

**Meeting** Trust Board

**Date & time** Monday 29 March 2010 at 10.30 am

**Venue** Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

## AGENDA

**To: Trust Board:**

**John Savage (Chair), Sarah Blackburn, Iain Fairbairn, Lisa Gardner, Paul May, Selby Knox, Kelvin Blake, James Catterall, Emma Woollett, Irene Gray, Steve Aumayer, Jonathan Sheffield, Paul Mapson, Alison Moon, Robert Woolley**

| No                             | Agenda Item                                                                                                                                                                                                                                                                                                                                                        | Lead                                                                                                                     | Page No.                         |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 1.                             | <b>Apologies :</b>                                                                                                                                                                                                                                                                                                                                                 | Chair                                                                                                                    | -                                |
| 2.                             | <b>Declaration of Interests</b> - Board Directors to declare any interests                                                                                                                                                                                                                                                                                         | Chair                                                                                                                    | -                                |
| 3.                             | <b>Minutes</b> - to agree minutes of the meeting held on 26 February 2010 for accuracy                                                                                                                                                                                                                                                                             | Chair                                                                                                                    | 1                                |
| 4.                             | <b>Matters Arising</b><br>- to note matters arising from meeting held on 26 February 2010                                                                                                                                                                                                                                                                          | Chair                                                                                                                    | 7                                |
| 5.                             | <b>Acting Chief Executive's Report</b> - to note                                                                                                                                                                                                                                                                                                                   | Robert Woolley                                                                                                           | Verbal                           |
| <b>Performance and Quality</b> |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                          |                                  |
| 6.                             | <b>Performance Recovery</b> – to receive a progress report                                                                                                                                                                                                                                                                                                         | Irene Gray                                                                                                               | 9                                |
| 7.                             | <b>Performance &amp; Quality Report</b> – to receive and discuss<br>(a) Summary Performance Report<br><br><ul style="list-style-type: none"> <li>- Workforce</li> <li>- Clinical Quality and Effectiveness</li> <li>- Patient Experience</li> <li>- Public Health</li> <li>- Patient Access and Targets</li> </ul><br>(b) Infection Control – to receive an update | Steve Aumayer<br>Jonathan Sheffield<br>Alison Moon<br>Jonathan Sheffield<br>Irene Gray<br><br>Alison Moon<br>Chris Perry | 17<br><br><br><br><br><br><br>73 |
| 8.                             | <b>Quality Strategy</b>                                                                                                                                                                                                                                                                                                                                            | Jonathan Sheffield                                                                                                       | 125                              |

| No                              | Agenda Item                                                                                                                                                                                  | Lead                            | Page No.  |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------|
| 9.                              | <b>Finance</b><br><b>Report from Finance Committee 23 March 2010</b> – to note<br><b>Financial Report</b> - to receive<br><b>Resources Book 2010/11</b> – to approve (Circulated separately) | Lisa Gardner<br><br>Paul Mapson | 143       |
| 10.                             | <b>Single Sex Declaration</b> –to approve                                                                                                                                                    | Alison Moon                     | 161       |
| <b>Assurance and Governance</b> |                                                                                                                                                                                              |                                 |           |
| 11.                             | <b>Minutes of the Audit &amp; Assurance Committee</b> - 9 March 2010 – to note                                                                                                               | Sarah Blackburn                 | 177       |
| 12.                             | <b>Assurance Framework 2009/10</b> – to approve a quarterly review                                                                                                                           | David Seabrooke                 | 183       |
| 13.                             | <b>Corporate Risk Register</b> – to approve a quarterly review                                                                                                                               | Anne Reader/<br>Alison Moon     | To follow |
| 14.                             | <b>Draft Assurance Framework 2010/11</b> – to note                                                                                                                                           | David Seabrooke                 | 207       |
| 15.                             | <b>Equality &amp; Diversity</b> – to approve                                                                                                                                                 | Steve Aumayer                   | 225       |
| 16.                             | <b>Capital investment planning - decision and monitoring structure</b> – to approve                                                                                                          | Robert Woolley                  | 233       |
| 17.                             | <b>Care Quality Commission Registration</b> – to approve                                                                                                                                     | Chris Swonnell                  | 241       |
| <b>Strategy &amp; Planning</b>  |                                                                                                                                                                                              |                                 |           |
| 18.                             | <b>Corporate Objectives and action plans 2010/11</b> - to approve                                                                                                                            | Robert Woolley                  | 277       |
| 19.                             | <b>Teaching and Learning</b> - Update on Progress                                                                                                                                            | Steve Aumayer                   | 299       |
| <b>For information</b>          |                                                                                                                                                                                              |                                 |           |
| 20.                             | <b>Emergency Planning - Pandemic Flu preparations update</b> - to note                                                                                                                       | Alison Moon                     | 311       |
| 21.                             | <b>Civil Contingencies annual report</b> – to note                                                                                                                                           | Irene Gray                      | 315       |
| 22.                             | <b>Six Lives – Learning disabilities briefing</b> - to note                                                                                                                                  | Alison Moon                     | 347       |
| 23.                             | <b>Any Other Business</b>                                                                                                                                                                    | Chair                           |           |
| 24.                             | <b>Date of next meeting</b> : Thursday 29 April 2010                                                                                                                                         | Chair                           |           |

David Seabrooke,  
Company Secretary  
Trust Services

The person dealing with this meeting is:  
David Seabrooke, 0117 342 3605

**University Hospitals Bristol NHS Foundation Trust**  
**Minutes of the Trust Board Meeting held on Friday 26 February 2010**

**Present**

John Savage (Chair)  
Kelvin Blake  
Prof Selby Knox  
Lisa Gardner  
Emma Woollett  
Sarah Blackburn  
Paul May

Robert Woolley  
Irene Gray  
Paul Mapson  
Steve Aumayer  
Alison Moon  
Jonathan Sheffield

**In attendance**

Dr Peter Wilde  
Dr Chris Monk

Dr Mike Nevin  
Chris Perry

**021/10 Apologies** were received from Dr Jacquie Cornish

**022/10 Declarations of Interest** There were no declarations of interest.

**023/10 Minutes**

The minutes of the meeting of the Trust Board held on 25 January 2010 were agreed as a correct record.

**024/10 Matters Arising**

The Board noted the proposed schedule of seminars through to June 2010.

**025/10 Acting Chief Executive's Report**

Robert Woolley reported on the following:

- As noted in the report on performance recovery, the Trust was expected to make substantial improvement in the position against red rated Monitor targets 4; a suggestion from Monitor of engagement from the NHS Flexible Resourcing to assist with the 4 hour target was being followed up
- The Histopathology Inquiry was proceeding, with interviews scheduled through to May. The results of the random sample audit had been sent to the Royal College of Pathologists whose opinion would be submitted to the inquiry direct; the external statistical analysis was being peer reviewed. It was likely now that the inquiry would extend into the summer.
- The inquiry report into Mid-Staffordshire hospital had been published; one of its recommendations was that all providers should review their performance, standards and governance arrangements. Arrangements were being made for this to take place in the Trust and this would be reported to the Board; any urgent matters arising from the report would be acted on straightaway. Printed copies of the full report would be made available to board members and governors. Copies of the report's findings were circulated at the meeting.
- The planned south Bristol community hospital had reached financial close in February and the Trust would continue to work closely with the PCT and community health

- In view of recent comments about the benefits of homeopathy, Robert Woolley confirmed that the Bristol Homeopathic Hospital was a mandatory service provided by the Trust and that it would continue to provide services commissioned by the PCTs

### **026/10 Performance Recovery – Progress Report**

The Board received a report from Irene Gray advising it on progress against the delivery of the 4 hour, 18 week admitted and cancer 31 and 62 day minimum standards. The report included details of the trajectories submitted to Monitor at their request on 11 February.

She reminded the Board of the current trajectories as follows:

- Overall Monitor governance rating – for Q3 had been red; expecting to be amber for Q4
- 4 hours A&E:
  - 98.3% achieved in January 2010 – the first time the standard had been achieved in the month of January and is a reflection of the impact of improvement actions taken over the past twelve months
  - The year-end projection remained 97.96%
  - Based on current performance, achievement of this standard was projected for Q4 and quarterly thereafter
- Cancer – actions had been implemented to address gaps in process and ensure robust processes across all tumour sites and the Trust was on track as follows:
  - 31 days (diagnosis to treatment)- achieve in Q4 and thereafter
  - 31 days (subsequent treatment) - achieve in Q4 and thereafter
  - 62 days – this is currently projected to be achieved from Q1 2010/11 and thereafter, however, work was continuing to bring forward achievement if possible
- 18 weeks (admitted) – in accordance with the approach agreed on 9 February, which varied the plans submitted to Monitor in January, the Trust was
  - closely managing waiting lists in February/March to minimise additions to the backlog, whilst reducing the backlog within agreed levels
  - planning further action in Quarter 1 2010/11 to reduce the backlog
- the adopted approach would result in:
  - Q4 – achieving the target
  - Q1 – The approach required to significantly reduce the backlog would impact on performance resulting in an amber rating. This would position the trust to meet the target in Q2 and onwards at specialty level

In relation to A&E Services, Irene Gray confirmed that capacity planning took account of variables such as the season, adverse weather, school and bank holidays, evening attendances at the Children's A&E and greater use was made of a shared events calendar. Week-end capacity had been increased to better manage patient flow. There remained a concern that community services provided less support at weekends and out-of-hours GP services often resulted in patients being referred to the emergency department inappropriately. Cases involving mental health and addiction were often turning into A&E breaches due to lack of strong mental health support. The issues are being the focus of discussion with the commissioners in developing a management plan. The management of outlying patients was beginning to improve and twice daily reviews were continuing. A new accountability framework for divisions and consultants at specialty level would be in place from April.

As well as strengthening its own capacity at weekends, the Trust was working with other providers to improve provision and to better manage demand for A&E services. Much scheduled activity had been moved to Tuesdays as there were often pressures in the system on Mondays following busy weekend activity.

Irene Gray undertook to report back to the Board on progress with and outcomes from the discussions about this that she was having; the Chair asked her to feed back on problems so that this could be followed-up.

Emma Woollett suggested there needed to be creativity and collaboration in the Trust's work with PCTs. The Board recorded its satisfaction with the progress on the targets set out in the report and articulated its determination that this standard should not be allowed to slip.

## **027/10 Performance & Quality Report**

The Board received the summary performance report.

### **Workforce**

Steve Aumayer highlighted the following:

- the reduction in the rate of unfilled shifts for nursing and midwifery since January 2009
- the closing gap between budgeted posts and actual in post including agency and bank
- winter flu absences had peaked; sickness reporting had improved, due to changes in process, but this would mean that meaningful trend data would not be available for a couple more months
- statutory and mandatory training compliance was still a mixed picture; there had been a strong forward movement in most areas, but child protection required further focus. The new Information Communication Technology system was able to track and write personally to staff about non-attendance on courses and could also remind staff when training would be due for renewal; this would be managed through by line managers as appropriate
- 90% compliance on training was felt to be an appropriate target for compliance as it ensured people were trained whilst allowing for new starters and job movers.

It was suggested that staff accountability could be improved as regards training compliance by linking this more closely to appraisal and reward systems. Staff also needed to be released to take part in training.

Jonathan Sheffield added that the website through which clinical appraisals were delivered had been off-line due to a security breach and this could delay completion of appraisals until July.

### **Clinical Quality and Effectiveness**

It was noted that the hospital standardised mortality rate was now 61.3 which was an outstanding achievement in relation to pressures of clinical demand. Quality plans would be considered at the March meeting of the Board that would capture and report patient experience, including clinical care, the standard of communications and staff attitude. Robert Woolley added that the proposed corporate values included a focus on how the trust recognised and celebrated success.

### **National Performance**

Irene Gray introduced the new style report which gave an 'at a glance' view of performance across all targets by month and by quarter for CQC and Monitor compliance. The report highlighted the three continuing challenges of underperformance and performance not met. The Monitor compliance

framework identified that, the Trust was expecting to report as amber for Quarter 4 with current performance trajectories. As requested at the January Board meeting, a table setting out the Trust's performance on 4 hour A&E had been introduced, which gave a comparator with a selection of like size organisations from the national table of 157 other providers. The Trust ranking had improved on performance in quarter and performance in month currently placed the Trust at 33<sup>rd</sup> in ranking.

Paul May reflected that the improved summary performance report was a good step forward and emphasised the need to use the information effectively. He added that a culture of openness and the ability for patient experience to be captured were important factors.

### **Infection Control**

The Board received a report giving the latest information in relation to controlling Clostridium Difficile and MRSA. Chris Perry informed the Board that work to improve screening performance was underway. It was noted that the Jan 10 figures for hand hygiene should have been shaded green.

### **028/10 Financial Report**

The Board received the report of the meeting of the Finance Committee on 23 February and the report of the Director of Finance.

Lisa Gardner highlighted the following points:

- There was a month 10 deficit of £4m
- It was still projected that the Trust would end the year on plan, but this was reliant on the unsustainable use of reserves
- There was a slight improvement by divisions in the run rate
- The Finance Committee continued to raise concern that Cash Releasing Efficiency Savings was not being achieved and had scrutinised the establishment of a Performance Improvement Committee which was putting in place work streams to address Cash Releasing Efficiency Savings shortfalls
- The working capital facility would be re-tendered

Paul Mapson informed the Board that some of the income the Trust had earned through activity would present a financial challenge to its commissioners. He also highlighted that the banking tender had been awarded to RBS Nat West for 3 years from April 2010. Irene Gray added that a committee she had established in 2008 had now reformed to identify and oversee corporate work streams to achieve Cash Releasing Efficiency Savings.

### **029/10 NHS Constitution**

The Board received a report setting out the provisions of the NHS Constitution, comprising rights and pledges and responsibilities for patients and NHS staff. The duty for the Trust to have regard to the provisions of the NHS Constitution had come into force in January 2010.

The Strategic Health Authority had requested all Trusts in the south-west to complete a matrix assessing compliance with the rights and pledges to patients and staff to provide information to the Department of Health. It had been agreed to comply with the Strategic Health Authority's request as a good corporate citizen.

The Trust would declare compliance in terms of its policies and systems on all aspects; however in terms of staff and patient experience, it was felt that an amber rating should apply to the pledges to staff, on infection control and equalities. The pledge as to treatment times was assessed as amber, pending the completion of all the action plans in quarter 1 of 2010/11. A gap in respect of an adopted policy on copying medical letters to patients was being remedied. An amendment to the description in respect of infection control (row 14) was agreed.

The report set out proposals for the appointment of an NHS Constitution champion and it was also agreed to re-visit the vision and values to ensure these reflected the requirements of the NHS Constitution.

The Board approved the response to the SHA set out as appendix b to the report and asked David Seabrooke to ensure that arrangements were in place for Trust policies and reports to the Board to take account of the NHS Constitution.

### **030/10 Annual Planning 2010/11**

The Board received a report outlining the process for the production of the annual plan. Action plans for the delivery of each adopted objective would be reported to the Trust Board, which would include measurable objectives.

### **031/10 Making Our Hospitals Better – Programme Priorities 2010/11**

The Board received a report setting out the proposed focus and priority projects of the transformation programme. Jonathan Sheffield informed the Board that the plans were expected to release 18,000 bed days per year by reducing length of stay and a further 6,000 by improvements to the monitoring of day cases. The productive ward and productive theatre initiatives would continue and the new programme management office would be opened in April. Robert Woolley added that the focus of the project had been primarily the services provided within the Bristol Royal Infirmary and that divisions covering the other locations had requested support from the transformation team; these divisions had been asked to detail these requests for consideration.

Jonathan Sheffield confirmed that patient experience would not be compromised as a result of the planned efficiencies. The Board approved the priorities set out in the report.

### **032/10 Future meeting dates**

An additional meeting of the Board on 4 June at midday was agreed to finalise the Annual Report and Audited Accounts for 2009/10.

The next meeting of the Board was scheduled for Friday 29 March.





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| <b>Trust Board – 29 March 2010</b>                                                                                                                                                                                                                                                                                                          | <b>Agenda item 4</b> |
| <b>Matters Arising from 26 February 2010</b>                                                                                                                                                                                                                                                                                                |                      |
| <b>025/10 Matters Arising</b><br>The inquiry report into Mid-Staffordshire hospital had been published; one of its recommendations was that all providers should review their performance, standards and governance arrangements. Arrangements were being made for this to take place in the Trust and this would be reported to the Board. |                      |
| <b>030/10 Annual Planning 2010/11</b><br>The Board received a report outlining the process for the production of the annual plan. Action plans for the delivery of each adopted objective would be reported to the Trust Board, which would include measurable objectives.                                                                  |                      |



|                               |                                                                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>TRUST BOARD MEETING</b>    | <b>29 March 2010</b>                                                                                                                                                                                                                                                                                                                                                              |
| <b>TITLE</b>                  | <b>Performance Recovery – Progress Report</b>                                                                                                                                                                                                                                                                                                                                     |
| <b>PURPOSE</b>                | To update the Trust Board on delivery against agreed Trajectories submitted to Monitor on 11 <sup>th</sup> February 2010 and the delivery of performance against the following standards:<br>4 hour emergency access<br>31 and 62 day cancer standards<br>18 referral to treatment time admitted standard<br>To identify options for managing the 18 week waiting list in 2010/11 |
| <b>FORMAT</b>                 | Description of performance to date and projected performance for 2010/11<br>Data supporting the delivery of Monitor compliance in quarter 4 and the reduction in the 18 week admitted backlog.                                                                                                                                                                                    |
| <b>THE BOARD IS ASKED TO:</b> | The Trust Board are asked to note progress against the delivery of the above standards through the delivery of action plans and receive this report.                                                                                                                                                                                                                              |

## Introduction

The Trust took action to improve performance against the 4 hour emergency access, 31 and 62 day cancer standards and the 18 referral to treatment admitted standard. Actions have resulted in the Trust remaining on target to achieve the trajectories submitted to Monitor on 11<sup>th</sup> February 2010. Governance around delivery of the plans established to achieve these standards remains in place and robust controls have been established to ensure projections are accurate.

## Conclusions and recommendations

The Trust Board is recommended to support the plan to manage reduction of the 18week waiting list.

The Trust has demonstrated that it has responded to the identified challenges in meeting the minimum standards and has analysed processes and activity to enable it to continue to determinedly meet all patient standards on a consistent and ongoing basis.

Assurance and accountability frameworks have been revised to meet new processes and a refocus of actions has underpinned improvements in performance, including increased engagement of clinicians. Action plans and resultant trajectories are consistently reviewed and revised.

Prepared by: Irene Gray; Chief Operating Officer

Presented by: Irene Gray; Chief Operating Officer



## **Performance Recovery - Progress Report**

### **1. Introduction**

This report is presented to advise the board on progress against the delivery of the 4 hour, 18 week admitted and Cancer 31 and 62 day minimum standards following the intervention meeting with Monitor and the subsequent trajectories the Trust submitted to Monitor and approved at the extraordinary Trust Board meeting held on Tuesday 9<sup>th</sup> February 2010.

Further to the meeting with Monitor on 13<sup>th</sup> January 2010, the Trust Board awaits the final recommendations from Monitor regarding its view of the Trusts Status against its Terms of Authorisation.

### **2. Approved submission to Monitor**

Following approval of the Trust Board on 9<sup>th</sup> February, the following trajectories were submitted to Monitor on Thursday 11<sup>th</sup> February 2010.

- i) 98% 4 hour emergency access target - the trust projects to achieve the 98% standard in quarter 4, 2009/10 and be at 97.96% for the full year.**
- ii) Cancer 31 day diagnosis to treatment for all cancers will be achieved in quarter 4, 2009/10 and thereafter**
- iii) Cancer 31 day for subsequent treatment for all cancers will be achieved in quarter 4, 2009/10 and thereafter**
- iv) Cancer 62 day referral to treatment for all cancers, will be achieved in quarter 1, 2010/11 and thereafter**
- v) 18 week admitted standard will be achieved at an aggregate level in quarter 4, 2009/10, will be underachieved in quarter 1, 2010/11 and then full achievement at specialty level thereafter.**

Delivery against action plans to achieve the above standards is described in the Trust Board Performance Report.

### 3. Quarter 3 Declaration:

The following table identifies how the declaration at each quarter to date along with the projected performance for quarter 4, 2009/10 has been submitted. The quarter 4 projection is based on activity and performance during January and February and the projected impact of the plans agreed and put in place. **Table 1.**

**MONITOR'S COMPLIANCE FRAMEWORK – summary table**

|                                                                                                         |               | Number                                            | Target                                                        | Thresholds    |               | Year To Date | Quarterly Performance |                |              |            | Q4 forecast  | Current Forecast Q4 Governance rating score |
|---------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------|---------------------------------------------------------------|---------------|---------------|--------------|-----------------------|----------------|--------------|------------|--------------|---------------------------------------------|
|                                                                                                         |               |                                                   |                                                               | Green         | Red           |              | Q1                    | Q2             | Q3           | Q4 to date |              |                                             |
| Monitor Compliance Framework                                                                            | Weighting 1.0 | 1                                                 | Infection Control - MRSA Bloodstream Cases Against Trajectory | 0%            | 0%            | -8           | -3                    | -1             | -2           | -2         | -3           | Achieved                                    |
|                                                                                                         |               | 2                                                 | Infection Control - C.Diff Infections Against Trajectory      | 0%            | 0%            | -130         | -23                   | -31            | -46          | -30        | -45          | Achieved                                    |
|                                                                                                         |               | 3a                                                | Cancer 62 Day Referral To Treatment (Urgent GP Referral)      | 85.0%         | 80.0%         | 80.1%        | 79.7%                 | 77.8%          | 79.2%        | 91.3%      | 83.2%        | Failed                                      |
|                                                                                                         |               | 3b                                                | Cancer 62 Day Referral To Treatment (Screenings)              | 90.0%         | 85.0%         | 87.6%        | 87.7%                 | 81.8%          | 91.1%        | 89.7%      | 83.1%        |                                             |
|                                                                                                         |               | 3c                                                | Cancer 62 Day Referral To Treatment (Upgrades)                | Not published | Not published | 95.2%        | 96.7%                 | 88.5%          | 100.0%       | 93.0%      | 93.4%        |                                             |
|                                                                                                         |               | 4a                                                | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)    | 98%           | 95%           | 99.5%        | 99.4%                 | 100.0%         | 98.8%        | 100.0%     | 100.0%       | Achieved                                    |
|                                                                                                         |               | 4b                                                | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | 94%           | 91%           | 91.6%        | 93.4%                 | 90.5%          | 90.8%        | 92.3%      | 94.7%        | Achieved                                    |
|                                                                                                         | 5             | Referral To Treatment Admitted Under 18 Weeks     | 90%                                                           | 80%           | 90.3%         | 92.0%        | 90.4%                 | 88.3%          | 90.4%        | 90.3%      |              |                                             |
|                                                                                                         | 6             | Referral To Treatment Non Admitted Under 18 Weeks | 95%                                                           | 85%           | 97.6%         | 97.7%        | 97.5%                 | 97.5%          | 97.4%        | 96.5%      | Achieved     |                                             |
|                                                                                                         | Weighting 0.5 | 7                                                 | Cancer - 31 Day Diagnosis To Treatment (First Treatments)     | 96%           | 93%           | 95.9%        | 95.8%                 | 95.1%          | 96.6%        | 96.6%      | 96.5%        | Achieved                                    |
|                                                                                                         |               | 8                                                 | Emergency Care 4 Hour Throughput (including WIC)              | 98%           | 97%           | 97.94%       | 98.44%                | 98.10%         | 97.10%       | 98.16%     | 98.30%       | Achieved                                    |
|                                                                                                         |               | 9                                                 | Cancer - Urgent Referrals Seen In Under 2 Weeks               | 93%           | 90%           | 93.4%        | 92.7%                 | 93.2%          | 94.5%        | 92.3%      | 93.3%        |                                             |
|                                                                                                         |               | 10                                                | MRSA Screening                                                |               |               | ✓            | ✓                     | ✓              | ✓            | ✓          | ✓            |                                             |
|                                                                                                         |               | 11                                                | 60 Minute Thrombolysis Call To Needle Time                    | 68%           | 48%           | 100.0%       | 100.0%                | 100.0%         | 100.0%       |            | 100.0%       | Achieved                                    |
|                                                                                                         | Weighting 0.4 | 12                                                | Core standards                                                |               |               | All achieved | All achieved          | 1 not achieved | All achieved |            | All achieved | Achieved                                    |
| AMBER                                                                                                   |               |                                                   |                                                               |               |               |              |                       |                |              |            | 1.0          |                                             |
| Additional rule applied of 3 consecutive quarterly amber ratings for 62-day cancer = overall Red rating |               |                                                   |                                                               |               |               |              |                       |                |              |            |              |                                             |
| RED                                                                                                     |               |                                                   |                                                               |               |               |              |                       |                |              |            |              |                                             |

The above declaration identifies that the Trust is meeting all standards with the exception of the 62 day cancer screening target and therefore is within the trajectories submitted to Monitor. This therefore calculates performance ratios to be 1.0 giving the Trust an amber rating for Q4. However, it must be noted that Monitor automatically apply a red rating to a quarter regardless of overall performance if the same standard has been breached in 2 previous quarters.

### 3. Delivery Trajectories

#### 3.1 4 hour emergency access

The Trust remains on target to meet 97.96% annual performance trajectory submitted to Monitor in January 2010. Performance in February is 98.1% bringing performance for the quarter to date to 98.16 and year to date to 97.98 %. The current performance has been achieved in an exceptionally challenging period where up to 7 wards and 45 beds have been closed due to a Norovirus outbreak. Performance for the current month up to 22<sup>nd</sup> March stands at 98.7 %. The Trust has committed to achieving the 4 hour emergency access for subsequent quarters. All actions to achieve this standard in 2010/11 are continuously assessed for impact and revised where necessary. Key to delivery of this target is the reduction of demand on services. The Trust initiated

discussions with the commissioners to determine what actions should be taken, resulting in the NHS Bristol developing an action plan. This plan will be monitored monthly alongside the Trust internal plans to improve the management of patient flow, including the revision of acute medical cover to provide 7 day acute physician cover.

### **3.2 Monitoring and Assurance**

The delivery of the 4 hour emergency action plan is monitored weekly at by the Executive Performance Recovery meeting. The detail of the plan is reviewed and revised by the Emergency Access Steering Group monthly and by the Trust Operational Group on alternate weeks. A full report is received by the Trust Executive Group on a Monthly basis.

Daily reports are produced and circulated on performance, including breach reasons. These are monitored closely by the executive and action taken when challenges appear in daily performance. Twice daily patient flow meetings, monitor activity, prepare for projected activity, monitor and take action when patient discharge is delayed and monitor and take action where breaches occur.

### **3.3 Cancer Standards**

The Trust analysed performance against each tumour site and established where there are gaps in process, implemented actions to ensure patients follow agreed pathways of care and that robust processes and assurances are in place. Through detailed mapping and review of pathways, the Trust committed to achieving the 31 day, diagnosis to treatment for all cancers in quarter 4 and thereafter, the 31 day subsequent treatment in quarter 4 and thereafter and the 62 day referral to treatment for all cancers in quarter 1, 2010/11 and thereafter. The Trust is now meeting all cancer standards with the exception of the 62 day screening and urgent GP referral target. The Trust is however, continuing to review all processes and identify opportunities to bring forward achievement of the 62 day cancer target. These trajectories are consistent with those submitted to Monitor at the meeting on 13<sup>th</sup> January 2010. The Trust remains on track to meet these trajectories.

### **3.4 Monitoring and Assurance**

Performance against this target and delivery of the action plan is reviewed weekly at the Performance recovery meeting. The weekly cancer patient tracking list review monitors performance and identifies actions to be taken. Divisional Boards review performance and actions on a monthly basis. The Trust Operational Group reviews performance on alternative weeks by tumour site and identifies what actions need to be taken in other directorates to support delivery of the plan. The Trust Executive

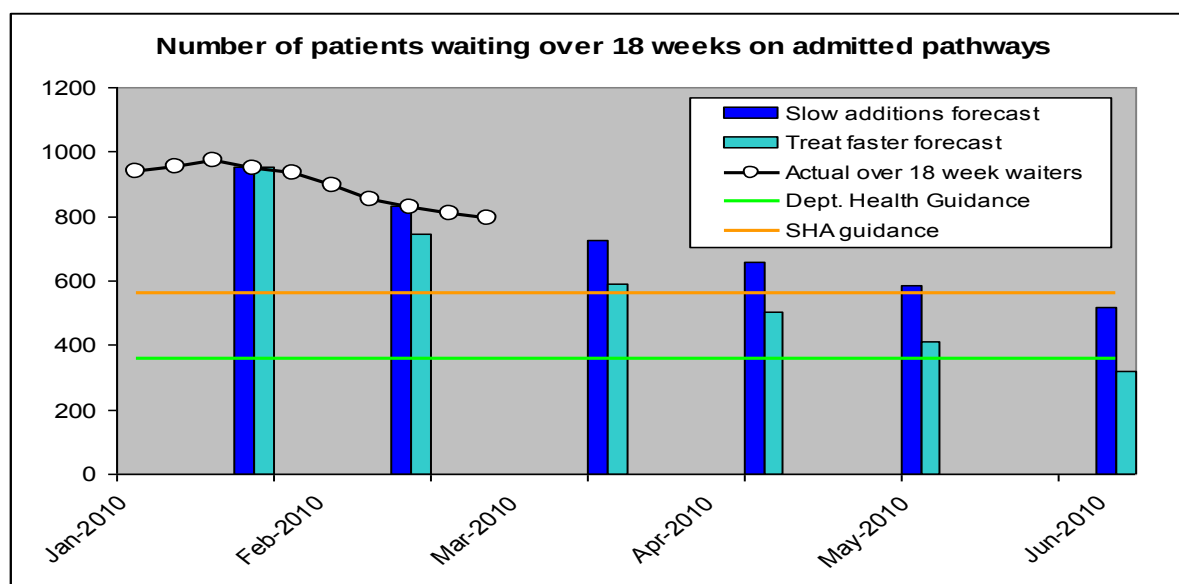
Group review performance monthly and challenges any deviation from the plan. The Cancer Board, now review actions and patient pathways routinely and assures performance against targets is understood and met.

### 3.5 18 week referral to treatment admitted standard

The Trust committed to achieving this standard at aggregate level in quarter 4 under the current set of rules for this standard and will be compliant. For quarter 1, 2010/11, when the rules change to require compliance at speciality level, the Trust identified that it would underachieve whilst addressing the existing waiting list backlog and then would be compliant in quarter 2 and in subsequent quarters.

Significant planned progress has been made against this target and the reduction of patients waiting above 18 weeks is demonstrably in line with plan (see table 2).

**Table 2.**



Key actions have been targeted at high volume specialties and all specialties have targeted reducing the number of patients added to the backlog. Continuing current rigorous management of waiting lists will bring the Trust to compliance with this standard against all but two specialties (ENT and Other) in quarter 1, 2010/11. Actions required to bring both specialties to compliance will mean that the standard for each of these targets will not be met until quarter 2, 2010/11. This is in line with the trajectory submitted to Monitor. , At the extraordinary meeting of the Trust Board on 9<sup>th</sup> February, the Board agreed to review how the Trust should address the ongoing reduction of the waiting list. There are two approaches to managing the current waiting list, whilst minimising adding to the list. The first approach is to continue to manage reduction as currently. The second is to rapidly bring the waiting list down to 0.8 of week. Taking the second approach may compromise 4 hour and possibly cancer



performance. It is therefore recommended that the Trust continue to take the existing approach to reducing the waiting list at a managed level.

### **3.16 Monitoring and Assurance**

Performance against this target and delivery of the action plan is reviewed weekly at the Performance recovery meeting. Divisions are monitoring performance and taking action on a daily basis and reporting deviation to the plan to the Head of Performance and reviewing performance and actions at divisional board meetings. The Trust Operational Group monitors performance and seeks assurance at specialty level on alternate weeks and agrees and supports any mitigating actions. The Trust Executive Group review performance against target and challenge any deviation from plan

## **4. Next Steps**

The Trust remains highly committed to delivering all national and local standards and working toward setting new standards for those in our care. Over the next 6 months the trust continues to have a significant challenge in ensuring all actions are executed, impact monitored and standards met. This will be undertaken through vigilance of monitoring, commissioning and enabling support where need is identified, and a demonstration of a consistent expectation of adherence to core standards and practices. The Trust Executive have approved the implementation of a new accountability framework which will enable consultants at a specialty level to review performance on a monthly basis and ensure teams can hold each other to account for delivery of targets and offer support where needed. The framework will ensure assurances through to the Trust Operational Group, the Trust Executive and the Trust Board.

Following the meeting with Monitor on the 13<sup>th</sup> January 2010, the Trust agreed with Monitor that they will invite NHS Flexible Support to work with the Trust in ensuring sustainable delivery of the 4 hour emergency access target. NHS Flexible Support is designed to support NHS organisations that ask for short or medium term help and pull together expertise that exists throughout the NHS and coordinates it to focus on specific assignments. Arrangements to work with NHS Flexible Support are in process.

## **5. Conclusion and Recommendations**

The Trust has demonstrated that it has responded to the identified challenges in meeting the minimum standards and has analysed processes and activity to enable it to continue to determinedly meet all patient standards on a consistent and ongoing basis.

Assurance and accountability frameworks have been revised to meet new processes and a refocus of actions has underpinned improvements in performance, including

increased engagement of clinicians. Action plans and resultant trajectories are consistently reviewed and revised.

The Trust Board are asked to agree the recommendation re future management of the 18 week referral to treatment admitted standard and note progress against the delivery of the above standards through the delivery of action plans and receive this report.

**Irene Gray**

Chief Operating Officer

March 2010

# SUMMARY PERFORMANCE REPORT

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March 2010

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## SECTION 1 - WORKFORCE

### 1.1 Data Summary

- Vacancy and Turnover are expressed as percentages. ‘Turnover’ measures the number of leavers expressed as a percentage of the average number of staff in post in the defined period. ‘Vacancy’ measures the number of vacant posts as a percentage of the budgeted establishment.
- The Sickness Rate is expressed as a percentage of total whole time equivalent (fte) staff in post.

| Measure                                  | Feb-09 | Mar-09 | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 |
|------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Agency (fte) Admin & Clerical            | 13.7   | 12.7   | 11.0   | 9.1    | 8.9    | 10.9   | 8.0    | 7.8    | 8.7    | 8.4    | 5.3    | 4.9    | 8.9    |
| Agency (fte) Ancillary Staff             | 49.8   | 67.6   | 57.1   | 56.8   | 56.4   | 50.3   | 42.9   | 30.8   | 32.0   | 33.2   | 32.5   | 35.8   | 36.9   |
| Agency (fte) Nursing & Midwifery         | 27.4   | 24.6   | 11.1   | 16.7   | 13.4   | 17.6   | 16.9   | 15.5   | 18.7   | 14.3   | 23.7   | 13.6   | 11.6   |
| Bank (fte) Admin & Clerical              | 103.5  | 115.8  | 109.9  | 101.3  | 123.3  | 135.9  | 122.3  | 119.7  | 105.0  | 96.9   | 89.7   | 85.1   | 86.2   |
| Bank (fte) Ancillary Staff               | 20.6   | 27.4   | 24.2   | 25.9   | 26.8   | 38.1   | 37.2   | 38.0   | 35.6   | 28.9   | 31.3   | 22.6   | 18.9   |
| Bank (fte) Nursing & Midwifery           | 202.6  | 224.3  | 230.6  | 236.3  | 234.3  | 268.2  | 275.0  | 242.8  | 237.3  | 203.7  | 191.0  | 199.4  | 191.4  |
| Bank Nursing & Midwifery % unfilled      | 14.0%  | 12.0%  | 12.0%  | 13.0%  | 11.3%  | 11.7%  | 9.8%   | 11.6%  | 12.4%  | 2.7%   | 3.8%   | 2.0%   | 3.4%   |
| Bank Nursing & Midwifery Unfilled Shifts | 775    | 676    | 705    | 786    | 658    | 785    | 657    | 697    | 744    | 124    | 170    | 89     | 146    |
| Sickness Rate (%)                        | 4.1%   | 3.9%   | 3.8%   | 3.8%   | 4.0%   | 4.5%   | 4.1%   | 3.8%   | 4.4%   | 4.7%   | 5.0%   | 5.1%   | 4.7%   |
| Total Budgeted Posts (fte)               | 6736.5 | 6742.4 | 6580.8 | 6750.1 | 6946.1 | 6883.1 | 6956.3 | 7001.5 | 7066.2 | 7074.6 | 7094.8 | 7114.2 | 7121.8 |
| Total In Post (fte)                      | 6556.2 | 6557.3 | 6452.1 | 6486.9 | 6584.9 | 6606.2 | 6630.2 | 6653.3 | 6741.8 | 6771.6 | 6773.8 | 6784.7 | 6807.2 |
| Rolling Average Turnover (%)             | 11.6%  | 13.6%  | 13.1%  | 12.8%  | 12.5%  | 11.9%  | 11.8%  | 11.5%  | 11.2%  | 11.1%  | 13.1%  | 13.3%  | 13.4%  |
| Rolling Average Voluntary Turnover (%)   | 9.7%   | 9.6%   | 9.9%   | 9.9%   | 9.9%   | 9.8%   | 9.6%   | 9.4%   | 9.1%   | 8.8%   | 8.6%   | 8.3%   | 8.2%   |
| Vacancy Rate (%)                         | 2.7%   | 2.7%   | 2.0%   | 3.9%   | 5.2%   | 4.0%   | 4.7%   | 5.0%   | 4.6%   | 4.3%   | 4.5%   | 4.6%   | 4.4%   |
| Appraisal (%)                            | 78.5%  | 80.3%  | 78.7%  | 82.0%  | 82.4%  | 81.9%  | 81.5%  | 84.5%  | 84.4%  | 82.5%  | 81.0%  | 81.4%  | 81.5%  |

## SECTION 1 - WORKFORCE

### 1.2 Supporting Information

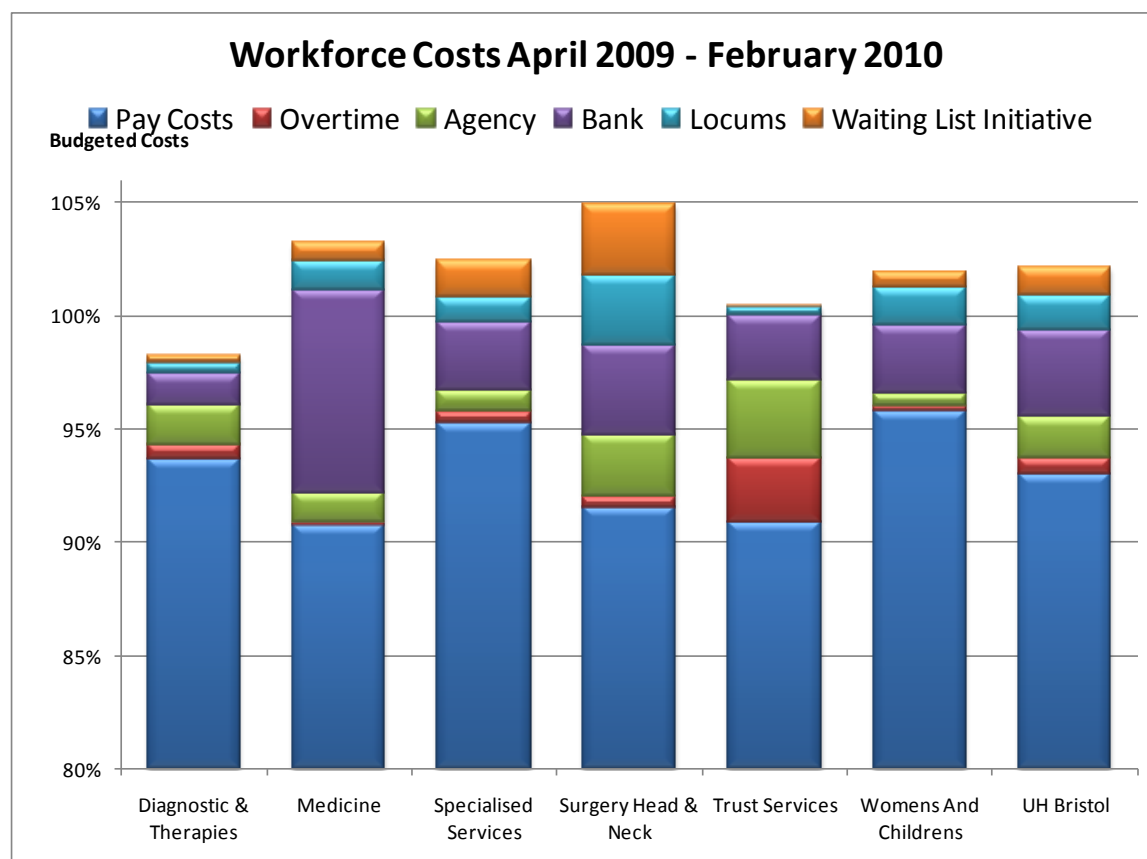
#### Workforce Costs

The following charts and tables show the expenditure by Division and staff group for the year to date compared with budgeted costs; 100% represents the total budgeted cost.

#### **Workforce Costs by Division (April 2009-February 2010)**

|                                    | Diagnostic<br>and<br>Therapies | Medicine | Specialise<br>d Services | Surgery<br>Head and<br>Neck | Trust<br>Services | Womens<br>And<br>Childrens | Totals   |
|------------------------------------|--------------------------------|----------|--------------------------|-----------------------------|-------------------|----------------------------|----------|
|                                    | £ '000                         | £ '000   | £ '000                   | £ '000                      | £ '000            | £ '000                     | £ '000   |
| <b>Pay Costs*</b>                  | £32,462                        | £34,108  | £28,948                  | £54,470                     | £36,111           | £55,967                    | £242,065 |
| <b>Overtime</b>                    | £234                           | £44      | £145                     | £281                        | £1,153            | £128                       | £1,985   |
| <b>Agency</b>                      | £608                           | £490     | £278                     | £1,611                      | £1,361            | £313                       | £4,661   |
| <b>Bank</b>                        | £491                           | £3,368   | £919                     | £2,352                      | £1,123            | £1,749                     | £10,003  |
| <b>Locums</b>                      | £157                           | £482     | £341                     | £1,840                      | £146              | £979                       | £3,944   |
| <b>Waiting List<br/>Initiative</b> | £116                           | £313     | £482                     | £1,882                      | £21               | £425                       | £3,239   |
| <b>Total</b>                       | £34,068                        | £38,805  | £31,113                  | £62,436                     | £39,915           | £59,560                    | £265,897 |
| <b>Budgeted Costs</b>              | £34,673                        | £37,590  | £30,379                  | £59,508                     | £39,747           | £58,424                    | £260,321 |
| <b>variance target £<br/>+/-</b>   | £604                           | -£1,215  | -£734                    | -£2,928                     | -£167             | -£1,137                    | -£5,576  |

Pay Costs are from Finance Department. Costs exclude Salary Recharge

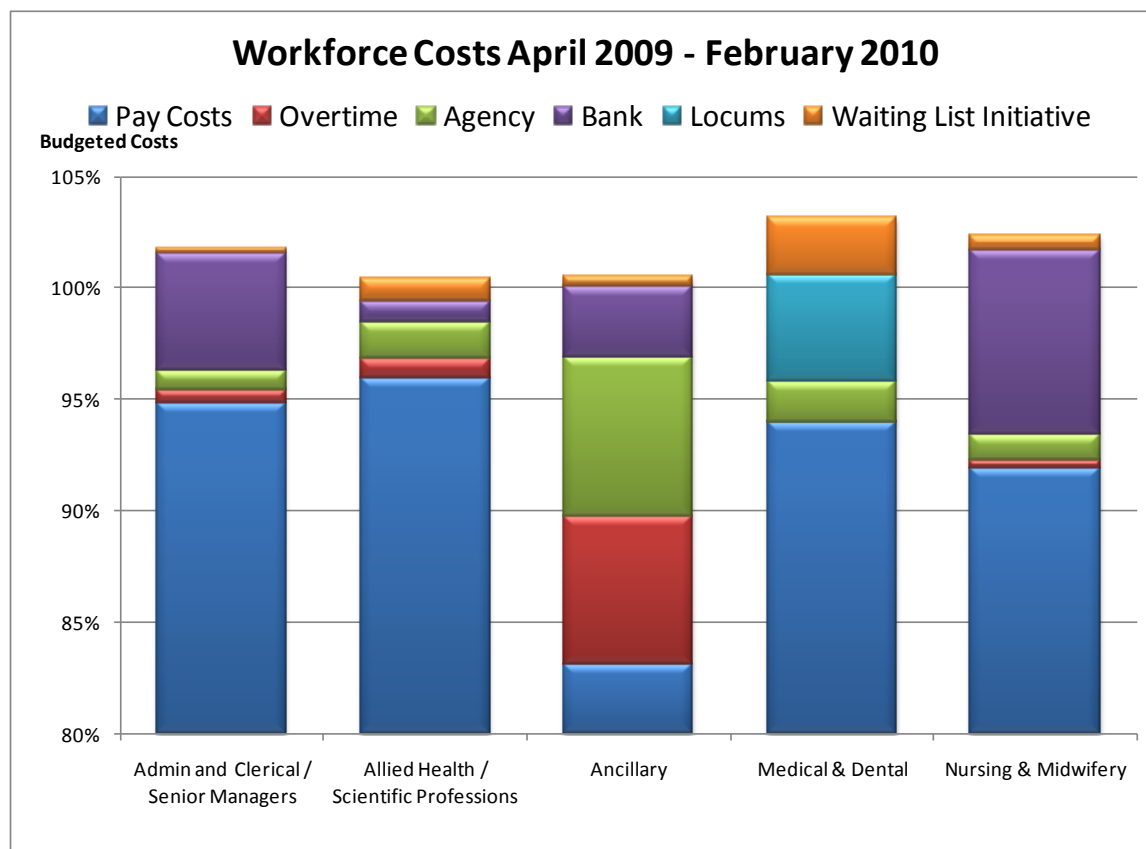


## SECTION 1 - WORKFORCE

### Staff Group Workforce Costs by Staff Group (April 2009-February 2010)

Pay Costs are from Finance Department. Costs exclude Salary Recharge

|                                | Admin and Clerical / Senior Managers | Allied Health / Scientific Professions | Ancillary | Medical & Dental | Nursing & Midwifery | Totals   |
|--------------------------------|--------------------------------------|----------------------------------------|-----------|------------------|---------------------|----------|
|                                | £                                    | £                                      | £         | £                | £                   |          |
| <b>Pay Costs</b>               | £35,925                              | £35,428                                | £13,830   | £77,331          | £79,551             | £242,065 |
| <b>Overtime</b>                | £224                                 | £327                                   | £1,098    | £8               | £329                | £1,985   |
| <b>Agency</b>                  | £336                                 | £606                                   | £1,194    | £1,523           | £1,001              | £4,661   |
| <b>Bank</b>                    | £1,973                               | £345                                   | £523      | £0               | £7,161              | £10,003  |
| <b>Locums</b>                  | £0                                   | £0                                     | £0        | £3,944           | £0                  | £3,944   |
| <b>Waiting List Initiative</b> | £90                                  | £370                                   | £82       | £2,107           | £590                | £3,239   |
| <b>Total</b>                   | £38,548                              | £37,075                                | £16,727   | £84,914          | £88,633             | £265,897 |
| <b>Budgeted Costs</b>          | £37,881                              | £36,924                                | £16,638   | £82,303          | £86,575             | £260,321 |
| <b>variance target £ +/-</b>   | -£667                                | -£152                                  | -£89      | -£2,610          | -£2,058             | -£5,576  |

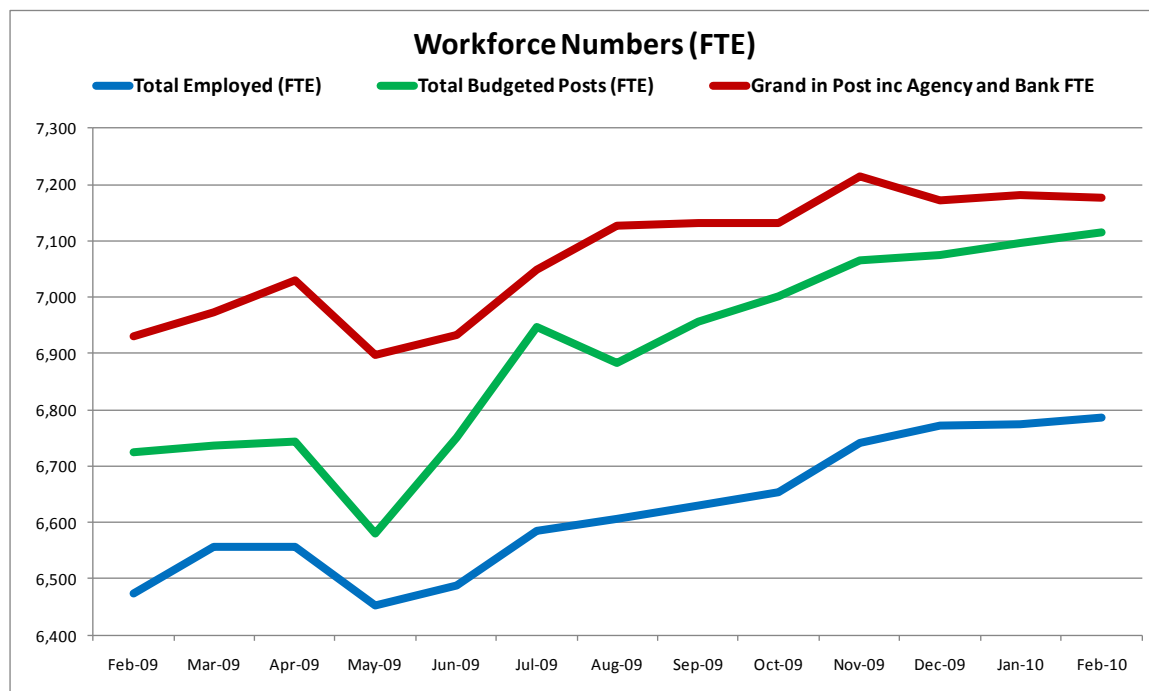


## SECTION 1 - WORKFORCE

### Workforce Numbers, Vacancies and Turnover

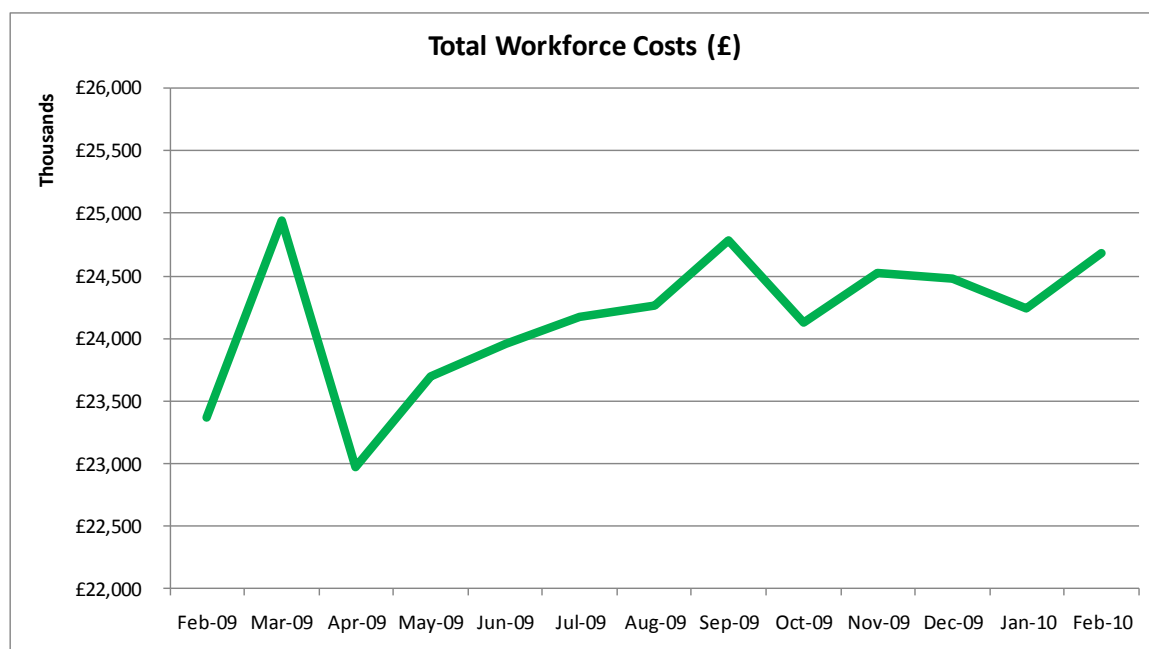
The graph below shows staff in post, (including bank and agency) compared with budgeted posts and total employed (excluding bank and agency). The second graph shows changes in workforce costs during the same period.

#### Changes in Workforce Numbers (February 2009 – February 2010)



(Excludes overtime)

#### Changes in Workforce Costs (February 2009 – February 2010)



(Includes overtime)



## SECTION 1 - WORKFORCE

Changes in staff numbers by Division are shown in the table below

### Workforce Numbers, February 28<sup>th</sup> 2010

| February 2010           | All Staff Groups |               |                |               |
|-------------------------|------------------|---------------|----------------|---------------|
|                         |                  |               | Change Jan-Feb |               |
| Division                | Budgeted         | Staff In Post | Newly Budgeted | Staff In Post |
| Diagnostics & Therapies | 933.5            | 900.8         | 0.0            | -1.5          |
| Medicine                | 1082.9           | 1032.7        | 2.0            | 17.3          |
| Surgery Head & Neck     | 1552.2           | 1462.2        | -1.1           | 3.0           |
| Specialised Services    | 753.3            | 722.9         | 2.5            | -0.5          |
| Womens & Children       | 1401.5           | 1368.7        | 0.7            | 5.8           |
| Trust Services          | 1398.3           | 1319.9        | 3.5            | -1.7          |
| Grand Total             | 7121.8           | 6807.2        | 7.6            | 22.5          |

### Workforce changes

There is an overall increase in budgeted establishment of 7.6 fte, and an increase of 22.5 fte staff in post, including the following:

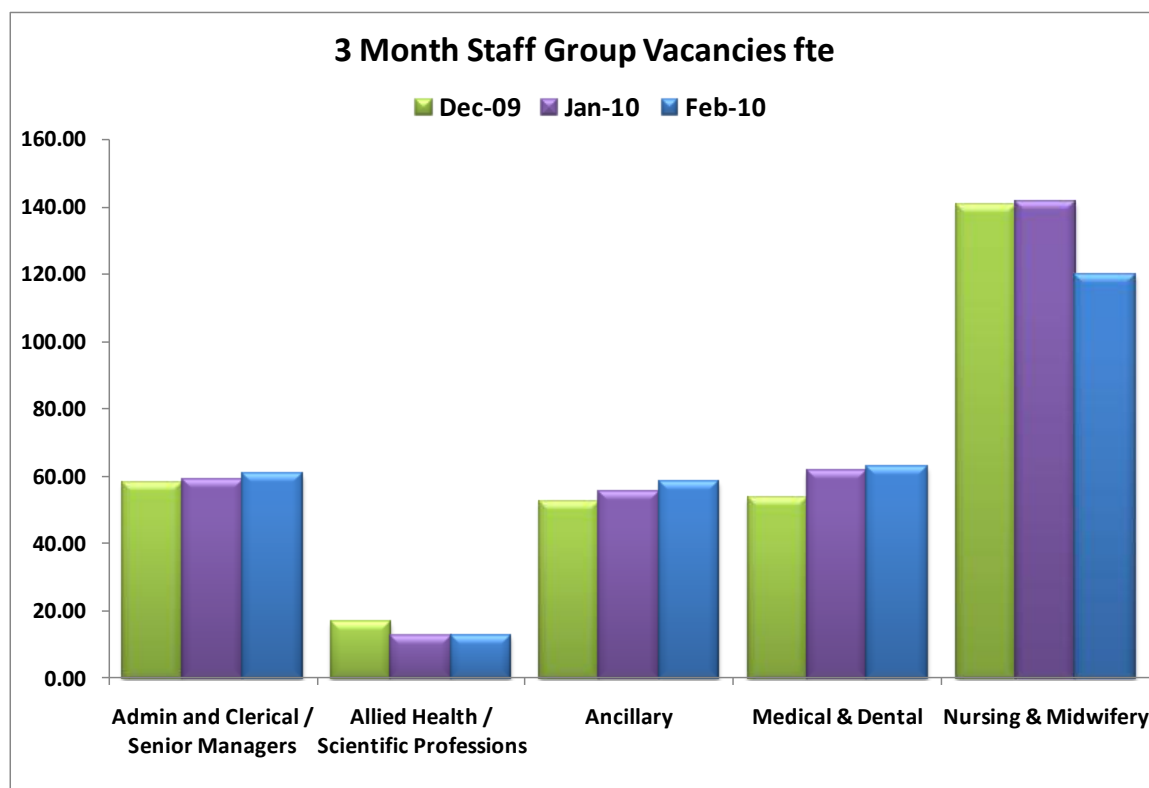
- Surgery Head and Neck:
  - Increase in staff in post of 2.8 fte nursing in ITU and 3.0 theatre staff
- Women`s and Children`s:
  - An increase in staff in post due to recruitment in nursing staff 2.2 fte Accident & Emergency and 2.7 fte Theatres, although vacancies in these areas still remain
- Medicine:
  - Increase in budgeted establishment of 2.0 fte administrative and clerical posts, both funded by Avon and Wiltshire NHS Partnership.
  - An increase of 17.6 fte nursing staff due to recruitment to vacancies within medical assessment and Ward 23
- Trust Services:
  - Increase in budgeted establishment of 3.5 fte administrative and clerical posts, due to additional funding within Research and Development Management, and income generation from Bristol Heart Institute coffee shop

The remainder of the changes in budgeted and staff in post are the result of individual changes in posts across many cost centres.

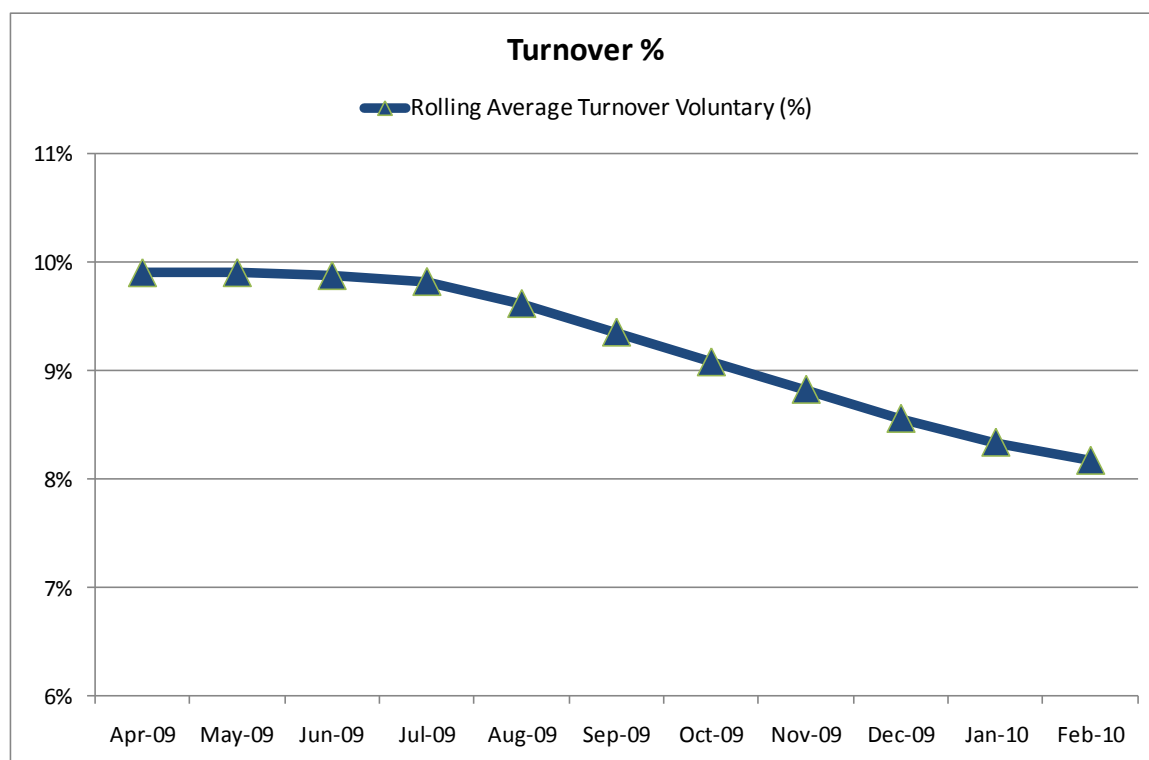
## SECTION 1 - WORKFORCE

### Vacancies and turnover

Vacancies are usually reported as the gap between employed staff and planned staff, and this is shown in the graph below for key staff groups.



The rolling average turnover figure for February 2010 for all reasons is 13.4%, compared to voluntary turnover at 8.2%, (see graph below).



## SECTION 1 - WORKFORCE

### Bank and Agency

- Bank usage reduced by 21.6 fte compared with the previous month
- Agency usage increased by 2.1 fte
- Bookings due to sickness reduced by 8.9 fte this month
- Bookings due to holidays showed an increase of 2.2 fte including 1.8 fte on Ward 25.
- Agency usage was highest for in house cleaning, at 21.0 fte, an increase of 1.1 fte on last month.

The tables below shows bank and agency booked in January 2010 compared with February 2010:

|                             | Jan-10       |             |             |             | Feb-10       |             |             |             |
|-----------------------------|--------------|-------------|-------------|-------------|--------------|-------------|-------------|-------------|
| Reason for booking          | Bank         |             | Agency      |             | Bank         |             | Agency      |             |
|                             | fte          | %           | fte         | %           | fte          | %           | fte         | %           |
| Sickness                    | 67.5         | 20.5%       | 6.9         | 10.8%       | 56.2         | 18.3%       | 9.3         | 14.0%       |
| Training                    | 3.1          | 1.0%        | 0.4         | 0.6%        | 3.9          | 1.3%        | 0.1         | 0.1%        |
| Holiday                     | 11.7         | 3.6%        | 3.4         | 5.4%        | 15.2         | 4.9%        | 2.1         | 3.2%        |
| Workload increase           | 87.4         | 26.6%       | 6.9         | 10.8%       | 85.9         | 28.0%       | 6.5         | 9.9%        |
| Vacancies                   | 141.3        | 43.0%       | 45.0        | 70.2%       | 134.4        | 43.8%       | 46.9        | 71.0%       |
| Maternity and special leave | 15.1         | 4.6%        | 1.0         | 1.6%        | 11.0         | 3.6%        | 1.1         | 1.7%        |
| Other/reason not given      | 2.7          | 0.8%        | 0.4         | 0.6%        | 0.4          | 0.1%        | 0.1         | 0.1%        |
| <b>Total</b>                | <b>328.7</b> | <b>100%</b> | <b>64.0</b> | <b>100%</b> | <b>307.1</b> | <b>100%</b> | <b>66.1</b> | <b>100%</b> |

Bank office data

The table below shows reason for bank and agency by staff group for February 2010:

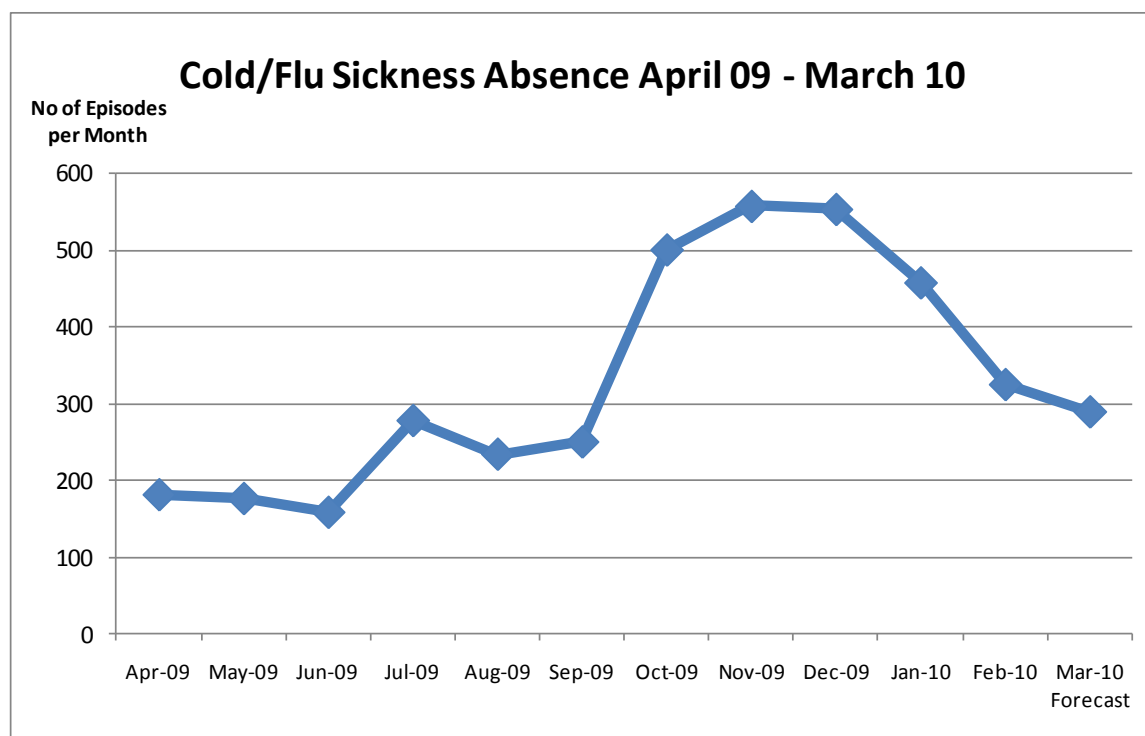
| Staff Group                 | Nursing & Midwifery |             | Ancillary   |             | Admin and Clerical |            |
|-----------------------------|---------------------|-------------|-------------|-------------|--------------------|------------|
|                             | Bank                | Agency      | Bank        | Agency      | Bank               | Agency     |
| Reason for booking          | fte                 | fte         | fte         | fte         | fte                | fte        |
| Holiday                     | 13.8                | 0.4         | 0.1         | 1.5         | 1.2                | 0.2        |
| Maternity and special leave | 7.8                 | 0.5         |             | 0.6         | 3.0                |            |
| Other                       | 0.4                 | 0.1         |             |             | 0.1                |            |
| Sickness                    | 46.6                | 4.6         | 0.1         | 1.3         | 7.1                | 0.2        |
| Training                    | 3.2                 | 0.1         | 0.1         |             | 0.6                |            |
| Vacancies                   | 69.9                | 2.5         | 13.7        | 31.9        | 46.3               | 8.5        |
| Workload increase           | 49.7                | 3.5         | 5.0         | 1.5         | 27.8               |            |
| <b>Total</b>                | <b>191.4</b>        | <b>11.6</b> | <b>18.9</b> | <b>36.9</b> | <b>86.2</b>        | <b>8.9</b> |

Bank office data

## SECTION 1 - WORKFORCE

### Sickness Absence

The forecast for February 2010, based on 14<sup>th</sup> March, indicates that there is a further reduction in cold and flu related absence, as the graph below shows.

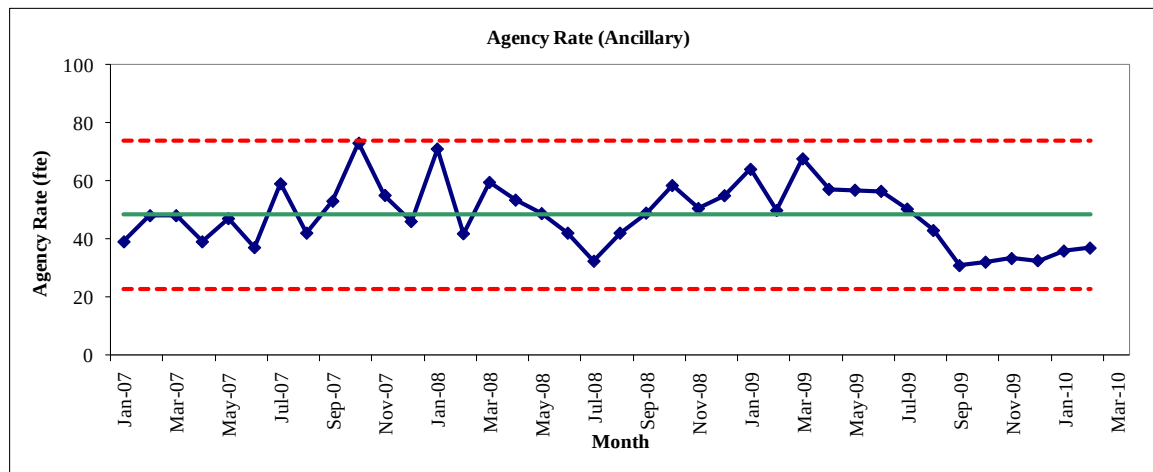
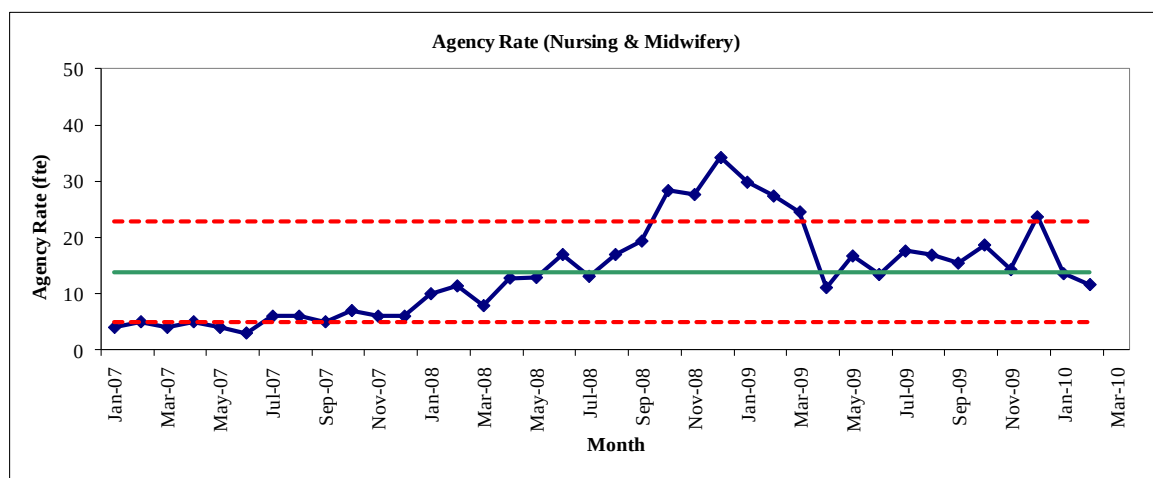
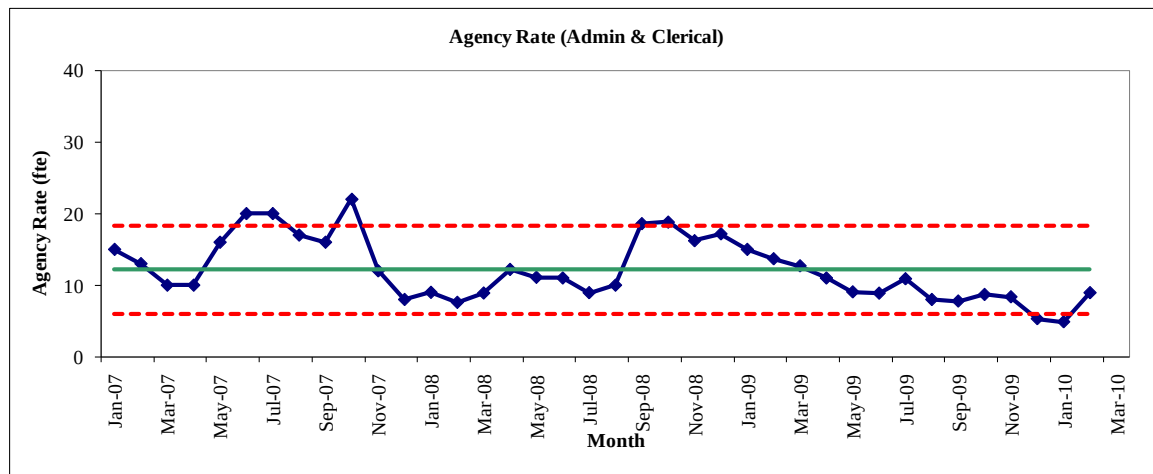


The reasons for sickness absence over the last four months are shown below.

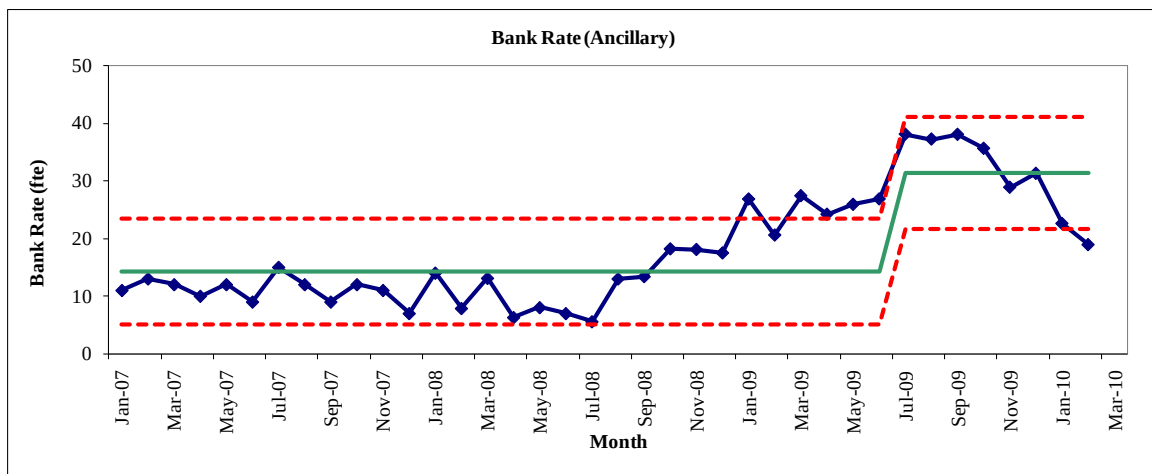
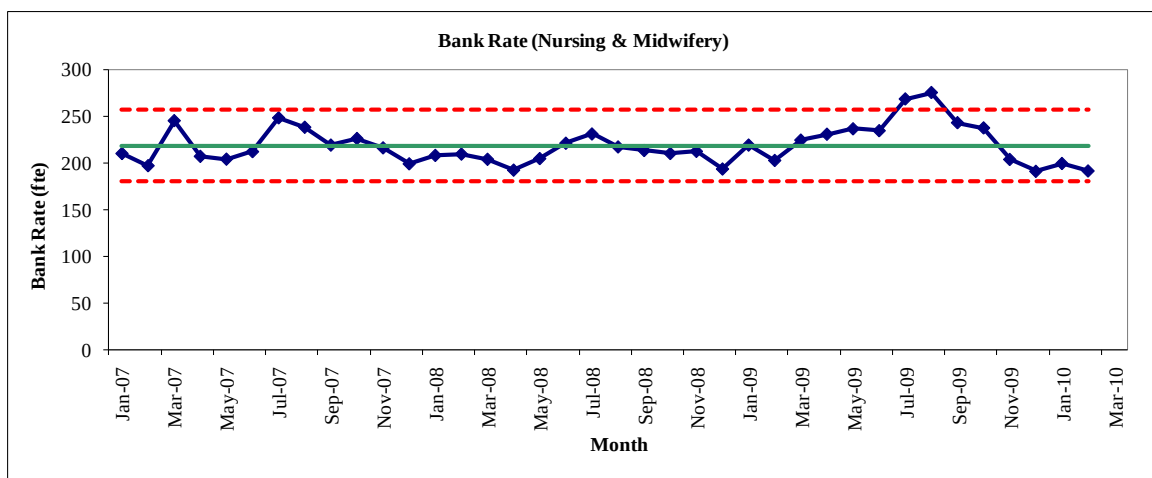
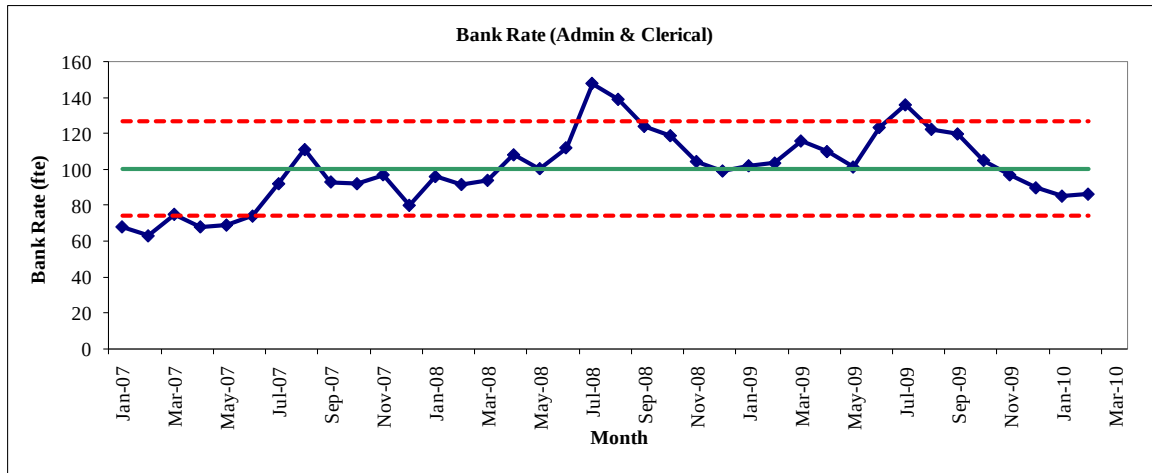
| Absence Reasons<br>% of Total Months<br>Episodes | Nov-09      |             | Dec-09      |             | Jan-10      |             | Feb-10      |             | Mar-10<br>Forecast |             |
|--------------------------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------------|-------------|
|                                                  | No          | %           | No          | %           | No          | %           | No          | %           | No                 | %           |
| Cold/Influenza                                   | 558         | 31%         | 554         | 33%         | 458         | 27%         | 325         | 23%         | 289                | 21%         |
| Diarrhoea/Vomiting                               | 213         | 12%         | 222         | 13%         | 243         | 14%         | 267         | 19%         | 316                | 23%         |
| Musculo-skeletal                                 | 180         | 10%         | 202         | 12%         | 239         | 14%         | 196         | 14%         | 157                | 11%         |
| Stress/Anxiety                                   | 79          | 4%          | 90          | 5%          | 88          | 5%          | 89          | 6%          | 82                 | 6%          |
| Surgery                                          | 70          | 4%          | 71          | 4%          | 70          | 4%          | 60          | 4%          | 67                 | 5%          |
| Not Known                                        | 214         | 12%         | 50          | 3%          | 48          | 3%          | 15          | 1%          | 16                 | 1%          |
| All Other                                        | 494         | 27%         | 493         | 29%         | 562         | 33%         | 491         | 34%         | 443                | 32%         |
| <b>Total Episodes</b>                            | <b>1808</b> | <b>100%</b> | <b>1682</b> | <b>100%</b> | <b>1708</b> | <b>100%</b> | <b>1443</b> | <b>100%</b> | <b>1369</b>        | <b>100%</b> |

## SECTION 1 - WORKFORCE

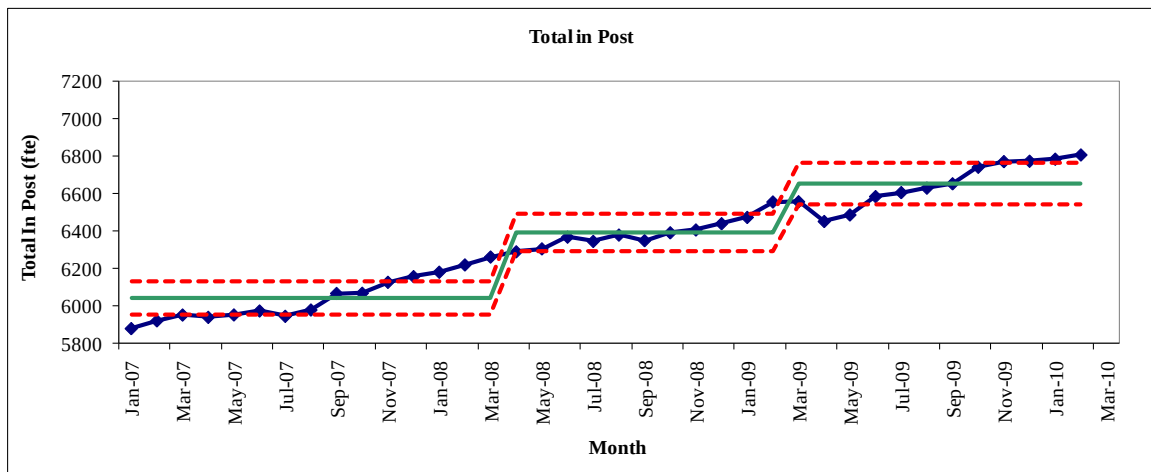
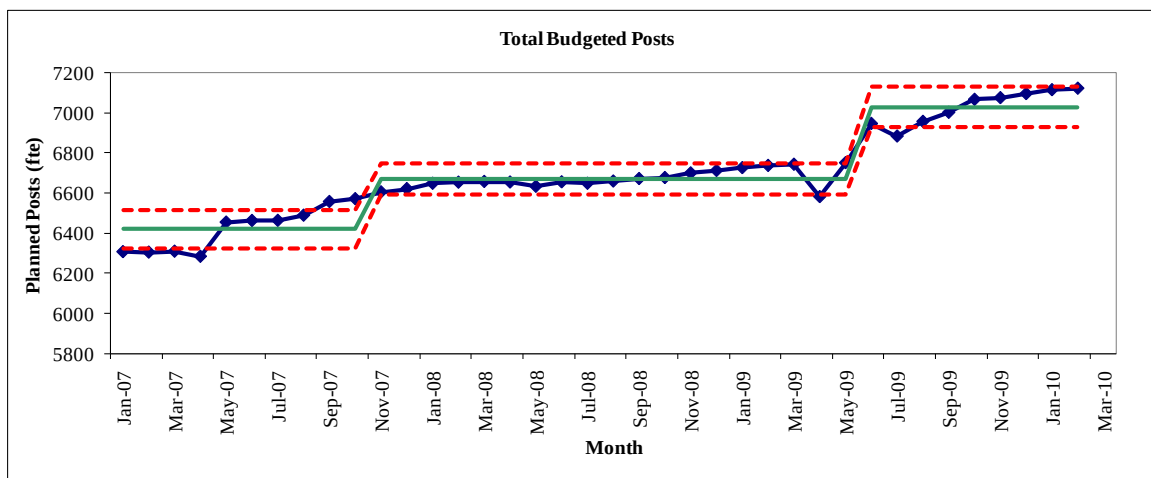
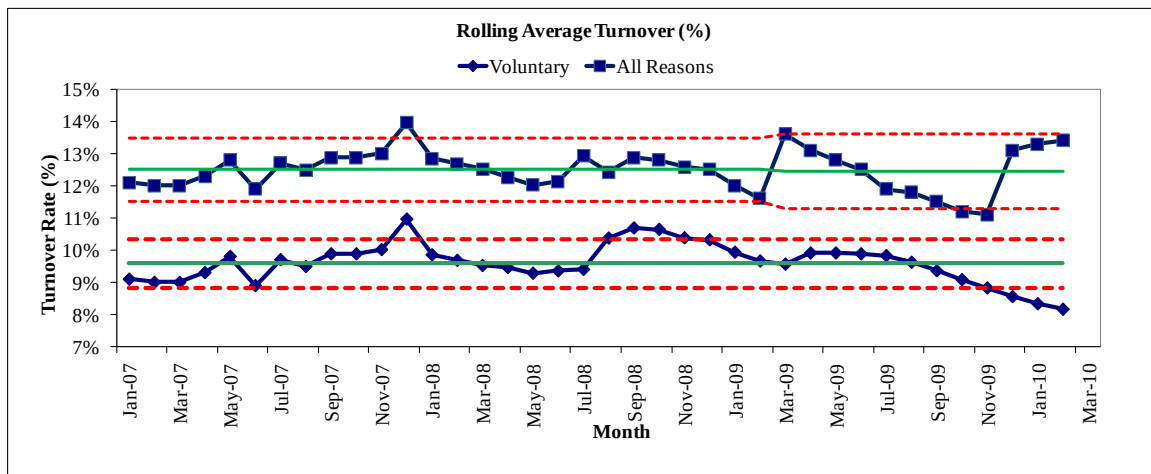
### 1.3 Trend Graphs



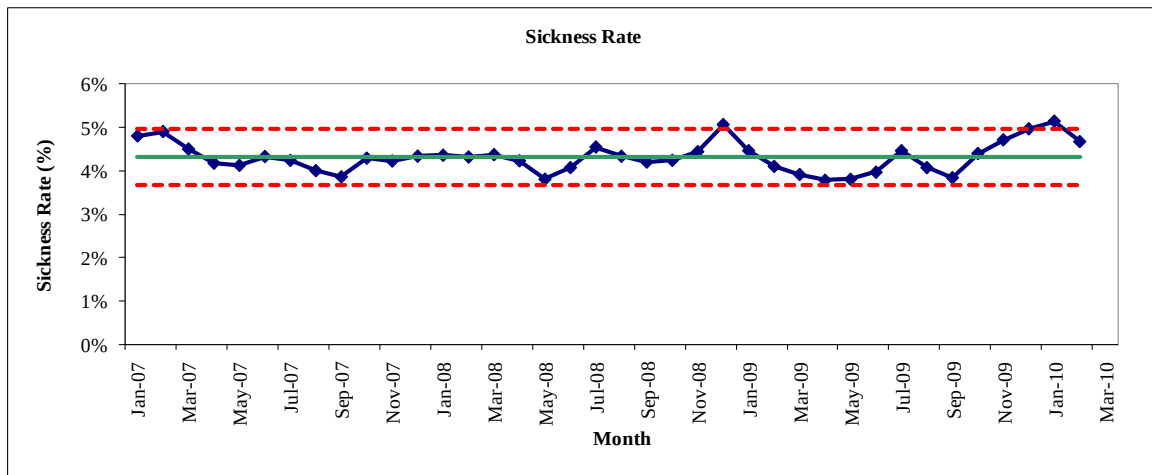
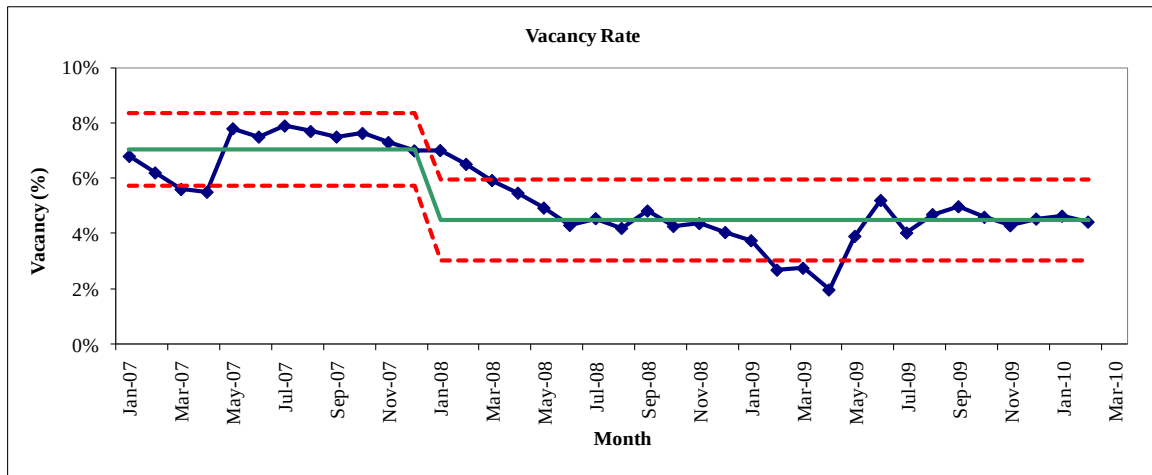
## SECTION 1 - WORKFORCE



## SECTION 1 - WORKFORCE



## SECTION 1 - WORKFORCE





## SECTION 1 - WORKFORCE

### 1.4 Exception Reports

|                    |                                                                                                                                                                                                        |      |      |      |          |                      |      |                |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|----------|----------------------|------|----------------|
| Objective /Target: | <b>To reduce sickness absence in line with Divisional CRES(Cash Releasing Efficiency Savings) plans</b> Sickness absence figures are shown as percentage of available fte(full time equivalent) absent |      |      |      |          |                      |      |                |
|                    |                                                                                                                                                                                                        | UHB  | SHN  | D&T  | Medicine | Specialised Services | W&C  | Trust Services |
|                    | 2008/09 average                                                                                                                                                                                        | 4.3% | 4.7% | 3.0% | 5.0%     | 3.7%                 | 4.3% | 4.6%           |
|                    | CRES plan target 2009/10                                                                                                                                                                               |      | 4.2% | 2.8% | 4.5%     | 3.5%                 | 4.1% | 4.6%           |
| Exception:         | Absence Feb 2010                                                                                                                                                                                       | 4.7% | 3.7% | 3.9% | 5.1%     | 4.8%                 | 5.0% | 5.3%           |
|                    | Cumulative absence Feb 2010                                                                                                                                                                            | 4.4% | 4.2% | 3.5% | 4.9%     | 4.6%                 | 4.2% | 4.7%           |
| Reason:            | All Divisions except Surgery Head and Neck are under achieving on cumulative absence against their CRES plan target in 2009/10.                                                                        |      |      |      |          |                      |      |                |
| Action:            | Implementation of the Supporting Attendance policy.                                                                                                                                                    |      |      |      |          |                      |      |                |
| Date:              | Ongoing                                                                                                                                                                                                |      |      |      |          |                      |      |                |

|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             |               |                            |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------|----------------------------|
| Objective /Target: | <b>Achievement of Planned fte CRES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             |               |                            |
| Exception:         | <b>Division</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Plan to end Dec 2009</b> | <b>Actual</b> | <b>Variance (Dec 2009)</b> |
|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>fte</b>                  | <b>fte</b>    | <b>fte</b>                 |
|                    | Diagnostic and Therapies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11.0                        | 9.0           | (2.0)                      |
|                    | Medicine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 14.8                        | 4.0           | (10.8)                     |
|                    | Specialised Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10.3                        | 7.7           | (2.6)                      |
|                    | Surgery Head and Neck                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3.3                         | 3.3           |                            |
|                    | Women and Children`s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0.5                         | 1.7           | 1.2                        |
|                    | Trust Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2.3                         | 3.0           | (0.6)                      |
|                    | <b>Totals</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>42.2</b>                 | <b>28.7</b>   | <b>(13.5)</b>              |
| Reason:            | <ul style="list-style-type: none"> <li>Trust Services:<br/>0.6fte will not be achieved this year and is offset by a non pay scheme;</li> <li>Specialised Services:               <ol style="list-style-type: none"> <li>Difficulties in achieving nurse workforce savings following the move to the BHI;(1.3 fte)</li> <li>A decrease in oncology consultants has reduced the potential to achieve planned savings generated from peripheral clinics (0.5 fte)</li> <li>slippage in absence management (1.4 fte).</li> </ol> </li> <li>Medicine:<br/>Planned savings from Sexual Health Amalgamation not yet materialised due to extended service hours trial (2.0 fte)<br/>Nurse absence rates not reducing (6.5 fte)<br/>Reduced Length of Stay not releasing any savings as planned (2.3 fte).</li> <li>Diagnostics and Therapies<br/>Procurement process for Voice Recognition in Radiology well under way.<br/>Review of A&amp;C staffing is part of this process, and has started to deliver savings ahead of voice recognition implementation.</li> </ul> |                             |               |                            |

## SECTION 1 - WORKFORCE

|         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Action: | <ul style="list-style-type: none"> <li>Medicine:               <ol style="list-style-type: none"> <li>1) Budget restructure, termination of the trial if not financially beneficial by December and vacancy control to ensure savings delivered in year by Sexual Health Service</li> <li>2) Alternative schemes being identified at Divisional CRES Committee</li> </ol> </li> <li>Specialised Services:               <ol style="list-style-type: none"> <li>1) The Division's Finance Committee has identified some recurring and non recurring alternative schemes. 2) Slippage on development funding wherever practicable. 3) Targeted sickness absence intervention by HR team in areas with high sickness absence levels (Coronary Intensive Care Unit and Bristol Oncology and Haematology Centre outpatients)</li> </ol> </li> <li>Diagnostics and Therapies               <p>Procurement process for Voice Recognition in Radiology well under way. Review of A&amp;C staffing is part of this process.</p> </li> <li>Achievement of CRES plans is monitored monthly at Divisional Performance Reviews.</li> </ul> |
| Date:   | End March 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Objective /Target: | <b>Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations (RIDDOR) 1995–</b> <ul style="list-style-type: none"> <li>To comply with the 10 day notification period of reportable incidents to the Health &amp; Safety Executive (HSE), improving the delay in reporting by 10% each year, commencing 2008/09.</li> <li>To reduce the number of reportable incidents by 5% during 2009/2010.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                           |
| Exception          | <b>RIDDOR's not reported within 10 days</b><br>In the first 9 months of 2009/10, 29 reportable incidents were registered with 7 (24%) delays in reporting time scale. This compares with a total of 47 reportable incidents registered in year ending April 2009 of which 31 (66%) were non compliant with the 10 day time frame so is a vast improvement                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Reason:            | <ul style="list-style-type: none"> <li>High risk of scrutiny by enforcing authorities not realised by Department Managers/ Divisions</li> <li>Time pressures regarding investigation time versus service needs</li> <li>The cost of not investigating is currently unknown but not to investigate may lead to a more serious incident in terms of harm to person and/or damage to property</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                           |
| Action:            | <ul style="list-style-type: none"> <li>Accident investigation training awareness sessions to continue in 2009/10. Further training has also commenced this year for Investigating Managers.</li> <li>Ongoing investigation of costs of RIDDOR's in partnership with Avon Occupational Health Services to be completed</li> <li>Pilot of on-line incident reporting in progress, being rolled out Trust wide in 2009/10, completion date for roll out is July 2010</li> <li>Director of Workforce and Organisational Development to be alerted to all delays of 2 weeks or more from August 1<sup>st</sup> 2009</li> <li>If maintained at this rate for the last quarter – no longer an exception and achieved target</li> </ul> <p>Lead: Head of Health and Safety Services: Melanie Fewkes</p> |
| Delivery Date:     | March 2010 with quarterly review of progress ongoing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

## SECTION 2 – CLINICAL QUALITY AND EFFECTIVENESS

### 2.1 Data Summary

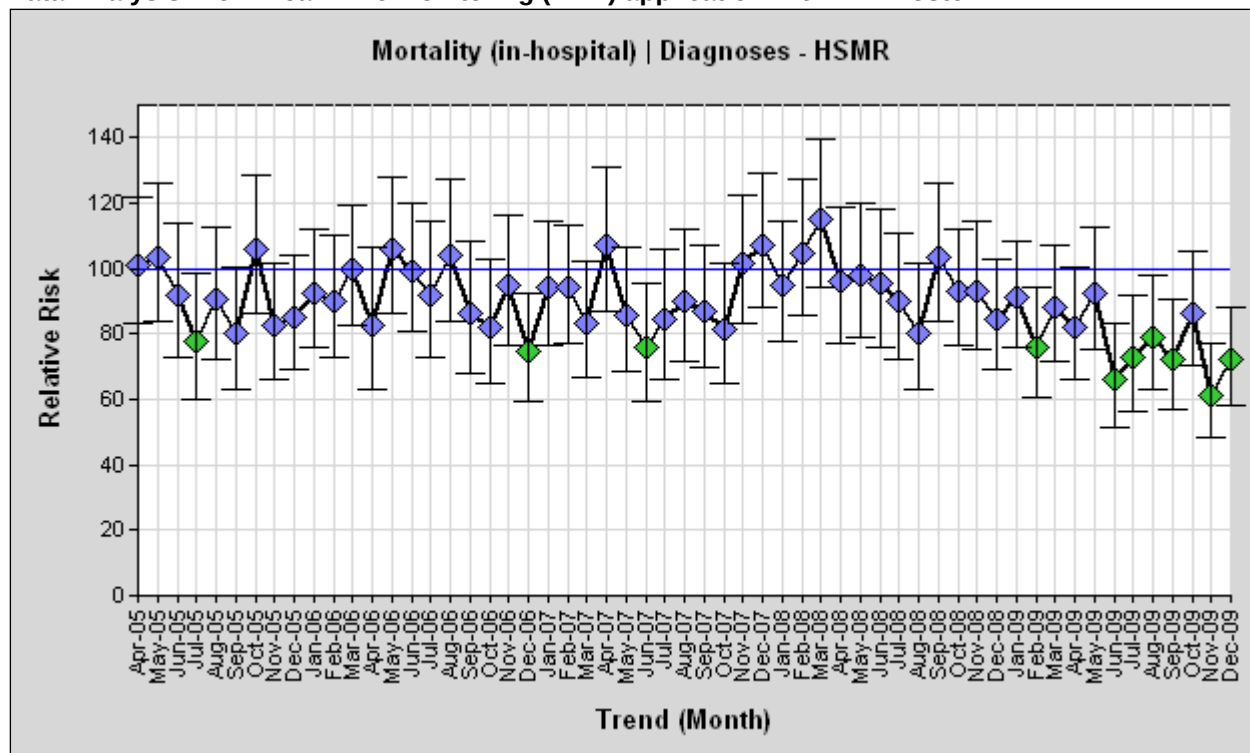
- HSMR is the Hospital Standardised Mortality Ratio and covers the diagnoses that account for 80% of the in-hospital deaths. The methodology was developed at Imperial College London by Professor Brian Jarman and uses national Hospital Episode Statistics (HES) data. Relative Risk is the Observed Outcome divided by the Expected Outcome, expressed as a percentage. So a Relative Risk value of 100 indicates there were exactly as many deaths as would be expected when compared against England data (age, gender and casemix adjusted). A value of less than 100 indicates less than expected. However, the 95% confidence interval is critical as the Relative Risk is based on statistical modelling so these intervals indicates that UBHT's Relative Risk could've actually fallen anywhere within these limits with 95% certainty. So if both confidence limits lie below 100 then the Trust can be said to be "statistically significantly better than expected", hence data point is green.
- For Delayed Discharges, the data is taken from the weekly Situation Reports (SitReps). Here, the number of delays is reported as at a Thursday snapshot. For acute delays, this is the total number on each census within the month (could be four or five census points). The "total occupied beddays" figure is the number of acute beds occupied at midnight on the corresponding Thursdays. For non-acute, the number of delays is the total number of delays from the first four Thursdays in a month.

| Measure                                                  |                  | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 |
|----------------------------------------------------------|------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Hospital Standardised Mortality Ratio (HSMR)             | Relative Risk    | 82     | 92.7   | 65.9   | 72.8   | 79.1   | 72.5   | 86.6   | 61.4   | 72.1   |        |        |
|                                                          | Lower Limit      | 66.3   | 75.3   | 51.2   | 56.6   | 62.9   | 57.1   | 70.4   | 48.2   | 58.4   |        |        |
|                                                          | Upper Limit      | 100.2  | 112.8  | 83.3   | 92.1   | 98.2   | 90.7   | 105.4  | 77.1   | 88.0   |        |        |
| Delayed Discharges (Acute) – Percentage of Occupied Beds | Total Delays     | 15     | 42     | 29     | 26     | 38     | 27     | 33     | 34     | 40     | 48     | 34     |
|                                                          | Occupied Beddays | 2979   | 3754   | 2872   | 2759   | 3541   | 2889   | 3086   | 3832   | 2885   | 3766   | 3097   |
|                                                          | Percentage       | 0.50%  | 1.12%  | 1.01%  | 0.94%  | 1.07%  | 0.93%  | 1.07%  | 0.89%  | 1.39%  | 1.27%  | 1.10%  |
| Delayed Discharges – Non Acute Total Number              |                  | 7      | 8      | 12     | 9      | 14     | 10     | 9      | 14     | 4      | 7      | 6      |

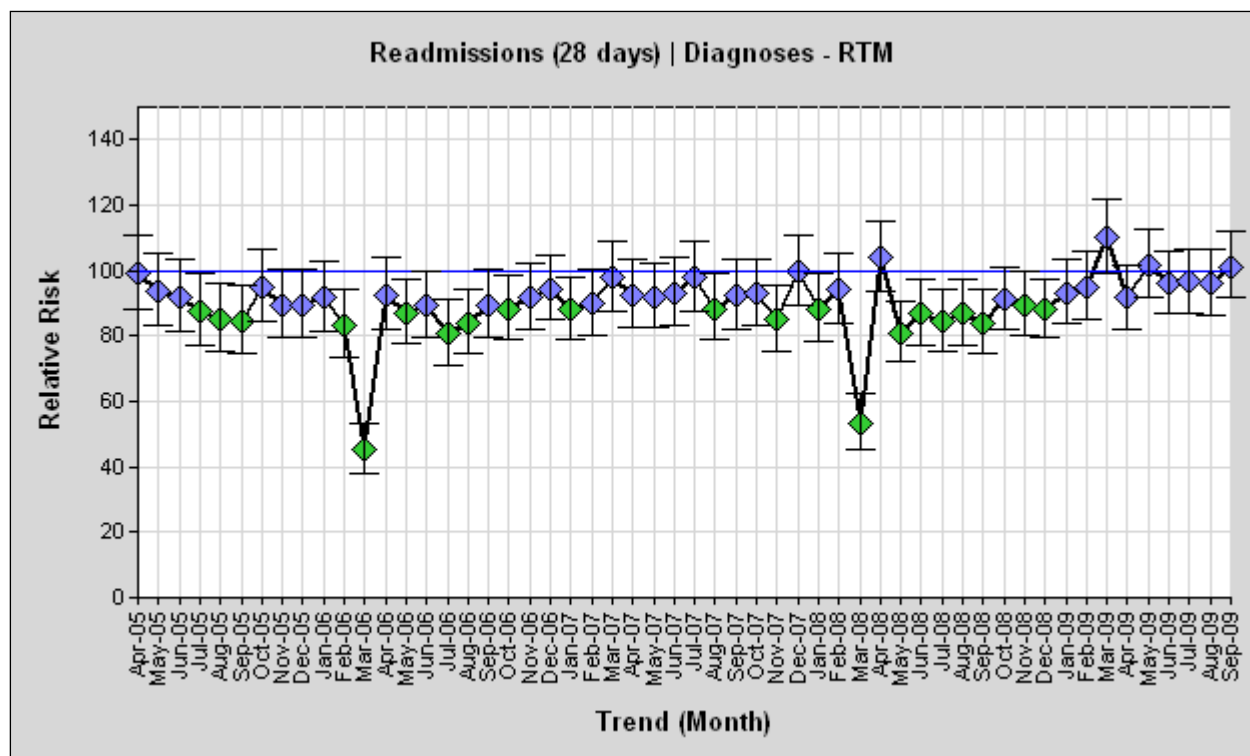
## SECTION 2 – CLINICAL QUALITY AND EFFECTIVENESS

### 2.2 Trend Graphs

Data Analysis From Real Time Monitoring (RTM) application within Dr Foster



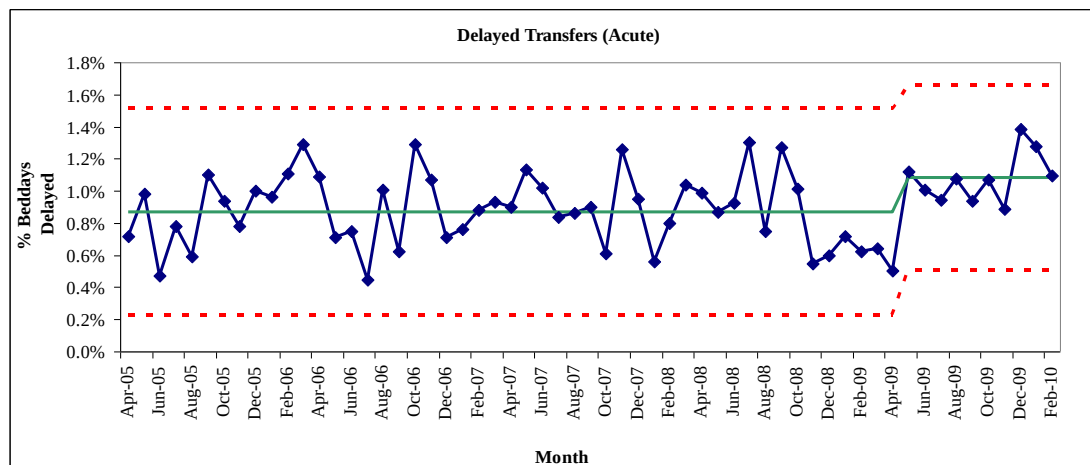
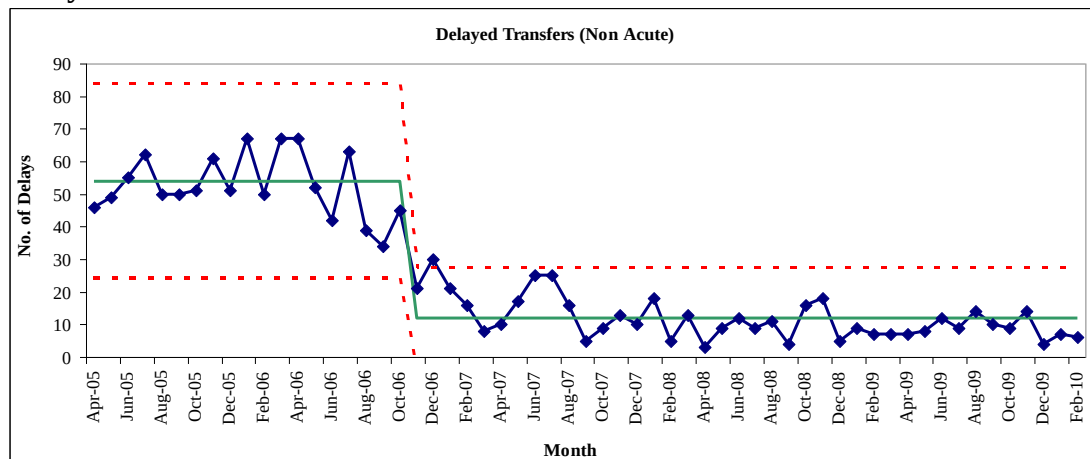
HSMR is the Hospital Standardised Mortality Ratio and covers the diagnoses that account for 80% of the in-hospital deaths.



Readmissions relates to emergency readmissions (at any hospital) within 28 days of discharge from UBHT. The vertical bars on each data point are the 95% confidence intervals. Please refer to the notes in Section 3.2 for an explanation.

## SECTION 2 – CLINICAL QUALITY AND EFFECTIVENESS

### Delayed Transfers of Care



### 2.3 Exception Reports

No Exceptions Reported

## SECTION 3 – PATIENT EXPERIENCE

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### 3.1 Data Summary

The new Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 came into effect on 1<sup>st</sup> April 2009. New processes have been established within the Trust and the new Complaints and Concerns Policy v4 which reflects these changes has been ratified by the Governance and Risk Management Committee.

The emphasis is on getting it right first time via local resolution and complainants who remain dissatisfied will only have further recourse to the Parliamentary and Health Service Ombudsman.

The new complaints regulations dispense with the standard 25 day complaint response deadline which will be replaced by individually negotiated local resolution plans which are required to be proportionate and transparent. Intelligence from early adopters of the new arrangements suggests improved performance and fewer dissatisfied complainants.

Monthly Board reporting on Complaints has been amended to include:

- Total number of complaints received in the month.
- Number and % of complaints per patient attendances in the month
- Number and % of complaints resolved outside of the Local Resolution Plan (LRP) timescale
- Number of complainants dissatisfied with their response received in the month
- Total number of compliments received in the month

The Parliamentary and Health Service Ombudsman has stated Principles of Good Complaints Handling (February 2009) that “putting things right” should include, where appropriate, financial compensation for direct financial loss, and also consolatory payment for loss of opportunity, inconvenience, distress or any combination of these, to include the difficulty experienced by the complainant in pursuing their complaint. Further guidance is being drawn up in this respect.

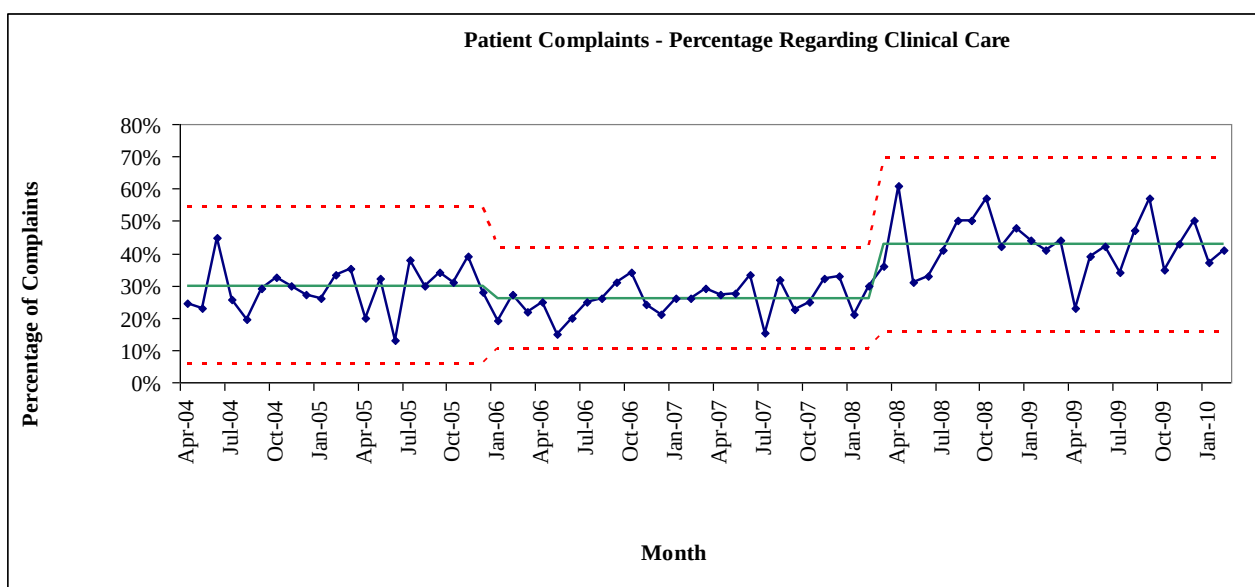
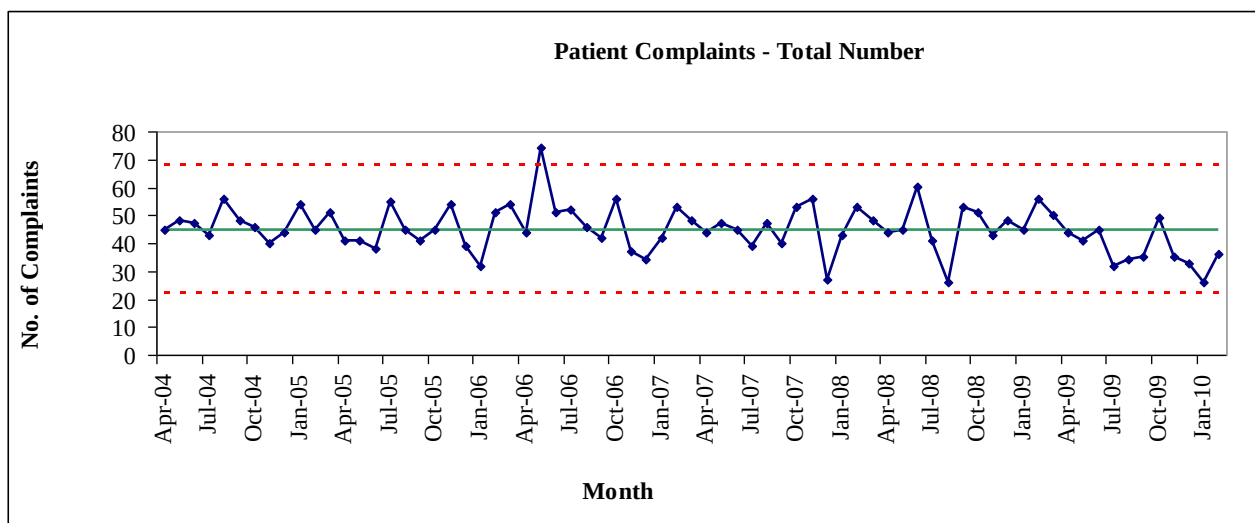
## SECTION 3 – PATIENT EXPERIENCE

### High Level Formal Complaints Data up to February 2010

|                                                                                                           | Feb-09                   | Mar-09                   | Apr-09                   | May-09                   | Jun-09                   | Jul-09                   | Aug-09                   | Sep-09                   | Oct-09                   | Nov-09                   | Dec-09                   | Jan -10                  | Feb -10                  |
|-----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Number of formal complaints received                                                                      | 56                       | 50                       | 44                       | 41                       | 45                       | 32                       | 34                       | 35                       | 49                       | 35                       | 33                       | 26                       | 36                       |
| Number & % of Complaints Per Patient Attendance in the Month                                              | 0.137%<br>56 of<br>40853 | 0.105%<br>50 of<br>47766 | 0.097%<br>44 of<br>45213 | 0.099%<br>41 of<br>42270 | 0.091%<br>45 of<br>49268 | 0.068%<br>32 of<br>47307 | 0.079%<br>34 of<br>42787 | 0.068%<br>35 of<br>51236 | 0.097%<br>49 of<br>50628 | 0.069%<br>35 of<br>50667 | 0.072%<br>33 of<br>45522 | 0.058%<br>26 of<br>44534 | 0.075%<br>36 of<br>48217 |
| % formal complaints regarding clinical care                                                               | 41                       | 44                       | 23                       | 39                       | 42                       | 34                       | 47                       | 57                       | 35                       | 43                       | 50                       | 37                       | 41                       |
| Number and % resolved outside of the LRP timescale(Those prior to 1/4/09 are outside of 25 day timescale) | 2.56%<br>1 of 39         | 15.38%<br>8 of 52        | 5.77%<br>3 of 52         | 4.55%<br>2 of 44         | 13.46%<br>7 of 52        | 18.6%<br>8 of 43         | 8.1%<br>3 of 37          | 20%<br>6 of 30           | 7%<br>2 of 28            | 0%<br>0 of 48            | 0%<br>0 of 33            | 7%<br>2 of 28            | 8.7%<br>2 of 23          |
| Number of Complainants Dissatisfied with Quality or Content of Response                                   |                          |                          |                          |                          |                          |                          |                          |                          |                          | 4                        | 0                        | 2                        | 2                        |
| Number of Complainants requesting further information.                                                    |                          |                          |                          |                          |                          |                          |                          |                          |                          | 1                        | 0                        | 2                        | 2                        |
| Compliments                                                                                               | 913                      | 837                      | 790                      | 943                      | 914                      | 543                      | 724                      | 989                      | 1014                     | 994                      | 1776                     | 613                      |                          |

## SECTION 3 – PATIENT EXPERIENCE

### 3.2 Trend Graphs





**3.3 Exception Reports**

|                    |                                                                                                                                                                                                                                                                     |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Objective /Target: | 98 % formal complaints responded to within individually agreed local resolution plan timescale.                                                                                                                                                                     |
| Exception:         | 91.3% of responses were within the timescale agreed with the complainant in the local resolution plan. 2 responses were sent out after the agreed time and both of these letters were 1 working date late leaving the Trust.<br><br>Compliments data not available. |
| Reason:            | Staff vacancy, sickness and annual leave co-inciding with both corporate and divisional complaints teams.                                                                                                                                                           |
| Action:            | The corporate complaints post remains vacant, and sickness has been resolved.<br><br>Systems for collating compliments data do not allow this to happen in a timely manner and will be reviewed during early 2010/11                                                |
| Delivery Date:     | It is anticipated complaint resolution will be back on track March 2010.<br><br>It is anticipated compliments data will be included in the 2010/11 Trust Quality dashboard, and improved data collection will allow more timely data provision by the end of Q1.    |

## SECTION 4 – PUBLIC HEALTH

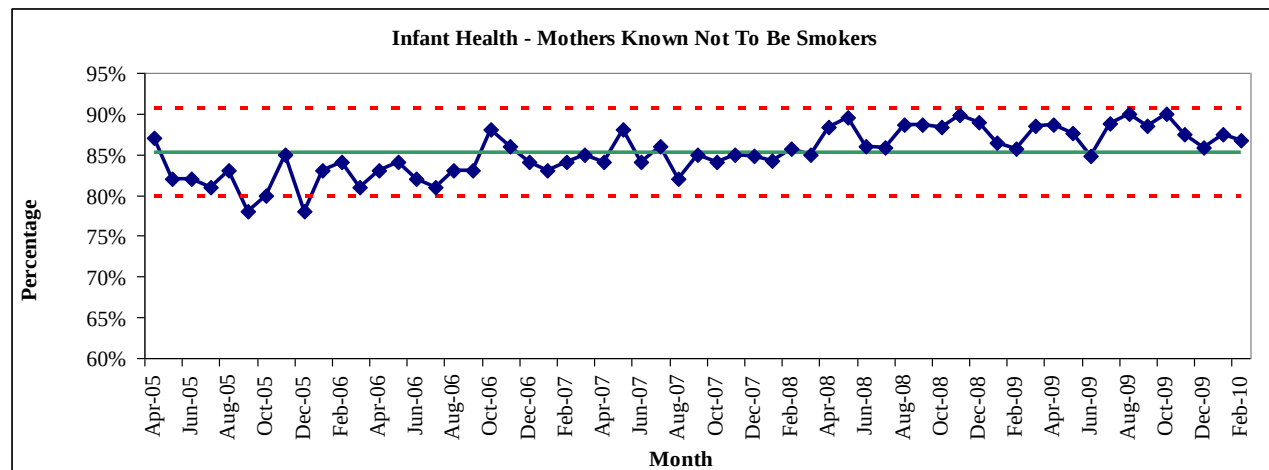
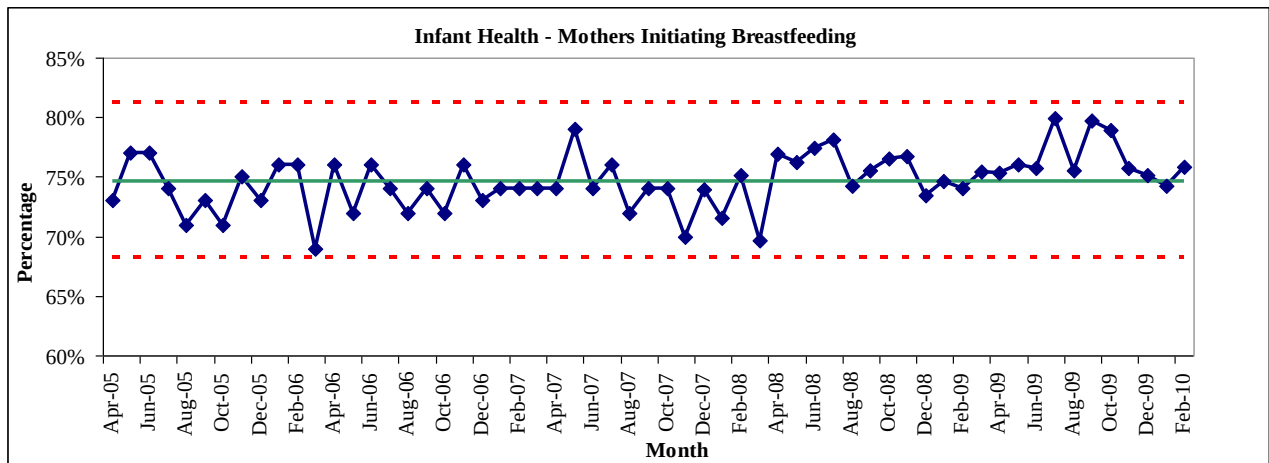
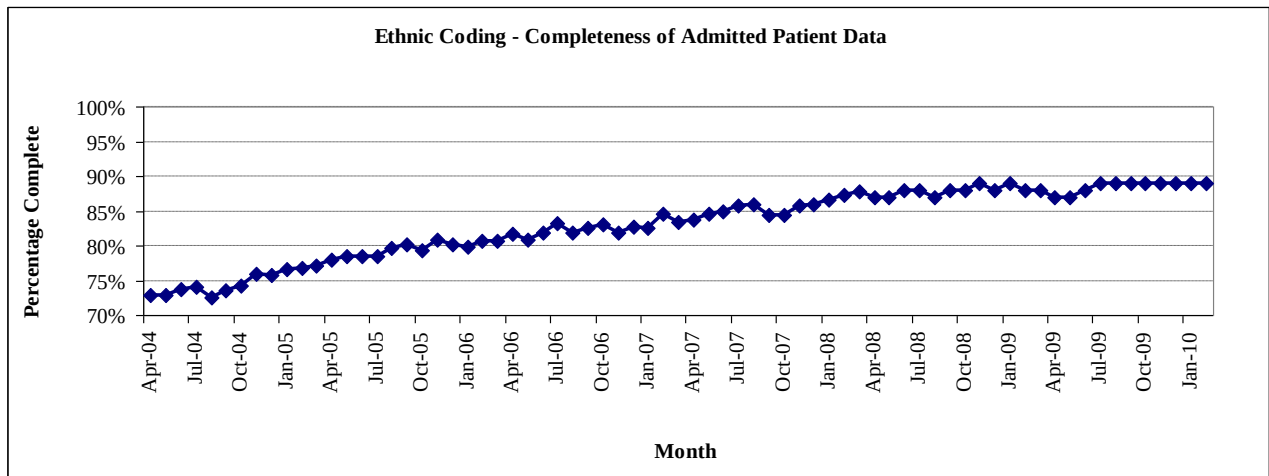
### 4.1 Data Summary

- The ethnic coding measure counts the number of admitted patient episodes, referred to as Finished Consultant Episodes (FCEs) that have a valid ethnic group code. Ethnic data monitoring is vital to ensure that a fair and equitable provision of service is given to the whole population, recognising that different ethnic groups have different health issues.
- There are two measures of Infant Health. One records the number of mothers who were known to have initiated breastfeeding, and the second is the number of mothers who were known NOT to be smokers as at the time of delivery. In both cases, the target data is the total number of deliveries (i.e. number of mothers) for the month.
- The Breast Screening section shows the number of invitations and screenings for the Avon Breast Screening Unit. The target for Invites is higher than the Screening target as this takes into account the take-up-rate. Note that Screening data for the latest month is not available in time for inclusion.
- The section on Stroke Care represents the number diagnosed Stroke patients who spend time on a designated Stroke ward. The Target represents the total number of diagnosed Stroke patients who were appropriate admissions to a Stroke Unit.

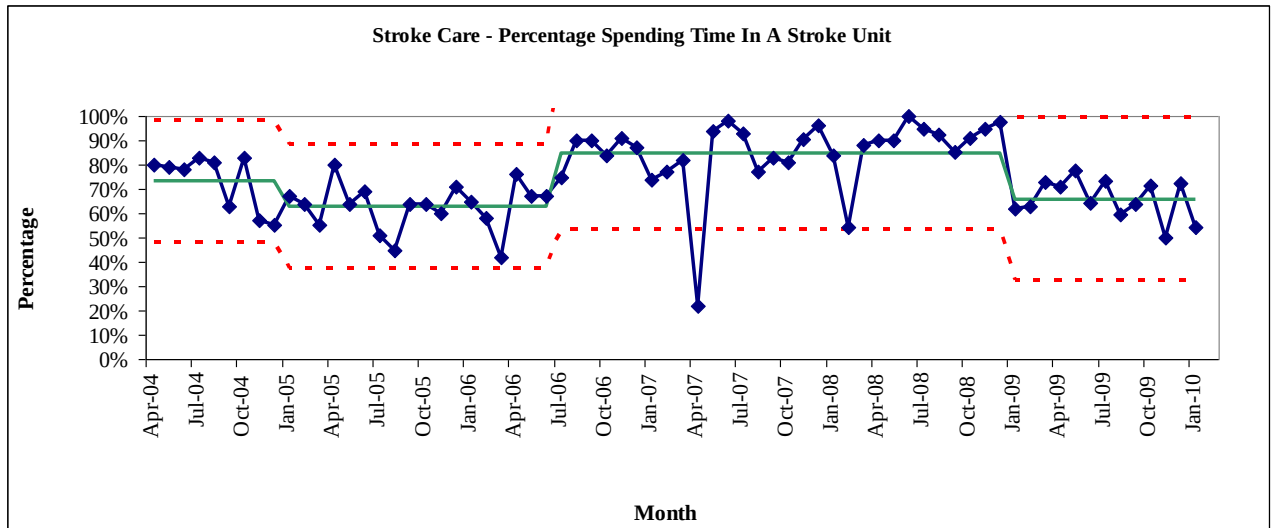
| Measure                                                         |            | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 |
|-----------------------------------------------------------------|------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Ethnic Coding – Completeness of Admitted Patient Data           |            | 87%    | 88%    | 89%    | 89%    | 89%    | 89%    | 90%    | 89%    | 89%    | 89%    |
| Infant Health - Mothers Initiating Breastfeeding                | Actual     | 320    | 293    | 370    | 331    | 331    | 363    | 321    | 317    | 325    | 310    |
|                                                                 | Total      | 421    | 387    | 463    | 438    | 415    | 460    | 424    | 422    | 438    | 409    |
|                                                                 | Percentage | 76%    | 76%    | 80%    | 76%    | 80%    | 79%    | 76%    | 75%    | 74%    | 76%    |
| Infant Health - Mothers Who Are Not Smokers At Time of Delivery | Actual     | 369    | 328    | 411    | 394    | 367    | 414    | 371    | 362    | 383    | 355    |
|                                                                 | Total      | 421    | 387    | 463    | 438    | 415    | 460    | 424    | 422    | 438    | 409    |
|                                                                 | Percentage | 88%    | 85%    | 89%    | 90%    | 88%    | 90%    | 88%    | 86%    | 87%    | 87%    |
| Stroke Patients Spending Time in a Specialised Stroke Unit      | Actual     | 31     | 20     | 19     | 22     | 21     | 25     | 18     | 29     | 18     |        |
|                                                                 | Total      | 40     | 31     | 26     | 37     | 33     | 35     | 36     | 40     | 33     |        |
|                                                                 | Percentage | 78%    | 65%    | 73%    | 59%    | 64%    | 71%    | 50%    | 73%    | 55%    |        |

## SECTION 4 – PUBLIC HEALTH

### 4.2 Trend Graphs



## SECTION 4 – PUBLIC HEALTH



### 4.3 Exception Reports

No Exceptions Reported

## SECTION 5 – NATIONAL PERFORMANCE

### 5.1 Executive Summary

A summary of the Trust's performance for the year to February 2010 is shown below.

| Target summary                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|    | <p>The Trust is currently <b>achieving</b> the following targets:</p> <ul style="list-style-type: none"> <li>- MRSA bacteraemia rates</li> <li>- Clostridium difficile rates</li> <li>- Inpatient waiting times (26 weeks)</li> <li>- Outpatient waiting times (13 weeks)</li> <li>- Genito-Urinary Medicine (GUM) 48-hour access</li> <li>- Revascularisation (13 weeks)</li> <li>- Rapid access chest pain clinic waiting time (2 weeks)</li> <li>- Delayed transfers of care</li> <li>- Ethnic group data quality</li> <li>- Reperfusion times (thrombolysis and primary percutaneous coronary interventions)</li> <li>- Maternity breastfeeding initiation</li> <li>- 18-week Referral to Treatment Time (RTT) – non-admitted pathways</li> <li>- 2-week wait for urgent suspected cancer appointment</li> </ul> |
|  | <p>The Trust is currently <b>underachieving</b> the following targets:</p> <ul style="list-style-type: none"> <li>- Emergency care 4 hour access</li> <li>- Cancelled operations / 28-day readmission</li> <li>- 18-week Referral to Treatment Time (RTT) - admitted pathways</li> <li>- 31-day cancer standard*</li> <li>- 62-day cancer standard*</li> <li>- Maternity non smoking rates</li> </ul> <p><i>* Fail threshold not confirmed but estimated on the basis of previous years assessments</i></p>                                                                                                                                                                                                                                                                                                          |
|  | <p>The Trust is currently <b>failing</b> the following targets:</p> <ul style="list-style-type: none"> <li>- 2-week wait for urgent suspected cancer appointment (breast symptoms)*</li> </ul> <p><i>* Fail threshold not confirmed but estimated on the basis of previous years assessments</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|  | <p>Targets for which the performance thresholds have not been confirmed and/or the figures are not yet available:</p> <ul style="list-style-type: none"> <li>- Participation in heart disease audit<sup>†</sup></li> <li>- Engagement in clinical audit<sup>‡</sup></li> <li>- Maternity Hospital Episode Statistics (HES) data quality<sup>‡</sup></li> <li>- Experience of patients<sup>‡</sup></li> <li>- NHS Staff Satisfaction Survey<sup>‡</sup></li> </ul> <p><sup>†</sup> not achieved in 2008/09 but corrective action taken to support achievement in 2009/10<br/> <sup>‡</sup> achieved in 2008/09</p>                                                                                                                                                                                                    |

For further details of performance against each of these targets, please see the summary tables on the following page

## SECTION 5 – NATIONAL PERFORMANCE

### 5.2 Care Quality Commission Framework

|                      | Domain                   |     | Target                                           | Thresholds |       | Last Year To Date | Year To Date | Forecast Score | Monthly Performance |        |        |        |        |        |        |        |        |        |        |        |        | Quarterly Performance |        |        |  |
|----------------------|--------------------------|-----|--------------------------------------------------|------------|-------|-------------------|--------------|----------------|---------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------------------|--------|--------|--|
|                      |                          |     |                                                  | Green      | Red   |                   |              |                | Apr-09              | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 | Q1     | Q2                    | Q3     | Q4     |  |
| Existing Commitments | Health and WellBeing     | 1   | GUM Offer Of Appointment Within 48 Hours         | 98%        | 95%   | 100.0%            | 100.0%       | 3              | 100.0%              | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.9%  | 100.0% | 100.0% | 100.0% | 100.0% |        | 100.0% | 100.0%                | 100.0% | 100.0% |  |
|                      |                          | 2   | Data Quality on Ethnic Group                     | 85%        | 70%   | 87.8%             | 88.7%        | 3              | 87.1%               | 87.2%  | 88.4%  | 88.6%  | 88.9%  | 89.4%  | 89.3%  | 89.0%  | 89.1%  | 89.4%  | 89.1%  |        | 87.6%  | 89.0%                 | 89.1%  | 89.3%  |  |
|                      | Clinical Quality         | 3A  | 60 Minute Thrombolysis Call To Needle Time       | 68%        | 68%   | 76.9%             | 100.0%       | 3              | 100.0%              | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |        |        |        | 100.0% | 100.0% |                       |        |        |  |
|                      |                          | 3B  | Primary PCI - 150 Minutes Call To Balloon Time   | 68%        | 68%   |                   | 68.3%        |                | 66.7%               | 61.5%  | 80.0%  | 58.3%  | 69.6%  | 72.2%  | 69.4%  | 71.9%  | 68.8%  |        |        |        | 67.7%  | 66.2%                 |        |        |  |
|                      | Patient Focus and Access | 4   | Delayed Transfers Of Care (Acute)                | 3.5%       | 5.0%  | 0.9%              | 1.0%         | 3              | 0.5%                | 1.1%   | 1.0%   | 0.9%   | 1.1%   | 0.9%   | 1.1%   | 0.9%   | 1.4%   | 1.3%   | 1.1%   |        | 0.9%   | 1.0%                  | 1.1%   | 1.2%   |  |
|                      |                          |     | Emergency Care 4 Hour Throughput (excluding WIC) | 98%        | 97%   | 96.43%            | 97.00%       | Not scored     | 97.27%              | 97.01% | 98.87% | 97.06% | 97.67% | 96.95% | 93.78% | 97.16% | 96.74% | 97.64% | 97.09% |        | 97.72% | 97.22%                | 95.86% | 97.40% |  |
|                      |                          | 5   | Emergency Care 4 Hour Throughput (including WIC) | 98%        | 97%   | 97.61%            | 97.93%       | 2              | 98.13%              | 97.95% | 99.23% | 97.99% | 98.42% | 97.90% | 95.69% | 98.03% | 97.68% | 98.27% | 98.01% |        | 98.44% | 98.10%                | 97.10% | 98.16% |  |
|                      |                          | 6   | Elective Breaches of 26 Weeks                    | 0.03%      | 0.15% | 0.00%             | 0.01%        | 3              | 0.03%               | 0.03%  | 0.02%  | 0.00%  | 0.00%  | 0.00%  | 0.00%  | 0.00%  | 0.00%  | 0.00%  | 0.03%  |        | 0.03%  | 0.00%                 | 0.00%  | 0.02%  |  |
|                      |                          | 7   | New Outpatients (GP/GDP) Breaches of 13 Weeks    | 0.03%      | 0.15% | 0.01%             | 0.02%        | 3              | 0.00%               | 0.02%  | 0.00%  | 0.03%  | 0.00%  | 0.02%  | 0.05%  | 0.02%  | 0.04%  | 0.04%  | 0.04%  |        | 0.01%  | 0.02%                 | 0.04%  | 0.04%  |  |
|                      |                          | 8   | Revasc Breaches of 13 Weeks                      | 0.10%      | 0.20% | 0.0%              | 0.0%         | 3              | 0.0%                | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   |        | 0.0%   | 0.0%                  | 0.0%   | 0.0%   |  |
|                      |                          | 9   | Rapid Access Chest Pain 2 Week Wait              | 98%        | 95%   | 100.0%            | 100.0%       | 3              | 100.0%              | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |        | 100.0% | 100.0%                | 100.0% | 100.0% |  |
|                      |                          | 10A | Number of Last Minute Cancelled Operations       | 0.80%      | 1.50% | 1.19%             | 1.07%        | 2              | 0.67%               | 1.04%  | 1.13%  | 0.86%  | 0.63%  | 1.21%  | 1.49%  | 1.29%  | 1.26%  | 1.06%  | 1.06%  |        | 0.95%  | 0.90%                 | 1.35%  | 1.06%  |  |
|                      |                          | 10B | 28 Day Readmissions                              | 95%        | 85%   | 89.6%             | 91.9%        |                | 93.5%               | 97.4%  | 87.0%  | 94.1%  | 96.2%  | 100.0% | 94.3%  | 90.9%  | 96.0%  | 78.3%  | 89.8%  |        | 92.1%  | 96.1%                 | 93.6%  | 83.6%  |  |
| Total                |                          |     |                                                  |            |       |                   | 28           | Out of 30      |                     |        |        |        |        |        |        |        |        |        |        |        |        |                       |        |        |  |

## SECTION 5 – NATIONAL PERFORMANCE

|                     |                          |     |                                                                                                    | Thresholds |               | Last Year To Date | Year To Date | Forecast Score | Monthly Performance |                                                                                     |        |        |        |        |        |        |        |        |        |        |       |        | Quarterly Performance |        |       |  |  |
|---------------------|--------------------------|-----|----------------------------------------------------------------------------------------------------|------------|---------------|-------------------|--------------|----------------|---------------------|-------------------------------------------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------|--------|-----------------------|--------|-------|--|--|
|                     | Domain                   |     | Target                                                                                             | Green      | Red           |                   |              |                | Apr-09              | May-09                                                                              | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 | Q1    | Q2     | Q3                    | Q4     |       |  |  |
|                     |                          |     |                                                                                                    |            |               |                   |              |                |                     |                                                                                     |        |        |        |        |        |        |        |        |        |        |       |        |                       |        |       |  |  |
| National Priorities | Health and WellBeing     | 11A | Infant Health - Mothers Who Are Not Smokers At Delivery                                            |            | 87.9%         | 87.9%             | 87.9%        | 87.8%          | 2                   | 88.7%                                                                               | 87.6%  | 84.8%  | 88.8%  | 90.0%  | 88.4%  | 90.0%  | 87.5%  | 85.8%  | 87.4%  | 86.8%  |       | 87.1%  | 89.1%                 | 87.8%  | 87.1% |  |  |
|                     |                          | 11B | Infant Health - Mothers Initiating Breastfeeding                                                   |            | 70.8%         | 70.8%             | 75.9%        | 76.6%          |                     | 75.3%                                                                               | 76.0%  | 75.7%  | 79.9%  | 75.6%  | 79.8%  | 78.9%  | 75.7%  | 75.1%  | 74.2%  | 75.8%  |       | 75.7%  | 78.4%                 | 76.6%  | 75.0% |  |  |
|                     | Clinical Quality         | 12  | Participation in Heart Disease Audits                                                              |            | Not published | Not published     | Not achieved | TBC            | 3                   | Audit data to be submitted in Quarter 1 2010/11                                     |        |        |        |        |        |        |        |        |        |        |       |        |                       |        |       |  |  |
|                     |                          | 13  | Engagement in Clinical Audits                                                                      |            | Not published | Not published     | Achieved     | TBC            | 3                   | Care Quality Commission Questionnaire to be submitted in Quarter 1 2010/11          |        |        |        |        |        |        |        |        |        |        |       |        |                       |        |       |  |  |
|                     |                          | 14  | Stroke Care                                                                                        |            | 60%           | 40%               | 62.2%        | 65.8%          | 3                   | 71.0%                                                                               | 77.5%  | 64.5%  | 73.1%  | 59.5%  | 63.6%  | 71.4%  | 50.0%  | 72.5%  | 54.5%  |        |       | 71.6%  | 64.6%                 | 64.9%  | 54.5% |  |  |
|                     |                          | 15  | Maternity Data Quality Indicator                                                                   |            | Not published | Not published     | Achieved     | TBC            | 3                   | Performance indicators to be confirmed                                              |        |        |        |        |        |        |        |        |        |        |       |        |                       |        |       |  |  |
|                     | Safety                   | 16  | Infection Control - MRSA Bloodstream Cases Against Trajectory                                      |            | 0             | 0                 | -9           | -8             | 3                   | -2                                                                                  | -2     | 1      | 0      | 1      | -2     | -2     | 1      | -1     | -1     | -1     |       | -3     | -1                    | -2     | -2    |  |  |
|                     |                          | 17  | Infection Control - C.Diff Infections Against Trajectory                                           |            | 0             | 0                 | -9           | -130           | 3                   | -4                                                                                  | -10    | -9     | -10    | -15    | -6     | -12    | -15    | -19    | -15    | -15    |       | -23    | -31                   | -46    | -30   |  |  |
|                     | Patient Focus and Access | 18A | Referral To Treatment Admitted Under 18 Weeks                                                      |            | 90%           | 80%               | 92.1%        | 90.3%          | 2                   | 92.4%                                                                               | 91.3%  | 92.2%  | 90.8%  | 90.5%  | 90.0%  | 87.4%  | 87.0%  | 90.5%  | 90.8%  | 90.1%  |       | 92.0%  | 90.4%                 | 88.3%  | 90.4% |  |  |
|                     |                          | 18B | Referral To Treatment Non Admitted Under 18 Weeks                                                  |            | 95%           | 85%               | 95.9%        | 97.6%          |                     | 96.9%                                                                               | 98.3%  | 98.1%  | 97.4%  | 97.3%  | 97.8%  | 98.1%  | 97.5%  | 96.9%  | 97.7%  | 97.1%  |       | 97.7%  | 97.5%                 | 97.5%  | 97.4% |  |  |
|                     |                          | 19A | Cancer - Urgent Referrals Seen In Under 2 Weeks                                                    |            | 93%           | 90%               |              | 93.4%          | 0                   |                                                                                     |        | 92.7%  |        |        | 93.2%  |        |        | 94.5%  | 92.3%  |        |       | 92.7%  | 93.2%                 | 94.5%  | 92.3% |  |  |
|                     |                          | 19B | Cancer - Urgent Referrals Seen In Under 2 Weeks (breast - not initially thought to be symptomatic) |            | 93%           | 90%               |              | 25.0%          |                     |                                                                                     |        |        |        |        |        |        |        | 25.0%  |        |        |       |        |                       | 25.0%  |       |  |  |
|                     |                          | 20A | Cancer - 31 Day Diagnosis To Treatment (First Treatments)                                          |            | 96%           | 93%               |              | 95.9%          | 2                   |                                                                                     |        | 95.8%  |        |        | 95.1%  |        |        | 96.6%  | 96.6%  |        | 95.8% | 95.1%  | 96.6%                 | 96.6%  |       |  |  |
|                     |                          | 20B | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)                                         |            | 98%           | 95%               |              | 99.5%          |                     |                                                                                     |        | 99.4%  |        |        | 100.0% |        |        | 98.8%  | 100.0% |        | 99.4% | 100.0% | 98.8%                 | 100.0% |       |  |  |
|                     |                          | 20C | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)                                      |            | 94%           | 91%               |              | 91.6%          |                     |                                                                                     | 93.4%  |        |        | 90.5%  |        |        | 90.8%  | 92.3%  |        | 93.4%  | 90.5% | 90.8%  | 92.3%                 |        |       |  |  |
|                     |                          | 21A | Cancer 62 Day Referral To Treatment (Urgent GP Referral)                                           |            | 85%           | 80%               |              | 80.1%          | 2                   |                                                                                     |        | 79.7%  |        |        | 77.8%  |        |        | 79.2%  | 91.3%  |        | 79.7% | 77.8%  | 79.2%                 | 91.3%  |       |  |  |
|                     |                          | 21B | Cancer 62 Day Referral To Treatment (Screenings)                                                   |            | 90%           | 85%               |              | 87.6%          |                     |                                                                                     |        | 87.7%  |        |        | 81.8%  |        |        | 91.1%  | 89.7%  |        | 87.7% | 81.8%  | 91.1%                 | 89.7%  |       |  |  |
|                     |                          | 21C | Cancer 62 Day Referral To Treatment (Upgrades)                                                     |            | Not published | Not published     |              | 95.2%          |                     |                                                                                     |        | 96.7%  |        |        | 88.5%  |        |        | 100.0% | 93.0%  |        | 96.7% | 88.5%  | 100.0%                | 93.0%  |       |  |  |
|                     |                          | 22  | Patient Experience                                                                                 |            | Not published | Not published     | Achieved     | TBC            | 3                   | Results of survey available but scoring by CQC to be confirmed in Quarter 2 2010/11 |        |        |        |        |        |        |        |        |        |        |       |        |                       |        |       |  |  |
|                     |                          | 23  | NHS Staff Satisfaction                                                                             |            | Not published | Not published     | Achieved     | TBC            | 3                   | Results of survey due to be available in draft form in Quarter 1 2010/12            |        |        |        |        |        |        |        |        |        |        |       |        |                       |        |       |  |  |
|                     |                          |     |                                                                                                    |            | Total         | 32                | Out of 39    |                |                     |                                                                                     |        |        |        |        |        |        |        |        |        |        |       |        |                       |        |       |  |  |

### Notes

Green thresholds show the level performance has to reach to 'achieve' the required standard set by the Department of Health; Red thresholds show the level below which the Care Quality Commission (CQC) considers a Trust to have 'failed' a target; Where performance is between these two values the target has been 'underachieved'. For some targets the fail threshold has been estimated based upon previous years' thresholds. However, where no fail threshold has been published anything below the 'green' threshold is considered to be a fail (and hence the 'red' threshold will be the same as the 'green').

The CQC awards 3 points for each target that is 'achieved', 2 points for a target that is 'underachieved' and no points for a target that is failed. These combined scores are added together to provide an overall score for the Trust, from which the overall Periodic Review (Quality of Services) rating is derived.

|     |
|-----|
|     |
| TBC |

Target not in effect in 2009/10 or measured differently

To be confirmed

|                      |           |
|----------------------|-----------|
| Existing commitments | Excellent |
| National priorities  | Fair      |
| Overall rating       | Fair      |

## SECTION 5 – NATIONAL PERFORMANCE

### 5.3 Monitor's Compliance Framework

|                                                                                                         |               | Number | Target                                                        | Thresholds    |               | Year To Date | Quarterly Performance |                |              |            | Q4 forecast  | Current Forecast Q4 Governance rating score |
|---------------------------------------------------------------------------------------------------------|---------------|--------|---------------------------------------------------------------|---------------|---------------|--------------|-----------------------|----------------|--------------|------------|--------------|---------------------------------------------|
|                                                                                                         |               |        |                                                               | Green         | Red           |              | Q1                    | Q2             | Q3           | Q4 to date |              |                                             |
| Monitor Compliance Framework                                                                            | Weighting 1.0 | 1      | Infection Control - MRSA Bloodstream Cases Against Trajectory | 0%            | 0%            | -8           | -3                    | -1             | -2           | -2         | -3           | Achieved                                    |
|                                                                                                         |               | 2      | Infection Control - C.Diff Infections Against Trajectory      | 0%            | 0%            | -130         | -23                   | -31            | -46          | -30        | -45          | Achieved                                    |
|                                                                                                         |               | 3a     | Cancer 62 Day Referral To Treatment (Urgent GP Referral)      | 85.0%         | 80.0%         | 80.1%        | 79.7%                 | 77.8%          | 79.2%        | 91.3%      | 83.2%        | Failed                                      |
|                                                                                                         |               | 3b     | Cancer 62 Day Referral To Treatment (Screenings)              | 90.0%         | 85.0%         | 87.6%        | 87.7%                 | 81.8%          | 91.1%        | 89.7%      | 83.1%        |                                             |
|                                                                                                         |               | 3c     | Cancer 62 Day Referral To Treatment (Upgrades)                | Not published | Not published | 95.2%        | 96.7%                 | 88.5%          | 100.0%       | 93.0%      | 93.4%        |                                             |
|                                                                                                         |               | 4a     | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)    | 98%           | 95%           | 99.5%        | 99.4%                 | 100.0%         | 98.8%        | 100.0%     | 100.0%       | Achieved                                    |
|                                                                                                         |               | 4b     | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | 94%           | 91%           | 91.6%        | 93.4%                 | 90.5%          | 90.8%        | 92.3%      | 94.7%        |                                             |
|                                                                                                         |               | 5      | Referral To Treatment Admitted Under 18 Weeks                 | 90%           | 80%           | 90.3%        | 92.0%                 | 90.4%          | 88.3%        | 90.4%      | 90.3%        | Achieved                                    |
|                                                                                                         |               | 6      | Referral To Treatment Non Admitted Under 18 Weeks             | 95%           | 85%           | 97.6%        | 97.7%                 | 97.5%          | 97.5%        | 97.4%      | 96.5%        |                                             |
|                                                                                                         | Weighting 0.5 | 7      | Cancer - 31 Day Diagnosis To Treatment (First Treatments)     | 96%           | 93%           | 95.9%        | 95.8%                 | 95.1%          | 96.6%        | 96.6%      | 96.5%        | Achieved                                    |
|                                                                                                         |               | 8      | Emergency Care 4 Hour Throughput (including WIC)              | 98%           | 97%           | 97.94%       | 98.44%                | 98.10%         | 97.10%       | 98.16%     | 98.30%       |                                             |
|                                                                                                         |               | 9      | Cancer - Urgent Referrals Seen In Under 2 Weeks               | 93%           | 90%           | 93.4%        | 92.7%                 | 93.2%          | 94.5%        | 92.3%      | 93.3%        | Achieved                                    |
|                                                                                                         |               | 10     | MRSA Screening                                                |               |               | ✓            | ✓                     | ✓              | ✓            | ✓          | ✓            |                                             |
|                                                                                                         |               | 11     | 60 Minute Thrombolysis Call To Needle Time                    | 68%           | 48%           | 100.0%       | 100.0%                | 100.0%         |              | 100.0%     | Achieved     |                                             |
|                                                                                                         | Weighting 0.4 | 12     | Core standards                                                |               |               | All achieved | All achieved          | 1 not achieved | All achieved |            | All achieved | Achieved                                    |
| AMBER                                                                                                   |               |        |                                                               |               |               |              |                       |                |              |            |              | 1.0                                         |
| Additional rule applied of 3 consecutive quarterly amber ratings for 62-day cancer = overall Red rating |               |        |                                                               |               |               |              |                       |                |              |            |              |                                             |
| RED                                                                                                     |               |        |                                                               |               |               |              |                       |                |              |            |              |                                             |



## SECTION 5 – NATIONAL PERFORMANCE

### 5.4 KEY PERFORMANCE INDICATORS (KPIs) – summary of performance improvement measures

|                                  | Key performance indicator                                                                                                                           | Green | Red    | Monthly performance                                                       |        |        |        |        |        |        |        |        |        |        |        |     |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------|--------|---------------------------------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
|                                  |                                                                                                                                                     |       |        | Apr-09                                                                    | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 |     |
| Emergency care 4-hour access     | Percentage of days in which 98% target not achieved                                                                                                 | 30.0% | 50.0%  | 33.3%                                                                     | 41.9%  | 3.3%   | 38.7%  | 29.0%  | 43.3%  | 77.4%  | 40.0%  | 45.2%  | 32.3%  | 28.6%  |        |     |
|                                  | 4-hour performance within the Bristol Royal Infirmary (BRI)                                                                                         | 98.0% | 97.0%  | 95.9%                                                                     | 95.4%  | 98.3%  | 94.7%  | 96.0%  | 94.6%  | 89.0%  | 95.2%  | 95.7%  | 96.2%  | 94.7%  |        |     |
|                                  | 4-hour performance within the Bristol Eye Hospital (BEH)                                                                                            | 98.0% | 97.0%  | 100.0%                                                                    | 99.8%  | 99.9%  | 99.8%  | 100.0% | 99.8%  | 99.7%  | 99.9%  | 99.9%  | 99.8%  | 99.8%  |        |     |
|                                  | 4-hour performance within the Bristol Children's Hospital (BCH)                                                                                     | 98.0% | 97.0%  | 98.1%                                                                     | 98.2%  | 99.3%  | 99.6%  | 99.7%  | 99.4%  | 99.1%  | 99.0%  | 96.8%  | 99.6%  | 99.8%  |        |     |
|                                  | Conversion rate of emergency department attendances to admissions                                                                                   | TBC   | TBC    | 33%                                                                       | 30%    | 31%    | 29%    | 30%    | 31%    | 32%    | 34%    | 35%    | 35%    | 34%    |        |     |
|                                  | Emergency admission levels relative to 2008/09                                                                                                      | 0.0%  | 5.0%   | 12.5%                                                                     | 5.2%   | 5.0%   | 5.9%   | 3.1%   | 8.5%   | 8.4%   | 6.1%   | 8.8%   | 4.7%   | 8.8%   |        |     |
| Cancer standards                 | Number of 31 day cancer patients undated within 14 days of their breach date*                                                                       | 0     | 5      | Report to be set-up to provide data going back to April 09 where possible |        |        |        |        |        |        |        |        |        | 17     | 7      | 1   |
|                                  | Number of 62 day cancer patients undated within 14 days of their breach date*                                                                       | 0     | 5      | Report to be set-up to provide data going back to April 09 where possible |        |        |        |        |        |        |        |        |        | 3      | 5      | 2   |
|                                  | Number of patients past day 62 in their pathway without a Decision to Treat (DTT)*                                                                  | 8     | 35     | Report to be set-up to provide data going back to April 09 where possible |        |        |        |        |        |        |        |        |        | 125    | 58     | 37  |
|                                  | Number of 31 day cancer patients on the waiting list and dated within their breach date*                                                            | 130   | 115    | Report to be set-up to provide data going back to April 09 where possible |        |        |        |        |        |        |        |        |        | 110    | 120    | 186 |
|                                  | Number of 62 day cancer patients on the waiting list and dated within their breach date*                                                            | 45    | 30     | Report to be set-up to provide data going back to April 09 where possible |        |        |        |        |        |        |        |        |        | 18     | 32     | 38  |
|                                  | Percentage of 62-day screening patients breaching the standard due to choosing to wait longer for appointments or diagnostic tests                  | TBC   | TBC    | 50.0%                                                                     |        |        | 62.5%  |        |        | 50%    |        |        |        |        |        |     |
|                                  | Number of 62-day screening patients breaching the standard due to choosing to wait longer for appointments or diagnostic tests                      | TBC   | TBC    | 2                                                                         |        |        | 5      |        |        | 3      |        |        |        |        |        |     |
|                                  | Number of 62 day breaches resulting from delayed referrals sent by other providers                                                                  | TBC   | TBC    | 1                                                                         | 0      | 2.5    | 2      | 1      | 1      | 0      | 3      | 2      | 0      |        |        |     |
| 18 weeks                         | Number of admitted patients waiting over 18 weeks RTT wait not yet treated                                                                          | 360   | 575    | 830                                                                       | 839    | 812    | 869    | 921    | 815    | 877    | 849    | 893    | 954    | 826    |        |     |
|                                  | Number of admitted patients waiting over 18 weeks RTT wait not yet treated, expressed in terms of the number of weeks of admissions this represents | 0.50  | 0.80   | 1.15                                                                      | 1.17   | 1.13   | 1.21   | 1.28   | 1.13   | 1.22   | 1.18   | 1.24   | 1.33   | 1.20   |        |     |
|                                  | Number of admitted patients exceeding 18 weeks RTT each week, as a percentage of weekly activity**                                                  | 10.0% | 12.5%  |                                                                           |        |        |        |        |        | 21%    | 23%    | 12%    | 13%    | 11%    |        |     |
|                                  | Total number of admitted specialties for which the 90% 18-week target was not achieved in a month (out of a total of 14)                            | 0     | 2      | 5                                                                         | 5      | 5      | 7      | 7      | 5      | 6      | 6      | 4      | 4      | 3      |        |     |
|                                  | Total number of admitted non-specialties for which the 95% 18-week target was not achieved in a month (out of a total of 15)                        | 0     | 2      | 4                                                                         | 2      | 2      | 3      | 2      | 3      | 3      | 3      | 3      | 3      | 4      |        |     |
| Last minute cancelled operations | Number of bed related last minute cancellations                                                                                                     | 3     | 12     | 2                                                                         | 31     | 4      | 6      | 2      | 21     | 21     | 12     | 6      | 17     | 21     |        |     |
|                                  | Number of bed related last minute cancellations as a % of the same month last year                                                                  | 25.0% | 100.0% | 11%                                                                       | 443%   | 19%    | 100%   | 22%    | 62%    | 150%   | 32%    | 21%    | 68%    | 111%   |        |     |

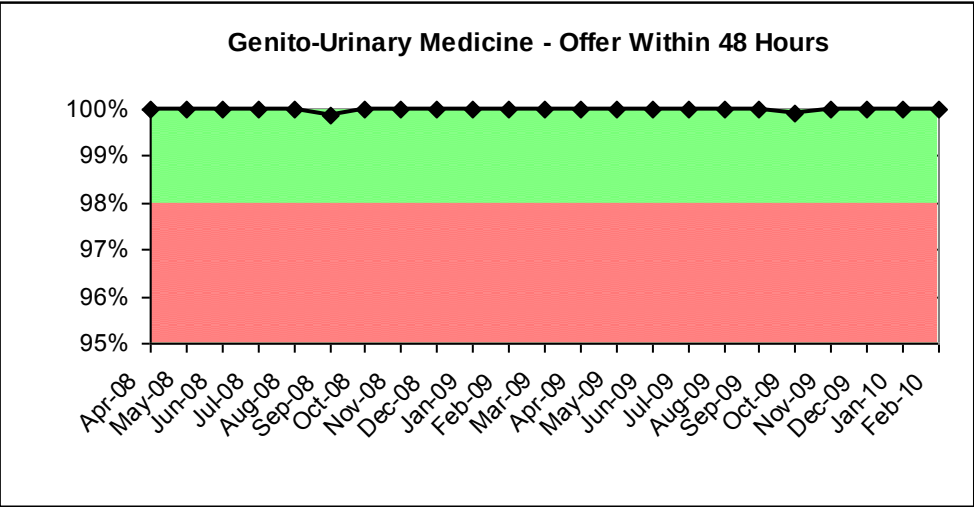
#### Notes

The thresholds are based upon national targets where applicable and in all other cases the estimated level of performance required for sustainable target achievement. Many of the thresholds for areas not consistently achieving the standard represent stretch where applicable and in all other cases the e Where indicated the census date was taken from the weekly figures reported on the second (\*) and last (\*\*) Wednesday of the month. TBC = To be confirmed.

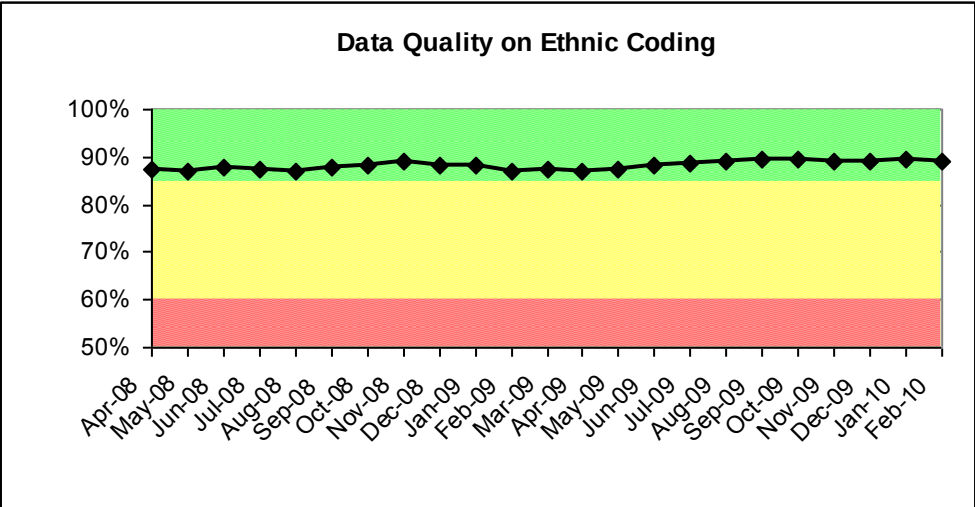
SECTION 5 – NATIONAL PERFORMANCE

5.5.1 Trend Graphs (National Priorities)

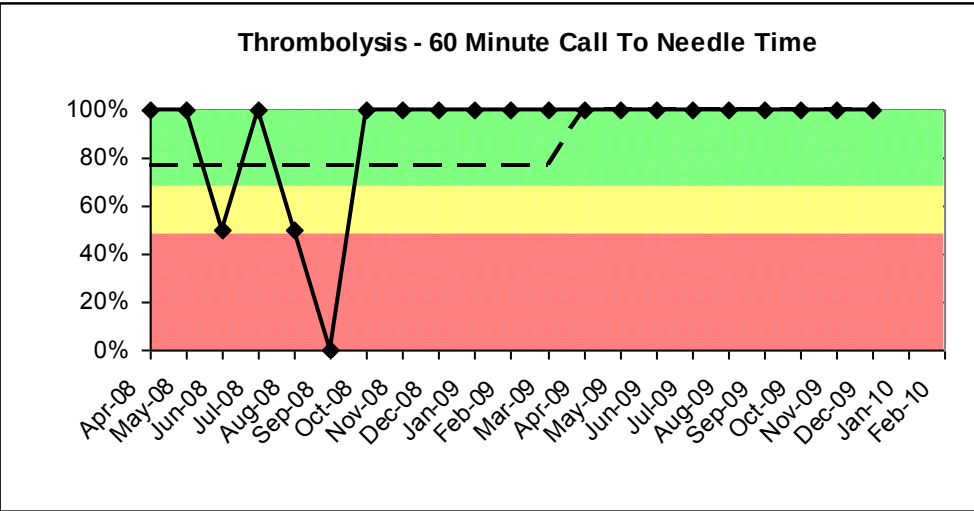
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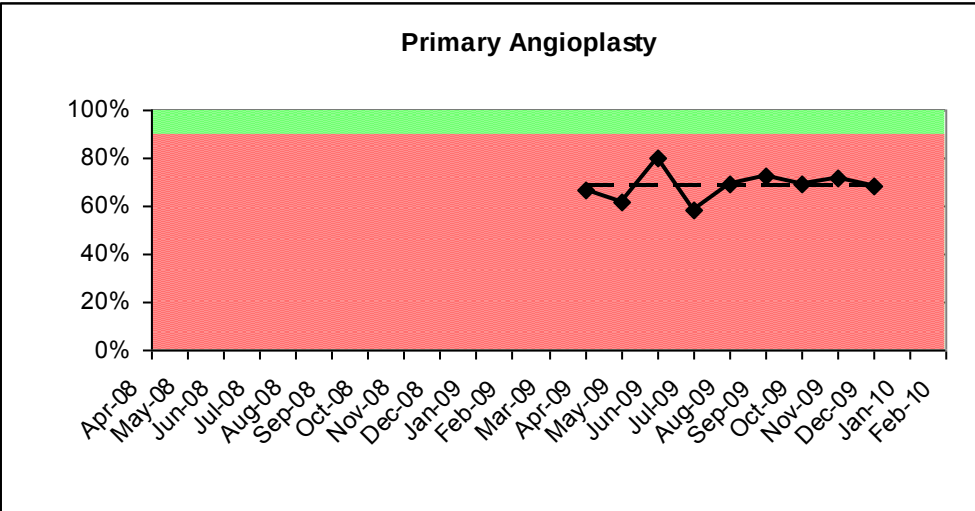
2



3A



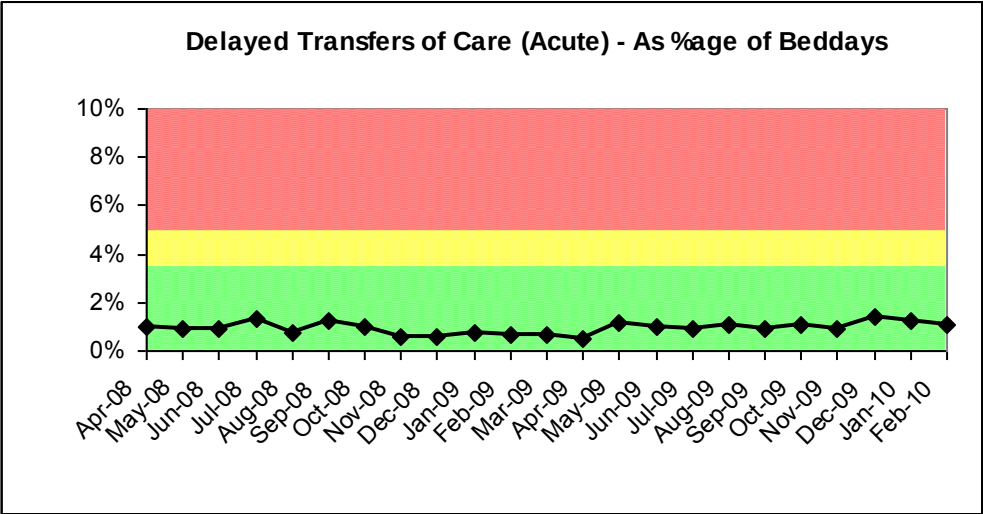
3B



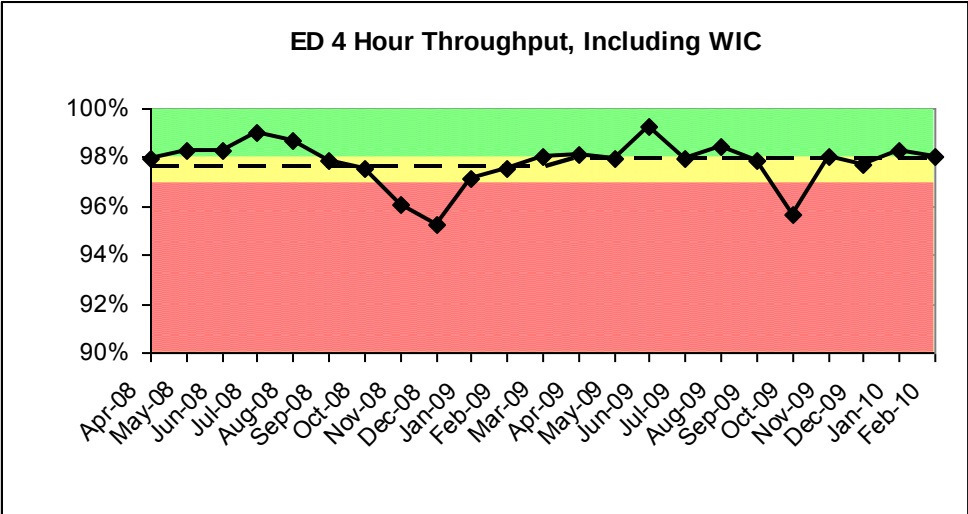


SECTION 5 – NATIONAL PERFORMANCE

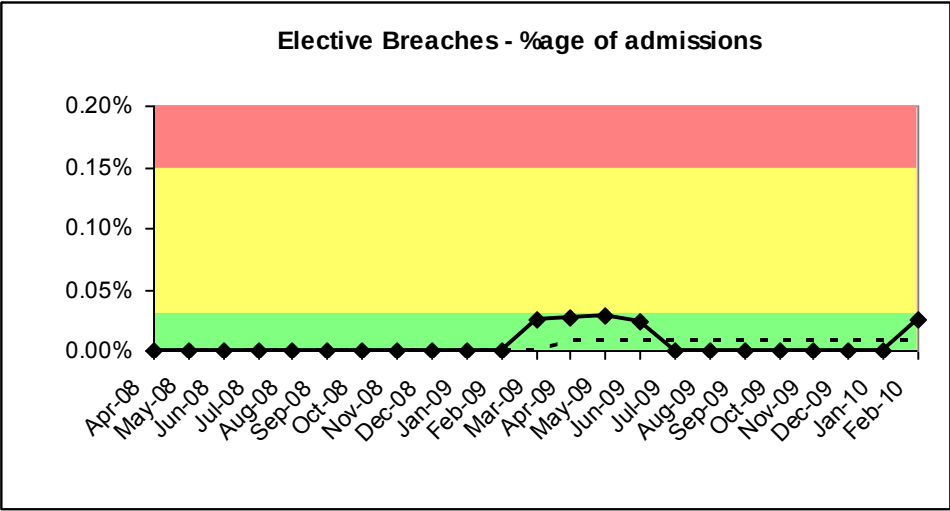
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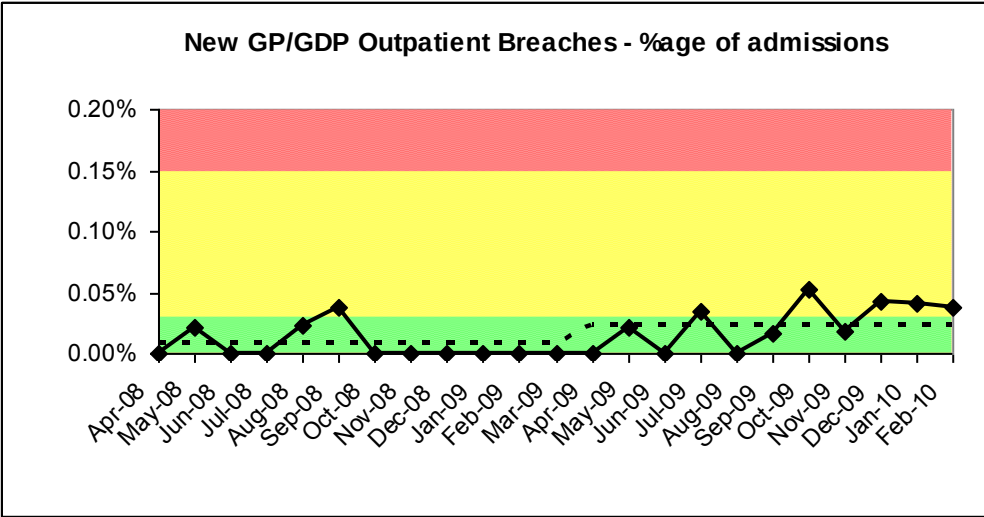
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6

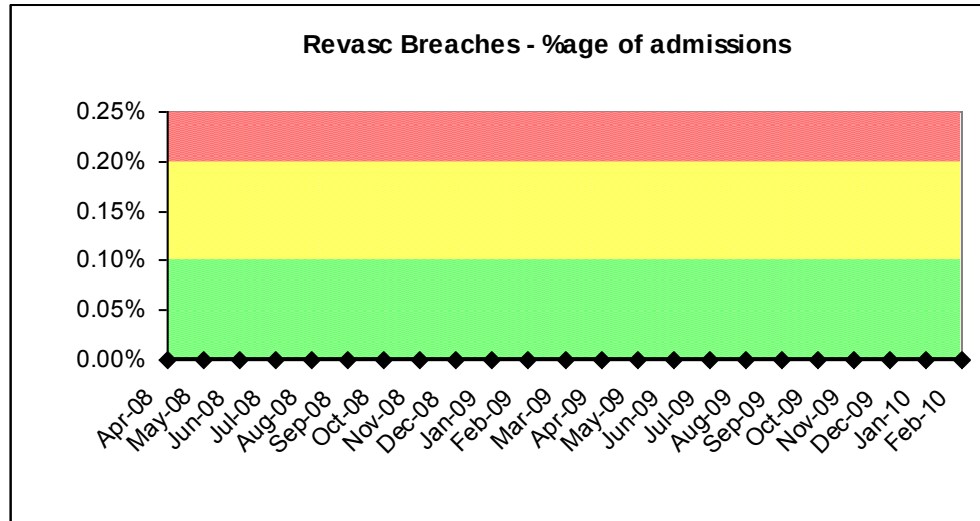


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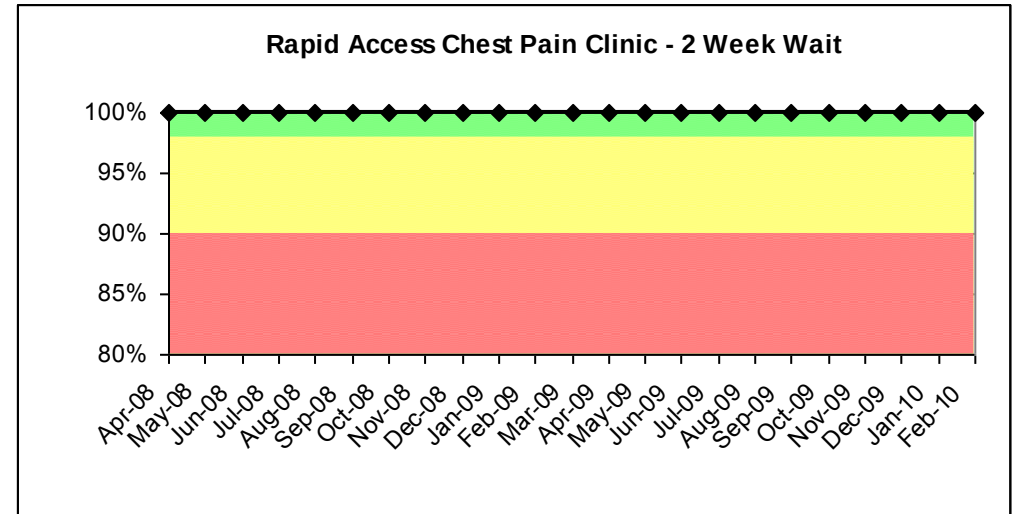


## SECTION 5 – NATIONAL PERFORMANCE

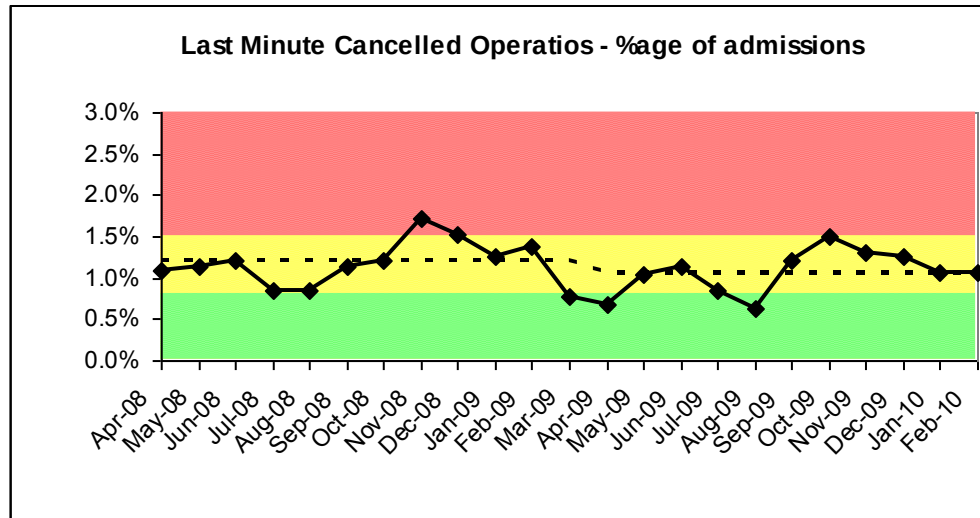
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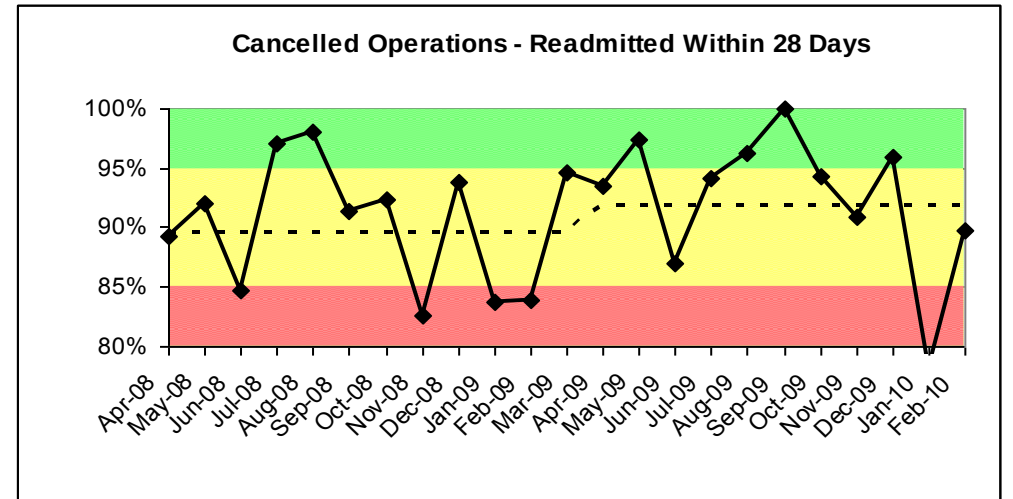
9



10A



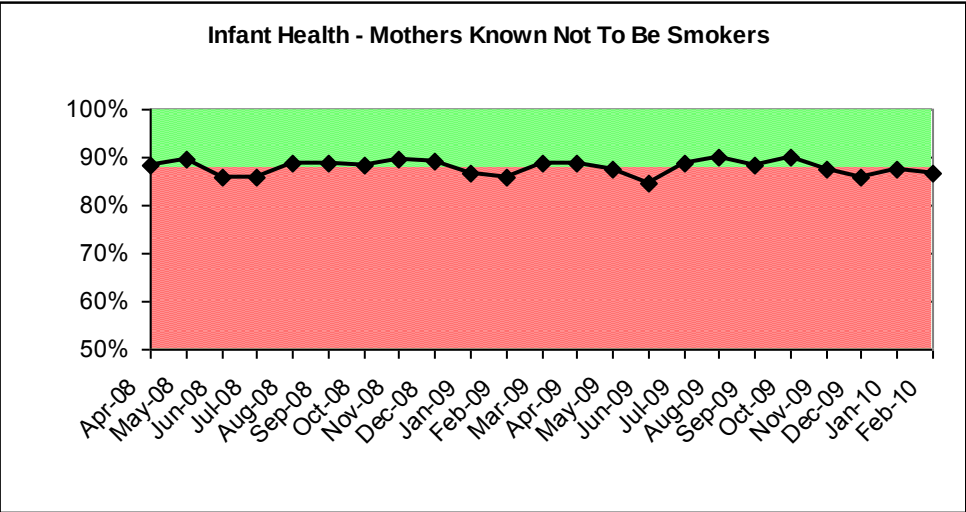
10B



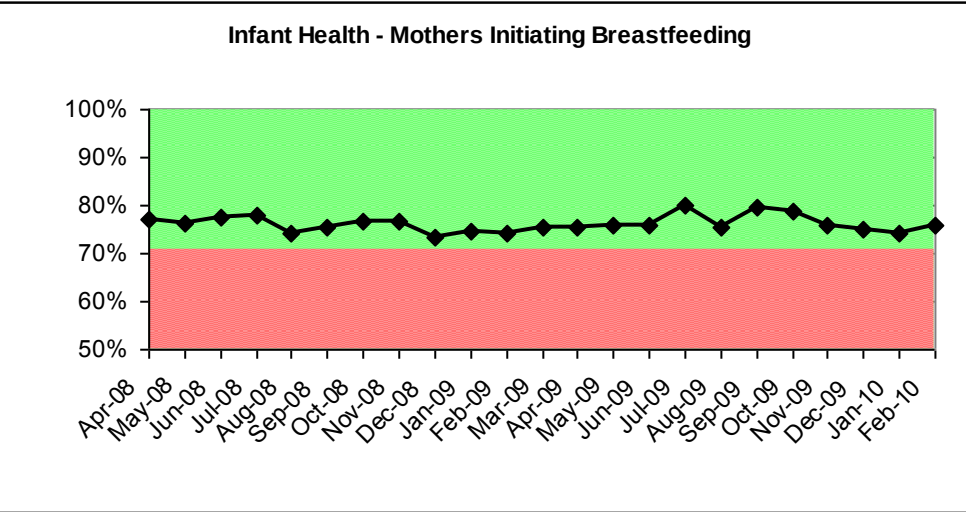
SECTION 5 – NATIONAL PERFORMANCE

5.5.2 Trend Graphs (Existing Commitments)

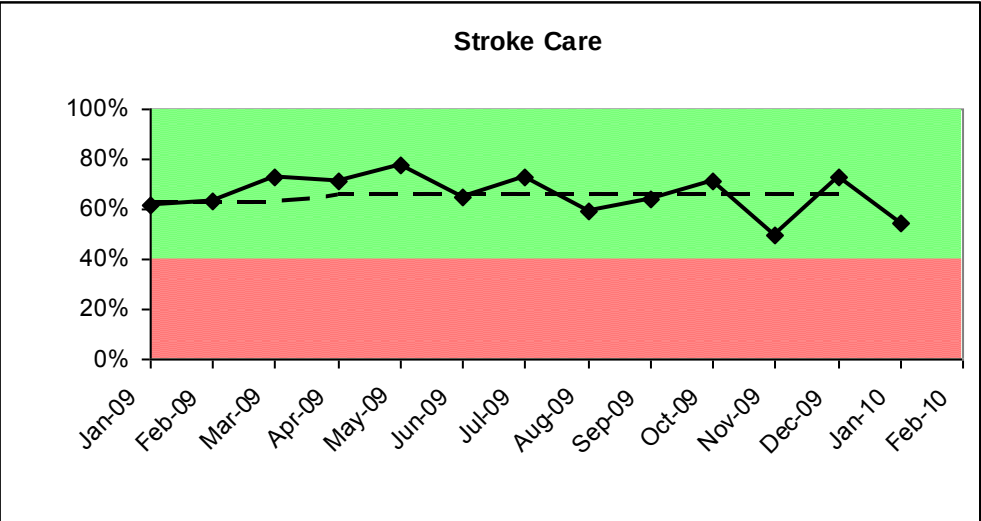
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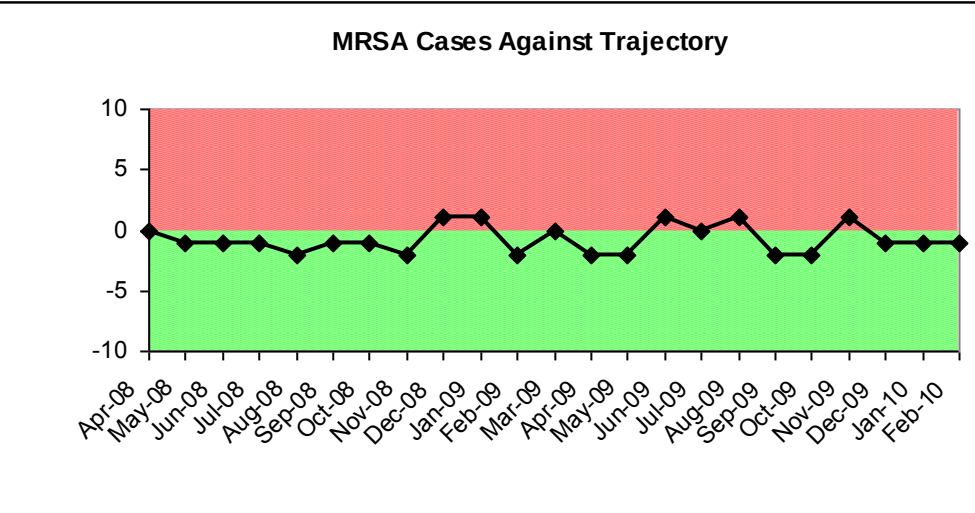
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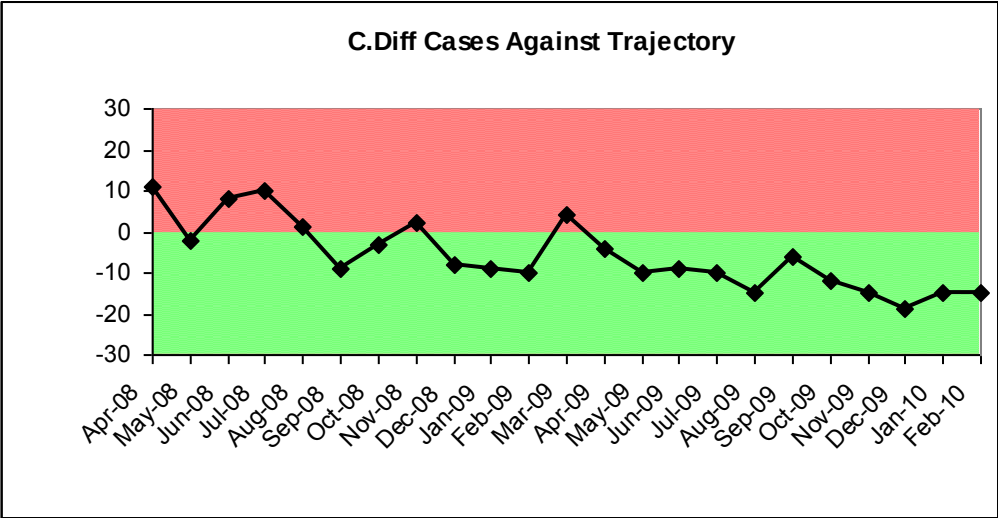
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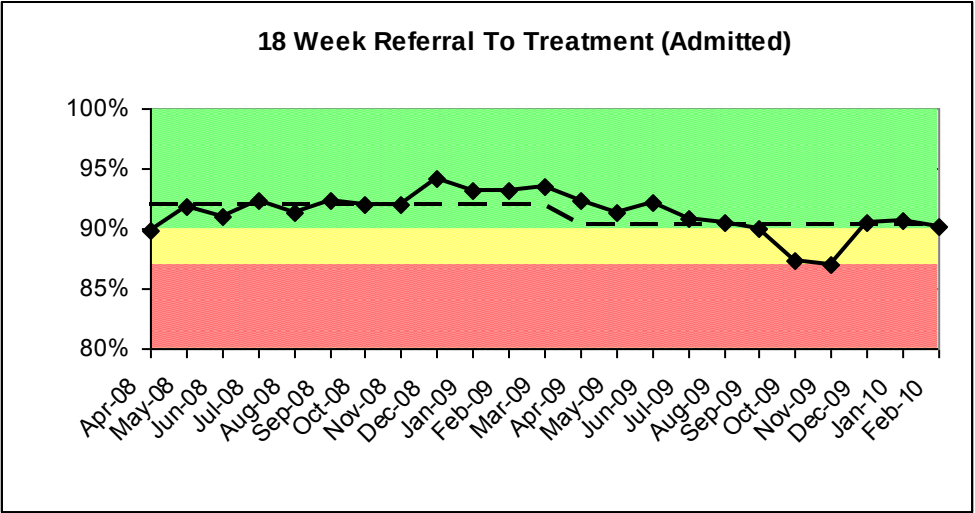
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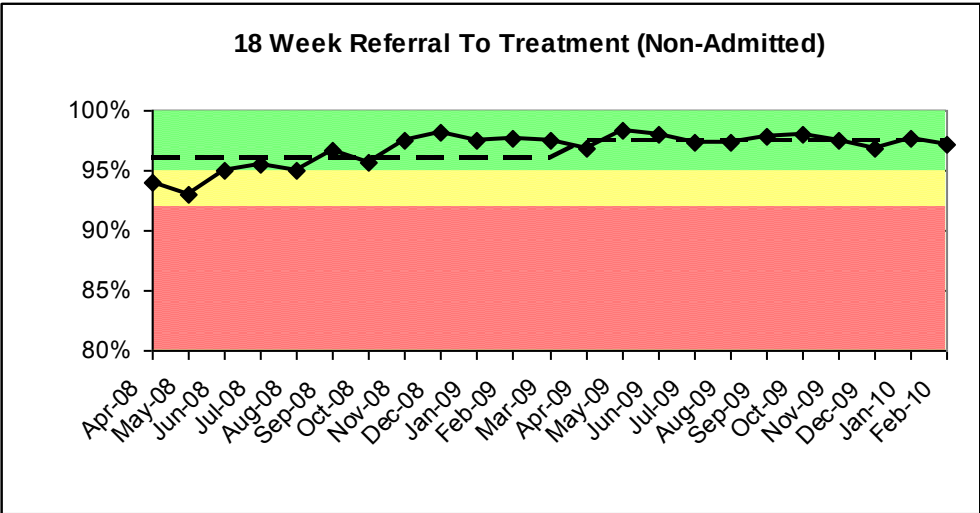
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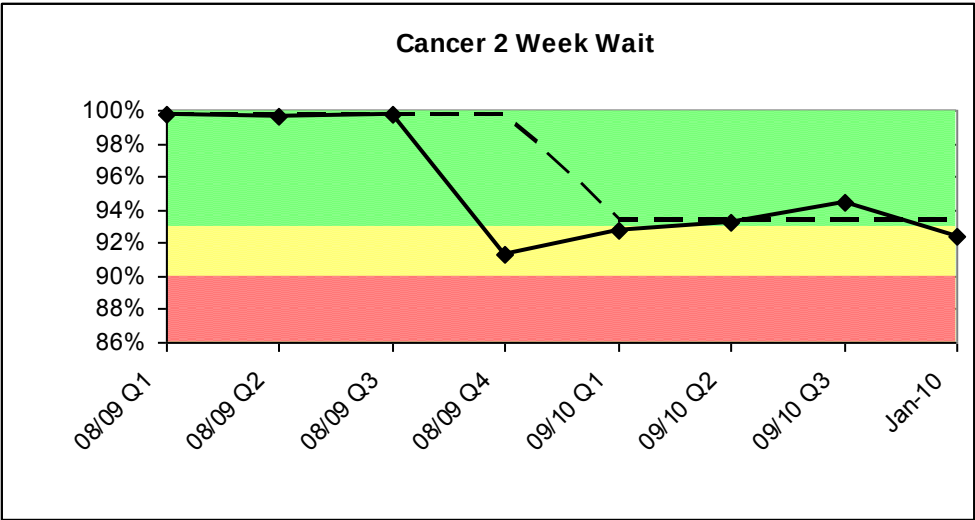
18A



18B

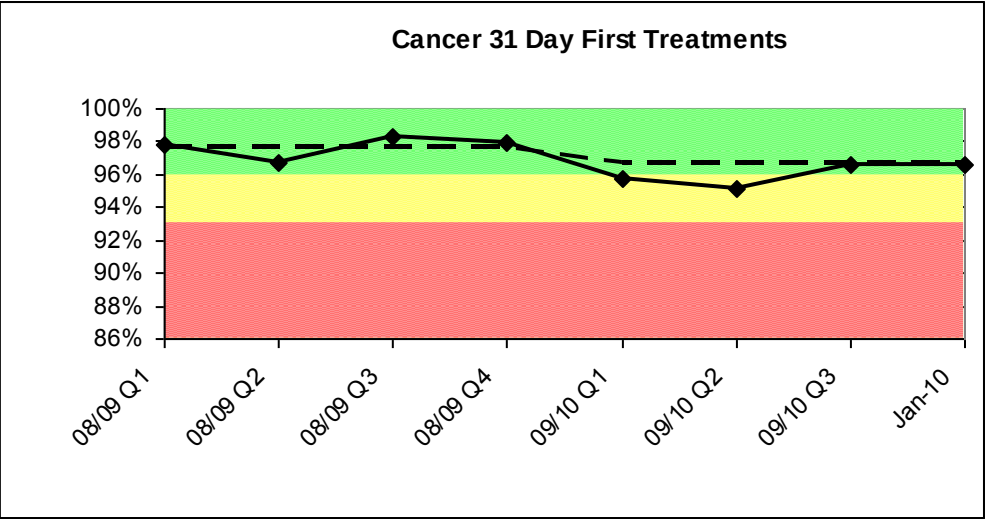


19A

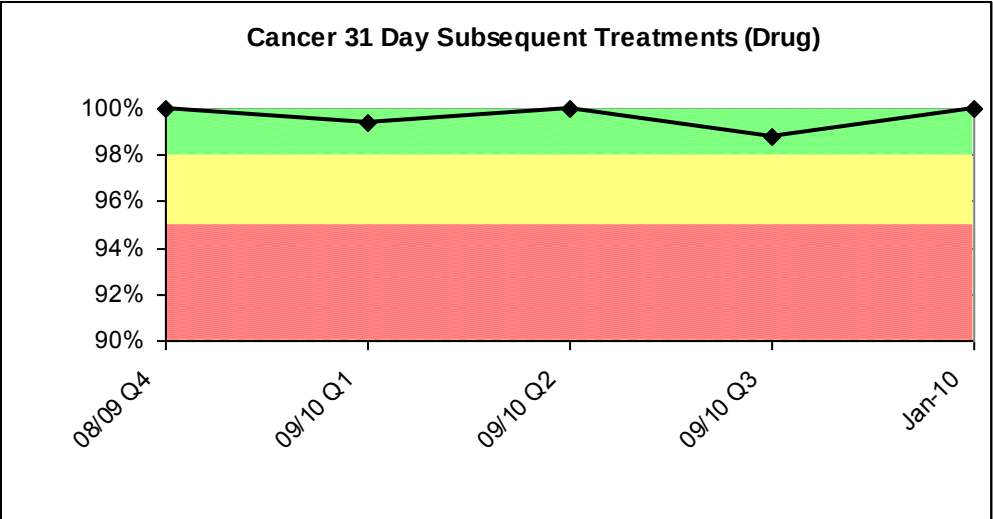


SECTION 5 – NATIONAL PERFORMANCE

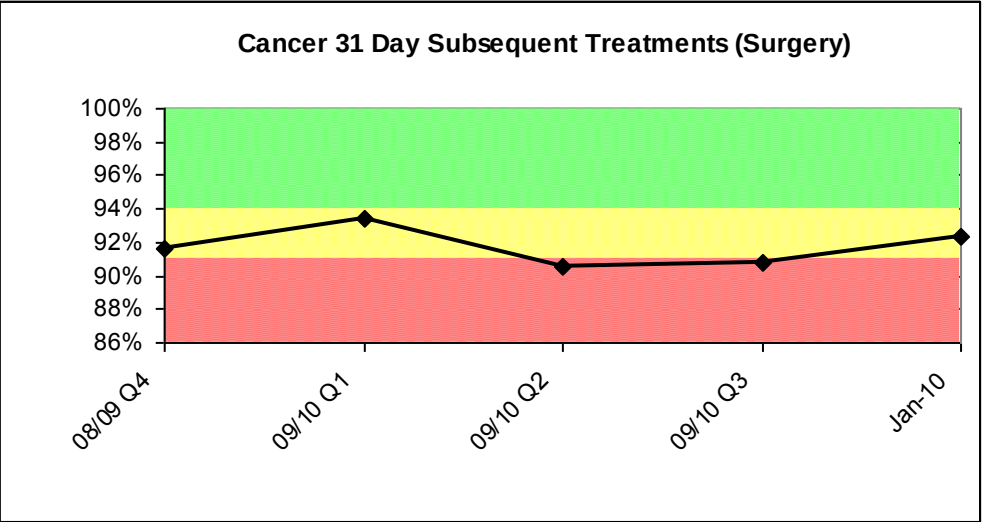
20A



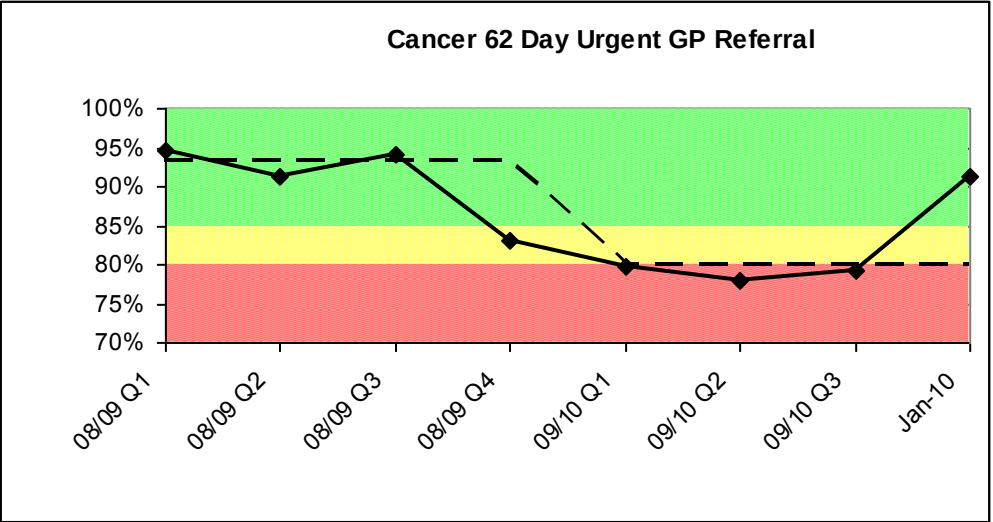
20B



20C



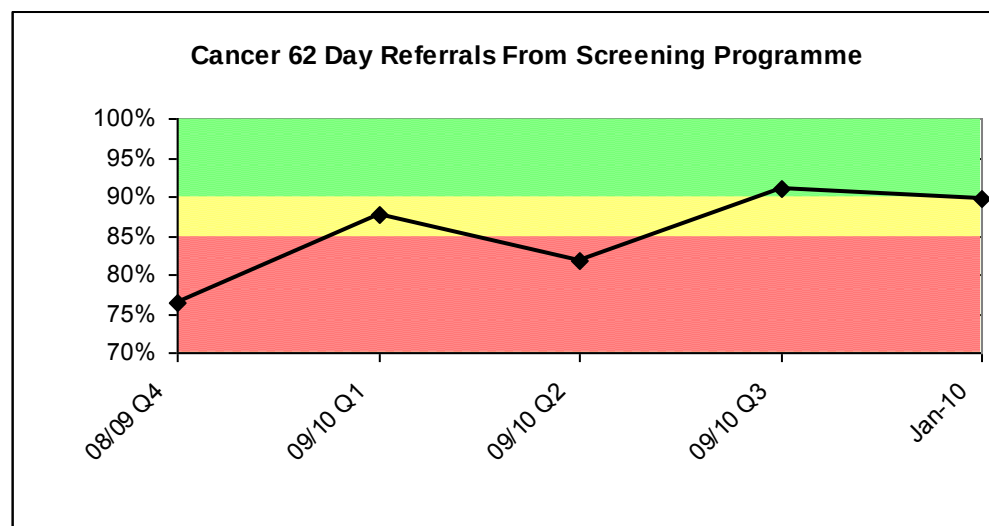
21A





## SECTION 5 – NATIONAL PERFORMANCE

22B



## SECTION 5 – NATIONAL PERFORMANCE

### 5.6 Exception Reports

**TARGET:** Emergency care 4-hour access

**RESPONSIBLE DIRECTOR:** Chief Operating Officer

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

The number of patients admitted, discharged or transferred within 4 hours of arrival in the Trust's Bristol Royal Infirmary (BRI), Bristol Children's Hospital and Bristol Eye Hospitals, as a percentage of all patients seen. The local Walk in Centre attendances are also included in the performance figures by the Department of Health.

**Care Quality Commission (CQC) measurement period:** Annual, with quarterly submissions

**Monitor measurement period:** Quarterly

#### Reasons for underperformance:

- Increased levels of emergency admissions in Q3
- High level of demand on beds within the Bristol Royal Infirmary
- Capacity of the Bristol Children's Hospital Emergency Department to meet demand during peak levels of attendances

#### Key performance indicators for the target:

- 1) Percentage of days in which 98% target not achieved
- 2) Performance within each Emergency Department
- 3) Conversion rate of Emergency Department attendances to admissions
- 4) Emergency admission levels relative to 2008/09

| Key actions:                                                                                                                                                                                                                                                                                 | Completed | Due date (end of) | Risk rating |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------------|-------------|
| <b>Demand Management</b>                                                                                                                                                                                                                                                                     |           |                   |             |
| Trial a GP-led service within the Children's Hospital Emergency Department                                                                                                                                                                                                                   | 100%      | February          | Green       |
| Increase REACT service in the BRI Emergency Department, to cover weekends                                                                                                                                                                                                                    | 100%      | February          | Green       |
| Establish joint PCT/Trust Demand management group to achieve reductions in emergency admission levels                                                                                                                                                                                        | 100%      | January           | Green       |
| Data of levels of emergency admissions by time of day and day of week shared with the PCT to support the planning of hours of coverage of the GP Support Unit                                                                                                                                | 100%      | February          | Green       |
| Increase GP Support Unit (GPSU) cover to include weekends                                                                                                                                                                                                                                    | 25%       | April             | Amber       |
| <u>Exception Report:</u> Primary Care Trust (PCT) not yet able to increase the cover and/or scope of the GPSU due to staffing problems. Their contact with the providers of the service will include an expansion of the service in 2010/11. Deadline amended to April 2010 to reflect this. |           |                   |             |

## SECTION 5 – NATIONAL PERFORMANCE

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |      |           |              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------|--------------|
| Implement programme of work aimed at reducing emergency admission levels down to 2008/09 levels                                                                                                                                                                                                                                                                                                                                                             | 10%  | September | <b>Green</b> |
| <b>Patient Flow</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |      |           |              |
| Protocol for Emergency Department consultants to determine route of specialist opinion agreed and implemented                                                                                                                                                                                                                                                                                                                                               | 100% | February  | <b>Green</b> |
| Scope options for expanding Medical Assessment Unit (MAU) capacity                                                                                                                                                                                                                                                                                                                                                                                          | 100% | February  | <b>Green</b> |
| Implement expansion of MAU capacity<br><u>Exception Report:</u> A male and female MAU will be established before April. This will allow the Trust to maintain compliance with the single sex accommodation policy. The approach involves the amalgamation of Short Stay and MAU across the two wards. MAU capacity will therefore remain unchanged from November 2009. Medical model of care currently under review to provide 7 day acute physician cover. | 10%  | August    | <b>Amber</b> |
| Increase the physical capacity of the Children's Hospital Emergency Department.                                                                                                                                                                                                                                                                                                                                                                             | 25%  | September | <b>Amber</b> |
| <b>Discharge</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |      |           |              |
| Review of sample of patient notes for surgical and medical wards completed; information on added value steps and delays to discharge shared with Productive Ward team                                                                                                                                                                                                                                                                                       | 100% | January   | <b>Green</b> |
| All wards to have commenced the Discharge Planning module of the Productive Ward                                                                                                                                                                                                                                                                                                                                                                            | 100% | February  | <b>Green</b> |

*Please note: completed actions are greyed-out the month after they are reported as complete and removed from the list at the end of each quarter.*

## SECTION 5 – NATIONAL PERFORMANCE

### TARGET: Emergency care 4-hour access

#### Progress against the Key Performance Indicators

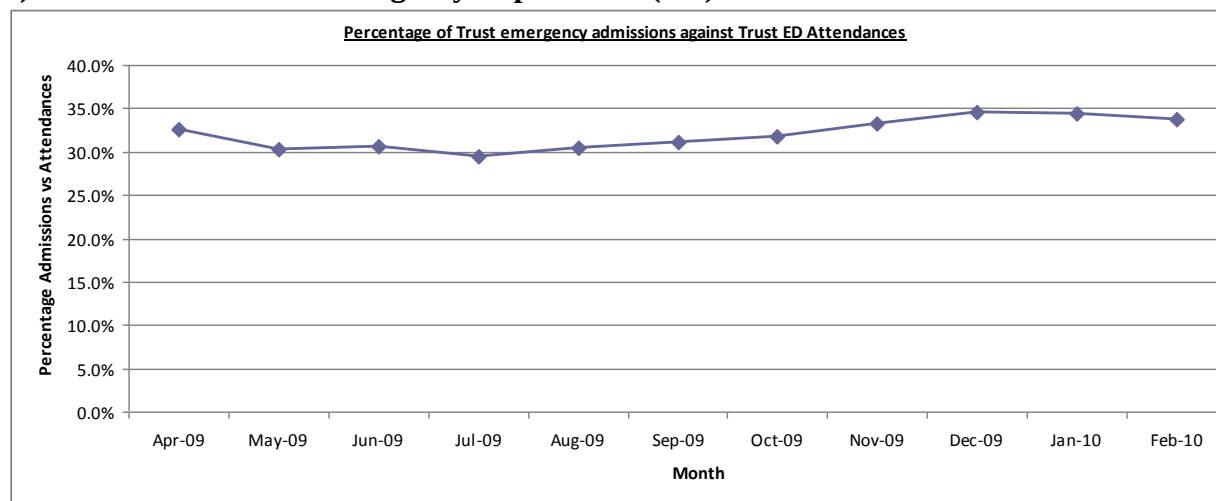
##### 1) Percentage of days in which 98% target not achieved

The 98% standard is not consistently achieved. There have been improvements against this indicator during February. The 2010/11 plans will aim to address weekend dips in performance currently seen during some weeks.

##### 2) Performance within each Emergency Department

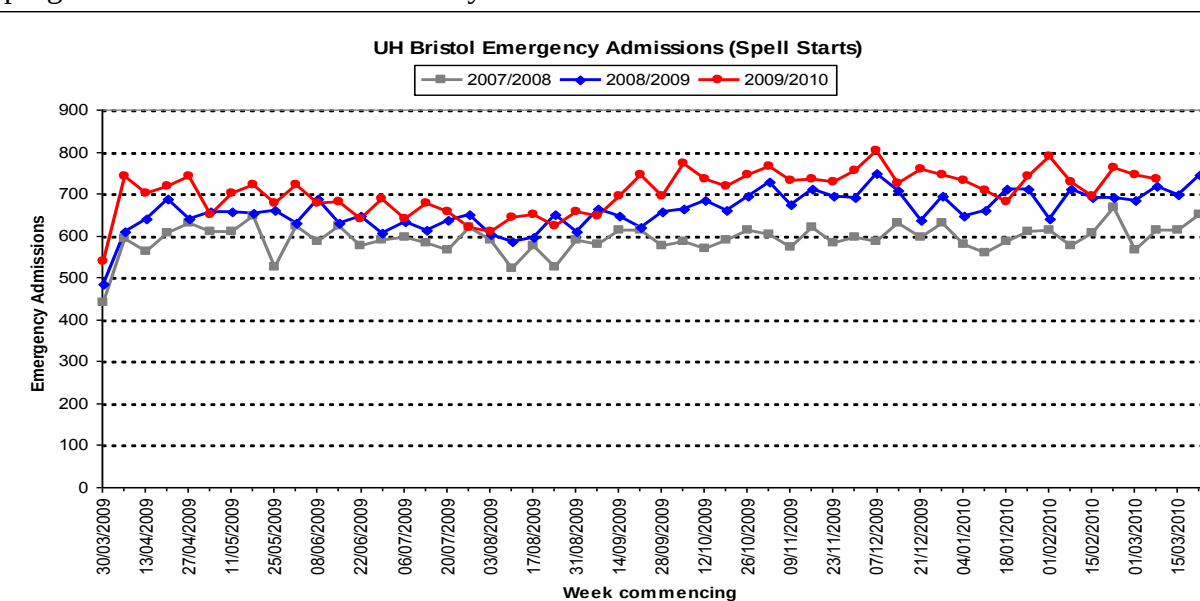
Performance in the Children's hospital and Bristol Eye Hospital are now consistently above the 98% standard. The focus of the 2010/11 plans is achievement of the 98% standard for the Bristol Royal Infirmary. The Bristol Eye Hospital achieves a minimum of 98% consistently.

##### 3) Conversion rate of Emergency Department (ED) attendances to admissions



##### 4) Emergency admission levels relative to 2008/09

Emergency admissions are still significantly above 2008/09 levels. This is the focus of a joint programme of work with the Primary Care Trust in 2010/11.



## SECTION 5 – NATIONAL PERFORMANCE

### TARGET: 31-day, 62-day and breast 2-week wait cancer standards

**RESPONSIBLE DIRECTOR:** Chief Operating Officer

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

The number of patients with confirmed cancers treated within 31 days of diagnosis, and 62 days of referral, as a percentage all cancer patients treated during the period under that standard. The percentage of patients referred to the breast outpatient service, not initially thought to have cancer related symptoms, seen by a specialist within 2 weeks.

**Care Quality Commission (CQC) measurement period:** Quarterly, with monthly submissions and a quarterly refresh of submissions

**Monitor measurement period:** Quarterly

#### Reasons for underperformance:

- Insufficient surgical capacity for some tumour sites (e.g. upper GI and lung)
- Patients choosing to wait longer for appointments and diagnostic tests, especially for patients on screening pathways
- Delays in patient pathways where multiple diagnostic tests are required
- Delays to be seen in outpatients for some tumour sites
- Late tertiary referrals

#### Objectives of the action plan to improve performance:

- To ensure all cancer patients have a treatment date within breach, within 14 days of their breach date
- To reduce the number of patients that have not reached a diagnosis (i.e. a Decision to Treat – DTT) by day 62 on their pathway
- To reduce the number of patients choosing to wait longer than the waiting times standard
- To reduce delayed referrals from other providers

#### Key performance indicators for the target:

- 1) Number of 31 and 62-day day cancer patients on the waiting list that are within 14 days of their breach date and are not dated within target
- 2) Number of patients past day 62 in their pathway without a Decision to Treat (DTT)
- 3) Number of 31 and 62 day cancer patients on the waiting list dated within their breach date
- 4) Percentage and number of 62-day screening patients breaching the standard due to choosing to wait longer for appointments or diagnostic tests
- 5) Number of breaches resulting from delayed referrals received during the period

| Key actions:                                                                                                        | Completed | Due date (end of) | Risk rating |
|---------------------------------------------------------------------------------------------------------------------|-----------|-------------------|-------------|
| Weekly Primary Targeting List (PTL) meetings held to review progress with dating patients within their breach dates | 100%      | Weekly            | Green       |
| Additional theatre sessions arranged for February for tumour sites with high demand (i.e. upper GI and lung)        | 100%      | January           | Green       |
| Away Day held with screening practitioners,                                                                         | 100%      | January           | Green       |

## SECTION 5 – NATIONAL PERFORMANCE

|                                                                                                                                                                                                                                                                                                                                                                                      |      |                               |       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------|-------|
| actions discussed regarding how the Trust encourages patients to be seen promptly to rule-out cancer diagnosis                                                                                                                                                                                                                                                                       |      |                               |       |
| Key Performance Indicators agreed and reported to weekly Performance Recovery Meeting                                                                                                                                                                                                                                                                                                | 100% | February                      | Green |
| Letter sent by Chief Operating Officer to referring trusts to outline recent performance for tertiary referrals                                                                                                                                                                                                                                                                      | 100% | February                      | Green |
| Letter sent by Chief Operating Officer to referring trusts when referrals received after agreed milestones in pathway                                                                                                                                                                                                                                                                | 100% | Weekly                        | Green |
| Escalation process implemented for patients for which dates for surgery cannot be identified within 3 days of listing.                                                                                                                                                                                                                                                               | 100% | January                       | Green |
| Additional thoracic outpatient capacity established to reduce delays for tertiary referrals and patients needing pre-operative assessment                                                                                                                                                                                                                                            | 100% | January                       | Green |
| Additional sessions established to improve performance against the breast (cancer not initially suspected) 2-week wait target                                                                                                                                                                                                                                                        | 100% | February                      | Green |
| New breast 2-week wait pathway piloted, with straight to test for appropriate patients                                                                                                                                                                                                                                                                                               | 100% | February                      | Green |
| Good practice guidance sought from other providers to help reduce breaches for 62-day screening pathways due to patient choice<br><br><u>Exception Report:</u> Performance in some previously high performing trusts has dipped. Discussions with lead GP to discuss referral practices which results in delays. Plan to be developed for greater engagement/ communication with GP. | 100% | January (completed mid March) | Green |
| Generate greater involvement of GPs in the pathway of screening patients to reduce patient choice delays                                                                                                                                                                                                                                                                             | 0%   | April                         | Green |
| Plan developed for ensuring no delays to pathways during the Easter and May bank holidays (e.g. theatre sessions and Multi-Disciplinary Team (MDT) review meetings)                                                                                                                                                                                                                  | 100% | February                      | Green |
| Plan to be developed for the use of general Intensive Treatment Unit (ITU) and Cardiac Intensive Care Unit (CICU) beds to support continued target achievement during 2010/11.                                                                                                                                                                                                       | 30%  | April                         | Green |
| Divisional operating plans to include theatre capacity required to meet cancer surgery demand on an ongoing basis.                                                                                                                                                                                                                                                                   | 75%  | March                         | Amber |
| Thoracic consultant job plans being reviewed following the appointment of a new consultant, to allocate sessions to meet demand.                                                                                                                                                                                                                                                     | 10%  | April                         | Amber |

*Please note: completed actions are greyed-out the month after they are reported and removed from the list at the end of each quarter.*

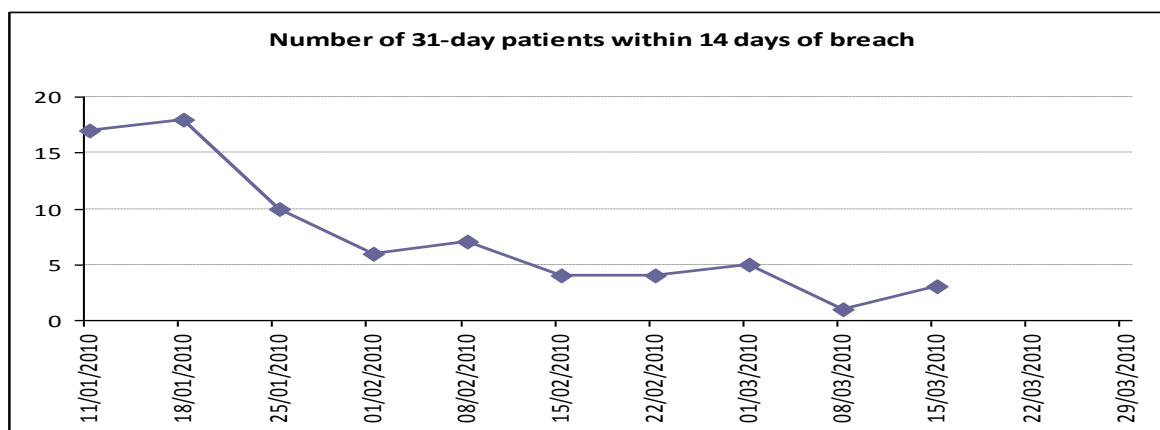
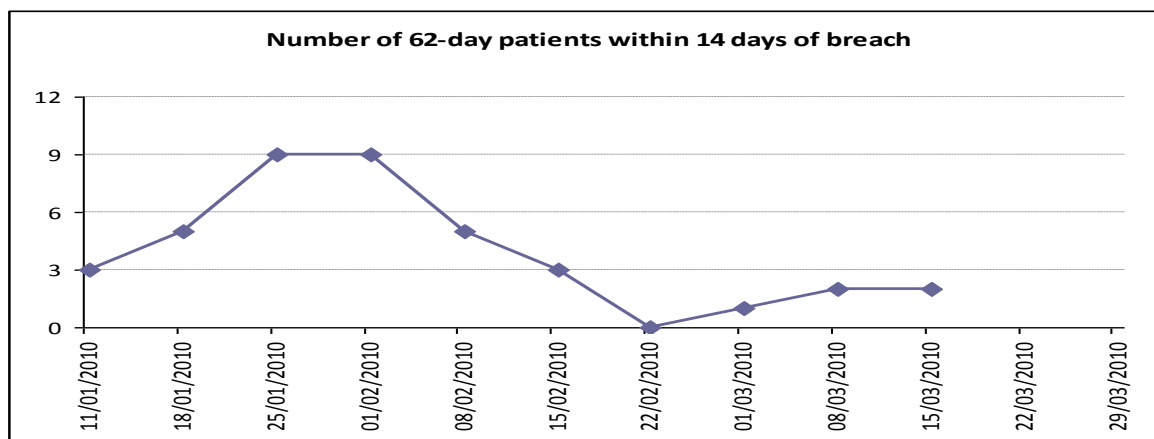
## SECTION 5 – NATIONAL PERFORMANCE

### TARGET: 31-day, 62-day and breast 2-week wait cancer standards

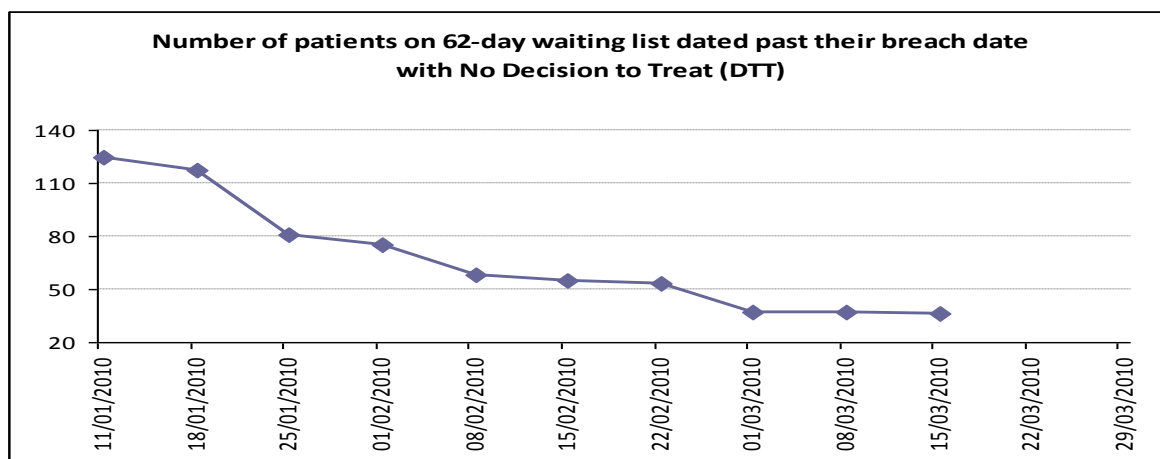
#### Progress against the Key Performance Indicators

The following three indicators provide a measure of how patients currently on cancer pathways are being managed within the national waiting times standards. These are therefore indicators for future performance. Good progress is being made against these indicators for both 31 and 62-day pathways.

#### 1) Number of 31 and 62-day day cancer patients that are within 14 days of their breach date and are not dated within target

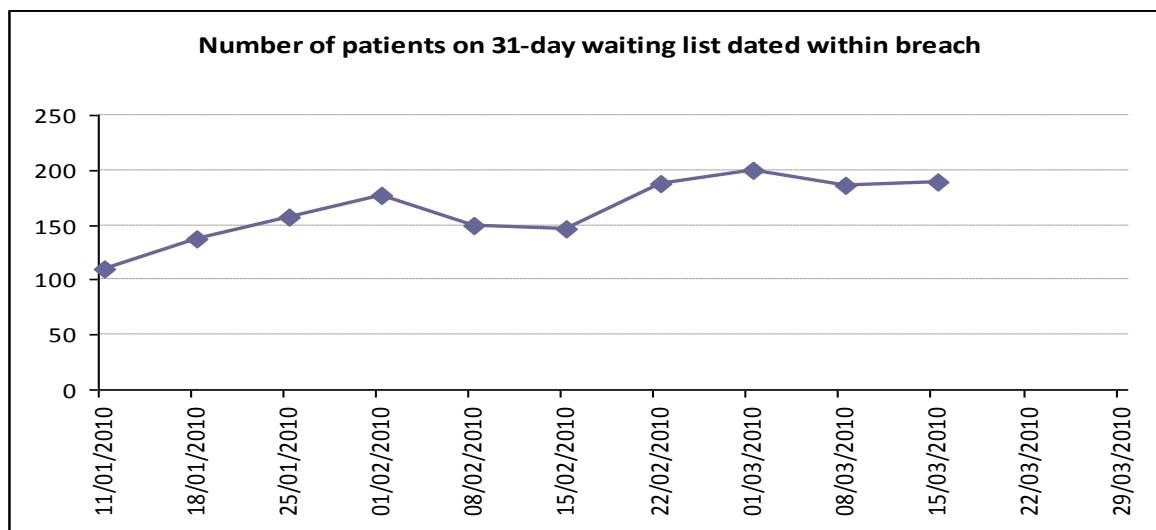
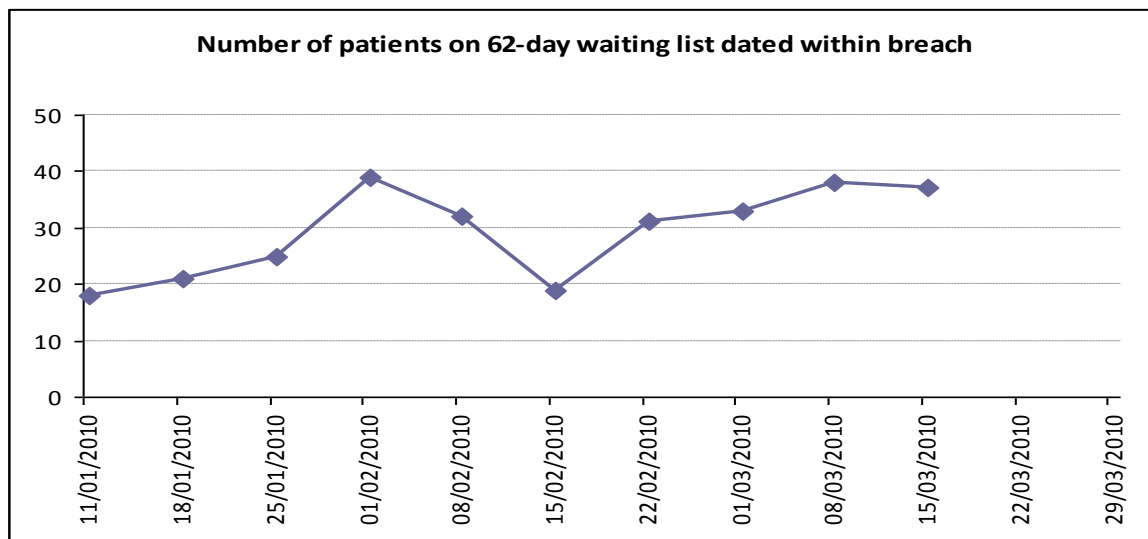


#### 2) Number of patients past day 62 in their pathway without a Decision to Treat (DTT)



#### 3) Number of 31 and 62 day cancer patients on the waiting list dated within their breach

date



**4) Percentage and number of 62-day screening patients breaching the standard due to choosing to wait longer for appointments or diagnostic tests**

Actions planned around greater involvement of GPs in patients referred with a potential cancer from screening programmes. The full impact of this is not expected to be seen until quarter 2.

**5) Number of breaches resulting from delayed referrals received during the period**

Letters have been sent to referring providers detailing where delays have occurred in the past three quarters. Weekly updates are sent of referrals made outside of the agreed timescales. The full impact of these actions is not expected to be seen in until quarter 2.



## SECTION 5 – NATIONAL PERFORMANCE

**TARGET: 18-week Referral to Treatment Time (RTT) for patients on admitted pathways**

**RESPONSIBLE DIRECTOR:** Chief Operating Officer

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

The number of patients on 18-week pathways admitted as part of their treatment that were treated within 18 weeks of being referred, as a percentage of all 18-week admitted patients.

There are nine parts to the 18-week RTT Care Quality Commission indicator, with aggregated Trust admitted pathway performance in each quarter representing four of the nine, and the proportion of specialties for admitted and non-admitted pathways for which the 90 and 95% targets (respectively) were achieved in quarter 4 representing one of the nine. The remaining four parts of the indicator are made up by combined non-admitted pathways and direct access Audiology 18-week performance in each quarter.

**Care Quality Commission (CQC) measurement period:** Quarterly, with monthly submissions

**Monitor measurement period:** Quarterly (with monthly achievement required at a Trust level, and from April 2010 quarterly achievement at a specialty level)

### **Reasons for underperformance:**

- Elective activity slowed earlier in the year
- Numbers of patients waiting over 18 weeks increased
- Insufficient surgical capacity in some specialties (e.g. General surgical specialties and Paediatric Ear, Nose & Throat (ENT))
- Lengthening outpatient waits in some specialties (e.g. Trauma & Orthopaedics & ENT)

### **Objectives of the action plan to improve performance:**

- To reduce the number of admitted patients that have already waited over 18 weeks to less than 0.8 of a week's worth of activity, for sustainable achievement of the target
- To reduce the number of patients exceeding an 18-week wait each week down to less than 10% of weekly activity, for sustainable achievement of the target
- To reduce the total number of specialties for which the 18-week target was not achieved in a month

### **Key performance indicators for the target:**

- 1) Number of admitted patients waiting over 18 weeks not yet treated / Number of admitted patients waiting over 18 weeks not yet treated measured in weeks of activity
- 2) Number of admitted patients exceeding the 18 week wait in the period, as a percentage of 18-week activity
- 3) Total number of specialties for which the 18-week target was not achieved in the month

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| Key actions:                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Completed | Due date (end of) | Risk rating |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------------|-------------|
| Additional theatre sessions have been established for high volume specialties that were under performing against the 90% standard                                                                                                                                                                                                                                                                                                                                   | 100%      | January           | Green       |
| Dashboard of 18-week RTT Key Performance Indicators (KPIs) established, with weekly report on these being presented to the Performance Recovery Meeting                                                                                                                                                                                                                                                                                                             | 100%      | January           | Green       |
| Weekly management meeting established for each of the underperforming specialties, to monitor progress with booking patients within the 18-week target and reducing backlogs                                                                                                                                                                                                                                                                                        | 100%      | January           | Green       |
| Additional outpatient capacity to address delays in Orthopaedic pathways established                                                                                                                                                                                                                                                                                                                                                                                | 100%      | January           | Green       |
| Guidance issued to Divisional Teams, clarifying booking and waiting list management rules                                                                                                                                                                                                                                                                                                                                                                           | 100%      | February          | Green       |
| Modelling undertaken of expected levels of activity required in next year's contract with the Primary Care Trusts to reduce the size of the elective waiting list and support specialty level achievement                                                                                                                                                                                                                                                           | 100%      | February          | Green       |
| Additional actions implemented to offer routine, low complexity patients the opportunity to be treated in the Independent Sector at no additional cost to the Trust<br><br><u>Exception report:</u> Changes to outpatient services offered on Choose & Book approved by the Trust Executive Group and in the process of being agreed with the Primary Care Trust (PCT). This action was planned for the end of February but is now to be completed by end of March. | 75%       | March             | Amber       |
| Plan to be developed for further reducing the number of patients waiting over 18 weeks for treatment during the first quarter of 2010/11, to support achievement in every specialty.                                                                                                                                                                                                                                                                                | 75%       | March             | Green       |
| Patient access training sessions, covering 18-weeks, cancer and other key targets, in place and to be completed for all waiting list and booking co-ordinators.                                                                                                                                                                                                                                                                                                     | 10%       | May               | Green       |

*Please note: completed actions are greyed-out the month after they are reported and removed from the list at the end of each quarter.*

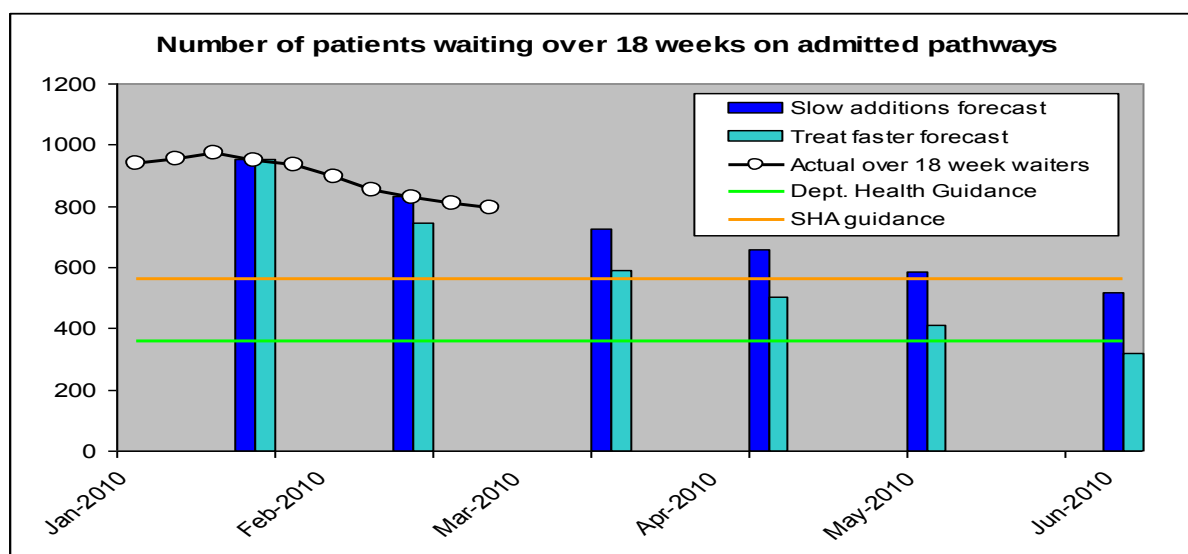
## TARGET: 18-week Referral to Treatment Time (RTT) for patients on admitted pathways

### Progress against the Key Performance Indicators

#### 1) Number of admitted patients waiting over 18 weeks not yet treated / Number of admitted patients waiting over 18 weeks not yet treated measured in weeks of activity

In preparation for the NHS Constitution that comes into effect from 1<sup>st</sup> April 2010, the Board was asked to consider two different approaches for ensuring that patients that want to, and are clinically able, to be treated within 18 weeks of referral are treated on time. The aim of both approaches was to ensure that the number of patients waiting over 18 weeks for treatment was reduced down to a manageable level, to support ongoing achievement of the 18 week standard for all appropriate patients. The first approach ('Slow additions') was to improve the management of the waiting list in such a way that as many patients as possible could be offered treatment within 18 weeks. The second approach was to, undertake the above action and treat more patients that had already waited over 18 weeks, as a one-off exercise to reduce the backlog significantly.

The graph below shows the progress with implementing the agreed approach of a paced approach to reducing the backlog of patients waiting over 18 weeks by more rigorous waiting list management alone. To date this action has brought the number of long waiters down in-line with the forecast trajectory supporting the delivery of 90% achievement at aggregate level for Q4.

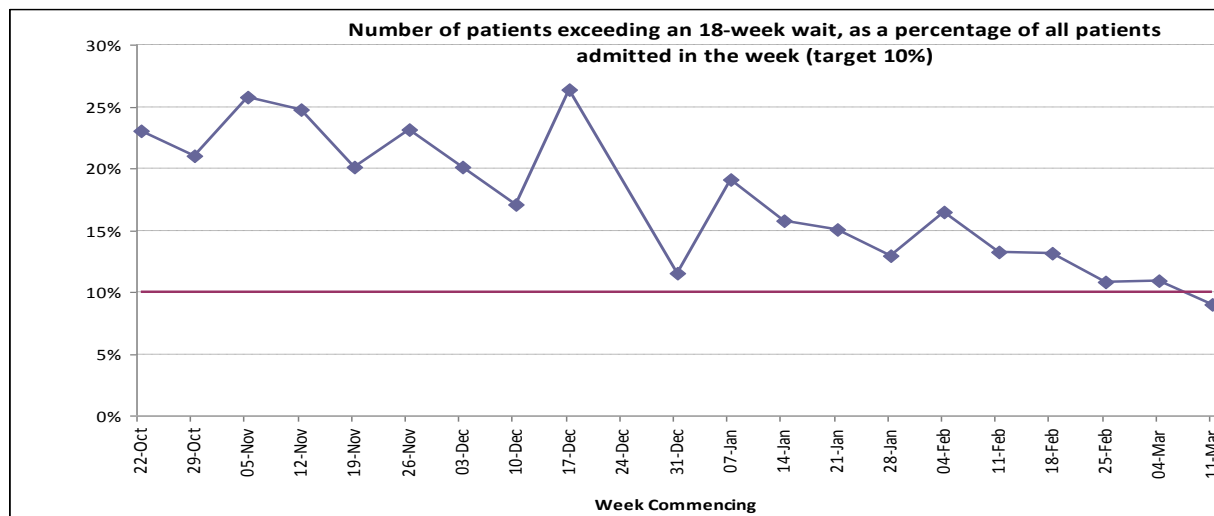


The Board requested that the ongoing approach to reducing the number of patients waiting over 18 weeks be reviewed at the end of March. Compliance for this standard in 2010/11 requires all specialties to meet the 90% target. From the 1<sup>st</sup> April patients waiting longer than 18 weeks will have the option to elect to have their treatment provided by a provider of their choice. The commissioner will not pay for patients who take this action. For the first quarter of 2010/11 the two options are for the Trust to continue to implement the current strategy to pace reduction of the backlog. This approach will allow the 18-week Referral to Treatment target to be achieved for 90% of patients on a monthly basis, and in all except two national specialties on a quarterly basis. The alternative approach remains, that the Trust could treat an increased number of patients waiting over 18 weeks as a one-off exercise in Q1. This approach would bring the numbers waiting over 18 weeks down to the levels the Department of Health and Strategic Health Authority (SHA) recommended levels more quickly, but would result in the

## SECTION 5 – NATIONAL PERFORMANCE

Trust failing the monthly 90% target.

### 2) Number of admitted patients exceeding the 18 week wait in the period, as a percentage of 18-week activity



### 3) Total number of specialties for which the 18-week target was not achieved in the month

Admitted 18-week Referral to Treatment Time (RTT) performance in February

| Specialty             | Under 18 Weeks | Total Clock Stops | Percentage under 18 Weeks |
|-----------------------|----------------|-------------------|---------------------------|
| CARDIOLOGY            | 134            | 147               | 91.2%                     |
| DERMATOLOGY           | 90             | 91                | 98.9%                     |
| E.N.T.                | 52             | 74                | 70.3%                     |
| GASTROENTEROLOGY      | 71             | 73                | 97.3%                     |
| GENERAL MEDICINE      | 26             | 26                | 100.0%                    |
| GYNAECOLOGY           | 196            | 209               | 93.8%                     |
| OPHTHALMOLOGY         | 822            | 904               | 90.9%                     |
| ORAL SURGERY          | 293            | 343               | 85.4%                     |
| OTHER                 | 871            | 984               | 88.5%                     |
| RHEUMATOLOGY          | 43             | 43                | 100.0%                    |
| TRAUMA & ORTHOPAEDICS | 52             | 56                | 92.9%                     |
| UROLOGY               | 122            | 125               | 97.6%                     |
| <b>Grand Total</b>    | <b>2772</b>    | <b>3075</b>       | <b>90.15%</b>             |

Non-admitted 18-week Referral to Treatment Time (RTT) performance in February

| Specialty             | Under 18 Weeks | Total Clock Stops | Percentage Under 18 Weeks |
|-----------------------|----------------|-------------------|---------------------------|
| CARDIOLOGY            | 99             | 105               | 94.3%                     |
| DERMATOLOGY           | 238            | 245               | 97.1%                     |
| E.N.T.                | 358            | 378               | 94.7%                     |
| GENERAL MEDICINE      | 335            | 342               | 98.0%                     |
| GERIATRIC MEDICINE    | 51             | 51                | 100.0%                    |
| GYNAECOLOGY           | 360            | 365               | 98.6%                     |
| NEUROLOGY             | 35             | 39                | 89.7%                     |
| OPHTHALMOLOGY         | 775            | 786               | 98.6%                     |
| ORAL SURGERY          | 218            | 228               | 95.6%                     |
| OTHER                 | 3003           | 3063              | 98.0%                     |
| RHEUMATOLOGY          | 65             | 65                | 100.0%                    |
| THORACIC MEDICINE     | 19             | 19                | 100.0%                    |
| TRAUMA & ORTHOPAEDICS | 205            | 234               | 87.6%                     |
| UROLOGY               | 92             | 108               | 85.2%                     |
| <b>Grand Total</b>    | <b>5853</b>    | <b>6028</b>       | <b>97.10%</b>             |

## **SECTION 5 – NATIONAL PERFORMANCE**

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Actions have been prioritised to reduce the number of patients waiting over 18 weeks that have not yet been treated. Planned improvement against this indicator to be seen in quarter 1 2010/11.

## SECTION 5 – NATIONAL PERFORMANCE

**TARGET: Last-minute cancelled operations / 28-day readmission**

**RESPONSIBLE DIRECTOR:** Chief Operating Officer

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

The number of patients whose operation was cancelled at last minute for non clinical reasons, as a percentage of all admissions.

The number of patients readmitted within 28 days of their procedure being cancelled at last minute for non-clinical reasons, as a percentage of all last minute cancellations in the period.

**Care Quality Commission (CQC) measurement period:** Annual, with quarterly submissions

**Monitor measurement period:** Not applicable

**Reasons for underperformance:**

- High volumes of bed related cancellations
- Potential cancellations on the day of admission not always escalated and/or avoided where possible

**Objectives of the action plan to improve performance:**

- To reduce the number of last minute cancellations relative to last year
- To reduce the number of last minute cancellations due to ward beds not being available

**Key performance indicators for the target:**

- 1) Number of bed related last-minute cancellations / number of bed related last-minute cancellations as a percentage of the same period last year
- 2) Percentage of last-minute cancellations escalated to management teams (*to be added when reporting established*)

| Key actions:                                                                                                                                                                                                                           | Completed | Due date (end of) | Risk rating |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------------|-------------|
| Weekly Cancelled Operations Review meeting re-focused                                                                                                                                                                                  | 100%      | January           | Green       |
| Cancelled operations Action Plan refreshed                                                                                                                                                                                             | 100%      | January           | Green       |
| Validation and sign-off of individual breaches to be revised to ensure cancellations are being reported appropriately (i.e. not over reported)                                                                                         | 100%      | February          | Green       |
| Cancelled operation management / escalation protocol reviewed to ensure fit for purpose<br><u>Exception Report:</u> BRI review now complete, other sites in the process of completing the review. To be completed by the end of March. | 75%       | January           | Red         |
| Staff to be re-trained in management / escalation process<br><u>Exception Report:</u> Review of training complete; staff to be trained as part of patient access refresher training. All patient access refresh                        | 0%        | February          | Amber       |

## SECTION 5 – NATIONAL PERFORMANCE

|                                                                                               |     |         |              |
|-----------------------------------------------------------------------------------------------|-----|---------|--------------|
| training to be amalgamated (including 18-weeks and cancer) and completed by end May.          |     |         |              |
| Implementation of actions in A&E 4-hour emergency access plan, to reduce bed-related breaches | 75% | Monthly | <b>Amber</b> |

*Please note: completed actions are greyed-out the month after they are reported as complete and removed from the list at the end of each quarter.*

|                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>TARGET: Last-minute cancelled operations / 28-day readmission</b>                                                                                                                                                                                                                                                                                                                                               |
| <b>Progress against the Key Performance Indicators</b>                                                                                                                                                                                                                                                                                                                                                             |
| <p>1) Number of bed related last-minute cancellations / number of bed related last-minute cancellations as a percentage of the same period last year</p> <p>Please see table of Key Performance Indicators in section 5.3. So far this year the percentage of cancellations per month that were due to a ward bed not being available has been lower in 2009/10 than in 2008/09 in seven out of eleven months.</p> |
| <p>2) Percentage of last-minute cancellations escalated to management teams (<i>to be added when a monthly reporting process is established</i>)</p>                                                                                                                                                                                                                                                               |

## SECTION 5 – NATIONAL PERFORMANCE

**TARGET: Infant Health Inequalities – [not] smoking at the time of delivery**

**RESPONSIBLE DIRECTOR:** Chief Operating Officer

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

The percentage of mothers that were smokers at the time of delivery of their baby.

**Care Quality Commission (CQC) measurement period:** Annual special data collection exercise carried-out in April/May each year.

**Monitor measurement period:** Not applicable

**Reasons for underperformance:**

- Please note: the threshold for achieving this target is set at last year's performance or the national average for 2008/09 (not yet published). The national average in previous years has been considerably lower than the Trust's performance against this standard. It is therefore expected that this target will be met.
- Variation between months in the numbers of women choosing to smoke, despite health advice having been given, has a significant impact on performance against this standard.

**Key performance indicators for the target:**

No additional Key Performance Indicators have currently been set for this target.

| Key actions:                                                                                                                                | Completed | Due date (end of) | Risk rating |
|---------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------------|-------------|
| All Midwives will be reminded to discuss smoking cessation in more depth and make referrals on to Smoking Cessation Midwife, as appropriate | 0%        | March             | Green       |
| Smoking Cessation Midwife to undertake more publicity about her role to staff and patients                                                  | 0%        | April             | Green       |

*Please note: completed actions are greyed-out the month after they are reported as complete and removed from the list at the end of each quarter.*



## SECTION 5 – NATIONAL PERFORMANCE

### 5.7 National Statistics - quarterly performance summary

National quarterly 4-hour Emergency Access performance for a selection of teaching and Foundation trusts (excerpt from the national report issued by the Department of Health for the week ending March 14<sup>th</sup> 2010)

| SHA       | Trust                                                        | FT |
|-----------|--------------------------------------------------------------|----|
| E Mids    | University Hospitals of Leicester NHS Trust                  |    |
| E Mids    | Nottingham University Hospitals NHS Trust                    |    |
| East Eng  | Norfolk & Norwich University Hospitals NHS Foundation Trust  | FT |
| East Eng  | Colchester Hospital University NHS Foundation Trust          | FT |
| London    | Barts and the London NHS Foundation Trust                    |    |
| London    | Guy's and St Thomas' NHS Foundation Trust                    | FT |
| London    | King's College Hospital NHS Foundation Trust                 | FT |
| N East    | The Newcastle Upon Tyne Hospitals NHS Foundation Trust       | FT |
| N West    | University Hospital of South Manchester NHS Foundation Trust | FT |
| N West    | Royal Liverpool & Broadgreen University Hospitals NHS Trust  |    |
| S Central | Oxford Radcliffe Hospitals NHS Trust                         |    |
| S Central | Southampton University Hospitals NHS Trust                   |    |
| W Mids    | University Hospitals Birmingham NHS Foundation Trust         | FT |
| W Mids    | University Hospitals Coventry & Warwickshire NHS Trust       |    |
| W Mids    | Heart of England NHS Foundation Trust                        | FT |
| S West    | North Bristol NHS Trust                                      |    |
| S West    | Royal Devon & Exeter Foundation Trust                        | FT |
| S West    | Gloucester Hospital NHS Foundation Trust                     | FT |
| S West    | University Hospitals Bristol Foundation Trust                | FT |
| YatH      | Leeds Hospitals Teaching NHS Trust                           |    |
| YatH      | Sheffield Teaching Hospitals NHS Foundation Trust            | FT |

| Performance year to date | Rank | Performance quarter to date | Rank | Performance last full quarter | Rank |
|--------------------------|------|-----------------------------|------|-------------------------------|------|
| 98.2                     | 95   | 97.8                        | 97   | 97.5                          | 114  |
| 98.1                     | 108  | 99.1                        | 11   | 95.6                          | 148  |
| 98.1                     | 112  | 96.8                        | 125  | 97.0                          | 128  |
| 98.8                     | 29   | 98.9                        | 18   | 98.6                          | 31   |
| 98.4                     | 56   | 98.0                        | 82   | 98.5                          | 41   |
| 97.7                     | 129  | 96.0                        | 135  | 98.0                          | 75   |
| 98.3                     | 79   | 98.2                        | 67   | 98.3                          | 52   |
| 99.0                     | 17   | 98.7                        | 29   | 98.9                          | 21   |
| 98.2                     | 96   | 97.8                        | 94   | 97.5                          | 112  |
| 99.1                     | 16   | 98.6                        | 38   | 99.2                          | 11   |
| 97.1                     | 146  | 97.1                        | 118  | 96.3                          | 141  |
| 98.0                     | 119  | 97.4                        | 106  | 97.1                          | 125  |
| 98.5                     | 50   | 98.5                        | 44   | 98.3                          | 55   |
| 98.1                     | 107  | 97.1                        | 120  | 98.3                          | 56   |
| 96.9                     | 147  | 95.1                        | 148  | 95.5                          | 149  |
| 98.4                     | 76   | 97.7                        | 98   | 98.2                          | 62   |
| 98.6                     | 47   | 98.1                        | 78   | 97.9                          | 84   |
| 97.4                     | 139  | 97.1                        | 122  | 97.0                          | 126  |
| 98.0                     | 120  | 98.3                        | 59   | 97.0                          | 129  |
| 98.1                     | 105  | 98.7                        | 31   | 98.5                          | 40   |
| 98.2                     | 101  | 98.0                        | 86   | 97.7                          | 97   |

#### Notes:

- 1) Ranks shown are the national rankings.
- 2) Performance quarter to date is for quarter 4 2009/10
- 3) Performance last full quarter is for quarter 3 2009/10



Trust Board Meeting

|                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <b>Agenda Item</b>                                                                                                   | 7(b)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Date: 29<sup>th</sup> March 2010</b> |
| <b>Title of Report</b>                                                                                               | Infection Control Report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |
| <b>Recommendations (please outline the purpose of the report and the key issues for consideration/decision)</b>      | <p>Monthly report to update the Board on the position in relation to infection control.</p> <p>The Board is asked to note the continued good progress with Clostridium difficile and MRSA.</p> <p>A summary of the progress made in implementing the 2009/10 infection control programme is appended for information. The proposed programme for 2010/11 is appended for the Board's approval. The programme is based on maintaining compliance to the Hygiene Code, delivering reductions required in MRSA and Clostridium difficile as national targets, delivering Corporate objectives and priorities as well as addressing other areas of concern, for example, staff survey results.</p> |                                         |
| <b>Actions Required</b>                                                                                              | <p>To receive the report and comment on any issues of concern</p> <p>To approve the proposed infection control programme for 2010/11</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |
| <b>Which Corporate Objective(s) are supported by this paper</b>                                                      | Corporate Objectives 2009/10 Section 5 – “To improve the patient experience and safety by further reducing the incidence of healthcare associated infections, also meeting national and locally agreed targets”                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| <b>Implications for the NHS Constitution</b>                                                                         | The Trust's infection control regime supports the pledge to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |
| <b>Is this on the Trust's risk register? If yes please give details. If not, why not? Eg. Risk Score is below 15</b> | <p>The following are on the Corporate Risk Register:</p> <ul style="list-style-type: none"> <li>○ Failure to reduce the incidence of healthcare associated infection specifically MRSA and Clostridium difficile – medium residual risk</li> <li>○ Norovirus outbreaks which will introduce significant risk to the achievement of the 4 hour and elective targets – medium residual risk</li> <li>○ Failure to comply with revised Care Quality Commission standards on decontamination – low residual risk</li> </ul>                                                                                                                                                                        |                                         |
| <b>Which healthcare commission standard does this report provide evidence for?</b>                                   | <p>Healthcare Standard C4A and C4C</p> <p>C4A - Healthcare organisations keep patients, staff and visitors safe by having systems to ensure the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA</p> <p>C4c – Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed</p>                                                                            |                                         |

|                                       |                                                                                                              |                |            |                |            |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------|------------|----------------|------------|
| <b>Financial Implications</b>         | <table><tr><td><b>Revenue</b></td><td><b>£ 0</b></td><td><b>Capital</b></td><td><b>£ 0</b></td></tr></table> | <b>Revenue</b> | <b>£ 0</b> | <b>Capital</b> | <b>£ 0</b> |
| <b>Revenue</b>                        | <b>£ 0</b>                                                                                                   | <b>Capital</b> | <b>£ 0</b> |                |            |
| <b>Prepared by: Name &amp; Title</b>  | Christine Perry – Director of Infection Prevention and Control                                               |                |            |                |            |
| <b>Presented by: Name &amp; Title</b> | Alison Moon – Chief Nurse and Director of Governance                                                         |                |            |                |            |

### Previous Meetings

Please insert the date the paper was presented next to the relevant group

| <b>Exec Team</b> | <b>Audit &amp; Assurance Committee</b> | <b>Governance Risk and Risk Management</b> | <b>Finance Committee</b> | <b>Trust Executive Group</b> | <b>Other Meeting Please state</b> |
|------------------|----------------------------------------|--------------------------------------------|--------------------------|------------------------------|-----------------------------------|
|                  |                                        |                                            |                          |                              | Infection Control Committee       |

**UNIVERSITY HOSPITALS BRISTOL ROYAL INFIRMARYSTOL NHS  
FOUNDATION TRUST  
INFECTION CONTROL REPORT  
SUMMARY PERFORMANCE DASHBOARD**

**1.1 *Clostridium difficile***

|              | Nov 09 | Dec 09 | Jan 10 | Feb 10 | April 09 – Feb10 | National target position | Stretch target position |
|--------------|--------|--------|--------|--------|------------------|--------------------------|-------------------------|
| Target cases | 4      | 2      | 6      | 6      | 90               | -130                     | -86                     |
| Total cases  | 12     | 6      | 13     | 8      | 162              |                          |                         |

**1.4 *Clostridium difficile* Dashboard**

|                              |                |        |               |        |
|------------------------------|----------------|--------|---------------|--------|
| 0-79% = red                  | 80-94% = amber |        | 95-100%=green |        |
|                              | Nov 09         | Dec 09 | Jan 10        | Feb 10 |
| Hand hygiene (15 mins)       | 95%            | 93%    | 99%           | 96%    |
| Antibiotic compliance        | 66%            | 57%    | 74%           | 68%    |
| Matrons checklist            | 95%            | 95%    | 94%           | 94%    |
| Bristol stool chart          | 89%            | 94%    | 90%           | 87%    |
| Protective clothing          | 83%            | 76%    | 49%           | 70%    |
| Isolation                    | 77%            | 71%    | 55%           | 77%    |
| Bathroom & toilet monitoring | 90%            | 95%    | 95%           | 96%    |

**2.1 MRSA bacteraemias**

|             | Oct 09 | Nov 09 | Dec 09 | Jan 10 | April 09 – Jan 10 | National target position | Stretch target position |
|-------------|--------|--------|--------|--------|-------------------|--------------------------|-------------------------|
| Total cases | 0      | 3      | 1      | 1      | 14                | -8                       | -5                      |
| Post 2 days | 0      | 3      | 1      | 0      | 9                 |                          |                         |
| Pre 2 days  | 0      | 0      | 0      | 1      | 5                 |                          |                         |

**2.3 MRSA Screening**

|                                    |                |        |               |        |
|------------------------------------|----------------|--------|---------------|--------|
| 0-79% = red                        | 80-94% = amber |        | 95-100%=green |        |
|                                    | Nov 09         | Dec 09 | Jan 10        | Feb 10 |
| Total screened                     |                | 76.4%  | 73.4%*        | 83%    |
| Total screened prior to admission  |                | 89.3%  | 91.2%         | 96%    |
| Total number of all MRSA screening | 1697           | 1651   | 1826          | 1909   |

\* Figure not validated at time of compiling report

**2.4 Saving Lives Dashboard**

|                                       |                |        |               |        |
|---------------------------------------|----------------|--------|---------------|--------|
| 0-79% = red                           | 80-94% = amber |        | 95-100%=green |        |
|                                       | Nov 09         | Dec 09 | Jan 10        | Feb 10 |
| Central venous catheters insertion    | 69%            | 77%    | 96%           | 99%    |
| Central venous catheters ongoing care | 86%            | 81%    | 81%           | 94%    |
| Peripheral cannulae insertion         | 82%            | 84%    | 83%           | 88%    |
| Peripheral cannulae ongoing care      | 84%            | 81%    | 86%           | 85%    |
| Urinary catheters insertion           | 94%            | 88%    | 89%           | 94%    |
| Urinary catheters ongoing care        | 84%            | 90%    | 82%           | 95%    |

**3. Glycopeptide resistant Enterococci bacteraemias**

|                 |               |        |                 |        |                   |                   |
|-----------------|---------------|--------|-----------------|--------|-------------------|-------------------|
| More than 09/09 | Same as 08/09 |        | Less than 08/09 |        |                   |                   |
|                 | Nov 09        | Dec 09 | Jan 10          | Feb 10 | April 09 – Feb 10 | April 08 – Jan 09 |
| Total cases     | 0             | 0      | 1               | 1      | 12                | 15                |

**4. Hand Hygiene (monthly audit)**

|                             |                |        |               |        |
|-----------------------------|----------------|--------|---------------|--------|
| 0-79% = red                 | 80-94% = amber |        | 95-100%=green |        |
|                             | Nov 09         | Dec 09 | Jan 10        | Feb 10 |
| Overall compliance          | 97%            | 97%    | 97%           | 96%    |
| Nursing                     | 98%            | 97%    | 99%           | 96%    |
| Medical                     | 95%            | 94%    | 96%           | 94%    |
| Allied Health Professionals | 96%            | 97%    | 96%           | 98%    |
| Support Services            | 95%            | 97%    | 97%           | 95%    |

**5.1 Cleanliness scores**

|                |                |        |               |        |
|----------------|----------------|--------|---------------|--------|
| 0-69% = red    | 70-94% = amber |        | 95-100%=green |        |
|                | Nov 09         | Dec 09 | Jan10         | Feb 10 |
| Trust score    | 90%            | 94%    | 94%           | 93%    |
| Very high risk | 95%            | 95%    | 94%           | 95%    |
| High risk      | 90%            | 95%    | 93%           | 92%    |

**5.3 Training compliance**

|                  |                |        |                |               |
|------------------|----------------|--------|----------------|---------------|
| 0-69% = red      | 70-89% = amber |        | 90-100%= green |               |
|                  | Nov 09         | Dec 09 | Jan 10         | Feb 10        |
| Compliance score | 73.4%          | 74.4%  | 74.4%          | Not available |

## **1. *Clostridium difficile***

### **1.1. *Clostridium difficile* performance against target** (Figures 1 and 2)

The number of *Clostridium difficile* in February 2010 remained under the national and stretch<sup>1</sup> target and the internally set target. Although a slight increase in cases was seen, investigation of each case has shown that this is not likely to be an increasing trend. Benchmarking information will be included in March Board report, however, in a report recently published by the Health Protection Agency, the Trust had the lowest rate for *Clostridium difficile* infection by population in the South West Region for July to September 2009.

### **1.2. Divisional Performance**

Figures 3-6 show the apportionment of cases by Division. All Divisions are below their set trajectory.

### **1.3. *Clostridium difficile* comparative data**

Comparative data for English Teaching Trusts and Trusts within NHS South West are shown in figures 7 and 8. The Trusts is currently performing well with rates of infection in comparison locally and nationally.

### **1.4. *Clostridium difficile* dashboard** (Figure 9)

The score for the Matrons checklist remains low due to the continued addition of non-inpatient areas as reported to the February Board. The reduction in compliance to use of the Bristol Stool chart is due to a small number of wards recording particularly poor scores. These wards have been identified with the Matrons and actions are being taken to make improvements; a large number of these wards are not areas considered to be the highest risk for *Clostridium difficile*. Improvements have been noted in the isolation and protective clothing monitoring scores, although Matrons are actively working with wards to improve this further.

### **1.5. Antibiotic prescribing** (Figures 10 – 13)

Prescribing compliance continues to improve in Medicine and Specialised Services Divisions. The reduction noted in the *Clostridium difficile* dashboard score was due to lower compliance scores from Surgery Head and Neck and Women and Children's Divisions. The poor compliance scores are again predominantly related to failure to document the indication for and antibiotic and the length of course; compliance to prescribing the correct antibiotic remains at a high level.

The antimicrobial leads from the Divisions met as part of the anti-infective steering group in February and have agreed urgent actions that are being implemented to improve junior medical staffs' awareness of prescribing. These include:

- Re-issuing the antibiotic indication stop and review policy highlighting the escalation procedures
- Letter to be sent to Junior Doctors regarding the policy stating a zero tolerance approach to failure to comply
- Production of credit card size instructions for Junior Doctors on antibiotic prescribing requirements; this will be formally distributed with signed acknowledgment of receipt

The Trust participated in a prevalence survey of antibiotic prescribing in February which will enable bench marking of current practice across the region. The results are

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<sup>1</sup> The stretch target is the one agreed with NHS Bristol to align the number of cases per 1 000 bed days with the best performing Trusts in NHS South West

not as yet available as collation and analysis is undertaken regionally; results will be included in a future Board report.

## **2. MRSA**

### **2.1. Performance against target (Figure 14)**

There was one MRSA bacteraemia reported in January 2010. The bacteraemia was identified within 48 hours of the patient being admitted, therefore, the root cause analysis is focusing on care and management within the community.

### **2.2. MRSA comparative data**

Figures 15 and 16 show comparative data for English Teaching Trusts and Trusts within NHS South West. Due to the small numbers of cases per month, data for the three months November 2009 to January 2010 are shown. Nationally published MRSA data includes all cases of MRSA bacteraemia whether this is acquired within the trust or before admission. This information shows that whilst the Trust has achieved year on year reductions in MRSA there is potential for greater reductions. The infection control programme for 2010/11 includes specific actions to Bristol Royal Infirmary about these reductions.

### **2.3. MRSA Screening (Figure 17)**

Compliance for screening within the subset of elective patients increased to 83% in February with 96% of these patients being screened before admission. Further improvements are focused on medical elective admissions, surgical in patients and day cases and Cardiology patients.

### **2.4. Saving Lives Dashboard (Figure 18)**

Improvements in compliance scores have been seen in all but the ongoing management of peripheral venous cannulae. Actions to further improve practice for invasive devices are included within the infection control programme for 2010/11.

## **3. Glycopeptide resistant Enterococci (GRE) bacteraemias (Figure 19)**

There was one case of glycopeptides resistant Enterococci bacteraemia in February 2010. This case was identified within the Emergency Department of the Children's Hospital and is not thought to be linked to inpatient care.

## **4. Hand Hygiene Audits**

Figures 20 and 21 show results for the monthly hand hygiene audits. Overall compliance within the Medical Division dropped to 93% in February. This decrease was due to three wards scoring particularly badly; the relevant matrons have addressed these specific areas of concern. Medical staff hand hygiene compliance also dropped below the 95% standard in February. Specific clinical areas of poor compliance have been identified and are being targeted with additional education.

## **5. Other Issues**

### **5.1. Cleanliness (Figure 22) – report submitted by Dena Ponsford – General Manager Facilities**

The average cleanliness score across all sites and risk category areas was 93%, 1% lower than in January. The result was significantly influenced by one score in the low risk category area at the Bristol Royal Infirmary where a score of 83% was achieved in an office area. This adversely impacted on the overall average score. The average score achieved in the very high risk category across the site improved by 1% to 95%



with Bristol Childrens Hospital and St Michaels Hospital each achieving 97% and Bristol Dental Hospital 96%.

Within the high risk category areas, excellent average results were achieved at Bristol General Hospital, Bristol Haematology and Oncology Centre and Bristol Childrens Hospital. At St Michaels Hospital, in one specific high risk area the score significantly dropped by 12% to 82%, which is being addressed by management staff. Performance management also applies within a number of areas within the Bristol Royal Infirmary. Dena Ponsford reports that an improvement is anticipated in a number of the high risk category areas within the Bristol Royal Infirmary/Bristol Heart Institute in March. Within the very high risk category areas at the Bristol Royal Infirmary/Bristol Heart Institute, all scores improved with one exception which reduced by 1% to 94%. Seven out of the ten areas monitored in the very high risk category achieved 95% and above. Supervisory and management absence during February posed a key challenge at the Bristol Royal Infirmary and the Bristol Eye Hospital which has been resolved during March.

The Patient Environment and Action Team assessments are being carried out in February and March 2010. The assessments involve facilities staff, infection control team, Heads of Nursing, Matrons and Trust Members, Governors and Youth Council representatives; the latter have provided very positive comments on the overall standard of cleanliness across the site. Submitted assessment results will be included in a future Board report.

#### **5.2. Matrons quarterly report** – submitted by Graham Brant – Matron Representative to Infection Control Committee

Norovirus has been the biggest issue for Matrons since the last report. Staff are ensuring vigilance of hand hygiene and working closely with facilities and infection control to ensure specimens and cleaning is undertaken appropriately. With a number of wards closed matrons are ensuring that restrictions put in place to reduce spread are adhered to. The monthly *Clostridium difficile* dashboard results continue to improve with the non clinical areas now also being included. MRSA numbers within the trust remain low; Matrons continue to ensure relevant audits are maintained.

There have been changes in Linen personnel in recent weeks and this at present appears to have made things better particularly at the BRI site. Sunlight appear to be communicating issues much more quickly with the facilities team meaning staff are made aware of delays, vehicle breakdown etc. in a timely manner. The Estates responses have improved and matrons report that in certain parts of the trust a named building estates officer is working well. Concern still remains with the time taking to undertake some jobs and the lack of clarity from the helpdesk as to the priority they have been allocated.

#### **5.3. Training compliance**

Training compliance figures for February 2010 are not available at the time of composing the report.

#### **5.4. Norovirus**

The Trust has experienced a number of ward closures due to Norovirus outbreaks. Outbreak management has been implemented in line with national and regional guidance.

### **5.5. Care Quality Commission Staff Survey Infection Control Related Results**

The infection control related results of the staff survey 2009 are summarised in figure 23. It is disappointing that the availability of hand hygiene facilities has continued to score below the national average benchmark and has not improved since 2008. The infection control programme for 2010/11 includes specific actions aimed at improving the scores for availability of hand hygiene facilities and promotion of importance of hand hygiene above the national benchmark figure for the 2010 survey. Analysis of the results shows that allied health professionals, clinical scientists and medical and dental staff scored the availability of hand hygiene facilities lower than other staff groups; this will be addressed by providing all transient staff with individual carried alcohol hand gels. A higher than average score was obtained for staff having received infection control training in the last 12 months and for staff agreeing that infection control applies in their role.

### **6. Infection Control Programme**

Progress with the infection control programme for 2009/10 is given in appendix I. Whilst there are some areas where actions have not been completed within the set timescales none of these are direct clinical issues and therefore do not present a high risk to patients.

The proposed programme for 2010/11 (appendix II) is based on maintaining compliance to the hygiene code, achieving nationally set targets and achieving internally agreed objectives. The programme has been produced in consultation with members of the Infection Control Committee. The Board is asked to formally approve the proposed programme.

**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**  
**INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME UPDATE FEBRUARY 2010**

| <b>Hygiene Code Compliance Criterion</b>                                                                                                                                    | <b>Key success factors/outcomes</b>                                                                                                                  | <b>Accountable person(s)</b>           | <b>Delivery date(s)</b>                                    | <b>Status</b>                                                    | <b>Risk</b> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------|------------------------------------------------------------------|-------------|
| 1. Have in place and operate effective management systems for the prevention and control of HCAI which are informed by risk assessments and analysis of infection incidents | a. Restate the Board commitment to IP&C in annual report                                                                                             | Christine Perry                        | July 2009                                                  | Complete                                                         | Green       |
|                                                                                                                                                                             | b. Provision of a formal update on the implementation of the Infection Control Compliance and Improvement plan to the Trust Board at least Quarterly | Christine Perry                        | June 2009<br>September 2009<br>December 2009<br>March 2010 | Not completed June or December. Will be included in March report | Amber       |
|                                                                                                                                                                             | c. Minuted review of the risk register at Infection Control Committee Meetings                                                                       | Christine Perry                        | June 2009<br>September 2009<br>December 2009<br>March 2010 | Completed June, September and December                           | Green       |
|                                                                                                                                                                             | d. Minuted review of the controls within the Assurance Framework at Infection Control Committee meetings                                             | Christine Perry                        | June 2009<br>September 2009<br>December 2009<br>March 2010 | Not completed June or December. Completed for September 2009     | Amber       |
|                                                                                                                                                                             | e. Production of annual report and presentation to Trust Board                                                                                       | Pat Fields                             | June 2009                                                  | Completed                                                        | Green       |
|                                                                                                                                                                             | f. Production of monthly report and present to Trust Board                                                                                           | Pat Fields/ Alison Moon (July onwards) | Monthly                                                    | Completed to February 2010                                       | Green       |

|  |                                                                                                    |                   |                                                            |                                                                                                                              |       |
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|  | g. Production of quarterly report for inclusion in infection control report to Trust Board         | Graham Brant      | June 2009<br>September 2009<br>December 2009<br>March 2010 | Completed for June, September and December 2009                                                                              | Green |
|  | h. Production of statistics on incidence of alert organisms for inclusion in Board report          | Corporate Analyst | Monthly                                                    | Completed to February 2010                                                                                                   | Green |
|  | i. Implementation of revised infection control nursing structure and on call arrangements          | Joanna Davies     | July 2009                                                  | Revised structure implemented. On call not implemented as funding not agreed                                                 | Amber |
|  | j. Designation or appointment of Infection Control Doctor within Health Protection Agency contract | Gary Higgins      | June 2009                                                  | Outstanding, discussions still underway with HPA/Jonathan Sheffield/Paul Mapson re funding. <b>No update received Feb 10</b> |       |

|                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                        |                                   |                                                            |       |
|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------|------------------------------------------------------------|-------|
| 2. Provide and maintain a clean and appropriate environment which facilitates the prevention and control of HCAI | a. Estates/ Facilities policies listed below are within review date to end of March 2010 and include statement of liaison with infection control: <ul style="list-style-type: none"> <li>➤ Cleaning services</li> <li>➤ Building and refurbishment</li> <li>➤ Air handling systems</li> <li>➤ Healthcare waste management</li> <li>➤ Planned preventative maintenance</li> <li>➤ Pest control</li> <li>➤ Management of potable and non-potable water supplies</li> </ul> Food services and hygiene | Bob Pepper             | March 2010                        | Will all be on the Document Management System by mid march | Green |
|                                                                                                                  | b. Production and implementation of a Decontamination Programme                                                                                                                                                                                                                                                                                                                                                                                                                                    | Claire Thompson        | July 2009 with ongoing monitoring | Completed                                                  | Green |
|                                                                                                                  | c. Cleanliness monitoring results are included in Board reports                                                                                                                                                                                                                                                                                                                                                                                                                                    | Dena Ponsford          | Monthly                           | Completed to February 2010                                 | Green |
|                                                                                                                  | d. Matrons contribute to cleanliness monitoring through multi-disciplinary walkrounds and CDI reduction monitoring                                                                                                                                                                                                                                                                                                                                                                                 | Chair of Matrons Group | Ongoing                           |                                                            | Green |

|                                                                                                                                                                                              |                                                                                                           |               |                |                                                                                                                                                                                                                                                                                                              |       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
|                                                                                                                                                                                              | e. An audit of hand washing facilities and alcohol hand gel locations is completed                        | Joanna Davies | March 2010     | In progress February 2010                                                                                                                                                                                                                                                                                    | Green |
|                                                                                                                                                                                              | f. An audit of linen handling and management at ward level is completed                                   | Joanna Davies | March 2010     | Currently being audited. Report for July Infection Control Committee                                                                                                                                                                                                                                         | Green |
| 3. Provide suitable and sufficient information on HCAI to the patient, public and other service providers when patients move to the care of another healthcare or other social care provider | a. Generic and specialist patient information leaflets relevant to infection control are reviewed in year | Joanna Davies | March 2010     | All updated – awaiting upload to DMS                                                                                                                                                                                                                                                                         | Green |
|                                                                                                                                                                                              | b. A bespoke infection control section is available on the Trust Internet with appropriate information    | Sarah Pinch   | September 2009 | Work commenced. Identifying good examples from other Trusts. Frequently asked questions and answers also identified. Further development delayed due to unavailability of key link within infection control team. Agreed with DIPC to delay until return of member of staff as not crucial to patient safety | Amber |
| 4. Ensure that patients presenting with an infection or who acquire an                                                                                                                       | a. An audit of the awareness and use of the yellow alert organism indicator dot is completed              | Joanna Davies | October 2009   | Commenced February. Anticipated completion April with report to July Infection Control Committee                                                                                                                                                                                                             | Green |

|                                                                                                                                           |                                                                                                                       |                 |              |                                                                                                             |       |
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| infection during their care are identified promptly and receive appropriate management and treatment to reduce risk of transmission       | b. The care pathway for management of MRSA positive patients is within review date and reflects current best practice | Joanna Davies   | March 2010   | Review complete. To be uploaded to DMS by mid march                                                         | Green |
|                                                                                                                                           | c. An audit of the care and management of MRSA positive patients is completed                                         | Joanna Davies   | August 2009  | Audit completed. Reported at December ICC meeting.                                                          | Green |
|                                                                                                                                           | d. A care pathway for the management of CDI positive patients is developed                                            | Joanna Davies   | October 2009 | Agreed to continue with current documentation which is within review date                                   |       |
|                                                                                                                                           | e. An audit of the care and management of CDI positive patients is completed                                          | Joanna Davies   | March 2010   | Care of patients formally reviewed at weekly IC meeting, therefore agreed not to undertake additional audit |       |
| 5. Gain the co-operation of staff, contractors and others involved in the provision of healthcare in preventing and controlling infection | a. 'Action Cards' detailing staff group responsibilities are issued to Ward/Department managers                       | Christine Perry | July 2009    | Included in revision of infection control policy                                                            | Green |
|                                                                                                                                           | b. Guidance for assessing infection control competence at appraisal is issued                                         | Christine Perry | July 2009    | Included in revision of infection control policy                                                            | Green |
| 6. Provide or secure adequate isolation facilities                                                                                        | a. Bespoke Trust isolation policy is issued*                                                                          | Christine Perry | June 2009    | Completed and issued September 2009                                                                         | Green |
|                                                                                                                                           | b. A review of isolation capacity and facilities is completed                                                         | Joanna Davies   | March 2010   | In progress in collaboration with Estates Department                                                        | Green |

|                                        |                                                                                                            |                    |           |                                                               |       |
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| 7. Secure access to laboratory support | a. Contract with Health Protection Agency includes explicit standards for infection prevention and control | Gary Higgins       | June 2009 | 2009/20 contract now signed with inclusion of these standards | Green |
|                                        | b. A Consultant Microbiologist is designated as Infection Control Doctor                                   | Jonathan Sheffield | June 2009 | <b>No update received February 10</b>                         |       |

|                                                                                                 |                                                                                                                        |                        |               |                                                                                                                      |       |
|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|------------------------|---------------|----------------------------------------------------------------------------------------------------------------------|-------|
| 8. Have and adhere to appropriate policies and protocols for the prevention and control of HCAI | a. A Universal/ Standard precautions policy is issued*                                                                 | Carly Hall             | December 2009 | Draft to be approved at infection control committee and then ratified at TEG by end of March                         | Green |
|                                                                                                 | b. Monitoring of hand hygiene, protective clothing use and equipment decontamination is performed a minimum of monthly | Chair of Matrons Group | Ongoing       | Completed to January 2010                                                                                            | Green |
|                                                                                                 | c. An aseptic technique policy is issued*                                                                              | Carly Hall             | December 2009 | Policy in date on intranet                                                                                           | Green |
|                                                                                                 | d. An audit of aseptic technique is completed                                                                          | Joanna Davies          | March 2010    | Audits completed at St Michaels, Oncology and Childrens Hospital. Audit for BRI and BHI to be implemented April 2010 | Amber |
|                                                                                                 | e. An incident, outbreak and ward closure policy is issued*                                                            | Christine Perry        | July 2009     | Completed and issued September 2009                                                                                  | Green |
|                                                                                                 | f. A policy for prevention of blood borne viruses is issued*                                                           | Carly Hall             | August 2009   | Completed and issued September 2009                                                                                  | Green |



|  |                                                                                |                 |                |                                                                                                                                                                                               |       |
|--|--------------------------------------------------------------------------------|-----------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
|  | g. An audit of sharps handling and disposal is completed                       | Joanna Davies   | March 2010     | Audit completed with results taken to December ICC meeting                                                                                                                                    | Green |
|  | h. A decontamination policy is issued*                                         | Christine Perry | July 2009      | Delayed due to prioritisation of policies for NHSLA. Short life policy approved by Infection Control Committee and ratified by Clinical Risk Assurance Committee. Will be revised by in March | Green |
|  | i. Antimicrobial prescribing policies and protocols are issued and within date | Liz Jonas       | March 2010     | Policies frequently come up for review and are addressed before the review date                                                                                                               | Green |
|  | j. Monitoring of Antimicrobial prescribing is completed monthly                | Liz Jonas       | Ongoing        | Completed to August 2009                                                                                                                                                                      | Green |
|  | k. A policy on transmissible spongiform encephalopathies is issued*            | Carly Hall      | July 2009      | Policy delayed due to additional requirements from guidance issued in 2009. Expected to be ratified by May 2010                                                                               | Amber |
|  | l. A policy on alert and resistant micro-organisms is issued*                  | Carly Hall      | September 2009 | Completed and issued September 2009                                                                                                                                                           | Green |
|  | m. An updated Legionella Policy is issued*                                     | Nigel Phillips  | June 2009      | Policy completed and placed on intranet                                                                                                                                                       | Green |
|  | o. A policy on surveillance and reporting of HCAI is issued                    | Christine Perry | July 2009      | Completed and issued September 2009                                                                                                                                                           | Green |

|                                                                                                                                                                                                                                                          |                                                                                                                      |                                                     |                                                            |                                                                                                                                                                                                                                                                                                   |       |
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| 9. Ensure as far as is reasonably practicable that healthcare workers are free of and protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAI | a. An updated service level agreement with Occupational Health is produced                                           | Alex Nestor/<br>Claire Buchanan                     | July 2009                                                  | Draft Service Level Agreement is currently with the APOHS board. Board to meet on September 18 <sup>th</sup> . <b>No update received February 2010</b>                                                                                                                                            |       |
|                                                                                                                                                                                                                                                          | b. A process to ensure staff complete pre-employment screening, health checks and immunization is implemented        | Alex Nestor                                         | August 2009                                                | Statement of Fitness sent to manager based on the Pre-employment Health questionnaire. This is matched with the Risk Assessment for the role produced by the manager, to identify immunisation needs. Appointments for needed immunisations arranged during induction. Introduced September 2009. | Green |
|                                                                                                                                                                                                                                                          | c. An Occupational Health section is available on the Intranet that includes all relevant documentation and policies | Alex Nestor/<br>Steve Aumayer<br>(from August 2009) | December 2009                                              | Policies in draft format awaiting ratification                                                                                                                                                                                                                                                    | Amber |
|                                                                                                                                                                                                                                                          | d. Immunisation uptake levels are reviewed at Infection Control Committee meetings                                   | Barry Lane                                          | June 2009<br>September 2009<br>December 2009<br>March 2010 | Completed to December 2009                                                                                                                                                                                                                                                                        | Green |
|                                                                                                                                                                                                                                                          | e. A training needs analysis and matrix is completed and issued                                                      | Carly Hall                                          | July 2009                                                  | Completed and included in Trust matrix                                                                                                                                                                                                                                                            | Green |

|  |                                                                                                                         |                 |                                                            |                                                                                        |       |
|--|-------------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------|----------------------------------------------------------------------------------------|-------|
|  | f. Induction and update sessions are reviewed and content is up to date                                                 | Carly Hall      | June 2009<br>September 2009<br>December 2009<br>March 2010 | Completed to February 2010                                                             | Green |
|  | g. Statutory induction and update training coverage and compliance are reviewed at Infection Control Committee meetings | Christine Perry | June 2009<br>September 2009<br>December 2009<br>March 2010 | Completed June, September and December 2009.<br>Compliance below the 80% set standard. | Green |

**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**  
**INFECTION PREVENTION AND CONTROL ANNUAL COMPLIANCE AND DELIVERY PLAN**

The infection prevention and control annual compliance and delivery plan is based on delivering the following

1. Compliance to the Hygiene Code
2. Achievement of the corporate objective to reduce further rates of healthcare associated infection
3. Implementation of relevant High Impact Actions

Progress will be formally monitored quarterly by Infection Control Committee and Trust Board.

The plan is dynamic in that issues and actions identified in year will become part of the delivery plan

| Hygiene Code Compliance Criterion/ Delivery Workstream                                                                                                                                                                                         | Action                                                                                    | Accountable person(s) | Delivery date(s) | Measurable outcome                                                        | Progress | Risk Rating |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------|------------------|---------------------------------------------------------------------------|----------|-------------|
| 1. The Trust has Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other uses may pose to them | a. Restate the Board commitment to IP&C                                                   | Christine Perry       | Jul-10           | There is a statement regarding the Board Commitment in annual report      |          |             |
|                                                                                                                                                                                                                                                | b. Monitoring of progress with annual plan                                                | Christine Perry       | Jul-10           | Quarterly updates on progress with the plan are included in Board reports |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Oct-10           |                                                                           |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Jan-11           |                                                                           |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Apr-11           |                                                                           |          |             |
|                                                                                                                                                                                                                                                | c. Review risk register at infection control committee meetings                           | Christine Perry       | Jul-10           | Infection control committee minutes include discussion of review          |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Oct-10           |                                                                           |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Jan-11           |                                                                           |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Apr-11           |                                                                           |          |             |
|                                                                                                                                                                                                                                                | d. Review controls within the Assurance Framework at Infection Control Committee meetings | Christine Perry       | Jul-10           | Infection control committee minutes include discussion of review          |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Oct-10           |                                                                           |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Jan-11           |                                                                           |          |             |
|                                                                                                                                                                                                                                                |                                                                                           |                       | Apr-11           |                                                                           |          |             |

|                                                                       |                             |        |                                                                                                          |  |  |
|-----------------------------------------------------------------------|-----------------------------|--------|----------------------------------------------------------------------------------------------------------|--|--|
| e. Production of annual report and presentation to Trust Board        | Christine Perry             | Jul-10 | Annual report is publicly available on Trust website and report has been formally presented to the Board |  |  |
| f. Production of monthly summary report to Trust Board                | Chris Perry                 | Jul-10 | Trust Board papers and minutes include infection control report                                          |  |  |
|                                                                       |                             | Oct-10 |                                                                                                          |  |  |
|                                                                       |                             | Jan-11 |                                                                                                          |  |  |
|                                                                       |                             | Apr-11 |                                                                                                          |  |  |
| g. Matrons produce a quarterly report to Trust Board                  | Graham Brant                | Jul-10 | Trust Board papers and minutes include infection control report                                          |  |  |
|                                                                       |                             | Oct-10 |                                                                                                          |  |  |
|                                                                       |                             | Jan-11 |                                                                                                          |  |  |
|                                                                       |                             | Apr-11 |                                                                                                          |  |  |
| h. Include statistics on incidence of alert organisms in Board report | Corporate Analyst           | Jul-10 | Trust Board papers and minutes include infection control report                                          |  |  |
|                                                                       |                             | Oct-10 |                                                                                                          |  |  |
|                                                                       |                             | Jan-11 |                                                                                                          |  |  |
|                                                                       |                             | Apr-11 |                                                                                                          |  |  |
| i. Implement infection control nursing on call arrangements           | Joanna Davies/ Gary Higgins | Jul-10 | Evidence of rostered on call infection control nursing service                                           |  |  |
| j. Provide administration support to infection control team           | Gary Higgins                | May-10 | Permanent administration member of staff allocated to infection control team                             |  |  |

|                                                                                                                                           |                                                                                                                    |                        |         |                                                                                                                                          |  |  |
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| 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections | a. Implement revised cleaning strategy                                                                             | Bob Pepper             | May-10  | Revised cleaning strategy is located on DMS and is considered/monitored at quarterly PEOG meetings                                       |  |  |
|                                                                                                                                           | b. Produce and implement a Decontamination Delivery Programme                                                      | Claire Thompson        | Apr-10  | An annual programme is available on the decontamination workspace and progress is documented at Decontamination Board and CRAC quarterly |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Jul-10  |                                                                                                                                          |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Oct-10  |                                                                                                                                          |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Jan-10  |                                                                                                                                          |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Apr-11  |                                                                                                                                          |  |  |
|                                                                                                                                           | c. Report cleanliness monitoring results to Board                                                                  | Dena Ponsford          | Jul-10  |                                                                                                                                          |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Oct-10  |                                                                                                                                          |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Jan-11  |                                                                                                                                          |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Apr-11  |                                                                                                                                          |  |  |
|                                                                                                                                           | d. Matrons contribute to cleanliness monitoring through multi-disciplinary walkrounds and CDI reduction monitoring | Chair of Matrons Group | Ongoing | Matrons contribute information from these walkabouts to infection control monthly report                                                 |  |  |
|                                                                                                                                           | e. Audit hand washing facilities and alcohol hand gel                                                              | Joanna Davies          | Mar-11  | An audit is completed and reported to infection control committee                                                                        |  |  |
|                                                                                                                                           | f. An audit of linen handling and management at ward level is completed                                            | Joanna Davies          | Mar-11  | An audit is completed and reported to infection control committee                                                                        |  |  |
|                                                                                                                                           | g. Monitor cleanliness of patient equipment                                                                        | Matrons                | Jul-10  | More than 90% of ward areas have completed Matrons monitoring and Trust-wide results are over 80%                                        |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Oct-10  |                                                                                                                                          |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Jan-11  |                                                                                                                                          |  |  |
|                                                                                                                                           |                                                                                                                    |                        | Apr-11  |                                                                                                                                          |  |  |

|                                                                                                                                                           |                                                                                                           |                               |        |                                                                                                              |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------|--------|--------------------------------------------------------------------------------------------------------------|--|--|
| 3. Provide suitable and accurate information on infections to service users and their visitors                                                            | a. Generic and specialist patient information leaflets relevant to infection control are reviewed in year | Joanna Davies                 | Mar-11 | All infection control leaflets on DMS have last reviewed date of Apr 10- Mar 11                              |  |  |
|                                                                                                                                                           | b. Develop standard documentation for use in Norovirus outbreaks                                          | Sarah Pinch/<br>Joanna Davies | Aug-10 | Patient and relative leaflets and letters and press releases are agreed and held ready for release as needed |  |  |
| 4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion | a. Implement process for sending letters to GPs when discharged patients are identified as MRSA positive  | Joanna Davies                 | May-10 | All patients discharged before a new MRSA positive result is obtained have letter sent to GP                 |  |  |
|                                                                                                                                                           | b. Carry out an audit of discharge documentation for MRSA and CDI positive patients                       | Joanna Davies                 | Sep-10 | An audit is completed and reported to infection control committee                                            |  |  |

|                                                                                                                                                                                          |                                                                                              |               |        |                                                                   |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------|--------|-------------------------------------------------------------------|--|--|
| 5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on infection to other people | a. An audit of the awareness and use of the yellow alert organism indicator dot is completed | Joanna Davies | Oct-10 | An audit is completed and reported to infection control committee |  |  |
| 6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection                                    | a. Focus on Divisional delivery is maintained through regular Divisional link nurse meetings | Matrons       | Jul-10 | Each division holds a minimum of quarterly meetings               |  |  |
|                                                                                                                                                                                          |                                                                                              |               | Oct-10 |                                                                   |  |  |
|                                                                                                                                                                                          |                                                                                              |               | Jan-10 |                                                                   |  |  |
|                                                                                                                                                                                          |                                                                                              |               | Apr-11 |                                                                   |  |  |



|                                                                |                                                                                                                                             |               |        |                                                                                                                                    |  |  |
|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------|------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 7. Provide or secure adequate isolation facilities             | a. Audit compliance to isolation practice                                                                                                   | Matrons       | Jul-10 | More than 90% of ward areas have completed Matrons monitoring and results Trust-wide results are over 80%                          |  |  |
|                                                                |                                                                                                                                             |               | Oct-10 |                                                                                                                                    |  |  |
|                                                                |                                                                                                                                             |               | Jan-10 |                                                                                                                                    |  |  |
|                                                                |                                                                                                                                             |               | Apr-11 |                                                                                                                                    |  |  |
|                                                                | b. Complete review of isolation facilities with Estates Department                                                                          | Joanna Davies | May-10 | Review is presented to infection control committee and single room allocation status is included in cubicle tracker                |  |  |
|                                                                |                                                                                                                                             |               |        |                                                                                                                                    |  |  |
|                                                                | c. Ensure sufficient and appropriate isolation capacity is planned into BRI redevelopment                                                   | Andy Headdon  | Sep-10 | Planned isolation rooms are 50% of beds in redevelopment. Specialist isolation facilities comply with HBN 4 suppl 1                |  |  |
| 8. Secure adequate access to laboratory support as appropriate | a. There is adequate liaison and communication between the infection control team and the Health Protection Agency through regular meetings | Joanna Davies | Jun-10 | Formal meetings with the HPA and the infection control team are held at least quarterly and there are documented actions and notes |  |  |
|                                                                |                                                                                                                                             |               | Sep-10 |                                                                                                                                    |  |  |
|                                                                |                                                                                                                                             |               | Dec-10 |                                                                                                                                    |  |  |
|                                                                |                                                                                                                                             |               | Mar-11 |                                                                                                                                    |  |  |
|                                                                | b. The Health Protection Agency is delivering infection control related activity to contract                                                | Gary Higgins  | Jun-10 | The HPA are processing specimens for MRSA and CDI to the set standard as monitored monthly                                         |  |  |
|                                                                |                                                                                                                                             |               | Sep-10 |                                                                                                                                    |  |  |
|                                                                |                                                                                                                                             |               | Dec-10 |                                                                                                                                    |  |  |
|                                                                |                                                                                                                                             |               | Mar-11 |                                                                                                                                    |  |  |

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| 9. Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infection | a. Review aseptic technique policy                                                 | Senior Nurse<br>Chief Nurse<br>Team | Jun-10 | A revised policy is on the DMS and there is evidence of implementation                            |  |  |
|                                                                                                                                                | b. Audit aseptic technique                                                         | Joanna Davies                       | Sep-10 | An audit is completed and reported to infection control committee                                 |  |  |
|                                                                                                                                                | g. Audit sharps handling and disposal                                              | Joanna Davies                       | Dec-10 | An audit is completed and reported to infection control committee                                 |  |  |
|                                                                                                                                                | h. Audit identification of at risk vCJD patients                                   | Jane Palmer                         | Jun-10 | Audits are completed and reported to infection control committee with compliance greater than 95% |  |  |
|                                                                                                                                                |                                                                                    |                                     | Sep-10 |                                                                                                   |  |  |
|                                                                                                                                                |                                                                                    |                                     | Dec-10 |                                                                                                   |  |  |
|                                                                                                                                                |                                                                                    |                                     | Mar-11 |                                                                                                   |  |  |
|                                                                                                                                                | i. Audit hand hygiene                                                              | Matrons                             | Jul-10 | More than 90% of ward areas have completed Matrons monitoring and results Trust-wide are over 95% |  |  |
|                                                                                                                                                |                                                                                    |                                     | Oct-10 |                                                                                                   |  |  |
|                                                                                                                                                |                                                                                    |                                     | Jan-11 |                                                                                                   |  |  |
|                                                                                                                                                |                                                                                    |                                     | Apr-11 |                                                                                                   |  |  |
|                                                                                                                                                | j. Revise antimicrobial prescribing policies with a review date of Apr 10 – Mar 11 | Liz Jonas                           | Mar-11 | All policies are within review date                                                               |  |  |
|                                                                                                                                                | k. Monitor antimicrobial prescribing compliance                                    | Liz Jonas                           | Jun-10 | Monitoring is carried out monthly and is included in CDI dashboard                                |  |  |
|                                                                                                                                                |                                                                                    |                                     | Sep-10 |                                                                                                   |  |  |
|                                                                                                                                                |                                                                                    |                                     | Dec-10 |                                                                                                   |  |  |
|                                                                                                                                                |                                                                                    |                                     | Mar-11 |                                                                                                   |  |  |
|                                                                                                                                                | l. Improve compliance to antimicrobial prescribing                                 | Mark Callaway                       | Aug-10 | Antimicrobial prescribing compliance is above 80% by Aug 10 and above 95% by Nov 10               |  |  |
|                                                                                                                                                |                                                                                    |                                     | Oct-10 |                                                                                                   |  |  |

|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    |        |                                                                                                                                |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------|--------|--------------------------------------------------------------------------------------------------------------------------------|--|--|
| 10. Ensure, so far as is reasonably practicable, that care workers are free of and protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with provision of healthcare | a. Audit compliance to pre-employment screening and staff completion of vaccination etc            | Claire Buchanan                    | Jul-10 | Audit is completed and presented to Infection Control Committee                                                                |  |  |
|                                                                                                                                                                                                                                                                                 | b. Review immunisation uptakes at infection control committee meeting                              | Barry Lane                         | Jul-10 | Immunisation rates are included in occupational health report to infection control committee                                   |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Oct-10 |                                                                                                                                |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Jan-11 |                                                                                                                                |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Apr-11 |                                                                                                                                |  |  |
|                                                                                                                                                                                                                                                                                 | c. Formally review current trust guidance for screening and prevention of TB in healthcare workers | Brian Williams/<br>Christine Perry | Jul-10 | A formal report of the review is presented to infection control committee and any actions identified agreed for implementation |  |  |
|                                                                                                                                                                                                                                                                                 | d. Review training needs analysis for infection control                                            | Christine Perry                    | Apr-10 | Infection control review in trust training needs analysis evidence                                                             |  |  |
|                                                                                                                                                                                                                                                                                 | e. Update statutory and mandatory training sessions                                                | Joanna Davies                      | Jun-10 | All sessions are updated monthly with staff receiving the appropriate session for the month                                    |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Sep-10 |                                                                                                                                |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Dec-10 |                                                                                                                                |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Mar-11 |                                                                                                                                |  |  |
|                                                                                                                                                                                                                                                                                 | g. Monitor statutory and mandatory training compliance figures                                     | Christine Perry                    | Jul-10 | Training compliance figures are reported to infection control committee and board and are above 90%                            |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Oct-10 |                                                                                                                                |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Jan-11 |                                                                                                                                |  |  |
|                                                                                                                                                                                                                                                                                 |                                                                                                    |                                    | Apr-11 |                                                                                                                                |  |  |

|                                                                                                                                                   |                                                                                             |                   |        |                                                                                                                                         |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------|--------|-----------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 11. Corporate objective to reduce MRSA bacteraemia rate to or below 2.6 per 100 000 beds days i.e. no more than 7 hospital acquired cases in year | a. Continue to improve rates of MRSA elective screening                                     | Hheads of Nursing | Jun-10 | MRSA elective screening will be over 95% in elective subset monitoring and observational audits                                         |  |  |
|                                                                                                                                                   |                                                                                             |                   | Sep-10 |                                                                                                                                         |  |  |
|                                                                                                                                                   |                                                                                             |                   | Dec-10 |                                                                                                                                         |  |  |
|                                                                                                                                                   |                                                                                             |                   | Mar-11 |                                                                                                                                         |  |  |
|                                                                                                                                                   | b. Implement MRSA screening for all emergency admissions                                    | Christine Perry   | Jun-10 | MRSA emergency screening will be over 95% in observational audits                                                                       |  |  |
|                                                                                                                                                   |                                                                                             |                   | Sep-10 |                                                                                                                                         |  |  |
|                                                                                                                                                   |                                                                                             |                   | Dec-10 |                                                                                                                                         |  |  |
|                                                                                                                                                   |                                                                                             |                   | Mar-11 |                                                                                                                                         |  |  |
|                                                                                                                                                   | c. Revise MRSA screening policy to include emergency screening                              | Christine Perry   | Jun-10 | MRSA screening policy will be ratified, on DMS and distributed set within policy                                                        |  |  |
|                                                                                                                                                   | d. Improve compliance to saving lives compliance scores                                     | Hheads of Nursing | Jun-10 | Saving lives monitoring for PVCs and CVCs will be submitted for 90% of areas and will be at 95% trust average score                     |  |  |
|                                                                                                                                                   |                                                                                             |                   | Sep-10 |                                                                                                                                         |  |  |
|                                                                                                                                                   |                                                                                             |                   | Dec-10 |                                                                                                                                         |  |  |
|                                                                                                                                                   |                                                                                             |                   | Mar-11 |                                                                                                                                         |  |  |
|                                                                                                                                                   | e. Revise peripheral line policy and documentation                                          | Christine Perry   | May-10 | A revised policy and documentation is on the DMS and implemented in practice                                                            |  |  |
|                                                                                                                                                   | f. Revise central venous line policy                                                        | Christine Perry   | May-10 | A revised policy and documentation is on the DMS and implemented in practice                                                            |  |  |
|                                                                                                                                                   | g. Audit compliance to MRSA care pathway                                                    | Joanna Davies     | Sep-10 | An audit is completed and reported to infection control committee                                                                       |  |  |
|                                                                                                                                                   | h. Implement robust process for MRSA root cause analysis reporting and follow up of actions | Christine Perry   | Jun-10 | There is clear guidance and standard for MRSA root cause analysis and feedback that includes reporting and follow up from board to ward |  |  |
|                                                                                                                                                   | i. Provide root cause analysis training for matrons and other key staff                     | Joanna Davies     | Aug-10 | All Matrons will have attended root cause analysis training                                                                             |  |  |

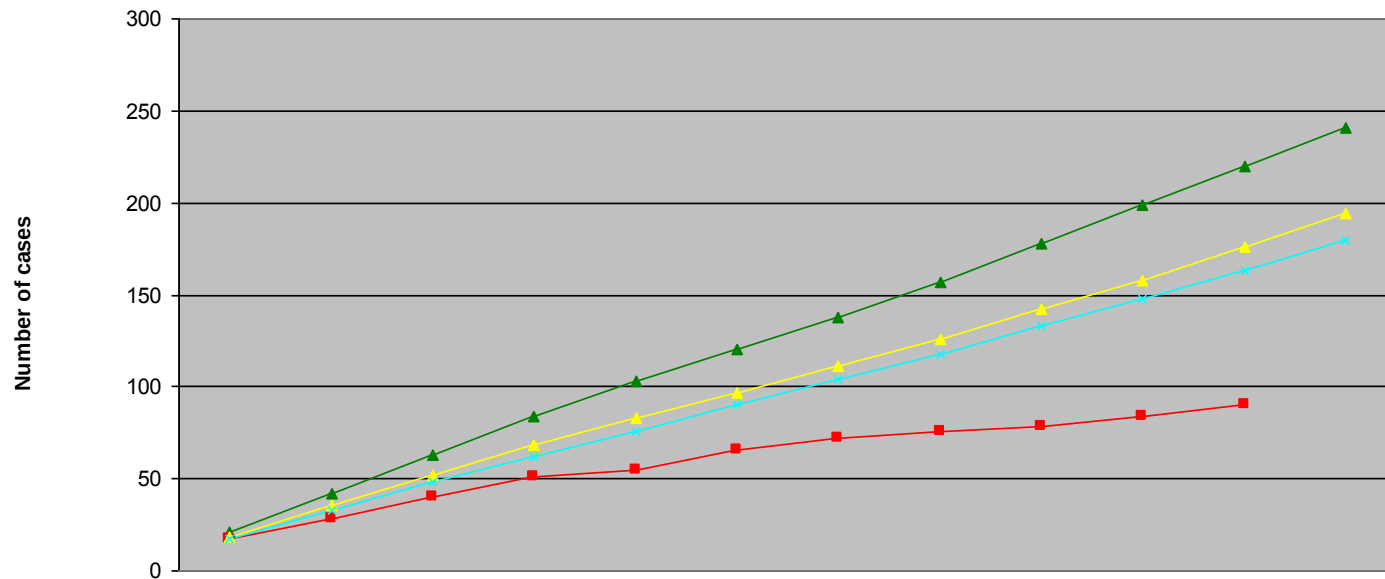
|                                                                                                                                                                |                                                                                                                                         |                                   |        |                                                                                                   |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------|---------------------------------------------------------------------------------------------------|--|--|
|                                                                                                                                                                | j. Implement ongoing competence checks for all staff undertaking insertion and/or management of peripheral and central venous catheters | Senior Nurse Practice Development | Sep-10 | Competence process will be agreed and implemented                                                 |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Dec-10 | 90% of relevant staff will have undergone competence checks at audit                              |  |  |
| 12. Corporate objective to continue reduction in hospital acquired <i>C difficile</i> cases to below 0.28 per 1000 bed days i.e. no more than 72 cases in year | a. Continue reporting of new cases on current proforma at least weekly                                                                  | Christine Perry                   | Jun-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Sep-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Dec-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Mar-11 |                                                                                                   |  |  |
|                                                                                                                                                                | b. Maintain daily ICN reviews of all positive patients                                                                                  | Joanna Davies                     | Jun-10 | CDI positive patient documentation or ICNet show record of daily ICN review                       |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Sep-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Dec-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Mar-11 |                                                                                                   |  |  |
|                                                                                                                                                                | c. Divisions take responsibility for improving antibiotic prescribing compliance                                                        | Heads of Division                 | Apr-10 | Divisions have specific objectives to improve antibiotic compliance                               |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Jun-10 | Divisions are achieving their set objectives                                                      |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Sep-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Dec-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Mar-11 |                                                                                                   |  |  |
|                                                                                                                                                                | d. Review current testing regimes and consider PCR testing                                                                              | Martin Williams                   | Sep-10 | The infection control committee has discussed and agreed any proposed changes to testing.         |  |  |
|                                                                                                                                                                | e. Sustain progress with implementation of the Bristol stool chart                                                                      | Matrons                           | Jun-10 | More than 90% of ward areas have completed Matrons monitoring and results Trust-wide are over 95% |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Sep-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Dec-10 |                                                                                                   |  |  |
|                                                                                                                                                                |                                                                                                                                         |                                   | Mar-11 |                                                                                                   |  |  |

|                                                                                                                                                         |                                                                                                                                                 |                              |        |                                                                                                                 |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------|-----------------------------------------------------------------------------------------------------------------|--|--|
| 13. Corporate objective to reduce all hospital acquired bacteraemias by 25% reduction on cases from previous year (exact number to be confirmed)        | a. Establish process for ongoing surveillance and reporting of bacteramias                                                                      | Christine Perry              | Apr-10 | Divisions receive monthly summary surveillance report                                                           |  |  |
|                                                                                                                                                         | b. Implement root cause analysis for all line related bacteraemias                                                                              | Christine Perry              | Jun-10 | Summary of root cause analysis reported in same process as for MRSA                                             |  |  |
| 14. Corporate objective to implement High Impact Actions planned programme to reduce catheter associated urinary tract to or below 2 per 100 admissions | a. Implement a programme of regular surveillance for catheter associated urinary tract infections                                               | Joanna Davies/<br>Wendy Hurn | Jun-10 | Surveillance is carried out and reported to Trust Board                                                         |  |  |
|                                                                                                                                                         |                                                                                                                                                 |                              | Sep-10 |                                                                                                                 |  |  |
|                                                                                                                                                         |                                                                                                                                                 |                              | Dec-10 |                                                                                                                 |  |  |
|                                                                                                                                                         |                                                                                                                                                 |                              | Mar-11 |                                                                                                                 |  |  |
|                                                                                                                                                         | b. Review continence and catheter policies documentation and revise where necessary                                                             | Joanna Davies/<br>Wendy Hurn | Jul-10 | Revised policies and documentation are on DMS and implemented in practice                                       |  |  |
|                                                                                                                                                         | c. Implement programme of education/awareness for catheter insertion and management                                                             | Joanna Davies/<br>Wendy Hurn | Jul-10 | There is a planned programme of education with evidence of staff attendance                                     |  |  |
|                                                                                                                                                         | d. Saving Lives high impact intervention for urinary catheters is fully implemented and monitored                                               | Matrons                      | Jun-10 | More than 90% of ward areas have completed monitoring and results Trust-wide are over 95%                       |  |  |
|                                                                                                                                                         |                                                                                                                                                 |                              | Sep-10 |                                                                                                                 |  |  |
|                                                                                                                                                         |                                                                                                                                                 |                              | Dec-10 |                                                                                                                 |  |  |
|                                                                                                                                                         |                                                                                                                                                 |                              | Mar-11 |                                                                                                                 |  |  |
|                                                                                                                                                         | e. Implement a system for alerts or reminders to identify all patients with urinary catheters and assess the need for continued catheterisation | Joanna Davies/<br>Wendy Hurn | Jul-10 | Patient ward and board rounds will include consideration of all patients with catheters regarding continued use |  |  |
|                                                                                                                                                         | f. Develop guidelines for nurse removal of unnecessary urinary catheters                                                                        | Joanna Davies/<br>Wendy Hurn | Jul-10 | Nurse led removal is included in revised policy                                                                 |  |  |

|                                                                                                               |                                                                                                                                             |                                                                                 |        |                                                                                                                                                 |  |  |
|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 15. Address areas of infection control concern within the annual staff survey and improve on all other scores | a. Implement a hand hygiene awareness campaign to coincide with Global hand hygiene day October 2010 to include staff patients and visitors | Joanna Davies                                                                   | Oct-10 | Awareness campaign carried out and staff survey 2010 demonstrates improved scores for promotion of hand hygiene to staff, patients and visitors |  |  |
|                                                                                                               | b. Introduce personal carried alcohol hand gels for all transient clinical staff                                                            | Joanna Davies                                                                   | May-10 | Transient staff have full access to personal carried gels.                                                                                      |  |  |
|                                                                                                               |                                                                                                                                             |                                                                                 | Mar-11 | The score for availability of hand hygiene products for transient staff has improved in the 2010 staff survey                                   |  |  |
|                                                                                                               | c. Update all hospital entrance signage regarding hand hygiene                                                                              | Chris Perry                                                                     | Jun-10 | New signage is in place at all entrances                                                                                                        |  |  |
|                                                                                                               | d. Implement multi-media hand hygiene facilities and information at ward entrances staged in accordance with current ward upgrade programme | Chris Perry                                                                     | Jun-10 | A standard entrance design is agreed with Matrons and implemented in accordance with planned roll out                                           |  |  |
|                                                                                                               |                                                                                                                                             |                                                                                 | Sep-10 |                                                                                                                                                 |  |  |
|                                                                                                               |                                                                                                                                             |                                                                                 | Dec-10 |                                                                                                                                                 |  |  |
|                                                                                                               |                                                                                                                                             |                                                                                 | Mar-11 |                                                                                                                                                 |  |  |
|                                                                                                               | e. Implement a planned programme of monthly hand hygiene awareness activity by infection control link staff                                 | Joanna Davies for programme and resources Matrons for link nurse implementation | Jun-10 | Activities are implemented in line with planned programme across each Division with confirmation reported to infection control committee        |  |  |
|                                                                                                               |                                                                                                                                             |                                                                                 | Sep-11 |                                                                                                                                                 |  |  |
|                                                                                                               |                                                                                                                                             |                                                                                 | Dec-10 |                                                                                                                                                 |  |  |
|                                                                                                               |                                                                                                                                             |                                                                                 | Mar-11 |                                                                                                                                                 |  |  |

### 1.1 – *Clostridium difficile* performance against target April 2009 – March 2010 to. Figure 1

#### *Clostridium difficile* (post): UH Bristol Cumulative April 2009 - March 2010



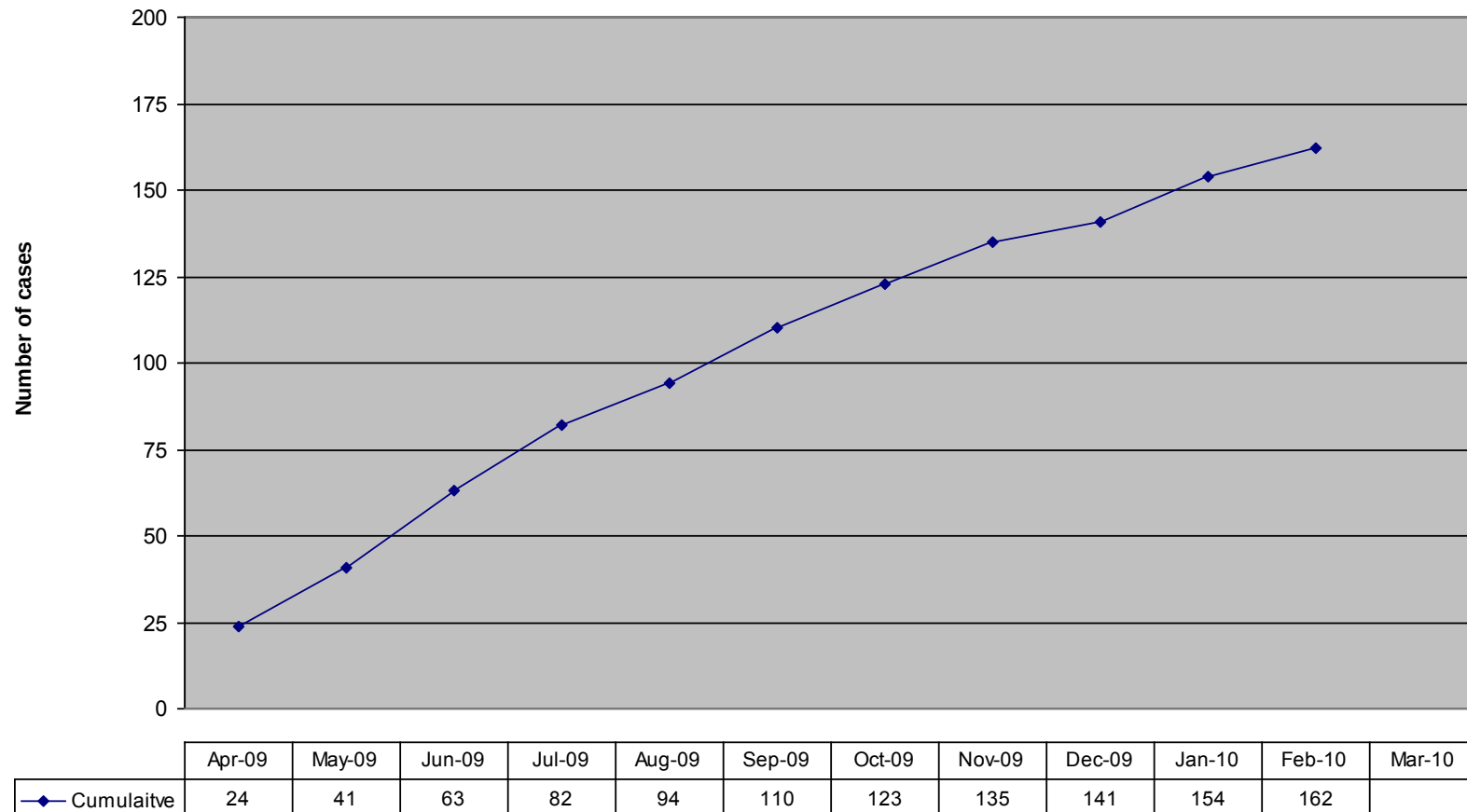
|                           | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| —▲— Cdiff National Target | 21     | 42     | 63     | 84     | 103    | 120    | 138    | 157    | 178    | 199    | 220    | 241    |
| —■— Cdiff Actuals         | 17     | 28     | 40     | 51     | 55     | 66     | 72     | 76     | 78     | 84     | 90     |        |
| —▲— Cdiff Stretch Target  | 18     | 36     | 52     | 68     | 83     | 97     | 111    | 126    | 142    | 158    | 176    | 194    |
| —x— Cdiff Internal Target | 17     | 33     | 48     | 62     | 76     | 90     | 104    | 118    | 133    | 148    | 163    | 180    |

The target for *Clostridium difficile* is based on the number of positive samples from in-patients, excluding those positive within 2 days of admission. Specimens from the same patient that are positive 28 days after the previous positive are counted as a new cases.



1.1 – *Clostridium difficile* cases reported for UHBFT April 2009 to March 2010. Figure 2

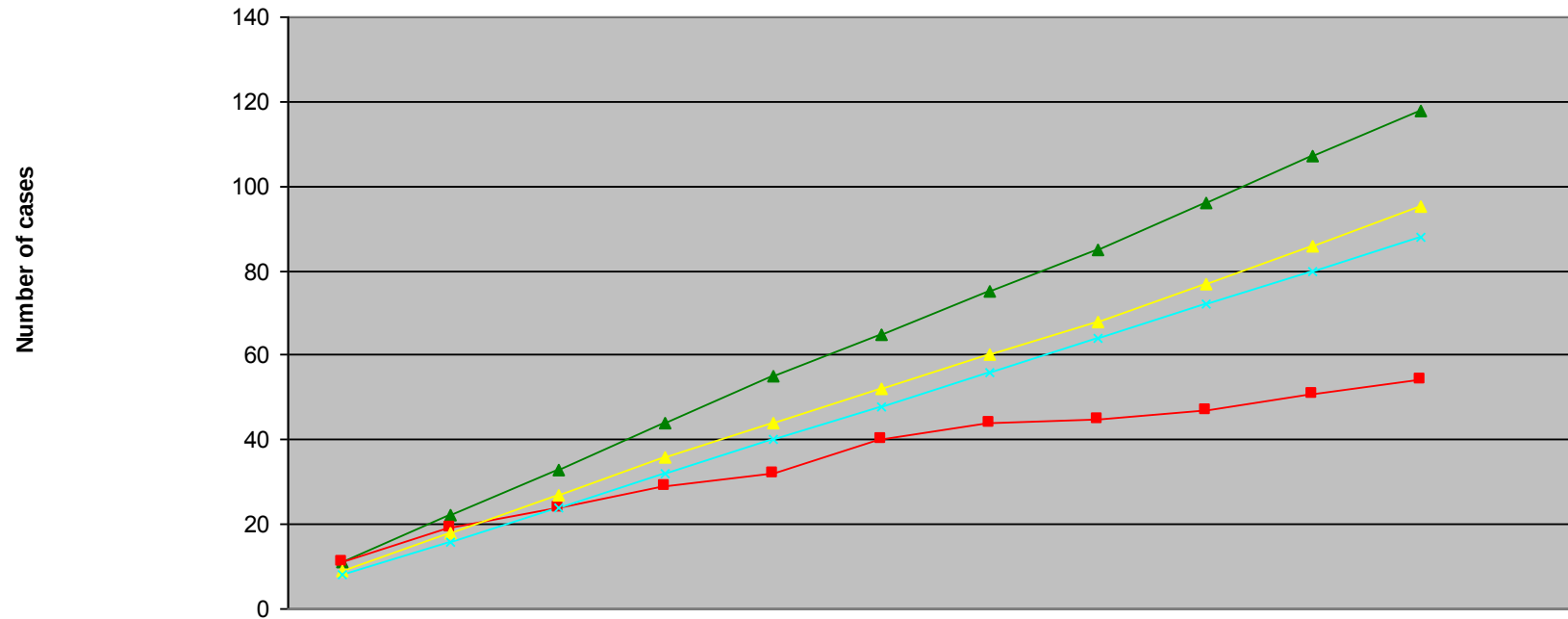
***Clostridium difficile* : Pre and Post Cumulative  
April 2009 - March 2010**



The national target excludes cases of *C. difficile* in outpatients and frequent attenders, as well as in-patients who are positive on the day of admission or the day following the day of admission. This information is provided to the Board for monitoring of cases that do not meet the criteria for target inclusion.

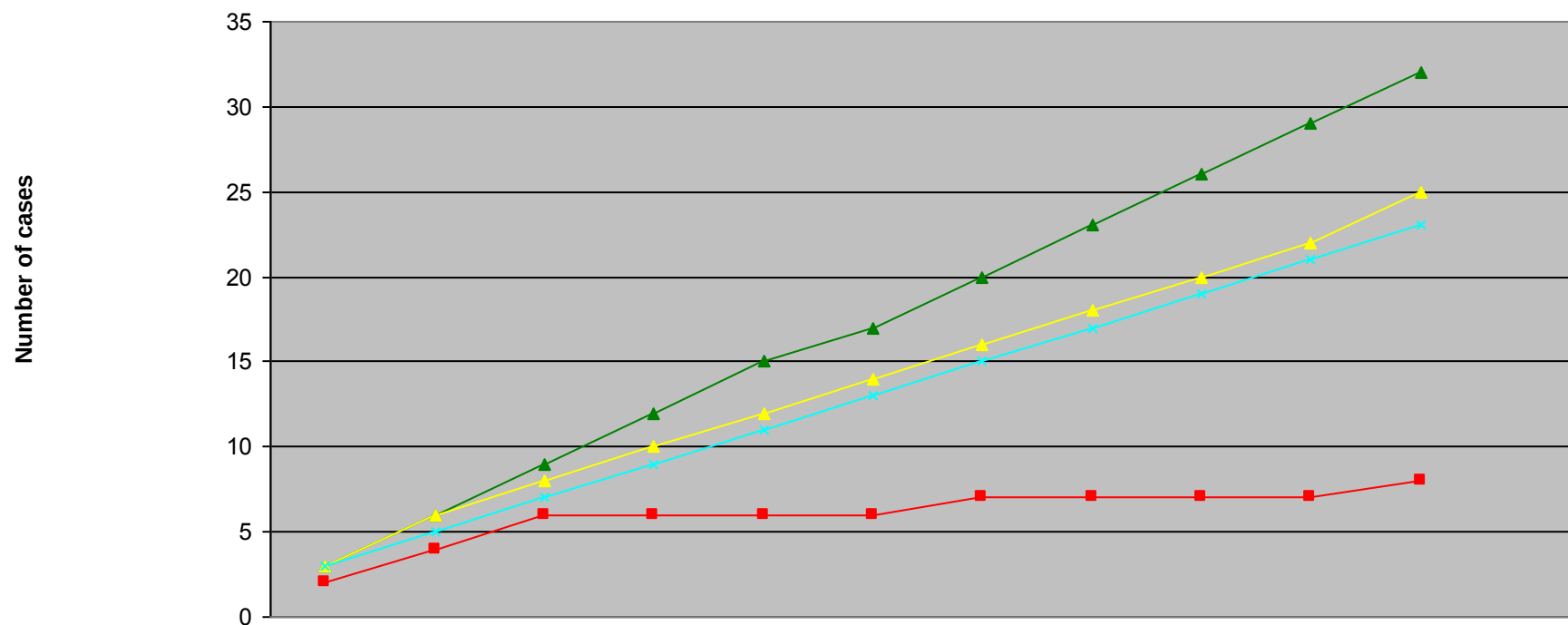
Figure 1.2 – *Clostridium difficile* performance against target by Division April 2009 – March 2010. Figures 3-6

***Clostridium difficile* (post) : Medicine**  
**Cumulative April 2009 - March 2010**



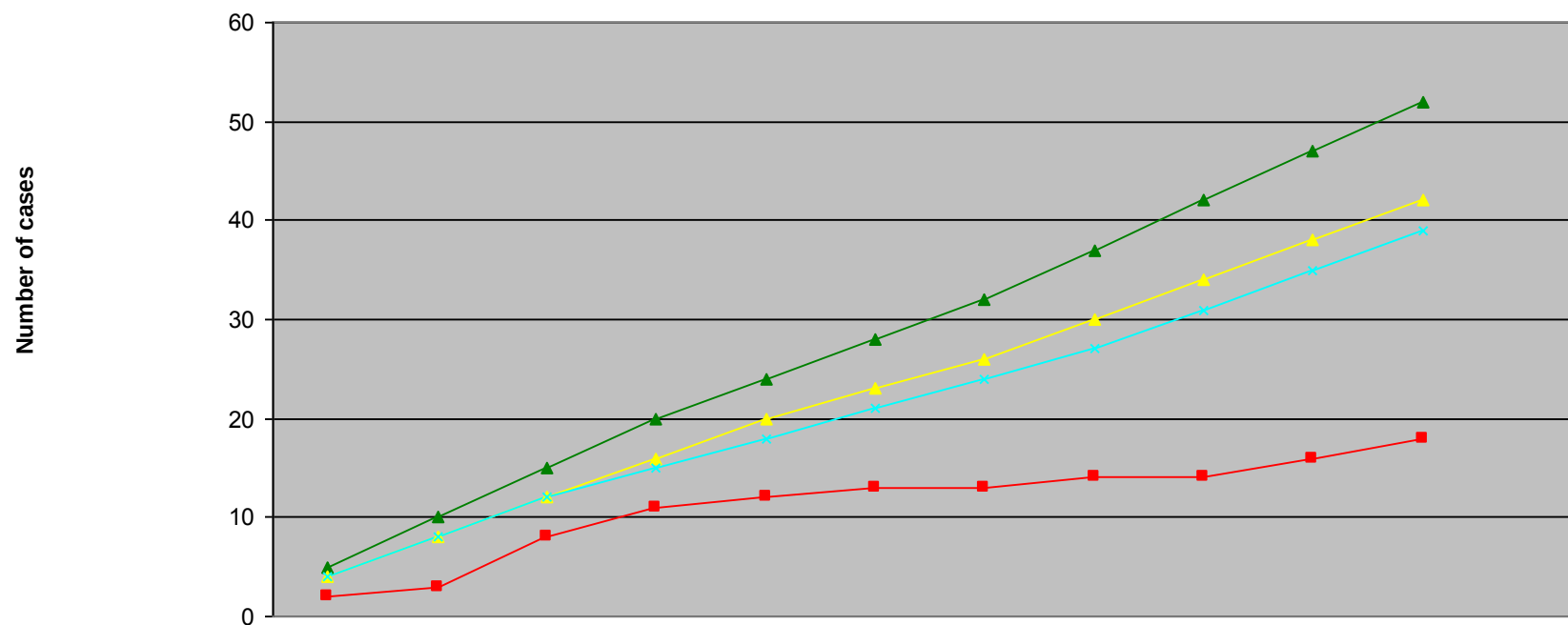
|                           | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| —▲— Cdiff National Target | 11     | 22     | 33     | 44     | 55     | 65     | 75     | 85     | 96     | 107    | 118    |        |
| —■— Cdiff Actuals         | 11     | 19     | 24     | 29     | 32     | 40     | 44     | 45     | 47     | 51     | 54     |        |
| —▲— Cdiff Stretch Target  | 9      | 18     | 27     | 36     | 44     | 52     | 60     | 68     | 77     | 86     | 95     |        |
| —×— Cdiff Internal Target | 8      | 16     | 24     | 32     | 40     | 48     | 56     | 64     | 72     | 80     | 88     |        |

# ***Clostridium difficile* (post) : Specialised Services** **Cumulative April 2009 - March 2010**



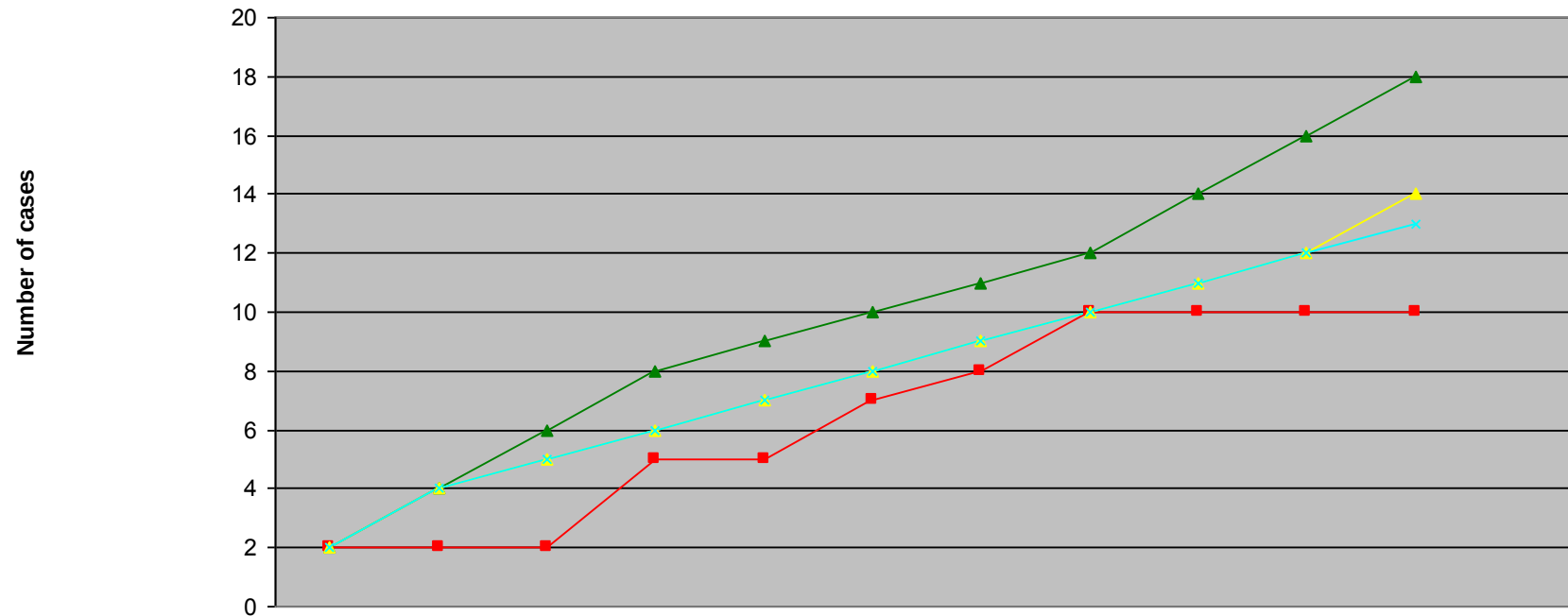
|                           | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| —▲— Cdiff National Target | 3      | 6      | 9      | 12     | 15     | 17     | 20     | 23     | 26     | 29     | 32     |        |
| —■— Cdiff Actuals         | 2      | 4      | 6      | 6      | 6      | 6      | 7      | 7      | 7      | 7      | 8      |        |
| —▲— Cdiff Stretch Target  | 3      | 6      | 8      | 10     | 12     | 14     | 16     | 18     | 20     | 22     | 25     |        |
| —x— Cdiff Internal Target | 3      | 5      | 7      | 9      | 11     | 13     | 15     | 17     | 19     | 21     | 23     |        |

# ***Clostridium difficile* (post) : Surgery, Head & Neck** **Cumulative April 2009 - March 2010**



|                           | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| —▲— Cdiff National Target | 5      | 10     | 15     | 20     | 24     | 28     | 32     | 37     | 42     | 47     | 52     |        |
| —■— Cdiff Actuals         | 2      | 3      | 8      | 11     | 12     | 13     | 13     | 14     | 14     | 16     | 18     |        |
| —▲— Cdiff Stretch Target  | 4      | 8      | 12     | 16     | 20     | 23     | 26     | 30     | 34     | 38     | 42     |        |
| —×— Cdiff Internal Target | 4      | 8      | 12     | 15     | 18     | 21     | 24     | 27     | 31     | 35     | 39     |        |

***Clostridium difficile* (post) : Womens & Childrens**  
**Cumulative April 2009 - March 2010**



|                         | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 |
|-------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| ▲ Cdiff National Target | 2      | 4      | 6      | 8      | 9      | 10     | 11     | 12     | 14     | 16     | 18     |        |
| ■ Cdiff Actuals         | 2      | 2      | 2      | 5      | 5      | 7      | 8      | 10     | 10     | 10     | 10     |        |
| ▲ Cdiff Stretch Target  | 2      | 4      | 5      | 6      | 7      | 8      | 9      | 10     | 11     | 12     | 14     |        |
| × Cdiff Internal Target | 2      | 4      | 5      | 6      | 7      | 8      | 9      | 10     | 11     | 12     | 13     |        |

### 1.3 *Clostridium difficile* comparative data January 2010 – figures 7 and 8

**Figure 7 – comparative data for Trusts in NHS South West**

| <b>Trust Name</b>                              | <b>Trust apportioned<br/>CDI Jan 10</b> | <b>Rate per 1 000<br/>admissions*</b> |
|------------------------------------------------|-----------------------------------------|---------------------------------------|
| Royal National Hospital for Rheumatic Diseases | 0                                       | 0.00                                  |
| Weston Area Health                             | 0                                       | 0.00                                  |
| Salisbury                                      | 1                                       | 0.07                                  |
| South Devon Healthcare                         | 1                                       | 0.09                                  |
| Northern Devon Healthcare                      | 1                                       | 0.10                                  |
| University Hospitals Bristol                   | 6                                       | 0.26                                  |
| Plymouth Hospitals                             | 7                                       | 0.28                                  |
| Poole Hospital                                 | 5                                       | 0.29                                  |
| Royal Cornwall Hospitals                       | 6                                       | 0.31                                  |
| The Royal Bournemouth & Christchurch Hospitals | 10                                      | 0.46                                  |
| Great Western Hospitals                        | 7                                       | 0.46                                  |
| Royal Devon & Exeter                           | 10                                      | 0.50                                  |
| Gloucestershire Hospitals                      | 17                                      | 0.53                                  |
| Dorset County Hospital                         | 6                                       | 0.56                                  |
| Yeovil District Hospital                       | 5                                       | 0.59                                  |
| North Bristol                                  | 21                                      | 0.65                                  |
| Taunton & Somerset                             | 11                                      | 0.76                                  |
| Royal United Hospital Bath                     | 17                                      | 0.90                                  |

\*Admission data derived from Health Protection Agency published mandatory surveillance data.

**Figure 8 – Comparative data for English Teaching Trusts**

| <b>Trust Name</b>                                 | <b>Trust apportioned<br/>CDI Jan 10</b> | <b>Rate per 1 000<br/>admissions*</b> |
|---------------------------------------------------|-----------------------------------------|---------------------------------------|
| Chelsea & Westminster Hospital                    | 1                                       | 0.10                                  |
| St. George's Healthcare                           | 3                                       | 0.13                                  |
| Southampton University Hospitals                  | 5                                       | 0.16                                  |
| Guy's & St. Thomas'                               | 5                                       | 0.20                                  |
| King's College Hospital                           | 6                                       | 0.24                                  |
| University Hospitals Bristol                      | 6                                       | 0.26                                  |
| Plymouth Hospitals                                | 7                                       | 0.28                                  |
| University College London Hospitals               | 6                                       | 0.29                                  |
| Sheffield Teaching Hospitals                      | 16                                      | 0.30                                  |
| Central Manchester University Hospitals           | 9                                       | 0.32                                  |
| Royal Free Hampstead                              | 6                                       | 0.34                                  |
| University Hospital of South Manchester           | 8                                       | 0.36                                  |
| Cambridge University Hospitals                    | 11                                      | 0.39                                  |
| Salford Royal                                     | 9                                       | 0.43                                  |
| Leeds Teaching Hospitals                          | 25                                      | 0.47                                  |
| University Hospitals of Leicester                 | 24                                      | 0.50                                  |
| Barts & the London                                | 13                                      | 0.51                                  |
| Nottingham University Hospitals                   | 24                                      | 0.54                                  |
| Oxford Radcliffe Hospitals                        | 21                                      | 0.61                                  |
| Imperial College Healthcare                       | 23                                      | 0.62                                  |
| University Hospitals Coventry & Warwickshire      | 19                                      | 0.64                                  |
| University Hospital Birmingham                    | 19                                      | 0.64                                  |
| The Newcastle upon Tyne Hospitals                 | 26                                      | 0.65                                  |
| Royal Liverpool & Broadgreen University Hospitals | 21                                      | 0.79                                  |
| Brighton & Sussex University Hospitals            | 21                                      | 0.97                                  |

\*Admission data derived from Health Protection Agency published mandatory surveillance data.

## 1.4 - Clostridium difficile dashboard. Figure 9

C Diff Dashboard: Division

University Hospitals Bristol



NHS Foundation Trust

|       |                   |
|-------|-------------------|
| Pink  | No Data Submitted |
| Green | 95% to 100%       |
| Amber | 80% to 94%        |
| Red   | 0% to 79%         |

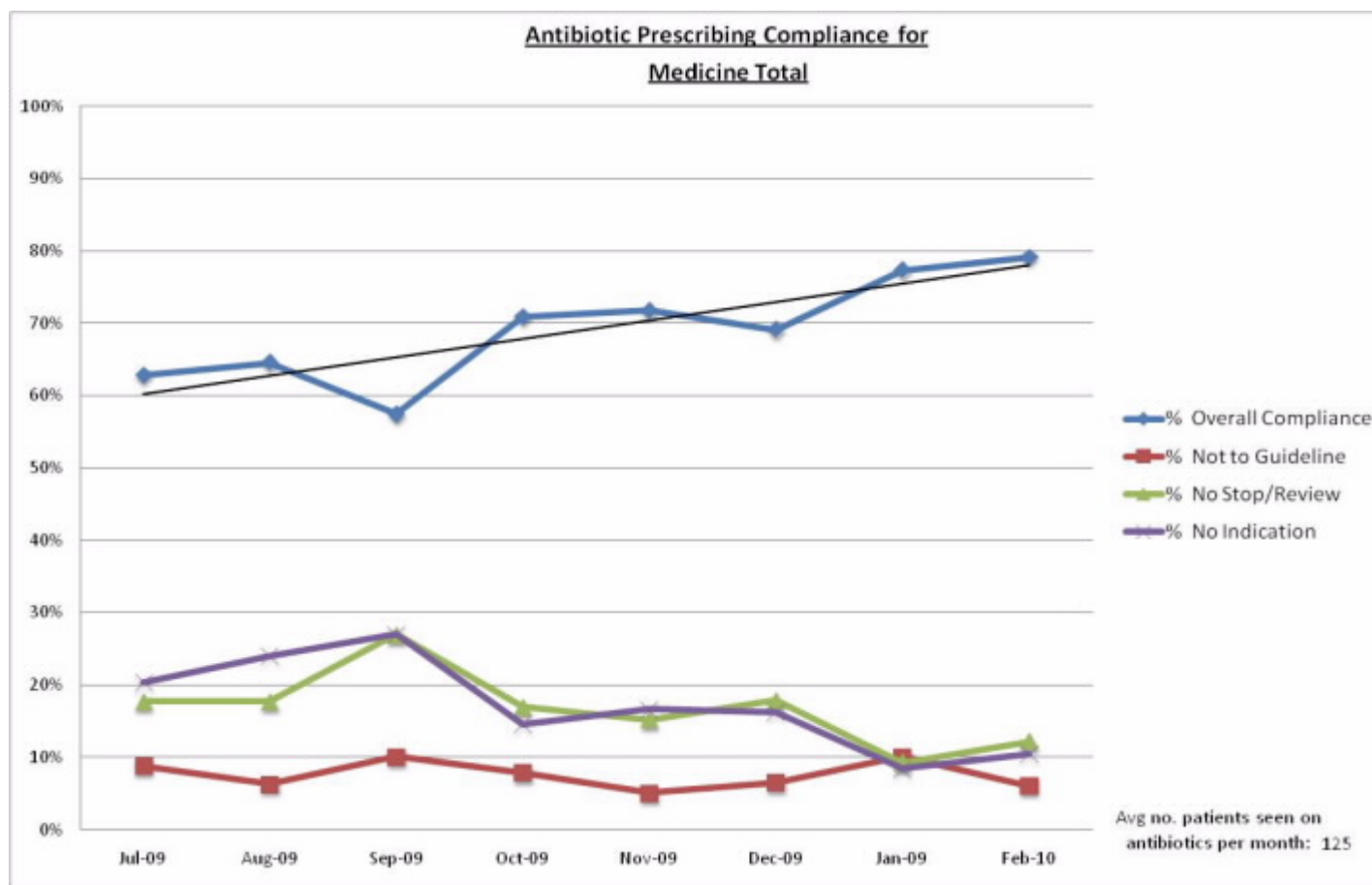
Select Month:

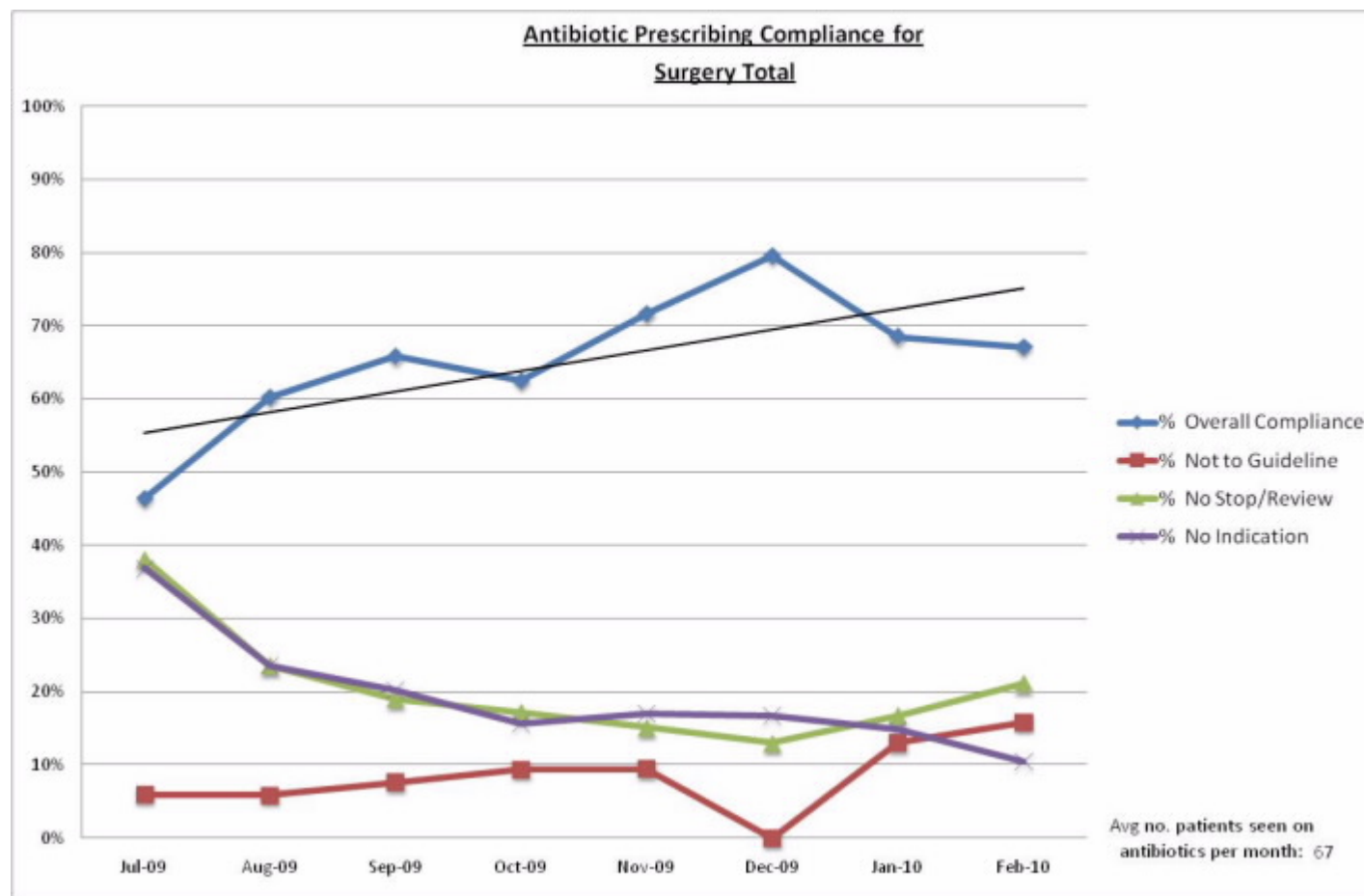
Feb-10

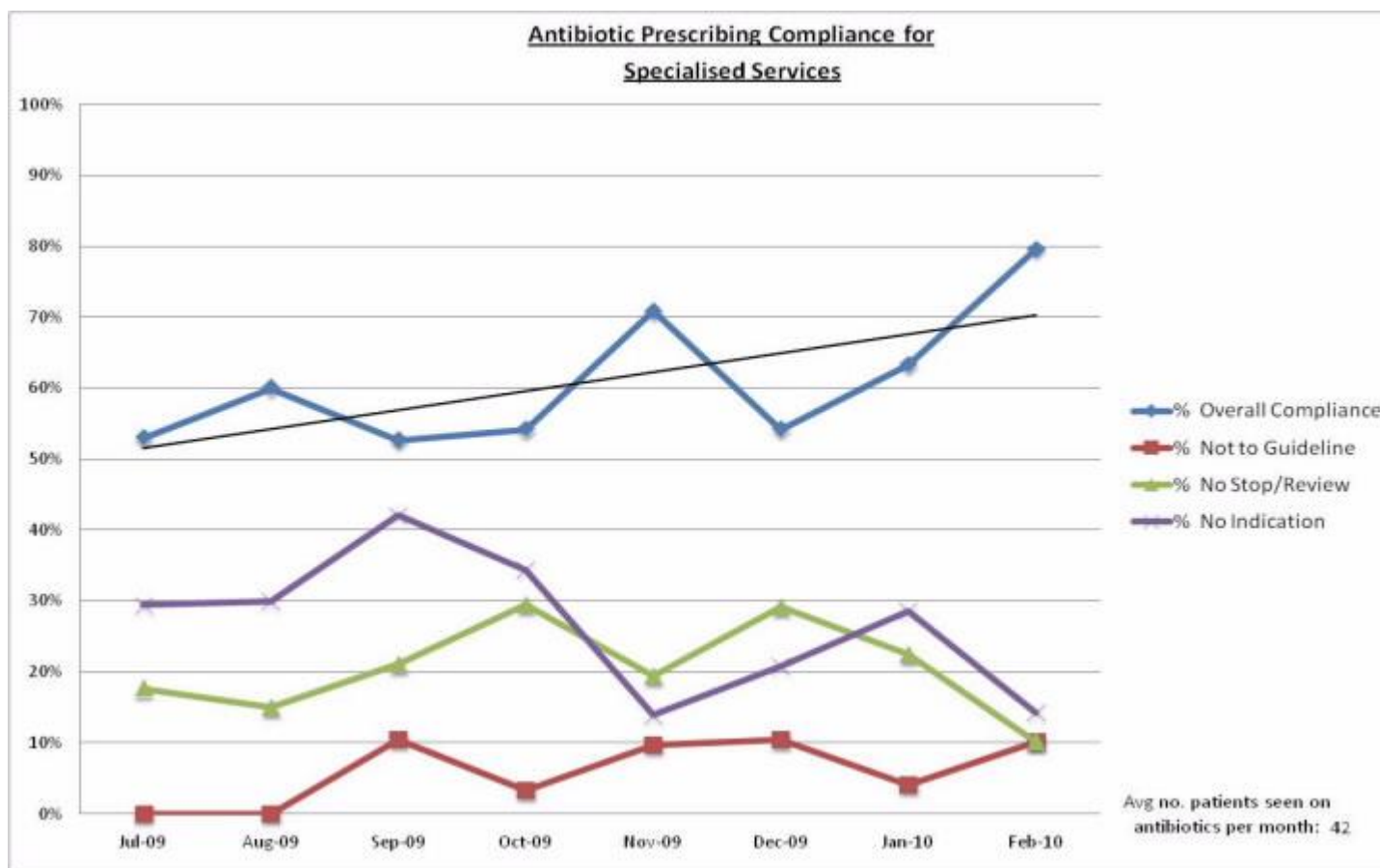
| Hospital                | Ward                      | New C Diff Cases | Hand Hygiene | Hand Hygiene (15 min dash) | Antibiotic Compliance % | No. of Patients on Antibiotics | Matrons Checklist (Cdif dash) | Bristol Stool Chart | Protective Clothing | Isolation | Isolation (Number of Observations) | Toilet and Bathroom Checklist | 4 Hour Isolation | Cleanliness |
|-------------------------|---------------------------|------------------|--------------|----------------------------|-------------------------|--------------------------------|-------------------------------|---------------------|---------------------|-----------|------------------------------------|-------------------------------|------------------|-------------|
| MEDICINE                | 10                        | 0                | 99%          | 90%                        | 88%                     | 26                             | 96%                           | 86%                 | 87%                 | 100%      | 6                                  | 94%                           | 0                | No Data     |
|                         | 11                        | 0                | 93%          | 87%                        | 80%                     | 10                             | 91%                           | 95%                 | 100%                | 100%      | 2                                  | 98%                           | 0                | No Data     |
|                         | 17                        | 0                | 98%          | 86%                        | 75%                     | 8                              | 98%                           | 100%                | 80%                 | 100%      | 2                                  | 93%                           | 0                | No Data     |
|                         | ED                        | 0                | No Data      | No Data                    | -                       | -                              | No Data                       | No Data             | No Data             | No Data   | 5                                  | 99%                           | 0                | 94%         |
|                         | 7 - MAU                   | 0                | No Data      | No Data                    | 57%                     | 7                              | No Data                       | No Data             | No Data             | No Data   | 4                                  | 93%                           | 0                | 90%         |
|                         | 18                        | 0                | No Data      | No Data                    | 57%                     | 7                              | 96%                           | 100%                | -                   | -         | 4                                  | 90%                           | 0                | 84%         |
|                         | 22                        | 0                | 78%          | 50%                        | 50%                     | 2                              | 89%                           | 100%                | 67%                 | -         | -                                  | 99%                           | 0                | 90%         |
|                         | 23                        | 0                | 90%          | 80%                        | 75%                     | 8                              | 96%                           | 100%                | 80%                 | 100%      | 3                                  | 99%                           | 0                | No Data     |
|                         | 24                        | 1                | 93%          | 82%                        | 94%                     | 17                             | 82%                           | 100%                | 67%                 | 67%       | 2                                  | 87%                           | 0                | No Data     |
|                         | 25                        | 0                | No Data      | No Data                    | 34%                     | 8                              | 93%                           | No Data             | 62%                 | 0%        | 0                                  | 84%                           | 0                | No Data     |
|                         | 26                        | 0                | 80%          | 83%                        | 78%                     | 9                              | 98%                           | 89%                 | 79%                 | 50%       | 3                                  | 86%                           | 0                | 91%         |
|                         | 27                        | 0                | 98%          | 95%                        | 59%                     | 2                              | 88%                           | 100%                | 100%                | -         | -                                  | 89%                           | 0                | No Data     |
|                         | 28                        | 0                | 98%          | No Data                    | 86%                     | 7                              | 94%                           | No Data             | 80%                 | 59%       | 1                                  | 92%                           | 0                | No Data     |
|                         | 80                        | 0                | 97%          | 100%                       | -                       | 0                              | 100%                          | 96%                 | 87%                 | 100%      | 1                                  | 92%                           | 0                | No Data     |
|                         | 87                        | 1                | 98%          | 88%                        | -                       | 0                              | 96%                           | 96%                 | 38%                 | 100%      | 1                                  | 100%                          | 0                | No Data     |
|                         | 89                        | 0                | 80%          | 100%                       | -                       | 0                              | 98%                           | 74%                 | 73%                 | 100%      | 1                                  | 100%                          | 0                | No Data     |
|                         | 54                        | 0                | 98%          | No Data                    | 76%                     | 17                             | 98%                           | 98%                 | 78%                 | 67%       | 6                                  | 99%                           | 0                | No Data     |
|                         | SRU                       | 0                | 100%         | 100%                       | 100%                    | 1                              | 90%                           | 92%                 | 33%                 | 100%      | 1                                  | 100%                          | 0                | No Data     |
|                         | Sexual Health             | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | Dermatology               | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | Rheumatology              | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | Clinic 2                  | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | 78%         |
|                         | Clinics Lv 4              | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | 82%         |
| SURGERY, HEAD & NECK    | 2                         | 0                | 98%          | 88%                        | 75%                     | 8                              | 94%                           | 82%                 | 67%                 | 100%      | 1                                  | 80%                           | 0                | No Data     |
|                         | 3                         | 0                | 90%          | 100%                       | No Data                 | No Data                        | 95%                           | 95%                 | 100%                | 100%      | 0                                  | No Data                       | 0                | 95%         |
|                         | 4                         | 0                | 99%          | 100%                       | 75%                     | 1                              | 100%                          | 92%                 | 11%                 | 0%        | 0                                  | 97%                           | 0                | 95%         |
|                         | 6                         | 0                | 99%          | 100%                       | 67%                     | 9                              | 92%                           | 100%                | 33%                 | 0%        | 0                                  | 99%                           | 0                | No Data     |
|                         | 9                         | 0                | 85%          | 50%                        | 53%                     | 17                             | 90%                           | 100%                | 57%                 | -         | -                                  | 91%                           | 0                | No Data     |
|                         | 12                        | 0                | 90%          | No Data                    | 67%                     | 6                              | 94%                           | 100%                | 25%                 | -         | -                                  | 97%                           | 0                | No Data     |
|                         | 14                        | 0                | 99%          | 93%                        | 72%                     | 18                             | 90%                           | 92%                 | 50%                 | 75%       | 3                                  | 99%                           | 0                | No Data     |
|                         | 15                        | 0                | 97%          | No Data                    | 53%                     | 19                             | 98%                           | 93%                 | 40%                 | -         | No Data                            | 91%                           | 0                | 86%         |
|                         | 41                        | 0                | 98%          | 100%                       | No Data                 | No Data                        | 94%                           | No Data             | 67%                 | 0%        | 0                                  | No Data                       | 0                | No Data     |
|                         | 72                        | 0                | No Data      | 86%                        | No Data                 | No Data                        | 100%                          | 48%                 | 38%                 | 100%      | 5                                  | 99%                           | 0                | No Data     |
|                         | POA BRI                   | 0                | -            | -                          | -                       | -                              | 100%                          | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | Theatres STMH             | 0                | -            | -                          | -                       | -                              | 83%                           | -                   | -                   | -         | -                                  | -                             | 0                | 96%         |
|                         | Theatres HGT              | 0                | -            | -                          | -                       | -                              | -                             | -                   | -                   | -         | -                                  | -                             | 0                | 95%         |
|                         | Theatres BDH              | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | 98%         |
|                         | Theatres BEH              | 0                | -            | -                          | -                       | -                              | 74%                           | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | QDU                       | 0                | -            | -                          | -                       | -                              | 74%                           | -                   | -                   | -         | -                                  | -                             | 0                | 80%         |
|                         | Recovery                  | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | SAS                       | 0                | -            | -                          | -                       | -                              | 88%                           | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | ENT OPD                   | 0                | -            | -                          | -                       | -                              | 72%                           | -                   | -                   | -         | -                                  | -                             | 0                | 92%         |
|                         | BEH OPD                   | 0                | -            | -                          | -                       | -                              | 93%                           | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | BEH POA                   | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | BEH A&E                   | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | BDH Ground Floor          | 0                | -            | -                          | -                       | -                              | 100%                          | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | Child Dental Health       | 0                | -            | -                          | -                       | -                              | 96%                           | -                   | -                   | -         | -                                  | -                             | 0                | 85%         |
| SPECIALISED SERVICES    | 51                        | 0                | 99%          | 84%                        | 100%                    | 9                              | 96%                           | 94%                 | No Data             | No Data   | 0                                  | 96%                           | 0                | No Data     |
|                         | 52                        | 0                | No Data      | No Data                    | -                       | 10                             | 90%                           | 94%                 | 89%                 | 100%      | 1                                  | 97%                           | 0                | No Data     |
|                         | 53                        | 0                | No Data      | 100%                       | 83%                     | 12                             | No Data                       | No Data             | No Data             | No Data   | 0                                  | 99%                           | 0                | 95%         |
|                         | 61                        | 0                | 98%          | 100%                       | 83%                     | 6                              | 94%                           | 92%                 | 55%                 | 83%       | 10                                 | 100%                          | 0                | 99%         |
|                         | 62                        | 0                | 98%          | 100%                       | 75%                     | 16                             | 92%                           | 92%                 | 50%                 | 100%      | 3                                  | 100%                          | 0                | 97%         |
|                         | CICU                      | 0                | 100%         | 100%                       | -                       | -                              | 92%                           | 96%                 | 63%                 | 100%      | 1                                  | 84%                           | 0                | 95%         |
|                         | CCU                       | 0                | 93%          | 89%                        | -                       | -                              | 100%                          | 100%                | No Data             | No Data   | 0                                  | 99%                           | 0                | 92%         |
|                         | CCL                       | 0                | -            | -                          | -                       | -                              | 97%                           | -                   | -                   | -         | -                                  | -                             | 0                | 95%         |
|                         | BHI OPD                   | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | BHOC OPD                  | 0                | -            | -                          | -                       | -                              | 100%                          | -                   | -                   | -         | -                                  | -                             | 0                | 100%        |
| WOMEN'S & CHILDREN'S    | 31                        | 0                | 97%          | 80%                        | 11%                     | 9                              | 100%                          | 23%                 | 100%                | 100%      | 4                                  | 97%                           | 0                | 93%         |
|                         | 32                        | 0                | 100%         | No Data                    | 50%                     | 2                              | No Data                       | No Data             | No Data             | No Data   | 0                                  | 100%                          | 0                | No Data     |
|                         | 33                        | 0                | 98%          | 100%                       | 67%                     | 15                             | 98%                           | 100%                | 100%                | 100%      | 4                                  | 100%                          | 0                | No Data     |
|                         | 34                        | 0                | 98%          | 100%                       | 75%                     | 8                              | 98%                           | 93%                 | 100%                | 100%      | 3                                  | 100%                          | 0                | 92%         |
|                         | 35                        | 0                | 98%          | No Data                    | 66%                     | 13                             | No Data                       | 67%                 | No Data             | No Data   | 0                                  | 99%                           | 0                | No Data     |
|                         | 37                        | 0                | 98%          | 100%                       | 100%                    | 1                              | 98%                           | 67%                 | 100%                | 100%      | 2                                  | 99%                           | 0                | No Data     |
|                         | 38                        | 0                | 94%          | 100%                       | 50%                     | 20                             | 96%                           | 86%                 | 100%                | 100%      | 6                                  | 95%                           | 0                | No Data     |
|                         | 39                        | 0                | 100%         | 100%                       | -                       | -                              | 100%                          | -                   | 100%                | 100%      | 2                                  | No Data                       | 0                | No Data     |
|                         | 71                        | 0                | 100%         | 100%                       | No Data                 | No Data                        | 100%                          | 100%                | 67%                 | 100%      | 3                                  | 99%                           | 0                | 96%         |
|                         | 74                        | 0                | 96%          | 100%                       | No Data                 | No Data                        | 100%                          | 83%                 | 80%                 | 100%      | 4                                  | 96%                           | 0                | 96%         |
|                         | 75                        | 0                | 96%          | 96%                        | No Data                 | No Data                        | 92%                           | -                   | 62%                 | 100%      | 2                                  | 93%                           | 0                | No Data     |
|                         | 76                        | 0                | 93%          | 100%                       | No Data                 | No Data                        | 100%                          | 100%                | 80%                 | 100%      | 3                                  | 99%                           | 0                | 100%        |
|                         | 77                        | 0                | 95%          | 100%                       | No Data                 | No Data                        | No Data                       | -                   | 0%                  | 0%        | No Data                            | No Data                       | 0                | No Data     |
|                         | 78                        | 0                | 98%          | 90%                        | No Data                 | No Data                        | 92%                           | 89%                 | 96%                 | 80%       | 4                                  | 96%                           | 0                | No Data     |
|                         | BMTD                      | 0                | 99%          | 100%                       | -                       | -                              | 100%                          | 100%                | 100%                | 100%      | -                                  | No Data                       | 0                | No Data     |
|                         | BMT                       | 0                | 99%          | 100%                       | -                       | No Data                        | 98%                           | 100%                | 100%                | 100%      | 4                                  | 98%                           | 0                | No Data     |
|                         | CIU                       | 0                | -            | -                          | -                       | -                              | 97%                           | -                   | -                   | -         | -                                  | -                             | 0                | 92%         |
|                         | Theatres BCH              | 0                | -            | -                          | -                       | -                              | 83%                           | -                   | -                   | -         | -                                  | -                             | 0                | 93%         |
|                         | 390                       | 0                | -            | -                          | -                       | -                              | No Data                       | -                   | -                   | -         | -                                  | -                             | 0                | 97%         |
|                         | BCH OPD/Audiology         | 0                | -            | -                          | -                       | -                              | 100%                          | -                   | -                   | -         | -                                  | -                             | 0                | No Data     |
|                         | ITU                       | 0                | 99%          | 83%                        | No Data                 | No Data                        | 100%                          | 100%                | 70%                 | 100%      | 3                                  | 100%                          | 0                | No Data     |
| DIAGNOSTICS & THERAPIES | BRI-Radiology Level 2 A   | -                | 98%          | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | BRI-Radiology Level 2 B   | -                | No Data      | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | BRI-Radiology Level 2 C   | -                | No Data      | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | BRI-Radiology Level 2 D   | -                | No Data      | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | BRI-Radiology Level 2 E   | -                | 99%          | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | BRI-Radiology Level 2 F   | -                | 100%         | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | BRI-Radiology Level 2 MRI | -                | No Data      | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | 83%         |
|                         | BRI-Radiology Level 3     | -                | No Data      | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | 97%                           | 0                | 83%         |
|                         | BCH-Radiology             | -                | No Data      | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | BGH-Radiology             | -                | No Data      | 100%                       | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | Physio Hand Clinic        | -                | No Data      | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | Physio Hydro pool         | -                | No Data      | No Data                    | -                       | -                              | No Data                       | -                   | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |
|                         | Physio                    | -                | No Data      | No Data                    | -                       | -                              | No Data                       | No Data             | No Data             | No Data   | No Data                            | 94%                           | 0                | No Data     |
|                         | Central Health Clinic     | -                | No Data      | No Data                    | -                       | -                              | No Data                       | No Data             | No Data             | No Data   | No Data                            | No Data                       | 0                | No Data     |



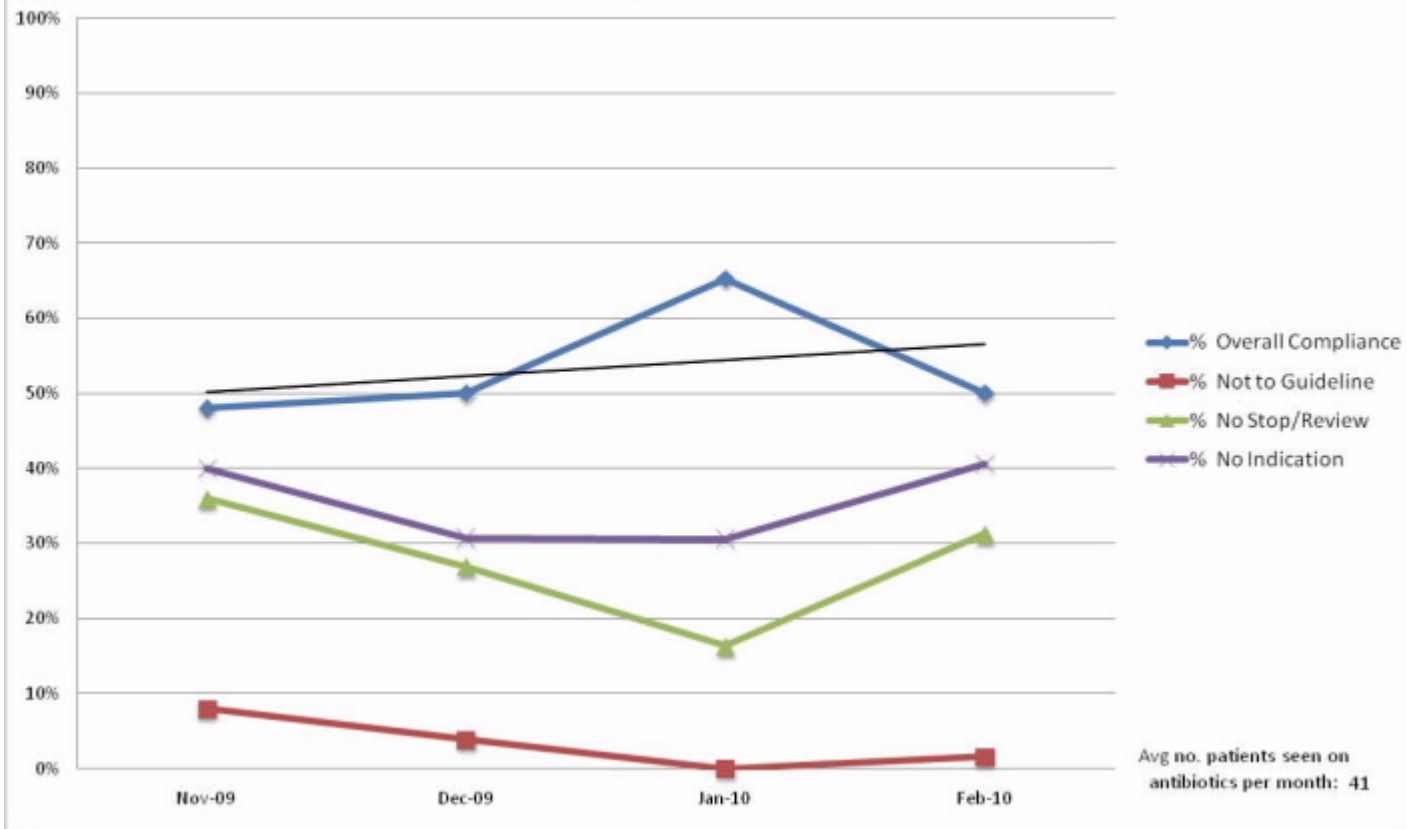
1.5. Antibiotic prescribing compliance. Figures 10-13.





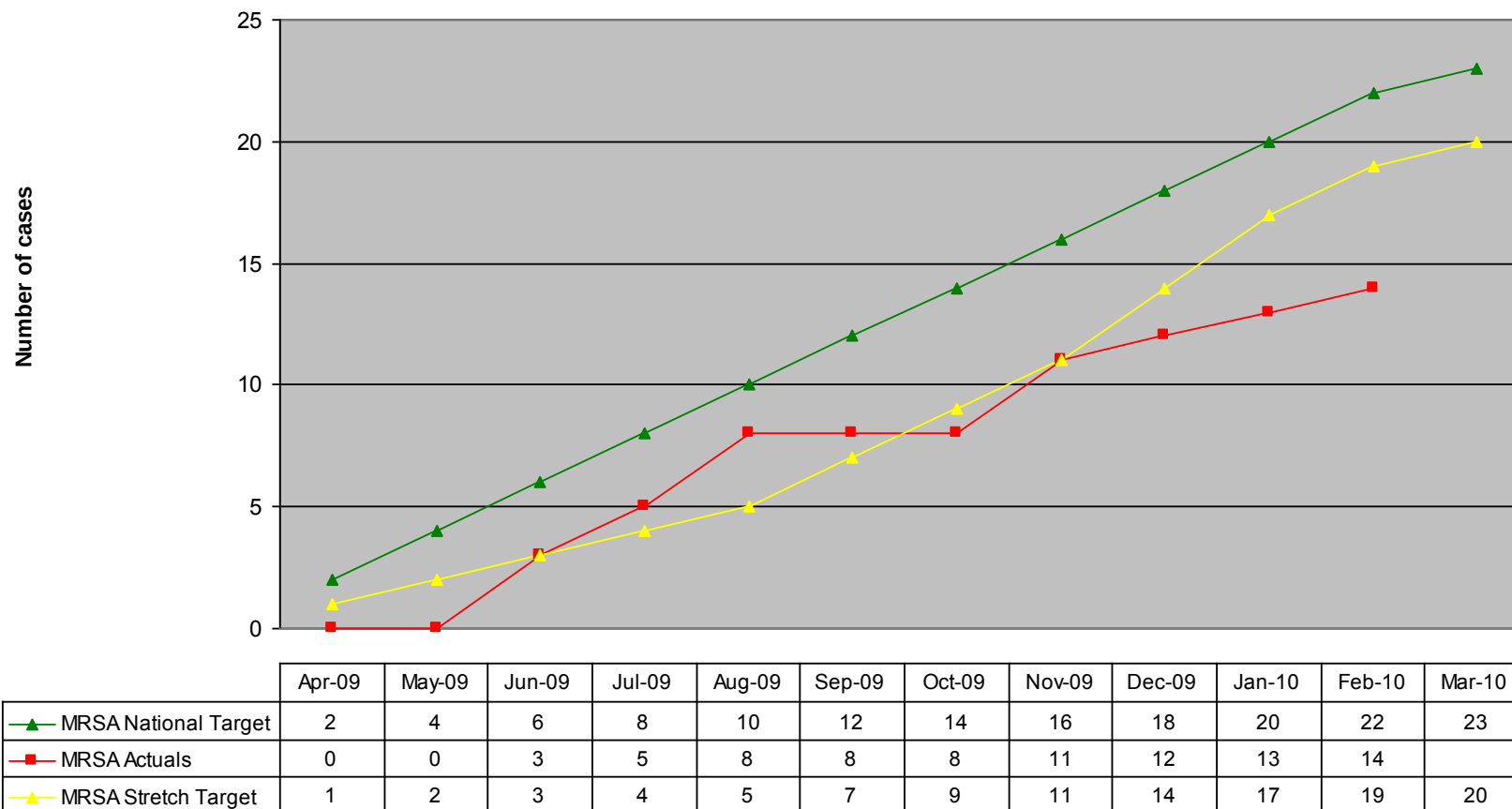


Antibiotic Prescribing Compliance for  
Women & Children



## 2.1 – MRSA bacteraemias performance against target – Figure 14

### MRSA: UH Bristol April 2009 - March 2010



## 2.2 - MRSA bacteraemia comparative data November 2009 to January 2010 – figures 15 and 16

**Figure 15 – MRSA bacteraemia comparative data for Trusts in NHS South West**

| <b>Trust Name</b>                              | <b>Total MRSA<br/>Nov 09 - Jan<br/>10</b> | <b>Rate per 10<br/>000 bed<br/>days*</b> |
|------------------------------------------------|-------------------------------------------|------------------------------------------|
| Royal Cornwall Hospitals                       | 0                                         | 0.00                                     |
| Royal National Hospital for Rheumatic Diseases | 0                                         | 0.00                                     |
| Salisbury                                      | 0                                         | 0.00                                     |
| The Royal Bournemouth & Christchurch Hospitals | 0                                         | 0.00                                     |
| Royal Devon & Exeter                           | 1                                         | 0.16                                     |
| Gloucestershire Hospitals                      | 2                                         | 0.20                                     |
| Great Western Hospitals                        | 1                                         | 0.21                                     |
| Plymouth Hospitals                             | 2                                         | 0.26                                     |
| South Devon Healthcare                         | 1                                         | 0.29                                     |
| Northern Devon Healthcare                      | 1                                         | 0.32                                     |
| Poole Hospital                                 | 2                                         | 0.38                                     |
| Taunton & Somerset                             | 2                                         | 0.47                                     |
| Dorset County Hospital                         | 2                                         | 0.64                                     |
| University Hospitals Bristol                   | 5                                         | 0.67                                     |
| Yeovil District Hospital                       | 2                                         | 0.75                                     |
| Weston Area Health                             | 2                                         | 0.81                                     |
| North Bristol                                  | 7                                         | 0.82                                     |
| Royal United Hospital Bath                     | 5                                         | 0.85                                     |

\*Bed day data derived from Health Protection Agency published mandatory surveillance data.

**Figure 16 – MRSA bacteraemia comparative data for English Teaching Trusts**

| <b>Trust Name</b>                                 | <b>Total MRSA<br/>Nov 09 -<br/>Jan 10</b> | <b>Rate per 10<br/>000 bed<br/>days*</b> |
|---------------------------------------------------|-------------------------------------------|------------------------------------------|
| University Hospital of South Manchester           | 1                                         | 0.15                                     |
| Plymouth Hospitals                                | 2                                         | 0.26                                     |
| Sheffield Teaching Hospitals                      | 5                                         | 0.30                                     |
| Central Manchester University Hospitals           | 3                                         | 0.33                                     |
| University Hospitals Coventry & Warwickshire      | 3                                         | 0.33                                     |
| Royal Free Hampstead                              | 2                                         | 0.34                                     |
| University Hospital Birmingham                    | 3                                         | 0.34                                     |
| The Newcastle upon Tyne Hospitals                 | 5                                         | 0.40                                     |
| University Hospitals of Leicester                 | 6                                         | 0.41                                     |
| St. George's Healthcare                           | 3                                         | 0.42                                     |
| Brighton & Sussex University Hospitals            | 3                                         | 0.44                                     |
| Chelsea & Westminster Hospital                    | 2                                         | 0.47                                     |
| Barts & the London                                | 4                                         | 0.48                                     |
| Royal Liverpool & Broadgreen University Hospitals | 4                                         | 0.51                                     |
| Guy's & St. Thomas'                               | 4                                         | 0.52                                     |
| Southampton University Hospitals                  | 5                                         | 0.54                                     |
| Salford Royal                                     | 4                                         | 0.58                                     |
| Nottingham University Hospitals                   | 8                                         | 0.58                                     |
| Cambridge University Hospitals                    | 5                                         | 0.59                                     |
| University College London Hospitals               | 4                                         | 0.63                                     |
| University Hospitals Bristol                      | 5                                         | 0.67                                     |
| Leeds Teaching Hospitals                          | 12                                        | 0.74                                     |
| King's College Hospital                           | 6                                         | 0.77                                     |
| Oxford Radcliffe Hospitals                        | 9                                         | 0.90                                     |
| Imperial College Healthcare                       | 12                                        | 1.08                                     |

\*Bed day data derived from Health Protection Agency published mandatory surveillance data.

## 2.3 – MRSA screening data – Figure 17

|                             | Screened After admission            |                                 |                                 | Screened Before admission       |                                     | Grand Total |
|-----------------------------|-------------------------------------|---------------------------------|---------------------------------|---------------------------------|-------------------------------------|-------------|
|                             | Not within 48 hours after admission | Within 48 hours after admission | Within 24 hours after admission | Within 3 weeks before admission | Not within 3 weeks before admission |             |
| MDC                         |                                     |                                 |                                 |                                 |                                     |             |
| GENERAL MEDICINE            | 20.0%                               | 0.0%                            | 0.0%                            | 30.0%                           | 50.0%                               | 100.0%      |
| SHN                         |                                     |                                 |                                 |                                 |                                     |             |
| BREAST SURGERY              | 0.0%                                | 0.0%                            | 0.0%                            | 81.1%                           | 18.9%                               | 100.0%      |
| COLORECTAL SURGERY          | 0.0%                                | 0.0%                            | 4.9%                            | 36.1%                           | 59.0%                               | 100.0%      |
| T & O SURGERY               | 0.0%                                | 2.6%                            | 0.0%                            | 31.6%                           | 65.8%                               | 100.0%      |
| THORACIC SURGERY            | 0.0%                                | 0.0%                            | 1.5%                            | 51.5%                           | 47.1%                               | 100.0%      |
| UPPER GASTROINTESTINAL SURG | 0.0%                                | 3.8%                            | 2.6%                            | 60.3%                           | 33.3%                               | 100.0%      |
| UROLOGY                     | 1.1%                                | 0.0%                            | 0.0%                            | 44.3%                           | 54.5%                               | 100.0%      |
| VASCULAR SURGERY            | 0.0%                                | 1.5%                            | 1.5%                            | 31.8%                           | 65.2%                               | 100.0%      |
| SPS                         |                                     |                                 |                                 |                                 |                                     |             |
| ADULT BMT                   | 0.0%                                | 0.0%                            | 0.0%                            | 60.0%                           | 40.0%                               | 100.0%      |
| CARDIAC SURGERY             | 1.8%                                | 0.0%                            | 2.8%                            | 92.7%                           | 2.8%                                | 100.0%      |
| CARDIOLOGY                  | 1.4%                                | 1.4%                            | 1.4%                            | 77.6%                           | 18.4%                               | 100.0%      |
| Grand Total                 | 1.0%                                | 1.0%                            | 1.7%                            | 60.4%                           | 35.9%                               | 100.0%      |



## 2.4 – Saving Lives Dashboard – Figure 18

### Saving Lives Dashboard

Select Month:

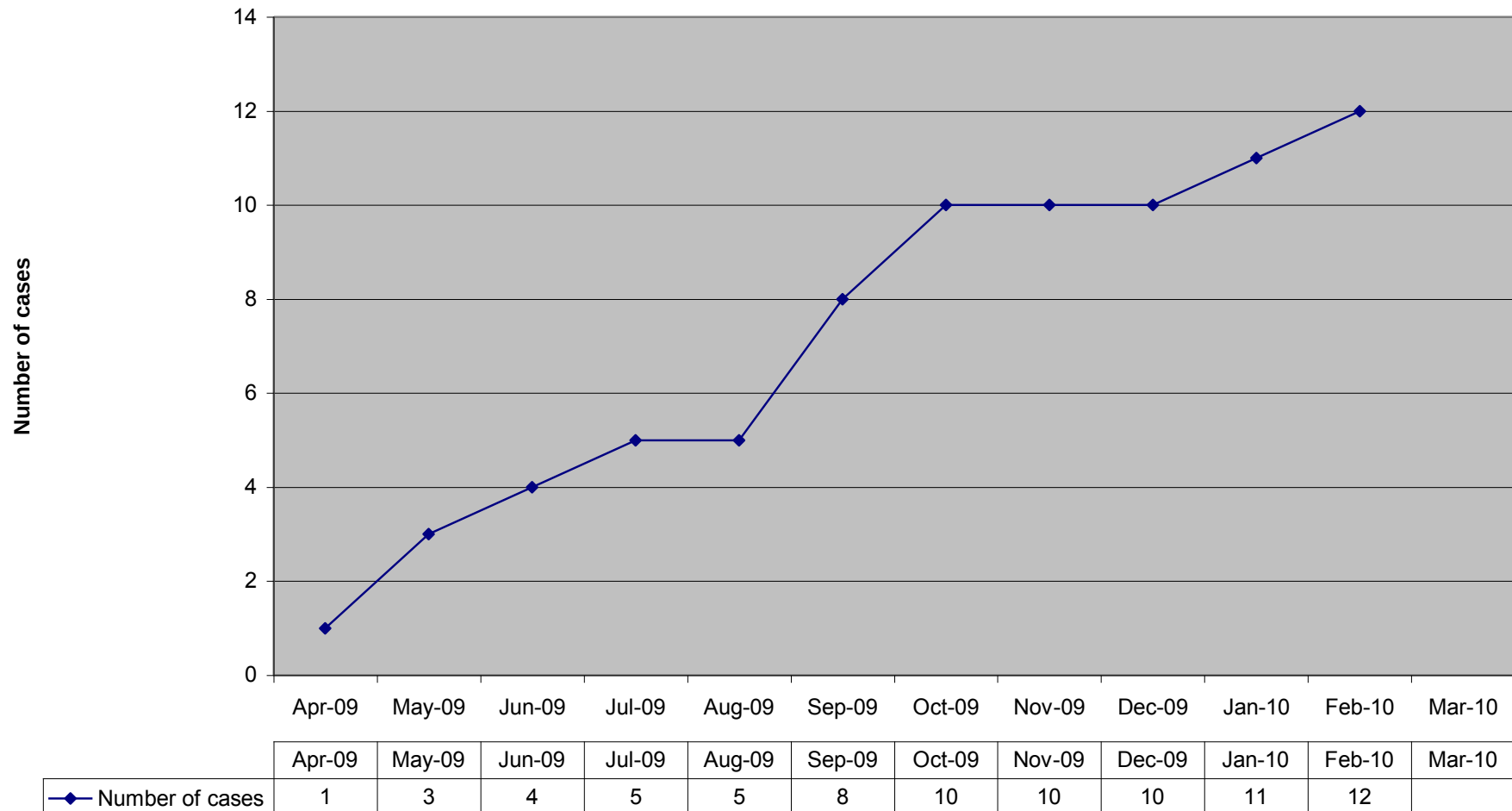
Feb 10

|       |                   |
|-------|-------------------|
| Pink  | No Data Submitted |
| Green | 95% to 100%       |
| Amber | 80% to 94%        |
| Red   | 0% to 79%         |

| Division                | Ward                                      | New MRSA bacteraemia cases Pre 48 hours | New MRSA bacteraemia cases post 48 hours | HII 1a (2007) CVC Insertion Actions | HII 1b (2007) CVC Ongoing Care Actions | HII 2a (2007) PVC Insertion Actions | HII 2b (2007) PVC Ongoing Care Actions | HII 3a (2007) Renal Insertion Actions | HII 3b (2007) Renal Ongoing Care Actions | HII 4a (2007) SSI Pre-op Actions | HII 4b (2007) SSI Peri-op Actions | HII 5a (2007) Vent. Regular Observations | HII 5b (2007) Vent. Ongoing Care | HII 6a (2007) Urinary Catheter Insertion Actions | HII 6b (2007) Urinary Catheter Ongoing Care | HII 7 (2007) C. difficile: Prevention of spread |
|-------------------------|-------------------------------------------|-----------------------------------------|------------------------------------------|-------------------------------------|----------------------------------------|-------------------------------------|----------------------------------------|---------------------------------------|------------------------------------------|----------------------------------|-----------------------------------|------------------------------------------|----------------------------------|--------------------------------------------------|---------------------------------------------|-------------------------------------------------|
| Diagnostics and Therapy | Radiology Suite A                         |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Radiology Suite B                         |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Radiology Suite C                         |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Radiology Suite D                         |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Radiology Suite E                         |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
| Medicine                | 10                                        |                                         |                                          | n/a                                 | n/a                                    | 100                                 | 86                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 10A                                       |                                         |                                          | n/a                                 | n/a                                    | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | No Data                                          | No Data                                     | n/a                                             |
|                         | 11                                        |                                         |                                          | n/a                                 | n/a                                    | 33                                  | 11                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | N/A                                              | N/A                                         | n/a                                             |
|                         | 7 - MAU                                   |                                         |                                          | n/a                                 | n/a                                    | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | No Data                                          | No Data                                     | n/a                                             |
|                         | 17                                        |                                         |                                          | n/a                                 | n/a                                    | 100                                 | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 22                                        |                                         |                                          | n/a                                 | n/a                                    | N/A                                 | N/A                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 23                                        |                                         |                                          | n/a                                 | n/a                                    | 100                                 | 80                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 24                                        |                                         |                                          | n/a                                 | n/a                                    | 90                                  | 82                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 90                                               | N/A                                         | n/a                                             |
|                         | 25                                        |                                         |                                          | n/a                                 | n/a                                    | 100                                 | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 26                                        |                                         |                                          | n/a                                 | n/a                                    | 80                                  | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 27                                        |                                         |                                          | n/a                                 | n/a                                    | 50                                  | 98                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 50                                               | 100                                         | n/a                                             |
|                         | 28                                        |                                         |                                          | n/a                                 | n/a                                    | 100                                 | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | Brunel                                    |                                         |                                          | n/a                                 | n/a                                    | 100                                 | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | Female/Male SRU                           |                                         |                                          | n/a                                 | n/a                                    | 100                                 | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | Hare                                      |                                         |                                          | n/a                                 | n/a                                    | N/A                                 | N/A                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | Redcliffe                                 |                                         |                                          | n/a                                 | n/a                                    | No Data                             | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | N/A                                         | n/a                                             |
|                         | 54                                        |                                         |                                          | n/a                                 | No Data                                | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | No Data                                          | No Data                                     | n/a                                             |
|                         | 18                                        |                                         |                                          | n/a                                 | No Data                                | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | No Data                                          | No Data                                     | n/a                                             |
| Specialised Services    | 51                                        |                                         |                                          | n/a                                 | No Data                                | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | No Data                                          | No Data                                     | n/a                                             |
|                         | 52                                        |                                         |                                          | n/a                                 | No Data                                | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | No Data                                          | No Data                                     | n/a                                             |
|                         | 53                                        |                                         |                                          | n/a                                 | No Data                                | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | No Data                                          | No Data                                     | n/a                                             |
|                         | BHOC Ward 61                              |                                         |                                          | n/a                                 | 98                                     | 88                                  | 92                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | 97                                          | n/a                                             |
|                         | BHOC Ward 62                              |                                         |                                          | n/a                                 | 100                                    | 100                                 | N/A                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | N/A                                              | 100                                         | n/a                                             |
|                         | Brachytherapy                             |                                         |                                          | 100                                 | n/a                                    | n/a                                 | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Cardiac Cath Labs                         |                                         |                                          | n/a                                 | n/a                                    | 100                                 | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | CCU                                       |                                         |                                          | 100                                 | 100                                    | 98                                  | 96                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | N/A                                         | n/a                                             |
|                         | CICU/CHDU                                 |                                         |                                          | N/A                                 | N/A                                    | 100                                 | 90                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | N/A                                              | N/A                                         | n/a                                             |
|                         | Outpatient Services inc Oncology Day Unit |                                         |                                          | n/a                                 | N/A                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
| Surgery, Head & Neck    | 12                                        |                                         |                                          | n/a                                 | 70                                     | 60                                  | 70                                     | n/a                                   | n/a                                      | 90                               | n/a                               | n/a                                      | n/a                              | 64                                               | 70                                          | n/a                                             |
|                         | 14 - STAU                                 |                                         |                                          | n/a                                 | 100                                    | 100                                 | 90                                     | n/a                                   | n/a                                      | 90                               | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 15                                        |                                         |                                          | n/a                                 | 80                                     | 67                                  | 70                                     | n/a                                   | n/a                                      | 100                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 2                                         |                                         |                                          | n/a                                 | 90                                     | 60                                  | 80                                     | n/a                                   | n/a                                      | 100                              | n/a                               | n/a                                      | n/a                              | 100                                              | 80                                          | n/a                                             |
|                         | 4                                         |                                         |                                          | n/a                                 | N/A                                    | 100                                 | 90                                     | n/a                                   | n/a                                      | 100                              | n/a                               | n/a                                      | n/a                              | N/A                                              | 100                                         | n/a                                             |
|                         | 6                                         |                                         |                                          | n/a                                 | 100                                    | 80                                  | 100                                    | n/a                                   | n/a                                      | 100                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | 72                                        |                                         |                                          | n/a                                 | n/a                                    | 70                                  | 80                                     | n/a                                   | n/a                                      | N/A                              | n/a                               | n/a                                      | n/a                              | N/A                                              | 100                                         | n/a                                             |
|                         | 9                                         |                                         |                                          | n/a                                 | 100                                    | 100                                 | 100                                    | n/a                                   | n/a                                      | 100                              | n/a                               | n/a                                      | n/a                              | 100                                              | 100                                         | n/a                                             |
|                         | BEH ED                                    |                                         |                                          | n/a                                 | n/a                                    | 100                                 | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | BEH OPD                                   |                                         |                                          | n/a                                 | n/a                                    | N/A                                 | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | BEH Theatres                              |                                         |                                          | n/a                                 | n/a                                    | 70                                  | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Dental OPD                                |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Dental Theatre                            |                                         |                                          | n/a                                 | n/a                                    | N/A                                 | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Gloucester                                |                                         |                                          | n/a                                 | n/a                                    | n/a                                 | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | N/A                                         | n/a                                             |
|                         | Heygroves Theatres 1-9                    |                                         |                                          | 100                                 | n/a                                    | 84                                  | n/a                                    | n/a                                   | n/a                                      | No Data                          | n/a                               | n/a                                      | n/a                              | 70                                               | n/a                                         | n/a                                             |
|                         | ITU - HDU                                 |                                         |                                          | 100                                 | 83                                     | No Data                             | 67                                     | n/a                                   | n/a                                      | 100                              | No Data                           | 88                                       | 100                              | 100                                              | 100                                         | n/a                                             |
|                         | Oral Surgery Dept                         |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | Queens Day Unit                           |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | N/A                                              | n/a                                         | n/a                                             |
|                         | SAS                                       |                                         |                                          | n/a                                 | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | N/A                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | St. Michaels Theatres                     |                                         |                                          | 95                                  | n/a                                    | No Data                             | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | n/a                                         | n/a                                             |
| Womens and Childrens    | 31                                        |                                         |                                          | n/a                                 | 100                                    | N/A                                 | 50                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | 100                                         | n/a                                             |
|                         | 32                                        |                                         |                                          | n/a                                 | N/A                                    | 100                                 | N/A                                    | n/a                                   | n/a                                      | N/A                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 33                                        |                                         |                                          | n/a                                 | n/a                                    | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 34                                        |                                         |                                          | n/a                                 | 100                                    | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 35                                        |                                         |                                          | n/a                                 | N/A                                    | n/a                                 | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 36                                        |                                         |                                          | n/a                                 | n/a                                    | n/a                                 | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 37                                        |                                         |                                          | n/a                                 | n/a                                    | No Data                             | 0                                      | No Data                               | No Data                                  | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 38                                        |                                         |                                          | n/a                                 | n/a                                    | 100                                 | 90                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 39                                        |                                         |                                          | n/a                                 | n/a                                    | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 71                                        |                                         |                                          | n/a                                 | n/a                                    | n/a                                 | 91                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 74                                        |                                         |                                          | n/a                                 | n/a                                    | n/a                                 | 75                                     | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 75 - NICU                                 |                                         |                                          | 100                                 | 96                                     | n/a                                 | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 76                                        |                                         |                                          | n/a                                 | n/a                                    | n/a                                 | N/A                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | 77 - CDS                                  |                                         |                                          | n/a                                 | n/a                                    | 100                                 | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | 100                                              | n/a                                         | n/a                                             |
|                         | 78                                        |                                         |                                          | n/a                                 | n/a                                    | No Data                             | 96                                     | n/a                                   | n/a                                      | N/A                              | No Data                           | n/a                                      | n/a                              | 100                                              | n/a                                         | n/a                                             |
|                         | BMT                                       |                                         |                                          | n/a                                 | 100                                    | No Data                             | 100                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | BMT Oncology Day Beds                     |                                         |                                          | n/a                                 | n/a                                    | No Data                             | No Data                                | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | BRCH - ED                                 |                                         |                                          | n/a                                 | n/a                                    | 90                                  | n/a                                    | n/a                                   | n/a                                      | n/a                              | n/a                               | n/a                                      | n/a                              | n/a                                              | n/a                                         | n/a                                             |
|                         | BRCH Theatres                             |                                         |                                          | N/A                                 | n/a                                    | N/A                                 | n/a                                    | n/a                                   | n/a                                      | No Data                          | n/a                               | n/a                                      | n/a                              | No Data                                          | n/a                                         | n/a                                             |
|                         | PICU                                      |                                         |                                          | 100                                 | 100                                    | No Data                             | 100                                    | n/a                                   | n/a                                      | n/a                              | 100                               | 90                                       | 100                              | N/A                                              | 90                                          | n/a                                             |

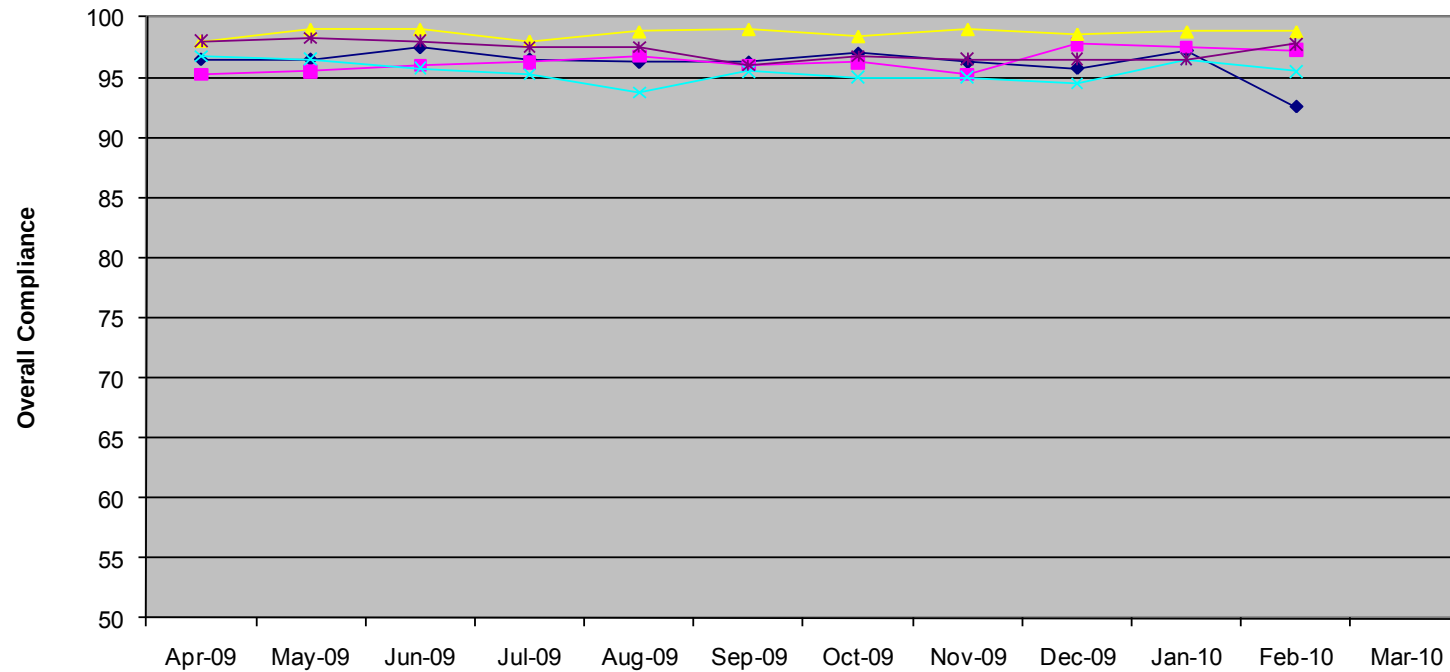
### 3 - Vancomycin resistant Enterococci bacteraemias – Figure 19

**Glycopeptide resistant Enterococci Bacteraemias: UHBristol**  
**Cumulative April 2009 - March 2010**



#### 4 - Overall Compliance with Hand Hygiene Policy – Figure 20

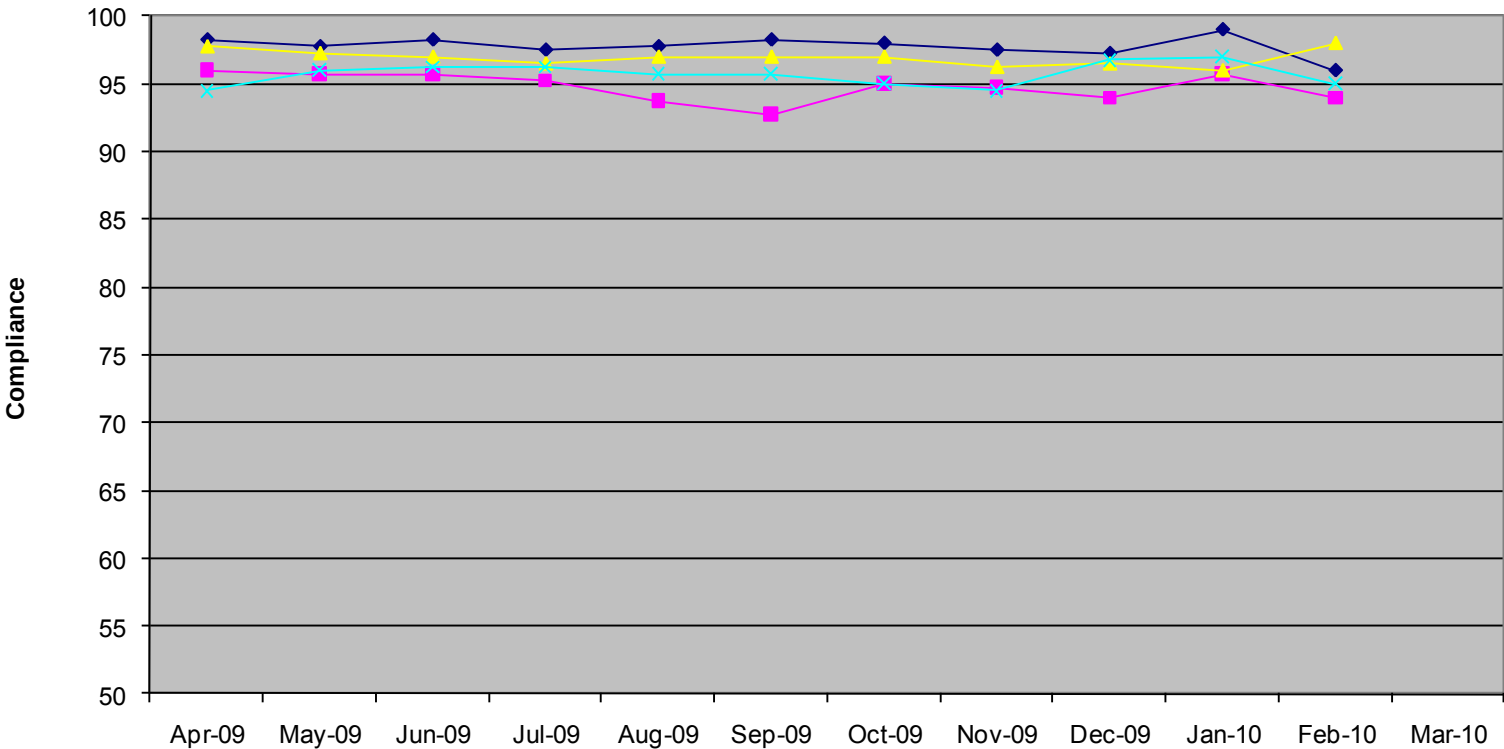
Hand Hygiene Monthly Divisional Compliance April 2008 - March 2010



|                          | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 |
|--------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| ◆ Medicine               | 97     | 97     | 98     | 97     | 96     | 96     | 97     | 96     | 96     | 97     | 93     |        |
| ■ Specialised Services   | 95     | 96     | 96     | 96     | 97     | 96     | 96     | 95     | 98     | 98     | 97     |        |
| ▲ Diagnostic and Therapy | 98     | 99     | 99     | 98     | 99     | 99     | 98     | 99     | 99     | 99     | 99     |        |
| × Surgery Head and Neck  | 97     | 97     | 96     | 95     | 94     | 96     | 95     | 95     | 95     | 97     | 96     |        |
| * Women and Children     | 98     | 98     | 98     | 98     | 98     | 96     | 97     | 97     | 97     | 97     | 98     |        |

4. Overall % compliance by profession (excluded Diagnostic and Therapies) – Figure 21

Hand Hygiene Compliance by Professional Group April 2009 - March 2010



|                               | Apr-09 | May-09 | Jun-09 | Jul-09 | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 |
|-------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| ◆ Nursing                     | 98     | 98     | 98     | 98     | 98     | 98     | 98     | 98     | 97     | 99     | 96     |        |
| ■ Medical                     | 96     | 96     | 96     | 95     | 94     | 93     | 95     | 95     | 94     | 96     | 94     |        |
| ▲ Allied Health Professionals | 98     | 97     | 97     | 97     | 97     | 97     | 97     | 96     | 97     | 96     | 98     |        |
| ✕ Support Services            | 95     | 96     | 96     | 96     | 96     | 96     | 95     | 95     | 97     | 97     | 95     |        |

## 5.1 – Cleanliness monitoring results – Figure 22

| RESULTS                                                                                                                                          |                | 2009             |     |     |     |     |     |                  |     |     |     |     |     | 2010 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|-----|-----|-----|-----|-----|------------------|-----|-----|-----|-----|-----|------|--|
| Risk Category                                                                                                                                    | Area           | Feb              | Mar | Apr | May | Jun | Jul | Aug              | Sep | Oct | Nov | Dec | Jan | Feb  |  |
| <b>VERY HIGH</b>                                                                                                                                 |                |                  |     |     |     |     |     |                  |     |     |     |     |     |      |  |
| <b>Areas include:</b><br>Theatres,<br>Intensive Care<br>Units (Adult &<br>Children),<br>Emergency<br>Departments,<br>Oncology Wards<br>etc.      | B.R.I          | 89               | 91  | 89  | 96  | 92  | 92  | 92               | 87  | 90  | 92  | 92  |     |      |  |
|                                                                                                                                                  | B.H.I.         |                  |     |     | 99  | 96  | 96  | 99               | 93  | 94  | 95  | 96  | 93  | 94   |  |
|                                                                                                                                                  | B.R.C.H        | 92               | 90  | 94  | 94  | 94  | 94  | 95               | 95  | 97  | 95  | 97  | 94  | 97   |  |
|                                                                                                                                                  | S.M.H          | 88               | 97  | 97  | 94  | 94  | 95  | 95               | 96  | 95  | 93  | 93  | 94  | 93   |  |
|                                                                                                                                                  | B.H.O.C        | 96               | 96  | 98  | 96  | 97  | 99  | 98               | 99  | 99  | 99  | 99  | 98  | 97   |  |
|                                                                                                                                                  | B.D.H          | 100              | 99  | 97  | 100 | 97  | 97  |                  |     | 90  | 97  |     | 96  | 96   |  |
|                                                                                                                                                  | B.E.H          | 96               | 96  |     |     | 95  | 95  |                  | 94  | 89  | 94  |     | 90  | 92   |  |
|                                                                                                                                                  | Total Average  | 93               | 95  | 95  | 96  | 95  | 96  | 96               | 94  | 93  | 95  | 95  | 94  | 95   |  |
| <b>HIGH</b>                                                                                                                                      |                |                  |     |     |     |     |     |                  |     |     |     |     |     |      |  |
| <b>Areas include</b><br>All ward areas<br>not covered<br>above, Clinics X-<br>ray Depts, etc.<br>Sterile Services,<br>Pharmacy etc               | B.R.I          | 86               | 87  | 82  | 91  | 85  | 86  | 83               | 89  | 84  | 86  | 84  |     |      |  |
|                                                                                                                                                  | B.H.I.         |                  |     |     | 99  | 97  | 97  |                  | 94  | 97  | 97  | 98  | 88  | 88   |  |
|                                                                                                                                                  | B.R.C.H        | 90               | 94  | 93  | 95  | 95  | 94  | 94               | 95  | 96  | 96  | 98  | 93  | 98   |  |
|                                                                                                                                                  | S.M.H          | 87               | 95  | 96  | 94  | 96  | 96  | 95               | 94  | 98  | 89  | 95  | 94  | 80   |  |
|                                                                                                                                                  | B.H.O.C        | 95               | 97  | 99  | 98  | 99  |     | 99               | 100 | 99  | 92  | 98  | 99  | 96   |  |
|                                                                                                                                                  | B.D.H          | 90               | 93  | 90  | 93  | 94  | 93  |                  | 96  | 95  |     | 94  | 87  |      |  |
|                                                                                                                                                  | B.E.H          | 91               | 89  |     |     | 92  |     | 95               | 97  |     | 77  |     | 95  |      |  |
|                                                                                                                                                  | B.G.H.         |                  | 99  |     | 94  | 88  | 92  | 99               | 99  | 100 | 95  | 99  | 97  | 99   |  |
| Total Average                                                                                                                                    | 90             | 93               | 92  | 95  | 93  | 93  | 94  | 95               | 96  | 90  | 95  | 93  | 92  |      |  |
| <b>SIGNIFICANT</b>                                                                                                                               |                |                  |     |     |     |     |     |                  |     |     |     |     |     |      |  |
| <b>Areas include:-</b><br>All Hospital<br>Entrances, Levels<br>and Stairwells,<br>Public Toilets,<br>Receptions<br>Physiotherapy<br>Departments, | B.R.I          | 79               | 82  | 81  | 86  | 81  | 72  | 63               | 90  | 80  | 87  | 84  |     |      |  |
|                                                                                                                                                  | B.H.I.         |                  |     |     | 100 | 100 | 100 |                  |     | 100 | 99  | 99  | 93  | 94   |  |
|                                                                                                                                                  | B.R.C.H        | 100              | 91  |     | 95  | 93  |     |                  |     | 93  |     |     |     | 97   |  |
|                                                                                                                                                  | S.M.H          | 92               | 88  |     | 90  | 90  |     |                  | 90  | 95  |     | 95  |     |      |  |
|                                                                                                                                                  | B.H.O.C        | 91               | 92  |     | 97  |     |     | 97               |     |     |     |     |     | 97   |  |
|                                                                                                                                                  | B.D.H          | 85               | 87  | 87  | 91  | 93  | 93  |                  |     |     |     | 85  |     |      |  |
|                                                                                                                                                  | B.E.H          | 96               | 88  |     |     | 86  |     |                  |     |     | 83  |     |     |      |  |
|                                                                                                                                                  | B.G.H.         | 76               | 99  |     | 97  | 88  | 100 | 98               | 98  | 99  | 98  | 98  | 97  | 100  |  |
| Total Average                                                                                                                                    | 88             | 89               | 84  | 94  | 90  | 91  | 86  | 93               | 93  | 92  | 92  | 95  | 97  |      |  |
| <b>LOW</b>                                                                                                                                       |                |                  |     |     |     |     |     |                  |     |     |     |     |     |      |  |
| <b>Areas include:-</b><br>Offices, Medical<br>Records, Stores<br>areas etc.                                                                      | B.R.I          | 83               | 83  |     |     |     |     |                  | 88  |     | 84  |     |     |      |  |
|                                                                                                                                                  | B.H.I.         |                  |     |     | 100 | 100 | 99  |                  | 97  |     |     | 94  |     | 83   |  |
|                                                                                                                                                  | B.R.C.H        |                  | 92  | 95  |     |     |     |                  |     |     |     |     |     |      |  |
|                                                                                                                                                  | S.M.H          |                  | 84  |     |     |     |     |                  |     |     |     |     |     |      |  |
|                                                                                                                                                  | B.H.O.C        |                  | 83  |     |     |     |     |                  |     |     |     |     |     | 97   |  |
|                                                                                                                                                  | B.D.H          | 85               | 88  |     |     |     |     |                  |     |     |     |     |     |      |  |
|                                                                                                                                                  | B.E.H          |                  | 62  |     |     | 92  |     |                  |     |     |     |     |     |      |  |
|                                                                                                                                                  | B.G.H.         | 93               |     |     |     |     | 100 |                  |     |     |     |     |     |      |  |
| Total Average                                                                                                                                    | 87             | 82               | 95  | 100 | 96  | 100 |     | 93               |     | 84  | 94  |     | 90  |      |  |
|                                                                                                                                                  | TRUST<br>SCORE | 90               | 90  | 91  | 96  | 94  | 95  | 92               | 94  | 94  | 90  | 94  | 94  | 93   |  |
| KEY                                                                                                                                              |                |                  |     |     |     |     |     |                  |     |     |     |     |     |      |  |
|                                                                                                                                                  |                | From 90% to 100% |     |     |     |     |     | From 95% to 100% |     |     |     |     |     |      |  |
|                                                                                                                                                  |                | From 70% to 89%  |     |     |     |     |     | From 70% to 94%  |     |     |     |     |     |      |  |
|                                                                                                                                                  |                | Under 70%        |     |     |     |     |     | Under 70%        |     |     |     |     |     |      |  |

### 5.5 – Care Quality Commission staff survey results – Figure 23

| <b>Question</b>                                                                          | <b>2009 score</b> | <b>Median score acute Trusts</b> | <b>2008 score</b> |
|------------------------------------------------------------------------------------------|-------------------|----------------------------------|-------------------|
| Received infection control training in last 12 months                                    | 73%               | 69%                              | 66%               |
| Suffered needlestick or sharps injury                                                    | 3%                | 3%                               | 5%                |
| Hand washing materials always available to staff                                         | 69%               | 76%                              | 69%               |
| Hand washing materials available most of the time to staff                               | 28%               | 21%                              | 28%               |
| Hand washing materials available sometimes for staff                                     | 2%                | 2%                               | 2%                |
| Hand washing materials never available for staff                                         | 0%                | 0%                               | 0%                |
| Hand washing materials always available for patients                                     | 63%               | 69%                              | 63%               |
| Hand washing facilities available most of the time for patients                          | 26%               | 20%                              | 24%               |
| Hand washing facilities sometimes available for patients                                 | 3%                | 2%                               | 4%                |
| Hand washing facilities never available for patients                                     | 0%                | 0%                               | 0%                |
| Hand washing facilities always available for visitors                                    | 62%               | 69%                              | 60%               |
| Hand washing facilities available for visitors most of the time                          | 26%               | 20%                              | 27%               |
| Hand washing facilities available sometimes for visitors                                 | 3%                | 2%                               | 4%                |
| Hand washing facilities never available for visitors                                     | 0                 | 0                                | 0                 |
| The Trust does enough to promote the importance of hand hygiene to staff                 | 89%               | 89%                              | 88%               |
| The Trust does enough to promote the importance of hand hygiene to patients and visitors | 81%               | 82%                              | 79%               |
| Infection control applies to me in my role                                               | 87%               | 85%                              | 90%               |

|                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                          |                |            |                |            |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------|----------------|------------|
| <b>Trust Board Meeting</b>                                                                                           | <b>Date: 29<sup>th</sup> March 2010</b>                                                                                                                                                                                                                                                                                                                  |                |            |                |            |
| <b>Agenda Item</b>                                                                                                   | <b>8</b>                                                                                                                                                                                                                                                                                                                                                 |                |            |                |            |
| <b>Title of Report</b>                                                                                               | Quality Strategy and Terms of Reference for Quality Committee                                                                                                                                                                                                                                                                                            |                |            |                |            |
| <b>Recommendations</b>                                                                                               | <p>This report will describe:</p> <ul style="list-style-type: none"> <li>• The Trust approach to Quality (Quality Strategy)</li> <li>• Clarification of assurance and delivery functions.</li> <li>• The proposed addition of a Quality Committee.</li> </ul>                                                                                            |                |            |                |            |
| <b>Actions Required</b>                                                                                              | <p>The Trust Board is asked to:</p> <ul style="list-style-type: none"> <li>• Discuss the contents of the report</li> <li>• Approve the Quality Strategy</li> <li>• Endorse the development of a Quality Committee</li> </ul>                                                                                                                             |                |            |                |            |
| <b>Which Corporate Objective(s) are supported by this paper?</b><br><br><b>Implications for the NHS Constitution</b> | <p>Delivery of Quality Accounts</p> <p>To improve care for patients and the overall patient experience</p> <p>To work with partners to deliver better patient care</p> <p>To increase the capacity and impact of Research and Development</p> <p>This report supports the provisions of the NHS Constitution relating to the quality of patient care</p> |                |            |                |            |
| <b>Is this on the Trust's risk register?</b>                                                                         |                                                                                                                                                                                                                                                                                                                                                          |                |            |                |            |
| <b>Which CQC registration standards does this report provide evidence for?</b>                                       | All standards relate to Health Quality Delivery.                                                                                                                                                                                                                                                                                                         |                |            |                |            |
| <b>Financial Implications</b>                                                                                        | <table border="1"> <tr> <td><b>Revenue</b></td><td><b>£ 0</b></td><td><b>Capital</b></td><td><b>£ 0</b></td></tr> </table>                                                                                                                                                                                                                               | <b>Revenue</b> | <b>£ 0</b> | <b>Capital</b> | <b>£ 0</b> |
| <b>Revenue</b>                                                                                                       | <b>£ 0</b>                                                                                                                                                                                                                                                                                                                                               | <b>Capital</b> | <b>£ 0</b> |                |            |
| <b>Prepared by: Name &amp; Title</b>                                                                                 | Dr Jonathan Sheffield, Medical Director                                                                                                                                                                                                                                                                                                                  |                |            |                |            |
| <b>Presented by: Name &amp; Title</b>                                                                                | Dr Jonathan Sheffield, Medical Director                                                                                                                                                                                                                                                                                                                  |                |            |                |            |

|                   |  |
|-------------------|--|
| <b>Appendices</b> |  |
|-------------------|--|

**Previous Meetings**

Please insert the date the paper was presented under to the relevant group

| Exec Team | Audit & Assurance Committee | Governance Risk and Risk Management | Finance Committee | Trust Executive Group | Other Meeting (Please state) |
|-----------|-----------------------------|-------------------------------------|-------------------|-----------------------|------------------------------|
|           |                             |                                     |                   |                       |                              |



## Quality Strategy

### ***Introduction***

“Boards must put quality at the heart of everything they do”. The Healthy NHS Board 2009.

The profile of quality management within the organisation continues to be a priority. Lord Darzi’s next stage review has provided clarification on the domains for measurement of quality; Patient Safety, Patient Experience and Clinical Effectiveness/ outcome. The purpose of this strategy is to outline how the Trust intends to cement and share its quality agenda and deliver the NHS and Monitors requirements to produce an annual report on Quality within the organisation.

There have been consequences seen nationally of different parts of the Health System not fulfilling their roles and responsibilities.

- “Where staff have not been encouraged to focus on high quality care for their patients and have not been supported to be open and learn from mistakes, patients have borne the brunt of those failings.
- Where providers and commissioners have failed to listen to and proactively engage with patients and the public patients have borne the brunt of these failings.
- Where the ambitions of both individuals and organisations have taken precedence over a focus on quality, patients have borne the brunt of those failings.
- Where the system have failed to share information on risk and work corroboratively to rectify problems, patients have borne the brunt of those failings”

National Quality Board – Review of Early Warning Systems in the NHS

Following the Kennedy Report the Trust has delivered an open approach to assuring the public on quality issues. The trust has led the way in delivery of open outcome reporting particularly in Cardiac surgical outcomes.

In developing the Safety agenda the Trust participated in the Health Foundation's Safer Patient Initiative II until its completion in October 2008. In order to continue with the developed methodologies the Trust is now registered with the Patient Safety First Campaign. As an evolving Foundation Trust Patient experience initiatives have arisen in two significant areas; firstly the Bristol Oncology Centre participated in the Monitor/MacKinsey patient experience pilot. Secondly, in order to develop continuous quality improvements in patient experience the Trust has commenced using the patient survey methodology to target patients and develop rapid feedback returns for the individual ward. This will allow rapid cycles of change to improve experience in all wards. The Trust has a strong record for collecting outcome data for many of its clinical specialties usually driven by enthusiastic clinicians. This information is produced in a variety of formats and publications it is appropriate that this Strategy pulls this work into a coherent programme which will deliver board and public reassurance on the quality of clinical services delivered by the Trust. The development of this strategy considers national reference document including the Francis Report into Mid Staffordshire NHS Foundation Trust.

## ***Our mission and strategic aims***

The values for University Hospitals Bristol NHS Foundation Trust, sit under our mission:

**'To provide patient care, education and research of the highest quality'**

Our values are:

- Respecting Everyone
- Embracing Change
- Recognising Success
- Working Together

### **Respecting Everyone**

- We treat everyone with respect and as an individual
- We put patients first and will deliver the best care possible
- We are always helpful and polite
- We have a can do attitude in everything we do

### **Embracing Change**

- We will encourage all change that helps us make the best use of our resources
- We learn from our experiences and research new ideas
- We look to constantly improve everything we do

### **Recognising Success**

- We say thank you and recognise everyone's contribution
- We take pride in delivering the best quality in everything we do
- We share and learn from each other
- We encourage new ideas that help us be the best we can

### **Working together**

- We work together to achieve what is best for patients
- We support each other across the whole Trust
- We listen to everyone
- We work in partnership inside and outside our organisation

This policy will cover the three Domains of a Quality Strategy and the three elements that are vital to its success: Leadership, Performance Management and Assurance Framework.

### ***Monitoring for Quality***

In order to demonstrate quality care is at the heart of all Trust business it is essential to be clear regarding the assurance and monitoring of Quality performance.

### **Trust Board**

- The board demonstrates top management commitment whole to quality by formerly including quality on every public board agenda.
- The formation of a Quality Committee reporting directly to the main board. (see appendix 1) Responsible for the assurance of performance of the executive and clinical services against clear quality indicators.
- Participation in Safety walk-rounds by all Executive Directors.
- Clear accountability for safety through the officers of the Trust.
- Accountability to our Stakeholders for delivery of high quality i.e. Trust Members and Governors, Primary Care Trust Commissioners, Links, Care Quality Commission, Monitor, staff and patients.
- Setting of the annual Quality targets and delivery of the annual Quality Account.

Specific roles for the Board members are:

- Chairman and Non-executive Directors to hold the designated officers of the Trust accountable for delivery of the Trust Quality.
- Chief Executive – Accounting officer delivering a clear statement in the Quality report.
- Medical Director- Lead for Patient Safety
- Chief Nurse- Responsible for the Quality Assurance Framework
- Chief Executive Officer- Delivering day to day Health care that meets Quality Standards
- Workforce and Organisational Development Director- Provision of staff development that appropriately prepares them to deliver safe high quality care.
- Director of Strategy and Development- Develop facilities and services with quality as a key outcome
- Finance Director- Provide resource and information services that meet the agenda.

## **Other key corporate committees**

- Quality Committee (proposed)
- Governance and Risk Management Committee
- Clinical Risk Assurance Committee
- Trust Executive Committee
- Divisional Boards and associated Governance committees

## ***Performance Management***

The Trust will develop corporate and divisional dashboards with clear quality targets and monitor outcomes against these targets. The Darzi domains will be used to develop a hierarchy to provide assurance on quality performance. In addition to local information where data is available the performance will be benchmarked against other NHS organisations. The introduction of CQUINNS and QUIPP brings additional quality priorities to the organisation. The trust will seek to benchmark itself against performance of other major academic health centres in Europe and North America.

## ***Links Between Quality and Efficiencies***

The issues of providing a high quality service which has inbuilt and continuous attention to efficiencies' are not mutually exclusive. It is very clear that if there is a continual focus on improving the safety of patients, ensuring a positive patient experience and a good clinical outcome, then the services provided will be more productive, efficient and effective.

Strong financial management and controls will also be in place. This has always been imperative, and will continue to be the case going forward.

## ***Assurance Framework***

There was a poor governance system noted by the Francis Report with key issues about quality and complaints not reaching the Trust Board. Systems in UHBristol are already in place for the key themes of the Quality Assurance Framework and it is not anticipated that major structural change for committees will be required. Currently the Clinical Risk Assurance Committee, chaired by the Medical Director is responsible for assurance on Patient Safety and is the guardian of the Healthcare Standards related to this topic. The committee reports to Governance and Risk Management Committee. It is proposed that future monthly reporting on Quality is assured at Board level by the introduction of the Quality Committee acting at sub-board level and chaired by a Non-Executive Director. (See appendix 1) Patient Experience assurance is captured through both the Clinical Risk Assurance

Committee through its assessment of complaints and incidents. Patient experience is also monitored through the Involving Patients Committee under the Leadership of the Chief Nurse with a specific agenda to pool the review of Patient experience monitoring. The Trust already has in place a Clinical Effectiveness Committee which has previously been focussed on the development, monitoring and implementation of the National Institute of Clinical Excellence guidance and guidelines and introduction of new procedures in the Organisation. In the future this would be the appropriate Committee to review and seek assurance on the array of reports on clinical outcome provided by the clinical speciality groups. Also key to the Quality Agenda is the Clinical Audit Committee which is working closely with the Effectiveness Committee. Future Clinical Audit will become balanced between local specialty priorities with corporate and national agendas. It is proposed this group also reports to the Quality committee.

## ***Patient Safety***

Patient Safety is at the heart of all NHS staff's priorities and is approached in three ways:

- *Monitoring for Safety.* Robust data collection of key safety indicators already occurs and is reported to the Board e.g. Hospital Standardised Mortality, Hospital Acquired Infections, Admission to Stroke Unit etc. Under the South West Safety and Quality Improvement Programme the Trust also collects more extensive data. This will be condensed into a format for presentation to the board for further assurance.
  - continuous safety improvement: Under the South West Safety and Quality Improvement Programme the Trust is engaged in safety projects under the following themes
  - *Executive Leadership Walk-rounds;* Led by executive directors with non-executives or governors partnering on some of the visit. These continue to be a priority for Board members to re-assure staff the commitment to safety from the Board.
  - *General Ward Observation Chart;* The Bristol Observation Chart was introduced to all wards in February 2009. Work will continue to cascade clear training in the development of the Medical Early Warning System with audit and further Training to ensure appropriate management of the declining patient.
  - *Medicines Management;* Emphasis on the management of high risk drugs with a priority continuing in anticoagulation management and expanding the work to include better control of insulin in diabetic in-patients. Increased investment will also see the development of robust medicines reconciliation plans.

- *Peri-operative Care*; Not only is this a key part of the safety programme it is also an essential component of the Productive Theatre improvement work carried out as part of *Making our Hospitals Better*.
- *Intensive Care*: Focused on the monitoring of Care bundles and applying them with reliability in order to deliver improved outcomes.
- *Continuous safety improvement in the Children's Hospital*; The South West Programme has a very high focus on Adult care and in order to deliver priority for children the Trust has entered the *Leadership in Patient Safety Programme* which has previously been successful in the development of paediatric safety management in Sheffield Children's Hospital
- *Incident Review and Improvement*; Key to all improvements in patient safety is the learning from specific incidents. These are reported through the Trust's incident reporting system and appropriately investigated with Root Cause Analyses of all major high risk incidents. The Clinical Risk Assurance Committee reviews the high risk incidents to share learning across the organisation.

The Trust will continue to use the Lean team to develop safety aspects of care delivery to individual clinical sites as part of *Making our Hospitals Better*.

Finally, a significant aspect of culture change in the approach to safety is the acquisition of the Bristol Simulation Centre with investment in Human Factors training for high risk procedures. Initial emphasis has been in the development of team understanding for error prevention in paediatric and adult cardiac theatres using the High Fidelity Theatre Simulation Suite and the Orpheus Perfusion Simulator.

## ***Patient Experience***

The Francis Report found a systematic failure in the provision of good care with a lack of compassion shown towards patients, and a tolerance of this by Senior Clinician and Managers. This Trust is committed to providing a high quality, patient-focused healthcare service that meets the needs of a diverse population and Patient and Public Involvement Strategy sets out a vision for how we will:

- Improve opportunities for patients, their families, and carers to give us feedback on our services.
- Use this feedback to improve our services
- Involve patients and the public in decisions about the Trust's services

- The Chief Nurse will lead this by the collection of robust patient feedback. See Appendix 2
- Facilitate Division-led Involvement initiatives based on learning from the McKinsey Patient Experience Project at the Bristol Haematology & Oncology Centre, drawing upon a wide range of data sources to gain a holistic view of patients' experience using them in *Making our Hospitals Better*.
- Exploring new and innovative ways of allowing patients and the public to give us feedback on our services.
- Developing a strong Public and Patient Involvement brand that staff can immediately associate with improvement and that patients / public will see as an opportunity to give feedback about our services.
- Ensure that our organisational processes allow findings from Involvement activities to be heard throughout the Trust: from Ward to Board.
- Reduce ad-hoc patient survey activity and encourage greater Divisional ownership of these activities where they continue.
- Ensure that we record and monitor Involvement activities accurately so that we can evidence our work in this area and share learning from it.
- Meet the requirements of any relevant CQUINs agreed with commissioners.
- Develop integrated reporting of different forms of patient feedback, including PALS and Complaints.
- Continue to engage our local communities about matters that affect them and the Trust

The Involving People Committee will be led by the Chief Nurse and will report to the Board through the Quality Committee.

## ***Clinical Outcome***

Service line reporting and management is now producing data specific to the multiple specialist areas of the Hospitals. The Clinical Effectiveness Committee has previously been focussed on safe deployment of new procedures within the clinical environment and also the establishment and monitoring of National Institute for Clinical Evidence guidance and guidelines within the Trust.

The Trust will review the Clinical Effectiveness committee Terms of Reference to establish a role with the Clinical Audit committee to monitor outcome data. The data will be provided from both Divisional and Corporate reporting structures.

The Medical Director will work with Divisions and the Clinical Effectiveness Committee to develop robust outcome measures across the Trust. We already have an established reputation for outcome measurement in many of our key specialist areas: Cardiac, Vascular, Ophthalmology, Obstetrics and of our specialist paediatric services, however, as with many other NHS organisations the Trust data collection systems are bespoke, often managed by enthusiastic clinicians with no managerial back-up. Some of these datasets are enormous; the cardiac has 200 individual items. Our strategy will deliver key outcome data measures for all our specialties which will be reported in a timely way to both the clinical groups and to the Quality Committee. It will be achieved by:

- Broad sets of clinical outcome data at a Corporate, Divisional and Clinical Service line level by stepwise development throughout the clinical areas of the Trust.
- Assurance of outcome Quality through the Clinical Effectiveness Committee and Clinical audit programme reporting to the Quality Committee.
- Robust Benchmarking of outcome through links with Regional Quality Observatories, National Specialist Bodies, the Care Quality Commission and commercial Benchmarking companies.

## ***Conclusion***

The Board is asked to:

- Discuss the Report
- Approve the Quality Strategy
- Endorse the development of a Quality Committee



University Hospitals Bristol NHS Foundation Trust

Quality Committee

TERMS OF REFERENCE

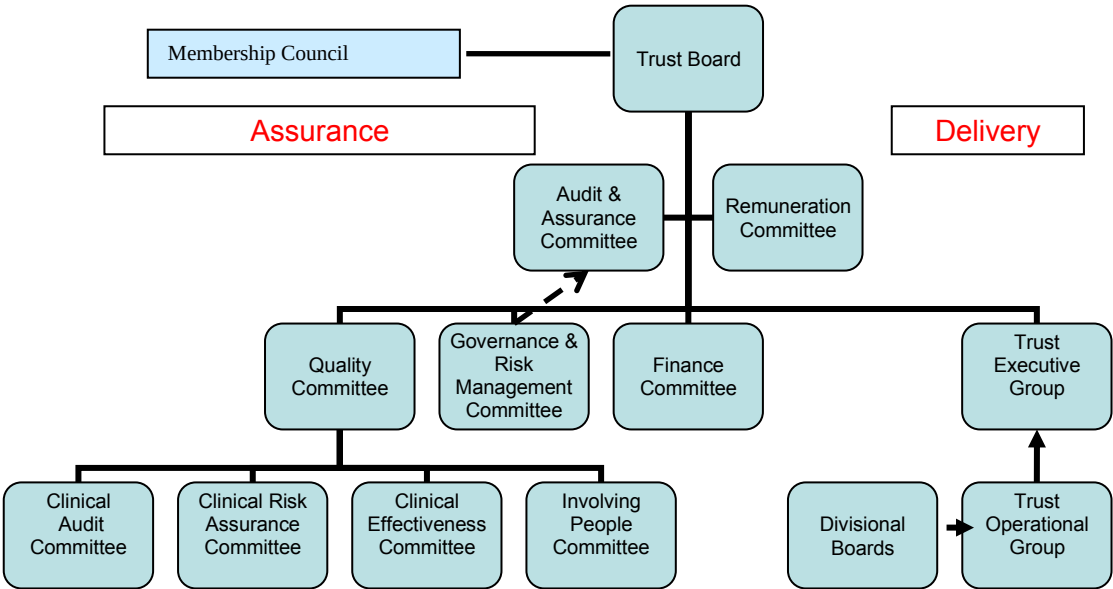
1 Constitution

The Quality Committee is a sub-committee of the Trust Board constituted for the purpose of carrying out specific duties as set out in Section below.

As part of UH Bristol’s Foundation Trust governance arrangements the Committee links to:

Corporate Objectives                      Quality  
Assurance Framework                      Quality

Committee Chart



## **2 Purpose**

The committee shall, subject to any limitations imposed by the Schedule of Matters Reserved to the Board, have delegated responsibility for seeking assurance that there are effective arrangements for monitoring and continually improving the quality of healthcare provided to or commissioned on behalf of patients. The committee will enhance board oversight of quality performance by ensuring input from people with quality expertise, such as clinical, nursing, management and non-healthcare domains. It will provide an opportunity to probe and scrutinise performance in relation to quality. However, the ultimate accountability for quality rests with the board. The Committee will focus on the matters related to the delivery of Quality Accounts as defined by the reporting framework proposed and developed by the Department of Health, Monitor, Care Quality Commission and NHS East of England, following the publication of *High Quality Care for All* in 2008. In doing so the committee shall consider the following domains of Quality:

- To advise the Board of Directors on the Trust's quality framework, including the appropriate quality and safety performance indicators for inclusion in the Trust's Quality Accounts.
- Agree an annual work plan with and receive an annual report from the Quality Sub-groups.

Review and monitor

- the Trusts Quality Accounts
- the Care Quality Innovation Standards (CQUINS)
- Patient Reportable Outcome Measures (PROMS)
- Any other relevant performance indicators relating to clinical effectiveness and patient safety as the committee may from time to time agree.

## **Patient Safety**

- Agree an annual work plan with and receive an annual report from the Patient Safety Executive.
- Review and monitor
  - The activities of the Patient Safety Executive and the Trusts Patient Safety Programme
  - The outcomes of Clinical Area Safety Assessments and the actions being taken
  - Key patient safety indicators
  - Serious Untoward Incidents reported and actions being taken
- Promote learning and sharing, both from within and outside of the Trust

## **Patient Experience**

- Agree an annual work plan and receive an annual report from the Involving People Committee
- Review and monitor
  - The activities of the Involving People Committee
  - The outcomes of PEST reports and the actions being taken
  - Key patient experience indicators
  - Serious complaints received, any recurring themes from all complaints and actions being taken
  - Patient survey results and actions being taken

## **Clinical Outcomes**

- Agree an Annual work plan and receive an Annual Report from the Clinical Divisions regarding the monitoring and publishing of Specialty outcomes.
- Agree an Annual Corporate work plan which considers the key outcomes for corporate clinical activity in the areas of :
  - Infection Control and Hospital Acquired Infections
  - Nutritional Services
  - Blood Transfusion
  - Organ and Tissue Transplant Donation
  - Never Events
  - Major Safety Reviews
  - Care Quality Commission Reviews

## **3 Membership**

Membership of the committee shall be appointed by the Board and shall be made up of at least three members. The initial members of the Committee are set out below. The Chair of the Audit and Assurance Committee shall not be a member of the committee.

The following shall be members of the Committee:

|                                                     |                  |
|-----------------------------------------------------|------------------|
| Non-Executive Director as Chairman of the Committee |                  |
| 2 further Non-Executive Directors                   | Chief Executive  |
| Chief Nurse                                         | Medical Director |
| Chair of the Governor Quality Group                 |                  |

### **Attendees**

In addition to committee members the following Staff may be required to attend a meeting.

Assistant Directors of Governance  
Clinical Audit Chair                      Clinical Effectiveness Chair  
Heads of Division                      Divisional Managers

Attendees shall not send deputies unless specifically approved by the committee chairman

## **Frequency of meetings**

The committee shall meet monthly and at such time as the Chairman of the committee shall require.

## **Quorum**

The Quorum of the Committee for the transaction of business shall be four, two non-executives and two executives. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee. One of the Medical Director or the Chief Nurse must always be in attendance.

## **Secretariat**

The Company secretary shall attend all the meetings and provide the appropriate support to the Chairman and committee members.

## **Reporting**

The committee chairman shall report to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any areas within its remit where action or improvement is needed.

## **4 DUTIES**

The Secretary's duties will include:

- Agreement of the agenda with the Chairman, collation and circulation of papers;
- Minute the proceedings and resolutions of all meetings of the Committee;

- Including recording the names of those present and in attendance. Minutes shall be circulated promptly to all members of the Committee;
- Keeping a record of matters arising and issues to be carried forward; and
- Advising the Committee on pertinent areas.

Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chairman of the Committee.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

## **5 APPROVAL AND REVIEW**

The Quality Committee shall, at least once a year, reviews its performance and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

## ***THE COLLECTION OF PATIENT FEEDBACK***

**In 2010/11, with the support of the Above and Beyond Appeal, we will do this by:**

1. Establishing a post-discharge postal survey for inpatients

This survey will be sent to approximately 1500 patients per month (out of approximately 2200 discharges in total) and will consist of 20-25 closed-ended questions including topics which we know from previous surveys to be key determinants of patients' satisfaction with our services.

The survey will be outsourced to an external contractor, however the Trust will have in-house facilities to enable detailed analysis of the data. Trust and Divisional Boards will receive a monthly report, whilst ward-level data will be reported on a quarterly basis.

2. Asking inpatients to complete an exit card at point of discharge

These cards will be used as improvement tools for the wards. They will ask a small number of open-ended questions: in essence, what was good and what we could have done better. Wards will be encouraged to display feedback from the exit cards on boards/screens which can be seen by staff, patients and visitors to the ward. It is hoped that improvements in patient experience resulting from the use of exit cards will be detected in the data generated by the postal survey.

3. Introducing the use of hand-held devices to gather bespoke survey data

Six targeted surveys will be undertaken during 2010/11: one survey every two months. Data will be collected by Governors, volunteers and members on the same day, across the Trust's sites. The choice of survey topics will be determined by a new patient experience working group whose membership will include representatives from the Trust's clinical Divisions; will be directed in part by the results of the postal survey; and may involve measuring the patient experience in outpatient settings. In between times, the devices will be available for Divisions to use for other targeted survey activity. Child-friendly hand-held devices will be introduced into the Bristol Royal Hospital for Children. It is anticipated that surveys of carers' views will also be captured in this way.

4. Piloting other methods of gathering real-time feedback from patients

For example, the Trust will explore the possibility of piloting 'Vital Signs' playing cards piloted successfully in the NHS North West Strategic Health Authority.

## 5. Continuing to engage our local communities

The Trust will run focus groups and qualitative interviews to develop greater insight into the things that matter to patients and public when it comes to hospital-based care. This will include consultation on any major service developments which affect our local communities and the Trust.

## Appendix 3

## UH Bristol Example Quality Dashboard

| Domain                 | Area                                                               | Quality Metric                                                                                    | Thresholds                  |                        |                            | Monthly Performance |        |        |        |        |        |        |        |        |        |        |        |
|------------------------|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------|------------------------|----------------------------|---------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|                        |                                                                    |                                                                                                   | Green                       | Amber                  | Red                        | Apr-10              | May-10 | Jun-10 | Jul-10 | Aug-10 | Sep-10 | Oct-10 | Nov-10 | Dec-10 | Jan-11 | Feb-11 | Mar-11 |
| Patient Safety         | Infection Control                                                  | MRSA screening                                                                                    | 95%                         | 80%                    | <80%                       |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Hand Hygiene Audits                                                                               | 95%                         | 80%                    | <80%                       |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Central line infections                                                                           | In development              |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Infections following urinary catheterisation                                                      | In development              |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Incidents                                                          | Serious Untoward Incidents                                                                        | Reduction on previous month | Same as previous month | Increase on previous month |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Never Events                                                                                      | 0                           | N/A                    | 1                          |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    |                                                                                                   |                             |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Falls                                                              | Number of in-patient falls                                                                        | Reduction on previous month | Same as previous month | Increase on previous month |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Repeat in-patient falls                                                                           | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Falls of in-patients aged over 65                                                                 | Reduction on previous month | Same as previous month | Increase on previous month |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Falls of in-patients aged over 65 with cognitive impairment                                       | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Total Pressure Ulcer incidence per 10,000 bed days                                                | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Tissue Viability- Reducing the prevalence of pressure ulcers CQUIN | Number of hospital acquired grade 2 pressure ulcers per 10,000 bed days CQUIN                     | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Number of hospital acquired grade 3 pressure ulcers per 10,000 bed days CQUIN                     | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Number of hospital acquired grade 4 pressure ulcers per 10,000 bed days CQUIN                     | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    |                                                                                                   |                             |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Venous Thrombo-embolism CQUIN                                      | % adult in-patients who have had a VTE risk assessment CQUIN                                      | 90%                         | 70%                    | 50%                        |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | % adult in-patients who received thrombo-prophylaxis                                              | 90%                         | 75%                    | 60%                        |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Nutrition                                                          | Patients with nutritional assessment within 24 hours                                              | To be agreed                |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Safety Checklist CQUIN                                             | WHO Surgical safety checklist compliance in theatres                                              | 95%                         | N/A                    | <95%                       |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Number of Executive Director Patient Safety Walk-arounds                                          | 6                           | 4-5                    | <4                         |                     |        |        |        |        |        |        |        |        |        |        |        |
| Clinical Effectiveness | Leadership                                                         | % actions completed within 2 months of patient safety walk-around                                 | 80%                         | 50%                    | <50%                       |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | HSMR                                                               | Hospital Standardised Mortality Ratio                                                             | <80                         | 80-90                  | >90                        |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | NICE Guidance                                                      | Quarterly measures to be determined                                                               |                             |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Elective length of stay CQUIN                                      | Reduction in elective length of stay CQUIN                                                        | To be determined            |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Emergency length of stay CQUIN                                     | Reduction in elective length of stay CQUIN                                                        | To be determined            |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Reduction in re-admissions CQUIN                                   | 14 day re-admissions                                                                              | To be determined            |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Learning Disability                                                | LD risk assessment of patients with known learning disability with 48 hours of hospital admission | 90%                         | 75%                    | <75%                       |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    |                                                                                                   |                             |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
| Patient Experience     | Complaints/ Compliments                                            | Number of Complaints per month                                                                    | <35                         | 35-45                  | >45                        |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | % complaints re Clinical Care                                                                     | <40%                        | 40-45%                 | >45%                       |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | % resolved within agreed local resolution plan                                                    | 98%                         | 90%                    | <90%                       |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | % complainants satisfied with response                                                            | 98%                         | 90%                    | <90%                       |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Number of Compliments.                                                                            | To be determined            |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Single Sex Accommodation                                           | Breaches of same sex accommodation                                                                | 0                           | N/A                    | 1                          |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        | Patient Experience CQUIN                                           | Involvement in decisions about treatment/care                                                     | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Hospital staff available to talk about worries/concerns                                           | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Privacy when discussing treatment                                                                 | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Informed about medication side effects                                                            | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |
|                        |                                                                    | Informed about who to contact if worried about condition after leaving hospital                   | To be established in Q1     |                        |                            |                     |        |        |        |        |        |        |        |        |        |        |        |



## Trust Board Meeting

|                                                                                                                      |                                                                                                                                        |                                         |            |                |            |                |            |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------|----------------|------------|----------------|------------|
| <b>Agenda Item</b>                                                                                                   | 9                                                                                                                                      | <b>Date: 29<sup>th</sup> March 2010</b> |            |                |            |                |            |
| <b>Title of Report</b>                                                                                               | Financial Report                                                                                                                       |                                         |            |                |            |                |            |
| <b>Recommendations<br/>(please outline the purpose of the report and the key issues for consideration/decision)</b>  | To inform the Trust Board of the Trust's financial position and report on related financial matters that require the Board's attention |                                         |            |                |            |                |            |
| <b>Actions Required</b>                                                                                              | To receive the report and comment on any issues of concern                                                                             |                                         |            |                |            |                |            |
| <b>Which Corporate Objective(s) are supported by this paper</b>                                                      |                                                                                                                                        |                                         |            |                |            |                |            |
| <b>Is this on the Trust's risk register? If yes please give details. If not, why not? Eg. Risk Score is below 15</b> |                                                                                                                                        |                                         |            |                |            |                |            |
| <b>Which healthcare commission standard does this report provide evidence for?</b>                                   |                                                                                                                                        |                                         |            |                |            |                |            |
| <b>Financial Implications</b>                                                                                        | <table border="1"> <tr> <td><b>Revenue</b></td> <td><b>£ 0</b></td> <td><b>Capital</b></td> <td><b>£ 0</b></td> </tr> </table>         |                                         |            | <b>Revenue</b> | <b>£ 0</b> | <b>Capital</b> | <b>£ 0</b> |
| <b>Revenue</b>                                                                                                       | <b>£ 0</b>                                                                                                                             | <b>Capital</b>                          | <b>£ 0</b> |                |            |                |            |
| <b>Prepared by: Name &amp; Title</b>                                                                                 | Paul Mapson, Finance Director<br>Paul Tanner, Head of Finance                                                                          |                                         |            |                |            |                |            |
| <b>Presented by: Name &amp; Title</b>                                                                                | Paul Mapson, Finance Director                                                                                                          |                                         |            |                |            |                |            |

## Previous Meetings

| Exec Team | Audit & Assurance Committee | Governance Risk and Risk Management | Finance Committee      | Trust Executive Group | Other Meeting Please state |
|-----------|-----------------------------|-------------------------------------|------------------------|-----------------------|----------------------------|
|           |                             |                                     | 23 <sup>rd</sup> March |                       |                            |

**TRUST BOARD**

|                                            |                                                                                                                                         |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| PAPER:                                     | Financial Report for the eleven months to 28 <sup>th</sup> February 2010                                                                |
| PURPOSE:                                   | To inform the Trust Board of the Trust's financial position and report on related financial matters that require the Board's attention. |
| FORMAT:                                    | Monthly report with revisions to reflect financial reporting requirements for NHS Foundation Trusts.                                    |
| THE FINANCE COMMITTEE<br>IS ASKED TO NOTE: | The February 2010 Financial Position                                                                                                    |

**Paul Mapson**  
**Director of Finance**  
**March 2010**

## Financial Overview

1. The summary income and expenditure statement shows a deficit of £4.321m for the eleven months to 28<sup>th</sup> February 2010. The cumulative position is £0.261m better than the proportion of the Annual Plan EBITDA<sup>1</sup> surplus for the period. A summary financial statement is attached as Appendix 1 with a further analysis of Divisional and other services provided as Appendix 2.

The estimated impact of the Modern Equivalent Value (MEA) revaluation of asset values has been included this month together with a proportion of the likely further reduction in the value of land and buildings to 31<sup>st</sup> March 2010. For clarity the position is shown below with and without the impact of asset revaluations:

|                              | Income and Expenditure for the<br>11 months to 28 <sup>th</sup> February |                                     |
|------------------------------|--------------------------------------------------------------------------|-------------------------------------|
|                              | Without Asset<br>Revaluations<br>£'000                                   | With Asset<br>Revaluations<br>£'000 |
| <b>EBITDA</b>                | <b>35,134</b>                                                            | <b>35,134</b>                       |
| Fixed Asset impairments      | -                                                                        | (14,493)                            |
| Depreciation                 | (16,730)                                                                 | (15,905)                            |
| Interest receivable          | 179                                                                      | 179                                 |
| Interest payable             | (428)                                                                    | (428)                               |
| PDC Dividend                 | (10,015)                                                                 | (8,808)                             |
| <b>Net Surplus/(Deficit)</b> | <b>8,140</b>                                                             | <b>(4,321)</b>                      |
| <b>Financial Risk Rating</b> | <b>3.65</b>                                                              | <b>4.05</b>                         |

2. The main Budget changes in February include the following:-

|                                              | £'000 |
|----------------------------------------------|-------|
| NICE funding to Divisions                    | 1,568 |
| Distinction Awards to Divisions              | 104   |
| European Working Time Directive to Divisions | 95    |

### 3. Overall Financial Position

The overspending on Divisional budgets in February represents a return to the average levels of adverse run rate reported for the period August to December. January showed an improvement against this trend because of (exceptionally) significantly higher than planned income. The income 'over performance' this month is £0.94m. Whilst income was higher than planned it did not fully cover higher levels of spending on pay and non pay budgets.

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<sup>1</sup> Earnings Before Interest Taxation Depreciation and Amortisation

This Divisional position can be summarised as follows:

|           |   |         |                                       |
|-----------|---|---------|---------------------------------------|
| August    | - | £0.983m |                                       |
| September | - | £1.006m |                                       |
| October   | - | £0.956m | (after R&D income change is excluded) |
| November  | - | £0.740m |                                       |
| December  | - | £1.128m |                                       |
| January   | - | £0.219m |                                       |
| February  | - | £0.895m |                                       |

Looking ahead then it is clear that the trend since August will not be sustainable in 2010/11. Every effort must now be made to ensure costs are properly controlled and CRES plans are in place to address not only slippage in 2009/10 but the full recurring requirement for 2010/11.

Pay expenditure for the month (excluding Skills for Health) shows costs running at £0.649m higher than planned in February. The detail for pay spending headings is shown in Appendix 3. This shows the actual spend by month by Division and at the Trust total level for key pay elements including bank, agency, waiting list payments and overtime payments. The Trust totals indicate that high levels of spend on these elements continue. Actual payments for bank, agency, waiting list and overtime (before the additional costs of employer's national insurance and pension contributions) were £1.599m in February. This represents a reduction in the rate of spending of £200k when compared with the average for the preceding 10 months.

The Trust achieved the contractual target required for the 18 week Referral to Treatment Time for admitted care in January. Initial indications show that February performance was above target, therefore a fine is not expected for this month.

The overall position on CRES shows an underachievement to date of £3.541m (January £3.248m). This represents further slippage of £0.293m in the month. The forecast year end under-achievement at month 11 is £3.835m. Not only will slippage on CRES schemes have a detrimental impact on the Trust's financial outturn this year but recurring schemes will be required from April 2010, in addition to the CRES requirement for that year.

As reported in previous months if the financial plan is to be achieved there must be both a higher level of CRES achievement and a significant reduction in pay costs for the remainder of the year. Management action to deliver this is essential.

#### **4. Income**

Contract income is £0.94m higher than planned in February and now stands at £8.27m over target for the year to date. This is summarised in the table below.

The majority of the over-performance is within BNSSG and the South West Specialised Commissioning Group. The main risk to contract income is that PCTs may refuse to pay for any over-performance, instead stating that the Trust must operate within the agreed contract value.

| <u>Clinical Income by Worktype</u> | <b>Plan</b>   | <b>Actual</b> | <b>Variance</b> |
|------------------------------------|---------------|---------------|-----------------|
| <i>Worktype</i>                    | <b>£m</b>     | <b>£m</b>     | <b>£m</b>       |
| Accident & Emergency attendances   | 8.04          | 8.48          | 0.44            |
| Planned Same Day (Day cases)       | 30.32         | 31.57         | 1.25            |
| Elective                           | 46.99         | 47.37         | 0.38            |
| Emergency                          | 62.52         | 65.08         | 2.56            |
| Non Elective                       | 23.19         | 23.51         | 0.32            |
| Critical Care Bed Days             | 25.60         | 26.30         | 0.70            |
| Outpatients                        | 42.38         | 42.67         | 0.28            |
| Excess Bed Days                    | 7.41          | 7.27          | (0.14)          |
| PbR Exclusion                      | 12.13         | 13.12         | 0.99            |
| At Cost Contracts                  | 1.76          | 1.86          | 0.09            |
| Exceptional Funding                | -             | 0.31          | 0.31            |
| Other                              | 45.41         | 46.49         | 1.08            |
| <b>Totals</b>                      | <b>305.75</b> | <b>314.02</b> | <b>8.27</b>     |

There may be minor differences in the totals due to roundings.

5. The income over-performance position for Bristol, North Somerset and South Gloucestershire PCTs needs to be understood. The position as at Month 10 (January) can be presented as follows:

| SLA Variances<br>(All £'000s)           | South<br>Glos<br>PCT | North<br>Somerset<br>PCT | Bristol<br>PCT | Total<br>BNSSG<br>PCTs |
|-----------------------------------------|----------------------|--------------------------|----------------|------------------------|
| Over-performance at Month 10            | 2,612                | 2,106                    | 1,708          | 6,426                  |
| Unidentified savings in SLA             | (1,160)              | (1,141)                  | (543)          | (2,844)                |
| A&E/Emergencies                         | (594)                | (1,110)                  | (1,443)        | (3,147)                |
| <b>Residual Over(Under) performance</b> | <b>858</b>           | <b>(145)</b>             | <b>(278)</b>   | <b>435</b>             |

This demonstrates that of the £6.4m over-performance to date £6.0m is due to unidentified savings in the SLA and emergency activity. In total there is, therefore, a residual over performance of £0.4m.

There are a number of income challenges in play currently. They include the following:

- Specialist Commissioning – Q1 and Q2 formal deadlines for queries have been missed by Commissioners so risk for Q1 and Q2 is nil. The risk for the rest of the year should be low as the Trust's cases are strong and charges are entirely valid;
- North Somerset – Q1 and Q2 formal deadlines for queries have been missed. The value of queries is £1.2m. The risk of significant loss is low.
- South Gloucestershire – Q1, Q2 and Q3 have been queried but formal deadlines for Q1 and Q2 have been missed. The risk of significant loss is low.

## 6. Expenditure

In total, Clinical Divisional budgets are overspent by £7.172m for the eleven months to 28<sup>th</sup> February. Pay and non pay budgets are overspent by £5.396m and £5.850m respectively. The surplus of £4.074m on income budgets partially offsets the expenditure overspendings.

**The Surgery, Head and Neck Division** reports an adverse variance of £2.384m after eleven months - a deterioration of £321k for the month. The adverse movement in February reflects a significant overspending on pay budgets - £347k in the month. Income and non pay budgets show small compensating net variances in the month.

The net overspending for the **Division of Women's and Children's Services** totals £2.231m for the eleven months to 28<sup>th</sup> February (January = £2,090k adverse). Pay budgets have overspent by £80k in the month. The income over performance of £253k has been offset by overspendings on non pay budgets of £314k.

The **Diagnostic and Therapies Division** reports a cumulative under spending of £103k after 11 months – an improvement in the month of £31k.

The **Division of Medicine** has overspent by £947k over the eleven month period to 28<sup>th</sup> February – an increase of £120k in the month. The overspending relates to the excess costs of providing additional capacity (50 beds) together with premium costs for vacancy and sickness absence cover and slippage on the CRES programme. These costs are greater than the favourable movement on income budgets in the month of £212k.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £1,392k (January £1,048k). The overspending in the month relates primarily to lower than planned income (£270k) for cardiac surgery and cardiology services as a result of difficulties having been experienced in getting sufficient access to theatres and ICU. The significant overspendings on non pay budgets relate to haemophilia services including £135k re inhibitor patients and Healthcare at Home (£129k). Both of these items of expenditure are covered by additional income. The Division reports the achievement of 77% of its CRES target of £1,615k to date. Representatives of the Division are to attend the Finance Committee meeting in March.

## 7. Forecast Outturn

The Trust, after excluding the impact of the MEA revaluation remains close to the target to achieve the Annual Plan surplus.

|                                      | Plan<br>£'000 | Forecast Outturn<br>£'000 |
|--------------------------------------|---------------|---------------------------|
| <b>EBITDA</b>                        | <b>38,042</b> | <b>39,000</b>             |
| Surplus before Impairments *         | 7,526         | 9,409                     |
| Impairments                          | (6,526)       | (15,819)                  |
| Depreciation – impact of impairments | -             | 900                       |
| PDC Dividend – impact of impairments | -             | 1,317                     |
| Net Surplus / (Deficit)              | <b>1,000</b>  | <b>(4,193)</b>            |

\* Additional surplus of £1,883k relates primarily to lower than planned depreciation in the light of slippage on the capital programme and balances on reserves.

## 8. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 28<sup>th</sup> February is 4. The actual value for each of the 5 metrics is given in the table below together with the bandings for each metric.

Appendix 6 provides further information on performance over the year together with a projection for the year end.

The Trust is also operating well within the 4 metrics specified in the Prudential Borrowing Limit.

|                     | Weighting | 28 <sup>th</sup> February | 5   | 4  | 3  | 2  | 1    |
|---------------------|-----------|---------------------------|-----|----|----|----|------|
| EBITDA              |           |                           |     |    |    |    |      |
| Margin %            | 25        | 7.88%                     | 11  | 9  | 5  | 1  | <1   |
| & achieved of Plan  | 10        | 100.7%                    | 100 | 85 | 70 | 50 | <50  |
| Return on Assets    | 20        | 6.18%                     | 6   | 5  | 3  | -2 | <-2  |
| I&E surplus margin  | 20        | 2.31%                     | 3   | 2  | 1  | -2 | <-2  |
| Liquid ratio (days) | 25        | 37.1 days                 | 60  | 25 | 15 | 10 | <-10 |

**Overall rating** **4 (actual weighted score = 4.05)**

## 9. Capital Programme

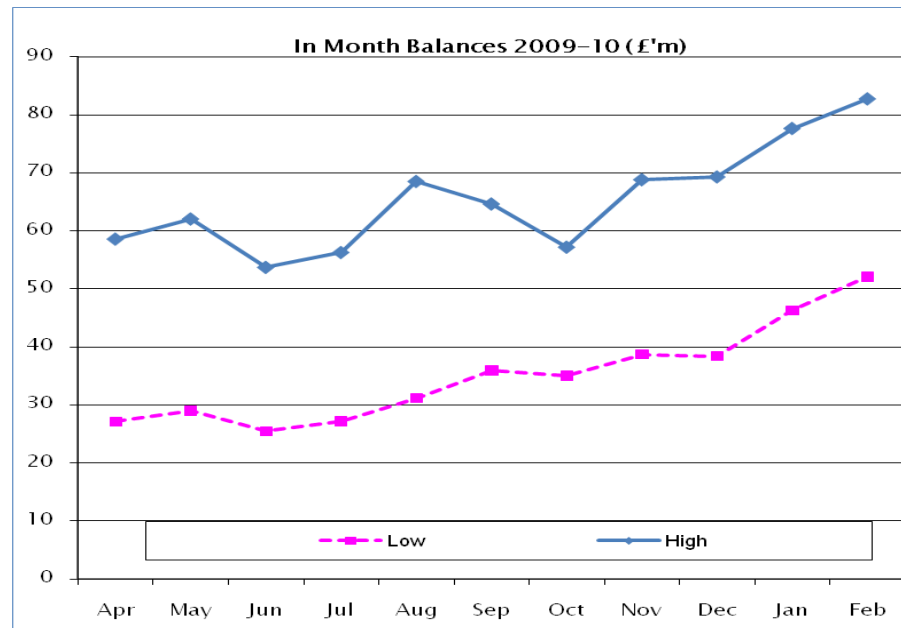
The Trust's capital programme for 2009/10 is £37.975m. The forecast expenditure for the financial year is £27.136m.

|                           | Approved Plan<br>for Year<br>£'000 | Position to 28 <sup>th</sup> February<br>Revised Plan<br>£'000 | Actual<br>£'000 | Variance<br>Fav / (Adv)<br>£'000 |
|---------------------------|------------------------------------|----------------------------------------------------------------|-----------------|----------------------------------|
| <b>Sources of Funding</b> |                                    |                                                                |                 |                                  |
| Public Dividend Capital   | 7,519                              | 7,519                                                          | 7,519           | -                                |
| Donations                 | 2,095                              | 15                                                             | -               | (15)                             |
| Asset Disposals           | -                                  | -                                                              | -               | -                                |
| Retained Depreciation     | 17,113                             | 15,687                                                         | 14,717          | (970)                            |
| Cash balances             | 11,248                             | (1,837)                                                        | (1,895)         | (58)                             |
| <b>Total Funding</b>      | <b>37,975</b>                      | <b>21,384</b>                                                  | <b>20,341</b>   | <b>(1,043)</b>                   |
| <b>Expenditure</b>        |                                    |                                                                |                 |                                  |
| Strategic Schemes         | (21,990)                           | (9,555)                                                        | (9,195)         | 360                              |
| Medical Equipment         | (9,247)                            | (6,157)                                                        | (5,536)         | 621                              |
| Information Technology    | (2,027)                            | (1,565)                                                        | (1,874)         | (309)                            |
| Roll Over Schemes         | (1,863)                            | (1,588)                                                        | (1,209)         | 379                              |
| Refurbishments            | (1,741)                            | (1,217)                                                        | (1,342)         | (125)                            |
| Operational / Other       | (4,989)                            | (1,302)                                                        | (1,185)         | 117                              |
| Anticipated Slippage      | 3,882                              | -                                                              | -               | -                                |
| <b>Total Expenditure</b>  | <b>(37,975)</b>                    | <b>(21,384)</b>                                                | <b>(20,341)</b> | <b>1,043</b>                     |

## 10. Statement of Financial Position (Balance Sheet) and Cashflow

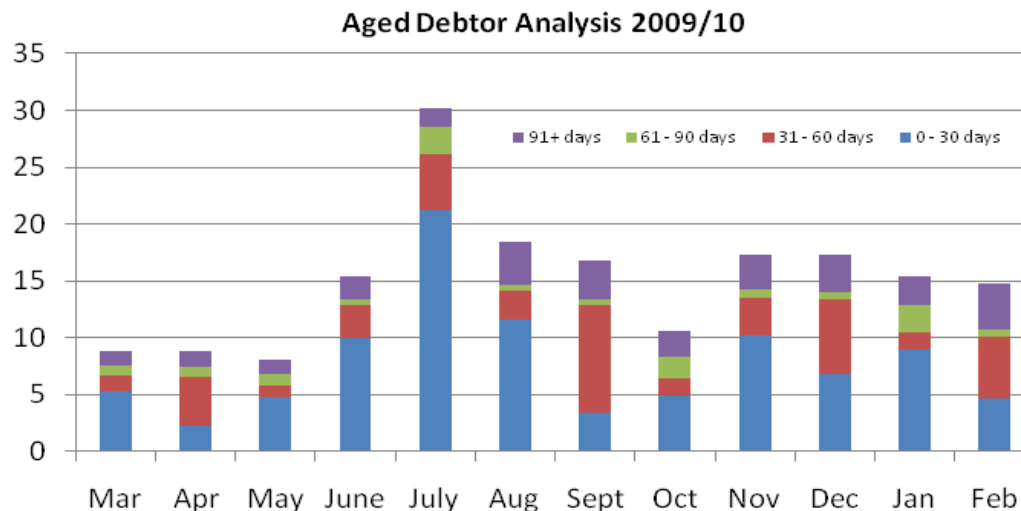
### Cash

The Trust held cash balances of £53.68m as at 28<sup>th</sup> February. This is higher than planned because of slippage on the capital programme (to be reinstated in 2010/11), and the early receipt of moneys re Skills for Health and Research and Development.



### Debtors

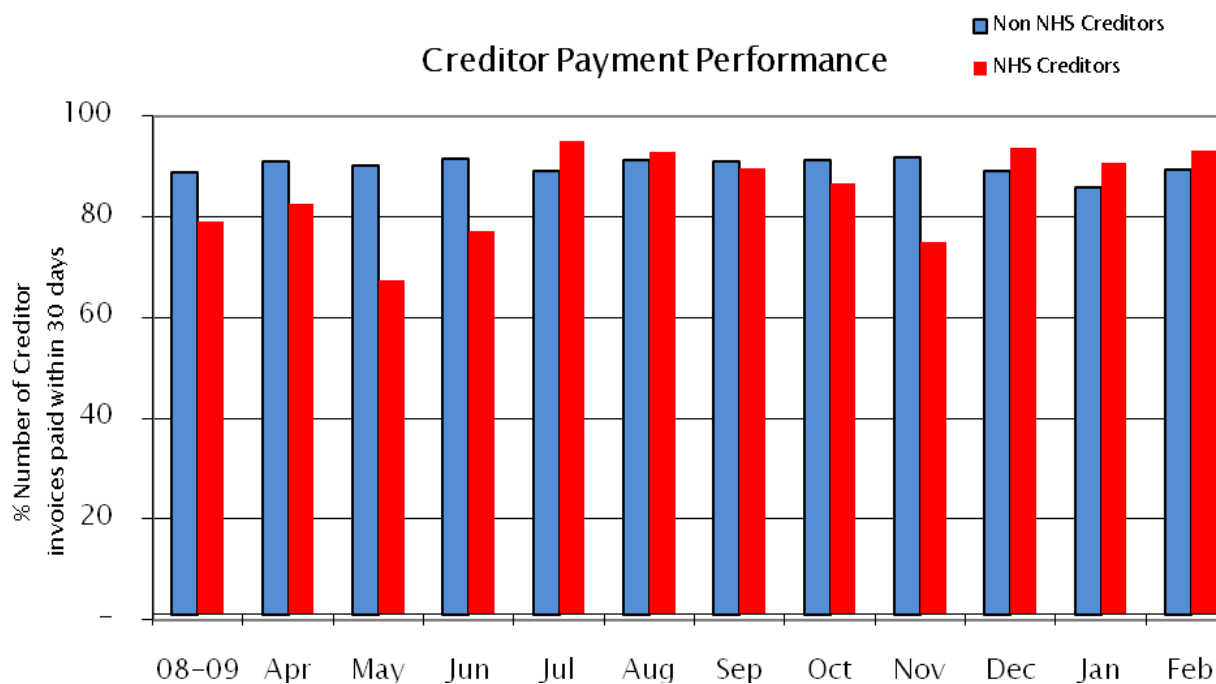
The total value of invoiced debtors has fallen by £0.705m during February to a closing balance of £14.733m. The amount owing is equivalent to 12.24 debtor days.





## Creditor Payments

The Trust aims to pay 90% of undisputed invoices within 30 days. The Trust achieved 93% and 89% compliance against the Better Payment Practice Code for NHS and Non NHS creditors. The cumulative position is 85% and 90% respectively.



### Attachments

- Appendix 1 – Summary Income and Expenditure Statement*
- Appendix 2 – Divisional Income and Expenditure Statement*
- Appendix 3 – Monthly analysis of pay expenditure 2009/10*
- Appendix 4 – Executive Summary*
- Appendix 5 – Financial Risk Matrix*
- Appendix 6 – Financial Risk Ratings*

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST  
Finance Report February 2010 – Summary Income & Expenditure Statement

| Approved Budget<br>/ Plan 2009/10 | Heading                                | Position as at 28th February |                  |                         | Actual to 31st<br>Jan | Forecast<br>Outturn |
|-----------------------------------|----------------------------------------|------------------------------|------------------|-------------------------|-----------------------|---------------------|
|                                   |                                        | Plan                         | Actual           | Variance<br>Fav / (Adv) |                       |                     |
| £'000                             |                                        | £'000                        | £'000            | £'000                   | £'000                 | £'000               |
|                                   | <b>Income (as per Table I and E 2)</b> |                              |                  |                         |                       |                     |
| 372,450                           | From Activities                        | 335,973                      | 341,508          | 5,535                   | 311,342               | 372,992             |
| 108,737                           | Other Operating Income                 | 98,205                       | 99,599           | 1,394                   | 91,348                | 109,008             |
| <b>481,187</b>                    | Sub totals income                      | <b>434,178</b>               | <b>441,107</b>   | <b>6,929</b>            | <b>402,690</b>        | <b>482,000</b>      |
|                                   | <b>Expenditure</b>                     |                              |                  |                         |                       |                     |
| (288,693)                         | Staffing                               | (264,047)                    | (269,866)        | (5,819)                 | (244,672)             | (294,763)           |
| (139,759)                         | Supplies and services                  | (128,238)                    | (136,107)        | (7,869)                 | (126,117)             | (148,237)           |
| <b>(428,452)</b>                  | Sub totals expenditure                 | <b>(392,285)</b>             | <b>(405,973)</b> | <b>(13,688)</b>         | <b>(370,789)</b>      | <b>(443,000)</b>    |
| (13,312)                          | <b>Reserves</b>                        |                              |                  |                         |                       |                     |
|                                   | Reserves                               | (7,020)                      | -                | 7,020                   | -                     | -                   |
| <b>(13,312)</b>                   | Sub Total Reserves                     | <b>(7,020)</b>               | <b>-</b>         | <b>7,020</b>            | <b>-</b>              | <b>-</b>            |
| <b>39,423</b>                     | <b>EBITDA</b>                          | <b>34,873</b>                | <b>35,134</b>    | <b>261</b>              | <b>31,901</b>         | <b>39,000</b>       |
| <b>8.19</b>                       | <b>EBITDA Margin – %</b>               |                              | <b>7.96</b>      |                         | <b>7.92</b>           | <b>8.09</b>         |
| (6,526)                           | Fixed asset impairments                | (6,052)                      | (14,493)         | (8,441)                 | (13,175)              | (15,819)            |
| (20,742)                          | Depreciation & Amortisation            | (19,643)                     | (15,905)         | 3,738                   | (14,502)              | (17,477)            |
| 104                               | Interest Receivable                    | 95                           | 179              | 84                      | 152                   | 180                 |
| (459)                             | Interest payable on loans & leases     | (421)                        | (428)            | (7)                     | (390)                 | (466)               |
| (10,800)                          | PDC Dividend                           | (9,900)                      | (8,808)          | 1,092                   | (8,008)               | (9,611)             |
| <b>1,000</b>                      | <b>NET SURPLUS / (DEFICIT)</b>         | <b>(1,048)</b>               | <b>(4,321)</b>   | <b>(3,273)</b>          | <b>(4,022)</b>        | <b>(4,193)</b>      |
| <b>0.21</b>                       | <b>Net margin – %</b>                  |                              | <b>(0.98)</b>    |                         | <b>(1.00)</b>         | <b>(0.87)</b>       |

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST  
Finance Report February 2010 – Divisional Income & Expenditure Statement

| Approved<br>Budget 2009/10 | Division                            | Total Net<br>Expenditure /<br>Income to Date | Position as at 28th February [Favourable / (Adverse)] |                |                     |                           |                           | Cumulative<br>Variance to<br>31st Jan | Forecast<br>Outturn<br>Variance |
|----------------------------|-------------------------------------|----------------------------------------------|-------------------------------------------------------|----------------|---------------------|---------------------------|---------------------------|---------------------------------------|---------------------------------|
|                            |                                     |                                              | Pay                                                   | Non Pay        | Operating<br>Income | Income from<br>Activities | Total Variance<br>to date |                                       |                                 |
| £'000                      |                                     | £'000                                        | £'000                                                 | £'000          | £'000               | £'000                     | £'000                     | £'000                                 | £'000                           |
|                            | <b>Service Agreements</b>           |                                              |                                                       |                |                     |                           |                           |                                       |                                 |
| 367,381                    | Service Agreements                  | 331,113                                      | -                                                     | -              | -                   | -                         | -                         | -                                     | -                               |
| (1,575)                    | SLA Performance                     | (1,574)                                      | -                                                     | (1,506)        | 9                   | 1,497                     | -                         | 78                                    | -                               |
| 40,789                     | NHSE Income                         | 37,353                                       | -                                                     | -              | (3)                 | -                         | (3)                       | -                                     | -                               |
| <b>406,595</b>             | <b>Sub Total Service Agreements</b> | <b>366,892</b>                               | <b>-</b>                                              | <b>(1,506)</b> | <b>6</b>            | <b>1,497</b>              | <b>(3)</b>                | <b>78</b>                             | <b>-</b>                        |
|                            | <b>Clinical Divisions</b>           |                                              |                                                       |                |                     |                           |                           |                                       |                                 |
| (41,872)                   | Diagnostic & Therapies              | (37,902)                                     | 276                                                   | (205)          | 202                 | (170)                     | 103                       | 72                                    | 132                             |
| (49,359)                   | Medicine                            | (46,522)                                     | (1,066)                                               | (1,263)        | 46                  | 1,336                     | (947)                     | (827)                                 | (990)                           |
| (58,487)                   | Specialised Services                | (54,219)                                     | (672)                                                 | (2,221)        | 95                  | 1,406                     | (1,392)                   | (1,048)                               | (1,600)                         |
| (79,576)                   | Surgery Head & Neck                 | (75,670)                                     | (2,758)                                               | (392)          | 100                 | 345                       | (2,705)                   | (2,384)                               | (2,900)                         |
| (76,482)                   | Women's & Children's                | (72,241)                                     | (1,176)                                               | (1,769)        | (139)               | 853                       | (2,231)                   | (2,090)                               | (2,416)                         |
| <b>(305,776)</b>           | <b>Sub Totals (1)</b>               | <b>(286,554)</b>                             | <b>(5,396)</b>                                        | <b>(5,850)</b> | <b>304</b>          | <b>3,770</b>              | <b>(7,172)</b>            | <b>(6,277)</b>                        | <b>(7,774)</b>                  |
|                            | <b>Corporate Services</b>           |                                              |                                                       |                |                     |                           |                           |                                       |                                 |
| (1,647)                    | Central Services                    | (1,546)                                      | (39)                                                  | 4              | -                   | -                         | (35)                      | (35)                                  | (40)                            |
| (55)                       | Community                           | (22)                                         | -                                                     | 27             | 1                   | -                         | 28                        | 27                                    | 32                              |
| (6,793)                    | Trust HQ                            | (6,178)                                      | 20                                                    | (346)          | 217                 | -                         | (109)                     | (129)                                 | (120)                           |
| (4,012)                    | Human Resources                     | (3,517)                                      | 250                                                   | 140            | (307)               | -                         | 83                        | 30                                    | 100                             |
| (5,143)                    | Information Technology              | (4,626)                                      | 65                                                    | (139)          | 93                  | -                         | 19                        | 14                                    | 20                              |
| (5,261)                    | Finance                             | (4,688)                                      | (62)                                                  | 152            | 59                  | -                         | 149                       | 106                                   | 150                             |
| (24,938)                   | Facilities & Estates                | (22,542)                                     | (266)                                                 | 41             | 38                  | 41                        | (146)                     | (190)                                 | (180)                           |
| (9,243)                    | Misc Support Services               | (8,800)                                      | 17                                                    | (718)          | 718                 | 227                       | 244                       | 142                                   | 162                             |
| 7,416                      | Research and Development            | 5,278                                        | (126)                                                 | 133            | 197                 | -                         | 204                       | 169                                   | 254                             |
| (30,306)                   | Capital Charges                     | (23,526)                                     | -                                                     | 4,830          | 55                  | -                         | 4,885                     | 4,342                                 | 4,454                           |
| <b>(79,982)</b>            | <b>Sub Totals (2)</b>               | <b>(70,167)</b>                              | <b>(141)</b>                                          | <b>4,124</b>   | <b>1,071</b>        | <b>268</b>                | <b>5,322</b>              | <b>4,476</b>                          | <b>4,832</b>                    |
| <b>(385,758)</b>           | <b>Sub Totals (1) and (2)</b>       | <b>(356,721)</b>                             | <b>(5,537)</b>                                        | <b>(1,726)</b> | <b>1,375</b>        | <b>4,038</b>              | <b>(1,850)</b>            | <b>(1,801)</b>                        | <b>(2,942)</b>                  |
| 1                          | <b>Skills for Health</b>            | 1                                            | (282)                                                 | 270            | 13                  | -                         | 1                         | -                                     | -                               |
| <b>(385,757)</b>           | <b>Totals I &amp; E</b>             | <b>(356,720)</b>                             | <b>(5,819)</b>                                        | <b>(1,456)</b> | <b>1,388</b>        | <b>4,038</b>              | <b>(1,849)</b>            | <b>(1,801)</b>                        | <b>(2,942)</b>                  |
|                            | <b>Reserves</b>                     |                                              |                                                       |                |                     |                           |                           |                                       |                                 |
| (2,413)                    | Inflation                           | -                                            | -                                                     | -              | -                   | -                         | -                         | -                                     | -                               |
| (6,526)                    | Modern Equivalent Asset Impairments | (14,493)                                     | -                                                     | (8,441)        | -                   | -                         | (8,441)                   | (7,596)                               | (9,293)                         |
| (10,899)                   | Other Reserves                      | -                                            | -                                                     | 7,020          | -                   | -                         | 7,020                     | 6,191                                 | 8,042                           |
| <b>(19,838)</b>            | <b>Sub Total Reserves</b>           | <b>(14,493)</b>                              | <b>-</b>                                              | <b>(1,421)</b> | <b>-</b>            | <b>-</b>                  | <b>(1,421)</b>            | <b>(1,405)</b>                        | <b>(1,251)</b>                  |
| <b>1,000</b>               | <b>TRUST TOTALS</b>                 | <b>(4,321)</b>                               | <b>(5,819)</b>                                        | <b>(4,383)</b> | <b>1,394</b>        | <b>5,535</b>              | <b>(3,273)</b>            | <b>(3,128)</b>                        | <b>(4,193)</b>                  |

## Analysis of pay spend month on month 2009/10

| Division               |                          | April<br>£'000 | May<br>£'000 | June<br>£'000 | July<br>£'000 | August<br>£'000 | September<br>£'000 | October<br>£'000 | November<br>£'000 | December<br>£'000 | January<br>£'000 | February<br>£'000 | Total<br>£'000 |
|------------------------|--------------------------|----------------|--------------|---------------|---------------|-----------------|--------------------|------------------|-------------------|-------------------|------------------|-------------------|----------------|
| Women's and Children's | Pay budget               | 5,134          | 5,207        | 5,065         | 5,147         | 5,170           | 5,316              | 5,154            | 5,218             | 5,262             | 5,266            | 5,334             | 57,273         |
|                        | Bank                     | 163            | 178          | 139           | 202           | 157             | 182                | 159              | 141               | 175               | 105              | 147               | 1,748          |
|                        | Agency                   | 17             | 39           | 20            | 29            | 25              | 13                 | 15               | 20                | 51                | 47               | 37                | 313            |
|                        | Waiting List initiative  | 52             | 45           | 49            | 46            | 49              | 40                 | 32               | 31                | 31                | 21               | 29                | 425            |
|                        | Overtime                 | 8              | 7            | 9             | 4             | 6               | 7                  | 5                | 5                 | 4                 | 12               | 8                 | 75             |
|                        | Other pay                | 4,982          | 5,029        | 5,133         | 5,139         | 5,150           | 5,139              | 4,938            | 5,106             | 5,052             | 5,027            | 5,193             | 55,888         |
|                        | Total Pay expenditure    | 5,222          | 5,298        | 5,350         | 5,420         | 5,387           | 5,381              | 5,149            | 5,303             | 5,313             | 5,212            | 5,414             | 58,449         |
|                        | Variance Fav / (Adverse) | (88)           | (91)         | (285)         | (273)         | (217)           | (65)               | 5                | (85)              | (51)              | 54               | (80)              | (1,176)        |
| Medicine               | Pay budget               | 3,168          | 3,393        | 3,391         | 3,341         | 3,364           | 3,381              | 3,351            | 3,302             | 3,341             | 3,500            | 3,376             | 36,908         |
|                        | Bank                     | 290            | 293          | 259           | 349           | 320             | 374                | 257              | 266               | 389               | 262              | 308               | 3,367          |
|                        | Agency                   | 16             | 63           | 37            | 58            | 63              | 22                 | 48               | 31                | 53                | 69               | 30                | 490            |
|                        | Waiting List initiative  | 35             | 27           | 43            | 9             | 8               | 30                 | 37               | 29                | 42                | 28               | 25                | 313            |
|                        | Overtime                 | 2              | 6            | 3             | 2             | 3               | 6                  | 4                | 5                 | 5                 | 4                | 4                 | 44             |
|                        | Other pay                | 2,825          | 3,134        | 2,978         | 2,942         | 3,002           | 3,100              | 3,019            | 3,151             | 3,133             | 3,198            | 3,278             | 33,760         |
|                        | Total Pay expenditure    | 3,168          | 3,523        | 3,320         | 3,360         | 3,396           | 3,532              | 3,365            | 3,482             | 3,622             | 3,561            | 3,645             | 37,974         |
|                        | Variance Fav / (Adverse) | 0              | (130)        | 71            | (19)          | (32)            | (151)              | (14)             | (180)             | (281)             | (61)             | (269)             | (1,066)        |
| Surgery Head and Neck  | Pay budget               | 5,210          | 5,302        | 5,173         | 4,683         | 5,199           | 5,219              | 5,200            | 5,310             | 5,049             | 5,178            | 5,153             | 56,676         |
|                        | Bank                     | 206            | 199          | 206           | 260           | 242             | 286                | 203              | 201               | 242               | 136              | 170               | 2,351          |
|                        | Agency                   | 156            | 124          | 151           | 143           | 102             | 131                | 177              | 135               | 172               | 170              | 150               | 1,611          |
|                        | Waiting List initiative  | 182            | 185          | 209           | 181           | 178             | 184                | 161              | 215               | 115               | 98               | 174               | 1,882          |
|                        | Overtime                 | 28             | 18           | 28            | 26            | 27              | 31                 | 26               | 29                | 15                | 19               | 13                | 260            |
|                        | Other pay                | 4,670          | 4,800        | 4,830         | 4,680         | 4,894           | 4,957              | 4,838            | 4,929             | 4,853             | 4,886            | 4,993             | 53,330         |
|                        | Total Pay expenditure    | 5,242          | 5,326        | 5,424         | 5,290         | 5,443           | 5,589              | 5,405            | 5,509             | 5,397             | 5,309            | 5,500             | 59,434         |
|                        | Variance Fav / (Adverse) | (32)           | (24)         | (251)         | (607)         | (244)           | (370)              | (205)            | (199)             | (348)             | (131)            | (347)             | (2,758)        |
| Specialised Services   | Pay budget               | 2,385          | 2,775        | 2,554         | 2,665         | 2,632           | 2,702              | 2,718            | 2,732             | 2,681             | 2,678            | 2,999             | 29,521         |
|                        | Bank                     | 66             | 79           | 86            | 121           | 88              | 109                | 72               | 72                | 87                | 66               | 73                | 919            |
|                        | Agency                   | 22             | (7)          | 28            | 13            | 76              | 51                 | 80               | 61                | (98)              | 42               | 10                | 278            |
|                        | Waiting List initiative  | 50             | 27           | 36            | 45            | 68              | 32                 | 32               | 59                | 7                 | 73               | 53                | 482            |
|                        | Overtime                 | 13             | 9            | 5             | 11            | 6               | 9                  | 9                | 11                | 11                | 15               | 9                 | 108            |
|                        | Other pay                | 2,408          | 2,603        | 2,582         | 2,509         | 2,530           | 2,587              | 2,527            | 2,635             | 2,581             | 2,555            | 2,889             | 28,406         |
|                        | Total Pay expenditure    | 2,559          | 2,711        | 2,737         | 2,699         | 2,768           | 2,788              | 2,720            | 2,838             | 2,588             | 2,751            | 3,034             | 30,193         |
|                        | Variance Fav / (Adverse) | (174)          | 64           | (183)         | (34)          | (136)           | (86)               | (2)              | (106)             | 93                | (73)             | (35)              | (672)          |

## Analysis of pay spend month on month 2009/10

| Division                                |                          | April<br>£'000 | May<br>£'000 | June<br>£'000 | July<br>£'000 | August<br>£'000 | September<br>£'000 | October<br>£'000 | November<br>£'000 | December<br>£'000 | January<br>£'000 | February<br>£'000 | Total<br>£'000 |
|-----------------------------------------|--------------------------|----------------|--------------|---------------|---------------|-----------------|--------------------|------------------|-------------------|-------------------|------------------|-------------------|----------------|
| Diagnostic & Therapies                  | Pay budget               | 2,749          | 2,813        | 2,864         | 2,857         | 2,934           | 2,969              | 3,207            | 2,959             | 2,939             | 3,076            | 2,848             | 32,215         |
|                                         | Bank                     | 31             | 32           | 43            | 56            | 54              | 68                 | 47               | 39                | 70                | 17               | 31                | 488            |
|                                         | Agency                   | 50             | 39           | 42            | 75            | 77              | 85                 | 82               | 37                | 19                | 47               | 55                | 608            |
|                                         | Waiting List initiative  | 14             | 8            | 10            | 13            | 19              | 9                  | 9                | 6                 | 3                 | 15               | 10                | 116            |
|                                         | Overtime                 | 13             | 9            | 5             | 11            | 6               | 9                  | 9                | 25                | 18                | 21               | 23                | 149            |
|                                         | Other pay                | 2,639          | 2,644        | 2,758         | 2,669         | 2,757           | 2,792              | 2,978            | 2,835             | 2,875             | 2,923            | 2,708             | 30,578         |
|                                         | Total Pay expenditure    | 2,747          | 2,732        | 2,858         | 2,824         | 2,913           | 2,963              | 3,125            | 2,942             | 2,985             | 3,023            | 2,827             | 31,939         |
|                                         | Variance Fav / (Adverse) | 2              | 81           | 6             | 33            | 21              | 6                  | 82               | 17                | (46)              | 53               | 21                | 276            |
| Facilities & Estates                    | Pay budget               | 1,261          | 1,427        | 1,373         | 1,604         | 1,390           | 1,612              | 1,390            | 1,378             | 1,676             | 1,468            | 1,443             | 16,022         |
|                                         | Bank                     | 36             | 36           | 38            | 57            | 53              | 69                 | 49               | 47                | 69                | 38               | 32                | 524            |
|                                         | Agency                   | 110            | 140          | 107           | 124           | 136             | 102                | 81               | 120               | 97                | 112              | 62                | 1,191          |
|                                         | Waiting List initiative  | 1              | 2            | 3             | 2             | 1               | 1                  | 1                | 2                 | 1                 | 2                | 2                 | 18             |
|                                         | Overtime                 | 89             | 90           | 99            | 116           | 103             | 123                | 87               | 90                | 89                | 99               | 94                | 1,079          |
|                                         | Other pay                | 1,084          | 1,184        | 1,174         | 1,343         | 1,181           | 1,363              | 1,172            |                   | 1,168             | 1,398            | 1,240             | 12,307         |
|                                         | Total Pay expenditure    | 1,320          | 1,452        | 1,421         | 1,642         | 1,474           | 1,658              | 1,390            | 1,427             | 1,654             | 1,420            | 1,430             | 16,288         |
|                                         | Variance Fav / (Adverse) | (59)           | (25)         | (48)          | (38)          | (84)            | (46)               | 0                | (49)              | 22                | 48               | 13                | (266)          |
| Trust Services                          | Pay budget               | 2,124          | 2,233        | 2,304         | 2,075         | 2,133           | 2,304              | 1,648            | 2,191             | 2,231             | 3,104            | 2,052             | 24,399         |
|                                         | Bank                     | 50             | 55           | 49            | 66            | 57              | 61                 | 36               | 43                | 56                | 37               | 34                | 544            |
|                                         | Agency                   | 20             | 27           | 4             | 18            | 19              | 19                 | 30               | 6                 | 11                | 5                | 11                | 170            |
|                                         | Waiting List initiative  | 1              | 0            | 0             | 1             | 0               | 0                  | 0                | 0                 | 0                 | 1                | 0                 | 3              |
|                                         | Overtime                 | 10             | 11           | 10            | 7             | 9               | 7                  | 4                | 7                 | 4                 | 6                | 5                 | 80             |
|                                         | Other pay                | 2,053          | 2,075        | 2,178         | 2,059         | 1,948           | 2,348              | 1,583            | 2,186             | 2,093             | 3,000            | 1,954             | 23,477         |
|                                         | Total Pay expenditure    | 2,134          | 2,168        | 2,241         | 2,151         | 2,033           | 2,435              | 1,653            | 2,242             | 2,164             | 3,049            | 2,004             | 24,274         |
|                                         | Variance Fav / (Adverse) | (10)           | 65           | 63            | (76)          | 100             | (131)              | (5)              | (51)              | 67                | 55               | 48                | 125            |
| Trust Total<br>(excl Skills for Health) | Pay budget               | 22,031         | 23,150       | 22,724        | 22,372        | 22,822          | 23,503             | 22,668           | 23,090            | 23,179            | 24,270           | 23,205            | 253,014        |
|                                         | Bank                     | 842            | 872          | 820           | 1,111         | 971             | 1,149              | 823              | 809               | 1,088             | 661              | 795               | 9,941          |
|                                         | Agency                   | 391            | 425          | 389           | 460           | 498             | 423                | 513              | 410               | 305               | 492              | 355               | 4,661          |
|                                         | Waiting List initiative  | 335            | 294          | 350           | 297           | 323             | 296                | 272              | 342               | 199               | 238              | 293               | 3,239          |
|                                         | Overtime                 | 163            | 150          | 159           | 177           | 160             | 192                | 144              | 172               | 146               | 176              | 156               | 1,795          |
|                                         | Other pay                | 20,661         | 21,469       | 21,633        | 21,341        | 21,462          | 22,286             | 21,055           | 22,010            | 21,985            | 22,829           | 21,015            | 237,746        |
|                                         | Total Pay expenditure    | 22,392         | 23,210       | 23,351        | 23,386        | 23,414          | 24,346             | 22,807           | 23,743            | 23,723            | 24,325           | 23,854            | 258,551        |
|                                         | Variance Fav / (Adverse) | (361)          | (60)         | (627)         | (1,014)       | (592)           | (843)              | (139)            | (653)             | (544)             | (55)             | (649)             | (5,537)        |

NOTE: Other Pay includes all employer's oncosts.

| Key Issue                                   | RAG                                                                                 | Executive Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Table                       |
|---------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Service Level Agreement Income and Activity |    | Contract income is £0.94m higher than planned in February and now stands at £8.27m over target for the year to date. The majority of the over-performance is within BNSSG and the South West Specialised Commissioning Group. The main risk to contract income is that PCTs may refuse to pay for any over-performance, instead stating that the Trust must operate within the agreed contract value.                                                                                                                                                                                                                                                                                                                                                                                                                               | INC 1                       |
|                                             |    | Accident & emergency attendances for April – January at 95,737 are 3,462 attendances higher than planned. Non elective activity at 14,307 spells is 1.6% less than planned, with a year on year increase of 2.3%. Emergency activity at 30,454 spells is 7.1% higher than planned, with a year on year increase of 6.5%. Overall elective activity is greater than planned to date - day cases by 1,596 spells partially offset by in patient activity being 390 spells less than planned for the period.<br>New outpatient activity and follow up out-patient activity are also greater than plan by 14,625 (13.4%) and 5,746 (1.9%) attendances respectively.<br>An income analysis by commissioner is shown at Table INC 2.<br>Information on clinical activity by Division, specialty and patient type is given at Table INC 3. | INC 2<br>INC 3              |
| Income and Expenditure                      |    | The overall position for the eleven months to 28 <sup>th</sup> February is a deficit of £4.321m. This is £261k (0.7%) better than the planned EBITDA surplus to date contained within the Annual Plan. The reported position for the period includes the estimated impact of the Modern Equivalent Asset revaluation together with a proportion of the impact of the forecast further downward revaluation of building values for March 2010. This has given rise to the reporting of a ‘technical deficit’ for the year to date.<br>Total income receivable to 28 <sup>th</sup> February is shown as £441.1m. This is £6.9m greater than plan to date.<br>Expenditure at £406m is higher than planned by £13.7m.                                                                                                                   | I&E 1<br><br>I&E 2<br>I&E 3 |
| Cash Releasing Efficiency Savings           |  | The 2009/10 CRES programme totals £14.909m. Actual savings are £3.541m (or 26%) behind target after 11 months. The forecast for the year using a weighted achievement methodology, which adjusts forecasts for the likelihood of successful delivery given progress and current status, indicates total CRES of £11.074m. This is of concern as it is £3.835m less than the target CRES.<br><br>The balance of the 2008/09 programme, which was not achieved recurrently in 2008/09, totals £2.892m. The required level of recurring savings to date has been achieved and Divisions forecast full achievement for the year.                                                                                                                                                                                                        | I&E 4a – 4b<br><br>4c - 4d  |

|                                 |                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          |
|---------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| Statement of Financial Position |    | <p>The cash balance on 28<sup>th</sup> February was £53.736m, of which £12.707m is attributable to Skills for Health under segmental reporting. The year-end cash balance is forecast to be £40.6m, an increase on the Annual Plan forecast given the likely slippage on the capital programme in 2009/10 and the projected impact of the Modern Equivalent Asset valuation.</p> <p>The balance on Invoiced Debtors has decreased by £0.705m in the month to £14.733m. Within this total are debtors for Skills for Health services of £0.644m (a decrease of £0.675m in the month).</p> <p>Creditors and accrual account balances total £66.188m although £14.977m relates to deferred income (including £8.709m for Skills for Health).</p> <p>Invoiced Creditors - payment performance for April – February of Non NHS invoices and NHS invoices within 30 days was 89% and 94% respectively.</p> | <p>BS 1<br/>BS 2<br/>BS 3<br/><br/>BS 4<br/><br/>BS5</p> |
| Capital                         |    | <p>Capital expenditure to 28<sup>th</sup> February totals £20.341m, this is £1.043m less than the revised plan to date of £21.384m.</p> <p>Projected expenditure for the year is £27.136. This is £10.839m less than planned primarily because of slippage on the BRI Redevelopment schemes, BHOC Refresh and Operational Capital schemes.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p>Capital 1<br/>Capital 2<br/>Capital 3</p>             |
| Financial Risk Rating           |    | <p>The Trust's overall financial risk rating using the results to 28<sup>th</sup> February has been calculated to be 4 (actual score 4.05). The Trust's ratings under the Prudential Borrowing Code are satisfactory with all ratios well within the Monitor thresholds.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                          |
| Private Patient Cap             |  | <p>Private patient income to 28<sup>th</sup> February was £1.73m. This equates to 0.51% of patient related income and is well below the Trust's Private Patient Cap of 1.1%.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                          |

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST  
Finance Report February 2010 - Risk Matrix

| Description of Risk                                                                   | Risk if no action taken |                 | Action to be taken to mitigate risk                                                                     | Lead | Residual Risk |                 | Progress / Completion                                                                                                               |
|---------------------------------------------------------------------------------------|-------------------------|-----------------|---------------------------------------------------------------------------------------------------------|------|---------------|-----------------|-------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                       | Risk Score              | Financial Value |                                                                                                         |      | Risk Score    | Financial Value |                                                                                                                                     |
| CRES Targets                                                                          | High                    | £'m<br>5.0      | CRES Group established. Monthly Divisional reviews to ensure targets are met.                           | IS   | High          | £'m<br>4.0      | Monthly reviews. Non recurring action if necessary.                                                                                 |
| Fixed asset revaluation to Modern Equivalent Asset basis (August Review)              | High                    | 10.0            | Provision in Financial Plan @ £1m. Discuss findings with District Valuer - September to December 2009   | PM   | High          | 4.1             | Meetings held with District Valuer to finalise valuations. Process and initial findings discussed and agreed with External Auditor. |
| Fixed asset impairments re Bristol Heart Institute and other major schemes            | High                    | 4.2             | Provision in Financial Plan @ £5.5m. Discuss findings with District Valuer - September to December 2009 | PM   | High          | 1.2             |                                                                                                                                     |
| SLA Performance Fines                                                                 | Medium                  | 6.6             | Infection Control plan implemented. Regular review of performance.                                      | IS   | High          | 0.5             | Notification received of fines re October and November performance on 18 week Referral to Treatment Time for admitted               |
| Maintain capacity to assist with delivery of 4 hour A&E maximum waits and 18 week PCT | Medium                  | 2.0             | Capacity plans developed by Divisions. Likely to be offset by additional income.                        | IS   | High          | 1.5             | Unfunded capacity in Medicine. Continued / increased use of waiting list initiative payments.                                       |
| PCT Income challenges                                                                 | Medium                  | 3.0             | Maintain reviews of data, minimise risk of bad debts                                                    | PM   | Medium        | 1.0             | Limited by SLA ceiling on in year challenges.                                                                                       |
| Fixed asset revaluation to Modern Equivalent Asset basis (March 2010 Review)          | Medium                  | 9.6             | Discuss with District Valuer - February 2010                                                            | PM   | Medium        | 9.4             | District Valuer advises of potential reduction of 14% on value of specialised buildings to March 2010                               |
| Energy costs                                                                          | Low                     | 0.5             | Carbon footprint / energy consumption awareness within Trust                                            | IS   | Low           | 0.1             | Monitoring of energy contract prices.                                                                                               |



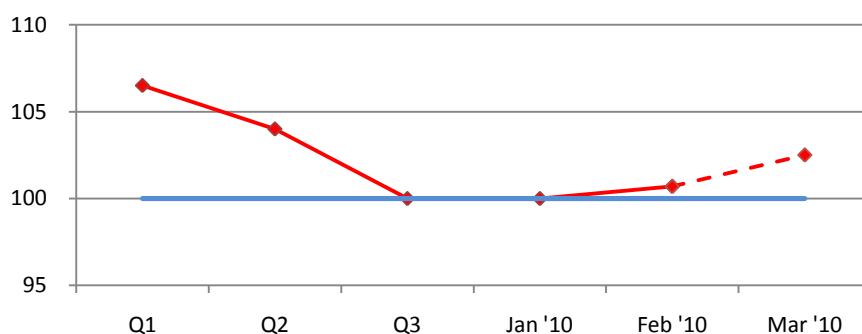
## Financial Risk Ratings – February 2010 Performance

### 1. Financial Risk Rating

Graphs showing performance against the 5 FRR metrics are provided below. Actual data showing Trust performance for 2009/10 is shown as a red line in each graph. Financial Risk Rating performance metrics are shown for FRR 5 (blue line); FRR 4 (green line) and FRR 3 (yellow line).

Planned performance as per the Trust's Annual Plan (agreed in May 2009) is given in the commentary for each graph.

#### EBITDA of Plan Achieved

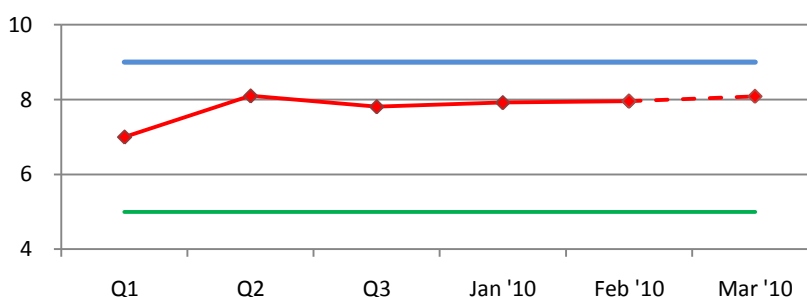


EBITDA Achieved at 100.7% is marginally greater than that shown in the Trust's Annual Plan submission to Monitor and therefore earns a rating of 5.

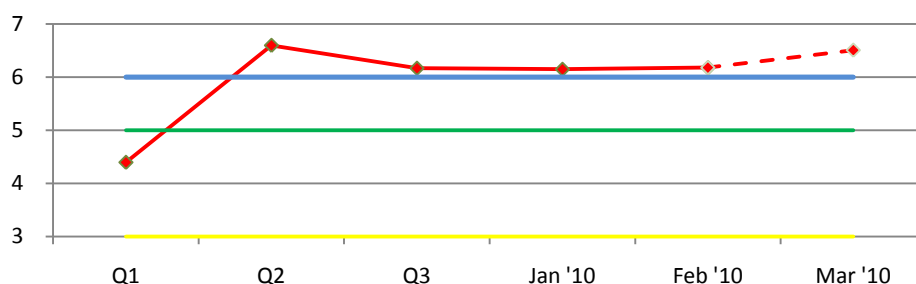
2009/10 Annual Plan EBITDA margin = 7.8%

The EBITDA Margin at 7.96% represents a small increase on the January rating (7.92%) and is now placed around the upper quartile of the band 3 rating (range 5 – 9%).

#### EBITDA Margin %



#### Return on Assets %



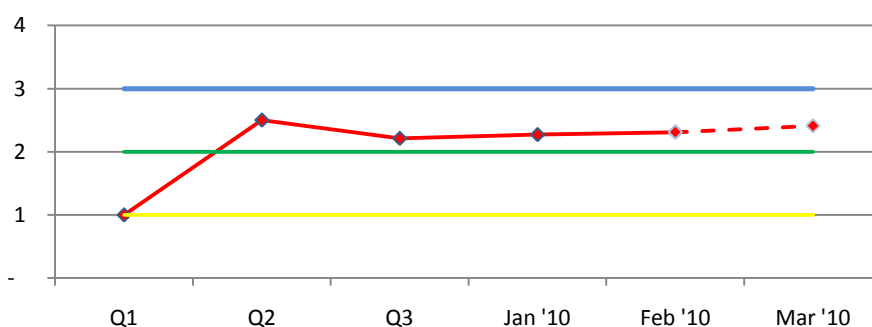
2009/10 Annual Plan Return on Assets = 5.1%

The Return on Assets has been calculated to be 6.18% - this is above the minimum value of 6% for this metric at level 5.

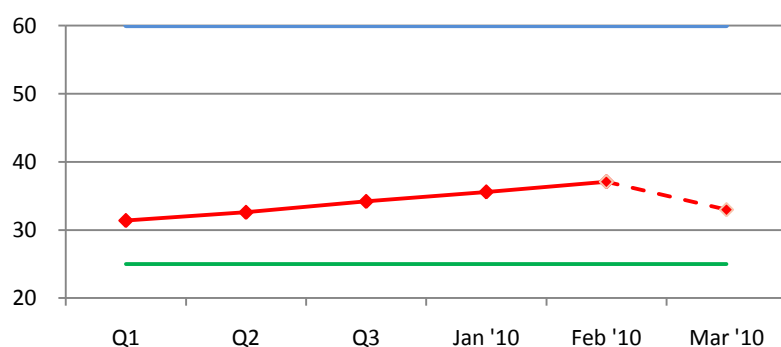
2009/10 Annual Plan I & E margin = 1.6%

The Income and Expenditure Surplus Margin at 2.31% falls into risk rating 4. This is on the lower quartile of the range (2 – 3%) for a band 4 rating.

## I & E Margin %



## Liquidity (days)



Annual Plan 2009/10 Liquidity = 26 days

The liquidity ratio at 37.1 days is above the band 4 minimum of 25 days. One day's operating expenditure equates to c£1.24m.

The liquidity ratio is expected to fall in March as a high level of payments / accruals are anticipated at the year end.

## 2. Prudential Borrowing Limit

Four ratio tests have been set by Monitor with the Trust required to ensure it remains within the individual thresholds. A summary of the Trust's performance for the nine months to 28<sup>th</sup> February is given in Table 2 below.

| Table 2                         | Monitor Ratio Tier 1 | 28 <sup>th</sup> February 2010 |
|---------------------------------|----------------------|--------------------------------|
| Minimum Dividend Cover          | >1x                  | 4.0x                           |
| Minimum Interest Cover          | >3x                  | 82x                            |
| Minimum Debt Service Cover      | >2x                  | 66x                            |
| Maximum Debt Service to Revenue | <2.5%                | 0.1%                           |

It can be seen that Trust performance to date against all of these ratios is satisfactory.

Trust Board Meeting

|                                                                                                                         |                                                                                                                                               |                                   |     |         |     |         |     |
|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----|---------|-----|---------|-----|
| Agenda Item                                                                                                             | 10                                                                                                                                            | Date: 29 <sup>th</sup> March 2010 |     |         |     |         |     |
| Title of Report                                                                                                         | Delivering Same Sex Accommodation                                                                                                             |                                   |     |         |     |         |     |
| Recommendations (please outline the purpose of the report and the key issues for consideration/decision)                | This purpose of this report is to appraise the Board of the current position with delivering same sex accommodation.                          |                                   |     |         |     |         |     |
| Actions Required                                                                                                        | The Board is asked to note the current status and to agree the declaration of compliance for publication by April 1 <sup>st</sup> 2010.       |                                   |     |         |     |         |     |
| Which Corporate Objective(s) are supported by this paper                                                                | This report supports the Trust’s 2009-10 objective (035) to comply with the standard on mixed sex accommodation.                              |                                   |     |         |     |         |     |
| Is this on the Trust’s risk register? If yes please give details. If not, why not? Eg. Risk Score is below 15           | Risk 1415 – failure to comply with new mixed sex ward standards                                                                               |                                   |     |         |     |         |     |
| Which registration commission standard does this report provide evidence for? Implications for the the NHS Constitution | No 1 – respecting and involving patients<br><br>The declaration supports the patient right to dignity and respect under the NHS Constitution. |                                   |     |         |     |         |     |
| Financial Implications                                                                                                  | <table><tr><td>Revenue</td><td>£ 0</td><td>Capital</td><td>£ 0</td></tr></table>                                                              |                                   |     | Revenue | £ 0 | Capital | £ 0 |
| Revenue                                                                                                                 | £ 0                                                                                                                                           | Capital                           | £ 0 |         |     |         |     |
| Prepared by: Name & Title                                                                                               | Pat Fields – Deputy Chief Nurse                                                                                                               |                                   |     |         |     |         |     |
| Presented by: Name & Title                                                                                              | Alison Moon – Chief Nurse                                                                                                                     |                                   |     |         |     |         |     |

**Previous Meetings**

Please insert the date the paper was presented next to the relevant group

| <b>Exec Team</b> | <b>Audit &amp; Assurance Committee</b> | <b>Governance Risk and Risk Management</b> | <b>Finance Committee</b> | <b>Trust Executive Group</b> | <b>Other Meeting Please state</b> |
|------------------|----------------------------------------|--------------------------------------------|--------------------------|------------------------------|-----------------------------------|
|                  |                                        |                                            |                          | 24/02/2010                   |                                   |

**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**  
**DELIVERING SAME SEX ACCOMMODATION**  
**BRIEFING PAPER FOR TRUST BOARD**  
**MARCH 2010**

**1. INTRODUCTION**

The purpose of this paper is to brief the Trust Board on the current status of delivering same sex accommodation within the Trust and provide assurance of level of compliance to enable the Board to make a declaration on compliance as required by Monitor. A self-assessment has been undertaken of patient experience, estates, systems and processes, and staff culture to provide the necessary assurance. This paper summarises key requirements, current status, actions that are being taken to deliver further improvements and monitoring processes.

**2. POLICY BACKGROUND**

The principle of same-sex accommodation in support of patient privacy and dignity is embedded in policy and guidance including the NHS Operating Frameworks for 2009/10 and 2010/11, a £100 million privacy and dignity fund to support improvements the launch of the *Same-Sex Accommodation: Your Privacy, Our Responsibility* campaign and a national improvement team to support trusts in delivery. Within the 2010/11 operating framework there are financial penalties associated with breaching same sex requirements.

Definitions and requirements for same sex accommodation for general and specialist areas were clarified in May 2009 with clear expectations that the principles of segregation in support of privacy and dignity were to be applied in all areas.

In February the Monitor Compliance Director advised all Trusts of a process to be followed in declaring compliance to delivering same sex accommodation by the end of March 2010. The actions required are:

- To carry out a self-assessment of readiness to deliver same sex accommodation;
- To develop a delivery plan to address areas of weakness that is agreed with the Commissioners;
- To post declaration on the website of whether the trust is compliant or non-compliant to virtual elimination of mixed sex accommodation;
- To implement agreed monitoring process with triggers and sanctions with the Commissioners; and
- To ensure the delivery plan is in NHS standard contract documentation.

### **3. SAME SEX-ACCOMMODATION STANDARDS AND REQUIREMENTS**

The Department of Health policy is that patients in any areas of hospital care should not usually have to share sleeping accommodation and sanitary facilities with members of the opposite sex. However, the policy does allow for exceptional circumstances where overriding clinical need (for example highly specialised or urgent care) may take priority over same-sex accommodation.

In practical terms, it is considered a breach of delivering same-sex accommodation where one or more of the following criteria apply to the placement of a patient:

- The patient occupies a bed space that is either next to or directly opposite a member of the opposite gender;
- The patient occupies a bed space that does not have access to single-sex washing and toileting facilities;
- No clinical justification exists or where a clinical justification applied is no longer appropriate.

For Children's Units it is recognised that clinical need and age and stage of development may take precedence over gender considerations and mixing of sexes is reasonable or even preferred. Decisions regarding mixing should also consider the psychological and social needs of children and the wishes of the parents. Children's services have formally reviewed processes and practices for delivering same sex accommodation in this area. This review has concluded that the facilities are sufficient to be able to offer choice of accommodation but that the challenge lies in communicating this to children and parents; this will be addressed in the communications strategy.

The Trust Executive Committee approved an operational policy for same sex accommodation in February 2010. The policy clearly outlines requirements for staff to follow, breaches to be reported, monitoring processes and actions to be taken in event of a breach.

### **4. THE TRUST'S POSITION**

Privacy and dignity has been an underlying principle in delivering care within the Trust. Aspects of delivering same sex accommodation have been addressed through this work, for example, bathroom and toilet upgrades. Heads of Nursing have reviewed their respective clinical areas, including all inpatient and day case areas, for compliance to same sex standards and to identify areas of good practice in applying the principles of segregation in specialist areas. This review confirmed the ability to provide same sex accommodation in all in patient areas by the end of March 2010. For specialist areas where mixing may occur for clinical reasons mitigating actions are in place as outlined in appendix I.

As required by Monitor, a further self-assessment has been undertaken focusing on four key areas:

- Patient experience;
- Estates;
- Systems and processes; and

➤ Staff culture.

For each area the survey requirement and the current evidence of compliance to the requirement are outlined in the table below.

| <b>Patient experience</b>                                                                                                                    | <b>Evidence</b>                                                                                                                                                                                                                                                                                                                                                                                 | <b>RAG</b> |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Patient experience has been measured on three separate occasions to demonstrate progress and submitted to SHA as requested                   | Surveys have been completed and submitted as required. The surveys have highlighted areas where further improvement in same sex accommodation was required and appropriate actions have been taken to address these                                                                                                                                                                             | Green      |
| There is an ongoing process in place to continue to measure patient experience of same sex accommodation with reports submitted to the Board | The monthly patient postal survey is being amended to include specific questions on same sex accommodation. Results will be included in quarterly board reports. Patients will also be able to provide real time comments using the proposed hand held consoles for patient experience monitoring                                                                                               | Green      |
| There is a process to track other mechanisms for determining patient experience of delivering same sex accommodation                         | Complaints related to same sex accommodation will be monitored quarterly by the Joint complaints, incidents and PALS review group and will be included in quarterly reports to Board                                                                                                                                                                                                            | Green      |
| Information leaflets for patients are available and used by staff in discussions                                                             | A leaflet has been developed and is available on wards. Staff will be made aware of this leaflet through the communication strategy                                                                                                                                                                                                                                                             | Green      |
| <b>Estates</b>                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                 |            |
| Privacy and dignity funding spent and projects completed                                                                                     | Estates works will be complete by end of March 2010. Work is still to commence on Ward 5, some of which is funded within the privacy and dignity funding. The ward is currently being used as a decant facility whilst other upgrade work is completed until the middle of April 2010. Ward 5 is scheduled for a major reconfiguration and upgrade which will address all same sex requirements | Green      |
| Estate is able to support virtual elimination of mixed sex accommodation                                                                     | Current and planned work has been undertaken to ensure the ward layouts can deliver same                                                                                                                                                                                                                                                                                                        | Green      |

|                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
|                                                                                                                                                                                                                                | sex accommodation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |       |
| Delivery of same sex accommodation is assured in planning of any new or refurbished capital development schemes                                                                                                                | Requirement included in policy. It has been confirmed that the current plans for the BRI redevelopment ensure compliance with same sex accommodation                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Green |
| <b>Systems and processes</b>                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       |
| Assurance to the board and monthly PCT reporting including a system of tracking all occurrences of mixing, whether clinically justified or not                                                                                 | A monthly snapshot of areas where mixing of sexes occurs for clinical need occur, e.g. ITU, will be included in reporting. Breach information will be collated by the BRI clinical site management. On a monthly basis this will be reported to NHS Bristol and will be included in the performance report that is presented to the Trust Executive Group and Trust Operational Group                                                                                                                                                                                                                        | Green |
| Where there are rare occurrences for non-clinical reasons, a process exists to investigate reason, take prompt action and take remedial actions as requires to prevent future occurrence                                       | A root cause analysis will be undertaken for each breach. A summary will be included in exception reporting for breaches as outlined above                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Green |
| Relevant trust policies refer to requirement to delivering same sex accommodation and privacy and dignity                                                                                                                      | The bed management policy is being revised and will include reference to same sex accommodation. The revision will be complete by the middle of April 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Green |
| The trust can demonstrate the virtual elimination of mixed sex accommodation in wards, assessment units, day facilities.<br>Patients do not share sleeping accommodation or toilet facilities with members of the opposite sex | The Divisions have confirmed that same sex accommodation has been the standard in most areas. Operational management of some admission areas (e.g. medical assessment unit; surgical and trauma assessment unit) has made the delivery of same sex accommodation more challenging. It is intended that by April 1 <sup>st</sup> 2010 the medical assessment facility, currently on ward 7, will be split with male only and female only facilities provided between wards 7 and 18. The surgical and trauma assessment unit will be addressed by using the whole of ward 14 as well as the assessment areas. | Green |



| <b>Staff culture</b>                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                               |       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| The board demonstrates a commitment to on-going delivery of same sex accommodation                                                                                                                                                | The board will formally make a declaration on compliance to delivering same sex accommodation as part of this paper. This declaration will be posted on the Trust website. Progress with the delivery plan and monitoring information will be reported to the board quarterly | Green |
| The trust has articulated its intent to deliver care with privacy and dignity within which delivery same sex accommodation is an integral component                                                                               | This is included in the annual plan and is included with corporate objectives. Trust induction programme will specifically include delivering same sex accommodation as a key value                                                                                           | Green |
| The trust believes that delivering same sex accommodation should be the norm. Mixing will only occur by exception for reasons of clinical justification or patient choice                                                         | The communications plan will focus on providing a zero tolerance message to staff corporately.                                                                                                                                                                                | Green |
| If mixing does occur, staff attempt to rectify the situation as soon as possible, whilst safeguarding the individuals dignity, keeping the patient informed about why the situation occurred and what is being done to address it | Remedial actions have been included within the Trust policy.                                                                                                                                                                                                                  | Green |

## 5. FINANCIAL CONSIDERATIONS

Within the 2010/11 contract there are sanctions that can be applied by the Commissioners. These sanctions include:

- Fines for not adhering to agreed delivery milestones
- Recovery of cost of procedure for all patient that breach

NHS Bristol has confirmed that within the contract they will determine three categories of breach:

- Category 1 Emergency Department and critical units
- Category 2 Medical Assessment Unit, Surgical Assessment Unit and day units
- Category 3 Inpatient wards

NHS Bristol have agreed that in the first year they will only issue a financial penalty for category 3 breaches only, with the anticipated financial penalty being £500.

## **6. DELIVERY PLAN**

The initial delivery plan for same sex accommodation and progress to date is included as appendix II. Ongoing improvement actions will be added to the delivery plan as required.

## **7. DECLARATION OF COMPLIANCE**

The Trust is required to publish a declaration of compliance to same sex accommodation on the website by end of March 2010. The Board is recommended to make a declaration of compliance based on the self assessment and evidence provided. A model declaration has been provided by Monitor (appendix III). The Board is asked to formally approve the declaration for immediate publication on the Trust website.

**Pat Fields – Deputy Chief Nurse/Operations**

**Mitigating actions for delivering principles of segregation in specialist areas**

| Division | Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medicine | <p><b>Emergency Department</b> - Solid fixed partitions between each cubicle at the majors end. The curtain tracking is doubled over at entry points to ensure that accidental breaching of patient privacy is avoided.</p> <p>The cubicles are arranged so that patients do not face each other. The resuscitation area has sturdy, but movable partitions.</p> <p><b>Ward 7</b> - 3 high care monitored beds in the central part of the ward immediately opposite the main nurses station. These beds have floor to ceiling partitioning to separate these 3 beds from the rest of the ward.</p> <p>There is 7 foot high partitioning that is extended to separate men from women within the high care area.</p> <p><b>Ward 11</b> - 4 high care monitored beds in the central part of the ward immediately opposite the main nurses station. These beds have floor to ceiling partitioning to separate these 4 beds from the rest of the ward. On either side of these beds is a side / isolation room.</p> <p>There is 7 foot high partitioning that is extended to separate men from women between each of the high care beds.</p> <p><b>Ward 10</b> – has a 6 bedded high care monitored beds in a separate area of the ward. There are 2 mobile flexible 7 foot high partitioning / screens that are used to separate male from female patients. 2 additional low level screens also are used to assist this segregation.</p> <p>There are a number of key principles that are applied to all of the above areas to enable single sex compliance:</p> <ul style="list-style-type: none"> <li>• Male or female patients are grouped together to assist with privacy and dignity (at one side of the high care section of the ward).</li> <li>• If patients in the adjacent beds are of different sexes then the fixed or mobile screens are extended so that patients can not see each other.</li> <li>• Toilet / bathroom / shower facilities all have ‘flicky’ signs to designate as either female or male use.</li> <li>• If the patients are mobile then they are grouped in such a way that they can exit the high care area to access a toilet with out pass in front of a patient of the opposite sex.</li> </ul> <p>(for ward 7 and 11 female patients grouped at the female side of the ward and male patients on the male side of</p> |

|                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      | <p>the ward respectively however ward 10 will rely on the positioning of the mobile screens).</p> <ul style="list-style-type: none"> <li>• All ward areas will have single sex compliance leaflets available for visitors and patients.</li> <li>• Staff are always based within these high care areas to observe and maintain patient dignity and privacy.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                      | <p><b>Ward 1a</b> - Admissions alternate between all male/all female to ensure compliance</p> <p><b>Queens Day Unit</b> - Patients in waiting area<br/> one: undressed patients split by sex<br/> dressed patients all together<br/> Patients in stage 1 recovery: have curtains insitu. High level of staffing in place to maintain privacy and dignity<br/> Patients in stage 2 recovery:<br/> A mobile screen is used between male and female patients</p> <p><b>Heygroves recovery</b> - 8 bay/bed space in PACU<br/> Mobile screens used between each patient to ensure privacy and dignity maintained<br/> High care patients based near the nurses station<br/> Appropriate level of staffing in place to ensure privacy and dignity</p> <p><b>St Michaels Recovery</b> - 7 bay/bed space (6 to standard size), curtained areas in all bed spaces<br/> Appropriate staffing levels in situ to ensure privacy and dignity is maintained</p> <p><b>ITU and HDU</b> - 15 bed spaces in ITU &amp; HDU<br/> ITU patients: 1:1 ratio per patient<br/> HDU patients: 1:1 ratio per patient<br/> Patients are discharged to a ward area (single sex compliant) as soon as clinically fit<br/> Each bed space has disposable curtains which can be used to maintain privacy and dignity</p> |
| Specialised Services | <p><b>Chemotherapy Day Unit</b> – patients all dressed, ability to curtain off areas if required. Examination rooms available if required</p> <p><b>CICU and HDU</b> - Patients are discharged to a ward area (single sex compliant) as soon as clinically fit<br/> Mobile screens – partitions used. High levels of observations.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

## Delivering same sex accommodation – Delivery plan 2010/11

|                | Issue                                                                                                  | Actions                                                                                                                                       | Accountable person            | Delivery date               | Measurable outcome                                                                                                                                                                                                                                                                                                | Progress                                                                                                          |
|----------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <b>Culture</b> | There is ongoing awareness at board level of same sex progress                                         | Develop processes for reporting to Board and include in policy                                                                                | Pat Fields/Jan Sutton/ J Wynn | March 31 <sup>st</sup> 2010 | The board receive a report on same sex implementation at least quarterly                                                                                                                                                                                                                                          | Achieved                                                                                                          |
|                | Staff awareness of same sex policy, patient expectations and processes for managing breaches is needed | Develop an internal communication plan that sets a zero tolerance approach to mixing sexes and ensures staff are aware of information sources | Sarah Pinch                   | May 2010                    | Staff will be able to describe the Trust policy on same sex accommodation, what information sources they can access and locate written patient information<br>Staff refer to mixing of sexes as the exception rather than inevitable in discussions<br>Written information for patients is available on all wards | Plan being developed, with input from privacy and dignity group and will be signed off by the Deputy Chief Nurse. |
|                | Same sex accommodation in paediatrics requires awareness by children, parents                          | Develop a bespoke communication plan for paediatrics                                                                                          | Sarah Pinch/Barbara Sherriff  | May 2010                    | Staff are able to describe the choices available to parents and children.<br>Staff can locate                                                                                                                                                                                                                     | Will form a subsection of main communications plan                                                                |

|                   |                                                                                                                          |                                                                     |                             |            |                                                                                                                                                                                        |                                          |
|-------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
|                   | and staff of the choices that can be made                                                                                |                                                                     |                             |            | resources to support discussion including written information. Children and parents demonstrate an awareness of the choices available<br>Written information is available in all wards |                                          |
|                   | Virtual elimination of mixed sex accommodation is not currently included in corporate objectives and actions for 2010/11 | Review objectives<br><br>Include in annual plan                     | A Moon/I Gray<br><br>B Hume | March 2010 | Virtual elimination of mixed sex accommodation is explicitly stated within corporate objectives or actions and progress is monitored                                                   | Achieved                                 |
|                   | Delivering same sex accommodation does not currently feature formally in trust training and education programmes         | Include delivering same sex accommodation in induction as a minimum | P Fields                    | March 2010 | Induction programme includes reference to eliminating mixed sex accommodation as a trust priority                                                                                      | Awaiting confirmation of inclusion       |
| <b>Experience</b> | An awareness of complaints related to mixed sex accommodation is                                                         | Include monitoring of mixed sex complaints at                       | Anne Reader                 | April 2010 | Review group minutes record discussion regarding mixed sex accommodation                                                                                                               | Reviewed and no complaints noted to date |

|                              |                                                                                                 |                                                                                                       |                                                               |                             |                                                                                                                       |                                           |
|------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
|                              | required                                                                                        | joint review group for incidents, claims, complaints and PALs and in Trust board reporting            |                                                               |                             | complaints Board reports includes reference to complaints received                                                    |                                           |
|                              | Surveying of patient experience is required ongoing                                             | Implement process for regular patient survey of same sex experience                                   | C Swonnell                                                    | April 2010                  | A patient survey is carried out at least quarterly and reports are included in reports to boards and other committees | Process for ongoing patient survey agreed |
|                              | Current level of mixing of sexes in the BRI admissions units (Wards 7 and STAU) is unacceptable | Implement split male female MAU on wards 18 and 7<br>Implement use of whole ward 14 for STAU patients | L Salmon/C Monk/H Julian/ I Gray/ M Nevin/J Palmer/C Thompson | April 2010                  | Breaches only occur for clinical need                                                                                 | In progress                               |
| <b>Systems and processes</b> | No Trustwide policy                                                                             | Compile, ratify and implement policy                                                                  | Jan Sutton/ J Wynn                                            | March 31 <sup>st</sup> 2010 | A ratified policy is on the DMS and the dissemination plan has been implemented                                       | Complete and policy on DMS                |
|                              | There are no robust monitoring and reporting processes for breaches and mixing of sexes for     | Develop monitoring processes within policy and implement in                                           | Jan Sutton/ J Wynn                                            | March 31 <sup>st</sup> 2010 | There is a clear monitoring reporting process within the policy at all levels from Ward to Board. The process         | Process agreed and being implemented      |

|               |                                                                 |                                                                      |                    |                             |                                                                                                                                                                                                      |                |
|---------------|-----------------------------------------------------------------|----------------------------------------------------------------------|--------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|               | clinical reasons                                                | practice                                                             |                    |                             | includes monitoring of breaches and of occasions of mixing when justified                                                                                                                            |                |
|               | A robust system for reporting to NHS Bristol is required        | Develop monitoring processes within policy and implement in practice | Jan Sutton/ J Wynn | March 31 <sup>st</sup> 2010 | NHS Bristol receive monthly monitoring information                                                                                                                                                   | Process agreed |
| <b>Estate</b> | There are outstanding privacy and dignity works to be completed | Ensure outstanding works are completed to schedule                   | Bob Pepper         | October 2010                | Programme of outstanding work is specifically identified within the ongoing works programme<br>Works are completed to schedule with exception reporting to Trust Operational Group of non compliance | Ongoing        |



### **Delivering Same-Sex Accommodation Declaration of compliance**

We are proud to confirm that mixed sex accommodation has been virtually eliminated in all our hospitals.

#### **Further information on our work to deliver same sex accommodation**

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The University Hospitals Bristol NHS Foundation Trust is committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

We are proud to confirm that mixed sex accommodation has been virtually eliminated in our trust. Patients who are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen by exception based on clinical need (for example where patients need specialist equipment such as in intensive care units and high dependency/high care areas), or when patients choose to share.

#### **What does this mean for patients?**

Other than in the circumstances set out above, patients admitted to University Hospitals NHS Foundation Trust can expect to find the following

**Same sex-accommodation means:**

- The **room where your bed is** will only have patients of the same sex as you
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area

It is possible that there will be both men and women patients on the ward, but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through opposite-sex areas.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (eg on your way to X-ray or the operating theatre).

It is probable that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting each other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

If you need help to use the toilet or take a bath (eg you need a hoist or special bath) then you may be taken to a “unisex” bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time.

**The NHS will not turn patients away just because a “right-sex” bed is not immediately available**

**What are our plans for the future?**

In all future developments a high standard of privacy and dignity, including same sex accommodation is included as a standard. The Trust will constantly monitor how well we are delivering care in same sex accommodation and will continue to make ongoing improvements.

**How will we measure success?**

We will undertake regular surveys of patient experience that will include same sex accommodation and privacy and dignity. We will monitor and act on any complaints that we receive regarding same sex accommodation.

**What do I do if I think I am in mixed sex accommodation?**

We want to know about your experiences. Whilst in hospital please talk to the nurse in charge of the ward, the Ward Sister or the Matron. Please contact the Acting Chief Executive if you have further comments or concerns.

**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**

**Audit and Assurance Committee**

**Minutes of a meeting held on Tuesday 9 March 2010**

**Present:** Sarah Blackburn (Chair), Non Executive Director  
Lisa Gardner, Non Executive Director  
Iain Fairbairn, Non Executive Director

**In attendance:** Robert Woolley, Acting Chief Executive  
Paul Mapson, Director of Finance  
Alison Moon, Chief Nurse  
Jonathan Sheffield, Medical Director  
Chris Swonnell, Assistant Director of Governance (Item 008)  
Steve Aumayer, Director of Workforce Development (Item 022)  
Jenny McCall, Head of Internal Audit  
Ian Whyte, Devon & Cornwall Internal Audit Consortium  
Kevin Henderson, Audit Commission  
Claire Thompson, Divisional Manager, Surgery Head and Neck (Item 014)  
Bob Pepper, Head of Estates & Facilities (Item 015)  
Sue Edmonds, Principal Counter Fraud Specialist (Items 016 – 019)

**Apologies:** Emma Woollett, Paul May

**006/10 Declarations of Interest**

There were no declarations of interest.

**007/10 Awayday – January 2010**

Sarah Blackburn reported that members of the Committee had completed a review of effectiveness at the awayday. Further consideration would be given to the committee's terms of reference.

**008/10 Role of clinical audit in supporting the delivery of strategic objectives**

The committee received a report discussing means by which the results of clinical audit activity could become an additional source of assurance.

Jonathan Sheffield was producing a report proposing a quality strategy which included proposals for a non-executive Quality Committee, reporting to the Trust Board. This body would lead the quality agenda and oversee the work of the clinical effectiveness and audit functions. It would enable Governance and Risk Management Committee to focus more on operational management.

The Strategic Review, which was launching on 22 March, would refer to the role of clinical audit in helping to deliver corporate objectives and risks. The findings and recommendations of the Francis Report would also be included, particularly in clarifying the respective roles of delivery and assurance. Joint working between clinical audit and resources audit was being considered.

It was emphasised by the committee that clinical audit should be adopting a pre-set work programme and reporting on outcomes.

### **009/10 Internal Audit – Progress and Performance Report 2009/10**

The committee received a report setting out the service's progress against the annual work programme and a summary of the status of audits and follow-ups.

It was noted that there were some instances where, upon follow-up, the assurance level had dropped; this was due to the implementation of earlier recommendations not being completed and a change of the scope of the Treasury Management audit. On managing of commissioning, it was noted that there had been delays in securing agreement to contracts by some health boards in Wales.

### **010/10 Internal audit reports**

The Committee received completed audit reports and action plans as follows:

- |                              |                                               |
|------------------------------|-----------------------------------------------|
| (a) anti-virus and spyware;  | (e) commissioning of contracts                |
| (b) creditor payments;       | (f) information governance                    |
| (c) final accounting 2009/10 | (g) financial reporting and budgetary control |
| (d) treasury management      |                                               |

In regard to treasury management, it was noted that the investment criteria were kept under review and that there was quarterly report to the Finance Committee on cash investments. The trust maintained a very low risk appetite.

The commissioning review had focused on the Trust's processes for managing contracts once signed. It was noted that there was limited formal control over services the Trust commissioned from other providers.

Paul Mapson circulated copies of a new staff leaflet in information governance requirements which had arisen from this audit. It was noted that the assessment of *reasonable* assurance had been a fine judgement. Quarterly meetings with the service and internal audit were continuing.

### **011/10 Limited assurance audits from 2008/09 – executive directors' actions**

The Committee received a report setting out the status of previous audits relating as follows:

| <b>Subject</b>                 | <b>Comments</b>                                                                                                                                                                                                                                                     |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| private and overseas patients  | Additional activity could be a means of using spare capacity and to gain income for the benefit of NHS patients; the Trust's income was well below the capping limit currently; non-compliance with the rules surrounding this would need to be dealt with robustly |
| business continuity planning   | It was noted that plans were in place and that testing was planned                                                                                                                                                                                                  |
| job planning for medical staff | It was emphasised that job planning processes needed to be managed through to scheduling and to reflect the Trust's objectives and its capacity requirements. The expectations around quality and performance were being defined                                    |

#### **012/10 Strategic internal audit plan 2010-13**

The Committee received a report detailing a finalised strategic internal audit plan following initial consideration at the 4 December meeting. It was noted that adjustments had been made to the allocation in respect of audits of performance management, CQC non-compliances and delivery of CRES. The Governance & Risk Management Committee would in future review draft audit reports before they reached the Audit and Assurance Committee.

The Committee approved the strategic internal audit plan.

#### **013/10 Merger of Avon and Devon & Cornwall internal audit consortiums**

The Chair welcomed Ian Whyte to the meeting. It was noted that the legal agreement setting up the new arrangement would be managed by UH Bristol; all the liabilities had been covered jointly by the participants. The Director of Finance would represent the Trust's client interests on the consortium's management board.

The consortium undertook audit work in a variety of health settings, but the big foundation trust hospital sites were considered to comprise the core membership. The consortium would represent a more sustainable approach and would retain a focus on the south-west. Jenny McCall would continue in her existing role, covering the Bristol locality.

#### **014/10 Update on progress with compliance with Healthcare Standard C4c – Decontamination and update on infection control audit**

The Committee received two reports updating on progress with addressing decontamination and infection control issues.

All the issues raised in 2008/09 healthcare standards declaration were now rated green with the exception of decontamination arrangements in ENT at St Michael's. It was noted that the Trust was in the third week of four commissioning new decontamination equipment. Concern was expressed about the need to ensure that equipment being inherited from other providers was fit for purpose before being accepted.

On infection control, the report detailed completed actions in relation to the audit that had given a rating of limited assurance. The Chief Nurse described the operation of the rapid response cleaning team that was deployed to help re-open wards closed for infection control reasons. The Infection Control Committee continued to make progress in addressing the issues.

#### **015/10 Dental Hospital lease**

The Committee received a report outlining proposals to regularise funding for the maintenance and usage/occupation for the Dental Hospital main building, the Wellcome Building, the University Extension and the Chapter House. Bob Pepper informed the Committee of proposals put forward by the Trust's legal advisers to agree a license that would set out the history and current arrangements. Paul Mapson stressed the urgency of this and Bob Pepper

confirmed the draft could be proposed to the University in two weeks. It was also emphasised that the license should provide termination arrangements.

#### **016/10 Counter-fraud – progress and performance on 2009/10 work plan**

The committee received a report detailing the days worked and remaining days and sanctions recently applied, including prosecutions and disciplinary action. It was noted that the service was undertaking a monthly poster campaign promoting awareness and was making presentations to divisional management board. There had been testing of awareness where to report instances of fraud.

#### **017/10 Audit Commission National Fraud Initiative**

The report gave details of a recent data matching exercise facilitated by the Audit Commission using public sector payroll, creditor, DWP and local authority information. The exercise had generated matches, but follow-ups had not detected any fraudulent activity.

#### **018/10 Implementation of recommendations made through counter-fraud work**

The Committee received a report indicating that of 28 recommendations made, 22 had been implemented and others were being progressed with management, including centralising of arrangements for booking agency staff. Improved arrangements had been introduced in MEMO and in relation to employee expenses.

#### **019/10 Counter Fraud Strategic Plan 2010-13**

The Committee received a report setting out the range of services provided by the service, the strategic work plan built on a mixture of culture, deterrence, prevention, detection, investigation, sanctions and redress, plans for 2010/11 and an assurance framework.

#### **020/10 External audit progress report and briefing paper**

The Committee received a report giving the status of outputs for 2009/10 including the annual audit letter, final accounts, report to those charged with governance and interim audit. The report also drew attention the developments with the Monitor consultation on Quality Accounts, private patient income and the payment by results assurance framework. Kevin Henderson also highlighted the publication by Monitor its consultation on changes to procedures to de-authorise foundation trusts and a report from CIPFA “Strategies to Modernise the NHS”.

#### **021/10 Opinion Audit Plan 2009/10**

The report set out the key risk issues and timescales in relation to the 2009/10 financial statements. The Trust undertook to provide the financial statements by 23 April and the audit opinion would be concluded by 8 June.

#### **021/10 Annual External Audit Fee 2010/11**

The Committee noted the proposed fee for the audit of the 2009/10 financial statements.

### **022/10 Response to Audit Commission recommendations on ward staffing**

The Committee received the report of the working group giving a response to the five recommendations from the Audit Commission review. The composition of the group had ensured a balanced approach between meeting financial and patient care requirements. There was good support for the recommendations for the initiative from the heads of nursing in divisions. The group's work had addressed the particular wards the subject of the Audit Commission study and one further ward.

Clinical Nurse Specialists were found in some instances not to have a job plan in place; this would be addressed and improved information on the impact of their work would be gathered. A separate work stream to look at ward staffing in the round would be starting in 2010/11. It was suggested that a similar approach to the one adopted in this exercise be applied to the work of consultants.

Iain Fairbairn expressed concern about unfunded beds referred to in the report and Alison Moon indicated that improvements to the effectiveness of the management of bed days would address this. For inpatients, changes to skills mixes were being implemented in 2010/11. Training for assistant practitioners was being made available as a long-term approach to possible shortages of skilled recruits in the future.

There was a 23% uplift to the required staffing numbers to cover absences in rosters; this was considered still to be the right figure, but the project was challenging the permanent/temporary staff ratio in the planning process. Improvements were being made to the management of sickness, including better information for line managers, fit notes and contact at pre-set intervals for longer-term cases.

It was agreed that further benchmarking through the Audit Commission would be deferred and would continue locally and with the Association of University Teaching Hospitals.

### **023/10 Assurance on Accounting Issues and Disclosures**

The report of the Director of Finance indicated that the Finance Committee would be considering a further amendment to the accounting rules which would clarify the methodology for valuing non-current assets.

### **024/10 Governance & Risk Management Committee – 11 February**

The Committee received the draft minutes of the recent meeting of the Governance and Risk Management Committee. In response to a question, Alison Moon confirmed that the issues around the exceptional admission of a small number of patients to the hospital that could not be cared for properly had been addressed.

It was noted that proposals to improve the risk register would be considered by the March meeting of the Trust Board. Sarah Blackburn requested that this address the Trust's strategic risks.

Robert Woolley informed the Committee that the Care Quality Commission had indicated that the Trust would receive unconditional registration, with a routine improvement letter asking to be kept informed of how the trust was addressing gaps and concerns.

**025/10 Losses and Compensation Report**

The Director of Finance reported for information on losses and compensation for November 2009 to January 2010 totalling £11,942.

**026/10 Recent meetings of Trust Executive Group**

Robert Woolley informed the Committee that the main issues considered by TEG at its February meeting were around operational performance, the operating plan 2010/11, the required declaration in relation to single sex patient accommodation.

**027/10 Appointment of external auditors**

It was noted that the Membership Council had agreed the appointment of the Audit Commission as the external auditor for a period of three years from 1 April 2010. A policy on the commissioning of non-audit work from the external auditor would be considered by the Membership Council.

**028/10 Draft Assurance Framework 2010/11**

The Committee received an outline of the proposed format for the Board Assurance Framework based on the draft aims and objectives.

**029/10 Matters Arising**

The summary of matters arising from the meetings of the committee held between June 2009 and January 2010 was noted.

**030/10 Dates of future meetings**

It was noted that the Trust Board had agreed an additional meeting on Friday 4 June 2010 to consider the draft annual report 2009/10 and annual accounts.



|                                                                                                    |                                                                                                                                                                           |         |     |  |         |     |         |     |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----|--|---------|-----|---------|-----|
| Trust Board Meeting                                                                                | Date: 29 March 2010                                                                                                                                                       |         |     |  |         |     |         |     |
| Agenda Item                                                                                        | 12                                                                                                                                                                        |         |     |  |         |     |         |     |
| Title of Report                                                                                    | Quarter 4 Review of Board Assurance Framework 2009/10                                                                                                                     |         |     |  |         |     |         |     |
| Recommendations                                                                                    | The Board is invited to receive the quarter 4 update of the assurance framework 2009/10.                                                                                  |         |     |  |         |     |         |     |
| Actions Required                                                                                   | As above. A revised format is proposed separately for the 2010/11 objectives.                                                                                             |         |     |  |         |     |         |     |
| Which Corporate Objective(s) are supported by this paper?<br>Implications for the NHS Constitution | All of the 2009/10 annual objectives are supported by the Assurance Framework.<br><br>There are no direct implications for the NHS Constitution arising from this update. |         |     |  |         |     |         |     |
| Is this on the Trust’s risk register?                                                              | If yes please give details. If not, why not? Eg. Risk Score is below 15<br><br>This work is not on the risk register, but links to it.                                    |         |     |  |         |     |         |     |
| Which CQC registration standards does this report provide evidence for?                            | This report is in relation to the Standards for Better Health objectives.                                                                                                 |         |     |  |         |     |         |     |
| Financial Implications                                                                             | <table><tr><td>Revenue</td><td>£ 0</td><td>Capital</td><td>£ 0</td></tr></table>                                                                                          |         |     |  | Revenue | £ 0 | Capital | £ 0 |
| Revenue                                                                                            | £ 0                                                                                                                                                                       | Capital | £ 0 |  |         |     |         |     |
| Prepared by: Name & Title                                                                          | David Seabrooke, Company Secretary                                                                                                                                        |         |     |  |         |     |         |     |
| Presented by: Name & Title                                                                         | David Seabrooke, Company Secretary                                                                                                                                        |         |     |  |         |     |         |     |
| Appendices                                                                                         | Appendix 1 – Board Assurance Framework 2009/10 Q4 update                                                                                                                  |         |     |  |         |     |         |     |

## Previous Meetings

Please insert the date the paper was presented under to the relevant group

| Exec Team | Audit & Assurance Committee | Governance Risk and Risk Management | Finance Committee | Trust Executive Group | Other Meeting (Please state)   |
|-----------|-----------------------------|-------------------------------------|-------------------|-----------------------|--------------------------------|
|           |                             |                                     |                   |                       | Trust Board – 22 December 2009 |

1. This is the final (quarter 4) iteration of the Board Assurance Framework 2009/10. The 2009/10 assurance framework was specifically in relation to the Healthcare Standards (rows 001, 006, 007, 009, 010, 019, 020 and 038) and the Trust's objectives from the Corporate Plan 2009/10.
2. This report comprises an update to the Board Assurance Framework, setting out changes to the systems of assurance and reporting that have occurred during the quarter. Some of the 2009/10 objectives are proposed to continue as objectives in the 2010/11 corporate plan, albeit with changes to the wording in most instances and are included on the new assurance framework for that year.
3. The Quality Strategy will implement new reporting streams and, if agreed, would establish a Quality Committee reporting to the Board. Putting this committee in place would re-route many of the assurance streams currently feeding into the Governance & Risk Management Committee.
4. The updates to the matrix reflect the following changes during 2010:
  - The proposed quality strategy for the Trust and work towards agreeing the content of quality metrics; work underway to ensure compliance with National Patient Safety Alerts and the recent attainment of Level 3 NHS litigation authority's benchmark by the maternity service
  - The nearing of completion of action plans to lead to compliance under Healthcare Standard C4c and recent internal report considered by the 9 March 2010 Audit & Assurance Committee giving an assurance level of 'reasonable'
  - The continuation of actions to improve A&E and cancer performance and the Monitor escalation
  - The post of Data Manager to conduct heart disease audits being filled in March 2010
  - Actions to bring about compliance with the CQC Outcome 5 standard on nutritional services, which include the roll-out of protected mealtimes on wards, adaptive cutlery, more consistent nutritional screening and nutrition care planning
  - The current situation with the BRI redevelopment
  - The introduction of improved training record-keeping arrangements
  - Completion and testing of civil Contingencies plans
- 5 Red ratings remain for two of the objectives:

| Ref | Summary                                     | Reasons                                                                                               |
|-----|---------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 003 | Reducing unnecessary A&E attendances        | Because of the current Monitor rating for A&E/4 hours performance                                     |
| 041 | Achieving Cash releasing efficiency savings | Current projections indicate there will be a significant shortfall in relation to the 2009/10 target. |

| Ref.                   | Objective                             | Date reviewed | S4BH/AFLink | Principal Risk                                         | Risk Type          | Key Controls                                                                          | Internal Assurance                                                         | Independent Assurance                                                      | Independent Assurance Level*                   | Gaps in Control or Assurance                             | Monitoring Systems          | Internal Assurance Committee                                       | Overall Assurance Level**                                          | Action Plans                        | Delivery date            | Responsible Director/s | Assurance level after action                                                                           |
|------------------------|---------------------------------------|---------------|-------------|--------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------|-----------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------|--------------------------|------------------------|--------------------------------------------------------------------------------------------------------|
| Trust allocated Ref No | What the organisation aims to deliver |               |             | What could prevent the objective from being delivered? | As per Annual Plan | What controls/systems do we have in place to assist secure delivery of the objective? | What internal evidence is there relating to the effectiveness of controls? | What external evidence is there relating to the effectiveness of controls? | Evaluation of the quality of assurance sources | Where are we failing to put effective controls in place? | Who is monitoring progress? | Who is receiving assurance that sufficient progress is being made? | How assured are we that this risk is being sufficiently mitigated? | What else are we doing/going to do? | By when will we do this? |                        | How assured are we now that this risk is being sufficiently mitigated? Do we accept the residual risk? |

|                                           |       |
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| * Quality of Independent Assurance Level: |       |
| Independent and reliable                  | GREEN |
| Somewhat independent and reliable         | AMBER |
| Not very independent or reliable          | RED   |

|                                                                                                        |       |
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| **Overall Assurance Level:                                                                             |       |
| Effective controls definitely in place and Board satisfied that appropriate assurances are available = | GREEN |
| Effective controls thought to be in place but assurances are uncertain and/or possibly insufficient =  | AMBER |
| Effective controls may not be in place and/or appropriate assurances are not available to Board =      | RED   |

Strategic Aim: To provide efficient, effective services to the highest standards

| Ref. | Objective                                                                                                                                                                                     | Date reviewed | S4BH/AFLink        | Principal Risk                                                         | Risk Type       | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Internal Assurance                                                                                                                                                                                                                                         | Independent Assurance                                                                                     | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                                                                                                                                                                      | Monitoring Systems                                                                                                                                                                                                                                                                                 | Internal Assurance Committee             | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                           | Delivery date                                     | Responsible Director/s           | Assurance level after action |
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| 001  | To produce an Annual Quality Report for the Trust and develop KPIs for Patient Safety, Clinical Effectiveness and Patient Experience (see also Corporate Objective 017 re patient experience) | 09/10/09      | C1a, C1b, C3, C5a, | See risk identified for Objective 017<br>Risk 885 re NHSLA compliance. | Governance Risk | <p>Corporate and Divisional Patient Safety and Clinical Effectiveness arrangements.</p> <p>Healthcare Standards compliance and HSMR monitoring</p> <p>VTE prevention programme</p> <p>Trustwide incident reporting and monitoring</p> <p>Participation in South West Quality and Patient Safety Improvement Programme</p> <p>BNSSG NICE Commissioning College, including monthly review of inter-agency actions</p> <p>Regular reports of NICE audits going to PCTs</p> <p>Quality Strategy being developed</p> | <p>Board papers of progress of Quality Accounts. Outputs from Quality Metrics Away day 25/11/09.</p> <p>Patient Safety and Clinical Effectiveness reports to GRMC.</p> <p>NICE Guidance dashboard.</p> <p>NHSLA Level 3 attained by Maternity Services</p> | <p>HCC inspection June 2008 C1a and C3 passed.</p> <p>NHSLA Level 1 assessment September 2009 passed.</p> | Green                       | <p>Accountability and expectations for auditing NICE guidance to be led by Clinical Effectiveness Committee/Clinical Audit Committee.</p> <p>Implementation delays for NICE Technology Appraisals where there is a significant commissioning component.</p> <p>7/50 NHSLA standards did not pass Level 1 assessment</p> <p>See objective 017.</p> | <p>Clinical Effectiveness Committee reviews of NICE compliance.</p> <p>Patient Safety reports to GRMC.</p> <p>Board reports on reviews of learning from governance incidents in other health providers.</p> <p>GRMC and Audit &amp; Assurance monitoring of Healthcare Standards to the Board.</p> | Governance and Risk Management Committee | Amber                   | <p>Further development of metrics for inclusion in the quality account for 2009/10.</p> <p>Patient Safety Teams are working on remaining 7 NHSLA standards and towards Level 2/3 assessment date in spring 2011.</p> <p>Development of high level KPIs for clinical effectiveness.</p> | Quality Report 01/04/10<br>Level 2 NHSLA 01/04/11 | Medical Director/<br>Chief Nurse | Green                        |

| Ref. | Objective                                                                                        | Date reviewed | S4BH/AFLink  | Principal Risk                                                                                                                                                                                                                                                                                                                                                                                                                                       | Risk Type       | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Internal Assurance                                                                                                                                                                                                                                    | Independent Assurance                                                                       | Independent Assurance Level | Gaps in Control or Assurance                                 | Monitoring Systems                      | Internal Assurance Committee | Overall Assurance Level | Action Plans                                                                                                                                                                                    | Delivery date | Responsible Director/s | Assurance level after action |
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| 002  | To improve patient safety by further reducing the incidence of healthcare associated infections. | 09/10/09      | C4a, C4c, N4 | <p>Risk 1414 that patient safety is compromised due to failure to comply with revised Care Quality Commission Standards on Decontamination</p> <p>Risk 1383 – Patient recovery is compromised due to failure to reduce the incidence of Health Care Associated Infection, specifically Clostridium Difficile and MRSA.</p> <p>Risk 1384 – Norovirus outbreaks which will introduce significant risk to the effective management of patient flow.</p> | Governance Risk | <p>Trust-wide Infection Control arrangements including policies, training, audits</p> <p>Infection Control Team lead by Director of Infection Prevention and Control, Infection Control Committee</p> <p>Weekly meetings to review actions against outturn. Guidance on prioritisation for isolation. Daily review of clostridium difficile numbers and movement of patients. Review of performance against plan at Trust Operational Group Meeting, Trust Executive Meeting and Trust Board.</p> <p>Trust-wide approach to increasing the number of single rooms.</p> <p>MRSA elective screening in place to meet national expectations.</p> <p>Investment in hydrogen peroxide vaporisation and deep clean teams.</p> | <p>Monthly Infection Control Board Reports.</p> <p>Hand hygiene compliance has returned to 95% compliance</p> <p>Internal audit of Infection Control - raising of Reasonable</p> <p>Action plan on decontamination leading to compliance with C4c</p> | <p>CQC Hygiene Code Inspection 2009 passed.</p> <p>Unconditional registration with CQC.</p> | Green                       | Hand Hygiene Audit results indicate further action required. | Monthly Infection Control Board reports | Infection Control Committee  | Green                   | There is an annual infection control programme/plan that ensures compliance with the Hygiene Code. Delivery is monitored at Infection Control Committee with a quarterly update to Trust Board. | March 2010    | Chief Nurse            | Green                        |

| Ref. | Objective                                                                                                                                                                 | Date reviewed | S4BH/ AFLink    | Principal Risk                                                                                                                                                                                                                                                                                  | Risk Type                                             | Key Controls                                                                                                                                                                                                                                                                                                                       | Internal Assurance                                                                                                                                       | Independent Assurance                                                                                                                                                                                                                                             | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                                                                                                                                                                               | Monitoring Systems                                                                                                                 | Internal Assurance Committee                                            | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                                                                                                                                    | Delivery date                                                                                                           | Responsible Director/s  | Assurance level after action |
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| 003  | To reduce unnecessary attendances at the Emergency Department through close working with Primary Care Trusts Social Services and relevant community and voluntary groups. | 28/10/09      | E10, C19        | Risk 743 –Risk to delivery of excellent services and foundation trust authorisation due to inability to meet demand arising from substantial activity changes in commissioned activity, resulting in failure to meet the 98% 4-hour access target.                                              | Operational Risk<br>Financial Risk<br>Governance Risk | Patient Flow meetings to manage demand<br><br>Acute Physicians increased Medical Assessment Unit (MAU) capacity<br><br>Short Stay Admissions Unit<br><br>Executive led action plan focused on high impact actions<br><br>Patient Access Steering Group and supporting action plan/routine performance monitoring/ divisional plans | Daily 4 hour performance figures<br><br>Delivery of all plans is reviewed by the Emergency Access Steering Group, chaired by the Chief Operating Officer | Monthly review of inter-agency actions by BNSSG<br><br>Monitor Q2 and Q3 risk assessment red. Detailed action plans submitted. Further formal review in May 2010<br><br>Routine reports provided to the Trust Executive Group, Trust Operational Group and Board. | Green                       | Bed capacity required to meet demand recent periods of very high demand is inadequate                                                                                                                                                                                                                                                                      | Monthly Performance Reports to the Board                                                                                           | Trust Operational Group                                                 | Red                     | Actions focusing on high impact areas:<br><br>1) increasing assessment unit capacity;<br><br>2) reducing any unnecessary admissions;<br><br>3) reducing length of stay, especially for long stay patients;<br><br>4) development of 'pull' systems to get patients into the right inpatient beds more quickly<br><br>5) Monitoring of action plans                                              | Most actions to be implemented by end January 2010                                                                      | Chief Operating Officer | Red                          |
| 004  | To reduce length of stay by reducing the number of patients staying longer than 7 days by 10%.                                                                            | 28/10/09      | C6, E12, N1, N2 | Risk 1413 –Risk of compromised patient outcomes due to failure to meet 18-week Referral to Treatment Time targets<br><br>Risk 1205-Community model of care for rehabilitation once Bristol General Hospital is closed prevents timely discharge and transfer of care from acute inpatient beds. | Operational Risk<br>Financial Risk<br>Governance Risk | Patient Flow meetings<br><br>Ward focus on complex delayed discharges, to expedite discharge<br><br>Acute physicians managing acute medical take<br><br>Programme of roll-out of protection of specialty surgical beds associated with planned reductions in length of stay                                                        | Weekly report on 7-day lengths of stay; monthly average length of stay reports                                                                           | Dr Foster length of stay data used as a benchmark of performance nationally                                                                                                                                                                                       | Green                       | Ability to manage community and other reasons for delays in complex discharge<br><br>Reporting/clinical management of outliers<br><br>Progress against roll-out of protection of surgical beds taking time due to systems which need to be established to manage theatre/bed bookings that support LOS reductions<br><br>Internal assurance committee: TOG | Monthly length of stay reports to the Trust Board<br><br>Quarterly reports on over 7-day stays via updates to Corporate Objectives | Exec-led Financial/Non-financial performance Divisional Review meetings | Amber                   | Transformation programme focusing on length of stay reductions<br><br>Roll-out of protection of surgical beds, associated with length of stay reduction<br><br>PCT providing additional nursing home beds to reduce delayed discharges<br><br>Review of adequacy of assessment unit capacity, to limit risk of patients having to be admitted to an inappropriate ward to manage bed pressures. | Most actions to be implemented by end March 2010, although full completion of transformation work likely to take longer | Chief Operating Officer | Amber                        |

| Ref. | Objective                                                                                         | Date reviewed | S4BH/ AFLink | Principal Risk                                                                                                                                                                               | Risk Type       | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Internal Assurance                                                                                                                                                                                                                                          | Independent Assurance                                                                                                                                                                                                                                                                                                                                              | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                                                                                                                                                                                    | Monitoring Systems                                                                                                                                                                                                                                                                          | Internal Assurance Committee                                           | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Delivery date | Responsible Director/s        | Assurance level after action |
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| 005  | To improve the quality of clinical care through clinical leadership, audit and skills development |               | C5d          | Risk 1593 risk to achieving required level of data completeness in CQC National Priority Indicator - Participation in Heart Disease Audits (the Trust has failed this in consecutive years). | Governance Risk | Well established systems in place for supporting and monitoring clinical audit activity; Clinical Audit Team: Clinical Audit Policy & Strategy<br><br>Data Manager post for Cardiac Services; Patient Analysis & Tracking Team; Data completeness requirements outlined by CQC/British Cardiovascular Interventional Society; Data uploaded to the Central Cardiac Audit Database                                                                                                                                     | UHBristol Annual Clinical Audit Report<br><br>Quarterly progress reports on audit activity<br><br>'Dashboard' of clinical audit Key Performance Indicators<br><br>Heart Disease Audit: weekly monitoring report on completion rates of key mandatory fields | Runner-up award for Clinical Audit Programme of the Year 2008/9<br><br>Heart Disease Audit: National Central Cardiac Audit Database report directly to the CQC                                                                                                                                                                                                     | Green                       | Results of national clinical audits and outcomes/ actions of local completed projects should be reviewed at Divisional/specialty level<br><br>Heart Disease Audit: Long term sickness of Data Manager leading to insufficient management of data collection process/scrutiny of data completion<br><br>Committee for assurance at Divisional level now assigned | Quarterly progress report<br><br>National Audit Register<br><br>Quarterly report to GRMC<br><br>Key Performance Indicators and outcome & actions arising from completed projects.<br><br>Heart Disease Audit: weekly data review by Performance and Operations Manager for Cardiac Services | Clinical Audit Committee<br><br>Governance & Risk Management Committee | Amber                   | Development of formal Clinical Audit Strategy for 2010-13 by CAC in April 2010; Redesign of current National Audit Register to allow easier recording of local review<br><br>Clinical Audit Database amended to better identify whether re-audit has led to improvement in quality of clinical care.<br><br>Heart Disease Audit: Specialised Services appointing new Data Manager; interviews in March 2010<br><br>Audit completion report to be reviewed at bi-monthly Divisional Clinical Governance Committee. | 01/05/2010    | Medical Director              | Amber                        |
|      |                                                                                                   |               | C5b, C5c     | None identified                                                                                                                                                                              | Governance Risk | Medical Director Team, Director of Medical Education and Divisional leads.<br><br>Specialty Doctor & Associate Specialist Tutor<br><br>Medical Advisory Board<br><br>Post Graduate Medical Education Committee<br><br>Consultant Development Programme and 360 feedback<br><br>Nursing and Midwifery Committee and Modern Matrons<br><br>Learning and Education teams and strategy<br><br>Education Centre, Simulation Centre, Learning Resource Services<br><br>Membership of NHS Bristol Service Development Groups | Compliance with appraisal, statutory & mandatory training, professional registration<br><br>Employer-based Clinical Excellence Awards process                                                                                                               | NHSLA Supervisory Score from PMETB Trainee Survey<br><br>Accreditation by Professional Bodies e.g. Royal Colleges, Clinical Pathology Accreditation, Cancer Peer Review<br><br>National Clinical Excellence Awards<br><br>Internal Auditor - audits of medical staffing, absence reporting, job planning<br><br>Audit Commission report on Consultant Productivity | Green                       | None identified                                                                                                                                                                                                                                                                                                                                                 | PGME Committee monitors Junior Doctor training<br><br>Divisional HR Teams monitor appraisal and statutory & mandatory training<br><br>Medical Director Team Monitors Medical & Dental Appraisal                                                                                             | Medical Advisory Board                                                 | Green                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Ongoing       | Medical Director/ Chief Nurse | Green                        |

| Ref. | Objective                                                                                            | Date reviewed | S4BH/ AFLink | Principal Risk                                                                                                                                                                                                                                                                                                                                                                                                                              | Risk Type       | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Internal Assurance                                                                                                                                                  | Independent Assurance                                                                                                                                                                      | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                                                                                                              | Monitoring Systems                                                                            | Internal Assurance Committee                                                                                 | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                                                                                                                                                                               | Delivery date | Responsible Director/s | Assurance level after action |
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| 006  | To improve patient safety through the safe acquisition and handling of medicines and medical devices | 20/11/09      | C4d          | Risk 825 - clinically relevant medication error                                                                                                                                                                                                                                                                                                                                                                                             | Governance Risk | Medicine Steering Group<br>Medicine Policies<br>Process for implementing NPSA guidance<br>Induction and medicine management training for relevant staff<br>IT decision support<br>Medicines information service<br>Ward based clinical pharmacy services<br>Incident review feedback .                                                                                                                                                                                                                                                                                                                  | Medicine Governance Group<br>Audit against prescribing and administration policies<br>Incident reviews<br>CD audits<br>Regional & International Patient safety work | NHSLA level 1 compliance<br>Medicines & healthcare products Regulatory Agency inspections<br>Royal Pharmaceutical Society inspections<br>Regional & international Patient safety programme | Amber<br>←                  | Gaps arise as the scope of medication practice is so broad and is relevant to all clinical practice and staff throughout the trust.<br>Difficulty in addressing the full range of potential medication incidents & comprehensively implementing the NPSA/NICE and other national guidance | Medicines Governance Group<br>Medicines Steering Group                                        | Clinical Risk Assurance Committee                                                                            | Amber                   | Comprehensive action plan with 6 monthly reports into Clinical Risk Assurance Committee                                                                                                                                                                                                                                                                                                                                                    | Ongoing       | Medical Director       | Amber                        |
|      |                                                                                                      |               | C4b          | Non compliance of users with Trust policy and processes                                                                                                                                                                                                                                                                                                                                                                                     | Governance Risk | Medical Devices Co-ordinator<br>Trust policy - Managing Medical Devices Safely<br>Medical Device Training                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D&T KPI's<br>Monitoring trends in clinical incidents involving medical equipment                                                                                    | NHSLA. Level 1 Assessment passed September 2009<br>ISO 13485: assessment passed 20/08/09                                                                                                   | Green<br>←                  | System for recording training needs of medical staff recently implemented                                                                                                                                                                                                                 | Medical Equipment Group reports to CRAC 6 monthly                                             | Clinical Risk Assurance Committee                                                                            | Amber                   | Use of junior doctors' clinical portal to improve communication from Jan 2010<br>NET Consent trial underway                                                                                                                                                                                                                                                                                                                                | Jun-10        | Medical Director       | Amber                        |
| 007  | To improve nutritional support to patient recovery                                                   | 26/11/2009    | C15a, C15b   | Risk 1540 W & C: Failure to provide therapeutic dietary management of children with inborn errors of metabolism (service unfunded).<br>Risk 1559 Arrangements for nutritional screening of new patients is not consistent or comprehensive<br>Risk of not meeting patients nutritional needs. From May 2010 failure to monitor nutrition Key Performance Indicators and target actions to prevent sub-optimal nutrition (service unfunded). | Governance Risk | Close monitoring of nutrition screening rates and targeted improvement actions to meet each patient's individual nutritional needs more appropriately until May 2010<br>Catering ward round audit takes place on a continuous basis – up to four wards a week are covered so that every ward is audited three times a year<br>Nutrition Steering Group lines of accountability agreed.<br>induction for nursing staff now includes Nutrition. Clinical Incidents and Informal Complaints monitored by the Nutrition Steering Committee.<br>Key Performance Indicators agreed and reported on quarterly. | Catering Ward Rounds Audits                                                                                                                                         | HSQC Audits<br>PEAT Assessment<br>National Patient Surveys<br>CQC monitoring progress with addressing declared concerns arising from this outcome                                          | Amber<br>←                  | Nutrition Screening at 60% within 24 hours at BRI.<br>Screening tool roll out is not complete.<br>Policies and Care Plans not up to date.<br>Supply of some dietary products and appliances requires full implementation.<br>Insufficient staff available to assist with feeding.         | Catering Ward Rounds Audit<br>Monitoring of Incidents and Complaints regarding Food Provision | Nutritional Steering Group, chaired by Deputy Chief Nurse and reporting to Clinical Risk Assurance Committee | Green                   | Nutrition screening training roll out.<br>Business Planning process bid for Dietetic Assistant and Nutrition Lead for Mealtimes Dietetic Assistant.<br>Annual work plan and Terms of Reference for Nutrition Steering Group in development.<br>Food as Treatment Policy being updated.<br>Core Care Plans for Nutrition Support in Paediatrics are being reviewed.<br>Supply chain for gluten-free and low protein products being sourced. | Apr-10        | Chief Nurse            | Green                        |

| Ref. | Objective                                                                                           | Date reviewed | S4BH/ ALink               | Principal Risk                                                                                                                               | Risk Type                               | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                              | Internal Assurance                                                                                                                                                                                                                                                                     | Independent Assurance                                                                                                                                              | Independent Assurance Level | Gaps in Control or Assurance                                                                                                            | Monitoring Systems                                                                                                              | Internal Assurance Committee                                                   | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                                                                                                                               | Delivery date                                | Responsible Director/s                    | Assurance level after action |
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| 008  | To develop clinical services in line with National Service Frameworks and national priorities       | 20/10/2009    | C23, E4, E5, E9, N3, N5-9 | None identified                                                                                                                              | Governance Risk                         | Clinical Strategy Group<br><br>Framework for the co-ordination of NSFs and national priorities<br><br>The Trust is fully engaged in a wide range of local, regional and national networks in developing its services in line with National Service Frameworks and priorities<br><br>Membership of NHS Bristol NICE College<br><br>Clinical Effectiveness Committee                                                        | The Trust hosts the Bristol and Weston Bowel Cancer Screening Centre as part of the National Bowel Screening Programme and the Avon Breast Screening Unit has improved its performance to above average                                                                                | South West Public Health Observatory Cancer Intelligence Reports<br><br>South West Breast Screening QA Reports<br><br>National Health Promotion in Hospitals Audit | Green                       | Identified need to make co-ordination of National Service Frameworks more explicit                                                      | Relevant Divisional Boards                                                                                                      | Trust Operational Group                                                        | Green                   | The Trust is working with local healthcare partners to improve the delivery of health promotion to staff and patients.                                                                                                                                                                                                                                                                     | Ongoing                                      | Medical Director/ Chief Operating Officer | Green                        |
| 009  | To provide timely access to cancer services in line with national targets                           | 26/11/09      | E6, E7, E8                | Risk 1412 – risk of delay in patient treatments leading to FT de-authorisation                                                               | Operational Risk<br><br>Governance Risk | Fast-Track Office to administer cancer services and the register of cancer patients<br><br>Strengthened Cancer Services Board<br><br>Weekly meetings to plan steps in individual patient pathways and improvement to forward planning<br><br>Breach analysis feedback to Divisional teams<br><br>Lists of patients on cancer pathways against their breach dates updated daily and available on-line to operational staff | Monthly internal reports on performance with analysis of the cause of breaches                                                                                                                                                                                                         | National cancer Standards performance reports showing Trust and national average performance against the standards<br><br>Local cancer network reports             | Green                       | Insufficient surgical and outpatient capacity for some tumour sites; complex diagnostic pathways that being redesigned to reduce delays | Monthly reports to the Trust Executive Group and the Trust Board                                                                | Trust Operational Group                                                        | Red                     | Weekly Cancer Action Meeting established to track progress with refreshed action plan focusing on gaps in controls<br><br>Cancer Action plan in place and reviewed at weekly performance meeting - Trust Operational Group reviews all performance against plan every two weeks. Weekly breach analysis, to identify causes of breaches and changes to process identified and implemented. | Most actions implemented by end January 2010 | Chief Operating Officer                   | Amber                        |
| 010  | To improve patient safety by maintaining patient confidentiality and improving information security | 20/11/09      | C9 C13c                   | Trust wide risk 880: Loose filing of reports<br><br>Trust wide risk 895: Missing case notes and issue of temporary folders. Lack of tracing. | Governance Risk                         | Senior Information Risk Owner<br><br>Information Governance Toolkit and Assurance Framework<br><br>Trust Health Records and Information Governance policies<br><br>Requirement for all removable devices to be encrypted                                                                                                                                                                                                  | Self assessment against Information Governance Toolkit and Assurance Framework<br><br>One serious untoward incident reported re information security and patient confidentiality<br><br>Internal audit of data security performed and reported at steering group; action plan in place | NHSLA Level 1 achieved for Health Records Management Policy Sept 2009.                                                                                             | Green                       | IGAF requirement not currently scored as a 2 which relates to SIRO and Information Asset Owners and Administrators                      | Assurance of Record Keeping Group reports to CRAC and GRMC<br><br>Information Governance Steering Group reports to IM & T Board | Assurance of Record Keeping Group<br><br>Information Governance Steering Group | Amber                   | Staff training in information governance and electronic tracer system<br><br>Order Communications project being implemented<br><br>Changes to Trust IT systems to make NHS Number the primary patient identifier.                                                                                                                                                                          |                                              | Medical Director                          | Amber                        |



| Ref. | Objective | Date reviewed | S4BH/AFLink | Principal Risk | Risk Type | Key Controls | Internal Assurance | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans | Delivery date | Responsible Director/s | Assurance level after action |
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Strategic Aim: To be the major specialist service provider for the population of Bristol & the South West region and to provide additional services for the local population

| Ref. | Objective                                                                                                                                                                                            | Date reviewed | S4BH/AFLink | Principal Risk                                                                                                                                                                                                                                   | Risk Type      | Key Controls                                                                             | Internal Assurance                                                                                                     | Independent Assurance                                                | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                                                                                                   | Monitoring Systems                                  | Internal Assurance Committee                                                                                                                                                                                                                              | Overall Assurance Level      | Action Plans                                                                                                                                                            | Delivery date | Responsible Director/s            | Assurance level after action |
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| 011  | To open the Bristol Heart Institute and reconfigure services within the Bristol Royal Infirmary                                                                                                      | 09/09/2009    | SP7         |                                                                                                                                                                                                                                                  |                |                                                                                          |                                                                                                                        |                                                                      |                             |                                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                                                                           | Complete BHI opened May 2009 |                                                                                                                                                                         |               |                                   |                              |
| 012  | To develop detailed plans for redevelopment of the Bristol Royal Infirmary and the centralisation of specialist children's services at the Bristol Royal Hospital for Children                       | 23/11/09      | SP7, SP8    | Risk 759 – Risk that Strategic Development Programme projects (includes BRI redevelopment, air ambulance landing facility and centralisation of specialist paediatrics) are not completed to time and budget and delivery of identified benefits | Strategic Risk | SOs and SFIs / Capital Investment Policy decision rights / Corporate committee structure | Trust Board papers / Redevelopment Programme Board papers / Capital Prioritisation Group papers / project board papers | Internal Audit report May 2009 / SHA and PCT OBC approvals (2007)    | Green                       | PCT support for BRI redevelopment in question<br><br>Affordability of specialist paediatric centralisation in doubt<br><br>Corporate committee structure is under review<br><br>Budget allocation in capital programme under review                                            | Re-development Programme Board reports to the Board | Re-development Programme Board                                                                                                                                                                                                                            | Amber                        | Engage with NHS Bristol / SHA                                                                                                                                           | Apr-10        | Director of Corporate Development | Amber                        |
| 013  | To work in partnership with NHS Bristol and Bristol Community Health Services over the development of the South Bristol Community Hospital                                                           | 23/11/09      | C22a, C22c  | Risk 753 –Risk of significant variance in patient flows and capacity requirements from projections                                                                                                                                               | Strategic Risk | Partnership Framework SBCH Steering Group                                                | TEG papers / SBCH Steering Group papers                                                                                | PCT Stakeholder Board / SBCH Provider Group                          | Amber                       | Bristol Community Health Project Plan to inform internal project planning and move forward to practical implementation. Commissioning intentions for the outpatient service, recognising that priorities may have altered since the original list of specialties was developed | SBCH Steering Group reports to TEG                  | The Trust Redevelopment Board has reviewed progress against this project to date. However, with the proposed revised governance of capital programmes this project will be monitored by the Capital Committee until further arrangements are in place TEG | Green                        | Continuing dialogue with the PCT and Bristol Community Health . Reinstatement of the SBCH Steering Group. Monitor key workstreams to transfer services to the community | Ongoing       | Chief Operating Officer           | Green                        |
| 014  | To improve the profile and enhance the reputation of the Trust, regionally and nationally and build a supportive stakeholder base.                                                                   | 23/11/09      | None        | Risk 1467-Risk of reputational damage due to adverse media publicity re allegations of poor quality pathology services                                                                                                                           | Strategic Risk | Media monitoring reports / media training                                                | Trust Board papers / TEG papers                                                                                        | SHA media monitoring report                                          | Green                       | Detailed monitoring of communications impact / Corporate pre-planning for risk issues                                                                                                                                                                                          | TEG reports to Trust Board                          | Trust Executive Group                                                                                                                                                                                                                                     | Green                        | Communications KPIs Hold crisis management seminar                                                                                                                      | Ongoing       | Director of Corporate Development | Green                        |
| 015  | To develop a strong vision, brand and identity for the Trust that identifies why it should be the provider of choice for Primary Care Trusts, General Practitioners, patients, staff and the public. | 23/11/09      | None        | Risk 1405 - risk of non-compliance with specialist commissioning standards                                                                                                                                                                       | Strategic Risk | Communications plan                                                                      | Trust Board papers / TEG papers                                                                                        | Internal surveys / GP surveys / commissioner feedback / Staff survey | Green                       | Brand development                                                                                                                                                                                                                                                              | TEG reports to Trust Board                          | Trust Executive Group                                                                                                                                                                                                                                     | Green                        | Develop new vision statement / detailed actions in Communications Plan                                                                                                  | Ongoing       | Director of Corporate Development | Green                        |

| Ref. | Objective | Date reviewed | S4BH/ AFLink | Principal Risk | Risk Type | Key Controls | Internal Assurance | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans | Delivery date | Responsible Director/s | Assurance level after action |
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Strategic Aim: To deliver services which are quick and easy to access and provide an excellent patient experience

| Ref. | Objective                                                                                                                                                                                                          | Date reviewed | S4BH/ AFLink          | Principal Risk                                                                                                                                                                                               | Risk Type        | Key Controls                                                                                                                                                                                                                                                                 | Internal Assurance                                                              | Independent Assurance                                                                                                                                                                  | Independent Assurance Level                                                                 | Gaps in Control or Assurance                                                                                                                                                                                                                                                          | Monitoring Systems                                                                                    | Internal Assurance Committee                                                                                                                       | Overall Assurance Level                                                                   | Action Plans                                                                                                                                                                                                                                                                                                             | Delivery date                                | Responsible Director/s                               | Assurance level after action                                                              |
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| 016  | To enhance patient and public areas to provide a welcoming environment, including professional front of house services, and improve accessibility of services to patients.                                         | 01/03/10      |                       | Risk to Trust's reputation as a service provider                                                                                                                                                             | Operational Risk | BRI Phase 2 project                                                                                                                                                                                                                                                          | Capital Committee Service re-location team                                      | None                                                                                                                                                                                   |  Green   | None identified                                                                                                                                                                                                                                                                       | Trust operational group                                                                               | The delivery of the BRI phase 2 project is reported and monitored by the Service Relocation Committee and reported to the Trust Capital Committee. |  Green | Option appraisals underway for increased parking on site and off site partnerships. Discussions with travel partners to identify improved transport to and from the Trust sites. Pilot now in place for patients to park at Cabot Circus with free hospital bus to transport to Trust. Plan to make substantive in 10/11 | Most actions implemented by end January 2010 | Chief Operating Officer                              |  Green |
| 017  | To establish a coordinated approach to patient and public involvement, through an operational framework, which works collaboratively with the new Quality / Patient Experience Structures and Governor Sub-groups. | 26/11/2009    | C14a, C14b, C14c, C17 | New risk identified: Funding to deliver board-level patient experience metrics and 'real-time' patient feedback and comprehensive roll-out of the McKinsey Patient Experience model has not been identified. | Governance Risk  | Corporate Patient & Public Involvement team<br>Involving People Committee<br>Governors' Involvement Sub-group<br>Ward-based survey working group<br>Questionnaire Interview & Survey Group<br>Divisional leads<br>Corporate and divisional complaints and PALS arrangements. | McKinsey Patient Experience outcomes in BHOC<br>Survey of Complainers Dec 2008. | NHSLA Level 1 achieved for Complaints and Concerns Policy Sept 2009.<br>National Patient Surveys<br>Recommendations from Healthcare Commission inspection of C14b June 2008 completed. |  Amber   | Patient Engagement and Experience Strategy being considered by Governors Involvement sub in March.<br>Funding obtained through Above & Beyond to deliver board-level patient experience metrics and 'real-time' patient feedback<br>To deliver McKinsey model on a significant scale. | Quarterly reports to Involving People Committee and onwards to Governance & Risk Management Committee | Involving People Committee                                                                                                                         | Amber                                                                                     | Ongoing tender process to procure IT system to support the strategy<br>Development of assurance on learning from complaints.                                                                                                                                                                                             | 1st April 2010                               | Chief Nurse                                          | Amber                                                                                     |
| 018  | To embed Equality and Diversity into all aspects of Trust business in order to enhance opportunities and services for all members of the community.                                                                | 20/10/2009    | C7e                   | Risk 1407 – Compliance with Equalities Legislation                                                                                                                                                           | Governance Risk  | Single Equality Scheme<br>Valuing Diversity Strategy<br>Statutory duties (EIAs),                                                                                                                                                                                             | Bi-annual Board report<br>Equality and Diversity Steering Group                 | SHA Audits                                                                                                                                                                             |  Amber | Insufficient improvement in numbers of EIAs completed                                                                                                                                                                                                                                 | Quarterly E&D Steering Group and Bi-Annual report                                                     | Equality and Diversity Steering Group                                                                                                              | Amber                                                                                     | Request review of EIAs by Heads of Services and Divisional managers<br>Approach to E&D being refreshed to put more emphasis on meeting the legislative requirements.<br>Conduct training needs analysis to ensure all E&D training requirements are met                                                                  | update to E&D steering Group March 2010      | Director of Workforce and Organisational Development | Amber                                                                                     |

| Ref. | Objective                                                 | Date reviewed | S4BH/AFLink | Principal Risk                                                                                                        | Risk Type       | Key Controls                                                                                                                                                                                                                                                                                                                   | Internal Assurance                                                             | Independent Assurance                                                          | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                 | Monitoring Systems                       | Internal Assurance Committee                                                                      | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                            | Delivery date | Responsible Director/s        | Assurance level after action |
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| 019  | To improve Safeguarding of Children and Vulnerable Adults | 26/11/2009    | C2          | Corporate risk 1483. Children may come to harm due to deficiencies in the Trust's Safeguarding Children arrangements. | Governance Risk | Child Protection Named Doctor<br>Named Nurses and Midwife in place<br>Child Protection Policy in place<br>Safeguarding Vulnerable Adults policy in place<br>Child Protection and Safeguarding Vulnerable adults Training<br>Safeguarding Children Board<br>Trust Executive Group and Governance and Risk Management Committee; | Review of Child Protection Training identified inadequate levels of compliance | CQC Swift Review Outcome March 2009                                            | Amber<br>←                  | Multiple paediatric notes and associated risk of fragmentation of information sharing.<br>Inadequate uptake of Child Protection training being addressed by improved training records system | 1                                        | Clinical Risk Assurance Committee and Governance and Risk Management Committee reporting to Board | Amber                   | Taskforce to review multiple notes in Children's Hospital<br>Conduct 2nd review of Child Protection Training<br>Action plan resulting from CQC Swift Review.                                                                                                            | Ongoing       | Chief Nurse                   | Amber                        |
| 020  | To improve patient experience of receiving clinical care  | 20/11/09      | C13a        | None                                                                                                                  |                 | Lead Nurse<br>Privacy and Dignity Steering Group<br>Pictorial signs in place<br>Same sex accommodation leaflet<br>Equipment screens installed in ED to maximise privacy<br>Significant works programme completed to ensure patient privacy<br>Mixed sex breach protocol in place<br>Modesty Gowns in use                       | Numbers of breaches of protocol<br>Complaints relating to privacy and dignity  | National In patient Survey<br>NHS South West Mixed Sex Accommodation Standards | Green<br>←                  | Aspects of poor practice identified via Patient Affairs and Mortuary Staff relating to last offices and care of property<br>Need to widen use of modesty gowns across the Trust              | Trust Privacy and Dignity Steering Group | Discussing reporting structure with Chief Nurse. Likely to be to Nursing and Midwifery Committee. | Amber                   | Launching last offices and property policies at Trust wide day<br>Reviewing patient property bags.<br>Roll out do not disturb signs once pilot concluded.<br>Drafting P&D trust wide strategy.<br>Reviewing location of modesty gowns and plan to increase distribution | ongoing       | Chief Nurse/ Medical Director | Green                        |

| Ref. | Objective | Date reviewed | S4BH/ AFLink | Principal Risk | Risk Type | Key Controls | Internal Assurance | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans | Delivery date | Responsible Director/s | Assurance level after action |
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Strategic Aim: To support research of national and international excellence and innovation

| Ref. | Objective                                                                                                                                                                  | Date reviewed | S4BH/ AFLink | Principal Risk                                                                                                      | Risk Type      | Key Controls                                                                                       | Internal Assurance                                                  | Independent Assurance                                                         | Independent Assurance Level | Gaps in Control or Assurance                                       | Monitoring Systems         | Internal Assurance Committee | Overall Assurance Level | Action Plans                                               | Delivery date | Responsible Director/s            | Assurance level after action |
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| 021  | To develop an innovation and enterprise framework in the Trust aligned to key strategic priorities.                                                                        | 23/11/09      | None         | None identified                                                                                                     | Strategic risk | Enterprise Framework<br>SOs and SFIs<br>Steering Group, reports to TEG                             | TEG papers<br>Reported actions from Steering Group and work streams | Legal advice taken as appropriate<br>Compliance with NHS Constitution pledges | Green<br>←                  | None identified                                                    | TEG reports to Trust Board | TEG<br>Finance Committee     | Green                   | Map Divisional enterprise activities                       | Dec-09        | Director of Corporate Development | Green                        |
| 022  | To engage staff in the vision and values of the Trust to ensure that the Trust can move towards an inclusive ownership model where development and innovation is the norm. | 26/11/09      | None         | New risk: Transformation Programme is not owned by all stakeholders and does not realise expected financial savings | Financial risk | Director and Deputy Director of Transformation in post<br>Transformation Programme being developed | Board papers<br>Outputs from Vision and Values workshops            | None                                                                          | Amber<br>←                  | Programme Management Office and associated governance now in place | Trust Executive Group      | Trust Executive Group        | Green                   | Current diagnostic process will define progress and goals. | Mar-11        | Medical Director                  | Green                        |

| Ref. | Objective | Date reviewed | S4BH/ AFLink | Principal Risk | Risk Type | Key Controls | Internal Assurance | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans | Delivery date | Responsible Director/s | Assurance level after action |
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Strategic Aim: To develop research activities in partnership with academic and healthcare organisations  
Strategic Aim: To develop collaborative and consultative research partnerships with patients, carers and the public

| Ref. | Objective                                                                                                                                    | Date reviewed | S4BH/ AFLink | Principal Risk                                                                                                                                                                                                                                      | Risk Type      | Key Controls                                                                                                                                                                                                                                                                                                                                                                                               | Internal Assurance                                                                                                                                                                                                                                                                                                                                                             | Independent Assurance                                                                                                                                                                | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                        | Monitoring Systems                                                                                                                                                                       | Internal Assurance Committee                                                                                                         | Overall Assurance Level | Action Plans                                                                                                                              | Delivery date | Responsible Director/s             | Assurance level after action |
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| 023  | To refresh the Research & Development strategy, in line with the strategy of the Bristol Health Community.                                   | 26/11/09      | C12          | Risk 747 – Research Funding – impact of new national arrangements hard to predict and results of programmes and other bids are not known. If the net loss of income is 25% higher than assumed this would lead to a loss of £8.03m over plan period | Financial Risk | Financial monitoring<br><br>The Trust has research governance systems in place to ensure that all research can be recorded and approved by the Research and Development Department.<br><br>Training for researchers in Good Clinical Practice has been made mandatory (every 3 years) and the course content and delivery have been modified to identify whether learning objectives are met by attendees. | R & D progress reports to Finance Committee and GRMC.<br><br>Internal assurances are in place for finance review and legal review of research contracts prior to Research and Development Department approval.<br><br>A risk-based monitoring programme is in place for research sponsored by University Hospitals Bristol and University of Bristol, and for hosted research. | All research is approved in accordance with the Research Governance Framework for Health and Social Care and the Medicines for Human Use Clinical Trials Regulations where relevant. | Green<br>←                  | Cannot control future funding<br><br>Monitoring of source data being done through quality management system for research for trust sponsored trials<br><br>Key performance indicators not defined   | A Research & Development Committee will be established by the end of May 2010 (originally Jan 10); this has been agreed by the Trust Executive Group and terms of reference are in place | Governance and Risk Management Committee                                                                                             | Green                   | Monitoring Standard Operating Procedures to be updated.<br><br>Key Performance Indicators to be agreed by the newly created R&D committee | May-10        | Medical Director/ Finance Director | Green                        |
| 024  | To work closely with the University of Bristol to implement the Clinical Research Imaging Centre project in preparation for opening in 2010. | 26/11/09      | C12          | Risk 747 – Research Funding – impact of new national arrangements hard to predict and results of programmes and other bids are not known. If the net loss of income is 25% higher than assumed this would lead to a loss of £8.03m over plan period | Financial Risk | Joint Working Party with University of Bristol established<br><br>Director of Research and Lead Manager in post.                                                                                                                                                                                                                                                                                           | Project Management                                                                                                                                                                                                                                                                                                                                                             | None                                                                                                                                                                                 | Green<br>←                  | Uncertainty of future funding<br><br>Monitoring of source data and entered data not currently done<br><br>Key performance indicators not place but being defined in Research & Development Strategy | Academic TEG                                                                                                                                                                             | A Research & Development committee will be established by the end of January 2010; this has been agreed by the Trust Executive Group | Green                   | Project Plan                                                                                                                              | 2010          | Chief Operating Officer            | Green                        |

| Ref. | Objective | Date reviewed | S4BH/ AFLink | Principal Risk | Risk Type | Key Controls | Internal Assurance | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans | Delivery date | Responsible Director/s | Assurance level after action |
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Strategic Aim: To pursue teaching and learning partnerships with education providers and others

| Ref. | Objective                                                      | Date reviewed | S4BH/ AFLink | Principal Risk  | Risk Type | Key Controls                                                                                                         | Internal Assurance      | Independent Assurance                                                                                                         | Independent Assurance Level | Gaps in Control or Assurance                              | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans                     | Delivery date | Responsible Director/s        | Assurance level after action |
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| 025  | To establish more formal relationships with academic partners. | 15/12/09      | C12, C22a    | None identified | N/A       | Joint appointment of Research and Development Director for acute Trusts and Bristol Research Innovation Group-Health | Reports to Academic TEG | Medical Research Committee<br>National Institute of Health Research Committee scrutiny of bids for evidence of collaboration. | Green<br>←                  | Health Innovation and Education Cluster approval Jan 2010 | Academic TEG       | Academic TEG                 | Amber                   | Bid put forward awaiting outcome | Jan-11        | Medical Director/ Chief Nurse | Green                        |

Strategic Aim: To ensure staff are enabled to provide safe, effective and high quality patient care

| Ref. | Objective                                                                                                                   | Date reviewed | S4BH/ AFLink | Principal Risk | Risk Type | Key Controls                                      | Internal Assurance                                                                        | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems                   | Internal Assurance Committee         | Overall Assurance Level | Action Plans                                                                                                                                                        | Delivery date | Responsible Director/s                               | Assurance level after action |
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|      | To develop the Teaching and Learning Strategy in line with the national and regional agenda and clinical services strategy. | 26/11/09      | None         | None           | N/A       | Teaching and Learning Strategy and Group in place | Teaching and Learning Strategy Group<br>Training Leads Meetings<br>AP/INVQ steering group | None                  | Amber<br>←                  | None                         | Teaching and Learning Strategy Group | Teaching and Learning Strategy Group | Green                   | Detailed action plan being developed to address three key priorities:<br>Head of Learning and Development post<br>Budgets for L&D<br>Training Activity in the Trust | Mar-09        | Director of Workforce and Organisational Development | Amber                        |

| Ref. | Objective                                                                                                                                                                  | Date reviewed | S4BH/AFLink | Principal Risk                                                                                                                                                      | Risk Type       | Key Controls                                                                                                                                                                                                                                                                                                                    | Internal Assurance                                                                                                                                                                                                                                | Independent Assurance                                                                                                                                                      | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                                                                                                                             | Monitoring Systems                                                                        | Internal Assurance Committee                                                                                                | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                                                        | Delivery date                                           | Responsible Director/s                                           | Assurance level after action |
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| 026  | To achieve 90% of staff trained in statutory and mandatory training                                                                                                        | 26/11/09      | C11b        | Risk 1405: Patients, visitors or staff come to harm due to staff not receiving statutory and mandatory training                                                     | Governance Risk | Corporate and Local Induction Policy<br>Study Leave Policy<br>Appraisal Policy<br>Risk Management Training Plan/ Training Needs Analysis/ Implementation plan<br>Audit & Assurance Committee Governance & Risk Management Committee<br>Trust Operational Group<br>Divisional Human Resources Managers Meeting                   | High level action plan in force since Sept 2009<br>Quarterly Compliance Reports by Division/ staff group<br>Non attendance reports through training records system<br>Appraisal monitoring                                                        | NHSLA Assessment Level 1<br>Estates returns information collection<br>Counter fraud security management system returns<br>Willis annual audit<br>Health & Safety Executive | Amber<br>←                  | Resource implications both trainers and venues<br>Clinical implications with winter pressures impacting on the ability to release staff for training                                                                                                                                                     | Director of Workforce and organisational development/<br>Head of Health & Safety Services | Audit & Assurance Committee                                                                                                 | Amber                   | Take high level action plan through to completion by attaining 90% in all statutory and mandatory training standards and maintain this position<br><br>Align with appraisal compliance rates                                                                                                                        | March 2010 and ongoing                                  | Director of Workforce and Organisational Development             | Green                        |
| 027  | To implement year 3 of the Assistant Practitioner and National Vocational Qualification teaching plan in support of Cash Releasing Efficiency Savings and skill mix plans. | 26/11/09      | None        | Lack of uptake for Assistant Practitioner programme and impact of skill mix plans and CRES plans see objective 041                                                  | Finance Risk    | AP/NVQ steering group<br>Assistant Practitioner training programme<br><br>Retention of staff on new career pathway for unregistered nurses                                                                                                                                                                                      | Successful outputs from the programme to date<br><br>Turnover rates for nursing assistants                                                                                                                                                        | None                                                                                                                                                                       | Amber<br>←                  | Potential curtailment of internal investment and resulting inability to plan for future cohorts due to resource constraints.<br><br>Potential lack of recruits to AP programme                                                                                                                           | AP/NVQ steering group                                                                     | Teaching and Learning Strategy Group                                                                                        | Green                   | Support potential recruits in developing basic skills                                                                                                                                                                                                                                                               | Ongoing                                                 | Chief Nurse/Director of Workforce and Organisational Development | Green                        |
| 028  | To deliver full compliance with Occupational Health and Health and Safety standards and so ensure the safety of staff and patients.                                        | 20/11/09      | C20a        | Health and Safety: Risk of harm to patients, visitors and staff due to difficulty in maintaining the estate due to its age and condition due to lack of compliance. | Governance Risk | Compliance with Estates returns and information collection<br><br>Compliance with Patient Environment Action Team (PEAT) audits<br>Compliance with Annual NHS Fire certificate<br>Compliance with Counter Fraud Security Management Service requirements<br>Compliance with national targets - smoke free policy implementation | Risk Management Strategy<br>Compliance reports<br><br>Audits and action plans<br>Patient satisfaction survey<br>Annual Security/ Fire and Health & Safety reports<br>Divisional Action Plans in response to audits<br>Project report from Estates | Submission to NHS estates<br>Counter Fraud Security Management Service<br><br>Willis annual audit against HSG 65                                                           | Amber<br>←                  | Fire safety and health and safety training compliance<br><br>Receipt of enforcement notice re Fire Safety Order compliance in November 2009<br><br>Some of the estate is not of a standard conducive to patient care and therefore redevelopment plans are in situ but over a significant period of time | Reports to key assurance committees                                                       | Trust Health & Safety Committee<br>Governance & Risk Management Committee<br>Trust Operational Group<br>Redevelopment Board | Amber                   | Enforcement notice action plan for St Michael's<br><br>Redevelopment plan for BRI/ BRHC<br><br>Occupational Health & Safety Standards Action place<br><br>Increased training compliance using e learning option to be encouraged as part of the recovery plan. Lead trainers also have action to achieve compliance | then 2014 and March 2010 respectively<br><br>March 2010 | Director of Workforce and Organisational Development             | Amber                        |

| Ref. | Objective | Date reviewed | S4BH/ AFLink | Principal Risk                                                                  | Risk Type       | Key Controls                | Internal Assurance                      | Independent Assurance              | Independent Assurance Level                                                         | Gaps in Control or Assurance                                                                                  | Monitoring Systems                      | Internal Assurance Committee | Overall Assurance Level | Action Plans                                                       | Delivery date | Responsible Director/s                               | Assurance level after action |
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|      |           |               |              | Occupational Health: Insufficient resources to deliver required Service Levels. | Governance Risk | Partnership board oversight | Monthly / Quarterly performance reports | Compliance with NHS Plus Standards |  | Insufficient resource provision by Partner Trusts is placing undue strain on the Occupational Health Service. | Monthly / Quarterly performance reports | Partnership Board Directors  | Amber                   | Ongoing negotiations with other Partners. Options paper completed. | Mar-10        | Director of Workforce and Organisational Development | Amber                        |

Strategic Aim: To embrace personal and organisational development

| Ref. | Objective                                                                                           | Date reviewed | S4BH/ AFLink | Principal Risk | Risk Type | Key Controls                         | Internal Assurance                   | Independent Assurance | Independent Assurance Level                                                         | Gaps in Control or Assurance                                                                                                                                           | Monitoring Systems                   | Internal Assurance Committee         | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                         | Delivery date                                                      | Responsible Director/s                               | Assurance level after action |
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| 029  | To ensure that teaching and learning metrics are embedded within the Trust's performance framework. | 26/11/09      | None         | None           | N/A       | Teaching and Learning Strategy Group | Teaching and Learning Strategy group | None                  |  | Effective co-ordination of this information across the Trust due to existing infrastructure. Individual leads have KPIs in place, this is not a Trust wide perspective | Teaching and Learning Strategy Group | Teaching and Learning Strategy Group | Amber                   | Detailed action plan being developed to address three key priorities:<br>1) Head of Learning and Development post<br>2) Budgets for L&D<br>3) Training Activity in the Trust.<br><br>This will underpin the delivery of this objective going forward | Action plan with timescales to be developed by the end of the year | Director of Workforce and Organisational Development | Amber                        |



| Ref. | Objective                                                                                                                                                                                                                             | Date reviewed | S4BH/ AFLink     | Principal Risk                                                                                                                                                                                                         | Risk Type       | Key Controls                                                                                                                                                                                                                                                      | Internal Assurance                                                                                                    | Independent Assurance                                          | Independent Assurance Level                                                                    | Gaps in Control or Assurance                                                          | Monitoring Systems                                                      | Internal Assurance Committee                         | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                                                                                               | Delivery date          | Responsible Director/s                               | Assurance level after action |
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| 030  | To continue to attract and retain high calibre staff.                                                                                                                                                                                 | 26/11/09      | C10a, C10b, C11a | Risk 1404 – Use of temporary staffing (Bank/Agency) may increase - leading to high cost, and risk quality issues                                                                                                       | Governance Risk | Ongoing work on AUKUH benchmarking at skill mix within wards - to address bank and agency usage<br><br>Trust Temporary Staffing Bureau                                                                                                                            | Rosterpro monitoring of bank and agency usage.<br><br>NMC briefing on bank and agency usage<br><br>Trust Board report | Audit Review 2008 of Bank and Agency                           | <br>Amber   | Estates and facilities - high levels of overtime, bank and agency                     | NMC briefing on bank and agency usage and as part of Trust Board report | Trust Operational Group                              | Amber                   | Newly established group to review nursing costs including bank and agency                                                                                                                                                                                                                                                                                  | Nov-09                 | Director of Workforce and Organisational Development | Amber                        |
| 031  | To ensure robust workforce planning with all business and service plans to ensure workforce implications are fully integrated.<br><br>Carry out a risk assessment to identify any potential workforce capacity and capability issues. | 26/11/09      | C8b, C11b, C11c  | Risk 1085 – Ageing workforce particularly in estates and administration leading to potential shortfalls. Risk of not attracting sufficient number of staff                                                             | Governance Risk | Annual Divisional Workforce Plans<br><br>Recruitment and Retention Plans                                                                                                                                                                                          | Annual risk assessment<br><br>Divisional Boards and Reviews<br><br>Skill mix change plan                              | Audit Commission Review of Nurse Numbers at UHB                | <br>Amber   | None                                                                                  | Director of Workforce and Organisational Development                    |                                                      | Amber                   | To develop specific skill-mix change plans by ward and department using the Audit Commission, Association of United Kingdom University Hospitals and internal data.                                                                                                                                                                                        | March 2010 and ongoing | Director of Workforce and Organisational Development | Amber                        |
|      | <i>To develop specific skill-mix change plans by ward and department using the Audit Commission, Association of United Kingdom University Hospitals and internal data.</i>                                                            |               |                  |                                                                                                                                                                                                                        |                 | <i>Note: this should not be an objective, but is a control to address objectives 33, 31, 30 and 32.</i>                                                                                                                                                           |                                                                                                                       |                                                                |                                                                                                |                                                                                       |                                                                         |                                                      |                         |                                                                                                                                                                                                                                                                                                                                                            |                        |                                                      |                              |
| 032  | To ensure compliance with the European Working Time Directive by August 2009.                                                                                                                                                         | 26/11/09      | None             | Risk 1406- Non-Compliance with European Working Time Directive                                                                                                                                                         | Governance Risk | Regular monitoring of Junior doctors' hours. Monthly reporting to Strategic Health Authority.<br><br>New contracts and Standard Operating Procedures for new doctors.<br><br>Participation in the Strategic Health Authority international recruitment initiative | Derogation of those rotas potentially not compliant                                                                   | Monthly reports to Strategic Health Authority                  | <br>Amber  | Derogation received for five rotas with action plans to achieve compliance.           | Strategic Health Authority                                              | Governance & Risk Management Committee               | Amber                   | Continue to monitor hours<br><br>Monitoring of rota's, monthly reports to Strategic Health Authority and project steering group, divisional actions plans for non compliant rota's. Divisions continue to review implementation plans following monitoring and to investigate reasons behind doctors working in excess of official start and finish times. | Ongoing                | Director of Workforce and Organisational Development | Amber                        |
| 033  | To produce a Recruitment and Retention Plan for Nursing and Midwifery, Pharmacy and Radiography.                                                                                                                                      | 26/11/09      | None             | Risk 752 – Recruitment of Specialist clinical posts. Recruitment difficulties for a small number of specialist posts may continue and compromise the quality of service that can be provided and/or limit that service | Governance Risk | Nursing and Midwifery recruitment strategy<br><br>Skill mix plan                                                                                                                                                                                                  | Divisional Reviews and Boards (bank and Agency usage and vacancy rates)                                               | External review by Audit Commission in 2008 of bank and agency | <br>Amber | Recruitment strategies and plans for Estates and Facilities, pharmacy and radiography | Director of Workforce and Organisational Development                    | Director of Workforce and Organisational Development | Amber                   | Divisional controls on circumstances when bank am agency can be authorised.<br><br>Review implications of downturn plan and risk assessment                                                                                                                                                                                                                | Reviewed monthly       | Director of Workforce and Organisational Development | Amber                        |

| Ref. | Objective                                                                                                                            | Date reviewed | S4BH/ AFLink | Principal Risk                             | Risk Type       | Key Controls                                                                                                                                                                      | Internal Assurance                   | Independent Assurance | Independent Assurance Level                                                                  | Gaps in Control or Assurance | Monitoring Systems                   | Internal Assurance Committee         | Overall Assurance Level | Action Plans                                                                                                                                                                     | Delivery date                                                      | Responsible Director/s                               | Assurance level after action |
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| 034  | To establish a leadership framework to ensure the Trust has the future capacity and capability to deliver high quality care for all. | 26/11/09      | C7b, C8a     | None identified in corporate risk register | Governance Risk | Existing review of the Teaching and learning priorities within the Trust with 3 year plan to deliver.<br><br>Phase 1 focus on management core skills has been delivered this year | Teaching and Learning Strategy group | None                  | Amber<br> | None                         | Teaching and Learning Strategy Group | Teaching and learning strategy group | Amber                   | Detailed action plan being developed to address three key priorities:<br><br>Head of Learning and Development post<br><br>Budgets for L&D<br><br>Training Activity in the Trust. | Action plan with timescales to be developed by the end of the year | Director of Workforce and Organisational Development | Amber                        |

| Ref. | Objective | Date reviewed | S4BH/AFLink | Principal Risk | Risk Type | Key Controls | Internal Assurance | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans | Delivery date | Responsible Director/s | Assurance level after action |
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Strategic Aim: To improve the environment for patients & staff, to improve ease of access for patients & visitors & to develop the Trust's estate to give the optimal configuration of services

| Ref. | Objective                                                                                                                                                                   | Date reviewed | S4BH Link | Principal Risk                                                                                                                            | Risk Type       | Key Controls                                                                                                                                                                                                                                                      | Internal Assurance                                                                                                                                                                                                                                                              | Independent Assurance                                                                                                     | Independent Assurance Level                                                                    | Gaps in Control or Assurance                                                                                                                                                                                                                                                                                                                     | Monitoring Systems                                                                                                                                                                                                                     | Internal Assurance Committee                                                                               | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                                                                         | Delivery date                                    | Responsible Director/s  | Assurance level after action |
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| 035  | The Trust will meet the recommendations as laid out in the new standard for Mixed Sex Accommodation.                                                                        | 26/11/2009    | C20b      | Risk 1415 – Failure to comply with new Mixed Sex Wards standards                                                                          | Governance Risk | Physical changes to the wards to separate male and female areas, and the designation of male/female bathrooms completed<br><br>The Delivery of Single Sex Compliance is reported to the Trust Executive and breaches of compliance are reported daily to the PCT. | Works completed for areas that come under the current standard and reported to Trust Operational Group<br><br>The Trust Operation Group monitor the delivery of this programme of work.<br><br>The Trust Executive Group and the Capital Committee review delivery of the plan. | Assessment carried-out by SHA and PCT                                                                                     | Green<br>   | Ongoing operational breaches of standard being recorded but not currently reported to a Trust committee, which would be required to provide additional assurance of ongoing compliance                                                                                                                                                           | Operational breaches of standard reported as clinical incidents and copied to the Clinical Site Team<br><br>Delivery is monitored by the Trust Governance & Risk Management Committee and also monthly by the Trust Operational Group. | Trust Operational Group and Governance & Risk Management Committee                                         | Green                   | Reporting breaches of standard to TOG to provide assurance of ongoing operational compliance                                                                                                                                                                                                                                         | Apr-10                                           | Chief Operating Officer | Green                        |
| 036  | To improve physical access for service users to the Trust's facilities.                                                                                                     | 26/11/2009    | C21a      | Risk 1416 – Reduced Patient and Service User satisfaction due to difficulties in parking on or near the Trust site.                       | Governance Risk | Governors are progressing an independent review of parking and access and a working group has been set up to move issues forward.<br><br>HUBS bus service<br><br>Cabot Circus bus service<br><br>Travel Plan.                                                     | Progressing a business case for the development of a multi-storey car park on the precinct will draw out further data regarding need / demand.                                                                                                                                  | Patient complaint system and PALS<br>A feedback system provides assurance regarding those arrangements that are in place. | Amber<br>   | There is a gap between the expectation of patients and visitors to the BRI cluster of hospitals relating to car parking / access provision.                                                                                                                                                                                                      | reports to the Internal Assurance Committees                                                                                                                                                                                           | Trust Operating Group<br><br>Trust Executive Group<br>Redevelopment Programme Board.                       | Amber                   | Travel Plan.<br><br>Action Plans being formulated by the Governor meetings.                                                                                                                                                                                                                                                          | Plan for 2009/2010 in place and progressing.     | Chief Operating Officer | Amber                        |
| 037  | To ensure that the Trust's estate and facilities are fit for purpose and meet the needs of existing and developing services across the Trust<br><br>See also objective 027. | 26/11/2009    | C21b      | Health and Safety: Risk of harm to patients, visitors and staff due to difficulty in maintaining the estate due to its age and condition. | Governance Risk | Key controls are revenue and capital investment levels in the estate. Revenue is "lowest in class".<br><br>Annual Risk Adjusted Backlog Assessment.<br><br>Annual preparation of ERIC data and benchmarking with peer groups.                                     | Reports to: Infection Control Committee, Capital Prioritisation Group, Redevelopment Programme Board, Trust Operating Group, Trust Executive Group, Fire Safety Audits (being revised currently)<br>Decontamination dashboard.                                                  | Decontamination Audit,<br><br>Avon Fire & Rescue Audit<br><br>Willis Risk Assessment.                                     | Amber<br> | Use of buildings which are not fit for purpose remains a gap e.g. Bristol General Hospital and BRI Old Building. Plans in place to eradicate these gaps by 2012 and 2014 respectively.<br><br>Low level in revenue investment in the estate leaves gaps in the replacement of old building fabric and building services e.g. Backlog Maintenance | Trust Operating Group, Health and Safety Committee, Infection Control Committee, Decontamination Committee                                                                                                                             | Trust Operating Group, Health and Safety Committee, Infection Control Committee, Decontamination Committee | Amber                   | Annual Backlog Maintenance Programme.<br><br>Annual Capital Programme.<br><br>BRI Redevelopment Programmes Phases 1, 2 and 3.<br><br>Planned Preventative Maintenance Programme.<br><br>Fire Safety Programme.<br><br>Pre Transformation Improvement Plans.<br><br>Health and Safety plan produced following Willis Risk Assessment. | Dependent on independent review scoping exercise | Chief Operating Officer | Amber                        |

| Ref. | Objective                                                                                                                                                                             | Date reviewed | S4BH/ AFLink | Principal Risk                             | Risk Type       | Key Controls                                                                                                                                            | Internal Assurance                                       | Independent Assurance                                                                                                                                                                                            | Independent Assurance Level | Gaps in Control or Assurance                                                                                                 | Monitoring Systems                                             | Internal Assurance Committee | Overall Assurance Level | Action Plans                                                                                                                 | Delivery date | Responsible Director/s  | Assurance level after action |
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| 038  | Healthcare organisations keep patients staff and visitors safe by having systems to ensure the prevention, segregation, handling, transport and disposal of waste is properly managed | 26/11/2009    | C4e          | None identified in corporate risk register | Governance Risk | Trust Waste Disposal Policy and Procedures.<br><br>Statutory processes for waste streams are monitored by external contractors as part of Duty of Care. | Absence of Enforcement Notices by the Environment Agency | Environment Agency inspection.<br><br>Disposal Contractor Duty of Care inspections, Registration Process for Domestic Waste with Environment Agency.<br><br>Public Health Officer Inspections of Catering Areas. | Green                       | If gaps are identified by an external agency inspection there is a remedy period normally identified. No key gaps identified | PEAT inspections.<br><br>Exec walkabouts.<br><br>Local checks. | Health and Safety Committee  | Green                   | If gaps are identified by an external agency inspection there is a remedy period normally identified. No key gaps identified | Continual     | Chief Operating Officer | Green                        |

| Ref. | Objective | Date reviewed | S4BH/AFLink | Principal Risk | Risk Type | Key Controls | Internal Assurance | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans | Delivery date | Responsible Director/s | Assurance level after action |
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Supporting Strategic Aim: To achieve a sustainable financial surplus

| Ref. | Objective                                                                       | Date reviewed | S4BH Link            | Principal Risk                                                                                                                                                                                                                                                                                                                                  | Risk Type      | Key Controls                                                                                                                                                                                                                                                                                                                                 | Internal Assurance                   | Independent Assurance             | Independent Assurance Level | Gaps in Control or Assurance                                                                         | Monitoring Systems                                                                                                      | Internal Assurance Committee | Overall Assurance Level | Action Plans                                                                                                                                                                                                                                                                                                     | Delivery date | Responsible Director/s  | Assurance level after action |
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| 039  | To deliver the financial plan for 2009/10                                       | 26/11/2009    | F1, F4, F5, SP3, SP6 | Risk 962 – The Trust's financial Strategy may not be deliverable in the likely national economic climate<br><br>Risk 1082 – Cost pressures - unforeseen cost pressures over allowance in long term financial plan.<br><br>Risk 1240 – Financial penalties are incurred under national contract due to under-performance against key indicators. | Financial Risk | Report monthly to Finance Committee.<br><br>Internal monthly Divisional Reviews<br><br>Transformation Programme<br><br>Oversight of preparation and delivery of operational plans for delivery of services to required standards.<br><br>Oversight of preparation and delivery of remedial action plans against specific indicators at risk. | Internal Audit. Finance Committee    | External Audit. Monitor monitors. | Green<br>←                  | CRES plan under-achievement will jeopardise achievement of financial plan.<br><br>See Objective 041. | Financial System                                                                                                        | Finance Committee            | Green                   | Divisional plans reviewed each month.                                                                                                                                                                                                                                                                            | Mar-10        | Finance Director        | Green                        |
| 040  | To continue to develop and improve financial management systems                 | 26/11/2009    | F3, F6               | None                                                                                                                                                                                                                                                                                                                                            | N/A            | Replacement of Core Financial Systems Project Board                                                                                                                                                                                                                                                                                          | Reports to IM&T Board                | Subject to Internal Audit         | Green<br>←                  | None                                                                                                 | Project Board for implementation                                                                                        | Finance Committee            | Green                   | Project Plan in place                                                                                                                                                                                                                                                                                            | Apr-10        | Finance Director        | Green                        |
| 041  | To fully realise the agreed Cash Releasing Efficiency Savings plans for 2009/10 | 26/11/2009    | F1                   | Risk 741 – Cash Releasing Efficiency Savings plan underachieve and impact on trust annual and planned outturn                                                                                                                                                                                                                                   | Financial Risk | CRES Committee<br><br>Monthly Divisional Reviews. Reports to Finance Committee.                                                                                                                                                                                                                                                              | Monthly Finance reports to the Board | None                              | Red<br>↓                    | Under performance in plans to address shortfall.                                                     | Monthly reporting to Finance Committee and Execs Workstream project groups being established by Chief Operating Officer | Finance Committee            | Red                     | Continue to review Divisional plans monthly, identify areas of challenge and ensure corporate support is put in place.<br><br>Executive support is in place for Women's and Children's services.<br><br>Close monitoring and support from the Director of Finance and Chief Operating Officer for all Divisions. | Mar-10        | Chief Operating Officer | Red                          |

| Ref. | Objective | Date reviewed | S4BH/ AFLink | Principal Risk | Risk Type | Key Controls | Internal Assurance | Independent Assurance | Independent Assurance Level | Gaps in Control or Assurance | Monitoring Systems | Internal Assurance Committee | Overall Assurance Level | Action Plans | Delivery date | Responsible Director/s | Assurance level after action |
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Supporting Strategic Aim: To ensure that the Trust has the governance and information structures, systems and processes necessary to deliver its mission efficiently, effectively and with the highest standards of probity

| Ref. | Objective                                                                                                                                                                                        | Date reviewed | S4BH/ AFLink  | Principal Risk                                                                                                                                                                         | Risk Type       | Key Controls                                                                                                                                                                 | Internal Assurance                                                                                                                                                                                             | Independent Assurance                                                                                                                                                                                                                                        | Independent Assurance Level                                                                      | Gaps in Control or Assurance           | Monitoring Systems         | Internal Assurance Committee                                                                                                                                                           | Overall Assurance Level | Action Plans                                | Delivery date | Responsible Director/s  | Assurance level after action |
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| 042  | To produce a comprehensive Civil Contingencies Plan (Business Continuity Plan, Major Incident Plan, Pandemic Flu Plan) to meet national requirements.                                            | 09/10/2009    | C24           | Risk 1417 – Non-compliance with the Civil Contingencies Act<br><br>Risk 1465 - the Trust being unable to deliver its mandatory services and meet targets due to impact of Pandemic Flu | Governance Risk | Emergency Planning Officer. Winter Plan.<br><br>Pandemic Flu Plan and Communication Strategy.<br><br>Revised Major Incident Plan.<br><br>Business Continuity Planning Group. | Testing of Winter Plan and Pandemic Flu Plan<br>Lead Director on Swine Flu able formally to stand down<br>Major Incident Plan Reviewed spring 2010<br>A formal report is provided to the Trust Board annually. | Pandemic Flu Plan amended in Dec '09 and accepted by NHS Bristol<br><br>The Trust meets the CQC core standard 24.<br><br>Avon Health Emergency Resilience Group works together to monitor plans and ensure consistency of working across the health economy. | <br><br>Amber |                                        | Emergency Planning Officer | Business Continuity Planning Group.<br><br>The Trust Civil Contingencies Committee monitors compliance with the Civil Contingencies Act 2004 and reports to the Trust Executive Group. | Amber                   | Refresh of winter plan from lessons learned | Feb-10        | Chief Operating Officer | Green                        |
| 043  | To continue the development of clinical information systems to enhance the delivery of patient care and improve service efficiency, aligned to the National Programme for Information Technology | 09/10/2009    | C9, IM&T 1-10 | Risk 1083 – Existing Patient Administration Systems become obsolete as National Programme for Information Technology is delayed                                                        | Governance Risk | Contract negotiations with existing supplier completed. System secure until Dec 2011.                                                                                        | Signed contract.                                                                                                                                                                                               | None.                                                                                                                                                                                                                                                        | <br><br>Green | Uncertainty of system beyond Dec 2011. | IM & T Board               | IM & T Board                                                                                                                                                                           | Green                   |                                             |               | Finance Director        | Amber                        |

| Ref. | Objective                                                                           | Date reviewed | S4BH/ AFLink   | Principal Risk       | Risk Type       | Key Controls                                                                                                                                                                                                                 | Internal Assurance                                                                                                                                                                                              | Independent Assurance                                                                                                | Independent Assurance Level | Gaps in Control or Assurance                                                                                                                                                                                                                                              | Monitoring Systems                                                                                                                                          | Internal Assurance Committee             | Overall Assurance Level | Action Plans                                                                                                                     | Delivery date | Responsible Director/s                                                  | Assurance level after action |
|------|-------------------------------------------------------------------------------------|---------------|----------------|----------------------|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------|------------------------------|
| 044  | To ensure that the Trust continues to meet the requirements set out by Monitor, the | 8/10/2010     | C7a , C7c, F2, | All governance risks | Governance Risk | Trust Board and Committees, Membership Council and divisional governance structures.<br>Risk Registers and Assurance Framework.<br>See controls for all governance risks.<br>Revised Business Planning process for 2010/2011 | Internal Audit of Integrated Governance April 2009.<br>Internal Audit of Risk Management Arrangements August 2009 and Swift review March 2010.<br>Head of Internal Audit Opinion 2008/09 significant assurance. | Achievement of governance criteria for FT authorisation June 2008.<br>Governance risk rating for Q2 and Q3 were red. | ← Green                     | Board Assurance Framework being strengthened for 2010/11 objectives.<br>Identified need to strengthen governance links with Divisions<br>Identified need for improved governance arrangements in contracts with external providers.<br>See gaps for all governance risks. | Trust Board Audit and Assurance Committee.<br>Governance and Risk Management Committee<br>Trust Executive Group                                             | Governance and Risk Management Committee | Red                     | Further work to develop governance arrangements in contracts with external providers. See action plans for all governance risks. | Apr-10        | Chief Nurse/ Chief Operating Officer/ Director of Corporate Development | Red                          |
|      |                                                                                     |               |                |                      |                 | Management of cancellations                                                                                                                                                                                                  |                                                                                                                                                                                                                 |                                                                                                                      |                             |                                                                                                                                                                                                                                                                           | The Trust Operational Group monitors delivery of targets and action plans every two weeks.<br>The Executive Performance review committee was established by |                                          |                         |                                                                                                                                  |               |                                                                         |                              |

| Ref. | Objective                                                                                                      | Date reviewed | S4BH/ AFLink | Principal Risk                                            | Risk Type                    | Key Controls                                                                                                                                                                                                                                                                                                                                                                                          | Internal Assurance                                                                                                                                                                                 | Independent Assurance                                    | Independent Assurance Level                                                                  | Gaps in Control or Assurance                                   | Monitoring Systems                                                                                                                                                                                                                                                                                                                              | Internal Assurance Committee                         | Overall Assurance Level | Action Plans                                                                                                        | Delivery date              | Responsible Director/s                                                        | Assurance level after action |
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|      | regulator for Foundation Trusts.                                                                               | 26/11/2009    |              | Risk of compromised patient outcomes due to cancellations | Governance Risk              | through Patient Flow meetings<br>Divisional escalation process for all potential cancellations<br>Trust Operational Group Commissioning and Planning Group<br>Trust Executive Group Governance and Risk Management Committee.<br>Trust Board approval of business planning process and annual plan.<br>Fully integrated planning and performance framework for all objectives in Assurance Framework. | Review of 2009/2010 Performance management process undertaken.<br>Trust Board approval of business planning process and Annual Plan.<br>Divisional/ Corporate Risk Registers/ Assurance Framework. | Signed contracts.<br>Monitor risk rating of Annual Plan. | <br>Green | Insufficient bed capacity to prevent bed-related cancellations | Established by the acting CEO in December 2009 and monitors delivery of plans weekly<br>The Trust Emergency Access Steering Group monitors delivery of the 4 hour emergency access plan monthly.<br>Commissioning and Planning Group<br>Trust Executive Group<br>Governance and Risk Management Committee<br>Trust Board Membership Council and | Trust Executive Group and GRMC report to Trust Board | Amber                   | Development of corporate KPIs and revised performance monitoring framework.                                         | Mar-10                     | Chief Operating Officer                                                       | Amber                        |
| 045  | To deliver the Corporate Social Responsibility Programme including delivery of the carbon reduction programme. | 26/11/2009    | None         | No specific risk identified for Carbon Management         | The management of ward moves | Suggested additional Annual Board reporting requirements from Monitor                                                                                                                                                                                                                                                                                                                                 | Annual reporting to TOG                                                                                                                                                                            | 2009/2010 - addition to Annual Report                    | <br>Amber | Reporting mechanisms. No gaps for Carbon Management            | Director of Workforce and Organisational Development/ Chief Operating Officer                                                                                                                                                                                                                                                                   | Trust Operating Group for Carbon Management          | Red                     | The 5-year Action Plan for Carbon Management is contained within the report approved by the Trust Board 26 Feb 2009 | 2014 for Carbon Management | Director of Workforce and Organisational Development/ Chief Operating Officer | Amber                        |



|                                                                                                    |                                                                                                                                                                                                                                                                                                                     |         |     |  |         |     |         |     |
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| Trust Board Meeting                                                                                | Date: 29 March 2010                                                                                                                                                                                                                                                                                                 |         |     |  |         |     |         |     |
| Agenda Item                                                                                        | 14                                                                                                                                                                                                                                                                                                                  |         |     |  |         |     |         |     |
| Title of Report                                                                                    | Draft Assurance Framework 2010/11                                                                                                                                                                                                                                                                                   |         |     |  |         |     |         |     |
| Recommendations                                                                                    | The Board is invited to receive the draft Assurance Framework for the 2010/11 Annual Plan objectives                                                                                                                                                                                                                |         |     |  |         |     |         |     |
| Actions Required                                                                                   | A further update will be provided when the Trust’s annual aims and objectives 2010/11 are confirmed.                                                                                                                                                                                                                |         |     |  |         |     |         |     |
| Which Corporate Objective(s) are supported by this paper?<br>Implications for the NHS Constitution | All objectives are supported by the Assurance Framework.<br><br>The Assurance Framework supports the attainment of the Trust’s objectives, which support the meeting of requirements in relation to treatment times, accessible, clean and suitable treatment locations, pledges to staff about working for the NHS |         |     |  |         |     |         |     |
| Is this on the Trust’s risk register?                                                              | The Assurance Framework does not systematically link to the risk registers; its purpose is to establish risks to the delivery of each objective.                                                                                                                                                                    |         |     |  |         |     |         |     |
| Which CQC registration standards does this report provide evidence for?                            | Where relevant, national standards are referred to in the Assurance Framework.                                                                                                                                                                                                                                      |         |     |  |         |     |         |     |
| Financial Implications                                                                             | <table><tr><td>Revenue</td><td>£ 0</td><td>Capital</td><td>£ 0</td></tr></table>                                                                                                                                                                                                                                    |         |     |  | Revenue | £ 0 | Capital | £ 0 |
| Revenue                                                                                            | £ 0                                                                                                                                                                                                                                                                                                                 | Capital | £ 0 |  |         |     |         |     |
| Prepared by: Name & Title                                                                          | David Seabrooke, Company Secretary                                                                                                                                                                                                                                                                                  |         |     |  |         |     |         |     |
| Presented by: Name & Title                                                                         | David Seabrooke, Company Secretary                                                                                                                                                                                                                                                                                  |         |     |  |         |     |         |     |
| Appendices                                                                                         | Appendix 1 – -Draft Board Assurance Framework 2010/11                                                                                                                                                                                                                                                               |         |     |  |         |     |         |     |

## Previous Meetings

Please insert the date the paper was presented under to the relevant group

| Exec Team | Audit & Assurance Committee | Governance Risk and Risk Management | Finance Committee | Trust Executive Group | Other Meeting (Please state) |
|-----------|-----------------------------|-------------------------------------|-------------------|-----------------------|------------------------------|
|           | 9/3/10                      |                                     |                   |                       |                              |

## Discussion

1. The Board Assurance Framework is defined in *The Healthy NHS Board* from the National Leadership Council as identifying the risks in relation to strategic objectives, along with controls in place and assurances on their operation. It continues, “the most effective boards use this as a dynamic tool to drive the Board agenda.” It then discusses as a separate item the Trust’s operational risk register.

2. The Board has given initial consideration to the annual objectives 2010/11 and these will be discussed and agreed by the Membership Council and the Board in April/May. It is considered helpful at this stage to begin to adopt a prospective approach, stating where assurances *will* come from in relation to the delivery of the Trust’s objectives. The attached framework is therefore still a work in progress. Further work is being undertaken to bring about a closer alignment of the quarterly Annual Plan progress updates with updates to the Board Assurance Framework.

3. More detailed delivery plans for the objectives will also be put in place and the Assurance Framework is an opportunity for delivery leads to think through and identify the major risks to success in progressing an objective. The assurance framework is designed to provide a line of sight between delivery and monitoring so that any objective that is going off-track can be recognised and addressed.

| Refere<br>nce                                                         | Date<br>reviewed | National<br>objectives | What and who<br>drives this<br>objective?                                  | What are the risks<br>to our achieving our<br>objective?                         | How are the risks<br>mitigated? (Controls)                                                                              | How do we receive<br>assurance that<br>controls are working?                    | whom is progress<br>with this<br>objective<br>monitored?                                                                                                                  | Risk rating | What else are we<br>going to do? | Delivery date | Respons-<br>ible<br>directors |
|-----------------------------------------------------------------------|------------------|------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------------------------------|---------------|-------------------------------|
| AIM A To improve care for patients and the overall patient experience |                  |                        |                                                                            |                                                                                  |                                                                                                                         |                                                                                 |                                                                                                                                                                           |             |                                  |               |                               |
| ve A1                                                                 | Meet the         | service standards      | mandated in national frameworks and agreed in local contracts as a minimum |                                                                                  |                                                                                                                         |                                                                                 |                                                                                                                                                                           |             |                                  |               |                               |
| A 1.1                                                                 |                  | CQC 4                  | CQC Standards                                                              | demand<br>management<br>schemes fail to<br>deliver reduced<br>demand on capacity | close monitoring of<br>performance and<br>early identification of<br>challenges                                         | monthly reporting to<br>the trust board                                         | Ttrust<br>Operational<br>Group to monitor<br>performance and<br>action plans twice<br>monthly,<br>reporting to TEG<br>and the Board<br>monthly<br>reporting to<br>Monitor |             |                                  |               | COO                           |
| A1.2                                                                  |                  |                        | Monitor<br>Compliance                                                      | failure to<br>reduce new to<br>follow up<br>referrals                            | close working<br>with key<br>stakeholders                                                                               |                                                                                 |                                                                                                                                                                           |             |                                  |               |                               |
| A 1.3                                                                 |                  |                        | Local<br>Commissioning<br>Standards                                        | failure to<br>transfer agreed<br>elective activity<br>to the ISTC                | implementation<br>of accountability<br>framework<br>across the Trust<br>and improved<br>engagement of<br>clinical staff | Regular progress<br>reports from the<br>Programme Board;<br>performance reports |                                                                                                                                                                           |             |                                  |               |                               |

| Refere<br>nce                                                                                                                                | Date<br>reviewed | National<br>objectives | What and who<br>drives this<br>objective? | What are the risks<br>to our achieving our<br>objective? | How are the risks<br>mitigated? (Controls) | How do we receive<br>assurance that<br>controls are working? | whom is progress<br>with this<br>objective<br>monitored? | Risk rating | What else are we<br>going to do? | Delivery date | Respons-<br>ible<br>directors |
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| Objective A2 To deliver at least upper quartile service efficiency across the Trust through the <i>Making Our Hospitals Better</i> programme |                  |                        |                                           |                                                          |                                            |                                                              |                                                          |             |                                  |               |                               |

|       |          |                          |                                                                                                                          |                                                            |                                                                          |                                          |                  |  |  |  |    |
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| A 2.1 | 01/03/10 | CQC 16, NHS Constitution | Programme Office<br>Implement action plan for reduction of length of stay, productive ward and length of stay programmes | Insufficient resources for the programme<br>Lack of buy-in | Management arrangements for Transformation programme; project management | Regular reporting to TEG and Trust Board | Programme Office |  |  |  | MD |
| A 2.2 |          |                          |                                                                                                                          | Lack of support for the programme                          | Active support by Executives                                             | Regular discussion at TEG                | TEG              |  |  |  |    |

| Refere<br>nce    | Date<br>reviewed | National<br>objectives | What and who<br>drives this<br>objective?                                                                                                                                         | What are the risks<br>to our achieving our<br>objective?                                                                                                                                                                                                                                                                                                                                                                                                                                               | How are the risks<br>mitigated? (Controls)                                                                                                                                                                                                                                                                                                                                                                                                                          | How do we receive<br>assurance that<br>controls are working?                                                                                                                                         | whom is progress<br>with this<br>objective<br>monitored?                                                                                     | Risk rating | What else are we<br>going to do? | Delivery date | Respons-<br>ible<br>directors |
|------------------|------------------|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------------------------------|---------------|-------------------------------|
| Objecti<br>ve A3 |                  |                        |                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                      |                                                                                                                                              |             |                                  |               |                               |
| A 3.1            | March<br>2010    | CQC 16                 | Assistant Director<br>for Audit &<br>Assurance (co-<br>ordinator for the<br>Quality Account);<br>any other Trust<br>managers who are<br>contributing<br>content to the<br>Account | Risks are associated<br>with producing the<br>report in<br>accordance with<br>requirements as to<br>content and<br>deadlines and<br>whether the report<br>will actually<br>demonstrate<br>improvement. This<br>is the first year the<br>Trust will have<br>produced a formal<br>Quality Account<br>(although a Quality<br>Report was<br>included in the<br>Annual report last<br>year) proposed<br>content has yet to<br>be confirmed and<br>availability of data is<br>therefore as yet<br>uncertain. | Asst Director<br>schedule/plan for<br>delivery; DH<br>guidance published<br>in February; likely<br>key indicators for the<br>Account, e.g.<br>Infection Control,<br>HSMR etc are<br>reported to Board<br>throughout the year.<br><br>Corporate and<br>divisional patient<br>safety and clinical<br>effectiveness<br>arrangements<br><br>VTE prevention<br>programme<br><br>Participation in<br>South West Quality<br>and Patient Safety<br>Improvement<br>Programme | Assistant Director<br>reports to Medical<br>Director and Chief<br>Nurse; Medical<br>Director Board<br>seminar on quality;<br>Non-Executive<br>Director attendance<br>at Quality Accounts<br>away-day | Monitored by<br>Medical Director<br>and Chief Nurse;<br>draft Quality<br>Account will be<br>submitted to the<br>Board - date to be<br>agreed |             | tba                              | MD/CN         |                               |

| Refere<br>nce                                                                | Date<br>reviewed | National<br>objectives | What and who<br>drives this<br>objective?       | What are the risks<br>to our achieving our<br>objective?                                    | How are the risks<br>mitigated? (Controls)                                                           | How do we receive<br>assurance that<br>controls are working?                                          | whom is progress<br>with this<br>objective<br>monitored? | Risk rating | What else are we<br>going to do? | Delivery date | Respons-<br>ible<br>directors |
|------------------------------------------------------------------------------|------------------|------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------|----------------------------------|---------------|-------------------------------|
| Objective A4 To reduce further the incidence of hospital acquired infections |                  |                        |                                                 |                                                                                             |                                                                                                      |                                                                                                       |                                                          |             |                                  |               |                               |
| A 4.1                                                                        |                  | CQC 8                  | Director of<br>Infection Control                | Weaknesses in<br>decontamination<br>arrangements                                            | Regular review by<br>the Director of<br>Infection Control<br>Estates<br>decontamination<br>dashboard | Internal Audit review<br>of decontamination -<br>reasonable assurance<br>Decontamination<br>Committee | Infection Control<br>Committee,                          |             |                                  |               |                               |
| A 4.2                                                                        |                  | Hygeine<br>Code        | Infection Control<br>Team<br>Cleansing Strategy | Poor management<br>of cleansing<br>Poor clinical<br>operating<br>procedures                 | Supervision of<br>cleaning; system of<br>Ward closures where<br>outbreak suspected                   | Monthly reporting to<br>Infection Control<br>Committee<br>Cleaning audit<br>dashboard                 | Director of<br>Infection Control<br>to Trust Board       |             |                                  | Apr-10        | CN                            |
| A 4.3                                                                        |                  |                        | Decontamination<br>Board and policy             | Infections borne in<br>hospital by visitors<br>or non-compliant<br>equipment/<br>procedures | Trust Wide infection<br>control<br>arrangements<br>including policies,<br>training and audits        | Reporting<br>arrangements for<br>D&V symptoms<br>Reporting and review<br>of audits                    | Decontamination<br>Committee                             |             |                                  |               |                               |

| Refere<br>nce    | Date<br>reviewed                      | National<br>objectives     | What and who<br>drives this<br>objective?                                                                              | What are the risks<br>to our achieving our<br>objective?                                                                 | How are the risks<br>mitigated? (Controls)                                                                                                                                                     | How do we receive<br>assurance that<br>controls are working?                                                   | whom is progress<br>with this<br>objective<br>monitored? | Risk rating                                                                                                                                                                                                                                                                                                    | What else are we<br>going to do?                                                                                                                                                                                                                                                                                    | Delivery date                                                                                                                  | Respons-<br>ible<br>directors |
|------------------|---------------------------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Objecti<br>ve A5 | To improve patient safety in hospital |                            |                                                                                                                        |                                                                                                                          |                                                                                                                                                                                                |                                                                                                                |                                                          |                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                |                               |
| A5.1             | 01/03/10                              | CQC 4; NHS<br>Constitution | Clinical Risk<br>Assurance<br>Committee, Patient<br>Safety leads in<br>divisions and<br>central patient<br>safety team | Preventable patient<br>harm. Non<br>compliances with<br>Trust policy and<br>processes. Failed<br>external<br>assessments | Training and<br>induction;<br>Incident reporting,<br>patient safety<br>programme and<br>adverse event<br>monitoring.<br>Mortality and<br>morbidity reviews.<br>External assesments<br>eg NHSLA | Clinical Risk<br>Assurance Committee<br>and Divisional<br>Governance Groups.<br>Ext assessment<br>project team | See G plus GRMC<br>for NHSLA<br>assessments              | High for<br>NHSLA<br>assessment<br>due to<br>financial<br>impact of<br>failed<br>assessment<br>(10% of<br>annual<br>premium)<br>and need<br>for all depts<br>in Trust to<br>demonstrat<br>e working at<br>level 2 for<br>all relevant<br>standards.<br>No single<br>project<br>group<br>allocated<br>for this. | NHSLA assessment<br>maternity level 3<br>achieved Feb 2010.<br>Acute standards<br>(rest of Trust) April<br>2011 aim for level<br>2. Additional<br>patient safety<br>programme for<br>paediatrics<br>commenced in<br>early 2010.<br>Deliver key<br>improvement<br>targets as set out in<br>the plan by March<br>2011 | 2014 for<br>Patient Safety<br>prog 30%<br>reduction in<br>adverse<br>events and<br>15%<br>reduction in<br>patient<br>mortality | MD                            |
| A5.2             | 01/03/10                              | CQC 9                      | Medicines<br>governance<br>arrangements                                                                                | Clinically relevant<br>medication errors                                                                                 | Medicines Steering<br>Group;<br>Incident Reviews;<br>Regional and<br>international patient<br>safety work                                                                                      | External inspections;<br>Rpyal Pharmaceutical<br>Society<br>Medicines and<br>Healthcare agency<br>inspections  | Review by Clinical<br>Risk Assurance<br>Committee        |                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                |                               |



| Refere<br>nce    | Date<br>reviewed                                              | National<br>objectives | What and who<br>drives this<br>objective? | What are the risks<br>to our achieving our<br>objective? | How are the risks<br>mitigated? (Controls) | How do we receive<br>assurance that<br>controls are working? | whom is progress<br>with this<br>objective<br>monitored? | Risk rating | What else are we<br>going to do? | Delivery date | Respons-<br>ible<br>directors |
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| Objecti<br>ve A6 | To ensure that every child in hospital is protected from harm |                        |                                           |                                                          |                                            |                                                              |                                                          |             |                                  |               |                               |

|      |          |       |                                               |                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                 |                                            |  |                                                                                                          |    |
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| A6.1 | 01/03/10 | CQC 7 | Safeguarding<br>Children Steering<br>Group    | Lack of compliance<br>with statutory and<br>mandatory training           | Safeguarding training<br>requirements<br>Pre-employment<br>background checks<br>2. Child Protection<br>Policies and systems are<br>up to date and robust,<br>including a process for<br>flagging up children<br>who miss outpatient<br>appointments and a<br>system for flagging<br>children for whom<br>there are safeguarding<br>concerns.<br>Named professionals<br>are clear about their<br>roles and have<br>sufficient time and<br>support to undertake<br>them. | There is a Board level<br>executive director lead<br>for safeguarding. The<br>Board reviews<br>safeguarding across the<br>organisation at least<br>once a year and has<br>robust audit<br>programmes to assure it<br>that safeguarding<br>systems and processes<br>are working.<br><br>NICE guidance on<br>maltreatment is fully<br>implemented | Safeguarding<br>Children Steering<br>Group |  | Robust system for<br>the monitoring of<br>all safeguarding<br>incidents to be<br>developed (Nov<br>2010) | CN |
|      |          |       | Child Protection<br>Policy                    | Work still ongoing<br>to reduce the risk of<br>multiple sets of<br>notes |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                 |                                            |  | Implementation of<br>Care Plus and<br>Contact Point                                                      |    |
|      |          |       | Safeguarding<br>Children Work Plan<br>2010/11 |                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                 |                                            |  |                                                                                                          |    |

#### AIM B To work with partners to deliver better patient care

|      |               |       |                                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                      |                                 |                                                                                                                                                          |     |  |                    |    |
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| B1.1 | March<br>2010 | CQC 6 | Assistant Director<br>for Audit &<br>Assurance; Patient<br>and Public<br>Involvement (PPI)<br>Strategy 2010-12 | Risk of apathy re.<br>participation<br>(public, staff,<br>membership); risk<br>of failure to deliver<br>technology<br>underpinning PPI<br>Strategy | PPI Strategy includes<br>proposals to develop<br>Divisional PPI<br>Strategy Groups who<br>will drive PPI activity;<br>Membership<br>Strategy focussed on<br>developing<br>engagement with<br>patient/public<br>members; Patient<br>Involvement<br>Facilitator leading<br>equipment<br>procurement, and<br>Assistant Director<br>monitoring progress. | Regular reporting and<br>review | Board metrics (to<br>be developed);<br>Involving People<br>Committee<br>(including LINK<br>and governor<br>input); Governor<br>Involvement Sub-<br>group | Low |  | 31st March<br>2011 | CN |
|------|---------------|-------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----|--|--------------------|----|



| Refere<br>nce                                                                                                                                  | Date<br>reviewed | National<br>objectives | What and who<br>drives this<br>objective?        | What are the risks<br>to our achieving our<br>objective?            | How are the risks<br>mitigated? (Controls)           | How do we receive<br>assurance that<br>controls are working?             | whom is progress<br>with this<br>objective<br>monitored?                      | Risk rating | What else are we<br>going to do?                                                          | Delivery date | Respons-<br>ible<br>directors |
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| Objective B2 To reduce delays in communicating with referrers about the care of their patients and improve the quality of information provided |                  |                        |                                                  |                                                                     |                                                      |                                                                          |                                                                               |             |                                                                                           |               |                               |
| B2.1                                                                                                                                           | March<br>2010    | CQC 6                  | National<br>standard                             | Failure to roll out<br>teaining<br>programmes in a<br>timely manner | Project lead<br>appointed, roll-out<br>plan in place | monitoring of roll-<br>out plan                                          | monitored<br>through<br>performance<br>monitoring<br>framework                | low         |                                                                                           |               | COO                           |
| B2.2                                                                                                                                           |                  |                        | Monitor<br>performance<br>through a GP<br>Survey |                                                                     |                                                      | feed back from<br>GP's                                                   |                                                                               |             |                                                                                           |               |                               |
| Objective B3 To work with health and social care providers to redesign services for patient benefit                                            |                  |                        |                                                  |                                                                     |                                                      |                                                                          |                                                                               |             |                                                                                           |               |                               |
| B3.1                                                                                                                                           |                  |                        | create improved<br>patient pathways<br>of care   | competing<br>agenda items<br>from agencies                          | agreed projects in<br>place                          | monitoring of<br>agreed plans and<br>delivery of key<br>national targets | monitored by<br>Trust<br>Operational<br>Group and<br>Trust Executive<br>Group | low         | Ensure plans for<br>tranistion to<br>South Bristol<br>Community<br>hospital are<br>robust |               | COO                           |

| Refere<br>nce    | Date<br>reviewed                                                       | National<br>objectives | What and who<br>drives this<br>objective? | What are the risks<br>to our achieving our<br>objective? | How are the risks<br>mitigated? (Controls) | How do we receive<br>assurance that<br>controls are working?             | whom is progress<br>with this<br>objective<br>monitored? | Risk rating | What else are we<br>going to do?                                                                                                                                                                                                                                               | Delivery date | Respons-<br>ible<br>directors |
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| Objecti<br>ve B4 | To achieve designated provider status for specialist areas             |                        |                                           |                                                          |                                            |                                                                          |                                                          |             |                                                                                                                                                                                                                                                                                |               |                               |
| B4.1             |                                                                        |                        |                                           |                                                          |                                            |                                                                          |                                                          |             | Co-ordinate responses to commissioner and network designation processes for relevant services, including paediatric cardiac surgery, paediatric neurosurgery, and cancer services. Develop and engagement plan and establish mutual priorities and key communication channels. | March 2011    | DCD                           |
| Objecti<br>ve B5 | To engage primary care practitioners in service improvement and design |                        |                                           |                                                          |                                            |                                                                          |                                                          |             |                                                                                                                                                                                                                                                                                |               |                               |
| B5.1             |                                                                        | CQC 6                  |                                           |                                                          |                                            |                                                                          |                                                          |             |                                                                                                                                                                                                                                                                                |               | DCD                           |
| B5.2             |                                                                        |                        |                                           |                                                          |                                            |                                                                          |                                                          |             |                                                                                                                                                                                                                                                                                |               |                               |
| AIM C            | To use our resources as efficiently as possible                        |                        |                                           |                                                          |                                            |                                                                          |                                                          |             |                                                                                                                                                                                                                                                                                |               |                               |
| Objecti<br>ve C1 | To deliver the agreed cash-releasing efficiency savings (CRES) plans   |                        |                                           |                                                          |                                            |                                                                          |                                                          |             |                                                                                                                                                                                                                                                                                |               |                               |
| C1.1             | 01/03/10                                                               | CQC 26                 | Direcor of Finance                        | non achievement of financial plan                        | divisional plans for each work stream      | monthly review at the performance meetings, and programme steering group | Head of Finance/ Divisional managers                     | high        |                                                                                                                                                                                                                                                                                | March 2011    | COO                           |
| C1.2             | 01/03/10                                                               | Monitor scorecard      | Annual Resource Book                      | non achievement of compliance framework                  | divisional plans for each work stream      | monthly review at the performance meetings, and                          | Head of Finance/ Divisional managers                     | high        |                                                                                                                                                                                                                                                                                |               |                               |

| Refere<br>nce    | Date<br>reviewed                                                                                                                                     | National<br>objectives        | What and who<br>drives this<br>objective?                    | What are the risks<br>to our achieving our<br>objective?     | How are the risks<br>mitigated? (Controls)                                          | How do we receive<br>assurance that<br>controls are working?                                                                                                                                                     | whom is progress<br>with this<br>objective<br>monitored?                                   | Risk rating | What else are we<br>going to do?                                                                                                              | Delivery date | Respons-<br>ible<br>directors |
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| Objecti<br>ve C2 | To design a performance management and reporting framework aligned to the objectives of the Trust that engages clinical staff in service improvement |                               |                                                              |                                                              |                                                                                     |                                                                                                                                                                                                                  |                                                                                            |             |                                                                                                                                               |               |                               |
|                  |                                                                                                                                                      | CQC 26                        | National<br>Standards                                        | non<br>achievement of<br>national<br>compliance<br>standards | performance<br>controls in place<br>through<br>divisional<br>boards, TOG and<br>TEG | performance<br>reported<br>monthly to the<br>Trust Board and<br>Trust Executive<br>Group<br>Routine<br>monitroing of<br>performance<br>against action<br>plan<br>action taken to<br>mitigate<br>challenges early | Progress<br>monitored at<br>individual<br>divisional<br>level and at<br>coprotate<br>level | high        |                                                                                                                                               | continuous    | continuo<br>us                |
|                  |                                                                                                                                                      | NHS<br>Constitution<br>CQC 26 | Replacement of<br>Core Financial<br>Systems Project<br>Board | None                                                         |                                                                                     | Reports to<br>Information<br>Management &<br>Technology<br>Committee                                                                                                                                             | Finance<br>Committee                                                                       |             | Develop service-<br>line management<br>reports showing<br>key financial and<br>non-financial<br>information Key<br>Performance<br>Indicators. | 01/06/2010    |                               |

| Refere<br>nce    | Date<br>reviewed                                                               | National<br>objectives | What and who<br>drives this<br>objective? | What are the risks<br>to our achieving our<br>objective? | How are the risks<br>mitigated? (Controls) | How do we receive<br>assurance that<br>controls are working? | whom is progress<br>with this<br>objective<br>monitored? | Risk rating | What else are we<br>going to do? | Delivery date | Respons-<br>ible<br>directors |
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| Objecti<br>ve C4 | To implement patient-level costing and service-line reporting across the Trust |                        |                                           |                                                          |                                            |                                                              |                                                          |             |                                  |               |                               |

CQC 21

Replacement of  
Core Financial  
Systems Project  
Board

None

Reports to  
Information  
Management &  
Technology  
Committee

Finance  
Committee

Routine production  
of quarterly Service  
Line Reports.  
Regular Divisional  
Service Line  
reviews using the  
information  
produced.

DF

| Refere<br>nce    | Date<br>reviewed                                                    | National<br>objectives | What and who<br>drives this<br>objective? | What are the risks<br>to our achieving our<br>objective? | How are the risks<br>mitigated? (Controls) | How do we receive<br>assurance that<br>controls are working? | whom is progress<br>with this<br>objective<br>monitored? | Risk rating | What else are we<br>going to do? | Delivery date | Respons-<br>ible<br>directors |
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| AIM D            | To increase the capacity and impact of research and development     |                        |                                           |                                                          |                                            |                                                              |                                                          |             |                                  |               |                               |
| Objecti<br>ve D1 | To improve information systems in the Trust to enhance patient care |                        |                                           |                                                          |                                            |                                                              |                                                          |             |                                  |               |                               |

01/03/10 CQC 16, 21

Implement order  
Communication  
system for Hospital  
and GP use in  
Pathology.

Implement e-  
discharges system  
to provide GPs with  
prompt patient  
discharge  
summary.

Ocrober 2010 DF

|                  |                                                                       |  |  |  |  |  |  |  |  |  |  |
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| Objecti<br>ve D2 | To open the Clinical Research Imaging Centre at St Michael's Hospital |  |  |  |  |  |  |  |  |  |  |
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01/03/10

Research &  
Development  
Strategy.  
Joint (UNB/UoB)  
CRIC Interim  
Project Board

Disruption to  
clinical activity on  
the site. Agreement  
with UoB regarding  
the operating  
arrangements

Stakeholder  
involvement in  
implementation  
plan, co-ordinated by  
the Project Manager

Monthly dashboard  
report from the  
project manager

Interim project  
board

COO

| Refere<br>nce    | Date<br>reviewed                                                                          | National<br>objectives | What and who<br>drives this<br>objective?                       | What are the risks<br>to our achieving our<br>objective?                        | How are the risks<br>mitigated? (Controls)                                                                                         | How do we receive<br>assurance that<br>controls are working?                                                          | whom is progress<br>with this<br>objective<br>monitored? | Risk rating | What else are we<br>going to do?                    | Delivery date | Respons-<br>ible<br>directors |
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| Objecti<br>ve D3 | To collaborate with university partners in successful bids for research programme funding |                        |                                                                 |                                                                                 |                                                                                                                                    |                                                                                                                       |                                                          |             |                                                     |               |                               |
|                  | 01/03/10                                                                                  |                        | Joint appointment<br>of Research and<br>Development<br>Director | Risk 747 - research<br>funding impact of<br>changes to national<br>arrangements | Financial monitoring<br>Research governance<br>mechanisms in place<br>Training for all<br>researchers in good<br>clinical practice | R&D Progress reports<br>to Finance<br>Committee and<br>GRMC<br>Approval process for<br>research projects on<br>record | A risk-based<br>monitoring<br>system is in place         |             | Research Committee<br>to be formed in<br>April 2010 |               | MD                            |
| Objecti<br>ve D4 | To develop a Bristol-wide research vision and infrastructure                              |                        |                                                                 |                                                                                 |                                                                                                                                    |                                                                                                                       |                                                          |             |                                                     |               |                               |
|                  | 01/03/10                                                                                  |                        | Joint appointment<br>of Research and<br>Development<br>Director |                                                                                 |                                                                                                                                    |                                                                                                                       | Research<br>Committee                                    |             |                                                     |               | MD                            |
| Objecti<br>ve D5 | To formalise academic partnerships                                                        |                        |                                                                 |                                                                                 |                                                                                                                                    |                                                                                                                       |                                                          |             |                                                     |               |                               |
|                  | 01/03/10                                                                                  |                        | Joint appointment<br>of Research and<br>Development<br>Director | None identified                                                                 |                                                                                                                                    |                                                                                                                       | Academic TEG<br>reports                                  |             |                                                     |               | MD                            |



| Refere<br>nce                                                                         | Date<br>reviewed | National<br>objectives                      | What and who<br>drives this<br>objective? | What are the risks<br>to our achieving our<br>objective?                         | How are the risks<br>mitigated? (Controls)                                                      | How do we receive<br>assurance that<br>controls are working?                        | whom is progress<br>with this<br>objective<br>monitored? | Risk rating | What else are we<br>going to do? | Delivery date                     | Respons-<br>ible<br>directors |
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| AIM E To provide high quality learning and development                                |                  |                                             |                                           |                                                                                  |                                                                                                 |                                                                                     |                                                          |             |                                  |                                   |                               |
| Objective E1 To develop and deliver a leadership programme across the organisation    |                  |                                             |                                           |                                                                                  |                                                                                                 |                                                                                     |                                                          |             |                                  |                                   |                               |
| E1.1                                                                                  |                  | CQC 14                                      | Teaching &<br>Learning<br>Strategy        | Infrastrucute<br>not currently fit<br>for purpose.<br>Limited budget<br>avaiable | Priorities for<br>next 12 months<br>will be<br>determined.                                      | Regular review of<br>priorities                                                     | Assistant<br>Director of<br>Development                  | low         |                                  | Paper to<br>the Board<br>March 10 | DW                            |
| Objective E2 To enable colleagues to achieve to the best of their abilities           |                  |                                             |                                           |                                                                                  |                                                                                                 |                                                                                     |                                                          |             |                                  |                                   |                               |
| F2.1                                                                                  |                  | CQC 12,<br>13, 14<br>NHS<br>Constitut<br>on | Teaching &<br>Learning<br>Strategy        | lack of<br>funding/time to<br>train staff                                        | Priorities for<br>next 12 months<br>will be<br>determined                                       | Regular review of<br>priorities in line<br>with clinical<br>services strategy       | Assistant<br>Director of<br>Development                  | Low         |                                  | Ongoing<br>2010                   | DW                            |
| Objective E3 To To enhance personal service skills, particularly for front-line staff |                  |                                             |                                           |                                                                                  |                                                                                                 |                                                                                     |                                                          |             |                                  |                                   |                               |
| E3.1                                                                                  |                  | CQC 12, 13,<br>14                           | Teaching &<br>Learning Strategy           | Poor levels of<br>participation in<br>development<br>activities                  | Follow-up of non-<br>attendance<br>Ongoing<br>improvement to<br>development activity<br>content | Records of<br>attendance rates<br>Compliants log<br>Participant feedback<br>content |                                                          |             |                                  |                                   | DW                            |

| Reference                                                                                            | Date reviewed | National objectives | What and who drives this objective?                                                        | What are the risks to our achieving our objective?                               | How are the risks mitigated? (Controls)                            | How do we receive assurance that controls are working?                                       | whom is progress with this objective monitored?                              | Risk rating | What else are we going to do? | Delivery date | Responsible directors |
|------------------------------------------------------------------------------------------------------|---------------|---------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------|-------------------------------|---------------|-----------------------|
| AIM F To become the local employer of choice                                                         |               |                     |                                                                                            |                                                                                  |                                                                    |                                                                                              |                                                                              |             |                               |               |                       |
| Objective F1 To ensure that all employees understand and maximise their contribution to the Trust    |               |                     |                                                                                            |                                                                                  |                                                                    |                                                                                              |                                                                              |             |                               |               |                       |
| F2.1                                                                                                 | 01/03/10      | CQC 12, 13, 14      | Recruiting the best strategy. Teaching and learning strategy. Clear performance management | Lack of management support for the objectives. Poor morale due to the down turn. | Clear performance and appraisal systems need to be place           | Appraisal compliance rates. Recruitment campaign outcomes. Performance management statistics | Head of Recruitment, Assistant Diretor of Development, Deputy Director of HR | low         |                               | Ongoing 2010  | DW                    |
| Objective F2 To To attact and retain high quality staff                                              |               |                     |                                                                                            |                                                                                  |                                                                    |                                                                                              |                                                                              |             |                               |               |                       |
| F2.1                                                                                                 | 01/03/10      | CQC 12, 13, 14      | "Recruiting the Best" strategy                                                             | Downturn may reduce ability to recruit                                           | Robust internal redeployment process for at risk staff             | Vacancy and fill rates                                                                       | Head of Recruitment. Deputy Director of HR                                   | Low         |                               | Ongoing 2010  | DW                    |
| Objective F3 To embed equality and diversity into all aspects of Trust business                      |               |                     |                                                                                            |                                                                                  |                                                                    |                                                                                              |                                                                              |             |                               |               |                       |
| F3.1                                                                                                 | 01/03/10      | CQC 1               | Single Equality Scheme                                                                     |                                                                                  |                                                                    |                                                                                              |                                                                              |             |                               |               | DW                    |
| F3.2                                                                                                 | 01/02/10      | Statutory duties    | Valuing Diversity Strategy                                                                 | Lack of compliance on equality & diversity training                              | Regular reporting on compliance rates                              | Bi-annual Board report, Equality and Diversity Steering Group,                               | Assistant Director of HR                                                     | Medium      | Recruitment of E&D manager    | Ongoing 2010  |                       |
| Objective F4 To develop a framework of competencies that will support succession and career planning |               |                     |                                                                                            |                                                                                  |                                                                    |                                                                                              |                                                                              |             |                               |               |                       |
|                                                                                                      | 01/03/10      | CQC 12, 13          | Teaching and learning strategy                                                             | lack of funding and release time for activities                                  | Regular reporting on all development activities though at learning | Teaching and learning strategy group                                                         | Assistant Director Development                                               | Low         |                               | Ongoing 2010  | DW                    |



| Reference                                                                                                                                                        | Date reviewed | National objectives             | What and who drives this objective?           | What are the risks to our achieving our objective?                                                                                                   | How are the risks mitigated? (Controls)                               | How do we receive assurance that controls are working?                                  | whom is progress with this objective monitored?         | Risk rating | What else are we going to do?                         | Delivery date | Responsible directors |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------|-------------|-------------------------------------------------------|---------------|-----------------------|
| AIM G To improve functions that support patient care                                                                                                             |               |                                 |                                               |                                                                                                                                                      |                                                                       |                                                                                         |                                                         |             |                                                       |               |                       |
| Objective G1 To invest in the Trust's estate, particularly in the patient environment and to ensure physical access to services for patients and visitors        |               |                                 |                                               |                                                                                                                                                      |                                                                       |                                                                                         |                                                         |             |                                                       |               |                       |
| G1.1                                                                                                                                                             | 01/03/10      | CQC 10                          | Capital Investment Programme Estates Strategy | Cost overrun programme. Disruption to clinical services                                                                                              | Joint clinical/estates project management. Prudent programme planning | Capital Programme Report                                                                | Individual project Boards. Capital Prioritisation Group |             |                                                       |               |                       |
| Objective G2 To reduce the carbon footprint of the Trust as part of the 5-year Carbon Management Programme                                                       |               |                                 |                                               |                                                                                                                                                      |                                                                       |                                                                                         |                                                         |             |                                                       |               |                       |
| G2.1                                                                                                                                                             | 01/03/10      | Saving Carbon, Improving Health | Saving Carbon, Improving Health               | The Approved 5-year Carbon Management Programme + 2010/11 Energy Reduction Capital Programme                                                         | Activity which results in above expected energy use.                  | Quarterly performance reports on energy use by building and by division to be prepared. | Energy Performance Reports. Capital Programme Report.   |             | Trust Operational Group. Capital Prioritisation Group | April 2014    |                       |
| Objective G3 To enhance the positive reputation of the Trust internally and externally, through proactive communications and celebrate the success of staff      |               |                                 |                                               |                                                                                                                                                      |                                                                       |                                                                                         |                                                         |             |                                                       |               |                       |
| G3.1                                                                                                                                                             | 01/03/10      |                                 | Head of Communications                        | Reputational damage due to adverse media coverage                                                                                                    | Regular monitoring of positive and negative coverage Media training   | Reports to TEG/ Trust Board                                                             | Head of Communications                                  |             |                                                       |               | CE                    |
| Objective G4 To develop full business cases for redevelopment of the Bristol Royal Infirmary and the centralisation of specialist children's services in Bristol |               |                                 |                                               |                                                                                                                                                      |                                                                       |                                                                                         |                                                         |             |                                                       |               |                       |
| G4.1                                                                                                                                                             | 01/03/10      | CQC 10                          | Integrated Business Plan                      | PCT support for redevelopment Affordability of Centralisation of specialist paediatric services Budget allocation in capital programme not completed | Capital Investment Policy decision rights Redevelopment Board         | Redevelopment Board Clinical Strategy Group                                             | Reports to the Board from Redevelopment Board           |             | Site tour for PCT representatives completed           |               | DCD                   |



|                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                |            |                |            |                |            |
|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------|----------------|------------|----------------|------------|
| <b>Trust Board Meeting</b>                                                                                 | <b>Date: 29 March 2010</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                |            |                |            |                |            |
| <b>Agenda Item</b>                                                                                         | <b>15</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                |            |                |            |                |            |
| <b>Title of Report</b>                                                                                     | Equality and Diversity Update                                                                                                                                                                                                                                                                                                                                                                                                      |                |            |                |            |                |            |
| <b>Recommendations</b>                                                                                     | The report is for information, although a representative from the Trust Board is sought to join the Trust's Physical and Sensory Impairment Group.                                                                                                                                                                                                                                                                                 |                |            |                |            |                |            |
| <b>Actions Required</b>                                                                                    | Name of a Trust Board representative                                                                                                                                                                                                                                                                                                                                                                                               |                |            |                |            |                |            |
| <b>Which Corporate Objective(s) are supported by this paper?<br/>Implications for the NHS Constitution</b> | <p>To embed equality and diversity into all aspects of Trust business</p> <p>This paper forms part of the response to the NHS Constitution's objective that staff and patients have the right not to be lawfully discriminated against in the provision of NHS services including on the grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age.</p> |                |            |                |            |                |            |
| <b>Is this on the Trust's risk register?</b>                                                               | The lack of Equality Impact Assessments across the Trust is listed on the Risk Register.                                                                                                                                                                                                                                                                                                                                           |                |            |                |            |                |            |
| <b>Which CQC registration standards does this report provide evidence for?</b>                             | 10.A.6; 1.A.3; 1.A.5;                                                                                                                                                                                                                                                                                                                                                                                                              |                |            |                |            |                |            |
| <b>Financial Implications</b>                                                                              | <table border="1"> <tr> <td><b>Revenue</b></td><td><b>£ 0</b></td><td><b>Capital</b></td><td><b>£ 0</b></td></tr> </table>                                                                                                                                                                                                                                                                                                         |                |            | <b>Revenue</b> | <b>£ 0</b> | <b>Capital</b> | <b>£ 0</b> |
| <b>Revenue</b>                                                                                             | <b>£ 0</b>                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Capital</b> | <b>£ 0</b> |                |            |                |            |
| <b>Prepared by: Name &amp; Title</b>                                                                       | Rebecca Ridsdale, Assistant Director of Human Resources                                                                                                                                                                                                                                                                                                                                                                            |                |            |                |            |                |            |
| <b>Presented by: Name &amp; Title</b>                                                                      | Steve Aumayer, Director of Workforce and Organisational Development                                                                                                                                                                                                                                                                                                                                                                |                |            |                |            |                |            |

|                   |                                                                                                                                                                                                                                             |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Appendices</b> | <p>Appendix A - Outstanding actions affecting one or more strands of equality and diversity</p> <p>Appendix B - List of areas where action plans and objectives affecting one or more strands of equality and diversity are in progress</p> |
|                   |                                                                                                                                                                                                                                             |

### Previous Meetings

Please insert the date the paper was presented under to the relevant group

| <b>Exec Team</b> | <b>Audit &amp; Assurance Committee</b> | <b>Governance Risk and Risk Management</b> | <b>Finance Committee</b> | <b>Trust Executive Group</b> | <b>Other Meeting (Please state)</b> |
|------------------|----------------------------------------|--------------------------------------------|--------------------------|------------------------------|-------------------------------------|
|                  |                                        |                                            |                          |                              |                                     |

# **UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**

## **EQUALITY AND DIVERSITY UPDATE**

**MARCH 2010**

### **Introduction**

This briefing updates the Trust Board on progress with the Trust's Equality and Diversity work, including the Single Equality Scheme.

### **'Respecting Everyone' - a new approach to Equality and Diversity**

A facilitated event was held with members of the Equality and Diversity Steering Group, Divisional Equality and Diversity Leads and Operational Group Chairs. The aim of the event was to review and reinvigorate the Trust's approach to Equality and Diversity. The group established that Equality and Diversity should be part of everyone's every day behaviour and interactions with patients and colleagues. The group identified that 'Respecting Everyone', one of the Trust's new core values, validated the aims and objectives of much of the work related to Equality and Diversity. The recommendation of the group was that Equality and Diversity be re-named 'Respecting Everyone'. Group ideas including expected staff behaviours are being incorporated into the Trust Values work programme.

### **New appointment**

Above & Beyond have funded a full-time Equality and Diversity Manager for 12 months. Following national advertisement, 4 candidates were interviewed last week from the 19 applications received. A conditional offer has been made and accepted. It is hoped the new manager will be in post by the beginning of June 2010.

Key areas of work for the new incumbent will be providing Equality and Diversity training for all managers, working with managers to provide service impact assessments; supporting Divisions to identify new objectives for the Trust's Single Equality Scheme and improving collaborative working with local PCTs and health providers.

### **The Single Equality Scheme**

The Single Equality Scheme is UHBristol's public commitment to meet statutory duties required by equality legislation. The Scheme contains detailed action plans on issues affecting all Equality and Diversity strands. The scheme covers the period 2008 – 2011. To date the Trust has made good progress and completed 32 out of 43 items (74%). Five actions remain outstanding with six also still in progress. Details of actions and their progress are attached in Appendices A and B).

## **Training**

The Staff Attitude Survey revealed that the number of staff who have received Equality and Diversity training in the last 12 months has increased from 19% (2008) to 42% in 2009. This increase can be attributed mainly to the on-line training now embedded in the Trust's local orientation programme. We recognise that not all staff groups have regular access to the internet and to meet this need from April 1<sup>st</sup> we will be running 'Respecting Everyone' training for staff Bands 1-4. This two hour programme can be accessed instead of the on-line training as required.

Despite training 89 managers last summer, the number of completed impact assessments remains very low and this is reflected on the Trust's Risk register. Feedback from managers suggests that some are still finding completion of the assessments difficult. To this end Rebecca Ridsdale and Tony Watkin are in the process of re-writing the managerial guidance on assessment completion. Progress in this area will be provided in future reports for the Trust Board.

## **Physical and Sensory Impairment**

### **Stakeholders Event**

In December 2009, Steve Aumayer (Director of Workforce and Organisational Development) and Alison Moon, (Chief Nurse and Director of Governance), along with Tony Watkin, (Public Patient Involvement Lead) and Rebecca Ridsdale, met representatives from various local stakeholder groups such as Bristol Physical Access Chain, Action for Blind People and the West of England Centre for Inclusive Living. The stakeholders gave their perspectives of care and treatment received in UHBristol. Issues raised included lack of ward orientation, the need for independent advocacy, training for all staff, access and discharge issues. Many stakeholders were keen to work with the Trust and to contribute their experiences to improve patient care.

### **Physical and Sensory Impairment Group and Staff Disability Group**

A meeting took place with the Trust's Physical and Sensory Impairment Operational Group and the Trust's Staff Disability Group. Members identified key drivers which require both staff and patient perspectives and expertise such as changing legislation, commissioning, the BRI redevelopment and recruitment. Due to the commonality of issues between the Operational Group and the Staff Forum, the two groups have agreed to merge. Future work areas include identifying live issues affecting disabled staff and patients from existing information such as the risk register and PALS/complaints data and involving local stakeholders and using their issues to improve patient care.

The Group is keen to have senior support to help drive chosen initiatives forward. The Group would welcome any non-executives or executives who have an interest in the subject to attend and/or chair future meetings.

## **Black and Minority Ethnic Workers Forum**

The Trust's Black Minority Ethnic (BME) Workers Forum will be celebrating its 10<sup>th</sup> anniversary on 30<sup>th</sup> April 2010 and will be holding an event in the Plantation Restaurant on Gloucester Road, Bristol. The event will take a look back at the Forum's successes and start planning for the future.

The celebrations have been widened to include the launch of a South West branch of the National NHS Black Minority Ethnic (BME) Network. The National Network will be formally launched in London in June and will be 'an independent and effective voice for Black Minority Ethnic staff, patients and service users to ensure the NHS delivers on its statutory duties regarding race equality'. Black Minority Ethnic representatives from NHS and public sector organisations across the South West will be invited to attend the event including representatives from the Strategic Health Authority.

**OUTSTANDING ACTIONS AFFECTING ONE OR MORE STRANDS OF EQUALITY AND DIVERSITY (Appendix A)**

|   | <b>Area</b>                                                                                                                            | <b>Action</b>                                                                                                                                                                                                                | <b>Who</b>                                                     | <b>Revised timescale</b> | <b>Progress</b>                                                                                                                                                                                                     |
|---|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Translating and Interpreting.                                                                                                          | Scope how existing employees interpretation levels can be captured using Electronic Staff Record.                                                                                                                            | Head of Recruitment and Retention                              | Summer 2010              | Need to review whether the ESR system can record staff second languages and process for data capture.                                                                                                               |
| 2 | Monitor the sexual orientation of patients and staff.                                                                                  | Map areas where recording will be undertaken and introduce monitoring and evaluation systems.                                                                                                                                | Chair of the Gender and Sexuality Group                        | Summer 2010              | Due to the sensitivity of the subject, to be discussed with the Chief Nurse and Director of Workforce.                                                                                                              |
| 3 | Identify any specific issues for men's health.                                                                                         | Scope men's health services across areas. Identify any gaps and make recommendations to Divisional Boards/Trust Board.                                                                                                       | Head of Nursing Surgery, Head and Neck                         |                          | To be discussed with the Chief Nurse.                                                                                                                                                                               |
| 4 | Continue to improve and develop services for young people.                                                                             | Scope and review provision of Diabetes provision, particularly amongst young Somalians. Identify service needs, produce recommendations and draft action plan for consideration by Divisional Board                          | Assistant Divisional Manager/Head of Nursing                   |                          | Assessment has shown that diabetes is more prevalent among young Somalians, and the issue is compounded by language and cultural issues. A bid for a Somali link worker has been turned down UHBristol and the PCT. |
| 5 | Identify specific issues for Research and Development and embed equality and diversity across all aspects of Research and Development. | Review percentage of staff in undertaking research in divisions, by equality strands. Discuss with the universities and academic links, opportunities for students to research areas relating to the Single Equality Scheme. | Medical Director leading with Head of Research and Development | July 2010                | Meeting with Head of Research and Development to review processes for capturing this information.                                                                                                                   |



## Appendix B

### LIST OF AREAS WHERE ACTION PLANS AND OBJECTIVES AFFECTING ONE OR MORE STRANDS OF EQUALITY AND DIVERSITY ARE IN PROGRESS

|   | Area                                                                                                                                                                                                  | Action                                                                                                                                                                                                                                                                        | Who and                                                                                               | Revised timescales | Progress                                                                                                                                                                                               |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Hospital gowns providing dignity and respect for patients.                                                                                                                                            | Collect data on suitability of existing gown provision and suggestions of alternative provision if identified. Draw up action plan and implementation programme.                                                                                                              | Assistant Directors of Nursing and HR                                                                 | December 2009      | Scoping exercise underway including working with NBT and their new patient gown design.                                                                                                                |
| 2 | Improve access opportunities for socially deprived groups.                                                                                                                                            | Review current Trust services provided and identify any service gaps for these client groups. Devise action plan to identify gaps.                                                                                                                                            | Chair of the Social Inclusion Group                                                                   | September 2009     | The Group has met with Bristol City Council's Travelling Community Liaison Officer to understand access issues.                                                                                        |
| 3 | Implement extensive range of changes to the NHS pension scheme at local level.                                                                                                                        | Understand extent of changes to new pension arrangements                                                                                                                                                                                                                      | Assistant Director of Human Resources and Organisational Development                                  | May 2010           | Bulletin to staff issued in February 2009. Project plan being developed by Payroll Manager with Assistant Director of Human Resources for major communication exercise in May 2010.                    |
| 4 | Undertake detailed analysis of statistics on discipline, dismissal, grievances promotions, clinical excellence awards and Level 2 skills attainment, in trust areas with high ethnic minority ratios. | Whilst information is currently reported, the trust wishes to undertake more detailed analysis. Need to identify areas with high ethnic groups, define scope of data analysis, conduct detailed analysis of relevant data sets. Produce a report and make recommendations for | Assistant Directors of Human Resources and Training and Development with Chairs of Operational Groups | June 2010          | Information currently reported and information now provided in terms of ethnicity and bandings. Anticipated action plan will develop from the review of the Trust's Learning and Development strategy. |

|   |                                                                                                                                                                  |                                                                                                                                                                                                                                                 |                                          |         |                                                                                                                                                                                                                                                                                                |
|---|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|   |                                                                                                                                                                  | implementation.                                                                                                                                                                                                                                 |                                          |         |                                                                                                                                                                                                                                                                                                |
| 5 | Ensure thorough assessment and management of falls, immobility, delirium/acute confusion and incontinence, for older patients, and suitable discharge standards. | Scope the number of patients admitted due to falls by conducting an audit of admissions data. Assess usage and effectiveness of falls policy. Undertake audit of catheter management policy.                                                    | Consultants in Medicine/Consultant Nurse | Ongoing | Falls Policy rewritten in preparation for NHSLA visit. Trust accredited at Level 1. Falls group being restructured. Ongoing work with NBT regarding new assessment and care plan. Audit being undertaken on hip fractures and morbidity. Audit of catheter management policy due in June 2010. |
| 6 | Work with Bristol PCT to support the public health agenda and specifically health inequalities                                                                   | Meet regularly with Director of Public Health. Map out UH Bristol services which support the public health agenda. Identify gaps and develop actions plans. Implement action plans and conduct monitoring, review and feedback on action plans. | Medical Director                         | Ongoing | Ongoing                                                                                                                                                                                                                                                                                        |

*Rebecca Ridsdale*  
*Assistant Director of Human Resources*  
*March 2010*

|                                                                                                    |                                                                                                                                                                                                                                                                                           |         |     |  |         |     |         |     |
|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----|--|---------|-----|---------|-----|
| Trust Board Meeting                                                                                | Date: 29 March 2010                                                                                                                                                                                                                                                                       |         |     |  |         |     |         |     |
| Agenda Item                                                                                        | 16                                                                                                                                                                                                                                                                                        |         |     |  |         |     |         |     |
| Title of Report                                                                                    | Capital Investment Planning, Decision and Monitoring Structure                                                                                                                                                                                                                            |         |     |  |         |     |         |     |
| Recommendations                                                                                    | The paper presented proposes revision of the existing committee structure for capital investment planning, decision-making and monitoring.                                                                                                                                                |         |     |  |         |     |         |     |
| Actions Required                                                                                   | The Trust Board is asked to approve the proposals.                                                                                                                                                                                                                                        |         |     |  |         |     |         |     |
| Which Corporate Objective(s) are supported by this paper?<br>Implications for the NHS Constitution | 2010/11 Aim 7.1- to invest in the Trust’s estate<br><br>This report supports the right to expect the local NHS to assess health requirements and put in place services as considered necessary and to clear and transparent decision-making in relation to service planning and delivery. |         |     |  |         |     |         |     |
| Is this on the Trust’s risk register?                                                              | Risk No. 759 ‘Strategic Development Programme projects are not completed to time, budget and delivery of identified benefits’.                                                                                                                                                            |         |     |  |         |     |         |     |
| Which Care Quality Commission standards does this report provide evidence for?                     | Outcome 10 – ensuring that premises are suitable for the provision of quality healthcare (10.D.2)                                                                                                                                                                                         |         |     |  |         |     |         |     |
| Financial Implications                                                                             | <table><tr><td>Revenue</td><td>N/A</td><td>Capital</td><td>N/A</td></tr></table>                                                                                                                                                                                                          |         |     |  | Revenue | N/A | Capital | N/A |
| Revenue                                                                                            | N/A                                                                                                                                                                                                                                                                                       | Capital | N/A |  |         |     |         |     |
| Prepared by: Name & Title                                                                          | Robert Woolley, Acting Chief Executive                                                                                                                                                                                                                                                    |         |     |  |         |     |         |     |
| Presented by: Name & Title                                                                         | Robert Woolley, Acting Chief Executive                                                                                                                                                                                                                                                    |         |     |  |         |     |         |     |

## Previous Meetings

Please insert the date the paper was presented under to the relevant group

| <b>Exec Team</b> | <b>Audit &amp; Assurance Committee</b> | <b>Governance Risk and Risk Management</b> | <b>Finance Committee</b> | <b>Trust Executive Group</b> | <b>Other Meeting (Please state)</b> |
|------------------|----------------------------------------|--------------------------------------------|--------------------------|------------------------------|-------------------------------------|
|                  |                                        |                                            | 23/03/2010               |                              |                                     |

## CAPITAL INVESTMENT PLANNING, DECISION & MONITORING STRUCTURE

### 1. INTRODUCTION

This paper proposes revision of the existing committee structure for capital investment planning, decision-making and monitoring.

The key functions of such a structure are deemed to be:

- Development of capital investment strategy
- Stakeholder involvement in development of capital strategy, particularly site strategy
- Setting the policy and procedures framework for capital investment
- Evaluation, prioritisation and approval of capital proposals
- Corporate oversight of capital programme spend against budget
- Assurance of progress of capital schemes in line with plan.

### 2. CURRENT POSITION

The existing committee structure was established in 2004/05 and modified in the run-up to the Foundation Trust application in 2007/08.

Overall site strategy is developed and managed at the **Redevelopment Programme Board**, which also provides a forum for stakeholder involvement, reporting directly to the Trust Board.

The Redevelopment Programme Board monitors the progress of a small number of designated strategic schemes, such as the redevelopment of the Bristol Royal Infirmary and the Centralisation of Specialist Paediatrics in Bristol, and receives exception reports from the relevant project boards.

The Redevelopment Programme Board takes reports for information about other schemes but presently has no formal remit to monitor those schemes, such as the development of the Clinical Research Imaging Centre at St Michael's Hospital.

Under the terms of the Board-approved Capital Investment Policy, the **Finance Committee** has authority from the Trust Board for approving schemes within delegated limits and monitoring the capital programme.

The Finance Committee is supported by the **Capital Prioritisation and Review Group** which reports to the Trust Executive Group and has decision rights over capital expenditure as specifically and formally delegated by the Trust Executive Group (none delegated to date).

### 3. CASE FOR CHANGE

A Capital Investment Policy was developed in 2008 and approved by the Trust Board, which necessitates changes to the investment committee structure. These changes were intended to happen as part of a wider review of corporate committees which is still in progress.

Proposals concerning the investment committee structure are brought forward for separate consideration because:

- this is a relatively free-standing area where changes can be made without prejudice to the wider review of corporate committees
- the Redevelopment Programme Board has no locus in the updated Capital Investment Policy recently reviewed and approved by the Trust Board.

#### **4. PROPOSALS**

The following proposals are designed to encompass the full range of functions identified earlier as the key components of an effective committee structure for capital investment planning, decision-making and monitoring

##### **4.1 DEVELOPMENT OF CAPITAL AND SITE INVESTMENT STRATEGY**

The ***Trust Executive Group*** should be in charge of capital and site investment strategy, making recommendations as appropriate to the Trust Board.

The ***Clinical Strategy Group*** should be the forum for preparation of recommendations to the Trust Executive Group and ultimately the Trust Board about long-term strategic development priorities and the site master-plan. This will have the benefit of integrating consideration of the service and estates strategy.

The ***Trust Board*** should be given specific opportunities to influence strategy and policy development before plans reach approval stage.

##### **4.2 STAKEHOLDER INVOLVEMENT IN DEVELOPMENT OF CAPITAL STRATEGY**

A ***Redevelopment Stakeholder Board*** should be established reporting to the Trust Board, meeting on a 3-4 month or other cycle as needs dictate. Non-Executive Directors and Governors would be invited to be part of the Stakeholder Board.

The ***Governors' Strategy Group*** should continue to review the Trust's strategic plans on behalf of the ***Membership Council*** and make routine reports to the Council.

These proposals supplement the patient and public involvement activities routinely managed by individual project boards.

Existing formal arrangements should remain in place for routine liaison over site strategy with local residents' associations and with the Bristol City Council planning department.

##### **4.3 SETTING THE INVESTMENT POLICY AND PROCEDURES FRAMEWORK**

The ***Trust Board*** should continue to own the Capital Investment Policy and keep this under formal annual review.

#### **4.4 EVALUATION, PRIORITISATION AND APPROVAL OF CAPITAL PROPOSALS**

The **Finance Committee** should continue as now to exercise delegated decision rights from the Trust Board over major and high risk capital investment proposals, as articulated in the Capital Investment Policy.

The **Trust Executive Group** should continue as now to exercise delegated decision rights from the Trust Board over other capital investments.

The **Capital Prioritisation and Review Group** should continue to undertake initial evaluation of capital investment proposals, making recommendations to the Trust Executive Group and the Finance Committee in line with the provisions of the policy.

#### **4.5 CORPORATE OVERSIGHT OF CAPITAL PROGRAMME SPEND AGAINST BUDGET**

The **Finance Committee** should continue to have delegated responsibility from the Trust Board to oversee spending against the approved capital programme.

The Finance Committee should be supported in this task by the **Capital Prioritisation and Review Group**, as now.

#### **4.6 ASSURANCE ABOUT PROGRESS OF CAPITAL SCHEMES**

##### **4.6.1 Designated strategic schemes**

Exception reports about the progress of designated strategic schemes should go to the **Capital Prioritisation and Review Group**.

This should include project-initiated reports about spend against profile for each scheme, to give an operational perspective on the Finance-initiated capital programme status report.

The **Trust Board** should continue to receive quarterly formal reports of progress with the approved strategic schemes.

##### **4.6.2 Operational schemes**

The **Service Relocation Committee** should continue as now to function as the operational change co-ordination group with the following remit, making recommendations to the Trust Executive Group and reporting for information to the Capital Prioritisation and Review Group.

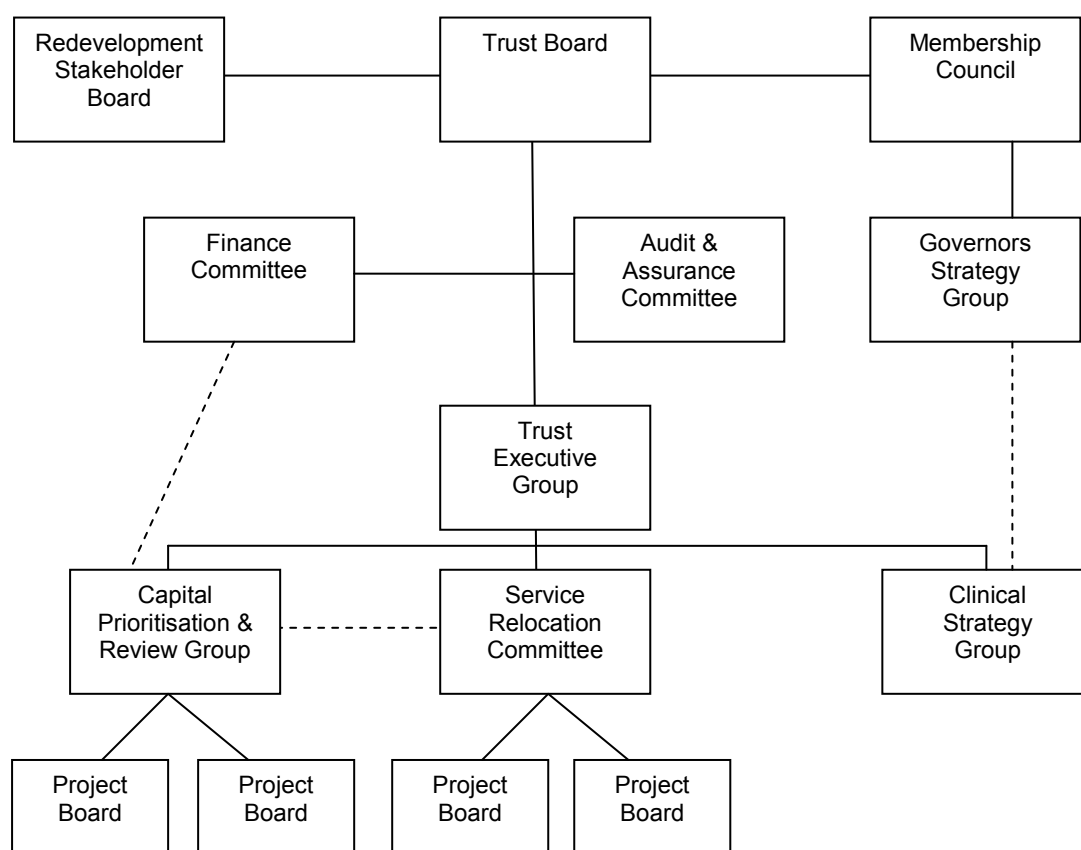
- Oversight of the allocation of space across the Trust
- Review of exception reports for approved operational projects
- Prioritisation of short-term corporate and Divisional proposals re space/capital
- Co-ordination across active or near-implementation projects
- Risk management and assurance of progress against in-year objectives
- Monitoring of space utilisation.

#### 4.7 INFORMATION MANAGEMENT AND TECHNOLOGY

- The **Information Management and Technology Board** will continue to be the forum for preparation of recommendations to the Trust Executive Group and Trust Board about Information Management and Technology plans. It has no decision rights per se.

#### 5. COMMITTEE STRUCTURE CHART

Figure 1 shows the proposed structure in graphical form.



#### 6. IMPLICATIONS

As a consequence of the proposals above, the existing **Redevelopment Programme Board** will be dissolved.

The remit of the **Capital Prioritisation and Review Group** will be extended to cover the oversight of both strategic and operational schemes. Consideration will need to be given to necessary support arrangements.



## **7. NEXT STEPS**

Subject to Trust Board approval of the proposals above, the following steps will be taken:

- Formal communication with existing members of the Redevelopment Programme Board
- Development of a proposal for membership of the new Redevelopment Stakeholder Board.

**Robert Woolley**  
**Acting Chief Executive**  
12 February 2010  
revised 17 March 2010



Trust Board Meeting

|                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |         |       |         |   |
|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------|-------|---------|---|
| Agenda Item                                                                                                             | 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Date: 29 March 2010 |         |       |         |   |
| Title of Report                                                                                                         | Care Quality Commission Registration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |         |       |         |   |
| Recommendations (please outline the purpose of the report and the key issues for consideration/decision)                | <p>This report is provided at the request of the Board, to update on progress with Care Quality Commission Registration and, specifically, to provide an assessment of compliance with those standards (‘Outcomes’) which do not form part of the Commission’s Judgement Framework (see Appendix E of the report).</p> <p>The Board is asked to support the decision of the Trust Executive Group to establish a quarterly Executive-led working group which will oversee practical issues relating to Registration and provide a forum for shared learning between Operational Leads and Divisional representatives.</p> |                     |         |       |         |   |
| Actions Required                                                                                                        | <p>To receive and note the content of the report.</p> <p>It should be noted that the Care Quality Commission has issued a clarification about Regulated Activities since this topic was discussed by the Trust Executive Group on 17<sup>th</sup> March 2010. See page 7 of the report.</p> <p>An Interim Statement of Purpose is included at Appendix E.</p>                                                                                                                                                                                                                                                             |                     |         |       |         |   |
| Which Corporate Objective(s) are supported by this paper                                                                | Registration with the Care Quality Commission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |         |       |         |   |
| Is this on the Trust’s risk register? If yes please give details. If not, why not? Eg. Risk Score is below 15           | Not applicable.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |         |       |         |   |
| Which Care Quality Commission standard does this report provide evidence for? How does it link to the NHS Constitution? | <p>Registration with the Care Quality Commission will replace the current Standards for Better Health with effect from 1<sup>st</sup> April 2010.</p> <p>Evidence of compliance with the Registration standards also supports a number of rights and pledges contained within the NHS Constitution.</p>                                                                                                                                                                                                                                                                                                                   |                     |         |       |         |   |
| Financial Implications                                                                                                  | <table><tr><td>Revenue</td><td>c£60k</td><td>Capital</td><td>£</td></tr></table> <p>Registration with the Care Quality Commission is mandatory. The Commission is yet to confirm its fee structure, however it is understood that the fee is likely to be in the order of £60k per annum.</p>                                                                                                                                                                                                                                                                                                                             |                     | Revenue | c£60k | Capital | £ |
| Revenue                                                                                                                 | c£60k                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Capital             | £       |       |         |   |

|                                       |                                                          |
|---------------------------------------|----------------------------------------------------------|
| <b>Prepared by: Name &amp; Title</b>  | Chris Swonnell, Assistant Director for Audit & Assurance |
| <b>Presented by: Name &amp; Title</b> | Alison Moon, Chief Nurse                                 |

### Previous Meetings

Please insert the date the paper was presented next to the relevant group

| <b>Exec Team</b> | <b>Audit &amp; Assurance Committee</b> | <b>Governance Risk and Risk Management</b> | <b>Finance Committee</b> | <b>Trust Executive Group</b> | <b>Other Meeting Please state</b> |
|------------------|----------------------------------------|--------------------------------------------|--------------------------|------------------------------|-----------------------------------|
|                  |                                        |                                            |                          | 17 <sup>th</sup> March 2010  |                                   |

**Paper to:**

Trust Board, 29<sup>th</sup> March 2010

**Subject:**

Care Quality Commission Registration update

**Author:**

Chris Swonnell, Assistant Director for Audit & Assurance

**Date:**

18<sup>th</sup> March 2010

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## **1. Purpose of this paper**

The purpose of this paper is:

- a) To update the Board on developments with regards to Care Quality Commission Registration since the previous Board paper dated January 2010
- b) To provide the Board with a summary of current compliance with Outcomes which are not part of the Care Quality Commission's Judgement Framework.

## **2. Background**

From 1<sup>st</sup> April 2010 the Trust must be registered with the Care Quality Commission in order to provide services.

In January 2010 the Trust Board accepted a recommendation that the Trust declare non-compliance with the following four standards (known as 'Outcomes', which relate to specific Regulations of the Health and Social Care Act):

- Outcome 5 - Meeting nutritional needs: The Trust has identified a need to roll-out a protected meal-times policy, to improve nutritional screening rates, and to improve consistency of nutritional care planning. These developments will be completed in adult services by September 2010, and in children's services by December 2010.
- Outcome 10 - Safety and suitability of premises: St Michael's Hospital is currently subject to a Fire Enforcement Notice. Necessary improvements to fire prevention and detection systems will be completed by May 2010.
- Outcome 14 - Supporting Workers: The Trust has identified a need to review and improve systems for local and corporate staff induction, and to improve corporate training and development records. This work will be completed by September 2010.
- Outcome 21 - Records: The Trust has identified a need to develop and implement a robust policy governing management, retention and disposal of corporate documents (as opposed to clinical records, for which such a system exists), and has undertaken to review the fitness-for-purpose of its in-house Document Management System. The Trust anticipates being fully compliant with Outcome 21 by the end of 2010.

At the January Board meeting it was agreed that an update report should be presented to the March Board which would include an assessment of compliance with additional Outcomes which are not part of the Care Quality Commission's Judgement Framework

## **3. Key guidance issued by the Care Quality Commission since January**

Since January, the Care Quality Commission has issued five key pieces of information about its system of Registration and ongoing monitoring. The salient points from this guidance are summarised below (points a-e):

### **a) "Setting the bar"**

The Care Quality Commission has published its scoring system for evaluating applications for Registration. The Commission states that the system is designed to encourage providers to make an honest assessment of their position. To this end, unless the Commission has a “Major Concern” (in which case compliance conditions are automatically imposed), *as long as providers have declared the issue*, they should expect to be registered without Compliance Conditions. An undeclared “Moderate Concern” would result in compliance conditions.

If there is a concern in one Registered Location, the Commission will seek to understand whether this might also be an issue in other Locations – and if found to be so, a compliance condition would be applied across an organisation.

#### **b) “How we use conditions of registration for existing NHS providers applying to the new registration system”**

During March the Trust will receive a “Notice of Decision”. This will include:

- The regulation/s breached
- What we have to do
- When we have to do it
- Why we’re being asked to do it

If we disagree with the decision, we will have 28 days in which to make representations which will be considered by the regional Care Quality Commission director, which further recourse to a First-tier Tribunal.

#### **c) “Your quick guide to Registration”**

Where compliance conditions are imposed, they will either:

1. be removed following improvement or
2. be followed by ‘enforcement action’ if things don’t improve

The Care Quality Commission has published the following list of ‘Enforcement Powers’:

- |                                                          |                                |
|----------------------------------------------------------|--------------------------------|
| • Warning notice                                         | • Penalty notices and fines    |
| • Imposition or variation of conditions                  | • Prosecution                  |
| • Suspension of registration to provide certain services | • Cancellation of registration |

#### **d) “Our approach to ongoing monitoring of compliance”**

This document sets out the Commission’s principles for continuous assessment, including Planned and Responsive Reviews.

##### **a. Planned reviews**



- Will take place at least once every two years, and no more frequently than every three months: services which give cause for concern will be reviewed more frequently than other services
  - Will look at all of the 16 key quality and safety outcomes
- b. Responsive reviews
- Will be triggered by Care Quality Commission negative intelligence
  - Will be targeted at the areas of concern, however the Commission reserves the right to extend the scope if further issues are identified in the course of the review.

The Commission will focus on outcomes and experiences of service users: its representatives will contact service users, request information from the provider and visit the site. Site visits will be **unannounced**, and will be completed in a day. The 'setting the bar' tool will be used to determine whether any compliance conditions are imposed following the review. The review will not lead to an overall quality rating. The requested information will include the Provider Compliance Assessment ('PCA') – see section f below.

#### **e) “Adding or removing regulated activities from applications for registration”**

The process of applying for Registration inevitably revealed a number of anomalies in how providers interpreted the Commission's guidance. The Commission has therefore published a clarification of definitions of certain Regulated Activities.

Any requests for changes must be submitted to the Commission by 31<sup>st</sup> March. There will be no fee on this occasion.

#### **f) Provider Compliance Assessment ('PCA') tool**

The Care Quality Commission has recently published its promised Provider Compliance Assessment (PCA) tool. This tool is very similar to the detailed compliance spreadsheets completed by the Trust as part of its preparation for registration: the Commission has confirmed that there is no obligation to use the PCA tool, however it is likely that we will be expected to submit relevant sections of our own tool as part of future inspections.

#### **g) Other clarifications sought from the Care Quality Commission**

The evidence presented to the Board in January included occasional gaps where clarification was being sought from the Care Quality Commission as to the meaning of particular Prompts. The Commission's response to our request for clarification has been that the Commission “does not provide guidance about guidance”.

#### **4. Implications for University Hospitals Bristol**

##### **a) Decision**

The Trust has yet to hear formally what the outcome of our application will be. We understand however that the recommendation is that we be registered 'without compliance conditions'. We also understand that the Care Quality Commission will make three specific stipulations:

- i) that we keep the Commission fully informed of progress with the current Pathology Inquiry
- ii) that we keep the Commission fully informed of progress with action plans relating to the current Fire Enforcement Notice at St Michael's Hospital
- iii) that the Trust provides clarification concerning the proposed completion dates in the action plan submitted for Outcome 5, Meeting Nutritional Needs, and that any risks and mitigating factors associated with current gaps are made clear

The Operational Leads for Outcome 5 feel that the timescales indicated in the action plan are appropriate and realistic. The action plan for Outcome 5, including responses to the Commission's questions, is shown at Appendix A. A detailed plan for the roll-out of protected mealtimes is currently being developed and this information will be shared with the Commission.

##### **b) Readiness for inspection**

The Trust will need to be prepared for an unannounced inspection by the Care Quality Commission from 1<sup>st</sup> April onwards.

###### **i) Review of Operational Leads for Outcomes**

The preferred position, supported by the Trust Executive Group, is that there should be a single Executive and Operational Lead identified to take responsibility for each Outcome. At present, responsibility for a number of Outcomes is shared. Executive Directors are asked to review the current position by the end of April. A full list of the Judgement Framework Outcomes and their current Executive and Operational Leads is provided at Appendix B.

###### **ii) Evidence: review of gaps and coding**

The Assistant Director for Audit and Assurance has arranged a review meeting with each Operational Lead. These meetings will take place between 15<sup>th</sup> and 31<sup>st</sup> March 2010. The purpose will be a) to review any gaps in the evidence gathered in January and b) to review the coding and archiving of items of evidence in readiness for possible inspection. The Commission's stated position that it does not provide guidance about guidance means that we must interpret the Commission's published Prompts as best we can.

##### **c) Registered Locations**

The Assistant Director for Audit and Assurance will be making an application on behalf of the Trust by 31<sup>st</sup> March to consolidate its Registered Locations.

The Trust will be making an application to register a main site Location. This site will consist of: Bristol Royal Infirmary, Bristol Eye Hospital, Bristol Dental Hospital, Bristol Heart Institute, Bristol Haematology & Oncology Centre, Bristol Royal Hospital for Children and St Michael's Hospital. The registration of St Michael's Hospital as part of the main site has been a moot point in discussion with the Care Quality Commission, the rationale for buildings to be considered as a single site being that they are either be connected or a 'short walk' apart. If the Commission later disagrees with our application, the Trust will incur a fee (as yet not stipulated) to re-register St Michael's Hospital as a separate Location.

The Commission has recommended that the Trust chooses a site name which reflects the name of the Trust, rather than one which focuses on any single hospital. The Trust Executive Group has accepted the recommendation that the main site be referred to as the "University Hospitals Bristol main site".

It is further proposed that the following Locations be registered as a single Location, the "Central Health Clinic": Bristol Sexual Health and Avon Breast Screening.

The Trust will there be registered to provide services in five Locations: the 'main site', Bristol General Hospital, Bristol Homeopathic Hospital<sup>1</sup>, Central Health Clinic, and Trust Headquarters (for community services<sup>2</sup>). On this basis, our list of Registered Locations and Regulated Activities would be as per Appendix C, notwithstanding any amendments which may be required in relation to section d below.

#### **d) Regulated Activities**

On 19<sup>th</sup> March the Care Quality Commission advised that all trusts providing acute hospital services will have to register in respect of 'Assessment or medical treatment for people detained under the Mental Health Act 1983'.

The Commission has also advised that the Trust will need to be registered for 'Management of supply of blood and blood-derived products', the rationale for this being that the Trust has a formal agreement in place to provide blood to Emerson's Green Treatment Centre and St Mary's Hospital, Nuffield Health, Bristol covering emergency situations.

The Commission has confirmed that hospital trusts will not be required to register as providers of 'Accommodation for people who require nursing or personal care'.

### **5. Statement of Purpose**

As part of our terms of Registration, the Trust is required to produce a Statement of Purpose for each Regulated Activity it provides. Once the Trust is registered with the Care Quality Commission, the Statement of Purpose must be kept under regular review. Guidance from the Commission states that "if [the Trust] provides treatment and any other services that are not in

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<sup>1</sup> Clarification from the Care Quality Commission is also being sought because 'alternative and complementary' treatments are a specific exclusion in the Commission's guidance

<sup>2</sup> The Commission has confirmed that community services must be registered as Trust Headquarters, not as part of their 'host' Location.

accordance with our Statement of Purpose, this will be an offence as a breach of regulation 15(1). The Care Quality Commission is unlikely to impose restrictive conditions on your registration but may require you to seek written approval at least one month prior to providing any treatments or services that are not in your statement of purpose.”

The Commission has not issued detailed guidance about the content of this Statement, however previous relevant guidance for independent healthcare providers has given a little more detail as to possible content for this document. This outline is shown at Appendix D.

The CQC has agreed to a proposal that our Statement of Purpose is developed in two stages:

- A interim statement reflecting Trust aims and objectives, and including a list of services drawn from our Terms of Authorisation with Monitor, has been drafted and is shown at Appendix E.
- The assumption (to be tested with the Commission) is that more detailed Statements of Purpose for each Regulated Activity will be developed over the coming months in line with the Clinical Services Strategy review

## **6. Outcomes not included in the Judgement Framework**

There are twelve Outcomes which do not form part of the Care Quality Commission’s Judgement Framework. The Trust will not be inspected on these standards, and our guidance from the Commission has been that the standards do not need to be reported to the Board *per se*. Nevertheless it is appropriate that the Board understands the scope of these Outcomes and receives an assessment of the Trust’s compliance.

A summary assessment of these Outcomes is provided at Appendix F. Action is required in respect of Outcomes 3, 15, 19 and 20 to ensure the Trust is fully compliant.

## **7. Developing relevant patient experience measures**

The Care Quality Commission accepts that at the point of registration most providers will be relying significantly on process and policy-based evidence. There is however a clear expectation that, over time, the Trust will develop relevant outcome based measures of ongoing compliance.

To this end, the Trust’s Patient Involvement Facilitator is currently mapping National Patient Survey (Outpatient and Inpatient) questions to the Registration Outcomes. There is also an opportunity to include priority patient experience measures in a post-discharge postal survey of inpatients which will commence in April 2010 as part of the roll-out of the Trust’s Patient and Public Involvement Strategy.

## **8. Divisional engagement and ongoing monitoring of compliance**

Over time, the Care Quality Commission also expects that trusts will gather compliance evidence which can increasingly be identified with specific Locations and services (remember that inspections will test compliance at service level).

Divisional Boards are currently developing plans for quality metrics and, over time, these could include key indicators of compliance with Registrations Outcomes.

The Assistant Director for Audit and Assurance will be producing a brief Powerpoint presentation about Registration for the purposes of dissemination to Divisional staff. This will be made available to Divisional management teams by the end of March.

Compliance with the Registration Standards will be monitored on a quarterly basis through the proposed Quality Committee and onwards to the Board. The format and appropriate level of detail for these reports have yet to be agreed. The timing of reporting to the Board will be set to coincide with quarterly self-certification for Monitor: on which basis, the Board can expect to receive a first quarterly update at its July 2010 meeting.

The Trust will need to be vigilant and prepared for an unannounced inspection at any time. Following a model adopted in some other Foundation Trusts, the Trust Executive Group has approved a proposal to create a quarterly Executive-led Registration standards working group which will focus on 'what needs doing'. This group will agree the content of reports to the Quality Committee. The working group will be led by the Chief Nurse and its membership will consist of the Assistant Director for Audit and Assurance, Operational Leads for each Outcome, representatives from Divisional management teams, the Clinical Audit Manager and the Patient Involvement Co-ordinator.

## **9. Care Quality Commission Special Reviews**

Although the purpose of this paper is to provide an update on Registration, members of the Board should also be aware of forthcoming 'Special Reviews'. These Reviews are topic-based, and although not directly related to Registration, the results of Special Reviews will be added to the intelligence which forms the Commission's Quality and Risk Profile for the Trust.

There are four Special Reviews which are due to take place in early 2010/11 and which will affect the Trust:

1. Services for people who have had a stroke and their carers (data collection from mid-April to mid-May, reporting in October)
2. Meeting the physical health needs of those with mental health needs and learning disabilities (data collection May, reporting in September/October)
3. Support for families with disabled children (data collection May/June, reporting in September/October)

Each of these studies will be undertaken as area-based assessment. There will not be a separate judgement relating to the University Hospitals Bristol, although information about our practice may appear in final review report. The Trust will need to identify a lead ('working contact') for each review.

Unlike Compliance Reviews, Special Reviews will be announced in advance. Special Reviews may involve site visits, as well as Care Quality Commission analysis of available data. The Commission is also reserving the right to use other methodologies such as mystery shoppers, on-line questionnaires, etc. The Trust may be asked to provide additional data: if so, we will

have to adhere to strict deadlines for submission – data submitted in this way will be subject to spot checks. If a site visit is required, inspectors are likely to visit front-line services.

The Commission is also currently consulting on its future priorities for Special Reviews. The 'long-list' is as follows:

- The pathway for people with dementia
- Nutrition and hydration
- The impact on carers of discharge from hospital
- The quality of nursing care
- The use of restraint
- Safe and effective surgery
- Reducing preventable mortality in hospital
- Maternity services

## **Appendix A**

### **Action Plan for Outcome 5 – Meeting Nutritional Needs**

*(Comments in italics are in response to the Care Quality Commission's request for clarification)*

#### **Identified concerns**

Four concerns have been identified by the Trust in preparing for Registration.

##### **Concern: Protected mealtimes**

The Trust has agreed and commenced the roll out of a Protected Mealtimes Policy, however this scheme is only currently in operation at the Bristol General Hospital.

##### **Concern: Nutrition Screening**

All patients receive basic nutritional screening upon admission, however our latest audit data (December 2009) indicates that only 64% of patients have received detailed screening for risk of malnutrition within 24 hours of admission.

##### **Concern: Nutrition Care Planning**

The Trust uses standardised care plans for nutritional support and follows a system which should ensure that high risk patients have individualised care plans devised by registered dietitians. However a recent internal audit has highlighted inconsistent practice.

##### **Concern: Adapted cutlery**

The Nutrition and Dietetics service has highlighted an issue with the lack of, or inconsistent availability of adapted cutlery in the Bristol Royal Infirmary.

#### **What we will do to become compliant.**

##### **Protected mealtimes**

The Protected Mealtimes Policy will be extended to the Bristol Haematology & Oncology Centre, the Bristol Royal Infirmary, the Bristol Heart Institute and Wards 72 and 78 at St Michael's Hospital by September 2010 (other wards at St Michael's Hospital are maternity wards which have extended food service times); and to the Bristol Royal Hospital for Children by December 2010.

*The timescale for the roll-out is felt to be appropriate and realistic. A detailed schedule for the roll-out of protected mealtimes is currently being developed and will be made available to the CQC by the end of March 2010.*

*The risks for patients in wards not yet observing protected mealtimes are that:*

- patients who need assistance with eating may not always receive this*
- special diet provision may not be supervised*
- food and fluid intake may not be monitored*

*This risks are mitigated in the following ways:*

- hotel services staff provide support to patients*

- *practice on each ward is regularly audited (3-4 times per year) using PEAT criteria and any concerns are raised directly with ward managers and matrons; supportive actions may include further teaching sessions at ward level, attendance by a qualified member of the ward team at Food Groups, and the purchase of new equipment*
- *these audits also demonstrate a steady improvement in all aspects of nutritional care during the last 12 months (since catering ward rounds became a continuous audit)*
- *at the Children's Hospital, parents are present at most mealtimes throughout the day*

## **Nutrition Screening**

Levels of audit and monitoring will continue at current levels, however the reporting of results will be increased once per month to modern matrons in order to allow resources and training to be targeted in an appropriate and timely manner. Workspaces for all food groups and Nutrition Steering Group will be developed to allow more robust reporting governance. The Trust's target is to achieve 90% compliance for adults by September 2010 (excluding maternity services which are subject to different guidelines), and for children's services by December 2010 (validated screening tools for children's services have only recently become available, hence the later implementation date).

*Nutritional screening is being monitored regularly. The latest data for November 2009 - January 2010 shows an increased screening rate of 73% (up from 64% for the previous period). Results are fed back to multi-disciplinary operational food group meetings, and progress is overseen by bi-monthly meetings of the Nutrition Steering Group. Resources are targeted to wards which require most support to implement improvements. A detailed action plan for the implementation of nutritional screening in the Bristol Royal Hospital for Children will be agreed by the end of March 2010.*

*The associated risk is that patients who are at medium to high risk of disease related malnutrition may not identified in a timely manner to prevent or reduce the clinical and financial consequences of malnutrition.*

- *Disease related malnutrition leads to increased length of stay, poor wound healing, pressure ulcer development and secondary infections*
- *Reduced quality of life and increased mortality*
- *Increased readmission rates*

*The risk is mitigated in the following ways:*

- *by dietitians attending MDT meetings, ward rounds and other ward based activities*
- *Nutrition risk screening is part of the criteria for referral to dietitians - staff will be reminded of screening on referral*
- *All wards have a nutrition champion to lead on the implementation of the 10 key characteristics of good nutritional care*
- *Catering ward rounds identify areas for improvement and areas of best practice*
- *Screening rates are reported to operational food groups and then to nutrition steering group.*
- *All ward housekeepers and nutrition champions are to complete appropriate e-learning on nutrition*



- *Nutrition is part of clinical induction*
- *There are two nutrition study days per year*

### **Nutrition Care Planning**

A scoping exercise will take place across adult services commencing 5<sup>th</sup> February 2010 to develop a more detailed picture of the current state of practice with regards to nutritional care planning. A working party has been established to review and develop new paperwork for screening and care planning on admission to facilitate and standardise nutritional care. This paperwork will be introduced in adult services by March 2010. Evaluation of the impact of the new system will take place during catering ward round audits and will be reported in catering ward round dashboards. An initial evaluation will be completed by April 2010.

Standardised nutritional care plans are already available in children's services, however because staff are not yet consistently screening patients for risk of malnutrition (see comments re. Nutritional Screening), unless the patient is referred to the dietician the care plans are not always put into practice. Respective Heads of Nursing and Dietetics will lead a concerted drive to improve practice during 2010 and this will be formally audited/evaluated in December 2010.

*The position is that the Trust has care plans but they are not used consistently. The Director of Infection Prevention and Control is heading a working party to address the identified gap. The Bristol Royal Hospital for Children is to include guidelines for nutrition care planning in the roll-out programme for nutrition screening.*

*Care plans for nutrition support and palliative nutrition support are available on the Trust's Document Management Service for both adults and children. Starter regimes are also available for artificial feeding on DMS.*

### **Adapted cutlery**

Adapted cutlery has been purchased and made available on wards in the Bristol Royal Infirmary (January 2010).

Ongoing compliance with this Regulation will be actively monitored by the Trust's Nutritional Steering Group.

## Appendix B

### List of Judgement Framework Outcomes and current Operational Leads

| Outcome | Subject                                          | Executive Director Lead/s          | Operational Lead/s                      | Coverage<br>(core themes in <b>bold</b> )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------|--------------------------------------------------|------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1       | Respecting and involving people who use services | Alison Moon                        | Helen Morgan                            | <ul style="list-style-type: none"> <li>• <b>Involving patients in decisions about their care</b></li> <li>• <b>Privacy, dignity and respect</b></li> <li>• <b>Patient Information</b></li> <li>• <b>Translating and Interpreting</b></li> <li>• <b>Public Involvement</b></li> <li>• <b>Equality and Diversity</b> (<i>thread runs throughout the Outcomes</i>)</li> <li>• Complaints and advocacy (see 17)</li> <li>• Safeguarding (see 7)</li> <li>• Consent (see 2)</li> <li>• Records and confidentiality (see 21)</li> </ul>                                    |
| 2       | Consent                                          | Jonathan Sheffield                 | Nicky Henderson                         | <ul style="list-style-type: none"> <li>• <b>Consent</b></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 4       | Care and welfare of people who use services      | Alison Moon and Jonathan Sheffield | Pat Fields and Jane Luker               | <ul style="list-style-type: none"> <li>• <b>Assessment, planning and delivery of care</b></li> <li>• <b>Diagnostic testing</b></li> <li>• <b>Palliative care</b></li> <li>• <b>Involving <i>children</i> in decisions about their care</b></li> <li>• <b>Termination of pregnancy</b></li> <li>• <b>NICE guidance</b></li> <li>• Risk assessment/management (see 16)</li> <li>• Incident reporting (see 16)</li> <li>• Safety alerts (see 16)</li> <li>• Consent (see 2)</li> <li>• Patient Information (see 1)</li> <li>• Equality and diversity (see 1)</li> </ul> |
| 5       | Nutrition                                        | Alison Moon                        | Pat Fields, Helen Brown / Tony Williams | <ul style="list-style-type: none"> <li>• <b>Nutrition</b></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|    |                                                   |                                   |                                 |                                                                                                                                                                                                                                                                                                                                                      |
|----|---------------------------------------------------|-----------------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6  | Co-operating with other providers                 | Alison Moon and Irene Gray        | Pat Fields and Xanthe Whittaker | <ul style="list-style-type: none"> <li>• <b>Discharge planning</b></li> <li>• <b>Major Incident Planning</b></li> <li>• <b>Transition from child to adult services</b></li> <li>• Records and confidentiality (see 21)</li> <li>• Complaints and advocacy (see 17)</li> <li>• Safeguarding (see 7)</li> <li>• Patient Information (see 1)</li> </ul> |
| 7  | Safeguarding people who use services from abuse   | Alison Moon                       | Carol Sawkins and Anne Berry    | <ul style="list-style-type: none"> <li>• <b>Safeguarding</b></li> <li>• Whistleblowing (see 16)</li> <li>• Complaints and advocacy (see 17)</li> <li>• Patient Information (see 1)</li> <li>• Incident reporting (see 16)</li> </ul>                                                                                                                 |
| 8  | Cleanliness and infection control                 | Alison Moon                       | Chris Perry                     | <ul style="list-style-type: none"> <li>• <b>Cleanliness and infection control</b></li> </ul>                                                                                                                                                                                                                                                         |
| 9  | Management of medicines                           | Jonathan Sheffield                | Sarah Hepburn                   | <ul style="list-style-type: none"> <li>• <b>Medicines Management</b></li> <li>• Incident reporting (see 16)</li> <li>• Patient Information (see 1)</li> </ul>                                                                                                                                                                                        |
| 10 | Safety and suitability of premises                | Irene Gray                        | Bob Pepper                      | <ul style="list-style-type: none"> <li>• <b>Estates</b></li> </ul>                                                                                                                                                                                                                                                                                   |
| 11 | Safety, availability and suitability of equipment | Jonathan Sheffield and Irene Gray | Mandy Gemmell                   | <ul style="list-style-type: none"> <li>• <b>Medical Devices</b></li> <li>• <b>Radiation safety</b></li> <li>• <b>Non-medical equipment</b></li> </ul>                                                                                                                                                                                                |
| 12 | Requirements relating to workers                  | Steve Aumayer                     | Claire Buchanan                 | <ul style="list-style-type: none"> <li>• <b>Recruitment and selection</b></li> <li>• <b>Staff skills, training and support</b></li> </ul>                                                                                                                                                                                                            |
| 13 | Staffing                                          | Steve Aumayer                     | Claire Buchanan                 | <ul style="list-style-type: none"> <li>• <b>HR management systems</b></li> <li>• <b>Staffing levels, risk assessment</b></li> </ul>                                                                                                                                                                                                                  |
| 14 | Supporting staff                                  | Steve Aumayer                     | Claire Buchanan                 | <ul style="list-style-type: none"> <li>• <b>Induction</b></li> <li>• <b>Learning and development</b></li> <li>• <b>Codes of conduct</b></li> <li>• Risk to staff from premises and equipment (see</li> </ul>                                                                                                                                         |

|    |                                                       |                                    |                                    |                                                                                                                                                                                                                                                                                                                                                                                                              |
|----|-------------------------------------------------------|------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|    |                                                       |                                    |                                    | 10 & 11)                                                                                                                                                                                                                                                                                                                                                                                                     |
| 16 | Assessing and monitoring quality of service provision | Alison Moon and Jonathan Sheffield | Anne Reader and Chris Swonnell     | <ul style="list-style-type: none"> <li>• <b>Quality and safety</b></li> <li>• <b>Clinical Audit</b></li> <li>• <b>Risk management strategy</b></li> <li>• <b>NPSA</b></li> <li>• <b>SUIs</b></li> <li>• <b>Whistleblowing</b></li> <li>• <b>Patient Surveys</b></li> <li>• NICE guidance (see 4)</li> <li>• Complaints (see 17)</li> <li>• Patient Information (see 1)</li> <li>• Consent (see 2)</li> </ul> |
| 17 | Complaints                                            | Alison Moon                        | Anne Reader / Simon Harrison-Boyle | <ul style="list-style-type: none"> <li>• <b>Complaints</b></li> </ul>                                                                                                                                                                                                                                                                                                                                        |
| 21 | Records                                               | Jonathan Sheffield                 | Andrew Hooper / Liz Nasey          | <ul style="list-style-type: none"> <li>• <b>Records management</b></li> <li>• <b>Confidentiality</b></li> <li>• <b>Freedom of Information</b></li> </ul>                                                                                                                                                                                                                                                     |

## Appendix C

### Adjusted list of Regulated Activities, by Location, pending clarification by the Care Quality Commission

| <b>Activity</b>                                        | Surgical procedures | Diagnostic and screening procedures | Maternity and midwifery services | Termination of pregnancies | Treatment of disease, disorder or injury | Management of supply of blood and blood-derived products | Assessment or medical treatment for people detained under the Mental Health Act 1983 |
|--------------------------------------------------------|---------------------|-------------------------------------|----------------------------------|----------------------------|------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------|
| <b>Location</b>                                        |                     |                                     |                                  |                            |                                          |                                                          |                                                                                      |
| University Hospitals Bristol Main Site                 |                     |                                     |                                  |                            |                                          |                                                          |                                                                                      |
| Central Health Clinic                                  |                     |                                     |                                  |                            |                                          |                                                          |                                                                                      |
| Bristol General Hospital                               |                     |                                     |                                  |                            |                                          |                                                          |                                                                                      |
| Bristol Homeopathic Hospital                           |                     |                                     |                                  |                            |                                          |                                                          |                                                                                      |
| Trust Headquarters, <i>i.e. for community services</i> |                     |                                     |                                  |                            |                                          |                                                          |                                                                                      |

## **Appendix D**

### **Outline content of a Statement of Purpose**

#### **1. A Statement of Purpose for the Trust**

- Our aims and objectives as an organisation
- A description of population served by the Trust
- Information about any relevant 'global' quality systems the Trust may be signed up to – for example, Investors in People, HQS, etc
- A list of the Regulated Activities we provide and the Locations in which these take place (as per Appendix C)
- A site map showing our Locations
- An organisational chart

#### **2. A Statement of Purpose for each Regulated Activity**

This should include:

- Aims and objectives of the Regulated Activity ("what you want to achieve")
- List of wards/units/facilities and the services offered\*
- A description of the range of needs these services are intended to meet
- The number of beds (to accommodate persons overnight)
- The number of beds (to accommodate day case patients)

\* "e.g. if you are registered for 'surgical procedures' your Statement of Purpose should define exactly what type of surgery this is, such as cardiac or neurosurgery, and whether this is for children as well as adults". We also need to indicate where services are provided in-house and where they are contracted out.

#### **3. Information required by Schedule 3 of the Health and Social Care Act**

This is information the Trust has already submitted as part of its application for Registration.

Definitions of two of the more complex Regulated Activities are provided below:

##### Diagnostic and screening procedures

All diagnostic imaging services, pathology and other laboratory analyses, and diagnostic physiological measurement. It also includes screening procedures that have separate quality control systems.

Physiological measurement includes the following:

- Audiology
- Cardiac physiology
- GI physiology

- Neurophysiology
- Ophthalmic and vision science
- Respiratory and sleep physiology
- Urodynamics
- Vascular technology.

However the following are not included in the activity:

- Audiology that does not involve an invasive procedure or is limited to the use of an auroscope.
- Ophthalmic and vision testing that does not involve the insertion of a medical device into the eye or its surrounding structure
- Respiratory or cardiac physiology undertaken as part of fitness screening procedures carried out in a gymnasium in order to decide whether a person is sufficiently healthy to use fitness equipment or take part in fitness routines safely.

#### Treatment of disease, disorder or injury

This activity allows for any treatment service that is (a) provided by a healthcare professional or by a multi-disciplinary team including one, and (b) related to disease, disorder or injury. It will include a wide range of treatment such as:

- emergency treatment
- ongoing treatment for long-term conditions
- treatment and care for mental health problems and learning disabilities
- treatment of disease, disorder or injury in any setting, ranging from hospitals to clinics and community services.

Treatment of disease, disorder and injury does not include alternative and complementary treatments.

A healthcare professional is defined as a:

- Medical practitioner
- Dental practitioner, hygienist, therapist, nurse, technician
- Orthodontic therapist
- Nurse
- Midwife
- Biomedical scientist
- Clinical scientist
- Operating department practitioner
- Paramedic
- Radiographer

Clinical psychologists, occupational therapists, physiotherapists and speech and language therapists are not included in the list, and standalone services run by these professionals are not required to register. But where such professionals work in multi-disciplinary teams with anyone from the list above, the service will need to be registered and the registered provider must ensure compliance in all aspects of the treatment provided, including the components provided by these professionals.

## Appendix E

# University Hospitals Bristol NHS Foundation Trust

## Interim Statement of Purpose

### 1. Introduction

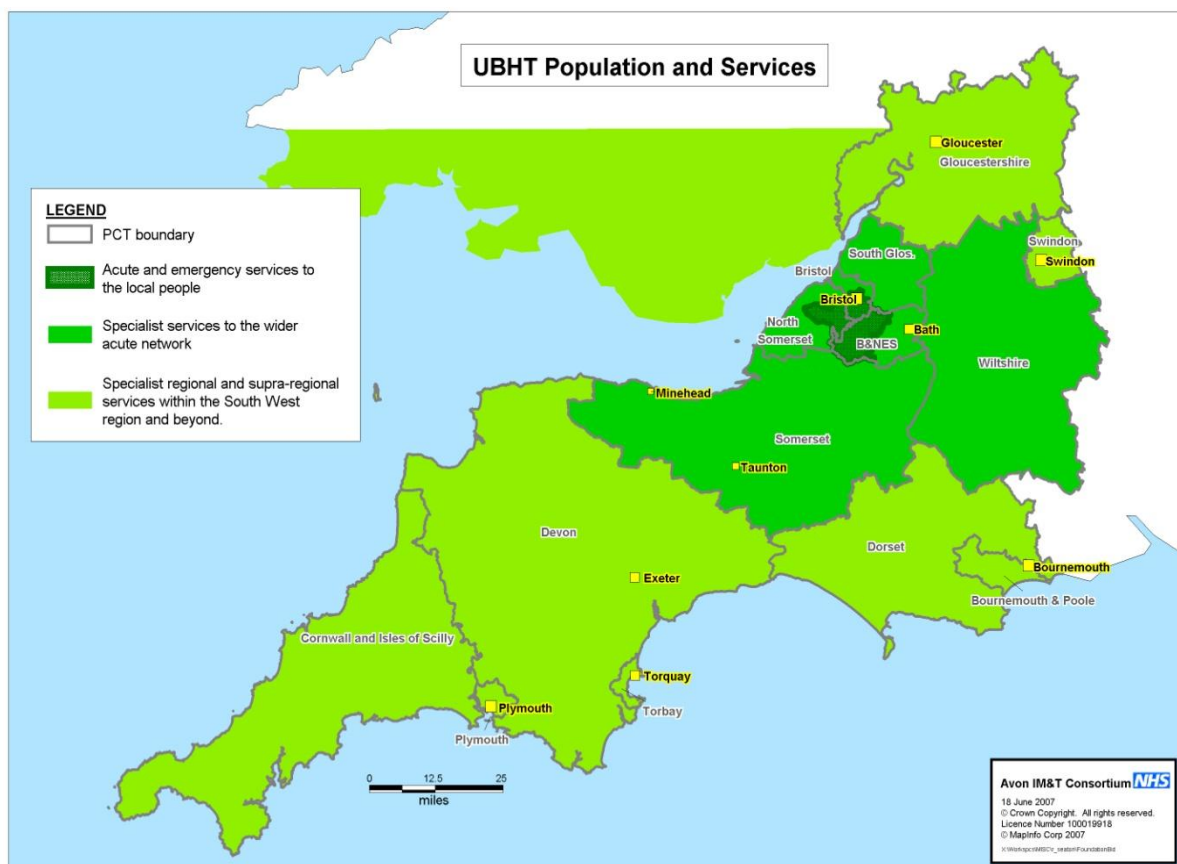
The University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of hospitals in the heart of Bristol. The Trust employs 7,900 staff and is one of the country's largest acute NHS Trusts with a 2008/2009 income of £454 million. With strong links to the University of Bristol and University of West of England the University Hospitals Bristol is the major medical research centre in the South West of England.

### 2. Population served

The Trust provides services to three distinct populations, as follows:

- Acute and emergency services to the local catchment population of around 300,000 in central and south Bristol.
- Specialist services to the wider acute “network” (comprising Bristol, North Somerset and South Gloucestershire PCTs, Bath and North East Somerset, Wiltshire and Somerset) with a 2.4 million population.
- Specialist regional and supra-regional services to the South West region, South Wales and beyond to a population of 5 million plus.

See Figure 1 below.





### 3. Mission and Strategic Aims

The Trust's mission is to provide patient care, education and research of the highest quality.

In pursuit of this mission we abide by the following values:

- Respecting everyone
- Working together
- Embracing change
- Recognising success

Our strategic aims in the three core business areas of clinical services, research and teaching are shown below, along with aims in key supporting areas.

| Clinical Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Research and Development                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Teaching and Learning                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• To provide efficient and effective services, affordable to commissioners and desirable to patients and referring clinicians</li> <li>• To be the major specialist service provider for the population of Bristol &amp; the South West region</li> <li>• To provide additional services for the local population</li> <li>• To support the principle of local access wherever possible</li> <li>• To provide services which are quick and easy to access and provide an excellent patient experience</li> <li>• To deliver services to the highest standards</li> </ul> | <ul style="list-style-type: none"> <li>• To develop collaborative and consultative research partnerships with patients, carers and the public</li> <li>• To support research of national and international excellence and innovation</li> <li>• To develop the Trust's research portfolio in line with its service strategy</li> <li>• To develop a Clinical Research Imaging Centre in partnership with the University of Bristol</li> <li>• To develop research activities in partnership with academic and healthcare organisations</li> <li>• To further develop research governance</li> </ul> | <ul style="list-style-type: none"> <li>• To ensure staff are enabled to provide safe, effective and high quality patient care</li> <li>• To pursue teaching and learning partnerships with education providers and others</li> <li>• To embrace personal and organisational development</li> <li>• To encourage a culture of innovation and enterprise</li> <li>• To maximise recruitment and retention by meeting the development needs of current and prospective staff</li> </ul> |

| Supporting aims                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• To achieve a sustainable financial surplus</li> <li>• To improve the environment for patients and staff, to improve ease of access for patients and visitors and to develop the Trust's estate to give the optimal configuration of services</li> <li>• To ensure that the Trust has the governance and information structures, systems and processes necessary to deliver its mission efficiently, effectively and with the highest standards of probity.</li> </ul> |

#### 4. Registered Locations

The Trust is registered with the Care Quality Commission to provide healthcare services from five Locations:

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>University Hospitals Bristol main site</b> | <p>This Location consists of six hospitals, co-located in the centre of Bristol. 1,070 beds.</p> <p><b>Bristol Royal Infirmary, including the Bristol Heart Institute</b><br/>607 beds. Provides general and acute medicine and surgery, critical care, trauma and orthopaedic care and emergency treatment. The BRI is the centre for cardiothoracic services for the northern part of the South West region.</p> <p><b>Bristol Eye Hospital</b><br/>23 day case beds. The region's leading ophthalmology centre.</p> <p><b>Bristol Royal Hospital for Children</b><br/>189 beds. The only dedicated children's hospital in the South West. It is the regional centre for a wide range of specialist paediatric services and is the base for the internationally renowned bone marrow transplant unit. The intensive care unit provides the highest level of specialist paediatric critical care.</p> <p><b>Bristol Haematology and Oncology Centre</b><br/>77 beds. Provides inpatient and day case chemotherapy and radiotherapy, inpatient oncology, a full range of haematology services, including adult stem cell transplantation and a comprehensive care centre for haemophiliacs, and is a base for the Trust's palliative care team.</p> <p><b>St Michael's Hospital</b><br/>168 beds. Provides obstetrics and gynaecology care and ear, nose and throat (ENT) surgery. The hospital is a regional referral unit for high-risk pregnancies and for foetal medicine.</p> <p><b>University of Bristol Dental Hospital</b><br/>6 day case beds. Provides routine and specialist clinical dental services for the South West, as well as research and undergraduate and postgraduate teaching.</p> |
| <b>Bristol General Hospital</b>               | 80 beds. Cares for the elderly and is a centre for rehabilitation and intermediate care. Due to transfer most activity to the new South Bristol Community Hospital in 2012.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Central Health Clinic</b>                  | Central Health Clinic provides the Avon Breast Screening Service and the Integrated Sexual Health Service.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Homeopathic Hospital</b>                   | Outpatient facilities only. The only homeopathic hospital in the region.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Trust Headquarters</b>                     | As the registered address for the Trust's community services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

A map of the University Hospitals Bristol main site is shown at Figure 2.

## 5. Organisational structure

Services to patients are delivered through five clinical Divisions:

- Medicine
- Surgery Head & Neck
- Women's & Children's Services
- Specialised Services
- Diagnostics and Therapies

Corporate services, directly managed by Executive Directors, include Human Resources, Finance, Facilities & Estates, Information Management & Technology, Research and Development, and Purchasing and Supply.

## 6. Regulated Activities

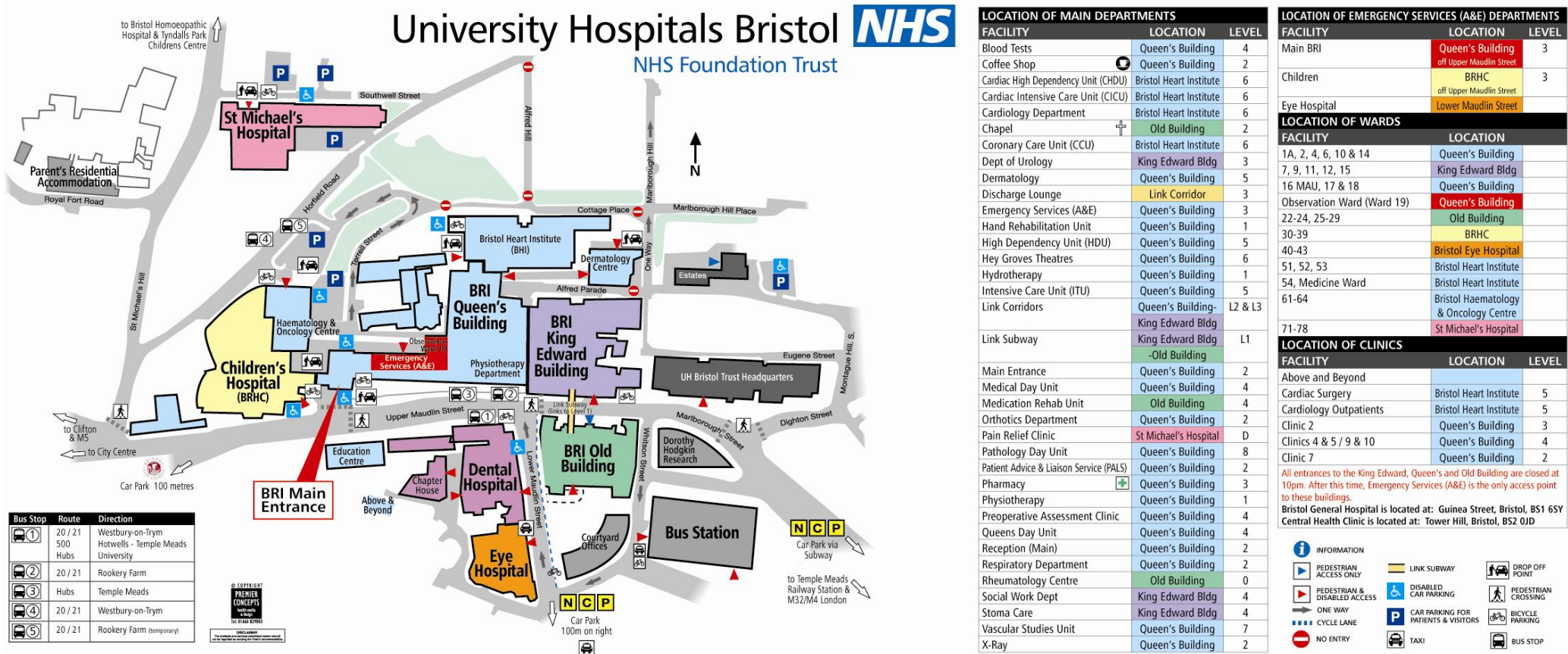
The Trust is registered with the Care Quality Commission to provide the following Regulated Activities:

- Surgical procedures
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Maternity and midwifery services
- Termination of pregnancies
- Management of supply of blood and blood-derived products
- Assessment or medical treatment for people detained under the Mental Health Act 1983

The table below lists the services provided by the Trust which fall within the scope of each Regulated Activity.

| Regulated Activities | Services provided<br><i>Information according to the Mandatory Goods and Services Schedule of the Trust's Terms of Authorisation with Monitor.</i> |           |            |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------|
|                      |                                                                                                                                                    | Inpatient | Outpatient |
| Surgical procedures  | General surgery                                                                                                                                    | √         | √          |
|                      | Urology                                                                                                                                            | √         | √          |
|                      | Trauma and orthopaedics                                                                                                                            | √         | √          |
|                      | Ear, nose and throat (ENT)                                                                                                                         | √         | √          |
|                      | Ophthalmology                                                                                                                                      | √         | √          |
|                      | Oral surgery                                                                                                                                       | √         | √          |
|                      | Restorative dentistry                                                                                                                              | √         | √          |
|                      | Paediatric dentistry                                                                                                                               | √         | √          |
|                      | Orthodontics                                                                                                                                       |           | √          |
|                      | Oral and maxillo facial surgery                                                                                                                    | √         | √          |
|                      | Periodontics                                                                                                                                       |           | √          |
|                      | Prosthodontics                                                                                                                                     |           | √          |
|                      | Neurosurgery                                                                                                                                       | √         |            |
|                      | Plastic surgery                                                                                                                                    | √         |            |
|                      | Cardiothoracic surgery                                                                                                                             | √         | √          |
|                      | Paediatric surgery                                                                                                                                 | √         | √          |

Figure 2.



|                                          |                                    |   |   |
|------------------------------------------|------------------------------------|---|---|
| Treatment of disease, disorder or injury | Accident and emergency (A&E)       | √ |   |
|                                          | Anaesthetics                       | √ | √ |
|                                          | Critical care medicine             | √ |   |
|                                          | General medicine                   | √ | √ |
|                                          | Gastroenterology                   | √ | √ |
|                                          | Endocrinology                      |   | √ |
|                                          | Clinical genetics                  |   | √ |
|                                          | Clinical immunology and allergy    |   | √ |
|                                          | Rehabilitation                     | √ |   |
|                                          | Palliative medicine                | √ | √ |
|                                          | Cardiology                         | √ | √ |
|                                          | Paediatric cardiology              | √ | √ |
|                                          | Dermatology                        | √ | √ |
|                                          | Thoracic medicine                  | √ | √ |
|                                          | Genito-urinary medicine            |   | √ |
|                                          | Nephrology                         | √ | √ |
|                                          | Medical oncology                   | √ | √ |
|                                          | Neurology                          |   | √ |
|                                          | Rheumatology                       | √ | √ |
|                                          | Paediatrics/Special Care Baby Unit | √ | √ |
|                                          | Paediatric neurology               | √ | √ |
|                                          | Geriatric medicine                 | √ | √ |
|                                          | Dental medicine                    | √ | √ |
|                                          | Obstetrics                         | √ | √ |
|                                          | Gynaecology                        | √ | √ |
|                                          | Child and adolescent psychiatry    |   | √ |
|                                          | Homeopathy                         |   | √ |
|                                          | Dental SIFT                        |   | √ |
|                                          | Blood And Marrow Transplantation   | √ |   |
|                                          | Well Babies                        | √ |   |
|                                          | CHDU                               |   |   |
|                                          | Adult ITU                          |   |   |
|                                          | NICU                               |   |   |
|                                          | PICU                               |   |   |
|                                          | Clinical oncology (Radiotherapy)   | √ | √ |
|                                          | Clinical haematology               | √ | √ |
| Diagnostic and screening procedures      | Clinical physiology                | √ | √ |
|                                          | Audiological medicine              |   |   |
|                                          | Chemical pathology                 | √ | √ |
|                                          | Haematology                        |   |   |
|                                          | Radiology                          |   |   |
|                                          | Diagnostic Imaging                 |   | √ |
|                                          | Direct Access Pathology            |   |   |
|                                          | Direct Access Radiology            |   |   |
|                                          | Clinical pharmacology              |   |   |
|                                          | Infectious diseases                |   |   |
| Maternity and                            | Midwifery                          | √ | √ |

|                                                                                      |                                                                                                                                                                                                            |  |  |
|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| midwifery services                                                                   | Special Care Baby Unit                                                                                                                                                                                     |  |  |
| Termination of pregnancies                                                           | A termination of pregnancy service is provided at St Michael's Hospital.                                                                                                                                   |  |  |
| Management of supply of blood and blood-derived products                             | The Trust has a formal agreement in place to provide blood to Emerson's Green Treatment Centre and St Mary's Hospital, Nuffield Health, Bristol covering emergency situations.                             |  |  |
| Assessment or medical treatment for people detained under the Mental Health Act 1983 | As with all providers of acute hospital services, a situation may arise in any of our inpatient facilities whereby a patient is treated by the Trust whilst they are detained under the Mental Health Act. |  |  |

## Appendix F

### Assessment of current compliance with Outcomes not included in the Judgement Framework

#### CQC Outcomes which do not form part of the Judgement Framework

There are eight Outcomes which do not form part of the Judgement Framework but require internal assurances of compliance.

*Coding: Green = Compliant; Yellow = action required to achieve full compliance*

| Outcome | Executive Lead | Subject | Operational Lead | What does the Outcome require?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What is our compliance position?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------|----------------|---------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3       | Irene Gray     | Fees    | Harjit Lalli     | <p>“People who use services, or other acting on their behalf, who pay the provider for the services they receive:</p> <ul style="list-style-type: none"> <li>• Know how much they are expected to pay, when and how</li> <li>• Know what the service will provide for the fee paid</li> <li>• Understand their obligations and responsibilities</li> </ul> <p>This is because providers who comply with the regulation will be transparent in the information they provide about any fees, contracts and terms and conditions, where people are paying either in full or in part for the cost of their care, treatment and support.”</p> | <p>Practice is currently fragmented and inconsistent. Non-NHS Income Patient Manager appointed with responsibility for Trust-wide management of both private patient and overseas patient processes and the development of appropriate policies and procedures.</p> <p>Private Patient Policy has been drafted prior to approval by the Finance Committee and ratification by the Board. An interim letter is being sent to consultants advising them of the principles they must adhere to if they wish to conduct private practice on Trust premises. The Overseas Patient Policy has also been drafted and will be submitted to Trust Board for sign off. Implementation of the policies should begin in summer 2010.</p> |

|    |                    |                                                                                    |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                               |
|----|--------------------|------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 15 | Alison Moon        | Statement of purpose                                                               | Chris Swonnell                | <p>By 1<sup>st</sup> April the Trust Board will need to have agreed a Statement of Purpose which states:</p> <ul style="list-style-type: none"> <li>• The <b>aims and objectives</b> of the service provider in carrying on each regulated activity</li> <li>• The <b>kinds of services</b> provided for the purposes of the carrying on of each regulated activity and the <b>range of users' needs</b> which those services are intended to meet</li> </ul> | A Statement of Purpose will be drafted and presented to the March Board for approval.                                                                                                                                                                                                                                                                                         |
| 18 | Jonathan Sheffield | Notification of death of service user                                              | Anne Reader                   | <p>Confirmation that the Trust must send details of patient deaths to the NPSA, who in turn send them to the CQC</p>                                                                                                                                                                                                                                                                                                                                          | <p>Compliant (all patient deaths as high risk incidents are automatically notified to the NPSA as required)</p> <p>All unexpected deaths would also be reported to HM Coroner and where necessary, the Police would be informed.</p> <p>All unexpected patient deaths are reviewed internally to determine if they are SUI and therefore are notified to the PCT and SHA.</p> |
| 19 | Jonathan Sheffield | Notification of death or unauthorized absence of a service user who is detained or | Clinical Site Management Team | <p>"People using the service who are detained under the Mental Health Act can be confident that important events that affect their welfare, health and safety are reported to the CQC so that, where needed, action can</p>                                                                                                                                                                                                                                   | <p>Publication of the CQC guidance has been welcomed by the Clinical Site Management Team and has highlighted gaps in previous practice. An algorithm has been developed to provide clarity to staff about the required reporting process. CSM team is confident that future practice will be compliant with the</p>                                                          |



|    |                    |                                                        |             |                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----|--------------------|--------------------------------------------------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|    |                    | liable to be detained under the Mental Health Act 1983 |             | <p>be taken.</p> <p>This is because providers who comply with the regulations will notify the CQC about the death or unauthorized absence of a person detained under the MHA who uses services.”</p> | <p>Outcome.</p> <p>The Trust’s CSM mental health lead has discussed the Outcome in detail with the administrator at Callington Rd psychiatric hospital. There are ambiguities in the guidance regarding coding and patient identification which need to be clarified with the CQC.</p>                                                                                                                                                                                                                                                                                                                                    |
| 20 | Jonathan Sheffield | Notification of other incidents                        | Anne Reader | <p>This Outcome sets out two kinds of incidents and events which must be notified to the CQC:</p>                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|    |                    |                                                        |             | <p>1. Incidents affecting a person who uses the service:</p> <ul style="list-style-type: none"> <li>• <b>injuries</b> (notified via NPSA),</li> </ul>                                                | <p><b>Compliant for injuries</b></p> <p>Reporting of incidents where the person may have suffered long term harm or impairment is covered via incident reporting.</p> <p>N.B. We do not always know severity of harm at the time of reporting and so the 28 day definition in the CQC guidance may be missed in our current process. Grade 3 or above pressure sores are monitored as incidents and therefore reported to NPSA.</p> <p>Serious injuries would be also be reported as SULs and so PCT and SHA would also be notified.</p> <p>Policies/training may need to be made more explicit re. CQC requirements.</p> |
|    |                    |                                                        |             | <ul style="list-style-type: none"> <li>• <b>applications to deprive someone of their liberty</b> under the MHA (directly to CQC);</li> </ul>                                                         | <p>Currently non-compliant for deprivation of liberty.</p> <p>If we wish to deprive someone of their liberty, then we have to formally request a Standard Authorisation from the Supervisory Body, which incorporates both the local authority and PCT. If after the formal assessments the Supervisory Body agrees with us then they will authorise it.</p>                                                                                                                                                                                                                                                              |

|  |  |  |  |                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                      |
|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  |  |  |  |                                                                                                                                                                                                                                           | We do not directly inform the CQC of applications to deprive someone of their liberty, but this can be easily rectified by triggering an incident report in these circumstances. Policies/training may need to be made more explicit re CQC requirements.                                                                                                                                            |
|  |  |  |  | <ul style="list-style-type: none"> <li>allegations of <b>abuse in certain circumstances</b> (via NPSA);</li> </ul>                                                                                                                        | Compliant for abuse. Allegations of abuse should be picked up in incident reporting (clinical and non-clinical depending on victim). We may need to update policies to reflect the specific circumstances where abuse is required to be reported to the CQC i.e. abuse by staff or another service user or on our premises. Policies/training may need to be made more explicit re CQC requirements. |
|  |  |  |  | 1. Events involving the service in a way that could affect all of the people who use it: <ul style="list-style-type: none"> <li>events that stop or may <b>stop the services from operating safely and properly</b> (via NPSA)</li> </ul> | Compliant for events<br>Those specified by the CQC meet the criteria to trigger an incident report and SUI report. Policies/training may need to be made more explicit re CQC requirements.                                                                                                                                                                                                          |
|  |  |  |  |                                                                                                                                                                                                                                           | Data capture for incident reporting does not currently include prompts for the following: <ul style="list-style-type: none"> <li>Details of restraint although this may be recorded in free text box</li> <li>Ethnicity, gender, disability, religion or sexual orientation (disability, religion and sexual orientation are not routinely captured on PAS either)</li> </ul>                        |

|    |                                  |                                                                            |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |
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| 23 | Alison Moon                      | Requirements where the service provider is a body other than a partnership | Chris Swonnell | This Outcome relates to requirements for the nominated persons (i.e. The Chief Nurse and the Medical Director). They must be of good character, physically and mentally able to perform their role and have the necessary qualifications, skills and experience to supervise the management of the regulated activity.                                                                                                                                                                                                                                                                                                                    | Compliant (covered by statements included in our application for registration) |
| 25 | Alison Moon / Jonathan Sheffield | Registered person/s: training                                              | Chris Swonnell | <p>This Outcome sets out further requirements for the nominated persons (i.e. The Chief Nurse and the Medical Director). They must undertake any training necessary to ensure they can perform their role and keep knowledge and skills up to date.</p> <p>Also specifically, we must:</p> <ul style="list-style-type: none"> <li>• Have a clear organizational structure with well-defined, transparent and consistent lines or responsibility</li> <li>• Have effective processes and systems to identify, manage, monitor, and report risks, which must include systems to gather information from people who use services,</li> </ul> | Compliant                                                                      |

|    |             |                    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                           |
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|    |             |                    |             | professionals, and published audits and reports <ul style="list-style-type: none"> <li>• Use this information to reduce unacceptable risks and keep this under review</li> </ul>                                                                                                                                                                                                                                                                                                           |                                                           |
| 26 | Paul Mapson | Financial position | Paul Mapson | “People who use services are confident that the provider has: <ul style="list-style-type: none"> <li>• The financial resources needed to provide and continue to provide the services as described in the statement of purpose to the required standards</li> <li>• Wherever it is available, insurance and suitable indemnity arrangements to cover potential liabilities arising from death, injury, or other causes, loss or damage to property, and other financial risks.”</li> </ul> | Compliant (subject to producing the SoP – see Outcome 15) |

There are two further Outcomes which list instructions the Trust would need to follow if the situations ever arose:

|    |                                  |                                                           |                |                                                                                                                                                                                                                                                                                                                                             |
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| 27 | Alison Moon / Jonathan Sheffield | Notifications – notice of absence [of nominated person/s] | Chris Swonnell | This Outcome sets out further requirements for the nominated persons (i.e. The Chief Nurse and the Medical Director).<br><br>We must inform the CQC: <ul style="list-style-type: none"> <li>• About any significant planned absences from the service (i.e. 28 days or more)</li> <li>• About any significant unplanned absences</li> </ul> |
|----|----------------------------------|-----------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|    |                                  |                                   |                |                                                                                                                                                                                                                                                                                                                                                                                                                |
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|    |                                  |                                   |                | <ul style="list-style-type: none"> <li>• How the service will be run while they are away</li> <li>• When they return from a significant absence (no later than 7 days after their return)</li> </ul> <p>We must give 28 days' notice of planned absence.<br/>In the case of an emergency absence likely to last for 28 days or more, we must inform the CQC within 5 working days after the absence began.</p> |
| 28 | Alison Moon / Jonathan Sheffield | Notifications – notice of changes | Chris Swonnell | <p>This Outcome sets out requirements for informing the CQC of any changes:</p> <ul style="list-style-type: none"> <li>• If our nominated persons change</li> <li>• If the registered details of our services change</li> <li>• If a service closes</li> </ul>                                                                                                                                                 |

Finally, there are two conditions which do not currently apply to our organisation:

- Outcome 22 – Requirements where the service provider is an individual or partnership
- Outcome 24 – Requirements relating to registered managers (only applies where CQC has decided to apply a registered manager condition)



|                                                                                                 |                                                                                                                                                                                                                                                                                                        |         |     |  |         |     |         |     |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----|--|---------|-----|---------|-----|
| Trust Board Meeting                                                                             | Date: 29 <sup>th</sup> March 2010                                                                                                                                                                                                                                                                      |         |     |  |         |     |         |     |
| Agenda Item                                                                                     | 18                                                                                                                                                                                                                                                                                                     |         |     |  |         |     |         |     |
| Title of Report                                                                                 | Corporate Objectives and Action Plans – 2010/11                                                                                                                                                                                                                                                        |         |     |  |         |     |         |     |
| Recommendations                                                                                 | The Board is asked to note the Corporate Objectives and associated Action Plans for 2010/11. This item links to Item 14 on the Agenda.                                                                                                                                                                 |         |     |  |         |     |         |     |
| Actions Required                                                                                | To note revised Corporate Objectives and Action Plans for 2010/11.                                                                                                                                                                                                                                     |         |     |  |         |     |         |     |
| Which Corporate Objective(s) are supported by this paper? Implications for the NHS Constitution | This paper seeks to set the Corporate Objectives for 2010/11.<br><br>This report supports the right to expect the local NHS to assess health requirements and put in place services as considered necessary and to clear and transparent decision-making in relation to service planning and delivery. |         |     |  |         |     |         |     |
| Is this on the Trust’s risk register?                                                           | N/a                                                                                                                                                                                                                                                                                                    |         |     |  |         |     |         |     |
| Which CQC registration standards does this report provide evidence for?                         | N/a                                                                                                                                                                                                                                                                                                    |         |     |  |         |     |         |     |
| Financial Implications                                                                          | <table><tr><td>Revenue</td><td>£ 0</td><td>Capital</td><td>£ 0</td></tr></table>                                                                                                                                                                                                                       |         |     |  | Revenue | £ 0 | Capital | £ 0 |
| Revenue                                                                                         | £ 0                                                                                                                                                                                                                                                                                                    | Capital | £ 0 |  |         |     |         |     |
| Prepared by: Name & Title                                                                       | Ben Hume, Head of Business Planning                                                                                                                                                                                                                                                                    |         |     |  |         |     |         |     |
| Presented by: Name & Title                                                                      | Robert Woolley, Acting Chief Executive                                                                                                                                                                                                                                                                 |         |     |  |         |     |         |     |
| Appendices                                                                                      | Appendix 1: Corporate Objectives and Action Plans 2010/11                                                                                                                                                                                                                                              |         |     |  |         |     |         |     |

## Previous Meetings

Please insert the date the paper was presented under to the relevant group

| <b>Exec Team</b>               | <b>Audit &amp;<br/>Assurance<br/>Committee</b> | <b>Governance<br/>Risk and Risk<br/>Management</b> | <b>Finance<br/>Committee</b> | <b>Trust<br/>Executive<br/>Group</b> | <b>Other Meeting<br/>(Please state)</b>                 |
|--------------------------------|------------------------------------------------|----------------------------------------------------|------------------------------|--------------------------------------|---------------------------------------------------------|
| 11 <sup>th</sup> March<br>2010 | -                                              | -                                                  | -                            | 17 <sup>th</sup> March<br>2010       | Governor's Strategy<br>Group: 17 <sup>th</sup> Feb 2010 |



## **Annual Planning 2010-11 Update**

### **Corporate Objectives and Action Plans Trust Board Briefing Paper: 22<sup>nd</sup> March 2010**

#### **1. INTRODUCTION**

The Trust Board received draft Corporate Objectives at its last meeting, as part of the Annual Planning Update (26<sup>th</sup> February 2010, Agenda item 10).

#### **2. ACTION PLANS AND MONITORING**

The Corporate Objectives for 2010-11 have now been further refined and Action Plans for delivery have been identified. These are based on documented consultation with the Governor's Strategy Group, Trust Executive Group and Executive Team.

It is proposed that Corporate Objectives for 2010-11 are monitored through a revised Board Assurance Framework and Review of Action Plans. Further details about these processes will be made available to the Board for comment at a later date – please also see Item 14 on today's Agenda.

#### **3. RECOMMENDATION**

The Trust Board is asked to note the revised Corporate Objectives for 2010-11 and associated Action Plans for delivery. These are listed below, starting page 2 of this document.

The approved Corporate Objectives and Action Plans will be incorporated in the Trust's Annual Plan for 2010-11, which will be presented to the Board on 26<sup>th</sup> May 2010.

| Aim |                                                                        | Objective | Owner | Action                                                                                                                                     | Delivery                                                                                                                 |
|-----|------------------------------------------------------------------------|-----------|-------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| 1.  | <b>To improve care for patients and the overall patient experience</b> | 1.1       | COO   | Meet the service standards mandated in national frameworks and agreed in local contracts at a minimum                                      | March 2011                                                                                                               |
|     |                                                                        |           |       | Implement robust accountability framework                                                                                                  | March 2011                                                                                                               |
|     |                                                                        |           |       | Deliver agreed action plans                                                                                                                | March 2011                                                                                                               |
|     |                                                                        | 1.2       | MD    | Revise actions as required                                                                                                                 | March 2011                                                                                                               |
|     |                                                                        |           |       | Implement action plan for reduction of length of stay, Productive ward and theatre programmes                                              | Phase one September 2010<br>Phase 2 March 2011                                                                           |
|     |                                                                        |           |       | Implement Quality Committee and Deliver work programme of the committee                                                                    | Committee April 2010<br>Work plan Delivery March 2011                                                                    |
|     |                                                                        | 1.3       | MD    | To demonstrate the improving quality and effectiveness of clinical services across the Trust and report this publicly in a Quality Account |                                                                                                                          |
|     |                                                                        | 1.4       | CN    | To reduce further the incidence of healthcare-acquired infections                                                                          | Programme approved by Board April 2010 with ongoing delivery.<br><br>Outcome of no more than 6 at the end of March 2010. |

|  |  |  |  |                                                                                                                                                                                    |                                                                                                                                     |
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|  |  |  |  | Implement planned programme to continue reduction in C Difficile infections. Hospital acquired C difficile cases to below 0.28 per 1000 bed days ie no more than 72 cases in year. | Programme approved by the Board by April 2010 with ongoing delivery.<br><br>Outcome of no more than 72 at end of March 2010.        |
|  |  |  |  | Implement planned programme to reduce all hospital acquired bacteraemias by 25% on cases from previous year (exact number to be confirmed).                                        | Programme approved by Board by April 2010 with ongoing delivery.<br><br>Outcome of no more than previous year at end of March 2010. |
|  |  |  |  | Maintain same sex accommodation standards                                                                                                                                          | Ongoing monthly monitoring                                                                                                          |

|  |  |                                           |    |                                                                                                                                                                  |                                                                                                                                      |
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|  |  |                                           |    | Implement planned programme to reduce catheter associated urinary tract infection (High Impact Actions for Nursing and Midwifery) to below 2 per 100 admissions. | Programme approved by Board by April 2010 with ongoing delivery.<br><br>Outcome of no more than previous years at end of March 2010. |
|  |  |                                           |    | Implement programme of planned educational activities to ensure compliance to statutory infection control updating over 90% monthly.                             | Ongoing monthly monitoring.                                                                                                          |
|  |  | 1.5 To improve patient safety in hospital | MD | To participate in the South West Quality and Patient safety improvement Programme                                                                                | Deliver key improvement targets as set out in the plan by March 2011                                                                 |

|  |  |                                                                   |    |                                                                                                  |                                                                                                                                  |
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|  |  | 1.6 To ensure that every child in hospital is protected from harm | CN | All staff are aware of their child protection responsibilities and are appropriately trained.    | Ongoing -Training Strategy and Matrix to be reviewed March 2010.<br><br>Training compliance figures monitored monthly/ quarterly |
|  |  |                                                                   |    | National Vetting and Barring (including ISA) guidance is fully implemented and audited annually. | Ongoing - Monitored as part of Recruitment and Selection Policy, by Human Resources.                                             |
|  |  |                                                                   |    | Robust child protection policies and procedures are maintained.                                  | Ongoing                                                                                                                          |

|  |  |  |  |                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                            |
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|  |  |  |  | Governance for child protection. Including participation in Serious Case Review process and implementation of action plans, and child Death Review process and including monitoring of near misses. | <p>Robust system for the monitoring of all Safeguarding Incidents to be developed (Nov 2010)</p> <p>Serious Case Review action plans reviewed quarterly.</p> <p>Child Death Review Process fully implemented, reports to be sent to Child protection Team (March 2010)</p> |
|  |  |  |  | NICE Maltreatment Guidance is fully implemented across the Trust and incorporated into mandatory training.                                                                                          | <p>Ongoing</p> <p>Some specific targeted awareness training to be completed (Sept 2010)</p>                                                                                                                                                                                |
|  |  |  |  | Make significant progress in reducing the risk of multiple sets of notes.                                                                                                                           | <p>Ongoing - Working Group continues to work towards mitigating risks and reviewing implementation of Care Plus and Contact Point 2010/2011</p>                                                                                                                            |

|  |  |  |  |                                                                                                    |                                                                                  |
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|  |  |  |  | Confirmed implementation of action plan recommendations from Healthcare Commission 'SWIFT REVIEW'. | Outstanding actions incorporated into Safeguarding Children Work Plan 2010/ 2011 |
|--|--|--|--|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|

| Aim |                                                      | Objective |                                                                                                                                      | Owner | Action                                                                                                                                                                                                                              | Delivery                   |
|-----|------------------------------------------------------|-----------|--------------------------------------------------------------------------------------------------------------------------------------|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| 2.  | To work with partners to deliver better patient care | 2.1       | To increase the level of patient and public involvement in service improvement                                                       | CN    | To implement the Trust’s Patient & Public Involvement Strategy for 2010-12.                                                                                                                                                         | Ongoing throughout 2010-11 |
|     |                                                      | 2.2       | To reduce delays in communicating with referrers about the care of their patients and to improve the quality of information provided | COO   | To successfully rollout e-discharge across the Trust and monitor performance via GP survey.                                                                                                                                         | December 2010              |
|     |                                                      | 2.3       | To work with health and social care partners to redesign services for patient benefit                                                | COO   | Work with Primary Care Trust and Social Care to improve patient discharge and reduce unnecessary attendances at Emergency Department. Ensure plans and management of transition to the South Bristol Community Hospital are robust. | Ongoing                    |
|     |                                                      | 2.4       | To achieve designated provider status for key specialist services                                                                    | DCD   | Co-ordinate responses to commissioner and network designation processes for relevant services, including paediatric cardiac surgery, paediatric neurosurgery, and cancer services.                                                  | March 2011                 |



|  |  |     |                                                                        |     |                                                                                             |                |
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|  |  | 2.5 | To engage primary care practitioners in service improvement and design | DCD | Develop and engagement plan and establish mutual priorities and key communication channels. | September 2010 |
|--|--|-----|------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------------|----------------|

| Aim |                                                 | Objective |                                                                                                                                                      | Owner | Action                                                                                                                                                            | Delivery   |
|-----|-------------------------------------------------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 3.  | To use our resources as efficiently as possible | 3.1       | To deliver the agreed cash releasing efficiency savings plans                                                                                        | COO   | To work closely with the divisions to support and identify plans and co-ordinate corporate programmes.                                                            | March 2011 |
|     |                                                 | 3.2       | To design a performance management and reporting framework aligned to the objectives of the Trust that engages clinical staff in service improvement | COO   | Agree Key Performance Indicators and create and roll out a dashboard to support the accountability framework                                                      | July 2010  |
|     |                                                 | 3.3       | To refine financial management, income recovery and procurement systems                                                                              | DF    | Develop service-line management reports showing key financial and non-financial information Key Performance Indicators.                                           | June 2010  |
|     |                                                 |           |                                                                                                                                                      |       | Develop ‘Manage Self-Service’ access to core financial systems.                                                                                                   | March 2011 |
|     |                                                 |           |                                                                                                                                                      |       | Extension of electronic data collection interfaces to Electronic Staff Record. Develop the availability and usage of captured data for managers within the Trust. | March 2011 |

|  |  |                                                                                    |    |                                                                                                                               |            |
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|  |  | 3.4 To implement patient-level costing and service-line reporting across the Trust | DF | Routine production of quarterly Service Line Reports. Regular Divisional Service Line reviews using the information produced. | March 2011 |
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| Aim |                                                                        | Objective                                                                                     | Owner | Action                                                                              | Delivery     |
|-----|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------|-------------------------------------------------------------------------------------|--------------|
| 4.  | <b>To increase the capacity and impact of research and development</b> | 4.1 To improve information systems in the Trust to enhance patient care                       | DF    | Implement order Communication system for Hospital and GP use in Pathology.          | October 2010 |
|     |                                                                        |                                                                                               |       | Implement e-discharges system to provide GPs with prompt patient discharge summary. | October 2010 |
|     |                                                                        |                                                                                               |       | Refresh desktop for Trust with up to date software.                                 | October 2010 |
|     |                                                                        |                                                                                               |       | Continue implementation of EDS PAS improvements.                                    | October 2010 |
|     |                                                                        | 4.2 To open a Clinical Research Imaging Centre at St Michael's Hospital                       | COO   | To chair and co-ordinate the delivery of the project plan.                          | March 2011   |
|     |                                                                        | 4.3 To collaborate with University partners in successful bids for research programme funding | MD    | Continue progress towards delivery of integrated research programme across Bristol  | March 2011   |
|     |                                                                        | 4.4 To develop a Bristol-wide research vision and infrastructure                              | MD    | Participate and inform the BRIG-R                                                   | October 2010 |
|     |                                                                        |                                                                                               |       | Review as planned with NHS and Academic partners                                    |              |

|  |  |                                        |    |                                                   |            |
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|  |  | 4.5 To formalise academic partnerships | MD | Realise the benefits from the investment in SMART | March 2011 |
|--|--|----------------------------------------|----|---------------------------------------------------|------------|

| Aim |                                                      | Objective                                                                 | Owner | Action                                                                                                                                                             | Delivery                                                                                                |
|-----|------------------------------------------------------|---------------------------------------------------------------------------|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| 5.  | <b>To provide high quality teaching and training</b> | 5.1 To develop and deliver a leadership programme across the organisation | DW    | Scope out initial leadership programme for 'standards for managers'.                                                                                               | June 2010                                                                                               |
|     |                                                      |                                                                           |       | Develop leadership competencies.                                                                                                                                   | May 2010                                                                                                |
|     |                                                      |                                                                           |       | Develop pilot leadership programmes which underpin identified competencies.                                                                                        | July 2010                                                                                               |
|     |                                                      |                                                                           |       | Rollout programme.                                                                                                                                                 | September 2010                                                                                          |
|     |                                                      |                                                                           |       | Continue with existing management development programme for middle managers.                                                                                       | Ongoing                                                                                                 |
|     |                                                      | 5.2 To enable colleagues to achieve to the best of their abilities        | DW    | To deliver a new Teaching and Learning structure and action plan which will include training planning and a complete review of infrastructure in order to deliver. | Structure identified – April 2010.                                                                      |
|     |                                                      |                                                                           |       |                                                                                                                                                                    | Structure implemented July 2010.<br><br>Training Planning process agreed for 2011/2012 – December 2010. |

|  |  |                                                                          |    |                                                                                       |                           |
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|  |  | 5.3 To enhance personal service skills, particularly in front line staff | DW | Review training delivered in 2009 and existing packages.                              | Ongoing to April 2010     |
|  |  |                                                                          |    | Devise training package and ensure accredited unit for NVQ, customer service-rollout. | April 2010                |
|  |  |                                                                          |    | Roll-out to audiences agreed by Trust Executive Group.                                | May 2010 – September 2010 |

| Aim       |                                               | Objective                                                                                            | Owner | Action                                                                                                                                    | Delivery       |
|-----------|-----------------------------------------------|------------------------------------------------------------------------------------------------------|-------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>6.</b> | <b>To become the local employer of choice</b> | 6.1 To ensure that all employees understand and maximise their contribution to the work of the Trust | DW    | KSF promotion programme implemented linking competencies more closely to job expectations and performance management.                     | July 2010      |
|           |                                               |                                                                                                      |       | Performance Scorecard developed for use in talking to all employees about Trust performance.                                              | September 2010 |
|           |                                               |                                                                                                      |       | Cascade processes for future objectives developed and integrated into performance management.                                             | May 2011       |
|           |                                               | 6.2 To attract and retain high calibre staff                                                         | DW    | Produce recruitment plans in line with 2010/2011 workforce plans.                                                                         | Commence 2010  |
|           |                                               |                                                                                                      |       | Plan open days and external recruitment events responsive to the workforce needs.                                                         | Ongoing        |
|           |                                               |                                                                                                      |       | Develop creative and innovative campaigns in response to specific recruitment needs such as the existing work with Pharmacy and Theatres. | Ongoing        |



|  |  |                                                                        |    |                                                                                                                                                                      |                                                                                                 |
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|  |  |                                                                        |    | Develop a strong recruitment brand in line with the new Visions and Values for the Trust.                                                                            | June 2010                                                                                       |
|  |  |                                                                        |    | Enhance the Trust's internet and intranet sites ensuring it is an effective and accessible recruitment tool.                                                         | June 2010                                                                                       |
|  |  |                                                                        |    | Respond to the 2009 Staff Survey developing appropriate and meaningful plans with robust action driven outcomes.                                                     | Commence action planning March 2010. Actions plans to be in progress with effect from May 2010. |
|  |  | 6.3 To embed equality and diversity into all aspects of Trust business | DW | Refresh the Trust's Valuing Diversity Strategy and other associated Equality and Diversity documents and develop clear action plans.                                 | April 2010                                                                                      |
|  |  |                                                                        |    | Equality and Diversity to form part of Divisional Performance Reviews and Division Board reporting and Trust business planning.                                      | April 2010                                                                                      |
|  |  |                                                                        |    | Develop further actions for the Single Equality Scheme, which enhance patient care. Use these new actions to consult with the public, patients and key stakeholders. | September 2010                                                                                  |

|  |     |                                                                                         |    |                                                                                              |               |
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|  |     |                                                                                         |    | Ensure all Trust policies/functions and services have an Equality Impact Assessment (EIA).   | Ongoing       |
|  |     |                                                                                         |    | Conduct an Equality and Diversity training needs analysis to support all managers and staff. | October 2010  |
|  |     |                                                                                         |    | Appoint a full time, fixed term Respect for All Programme Manager.                           | April 2010    |
|  | 6.4 | To develop a framework of competencies that will support succession and career planning | DW | Develop leadership competencies.                                                             | May 2010      |
|  |     |                                                                                         |    | Develop career pathways.                                                                     | December 2010 |
|  |     |                                                                                         |    | Create talent management pool.                                                               | March 2011    |
|  |     |                                                                                         |    | Develop talent centre for the Trust for all succession and talent planning.                  | March 2011    |

| Aim |                                                       | Objective | Owner | Action                                                                                                                                                                                                                                                               | Delivery      |
|-----|-------------------------------------------------------|-----------|-------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| 7.  | <b>To improve functions that support patient care</b> | 7.1       | COO   | To agree a plan to improve the environment in patient and public areas.                                                                                                                                                                                              | March 2011    |
|     |                                                       |           |       | Continue to work closely with the Governors and local transport services to improve access to the Trust.                                                                                                                                                             | March 2011    |
|     |                                                       | 7.2       | COO   | Continue to support the development of 'The Big Green Scheme' in the Trust.                                                                                                                                                                                          | March 2011    |
|     |                                                       | 7.3       | CE    | Establish a consistent brand that reflects the life and work of the Trust through positive and balanced media coverage.                                                                                                                                              | July 2010     |
|     |                                                       |           |       | Develop communication channels and processes to embed the Trust's vision and values in the organisation.                                                                                                                                                             | May 2010      |
|     |                                                       | 7.4       | DCD   | Submit full Business Cases for Trust Board approval for the: <ul style="list-style-type: none"> <li>• redevelopment of the Bristol Royal Infirmary</li> <li>• Centralisation of specialist children's services at the Bristol Royal Hospital for Children</li> </ul> | December 2010 |

|  |  |                                            |     |                                                                |                |
|--|--|--------------------------------------------|-----|----------------------------------------------------------------|----------------|
|  |  | 7.5 To review long term service priorities | DCD | To conduct a strategic review for long term service priorities | September 2010 |
|--|--|--------------------------------------------|-----|----------------------------------------------------------------|----------------|

## Key

|     |                                                    |
|-----|----------------------------------------------------|
| CE  | Chief Executive                                    |
| DCD | Director of Corporate Development                  |
| MD  | Medical Director                                   |
| COO | Chief Operating Officer                            |
| CN  | Chief Nurse & Director of Governance               |
| DF  | Director of Finance                                |
| DW  | Director of Workforce & Organisational Development |

|                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |     |  |         |     |         |     |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----|--|---------|-----|---------|-----|
| Trust Board Meeting                                                                                | Date: 29 March 2010                                                                                                                                                                                                                                                                                                                                                                                                                               |         |     |  |         |     |         |     |
| Agenda Item                                                                                        | 19                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |     |  |         |     |         |     |
| Title of Report                                                                                    | Teaching and Learning- Update on Progress                                                                                                                                                                                                                                                                                                                                                                                                         |         |     |  |         |     |         |     |
| Recommendations                                                                                    | The Board is invited to receive the Teaching and Learning update and comment on future plans                                                                                                                                                                                                                                                                                                                                                      |         |     |  |         |     |         |     |
| Actions Required                                                                                   | For information and comment                                                                                                                                                                                                                                                                                                                                                                                                                       |         |     |  |         |     |         |     |
| Which Corporate Objective(s) are supported by this paper?<br>Implications for the NHS Constitution | <ul style="list-style-type: none"><li>To provide high quality teaching and training</li><li>To become the local employer of choice</li><li>To improve care for patients and the overall patient experience</li></ul> <p>The proposals support the patient right for NHS organisations to make efforts to improve the quality of health care that they provide and the commitment to continuous improvement in quality of care and treatments.</p> |         |     |  |         |     |         |     |
| Is this on the Trust’s risk register?                                                              | N/A                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |     |  |         |     |         |     |
| Which CQC registration standards does this report provide evidence for?                            | Outcome 13- Staffing<br>Outcome14- Supporting workers                                                                                                                                                                                                                                                                                                                                                                                             |         |     |  |         |     |         |     |
| Financial Implications                                                                             | <table><tr><td>Revenue</td><td>£ 0</td><td>Capital</td><td>£ 0</td></tr></table>                                                                                                                                                                                                                                                                                                                                                                  |         |     |  | Revenue | £ 0 | Capital | £ 0 |
| Revenue                                                                                            | £ 0                                                                                                                                                                                                                                                                                                                                                                                                                                               | Capital | £ 0 |  |         |     |         |     |
| Prepared by: Name & Title                                                                          | Steve Aumayer- Director of Workforce and Organisational Development                                                                                                                                                                                                                                                                                                                                                                               |         |     |  |         |     |         |     |
| Presented by: Name & Title                                                                         | Steve Aumayer- Director of Workforce and Organisational Development                                                                                                                                                                                                                                                                                                                                                                               |         |     |  |         |     |         |     |

|                   |                                                                                                                                                                          |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Appendices</b> | Appendix 1 – Teaching and Learning organisational structure<br>Appendix 2- Teaching and Learning Trust Budget<br>Appendix 3- Teaching and Learning activity in the Trust |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Previous Meetings

Please insert the date the paper was presented under to the relevant group

| <b>Exec Team</b> | <b>Audit &amp; Assurance Committee</b> | <b>Governance Risk and Risk Management</b> | <b>Finance Committee</b> | <b>Trust Executive Group</b> | <b>Other Meeting (Please state)</b> |
|------------------|----------------------------------------|--------------------------------------------|--------------------------|------------------------------|-------------------------------------|
|                  |                                        |                                            |                          |                              |                                     |

## **Teaching and Learning – Update on Progress**

### **Introduction**

This paper describes the journey of Teaching and Learning over the last few years and the need to revolutionise its approach and infrastructure in order for this key component of the organisation to operate effectively and efficiently in the future, particularly in light of the imminent downturn.

The Trust reviewed its structures in 2004 moving from 13 directorates to 6 divisions. This has created a more efficient structure for accountability however, during this transition the teaching and learning resource and infrastructure was not addressed. The result of this is a hugely disparate structure and resources which is complex in terms of accountability; and indeed the ability to have sound metrics and performance measures across the breadth of development that is being delivered Trust wide.

### **Teaching and Learning Strategy**

The Trust developed a Teaching and Learning Strategy for 2007-2012; the specific aims of which are:

- To ensure that staff providing direct clinical care services within the Trust are able to provide safe, effective and high quality patient care, upholding the core values of the NHS, and that staff working in support services are able to provide efficient, customer focussed services to the same high standards of quality and governance.
- To develop existing partnerships with education providers and partner organisations, ensuring that curricula are fit for purpose and that students receive an excellent teaching and learning experience, both in the formal learning environment and during placement.
- To foster a climate in which staff of all disciplines embrace personal and organisational development, are committed to working and learning in multi-disciplinary teams, and are given real opportunities to progress.
- To encourage innovation and a 'can do, will do' culture across the organisation
- To support the Trust in being an employer of choice for people seeking work in both the local community and nationally

The Teaching and Learning and Workforce Strategies should enable the Trust to achieve internal and external quality and accreditation standards for service, research

and teaching, as well as providing the skill levels required in our workforce, both now and in the future.

The principles outlined in the strategy are still valid, however, the delivery is difficult to measure and quantify and as such ensuring we are on track is a challenging task.



## **Teaching and Learning Strategy Group**

The Trust has endeavoured to pull together the key teaching and learning leads to understand how we can deliver the strategy agenda. The group identified the need to have an away day in October and created three key priorities to mobilise the transition. The Teaching and Learning group members are as follows:

|                   |                                                           |
|-------------------|-----------------------------------------------------------|
| Steve Aumayer     | Director of Workforce and Organisational Development      |
| Sarah Bain        | Principal Director- Dental Hospital                       |
| Ian Barrington    | Divisional Manager                                        |
| Samantha Bennett  | Assistant Director of Development                         |
| Kay Collings      | Assistant Director of Clinical Skills                     |
| Mel Fewkes        | Head of Health and Safety Services                        |
| Pat Fields        | Deputy Director of Nursing                                |
| Sue Fyfe Williams | Patient Safety Lead                                       |
| Jane Luker        | Deputy Medical Director                                   |
| Mary Perkins      | Head of Research and Development                          |
| Claire Thompson   | Divisional Manager                                        |
| Gerald Tobin      | Academic Dean                                             |
| Heather Toyne     | Assistant Director of Workforce                           |
| Simon Walrond     | Clinical Liaison and Information Systems Training Manager |
| Jayne Weare       | Head of OT                                                |

## **Key Priorities**

### **1. Structure**

At present there are no clear lines of accountability that enable the strategy to be delivered in a cohesive way. There are numerous 'lead' roles that report into three Executives. The group consider that there are inefficiencies within the current structure based on duplication of effort and inconsistency of practice.

Steve Aumayer, Director of Workforce and Organisational Development has taken the lead Executive role with effect from October 2009 however, there is no Head of Teaching and Learning for the Trust to lead and facilitate and integrate activity across the Trust. This risks there being duplication in activity and potentially gaps where required support is not delivered. Through discussions to date, it is considered that in order to facilitate a joined up approach to Teaching and Learning a single operational lead for the area would assist the Trust in achieving its Teaching and Learning strategy. This is currently being considered and a full proposal will be presented to TEG in due course.

### **2. Funding**

The funding streams for Teaching and Learning are extremely complex involving both internal and external funds and resources. Whilst some parts of the Trust are well funded, there are other local and corporate requirements that cannot be met due to funding not being available. Whilst this may be inevitable due to the way we receive external funding, it should not be taken for granted that this is the case.

We are therefore reviewing all funding streams for Teaching and Learning and considering a proposal to develop three “buckets” of funds to support better allocation of budgets. This would not lead to an increase in overall costs.

*Corporate Budget-* To be used for the development of leadership training and other organisational priorities as defined in our corporate objectives

*Divisional Budget-* Divisional development as defined by the workforce skill mix needed for the future

*Individual Training Budget-* Held locally to fund education, teaching and learning requirements of employees not met through other means.

### **3. Divisional Internal Resource**

There are many people across the Trust either directly or indirectly involved in Teaching and Learning. This is not always clear from structures and is therefore complex to understand. This priority will enable us to identify resources and activities as well as any duplication of effort. Ultimately this priority will enable us to better deliver and structure our multi-professional training needs and delivery methods/function.

### **Progress to Date**

#### **1. Structure**

- Benchmarking with other Trusts and external organisations shows an overall operational lead for Teaching and Learning is common, a draft accountability matrix can be found at Appendix 1. Our initial view is that the efficiency gains through such a role could result in any post being self-funding over time.
- The current diverse training leads could report into this role. This would pull all of the multi-professional facets of training into one group focused on delivering the single Teaching and Learning Strategy.

#### **2. Funding**

- The group has identified the total funds for the Trust in terms of resource and funding streams. This can be found at Appendix 2. It should be noted that that much of this income is linked to specific training and posts, and there is no significant flexibility over its use.

### **3. Divisional Internal Resource**

- A training activity collation exercise was conducted in the Trust in order to understand what/ how/ who is developing our people, the proforma used for this can be found at Appendix 3. A full analysis of this data is being conducted.

### **The Way Forward**

The Teaching and Learning Strategy Group consider that in order to develop this agenda and improve the strategic direction of Teaching and Learning there is a need to invest in two project posts. It is considered that these two posts could be funded at zero cost to the organisation, through use of trainees and existing infrastructure.

### **These projects will review the following**

#### **Financial Review**

- Understanding and documenting the Trust sources of income and funding streams- creating an appropriate Trust model for funding
- Understanding allocation of funding by staff group/area
- Understanding actual training spend by staff group/area
- Determining funding allocated for education/trainers - actual costs
- Identifying how this funding is devolved to divisions and who manages the spend
- Identifying funding used for consultants/external training providers
- Identifying funding that is linked to educational contracts ie: UWE
- Reviewing financial procedures for the management and recording of training spend and budgets
- Reviewing the unallocated funding and how this can best be used for the overall benefit of the Trust.
- Identifying currently untapped sources of funding

#### **Teaching and Learning Activity**

- An analysis of all clinical training being undertaken in the Trust
- An efficiency review of activity in terms of return on investment
- A review of how this activity could potentially be delivered more efficiently (for example through central delivery removing duplication / other media etc).
- A recommendation of how to manage this activity in the future

The Teaching and Learning Strategy Group consider that this project work is essential to fully understand the requirements of the Teaching & Learning infrastructure and governance going forward.

### **Timeline**

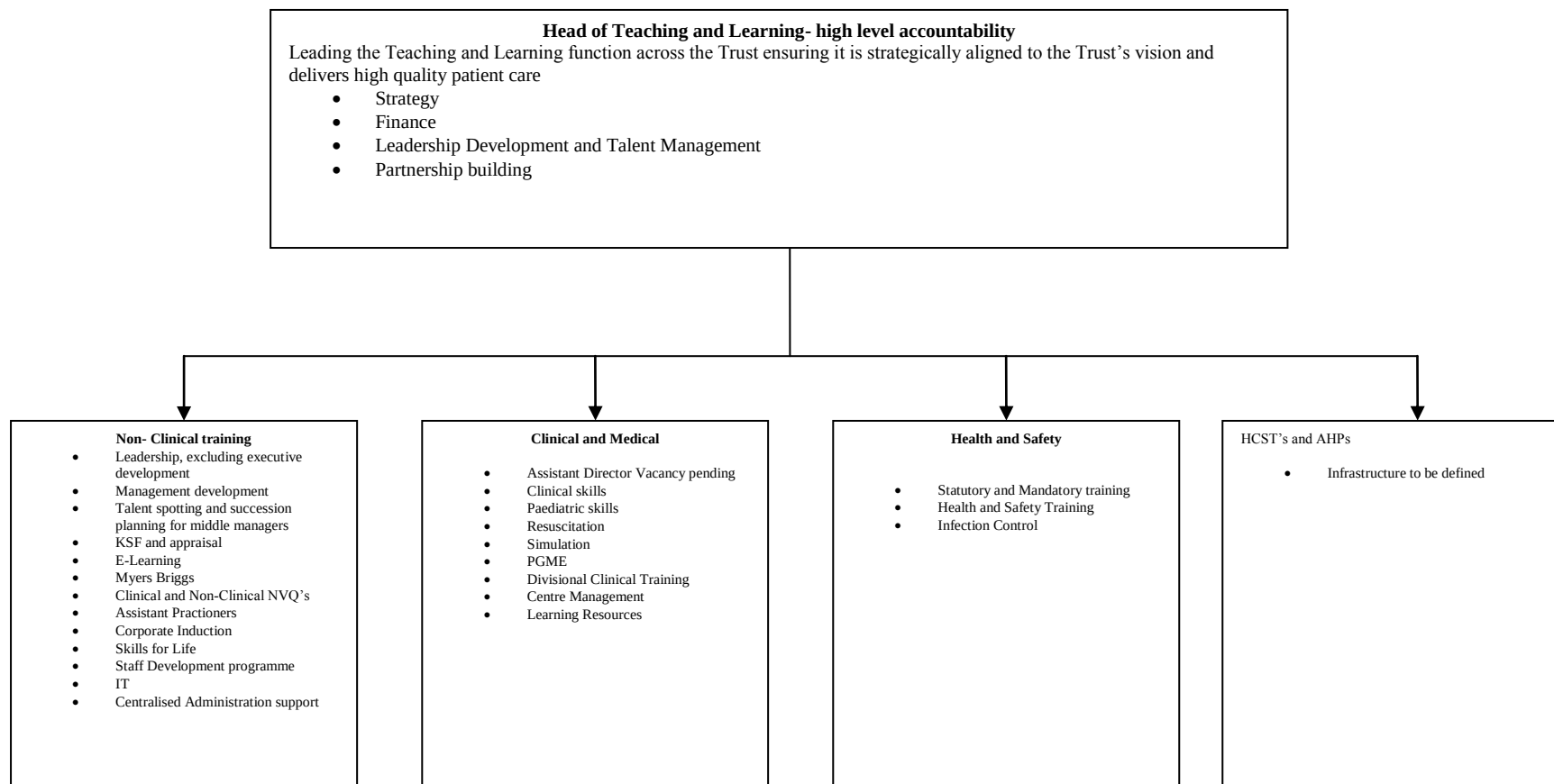
| Activity                                          | Timescales |
|---------------------------------------------------|------------|
| Project work underway                             | Q2         |
| Teaching & Learning Strategy review               | Q3         |
| Projects reports back to the Board                | Q3         |
| Final Proposal for Teaching & Learning structures | Q3         |
| Proposals implemented                             | Q4         |

### **Summary**

The current Trust practice, with dispersed and separately managed training infrastructures makes it difficult to deliver a fully integrated and efficient approach to Teaching & Learning.

The group is clear that a joined up approach can deliver many benefits and will result in a more efficient service.

The reviews currently undertaking will ensure that the approach we implement is appropriate and of maximum benefit to the Trust.





| <b>Budget Source</b>                               | <b>Trust Total (£)</b> |
|----------------------------------------------------|------------------------|
| Divisional Training Budgets                        | 853,755                |
| Medical Students                                   | 208,179                |
| NMET- Nursing and Midwifery Education and Training | 1,771,125              |
| MADEL- Medical and Dental Educational Levy         | 14,509,314             |
| SIFT- Service Increment for Teaching               | 13,326,089             |
| Dental SIFT- Service Increment for Teaching        | 9,120,713              |
| <b>Total</b>                                       | <b>39,789,175</b>      |

NMET funding is received from the NHS South West Strategic Health Authority. The funding covers backfill costs associated with training and the provision of education within Dental and Pharmacy.

MADEL funding is received from the NHS South West Strategic Health Authority to provide a support environment for post graduate medical and dental education. The funding covers basic salary costs, associated travel, interview and removal expenses, library and postgraduate administration costs.

Medical and Dental SIFT funding is received from the NHS South West Strategic Health Authority to provide support to undergraduate medical and dental teaching.

**Teaching, Training and Education activity in the Trust**

| Training Delivered                           | Who delivers this and what is their role? | How many courses are run each year and for what duration? | How many attendees can the course hold? | What is the average DNA rate? | Is this resource external/internal? | If internal is the resource a funded trainer post? | How many hours is this post funded for? | If internal who is the accountable lead for this training and what is their role? | If external what funding stream is used to fund the activity? | How would I know this training was available? | Who is the audience for this training?             |
|----------------------------------------------|-------------------------------------------|-----------------------------------------------------------|-----------------------------------------|-------------------------------|-------------------------------------|----------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------|
| <i>A worked example is illustrated below</i> |                                           |                                                           |                                         |                               |                                     |                                                    |                                         |                                                                                   |                                                               |                                               |                                                    |
| Appraisal Training                           | Tracy Gates-<br>People management Coach   | 16 courses<br>3.5 hours                                   | 16                                      | 20%                           | Internal                            | Yes                                                | 37.5                                    | Samantha Bennett-<br>Assistant Director of Development                            | N/A                                                           | CONNECT                                       | Any member of staff who manages/ supervises people |
|                                              |                                           |                                                           |                                         |                               |                                     |                                                    |                                         |                                                                                   |                                                               |                                               |                                                    |
|                                              |                                           |                                                           |                                         |                               |                                     |                                                    |                                         |                                                                                   |                                                               |                                               |                                                    |
|                                              |                                           |                                                           |                                         |                               |                                     |                                                    |                                         |                                                                                   |                                                               |                                               |                                                    |



## Trust Board Meeting

|                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                    |                     |       |         |   |         |       |
|----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------|---------|---|---------|-------|
| Agenda Item                                                                                                    | 20                                                                                                                                                                                                                                                                                                                                                                 | Date: 29 March 2010 |       |         |   |         |       |
| Title of Report                                                                                                | EMERGENCY PLANNING – PANDEMIC FLU<br>PREPAREDNESS UPDATE                                                                                                                                                                                                                                                                                                           |                     |       |         |   |         |       |
| Recommendations<br>(please outline the purpose of the report and the key issues for consideration/decision)    | Purpose: To update the Board on: <ul style="list-style-type: none"><li>• University Hospitals Bristol NHS Foundation Trust continuing preparations,</li><li>• the latest planning guidance, and</li><li>• the current extent of H1N1 Flu, and cases reported nationally.</li></ul>                                                                                 |                     |       |         |   |         |       |
| Actions Required                                                                                               | The Board is asked: <ul style="list-style-type: none"><li>• To note the progress to date.</li><li>• To acknowledge formally that the Executive lead for Pandemic Flu is ‘stood down’ from April 1<sup>st</sup> 2010.</li><li>• To support the ongoing staff vaccination programme.</li></ul>                                                                       |                     |       |         |   |         |       |
| Which Corporate Objective(s) are supported by this paper                                                       | 042- to produce a comprehensive civil contingencies plan to meet national requirements – including pandemic flu plan                                                                                                                                                                                                                                               |                     |       |         |   |         |       |
| Is this on the Trust’s risk register? If yes, please give details. If not, why not? Eg. Risk Score is below 15 | Yes – risk 1465 the Trust being unable to deliver services due to the impact of pandemic flu                                                                                                                                                                                                                                                                       |                     |       |         |   |         |       |
| Which healthcare commission standard does this report provide evidence for?                                    | Healthcare Standard C24                                                                                                                                                                                                                                                                                                                                            |                     |       |         |   |         |       |
| Implications for the NHS Constitution                                                                          | The Pandemic Flu plan supports the NHS Constitution as follows:<br>The right to expect the local NHS to assess the health requirements of the local community and to put in place the services to meet those needs as considered necessary and to receive vaccinations approved by the Joint Committee on Vaccination under an NHS provided immunisation programme |                     |       |         |   |         |       |
| Financial Implications                                                                                         | <table><tr><td>Revenue</td><td>£</td><td>Capital</td><td>£600k</td></tr></table>                                                                                                                                                                                                                                                                                   |                     |       | Revenue | £ | Capital | £600k |
| Revenue                                                                                                        | £                                                                                                                                                                                                                                                                                                                                                                  | Capital             | £600k |         |   |         |       |
| Prepared by: Name & Title                                                                                      | Pat Fields, Flu Director                                                                                                                                                                                                                                                                                                                                           |                     |       |         |   |         |       |
| Presented by: Name & Title                                                                                     | Pat Fields, Flu Director                                                                                                                                                                                                                                                                                                                                           |                     |       |         |   |         |       |

**Previous Meetings**

Please insert the date the paper was presented next to the relevant group

| <b>Exec Team</b> | <b>Audit &amp; Assurance Committee</b> | <b>Governance Risk and Risk Management</b> | <b>Finance Committee</b> | <b>Trust Executive Group</b> | <b>Other Meeting Please state</b> |
|------------------|----------------------------------------|--------------------------------------------|--------------------------|------------------------------|-----------------------------------|
|                  |                                        |                                            |                          |                              |                                   |

## **EMERGENCY PLANNING – PANDEMIC FLU PREPAREDNESS UPDATE**

### **INTRODUCTION**

This paper outlines progress to date against the Trust's Pandemic Flu Preparedness.

### **UPDATE**

All indications are that the UK has reached the conclusion of the second wave of the H1N1 (2009) Pandemic Flu. With the current low levels of influenza this paper provides an update to the Board of the Trust's response to this Pandemic Flu outbreak.

### **THE TRUST'S RESPONSE**

Whilst some parts of the country were disproportionately affected by the H1N1 Pandemic Flu outbreak, the South West as a region had significantly lower levels of cases and the Trust was only required to utilise its current Pandemic Flu plan to Amber escalation at the height of the Pan Avon peak in line with other local organisations.

### **PANDEMIC FLU KEY WORKSTREAMS**

Six key workstreams were the main focus:

- **Staff Vaccination**  
The Staff Vaccination programme worked well strongly supported by both the Heads of Nursing / Midwifery and Occupational Health. Despite the lack of additional resource, the Trust achieved over 51% of high priority staff vaccinated by the end of January 2010. This included 44% of medical staff and 47% of registered nurses.
- **Inpatient Vaccination**  
The Trust led the development of the Pan Avon Inpatient Vaccination protocols and supporting documents and introduced inpatient vaccination across all high-risk inpatient groups.
- **Critical Care.**  
Critical Care planning across the region was led by University Hospitals Bristol clinicians who developed a detailed plan to both increase Critical Care capacity across the various hospitals within the Trust and to support a very different way of working across the Region.
- The Paediatric Critical Care Unit led the model of care adopted throughout the Region with support from all Clinicians.
- **Supply Chain / Logistics**  
Whilst the supply of Personal Protective Equipment (PPE) was initially challenged at the start of Wave 1 and therefore ordering of PPE was centralised, the Trust

developed a robust arrangement to ensure all areas had timely access to appropriate PPE equipment.

- **Workforce and Training**

Dedicated training was developed in-house to support staff to manage higher dependency patients and potentially be redeployed to critical care areas.

- **Planning**

Throughout the Pandemic Flu outbreak work was undertaken both within the Trust and across the Pan Avon Health Community to develop local plans to support a continued and improved response to Pandemic Flu. As a result the Trust has already substantially updated the Trust wide Pandemic Flu Contingency Plan and is well placed to respond to a further outbreak of Pandemic Flu. The Trust was involved in three exercises to test the plan. The Health Community/Trust specific & a Regional event .

## CONCLUSIONS AND RECOMMENDATIONS

The Trust Board is asked:

- To note the overall progress to date.
- To support the ongoing requirement Nationally to promote the staff vaccination programme, this is ongoing to run until the seasonal Flu vaccination programme commences in Sept/Oct.
- Acknowledge the ‘standing down’ from March 31<sup>st</sup> of the Flu Director.

|                               |                                                                                                                                                                                                                                                                                         |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>TRUST BOARD MEETING</b>    | <b>29 March 2010</b>                                                                                                                                                                                                                                                                    |
| <b>TITLE</b>                  | <b>Civil Contingencies Annual Report</b>                                                                                                                                                                                                                                                |
| <b>PURPOSE</b>                | To assure the Trust Board of the Trust's compliance with the requirements of the Civil Contingencies Act 2004 and to inform the Board of continuing work and future plans surrounding Emergency Preparedness.                                                                           |
| <b>FORMAT</b>                 | Strategy and Plans                                                                                                                                                                                                                                                                      |
| <b>THE BOARD IS ASKED TO:</b> | Consider the contents of this report and recognise its importance, review the Trusts current position with regards to emergency preparedness and note the progress made and for the Board to commit full support to the continuation of the concept and practice of emergency planning. |

**Introduction**

The Civil Contingencies Act 2004 places a number of statutory duties on NHS organisations which are classed as either Category one or Category Two Responders.

As a Category One Responder University Hospitals Bristol Foundation Trust is required to prepare for emergencies in line with its responsibilities under the Civil Contingencies Act 2004

**Conclusions and recommendations**

Work is ongoing to ensure the Trusts continuing compliance with the Civil Contingencies Act 2004 and emergency core standard 24.

It is recommended that the Trust Board accepts and supports the proposed work program for 2009/10.

Prepared by: Cass Sandmann Emergency Planning Officer

Presented by: Irene Gray Chief Operating Officer



|                        |                                            |              |            |
|------------------------|--------------------------------------------|--------------|------------|
| <b>Title:</b>          | EMERGENCY PREPAREDNESS YEARLY REPORT       |              |            |
| <b>Owner:</b>          | Trust Executive for Emergency Preparedness |              |            |
| <b>Version:</b>        | 0.1                                        | <b>Date:</b> | 20/02/2010 |
| <b>Classification:</b> | NOT PROTECTIVELY MARKED                    |              |            |

# The State of Emergency Preparedness

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## Annual Report 2009/10

Prepared by: Cass Sandmann- Emergency Planning Officer

Presented by: Irene Gray- Chief Operating Officer/ Executive Lead for Emergency Preparedness

|                        |                                            |              |            |
|------------------------|--------------------------------------------|--------------|------------|
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## Executive Summary

The Civil Contingencies Act 2004 (CCA) places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 Responders

As a Category 1 Responder (see paragraph 1.2) University Hospitals Bristol Foundation Trust is required to prepare for emergencies in line with its responsibilities under the Civil Contingencies Act 2004.

This report outlines the position of the Trust in relation to emergency preparedness and how the trust will meet the duties set out in legislation and associated statutory guidelines, as well as any other issues identified by way of risk assessments and identified capabilities.

## Glossary

| Acronym  | Definition                                       |
|----------|--------------------------------------------------|
| A&S      | Avon & Somerset                                  |
| AHERG    | Avon Health Emergency Resilience Group           |
| BCM      | Business Continuity Management                   |
| BCP      | Business Continuity Plan                         |
| BS-25999 | British Standard: Business Continuity Management |
| CCA      | Civil Contingencies Act 2004                     |
| CRR      | Community Risk Register                          |
| DH       | Department of Health                             |
| EPLOF    | Emergency Planning Liaison Officer's Forum       |
| EPO      | Emergency Planning Officer                       |
| FOI      | Freedom of Information Act 2000                  |
| GWAS     | Great Western Ambulance Service NHS Trust        |
| LA       | Local Authority                                  |
| LRF      | Local Resilience Forum                           |
| NHS      | National Health Service                          |
| PCT      | Primary Care Trust                               |
| RASG     | Risk Assessment Sub-Group                        |

|                        |                         |
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# 1 Introduction

## 1.1 Purpose

This report outlines the Trust's activities during 2009/2010 that relate to the requirements of the Civil Contingencies Act 2004, its associated regulations, statutory and non-statutory guidance.

The report is presented to the University Hospitals Bristol NHS Foundation Trust Board inline with the requirements of the NHS Emergency Planning Guidance 2005 which states that:

*“The Chief Executive will ensure that the board receives regular reports, at least annually, regarding emergency preparedness, including reports on exercises; training and testing undertaken by the organisation and that adequate resources are made available to allow the discharge of these responsibilities.”*

(NHS Emergency Planning Guidance 2005, 2007)

The report follows the 'Statements of Intent' included within the University Hospitals Bristol NHS Foundation Trust Emergency Preparedness Policy.

## 1.2 Background

The Civil Contingencies Act 2004 (CCA) sets out a single framework for civil protection in the United Kingdom. The Civil Contingencies Act provides a statutory framework for civil protection at a local level and divides local responders into two categories depending on the extent of their involvement in civil protection work, and places a set of duties on each.

**Category 1** responders are those organisations at the core of emergency response. Foundation Status Trusts (FSTs) are identified as Category 1 responders and are subject to the full set of civil protection duties.

Foundation Status Trusts are therefore required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans
- Put in place Business Continuity Management Strategies and arrangements

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- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency; and
- Provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only).

### **1.3 Context**

2009 has been a demanding year for emergency planning with continual changing requirements from both Government, national and other healthcare community sources.

Given the gravity of ensuring the trust is well positioned to meet all the requirements of the Civil Contingencies act 2004 to continuously revise and test out plans and provide relevant training in a large inner city NHS trust, the position of Emergency Planning Officer was elevated to full time status from the 1<sup>st</sup> April 2009. This position was previously a joint appointment with North Bristol NHS Trust.

The emphasis of Emergency Preparedness in 2009/10 has been two fold. The Major Incident Plan in place in the Trust required detail revision, rewrite and dissemination. This coincided with the World Health Organisations declaration of an influenza pandemic. Department of Health guidance has consequently continually evolved requiring an iterative refresh of the Trusts Pandemic Flu Planning arrangements and processes.

Whilst the United Kingdom continues to see a downward trend in pandemic influenza activity, resulting activity has, and continues to be demanding of time and it is envisaged that the plan will continue to require constant review determined as new evidence is shared.

**The Trusts Major Incident Plan has now been reviewed and disseminated but will continue to require regular reviews. This is a critical aspect of preparedness and emergency planning.**

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## 2 Risk Assessment

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

### 2.1 *Community Risk Register*

University Hospitals Bristol NHS Foundation Trust contributes to the development and maintenance of the Community Risk Register (CRR) through the Chief Operating Officer who with the support of the Emergency Planning Officer attends the Avon & Somerset Local Resilience Forum (LRF) Risk Assessment Sub-Group (RASG).

#### **Changes to the Community Risk Register during 2009/2010**

Amendments following Cabinet Office 2009 Local and Regional Risk Assessment review.

Amendments following multi agency Risk Assessment Sub Group reviews of individual risk assessments.

Evidence: [Avon and Somerset Community Risk register](#)

### 2.2 *Local Authority Risk Register*

Bristol City Council has reviewed and applied the Community Risk Register to the Primary Care Trust area.

### 2.3 *Trust Risk Register*

The Trust also maintains a register of risks which may impact on service provision and this is regularly updated and then reviewed by the Governance and Risk Management Committee and Trust Board.

The Trust Risk Register is maintained with reference to the documents referenced above.

Evidence: [Corporate Risk Register](#)

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## Emergency Planning

This section details the activities undertaken to develop and maintain arrangements for responding to an emergency.

### **2.4 Generic Emergency Plan**

The Trusts Major Incident Plan was reviewed and rewritten in 2009 and formally signed off by the Trust Board in June 2009. Compliant with good practice, this plan will continue to be reviewed by the trust Civil Contingencies Committee, chaired by the Chief Operating officer, in line with Emergency Planning Guidance (2005, 2007)

Evidence: [Emergency Planning Pages](#)

### **2.5 Pandemic Influenza**

The World Health Organisation declared an Influenza Pandemic in May 2009, the Trust invoked its Pandemic Flu Plan at this point.

The Trust, under the direction of the Chief Operating Officer, immediately established a Pandemic Flu operations committee which met weekly to manage all related activities and ensure close working with key partners. In October 2009, the Department of Health made it a requisite that each Trust appoint a full time lead director for flu. The Trust appointed the Deputy COO/Director of Nursing to this position. The post was stood down in January 2010.

Throughout the flu planning process The Trust engaged and continues to engage locally with other health and social care providers to ensure parity of plans and inter relationships are of a sound standing.

Following two waves of the declared pandemic event work continues to be undertaken by the Trust's Pandemic Flu Planning Group to ensure that all preparations have been made to enable effective management of a third or subsequent pandemic flu wave. All aspects of the plan have been reviewed and amended as appropriate and in line with Department of Health recommendations and guidance and advice. The trust has completed regular self assessments of the Pandemic Flu plan and the latest assessment, using the Strategic Health Authority self assessment tool, was undertaken prior to the receipt of Department of Health Guidance on staff and patient vaccination. Therefore, the vaccination programme had not commenced and so resulting in 96% compliance. Since undertaking the audit the Trust has complied fully with the national guidance on vaccination.

A Pandemic Flu Communications strategy has been developed in cooperation with the Avon Health community.

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The Trust now has in place a robust plan for dealing with the effects of a pandemic flu outbreak including surge capacity and business continuity plans, however it must be recognised that this is an evolving project that requires continual updates and reviews. This will be conducted through the Trusts Pandemic Flu Planning and Business Continuity planning Groups.

During the two pandemic flu waves the Trust provided specific flu training for over 4,298 staff over a period of 3 months.

Additional specialist training in the use of personal protective equipment for flu was provided to an initial 320 members of clinical staff who in turn cascaded this training to other clinical staff.

The Trust admitted 83 confirmed positive patients suffering from swine flu since the formal declaration of a World Health Organisation Influenza Pandemic. Monitoring and reporting of patients admitted with confirmed swine flu continues.

Department of Health guidance suggests that the H1N1 virus will be prevalent during the next influenza season.

Evidence: [Pandemic Flu Plan](#)

## Specific Emergency Plans

The following new emergency plans and policy documents are being developed during 2009/10 and will be presented to the Trust Operational Group via the Trust Civil Contingencies Committee for ratification on completion:

- Severe Weather Plan
- Patients under armed guard policy
- Patients under the Witness Protection Scheme policy
- CBRNe Policy and Procedure Document
- Hospital Evacuation Plan

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### 3 Business Continuity Planning

This section details the Trust's activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.

The NHS recognises that the British Standard BS-25999 provides definitive guidance on business continuity management.

The Trust has been issued with BS-25999 self assessment tools and licence that will enable the trust to align itself with the standard during 2010/2011.

On completion of the self assessment the results will be presented to the Trust Executive Group via the Civil Contingencies Committee.

The Trust is currently fully compliant with Core Standard 24 with respect to Business Continuity Planning.

#### 3.1 Business Continuity Policy

A Trust Civil Contingencies Committee (CCC) has been established under the direction of the Chief Operating Officer and acts as the coordinating body of all business continuity policies, procedures and management of processes.

This committee reports to the Trust Executive Group

**Evidence: Minutes of the Civil Contingencies Committee/Terms of Reference**

**(Terms of reference Appendix A)**

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#### 3.2 Business Continuity Strategy

A revised over arching Business Continuity Policy document has been ratified by the Business Continuity Planning Group and will be presented, via the Civil Contingencies committee to the Trust Executive Group.

#### 3.3 Business Continuity Plans

The Trusts Business Continuity Plans were reviewed in 2009 as part of the annual review process. A list of business continuity plans is held by the Emergency Planning Officer and is available to view on the Trust Intranet.

Hard copies of the plans are held by the Emergency Planning Officer.

Business continuity plans for the Trust are currently undergoing assessment utilising a British Standards Institute NHS specific tool.

Evidence: Emergency Planning Pages

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## 4 Information Sharing

This section details how the Trust has responded to formal or informal requests for information under the provisions of the Civil Contingencies Act 2004.

### 4.1 Formal Requests for Information

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
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| <table> <tr> <td>2009</td><td></td></tr> <tr> <td><b>Month</b></td><td><b>No. of Requests</b></td></tr> <tr> <td></td><td></td></tr> <tr> <td>January</td><td>20</td></tr> <tr> <td>February</td><td>16</td></tr> <tr> <td>March</td><td>18</td></tr> <tr> <td>April</td><td>12</td></tr> <tr> <td>May</td><td>13</td></tr> <tr> <td>June</td><td>27</td></tr> <tr> <td>July</td><td>18</td></tr> <tr> <td>August</td><td>16</td></tr> <tr> <td>September</td><td>19</td></tr> <tr> <td>October</td><td>18</td></tr> <tr> <td>November</td><td>20</td></tr> <tr> <td>December</td><td>14</td></tr> <tr> <td><b>Total</b></td><td><b>211</b></td></tr> </table> | 2009                                          |  | <b>Month</b> | <b>No. of Requests</b> |  |  | January | 20 | February | 16 | March | 18 | April | 12 | May | 13 | June | 27 | July | 18 | August | 16 | September | 19 | October | 18 | November | 20 | December | 14 | <b>Total</b> | <b>211</b> | <table> <tr> <td>2010</td><td></td></tr> <tr> <td><b>Month</b></td><td><b>No. of Requests</b></td></tr> <tr> <td></td><td></td></tr> <tr> <td>January</td><td>25</td></tr> <tr> <td>February</td><td>8</td></tr> <tr> <td>March</td><td></td></tr> <tr> <td>April</td><td></td></tr> <tr> <td>May</td><td></td></tr> <tr> <td>June</td><td></td></tr> <tr> <td>July</td><td></td></tr> <tr> <td>August</td><td></td></tr> <tr> <td>September</td><td></td></tr> <tr> <td>October</td><td></td></tr> <tr> <td>November</td><td></td></tr> <tr> <td>December</td><td></td></tr> <tr> <td><b>Total</b></td><td></td></tr> </table> | 2010 |  | <b>Month</b> | <b>No. of Requests</b> |  |  | January | 25 | February | 8 | March |  | April |  | May |  | June |  | July |  | August |  | September |  | October |  | November |  | December |  | <b>Total</b> |  |
| 2009                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| <b>Month</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>No. of Requests</b>                        |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
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| January                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 20                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| February                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 16                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| March                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 18                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| April                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 12                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| May                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 13                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| June                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 27                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| July                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 18                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| August                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 16                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| September                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 19                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| October                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 18                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| November                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| December                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 14                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| <b>Total</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>211</b>                                    |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| <b>Month</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>No. of Requests</b>                        |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
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| January                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 25                                            |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| February                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8                                             |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| March                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| April                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| May                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| June                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| July                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| August                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| September                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| October                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| November                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| December                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| <b>Total</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                               |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |
| Average Number of Requests a month:<br>18                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Average Number of Requests a month:<br>month: |  |              |                        |  |  |         |    |          |    |       |    |       |    |     |    |      |    |      |    |        |    |           |    |         |    |          |    |          |    |              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |              |                        |  |  |         |    |          |   |       |  |       |  |     |  |      |  |      |  |        |  |           |  |         |  |          |  |          |  |              |  |

### 4.2 Informal Requests for Information

The Trust deals with routine informal requests for information as part of the normal activities of the Emergency Planning Liaison Officer (EPLO). Informal requests for information generally come from Emergency Planning Officers or their representatives from other NHS and non-NHS organisations relating to issues surrounding emergency preparedness.

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## 5 Cooperation

This section deals with how the Trust cooperates with other emergency responders.

### 5.1 *Avon & Somerset Local Resilience Forum*

The Avon Health Community is represented at the Local Resilience Forum by the Chair of the Avon Health Emergency Resilience Group.

The Trust is represented at the Local Resilience Forum by the Chief Operating Officer supported by the Emergency Planning Officer.

**Evidence:** Minutes of the Local Resilience Forum meetings are available on request to the Emergency Planning Officer.

### 5.2 *Avon Health Executive Resilience Group*

The Trust's Executive Lead for Emergency Preparedness, supported by the Emergency planning Officer attends and contributes to the work of the Avon Health Emergency Resilience Group (AHERG).

Evidence: [AHERG minutes](#)

### 5.3 *Local Resilience Forum Working Groups*

During 2009/2010 the Trust was represented on the following Local Resilience Forum working groups:

- Chemical, Biological, Radiological, Nuclear Working Group:
- Local Resilience Forum Site Specific Group: (Bristol)
- Avon and Somerset Local Resilience Forum
- Avon and Somerset Local Resilience Forum Pandemic Flu
- Avon and Somerset Local Resilience Forum Excessive Death sub group
- Regional Resilience Forum for massed casualties

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## 6 Warning & Informing

This section details how the Trust has undertaken activities to communicate with the public with regard to emergency preparedness and health protection. As a Category One responder under the Civil Contingencies Act 2004 the Trust has a “duty, in partnership with others to warn and inform the public”. (Civil Contingencies Act 2004)

### 6.1 *Warning and Informing*

A pandemic flu communications plan has been developed by the Trust that links with the NHS Bristol communications plan that has been presented to the Strategic Health Authority for approval. It is intended that this plan will be adapted for use in subsequent civil contingency situations where there is a perceived need to warn the public.

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## 7 Training & Exercising

This section details the training and exercising activities undertaken during 2009/10.

### 7.1 Training

The following training courses were run within the Trust during 2009/10:

- Emergency Department response to Chemical, Biological, Radiological, Nuclear incidents (rolling programme)
- Business Continuity Planning Awareness Training
- Pandemic Flu Exercise Trust Level

The Trust participated in the following training/exercise sessions during 2009/2010

- Pandemic Flu exercise at North Bristol Trust
- Pandemic Flu Exercise at Avon Health Community Level
- Exercise "Thornbury" Nuclear establishment multi-agency exercise

### 7.2 Live Exercises

The NHS Emergency Planning Guidance (2005, 2007) states that the Trust must undertake a minimum of one live exercise every three years.

The Trust participated in a declared Major Incident in September 2009. For the purposes of the Emergency Planning Guidance (2005, 2007) this constitutes a live exercise.

The Trust invoked its Major Incident Plan in response to a multiple motorcycle collision on the Weston Super Mare beach front during a planned racing event. A total of eighteen patients were successfully extricated from the scene and transported to emergency departments within the Avon area. Lessons learned, following the Trust cold debrief of the incident, have been identified and where appropriate included in the latest revision of the Trust major Incident plan.

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The University Hospitals of Bristol NHS Trust undertook an Emergo (Emergency simulation) exercise October 2007 and has a further Emergo exercise booked in September 2010.

Emergo exercises are designed to test the Trust major incident process and should involve representation from all Trust Divisions at all levels and should include representation at Executive Level.

### **7.3 Tabletop Exercises**

The NHS Emergency Planning Guidance (2005, 2007) states that the Trust must undertake a minimum of one tabletop exercise every year.

The Trust declared a Major Incident in September 2009. For the purposes of the Emergency Planning Guidance (2005, 2007) this constitutes a full tabletop exercise.

The further tabletop exercise has taken place in March 2010:  
Table top exercises can be designed to test the Trust Major Incident Plan, planning response and to identify any gaps in training. The exercises require the participation of Trust operational staff including On-Call Managers, Clinical Site Teams from across the Trust and key Emergency Department personnel.

### **7.4 Communications Cascade Tests**

The NHS Emergency Planning Guidance 2005 requires that the Trust must test its communications arrangements every six months as a minimum.

During 2009/2010 communications cascade exercises were held on the following dates:

19/05/09  
17/08/09  
16/11/09  
07/12/09

Feed back following these exercises identified gaps within the call-out process. Following this a revised call out system has been developed and put into practice.

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## ***7.5 Debriefing***

It is good practice to debrief staff participating in exercises to identify lessons learnt.

During 2009/2010 debriefing sessions were held following 100% of the exercises held. Key lessons learnt, and actions taken as a result, have been incorporated into revised plans and processes.

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## 8 Audit & Assurance

This section of the report details the internal and external assurance activities undertaken for University Hospitals Bristol during 2009/2010.

### 8.1 *Standards for Better Health: Core Standard 24*

The Trust currently complies with core standard 24

The Trust undertook an internal audit in December 2009. Appendix B)

### 8.2 *National Capabilities Survey*

The National Capabilities Survey (NCS) is biennially administered by the Cabinet Office Civil Contingencies Secretariat. The survey is part of the Governments programme to make the country more resilient to disruptive events, and provides an up to date picture of preparedness, and helps plan improvements.

The last NCS submission made by University Hospitals Bristol was on March 7<sup>th</sup> 2008

The latest National Capabilities Survey will be completed in March 2010.

### 8.3 *Assessments*

#### 2009

- Chemical, Biological, Radiological, Nuclear Explosive (CBRNe) Capability self Assessment 30<sup>th</sup> January 2009
- Pandemic Influenza Assurance self assessment 13<sup>th</sup> March 2009

#### 2010

- The Trust is required to submit a Chemical, Biological, Radiological and Nuclear Assessment during 2010
- CBRNe self assessment March 2010

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## 9 Work Programme 2009/10

The work programme for the Trust's Emergency Planning Group for 2009/10 has been developed in consultation with the Civil Contingencies Committee, the Trust Executive Lead for Emergency Preparedness and the Emergency Planning Officer.

It should be noted that the work programme will fluctuate in line with emerging Department of Health guidance.

**A copy of the work programme has been appended to this report. (Appendix C)**

### Significant Events During 2009/2010

The Trust has experienced the following untoward events during 2009/2010

- Declared Pandemic Influenza event. Two waves of an influenza pandemic (H1N1) were experienced by the Trust during this period.
- Major Incident declaration in September 2009 following multiple motorcycle rider incident at Weston Super Mare beach front.
- Severe weather events during 2009/2010
- ITU closure following infectious out break (acinetobactor) resulting in temporary relocation of ITU.

Lessons learned from debriefs following these events have been incorporated, where appropriate, into Trust plans.

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## 13 Conclusions

Significant progress has been made in maintaining a robust programme of emergency resilience and preparedness. Emphasis for the forthcoming year will be on developing, embedding and maintaining a robust business continuity management strategy, with a view to aligning the Trust with the BS25999 standard, ensuring that University Hospitals Bristol remains in a strong position to fulfil all its obligations as a Category One responder under the Civil Contingencies Act 2004.

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## Appendix A

### University Hospitals Bristol NHS Foundation Trust. Civil Contingencies Committee

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#### Terms of Reference

#### **1 Introduction**

- 1.1 The Civil Contingencies Committee has been set up to develop and drive forward Civil Contingency planning within U H Bristol NHS Foundation Trust ( the Trust) and ensure that the Trust is compliant with statutory obligations under the Civil Contingencies Act 2004, and the mandatory requirements of Standards for Better Health core standard 24:

‘Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.’

#### **2 Aim**

- 2.1 To ensure that the Trust is able to respond to emergencies, adverse and major incidents, which threaten the health of the population, or the provision of health care to the population.

#### **3 Objectives**

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3.1 In order to achieve this aim, the Civil Contingencies Committee will develop and oversee a work programme that will:

- Develop and maintain:
  - Strategic and tactical emergency plans for the Trust in line with local community risks, and
  - Specific emergency plans for identified hazards and threats.
- Ensure plans are disseminated to staff in an appropriate manner.
- Ensure plans are consistent and where appropriate cognisant of local health community and local authority plans. This includes plans of provider services, independent contractors and acute trusts.
- Develop and implement a Business Continuity Management (BCM) process across the Trust, putting in place adequate business continuity plans and ensuring that any services are commissioned with robust BCM arrangements.
- Communicate with internal and external key stakeholders.
- Maintain communication links with key external agencies including neighbouring Trust's, the Local Resilience Forum, Police Local Authority etc.
- Identify staff within the Trust that have specific responsibilities when responding to an emergency and ensure that they are given appropriate training.
- Ensure plans are tested in accordance with National Recommendations/guidance within the Trust and review them in line with current guidance. (Civil Contingencies Act 2004)
- Provide quarterly reports to the Trust Operational Group (TOG)
- Provide an annual report to the Trust Board on progress and readiness.
- Ensure the Trust is compliant with Core Standard 24 of the Standards for Better Health and statutory responsibilities under Civil Contingencies Act 2004.

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## **4 Chair and Secretariat**

- 4.1 The Chair of the group will be the Chief Operating Officer who is the Trust Executive Lead for Emergency Preparedness.
- 4.2 The Vice Chair will be the ADM for Medicine
- 4.3 The Chair will:
- Agree a work programme (with associated timetables and individual accountability on tasks and deliverables) with all members of the group.
  - Provide a conduit for the exchange of information between all other related working groups as required.
- 4.4 The Emergency Planning Liaison Officer will coordinate the:
- Setting of meeting schedules and coordinate the distribution of minutes.
  - Preparation and distribution of agenda and other papers at least two weeks in advance of the scheduled meetings.
  - Recording, preparation and distribution of minutes within at least two weeks of the respective meeting.
  - Provision of secretariat support.
  - The Committee will meet every two months.

## **5 Representation**

- 5.1 Representation will be as detailed in the attached schedule.
- 5.2 Representatives will:

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- Collaborate with and provide input to the various work programmes, from the perspective of their particular area of operation and its specific requirements.
- Involve whoever is necessary within their area of responsibility in ensuring that all aspects of planning are considered.
- Ensure that plans, policies and procedures initiated by the committee are operationalised within their own division.
- Attend scheduled meetings or send appropriate representation where they are unable to attend.
- Undertake action points assigned to them in meetings.
- Submit any items to be included on the agenda at least four weeks in advance of a prospective meeting with accompanying papers.
- Provide the chair with notice of items to be included as Any Other Business in advance of the respective meeting.
- Brief and debrief their respective Teams or organisations' nominated lead for emergency planning (if applicable) following meetings.

## **6 Quorum**

- 6.1 The group will require the attendance of the Chair or Vice-Chair supported by at least 10) Divisional representatives

## **7 Review**

- 7.1 The Representation of the group and terms of reference will be subject to an annual review by the group due December 2009

## **8 *Connections to Other Groups***

- 8.1 The following diagram (fig. 7) shows the primary links to other groups within the Trust.

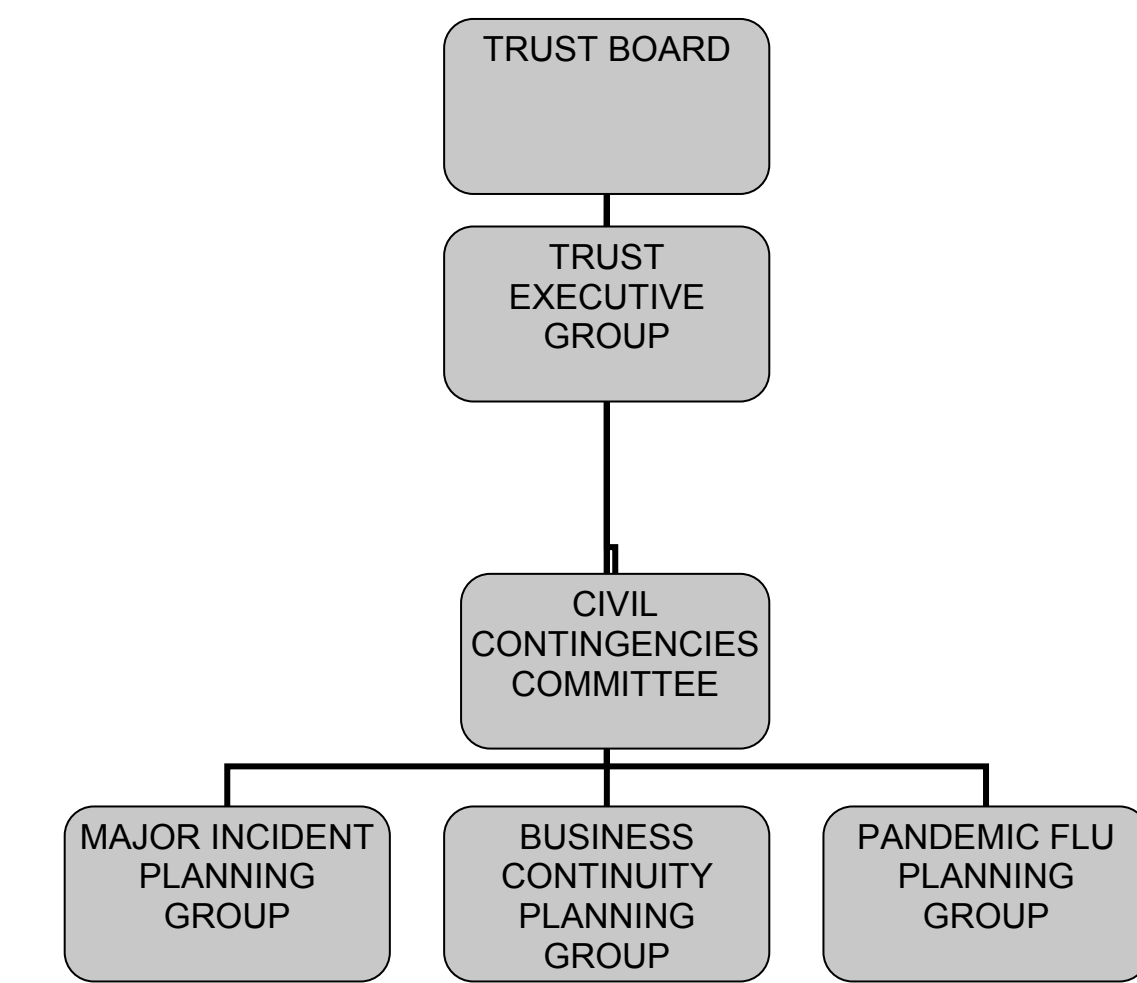
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*fig. 7: Primary Links to Other Groups*

The CCC reporting structure:

## **CIVIL CONTINGENCIES COMMITTEE** **REPORTING STRUCTURE.**



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### ***Schedule 1: Civil Contingencies Committee Membership***

| <b>Name</b>                                       | <b>Title</b>               | <b>Division/Group</b>                                                                                                                                                                                                          |
|---------------------------------------------------|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Irene Gray                                        | Chief Operating Officer    |                                                                                                                                                                                                                                |
| Cass Sandmann                                     | Emergency Planning Officer | Surgery, Head and Neck<br>Finance<br>Women's and Children's<br>Facilities<br>Medicine<br>Specialised Services<br>Infection Prevention and Control<br>Clinical Site Management Team<br>Human Resources<br>Radiology<br>Pharmacy |
| Others will be co-opted or invited as appropriate |                            |                                                                                                                                                                                                                                |

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| <b>Owner:</b>          | Trust Executive for Emergency Preparedness |              |  |
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## Appendix B

**University Hospitals Bristol**



NHS Foundation Trust

**Audit and Assurance Committee**

**Date: 4<sup>th</sup> December 2009**

**Agenda Item:**

### **Title**

Limited Assurance Audits 2008/09 – Executive Directors Actions to Date

### **Summary**

To present the Audit and Assurance Committee with a report on action taken by Executive Directors on audits graded limited assurance in 2008/09.

### **Recommendations**

For information

### **Author**

Jenny McCall, Chief Internal Auditor

### **Presented by**

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**Jenny McCall, Chief Internal Auditor**

**Impact Assessed**

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| <b>Yes</b> | <b>No</b> |
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| 14 Business Continuity Planning | A follow up review of the Business Continuity Planning audit reported in July 2007 found that little action has been taken on the recommendations due to the Emergency Planning Officer's post being vacant from March until September 2008 and the subsequent lack of awareness of the last report. | 1.Roles and responsibilities of Divisions defined in major incident plan      | <p>Following completion of the Trust Major Incident Plan 2009 the specific roles and responsibilities have been included in the plan. The plan was presented and accepted by the Trust Board in June 2009.</p> <p>The plan was released electronically with hard copies available in appropriate areas in October 2009</p> <p>Notice of plan release date was published prior to release with key staff given opportunities to familiarise themselves with its content and request guidance as required.</p> <p>The Emergency Planning Officer (EPO) holds both electronic and hard copies of all department and divisional business continuity plans (bcp's). The EPO also maintains a register of all bcp's</p> <p>Significant work has been undertaken by divisions to create emergency plans that specifically deal with issues surrounding</p> |
|                                 |                                                                                                                                                                                                                                                                                                      | 2.Final changes made to major incident plan                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                 |                                                                                                                                                                                                                                                                                                      | 3.Training of key staff undertaken                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                 |                                                                                                                                                                                                                                                                                                      | 4.Emergency plans held by departments available to Emergency Planning Officer |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

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|  |  | 5.Major incident exercises in planning | <p>pandemic influenza surge planning</p> <p>An overarching Trust bcp has been produced and presented to the Civil Contingencies Committee for review</p> <p>An Emergo major Incident plan has been provisionally booked for March 2010 (awaiting confirmation of venue only)</p> <p>Following a recent live Major Incident, lessons learned following cold debrief have been incorporated into the new planning arrangements</p> |
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## Appendix C

### Work Programme for 2009/10

- Continuing development of the current Trust Pandemic Flu Plan. This will be a continual process that will require regular review and update as and when guidance is made available. It is anticipated that this will be ongoing throughout the year.
- Review of the current location of the Command and Control room.
- Emergo Major Incident Exercise.
- Development of Emergency Planning and Business Continuity Training Programmes for appropriate staff.
- Development of training program for Emergency Department staff for new massed decontamination equipment. This training program has now been commenced.
- Review and rewrite of hospital evacuation plans
- Review and rewrite of shelter plans for evacuated patients incorporating memorandums of understanding with neighbouring organisations both NHS and non-NHS.
- Review of the Trust's capability to deal with nuclear incidents. Information from the Department of Health suggests that great emphasis will be placed this year on nuclear incidents and accidents. In view of the Trust's nuclear medicine expertise it is anticipated that the Trust will be one of the major receiving hospitals in the country in the event of a nuclear incident, and as such suitable plans should be developed.
- Implementation of a robust Business Continuity Management strategy in line with British standard BS-25999
- Development of the Trust lock-down capability.
- Awareness raising of issues surrounding the 2012 Olympic competition and the location of training camps within the Avon Health area

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| Trust Board Meeting                                                                                | Date: 29 March 2010                                                                                                                                                                                                                                                                                                                                                                                                         |         |     |  |         |     |         |     |
| Agenda Item                                                                                        | 22                                                                                                                                                                                                                                                                                                                                                                                                                          |         |     |  |         |     |         |     |
| Title of Report                                                                                    | Six Lives - Learning Difficulties                                                                                                                                                                                                                                                                                                                                                                                           |         |     |  |         |     |         |     |
| Recommendations                                                                                    | <p>The report will describe:</p> <ul style="list-style-type: none"><li>• A summary of the needs of patients with a learning difficulty</li><li>• A briefing on the “Six Lives” report</li><li>• The Trust Response to the Report using Care Quality Commission self assessment template</li><li>• An update on the activities of the Trust Learning Difficulties Service</li><li>• A plan to improve the service.</li></ul> |         |     |  |         |     |         |     |
| Actions Required                                                                                   | The Trust Board is asked to receive this report for information.                                                                                                                                                                                                                                                                                                                                                            |         |     |  |         |     |         |     |
| Which Corporate Objective(s) are supported by this paper?<br>Implications for the NHS Constitution | This report supports the right in the NHS Constitution not to be unlawfully discriminated against in the provision of NHS services on grounds of disability.                                                                                                                                                                                                                                                                |         |     |  |         |     |         |     |
| Is this on the Trust’s risk register?                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                             |         |     |  |         |     |         |     |
| Which CQC registration standards does this report provide evidence for?                            | 1 – respecting and involving patients                                                                                                                                                                                                                                                                                                                                                                                       |         |     |  |         |     |         |     |
| Financial Implications                                                                             | <table><tr><td>Revenue</td><td>£ 0</td><td>Capital</td><td>£ 0</td></tr></table>                                                                                                                                                                                                                                                                                                                                            |         |     |  | Revenue | £ 0 | Capital | £ 0 |
| Revenue                                                                                            | £ 0                                                                                                                                                                                                                                                                                                                                                                                                                         | Capital | £ 0 |  |         |     |         |     |
| Prepared by: Name & Title                                                                          | Kate Hopgood/Jane Merrifield, Senior Nurses                                                                                                                                                                                                                                                                                                                                                                                 |         |     |  |         |     |         |     |
| Presented by: Name & Title                                                                         | Alison Moon, Chief Nurse                                                                                                                                                                                                                                                                                                                                                                                                    |         |     |  |         |     |         |     |
| Appendices                                                                                         | Appendix 1 – Examples of Patient Input                                                                                                                                                                                                                                                                                                                                                                                      |         |     |  |         |     |         |     |



**Learning Difficulties Briefing Paper to the Trust Board**  
**The Provision of Public Services to People with Learning Disabilities (March 2009)**

**1. The Learning Difficulties Health Need**

It is well recognised that people with a Learning Difficulty (LD) often have poorer health than the general population and may face inequalities when accessing acute services for many different biological and socio-economic reasons. It is thought that up to 2.5% or 3.0% the population have an LD.

Up to 90% of people with a Learning Difficulty will have some form of communication problem which will impact on the ability of staff to diagnose, treat and discharge them safely, and some reports suggest that they are up to four times more likely to die of a preventable condition than a member of the general population.

Due to complex health conditions admissions to hospital are more likely than the general population (26% V 14%) and admissions will often be longer, and discharges more complicated. Patients with a Learning Difficulty have a different pattern of health needs with respiratory disease being the main cause of death in this patient group followed by heart disease (often associated with congenital heart disease). The prevalence of epilepsy, dysphagia, sensory and physical disabilities among this patient group is also high and often requires specialist knowledge and intervention. Anxiety and fear as well as a lack of understanding of Learning Difficulties by hospital staff can result in behaviour that put the patient and others at risk.

As well as the communication difficulties and complex health conditions described being in hospital removes people from family and carers who are familiar to the patient and their nuances. 60% of people with learning difficulty live with families; many of these will be elderly carers who will not necessarily be able to accompany their son/daughter to hospital. Often the remaining patients can lead very isolated lives with minimal input from any unpaid carers which leave them without advocates meaning they are often left out of decision making processes.

In recent years there has been much attention paid to the care of people with learning disabilities within acute care settings and evidence has shown that often this group of people can experience sub optimal care.

**2. Six Lives: The Provision of Public Services to People with Learning Disabilities. Parliamentary and Health Services Ombudsman.**

The report responds to complaints brought by the charity Mencap on behalf of the families of six people with learning difficulties who died whilst in NHS or local authority care between 2003 and 2005. Details of these cases are available in the document Death by Indifference (MENCAP, 2008).

**2.1 The recommendations from the Six Lives report were that all NHS and social care organisations should review:**

- The effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning difficulties in their areas.
- The capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning difficulties.

**Also:**

- That those responsible for the regulation of health and social care services (specifically the Care Quality Commission, Monitor and the Equality and Human Rights Commission) should

satisfy themselves, individually and jointly, that the approach taken in their regulatory frameworks and performance monitoring regimes provides effective assurance that health and social care organisations are meeting their statutory and regulatory requirements in relation to the provision of services to people with learning disabilities.

- That the DOH should promote and support the implementation of these recommendations, monitor progress against them and publish a progress report within 18 months of the publication of this report.

2.2 In UH Bristol we have used the Care Quality Commission self assessment tool to review our systems and the capacity and capabilities that they provide to support people with learning disabilities.

### **MONITOR Compliance**

It is important to note that from 1 April 2010, MONITOR, the regulator has included the issue of caring for people with learning difficulties in the Compliance Framework. The detail behind this is not known at this stage but it is anticipated that all NHS Trusts will need to demonstrate robust plans in place to ensure patients with learning difficulties receive appropriate and tailor made care taking note of National Reports on best practice.

### **3. The Trust Response to the Six Lives Report.**

This has been considered using the Care Quality Commission self assessment template.



# CQC scoring system

(1) Protocols/mechanisms are not in place

(2) Protocols/mechanisms are in place but not yet implemented

(3) Protocols/mechanisms are in place but are only partially implemented

(4) Protocols/mechanisms are in place and fully implemented

| Objective                                                                                                                                                                                                                                     | Risk rating | What we are doing (Or already have in place)                                                                                                | Lead person                                                                                                       | When                                                                                                                                                                                               | Measurement of progress to be used                                                                                                                                                                              | Outcomes                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>1: Does the trust have a mechanism in place to identify and flag patients with LD and protocols that ensure that pathways of care are reasonably adjusted to met the health needs of these patients?</b><br><br><b>(Currently score 3)</b> |             | IHCS has LD flagging system and can also ensure appointments are sent out in the correct format and in duplicate if needed.                 | LD Liaison Team input LD diagnosis and additional needs as can clinic organisers.                                 | Completed in set up but ongoing data entry.                                                                                                                                                        | Audit process                                                                                                                                                                                                   | Trust staff are alerted to patients who may have additional needs at an early stage.                                   |
|                                                                                                                                                                                                                                               |             | LD liaison team has a patient alert system for all known patients with LD.                                                                  | Mark Shiller manages workspace. The LD Liaison team input onto LD patient list.                                   | Completed in set up but ongoing.                                                                                                                                                                   | LD annual report will show statistics on referral source, highlighting those referred through alerts.                                                                                                           | More patients who are not referred by the ward or community will be brought to the liaison team's attention.           |
|                                                                                                                                                                                                                                               |             | Specific LD risk/dependency assessment completed for patients admitted over 48hours. CQUIN target relating to this agreed with NHS Bristol. | Completed and disseminated to some wards. Ongoing and other area such as St.Michael's and the BGH need more input | All wards in the main building to have risk assessment on ward and a poster with risk assessment location and referral information by May 2010. St. Michaels and BGH to have these by Winter 2010. | Ongoing LD awareness training offered to staff teams as well as support and training in using the risk assessment. Use of risk assessment is reflected in CQUIN data collection and subsequent audit (ongoing). | Patients with an LD will have specifics areas of vulnerability assessed and therefore care can be planned accordingly. |

|                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                         |                                                                                                                                                           |                                                                |                                                   |                                                                                                                                                                    |
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| <b>(Contd)</b><br><b>1: Does the trust have a mechanism in place to identify and flag patients with LD and protocols that ensure that pathways of care are reasonably adjusted to met the health needs of these patients?</b><br><br><b>(Currently score 3)</b> |  | Joint working with community teams and care providers prior to admission.                                                                                                                                                                               | LD liaison                                                                                                                                                | Ongoing                                                        | Annual report                                     | Joined up working and better pre-admission planning.                                                                                                               |
|                                                                                                                                                                                                                                                                 |  | Link in with LD link nurse on certain wards.                                                                                                                                                                                                            | LD liaison                                                                                                                                                | Ongoing                                                        | Annual report                                     | More person centred care on ward and early referral.                                                                                                               |
|                                                                                                                                                                                                                                                                 |  | Joint work with CLDT's to develop a more comprehensive data base of people with LD for alert system.<br>(GP lists in community now developed from DES framework).                                                                                       | LD liaison<br><br>NHS Bristol have sent a letter to GP alerting them of our service. Also the LD liaison service is on BCH Learning disabilities website. | March 2010 for data collection.<br>Summer 2010 for data entry. | Data on alerts to be presented in annual reports. | Comprehensive picture of the number of patients with an LD using UHBristol services.<br><br>Would pick up those patients not referred to the team for early input. |
| <b>2: In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005) does the trust provide readily available and comprehensive information?</b>                                                                                   |  | LD liaison team have developed a grabsheet (produced through joint working with people with LD) and promote this to care homes as well as increasing the awareness of ward staff to various communication passports/books etc in use around the county. | LD Liaison Team                                                                                                                                           | Documents completed but ongoing dissemination.                 | Annual report.                                    | Improved handover of relevant information from the community to the hospital. Reduces vulnerability of the patient.                                                |
|                                                                                                                                                                                                                                                                 |  | Development of a library of accessible resources through                                                                                                                                                                                                | LD liaison Team                                                                                                                                           | Dependant on staffing levels                                   | Annual report.                                    | Would improve person centred health education                                                                                                                      |

|                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                        |                              |                                                                                   |                   |                                                                                       |
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| <b>(Currently score 2 but better in certain areas such as cardiac services where 3)</b>                                                                                                                                                |  | collection of all accessible resources already in circulation at the trust and national NHS documentation and developing links with accessible information groups within the local CLDT's and patient involvement groups to highlight and fill gaps in the resources.                                  |                              |                                                                                   |                   | and promotion and support patients capacity to consent to procedures.                 |
| <b>3: Does the trust have protocols in place to provide suitable support for family carers who support patients with LD, relevant legislation and carers rights.</b><br><br><b>(Currently score 3/4) – protocol is not LD specific</b> |  | LD team support family as required.<br><br>The PALS & Complaints policy provides those who are unable to complain themselves due to disability. The Trust's Public Involvement Facilitator is working with hard to reach groups to develop conduits for these communities to interface with the Trust. | LD liaison Team<br><br>PAL's | Ongoing<br><br>Ongoing                                                            |                   | Mechanism of support and feedback between the trust and carers of people with and LD. |
| <b>4: Does the trust have protocols in place to routinely include training on LD awareness, relevant legislation, human rights,</b>                                                                                                    |  | No formal protocol in place. Bespoke training offered by LD liaison team as and when required to various hospital staff. LD awareness raising sessions are in conjunction with a health trainer with LD. Not currently part of induction programme.                                                    | LD liaison team.             | As requested or highlighted (currently limited staffing capacity for development) | Reported annually | Improved awareness of LD, communication and in turn better patient care.              |

|                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                               |                                               |                                                                                                     |                                                                                                                                                                                    |
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| <p><b>communication techniques, and person centred approaches to their staff development and/or induction programme for all staff?</b></p> <p><b>(Currently score 2) minimal implementation</b></p>                                                                                                                           |  | <p>Review the need for a formal protocol.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p>LD Liaison team</p>                                                        | <p>July 1<sup>st</sup> 2010</p>               |                                                                                                     | <p>Improved education and awareness of patients with LD.</p>                                                                                                                       |
| <p><b>5: Does the trust have protocols in place to encourage representation of people with LD and their family/carers within the trust boards, local groups and other relevant forums, which seek to include their views and interests in the planning and development of services?</b></p> <p><b>(Currently Score 3)</b></p> |  | <p>Most involvement is in isolated projects rather than ongoing dialogue.</p> <p>Joint working with local health groups run by people with LD for feedback on resources developed by the LD liaison team.</p> <p>All new Foundation members will be asked if they would like to be consulted on issues concerning LD. At present there are 630 individuals who are linked in this way on the special interest list to the more generic category of 'Disabilities/ethnicity'</p> <p>Involvement of local 'access' groups including those with</p> | <p>LD liaison</p> <p>Trust membership committee.</p> <p>BRI redevelopment</p> | <p>As required</p> <p>2010</p> <p>ongoing</p> | <p>Annual report</p> <p>Foundation Trust Membership reports</p> <p>Related reports and planning</p> | <p>SU involvement ensuring the resources produced are appropriate.</p> <p>Better involvement of interested board members.</p> <p>A more accessible and appropriate service for</p> |

|                                                                                                                                                                               |  |                                                                                                 |                                                |        |                                            |                                                                                                                           |
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|                                                                                                                                                                               |  | LD (people First Advocacy group) in the BRI redevelopment project                               | Project                                        |        |                                            | people with LD.                                                                                                           |
| <b>6: Does the trust have protocols in place to regularly audit its practise and to demonstrate the findings in routine public reports?</b><br><br><b>(Currently score 4)</b> |  | LD annual report demonstrates developments and data and identifies barriers to achieving goals. | LD liaison team                                | Annual | Annual report. Trust Executive Report.     | Allow the trust to identify when initiatives are not working and the barriers to achieving them.                          |
|                                                                                                                                                                               |  | CQUIN data collection and reporting to the PCT on percentage of target being met.               | LD liaison team, data analyst and NHS Bristol. | Annual | CQUIN annual report.                       | Achievement of CQUIN could enable financial reward to be placed back into the LD service to develop accessible resources. |
|                                                                                                                                                                               |  | Audit of risk assessment use within the trust to demonstrate if targets are being met.          | LD liaison team and UHBristol Audit team.      |        | Formal audit data results to be presented. |                                                                                                                           |

- 
1. Sir Jonathan Michael (2008) Healthcare for all: Report of the independent enquiry into access to healthcare for people with learning disabilities. Aldridge Press: London
  2. Mencap (2007) Death by Indifference. Mencap: London
  3. White, J and Abraham, A (2009) Six Lives: The provision of public services to people with learning disabilities. Parliamentary and Health Service Ombudsman:

#### 4. CQC targets: Possible mechanisms for Improvement:

| Mechanism of improvement                                                                                                                                                                                                                                                                                                                                                                                                                                        | Resources required                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Outcome 1:</b><br/>Development of an outpatient's pathway including process when patient lacks capacity (i.e: one stop appointments may not be appropriate to gain consent) through joint working with clinic organisers and specialist nurses.</p> <p>Greater involvement in Transition planning within the hospital and local community,</p> <p>To be able to offer Learning Difficulties Liaison for the Trust Mon –Fri (9-5) throughout the year.</p> | <p>This is within the capacity of current team and joint working with Matron for OPD.</p> <p>Systems to facilitate communication more easily between secondary and primary care.</p> <p>This is not currently achievable with funded 1 wte post as no cover for annual leave, or training.</p> |
| <p><b>Outcome 2:</b><br/>Link in with QDU and other specialities as well as staff producing patient information to develop more accessible resources for patients and promote our library of resources to the hospital staff.</p>                                                                                                                                                                                                                               | <p>LD nurse and patient information department time.</p> <p>Requires purchase of software 'Communication in Print' to aid making information accessible.</p> <p>Support form CLDT staff (especially SALT assistant for delivery of training).</p>                                              |
| <p><b>Outcome 3:</b> No identified gap.</p>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                |
| <p><b>Outcome 4:</b><br/>Introduction to LD training as part of staff induction.</p>                                                                                                                                                                                                                                                                                                                                                                            | <p>Corporate training and development team to include awareness of LD in induction programme.</p>                                                                                                                                                                                              |
| <p>Learning disabilities training as part of NVQ or PDR communication objectives.</p>                                                                                                                                                                                                                                                                                                                                                                           | <p>Liaison with Corporate training and development team in include in NVQ programmes, delivery by LD or training team.</p>                                                                                                                                                                     |
| <p>A more structured rolling programme of training on wards including the General and St Michaels for use of Risk Assessment Tool.</p>                                                                                                                                                                                                                                                                                                                          | <p>Within capacity of current LD team and local delivery of training package.</p>                                                                                                                                                                                                              |
| <p>Organise a training day for carers and community support services on planning for and supporting service users in hospital (their roles and responsibilities/important contacts).</p>                                                                                                                                                                                                                                                                        | <p>Within capacity of current LD team.</p>                                                                                                                                                                                                                                                     |
| <p><b>Outcome 5:</b><br/>Involvement of people with LD within the Trust PPI agenda.<br/>Increased involvement of LD nurse in community partnership boards and health groups as appropriate</p>                                                                                                                                                                                                                                                                  | <p>PPI strategy</p> <p>Within capacity of current LD team.</p>                                                                                                                                                                                                                                 |
| <p><b>Outcome 6:</b><br/>No identified gap.</p>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                |

## 5. UHBristol – The Learning Difficulties Service

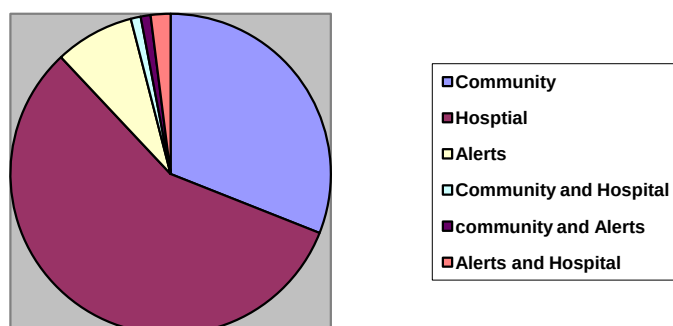
- 5.1 As a Trust we demonstrate commitment to the improvement of care for our patients who also happen to have a learning disability. Our Charitable Trustees funded a Learning Disability project nurse in 2003. The outcomes of the project included a resource folder for clinical staff and a website. During the project training was delivered and the needs of a caseload met.
- 5.2 This project demonstrated the benefit of this specialism in the skill mix of the Trust and following on from this the post of Learning Difficulties Specialist Nurse gradually became a full time post, and was made a permanent position in 2009. This post was previously funded through a local advocacy group and Bristol PCT but is now funded through a delivery plan with NHS Bristol.
- 5.3 The service has been extremely effective from a clinical governance perspective. The nurses mitigate risk, improve knowledge in teams and support highly complex patients and their carers, plus ensure seamless care with community services. Teaching for all staff and all professions is a vital part of the role in order to improve the care we offer. Please see attached vignettes for example of the work undertaken by the team.
- 5.4 As the benefits to patient care and safety tend to be difficult to quantify the savings can not be demonstrated financially however the team do avoid the occasional readmission through supporting discharge planning and failed day case through better planning and communication.
- 5.5 The service is overseen by a joint UHBristol, NHS Bristol and Bristol Community Health. These meetings are hosted by the Division of Medicine.

## 6. Current Service Provision

- 6.1 The service is now well known both by the Trust, community home, carers and the patients themselves. **Referrals to the Learning Difficulties Team have increased from 80 (2007/2008), to 102 (2008/2009) to a projected 140 (2009/2010).**

Liaison nurses in other areas identify that they struggle to raise awareness of their service in the acute sector and instead receive most of their referrals from community teams. However during the first 6 month period 46 of the 68 referrals we received were from within non LD specialist services at University Hospitals Bristol.

### Referral Source April 2009 – October 2009



- 6.2 **Targets and Audits:** The LD service has not previously had specific targets but has aimed to work to the recommendations of reports such as the Michael Report (2008).

In April 2009 we launched the Learning Disabilities Risk Assessment trustwide and agreed to a CQUIN target with NHS Bristol. If reached this will result in financial reward for the Trust which will hopefully be channelled back into resources for patients with a Learning Difficulty. To evidence the CQUIN work the team is working closely with the Trust's Audit and Governance teams.

The CQUIN data is completed for patients where English is the first language; however we have been ensuring that the needs of patients from all nationalities are catered for by working closely with their community learning disabilities services.

Joint working with wards to assess the vulnerability of patients soon after admission has enabled all involved to identify and predict areas of risk early on, and adjust care accordingly with an obvious benefit to the patient. Of the 135 referrals so far this year 73 have been patients admitted for greater than 48 hours. Over 80% of these patients have had the risk assessment completed for them. Reasons for non completion have been that the patient was discharged before being seen by the team.

Although it has ensured a much more equitable service for inpatients, and ultimately ensured that care can be adjusted appropriately for patients early on, this risk assessment has put large demands on the clinical input from the LD service. This has limited the ability of the team to contribute to other certain areas of service development such as training and transition. The service now being subject to formal hospital targets has contributed to an increased awareness of the service and probably the referrals to our team.

The formal Audit for this data will be available in April 2010.

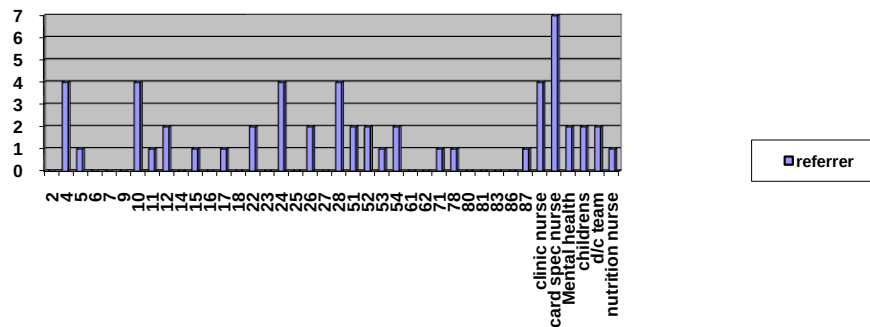
- 6.3 Alerts:** Through our input and liaison with community services a list of patients has been developed, who may need support from our services and the team are now alerted via email when they are admitted. This means that input is not reliant on a ward referring to our service. It also means that we can proactively support the patient from the beginning of their admission, rather than further along when problems arise. Over the previous year the clinical alerts have picked up several patients that wards had not referred to us and this is increasing as the list grows. There is not always have input with these patients but can ensure that the ward is aware of, and is comfortable in completing the risk assessment and supporting that patient well.
- 6.4 Clinical input:** As well as developing systems to support patients with learning difficulties when they use UHBristol the LD team also spends a majority of clinical time assessing the needs of individual patients and supporting them as required. The nurses develop accessible resources as required as well as increase patient's 1:1 support around vulnerable periods. (Please see examples of input at the end of the report). The team works very closely with community learning difficulties services to try and ensure appropriate discharges and continuity of care. Also supporting patients and their families in transition from the child to adult service, often joint working with the PAL's team.
- 6.5 Capacity and Consent:** The team act as experts on advising staff about Learning Difficulties services, specific health conditions and issues surrounding capacity, consent and best interest decisions. We work closely with the patients to try and enable them to give informed consent through personalised accessible information, repetition and supporting staff with communication. There is also close working with Bristol IMCA service and highlight the need for representation for patients when appropriate.
- 6.6 Teaching:** A significant amount of training and support takes place on the ward in the form of ad-hoc teaching, role modelling, and facilitating communication which is essential to the development of staff skills. There is also co-ordinated formal training on wards and A&E if requested or



identified as a need. Formal training delivery is assisted by a Co-trainer with Learning Difficulties employed by NHS Bristol.

**6.7 Prioritising need.** Because of resources the focus of our attention on has been on areas that patients with learning difficulties are most likely to be admitted (cardiac, respiratory, medical). This has been successful and is demonstrated by the snapshot of referral data. This has helped to highlight gaps in the service and as can be seen by the diagram there are limited referrals/input in areas such as gynaecology and The General hospital.

### Referring wards April 2009 – October 2009



6.8 **Arrangements** trustwide for the Safeguarding of Adults have been strengthened through a Steering Group with Executive Leadership. The Learning Difficulties service is a key part of the groups' function to improve the care given and will contribute to the achievement of the 2010/11 work plan. This work plan will be monitored through the Trust Operation Group.

**6.9 Appendix 1 describes three patient case studies where the LD team became involved.**

## 7. Conclusions.

7.1 People with a Learning Disability present many challenges when coming into acute care and their needs are likely to be complex. Their pattern of health needs is different and this needs to be understood.

7.2 Various mechanisms have been developed within the Trust to ensure that patients with a Learning Difficulty are identified early on and that care needs can be individualised and vulnerability minimised. These have proved very successful. These systems are proving especially effective in specialist areas where many patients with a Learning Difficulty are admitted (for example Cardiac and respiratory). However the effectiveness of these systems is not even throughout the trust and more input is required to ensure the same service is available trust wide.

7.3 The Trust has developed some accessible resources and professionals often produce them as required for patients, as well as frequent formal and informal teaching. However to further develop areas of accessible information and training as suggested by the CQC self assessment would require additional resources in the form of staff hours, or would mean reducing the amount of clinical input the Learning Difficulties team are able to give to patients.

7.4 Representation of people with Learning Difficulties in trust decision making and planning is an area under development. Currently most involvement is project based rather than being consistent. Increased liaison with local health groups is important for inclusion of this patient group's needs in the Trust.

- 7.5 With increasing referrals and a static staffing level development of areas such as training and accessible information is unlikely to be achieved without compromising the success of the mechanisms already put in place to support patients. As well as increasing risk for patients if these mechanisms are not supported it could prevent agreed targets such as the CQUIN being met and in turn prevent those funds being channelled back into the service for patient benefit. The Division of Medicine will be leading a cross-divisional bid for additional LD resources.
- 7.6 Awareness about the vulnerability of this group when in acute care must be continually raised and we must recognise that reasonable adjustments will be necessary in certain cases to provide safe delivery of care. Improving the quality of care for this group of people is everyone's responsibility.
- 7.7 Governance arrangements monitoring progress against self assessment have been clarified. The Trust Operational Group will be responsible for this in the first instance. Assurance will be gained through the existing Clinical Risk Assurance Committee. This may be reviewed in light of a newly formed Quality Committee.**

## **Appendix 1**

### **Examples of patient input.**

#### **Patient A**

A was admitted with recurrent aspiration pneumonia as a result of a deteriorating swallow associated with advanced dementia. Her family and care home had a limited understanding of how unwell A was and her future prognosis.

We liaised closely with her care home, family and ward staff and ensured that there were several opportunities for their views and wants' to be expressed in best interests meetings. We helped them explore various options including short term NG feeding alongside palliative care in her home environment. Unfortunately W was too unwell to participate in the decision making, but those close to her were.

By ensuring good communication and following the framework set out by the mental capacity Act 2005 we were able to ensure that end of life planning was appropriate and that decisions were made in the best interests of A. It also enabled those close to her to have a good understanding of what could and could not be done for A, helping them to cope with her loss when she died several weeks later in her own home.

A very similar scenario a year previously within the trust had resulted in a formal complaint and investigation as those involved had not been given the forum or opportunity to communicate, understand and plan end of life care.

#### **Patient B**

Patient B was admitted following collapse from a probable bleed and general recent decline. He was written up for palliative care and as not being appropriate for further investigations (he apparently would not cope with them).

We liaised with the ward and ensured that B had an IMCA allocated to advocate for him during his admission. We pushed for and supported B with further investigations which showed a massive brain tumour. This was unfortunately inoperable but we ensured that this decision was not based on his pre-existing Learning Difficulty and that he received the same investigations as anyone else.

Due to his confusion about his environment B was being heavily sedated on ward. He was also eating minimal amounts and engaging in minimal physiotherapy and activities because of the degree of support he required. We supplemented the ward's time and requested and were granted extra HCA hours for B to reduce his vulnerability and his sedative medications. We helped the ward in identifying the cause of his distress which was usually constipation and he required several episodes of intervention around this which were often missed by the ward as his behaviour was misinterpreted.

As B was now too disabled to return home our team worked closely with B and all those who knew B to ensure that he was placed in an appropriate environment. We fought for him to move to a learning difficulties specific home with CHC funding to ensure that he had the best chance of rehabilitation possible.

#### **Patient C**

Patient C came to A&E with a suitcase demanding that he stay at the hospital for respite else he would kill himself.

Alongside the mental health team we assessed his mental state and liaised with community services and his support workers to ensure that he would be safe on discharge. C's concerns were around his social circumstances and it was decided that he did not have any intent to harm himself and he was not mentally unwell. We gave him a forum to talk and created a care plan to minimise the risk of an overdose on discharge. We ensured that he would have follow up at home from Learning Difficulties services.

C went home with his wife and an unnecessary admission was avoided. The long term result of this was that his wife and C ended up having significant input from the community teams, which may not have otherwise occurred.