – May 6th 2016 and were still in the Trust were screened for the organism. Sixty-six patients were screened and no additional cases were found. Twenty-three scopes were tested and the outbreak strain was not found. There have been no further cases. No wards/ bays were closed. No source of the outbreak was found, and now new cases have been identified since May 2016. This outbreak has now been deemed closed.

Invasive Group A *streptococcus* (iGAS)

During February–March 2016 three patients (in the same bay), who had undergone treatment for head and neck cancer, developed iGAS. Specimens were typed and they were the same strain indicating the likelihood of cross-infection.

In line with national practice guidance and the Trust outbreak policy, this was declared an outbreak.

Actions taken

- Patient and staff screening was instigated (approximately 300 throat swabs were taken by ward staff). Staff and patients were given explanatory letters and information about GAS.
- A total of six patients were found to have similar GAS strain – all were successfully treated.
- A total five members of staff were found to be colonised with GAS – various strains. Staff members were followed-up by Occupational Health and treated with antibiotics (24 hours exclusion from work – first day of antibiotics).
- Three outbreak meetings were held with appropriate representation.
- Extra environmental cleaning was put in place by Facilities.
- Staff have focused on hand hygiene and patient equipment cleaning.
- One Bay on the ward was closed until affected patients were discharged or moved to side rooms.
- The ward was visited daily by IPCT.
- Short GAS training sessions provided to Ward staff by ICN. In addition GAS an information folder was left on Ward for staff.

  In line with national guidelines the situation was monitored for six months (April - September 2016). No further actions were required, and the outbreak is now deemed closed.

MSSA outbreak in the Paediatric Intensive Care Unit (PICU)

In July the IPCT were informed that there were two children in PICU with an MSSA bacteraemia. The MSSA were showing signs of an unusual resistance pattern. Both specimens were sent to Public Health England (PHE) for typing. An outbreak meeting was convened due to the concerns of the resistance patterns and the issue of cross-infection may have occurred. All children in the unit were screened, however, no other children were found to be positive. The results from the PHE laboratory showed that the strains were different. No transmission had occurred and the outbreak was closed.

Varicella (chickenpox) exposure incident in Rheumatology OPD

Rheumatology Out Patient Department staff contacted the ICN on 18th October 2016 to report a potential chickenpox exposure incident in the department. A patient attended the department with her son who had a rash that had the appearance of chickenpox. The child was seen by GP the next day who confirmed the diagnosis of chicken pox.

Occupational Health nurses informed and contact tracing of patients and staff commenced. There are a total of 38 patient contacts and 20 of them were potentially immunosuppressed due to their treatment. Therefore, as advised by the virology consultants, these patients had bloods taken to check for immunity to varicella. All 20 patients had confirmed immunity and no further action was required.

Pertussis

The ICN were notified of three non-connected cases of pertussis during October 2016, amongst staff members, two from the children's hospital and a further case in the BHI. Following investigations by the IPCT, no patients were found to be at risk from the exposure. Occupational Health continues to investigate and monitor staff members.

Multi Drug Resistant Tuberculosis (MDRTB

A patient was admitted in to the Trust with a confirmed Multi drug resistant form of TB. The patient was in a specialist isolation room, and received the appropriate treatment. The patient was homeless and had recently stayed in hostels, which resulted in a further two cases being admitted to the Trust who were subsequently found to be negative. The estimated number of contacts is 18, and the community TB nurses are aware. At risk patients have been added to the Medway system for identification in the future if required.

Tuberculosis (TB)

A patient, who was attending the day case area at the Haematology/Oncology centre over several months, was diagnosed with pulmonary TB in November 2016. A meeting was called with the appropriate staff, including Public Health England and Occupational Health. All "at risk" patients have been identified and the process of assessing these patients has been completed.

Norovirus Outbreak Activity

Norovirus cases are being managed more effectively following the opening of the new Bristol Royal Infirmary ward block, the closure of the old building and the King Edward building to in-patients and the corresponding increase in side room capacity. We continue to follow national norovirus guidance and report outbreaks through the Public Health England hospital norovirus outbreak reporting system.

Year	Wards Closed	Bays Closed	Bed days lost
2013-14	16	32	524
2014-15	6	19	161
2015-16	1	11	15
2016-17	4	14	191

Heater/Cooler Machines and Cardiac Surgery

Mycobacterium chimaera is a non-tuberculous mycobacterium which is a member of the *Mycobacterium avium* complex. This type of mycobacterium is widespread in the environment, including tap water, and is usually associated clinically with respiratory disease or with disseminated disease in the immunocompromised patient. It is now recognised that *M.chimaera* has caused severe infections in a number of patients who have undergone cardiac surgery. International and UK investigations have implicated contaminated heater cooler units from a particular manufacturer used for cardiopulmonary bypass, transmitting infection from their water tanks via generation of a contaminated aerosol with particles reaching the operative field.

Due to the ongoing identification of cases - for some patients, infection is only diagnosed post-mortem - it was agreed by NHS England that those patients at highest risk should be notified and provided with information in the event that they need healthcare in the future. The Trust:

- A national identification of patients who had undergone valve replacement surgery was completed. Universities Hospital NHS Foundation Trust was included in this exercise.
- A national help line was set up for patients who required more information.
  A total of 2,626 adult and paediatric patients from UHBristol were notified.
- Any queries from patients are being dealt with on a case by case basis.
- New patients are receiving a letter for information when they are booked for their surgery.

Surgical Site Infection Surveillance

An application for CQUIN money to develop the Surgical Site Infection Surveillance (SSIS) programme was successful for the year 2016/17. Three members of staff were employed to develop and initiate the programme. Adult and paediatric cardiac surgery, upper and lower gastro intestinal surgery, and abdominal hysterectomy surgery were included in the surveillance programme. All patients were followed three-times a week during the hospital stay and had a post-30 day discharge telephone call. The CQUIN was achieved 100%.

- Trauma & Orthopaedics surgery are included in the SSIS team's programme, utilising the national Public Health England surveillance programme (PHE).
- The Trust has agreed to continue the programme for a further year.

Vascular Access

The aim in 2016/17 was to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of infection, as well as to ensure the Trust meets statutory and national requirements related to vascular access device associated infection.

- Aseptic Non Touch Technique (ANTT) is now on Trust induction and E-learning.
- ANTT champions audit standards quarterly.
- A rolling programme of ANTT workshops continues Trust wide.
- The development and launch of ANTT educational videos.
- Post Infection reviews continue on patients with blood stream infections relating to vascular access.

Infection in Critical Care Quality Improvement Programme

Healthcare-acquired infections in critically ill patients in intensive care units increase morbidity and mortality, have a high economic impact, add to the problems of multidrug resistance, and are potentially preventable. Considerable success has been achieved in reducing rates of central venous catheter (CVC) blood stream infections (BSIs) through surveillance and feedback.

- The adult Intensive Care Unit has been entering data into the Public Health England Surveillance of blood stream infections in patients in England sentinel scheme, for 12 months as part of the critical care quality improvement programme. The Trusts involvement in this scheme is voluntary although a national rollout is set for May 2017 with incentives to participate. There is now participation from Paediatric, Cardiac and the Neonatal Intensive Care Units.
- The Trust has now fully implemented Tegaderm advanced securement dressing.
- The Peripherally Inserted Central Catheter (PICC) team continues to undertake post 24 hour line insertion follow-up of patients. A business case was declined for a Band 3 to join their team; however it will be represented for 2017/18.

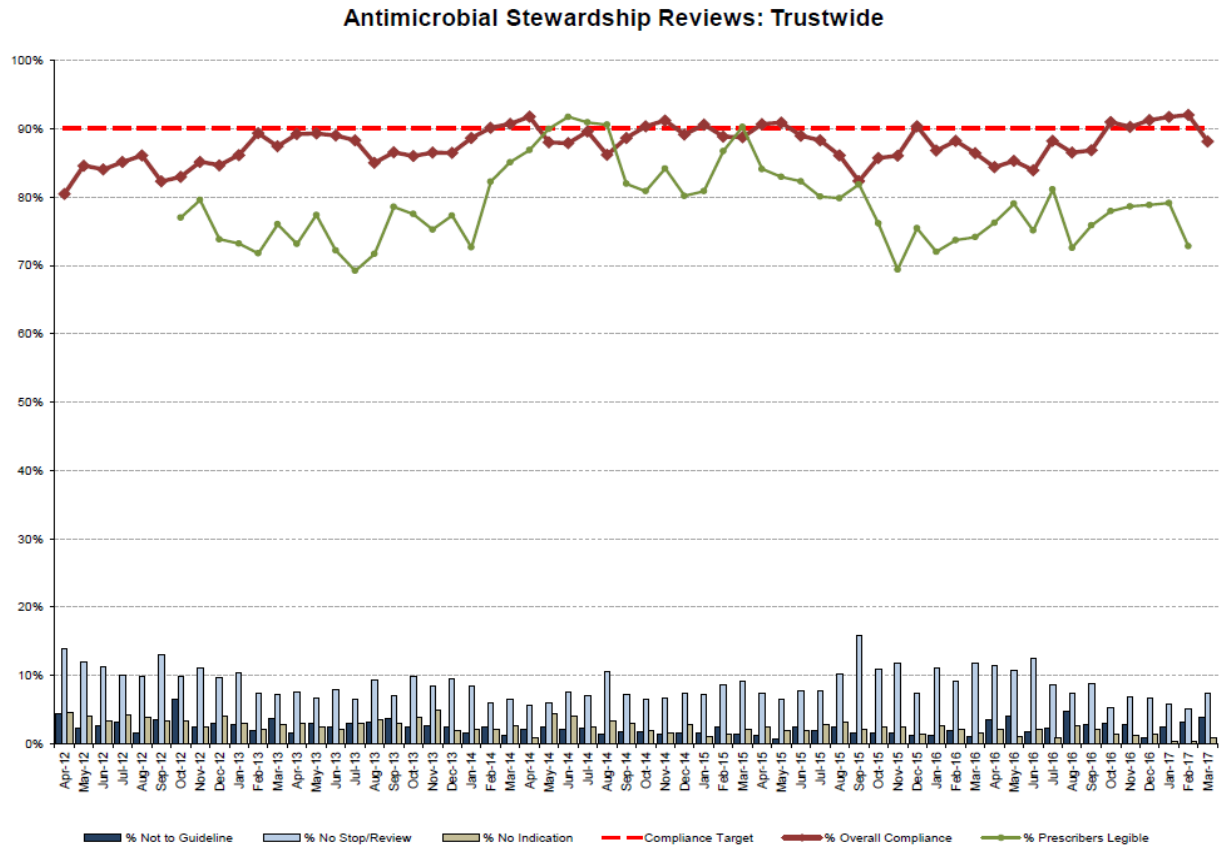
5. ANTIBIOTIC PRESCRIBING

Antibiotic lead structures

The Trust Anti-Infective Committee has continued to meet under the leadership of Dr Sean O'Kelly with representation from each of the divisions, microbiology, infection control and pharmacy. The Committee is responsible for antibiotic stewardship within University Hospital Bristol NHS Foundation Trust.

Antibiotic Ward Reviews

Antibiotic ward reviews continue across the Trust. The tables below summarise the trust-wide results. The pharmacists and microbiologists increased the number of ward rounds in 2016 in order to maintain a high profile and further scrutinize antimicrobial prescribing. This was undertaken in light of the national CQUIN targets aimed at reducing antibiotic consumption and focussed on the admissions' wards.



Average compliance at the end of 2015/16 was 88.29%; this is below our target of 90%. A lack of a stop or review date remains the main reasons for low compliance. This figure is an improvement on the previous year (84.38%) and in 2016/17 compliance was recorded as being above 90% for 5 consecutive months. Prescribing teams are being urged to continue to strive for this target.

Antibiotic guidelines

A continued review of antibiotic guidelines has been undertaken, with all indications covered by a guideline. Audit work and engagement with clinical leads over the year revealed areas where further guidelines were required and these are either in place or are under production. Where appropriate, dose ranges have been removed and all guidelines reviewed with a view to limiting the inclusion of very broad-spectrum agents.

6. DECONTAMINATION

Abbreviations	
AER	Automatic Endoscopic Reprocessor
QDU	Queens Day unit
BCH	Bristol Children's Hospital
RO	Reverse Osmosis
TVC	Total Viable Counts
CSSD	Central Sterile Services Department
HGT	Heygroves Theatre
ENT	Ears Nose and throat
BDH	Bristol Dental Hospital
DSEU	Day Surgery Endoscopy Unit
SBCH	South Bristol Community Hospital
BEH	Bristol Eye Hospital
TSSU	Theatre Sterile Services Unit
JAG	Joint Accreditation Group

Risks: 44 on the register for decontamination: 10 requiring action, 21 accepted, 10 closed, 2 rejected, 1 being assessed

Risks requiring action:

- Risk 2016 – Risk of deterioration to surgical instruments through the use of alkaline detergents in CSSD Kingsdown. CSSD to speak with suppliers of instruments that state a neutral detergent to be used for cleaning to ascertain whether damage will occur if the department was to use the alkaline detergent it routinely uses in the washer disinfectors.
- Risk 2009 - Risk that packing used on sterile items processed in CSSD becomes damaged prior to use. CSSD continuously exploring the market for more robust materials – also purchasing different sized containers to place sets in which eliminate the incidence of material damage occurring.
- Risk 1531 - Jet AER Failures – capital monies have been made available and procurement process will now commence to replace x 1 machine.
- Risk 1418 - Risk of contamination of cleaned instruments due to supply of inadequate air flow to the IAP room, BEH. Plan is to close the unit October 2017 once all refurbishment works are complete at CSSD Kingsdown.
- Risk 1412 - Risk of contamination of cleaned instruments due to supply of inadequate air flow to the IAP room, CSSD Kingsdown- AHU works have commenced and are expected to complete June 2017.
- Risk 1343 and 1334 - Risk of service interruption due to poor level of decontamination provision in Hey Groves Theatres – recently been agreed that HGT will look to fund a band 3 Decon lead who can then formalise links with QDU. A number of measures are being in place to reduce the decontamination of workload in hours to HGT and divert to QDU.
- Risk 1323 - Reliability of Reverse Osmosis plant – level 3, BCH continues to be a concern due to age profile being over 13 years old. A fully comprehensive service and maintenance contract that includes emergency call outs is in place,

but the plant and hence the service remains vulnerable. Capital monies to replace the machine have been agreed by estates and resolution is expected to be installed June 17.

- Risk 268 and 892 - Failure to complete in a timely manner the refurbishment of CSSD. AHU works have commenced and are expected to be completed by end of June 2017. Completion of rest of refurbishment works expected by September 2017. Risk 1343 and 1334 – poor Endoscopy service provision in HGT being reviewed and looked at by the division with regards to alternative ways of delivering the service more appropriately.

Successes for year 2016–17

- Installation and replacement of 2 further AER's for QDU – capital programme complete October 2016
- Refurbishment of CSSD – year 4. Refurbishment of 2/3rds of the department including painting, new flooring, new windows and commencement of replacement of AHU. Installation and commissioning of 4 new sterilisers.
- Purchase and installation of Sterrad for CSSD.
- Removal of 3 steam sterilisers and 1 hot oven from Pathology labs, level 8, following transfer of city wide Pathology services to NBT.
- Purchase and installation of vacuum packing system for flexible endoscopes that have 31 day life – enabling free movement of flexible endoscopes around the Trust as service needs require.
- Resolved ongoing TVC issue at SMH so that weekly water results achieve and maintain compliance with national standards.
- Agreement that estates would fund the replacement of level 3 RO plant and also standalone RO plant for paediatric renal services.

Project of works for 2017-18

- Continue with general refurbishment of CSSD – year 5, to include new flooring, and general small works.
- Purchase and installation of 7 sterilisers with integrated clean steam generators for CSSD.
- Full usage of Low Temperature Sterilising machine recently purchased for CSSD.
- Installation of new RO plant for BRCH – replacement of level 3 plant and also purchase/commissioning of standalone RO plant for paediatric renal services.
- Closure of BEH TSSU once CSSD Kingsdown works are fully completed – plan is to close by end of December 2017.
- Review and implementation of new HTM 0101 and 0106 guidance in terms of use of Process Control Devices and Residual Protein Detection testing. Reduction in decontamination processing costs in line with Divisional Cost Improvement Plans.

- Drawing up of and implementation of action plan following AED annual trust-wide decontamination audit.
- Spend to Save initiative to purchase a UV decontamination machine for BHI Cath labs for the decontamination of TOE scopes.
- Purchase of 1 new AER for BCH theatres.
- Continue to monitor decontamination risks and work through actions in order to close risks where possible or convert to accept.

7. CLEANLINESS REPORT

Cleanliness 2016-2017

The Facilities department has made continual improvements to performance and working strategy to ensure the best patient environment experience by:

- The **Cleanliness Responsibility Framework** has been updated and is available to all clinical and non-clinical staff. It is located on the infection control website.
- The Facilities team continue to support the Infection Prevention and Control Team with **deep cleans** of bed spaces, cubicles, rooms and whole ward areas. This cleaning is in addition to regular cleaning and is carried out in response to individual cases of infection, as well as outbreaks. In 2016-17 approximately 10,144 deep cleans were completed over all the sites. This was a 44% increase on the previous year. The hydrogen peroxide machines were used 1,081 times. This was an average of 21 per week and an increase of 49% on last year.
- Facilities **Service Level Agreements** for catering and cleaning services at ward level are in place. The stakeholders involved included Matrons and Ward Managers. These will be amended in September 2017 due to consultation on the change of the catering service model.
- **Microfibre mops and trolleys** are being implemented in St Michael's Hospital and will be completed by the end of September 2017. These are in use at the Bristol Royal Infirmary Queens Building and Bristol Heart Institute. Training on the use of the mops is completed by Vileda. This equipment has improved the standard of cleanliness further through the provision of a more efficient and effective mopping system.
- The **move of the Hotel Services Catering** department from BRI Old Building to its new location in the King Edward Building was completed seamlessly. There was no disruption to catering service and no infection control issues as a result of the move. The new facilities are clean, bright, and airy and have modern equipment.

Staff Training: A comprehensive training plan for Facilities Staff includes:

a. Training for all new Substantive and Bank Hotel Service Assistants, Supervisors and Managers is completed at a dedicated centre at Tyndall's Park. During this training for new starters, a substantial amount of time is spent building on their **infection control induction training**. Trainees are given the opportunity to put their skills and knowledge into practice when undertaking their cleaning tasks, following infection control protocols.
b. Staff receive further on the job **mentoring and coaching** within their work areas, which involves a week undertaking cleaning tasks and a week undertaking food duties. A shadowing SOP has now been implemented across Hotel Services to support new employees. Each new starter has a mentor who takes them through this process. All Hotel Service Assistants have their competency assessed within six weeks of commencing their role. Any shortfalls in performance are noted on an action plan, with a review date and are followed up by the Supervisor.
c. We continue to make improvements in **food service training** with the introduction of a new online level 2 food safety training programme. The training is interactive and consists of 10 modules including a section on

allergens. Each module has to be passed before the trainee can move onto the next module. On successful completion of the course a certificate is immediately available.

Quality Assurance for Cleanliness

Internal:

- The Trust receives assurance on cleanliness by monitoring cleanliness on a daily basis by an independent Audit Team. Over 180 areas per month are audited across all hospitals six days a week.
- Three elements are audited for each area and they are Facilities cleanliness, Clinical cleanliness and Estates cleanliness.
- Each area is assigned a risk category (very high, high, significant or low risk) and a RAG rating (red, amber or green). Very High risk areas such as Intensive Care Units and Theatres (where patients are more vulnerable to infection) are audited on a monthly basis if the areas are performing to a Green RAG rating. Should any Very High Risk Areas fall into amber or red RAG rating, the area can be audited weekly.
- Cleanliness auditing scores are reported at: Trust Board, Infection Control Group, Service Delivery Group and Patient Environment Operational Group.
- Mini-PLACE assessments are held on a monthly basis and feedback is given to clinical and non-clinical staff. The team consists of Facilities and Estates staff.
- Focus on under-performing areas has improved the quality of the cleanliness scores in all three elements (Facilities, Clinical and Estates). Support has included feedback to non-clinical and clinical staff after an audit, analysis of Estates elements and meetings with contractors.
- Benchmarking with Southmead Hospital was completed and it highlighted our processes were robust and support quality improvement.

External:

- Successful completion of the Patient-Led Assessment of the Care Environment assessments in February to May 2016 at six hospitals. The elements assessed included; cleanliness, dementia, privacy, dignity & wellbeing, food and condition & appearance. The assessment teams included representatives from Infection Control, clinical areas, Facilities and Estates, led by patient representatives including governors, volunteers, patients and Health Watch.

Next Financial Year (2017/18)

Deep Clean

Facilities will be assessing the potential for trialling a mobile UV device which has similar capabilities to our current Hydrogen peroxide machines.

Catering

Implementation of all menu and service model changes within catering.

Cleaning

To review changing supplier of the chlorine based cleaning product for facilities and the clinical teams.

Patient-Led Assessment of the Care Environment

- The completion of the Patient-Led Assessment of the Care Environment assessments across the Trust at six hospitals will be between February and April 2017. The information will be inputted into the Health and Social Care Information Centre database. The process for prioritising and monitoring the actions is part of the Patient Operating Environmental Group. This will assist in completing the actions associated with the assessments to ensure they are completed in a timely manner and within budget. Membership includes Clinicians, Facilities and Estates. Patient-Led Assessment of the Care Environment scores will be released in September 2017.
- Internal mini Patient-Led Assessment of the Care Environment assessments will be completed monthly.

8. NEXT STEPS

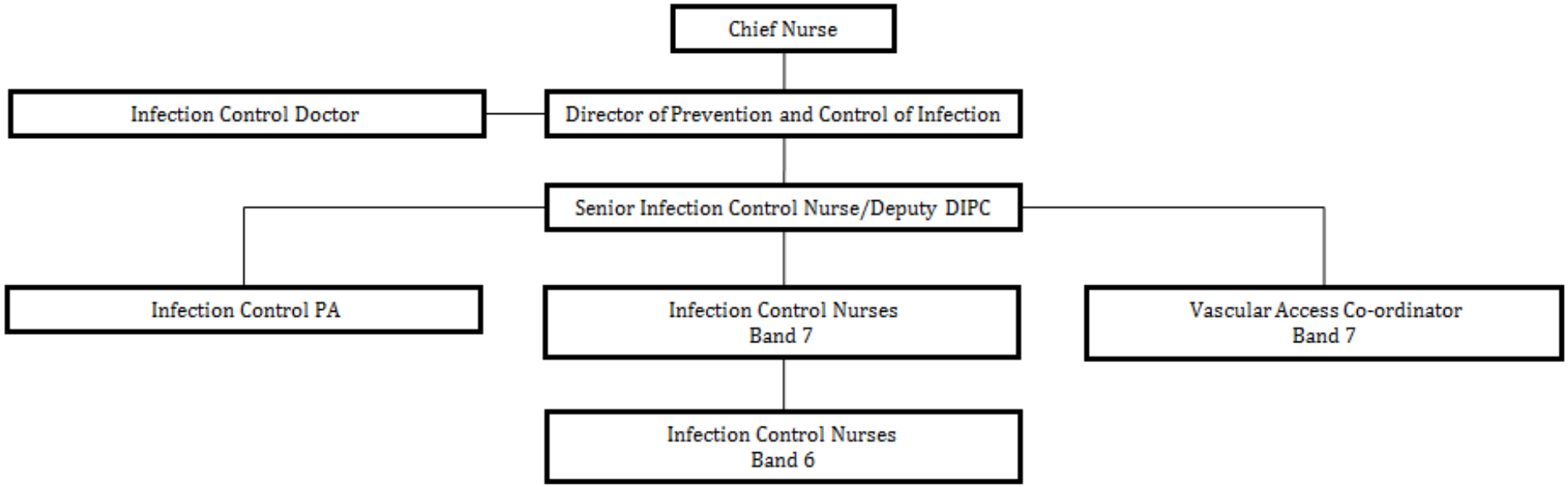
The Infection Prevention and Control Team's goal in 2017/18 remains to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of infection as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection.

The Infection Prevention and Control Team will:

- Comply with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code).
- Report and investigate cases and outbreaks of healthcare associated infection as mandated and share learning.
- Reduce the incidence of infections (specifically Methicillin-resistant *Staphylococcus aureus* and Meticillin-sensitive *Staphylococcus aureus* blood stream infections and *Clostridium difficile)*.
- Secure substantive posts for the Surgical Site Surveillance Team to be able to continue to develop and drive the surgical site infection surveillance programme.
- Continue to work with our commissioning partners and develop relationships.
- Work with the commissioners and colleagues across the whole healthcare economy with the ambition to reduce *E. coli* bacteraemia.
- Share Trust wide action plans and lessons learned with the commissioners at the monthly Healthcare Associated Infection meeting.

9. APPENDIX A

Infection Control Organogram



REPORTS TO

Infection Control Group, Divisional Board

Service Delivery Group, Clinical Quality Group

Regulatory Compliance Group.

LIAISES WITH

Clinical Risk Management Team, Chief Nurse,

DIPC, Heads of Nursing, Divisional Managers,

Bed Managers, Clinical Directors HPA/HPU

Directorate Clinical Governance,

Clinical Teams, Estates Facilities,

Modern Matrons

INPUT INTO

Training & Development, Facilities Procurement

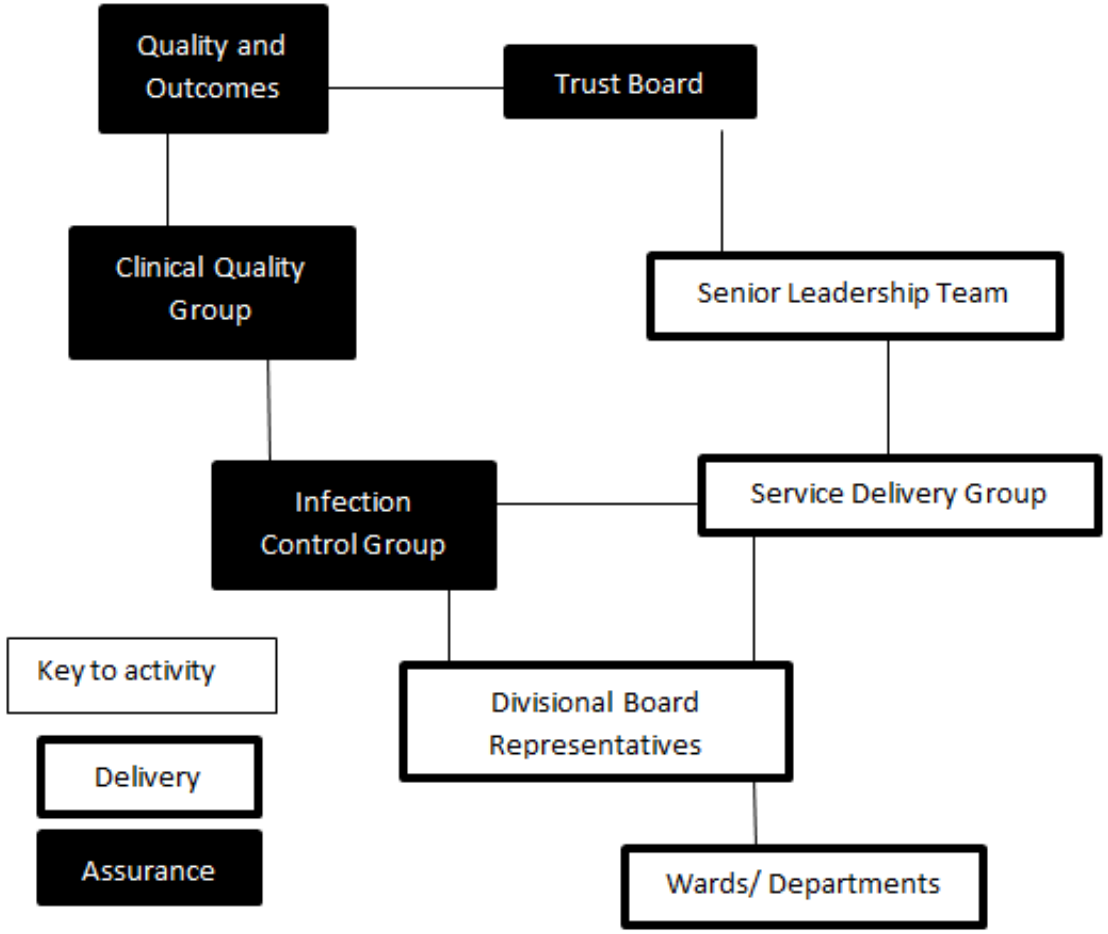
Practice Development, Estates

Waste Management, Redevelopment

Strategic Planning

10. APPENDIX B

Infection Prevention and Control Reporting/Governance Structures



- The Chief Nurse is the Executive Lead and chairs the Infection Control Group, which has met four times and includes Governor and partner organisation representatives.
- The Trust Quality Outcomes Committee received infection control reports within the quality report monthly and a detailed report quarterly.

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	18
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Education and Development Annual Report 2016/17		
Author	Alex Nestor, Acting Director of Workforce and Organisational Development		
Executive Lead	Alex Nestor, Acting Director of Workforce and Organisational Development		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

The Education, Learning and Development Annual report describes the high level context and background to how UH Bristol delivered against its education and teaching priorities during 2016/17.

Key Issues

The report demonstrates that there are a vast number of education and teaching programmes delivered across the Trust to ensure the experience of all our learners and staff is of high quality and contributes to providing exceptional care for our patients. Learner satisfaction has remained high for 2016/17 and external regulatory assessment visits have been extremely positive with excellent feedback. The Education, Learning and Development delivery plan for 2017/18 has been developed by education/professional leads with the support of and endorsement from the Executive Director with relevant accountability for the various professional staff groups.

Recommendations
Members are asked to: • **Note** the work that has taken place within Education, Learning and Development at UH Bristol during 2016/17, and • **Acknowledge** the Education, Learning and Development delivery plan for 2017/18

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

University Hospitals Bristol NHS
NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust

Education, Learning and Development Strategy

Delivery Plan

2017-2018

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Contents Page

Education, Learning and Development Delivery Plan high level generic objectives for

All learners on placement	Page 2
Medical and Dental Postgraduates	Page 3
Medical Undergraduates	Page 4
Dental Undergraduates and Dental Care Professionals	Page 5
Pharmacy	Page 6-7
Support Workers Bands 1 -4 Apprenticeships	Page 8-11
Leadership and Management Development	Page 12-13
Nursing, Midwifery and Allied Health Professions	Page 14-15
Healthcare Science	Page 16
Essential Training and Essential Training Specific to Role	Page 17
Library services	Page 18
Bristol Medical Simulation Centre	Page 19
Education, learning and Development Strategy	Page 20-21

Education, Learning and Development Delivery Plan high level generic objectives for all learners on placement
2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Trust wide	Deliver Health Education South West's Learning and Development Agreement contractual obligations for education and maintain levels of activity	Assures quality of education placements and learner experience Maintains Trust ambition 'best place to teach, best place to learn'	Achieve Green RAG rating in the Health Education South West outcome report	Education Leads & Head of Education	Sept 2017 submission April 2018 results
Trust wide	Implement Health Education England's quality framework into the Trust	Assures quality of education placements and learner experience Ensures funding for education is transparent and allocated appropriately	Local plan established Regulatory visits organised Defined set of KPIs agreed and in place	Head of Education	March 2018
	Review of Education and Development services	Education and development structure that is fit for purpose, and able to support education and development provision for Trust staff and learners	Appropriate structure in place Physical and financial resources are appropriately allocated and can deliver the Education Strategy Revised and updated Strategy in place	Head of Education	March 2018

Developed by Kay Collings Head of Education

***Education/Professional Leads** = Jayne Weare, Trish Hewitt, Helen Morgan, Mel Watson, Steve Brown, Sue Dolby, Rebecca Aspinall, Jane Sansom, Jane Luker, Sarah Bain, Tom Osborne, David Grant

Education, Learning and Development Delivery Plan high level objectives for Medical and Dental Postgraduates

2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Medical Post graduates	100% GMC accreditation of Educational Supervisor and Clinical Supervisor	Quality of education improved	Intrepid reports	Medical Education Manager	April 2018
Medical Post graduates	GMC survey results comparable to bench marked teaching hospitals	Quality of education assured	GMC survey report	Director of Medical Education	April 2018
Medical Post graduates	No bullying reports on GMC survey	Culture to learn safely	No bullying reported on GMC survey	Director of Medical Education	April 2018
Medical Post graduates	Manage the education exception reports appropriately	Deliver the educational component of the new doctors contract	Education Exception reports addressed	Director of Medical Education	April 2018

Developed by Dr Rebecca Aspinall, Director of Medical Education

Education, Learning and Development Delivery Plan high level objectives for Medical Undergraduates
2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Medical students	Successfully implement new curriculum, 'MB21' affecting Year 1 and year 5 medical students	Positive experience of clinical placements at UHBristol at crucial points in undergraduate career	Student feedback on clinical experiences and successful student performance in assessments, including national exams.	Undergraduate Academy Dean	July 2018
Medical students	Maintain high quality support and learning experience for students on placement at South Bristol Academy (UHBristol)	Students successfully complete placements and assessments and view this Trust as a supportive and positive environment which may attract them as high quality staff in the future	Positive student feedback; good student performance in assessments; positive outcome from annual University of Bristol visit	Undergraduate Academy Dean	July 2018
Medical students	Support student learning through appointment of high quality Clinical Teaching Fellows (CTFs), working with Postgraduate Education fellows to deliver teaching	Provides multi-layered pastoral and professional support for medical students	Feedback from medical students. Successful career progression of Clinical Teaching Fellows and successful delivery of teaching by CTFs and Postgraduate Education Fellows	Undergraduate Academy Dean	July 2018

Developed by Dr Jane Sansom, South Bristol Academy Dean

Education, Learning and Development Delivery Plan high level objectives for Dental Undergraduates and Dental Care Professionals 2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Dental Undergraduates University of Bristol	To ensure the removal of the overseas student cap does not result in a loss of Dental Service Increment for Teaching funding to UH Bristol	Potential recovering of up to £200k per year	Agreement from UoB that overseas students pay full amount of DSift	General Manager BDH	Sept 2017
Dental Nurses	To introduce apprenticeship training model for September 2017 intake	Ongoing delivery of chairside support for dental undergraduates	Increase in numbers of Trainee dental nurses	Director DCP Training	August 2017
Dental Hygienists and Therapists	To identify appropriate funding stream to support Dental Hygiene and Therapy training In line with market demands develop and introduce a BSc in Dental Hygiene and Therapy.	No loss of clinical activity in these areas. Ability to conform to the GDC learning outcomes and therefore putting the Dental School and undergraduate programme at risk	HEFCE to announce funding model for Dental Hygiene and Therapy in July 2017. A BSc in place.	Director DCP Training	July 2017 Sept 2018
Dental Technicians	To review technician training in light of the withdrawal of funding by HESW	Ongoing development of technicians in the South West of England.	A programme of education and training in place.	General Manager BDH	January 2018
Dental Hygiene and Therapy students	Development of a BSc degree programme in line with market demands, and ensure that the foreign student diploma is live for September 2018.	Skilled and accredited dental workforce Attracts high calibre applicants and supports retention	BSc degree in place and accessible Overseas student diploma available and operational.	Director DCP Training	Sept 2018

Developed by Sarah Bain and David Wynne-Jones

Education, Learning and Development Delivery Plan high level objectives for Pharmacy
2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Pre-registration pharmacists and technicians	For > 90% of pharmacy graduates and pharmacy technician students to successfully qualify having fully developed through a comprehensive and innovative training programme commissioned by HESW and delivered South West Medicines Information and Training (SWMIT) to enable the necessary training to be delivered.	Meets workforce demand in Pharmacy Operating Plan	For > 90% of pharmacy graduates and pharmacy technician students to successfully qualify. Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.	Director of Pharmacy	Sept 2017
Post registration Pharmacy technicians	For at least 3 Pharmacy Technicians to achieve regional accreditation (through SWMIT programmes) in order to develop professional practice and provide safe and efficient Pharmacy services.	Meets Pharmacy Operating Plan and Carter Hospital Pharmacy Transformation Plan objectives	For at least 4 Pharmacy Technicians to achieve regional accreditation. Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.	Director of Pharmacy	Sept 2017
Post registration Pharmacists	For at least 3 pharmacists to successfully complete diploma or masters programmes in clinical pharmacy and pharmaceutical technology and quality assurance specialties.	Meets Pharmacy Operating Plan and Carter Hospital Pharmacy Transformation Plan objectives	For at least 3 pharmacists to successfully complete diploma or masters programmes. Measurement: In year evidence of steady progress; end year 100% success; and excellent feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: Sept 2017 Feb 2018
Pharmacist independent prescribing	For at least 3 Pharmacists per annum to successfully qualify as Prescribing Pharmacists.	Meets Pharmacy Operating Plan and Carter Hospital	For at least 3 Pharmacists per annum to successfully qualify as Prescribing Pharmacists.	Director of Pharmacy	2 cohorts: Sept 2017 Jan 2018

		Pharmacy Transformation Plan objectives	Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.		
Pharmacy Assistants	Equipping all new Pharmacy Assistants with the knowledge and experience to deliver assigned services through commencing 100% of new Pharmacy Assistants on the NVQ2 programme within 6 months and completing 100% of the necessary modules within the required timeframes.	Meets workforce demand in Pharmacy Operating Plan	Commencing 100% of new Pharmacy Assistants on the NVQ2 programme within 6 months and completing 100% of the necessary modules within the required timeframes. Measurement: Successful commencement and completion of relevant Quality Credit Framework modules in a timely manner. Evidence of development and excellent feedback from evaluations of training experience.	Director of Pharmacy	Sept 2017
South West Regional Pharmacy Training Unit service delivery	South West Regional Pharmacy Training Unit (hosted by UHBristol) to be recognised by SW trust Chief Pharmacists as a high quality provider of the South West Pharmacy Training needs, and enables delivery of HESW commissioned courses.	Meets regional workforce requirements	South West Regional Pharmacy Training Unit (hosted by UHBristol) to be recognised by SW trust Chief Pharmacists as a high quality provider of the South West Pharmacy Training needs, and enables delivery of HESW commissioned courses. Measurement: Positive response by South West Chief Pharmacists to the SWMIT annual report and for SWMIT.	Director of Pharmacy	Sept 2017

Developed by Steve Brown, Director of Pharmacy, UH Bristol

Education, Learning and Development Delivery Plan high level objectives for Support Workers Bands 1 -4 Apprenticeships 2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Vocational Education	Implement trust wide Apprenticeship programme for support workers (bands 1-4) as part of Health Education England's 'Widening Participation' and 'Talent for Care' strategies	New and existing employees within bands 1 -4, across all divisions (from 460 vacancies in 16/17) Conversion of vocational training within Nursing Assistants & Dental Nursing to an apprenticeship Conversion to an apprenticeship under the HCSW, Customer Service Practitioner, Team Leader & Operational Manager standards Maximise the amount drawn from the apprenticeship levy	Target apprenticeship recruitment of 348 apprentices by May 2019, comprising: 130 Healthcare Support Workers, formerly Nursing Assistants 20 Dental Nurses 6 Healthcare Science Practitioner/Associate 192 generic apprenticeships Implementation of the apprenticeship standards to address workforce needs, particularly in areas with high vacancies or requiring a bespoke skill set	Deputy Head of Education/ Divisions	2 years
	Achieve apprenticeship growth across all divisions, apprenticeship levels and NHS bands	Implementation of new and developing standards, especially professional apprenticeships	UH Bristol involvement in an apprenticeship trailblazer All apprenticeship programmes develop progression pathways into	Deputy Head of Education/ Divisions/ external providers	2 years

			higher apprenticeship roles		
	Develop measurements of apprenticeship impact upon the effectiveness and efficiency of the Trust	Apprentices contribute to the development of the Trust's values and growth Apprenticeships add value to the organisation Apprenticeships meet the organisational skill set Apprenticeships are the route of choice for career progression and development Apprentices are recognised for their diligence and commitment, by the Trust and externally	Internal and external communications plan is in place from May 2017 Case studies highlighting the value of an apprenticeship, evidence by a range of stakeholders Apprenticeship feedback has a positive response to the value of their input All apprentices have a mentor who is trained and supports the apprentice Apprenticeship retention rates are at or above national benchmark data Apprenticeship progression rates are developed and benchmarked against national standards Annual awards ceremonies are introduced to credit apprentices for their efforts, achievements and development	Deputy Head of Education/divisions/Communications Team/Resourcing/Learning & Development Team	1 month – 12 months
	High quality standards are a discernible feature of UH Bristol's apprenticeship provision	Apprenticeship programmes, delivery, assessors, support and assessments are at a high quality standards, against national benchmark data	Apprenticeship data is compiled and recorded for external audit by the SFA	Deputy Head of Education/Education Board/external providers/region	2 years

		Apprentices are supported and flagged when ready for the assessment gateway and therefore completion GCSE English and maths data is collected upon recruitment and reported to the assessing team. Apprentices without either GCSE English or maths are referred to Functional Skills classes in Literacy and Numeracy Data is collected at recruitment on learning needs and a system in place to report such needs to the assessing team In conjunction with other regional providers, UH Bristol will explore an opportunity to collaborate in the administration of the End Point Assessment (EPA)	Apprenticeship successful completion rates are at, or above, national benchmark of 85% across all provision Apprentices lacking GCSE English and maths, to complete and achieve the relevant functional skill attached to their programme Apprenticeship programme self-assess their provision, through robust quality improvement plans which are reported to the Education Board The Education Department will liaise with other NHS providers to assess the viability of an EPA consortium	al NHS partners	
	Review opportunities and entry routes for local young people into support roles with UH Bristol	Stakeholder engagement with the local community Through put to the Trust's apprenticeship provision Job opportunities within the NHS, by overcoming real and	Target participant numbers for the following programmes: Work experience – 60 participants Princes Trust – 15 participants Traineeships – 10 participants Progression to an apprenticeship –	Deputy Head of Education	1 year

		perceived barriers by applicants Establish collaborative projects with the Prince's Trust and Job Centre Plus to run extended work placements and traineeships	target 20 applicants Age profile of participants to include a cross section of school and adult applicants, from the region.		

Developed by Julian Newberry, Deputy Head of Education

Education, Learning and Development Delivery Plan high level objectives for Leadership and Management Development
2017 – 2018

Leadership & Management Development	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Leaders, Managers and Supervisors Trust wide	To provide a comprehensive approach to leadership and management training and development, so that all managers and leaders have the skills and competencies to support and develop staff creating a culture of high performance and continuous improvement Engaging the workforce, so staff are central to decisions that affect them, their patients and their services Leaders and Managers at all levels with the skills and knowledge to transform the way care is delivered and who know how to bring about innovation and change We will strive to employ the best staff and help all our staff fulfil their individual potential To improve the opportunities for	Ensure all Leaders role model leadership behaviours that promote a collective leadership culture Engage our leaders to encourage team working across the organisation and the system Deliver high quality leadership development programmes and interventions measured through robust return on investment KPI's Use Leadership behaviours and our Values to drive leadership at all levels of the organisation	Workforce & OD Strategy 2015/20 Quality Strategy 2016/20 Strategic Workforce Priority No.1 BAF No3., Strategic Priority 3 Equality & Diversity Strategic Objectives 2016-2019 Staff Survey Results Friends & Family Test	Head of OD	Financial Year 2017-18

	members of our diverse communities to gain employment with and progress within the Trust.				

Developed by Sam Chapman/Tracy Gates

Education, Learning and Development Delivery Plan high level objectives for Nursing, Midwifery and Allied Health Professions 2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Nurses/Midwives /AHPs	90 % compliance of up to date mentors	Ensure the current NMC requirements are met. Supports the student nurse/midwife placement learning experience AHP – ensure the internal standards are met and support the learning experience of all AHP students on placements from multiple HEIs	Mentor database held by Learning Education facilitator team (LEF) AHP – mentor record held by each HOS	Academic Dean Pre Registration AHP HOS	Review quarterly
Nurses/Midwives	% of learners recruited to UH Bristol post qualification **Need to confirm %**	Ensures the % RN vacancy rate remains within a target of 4% or lower	Database held by Nurse Recruitment Lead	Nurse Recruitment Lead	Monitored monthly
Nurses/Midwives/ AHPs	100% of contract CPD courses taken up	Supports improved patient care/safety, service development and meets specific speciality national requirements	Database held on Nurse CPD workspace	Deputy Chief Nurse	Review quarterly
Nurses/Midwives/ AHPs	100% of contract CPD courses completed	As above	As above	As above	As above
Nurses/Midwives	85% and above score for student Nursing and Midwifery overall placement evaluations	A positive student placement experience will support Registered Nurse and Midwife recruitment	Paper presented to Trust Education Group	Academic Dean Pre Registration	Presented quarterly

	80% and above score for student Diagnostic Imaging, Radiotherapy, OT and PT students on placement from UWE. Different feedback processes are in place across the various HEIs which provide AHP training.	A positive placement experience may support future recruitment as well as contribute to the quality of the wider NHS workforce		Trust Lead AHP	
AHPs	85% of all AHPs have agreed CPD profiles for their job role – covering ET, ESRT and additional required training and development	Supports the development of staff as well as provides clarity of the employer's responsibility to CPD, managing staff expectations etc.	Paper presented to AHP Forum	Trust Lead AHP	Presented 6 monthly.
AHPs	For all formally developed advanced practitioner, ESP and Consultant roles to have a clear educational plan which identifies the education required for the role as well as links to HEIs and the education contribution the roles will make.	Supports a formal framework for the development of post-graduate and advanced roles.	Paper to be presented to AHP Forum in Q2 17/18 – to create an overall Trust wide approach to the development and sign off of roles.	Trust Lead AHP	New roles presented and reviewed at AHP Forum

Developed by Helen Morgan, Deputy Chief Nurse and Jayne Weare, Head of Therapy Services

Education, Learning and Development Delivery Plan high level objectives for Healthcare Science
2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Healthcare Scientists - Assistant and Associate (Bands 1-4)	Raise awareness of apprenticeship frameworks for HCS and work with HCS service leads to identify opportunities to access apprenticeships, as appropriate.	Mitigation of risk of shortage of workforce supply in departments where there are a national shortage Supports Health Education England's widening participation strategy	One Clinical Engineering apprentice enrolled on Apprenticeship Run Apprenticeship workshop for all trust HCS	Lead Healthcare Scientist	December 2017
Healthcare Scientist Practitioners (Band 5)	Raise awareness of apprenticeship frameworks for all HCS services and work with HCS service leads to identify opportunities to access apprenticeships, as appropriate.	Trust department will be leader in region and nationally for piloting new apprenticeship frameworks	Three Clinical Engineers enrolled on Degree Apprenticeship by September 2017 (*delayed from 2016 so we can use Apprenticeship Levy money)*	Lead Healthcare Scientist	September 2017
Healthcare Scientists - Clinical Scientists	All Healthcare Science Departments to have at least interim accreditation with the National School of Healthcare Science (Education Governance strategy)	Quality training delivery Sharing of learning across Healthcare Science departments	To have a Trust database holding all accreditation self-assessment records for all Healthcare Science departments involved in postgraduate training programmes	Lead Healthcare Scientist	100% by September 2017
Healthcare Scientists –Higher Specialist Scientific Training	Raise awareness of opportunities in the future for using HCS trained as Higher Specialists to undertake specific roles currently delivered by medical doctors	Mitigation of risk of shortage of workforce supply in clinical services where there are a national shortage	Presentation to relevant Trust groups	Lead Healthcare Scientist	December 2017

Developed by Dr Diane Crawford – Lead Healthcare Scientist

Education, Learning and Development Delivery Plan high level objectives for Essential Training and Essential Training Specific to Role

2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Essential training	Development of an internal 'Train the Trainer' programme	To support all Trust trainers/subject matter experts in achieving a uniformly high standard of quality related to all Trust training.	Train the Trainer course developed and accessible to staff Bookable via the Learning portal and reports available	Deputy Head of Education	March 2018
Essential Specific to Role Training	Development of an annual divisional training needs analysis	Aligns training with divisional operation plans Identifies priorities and enables appropriate allocation of funding	Implementation of a new Essential Specific to Role Training governance model.	Deputy Head of Education	Sept 2017

Developed by Mark Kellinger, Essential Training Lead

Education, Learning and Development Delivery Plan high level objectives for Library services
2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Library	Adhere to criteria in Health Education England's Library Quality Assurance Framework (LQAF) and develop library based on HEE's Knowledge for Healthcare Framework	Trust staff agree that UHBristol provide the best resources, knowledge training, and study facilities in the South West Conforms with LDA and SIFT requirements for a staffed, well-resourced library space	Continue to achieve a score of 90 - 100% in LQAF Instigate at least one new project directly related to Knowledge for Healthcare Green flag for resources Maintain subscription to 2000+ journals		April 2018
Library	Increase visibility and impact of all current library services whilst maintaining quality and efficiency.	More Trust staff become aware of essential evidence based medicine resources paid for by the Trust, and know where and how to access all resources. More Trust staff practice evidence based medicine on a daily basis	At least 80 users trained in knowledge skills per month Grow outreach operation to 45 departments. Implement 'Knowledgeshare' current awareness tool across departments Achieve 35% Athens registration Target an average £2 cost per click of electronic resources		April 2018
Library	Develop library space in line with the needs of a modern library post Knowledge for Healthcare (2015)	The Library will become increasingly digital, ensuring access for all Trust staff wherever they are Better use of physical facility, enabling more Trust staff to train in essential evidence based medicine skills	Implement Uptodate "Anywhere", and upload Mobile App to 100+ users Develop thorough impact analysis Continue 'Digital by default' policy Investigate Library role in Patient Information Investigate Library role in Knowledge Management		Dec 2017 March 2018

Education, Learning and Development Delivery Plan high level objectives for Bristol Medical Simulation Centre
2017 – 2018

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Multidisciplinary	Increase external course delivery by 1 course in the next 12 months	Increase in external delegates trained and increase in income generation	Course designed, added to website and delivered. Evaluation feedback from attendees and measurement of number of enquiries and from which disciplines and areas	BMSC Senior Team	By March 31st 2018
Expanding inter-professional training	To increase the amount of inter-professional training at the centre within the next 12 months	Increase in inter-professional training numbers to improve patient safety with particular reference to the deteriorating patient.	Links with patient safety and QI Audit. Numbers attending see an increase in HCA and non-registered nurses, as well as an increase in other disciplines	BMSC Senior Team	Ongoing throughout the year
Multidisciplinary	Fulfil the expectations of delivering 4 BASIM Courses and 2 BASIM Refresher courses as part of the Health Education England funding to SWAST and Bristol CIC	To increase the use of simulation as an educational aid within the region	Measured by use of electronic feedback, with post surveys asking for examples of how the learning has been put into practice	BMSC Senior Team	All to be delivered by March 2018

Developed by Bristol Medical Simulation Centre senior team

Education, learning and Development Strategy

Vison statement: To enable our staff to deliver exceptional patient care through our excellence in education and our culture of continuous learning and development

The vision will be characterised by:

- Trust commitment to ensure staff and learners develop the skills and behaviours needed for patients to experience high quality individualised, compassionate and dignified clinical care
- Patient focussed philosophy with staff acting as health and wellbeing advocates
- Effective partnerships with patients, with and between divisions and corporate departments
- Equality and diversity of opportunity
- Effective partnerships with universities and other National Health Service organisations, with Health Education South West, Bristol Health Partners, the West of England AHSN
- Ambition based on sound foundations with basic building blocks in place.
- Responsive, seamless education, learning and development team working within an effective hub and spoke model
- Multi-professional opportunities to further enhance effective team working used whenever possible
- Modern environments that enable learning in different settings including in clinical practice and via different media
- Cross cutting themes and values woven through all education, learning and development
- Staff responding positively to research, innovation and evidence based changes in practice
- Taking opportunities to showcase our specialist education, learning and development skills e.g. point of care learning

Education, Learning and Development strategy outcomes:

Outcome 1 - Local and regional education leadership.

UH Bristol will expand its role and reputation within the education, learning and development system and wider systems as an effective regional leader, partner, and collaborator.

Outcome 2 - Innovative learning and working.

We will work in new ways with patients and education partners, using modern methods of delivery, blended approaches and technology to transform our education and teaching approach

Outcome 3 – Education - Best place to teach, best place to learn.

With our university and education partners we will help attract the best learners to Bristol due to the diverse and specialist learning placements we have as well as the excellence of our teaching. We will achieve our LDA obligations, improve learner experience, enhance the reputation of the Trust as a teaching trust and enable future staff recruitment.

Outcome 4 - How does the Trust value my learning and development?

Staff will recognise how our Trust values them through equipping them to safely discharge their roles and deliver high quality care with compassion, and helping them towards their potential, through opportunities to gain improved knowledge as well as fulfilling career development.

Outcome 5 - Multi-professional by default.

We will use multi professional relationships, working and solutions as our standard way of learning, maximising opportunities for learning and problem solving as a team.

Outcome 6 – Effective governance of high quality education, learning & development.

Education, learning and development will be governed with processes in place from ward to Board, including flow of information and KPIs reporting on the two audiences. This will contribute to the sound governance of the Trust and enhance our profile and reputation for education, learning and development

University Hospitals Bristol NHS
NHS Foundation Trust

Education, Learning and Development Annual Report

APRIL 2016 – MARCH 2017

CONTENTS

Section	Title	Page
1	Executive Summary: Introduction	3 3
2	Education, Learning and Development Strategy and 2016/17 Delivery Plan	4
3	Education, Governance and Leadership	5
4	Health Education England Quality Framework:	6
5	Sustainability and Transformation Plan for Bristol, North Somerset and South Gloucestershire	7
6	South West Genomics Medical Centres progress	7
7	Education updates: 7.1 Medical Education	 8
	7.2 Dental Care Professionals and dental students	10
	7.3 Leadership and Management Development	11
	7.4 Postgraduate nursing, midwifery	11
	7.5 Allied health professionals	12
	7.6 Health Care Scientists	12
	7.7 Pharmacy	13
	7.8 Essential Training and Essential Training Specific to Role	14
	7.9 Bands 1-4 Apprenticeships	15
	7.10 Library	17
	7.11 Bristol Medical Simulation Centre	17
8	Education & Development Challenges	18
9	High level risks	21
10	Financial Overview	22
11	Conclusion/Priorities for 2017/18	22
	Appendices	25
	Appendix 1 - Education Plan Delivery Progress & Outcomes 2016 – 2017	25-49
	Appendix 2 - Education Income 2016/17 overview	50

1. Executive Summary

Introduction

2016 has been another successful year for education and development in the main, albeit with some continuing challenges both financial and physical.

Despite increasing challenges to the funding and provision of education and development for staff, there continues to be high levels of activity and developments made across the various staff and professional groups, detailed further within this report. We have received positive evaluations from our learners and excellent results and commendations have been made following recent quality assurance visits for nursing and medical education.

Earlier in 2016, we received excellent external education quality visits in some of our professional areas such as medical undergraduate and postgraduate education, and pre-registration nursing and midwifery education. As a result of the positive feedback for medical education, the department was asked to present its preparation plans and experience to other Trusts as best practice for education governance. A further quality management visit by Health Education South West in December 2016 commended the team on its efforts to improve the quality of education in five specialist areas across the Trust. Whilst we revel in the positive comments, it is accepted that some learner areas require improvements, and these are captured within action plans that have been submitted to the relevant visiting faculty for approval.

Exam pass rates for 2016, once again ranged from 95 – 100% for the majority of our education practice placements at UH Bristol. This is testament to the high quality teaching, education, commitment and support that our staff and mentors continue to provide to learners.

We have expanded our e-learning offer in 2016/17 in response to increased pressures on staff, making release for face to face education and training difficult. Our subject matter experts and the divisions have helped us to understand this, and we have added many essential and specific to role training topics, making them available to all Trust staff via the electronic learning portal. As a result we had 87% compliance against an essential training target of 90% of approximately 9000 staff by March 2017. This is an improvement on the previous year, and further developments and refinements continue to be made to the essential training provision to support the divisions in achieving 90% in the coming year.

Following the government's recent Comprehensive Spending Review in 2015, the proposals to withdraw non-medical bursaries for students undertaking nursing, midwifery and allied health professional degrees from September 2017 is a cause for great concern for health service employers. There is an assumption that this increased cost to students will result in some healthcare professions becoming less attractive, impacting on workforce planning and recruitment in years to come. The University of the West of England has reported a lower number of applications in 2016/17 than usual for some of their degree programmes starting in September 2017, supporting this theory. The impetus to increase the education and development opportunities for health care support staff to fill an increasing age profile gap, has resulted in the Trust's enthusiasm and commitment to support the introduction and implementation of apprenticeships from May 2017.

Within the national apprenticeship agenda, the focus for 2016 was to build a foundation for a Trust wide offer. The apprenticeship strategy set out an apprenticeship delivery plan, to recover a significant proportion of the £1.4m levy to be applied to the Trust from April 2017. Four operational groups were formed to respond to the practicalities of the apprenticeship offer, ahead of the implementation of the levy and in readiness for an application as a Main Provider. Main Provider status will facilitate delivery upon a range of apprenticeship standards, thus maximising our opportunities to draw from the levy. The Trust has led on the formation of the Healthcare Science trailblazer, thereby forming the standards for this pathway.

2. Education, Learning and Development Strategy and 2016/17 Delivery Plan

The Trust continues to be committed to ensuring staff and learners develop the skills and behaviours needed for patients to experience high quality individualised, compassionate clinical care. The education, learning and development of current and future staff are central to the achievement of UH Bristol's vision, mission and clinical strategy. The Education, Learning and Development Strategy, underpinning the Trust's mission, was developed in 2015, and will be reviewed and refreshed in 2017/18.

The Education Strategy delivery plan detailing the progress and achievement against the education objectives set for 2016/17 for UH Bristol was completed and signed off at the Education Board in February 2017 (Appendix 1). A number of objectives have deadlines that extend into 2017, as they follow the academic year September – August. They will be carried over into the 2017/18 delivery plan.

Progress to deliver the strategy is evidenced within the annual training plan exercise, which is continually reviewed and revised year on year, to ensure that the needs of all staff, regardless of role or grade, are captured. The Education Board regularly reviews the progress against education objectives and much activity has been delivered in the past year, ensuring teaching and learning continues to underpin the mission and vision of the Trust. Following the Education Board in December 2016, it was agreed that the Education Delivery Plan for 2017/18 would include a set of local education Key Performance Indicators that can be used as assurance to the Board for the delivery of the Health Education England Learning and Development Agreement. A revised format for recording and reporting specific local education Key Performance Indicators is under development, for discussion at the next Education Board on May 30th 2017. The Education Strategy delivery plan detailing the progress and achievement against the education objectives set for 2016/17 for UH Bristol was completed and signed off at the Education Board in February 2017. A number of objectives have deadlines that extend into 2017, as they follow the academic year September – July, and due to emerging changes within Health Education England they will be carried over into the 2017/18 delivery plan.

3. Education governance and leadership

The Education group has undergone a recent review to strengthen the purpose, membership and governance, changing its name to Education Board, emphasising the Trust's continued commitment to the education and development of its existing and future workforce. Attended by the executive directors responsible for education across the multi-professions e.g. nursing, allied health professions, healthcare scientists, doctors, dentists and the non-clinical workforce, the Education Board ensures it is informative and interactive, but also reflective of the Trust vision and corporate strategy and objectives.

Risks to the delivery of education and development are raised at this group and managed through robust challenge and scrutiny.

Evidence of our strength and commitment in education leadership, was highlighted in the recent 2016 quality assurance visit by the General Medical Council, which reported on the noticeable senior management support and interest from the executive directors and Senior Leadership Team.

4. Health Education England Quality Framework

In 2015/16, Health Education England committed to developing a single Quality Framework for education and training introduced into the wider health community in 2016. Since then quality teams and key stakeholders have been testing and piloting some of the quality tools to refresh the framework, developing and improving upon it further.

The new framework focusses on the learning environment and expectations of placement providers in delivering high quality work-based learning. Current education quality models are specialty focussed e.g. General Medical Council and Nursing and Midwifery Council regulations, and the intention for the new quality framework is to have one multi-professional assessment tool that is all encompassing.

Currently the Trust is required to complete an annual self-assessment against the Learning and Development Agreement's key performance indicators, and we were awarded 96% against the full suite of obligations in 2015/16. An action plan to achieve the remaining 4% was submitted in September 2016 and accepted by Health Education England. A follow-up self-assessment is due to be carried out in mid-2017 before the Learning and Development Agreement in its current state is replaced by the new Quality Framework in 2018.

Several education quality visits occurred in 2016 at UH Bristol, with visits to medical undergraduate and postgraduate education and pre-registration nursing programmes. All outcomes were very positive, and in particular an excellent report was given for our medical education provision, which included commendations for the administration team and doctor's in training mentor and support lead. The Trust was also commended by the General Medical Council for its strong leadership and support in medical education. These visits are due to be replaced by one multi-professional quality visit when the Health Education England Quality Framework is fully implemented in 2018/19. However, we assume that the professional regulatory bodies such as General Medical and Dental Councils and Nursing and Midwifery Council will continue to visit placement provider organisations in the coming years, as we will expect Her Majesty's Inspectors Ofsted (Office for Standards in Education) when our apprenticeship programmes are fully implemented in 2018/19.

5. Sustainability and Transformation Programme (STP) for Bristol, North Somerset and South Gloucestershire (BNSSG)

The Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Programme Local Workforce Action Board include partner organisations across health and social care. This includes acute Trusts, commissioners and community providers, as well as key stakeholders such as Health Education England, Skills for Care, and the West of England Academic Health Science Network. The group is co-chaired by the chief executive for Avon Wiltshire Partnership Trust. The function of the group is to agree a work programme to support the sustainability and transformation plans. This includes developing a system-wide workforce planning and scenario-modelling capability, and workforce implementation planning, in order to support and enable other sustainability and transformation plan work streams and projects. The outputs from the group will include a high level workforce strategy, and an action plan. This work is in the early stages, and the first priority will be to appoint a programme manager to take this forward. The Local Workforce Action Board has an education and training subgroup, which first met in January 2017, and its role will be to deliver workforce transformation across Bristol, North Somerset and South Gloucestershire through education and training. It replaces a number of pre-existing groups including the advanced practice continuing professional development group, previously chaired by the health dean of Health Education England. There is also a separate social partnership forum, chaired by the chief executive of North Bristol Trust, which provides the forum for engagement with staff side representatives across the sustainability and transformation plan footprint.

The sustainability and transformation plan has identified three main work streams for the Bristol, North Somerset and South Gloucestershire locality: stroke; diabetes; and mental health. Whilst there is some money to support the set up costs and interim project plans for 2017/18, it is evident that future funding to support the education costs involved in these work streams, will be redirected from education activity currently funded within National Health Service organisations.

6. South West Genomics Medicine Centres progress in first year 2016/17

The West of England National Health Service Genomics Medicine Centre was designated as a centre in December 2015 and serves a local population of 2.8 million. It is one of thirteen in a network of centres delivering the National Health Service England 100,000 genome project. The West of England General Medical Council consortium comprises five Trust partners: University Hospitals Bristol as host, with North Bristol Trust, Royal

United Hospital Bath, Gloucestershire Hospitals and Weston General acting as delivery partners. It collaborates with clinical Commissioning Groups, Health Education England South West, Avon and Wiltshire Mental Health Partnership National Health Service Trust, West of England Clinical Research Network and West of England Academic Health Science Network. Following recruitment of the first patient in the region in June 2016, a number of rare disease and cancer pathways have gone live offering our patients opportunity to participate in this ground breaking project.

Health Education England has funded an education and training lead post to support the workforce transformation element of the project required to ensure a capable workforce. The lead took up post on August 2016 and has continued funding until March 2018.

The West of England General Medical Council has led on a number of initiatives, including: commissioning Masters level education, with 15 successful applicants from UH Bristol; establishing a network and communication plan both for multi-professional groups and across delivery partners, supported by seven genomic champions; establishing links with local higher education Institutions for example University of the West of England, University of Gloucestershire and University of Bristol, all of who are collaborating on piloting undergraduate education tool boxes in various programmes; delivering science technology engineering and maths outreach activities in conjunction with University of the West of England to 15 Bristol schools; making use of patient contributors in education development delivery sessions through linkages with the West of England Academic Health Science Network.

7. Education updates

The following section highlights the varied activity and vast number of education and teaching programmes delivered across the Trust to ensure the continued high quality and positive learning experience for all our staff and learners at UH Bristol.

7.1 Medical Education

Undergraduate Medical Education

2016/17 has been an eventful year for the undergraduate medical education team once again. Following a successful General Medical Council combined Quality Assurance visit to undergraduate and postgraduate medical education at UH Bristol earlier in 2016, the University of Bristol faculty visit, which occurred in March 2017, acknowledged the significant progress made in supporting undergraduate learning experience together with the close working relationship between the two organisations. In 2016/17 there was a

97.5% pass rate in University of Bristol medical final year exams at the first attempt, with 100% pass rate for UH Bristol medical students undertaking the national prescribing skills assessment.

A key success for the undergraduate education department has been the creation and appointment of 4 undergraduate clinical teaching fellow posts, which continues to attract a high calibre of applicants. These fellows support the Trust to fill difficult to recruit posts and maintain a safe environment and quality care for our patients. All our fellows have gone on to achieve their top choice training placements against tough competition. A recent innovation from the 2016/17 teaching fellows was the design and implementation of a technology enhanced interactive case based learning tool called 'Ontake'. This was made widely available to any medical student and foundation doctor across the country.

Other innovations include an increase in the number of students and doctors in training presenting educational research at national and international meetings, coupled with an extension to the simulation teaching programme for medical students across the undergraduate curriculum. 'Point of Care' scenarios have been introduced for final year students and paediatric simulation for year 4 students, both of which have been very positively received by the students.

Finally the University of Bristol has recently introduced Gateway Summer School programmes for school pupils and students interested in a career in medicine in response to Health Education England's Widening Participation Framework. UH Bristol undergraduate faculty and administration teams are involved in supporting this valuable initiative, to encourage more young people into medical and National Health Service careers for the future.

Postgraduate Medical Education

Following the successful General Medical Council combined Quality Assurance visit to postgraduate and undergraduate medical education earlier in 2016, the postgraduate department was asked to present its planning and experience to other Trusts as best practice for education governance. A further quality management visit by Health Education South West in December 2016 commended the team on its efforts to improve the quality of education in five specialist areas across the Trust. However it was acknowledge that paediatrics continues to experience medical staffing issues, which in turn has impacted poorly on the quality of education delivered to our paediatric doctors in

training. The division of Women and Children, with the support of the director of medical education and specialty tutors for paediatrics, are working to improve the situation. One particular focus is the creation of several education fellow posts across a number of paediatric specialisms, to be appointed in 2017.

The postgraduate education fellow programme which commenced in 2015 at UH Bristol has proved a great success, resulting in improved quality of education for doctors in training in those areas where fellow posts were appointed, and contributing to a reduction in locum costs for the relevant divisions. All our education fellows have gained successful career progression as a result of these sought-after opportunities. The success of the education fellow programme has seen an increase this year of a further 9 posts bringing a total of 18 education fellow posts across the Trust; for 2017/18 many more posts are being considered in hard to recruit areas, and in response to the new junior doctor contract implemented in 2016/17.

Work is now being led by the director of medical education and the medical education manager to create a 'Trust Brand' for education fellows, with the ambition to be seen as a future designated faculty to support the Trust's quality programme for improved patient safety.

Finally, the Trust values the involvement of patients in designing and developing its services, and the postgraduate medical education faculty has been concentrating on increasing the involvement of patients with a new initiative called 'partners in the learning for doctors on values and behaviours'. There has also been an increase in the provision of simulation fellows to support and innovate multi-professional learning across the Trust.

7.2 Dental Care Professionals and dental students

2016 was very successful year for Dental education, achieving 100% pass rate at finals for Dental Nurse, Dental Hygiene and Dental Therapy programmes, which included key programme changes to the Hygiene and Therapy diploma mapped to the General Dental Council expected learning outcomes, and approved by the University of Bristol.

More recently in 2017, the Dental School participated in two quality visits from the University of Bristol faculty quality teaching team and the General Dental Council. Both visits focused on the diplomas in dental hygiene and dental therapy. The outcome of the quality team visit to the diploma in dental hygiene and therapy was positive with a satisfying final report.

The General Dental Council has completed its visit to the therapy diploma and has its final visit to hygiene in June 2017. The General Dental Council will produce a final report which is published on its website following its visit next month. The interim report was good, with no major issues reported, but final sign off will be after inspection of the final examination process.

Non-Medical Education

7.3 Leadership and Management Development

The Trust values its commitment to developing and training its existing managers and leaders of the future. This was recently acknowledged in the 'Outstanding' Care Quality Commission report of November 2016, where recognition was made for the strong leadership demonstrated across the Trust.

In the past year we have engaged staff in focus groups to develop e-Appraisal within the appraisal improvement project, and revised our leadership & management development interventions launched following a comprehensive training needs analysis conducted in autumn 2016. This resulted in leadership & management development programmes being made available to all staff on the Trust's intranet system, Connect, and through the Learning & Development Portal self-serve system.

7.4 Postgraduate nursing, midwifery

Overall 2016/17 was a successful year for pre-registration and postgraduate nursing and midwifery education, with the overall successful completion of agreed education objectives, together with continued positive placement feedback from students throughout the year. Following a reduction in the number of continuing professional development modules for nurses and midwives in 2015/16, the Trust received a substantive increase in the number of modules available in 2016/17 from 60 to 160, which was well received and enabled sustained development of key skills for staff to maintain the safe quality of care we provide to our patients.

The faculty of children's nurse education team continues to deliver excellent education and training programmes that are positively evaluated. This culminated in the achievement of the chair's 'Team Award' for National Health Service values at the Health Education England's recent star awards ceremony at the beginning of this year.

In November 2016, the Trust participated in a successful Nursing and Midwifery Council placement quality visit; in particular the quality team visited the Division of Women and Children's services, which formed part of the University of the West of England nursing and midwifery programme validation event. During this event the Nursing and Midwifery Council visited some of our practice placement areas. They reviewed mentorship provision and Nursing and Midwifery Council standards monitoring, including the Trust's nursing and midwifery mentor database. Overall the feedback was positive. The area identified as requiring improvement has already been addressed and will continue to be closely monitored.

7.5 Allied health professionals

In the main, education objectives were achieved in 2016/17, and the Bristol placement score for orthoptic students was higher than average in the national audit. The division of Diagnostic and Therapies received 9 very positive link lecturer visits from the University of the West of England to the radiography department, with excellent feedback provided, and new radiography-specific courses are being developed in partnership with University of the West of England to provide continuing professional development opportunities for our postgraduate radiography staff in the future.

The 1:2 and 1:4 mentor to student model already present in some programmes will be further rolled-out across adult physiotherapy and occupational therapy programmes within the Trust in 2017/18, supporting the Trust to achieve the Health Education England's Learning and Development Agreement obligation to provide all learners with qualified mentors and supervision.

Allied Health Professionals have been working hard to increase their education provision to medical students, with 3 new innovative programmes that have received very positive feedback.

7.6 Health Care Scientists

A key education objective and main focus for the lead healthcare scientist, was the development of apprenticeship frameworks with National Health Service England chief scientific officer' team, Health Education England and local education providers to deliver the education and development required to support the known workforce gaps in the healthcare science services. The higher apprenticeship model for healthcare science is still in consultation at the trailblazer stage with Department of Business and Innovation,

and therefore the original delivery timeline has slipped. However, key healthcare science staff have been involved and participated on the trailblazer group, ensuring that this qualification is fit for purpose, serves our needs and comes to fruition with an expected date to access the apprenticeship from September 2017.

All healthcare science departments hosting clinical scientist and higher specialist scientist trainees from the national programmes Health Education England funded programmes, were expected to have interim accreditation status awarded through a self-assessment process subject to a desktop audit as of September 2016. Full accreditation by onsite visit is at 30% as of September 2016, on track for the 100% required by September 2017.

Meetings between our Lead Healthcare Scientist's and the Bristol Technology Engineering Academy (a university technical college specialising in offering education to 14-18 year olds in applied science and engineering) has led to the Academy showing interest in highlighting applications of these skills for National Health Service Healthcare Scientist services. This is excellent news for UH Bristol and will re-enforce scientist jobs and careers at UH Bristol, helping us to recruit our workforce of the future. Our scientific and educational experts within the Trust will work to support workplace orientated learning of these students through a range of initiatives e.g. talks on healthcare science issues, topics for development projects and work experience. The Trust logo will be incorporated into the literature that is currently produced by the Technical Academy, and will highlight the new Applied Science courses being offered from September 2017 and the career opportunities that can follow.

7.7 Pharmacy

The pharmacy department prides itself on its continued success for the pre-registration pharmacists and pharmacy technicians, with a 100% pass rate in final year exams in 2016. The work programme for South West Medicines Information and Training has incorporated a broad range of post registration pharmacy technician accreditations, including the comprehensive revision of Medicine Management Programme as 'Medicines Optimisation', to enable more effective delivery of clinical services at ward level.

Throughput increased in 2016 for post-registration placements in topics such as clinical diplomas and non-medical prescribing, and the Trust now accesses a much wider range

of course providers to enable a greater choice of education provision from high quality providers.

7.8 Essential Training and Essential Training Specific to Role

The Education, Learning and Development Strategy for 2015-20 recognised two distinct 'audiences': those who are at UH Bristol for a defined period of time on placement, and those who are in their career with the Trust as members of staff. As such two service departments were created to manage this model, with limited interaction between the two departments, except for the regular interaction and collaboration of the two service leads. Both services reported to separate governance groups, and there was confusion within the organisation around higher level responsibility and accountability for education, learning and development.

Following a minor reorganisation in September 2016, education, learning and development has now amalgamated under the management of one head of education, resulting in the governance of all Trust training residing with one learning and development team; oversight now includes all 'essential training', and more recently the management and governance of 'essential specific to role' training, and the potential governance of all continuing professional development. During the latter part of 2016, the learning and development team placed special focus on the governance and management of essential specific to role training and continuing professional development.

Essential Training

Essential training incorporates just over 30 statutory and mandatory education and training programmes that require monthly compliance monitoring to the Divisions and Trust Board. The Trust continues to aim to achieve 90% compliance in each of the 30 essential training programmes. By March 2017 compliance was 87% overall with more than half of all essential training programmes having achieved or surpassed the target compliance of 90%. This overall target achievement is slightly lower than the 89% compliance reported in February 2017, however external changes beyond our control to the governance of certain statutory topics have resulted in the overall compliance achievement for March reducing slightly. Robust communication and trajectory plans will provide the divisions with the opportunity to recover their compliance for essential training. Consideration for the importance of this training has resulted in a risk being

placed on the Trust corporate risk register, and allows for the continual monitoring and review of training compliance within divisions.

Essential – Specific to Role Training

Special focus was made to address the governance and monitoring of essential specific to role training and continuing professional development activity within the Trust during 2016, following on from the success of the essential training governance and monitoring work carried out in 2013-15, to raise essential training compliance from a very low base to where it is today.

Essential specific to role training programmes are more numerous than essential training, and can refer to any training that may link to competencies within a role or set of roles, and is therefore an instrumental component of continuing professional development. Internal essential specific to role training provision within the Trust is widely varied, and currently some 65 clinical skills are taught 'in-house', with a minimum of 70 non-clinical subjects, including the various leadership and management education and training programmes.

Training methodology is varied as well, with approximately 120 'in-house' essential specific to role training programmes offered to relevant staff each month. 100 of these programmes are provided as face-to-face sessions and the other 20 as eLearning. Much of the eLearning has been developed internally by our own staff. Attendance or completion results are recorded on the Electronic Learning Portal for reporting and data retrieval purposes. Each month about 700 Trust staff attend essential specific to role training face-to-face sessions, and about 200 staff take up various essential specific to role e-Learning.

7.9 Bands 1- 4 Apprenticeships

The introduction of the apprenticeship levy and reforms to apprenticeship standards provide a steer, from government to employers, to set their own training agenda. The levy enables employers to frame their training provision to develop an apprenticeship offer that best fits the workforce, skills and organisational needs. The levy monies (set at approximately £1.4m for UH Bristol) are the means by which to set the direction and design of the Trust's training programme. The emphasis is upon the employer to determine the scope, occupational focus and level of the apprenticeship offer. The Skills Funding Agency oversees the funding values and determines the structure of the

apprenticeship standard; however ownership of the apprenticeship content and quality of delivery rest firmly with the employer. Consequently, the Skills Funding Agency and Her Majesty's Inspectors Ofsted will seek to benchmark Trust apprenticeship successful completion rates against national rates.

Much work has been done in 2016/17 to prepare the Trust for the introduction of apprenticeships from May 2017, resulting in the development of an apprenticeship delivery plan approved by the Senior Leadership Team and in place for the 1st May 2017 launch date. A robust communications plan is in progress visiting divisional boards and staff meetings. Vocational areas in healthcare support work for nursing assistants and dental nursing are delivery ready for the apprenticeship standards, with the development of professional standards in place for healthcare science apprenticeships, supported by the division of Diagnostics and Therapies.

Our delivery plan builds upon previously submitted apprenticeship papers and the work developed by the apprenticeship steering group and sub groups. The plan sets out a two-year delivery strategy for UH Bristol to build apprenticeship numbers, through the growth of our existing accredited provision and new 'starts' into professional (bespoke) and generic apprenticeship standards. The aim is to maximise the levy recovery – through the Trust's status as a Main Provider, delivering standards closest aligned to our areas of expertise and workforce plans.

The delivery plan forms the first element of a two-part approach to apprenticeship growth and development. A further paper will develop a compliance and quality assurance strategy for the apprenticeship provision.

Setting an apprenticeship offer will support the Trust to address:

- Training opportunities – apprenticeships provide career development routes for new and existing employees to progress within their job role.
- Skills gap – the levy will encourage the medium-term funding of learner (apprentice) progression and skills enhancement. This has particular value for specialist areas with 'hard to recruit' gaps within their workforce.
- Retention of staff through a coherent and progressive training programme, based upon a continuous cycle of development for the learner (apprentice).

Education and Learning Resources

7.10 Library

The Library has undergone a year of modernisation and immense change. The physical library space has been fully refurbished, creating an open-plan study space to rival any academic library in the region, with the overall capacity increased by one third to meet increasing demand. We have also installed Radio Frequency Identification self-issue machines and security which will save the Trust £3000 per annum in lost materials. The electronic library is now fully functional with an increase in electronic journal subscription from just 10 in 2016 to over 2500 since January 2017 to date, and 200 eBooks purchased directly from library user request. The Library is also about to launch "Uptodate Anywhere" across the Trust – the world's leading point of care tool made available on an app, with the target of ensuring every doctor in the Trust has instant access via their mobile phones.

Outreach services continue to flourish, with UH Bristol library training more people than any other Trust in the South West (1063). This year we have also delivered 455 synthesised literature searches – an increase from 371 last year, and more than ever before. We also continue to have the highest percentage of users registered for electronic resources (31%). Our Outreach Librarians spend 20% of their contracted time promoting library services throughout the Trust, and this has led to nearly 50 departments using the Library to ensure they are kept up to date with latest published evidence.

7.11 Bristol Medical Simulation Centre

2016/17 has been a busy year for the Bristol Medical Simulation Centre, with the continuation of popular multi-professional training programmes across the Trust, coupled with an increase in undergraduate simulation training for Years 3 and 4 medical students, and the introduction of new courses such as the Ear Nose and Throat national simulation skills course.

The Bristol Medical Simulation Centre continues to support wards and depts. experiencing difficulties releasing their staff for training, by providing a variety of training programmes in the work place known as 'Point of Care' simulation. A multi-disciplinary team of doctors, nurses and technicians have delivered the following Trust work based training in 2016/17:

- Adult Simulation Programme, – Point of Care activity to 900 participants in 18 clinical areas. Several Quality Improvement programs in a number of clinical areas.
- Paediatric Simulation Programme – Point of Care activity to 86 participants (10 medical, 68 nursing and 12 other). A total of 100 educational hours were delivered.

Recent partnership working has involved patient safety collaboration between the simulation team and patient safety team to align simulation activity to the Trust's 'Sign up to Safety Campaign'.

The Bristol Medical Simulation Centre is required to generate income to support the development and upkeep of the Centre, and has provided many courses accessible to a range of staff groups from across the region, nationally and internationally. Bristol Medical Simulation Centre took a lead role in the national association for simulation practice in healthcare conference, including running pre-conference workshops and hosting the innovations suite at the conference, and participated in the popular 'Bristol Open Doors Day' in 2016 with nearly 100 members of the public visiting the centre.

The Centre's continued support for Health Education England's 'Widening Participation Framework' included an 'Into University' visit for students to highlight the varied careers available in healthcare. The Bristol Medical Simulation Centre were awarded the National Clinical Assessment Service (NCAS) contract to develop and deliver assessments for anaesthetists returning to work, and recent joint working with the medical education team has provided placements for simulation teaching fellows for 6 months in two 3 month blocks, which have been positively evaluated.

8. Challenges to the delivery of education and development

Funding

- Changes to the funding support provided by Health Education England over the coming years will take its toll on the provision of key education and development programmes across the Trust, with a detrimental impact in specific areas such as:

  - Continual professional development modules for nurses and Allied Healthcare Professionals
  - Increase in student placements with no additional funding support
  - Withdrawal of funding support for dental nurse and technician training,

creating a substantive cost pressure to the Trust, and the need for us to find alternative training provision such as through apprenticeships.

- Identification of future funding to sustain the dental therapy and hygiene training at UH Bristol, with the possibility of a funding model developed by the Higher Education Funding Council of England in July 2017

- Possible withdrawal of Health Education England funding from September 2017, that currently supports both training and salary costs for pharmacy technicians. The impact of this change not only affects the Trust's ability to provide sufficient funded placements for UH Bristol learners, but also affects the ability to support the wider pharmacy workforce especially in the community and mental health. If provider placements reduce, it is likely that Somerset College, which provides the training now, will be unable to support a course with reduced numbers. Whilst apprenticeships may address the training implications for pharmacy technicians, salary support will continue to pose a challenge to the Trust.

- The Simulation Centre continues to experience resource pressures in terms of both space and staffing. Limited space inhibits the ability to expand training programmes; further investment is required in additional technical staff as courses become more mechanically intensive. The adverse impact of such resource limitations have recently been realised through the inability to meet specific training requests and support other opportunities such as work experience, university and overseas visits to the Centre. With growing financial pressures across the region and internally, income generation is becoming more challenging, thus impacting on the future sustainability of simulation training provision at UH Bristol.

- Managing the continued increase in journal and database subscription costs for the Library, to ensure our staff continue to have access to evidence based information.

Capacity and support

- Delivery of the new medical undergraduate curriculum 'MB21' starting in October 2017, introducing first year medical students to clinical placements in the Trust, which have not previously occurred.
- Maintaining high quality learning experience across all areas of the undergraduate curriculum including close working relationships with NBT to cover specialist areas not available at UH Bristol e.g. neurology, breast cancer and elective orthopaedics.

- Ensuring doctors in training continue to access quality education opportunities, despite the changes that will occur due to the new contract going live in Aug 2017
- Pharmacy challenges to supporting increases in staff numbers through non-medical prescribing and clinical diploma courses, in response to the Cater Hospital Pharmacy Transformation Plan.
- Fulfilling our Learning and Development agreement obligations for ensuring a minimum of 90% education mentors and supervisors are fully trained to support learners on placements e.g. nursing, medical and dental professions.
- Ensuring the number of applications for nurse training des not decrease following removal of the bursary in September 2017. Numbers are yet to be confirmed for both adult and child branches.
- Delivering more in response to Health Education England's Knowledge for Healthcare Framework in 2017 to include supporting patient information and knowledge management.

Apprenticeships

Introduction of apprenticeships across all divisional areas has been delayed and will not be ready for the May 2017 Launch date. Apprenticeship standards are not developed in all areas and levels and the funding bands lack consistency, especially in the values of level 2 and 3 Healthcare Support Workers. UH Bristol has not engaged in the apprenticeship trailblazers and therefore hasn't offered input into the writing of new standards. Systems are not sufficiently robust to record General Certificate of Secondary Education results upon enrolment for the Qualifications Credit Framework programmes. Initial assessment is dated and the outcomes are not shared with assessing teams. Learning support is not collected at the application stage and therefore the learner support package is not sufficiently robust.

Essential training and Specific to role training

Compliance has dropped by 2% in 2016/17, largely due to the changes in target audience and duration for certain topics. These challenges are ongoing as many changes occur externally to the control of the Trust, and have to be adhered to. In every case where compliance is below target, divisional HR business partners are asked to oversee recovery planning to meet compliance.

Historically the governance and provision of Essential Specific to Role Training has not been centralised, nor has Essential Specific to Role Training been closely linked

to job role competencies and Continuous Professional Development planning. Managers and staff are asked to plan accomplishment of Essential Specific to Role Training and Continual Professional Development during local induction and annual appraisals, but training offerings may be dispersed between the Trust's intranet and the Learning Portal. Even when accomplished, some local training is recorded on paper records kept at source within divisional areas.

Training plans developed previous to 2017 detailed some Essential Specific to Role Training requirements by division, but did not establish clear links between this training and specific job role, competencies, the volume of staff requiring training, compliance goals, and priority among various training programmes. Training plans also focused upon training requiring funding rather than internalised and non-accredited (on-the-job) training. Excellent work to link training to relevant competencies is noted in some clinical areas, but mapping work is uneven across all areas.

9. High level risks

All high level risks to the delivery of education at UH Bristol are managed through the Education Board, and where appropriate placed on the Trust risk register. The Education, Learning and Development service currently own and monitor two risks held on the Trust corporate risk register.

Risk 921 refers to the potential non-compliance of Essential Training for less than 90% of all staff, leading to potential patient and staff safety concerns. Controls are in place to mitigate the potential hazard to staff and patients with actions plans provided by divisions to achieve 90% compliance for all essential training subjects. The risk target is set at 12 and is being reviewed with the intention of reducing it to 9, following a vast improvement in compliance overall to 89% by the end of March 2017.

Risk 491 refers to the potential risk to patient safety due to limited recording of essential specific to role training for staff. Following efforts in 2016/17 to upload in-house clinical skills and management and leadership training onto the Training Portal, and the recent development of an Essential Specific to Role governance and monitoring plan, it is expected that the target risk currently set at 15 will be reduced below 12 for 2017/18.

Both these risks are monitored and reviewed on a monthly basis reporting into the Risk Management Group and Trust Board on a quarterly basis.

10. Financial Overview

The Trust has continued to receive funding from Heath Education England via the Multi Professional Education and Training levy in support of its delivery of the Learning and Development Agreement. In 2016/17 this amounted to £33.8m (Appendix 2). During 2016/17 the Trust entered the first year on the new Medical Service Increment for Teaching (SifT) tariff, having previously received transition funding.

The implementation of Health Education England's approach to the introduction of tariffs for education and costing Education and Training exercise has continued during 2016/17. Significant improvements have been made in data quality at a national level. The 2016/17 cost collection exercise contains one significant change in that the deadline for the submission has been brought forward by two months, to the end of July 2017, which is in line with the annual Reference Cost submission. In addition the return will require sign off by the Executive lead for Education. The costing exercise continues to net off of education income for the annual Reference Costs whilst a second submission will split the Trust costs between education and service. This will allow an opportunity to assess the potential impact on service tariffs resulting from an introduction of education tariffs. However there are currently no firm timelines regarding the implementation of new education tariffs. The Trust continues to engage fully in the education cost collection exercise**.**

11. Conclusion/Priorities for 2017/18

Once again our greatest strengths lie in the positive experience our learners feedback in student quality surveys and visits; with another tremendous year of success in pass rates for final year exams across the professional education programmes supported by UH Bristol.

With major changes occurring within Health Education England, there remains uncertainty about the future of funding for the provision of education across Healthcare organisations, in particular for the larger acute Teaching Trusts such as UH Bristol. Concerns regarding pressures on recruitment and filling specialist clinical roles e.g. doctor and nurse positions, are resulting in the need for UH Bristol to review its workforce

plans and consider alternative roles and opportunities available e.g. apprenticeships, advanced clinical practitioners, physicians associates, and the associate nurse roles.

We need to be responsive to these challenges and build on existing strengths, and together with the exciting developments and work schedules for the sustainability and transformation planning groups over the next few years, UH Bristol will be in a stronger position to attract and retain both students and employees.

The design and development of the Education Strategy delivery plan objectives, together with the launch of apprenticeships from May 2017 and the achievement of the divisional apprenticeship recruitment targets and recovery and investment of the apprenticeship levy, will be the main focus of our attention for 2017/18. However other education objectives will continue to play an important role for our professional education leads in 2017/18:

- Ensuring the quality of medical education for our doctors in training and medical students continues with the challenges the new 'Doctors in Training Contract' brings with it in 2017/18, and the successful introduction of the 'MB21' medical undergraduate curriculum.
- Development of Trust wide plans for 18/19, for all of our pre and post registration placements and education programmes and continuing professional development modules to mitigate the funding changes by Health Education England.
- Further work to achieve >90% Mentor and Supervisor update training compliance for all staff who manage and supervise learners across all professional staff groups.
- Development of new courses and delivery of apprenticeships to support the development and skills of our staff, utilising the expertise of our own education teams, in particular the UH Bristol Faculty of Children's Nurse Education team, Bristol Medical Simulation Centre, Dental School and Vocational Education team; drawing on the potential to generate income to support the sustainability of these services.
- Development of plans which describe the costs/benefits, service and education implications for emerging roles and training access routes such as: nurse apprenticeships, nurse first programme and nurse associates
- Clarification of future salary funding arrangements for student pharmacy technicians and implement the necessary staffing changes to meet trainee requirements.

APPENDIX 1

University Hospitals Bristol National Health Service Foundation Trust

Education Plan Delivery Progress & Outcomes

2016-2017

Contents

Education Plan high level generic objectives for all learners on placement 27
Education Plan high level objectives for Medical Undergraduates 31
Education Plan high level objectives for Dental Undergraduates and Dental Care Professionals 33
Education Plan high level objectives for Nursing, Midwifery and Allied Health Professions 35
Education Plan high level objectives for Healthcare Scientists 39
Education Plan high level objectives for Pharmacy 41
Education Plan high level objectives for Clinical Psychology 44
Education Plan high level objectives for Support Workers Bands 1 -4 45
Education Plan high level objectives for Learning Resources 47
Education, learning and Development Strategy 49
Education, Learning and Development strategy outcomes: 50

Education Plan high level generic objectives for all learners on placement
2016 – 2017

Objective/Aim	Measureable Outcome	Lead	Timescale/ RAG rating	Progress/ actions to achieve
Deliver Health Education South West's Learning and Development Agreement contractual obligations for education and maintain levels of activity	• Achieve Green RAG rating in the Health Education South West outcome report	Education/ Professions; Leads & Head of Education	April 2016	Trust achieved 96% compliance and RAG rating of green in June 2016. Action plan to achieve the remaining 4% was produced and returned to Health Education England in June 2016, to be achieved by April 2017.
Improve the learner experience for students and trainees	• Learner satisfaction percentage for UH Bristol is same or higher than previous year • A developed set of Key Performance Indicators that mirrors Universities of Bristol and West of England	All Education Leads	July 2016	Learner satisfaction outcomes have been maintained throughout 2016/17. Proposal to present the results of the General Medical Council, LDA and Pre-registration survey results to the Trust Board to provide assurance and progress against national KPI's. (Education group minutes Oct 2016) Local Key Performance Indicators for education and development at UH Bristol will be discussed at an extraordinary meeting of Education leads in December 2016.
Conduct a Trust wide Training review that is bottom up with patient and service needs and priorities assessed and matched to corporate and divisional education resources	• Training requirements will be summarised and costed by division • Training provision is matched to funding available within divisional budgets	Deputy Director of Workforce and OD	C/F to Sept 2017	Divisional operating plans were received and training needs collated in August 2016, however costs for training were not supplied against the requests creating difficulty in calculating training requirements matched to divisional education resources available. Education and Development team are rethinking the method of collecting this information

				starting with a project looking at specific to role training for staff provided through specific competency frameworks that can be mapped to training requirements and recorded centrally on the Trust Training portal. This will be a new objective for 2017/18.
Improve our relationships with key stakeholders to enhance our access to education: • University of Bristol • University of the West of England • Higher Education colleges • Health Education South West • Clinical Commissioning Groups	• Secures financial investment to support continuing professional development from external stakeholders e.g. Health Education South West and Clinical Commissioning Groups • UH Bristol presence on external partner working groups	Head of Education	September 2016	UH Bristol/UoB has setup a Joint Partnership and Integration Board (JPIB) that meets quarterly, with an education subgroup made of various education leads from both organisations, to raise the profile of undergraduate (UG) and postgraduate (PG) teaching and education in the various partnership discussions and with their Academies. LDA KPI meetings in progress between University of the West of England and UH Bristol education leads to maintain high standards of education for learners across both organisations. UH Bristol has a presence on most education groups across the Bristol, North Somerset and South Gloucestershire footprint, in particular the newly set up Sustainability and Transformation Programme working groups, and Continual Professional Development commissioning groups.

Developed by Kay Collings Head of Education

***Education/Professional Leads** = Jayne Weare, Trish Hewitt, Helen Morgan, Mel Watson, Steve Brown, Sue Dolby, Rebecca Aspinall, Jane Sansom, Jane Luker, Sarah Bain, Tom Osborne, David Grant, Paula Tacchi

Education Plan high level objectives for Medical and Dental Postgraduates

Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
Achieve positive evaluation from any external review of our medical and dental education environment. (General Medical Council review visit April 2016 and Health Education South West contract visit October 2016)	• Specialty medical and dental education leads communicate risks with an action plan against education quality, to the Medical and Dental Education Committee • Medical and Dental Education Committee ensures education risks are communicated to Divisional management teams • Continue to reduce red outliers in the General Medical Council trainee survey and increase the number of green outliers • Any reports or suggestions of bullying and harassment are dealt with by the Director of Medical education and the Medical Director • Any significant issues involving medical and dental trainees is communicated through the Director of Medical Education via: regular meetings with the medical director, The Medical and Dental education Committee, the annual Education Supervisors away day and the annual exception exit reports for revalidation	Director of Medical Education	April 2016 (General Medical Council Visit) October 2016 (Health Education England Visit)	All Education leads are reporting risks to MDEC with action plans that are communicated to respective Divisions. External Review by General Medical Council in April. The Trust was congratulated on 4 areas of excellence. Report will be in the public domain end of November. One area needing improvement has a clear action plan in place. This was access to educational opportunities in outpatients in medicine. Green outliers have increased this year regarding Key Performance Indicators for quality in General Medical Council survey. We have the largest number of green outliers in the region and are a close second to Taunton on overall quality of medical education Red outliers have remained static with a large number referring to inability to access regional teaching due to either manpower pressures or no teaching organised by Heads of School. No bullying reports on General Medical Council survey

				(first year and only Trust with no returns) Although two cases are currently being managed through the Medical Directors office. Quality report completed and updated with progress on action plans for HESW
Meet the General Medical Council & General Dental Council requirements to formally recognise and approve medical trainers (educational and clinical supervisors)	• 100% of medical and dental supervisors are accredited • Educational roles are identified in medical job plans as Educational Programmed Activities (EPAs), including Educational Supervisors, Training Programme Directors and Specialty Medical Education Leads	Director of Medical Education	July 2016 C/F to 2017	All accredited now except those who are new consultants and booked onto accreditation courses. Still not achieved Education PAs in all job plans in Divisions. Continuing to request this action of the Divisions
To achieve a positive evaluation from the General Medical Council trainer survey	• Outcome is determined to be reduced number of outliers from General Medical Council trainer survey • An action plan will be created and submitted to Health Education South West Postgraduate Medical Education by the deadline to address any outliers	Director of Medical Education	Oct 2016	The South West remains top in England in the 2016 General Medical Council Trainer survey: for Trainer support, organisational culture and supervisor training. 2nd in Educational Governance and 3rd for trainer appraisals. UH Bristol locally had 8 green outliers on General Medical Council survey and 13 red outliers on Trainer survey. Action Plans developed for Health Education Southwest.

Developed by Dr Rebecca Aspinall, Director of Medical Education

Education Plan high level objectives for Medical Undergraduates
2016 – 2017

Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
To implement a process to coordinate the recruitment of clinical teaching/education fellows, both undergraduate and postgraduate across UH Bristol	• Standard process for recruiting teaching/education fellows is implemented	South Bristol Academy Dean and Director of Medical Education	March 2017	Job descriptions of both roles to be edited in line with a standardised teaching/education fellow template. Plans are in place to run parallel interviews on one day for undergraduate teaching fellows and postgraduate education fellows.
Achieve positive evaluation from the General Medical Council external review of medical undergraduate education at UH Bristol. (General Medical Council review visit April/May 2016)	• General Medical Council report is shared at Medical and Dental Education Committee • Detailed action plan following visit is created and submitted within agreed timeframe	South Bristol Academy Dean	October 2016	Report received from the General Medical Council noted, 2 areas of good practice: • The 'scared to prepared' induction programme for doctors in training and treasure hunt for medical students are innovative ways that prepare doctors in training and students for their placements. • The Trust board demonstrates strong accountability for educational governance and this ensures that both undergraduate and postgraduate education and training are taken seriously at board level. 2 areas that are working well: • The mentor and career support services that the Trust provides for postgraduates are commendable. • Medical students reported that they value the level of help and support

				given to them by the Trust administrative staff. 1 requirement: • The Trust must make sure that all doctors in core medical training have the opportunity to attend teaching sessions and clinics, so they can meet the curriculum outcomes. 1 recommendation: • The Trust should ensure that they monitor and manage any adverse impact that non-training grades and other healthcare professionals may have on the education of doctors in training and medical students. Areas of good practice and areas that are working well have been commended. There are action plans in place for the one requirement and one recommendation.

Developed by Dr Jane Sansom, South Bristol Academy Dean

Education Plan high level objectives for Dental Undergraduates and Dental Care Professionals 2016 – 2017

Professional Area	Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
Dental Undergraduates/ Bristol Dental School	Minimise the risk of a decrease in Dental Service Increment for Teaching funding to UH Bristol as a result of a national reduction in dental student placements	• Student numbers from overseas increase to mitigate funding loss • Funding is maintained at current level (£9.9m) • Possible loss of up to £200k per year from 2015 to 2016	General manager BDH	February 2017	Ongoing work between University and Hospital to look to launch the programme as soon as reasonably possible. Several discussions have taken place with various embassies during February 2017, resulting in an increase in the total number of overseas students and confirmation of fees payable by these students.
Dental therapists, hygienists, nurses & technicians	Submit business case to Health Education South West to secure commissioning for all Dental Care Professionals (Dental Care Professionals) training programmes 2016 onwards	• Funding available to support Dental Care Professionals is sustained	Director of Dental Care Professionals School	Aug 2017	In April 2016 HESW notified UHB of the withdrawal of funding for Hygiene and Therapy from 2018/19. This drastic change to funding from HESW left the Dental Care Professional School financially unsustainable and jeopardising the ability to provide this training in the future. Having explored several options with UoB and UHB, a proposal has been agreed in principal to

					futureproof this training. A further update on this proposal will be made clear in Feb 2017.
Dental nurses	To establish an appropriate apprenticeship training alternative to the current training model for Dental Nurses to start September 2017.	• Apprenticeships in Dental Care Professionals visible within UH Bristol • An increase in numbers of trainee dental nurses/assistants to meet the workforce need	Director of Dental Care Professionals School	Sept 2017	Ongoing meetings with Tutor Dental Nurse/Trust Lead for Apprenticeships and City and Guilds to establish an Apprenticeship Training programme for Dental Nurses from September 2017. Considering increasing student numbers to a 2x intake per year of 10 students. We have been advised by City and Guilds that of the need to appoint to a second internal assessor in order to progress with this training. Without a current budget attached to this training it is proving difficult. However, this is currently being progressed.

Developed by Sarah Bain, Director of School for dental Care Professionals

Education Plan high level objectives for Nursing, Midwifery and Allied Health Professions
2016 – 2017

Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
To increase in the number of placement options for student placement capacity UH Bristol 2016/17 for nursing	• Increased number approved placement options available	Deputy Chief Nurse Lead Allied Health Professional	Sept intake 2016	A small number of additional placements have been identified, including placements with Research Nurses and Clinical Nurse Specialists
To deliver an improved experience of students specifically in any areas of variance identified via student placement feedback.	• The number of positive placement evaluations • For areas where improvement is required clear actions identified to improve placement. • Positive evaluation by students following improvement actions being taken	Deputy Chief Nurse Lead Allied Health Professional	April 2016 July 2016 Oct 2016 Jan 2017	The last report was presented to the Education Group in October 16. Overall the experience of our students is very well evaluated. Divisions have their own action plans to address any areas of improvement identified by the students. Reports have been presented to the Education Group on a quarterly basis. Overall placement evaluations remain positive, with actions in place to address areas of improvement when required
That 90% of mentors are up to date with mentorship training (rolling %).	• Live mentor update which demonstrates 90% compliance. • Positive feedback from placement evaluations regarding mentors role	Deputy Chief Nurse Lead Allied Health Professional	April 2016 July 2016 Oct 2016 Jan 2017	Divisions have made good progress. Nov 2015 = 51.3% August 2016 = 72.77%. The DCN and Post Registration Academic Dean meet quarterly with the Heads of Nursing/Midwifery to ensure a strong focus is maintained towards achieving 90% compliance. Compliance for May 2017 is 73.79% Changes to the NMC standards are due in 2018. Mentorship and therefore mentor compliance is likely to end.

				There is no requirement for Allied Healthcare Professionals to undertake a formal mentoring qualification – so we maintain an internal register of fieldwork educators and keep a record of the training they have undertaken which includes a standard of having attended an update in the last 3 years.
To ensure 'fair shares' allocation of Health Education South West Continual Professional Development funding for 2016/17.	• New methodology used by HESW and Commissioners to determine allocation to Trusts is based on a fair shares formula.	Deputy Chief Nurse Lead Allied Health Professional	Mar 2016	Completed. UH Bristol saw an increase in 100 contract modules for 16/17 from 15/16 allocation of 60 modules. The internal process was inclusive of Allied Healthcare Professionals but many of the course and modules required by the Allied Healthcare Professionals was not included in the contract and responsibilities remain with individual services and divisions.
To align Health Education South West funded/ commissioned courses with organisational operating plans / priorities.	• Access to modules which reflect professional and service delivery plans, outlined in Divisional Operating Plans	Heads of Nursing and lead Allied Health Professional (identification of need) Deputy Chief Nurse (negotiation with Health Education South West)	March 17	This is an evolving and improving process. Heads of Nursing/Midwifery and the Lead Allied Healthcare Professional have recently completed a scoping exercise to ensure an even greater alignment and which has been used to inform 17/18 Operating plans. This will has also been shared with University of the West of England to inform their programme plans for 17/18
To develop divisional ownership and understanding of: 1. Process for accessing allocated Health Education South West funded modules in 2016/17.	• Access to modules which reflect professional and service delivery plans, outlined in Divisional Operating Plans	Head of Developing People capability	March 2016	Process for accessing Continual Professional Development modules in place, centrally managed and recorded by the training admin team. Regular reviews of process and take up of modules occur 1/4rly. Planning for year ahead introduced October 2016

2. Process of accessing UH Bristol funded modules				
To strengthen / formalise Faculty of Children's Educational Bristol Royal Hospital for Children (BRHC) relationship with the University of the West of England (University of the West of England) / Child Health teams.	• Contract agreed and in place between the Faculty of Children's Nurse Education and University of the West of England	Head of Nursing Bristol Royal Hospital for Children	May 2017	Neurosciences Lecturer / Practitioner post-funding agreed from Above& Beyond. Post to be appointed in 2017, course to commence in 2018. Discussions will take place with UWE re: accreditation of this course. 'Pilot' Children's Pain course commenced April 2017 – in liaison with UWE re: academic accreditation
To make the faculty of Children's Education self-funding.	• Faculty will generate income to offset staffing and other costs	Head of Nursing Bristol Royal Hospital for Children	By 2017	Income in excess of original Business Plan. However, increased demand by BRHC for education of their nursing staff, where funds are not paid to the Faculty, means it is not fully self-funded, but supported by the Division.
Develop opportunities for formalising links with non-medical consultant roles with the University of the West of England (University of the West of England).	• Formal links in place with some non-medical consultants	Chief Nurse/Lead Allied Health Professional	June 2016	University of the West of England have agreed for Non-Medical Consultants to have honorary contracts and access to University of the West of England structures and resources. This has been communicated to the Heads of Nursing and Non-Medical Consultants
Develop the clinical nursing professor role within UH Bristol to maximise benefits to UH Bristol.	• Non-medical research	Chief Nurse	Sept 2016	In discussion with University of the West of England, UH Bristol has agreed to review its involvement (financial and other) once appointment has been made. University of the West of England have not appointed to this post to date April 2017. Associate Professor appointed and in post
To ensure no decrease in student	Student numbers/recruitment of	Chief Nurse/Deputy	April 2016	The Trust is working closely with University of

numbers for UH Bristol when the bursary changes for student nurses are introduced in Sept 2017.	new qualifiers does not decrease.	Chief Nurse		the West of England on a marketing strategy to ensure there is no decrease in numbers applying to University of the West of England. Current figures indicate that the September 17 places for adult and children have been filled. Places for February 18 have yet to be confirmed
To increase access to widening participation into pre-registration nursing and Allied Health Professional programmes undergraduate courses for existing National Health Service employees in *Agenda for Change* bands 1-4.	Increased No's of staff accessing these opportunities via HESW/or spot purchase by Trust.	Deputy Chief Nurse	March 2016	The Trust was allocated 6 places for 16/17 from an original bid of 11, and has currently only used 4 places. This has been due to some staff not being offered a place and/ or not meeting the academic requirements.
To understand the education & service implications for the newly announced nursing associate roles.	Clear Trust position on costs/benefits and potential commissioned numbers required.	Chief Nurse/Deputy Chief Nurse	2017	The first pilot programme has been filled by 5 organisations that were able to accommodate 1000 trainees. A second pilot will be available. UH Bristol has decided not to participate in the second pilot which has been discussed with University of the West of England. UH Bristol remains engaged and receives regularly feedback on progress with the programme.

Developed by Carolyn Mills Chief Nurse, Helen Morgan, Deputy Chief Nurse and Jayne Weare, Head of Therapy Services

Education Plan high level objectives for Healthcare Scientists
2016 – 2017

Professional Area	Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
Health Care Scientists Bands 1-4	Develop apprenticeship frameworks with Health Education South West and local education providers to deliver the education and development required for the known workforce gaps in the Healthcare Science Services.	• Two medical Engineers enrolled on Higher apprenticeship by first intake September 2016	Diane Crawford, Lead Scientist	September 2016 C/F to Sept 2017	Slippage in timescale the higher apprenticeship model for Healthcare Science is still in consultation ay Trailblazer stage with Department of Business and Innovation. Key healthcare science staff on trailblazer group ensuring that this qualification comes to fruition. Expected delivery September 2017
Health Care Scientists	All Healthcare Science Departments to have at least interim accreditation with the National School of healthcare Science Education Governance strategy	• To have a Trust database holding all accreditation self-assessment records for all Healthcare Science departments involved in postgraduate training programmes	Diane Crawford, Lead Scientist	50% by September 2016 100% by September 2017	All Healthcare Science departments hosting Scientist trainees from the national programmes have interim accreditation as of September 2016. Interim status is awarded through a self-assessment

					process subject to a desktop audit. Full accreditation by onsite visit is at 30% as of September 2016, on track for the 100% required by September 2017

Developed by Melanie Watson, Healthcare Scientist, Deputy Lead for Education

Education Plan high level objectives for Pharmacy
2016 – 2017

Professional Area	Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
Pre-registration pharmacists and technicians	For > 90% of pharmacy graduates and pharmacy technician students to successfully qualify having fully developed through a comprehensive and innovative training programme commissioned by HESW and delivered South West Medicines Information and Training (SWMIT) to enable the necessary training to be delivered.	• For > 90% of pharmacy graduates and pharmacy technician students to successfully qualify. • Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: Sept 2016 Sept 2017	Achieved 100% success for student pharmacists (2015/16) and 100% success for student pharmacy technicians (2014-16)
Post registration Pharmacy technicians	For at least 4 Pharmacy Technicians to achieve regional accreditation (through SWMIT programmes) in order to develop professional practice and provide safe and efficient Pharmacy services.	• For at least 4 Pharmacy Technicians to achieve regional accreditation. • Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: Sept 2016 Sept 2017	Achieved 10 pharmacy technicians regionally accredited in 2015-2017
Post registration Pharmacists	For at least 3 pharmacists to successfully complete diploma or masters programmes in clinical pharmacy and pharmaceutical technology and quality assurance specialties.	• For at least 3 pharmacists to successfully complete diploma or masters programmes. • Measurement: In year evidence of steady progress; end year 100% success; and excellent feedback from evaluations of training	Director of Pharmacy	2 cohorts: Sept 2016 Sept 2017	Achieved 5 pharmacists completed diploma programme

		experience.			
Pharmacist independent prescribing	For at least 3 Pharmacists per annum to successfully qualify as Prescribing Pharmacists.	• For at least 3 Pharmacists per annum to successfully qualify as Prescribing Pharmacists. • Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: Sept 2016 Sept 2017	Achieved 4 pharmacists qualified as pharmacist prescribers
Pharmacy Assistants	Equipping all new Pharmacy Assistants with the knowledge and experience to deliver assigned services through commencing 100% of new Pharmacy Assistants on the NVQ2 programme within 6 months and completing 100% of the necessary modules within the required timeframes.	• Commencing 100% of new Pharmacy Assistants on the NVQ2 programme within 6 months and completing 100% of the necessary modules within the required timeframes. • Measurement: Successful commencement and completion of relevant Quality Credit Framework modules in a timely manner. Evidence of development and excellent feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: Sept 2016 Sept 2017	Achieved All pharmacy assistants completed necessary training
Joint working with Bath University	Develop joint practice educator post with Bath University to commence in 2016	• Joint practice educator post with Bath University to commence in 2016. • Measurement: Final agreement of role and successful appointment of high calibre candidate.	Director of Pharmacy	By January 2017	Achieved Post commencing January 2017
South West	South West Regional Pharmacy	• South West Regional Pharmacy	Director of	Sept 2016	Achieved

Regional Pharmacy Training Unit service delivery	Training Unit (hosted by UHBristol) to be recognised by SW Trust Chief Pharmacists as a high quality provider of the South West Pharmacy Training needs, and retains HESW commissioned services.	Training Unit (hosted by UHBristol) recognised by SW Trust Chief Pharmacists as a high quality provider of the South West Pharmacy Training needs, and retains HESW commissioned services. • Measurement: Positive response by South West Chief Pharmacists to the SWMIT annual report and for SWMIT to retain the existing HESW commissioned service level agreements.	Pharmacy		Positive results and feedback, retaining HESW commissioned services

Developed by Steve Brown, Director of Pharmacy

Education Plan high level objectives for Clinical Psychology
2016 – 2017

Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
Increase the offer of specialist clinical health training placements for Doctorate Clinical Psychology trainees to 6 per annum	2016 - 17 Offer of 4 placements 2017 – 18 Offer of 6 placements	Consultant Clinical Psychologist	September 2016 for 1st cohort January 2018 for 2nd cohort	Over 4 placements offered and accepted for 2016/2017. 2017/2018 To be agreed
100% of staff eligible to be clinical supervisors have completed clinical supervision training recognised by the British Psychological Society and	100% of eligible supervisors trained	Consultant Clinical Psychologist	January 2017	Training is still being investigated.

Developed by Sue Dolby, Consultant Clinical Psychologist

Education Plan high level objectives for Support Workers Bands 1 -4
2016 – 2017

Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
Implement Trust wide Apprenticeship programme for support workers (bands 1-4) as part of Health Education England's 'Widening Participation' and 'Talent for Care' strategies	• Robust plan in place to support implementation of apprenticeships within UH Bristol • A minimum of 30 apprentices will be registered by April 2016 to meet obligations as agreed with Health Education South West • Higher apprenticeship framework available in Healthcare Science	Head of Education	April 2017 September 2017	National implementation date now moved to May 2017 Approx. 14 apprentices at UH Bristol 2016. Decision to wait for proposed new pay structure for apprentices starting in May 2017, before recruiting any more apprentices in 2016. Therefore target of 30 will not be met for 2016. HESW have been informed Since August 2016 - Apprenticeship steering group set up in the Trust chaired by interim director of Workforce and OD to manage risks and 3 sub-groups to address the key factors for implementing a robust scheme: • Pay group • Recruitment, terms and conditions group • Training and education group
Review opportunities and entry routes for local young people into support roles with UH Bristol	• Active directory of Trust 'healthcare ambassadors' who can attend school and college careers events • Trust workforce better reflects the diversity of the local population we serve, using equality and diversity workforce data as guide.	Head of Education	April 2016 April 2017	New work experience person in post July 2016. Work just completed to update the ambassador list, survey all schools and colleges to ensure UH Bristol is on circulation list for career fairs etc., and action to advertise the ambassador role more widely with the divisional HRBPs has started Nov 2016.

	• Increased number of employees aged 16-24 above current position of total headcount 81 staff.		April 2017	Apprenticeship scheme will commence in May 2017 and data will be collected as part of a national requirement through a digital system to understand apprentice diversity of the local population, ages, gender etc.

Developed by Kay Collings, Head of Education

Education Plan high level objectives for Learning Resources
2016 – 2017

Objective/Aim	Measureable Outcome	Lead	Timescale	Progress/ actions to achieve
Adhere to criteria in Health Education England's Library Quality Assurance Framework and develop library based on Health Education England's Knowledge for Healthcare Framework	• Continue to achieve a score of 100% in the Library Quality Assurance Framework • Instigate at least one new project directly related to Knowledge for Healthcare • Green flag for resources	Library Manager		Scored 96% in the Library Quality Assurance Framework. The 4% drop was due to lack of access to resources, and the fact that the library is not patient facing. Library Quality Assurance Framework will be retired end of 2017/18 to be replaced by a more effective scoring. We have recruited a new 'Graduate Trainee'. We're working together with Sustainability and Transformation Programme footprint to streamline back office duties including Inter Library Loans and share training sessions.
Increase visibility and impact of all current library services whilst maintaining quality and efficiency.	• At least 80 users trained in knowledge skills per month • Grow outreach operation to 25 departments • Achieve 32% Athens registration • Target an average £2 cost per click of electronic resources	Library manager	December 2016 achieved	On average we train between 70-80 library users each month The Outreach operation is currently in 40 departments We now have 38% Athens registrations, which are 1000 more members than NBT. A phenomenal increase. Electronic resource statistics will be collated at year end
Develop library space in line with the needs of a modern library post Knowledge for Healthcare recommendations (2015)	• Development of a "digital first" purchasing policy • A successful refurbishment of the library space, with at least 20% increase in capacity and a new training	Library Manager	June 2016 March 2017	We now attempt to purchase electronically first, although prices are restrictive. The library refurbishment was successful. We now have more study spaces and a group discussion room. The new RFID self-issue

	space.			desk has been tendered and will be in place within the next two months.
Increase number of simulation based multi-professional education programmes within the Trust by 2 each year	• Increased of training programmes provided by two in the first year and by two in the second year and number of staff accessing the training	Director Bristol Medical Simulation Centre	Complete	Since April 2016, there have been a number of new Point of Care training programmes established. Examples of which are most notably in Paediatrics where training now takes place in Theatres Recovery (twice monthly) and WATCh (quarterly). In Adult Point of care, training is now delivered monthly on the Stroke Ward, along with further training relating to falls. The multi-disciplinary Deteriorating Patient Courses have run since March 2017 which train HCA's, Senior Nurses and F1's together which is unique.
Link Simulation Training to the Trust Patient Safety Agenda	• Production of a strategic plan to align simulation training to Patient safety objectives	Director Bristol Medical Simulation Centre	Complete and ongoing	Lead Educator of Bristol Medical Simulation Centre has established links and is collaborating with the Patient Safety team to try and identify themes and trends. In addition they are now part of the Deteriorating Patient Group at which the Bristol Medical Simulation Centre presents a report on activity undertaken. This link involves two way communications whereby they in turn let us know of any issues they wish the centre to focus on.

Developed by Tom Osborne, Library Manager and David Grant, Chair of Bristol Medical Simulation Centre

Education, learning and Development Strategy
Vison statement: To enable our staff to deliver exceptional patient care through our excellence in education and our culture of continuous learning and development

The vision will be characterised by:

- Trust commitment to ensure staff and learners develop the skills and behaviours needed for patients to experience high quality individualised, compassionate and dignified clinical care
- Patient focussed philosophy with staff acting as health and wellbeing advocates
- Effective partnerships with patients, with and between divisions and corporate departments
- Equality and diversity of opportunity
- Effective partnerships with universities and other National Health Service organisations, with Health Education South West, Bristol Health Partners, the West of England AHSN
- Ambition based on sound foundations with basic building blocks in place.
- Responsive, seamless education, learning and development team working within an effective hub and spoke model
- Multi-professional opportunities to further enhance effective team working used whenever possible
- Modern environments that enable learning in different settings including in clinical practice and via different media
- Cross cutting themes and values woven through all education, learning and development
- Staff responding positively to research, innovation and evidence based changes in practice
- Taking opportunities to showcase our specialist education, learning and development skills e.g. point of care learning

Education, Learning and Development strategy outcomes:
Outcome 1 - Local and regional education leadership.

UH Bristol will expand its role and reputation within the education, learning and development system and wider systems as an effective regional leader, partner, and collaborator.

Outcome 2 - Innovative learning and working.

We will work in new ways with patients and education partners, using modern methods of delivery, blended approaches and technology to transform our education and teaching approach

Outcome 3 – Education - Best place to teach, best place to learn.

With our university and education partners we will help attract the best learners to Bristol due to the diverse and specialist learning placements we have as well as the excellence of our teaching. We will achieve our LDA obligations, improve learner experience, enhance the reputation of the Trust as a teaching Trust and enable future staff recruitment.

Outcome 4 - How does the Trust value my learning and development?

Staff will recognise how our Trust values them through equipping them to safely discharge their roles and deliver high quality care with compassion, and helping them towards their potential, through opportunities to gain improved knowledge as well as fulfilling career development.

Outcome 5 - Multi-professional by default.

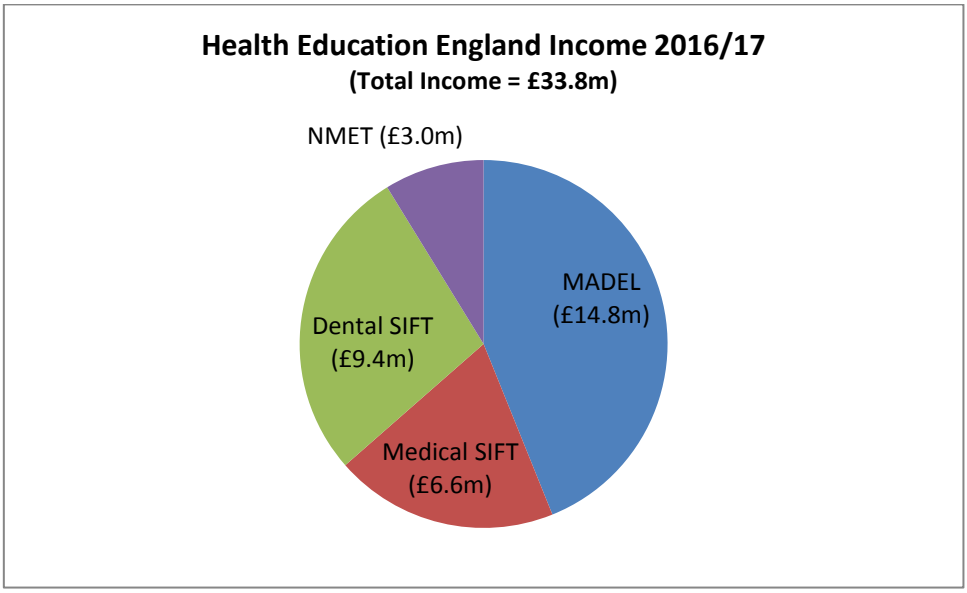
We will use multi professional relationships, working and solutions as our standard way of learning, maximising opportunities for learning and problem solving as a team.

Outcome 6 – Effective governance of high quality education, learning & development.

Education, learning and development will be governed with processes in place from ward to Board, including flow of information and Key Performance Indicators reporting on the two audiences. This will contribute to the sound governance of the Trust and enhance our profile and reputation for education, learning and development

APPENDIX 2

UH Bristol education income allocation 2016/17



Key to chart above:

MADEL	Medical and Dental Education Levy (Medical and Dental postgraduates)
SIFT	Service Increment for Teaching (Medical and Dental undergraduates)
NMEssential Training	Non-Medical Education and Training

Prepared by Nolan Price, Finance Manager Trust Services, June 2016

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	19
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Finance Report		
Author	Paul Mapson, Director of Finance and Information		
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

To inform the Finance Committee of the financial position of the Trust for June.

Key issues to note

The summary income and expenditure statement (appendix 1) shows a deficit for the period to the end of June 2017 (before technical items) of £0.070m. The position is therefore adverse to plan by £0.291m. The Trust's Operational Plan for June is a surplus of £0.221m (before technical items). After technical items the planned deficit is £0.169m and the actual deficit is £0.112m.

Recommendations
Members are asked to: • **Note** the report.

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

University Hospitals Bristol NHS Foundation Trust

REPORT OF THE FINANCE DIRECTOR

1. Summary

The summary income and expenditure statement (appendix 1) shows a deficit for the period to the end of June 2017 (before technical items) of £0.070m. The position is therefore adverse to plan by £0.291m. The Trust's Operational Plan for June is a surplus of £0.221m (before technical items). After technical items the planned deficit is £0.169m and the actual deficit is £0.112m.

The £13.313m Sustainability and Transformation (S&T) funding for the year is dependent on achieving the 'core' control total excluding S&T funding (70%) and achieving the A&E target (30%).

Excluding S&T funding the Trust is reporting a deficit of £1.767m against a planned (phased) deficit of £1.776m. Therefore the control total for quarter 1 excluding S&T funding has just about been met, and therefore receipt of £0.466m S&T core funding has been included for June.

A&E performance was not met for a third month in a row with performance of 87.9% against the joint NHS England / NHS Improvement nationally required trajectory of 90.0% meaning S&T performance funding of £0.599m to date was not earned. However, in a recent change communicated by NHS Improvement, the Trust is now eligible for 50% or £0.300m of the S&T performance funding planned to date of £0.599m due to A&E front door streaming initiatives being recognised. Therefore, the S&T performance funding loss to date was £0.300m.

Budgets are managed and profiled within Divisions at cost centre level. A profiling adjustment of £2.057m is required to reflect the June Operational Plan.

The position is summarised in the table below:

	Income / (Expenditure)		Variance
	Plan to date £m	Actual to date £m	Favourable /(Adverse) £m
Corporate Income	147.915	147.591	(0.324)
Divisions & Corporate Services	(136.896)	(139.272)	(2.376)
Financing	(8.741)	(8.389)	0.352
Operating Plan Profile Adjustment	(2.057)		2.057
Surplus/(deficit) including S&T funding	0.221	(0.070)	(0.291)
Remove S&T Core Funding	(1.398)	(1.398)	-
Remove S&T Performance Funding	(0.599)	(0.299)	0.300
Surplus/(deficit) excluding S&TF	**(1.776)**	**(1.767)**	**0.009**

Divisions and Corporate Services are £2.376m adverse to plan, a deterioration of £1.146m in June. The position is now extremely concerning given the £13.0m corporate support funding provided to remove underlying deficits to facilitate the delivery of balanced Divisional Operating Plans. The Trust requires Divisions to break-even to ensure the Trust meets its overall financial plan for the year on a sustainable basis.

Two of the four areas of concern reported last month have deteriorated significantly in June to the extent that they are now of serious concern. They are:

- Nursing costs – the over spend in month is £0.492m compared to £0.061m in May. The cumulative overspend is now £1.021m;
- Medical staff costs – the overspend.in month is £0.398m compared to £0.269m in May. The cumulative overspend is now £0.875m;

Unmet savings delivery particularly within Surgery and Medicine remain a concern. Concerns regarding Cardiac Surgery activity performance have been addressed by a change of approach in commencing cases.

2. Year End Projection and Forecast Out-turn Declaration

The substantial deterioration in Divisional positions in June (Month 3) was not expected.

Effectively the overspend for the first two months of the year of £1.230m has been replicated in one month for June (£1.146m). In particular, action taken to restore Cardiac Surgery activity was successful in June but despite this specific factor improving (losses amounted to £0.6m for April and May) the overall deterioration was extremely high and driven predominantly by increased overspends on nursing and medical pay combined with an unexpected reduction in elective activity in Children's Services.

As a result the projection for the year end outturn has been revised which indicates a likely failure to deliver the 'core' control total (i.e. excluding performance S&T funding). This creates a 'cliff edge' scenario where the adverse variance combines with a loss of £7.922m of 'core' S&T funding to generate an absolute deficit projection of £2.600m.

The most immediate consequence of this position is that the cash funding planned for Phase 5 Strategic Capital schemes is no longer available, hence the schemes, whilst still being worked up, cannot be commenced.

It is important to understand the governance required by the regulator NHS Improvement. A formal change in forecast outturn can only be notified after a series of steps including the identification of a recovery plan. Hence the above projection will not result in a formal revision to the Trusts' forecast outturn at this stage.

Consequently the Trust will create a Recovery Plan with immediate effect which will include the following components:

- Divisions will assess their forecast out-turns (FOT) and describe recovery plans;
- Executives will review each Division's FOT and discuss recovery plan actions;
- Certain Divisions will be placed into Financial Recovery which includes increased scrutiny, regular review, restrictions on discretionary actions, additional controls and agreed mitigations;
- Corporate items will be pursued to improve the Trust position including:

- Wales HRG4+ tariffs - we will pursue with NHS Improvement a resolution of the dispute about the application of the HRG4+ tariffs to Wales (worth £1.5m);
- CQUIN income relating to the delivery of STP Control Totals will be negotiated by agreement with CCGs (worth £1.2m);
- Other CQUIN's will be maximised where possible;
- Other technical options will be considered where available; and
- The cost of the new Junior Doctor contract will be reviewed to minimise its cost.

- The impact of the Capped Expenditure Process (CEP) from CCGs will be reviewed to ensure that only savings that benefit the overall system will be implemented.

The Recovery Plan will be produced during July and early August and will be reported to the Board in August.

The projected adverse variance against the 'core' plan is £4m and is described as follows:

(Adverse) / Favourable Variance to Plan	**£m**	
Divisions		
- Clinical (£2.3m to month 3 adjusted for one-off items and projected)	(8.0)	
- Other	0.2	(7.8)
Financing costs – Depreciation and Public Dividend Capital		0.7
Corporate Income		
- Loss of STP based CQUIN income	(1.2)	
- Fines and penalties	(1.0)	
- 2016/17 March estimate adjustment	0.8	
- Wales HRG4+ tariff dispute	(1.5)	
- Corporate share of activity variance	1.0	(1.9)
Non Cash backed other items		
- Slippage on cost pressures	1.0	
- BGH overage agreement	0.3	
- Commercial trial	0.2	
- Other (contingencies, inflation etc.)	1.0	2.5
Non Cash backed other items:		
- Annual leave accrual	1.0	
- Balance sheet review	1.0	
- Other (transfer to capital etc.)	0.5	2.5
Total 'Core' adverse variance to plan		**(4.0)**
Sustainability & Transformation (S&T) Funding		
- Core – loss of funding from Q2 – Q4	(7.9)	
- Performance – A&E loss of funding Q2 – Q4	(3.7)	(11.6)
Total adverse variance to plan		(15.6)
Original Plan Surplus		13.0
Projected I&E deficit for the year		**(2.6)**

3. Division and Corporate Services Performance

Clinical Divisions and Corporate Services overspend against budget increased by £1.146m in June to a cumulative position of £2.376m adverse. This compares with the combined Operating Plan trajectory to June of £0.364m. This is summarised in the table below:

	Variance to Budget favourable/(adverse)			Operating Plan trajectory favourable/(adverse)	
	To 31 May £m	June £m	To 30 June £m	Trajectory To June £m	Variance £m
Diagnostic & Therapies	0.089	(0.034)	0.055	0.043	0.012
Medicine	(0.602)	(0.186)	(0.788)	(0.401)	(0.387)
Specialised Services	(0.251)	(0.024)	(0.275)	0.074	(0.349)
Surgery	(0.331)	(0.473)	(0.804)	(0.048)	(0.756)
Women's & Children's	(0.100)	(0.389)	(0.489)	(0.005)	(0.484)
Estates & Facilities	(0.020)	(0.005)	(0.025)	(0.027)	0.002
Trust Services	(0.002)	(0.019)	(0.021)	-	(0.021)
Other corporate services	(0.013)	(0.016)	(0.029)	-	(0.029)
Total	**(1.230)**	**(1.146)**	**(2.376)**	**(0.364)**	**(2.012)**

The key drivers are:

Medicine

The Division is adverse by £0.788m. The Division has submitted a revised Operating Plan which projected a shortfall to month 03 of £0.401m which mainly related to adverse variances on nursing. The Division is adverse to this revised trajectory by £0.387m. This is primarily due to additional nursing and medical staff costs and a failure to deliver the planned CIP savings to date. The Division's revised Operating Plan of £0.132m therefore represents a considerable challenge given the year to date position.

Specialised Services

Non-delivery of cardiac surgery activity remains the key driver for the £0.349m adverse variance to the Operating Plan trajectory. In June, however there was an improvement in the delivery of cardiac work indicating that plans put in place last month have been successful. The Division was broadly break-even in June.

Surgery

The Division's year to date adverse variance from Operating Plan is driven by its share of cardiac surgery activity shortfall of £0.167m and adverse positions on nursing and medical staff. The Division's position has deteriorated by £0.473m in June. Key drivers for this deterioration are: backdated junior doctor non-compliant rota costs at £0.100m; a savings shortfall of £0.073m; and a further deterioration within nursing budgets due to acuity in ITU along with agency usage covering sickness and vacancies at £0.124m.

The adverse variance on Medical staffing budgets deteriorated by a further £0.155m due to high levels of WLI payments, cover for sickness and vacancies.

Activity related issues resulted in a favourable variance in month on income offset by a deterioration in the non-pay position.

Women's and Children's

The Division's strong activity performance in May has not been repeated with an in month shortfall of £0.217m. The drop in income was caused by lower than expected activity particularly in elective specialties has exposed adverse variances on pay budgets. The main factors causing the Division being adverse year to date to trajectory are Nursing and Midwifery (£0.297m) with high agency costs in theatres and adverse variances on medical staff (£0.259m) due to maternity and sickness cover as well as additional consultant payments.

Further details on Divisional and Corporate Services financial performance is provided under agenda item 2.3.

4. Subjective Analysis

The adverse variances of £1.146m in June and £2.376m to date are analysed subjectively in the table below:

Favourable/(Adverse)	June £m	May £m	April £m	Year to date £m	2016/17 Outturn £m
Nursing & midwifery pay	(0.492)	(0.061)	(0.468)	(1.021)	(4.606)
Medical & dental staff pay	(0.398)	(0.269)	(0.208)	(0.875)	(1.442)
Other pay	0.030	(0.018)	(0.022)	(0.010)	2.107
Non-pay	(0.814)	(0.270)	0.265	(0.819)	(9.492)
Income from operations	0.447	(0.366)	(0.181)	(0.100)	0.513
Income from activities	0.081	0.615	(0.247)	0.449	(1.429)
Total	**(1.146)**	**(0.369)**	**(0.861)**	**(2.376)**	**(14.349)**

Movements between May and June included budget virements between Non-Pay and Operating Income in Research.

Further information is provided below.

Nursing & Midwifery Pay

The nursing and midwifery pay variance for June is £0.492m adverse. Nursing expenditure on substantive posts, bank and agency has resulted in an adverse movement. The table below shows analysis between substantive, bank and agency:

Favourable/(Adverse)	June £m	May £m	April £m	Year to date £m		March £m	Feb £m	Jan £m	2016/17 Outturn £m
Substantive	0.825	0.895	0.599	2.319		0.806	0.813	0.581	9.130
Bank	(0.625)	(0.520)	(0.630)	(1.775)		(0.654)	(0.543)	(0.553)	(6.340)
Agency	(0.692)	(0.436)	(0.437)	(1.565)		(0.657)	(0.560)	(0.569)	(7.397)
Total	**(0.492)**	**(0.061)**	**(0.468)**	**(1.021)**		**(0.505)**	**(0.290)**	**(0.541)**	**(4.606)**

Surgery report a reduction in the level of vacancies in June resulting in a reduction in the favourable variance for substantive staffing. However, the increased adverse variance on bank staff of £0.105m reflects increased vacancies in June particularly within Medicine (an increase of 0.5% to 9.9% compared with 5% target), Specialised (an increase of 1.5% to 6.0% compared with a target of 5%) and Women's and Children's (an increase of 0.8% to 4.4%).

The increased agency over spend in June of £0.256m is primarily driven by the Medicine Division and Women's and Children's Division. Expenditure on agency is considerably higher than their Operating Plans reflecting the use of agency to cover and an upward trend in nursing vacancies.

With the exception of the Medicine Division, sickness is higher than target across all Divisions, most markedly in Specialised Services and Women's and Children's.

Nursing controls are auditing compliance with the recently introduced SOP for supervisory staff during June and July to ensure that the additional 'double running' costs are minimised in line with agreed process. Work on the implementation of a neutral vendor contract across the region continues. The contract has been awarded and the focus is now on ensuring all organisations work consistently.

The nursing control dashboard is attached at appendix 3.

Medical & Dental Pay

The year to date variance on Medical and Dental staff is £0.875m compared to £1.442m for the whole of 2016/17 i.e. more than double the rate of overspend. The adverse variance of £0.398m in June and £0.875m year to date is summarised in the table below:

Favourable/(Adverse)	June £m	May £m	April £m	Year to date £m	2016/17 Outturn £m
Consultant					
- Substantive costs	0.068	0.135	0.131	0.334	0.277
- Additional hours payments	(0.208)	(0.149)	(0.157)	(0.514)	
- Locum	(0.044)	0.013	(0.023)	(0.054)	(0.143)
- Agency	(0.064)	(0.028)	(0.020)	(0.112)	(0.741)
Other medical					
- Substantive costs	0.139	(0.027)	0.095	0.207	(0.369)
- Additional hours payments	(0.196)	(0.197)	(0.192)	(0.585)	
- Exception reporting	-	-	-	-	
- Locum	(0.057)	(0.058)	(0.045)	(0.160)	(0.469)
- Agency	(0.036)	0.042	0.003	0.009	0.003
Total	**(0.398)**	**(0.269)**	**(0.208)**	**(0.875)**	**(1.442)**

(note – analysis of additional hours payments was not available throughout 2016/17)

The Divisions of Women's and Children's, Surgery, and Medicine were significantly overspent in June on Medical & Dental pay. The Women's and Children's adverse variance of £0.112m was attributable to the cost of covering sickness in NICU and Obstetrics and Gynaecology and cover for the junior doctor rotas in PICU.

Surgery reports an adverse variance of £0.204m. £0.101m is due to a backdated payment to OMF/Dental medical staff arising from the reassessment of on-call banding from the previous year, as well as the cost of covering sickness and parental leave in Anaesthesia and OMF. Medicine reports an adverse variance of £0.041m due to agency costs in Geriatrics to cover vacancies and in Dermatology to manage increased activity.

Non Pay

The non pay variance deteriorated by £0.544m in June. However, £0.377m is due to budget virements in Research actioned in June between non pay and income from operations headings. The Research year to date favourable variance of £0.002m represents the corrected position going forward. The net adverse movement is therefore £0.167m. An analysis is shown below:

Favourable/(Adverse)	June £m	May £m	April £m	Year to date £m
Blood	0.085	(0.027)	0.008	0.066
Clinical supplies & services	(0.215)	(0.210)	0.025	(0.400)
Drugs	(0.055)	0.092	(0.111)	(0.074)
Establishment	(0.018)	(0.004)	0.054	0.032
General supplies & services	(0.010)	0.011	0.023	0.024
Outsourcing	(0.164)	(0.176)	(0.098)	(0.438)
Premises	(0.056)	0.032	0.003	(0.021)
Services from other bodies	(0.104)	0.141	(0.209)	(0.172)
Research	(0.310)	0.067	0.245	0.002
Other non-pay expenditure	0.033	(0.196)	0.325	0.161
Totals	**(0.814)**	**(0.270)**	**0.265**	**(0.820)**

The Trust continues to outsource work to private sector providers and has cumulative adverse variances of £0.146m relating to South West Eye Surgeons, £0.156m to Glanso, and £0.038m to dermatology. The remaining balance relates to the virtual ward provided by Orla, which has now closed.

The £0.400m cumulative adverse variance against Clinical Supplies and Services reflects increased clinical activity that in part relates to clinical supplies for the outsourcing arrangements described above.

Services from other bodies is adverse by £0.172m. Notable variances include: £0.025m for microbiology testing provided by Public Health England; £0.020m Biochemical tests from other trusts; £0.019m for the transfer of PICU patients; £0.017m for Maternity pathway costs; and £0.015m relating to the Cystic Fibrosis pathway.

Income from Operations:

Last month, we reported an adverse variance of £0.301m in relation to Research. The position to the end of June is £0.009m adverse. The improvement is due to the budget virement described above and a further assessment of commercial trials income.

5. Clinical Activity and Contract Income

The table below summarises the contract income by work type, which is described in more detail under agenda item 2.2.

	June Variance Fav/(Adv) £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based				
Accident & Emergency	0.04	4.34	4.50	0.16
Emergency Inpatients	0.37	21.61	22.67	1.06
Day Cases	(0.06)	9.52	9.64	0.12
Elective Inpatients	(0.33)	13.71	13.37	(0.34)
Non-Elective Inpatients	0.07	7.98	7.84	(0.14)
Excess Beddays	0.04	1.34	1.53	0.19
Outpatients	0.04	18.85	19.22	0.37
Bone Marrow Transplants	0.21	2.02	2.18	0.16
Critical Care Beddays	0.13	10.96	10.87	(0.09)
Other	(0.63)	23.43	22.44	(0.99)
Total Activity Based	**(0.11)**	**113.76**	**114.26**	**0.50**
Contract Penalties	(0.11)	(0.25)	(0.56)	(0.31)
Contract Rewards	0.00	2.33	2.33	0.00
Pass through payments	(0.65)	21.23	20.94	(0.29)
Sustainability and Transformation Funding	0.10	2.00	1.70	(0.30)
2017/18 Total	**(0.76)**	**139.07**	**138.67**	**(0.40)**
Prior year income	0.06	0.00	0.28	0.28
Overall Total	**(0.70)**	**139.07**	**138.95**	**(0.12)**

Activity based income was £0.110m adverse to plan in June, giving a cumulative over performance to date of £0.500m.

Emergency activity was £0.440m above plan in month, and is £0.920m above plan to date. Whilst Women's and Children's and Surgery are above plan by £0.790m and £0.490m respectively, Specialised Services is £0.550m below plan, predominantly cardiac surgery at £0.520m below plan.

Elective inpatient activity is £0.340m behind plan mainly in Women's and Children's at £0.370m behind plan with Cleft Lip & Palate at £0.170m behind plan and spinal surgery at £0.120m behind plan.

Outpatients are £0.370m higher than plan to date, notably in Specialised Services at £0.320m ahead of plan. This mainly relates to Cardiology at £0.200m and Haemophilia at £0.140m above plan.

Critical care bed days are £0.09m behind plan, particularly within Women's and Children's which was £0.21m below plan.

The plan assumes 82% achievement of CQUINs, which is £9.43m. An early assessment indicates achievement of 68%. It is vital to the achievement of the Trust's Operating Plan that the full CQUIN value is earned, therefore targeted action will be required.

Given the Trust has accepted the control total, national core penalties and local penalties will not apply. Other national penalties will apply and the Trust has received penalties of £0.560m to date, £0.310 worse than plan. Of the £0.560m to date, £0.400m relate to the emergency marginal tariff with emergency readmissions.

Pass through payments for excluded drugs were £0.65m below plan in June. Expenditure on homecare drugs was very low in June. The Trust spent £0.900m compared with £1.600m in May.

Month 12 activity for 2016/17 has been finalised and there is £1.100m additional income due from Commissioners, of which £0.280m is recognised in the year to date position.

6. Savings Programme

The savings requirement for 2017/18 is £11.520m. In June, achievement of savings is reported as £2.328m against a plan of £2.818m. Divisional performance is summarised in appendix 4. A summary of progress of the key work streams is summarised in the following table. A more detailed report is given under item 2.4 on this month's agenda.

The performance for the year by category is shown in the following table.

	2017/18 Plan	Year to date			Forecast Outturn
		Plan	Actual	Variance fav / (adv)	Variance fav / (adv)
	£m	£m	£m	£m	£m
Pay	1.823	0.397	0.327	(0.070)	(0.093)
Drugs	0.400	0.097	0.175	0.078	0.263
Clinical Supplies	2.229	0.548	0.482	(0.066)	0.503
Non Clinical Supplies	3.178	0.777	0.498	(0.279)	(0.449)
Other Non-Pay	0.216	0.049	0.045	(0.004)	(0.014)
Income	2.582	0.677	0.551	(0.126)	0.209
Capital Charges	1.000	0.250	0.250	-	-
Unidentified	0.092	0.023	-	(0.023)	(0.092)
Totals	**11.520**	**2.818**	**2.328**	**(0.490)**	**0.327**

Whilst clinical supplies and income are behind plan to date, it is expected that this position will improve and the planned savings will be achieved. Of greatest concern are pay, non-clinical supplies and unidentified savings.

With the exception of Medicine and Surgery, Divisions are expecting to achieve their required savings; Diagnostics and Therapies have a small adverse variance. The Division of Surgery is forecasting a shortfall of £0.398m and are establishing savings targets against service lines. The Division of Medicine's unidentified savings have reduced to £0.132m with shortfalls in non-pay savings.

Savings performance by Division is shown in the table below, with further information provided at agenda item 2.4.

	2017/18 Requirement £m	Year to Date			Forecast Outturn £m
		Plan £m	Actual £m	Variance fav / (adv) £m	
Diagnostics and Therapies	1.386	0.347	0.294	(0.053)	(0.013)
Medicine	2.071	0.448	0.309	(0.139)	(0.151)
Specialised Services	1.192	0.287	0.319	0.032	0.565
Surgery	2.393	0.651	0.360	(0.291)	(0.398)
Women's and Children's	2.036	0.499	0.468	(0.031)	0.160
Facilities and Estates	0.817	0.178	0.163	(0.015)	0.061
Trust Services	0.545	0.138	0.123	(0.015)	0.014
Corporate	1.080	0.270	0.292	0.022	0.088
Totals	**11.520**	**2.818**	**2.328**	**(0.490)**	**0.327**

7. Use of Resources Rating

The Use of Resources Rating (URR) for the Trust to date is 2, against the plan of 2. The variance in income and expenditure margin scores a metric rating of 2 compared with a plan of 1 due to the net deficit to date of £0.070m, £0.291m adverse to plan. The following table summarises the position.

		30 June 2017	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		11.56	13.90
Metric Rating	20%	1	1
Capital Servicing Capacity			
Metric Result – times		1.48	1.44
Metric Rating	20%	3	3
Income & expenditure margin			
Metric Result		0.1%	0.0%
Metric Rating	20%	2	2
Variance in I&E margin			
Metric Result		0.00%	-0.10%
Metric Rating	20%	1	2
Variance from agency ceiling			
Metric Result		41.0%	18.0%
Metric Rating	20%	1	1
Overall URR		**1.6**	**1.8**
Overall URR (rounded)		**2**	**2**
Overall URR (subject to override)		**2**	**2**

8. Capital Programme

The capital programme for the year submitted in the Operational Plan is £47.885m. It includes £16.040m slippage from the previous year and £37.379m of new schemes in 2017/18. Delivery of the programme is challenging and slippage of £5.534m was assumed.

The Trust has agreed expenditure profiles for: medical equipment; operational capital; Information Technology; and estates replacement. These profiles inform the internal plan against which performance is measured via the Trust Capital Group. The Strategic Scheme profile contains to the remaining phase 4 schemes and funding for phase 5 which is profiled towards the end of the year pending prioritisation of phase 5 schemes.

Expenditure in the month was £1.624m and at the end of quarter one, capital expenditure totalled £4.102m, £0.092m behind plan. The table below shows expenditure to date as broadly in line with the internal plan.

The forecast outturn has been assessed at £35.665m against the Internal Plan of £47.897m. The forecast reduction in expenditure of £12.232m primarily relates to significant slippage on phase 5 schemes as indicated last month. The significant slippage is due to the ongoing prioritising the Trust's phase 5 schemes.

Operational Plan £m	Subjective Heading	Year to date			Year end		
		Internal Plan £m	Actual spend £m	Variance £m	Internal Plan £m	Forecast £m	Variance £m
	Sources of Funding						
3.800	PDC	-	-	-	3.800	3.800	-
	Donations	0.342	0.342	-	0.342	0.342	-
	Cash:						
22.764	Depreciation	5.469	5.469	-	22.764	22.447	(0.317)
21.321	Cash balances	(1.617)	(1.709)	(0.092)	20.991	9.076	(11.915)
47.885	**Total Funding**	**4.194**	**4.102**	**(0.092)**	**47.897**	**35.665**	**(12.232)**
	Expenditure						
(16.035)	Strategic Schemes	(0.438)	(0.447)	(0.009)	(19.933)	(1.877)	18.056
(10.278)	Medical Equipment	(1.384)	(0.760)	0.624	(11.091)	(11.107)	(0.016)
(11.370)	Operational Capital	(1.419)	(1.163)	0.256	(10.280)	(9.941)	0.339
(7.328)	IT	(0.809)	(1.563)	(0.754)	(9.195)	(9.802)	(0.607)
(2.874)	Estates Replacement	(0.145)	(0.169)	(0.024)	(2.932)	(2.938)	(0.006)
(47.885)	**Gross Expenditure**	**(4.194)**	**(4.102)**	**0.092**	**(53.431)**	**(35.665)**	**17.766**
	In-year Slippage				5.534		(5.534)
(47.885)	**Net Expenditure**	**(4.194)**	**(4.102)**	**0.092**	**(47.897)**	**(35.665)**	**12.232**

The forecast outturn for depreciation incorporates the 2016/17 revaluation of assets, prioritisation, the profiling of the Phase 5 schemes, operational capital and major medical capital expenditure profiles agreed with Divisional Capital Leads. This has resulted in a forecast reduction of £0.317m from the Operational Plan.

Further information is provided at agenda item 3.1.

9. Statement of Financial Position and Cashflow

Net current assets at 30 June 2017 were £35.766m, £5.043m higher than the Operational Plan.

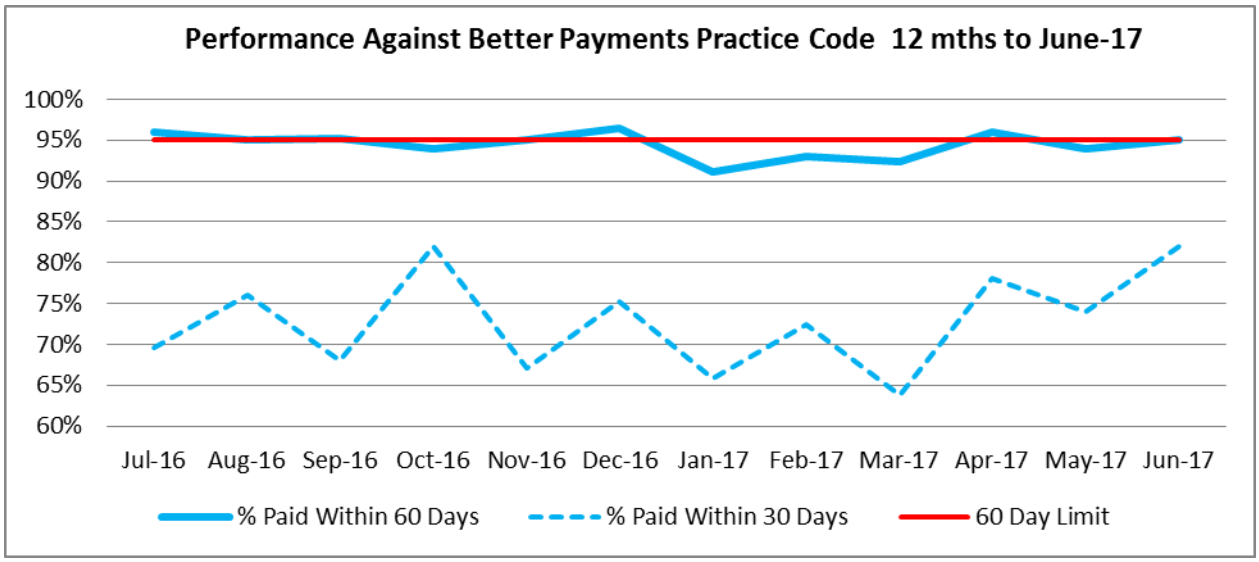
Current assets are £9.773m higher than plan. The NHS receivables position is £6.567m higher than plan primarily due outstanding S&T funding of £4.949m from NHS England and aged SLA debt of £1.611m with North Bristol NHS Trust. The non NHS receivables position is £3.072m higher than plan due to £2.141m of outstanding debt with Bristol City Council.

Current liabilities are £75.643m, £4.730m higher than plan reflecting expenditure accruals in advance of finalising provider to provider arrangements.

The Trust's cash balance at the end of June was £58.227m, which is £9.309m lower than the Operating Plan and reflects the high level of receivables.

The total value of debtors was £26.403 (£18.358m SLA and £8.045m non-SLA). This represents an increase in the month of £3.824m (£3.810m SLA increase and £0.014m non-SLA decrease). Debts over 60 days old have decreased by £1.630m (£1.629m SLA and £0.001m non-SLA) to £11.914 (£7.909m SLA and £4.005m non-SLA) and represents 45% of total debtors compared with 60% in May.

In June, 95% of invoices were paid within the 60 day target set by the Better Payments Practice Code. Performance is shown in the graph below:



Further information is provided at agenda item 4.1.

Attachments *Appendix 1 – Summary Income and Expenditure Statement*
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing KPIs
Appendix 4 – Key Financial Metrics
Appendix 5 - Risks

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2017– Summary Income & Expenditure Statement

Approved Budget / Plan 2017/18	Heading	Position as at 30th June			Actual to 31st May	Projection
		Plan	Actual	Variance Fav / (Adv)		
£'000		£'000	£'000	£'000	£'000	£'000
	Income					
556,839	From Activities	137,439	137,834	395	91,596	553,939
103,085	Other Operating Income	24,329	23,935	(394)	15,028	91,440
659,924	**Sub totals income**	**161,768**	**161,769**	**1**	**106,624**	**645,379**
	Expenditure					
(370,008)	Staffing	(93,426)	(95,332)	(1,906)	(63,906)	(384,809)
(231,437)	Supplies and Services	(57,323)	(58,118)	(795)	(38,428)	(228,788)
(601,445)	**Sub totals expenditure**	**(150,749)**	**(153,450)**	**(2,701)**	**(102,334)**	**(613,597)**
(10,441)	Reserves	–	–	–	–	–
–	NHS Improvement Plan Profile	(2,057)	–	2,057	–	–
48,038	**EBITDA**	**8,962**	**8,319**	**(643)**	**4,290**	**31,782**
7.28	**EBITDA Margin – %**		**5.14**		**4.02**	**4.92**
	Financing					
(22,792)	Depreciation & Amortisation – Owned	(5,698)	(5,469)	229	(3,662)	(22,447)
244	Interest Receivable	61	26	(35)	24	104
(264)	Interest Payable on Leases	(66)	(67)	(1)	(44)	(268)
(3,022)	Interest Payable on Loans	(726)	(692)	34	(467)	(3,022)
(9,247)	PDC Dividend	(2,312)	(2,187)	125	(1,541)	(8,749)
(35,081)	**Sub totals financing**	**(8,741)**	**(8,389)**	**352**	**(5,690)**	**(34,382)**
12,957	**NET SURPLUS / (DEFICIT) before Technical Items**	**221**	**(70)**	**(291)**	**(1,400)**	**(2,600)**
	Technical Items					
–	Profit/(Loss) on Sale of Asset	–	–	–	–	–
–	Donations & Grants (PPE/Intangible Assets)	–	343	343	266	343
(1,314)	Impairments	–	–	–	–	(1,431)
–	Reversal of Impairments	–	–	–	–	408
(1,561)	Depreciation & Amortisation – Donated	(390)	(385)	5	(257)	(1,561)
10,082	**SURPLUS / (DEFICIT) after Technical Items**	**(169)**	**(112)**	**57**	**(1,836)**	**(4,841)**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2017- Divisional Income & Expenditure Statement

Approved Budget / Plan 2017/18	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st May	Operating Plan Trajectory 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
	Corporate Income											
35,511	Contract Income	8,849	8,849	–	–	–	–	–	–	–		
–	Sustainability and Transformation Funding	–	–	–	–	–	(300)	–	(300)	(399)		
–	Penalties	–	–	–	–	–	(250)	–	(250)	(169)		
–	Overheads	–	(324)	–	27	–	200	–	227	463		
567,794	NHSE Income	139,066	139,066	–	–	(296)	296	–	–	–		
603,305	**Sub Total Corporate Income**	**147,915**	**147,591**	**–**	**27**	**(296)**	**(54)**	**–**	**(323)**	**(105)**		
	Clinical Divisions											
(51,596)	Diagnostic & Therapies	(12,951)	(12,896)	243	(243)	(51)	159	(53)	55	89	43	12
(79,541)	Medicine	(20,150)	(20,938)	(655)	16	(40)	100	(209)	(788)	(602)	(401)	(387)
(111,273)	Specialised Services	(27,734)	(28,009)	(153)	49	(2)	(190)	21	(275)	(251)	74	(349)
(109,286)	Surgery	(27,588)	(28,392)	(765)	(312)	(20)	531	(238)	(804)	(331)	(48)	(756)
(124,771)	Women's & Children's	(31,099)	(31,588)	(563)	235	(13)	(108)	(40)	(489)	(100)	(5)	(484)
(476,467)	**Sub Total – Clinical Divisions**	**(119,522)**	**(121,823)**	**(1,893)**	**(255)**	**(126)**	**492**	**(519)**	**(2,301)**	**(1,195)**	**(337)**	**(1,964)**
	Corporate Services											
(36,623)	Facilities And Estates	(9,162)	(9,187)	32	(23)	(2)	9	(41)	(25)	(20)	(27)	2
(26,213)	Trust Services	(6,991)	(7,012)	104	(64)	(47)	–	(14)	(21)	(2)	–	(21)
(5,523)	Other	(1,221)	(1,250)	(19)	(151)	130	(11)	22	(29)	(12)	–	(29)
(68,359)	**Sub Totals – Corporate Services**	**(17,374)**	**(17,449)**	**117**	**(238)**	**81**	**(2)**	**(33)**	**(75)**	**(34)**	**(27)**	**(48)**
(544,826)	**Sub Total (Clinical Divisions & Corporate Services)**	**(136,896)**	**(139,272)**	**(1,776)**	**(493)**	**(45)**	**490**	**(552)**	**(2,376)**	**(1,229)**	**(364)**	**(2,012)**
(10,441)	Reserves	–	–	–	–	–	–	–	–	–		
–	NHS Improvement Plan Profile	(2,057)	–	–	2,057	–	–	–	2,057	844		
(10,441)	**Sub Total Reserves**	**(2,057)**	**–**	**–**	**2,057**	**–**	**–**	**–**	**2,057**	**844**		
48,038	**Trust Totals Unprofiled**	**8,962**	**8,319**	**(1,776)**	**1,590**	**(341)**	**436**	**(552)**	**(643)**	**(490)**		
	Financing											
(22,792)	Depreciation & Amortisation – Owned	(5,698)	(5,469)	–	229	–	–	–	229	132		
244	Interest Receivable	61	26	–	(35)	–	–	–	(35)	(17)		
(264)	Interest Payable on Leases	(66)	(67)	–	(1)	–	–	–	(1)	–		
(3,022)	Interest Payable on Loans	(726)	(692)	–	34	–	–	–	34	3		
(9,247)	PDC Dividend	(2,312)	(2,187)	–	125	–	–	–	125	–		
(35,081)	**Sub Total Financing**	**(8,741)**	**(8,389)**	**–**	**352**	**–**	**–**	**–**	**352**	**118**		
12,957	**NET SURPLUS / (DEFICIT) before Technical Items**	**221**	**(70)**	**(1,776)**	**1,942**	**(341)**	**436**	**(552)**	**(291)**	**(372)**		
	Technical Items											
–	Profit/(Loss) on Sale of Asset	–	–	–	–	–	–	–	–	–		
–	Donations & Grants (PPE/Intangible Assets)	–	343	–	–	343	–	–	343	266		
(1,314)	Impairments	–	–	–	–	–	–	–	–	–		
–	Reversal of Impairments	–	–	–	–	–	–	–	–	–		
(1,561)	Depreciation & Amortisation – Donated	(390)	(385)	–	5	–	–	–	5	3		
(2,875)	**Sub Total Technical Items**	**(390)**	**(42)**	**–**	**5**	**343**	**–**	**–**	**348**	**269**		
10,082	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**(169)**	**(112)**	**(1,776)**	**1,947**	**2**	**436**	**(552)**	**57**	**(103)**		

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **Sickness**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*3.8%*	*3.8%*	*3.8%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*3.9%*	*3.9%*	*3.9%*
Medicine	Actual	3.1%	3.5%	3.4%									
Specialised Services	*Target*	*3.5%*	*3.5%*	*3.5%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.6%*	*3.6%*	*3.6%*
Specialised Services	Actual	3.7%	4.5%	5.0%									
Surgery, Head & Neck	*Target*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*
Surgery, Head & Neck	Actual	4.5%	4.4%	3.5%									
Women's & Children's	*Target*	*3.3%*	*3.3%*	*3.3%*	*3.6%*	*3.6%*	*3.6%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*
Women's & Children's	Actual	4.1%	4.4%	4.5%									

Source: HR info available after a weekend

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	6.9%	9.4%	9.9%									
Specialised Services	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Specialised Services	Actual	4.0%	4.5%	6.0%									
Surgery, Head & Neck	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Surgery, Head & Neck	Actual	8.6%	8.4%	8.1%									
Women's & Children's	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Women's & Children's	Actual	2.3%	3.6%	4.4%									

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*
Medicine	Actual	13.5%	12.8%	13.1%									
Specialised Services	*Target*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*
Specialised Services	Actual	13.6%	14.7%	15.0%									
Surgery, Head & Neck	*Target*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*
Surgery, Head & Neck	Actual	11.8%	11.8%	12.7%									
Women's & Children's	*Target*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*
Women's & Children's	Actual	13.0%	12.6%	12.8%									

Source: HR - Registered
Note: M4 figs restated

Graph 4 **Operating plan for nursing agency £000**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*118.8*	*118.8*	*109.8*	*100.8*	*91.8*	*82.9*	*82.9*	*91.8*	*100.8*	*109.8*	*109.8*	*109.8*
Medicine	Actual	207.9	116.5	215.9									
Specialised Services	*Target*	*61.5*	*75.0*	*68.5*	*64.2*	*64.2*	*59.8*	*59.8*	*54.4*	*65.3*	*62.5*	*58.8*	*58.8*
Specialised Services	Actual	20.7	49.6	106.5									
Surgery, Head & Neck	*Target*	*64.6*	*69.6*	*79.5*	*85.5*	*80.5*	*89.6*	*89.3*	*55.7*	*64.6*	*69.5*	*69.5*	*64.6*
Surgery, Head & Neck	Actual	158.2	147.6	157.9									
Women's & Children's	*Target*	*110.0*	*110.0*	*110.0*	*110.0*	*110.0*	*110.0*	*50.0*	*50.0*	*50.0*	*50.0*	*50.0*	*50.0*
Women's & Children's	Actual	85.3	163.8	216.6									
Trust Total	*Target*	*354.9*	*373.4*	*367.9*	*360.5*	*346.5*	*342.3*	*281.9*	*251.9*	*280.6*	*291.9*	*288.1*	*283.2*
Trust Total	Actual	472.1	477.5	696.9	-	-	-	-	-	-	-	-	-

Source: Finance GL (excludes NA 1:1)

Graph 5 **Operating plan for nursing agency wte**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*14.0*	*14.0*	*13.0*	*12.0*	*11.0*	*10.0*	*10.0*	*11.0*	*12.0*	*13.0*	*13.0*	*13.0*
Medicine	Actual	25.3	26.3	25.4									
Specialised Services	*Target*	*9.5*	*12.0*	*10.8*	*10.0*	*10.0*	*9.2*	*9.2*	*8.2*	*10.2*	*9.7*	*9.0*	*9.0*
Specialised Services	Actual	2.4	6.1	11.5									
Surgery, Head & Neck	*Target*	*13.0*	*14.0*	*16.0*	*17.2*	*16.2*	*18.2*	*18.2*	*11.2*	*13.0*	*14.0*	*14.0*	*13.0*
Surgery, Head & Neck	Actual	17.8	19.2	15.1									
Women's & Children's	*Target*	*11.0*	*11.0*	*11.0*	*11.0*	*11.0*	*11.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*
Women's & Children's	Actual	10.0	10.1	18.3									
Trust Total	*Target*	*47.5*	*51.0*	*50.8*	*50.2*	*48.2*	*48.4*	*42.4*	*35.4*	*40.2*	*41.7*	*41.0*	*40.0*
Trust Total	Actual	55.5	61.7	70.2	-	-	-	-	-	-	-	-	-

Source: Finance GL (excludes NA 1:1)

Graph 6 **Operating plan for nursing agency as a % of total staffing**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*6.6%*	*6.6%*	*6.2%*	*5.7%*	*5.2%*	*4.7%*	*4.7%*	*5.2%*	*5.7%*	*6.2%*	*6.1%*	*6.1%*
Medicine	Actual	11.1%	6.3%	11.2%									
Specialised Services	*Target*	*4.4%*	*5.4%*	*4.9%*	*4.6%*	*4.6%*	*4.3%*	*4.3%*	*3.9%*	*4.7%*	*4.5%*	*4.2%*	*4.2%*
Specialised Services	Actual	1.5%	3.5%	7.2%									
Surgery, Head & Neck	*Target*	*3.7%*	*3.9%*	*4.5%*	*4.8%*	*4.5%*	*5.0%*	*5.0%*	*3.2%*	*3.7%*	*3.9%*	*3.9%*	*3.7%*
Surgery, Head & Neck	Actual	8.5%	8.0%	8.3%									
Women's & Children's	*Target*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*
Women's & Children's	Actual	2.4%	4.5%	6.0%									
Trust Total	Actual	5.5%	5.4%	7.8%									

Source: Finance GL (RNs only)

Graph 7 **Occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Actual	9,071	9,542	9,042									
Specialised Services	Actual	4,392	4,719	4,517									
Surgery, Head & Neck	Actual	4,481	4,616	4,414									
Women's & Children's	Actual	6,179	6,658	5,959									

Source: Info web: KPI Bed occupancy

Graph 8 **NA 1:1 and RMN £000 (total temporary spend)**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*
Medicine	Actual	100	80	92									
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	9	32	34									
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	34	30	44									
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	5	9	25									
Trust Total	*Target*	*118.6*	*118.6*	*118.6*	*118.6*	*118.6*	*118.6*	*118.6*	*118.6*	*118.6*	*118.6*	*118.6*	*118.6*
Trust Total	Actual	147.0	151.7	195.4	-	-	-	-	-	-	-	-	-

Source: Finance temp staffing graphs (history changes)

Graph 9 **CIP - Nursing & Midwifery Productivity**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Trust Total	*Target*	*31*	*63*	*94*	*126*	*157*	*189*	*220*	*251*	*283*	*314*	*346*	*377*
Trust Total	Actual	22	33	60									

Source: Service Improvement Team - Amy

Division	Nursing Category	Price Variance fav/ (adv) £'000	Volume Variance fav/ (adv) £'000	Total Variance fav/ (adv) £'000	Lost Time % (Wards/ED/Theatres)
Medicine	Ward	(5)	(126)	(132)	
	Other	(17)	(2)	(19)	
	ED	3	(28)	(24)	
Medicine Total		**(20)**	**(156)**	**(175)**	**129%**
Surgery, Head & Neck	Ward	(11)	(74)	(84)	
	Theatres	(42)	10	(31)	
	Other	(34)	(17)	(51)	
	ED	8	4	12	
Surgery, Head & Neck Total		**(78)**	**(76)**	**(154)**	**129%**
Specialised Services	Ward	(28)	(43)	(72)	
	Other	53	(47)	6	
Specialised Services Total		**24**	**(90)**	**(66)**	**129%**
Women's & Children's Services	Ward	5	(42)	(36)	
	Theatres	(115)	(12)	(127)	
	Other	37	(2)	35	
	ED	(9)	(1)	(10)	
Women's & Children's Services Total		**(82)**	**(56)**	**(138)**	**130%**
Clinical Division Total	Ward	(34)	(290)	(324)	
	Theatres	(158)	(1)	(158)	
	Other	41	(71)	(29)	
	ED	3	(25)	(22)	
CLINICAL DIVISIONS TOTAL		**(147)**	**(386)**	**(534)**	**129%**
NON CLINICAL DIVISIONS	Other	1	8	9	
NON CLINICAL DIVISIONS TOTAL		**1**	**8**	**9**	
TRUST TOTAL		**(146)**	**(379)**	**(525)**	**129%**

Key Financial Metrics -May 2017 **Financial Metrics- June** **Appendix 4**

		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 - Penalties										
	Current Month									
	Plan	0	(16)	(2)	(8)	(4)	0		(51)	(81)
	Actual	0	(28)	(2)	(11)	(2)	0		(147)	(190)
	Variance Fav / (Adv)	-	(12)	0	(3)	2	-	-	(96)	(109)
	Year to date									
	Budget	0	(49)	(7)	(24)	(11)	0		(154)	(245)
	Actual	0	(76)	(9)	(64)	(9)	0		(405)	(563)
	Variance Fav / (Adv)	-	(27)	(2)	(40)	2	-	-	(251)	(318)
Contract Income - Activity based										
	Current Month									
	Plan	3,551	4,992	5,609	7,217	9,416	340		8,044	39,169
	Actual	3,562	5,151	5,596	7,417	9,230	344		8,139	39,439
	Variance Fav / (Adv)	11	159	(13)	200	(186)	4	-	95	270
	Year to date									
	Plan	10,216	14,750	16,090	20,742	27,584	990		23,383	113,755
	Actual	10,374	15,117	15,578	21,279	27,589	995		23,709	114,641
	Variance Fav / (Adv)	158	367	(512)	537	5	5	-	326	886
		Information shows the financial performance against the planned penalties as per agenda item 5.2								
Contract Income - Rewards										
	Current Month									
	Plan	80	118	159	163	185	96	-	-	801
	Actual	80	118	159	164	186	96	-	-	803
	Variance Fav / (Adv)	0	0	0	1	1	0	-	-	2
	Year to date									
	Plan	232	343	462	475	538	279	-	-	2,329
	Actual	233	344	463	476	539	280	-	-	2,335
	Variance Fav / (Adv)	1	1	1	1	1	1	-	-	6
		Information shows the financial performance against the planned rewards as per agenda item 5.2								
Cost Improvement Programme										
	Current Month									
	Plan	129	68	97	211	168	61	45	90	870
	Actual	98	130	114	124	173	55	45	97	836
	Variance Fav / (Adv)	(31)	62	17	(87)	5	(6)	(1)	7	(34)
	Year to date									
	Plan	347	448	287	651	499	178	137	270	2,818
	Actual	294	309	319	360	468	163	123	292	2,328
	Variance Fav / (Adv)	(53)	(139)	32	(291)	(31)	(15)	(15)	22	(490)

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2017 - 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		Target Risk	
		Risk Score & Level	Financial Value			Risk Score & Level	Financial Value	Risk Score & Level	Financial Value
1843	Failure to deliver the Trust's Operating Plan Control Total surplus of £12.957m based on the Divisions current rate of overspend to the end of June (month 3).	20 - Very High	£7m	Each Division is required to achieve a balanced Operating position which must be delivered. Three Divisions will be placed in "escalation" and require a financial recovery plan to restore the run rate back to the Operating Plan.	PM	20 - Very High	£15m	4 - Moderate	£0m
959	Risk that Trust does not deliver the required savings in year.	16 - Very High	£3m	The Trust has made progress in closing the unidentified savings gap of £0.6m in May to £0.1m in June. Delivery of these plans will be key. Delivery to date is 83% of the plan. Divisions, Corporate and transformation team are actively working to ensure delivery of savings schemes.	MS	12 - High	£2m	4 - Moderate	£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 the loss of Sustainability & Transformation (S&T) Funding due to failure to achieve the financial control total from quarter 2 and under-performance against the A&E 4 hour wait trajectory (all year).	20 - Very High	£15m	100% of the agreed Sustainability & Transformation Funding is subject to forfeit if the Trust does nots deliver its financial control total from quarter 2. Failure to achieve in quarter 2 forfeits all performance S&T funding. The current risk of loss is very high.	PM	20 - Very High	£15m	3 - Low	£0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3m	The Trust has strong controls of the SLA management arrangements.	PM	9 - High	£3m	3 - Low	£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	-

Cover report to the Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am – 1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Agenda Item	21

Meeting Title	Audit Committee
Report Title	Chairs Report
Author	Pam Wenger, Trust Secretary
Executive Lead	Robert Woolley, Chief Executive
Freedom of Information Status	Open

Reporting Committee	Audit Committee
Chaired by	John Moore, Non Executive Director
Lead Executive Director	Pam Wenger, Trust Secretary
Date of last meeting	11 July 2017

Summary of key matters considered by the Committee and any related decisions made.

Matters Arising

Estates and Facilities
Members received the follow up report in relation to Estates and Facilities and agreed to receive a report at the next Audit Committee in relation to the actions to address the outstanding recommendations and to adopt best practice in relation to procurement.

Counter Fraud
Members received an annual report in respect of counter fraud activity during 2016/17. The report provided evidence of the Trust's compliance with NHS Protect's Fraud, Corruption and Bribery standards for provider organisations.

Internal Audit
Members received the annual report covering the period 2016/17 and an update report on the audits undertaken in the last quarter. It was noted that 8 reports have been issued of which 6 reports are graded as Satisfactory.

The details of the audits are shown in the table below

Audit Assurance		**Overall Assurance Opinion**
1	Electronic Data Management	Green
2	Immigration Checks	Satisfactory
3	Whistleblowing	Satisfactory
4	CQC Governance & Compliance	Satisfactory
5	Payroll Systems	Significant
6	Workforce Planning	Satisfactory
7	Cancer Performance Improvement	Satisfactory
8	Estates Maintenance	Follow-Up

Members received a professional briefing note on the General Data Protection Regulation which becomes mandatory in May 2018 after coming into law in June, 2016. While many of

the concepts and principles of the GDPR are the same as those that underpin the Data Protection Act (DPA), the new legislation introduces new measures and enhances others. It was noted that a review was planned as part of the Trust's Internal Audit Plan for 2017/18.

External Audit Report
Members received an update from the External Auditors.

Risk Management Strategy
Members received the draft Risk Management Strategy 2017/18 which had been updated following the Board Seminar in June 2017. Members agreed to recommend approval of the Risk Management Strategy for approval.

Board Assurance Framework (BAF) – Quarter 1
Members received and reviewed the BAF for quarter 1 and agreed to minor changes and additions to Strategic Priority 1 before consideration by the Board of Directors.

Corporate Risk Register
Members received the Corporate Risk Register as at the end of June 2017 and noted the scrutiny that had taken place at Risk Management Group. Assurance was provided that the risks were considered and reviewed by the Senior Leadership Team as part of the agreed risk management process. Members noted the plans for a development of the system to support management of essential training across the Trust and that a review of Essential Training would be undertaken by Quality & Outcomes Committee.

Gifts and Hospitality Register and Register of Interests Policy
Members received the updated Gifts, Hospitality and Register of Interest Policy that had been updated as a result of the recent NHS Guidance on Conflicts of Interest. There was a discussion in relation to dissemination of the policy. It was agreed that an update to be provided at the next Audit Committee.

Speaking Up Annual Report
Members received the first Speaking Up Annual Report covering the period 2016/17. Members were pleased to review the detail of the report, the actions that had been taken in responding to Speaking Up concerns and the appointment of the Speaking Up Staff Advocates. The Audit Committee agreed to receive regular update reports.

Committee Self-Assessment
Members received the outcome of the Audit Committee Handbook Self-Assessment and agreed a number of actions for the forthcoming year including, action review at the end of each meeting.

Clinical Audit Quarterly Report and Forward Plan
Members received the forward plan for 2017/18 and quarter one update on the progress against the plan during the 2017/18 financial year. It was noted that 35/37 (95%) of Priority 1 projects have commenced as scheduled and that performance was comparable to previous years.

Chair Reports
Members received Chair Reports from Finance Committee, Risk Management Group and Quality and Outcomes Committee. In particular the triangulation between the Audit Committee and the Quality and Outcomes Committee was noted.

Members discussed the financial position at the end of 2016/17 and noted that non-recurring measures at the end of year had assisted in the achievement of the financial plan. Members received assurances that the Executive Team and the Senior Leadership Team were fully focused on the delivery of the financial plan for 2017/18.

Losses and Special Payments
Members received the routine report on losses and special payments. An update was provided by the Director of Pharmacy in relation to drugs management and the reporting of damages and losses. Members noted the challenges faced with benchmarking against other Trusts due to differing stock management and accounting practices.

Members noted the following assurance report:

- Single Tender Action

Key risks and issues/matters of concern and any mitigating actions	
None identified.	
Matters requiring Committee level consideration and/or approval	
None identified.	
Matters referred to other Committees	
None identified.	
Date of next meeting	10 October 2017

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	22
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Risk Management Strategy		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☒	For Information	☐

Executive Summary

Purpose

The revised Strategy presents a high-level strategic statement on the management of risk, including the Risk Appetite statement to be considered by the Trust Board of Directors.

The Risk Management Strategy was approved for submission by the Risk Management Group and Senior Leadership Team in July 2017.

Key issues

The Trust's risk management strategy sets out its approach to and appetite for risk and its approach to risk management and describes:

- Risk management objectives and risk appetite;
- Structures and responsibilities in place, including roles and responsibilities for risk

management at different levels of the organisation;
- Risk management processes and tools in place, including reference to the risk register, risk reporting, frequency of risk activities and available guidelines.
- At each level of the organisation, risk management responsibilities should be clearly defined.

The Risk Management Strategy has been reviewed, by the Risk Management Group and has resulted in the following changes
- Roles and responsibilities have been updated to reflect the implementation of the strategy rather than risk management framework in general.
- Identification of risk management priorities for 2017/18
- Presentation of risk appetite improved
- Addition of governance structure diagrams

Risk Appetite Statement
The Trust Board approved the Risk Appetite Statement in 2016 and is required to review this statement annually. The Board is asked to confirm the agreement of the following statement:.

The Trust operates within a high overall range of risks. The Trust's lowest risk appetite is for safety risks, specifically patient, staff and visitor safety and for breaching our legal obligations. This means that reducing these risks so far as is reasonably practicable will take priority over meeting our other business and strategic objectives.

Recommendations

Members are asked to:
- **Note** the report;
- **Approve** the risk appetite statement for the period 2017/18; and
- **Approve** the risk management strategy

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☒	Workforce	☒

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Risk Management Group	**Audit Committee**	**Senior Leadership Team**	**Quality and Outcomes Committee**	
04/07/2017	11/07/2017	19/07/2017	26/07/2017	

University Hospitals Bristol
NHS Foundation Trust

Risk Management Strategy

Document Data			
Subject:	Risk Management		
Document Type:	Strategy		
Document Reference	10790		
Document Status:	Draft		
Document Owner:	Trust Secretary		
Executive Lead:	Chief Executive		
Approval Authority:	Trust Board of Directors		
Review Cycle:	12 Months		
Date Version Effective From:	01/08/2017	**Date Version Effective To:**	31/07/2018

Introduction

University Hospitals Bristol NHS Foundation Trust ('the Trust') is faced with a number of factors that may impact upon its ability to meet its objectives. The effect of uncertainty on those objectives is known as risk.

Risk Management can be defined as the identification, assessment, and prioritisation of risks followed by a coordinated and economical application of resources to minimise, monitor and control the probability and/or impact of unfortunate events. Risks should also be reviewed at regular intervals to ensure they continue to be appropriately mitigated.

It is widely recognised that an effectively planned, organised and controlled approach to risk management is a cornerstone of sound management practice and is key to ensuring the achievement of objectives. A comprehensive management approach to risk reduces adverse outcomes, and can result in benefit from what is often referred to as the 'upside of risk'.

Risk Management is an integral part of good governance and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical, organisational or financial.

This **strategy** is the high level document within the Trust and does not set out to cover in detail the management of specific risks. This more detailed information is set out in related policies, in particular the **Risk Management Policy**.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
20/08/2009	1.0	Assistant Director of Governance	Major	Supersedes United Bristol Healthcare Trust Risk Management Strategy.
12/08/2010	2.0	Assistant Director of Governance	Major	Updated following NHLSA Level 1 assessment
09/02/2012	2.1	Chief Executive	Major	Rewrite to reflect NHS NHSLA Level 2
27/02/2012	3.0	Chief Executive	Major	Approved by Trust Board of Directors
29/03/2013	4.0	Trust Risk Manager	Major	Approved by Trust Board of Directors
22/04/2015	5.0	Trust Secretary	Major	Complete restructuring
30/06/2016	5.1	Trust Secretary	Minor	Additions to include Risk Management Objectives and greater clarity in terms of the risk appetite
31/07/2017	6	Trust Secretary	Major	Roles & responsibilities updated. Objectives for 2017/18 identified.

Table of Contents

1.	Introduction	4
2.	Purpose	5
3.	Risk Management Objectives	5
4.	Risk Management Priorities for 2017/18	5
5.	Process for Risk Management	6
6.	Board Statement of Risk Appetite and Tolerance	6
7.	Duties, Roles and Responsibilities	7
8.	Responsibility for Monitoring Compliance	10
9.	Compliance & Assurance	10
10.	Associated Documentation	11

1. Introduction

1.1 An understanding of the risks that face NHS Trusts is crucial to the delivery of healthcare services moving forward. The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing University Hospitals Bristol NHS Foundation Trust (UHB) Board with assurance on the framework for clinical quality and corporate governance.

1.2 Our mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. Our vision is for Bristol and our hospitals, to be among the best and safest places in the country to receive care. To ensure that the care provided at UHB is safe, effective, caring and responsive for patients, the board must be founded on and supported by a strong governance structure.

1.3 UHB is committed to developing and implementing a risk management strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its objectives. The board assurance framework (BAF) will be used by the Trust Board and assuring committees to identify, monitor and evaluate risks to the achievement of the strategic objectives. It will be used alongside other key management tools, such as performance and quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

1.4 The management of risk underpins the achievement of the Trust's objectives. UHB believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users and staff, it is also significant in the financial and business planning process. This illustrates that risk management is the responsibility of all staff.

1.5 The risk management process involves the identification; evaluation and treatment of risk as part of a continuous process aimed at helping the Trust reduce the incidence and impacts of risks that they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks.

1.6 The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. The risk management strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

1.7 The Trust recognises that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding at Board level on risk appetite.

1.8 As part of the Annual Governance Statement, UHB will make a public declaration of compliance against meeting risk management standards. The Trust currently has good systems and process for risk management in place as evidenced by internal and external review.

2. Purpose

The purpose of the Risk Management Strategy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, NHS Improvement (NHSI) compliance requirements, key regulatory requirements such as Care Quality Commission, and its strategic objectives and to communicate the Trusts statement of risk appetite and tolerance. The risk management strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

3. Risk Management Objectives

The strategic objectives in relation to risk management will be achieved by:

- Ensuring that all staff are adequately trained and competent to execute their duties in respect of risk management;
- Including risk management issues when writing reports and considering decisions;
- Continuing to demonstrate the application of risk management principles in line with the Risk Management Policy;
- Reinforcing the importance of effective risk management as part of the everyday work of all staff employed or engaged by the Trust;
- Maintaining a comprehensive register of risks (clinical and non-clinical) and reviewing these on a periodic basis;
- Ensuring controls are in place to effectively mitigate the risk and are understood by those expected to apply them;
- Ensuring gaps in control are rectified and assurances are reviewed and acted on in a timely manner;
- Maintaining documented procedures of the control of risk and provision of suitable information, training and supervision; and
- Monitoring arrangements and continually seeking improvement

4. Risk Management Priorities for 2017/18

The following priorities have been identified to be delivered within the next year:

- Work with divisions to ensure the implementation of risk treatment is sufficient to effectively mitigate the risks identified.
- Improve access to educational risk material including risk management eLearning
- Improve the descriptions of risk by adopting a method of risk metadata, focussing on cause and effect of risks.
- Ensure that risk registers maintained at a departmental level are of an acceptable level and subject to regular review.
- Embed the practice of risk reviews being in alignment with quarterly and annual reporting.
- Clearly defining the processes for approval of risks and assuring the approach is consistent across divisions.
- Monitor reports to Risk Management Group to ensure that all areas of known risk are identified and formalised onto a risk register.
- Undertake a review of the presentation of the Trusts risk appetite to ensure it can be used as a meaningful tool for staff making decisions around application of risk treatment.

5. Process for Risk Management

5.1 Risk Management can be defined as the identification, assessment, and prioritisation of risks followed by a coordinated and economical application of resources to minimise, monitor and control the probability and/or impact of unfortunate events. Risks should also be reviewed at appropriate intervals to ensure they continue to be appropriately mitigated.

5.2 The Board Assurance Framework (BAF) acts as the Trust's primary mechanism for ensuring that the Trust Board receives adequate assurance, that the Trust is actively pursuing its corporate objectives and that the risks to these objectives are being appropriately treated. UHB is faced with a number of factors that may impact upon its ability to meet its objectives. This strategy describes the direction that the Trust will take to manage risk.

5.3 The Board Assurance Framework and Corporate Risk Register reflect the organisation's risk profile. They contain the strategic risks identified by the Trust, describe the controls in place and give the strength and quality of assurance available on how well the risks are being managed. These documents support the Board in making a declaration on the effectiveness of the Trust's system of internal control in the Annual Governance Statement.

6. Board Statement of Risk Appetite and Tolerance

6.1 "University Hospitals Bristol NHS Foundation Trust operates within a high overall range of risks. The Trust's lowest risk appetite is for safety risks, specifically patient, staff and visitor safety and for breaching our legal obligations. This means that reducing these risks so far as is reasonably practicable will take priority over meeting our other business and strategic objectives.

6.2 Where business and strategic risks can be effectively controlled, and within clearly defined limits of authority, positive risk taking will be encouraged where it may deliver innovation, service improvement or greater efficiency in our operations".

6.3 The Trust has adopted the following definitions, to be applied in determining the appetite for risks that are likely to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users

Appetite	Definition
4. Very High Risk Appetite	The Trust is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust, and is Eager to be innovative and to choose options offering potentially higher business rewards
3. High Risk Appetite	The Trust is willing to consider all potential delivery options and choice while also providing an acceptable level of service (and value for money).
2. Moderate Risk Appetite	The Trust has a preference for safe delivery options that have a low degree of risk and may only have limited potential for reward.

1. Low Risk Appetite	The Trust has a preference for ultra-safe delivery options that have a low degree of risk and only for limited reward potential. (as low as reasonably practicable)
0. Zero Risk Appetite	Avoidance of risk and uncertainty is a key organisational objective.

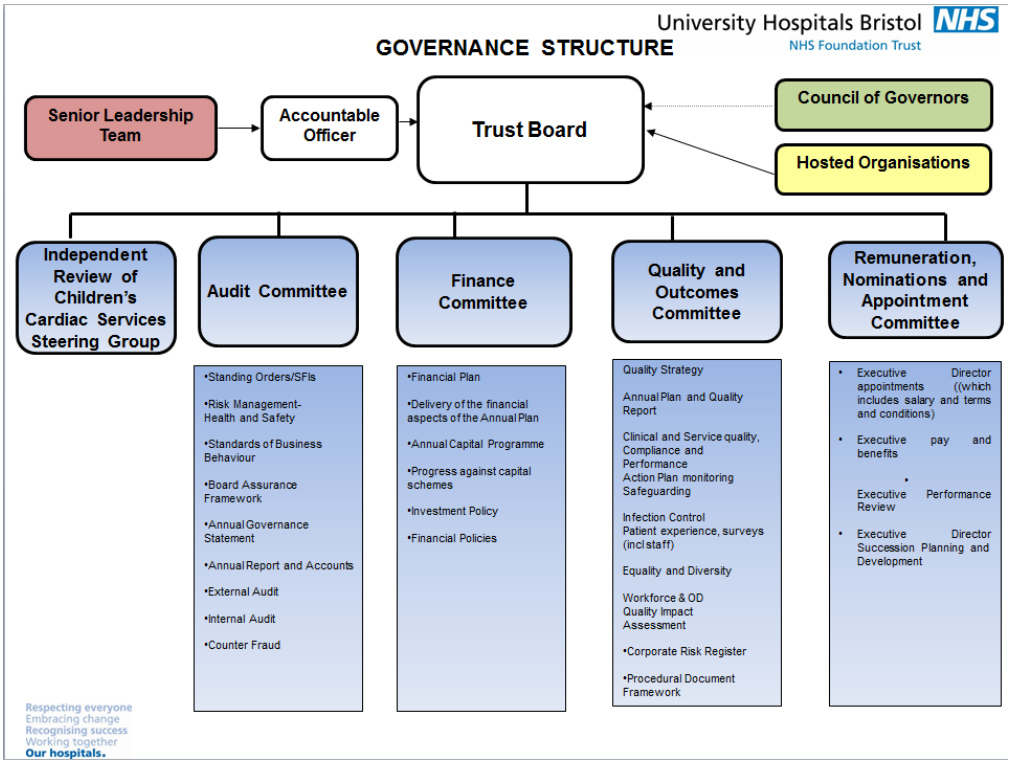
6.4 Risk Appetite for 2017/18

Risk Domain	Definition	Appetite	Risk Rating
Safety	Impact on the safety of patients, staff or public	Low	
Quality	Impact on the quality of our services. Includes complaints and audits.	Moderate	
Workforce	Impact upon our human resources (not safety), organisational development, staffing levels and competence and training.	Moderate	
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.	Low	
Reputation	Impact upon our reputation through adverse publicity.	High	
Business	Impact upon our business and project objectives. Service and business interruption.	Moderate	
Finance	Impact upon our finances.	Moderate	
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.	Moderate	

7. Duties, Roles and Responsibilities

The success of the risk management programme is dependent on the defined and demonstrated support and leadership offered by the Senior Leadership Team and Trust Board as a whole. However, the day-to-day management of risk is the responsibility of all staff, and the identification and management of risks requires the active engagement and involvement of staff at all levels. Staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework. The specific roles and responsibilities in relation to risk management are laid out in detail in the Risk Management Policy.

Governance Structure



7.1 *Reporting Structure to Trust Board*

Divisional Governance Group and Risk Forums report into divisional boards who in turn provide monthly exception report to SLT. SLT also receive a report of any divisional risks, of 12 or above that have been recommended by SLT to remain at a divisional level. Risk Management Group meets on a quarterly basis and receives speciality risk report and divisional risk registers on a rolling annual cycle. Audit Committee and Quality & Outcomes Committee receive the Corporate Risk Register and Board Assurance Framework for assurance.

7.2 *Trust Board of Directors*

In relation to the delivery of this strategy, the Executive and Non-Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives. The Executive and Non-Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role.

The Board is also responsible for reviewing the effectiveness of its internal control systems and is required to ensure that the Trust's risk management arrangements are sound and protects patients, staff, the public, and other stakeholders against risks of all kinds.

The Annual Governance Statement made by the Trust's Chief Executive in the annual report and accounts must demonstrate that the Trust Board has been informed on all risks and has arrived at its conclusions on the totality of risk based on all the evidence presented to it through the responsibilities delegated to the committees within the organisation.

7.3 *Executive Directors*

Executive Directors are responsible for managing risk as delegated by the Chief Executive and set out in the Risk Management Policy and the Terms of Reference of the Risk Management Group. Executive Directors are also responsible for risks allocated to them on the Corporate Risk Register and Trust-wide Risk Register.

7.4 *The Chief Executive*

The Chief Executive is accountable to the Chairman and the Board and, as the Accountable Officer, has overall responsibility for ensuring that the Trust operates effective risk management processes in order to protect all persons who may be affected by the Trust's business. The Chief Executive is required to sign annually, on behalf of the Board, an Annual Governance Statement, in which the Board acknowledges and accepts its responsibility for maintaining and reviewing the effectiveness of a sound system of internal control, including risk management.

7.5 *Trust Secretary*

The Trust Secretary is responsible for ensuring that the Trust Board of Directors is cognisant of its duties towards risk governance and management and for coordinating the annual cycle of Board business to ensure these duties are incorporated on the Board's agenda. The Trust Secretary is also responsible for the coordination of the Trust's Board Assurance Framework to ensure that the Board remains sighted on the key risks facing the Trust.

7.6 *Head of Risk Management*

The Head of Risk Management develops, implements and monitors compliance with the risk management policy and is responsible for maintaining the overall structure for risk management within the Trust. The post-holder facilitates the development of a risk aware culture within the Trust, compiles risk information and prepares reports for the Senior Leadership Team, Risk Management Group and Trust Board of Directors on risk information and the achievement of the risk management objectives.

7.7 *Risk Management Group*

As a Management Group established and chaired by the Chief Executive, the Risk Management Group (RMG) is responsible for discharging the responsibility of the Senior Leadership Team for the management of organisational risk. This includes receiving the Corporate Risk Register and divisional risk registers in full on a rotational basis and monitoring the achievement of the risk management objectives.

7.8 Audit Committee

The Audit Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities.

7.9 *Divisional Management Boards*

Divisional Management Boards are responsible for having a planned risk assessment programme in place, comprised of quarterly Divisional Management Board meetings and monthly Divisional Governance meetings, at which, the implementation of

recommendations from risk assessments and action plans with realistic timescales for mitigating risks are reviewed.

Divisional Management Boards shall adopt a standardised approach to the management of risk in accordance with the duties defined in the Risk Management Policy and the Terms of Reference of the Risk Management Group. They are also responsible for reviewing the divisional risk register and considering risks escalated to the management board from their departments for adding to the Divisional Risk Register.

Divisional Directors are accountable to the Chief Operating Officer for the implementation of the Risk Management Strategy and Policy locally.

8. Responsibility for Monitoring Compliance

- This strategy shall be reviewed annually by the Trust Board.
- The organisational risk management structure shall be reviewed annually at the Trust Board risk workshop
- The Head of Risk Management shall monitor that the process for managing risk locally is being complied with as per this Strategy and the Risk Management Policy and Procedure.
- The overall implementation of this strategy shall be monitored through the annual internal audit review.
- The Risk Management Group shall monitor the implementation of the annual risk management objectives via quarterly progress reports.

9. Compliance & Assurance

9.1 NHSI have consulted on a 'Single Oversight Framework' to ensure there is a clear compliance framework which ensures that all Trusts are able to demonstrate that they are remaining within their agreed provider licence. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

9.2 The Board Assurance Framework provides the Trust Board with a vehicle for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of objectives is at risk due to a gap in control and/or assurance.

9.3 All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The Annual Report brings together this evidence.

9.4 The designated Assurance Committees of the Trust Board are the Quality & Outcomes Committee (Clinical Quality Risk), the Finance Committee (Financial Risk), Workforce & Organisational Development Group (Workforce Risk), Service Delivery Group (Operational Risk), Trust Health, Safety & Fire Committee (H&S Risk). The Audit Committee reviews the risk management framework and process overall on an annual basis.

9.5 It is the responsibility of the Assurance Committees to report to the Trust Board, on a quarterly basis any new risks identified, gaps in assurance/control, as well as positive assurance on an exception basis.

9.6 The Head of Risk Management will work closely with the Executive Leads, Governance to ensure that the document remains dynamic and is integral to the Business Planning cycle.

9.7 If at any time performance reporting and risk management processes indicate that the Trust will not meet a current or future regulatory requirement/target then the Board must notify NHSI via an Exception Report.

10. Associated Documentation

This strategy should also be read in conjunction with the following Risk Management Policies which are all available on the intranet:

10.1 Risk Management Policy and Procedure

10.2 Incident Management Policy

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	23
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Transforming Care Programme Board		
Author	Simon Chamberlain, Transformation Director		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme.

Key issues to note

The report sets out the highlights of progress over the last quarter and the next steps

Recommendations

Members are asked to:

- **Receive** the report for assurance.

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☒	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☒
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Transforming Care

Transforming Care Update to Trust Board

July 2017

The purpose of this report is to update the Trust Board on progress over the last quarter with the programmes of work within the Transforming Care programme.

1. Over the last quarter we have mobilised work against the transformation priorities for 2017/18 and where required reset priorities for those programmes carried forward from 2016/17. The Transformation Priorities for 2017/18 are shown in Appendix 1.

2. In April a workshop was held to launch the scoping of the "Customer Care Mind-set" programme. Participants represented all professional groups, non-clinical functions and included a patient governor. Working sessions allowed participants to consider what customer service means in our environment, and highlighted the importance of improving our internal customer service mind-set – for example between Estates or IM&T and its users. An external speaker covered the importance of addressing the "touchpoints" where our "customers" come into contact with our Trust, and also discussed why we hold some private sector organisations in such high regard for their service. The subject of customer service was enthusiastically embraced by the participants.

3. In response, we are finalising the specific scope of work to be taken forward during 2017/18 as well as the proposed projects for the following two years. Projects we plan to mobilise will include work to improve voice communications and management of incoming telephone calls; developing a stronger customer service mind-set through the Outpatients Transformation programme, specifically in how we grow compliance with our standards for the delivery of outpatients clinics; and work to define more clearly what we mean by good customer service at UHB, to be enshrined in a set of principles which we will seek wide input to over the next quarter. Following this we expect to strengthen our training around customer care.

4. Alongside the work on telephone communications, we continue to roll out new appointment letters meeting the letter quality standards we developed in 2016. These are being adopted by specialty teams across all divisions and the roll out is expected to cover the majority of areas by the end of this calendar year. This is a complex project as it requires development of some supporting patient information leaflets, but its value has been noted by NHS Improvement who are keen to use our story about how patient letters can be improved.

5. In support of our Quality Strategy, we have been developing our approach to promoting innovation and to making improvement a part of everyone's work. To this end we are pursuing three strands of work:

- We have launched our Quality Improvement (QI) Academy to make training in improvement skills available to all our staff. Our "Bronze" level programme which provides an introduction to QI methods and tools has been run five

times over the last quarter with participants from all backgrounds and professional groups. Feedback from participants has been very positive with all agreeing that they would be able to use the skills they had learned, and would recommend the course. A "Silver" level course which will provide more advanced skills to staff members who are undertaking an improvement project has been designed and will be launched later this year.

- To recognise staff who have delivered QI projects, in July we held our first QI Poster Forum event. The brought together staff from across our hospitals to showcase the work they have been doing and to network with other staff who are leading QI projects. 55 posters were submitted and displayed representing a wide range of areas of our trust and a diverse range of subjects, and all of very high quality. Prizes were awarded for the three best posters; these were: Lucinda Armstrong for Criteria Led Discharge for wheezy children; Naomi Hryb for The Identification and Treatment of sepsis in adults, and Tom Badenoch, Peter Gravestock and Nathaniel Ahearn for Optimising the BRI fracture clinic. Participants were delighted to have the opportunity both to showcase their work and to exchange ideas and experiences with others. The forum was a very well supported event with a lively and vibrant atmosphere. The event is one we would wish to repeat at least annually.
- To support staff seeking support with improvement ideas our QI Hub will launch shortly providing a selection of resources and contacts. This will allow staff to make contact with QI experts to seek advice and guidance. The online QI Hub has been developed and is in final testing for launch late this month.

6. Our Outpatients Programme has undertaken preparatory work for two important developments. First is the further development of the Appointment Centre, including proposals to centralise appointment booking to the newly relocated appointment centre. This development will help increase operational productivity and improve the quality of service provided to patients. The proposals are being discussed with divisional teams before a detailed plan is agreed. The second development is to develop our use of the Electronic Referral System. This involves improvements to clinic management procedures, and the development of an electronic triage procedure to remove the paper from referral management. This work is key to reducing delays and will support the attainment of a CQUIN target.

7. In 2016/17 our work to improve patient flow in inpatient wards focussed on the roll out of our Ward Processes programme. Alongside this we have been developing tools to support flow through improved use of information in real time. The use of the Wardview electronic whiteboard is growing with the boards now operating successfully in several Medical ward areas. Preparations to implement in number of other wards are well advanced and we aim to deploy this to most inpatient areas this year. This work aligns with work to improve our use of Expected Dates of Discharge. Earlier this year we developed training and communications to drive use of EDDs and the whiteboard supports more timely updating of changes to EDD which aids both communication with patients and planning of care.

8. Alongside this we have been testing the use of electronic real time operational reporting. This means that data which is currently manually gathered and shared on paper in daily meetings such as the Division of Medicine Leadership in Flow meeting

and used to support site team meetings can be made available electronically. The methods and reports have been enthusiastically received by the ward teams. The use of electronic reporting of patients for the Discharge lounge is now being developed to provide the Discharge Lounge team with a forward view of patients suitable for their care.

9. We continue to work closely with partners on development of our Integrated Discharge Service. The project team is engaging extensively with staff from across inpatient areas to improve the process of discharge planning, with a specific emphasis on gathering and collating the various data on patient and family circumstances which is required for discharge planning. The work feeds into the important work to ensure a trusted single patient assessment which can be shared across partners and easily accessed and maintained.

10. Our Children's Flow programme continues to oversee a broad scope of flow improvement work across the BRHC. An online library of procedures and training materials has been approved by the Children's Executive and will shortly go live. This sets out standard procedures for numerous booking and flow management processes which have been developed with staff. Alongside this teams are working on a range of pathway improvement projects, and taking forward the ward processes programme. This work all supports our aim of maintain good ED performance in the Children's hospital and of maximising capacity ahead of the winter period to improve flow and minimise the impact of winter pressures on surgical services.

11. These areas of work support an overarching Urgent Care improvement plan which focuses on work to improve patient flow and improve our ED performance and patient experience. Further areas of work will be developed in the next quarter, including improvements to patient flow through the emergency department and into assessment areas and inpatient wards.

12. Close work has been taking place between IM&T and Transformation to agree how we maximise the benefits to our patients and staff form the digital transformation work which will take place under the GDE programme. We know that the key to maximising the benefits is securing the "Hearts and Minds" of the staff who will adopt the new tools and ways of working. To support this we are working on a joint methodology which will bring together users, IM&T, Transformation and Communications in partnership with suppliers to ensure we engage staff early and maintain an effective communication and engagement programme. Part of the benefits realisation work must capture how the new tools can address the issues and "gripes" that staff currently experience, and we wish to establish effective communications from the outset so that we maximise the benefits of this important programme.

13. Our Admin Teams Transformation programme in 2016/17 focussed on addressing some of the underlying causes of staff turnover in the teams supporting clinical admin. The group developed a competency framework and common job descriptions for the core clinical admin roles and used these to establish values abased recruitment. This work has also been used to develop a common training programme for admin staff. Beyond these areas, in 2017/18 based on stakeholder feedback, work will focus on three areas: Standardising and streamlining admin

processes to simplify the work, improve productivity and allow greater resilience and cross cover between teams; Developing the recommended training, including greater customer service and IT system training; and ensuring that we make better use of IT systems to support admin teams – both existing IT systems and those to come through the GDE programme – to support better customer service and productivity.

14. To support the delivery of savings from our transformation work, a newly established Productivity and Efficiency group is focussing on specific actions to implement savings measures from product ivy opportunities across our services. These include for example a focus on actions to respond to the outpatients clinic utilisation and DNA reports, and deriving efficiencies form the use of technology in our clinical admin processes. The group is proving beneficial in driving benefits realisation from transformational change work.

15. To support Building Capability among our teams we are focussed on actions to further improve the staff experience at UH Bristol. We know that improving the consistency of leadership behaviours will support this. To this end we have undertaken extensive engagement with leaders at all levels to hear what it is like to have a leadership role at UH Bristol, what challenges leaders face and what support is needed to help their development. This feedback has been used to develop a blueprint of desirable behaviours that we want all leaders in the Trust to exhibit. These will be shared widely during August and a series of 'Leadership Conversation' sessions across the Trust, led by members of the Senior Leadership Team, covering what it means to lead a team at our Trust.

16. To further improve staff experience across our Trust we have rolled out the Happy App extensively across our Hospitals. In 2017/18 we will continue to encourage its spread and introduce it to areas who wish to adopt the tool, but alongside this we will support teams to fully utilise the tool and the information it provides. A part of this will be improving our analysis of staff engagement figures so that we can better correlate findings and target support where required.

17. The latest version of the Transforming Care programme status report as prepared for the Transformation Board is attached at Appendix 2. The report is updated and added to each month as plans are agreed by the relevant project steering group.

Transformation priorities 2017-18

Delivering Best Care

- "Customer service mind set"
- Patient Communications
  - Letters
  - eMail
  - Voice/Telecoms
- Innovation & "Bright ideas"
- Outpatients Transformation

Improving Patient Flow

- Urgent Care
  - Ward processes & Real Time
  - Integrated Discharge
  - Capacity in and out of hospital
- Children's Programme
- Theatres Transformation

Delivering Best Value

- Efficiency & productivity improvement
- Benchmarking inc. the Model Hospital
- Savings Board programme

Renewing Our Hospitals

- Digital Transformation programme
- Strategic capital priorities
  - Multi-storey patient car park

Building Capability

- Improving Staff Experience
  - "Happy App" Roll-out
- QI Academy
- Leadership Development
- Admin teams Transformation
- Appraisals Improvement

Leading in Partnership

- Sustainability& Transformation across BNSSG
- 'Connecting Care'
- Partnerships:
  - Weston
  - N. Bristol
- Academic partnerships:
  - BRC
  - Genomics

Transforming Care Programme report - June 2017

Pillar	Details	Purpose	Key deliverables	Planned		Foreca	Current status	Risks	Benefits / Measures
Delivering best care	**Patient Communication** • Letters • Email • Telecoms **Exec lead:** Carolyn Mills **Project lead:** Alison Grooms **Transformation:** Caitlin Bateman **Project phase:** implementation	**Patient Letters** To improve and standardise the quality of all appointment letters that are sent by UHBristol to patients, guardians and carer (both electronically and non-electronically generated) in line with the Trust's Objective 5 - 'To improve how the Trust communicates with patients'.	• Phased roll out of letter upgrades underway in SHN, BHI, D&T, Med & BHOC • Elective patient leaflet signed off with patients • Children's outpatient leaflet signed off • Ongoing governance of patient letters to be agreed	Feb-Apr Dec Jul Sep	G G G G	Sep Jun	• Chemical Pathology letters have gone live. Gynaecology, NICU and SHN inpatients will go live in July. Majority of D&T, Children's outpatients and BHI inpatients letters have been signed off • Leaflets will be in use from 12th July • Signed off by parents in June and taken for final sign off at SDG 3rd July	• Ability to resource the rewriting of letters Trust wide against the letter quality standards. • Costs associated with sending of new Outpatient and Inpatient leaflets. Costs will be established during pilot phase.	• To improve patient experience and reduce patient communication related complaints and DNA's
		Medway based email correspondence To provide our patients with the option of receiving their appointment letter via email instead of post, as preferred by many of our patients, especially those with visual impairment.	• IT changes to Medway made to allow email validation • Training session arrangements in place for Appointment Centre Staff, Receptionists and Booking Coordinators. • Email collection commenced	May Feb Feb	A A A	Sep TBC	• Dependent on availability of final system • Go live date depending on IT timelines	• Low up-take of email option • Access to staff for training • Recruiting of Email Validators	• To provide our patients with the choice of receiving their appointment letter via email. • To reduce printing and postage costs
		Voice/Telecoms: Planning to be completed							
	Innovation & "Bright Ideas" **Exec lead:** Paula Clarke **Project lead:** Anne Frampton **Transformation:** Stephen Brown **Project phase:** Planning	To promote and encourage innovation and improvement, in order that staff with good ideas can bring them to life, so that patients, staff, the Trust and the wider NHS will benefit	• QI Connect pages set up • QI Forum Launched • First QI Forum held • QI hub go live	Mar Jun July July	G G G G				• Recognition of the quantity and quality of work being undertaken by staff
	Outpatients Transformation **Exec lead:** Mark Smith **Project lead:** Nina Stock **Transformation:** Marjolein Vries **Project phase:** planning	To deliver a high quality service through a friendly, accessible, consistent and timely service.	• DNA reduction targets and plans set by Divisions via Outpatients Steering Group • eRS CQUIN plan submitted (Q1 deliverable) • Workstreams plans developed • 93% of GP to Consultant referral clinics available on eRS • Transfer plan (for remaining Specialties to the Appointment Centre, including staffing model and timelines) presented at Outpatients Steering Group	Apr Jun Jul Oct Jun	G G G G A	Jun Jul	• To achieve the Q2 CQUIN target we need to be at 70% by Oct • To be presented 6th July	• Availability of technical solution to support refferal triage • Organisation support for Appointment Centre plans • Capacity to support Training workstream	• Improved patient experience • Productivity improvement from DNA reduction/activity increase • Achievement of eRS and Advice & Guidance CQUINs quarterly targets
Improving patient flow	**Urgent Care** **• Ward Processes & Real Time** **• Integrated Discharge** **• Capacity in and out of hospital** **Exec lead:** Mark Smith **Transformation Lead:** Jan Belcher & Lucy Morgan **Project phase:** implementing **Project leads:** Dr Rachel Bradley and Sarah Chalkley **EDD and ?Home within 24 hours:** Miss Meg Finch-Jones **Discharge Lounge:** Trevor Brooks **Operational Reporting:** Dr Rachel Bradley and Jan Sutton **e-Whiteboards and effective board rounds:** TBC **Flow Trackers:** TBC **IDS lead:** Andy Burgess **Capacity in and out of hospital:** Andy Burgess	Achieve agreed trajectories for performance against the 4-hour standard	• Urgent Care Programme signed off by SLT. Monitoring by Urgent Care Steering Group	Jun	G		• Priority actions agreed and underway • Additional prjects to be scoped	• Capacity within Divisions to lead and support programmes cross divisionally given operational demands and winter pressures • Short term capacity constraints within the Transformation Team • Divisions do not enact commitment to prioritise governance of ward processes at Divisional level	• Achievement of 4 hour improvement trajectory • Improve patient experience • Improved Bed Occupancy and reduction in outliers • Increase in before 12 noon discharges • Increase nos. to the discharge lounge • Reduced Green to go patient numbers
		Ward Processes and Real Time Roll out an integrated Ward Processes and Real Time programme	• Ward Processes roll out complete and embedded as business as usual	Mar	A	Oct	• W&C 7 Workshops complete, 2 outstanding. • SpS further follow up to be provided •SH&N have appointed project support, current focus remains for the general surgical wards •Repeated a discharge audit on A700 and A800		
			• EDD refresher training started • Comms and guidance on EDD is developed and delivered	Jun Jul	G G		• Training for ward clerks starts July, for junior doctors takes place at their induction in August • Approach to train and engage with nurses is being decided • Comms plan agreed and being rolled out		
			• Discharge Lounge: Band 6 nurse to manage improvement recruited • Link with Ward View to Include Opt Out Discharge Lounge Status pilot • Pharmacy process review • Operational Reporting and Bed Management: New reports rolled out to Respiratory and Hepatology pathway (A525,A524 and A522) • New Discharge Lounge report developed and ready to pilot	Jun Jul Ongoing Jun Jul	G G G A G	 Jul 	• Completed ahead of schedule. • TTAs management review complete, draft proposals to be considered by Physicians Exec • Electronic reporting used in Leadership and Flow meetings for A528, A400, A900 and C808 • Work started on report to identify patients suitable for the Discharge Lounge		
			• Ward View roll out	Aug	G		• C805, C705, C708 A515 live. Roll out plan for all divisions. Business continuity plan complete		
			• Surgical flow tracker implemented across SHN (including escalation SOP) • BHI flow tracker implemented across BHI (including escalation SOP)	Mar	G TBC		• Feedback from SH&N regarding next steps required with regard to escalation SOP • Requirements agreed and submitted to IM&T.		
		Integrated Discharge Service To establish a fully Integrated Discharge Service which reduces occupied bed days whilst improving patient outcomes and experience	• Discharge to assess pathways 2 review commenced with a SBCH focus • Revised BNSSG Managing Expectations for Discharge Policy launched • Pilot Single Referral Form	Jun Jun Jun	G G A	 Aug		• Insufficient capacity in the community • Insufficient resilience in community	
		Capacity in and out of hospital Work collaboratively with UHB stakeholders and system partners to identify the preferred model for out of hospital acute care provision.	• Short-life Task and Finish Group to develop model for acute care at home/IVT services set up • Develop business case for preferred model and present to SLT/Trust Board • Ensure full evaluation of Pulse initiative • Implement acute care at home service	May Jul Jul Oct	G G G G	 		• Funding availability • Time to mobilise • System partner engagement	
	Children's Programme **Exec Lead:** Mark Smith **Project Lead:** Lisa Davies **Transformation:** Melanie Jeffries **Project phase:** Implementation	To improve patient flow at Bristol Children's Hospital so that children and young people receive quality healthcare at the right time, in the right place with no delays.	• 'Regional hospital and network' work stream milestones agreed • Admissions to BRHC Connect hub go live • Analysis of CIU bed and room scheduling processes, including IM&T systems completed • 7 day working survey analysis completed. Options workshop held with staff to agree proposals. • Trial of Surgery in Winter process •Divisional EDD action plan implemented • Revised BRHC SAFER bundle launched alongside BRHC Professional Standards	Feb Feb May Jul Aug Sep Sep	A A G G G G G	Jul Jul Jun 	• Planned survey to whole hospital to understand current situation. • Elective booking standards for all 27 Specialties in BRHC currently being finalised and exceptions identified before go live. Aiming for 12th July launch. • Pilot of the bed request service order with one Specialty commencing July 3rd •Survey responses received. Plan to develop options for discussion with key stakeholders, which will feed into business planning • Two theatre lists per day identified 6 weeks in advance as "for cancellation" if no beds or staff available. This will enable lists with non urgent patients to be booked and help flow on the day. • EDD plan currently being developed in line with Trustwide Ward processes and real-time group • SAFER bundle written, circulated and consultation underway.	• Capacity of Programme Lead and Transformation Lead slows down delivery of programme	• Improvement in 4 hour target • Reduction in last minute cancellations
Renewing Our Hospitals	**Digital Transformation Programme** **Exec lead:** Paul Mapson **Project lead:** Steve Gray **Project phase:** implementation	Implementation of a cohesive set of clinically-focused applications and technologies that will transform business processes and provide users with tools and opportunities to improve patient care and achieve efficiencies.	• Nursing Electronic Observations pilot begins • EDM go-live in remaining sites • 'BigHand Go' project initiation phase • A project plan has been agreed for the paediatric chemotherapy project that will enable the project to meet the September deadline.	TBC Mar-18 Jun Sep	 G A G	 Jul 	• The project is currently in procurement. Subject to procurement Electronic Observation pilot could commence in August. • Using demand and capacity information of scanning to produce target go live dates for remaining sites • Initial dependent on IT infrastructure being in place. 'BigHand Go' will allowing clinicians to manage their dictations on a mobile device. • Little leeway in the plan to accommodate any delays.	• The are concerns around sufficient capacity within the EDM change team and scanning bureau.	• Improved patient safety and experience through ready access to timely, accurate information • Improved efficiency for all staff involved in handling/ viewing/creating patient information • Increased security of patient information
Building capability	**Improving Staff Experience - "Happy App" roll out** **Exec Lead:** Alex Nestor **Project Lead:** Anne Frampton **Transformation:** Caitlin Bateman **Project phase:** implementation	To provide a method for staff to leave real-time feedback regarding how they are feeling and the related causes. By doing so we will improve engagement with staff, and in turn we believe this will help us to provide a better quality of care to our patients.	• UHB governance ongoing to be agreed • Future roll out plans to be agreed	Apr Jul	A G	Jul 	• Recommend governance structure and how Happy App is run within UHB produced. • Roles agreed, specific targets to be agreed with Divisions	• Availability of IT support/resource • Willingness of staff to engage • Administrator resource to respond to comments	• Use of app (number of hits a day per area) • No of areas using website • No of resolved & closed actions per area • Improved staff Friends and Family
	QI Academy **Exec Lead:** Paula Clarke **Project Lead:** Anne Frampton **Transformation:** Stephen Brown **Project phase:** Implementation	To provide an overview of common QI methods, provide staff with the knowledge and skills to conduct their own Quality Improvement projects and signpost staff existing training and teams within the Trust who can help improve care.	• 3rd Bronze programme taken place • 4th Bronze programme held • Silver programme live • Plan for making training available to new Junior Doctor intake to be agreed	Jun Sep Q4 Jul	G G G G		• Take up of future sessions very popular, September session already fully booked	• Teaching resource to deliver the programmes	• Staff feedback on usefulness of Academy programmes • Increased knowledge around QI projects taking place across the Trust
	Leadership Development **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** Implementation	To improve staff experience and consistency of leadership behaviours across the Trust this programme is designed to introduce UHBristol Leadership Behaviours in 2017.	• Roll out of leadership behaviours across the Trust discussion held by subgroup • Roll out plan developed • Launch week of Leaderships behaviours • Subsequent briefings and communication sessions	Jun Jun Aug Sep	G G G G	 	• To be signed off by Execs on 28th June • Launch sessions planned		• Improvement in staff expereince
	Admin Teams Transformation **Exec Lead:** Alex Nestor **Workstream leads:** Peter Russell, Kate Parraman, Jenny Holly and Simon Walrond **Transformation:** Caitlin Bateman	To join up the work going on across the Trust in relation to our admin teams and realise the benefits that we could be recognising in our savings programme.	• Training plans and competency frameworks per role designed • Scoping the impact of job description roll out to current staff completed • Recruitment pilot finished and continuing as a cost pressure in HR • SOPs for each role created • Bank and agency recruitment process rolled out	Sep Sep Jun Mar Jun	A G G A G	 Jul 	• Feedback from managers about the TNA has lead to the development of training plans and timelines for new starters, and competency frameworks for existing staff, which will be developed for each role. • Initial scoping undertaken. • Business case to secure funding for assessment centre to be pursued • Existing SOPs have been edited for additional roles but capacity issues in the divisions is delaying the drafting of new SOPs relevant to each role • New process to request bank and agency staff rolled out	• Divisional ability to resource project • Possibility for consultation required for changes to job descriptions	• Reduction in bank and agency spend • Reduction in manager time spent recruiting admin roles • Reduction in staff turnover • Improved staff retention • Reduction in sickness
	Appraisal Improvement **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** Planning phase 2	• Staff appraisals are considered valuable and worthwhile • Staff receive an annual appraisal and regular reviews which integrate objectives, development, performance and career discussions • Staff appraisals link to the overall strategic direction of the organisation	• Scoping meeting phase 2 held	Aug	G		• To include leadership behaviours, 360, talent management		• Improved Staff Experience • Reduction in staff turn over • Able to monitor the quality of appraisals • Support a culture of Collective Leadership

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

Updated: 27.06.2017

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	24
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Congenital Heart Disease Network Annual Report		
Author	Andrew Tometzki, Clinical Director; Sheena Vernon, Lead Nurse; James Dunn, Network Manager		
Executive Lead	Sean O'Kelly, Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

The Congenital Heart Disease Network Annual Report sets out the key achievements of the network in its first year of operation, the key priorities for future years, and identifies risks to the delivery of NHS England's CHD standards

Key issues to note

Background:

The Congenital Heart Disease (CHD) standards were agreed by NHS England in July 2015 mandating that all CHD care be delivered through formal networks. The South Wales and South West Congenital Heart Disease Network was established in April 2016.

Hosting and Oversight:

- Hosted and funded by UHB, although funding for the network posts continues to be sought from NHS England.

- Formally reports to NHS England ODN Oversight Board and to NHS Welsh Health Specialised Services Committee (WHSSC)
- All provider Trusts in network are constituent members of the network (contractually bound through 17/18 contracts with NHS England and the Joint Committee in Wales). This means that they are required to work with the network to meet the CHD standards in their Trusts
- WHSSC are progressing toward adoption of the NHS England CHD Standards in Wales, subject to a minor amendment relating to interventional procedures.

NHS England Consultation:
The National Review of Congenital Cardiac Services is currently in the midst of a public consultation process due to end in July 2017. We await the results of the NHSE consultation so that the full impact on future activity within the Network, and importantly the Level 1 Centre (UHBristol), can be realised and then discussed with adjacent networks.

The CHD Network is now a year into a very intense programme focusing on gap analyses against NHS England's CHD Standards and forging formal links with specialist commissioning in NHSE and WHSSC as well as greater public/patient engagement. That said the full team was not fully established until October 2016 with the important appointment of a Network Lead Nurse (Sheena Vernon). This is a huge network with nearly 40 teams across the South West and South Wales. There is an ambitious year 2 programme planned.

Successes

- Governance and accountability fully signed off by WHSSC and NHS England
- Implemented risk, adverse incident & morbidity reporting system to gather and learn from whole network
- Gathered key performance data (waiting times, access to imaging, nurse provision) from all Trusts and used this to drive equity in access
- Developed network-wide Adult Congenital Heart Disease (ACHD) clinical protocols, with paediatric protocols in progress
- Established an annual CPD programme for paediatric CHD. ACHD programme already exists
- Agreed a partnership with Above & Beyond to raise charitable funds across region
- Network-wide working group developing best practice guidance for palliative care and bereavement
- Established comprehensive Patient & Public Involvement (PPI) via clinic visits, listening events and online surveys
- Analysed current gap analysis of self-assessments against standards supported by peer review visits.
- Request from Swindon to increase peripheral clinic activity leading to growth in surgical caseload in Bristol.
- Created a tiered approach to psychology support across the whole network bridging local through to tertiary level services.

Priorities

- Develop a consistent network wide approach to paediatric/adult transition with specialist nurse support.
- Develop a network of local link nurses with appropriate competences supporting models of best practice
- Review and support peripheral hospitals in closing the gap against standards following peer review visits.
- Survey medical workforce to assess and advise regarding risk of impending consultant

retirements
- Launch comprehensive network website
- Commence remote surgical pre-assessment clinics in Cardiff in autumn 2017 using video conferencing to link to Bristol, with a view to rolling out model across region
- Improve inpatient transfer between Bristol and Cardiff to include transfer checklist, provision of ward welcome booklets to patients before transfer and escalation of delays
- Establish programme of audits to drive clinical quality across network
- Establish an annual patient information / education day in 2018
- Establish network best-practice in line with standards on dental, fetal, learning difficulties and transition
- Uncover funding flows into each centre, 'ideal' tariffs, and opportunities for using different funding models to deliver quality investments

Opportunities
- Link into research and transport networks
- Working with Clinical Reference Group to develop patient held record nationally
- Work with adjacent CHD networks to improve patient centred care

Risks
The network is proactively managing risks and threats as they are identified. The mitigations that have been put in place are detailed on page 9 of the Annual Report. The key risks are:
- Long outpatient waiting times in several centres, including Bristol Children's
- Long waiting times for surgery in Bristol Children's
- Workforce risk due to lack of consultants in training with expertise in congenital cardiology, particularly in the adult services
- The pressures on general paediatric and general adult cardiology services in DGHs mean that CHD services struggle to attract investment.
- Identifying funding of nursing staff to develop as CHD link nurses hence core quality elements of the NHSE standards will be difficult to deliver

Threats
- No funding secured from NHS England for core network posts
- No additional funding across network to meet standards
- Sufficient PICU and ward capacity will be required to ensure Bristol can meet NHS England's requirement for 500 surgical cases by 2021

Appendices
- CHD Network Annual Report
- Latest newsletter can be found at https://tinyurl.com/CHDNews
- The NHS England Congenital Heart Disease Standards can be accessed at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/chd-spec-standards-2016.pdf

Recommendations

Members are asked to:
- **Note** the report.

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☒
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☒	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

South Wales and South West
Congenital Heart
Disease Network

Annual Report

2016/17

GIG CYMRU NHS WALES

NHS

Contents

Introduction from the Clinical Director 2

Foreword 3

The CHD Network in Context 3

Our Vision 4

Our Strategy and Work 4

Notable Clinical Progress 4

Funding 4

Network Oversight 5

Nursing Update 6

Assessment against Standards 7

Priority Actions for CHD Standards by Section 8

Communications and Engagement 9

Governance & Monitoring 10

Key Risks and Mitigations 10

Work Plan – 16/17 Review and Plans for 17/18 12

Annual Report

Introduction from the Clinical Director

Welcome to the 2017 Annual Report for the South Wales and South West Congenital Heart Disease (CHD) Network.

First and foremost I am grateful to University Hospitals Bristol NHS Foundation Trust for hosting and pump priming the CHD network team since April 2016 whilst we seek alternative funding streams for the future.

Our primary aim as a network is to bring together the clinicians, commissioners, patient and parent representatives, and other stakeholders to meet NHS England's CHD Standards. Whilst there is a small team coordinating the network, our success is dependent on the commitment and energy of all those involved with CHD services across the region. Accordingly, we have been humbled by the enthusiastic support of all stakeholders from clinical, nursing and managerial staff in all the CHD centres across South Wales and South West England. Importantly we have commissioning representation from both NHS England and NHS Wales agreeing our terms of reference and governance structure. I'm especially grateful to our parent and patient advocates who have used their voice effectively at both board meetings and listening events throughout our first year.

It has been a very busy first year since our launch event in June 2016. Caitlin Marnell, the CHD Network Manager, drew together input from across the network to put in place a robust and challenging work plan. This work has been continued by James Dunn, whilst covering Caitlin's maternity leave. Sheena Vernon, Lead Nurse for the CHD Network, joined us in October 2016, providing a central point to draw together and drive the momentum of the nursing and clinical priorities across the region. We are ably supported by Rachel Benefield, Network Administrator. Finally we made the important appointment of David Mabin as Chairman. He brings a wealth of experience as a senior clinician in paediatrics as well we being an Associate Clinical Dean at the University of Exeter Medical School.

This report sets out the achievements of the network to date, ongoing challenges and importantly our goals for the future. The network team has visited almost all of our Level 3 centres, seeing the progress the centres have already made and quantifying a gap analysis against NHS England's standards for congenital heart disease. This analysis has been central to informing our work plan and ensuring our activities as a team are directed towards supporting centres to meet the standards.

There is much work to do and, I along with my team, look forward to working with our partners across the network in fulfilling our aims and objectives for the coming year.

Dr Andrew J P Tometzki

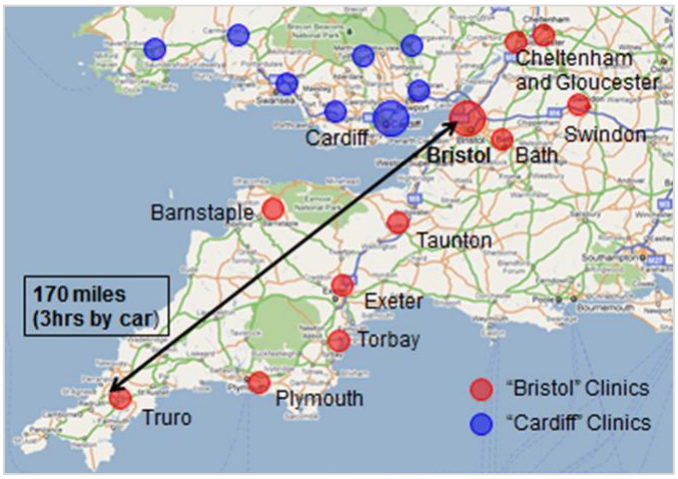
Clinical Director

South Wales and South West Congenital Heart Disease Network

Foreword

The South Wales and South West Congenital Heart Disease Network brings together clinicians, managers, patients and commissioners across the region to work towards meeting the new standards. The network comprises:

- 18 adult and 19 paediatric providers, covering level 1 (specialist surgical), 2 (specialist medical) and 3 (local centre) services
- over 6,500 children and 8,000 adults with congenital heart problems
- 30 clinics per week, seeing more than 20,000 outpatient attendances per year
- over 40 specialist and link nurses
- 37 paediatricians with expertise in cardiology
- 17 adult cardiologists with specialist congenital interest
- over 425 heart operations



The CHD Network in Context

For well over a decade congenital heart disease has been under scrutiny within the UK. There were long-standing concerns that smaller centres were not sustainable. In 2006 Dr Shribman, National Clinical Director for Children, Young People and Maternity, along with Prof Roger Boyle who was then the National Director for Heart Disease, conducted a workshop on congenital heart services.

In October 2009, Prof Sir Bruce Keogh launched the safe and sustainable review of congenital heart services in the UK. This concentrated on paediatric services alone, despite the advice from clinical advocates who wished that adult congenital heart services be considered simultaneously. This process concluded on July 4, 2012 however this resulted in judicial reviews. Consequently, the Secretary of State requested an independent review. The review concluded that the recommendations were flawed and suggested a rethink encompassing the whole patient journey to include fetal through to adult congenital heart disease. (Ref 1)

NHS England therefore announced in July 2013 that it would embark on a new congenital heart review. After a lengthy period of consultation recommendations were made in July 2015. Service specification standards were published in May 2016. We are now in a period of consultation on the implementation of these standards.

A cornerstone of these recommendations is the formation of a formal network to include a Clinical Lead, Network Manager, and Nurse Lead. As such, in April 2016, University Hospital Bristol established to South Wales and South West Congenital Heart Disease Network to work with clinicians, managers, patients and commissioners across the region to work towards meeting the new standards.

Our Vision

Our vision is to be a Network whereby:

- Patients have **equitable access** to services regardless of geography
- **Care is provided seamlessly** across the Network and its various stages of transition (between locations, services and where there are co-morbidities)
- **High quality care** is delivered and participating centres meet national standards of CHD care
- The provision of **high quality information** for patients, families, staff and commissioners is supported
- There is a strong and **collective voice** for Network stakeholders
- There is a strong culture of collaboration and action to **continually improve** services

Our Strategy and Work

Our objectives and work plan were developed in collaboration with key stakeholders from across the network and underpin a detailed work plan overseen by the network team

Strategic Direction	To lead providers in meeting the new standards
Monitor and Improve Quality	To measure and drive achievement of standards
Timely, Equitable Access	To ensure equity across the region
Improve Patient Experience	To understand and improve patient experience
Education & Training	To increase access to training opportunities
Information and Communication	To be a central point of information
Value for Money	To maximise the impact of investments in CHD services

Notable Clinical Progress

The full details of our progress and plans are detailed in the *Work Plan – Review and Future Plans* section. Key successes include:

- Completion and publication of ACHD protocols – pregnancy, obstetrics and lesion-specific guidance
- Palliative care pathway work under way
- Paediatric lesions pathways in progress
- Risk & incident reporting processes in place
- Annual M&M / governance meeting in place
- Securing local service provision through SLAs for shared medical input between DGH providers
- Supporting the rationalisation of provision between Gloucester and Cheltenham, supported by parent representatives

Funding

The network is currently funded by University Hospitals Bristol, although alternative funding models are being sought with commissioners.

The pay budget in 2016/17 was over-spent to fund back-fill arrangements for maternity cover. The service expects to be within the pay budget in 2017/18.

The non-pay budget was underspent in 2016/17. There is expected to be a higher degree of non-pay spend in 2017/18, including the design, build and hosting of the network website.

Network Funding	2016/17
Pay	
Pay total expenditure	£139,642
Pay budget	£116,149
Pay Variance	***-£23,493***
Non pay	
IT, phones & office	£3,328
Travel	£932
Network events	£1,897
Miscellaneous	£645
Non-pay total expenditure	£6,802
Non-pay budget	£16,000
Non pay variance	***£9,198***
Total Variance	***-£14,295***

Meet the Team

David Mabin, Network Chair

Sheena Vernon, Lead Nurse

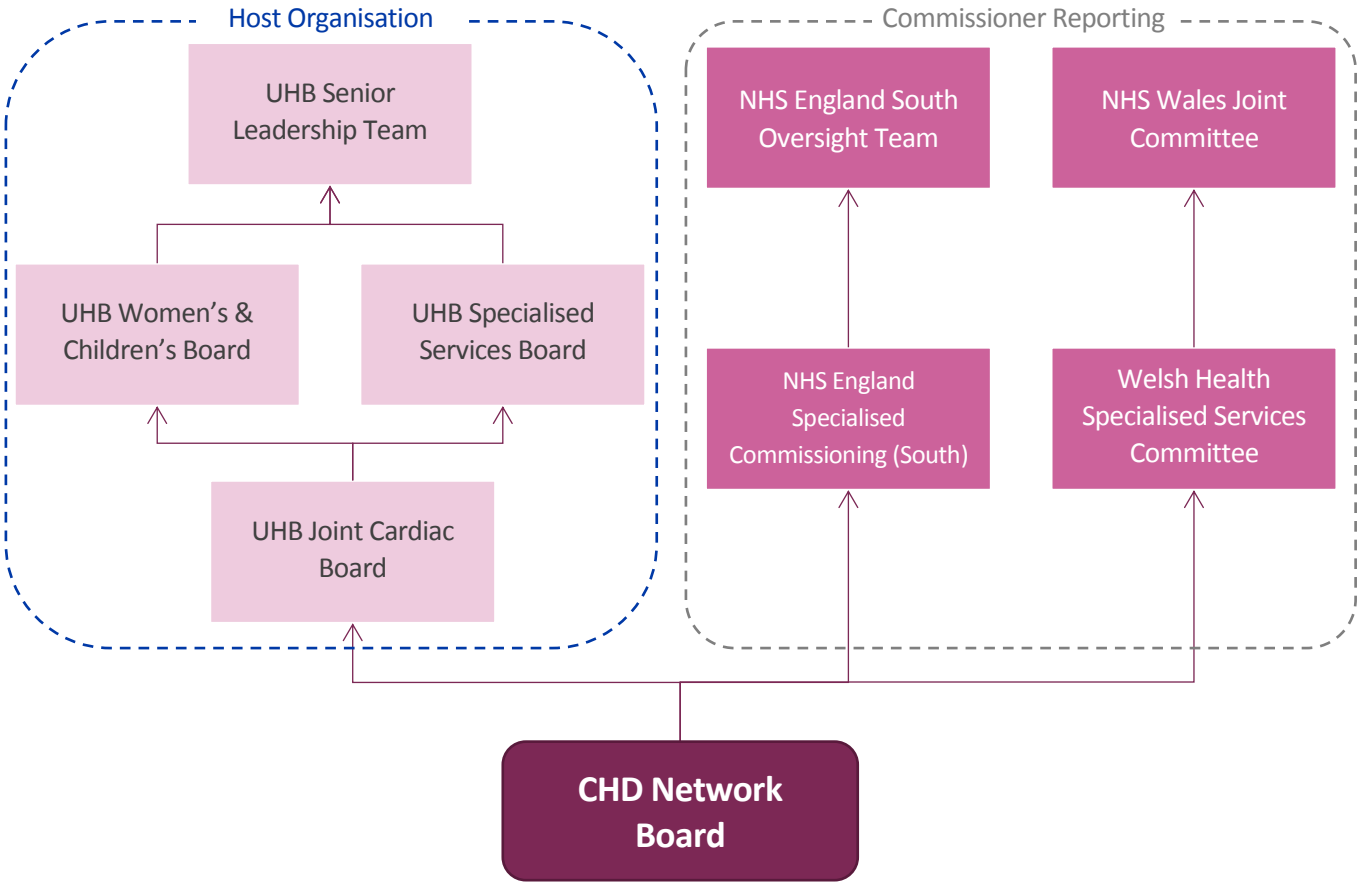
Andrew Tometzki, Clinical Director

Rachel Benefield, Administrator

James Dunn, Network Manager

Network Oversight

The network is governed by a Board which has representatives from across the level 1, 2 and 3 centres, including clinicians, nurses, managers, patients and parents, and commissioners. The Board is accountable to the Joint Cardiac Board in the host organisation, University Hospitals Bristol NHS Foundation Trust (UHB); in NHS England to the Specialised Commissioning (South) ODN Oversight Board; and in Wales to the Welsh Health Specialised Services Committee. This network is unique in that it covers two separate national health bodies i.e. NHS Wales and NHS England. There are fundamental differences in structure and funding. The network is enjoying very positive engagement from both specialised commissioning bodies in both NHS England and NHS Wales.



Nursing Update

The CHD standards dictate that each centre should have a CHD Link Nurse and that patients should have access to a Clinical Nurse Specialist (CNS). Centres have found it difficult to identify nurses within their institutions and to release them from other duties to undertake this role. Some, however, have been able to develop a link nurse role and the network is supporting these to ensure delivery of quality benefits. Network support has included clarifying the expectations of a link nurse in line with the RCN standards and developing a 3 year education programme.

Cardiology training days targeted at paediatric and community nurses have been established hosted by the Faculty of Children's Nurse Education in Bristol. The 15th Annual Regional Adult Congenital Training day is on September 19th 2017. Comparable training days for the paediatricians with expertise in cardiology are planned for February 2018.

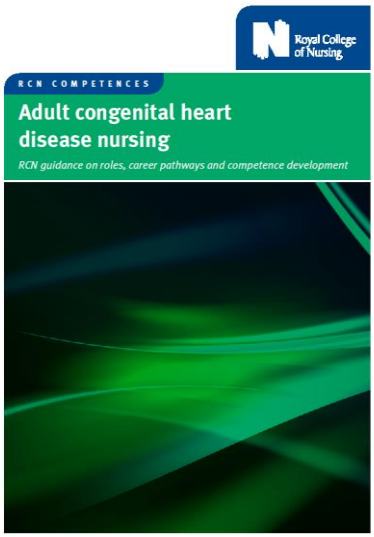
There are plans to increase the support that the level 1 and level 2 Clinical Nurse Specialists provide to local centres, both in terms of attending annual young person's clinics, and by providing advice and support for locally based link nurses. Ultimately this is reliant on the local centres identifying, releasing or appointing appropriate members of staff.

The timescales of the action plan for Link Nurses role

Year 1 (2017)	Year 2 (2018)	Year 3 (2019)
- Identify nurse Level 3 centres - Clarify support in Level 2/3 centre - Shadowing in Level 1 on ward and OPD - Meet Level 2 CNS teams - Gap analysis 31 surveys from ACHD Day - Book onto appropriate course 'Congenital Network Nurses' group email for comms, training, peer support	- First nurses attending Adult and Paed courses - Participate in local clinics - Explore 'Helpline' options - Set up 3-6monthly Link Nurse Meetings - Charity funding to support - RCN competences completed - Annual transition clinics in Level 3 centres supported by Level 1 CNS	- All nurse have completed courses - Local education to up skill other RGN - Helpline established - In patient support established

Other nursing work in 2016/17 has included:

- Development of the palliative care pathway
- A fetal service survey
- Gathering patient information for the website
- Taking forward work on transition
- Identifying appropriate cardiac information for the outreach clinics to give to patients and families
- Supporting the Level 1 and 2 clinical nurse specialist teams
- Presenting the work of the CHD network to other associated nursing network (e.g. South West Palliative Care and the Paediatric High Dependency Nursing Network).



Assessment against Standards

One of the key priorities of the network is to support constituent members to achieve the NHS England Standards. In year one a considerable amount of work has gone into benchmarking each centre against the 200 standards. 28 of 30 centres have now completed the self-assessment. The network has visited 27 of these centres to validate the self-assessment scoring.

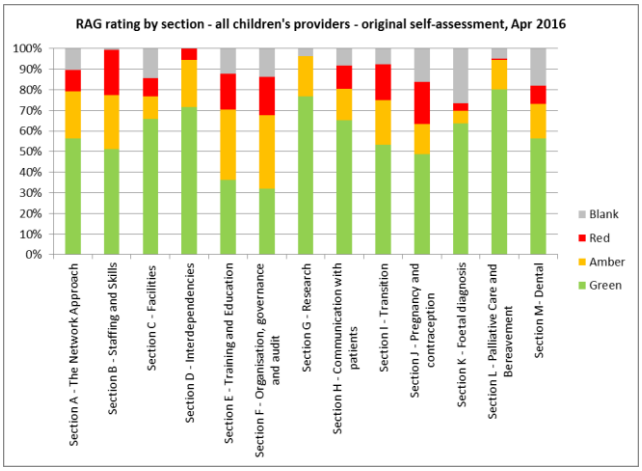
Through the self-assessments, validation visits and workshops we have identified the actions required to meet the outstanding standards. These have been grouped into those that the network will lead, and those that local centres need to address with network support (*See* Priority *Actions for CHD Standards by Section).* Over the coming months the network team will be writing to each centre providing a breakdown on their outstanding actions and seeking assurance that there is commitment to work with the network partners to achieve these.

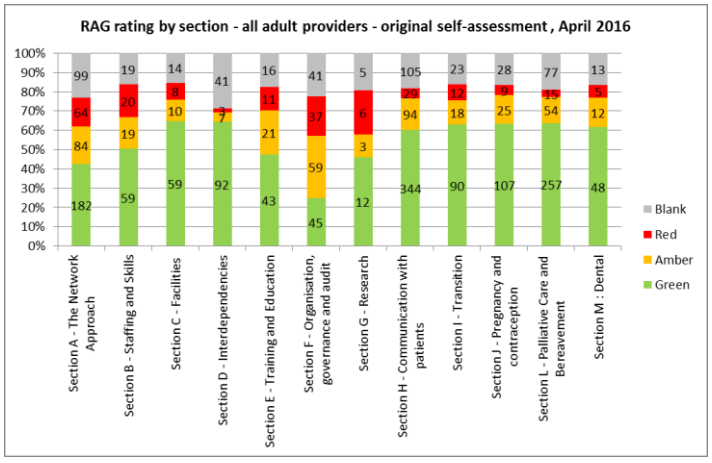
Progress to date

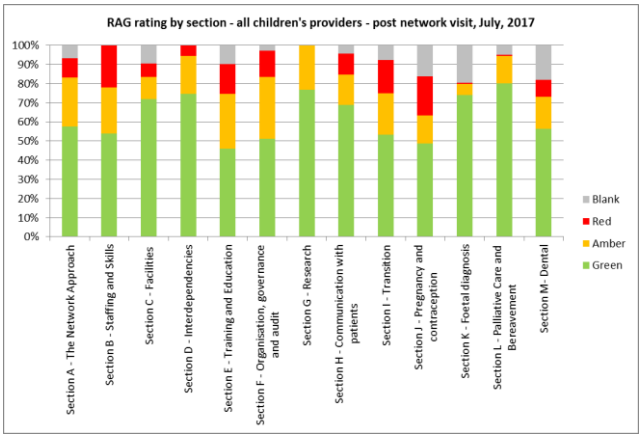
As well as undertaking baseline assessments, in year 1 there has been progress in achieving the NHS England standards through collaborative work at the network meetings as well as action taken locally in each centres. The tables below detail the increase in 'green' standards since the inception of the network.

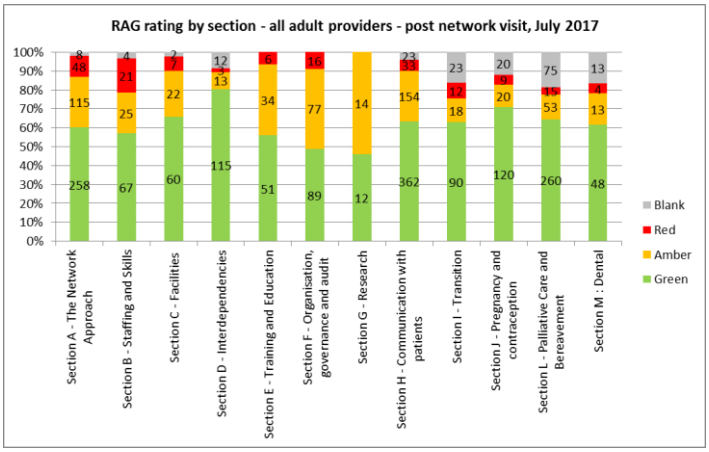
Total Standards for all Adult's Providers	2016	2017	Change	% change
Green	1338	1478	140	**10%**
Amber	406	414	8	**2%**
Red	219	150	-69	**-32%**
Blank	105	26	-79	**-75%**

Total Standards for all Children's Providers	**2016**	**2017**	**Change**	**% change**
Green	1586	1688	102	**6%**
Amber	513	511	-2	**0%**
Red	285	263	-22	**-8%**
Blank	255	177	-78	**-31%**









Priority Actions for CHD Standards by Section

Section	Priority Actions for Network	Priority Actions for Local Centres
Section A - The Network Approach	- Develop guidelines and protocols - Support development of national care templates - Roll-out telemedicine and remote MDT access	- Release staff for CPD, remote MDT access - Ensure network protocols and approaches are embedded
Section B - Staffing and Skills	- Enable L1/L2 CNS to provide support to link nurses and clinics across network - Identify key data for databases	- Identify link nurses to work alongside consultants in clinics - Ensure that basic data (e.g. wait times) can be provided
Section C – Facilities	- Support local centres with business cases - Coordinate between centres for access to facilities provided at a network level	- Ensure facilities can be provided in line with standards and promote these requirements in capital business planning
Section D – Interdependencies	- Ensure that every centre has a pathway access to all relevant services, even where not provided locally	- Ensure network escalation protocols are adhered to and that non-cardiac services (e.g. A&E) are aware of the 24/7 network support for cardiac patients
Section E - Training and Education	- Deliver planned training for consultants and nurses, including making talks available online - Continue to identify additional needs - Enable access to MDT for CPD	- Support staff to attend or access talks online - Ensure that staff attend appropriate local non-specialist training and escalate to network if this is not provided locally
Section F - Organisation, governance and audit	- Develop a network audit plan - Continue to develop a network database (e.g. of waiting times)	- Ensure participation in network audits - Collect and submit basic data (e.g. waiting times / patient numbers)
Section G – Research	- Work with clinicians involved in research to ensure that access is equitable	- Ensure patients are informed of any research opportunities that arise
Section H - Communication with patients	- Provide access to information and advice through the network website - Work with L1/L2 CNSs to provide support to link nurses in peripheral clinics - Implement a psychology plan giving criteria-based access to information and support, including web resources, telephone and face-to-face appointments	- Through link nurses and local clinicians ensure that patients are sign-posted to relevant information on the network website - Ensure that patients are given as much information and support locally, and directing appropriately to L1 and L2 services as these are developed
Section I – Transition	- Establish CNS support for a transition clinic in each centre at least once per year	- Ensure a structured approach to transition locally, following a recognised pathway, engaging with local hospital transition nurse
Section J - Pregnancy and contraception	- Share network protocols for pregnancy and contraception	- Adopt network protocols, promote these across local hospital, and highlight any further training / service needs to network
Section K - Foetal diagnosis	- Understand and address inconsistent fetal pick-up rates - Support cases for service investments in UHB and UHW - Ensure CNS support for all diagnoses	- Review local CHD detection rates - Assess compliance with Fetal Anomaly Screening Programme (FASP) guidelines - Support sonographer cardiac focused training e.g. Tiny Tickers
Section L - Palliative Care and Bereavement	- Develop network palliative care and bereavement pathway	- Adopt network pathway and ensure that patients are given access to local and network support services
Section M : Dental	- Work with dental specialists to develop network guidance	- Ensure that patients are informed of the need for regular dental check-ups. Refer to specialist centres where required

Communications and Engagement

Engaging with our patient and clinical colleagues has been an essential part of our work in the first year. We have undertaken a significant amount of work to ensure that we are involving patients and parents in shaping our work and that we represent the whole clinical network.

Key activities have included:

- Patient and parent representatives as members of the network board
- Newsletter circulated to all inpatients, in clinics and via email
- Visits arranged to 10 peripheral clinics to meet with patients and families in clinic
- Fetal survey undertaken looking at the experiences of all service users across England and Wales for 12 months
- Formed a charity partnership with Above & Beyond
- Developed strong links with patient and parent support groups
- Evening listening and engagement events in Gloucester and Exeter attended by 50+ families. Videos and FAQs posted online
- Hosting an engagement event in May in response to the NHS England consultation
- Patient and parent virtual reference group established to advise on service changes
- Web site due to launch Summer 2017
- Facebook due to launch Summer 2017
- Patient engagement event planned in Cardiff in autumn

In 2017/18 we will continue to develop our methods of engaging with and listening to patients and parents. Central to this will be the launch of our network website, due for late summer 2017. This will be a central resource for patients, parents and clinicians.

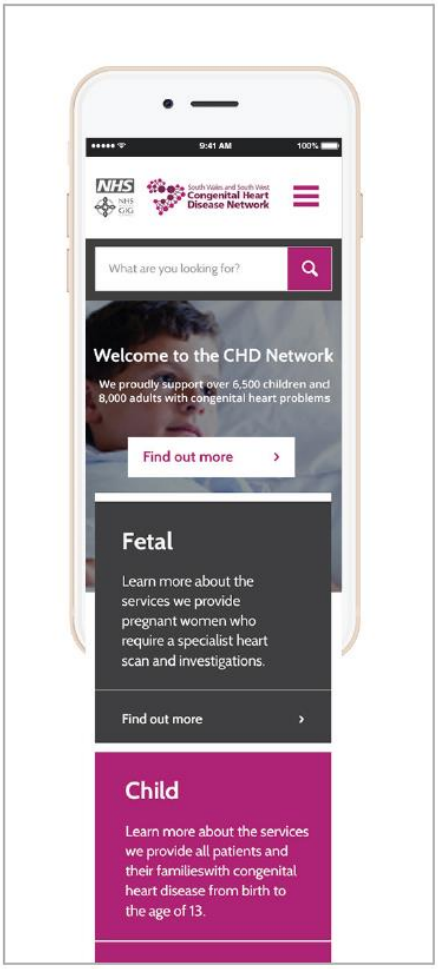
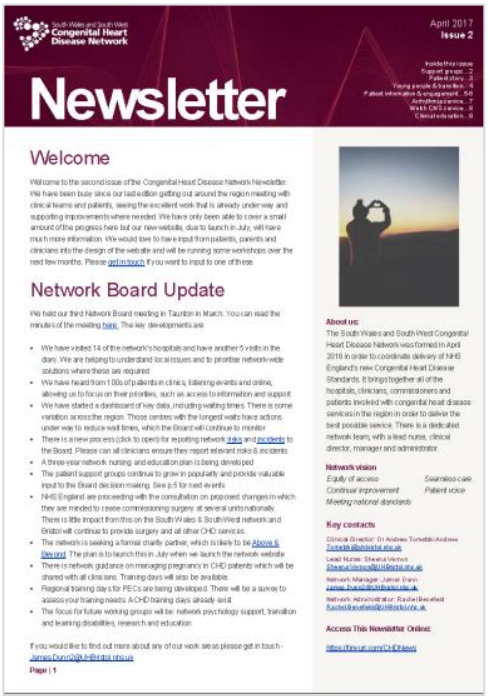


Figure 1 - Mock-up mobile-friendly website design



Governance & Monitoring

In line with the CHD standards, the network has established a governance and reporting structure. Whilst individual providers are still responsible for reporting and acting upon incidents and risks locally, the network reporting structure ensures that learning this can be shared across institutions and that the network can support if multi-provider intervention is required. The structure also gives a clear route of escalation to the network and then to commissioners should organisations be unable to effectively mitigate risks or address incidents internally.

Risks and incidents will be reviewed quarterly at the Network Board meeting. All clinicians are invited to annual Governance and M&M meeting where there is discussion and dissemination of broader learning from incidents and adverse events; aggregate review of mortality and morbidity and learning from this; review of new guidelines & changes in practice; summary of national (NICOR) and local data (waiting times, audits etc.); and forward view of planned audit / research.

Key metrics such as outpatient waiting times, wait for MDT discussion and surgical waiting lists are monitored quarterly. Actions are agreed for those areas that present a concern to the Board.

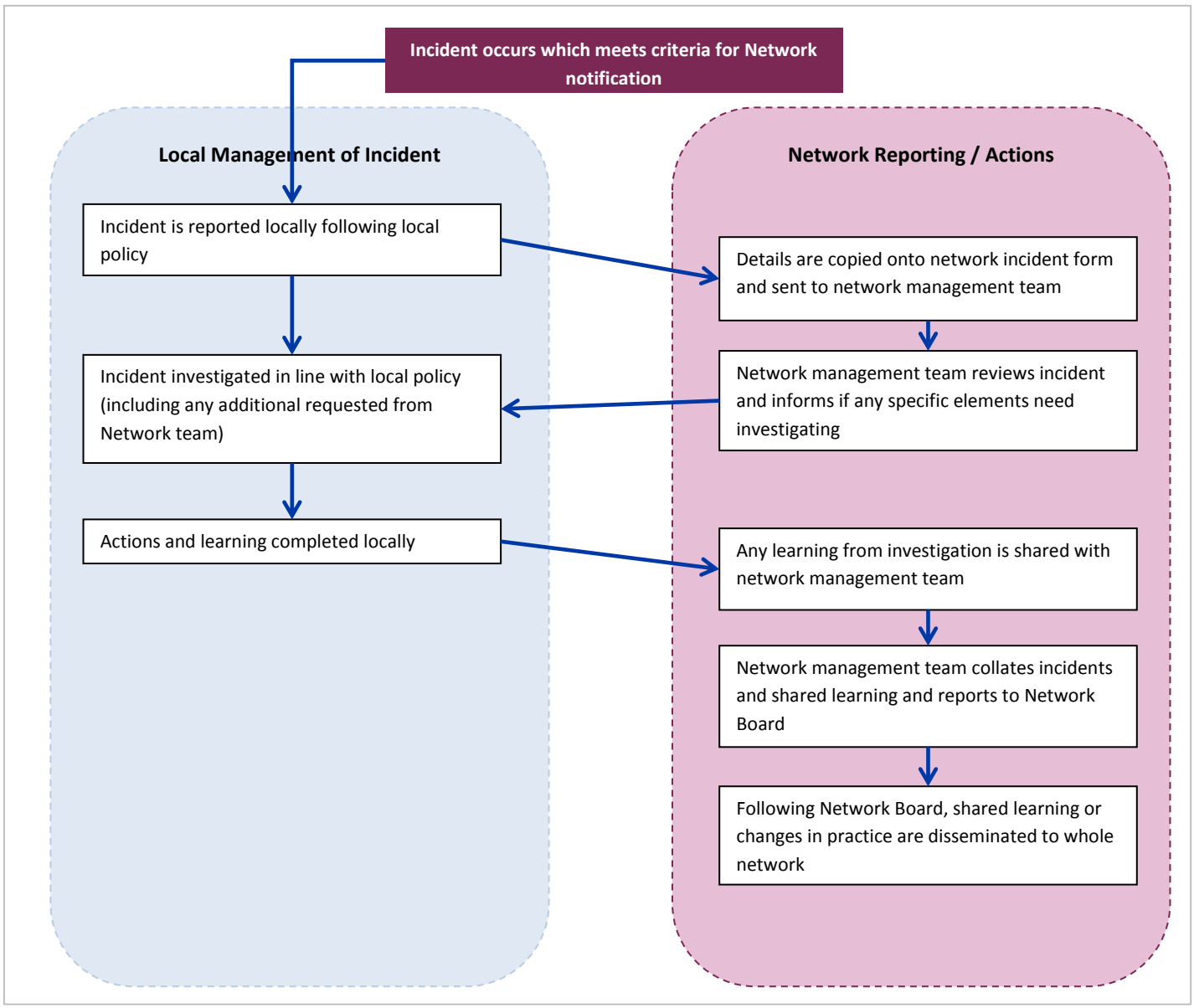


Figure 2 - Reporting & Learning From Network Incidents

Key Risks and Mitigations

Risk	Mitigation
There are long outpatient waits in a number of centres, including Bristol children's service	The board is monitoring waiting times quarterly and seeking assurance from local centres that plans are in place to address these. Where required the network has supported with capacity planning and will oversee proactive solutions to staffing gaps (e.g. through joint appointments or SLAs)
There are long waits for surgery in Bristol children's service	The board is requesting quarterly assurance from UHB that it has a robust plan in place to meet current and projected surgical demand. The network team has provided assistance with developing capacity plans.
There is a longer term workforce risk associated with a lack of consultants training with expertise in congenital cardiology, particularly in the adult services	The network is undertaking an anonymous survey of consultants' intentions with regard to service provision and retirement. This will enable a true picture of the risk to be shared with commissioners, Trusts and medical training bodies. Where there are known issues the network is working with individual providers to gain commitment to proactive succession planning for CHD medical workforce
The pressures on general paediatric services and general cardiology services in DGHs mean that CHD services struggle to attract investment or recognition from Trust managements. This includes pressure on local clinicians delivering core clinical commitments, as well as on the additional, but essential service coordination, clinical advice and CPD.	The network team has sought to meet with senior clinical and operational managers as part of our site visits to raise awareness of the network and clinical standards. All Clinical Directors have been written to requesting they support protected time for CHD (including non-DCC activities) within clinician job plans. In 17/18 the network will be writing to each centre seeking commitment to work towards meeting the CHD standards. This is also laid out in contractual commitments between NHS England / WHSSC and each provider
Some local services are currently unable to release nursing staff to develop as CHD link nurses, meaning some of the core quality elements of the standards will be difficult to deliver	The network team has produced clear guidance on the link nurse role and a 3-year training plan. We will continue to engage with nurse managers to support the identification of suitable staff. The network will actively support those link nurses that have been identified to ensure their value can be demonstrated within their Trust and across the network.

Threats	Mitigation
No funding secured from NHS England for core network posts	Through the UHB contract managers, the network will continue to seek funding arrangements, either through NHS England and WHSSC or as a contribution from provider Trusts
No additional funding across network to meet standards	The network will continue to provide innovative solutions to minimise the need for additional investment (e.g. criteria based access to psychology services). Where there is significant risk to the quality of service delivery as a result of a lack of investment the network will use its risk procedures to escalate this to local Trust management and commissioners for re-consideration of funding priorities
Sufficient PICU and ward capacity will be required to ensure Bristol can meet NHS England's requirement for 500 surgical cases by 2021	UHB are actively involved in the national PIC review. It is considered that this may be delayed by the outcome of the NHS England Congenital Cardiac Consultation, so it may be wise for UHB to consider proactive investment in PIC capacity ahead of the publication of the PIC review. The network team are happy to support evidence for any such case.

Work Plan – 16/17 Review and Plans for 17/18

Key Objective	Successes in Year 1 (16/17)	Aims for Year 2 Onwards (17/18)
To provide strategic direction for CHD care across South Wales and the South West	- Established network board, governance structures - Gained commitment from English and Welsh commissioners to formally recognise role of network in supporting provider trusts to work towards the national standards - Commitment from all provider Trusts to be constituent members of the network and collaboratively work to achieve standards	- A statement of intent from each provider committing to CHD services, including achievement of standards, development of current workforce and succession planning, addressing service risks and equipment issues - Identify an ideal tariff for CHD clinics and work with local services and commissioners to ensure that services are appropriately funded to meet standards. Where block contracts are in place, to support contractual discussions about CHD provision (as above) - To have oversight and assurance of delivery of the relevant outstanding actions from the Bristol Independent Review and UH Bristol's action plan with NHS England
To monitor and drive improvements in quality of care	- 28 out of 30 CHD centres have self-assessed against the CHD standards - 27 out of 30 centres have been visited, or have upcoming visits from the network team to review assessments and support work towards achieving standards - Work-streams have been started in key areas including palliative care, pregnancy care, psychology support - Clinical protocols for ACHD have been shared and adherence is being audited - Network governance and incident reporting structure in place to ensure there is knowledge of and learning from adverse events and risks	- Continue to use self-assessment data to drive service improvements and share best practice, focusing on those areas (such as transition, psychology, information and support) where the biggest impacts can be made - Work with commissioners, independent bodies and providers to ensure standards are met when deficiencies are identified - Continue to develop clinical guidance and protocols and promote audit of those protocols already in place to demonstrate improvements - Continue to develop a dashboard of key metrics, using this to drive equity in provision, for example of waiting times for treatment - Promote the use of the risk and incident reporting processes, sharing learning through board meetings and annual M&M - Set up of Network Mortality and Morbidity reviews - Delivery of an annual audit programme agreed with members, and reporting outcomes
To support the delivery of equitable, timely access for patients	- Established a network dashboard of wait times, using this to identify and improve long waits - Supporting local capacity planning and business cases for investment in services, including (UHB children's service, Truro adult service, Hywel Dda paediatric service)	- Use newly published fetal datasets to understand variations in fetal identification and implement actions to address these - To develop better mechanisms for sharing patient information, images and access for MDTs - Implement options for increased access to L1/L2 CNS through telephone / video appointments - Demonstrate increased access to L1/L2 specialist psychology for patients from across the network, through telephone / video / f2f appointments, as well as access to information and local support where specialist input is not required - Use relationships with clinicians, mangers and commissioners to work with centres to address issues where inequities exist

To support improvements in patient and family experience	- Invited 6 patient / parent reps to join our network Board - Run workshops in Bristol, Gloucester and Exeter, with further planned in Cardiff - Collated patient information leaflets and shared this with each centre - Attended 10 outpatient clinics (children's and adults) to speak to patients about what we can do differently - Supported the NHS England public consultation on changes to CHD services	- Formally launch partnership with Above & Beyond with network website launch. Continue to strengthen partnerships with other charities - Support Heart Families South West and other support groups to grow local support groups across the region - Use website as single resource to direct patients to support and information. Ensure that every clinician knows about, and directs patients to these resources - Through the website, gather patient feedback, both about specific services and the overall provision of CHD care - Continue to grow engagement along the lines patients and families want - e.g. evening Q&A sessions, events closer to home
To support the education, training and development of the workforce within the Network	- Set up a Paediatrician with Expertise in Cardiology (PEC) study day for February 2018 - Promoted adult congenital study days - Established learning needs for link nurses - Supported medical job planning to protect time for CHD, including CPD and MDT attendance - Mapped the provision of nursing workforce across the network - Presented at the all-Wales audit day - Presented at the SW palliative care network meeting	- Support the delivery of targeted training and education to cover - ACHD & paed nurse training, PEC and ACHD study days - Undertake a review of medical workforce and develop a forward view, taking account of the risks in succession planning, particularly around ACHD services - Use network board events to deliver training or CPD alongside core network business - Support development of a programme of research across the Network
To be a central point of information and communication for Network stakeholders	- Established a quarterly newsletter - Communicated the network priorities, work plan and Board summaries to system executives	- Ensure website is key resource for communication to all stakeholders. Use feedback options to guide development of new content - Continue to communicate key information to all stakeholders, moving away from paper newsletters towards electronic communication options
To ensure it can demonstrate the value of the Network and its activities	- Rapidly established credibility with commissioners, clinicians and managers - Raised the profile of CHD services within provider organisations and commissioners - Begun to deliver improvements against CHD standards and to share learning between centres - Able to demonstrate improvements towards more equitable access to care across the region - Increased understanding of congenital services and pathways in associated networks - Created a forum for addressing core issues – e.g. pregnancy services, palliative care and psychology	- Proactively seek funding opportunities for Network and its stakeholders from different sources e.g. CQUINs, charity, grants etc. - Undertake review of Network against relevant 'Value for Money' Framework - Continue to seek feedback from stakeholders on value of events etc. - Remain within budget and ensure effective use of resources - Escalate Network issues appropriately to commissioners, external bodies etc. and ensure action is take when required

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	25
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Clinical Research Network Annual Report		
Author	Dr Stephen Falk		
Executive Lead	Sean O'Kelly, Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☐

Executive Summary

Purpose

The purpose of this report is to receive for information the Clinical Research Network: West of England Annual Report 2016/17 and Annual Plan 2017/18 as the host organisation.

Key issues to note

The working relationship between the Local Clinical Research Network's (LCRN) senior leadership team and the Host Organisation University Hospitals Bristol NHS Foundation Trust remains strong and effective.

The Host Organisation engages directly via the Local Clinical Research Network Executive Group chaired by the Trust Medical Director or Deputy maintaining oversight of all aspects of the Network's business including contract compliance, local funding models and performance.

The Host Organisation has continued to fulfill its responsibilities as an Network Host Organisation in line with Department of Health Local Clinical Research Network's Host Organisation agreement.

The report has been approved in principle by the National Institute of Health Research (NIHR), Clinical Research Network, Coordinating Centre (CRN CC). A review of progress against the report was completed on the 29 June 2017 with the CRN CC, attended by Dr Mark Callaway Deputy Medical Director/ CRN Executive Chair, Dr Stephen Falk Clinical Director, Dr Sue Taylor Interim Chief Operating Officer. The network was commended on progress against its Annual Report 2016/17.

The Network Annual Report for 2016/17 and Annual Plan for 2017/18 is available in the supporting papers pack.

Recommendations

Members are asked to:

- **Note** the Annual Report 2016/17 and Annual Plan 2017/18 for the Clinical Research Network for assurance.

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☒

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Clinical Research Network**
				29 June 2017

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	26
Meeting Title	Trust Board	**Meeting Date**	28 July 2017
Report Title	Changes to UH Bristol Constitution		
Author	Amanda Saunders, Head of Membership and Governance		
Executive Lead	Pam Wenger, Trust Secretary		
Freedom of Information Status	Open		

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

The purpose of this report is to seek approval from the Board for the following changes to the Trust's Constitution.

Key issues to note

The Constitution is a core requirement in a Trust's application for NHS Foundation Trust status. As a minimum it must be in accordance with Schedule 7 of the NHS Act 2006. Any review of the Constitution requires the approval of the Board and the Council of Governors' and the proposed changes will be considered by the Council of Governors in July 2017.

The Governors' Constitution Focus Group has undertaken an annual review of the constitution and this report proposes a number of amendments.

Proposed amends: The amends are noted below.

1. **Non-executive Director Designate role** – to add further clarity to the role, an additional point to be added to the section on Board of Directors – Composition, to follow 25.2.3 on p. 14, to read:
   '*25.2.4 Non-executive Directors (Designate) will attend Board of Director meetings and relevant Committee meetings playing an active role by providing advice and appropriate challenge across the range of Trust healthcare services and supporting business areas. However, Non-executive Director (Designates) are not formally appointed as a board member and should circumstances arise, will not be eligible to vote.'*

2. **Appointed Governor Voluntary & Community Sector** – in lieu of an appropriate and equitable appointing body it is recommended that the role is removed from the Constitution. Engagement with the voluntary and community sector will continue via other stakeholders internal and external to the Trust.
   Remove reference to the Voluntary & Community Sector role in Annex 4, p. 27.

   A copy of the Constitution is available at University Hospitals Bristol Foundation NHS Trust Constitution 2016

Recommendations

Members are asked to:

- **Approve** the changes to the Constitution.

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☒	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Constitution Focus Group**
				19 July 2017

Cover report to the Public Trust Board meeting to be held on Friday, 28 July 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	27
Meeting Title	Trust Board	**Meeting Date**	29 June 2017
Report Title	Governors Log of Communication		
Author	Amanda Saunders, Head of Governance and Membership		
Executive Lead	John Savage, Chairman		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

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.

Recommendations
Members are asked to: • **Receive** the report.

Intended Audience (please select any which are relevant to this paper)								
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public ☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

ID	Governor Name		
188	Malcolm Watson	***Theme:*** Estates - Fire Safety	***Source:*** From Constituency/ Members

Query **03/07/2017**

A number have Trust members have contacted the Trust seeking assurance of the fire safety standards of the cladding recently installed to the BRI façade, in light of the Grenfell Tower disaster.

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **04/07/2017**

The Trust can advise that I can advise that the d&b facades system installed utilises only inert, solid aluminium which has an A1 NON COMBUSTIBLE fire rating, the highest that you can have, with no requirement for fire retardants. The system also incorporates A1 NON COMBUSTIBLE integral mineral wool insulation and firebreaks. Incidents of severe fire have occurred in our completed buildings, (d&b completed projects, not at the Trust), and the system has met the fire performance requirements in all respects, the fire has not propagated and has been fully and successfully contained.
UHB Estates leads have also reviewed the installation at the BRI with our Fire Adviser and have provided reassurance that all the required fire breaks are in place. A further check of other areas of over cladding, particularly the cedar panelling to the rear of the Children's Hospital and the face of the ward block, have also been undertaken and the Trust fire officer is carrying out a review of the build drawings to reassure that these have been constructed correctly with the right fire breaks. These are relatively new installations and so the expectation would be that have been constructed correctly with all the relevant sign off from Building Control, Site Inspectorate etc. In the light of any issue this will be escalated and appropriately addressed.

Status: *Closed*

ID	Governor Name		
187	Clive Hamilton	***Theme:*** Performance	***Source:*** Governor Direct

Query **09/05/2017**

18 week Referral to Treatment target for Neurology - noted on page 81 of the March 2017 Board Report (Appendix 3) the neurology pathway is only achieving a 79.9% response to the 92% target and again on page 115 of the April Board report (Appendix 3).

As this pathway is significantly and consistently below target have action plans been developed to bring the referral time into line?

Division: Medicine ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 10/05/2017

Response **19/05/2017**

Neurology performance has been below the 92% national RTT standard due to difficulties and delays in recruiting to key posts within the service. The number of long waiters had now reduced down from a peak in January of 122 to 84 at the end of April. Waiting List initiatives are being offered to the Clinical Fellow for the service, to attempt to further reduce the number of long waiters. This is a part of the Trust's overall RTT Sustainability Plan for 2017/18.

Status: *Closed*

ID	Governor Name		
186	Florene Jordan	***Theme:*** Incident reporting	***Source:*** Governor Direct

Query **25/04/2017**

Can governors understand what steps are taken by managers in the Trust when investigating incidents to ensure that the correct contributory factors to the incident are identified and correctly documented?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **21/06/2017**

The trust requires timely reporting of all incidents and 'near misses' to improve patient and staff safety and quality of care. The trust has a Policy for the Management of Incidents, which applies to all staff. The purpose of this policy is to ensure there is a systematic trust wide approach to the reporting and investigation of incidents and to ensure that analysis of incidents takes place to capture learning which is used to reduce the risk of a recurrence and to inform service improvements. The trust promotes an open and transparent approach to incident reporting and investigation and to seek to learn lessons and implement risk reduction measures when things have gone wrong. The incident reporting process must therefore be viewed as non-threatening to ensure the involvement of staff.

The policy details the process for responding to a reported incident and when followed this should ensure the contributory factors are assessed and correctly documented or in the event of this not being the case in the initial logging of the incident the correct information added at initial review. Regular review of incidents reported and the incident reporting process is undertaken at a local and trust wide level, and where there is an identified cause for with concern with regards to accuracy of documented information this is addressed with staff/ departments/ divisions as a point of learning improvement to the overall process.

Status: *Awaiting Governor Response*

ID	Governor Name		
185	Rashid Joomun	***Theme:*** Clinical Genetics department	***Source:*** Other

Query **20/04/2017**

On a recent walk around with the Division of Specialised Services we visited the Clinical Genetics department at St Michael's Hospital. The location of a maternity hospital as the site for a clinical genetics team is far from ideal and conditions for staff are cramped. Are there any plans for the department to be relocated to a site more conducive to the type of work they do? And furthermore, when will this team benefit from its patient records being available electronically via Evolve?

Division: Specialised Services ***Executive Lead:*** *Medical Director* ***Response requested:***

Response **26/04/2017**

As part of the Trust's strategic plans we are looking at long term solutions for the accommodation of the Genetics department. While we evaluate the options we have made available additional rooms at South Bristol Community Hospital and the children's hospital to help ease pressures. The genetics department will benefit from Evolve later in the year, once the system has been rolled out through the Bristol Royal Infirmary and Bristol Heart Institute.

Status: *Awaiting Governor Response*

184	Mo Schiller	***Theme:*** Changes to doctors' mess at BRHC	***Source:*** Other

Query **20/04/2017**

Governors are aware of plans to convert the current doctors' mess in the children's hospital into space for another use, and that this has caused concern among doctors working in this hospital. What assurance can governors seek that any proposed changes have been properly assessed and communicated to the doctors involved, and that any proposed alternative space for the doctors mess is fit for purpose?

Division: Women's & Children's Services ***Executive Lead:*** *Medical Director* ***Response requested:***

Response

There are no current plans to move the doctors mess. There was a proposal a couple of years ago as part of a review of accommodation in the King David's building. This went to full consultation with the junior doctors. This proposal is no longer on the table as other solutions were found.

Status: *Closed*

ID	Governor Name		
183	Mo Schiller	***Theme:*** Heygroves Theatres	***Source:*** From Constituency/ Members

Query **23/03/2017**

A Foundation Trust member who had surgery in Heygroves Theatres at the end of last year raised with me a concern that the pre-operative area was so cold that she needed to be warmed by a special heat blanket before staff could insert an IV line. I understand that this has been a common problem and am keen to find out why there is an issue with the heating in this area so that it can be resolved for future patients.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **24/04/2017**

The heating in the pre-operative area, located in the King Edward Building, is now connected to the constant temperature hot water supply and commissioned to our requirements. The Trust Estates team is not aware of any current issues, however from time to time, breakdowns do occur, especially with the older parts of the estate linked to this area.

The pre-operative area (or SAS Pod) is a new addition to our estate, located on the roof of the King Edward Building, completed in 2015. Adjustments were made in the first winter of 2015/16 in order to optimise the system which was originally commissioned summer 2015.

When the refurbishment of the whole King Edward Building was completed in winter 2016/17, the heating to the pre-operative area was rebalanced as there were additional demands on the supply. The Capital team has confirmed that this was around Christmas 2016 which may in fact coincide with your operation.

Now having three months data, we believe there is a further local balancing optimisation that would benefit the system including the SAS Pod and we are just commissioning this. Please be assured that this system is monitored and we are able to respond swiftly to any issues, however we continue to strive to optimise our energy as part of on-going savings and sustainability work.

Status: *Closed*

ID	Governor Name		
182	Bob Bennett	***Theme:*** Return of NHS equipment	***Source:*** From Constituency/ Members

Query **23/03/2017**

I have been approached by many outpatients regarding the return of NHS equipment such as crutches, walking sticks, commodes etc. as they do not know of any way of returning these items when no longer required. One patient has six walking sticks given to her on many visits to hospital. Can the Trust clarify the process of returning such items for reuse as it is costing the NHS many thousands of pounds in 'lost' equipment.
Follow up question added 10/05/17:
In light of the response received, please can we be advised as to when and how patients are informed of the process for returning items as several patients have informed me that no information was provided, raising the original query.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **24/04/2017**

Currently there is a process in place via an external contractor for collection and recycling of frames and crutches provided via community services, the Trust is in negotiation to try and expand this collection service for equipment provided by the Trust to inpatients on discharge. The service will have responsibility for collecting items to patients, patients will be advised of this. in addition, patients can choose to, and do bring back equipment once they have finished with it and this, where appropriate, is recycled.

Status: *Closed*