University Hospitals Bristol NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC

Date: Tuesday 31 March 2015
Time: 11.00 am – 13.00 pm
Venue: Conference Room, Trust Headquarters

Distribution:

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

*Agenda and Minutes only

Contact for apologies or any enquiries concerning this meeting should be made to:

Isobel Vanstone, Corporate Governance Administrator, Trust Headquarters. Telephone: 0117 34 23602
Email: isobel.vanstone@uhbristol.nhs.uk

University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for the Meeting of the Trust Board of Directors held in Public
To be held on 31 March 2015 at 11.00am – 1.00pm
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page No*
1. Chairman's Introduction and Apologies To note apologies for absence received	Chairman	
2. Declarations of Interest To declare any conflicts of interest arising from items on the meeting agenda	Chairman	
3. Minutes from previous meeting To approve the Minutes of the Board of Directors Meeting held in public on 27 February 2015	Chairman	4
4. Matters Arising (Action log) To review the status of actions agreed	Chairman	13
5. Chief Executive's Report To receive the report from the Chief Executive to note	Chief Executive	14
Delivering Best Care and Improving Patient Flow		
6. Patient Experience Story To receive the Patient Experience Story for review	Chief Nurse	18
7. Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Quality and Outcomes Committee Chair's report c) Board Review – Quality, Workforce, Access	Deputy Chief Executive/ Director of Strategic Development	25
8. Preparation for Annual Quality Report (Quality Account) including Draft Corporate Quality Objectives for 2015/16 To receive the report for assurance	Chief Nurse	120
9. Quarterly Complaints & Patient Experience Reports To receive the reports for assurance a) Quarterly Complaints and Patient Experience Report b) Bristol Eye Hospital Patient Experience Update Report c) Actions relating to low Patient Scores on Maternity and Postnatal Wards	Chief Nurse	131
10. National Staff Survey Results To receive the report for assurance	Director of Workforce & OD	180

Delivering Best Value		
11. Finance Report To receive the report for assurance	Director of Finance & Information	203
12. Finance Committee Chair's Report To receive the verbal report for assurance	Finance Committee Chair	
Compliance, Regulation and Governance		
13. Monitor feedback on Quarter 3 submission against the Risk Assessment Framework To receive the feedback for assurance	Chief Executive	222
14. Audit Committee Chair's Report To receive the verbal report for assurance	Audit Committee Chair	
Information		
15. Governors' Log of Communications To receive the report to note	Chairman	227
16. Any Other Business To consider any other relevant matters not on the Agenda	Chairman	
Date of Next Meeting of the Board of Directors held in public: 30 April 2015, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU		

University Hospitals Bristol NHS
NHS Foundation Trust

Unconfirmed Minutes of the Meeting of the Trust Board of Directors held in Public on 27 February 2015 at 11:00am, Conference Room, Trust Head Quarters, Marlborough Street, BS1 3NU

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

Present or in attendance:
Debbie Henderson – Trust Secretary
Penny Hilton – Fast-Track Executive
Aidan Fowler – Fast-Track Executive
Fiona Reid – Head of Communications
Sue Silvey – Public Governor/ Lead Governor
Tony Tanner – Public Governor
Angelo Micciche – Patient Governor
Pauline Beddoes – Public Governor
Florene Jordan – Staff Governor
Brenda Rowe – Public Governor
Clive Hamilton – Public Governor
Pam Yabsley – Patient Governor
John Steeds – Patient Governor
Wendy Gregory – Carer Governor
Jeanette Jones – Appointed Governor
Sue Milestone – Carer Governor
Thomas Davies – Staff Governor
Chris Taylor – Trust Member
Phoebe Syme – Staff Member
Helen Cain – Staff Member
Natasha Joshi – Staff Member

80/02/15 Chairman's Introduction and Apologies
Apologies for absence were received from Lisa Gardner (Non-Executive Director)

81/02/15 Declarations of Interest
In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. No new declarations of interests were received.

82/02/15 Minutes and Actions from Previous Meeting
The Board considered the minutes of the meeting of the Board of Directors held in public on 29 January 2015 and approved them as an accurate record, subject to the following:
Page 7 – it was agreed to delete the reference to 'no evidence to support complaints due to the failure to deliver the Referral to Treatment standard' and Carolyn Mills confirmed that a high number of complaints received were due to cancelled operations.

Following a query from Emma Woollett regarding a request for reassurance in relation to quota management, Robert Woolley confirmed that the current methodology cannot be guaranteed as this is dependent on contract negotiations with the Commissioners. Robert did however confirm that if the Board are required to revisit the methodology, all financial implications would be considered.

Carolyn Mills referred to page 10 and it was agreed that the final paragraph should read "capacity" not "admissions". It was:

RESOLVED:
- **That the minutes of the meeting held 29th January 2015 be agreed as an accurate record of proceedings, subject to amendments outlined in the minutes**

83/02/15 Matters Arising
Matters arising and actions complete were noted by the Board. Emma Woollett referred to an action from the previous meeting relating to a review of the Board of Directors Code of Conduct and it was agreed that the action be included on the action log. It was:

RESOLVED:
- **That an action relating to a review of compliance of a Code of Conduct for Board members be included on the action log**

84/02/15 Chief Executive Report
Robert Woolley referred to the Trust's performance against Monitor's Risk Assessment Framework and noted clear progression with regard to Referral to Treatment Times (RTT) against the recovery trajectory. A&E performance and cancer waiting times remained challenging and Robert emphasised the need to demonstrate improvement as a Trust as well as system-wide. Monitor are holding the Trust to account for driving this improvement and had asked Robert and John to demonstrate this prior to making a decision about whether to move to formal assessment.

Robert referred to the significant uncertainty regarding the development of plans for 2015/16 including recovery plans and noted that these were conditional on contract negotiations with the Commissioners. The Board had agreed to delegate authority to Robert to respond to the proposals around the enhanced tariff offer.

Robert briefed members of the Committee on the National Staff Survey Results from 2014, which were noted in the Board meeting held in private due to the embargo until Tuesday 24th

February. Questionnaires were distributed on a census basis to all substantive staff as opposed to the default approach of surveying 850 members of staff. 3,641 people took part in the survey which reflected a response rate of 47%. Robert noted that the results were disappointing particularly in relation to staff engagement and acknowledged the potential impact of national issues, particularly related to pay and pensions, on staff experience.

Robert referred to the Savile Enquiry report and noted a number of recommendations for consideration by health care providers related to safeguarding vulnerable adults and children and how the Board receive assurance that appropriate safeguards were in place. The action plan and assurance would feed into the Trusts governance processes and be fed back to the Board in due course. In response to a question from Sue Milestone regarding robust management of volunteers, it was confirmed that the Trust had appropriate safeguards in place for the recruitment and management of Trust wide volunteers. It was:

RESOLVED:

- **That the Board receive the Chief Executive's Report to note**
- **That the action plan and assurance report in response to the Savile Enquiry be submitted to the Board for assurance**

85/02/15 Patient Experience Story

Carolyn Mills provided an overview of the patient story which referred to a patient who had anxieties prior to admission to hospital. Carolyn referred to elements of good practice and learning regarding the confidence of staff to listen to patients and acknowledge their feelings and anxieties and the importance of this in terms of patient experience.

In response to a query from John Moore regarding sharing the good practice and recognition, Carolyn confirmed that teams would be contacted personally including those who were personally involved in the patients' care. Deborah Lee also confirmed that any positive feedback is shared with teams at divisional level. It was:

RESOLVED:

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

86/02/15 Quality and Performance Report

Overall Performance

Deborah Lee presented the report and noted improvement with regard to Referral to Treatment times and meeting the Trust's trajectory. Deborah referred to the Standardised Hospital Mortality Index (SHMI) score for November and the indicator moving to a red rating and confirmed that the December figures have restored the indicator to a green rating. Investigations are still on-going with regard to the deterioration in November and noted that the expected death rate against which actual death rate is compared for November appeared exceptionally low.

Same sex accommodation breaches during the period had been due to exceptional pressures within the Emergency Department and patients queuing for a significant period of time. The breaches were incurred in order to prevent patients having an unnecessarily prolonged stay in the Emergency Department. Deborah confirmed that breaches were unlikely to recur.

Deborah reported that although the level of emergency re-admissions in the period had moved the indicator to a red rating, the indicator remained green rated for the year to date. The Trust continues the significant work to review emergency readmissions.

Patient complaints had moved from Amber to Red rated and Deborah confirmed that the divisions continued the analysis and reassured members of the Board that there were no emerging themes.

Deborah emphasised the current pressure with regard to the operational environment and what this meant for patient flow and noted that failure in six indicators was unacceptable. Although the recovery trajectory for Referral to Treatment times was being met, Deborah noted hot spots with regard to some specialities. However, she provided reassurance to the Board that these had been acknowledged by re-setting the trajectories in line with realistic objectives.

Quality and Outcomes Committee Chair's Report

Alison Ryan referred to a discussion at the Committee regarding the actions and initiatives outlined in the access recovery plan and noted the lack of evidence for which actions had impacted on patient flow or led to improvement. Alison asked for activity to be reported in terms of actual numbers as well as percentages so that the Committee could establish whether the Trust was being more effective in managing flow than before.

The Committee analysed in detail the Trust's recent never events, all of which related to wrong tooth extractions and Alison noted that the Trust are undertaking an internal review and are working with Manchester Dental Hospital to review how incidents can be avoided in the future.

Alison referred to the monthly nurse staffing report and queries from Non-Executive colleagues regarding impact of variances of staffing and noted that the Committee received assurance that the risk was mitigated through the use of bank and agency staff. The Committee received assurance that the staffing levels across the organisation were safe.

The Committee received the Care Quality Commission internal 'must do' action plans and Alison confirmed that the system-wide action plan would be received at the March meeting.

Alison referred to concerns regarding progress against key performance indicators related to workforce, particularly in relation to turnover figures and those members of staff who leave the Trust with no job to go to. The Committee was keen to support a focus on action and outcomes and would use insight from the staff survey and other staff feedback mechanisms including information from exit interviews, with a view to identifying national and local issues which could be addressed. Alison also referred to Board level discussions to focus on improving staff experience and looking at the pace of which the Trust could demonstrate the impact of the many workforce initiatives on-going.

Alison also noted that a meeting had taken place with Clive Hamilton, Governor Lead for the Governors' Quality Project Focus Group to discuss alignment between the group and Quality and Outcomes Committee in the future.

Quality and Access

With regard to the Never Events, Deborah Lee briefed the Board on progress in terms of implementing some of the lessons learnt from the Manchester review. Deborah confirmed that this was an improvement agenda and provided reassurance that a number of actions had

already been implemented. Deborah also confirmed that no single factor had contributed to the cause of the incidents in terms of systemic issues in relation to systems, process and culture in the Dental Hospital.

James Rimmer provided an update regarding the Trust's period of planned failure for Referral to Treatment times and the Trust's focus to remain on track to deliver the recovery trajectory. Deborah Lee provided detail regarding activity undertaken to address issues relating to backlog. The Trust now had in place a team of external validators, to facilitate validation of all patients in the Referral to Treatment times backlogs. This had been supplemented by support from a national team; a significant number of ongoing pathways were being closed down as a result of the validation. In response to a query from John Moore, Deborah Lee confirmed that cases will cease to be added to the backlog from March.

Carolyn Mills highlighted the improvements in the dementia CQUIN performance metrics following the go-live of the electronic solution. Deborah Lee noted a concerted effort in terms of support provided by nursing teams to deliver the project as a good example of strong working between corporate and divisional teams.

In response to a query from Emma Woollett related to grade 3 pressure sores, Carolyn confirmed that this remained a constant focus of attention with each case being closely analysed in terms of possible prevention.

In response to a query from Wendy Gregory regarding incident number 2015 811 and timescales of incident reporting, Alison Ryan confirmed that the Quality and Outcomes Committee dedicated a significant amount of time looking at delays and lessons learnt from serious incidents particularly embedding of lessons learnt. Carolyn Mills also confirmed that all serious incidents were reported within 72 hours to identify any immediate actions. Clive Hamilton confirmed that the serious incident report would be reported to the Governors Quality Project Focus Group from March to receive further assurance.

In response to a comment from Clive Hamilton regarding the importance of managing backlogs, John Savage briefed the Board on the previous discussion undertaken at the Board meeting held in private and the Board's focus on patient care first and foremost. Deborah Lee noted that work was on-going to develop dashboards for 2015/16 and backlogs would be incorporated as part of the review.

<u>Workforce</u>
Discussed under agenda item 87/02/15. It was:

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

87/02/15 Quarterly Workforce Report
Sue Donaldson presented the report and stated that the Trust continued to focus on recruitment and retention in terms of opportunities, challenges and risks. The number of substantive nursing posts had increased and although the vacancy rate was 6%, this compared favourably with available benchmarks. High turnover rates were particularly evident with regard to nursing assistants and speciality areas.

With regard to bank and agency use, Sue noted that some of this had been funded by the Operational Resilience funding, and noted that strong controls remained in place. Sickness

absence had increased to 4.5%, compared to 3.7% for quarter 3. Although there was a seasonal pattern, there had been an earlier than usual peak in colds and flu related absence.

Sue noted that compliance with essential training formed part of the Trust's CQC internal action plan and noted the positive impact following the introduction of e-learning and the importance of working with, and supporting divisions to achieve the target of 90%.

Sue took an opportunity to brief members of the Board on the Staff Survey results from 2014, which were embargoed until Tuesday 24th February and emphasised the importance of the Board receiving the headlines at an early stage, and referred to areas for improvement including staff engagement. A full report and action plan would be submitted to the April meeting of the Board.

Jill Youds referred to the vacancy benchmarking, particularly with regard to Nursing Assistants and noted discussions undertaken at Finance Committee regarding the impact on income in terms of theatre capacity as well as backlogs. Sue confirmed that theatres had received the appropriate level of attention however, emphasised the need to avoid looking at recruitment in isolation. Sue briefed members of the Board on the on-going work with regard to supporting recruitment and retention including marketing campaigns, bespoke open days, and exploring options related to international recruitment.

In response to a query from Jill Youds, Sue confirmed that the outcomes following improvements to exit arrangements would be included in the next report.

John Moore requested an update on e-rostering in light of the reduction in use of bank and agency staff. Carolyn Mills stated that a report had been previously presented to the Finance Committee outlining the key performance indicators relating to e-rostering. The report examined capacity to identify variations and reasons for this.

In response to a query from Graham Briscoe regarding health and safety and the link to safeguarding, Carolyn Mills confirmed that safeguarding issues were reported monthly via the divisions and were monitored via the Trust's Safeguarding Board.

Following a query from David Armstrong regarding the format of the report, Sue Donaldson noted that the narrative style of the report had been previously welcomed by the Board. The key performance indicators were reported monthly via the Quality and Performance Report. Sue also confirmed that a corporate plan was in place, monitored via Workforce and OD Group and reported into Senior Leadership Team. It was:

RESOLVED:

- **That the Board receive the Quarterly Workforce Report for assurance**
- **That the Board receive the response from the National Staff Survey**
- **That the outcome of the new exit arrangements be included in the May report**

88/02/15 Partnership Programme Board

Robert Woolley referred to the Partnership Programme Board update which detailed activity related to the partnership agenda between University Hospitals Bristol and North Bristol NHS Trust. In response to a query from Julian Dennis regarding ALAMAC, Robert Woolley noted that there had been no evidence of performance improvement as a result of the introduction of ALAMAC, but a request for detail of learning from elsewhere had been made. It was:

RESOLVED:

- **That the Board receive the Partnership Programme Board update to note**

89/02/15 National Accident and Emergency Patient Experience Survey

Carolyn Mills presented the report and referred to the action plan developed in response to the outcomes of the survey. The report highlighted positive results in relation to patient experience in A&E with 33 out of 35 questions in line with the national average or better.

Carolyn referred to a comment raised at the Quality and Outcomes Committee relating to the action to implement a patient survey on a monthly basis and the risk of negative feedback as a result of survey fatigue for patients. Carolyn noted the comments, and it was agreed to continue the development of the survey and monitor feedback.

James Rimmer noted the positive feedback, particularly taking consideration the current pressures on the Emergency Department Teams and noted that correspondence had been sent to the team on behalf of the Senior Leadership Team.

Jill Youds referred to concerns regarding patient experience and safety and James confirmed that learning had been taken into consideration with regard to a checklist approach for patients during the discharge process. Further work would be undertaken with regard to security issues particularly out of hours. John Savage requested that James pass on the Board's appreciation to the teams involved. It was:

RESOLVED:

- **That the Board receive the National Accidence and Emergency Patient Experience Survey for assurance**

90/02/15 Finance Committee Chair's Report

In the absence of Lisa Gardner, Finance Committee Chair, Jill Youds provided the Committee chairs report and noted that a paper had been received regarding service line reporting. With regard to the Trust's Reference Cost Index (RCI), Jill noted that the RCI had been increasing year-on-year resulting in an overall deterioration in cost efficiency. Training had been offered to divisions to enhance clarity of ownership and to improve divisional efficiency.

The Committee received an update on the Trust's financial plan for 2015/16 with the overall position being reported as relatively stable however, the Committee received an update regarding uncertainties in relation to the national tariff and activity levels for RTT.

A discussion took place with regard to Operational Resilience Funding and this being offset against contract penalties. The Divisional Finance Manager for Medicine had attended and had provided assurance regarding a strong set of actions to recover their financial position.

Concern was raised in relation to cost savings and the number of red rated workstreams and the need for a set of more achievable savings was acknowledged.

Alison Ryan queried ownership arrangements with regard to savings plans and James Rimmer confirmed that as Chief Operating Officer, he had overall responsibility for working with the divisional teams. James also confirmed that all divisions hold monthly meetings as

well as regular divisional finance meetings. Robert Woolley noted that ownership was reflected in the Finance Report within the risk table.

John Savage noted that a Board Development Session would be held on the afternoon of 27th February to discuss the Financial Plan for 2015/16 in further detail. It was:

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

91/02/15 Finance Report
Paul Mapson presented the financial report and noted that the Trust remained on target to deliver the planned surplus of £5.8m for the year. Activity had been slightly underachieved in January but Paul noted that this was likely to improve in February and March. It was:

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

92/02/15 Emergency Preparedness Annual Report
James Rimmer presented the report which detailed the Emergency Preparedness, Resilience and Response (EPRR) activities undertaken by the trust during 2013/14 and described the work plan for 2014/15 that would be used to ensure the Trust was compliant with EPRR core standards. The report provided internal and external assurance and James made particular reference to live exercises and reassured the Board that all outstanding issues had been addressed and the Trust remains in a strong position.

With reference to page 4 of the report, Alison Ryan noted that the NHS Emergency Planning Guidance 2013 should be reported to the Quality and Outcomes Committee. It was agreed that this would be included in the forward planner.

Following a query from Graham Briscoe, Robert Woolley confirmed that both he, as Chief Executive and John Savage as Chairman were up to date with media interview training and had access to additional training as and when required. It was:

RESOLVED:
- **That the Board receive the Emergency Preparedness Annual Report for assurance**
- **That the NHS Emergency Planning Guidance 2013 be included in the forward planner for the Quality and Outcomes Committee**

93/02/15 Report from the West of England Health Science Network
Robert Woolley referred to the quarterly report from the West of England Academic Health Science Network and made reference to the "Connecting Care" Programme in Bristol, North Somerset and South Gloucestershire, which would allow other health communities to use key documents to support feasibility studies. Robert noted that UHB had actively supported the programme and looked forward to reporting back on the roll-out. John Moore commented on responsibility for Information Governance under the programme and Robert confirmed that the Information Technology Department had continued to work closely with Avon teams to ensure all appropriate safeguards were in place. It was:-

RESOLVED:

- **That the Board receive the West of England Health Science Network to note**

94/02/15 Big Green Scheme Annual Report

James Rimmer presented the report regarding the development of a sustainability action plan drawing all of the environmental activities of the Trust under the Big Green Scheme. This included the development of sustainable models of care, procurement and travel. The report provided a summary of achievements and outlined plans for the future. Julian Dennis noted that the report also reflected the importance of the role played by UHB as a corporate citizen in Bristol.

Graham Briscoe suggested exploring the possibility of national awards based on the Trust's commitment to the 'green' agenda. It was:

RESOLVED:

- **That the Board receive the Big Green Scheme Annual Report to note**

95/02/15 Governor's Log of Communications

The Chairman reported that the Governor's Log had been acted upon. It was:-

RESOLVED:

- **That the Board receive the Governor's Log of Communications to note**

96/02/15 Any Other Business

There no further issues to report

Meeting close and Date and Time of Next Meeting

There being no other business, the Chair declared the meeting closed
The next meeting of the Trust Board of Directors will take place on Tuesday 31 March 2015, 11.00am, the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

……. ……2015
Chair Date

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board of Directors meeting held in Public 27th February 2015
Action tracker

Outstanding actions following meeting held 27th February 2015					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	**87/02/15**	Outcome of the review of new exit arrangements to be included in the May Quarterly Workforce report	Director of Workforce & OD	May 2015	N/A
2	**87/02/15**	Response to the National Staff Survey to be submitted to the Board for assurance	Director of Workforce & OD	April 2015	Full results to be submitted to the March Board
3	**84/02/15**	Action plan and assurance report from the Saville Review to be submitted to the Board for assurance	Chief Nurse	April 2015	N/A
4	**83/02/15**	Review of compliance of a Code of Conduct for the Board of Directors to be undertaken	Trust Secretary	April 2015	N/A
5	**33/11/14**	Discussion regarding structure and format of the Quality and Performance Report to ensure it remains fit for purpose	Director of Strategic Development/ Deputy CEO	April 2015	N/A
Completed actions following meeting held 27th February 2015					
6	**92/02/15**	Inclusion of NHS Emergency Planning Guidance 2013 to be included on the QoC forward planner	Trust Secretary/ Chief Operating Officer	N/A	Complete

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Tuesday 31 March 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
5. Chief Executive's Report									
Sponsor and Author(s)									
Robert Woolley, Chief Executive									
Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

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

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

Recommendations

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

Impact Upon Board Assurance Framework

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

Impact Upon Corporate Risk

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

Implications (Regulatory/Legal)

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

Equality & Patient Impact

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

Resource Implications

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

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

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

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – MARCH 2015

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in March 2015.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **received** an update on the financial position for the current year.

The group **received** a further update on the current status of the compliance actions following the Care Quality Commission inspection, for both internal Trust actions and the external pan-Bristol 'patient flow' actions.

The group **received** an update on progress in meeting the Trust's ongoing recruitment requirements including service improvements, recruitment activities and initiatives undertaken.

3. STRATEGY AND BUSINESS PLANNING

The group **noted** an update on the business planning round 2015-2016, including capital prioritisation, major medical capital, internal cost pressures, resilience bids and development of Divisional and Trust Operating Plans for that period.

The group **supported** a proposed approach for managing demand in services where it threatened to outstrip the Trust's commissioned capacity to deliver care to the standards in the NHS Constitution, subject to appropriate safeguards.

The group **approved** a proposed outline scope for a Trust-wide Breaking the Cycle Together event in April, as recommended by the tripartite bodies NHS England, Monitor and the Trust Development Agency.

The group received the Board Assurance Framework for 2015/2016 and **agreed** to further revision prior to presentation to the Trust Board.

The group **received** the outline plan for the 2015/2015 Quality Report, including the 2015/2016 quality objectives, noting that they would continue to be refined prior to presentation to the Trust Board in April.

The group received the draft Education, Learning and Development Strategy and **agreed** to further work being undertaken to provide more clarity on the proposed objectives and deliverables.

The group **supported** implementation of an online e-induction programme for rotating doctors in the South West Region, funded by the Health Education South West.

The group **approved** the Easter Plan for final sign-off by the Service Delivery Group.

The group **accepted** the revised Major Incident Plan as fit for purpose with the proviso that there may be minor amendment required following testing.

The group **noted** revisions to the Escalation Plan which would be finalised for sign-off by the Service Delivery Group.

4. RISK, FINANCE AND GOVERNANCE

The group **received** the headline results from the Staff Survey 2014 and agreed to a more collegiate approach between the Trust and Divisions towards the design of initiatives and actions for improvement.

The group **noted** the current position in respect of the transfer of Cellular Pathology to North Bristol Trust and some risks to the proposed timetable.

The group **received** the Quarter 3 2014/2015 Patient Experience and Complaints Reports, noting their onward submission to the Quality and Outcomes Committee and Trust Board.

The group **noted** low impact Internal Audit Reports in relation to Capital Accounting, Recruitment Processes and Meeting Nutritional Needs and a medium impact report in relation to Non-Purchase Order Recruitment.

Reports from subsidiary management groups were **noted**, including an update on the work of the Transforming Care programme and on the activities of the Communications Department.

The group **noted** risk exception reports from Divisions. No new high risks were reported.

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

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
March 2015

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public **to be held on**
Tuesday 31 March 2015 at 11:00am in the Conference Room, Trust Headquarters,
Marlborough Street, Bristol, BS1 3NU

Report Title									
6. Patient Story									
Sponsor and Author(s)									
Mark Woodcock – Patient Tony Watkin –Patient Experience Lead (Engagement and Involvement) Carolyn Mills – Chief Nurse									
Intended Audience									
Board **members**	**x**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

Patient stories reveal a great deal about the quality of services, the culture of an organisation and the effectiveness of systems and processes to manage, improve and assure quality. Mr Woodcock who is presenting their story to the Trust Board was approached by the Patient Experience Team to share their story. Mr Woodcock has previously worked with the Patient Experience Lead on a number of patient involvement projects. Following a discussion with the Chief Nurse, he agreed to share his story in person with the Trust Board, furthering the ambition to move towards the Board receiving first-hand accounts of patient's experience of our services.

The purpose of presenting a patent story to Board members is to:

- Set a patient focussed context for the meeting
- For Board members to understand the impact of the lived experience for Mr Woodcock and for Board members to reflect on what the story reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work

Key issues

The story highlights a number of key issues:

Positive:

- The quality of the clinical care received.
- The quality of the interactions with staff throughout the care pathway.
- The GP Open Access Referral Clinic which offers a patient centred service.
- The value of the Discharge Lounge at the BRI to the patient and patient flow.

Negative:

- The human impact of cancelling surgery when patients have a life threatening condition and feel frightened and vulnerable.
- The importance of providing clear and unambiguous information about the physical impact of

surgery so patients are fully informed.

- The challenge of supporting appropriate/safe decision making for those who live on their own who may face challenges in securing the post -surgery support they need (relates to point above re information)

Links to current organisational strategy/priorities

Reducing cancelled operations is a quality objective for the Trust for 14/15 and will be carried over for 15/16 as the Trust has not met its stated performance targets. Performance against the target is reported to Board monthly in the Quality section of performance report.

Actions

1. Division of Specialised Services will review share with relevant clinical teams and review access to information for patients on the impact of having cardiac procedures.

Recommendations

To receive the story

Impact Upon Board Assurance Framework

Links to annual Trust objective to deliver all annual quality objectives - which is risk red rated in the BAF.

Impact Upon Corporate Risk

No links to corporate risks.

Implications (Regulatory/Legal)

Feedback, learning from and taking actions to address concerns from patients supports compliance with the Care Quality Commission's Fundamental Standards: Regulation 4 – Person-Centred care, Regulation 5 – Dignity and Respect, Regulation 7 – Safe and appropriate care and treatment, Regulation 12 – Good governance.

Non-compliance with NHS Constitution - the right of patient to start treatment within 18 weeks

Equality & Patient Impact

Nil

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	x

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

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Story
Trust Board – 31st March 2015
My experience of hospital care

This patient story outlines the personal experience of a patient who was admitted to the Bristol Heart Institute initially to address a blocked artery by way of a stent and subsequently for cardiac bypass surgery. The narrative has been written by the patient and is presented here by way of an introduction to ensure that the Board is able to gain insight into the whole patient journey which may not be possible through the patient verbally sharing their story, which will focus on key impact areas only.

Background

In the summer and autumn of 2013, I started to notice stomach and chest pain. This was my first experience of anything physically wrong with me since the late 1980s when I had had chicken pox. So this was a new experience interacting with the NHS as a patient. I would have defined myself as relatively healthy up to that point; I walked quite a bit and didn't have really bad habits. However, I suspect the reality was that I could have been healthier. The GP made a tentative diagnosis of angina and after some tests carried out locally at the surgery, referred me to the Bristol Heart Institute. That started the process of the next year. Tests were undertaken and the diagnosis of angina was confirmed. In order to find out the cause of the angina, an angiogram was arranged which took place about 2 months later. This confirmed a blockage in one artery. Initially, it was thought it could be dealt with my inserting a stent, but this was then changed to cardiac bypass surgery. The surgery was carried out in August 2014 and as my discharge letter states, was "…uneventful…" On discharge I spent a month recovering not so much from the angina or the pain of the surgery, but from the body's inability to be able to do things again, such as lift things and carry things! I then spent 8 weeks on the Cardiac Rehabilitation programme (probably my first real exercise since school days) and continue to do my daily exercises. Although I will continue on medication and I'm aware the heart has been damaged, I've made a full recovery.

Observations of my care in hospital

My overriding observation is how well I was treated. Both technically from the clinical perspective, but also from the human interactions with the staff in various locations in the hospital. My other comments that follow are just observations from a patient's perspective and in no way is a criticism of my care. They do, however, provide some interesting insights that will hopefully inform the Board in its responsibilities to improve the service.

My diagnosis

The GP Open access referral clinic is brilliant! None of this waiting for exchange of letters and eventually getting an appointment, straight into the hospital, wait your turn and out you come with a diagnosis. Whoever thought that one up deserves a medal? There may be issues of how the Trust manages an open access clinic, with unknown demand of future

patients and the funding to cope, but from the patient's point of view an excellent idea. Expand to other areas where appropriate.

The angiogram took place about two months later. Although this is a day case procedure, I had to stay overnight, which was fine; but waiting for a bed to become free did result in two cancellations at short notice. I'll come back to this point later. The angiogram itself was fine. Lots of waiting until the team were ready and then before you know what's happening you've had your review with the clinician and you're in the theatre. The experience is a bit of a non-event. You can't feel anything going up your vein or the dye being used to check the flow of blood. The staff were all concerned to make sure I knew who they were and what they were going to do. What you don't get any warning about is the huge xray machine that hovers above you which can be a bit claustrophobic. However, it was all over in half an hour and into recovery. As pleasant a stay overnight as you can imagine in a hospital. Food was good and then discharged the next morning following the advice and recommendation from the doctor that a bypass graft was required. Great!

My surgery

My admission took place in mid-August 2014. I had been cancelled about three times on the day of admission. Met the surgeons and other clinical staff and next thing I know it's about 48 hours later in Intensive care and some "idiot" is trying to get me to stand up, which I am not having anything to do with!

I spent the rest of that day in Intensive Therapy Unit (ITU) cared for by a team of two nurses, one very experienced and one newly graduated and in her first job from UWE! What an introduction to the world of work your first day in an ITU. I was then transferred to the High Dependency Unit where about six heart patients were being managed by the nursing team. After about half a day here, I was transferred to a ward of four beds and stayed for 3 days before being discharged.

Cancellations, whether for the angiogram or the surgery, can be easily rationalised away. The priority has to be for emergency patients. During my three days in the ward at least four other patients occupied beds as emergency admissions. How to get that balance right is an almost impossible task. However, as much as you can understand the reasoning, whilst you're waiting, it's a rollercoaster ride of getting ready in the morning for the admission and then coming back down following the call or letter cancelling you.

Staff throughout the experience were informative and helpful. It was clear what was happening and why. The nursing staff were the ones you most interact with in the ward. The qualified nurses in charge were confident in managing the patients in their care. The nursing auxiliaries showed a dogged commitment to checking our vital signs every four hours. As a task, it later provides the medical team with crucial information on whether you're ok to be discharged or not or how you are responding to the surgery. But at the time of carrying it out it must be very tedious for the staff. Considering the wider context of how to ensure staff morale and the value of this effort is no mean task.

I was discharged on the 7th day as anticipated. The night before I required a chest xray, which had been booked in for much of the day, and took place at 11pm! However, it gave

the green light to be able to go. I was transferred to the discharge lounge on level 5. Again, a brilliant idea to help free up beds on the wards and as a safe place for people to wait for their ride home. The staff team and the volunteers working there were excellent, one helping me in the end with carrying my bag to the car. The only issues, it's in the wrong place on level 5 and should be by the main entrance of the BRI and of all the places you want to use a mobile phone, to confirm a pick up time, it's the one place you can't get a mobile phone signal.

My recovery and rehabilitation

Apart from general advice on how to look after yourself on discharge, the two things that stuck in my mind were, "we don't want you to lift anything" and "you need to be with someone for the first week", more in case of emergency than any carrying role.

The first is an understatement. It's not the case that we don't want you to lift anything, you can't! Having "broken" my breast bone to get access to the heart it takes 6 months for the bone to heal and recover such that you can again lift and carry things. You will be amazed at how much we take for granted things that you suddenly can't do. Thankfully, it does heal quickly and after the rehab programme, you wouldn't know it had been broken.

The second I think is underplayed and is an issue that the wider community needs to consider, not just the Trust. One understands the need to clear beds from being inappropriately occupied. What we don't readily understand is that some 34%, or 161,000 people in the city of Bristol alone, live in single person households. Whilst that is all ages, I find it a staggering figure. Moreover, we have as a society not ensured any capacity to assist people in finding somewhere to stay. This is not a matter for the Trust to resolve, it is more one for the NHS and Local Authority, but awareness of this point is important. In my case, I was ok; I went and stayed with family out of Bristol. But not all people will be s able to do so.

A successful 6 week outpatient session then launched the start of the rehab programme. An eight week programme of exercises and talks from key staff in the cardiac team. For some, this was probably the first exercise taken since school days, but the staff, the physiotherapists and the cardiac specialist nurses were very supportive of all concerned. What was particularly interesting was the use of much material produced by the British Heart Foundation. Leaflets, books and DVDs to carry on with your exercises at home, are a good example of the way in which the Third Sector can help the NHS.

The impact of this patient's experience at UHBristol

Positive:

- The quality of the clinical care received.
- The quality of the interactions with staff throughout the care pathway.
- The GP Open Access Referral Clinic which offers a patient centred service.
- The value of the Discharge Lounge at the BRI to the patient and patient flow.

Negative:

- The human impact of cancelling surgery when patients have a life threatening condition and feel frightened and vulnerable.
- The importance of providing clear and unambiguous information about the physical impact of surgery so patients are fully informed.
- The challenge of supporting appropriate/safe decision making for those who live on their own who may face challenges in securing the post -surgery support they need (relates to point above re information)

Ends

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Tuesday 31 March 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
7. Quality and Performance Report
Sponsor and Author(s)
Report sponsors: • 'Overview' – Deborah Lee (Deputy Chief Executive/Director of Strategic Development) • 'Quality' – Carolyn Mills (Chief Nurse) & Sean O'Kelly (Medical Director) • 'Workforce' – Sue Donaldson (Director of Workforce & Organisational Development) • 'Access' – James Rimmer (Chief Operating Officer) Report authors: • Xanthe Whittaker (Head of Performance Assurance & Business Intelligence / Deputy Director of Strategic Development) • Anne Reader (Head of Quality (Patient Safety)) • Heather Toyne (Head of Workforce Strategy & Planning)
Intended Audience

Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose To review the Trust's performance on Quality, Workforce and Access standards. Key issues to note The monthly Quality & Performance Report details the Trust's current performance on national frameworks, and a range of associated Quality, Workforce and Access standards. Exception reports are provided to highlight areas for further attention and actions that are being taken to restore performance.
Recommendations
The Committee is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
Links to achievement of the standards in Monitor's Risk Assessment Framework.
Impact Upon Corporate Risk
As detailed in the individual exception reports.
Implications (Regulatory/Legal)
Links to achievement of the standards in Monitor's Risk Assessment Framework.
Equality & Patient Impact

As detailed in the individual exception reports.							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
26/03/15					

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

March 2015

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SECTION A – Performance Overview

Summary

The key changes to Organisational Health Barometer indicators between the Previous and Current reported periods are as follows:

Improvements in the period:

Moving from RED to GREEN – 1 indicator

- Same sex accommodation breaches – no further breaches in the month;

Moving from AMBER to GREEN – 1 indicator

- Savings Plan achievement – see separate Finance Report for further details

Deteriorations in the period:

Moving from GREEN to AMBER – 2 indicators

- Summary Hospital-level Mortality Indicator (SHMI) – moving from a SHMI score of 58.7 to 68.9, but within normal monthly variation;

- Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment) – moving from 53.6% to 51.0%

Please note: The move from Amber to Red for the Number of Cancer Standards Failed, was reported last month but has not been highlighted again due to this being a quarterly measure.

The Organisational Health Barometer continues to highlight the challenges in meeting national waiting times standards in the face of rising demand and increasing patient complexity. The impact of the Trust's performance against the access standards is reflected in the Monitor Risk Rating, and also in the contract penalties forecast.

Overall Trust level performance against the 4-hour standard deteriorated in February, despite the Children's Hospital Emergency Department achieving the 95% standard. The deterioration in performance in the BRI correlates with an increase in bed occupancy due to the number of over 14 day stays increasing in the period. Importantly though, other measures of patient flow including levels of delayed discharges, ambulance hand-over delays, out of hours discharges and the number of bed-days patient spent outlying from their specialty wards, all showed improvements in the period.

There was a further reduction in the number of patients waiting over 18 weeks from Referral to Treatment in the period, for both non-admitted and admitted patient pathways (see Exception Reports A5 to A7), and the Trust also achieved the target reduction in the number of patients waiting over 6 week for a diagnostic test at month-end (see Exception Report A9). The Trust remains on track to deliver further reductions in long waiters in March, in line with the agreed trajectories for recovery of performance against the RTT standards during 2015/16.

For quarter 4 to date, the Trust is failing six of the standards in Monitor's Risk Assessment Framework. These are the A&E 4-hour standard, the Referral to

Treatment Time (RTT) Admitted, Non-admitted and Ongoing standards, and the 62-day GP and Screening Cancer Standards. In Monitor's Risk Assessment Framework failure of all three RTT standards, as in the current quarter, is capped at a score of 2.0. The two 62-day cancer standards are grouped into a single combined indicator, scoring 1.0. Overall this gives the Trust a Service Performance Score of 4.0 against Monitor's Risk Assessment Framework. Having restored the Trust to a GREEN rating for quarter 1, Monitor has requested and received further information following multiple breaches of the A&E, Referral to Treatment and cancer waiting time targets, before deciding next steps.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
A01	Patient Experience Tracker Score	89	89	N/A	Green: >= 86 Red: < 85	➡	Current month is January 2015
A02	Patient Complaints as a Proportion of Activity	0.267%	0.291%	0.260%	Green: <0.21% Red: >0.25%	⬆	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	4	0	4	Green: 0 Red> >0	⬇	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	1	1	7	Green: 0 Red: >= 1	➡	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	4.89	4.91	4.82	Green < 5.6 Red: >= 5.6	⬆	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
C01	Number of Serious Incidents (SIs)	7	4	72		⬇	
C02	Cumulative Number of Avoidable C.Diff cases	6	7	7	Below Trajectory	⬆	Latest data is up to end of January 2015

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	80.5%	80.4%	85.4%	Green: >=90% Red: <85%	⬇	
D02	Number of Cancer Standards Failed	1	2	2	Green: 0 Red: >=2	⬆	Previous is confirmed Q2. Current and YTD is confirmed Q3.
D03	A&E 4 Hour Standard	90.9%	89.5%	92.0%	Green: >=95% Red: <95%	⬇	

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
E01	Summary Hospital Mortality Indicator (SHMI) - In Hospital Deaths	58.6	68.9	64.5	Green: <65 Red: >=75	↑	Previous is December 2014 and Current is January 2015
E02	30 Day Emergency Readmissions	330	348	3148	Below 13/14 Readmission Rate	↑	Previous is December's discharges where there was an emergency Readmission within 30 days. Current is January's discharges.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
F01	Overall Length of Stay (Spell)	4.46	4.24	4.25	Green: <= Quarterly target 3.70 Red: >= Quartrely target 3.70	↓	The target for 2013/14 and 2014/15 for this overall indicator of Length of Stay has been derived from the Trust's bed model.
F03	Theatre Productivity - Percentage of Sessions Used	87.3%	85.1%	87.1%	Green: >= 90% Red: < 90%	↓	
F04	Outpatient appointment hospital cancellation rate	9.1%	9.1%	8.9%	Green: <=6.0% Red: >=10.7%	→	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Turnover	13.7%	13.8%	13.8%	Green: < target Red: >=10% above target	↑	
G02	Staff Sickness	4.7%	4.6%	4.2%	Green: < target Red: >=0.5 percent pts above target	↓	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
H02	Cumulative Weighted Recruitment	40,175	43,941	43,941	Green: Above 2012 Red: Below 2012		Current (and YTD) is rolling Calendar YTD position. Previous is Jan-Nov 2014 and Current is Jan-Dec 2014
H03	Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment)	53.6%	51.0%	51.0%	Green: >=53% (Upper Quartile) Red: <48% (Median)	↓	Previous is Q1 2013/14 – Q4 2013-14. Current is Q2 2012/13 - Q1 2014/15. Updated Quarterly. No change from last month.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
J01	Monitor Governance Risk Rating	4	4	N/A	Green: < 4 Red: > = 4		Previous shows the Q3 declared poisition. Current shows the position in quarter 4 to date. Please note that Monitor is still to confirm the Trust's official rating for quarter 3.

Delivering Our Contracts

The Previous column represents Month 10. Current (and YTD) represents Month 11 2014/15.

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£7.86	£7.98	£7.98	> 50% Green < 50% Red		This is Potential year-end rewards and reflects assessment of performance as at January (81%).
K02	Contract Penalties Incurred - Variance From Plan (£millions)	£1.29	£0.56	£0.56	Green: Below Plan Red: Above Plan		Data is variance above (+) or below (-) plan, with a higher negative value (and lower positive) value representing better performance.YTD and Current is variance reported for February which reflects assessments available so far for all penalties excluding EMTA, for which no baseline is agreed with commissioners. RTT waiver July 14 to March 15 is now confirmed.

Managing Our Finance

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
L01	Monitor Continuity of Service	4.0	4.0	4.0	Green: >=3.0 Red: <2.5		For financial measures except savings Current and YTD is Current Year To Date. For Savings there is a separate total for latest month and YTD. Previous is previous month's reported data.
L02	Liquidity	4.0	4.0	4.0	Green: >=3.0 Red: <2.5		
L03	Capital Service Capacity	4.0	4.0	4.0	Green: >=3.0 Red: <2.5		
L04	Savings plan achievement	80%	97%	79%	Green: >=90% Red: < 75%		

Notes

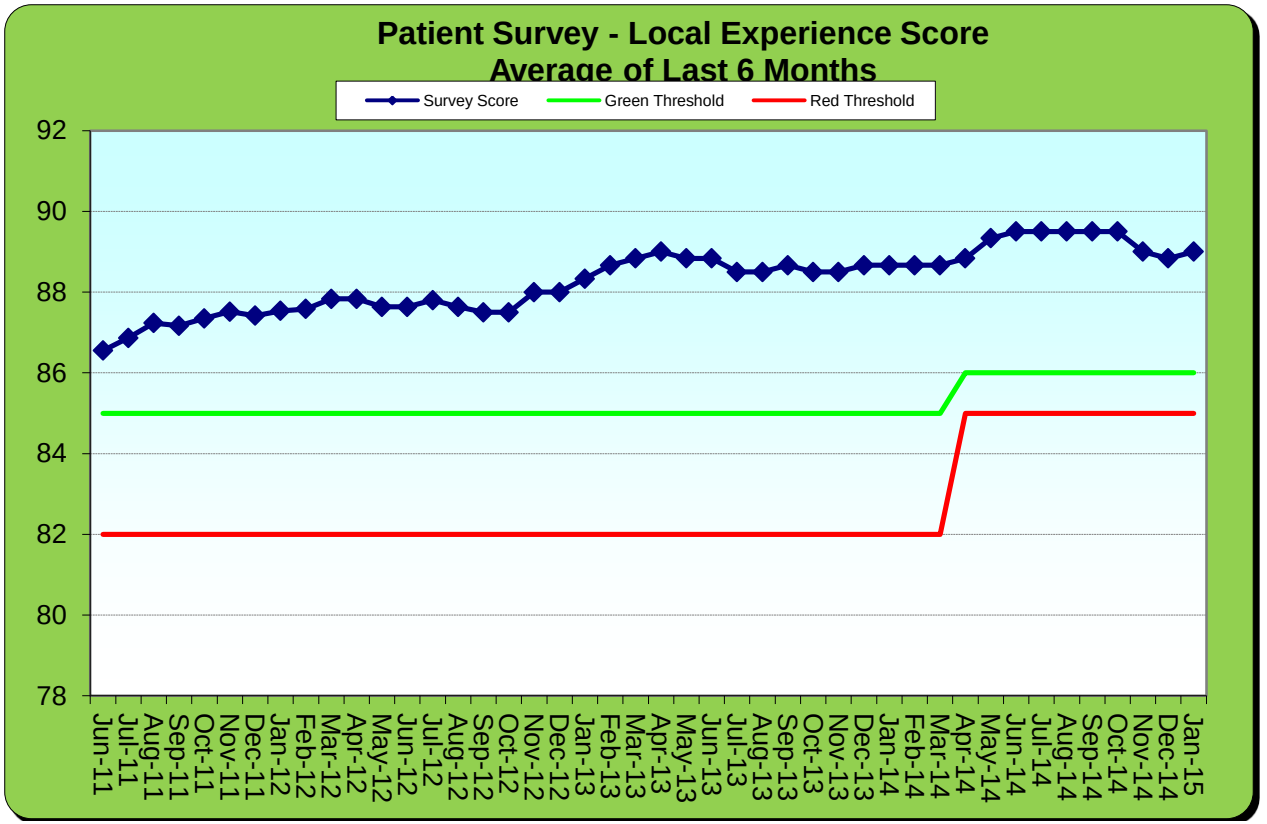
Unless otherwise stated, Previous is January 2014 and Current is February 2015

YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2014 up to and including the current month

RAG (Red/Amber/Green) rating only applied to YTD where an agreed target number of cases/score exists.

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Patient complaints as a proportion of activity	In *Quality* section of this report	
Hospital acquired pressure ulcers (grade 3 or 4)	In *Quality* section of this report	
18-week Referral to Treatment Times (RTT) admitted pathways	In *Access* section of this report	
Number of cancer standards failed	See Additional Information	The 62-day GP and 62-day Screening waiting times standards were confirmed as failed at the end of quarter 3, as previously reported. Further details of performance against these standards can be found in the *Access* section of this report.
A&E 4-hour standard	In *Access* section of this report	
30 Day Emergency Readmission	In *Quality* section of this report	
Overall Length of Stay	See A&E 4-hour Exception Report in the *Access* section of this report.	
Theatre productivity	See Additional Information	Overall theatre utilisation was lower than planned. This was mainly due to high levels of theatre staff sickness in the month, mainly at the Children's Hospital.
Staff sickness	In the *Workforce* section of this report	
Turn-over	In the *Workforce* section of this report	
Monitor Governance Risk rating	See Section C - *Monitor Risk Assessment Framework*	
Contract penalties above plan	See separate *Finance Report*	


Patient Survey - Local Experience Score
Average of Last 6 Months
Survey Score
Green Threshold
Red Threshold
92
90
88
86
84
82
80
78
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
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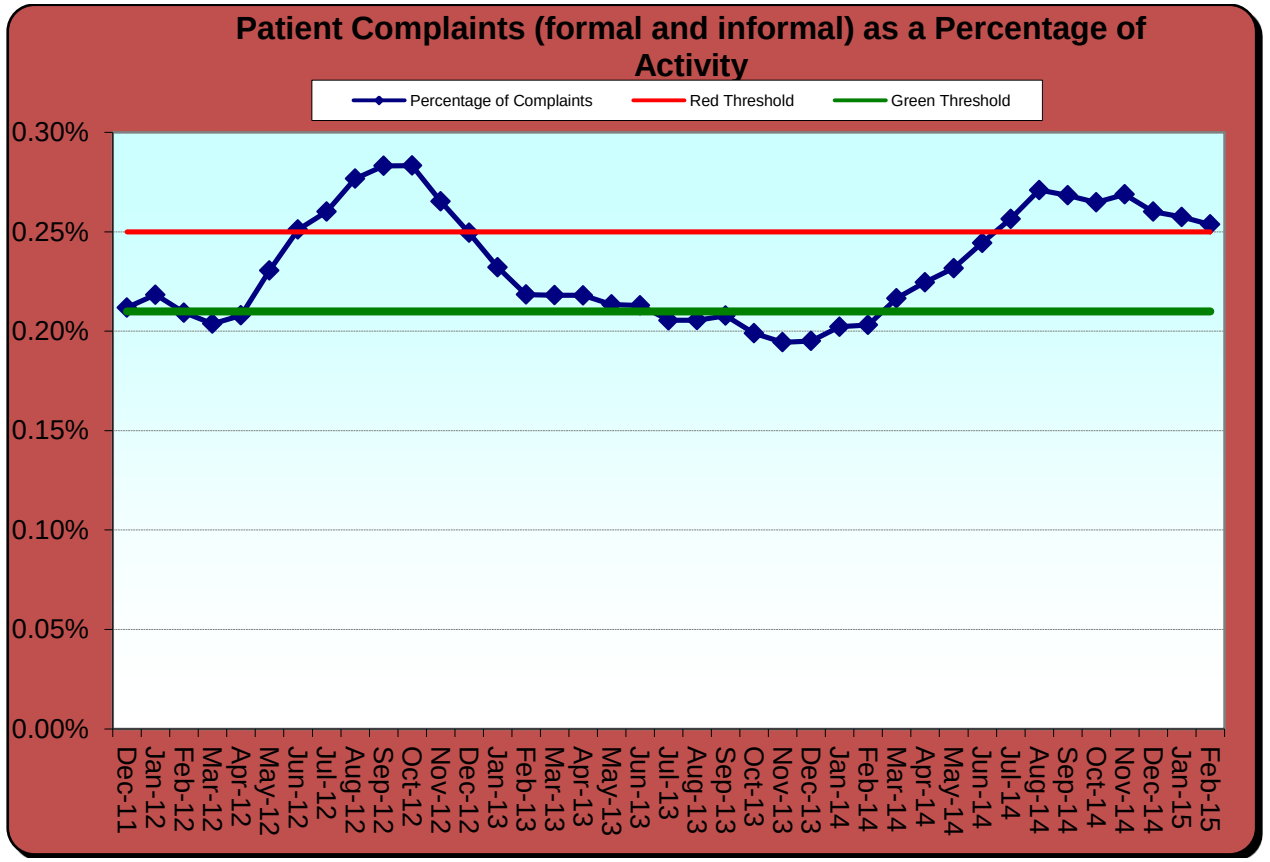
Dec-14
Jan-15


Patient Complaints (formal and informal) as a Percentage of Activity
Percentage of Complaints
Red Threshold
Green Threshold
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
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Jan-15
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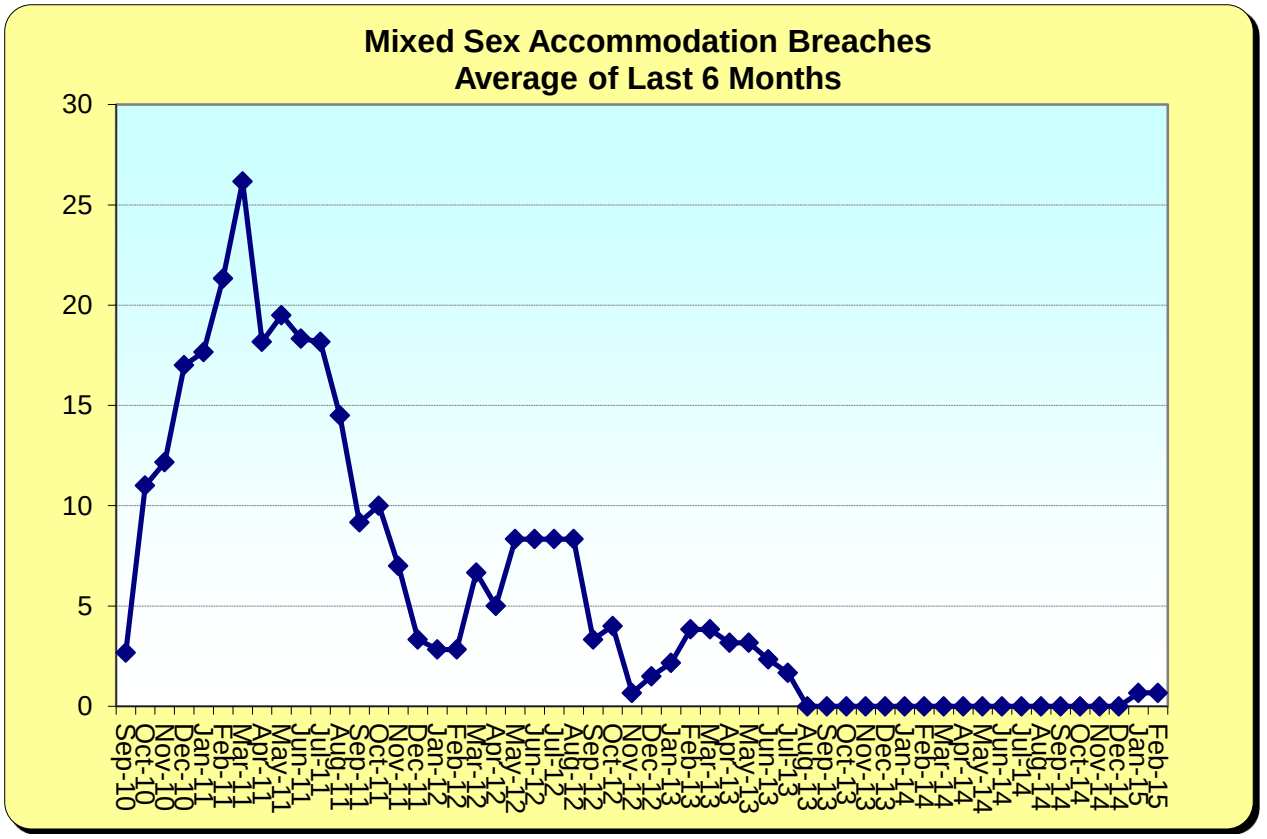
Mixed Sex Accommodation Breaches
Average of Last 6 Months
30
25
20
15
10
5
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
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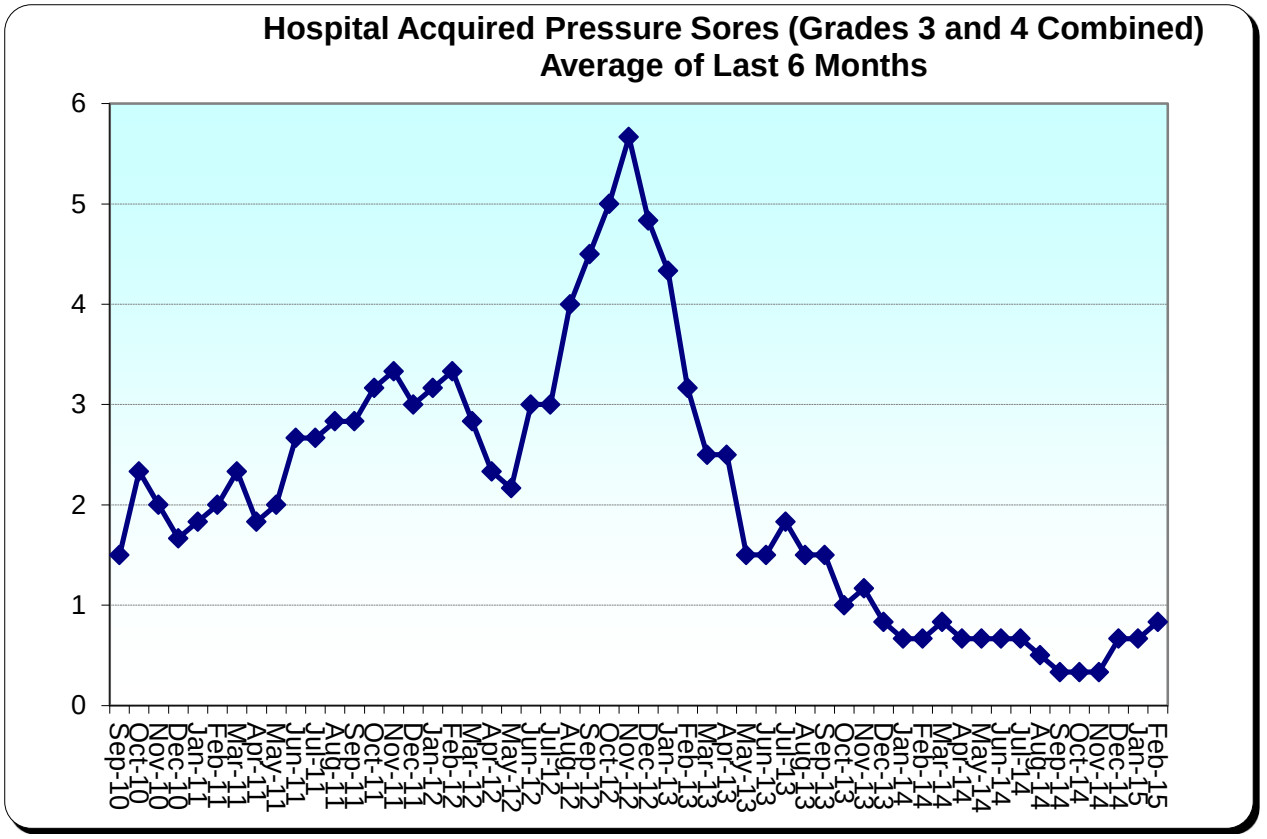
Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Average of Last 6 Months
6
5
4
3
2
1
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
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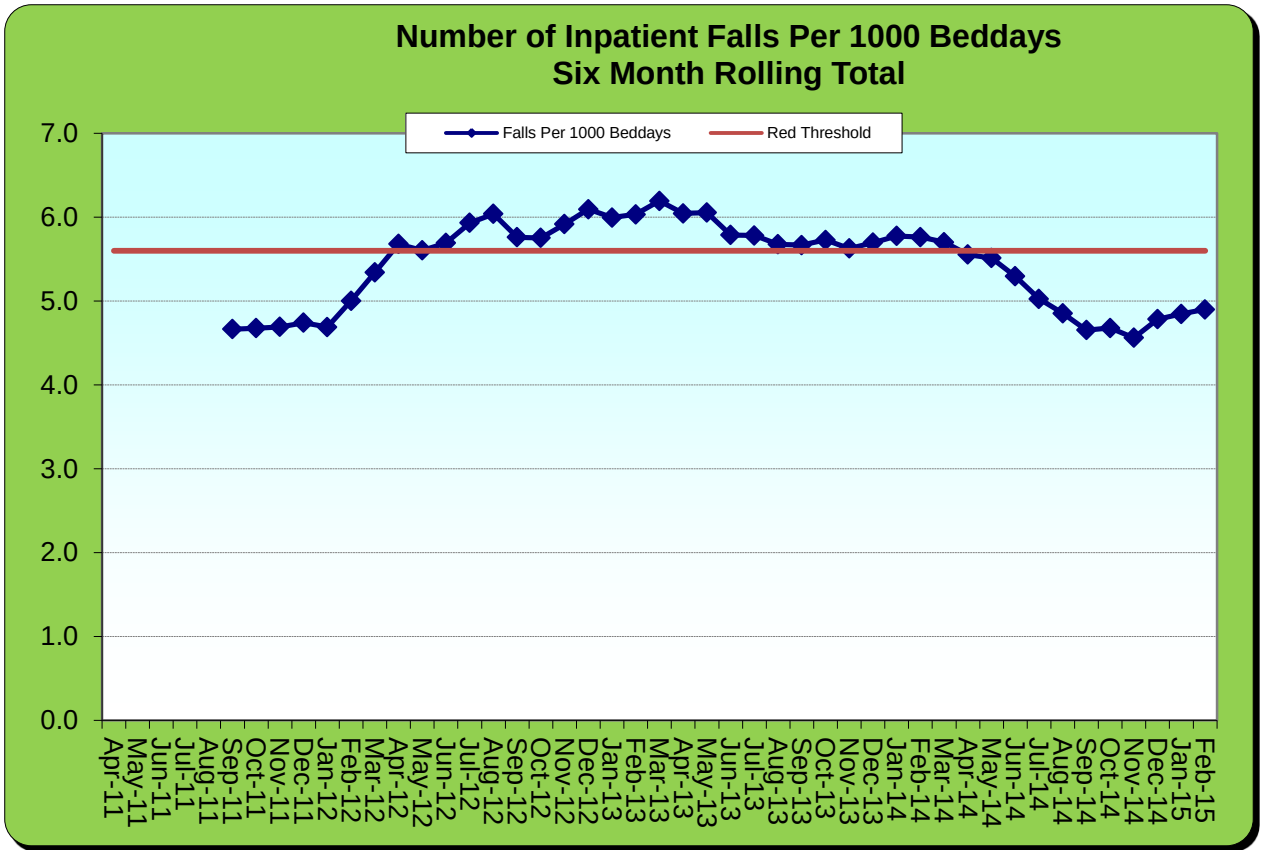
Number of Inpatient Falls Per 1000 Beddays
Six Month Rolling Total
Falls Per 1000 Beddays
Red Threshold
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
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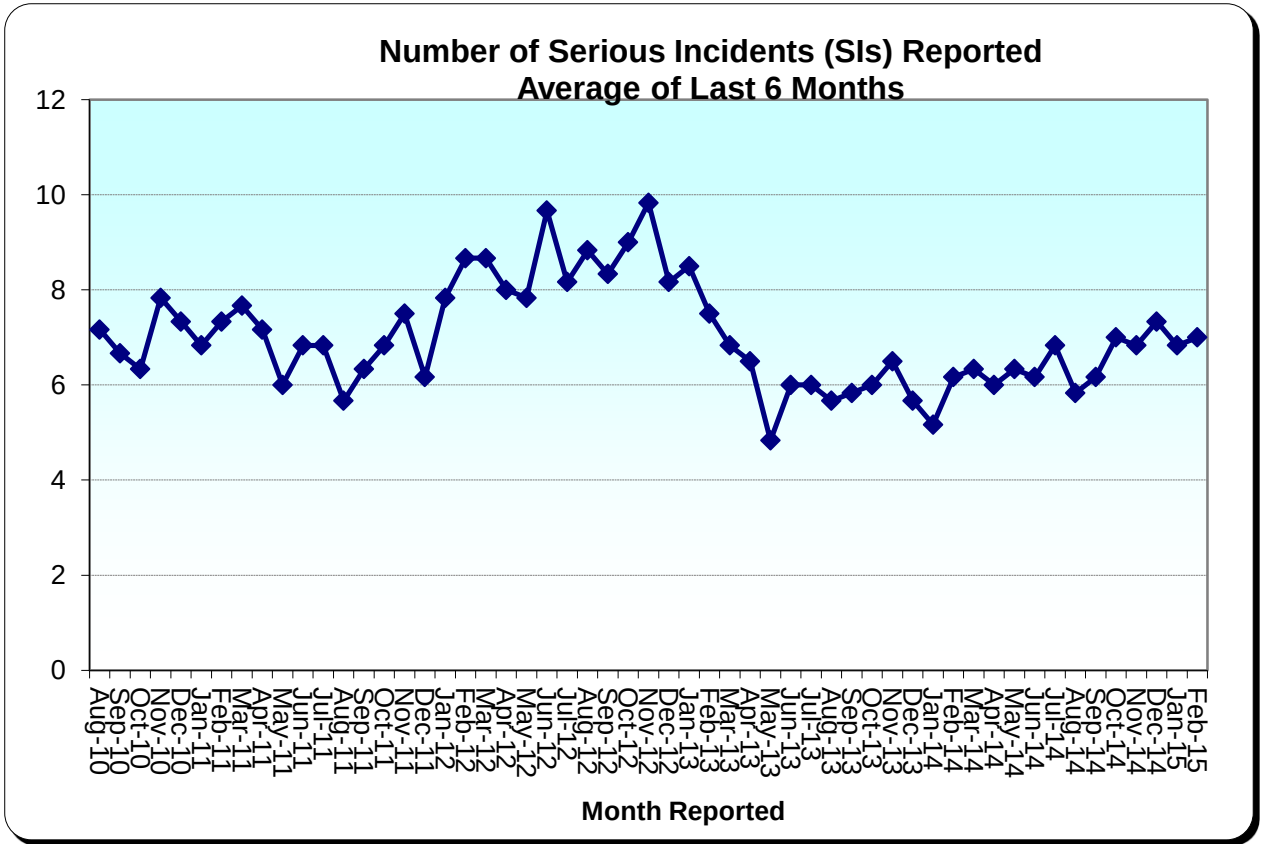
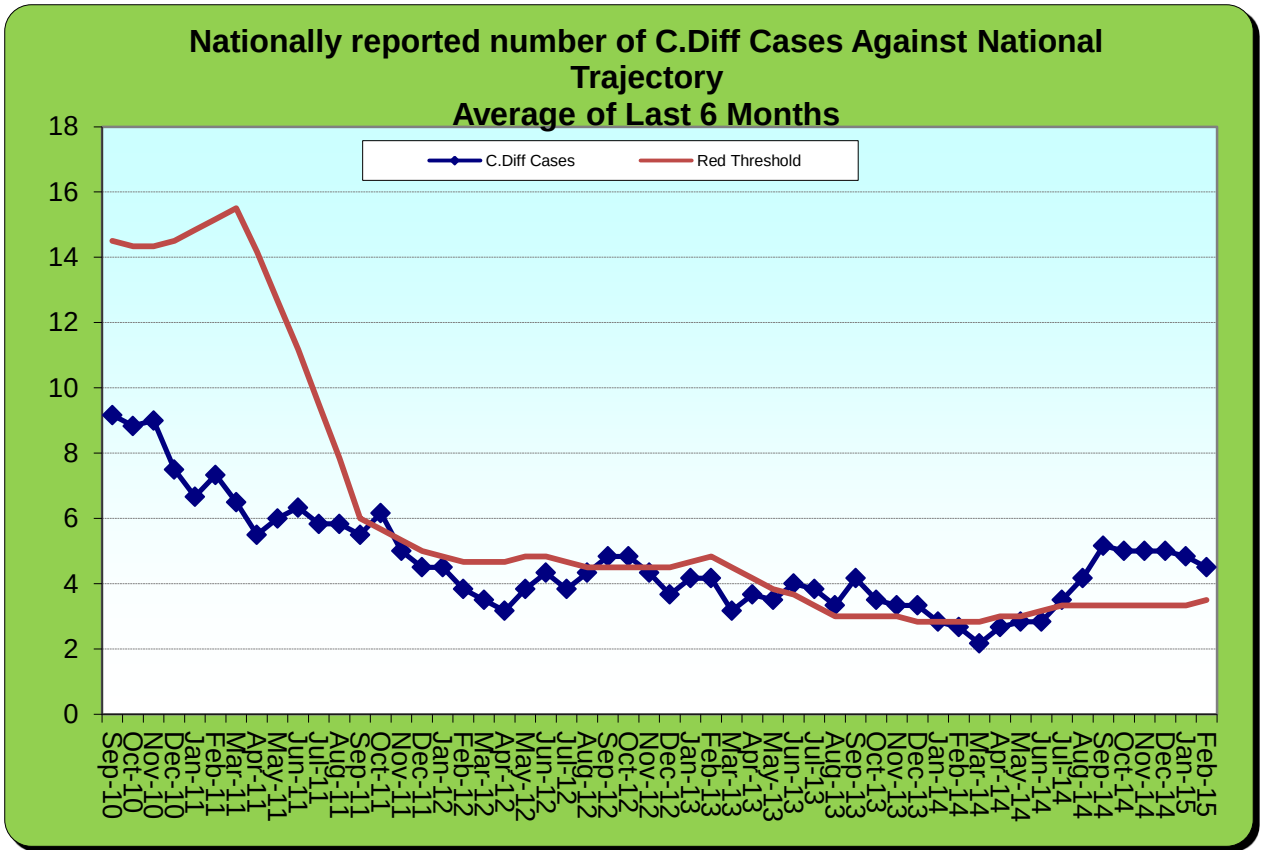
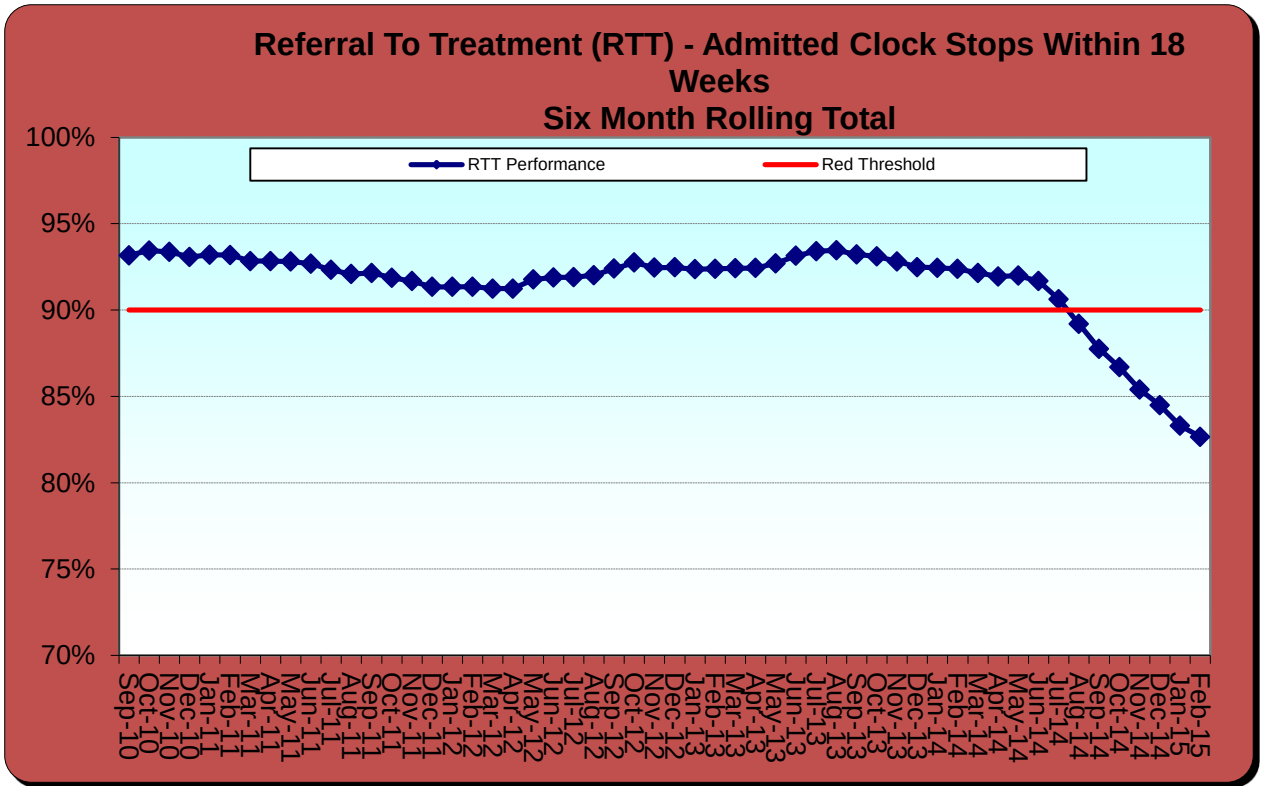
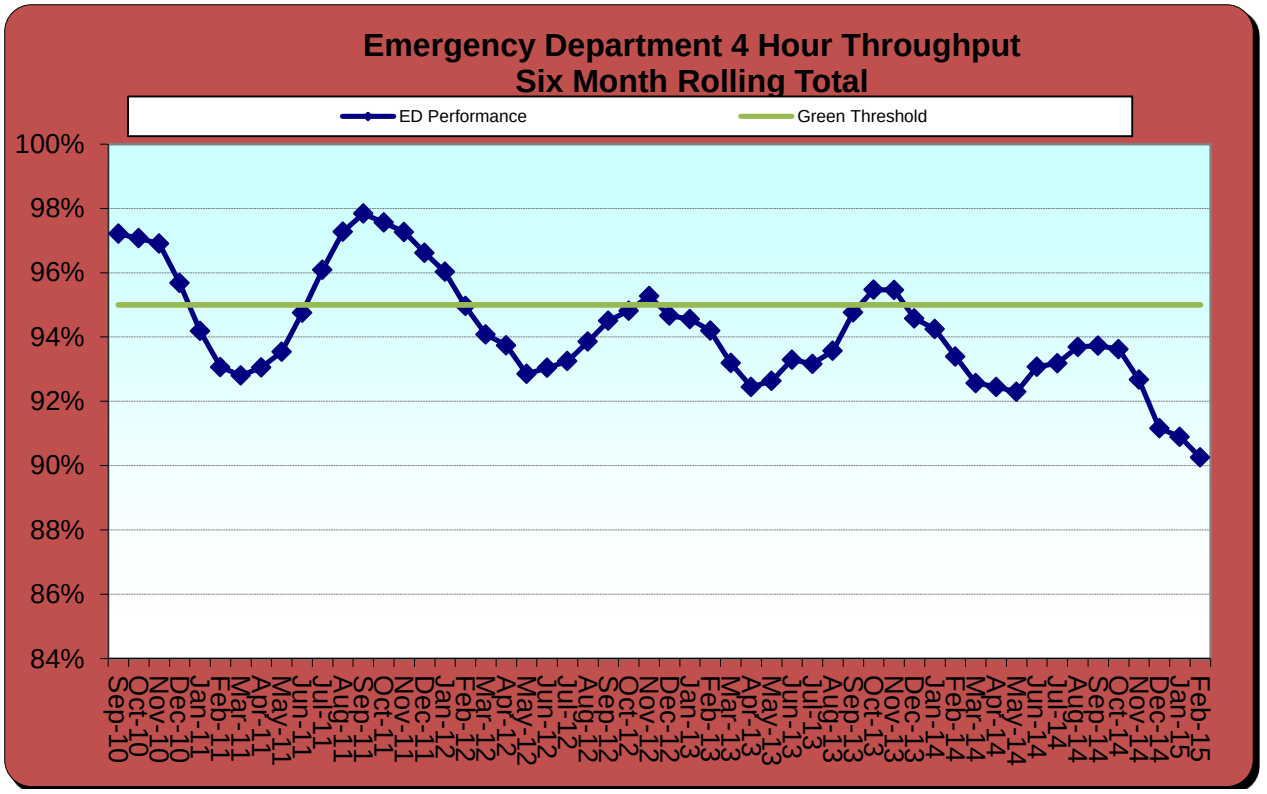
Feb-15


Number of Serious Incidents (SIs) Reported
Average of Last 6 Months
12
10
8
6
4
2
0
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Month Reported



Please note: The RAG rating for this graph is based upon our performance taking account of the level of potentially avoidable cases, and not the total cases report.


Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
Six Month Rolling Total
RTT Performance
Red Threshold
100%
95%
90%
85%
80%
75%
70%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15


Emergency Department 4 Hour Throughput
Six Month Rolling Total
ED Performance
Green Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
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Jun-13
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Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
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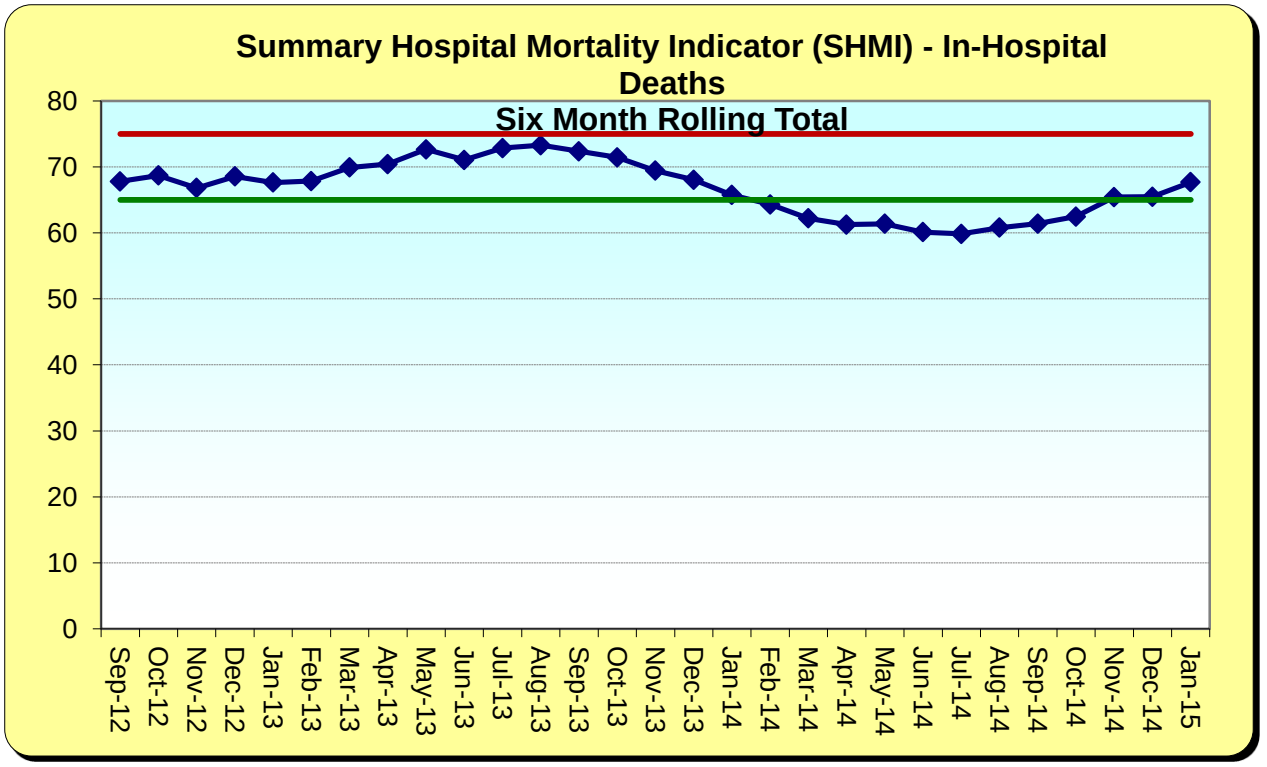
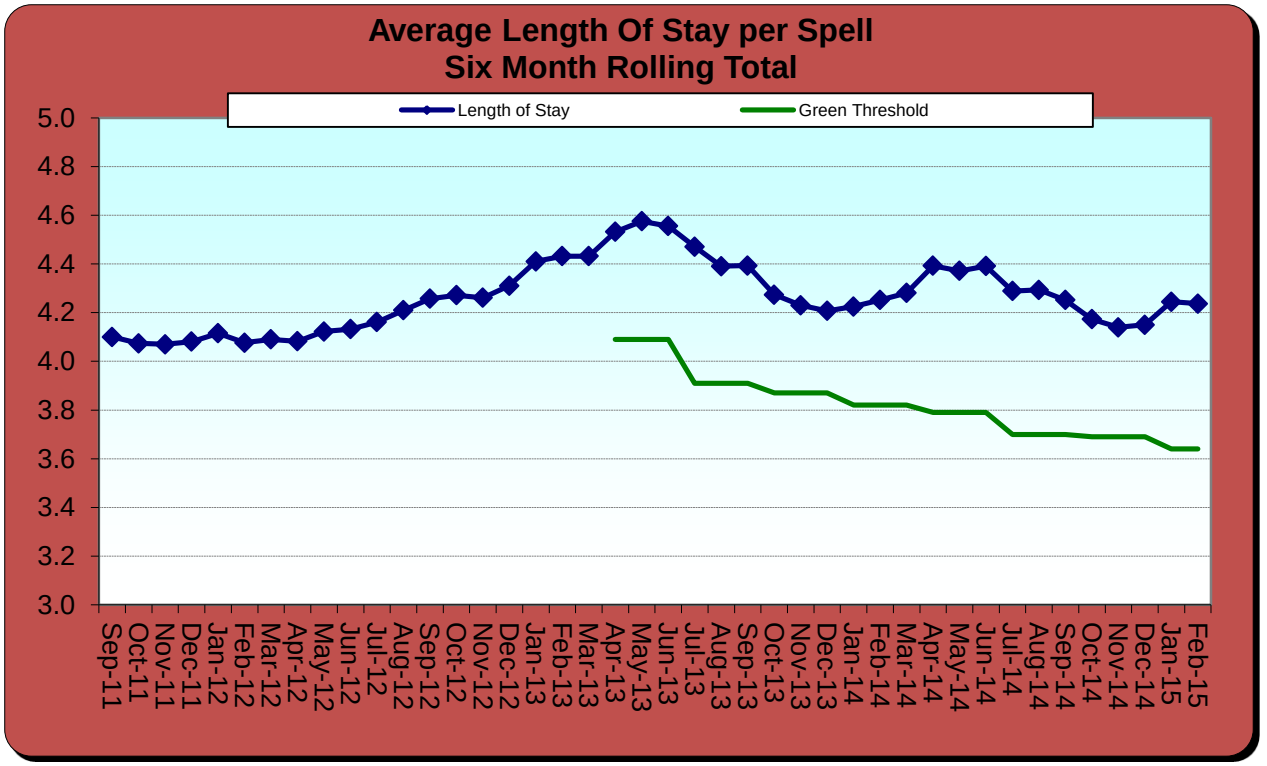
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15


Summary Hospital Mortality Indicator (SHMI) - In-Hospital Deaths
Six Month Rolling Total
80
70
60
50
40
30
20
10
0
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15


Average Length Of Stay per Spell
Six Month Rolling Total
Length of Stay
Green Threshold
5.0
4.8
4.6
4.4
4.2
4.0
3.8
3.6
3.4
3.2
3.0
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
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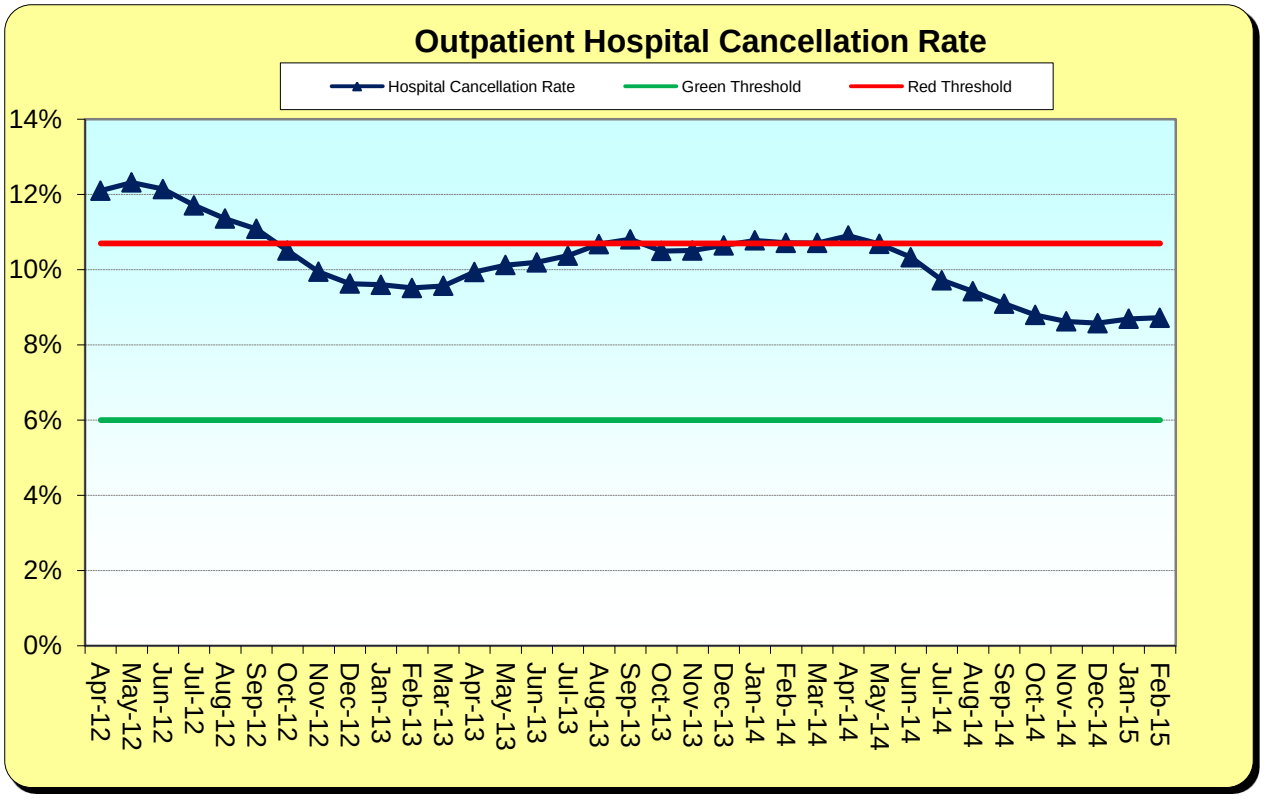
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15


Outpatient Hospital Cancellation Rate
Hospital Cancellation Rate
Green Threshold
Red Threshold
14%
12%
10%
8%
6%
4%
2%
0%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15

SECTION C – Monitor Risk Assessment Framework

In February the Trust failed to meet six of the standards in Monitor's 2014/15 Risk Assessment Framework. Exception reports are provided for these standards, as follows:

- A&E 4-hour maximum wait (1.0) – *Access section*
- RTT Non-admitted standard (1.0) – *Access section*
- RTT Admitted standard (1.0) – Exception report not provided (see note below)
- RTT Ongoing standard (no additional score – see note below) – *Access section*
- 62-day Referral to Treatment GP and 62-day Screening Cancer standards (1.0 combined standard) – *Access section*

Please note: In Monitor's Risk Assessment Framework failure of all three RTT standards as in the current quarter, is capped at a score of 2.0.

Overall this gives the Trust a Service Performance Score of 4.0 against Monitor's Risk Assessment Framework. Having restored the Trust to a GREEN rating for quarter 1, Monitor has requested and received further information following multiple breaches of the A&E, Referral to Treatment and cancer waiting time targets, before deciding next steps.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 4 2014/15.

PERFORMANCE OVERVIEW

Monitor's Risk Assessment Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15*	Q4 14/15*	Q4 Forecast*	Notes	Q4 Forecast Risk Rating Risk rating
Monitor Risk Assessment Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	7	✖	✓	✓	✓	7	✓	7 potentially avoidable cases year to date, against a limit of 40.	Achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.7%	✓	✓	✓	✓	99.6%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	94.8%	✓	✓	✓	✓	94.1%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.7%	✓	✓	✓	✓	96.5%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	79.7%	✖	✖	✖	✖	76.6%	✖		Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	89.4%	✓	✓	✓	✖	79.3%	✖		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	85.4%	Achieved each month	Achieved each month	Not achieved	✖	80.4%	✖		Not achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	90.4%	Not achieved	Not achieved	Not achieved	✖	89.1%	✖		Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	90.4%	Achieved each month	Achieved each month	Not achieved	✖	89.1%	✖	Standard failed - but scores for RTT failure capped at 2.0	Not achieved (see notes)
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	96.7%	✓	✓	✓	✓	97.0%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	95.8%	✓	✓	✓	✓	93.6%	✓		Achieved
	8b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
	9	A&E Total time in A&E 4 hours	1.0	95%	92.0%	✖	✖	✖	✖	90.2%	✖		Not achieved
	10	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
		CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
					Risk Rating	GREEN	GREEN	Triggers further investigation	Triggers further investigation	Triggers further investigation	Triggers further investigation		

Please note: If the same indicator is failed in three consecutive quarters, a trust will be put into escalation and Monitor will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur if the target is failed in two quarters in a twelve-month period and is then failed in the subsequent nine-month period or for the year as a whole. Quarterly figures quoted for the **62-day CANCER STANDARDS** include the impact of breach reallocations for late referrals, which are allowable under Monitor's Compliance Framework. For this reason, the quarterly figures may differ from those quoted in the Access Tracker. For the period shown Q1 and Q3 2013/14 have had corrections applied to the 62-day GP performance figures for breach reallocations.

***Q4 Cancer figures based upon confirmed figures for January and draft figures for the quarter to date. The C diff figures are for April to January.**

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

1.1 QUALITY TRACKER

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15 YTD	Monthly Totals Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Quarterly Totals 14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
Patient Safety																						
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	0	1	2	5	2	1	1	2	3	3	3	3	3	4	4	5	2	3	4	5
	DA03	C.Diff Cases - Monthly Totals	-	-	38	50	2	5	4	4	4	6	8	4	4	4	3	4	13	18	12	7
	DA03c	C.Diff Avoidable Cases - Cumulative Totals	40	40	-	7	-	0	1	1	2	3	5	6	6	6	7	-	1	5	6	7
	DA02	MSSA Cases - Monthly Totals	25	25	27	29	2	1	0	3	7	1	4	1	3	4	3	2	4	12	8	5
MRSA Screenings	DD01	MRSA Pre-Op Elective Screenings	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.6%	100%	100%	100%	100%	99.9%	100%
	DD02	MRSA Emergency Screenings	95%	80%	94.8%	94.6%	95.3%	96%	95.5%	94.9%	94.3%	95.3%	91.4%	95.8%	94.4%	93.4%	95.5%	94.4%	95.4%	93.6%	94.5%	95%
Infection Checklists	DB01	Hand Hygiene Audit Compliance	95%	80%	96.8%	97.2%	97.2%	97.6%	96.9%	97.8%	96.8%	96.9%	97.1%	96.3%	97.2%	97.6%	97.1%	97.4%	97.4%	97%	97%	97.3%
	DB02	Antibiotic Compliance	90%	80%	88%	89.4%	90.7%	91.8%	88.2%	87.9%	89.6%	86.2%	88.5%	90.3%	91.2%	89.1%	90.6%	88.8%	89.4%	88.2%	90.3%	89.7%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	87%	79%	95%	95%	96%	96%	95%	96%	93%	96%	96%	95%	95%	94%	95%	96%	96%	95%	95%	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	98%	89%	96%	96%	96%	95%	97%	95%	96%	97%	97%	97%	98%	98%	98%	98%	96%	97%	97%	-
	DC03	Cleanliness Monitoring - High Risk Areas	95%	79%	95%	95%	96%	96%	96%	96%	91%	96%	95%	95%	96%	95%	95%	96%	96%	94%	95%	-
Serious Incidents	S02	Number of Serious Incidents Reported	-	-	73	72	5	5	7	5	10	3	7	10	6	8	7	4	17	20	24	11
	S02a	Number of Confirmed Serious Incidents	-	-	71	55	5	5	7	5	8	3	6	8	4	7	2	-	17	17	19	2
	S02b	Number of Serious Incidents Still Open	-	-	-	12	-	-	-	-	-	-	-	1	1	1	5	4	-	-	3	9
	S03	Serious Incidents Reported Within 48 Hours	80%	80%	83.6%	88.9%	100%	80%	57.1%	80%	100%	100%	100%	80%	83.3%	100%	100%	100%	70.6%	100%	87.5%	100%
	S04	Percentage of Serious Incident Investigations Completed Within Timescal	80%	80%	92.4%	71.8%	100%	100%	50%	83.3%	70%	85.7%	100%	50%	66.7%	37.5%	80%	66.7%	82.4%	81.8%	46.7%	70.6%
Never Events	S01	Total Never Events	0	1	2	6	0	1	1	0	0	1	0	0	1	0	1	1	2	1	1	2
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	-	-	12090	10566	986	933	954	1010	1104	1038	1258	1151	1028	1073	1017	-	2897	3400	3252	1017
	S06a	Patient Safety Incidents Per 100 Admissions	-	-	9.24	9.35	9	8.71	8.56	9.07	9.14	9.52	10.48	9.84	9.45	9.7	8.92	-	8.78	9.72	9.67	8.92
	S07	Number of Patient Safety Incidents - Severe Harm	-	-	44	76	6	4	6	8	5	4	16	3	12	6	12	-	18	25	21	12
Patient Falls	AB01	Falls Per 1,000 Beddays	5.6	5.6	5.68	4.82	5.46	5.08	5.18	4.28	4.51	4.59	4.26	5.23	4.5	5.59	4.89	4.91	4.85	4.45	5.11	4.9
	AB06a	Total Number of Patient Falls Resulting in Harm	24	25	27	26	2	1	5	2	0	3	5	2	4	1	2	1	8	8	7	3
Falls (CQUIN Improvement)	AB07a	Number of Inpatient Falls (CQUIN)	429	429	0	1358	0	129	136	109	116	116	108	134	114	144	132	120	374	340	392	252
	AB07b	Inpatient Falls (CQUIN) - Improvement from Baseline	0	0	0	-269	0	-12	-8	-35	-44	-33	-43	-22	-26	-8	-23	-15	-55	-120	-56	-38
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.651	0.651	0.656	0.398	0.417	0.433	0.343	0.314	0.427	0.396	0.394	0.312	0.553	0.388	0.37	0.45	0.363	0.406	0.417	0.408
	DE02	Pressure Ulcers - Grade 2	-	-	184	105	10	11	8	8	10	10	10	8	13	8	9	10	27	30	29	19
	DE03	Pressure Ulcers - Grade 3	0	1	13	7	1	0	1	0	1	0	0	0	1	2	1	1	1	1	3	2
	DE04	Pressure Ulcers - Grade 4	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	96%	95%	98%	98.8%	98.5%	98.9%	98.7%	98.1%	98.4%	98.6%	98.9%	98.7%	99%	99%	99.1%	99.4%	98.6%	98.7%	98.9%	99.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	90%	93.4%	94.2%	94.5%	96.4%	94.3%	94%	95.3%	96.6%	93.2%	92.6%	92.3%	96.7%	92.4%	92.9%	94.9%	95.1%	93.8%	92.7%
Nutrition	WB05	Nutrition: Screening Tool Completed	90%	90%	-	93.4%	-	-	-	-	92.8%	91.8%	94.2%	93.4%	95.1%	93.8%	91.3%	94.6%	-	92.9%	94.1%	92.9%
	WB03	Nutrition: Food Chart Review	90%	85%	82.5%	89%	78.2%	94.7%	87.4%	87.7%	89%	89.3%	93.1%	88.3%	87.2%	87.8%	87.4%	88.4%	89.5%	90.4%	87.8%	87.9%
Safety	Y01	WHO Surgical Checklist Compliance	100%	99.5%	99.6%	99.7%	99.6%	99.7%	99.6%	99.4%	99.5%	99.7%	99.6%	99.7%	99.6%	99.4%	100%	100%	99.6%	99.6%	99.6%	100%

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15 YTD	Monthly Totals Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Quarterly Totals 14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
Medicines	WA01	Medication Errors Resulting in Harm	1.61%	2%	0.68%	0.48%	0%	1.3%	0%	0.78%	1.09%	0.52%	0.56%	0%	0.57%	0%	0%	-	0.66%	0.72%	0.2%	0%
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	95%	95%	98%	96.6%	100%	98.8%	100%	96.5%	93.3%	97.4%	97.6%	98.6%	97.1%	95%	90%	95.3%	98.4%	96%	97.7%	92.5%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	85%	75%	92%	95.3%	100%	98.8%	99.1%	90.9%	86.4%	94.7%	98.8%	98.3%	98.2%	95%	98.4%	-	96.1%	92.6%	97.8%	98.4%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.5%	2%	1.91%	1.05%	1.66%	1.18%	0.55%	0.38%	1.41%	1.42%	0.69%	1.21%	0.86%	0.37%	1.55%	1.54%	0.68%	1.19%	0.84%	1.55%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	95.6%	92.8%	94.1%	96.6%	95.2%	95.7%	96.7%	96%	96.7%	96.9%	96.5%	95.6%	96.7%	97%	96.7%	97.9%	96.1%	96.7%	96.5%	97.3%
	AK04	Safety Thermometer - No New Harms	98.2%	97%	97.2%	98.4%	97.6%	98.2%	98.4%	98.5%	98.9%	98.7%	98%	97.3%	97.8%	98.5%	98.4%	99.3%	98.3%	98.5%	97.9%	98.8%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	95%	90%	84%	89%	88%	89%	83%	91%	91%	96%	88%	88%	86%	83%	92%	96%	88%	92%	85%	94%
	CA01	Number of Verified Crash Calls from Adult General Wards	92	108	-	47	-	3	5	5	4	9	3	2	2	3	6	5	13	16	7	11
Discharges	TD04	Out of Hours Discharges			9%	8.1%	9.8%	9.5%	9%	8.2%	8.6%	7.6%	8.1%	7.7%	7.3%	7.6%	8.2%	7.1%	8.9%	8.1%	7.5%	7.7%
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	90%	80%	-	97.6%	-	-	-	-	-	90%	100%	85.7%	100%	100%	100%	100%	-	96.4%	97%	100%
	CS03	Number of CAS Alerts Overdue At Month End	0	0	-	0	-	-	-	-	-	0	0	0	0	0	0	0	-	0	0	0
Clinical Effectiveness																						
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital D	65	75	67.2	64.5	60.6	59.7	64.5	57.3	56.1	66.5	64.1	65.9	85.6	58.6	68.9	-	60.6	62.2	68.8	68.9
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	100	100	95.2	95.8	96.1	-	-	95.8	-	-	-	-	-	-	-	-	95.8	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline	80	90	75.8	69.4	73.2	67.1	66	63.1	58.1	74.7	73.9	69.2	90.5	63.5	71.3	-	65.4	69	73	71.3
Learning Disability	AA03	Learning Disability (Adults) - Percentage Adjustments Made	80%	50%	83.9%	89.7%	92.3%	100%	78.9%	100%	76.2%	82.4%	91.3%	90.5%	85%	100%	83.9%	95.5%	93.8%	83.6%	92.3%	88.7%
Readmissions	C01	Emergency Readmissions Percentage	2.7%	2.7%	2.71%	2.8%	2.86%	2.72%	2.97%	3.03%	2.51%	2.95%	2.96%	2.45%	2.39%	2.99%	3.06%	-	2.91%	2.8%	2.61%	3.06%
Maternity	G04	Percentage of Normal Births	64%	61%	61.7%	61.8%	61.4%	63.6%	58.9%	62.4%	64.7%	61.4%	63.8%	58.9%	65.5%	59.6%	60%	59.8%	61.7%	63.4%	61.3%	59.9%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	90%	90%	77.4%	76.2%	85.7%	88.9%	70%	82.6%	82.1%	71.4%	61.3%	77.8%	73.3%	70%	78.3%	89.7%	78.9%	71.3%	73.6%	84.6%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	90%	90%	78.8%	94%	100%	94.4%	93.3%	95.7%	100%	96.4%	93.5%	88.9%	86.7%	93.3%	95.7%	93.1%	94.4%	96.6%	90.3%	94.2%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	80%	61.7%	71.6%	85.7%	83.3%	66.7%	78.3%	82.1%	67.9%	54.8%	70.4%	60%	66.7%	78.3%	82.8%	74.6%	67.8%	66.7%	80.8%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	50%	55.1%	54.8%	63.9%	52.3%	53.6%	36.8%	48.6%	53.7%	61.1%	62.8%	59%	62.8%	55%	-	47.3%	54.4%	61.6%	55%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90%	80%	84.2%	85.6%	86.1%	90.9%	96.4%	81.6%	97.3%	78%	86.1%	88.6%	87.2%	79.1%	75%	-	89.1%	86.8%	84.9%	75%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	60%	55.8%	59.2%	50%	60%	30%	57.1%	25%	72.2%	66.7%	58.8%	73.3%	64.7%	50%	57.1%	48.3%	61.4%	65.3%	55%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	90%	80%	67.7%	63.4%	46.9%	57.1%	52.3%	49%	62.1%	67.5%	66.6%	61.4%	63.7%	62.9%	78.3%	77.3%	52.6%	65.4%	62.6%	77.8%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	90%	80%	60.6%	82.7%	66.7%	71.7%	78.3%	59.5%	84.7%	81.7%	87.3%	87.1%	92.2%	82.2%	90.7%	88.5%	70.3%	84.7%	86.3%	89.6%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	90%	80%	65.4%	56.5%	52.4%	47.6%	56.5%	22.7%	55.2%	50%	35.9%	78.3%	73.3%	68%	82.4%	81.3%	42.4%	44.8%	74.3%	81.8%
	AC04	Percentage of Dementia Carers Feeling Supported			-	75.2%	-	60%	62.5%	90%	-	-	70%	80%	88.9%	64.3%	87.5%	81.8%	69.7%	57.1%	78.7%	85.2%
Outliers	J05	Ward Outliers - Beddays	9029	9029	10626	10327	962	697	951	769	659	749	908	1338	876	1169	1364	847	2417	2316	3383	2211

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15 YTD	Monthly Totals Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Quarterly Totals 14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
Patient Experience																						
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	-	-	89	89	92	90	88	89	89	89	89	89	89	-	90	89	89	89
	P01g	Patient Survey - Kindness and Understanding	-	-	-	-	94	94	94	93	92	93	94	93	93	94	93	-	94	93	93	93
Friends and Family Test	P03a	Friends and Family Test Inpatient Coverage	30%	25%	29.6%	36.8%	46.7%	45.9%	39.5%	39.5%	35.5%	32.9%	33.1%	36.1%	41.3%	29.5%	37.9%	33.9%	41.6%	33.8%	35.5%	36%
	P03b	Friends and Family Test ED Coverage	20%	15%	13.3%	19.3%	26.7%	15.7%	21.4%	19.2%	16.1%	22.7%	26.2%	20.2%	14.9%	16%	17.3%	22.5%	18.9%	21.6%	17.1%	19.8%
	P04a	Friends and Family Test Score - Inpatients	70	64	75.9	75.6	76.1	78.4	73.3	73.5	72.4	75	76.8	73.6	73.4	81.8	79.9	73	75.2	74.8	75.8	76.8
	P04b	Friends and Family Test Score - ED	51	42	70.1	69.6	68.7	75.8	71.4	69.3	72.4	69.7	67.1	67	69.5	69.8	70.9	65.2	71.8	69.4	68.6	67.8
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.21%	0.25%	0.212%	0.26%	0.282%	0.238%	0.226%	0.277%	0.282%	0.321%	0.266%	0.224%	0.251%	0.224%	0.267%	0.291%	0.248%	0.288%	0.232%	0.279%
	T03a	Complaints Responded To Within Trust Timeframe	95%	85%	76.4%	86%	88.7%	93.1%	82.5%	83.3%	91.5%	88.3%	88.1%	84.4%	82.9%	82.9%	84.8%	83.7%	86.3%	89.5%	83.4%	84.4%
	T03b	Complaints Responded To Within Divisional Timeframe			71.1%	82.9%	75.5%	82.8%	86%	91.7%	76.1%	83.3%	81.4%	77.9%	78.6%	87.1%	87.9%	81.4%	86.9%	80%	81.1%	85.3%
	T04a	Complainants Disatisfied with Response			62	77	5	6	4	11	8	4	2	7	9	8	11	7	21	14	24	18
Ward Moves	J06	Average Number of Ward Moves			2.26	2.32	2.37	2.34	2.3	2.33	2.34	2.38	2.42	2.32	2.37	2.25	2.24	2.28	2.32	2.38	2.31	2.26
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.92%	0.92%	1.02%	1.08%	0.92%	0.98%	0.96%	1.1%	1.35%	0.97%	1.14%	0.84%	1.96%	0.73%	1%	0.85%	1.02%	1.16%	1.16%	0.93%
	F01a	Number of Last Minute Cancelled Operations	-	-	690	683	52	54	54	64	84	54	68	52	108	41	58	46	172	206	201	104

1.2 SUMMARY

In this month's report there are few key changes in metrics compared to previous months. We continue to focus efforts on improving fractured neck of femur, stroke and dementia care and are ramping-up vigilance on indicators where there are signs of a potential reversal of previous improvement, such as grade three pressure ulcers. Unfortunately, one never event occurred in February, the details of which are provided in the exception report.

Following our reports of higher mortality in November, the indicators in the quality dashboard returned to low levels of mortality in both December 2014 and January 2015, as seen in the Summary Hospital Mortality Indicator (SHMI) for in-hospital deaths and the Risk Adjusted Mortality Indicator (RAMI). We have completed the investigation into the reasons behind the higher mortality figures reported for November, and have concluded that there was no particular cause and this is likely to be due to normal statistical variation. The Board should note that Risk Adjusted Mortality Indicator remained below100 in November indicating that the number of observed deaths was lower than the number of expected deaths. As reported last month, all adult inpatients who die in our care are, however, the subject to a routine mortality case note review by a consultant, to identify any individual or systemic learning which we can act upon.

Achieving set threshold (38)	**Thresholds not met or no change on previous month (10)**
- Trust apportioned Clostridium difficile cases against national trajectory - MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - MRSA (Meticillin Resistant Staphylococcus aureus) screening – elective - Hand Hygiene Audit - Cleanliness monitoring: overall Trust score - Cleanliness monitoring: very high risk areas - Cleanliness monitoring: high risk areas - Serious Incidents reported with 48 hours - Inpatient falls incidence per 1,000 bed days - Falls resulting in harm - Falls improvement from baseline - Total pressure ulcer incidence per 1,000 bed days - Number of grade 4 hospital acquired pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Nutritional screening completed - Medicines reconciliation performed within one day of admission	- MRSA screening – emergency - Antibiotic prescribing compliance - Percentage adult in-patients who received thrombo-prophylaxis - 72 hour Food Chart review - WHO surgical checklist compliance - Non-purposeful omitted doses of listed critical medication - Summary Hospital Mortality Indicator (SHMI) in-hospital deaths - Dementia admissions-assessment completed - Dementia admissions-referred on to specialist services

QUALITY

(Assessment and cardiac wards) - Medicines reconciliation performed within one day of admission (Oncology and Gynaecology wards) - Reduction in medication errors resulting in moderate or severe harm - NHS Safety thermometer- harm free care - NHS Safety thermometer-no new harms - Deteriorating patient- appropriate response to an Early Warning Score of 2 or more. - Deteriorating patient- reduction in cardiac arrest calls from adult general ward areas - Central Alerting System (CAS) alerts completed within timescale - Percentage of CAS alerts overdue at month end. - Summary Hospital Mortality Indicator (SHMI) including out of hospital-deaths within 30 days of discharge - Risk Adjusted Mortality (Hospital Standardised Mortality Ratio equivalent) - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Learning disability (adults)-percentage adjustments made - Stroke care: percentage receiving brain imaging within 1 hour - Ward outliers bed-days - Patient experience local patient experience tracker - Monthly patient survey: kindness and understanding - Friends and Family Test (FFT) coverage: Inpatients - Friends and Family Test (FFT) coverage: Emergency Department - FFT Score: Inpatients - FFT Score: Emergency Department - Number of complainants dissatisfied with our response (not responded in full) - Last minute cancelled operations: percentage of admissions	
Quality metrics not achieved or requiring attention (13)	**Quality metrics not rated (11)**

QUALITY

- MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemias against trajectory
- Serious incident investigations completed within required timescale
- Never Events
- Number of grade 3 hospital acquired pressure ulcers
- 30 day emergency re-admission
- Fractured neck of femur patients treated with 36 hours
- Percentage of normal births
- Stroke care: percentage spending 90% + time on a stroke unit
- High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hour
- Dementia admissions-case finding applied
- Patient complaints as a proportion of all activity
- Percentage of complaints resolved within agreed timescale
- Average number of ward moves

Thresholds to be agreed

- Dementia-carers feeling supported
- Out of hours discharges

Metrics for information

- Monthly number of *Clostridium difficile* cases
- Number of serious incidents
- Confirmed number of serious incidents
- Total number of patient safety incidents reported
- Total number of patient safety incidents per 100 admissions
- Number of patient safety incidents severe harm
- Number of grade 2 hospital acquired pressure ulcers
- Number of falls
- Number of last minute cancelled operations

1.3 Summary of Performance against Commissioning for Quality and Innovation (CQUIN) Quality Dashboard Metrics

The CQUINs monitored in the quality dashboard for 2014/15 are:

1.3.1 Deteriorating patient:

The rescue of deteriorating patients is one of our quality objectives for 2014/15. It aligns with the Trust's existing proactive adult patient safety improvement programme.

We have agreed a two-part CQUIN with our commissioners relating to this area of quality:

- Adult patients with an Early Warning Score (EWS) of 2 or more to have an appropriate response according the escalation protocol. Our improvement target is 95% by Quarter 4. In February the percentage of documented appropriate responses for adult patients with a EWS of 2 or more was 96% against an improvement target of 95% for Q4.
- Reduction in cardiac arrest calls from general ward areas for confirmed cardiac or respiratory arrests. This has been identified as an outcome measure of identifying and responding to deterioration earlier. The target is a 5% reduction from a baseline of Q4 2013/14, to be measured at the end of 2014/15, which equates to no more than 91 cardiac arrest calls for the whole of 2014/15. In February the number of cardiac arrest calls was 5 against the GREEN threshold target of 7. We remain well below our cumulative trajectory of 83 by the end of February with 47 cardiac arrest calls year to date and therefore on track to achieve the second part of the CQUIN.

1.3.2 NHS Safety Thermometer improvement goal

We have agreed a two-part CQUIN with our commissioners:

- A reduction in the number of inpatient falls of five fewer per month on average over the whole of 2014/15, against a monthly age-adjusted baseline. In February there were 15 fewer falls against a target of 5 fewer than baseline;
- To implement five actions to enable closer working with our community partners to help reduce harm from pressure ulcers and improve infection prevention and control across the healthcare system. We are on track to achieve this element of the CQUIN.

1.3.3 Friends and Family Test

We report on two elements of the national Friends & Family Test CQUIN, achievement of which will be tracked via the Quality Dashboard: increasing response rates for Inpatients and the Emergency Departments. The targets are 25% in Quarter 1 rising to 30% in Quarter 4 for inpatients, and 15% in Quarter 1 rising to 20% in Quarter 4 for Emergency Departments. Performance in February was 33.9% against a target of 30% for inpatients, and 22.5%% against a target of 20% for Emergency Departments.

1.3.4 Dementia

We will continue to report the dementia case finding metrics as in 2013/14:

- Patients admitted with dementia:
    1. Percentage of patients aged over 75 years identified with a clinical diagnosis of delirium or who have been asked the dementia case finding question - performance in February was 77.3% against a target of 90%
    2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in February was 88.5% against a target of 90%
    3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in February was 81.3% against a target of 90%.

1.4 CHANGES IN THE PERIOD

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

- Early Warning Scores acted upon up ↑ from 92% in January to 96% in February.
- Friends and Family Test coverage in the Emergency Department up ↑ from 17.3% in January to 22.5% in February
- Ward outliers down ↓ from 1364 in January to 847 in February

Exception reports are provided for thirteen RED rated indicators and one amber rated* indicator.

1. MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory
2. Serious incident investigations completed within required timescale
3. Never Events
4. Number of grade 3 hospital acquired pressure ulcers
5. 30 day emergency re-admission
6. Fractured neck of femur patients treated with 36 hours
7. Fractured neck of femur patients achieving Best Practice Tariff *
8. Percentage of normal births
9. Stroke care: percentage spending 90% + time on a stroke unit
10. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hour
11. Dementia admissions-case finding applied
12. Patient complaints as a proportion of all activity
13. Percentage of complaints resolved within agreed timescale
14. Average number of ward moves

QUALITY

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

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

There was one Trust apportioned case of MRSA bacteraemia in February 2015.

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

Widespread screening for MRSA is undertaken in the Trust.

Recovery plan, including expected date performance will be restored:

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

QUALITY

Q2. EXCEPTION REPORT: Serious incident investigations completed within timescale	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

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

The contractual target is 80% compliance with the investigation timescales, which is measured quarterly.

Performance in the period, including reasons for the exception:

Twelve serious incident investigations were completed during February, of these four investigations breached the 45 working day timescale resulting in performance of 66.7%. The reasons are described below:

SI number	Incident	Division	Reason for investigation timescale breach
2014 29291	Child death following cardiac arrest in the emergency department	Women's and Children	Investigation not handed over during change of staff and subsequent investigation was complex and required multi-speciality input and involvement of parent's wishes.
2014 31927	Delay in diagnosis and review of a deteriorating patient	Specialised Services	Delay from Trust Headquarters. The Root Cause Analysis (RCA) was sent within deadline but was overlooked in emails in Trust Headquarters. The serious incident number was not included with the RCA, therefore the mailbox search did not find it.
2014 33616	Delay in providing intermittent pneumatic compression hosiery to a stroke patient whose post mortem showed they died of a pulmonary embolus.	Medicine	The 72-hour report initially suggested that this incident was not a serious incident and a downgrade was to be requested. However, subsequent information suggested that there could have been failings of care, therefore there was a delay in starting the RCA. This, and the clinical commitments of the Consultant and Ward Sister, led to the delay.
2014 38277	Fall resulting in fracture neck of femur.	Medicine	Ward moved during investigation timeframe. Ward Sister tried to prioritise the RCA, but the move took-up a significant proportion of her time.

The breaches included two "old" overdue investigations which were completed in the month, but were already known to have breached. It was

previously reported to the Board that there would be some further breaches in subsequent months for this reason.

Recovery plan, including expected date performance will be restored:

- Divisions have been reminded of the need to include the incident and serious incident numbers in the subject field when they submit RCAs to Trust Headquarters;
- The Division of Medicine is reviewing their patient safety team staffing;
- Serious incident investigations are more commonly being used at inquests. The rigour required, level of scrutiny and the need to involve all relevant staff (and the family if they so wish) can mean the timescales are sometimes extremely challenging.

QUALITY

Q3. EXCEPTION REPORT: Never Event	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

Never Events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. There are currently 25 different categories of Never Events listed by NHS England.

Performance in the period, including reasons for the exception:

One Never Event occurred in February in the category "Wrong (no) gas administered" whereby a patient requiring non-invasive ventilation was transferred to an appropriate ward without the oxygen being connected. The patient subsequently died.

A full Root Cause Analysis investigation is underway.

Recovery plan, including expected date performance will be restored:

- This incident is still under investigation;
- The family were fully informed of the incident;
- HM Coroner was fully informed of the incident and decided the death certificate could be issued by the hospital.

QUALITY

Q4. EXCEPTION REPORT: Number of hospital acquired grade 3 pressure ulcers	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

The rate of hospital acquired pressure ulcers grade 2 and above for January 2015 was 0.369 per 1,000 bed days against a trust target of 0.651.

Division	Feb 2015	Jan 15	Dec 14	Nov 14	Oct 14	Sep 14
Medicine	0.64	0.09	0.30	0.54	0.21	0.44
Specialised Services	0.26	0.92	0.23	0.72	0.47	0.48
Surgery Head &Neck	0.72	1.21	1.28	1.20	0.89	0.86
Women & Children's	0.15	0.00	0.13	0.13	0.00	0.00
Trust	**0.45**	**0.37**	**0.39**	**0.55**	**0.31**	**0.39**

There was one category 3 hospital acquired pressure ulcer reported for the month of February 2015, within the Division of Medicine. The initial review indicates that there are learning points for the ward. The reassessment of pressure ulcer risk for the patient was not consistently documented, nor was there any change or alteration in care requirements documented for the patient following reassessment.

A full Root Cause Analysis (RCA) is underway and the lessons learnt will be shared at the next Trust Tissue Viability meeting.

Recovery plan, including expected date performance will be restored:

- The Trust has seen a number of grade 3 hospital acquired pressure ulcers over the last few months. The Deputy Chief Nurse, together with the lead Tissue Viability Nurse, have re-instigated reviews with Ward Sisters and Matrons to review all grade 3 RCAs to offer support and help identify any themes or further actions required.

QUALITY

Q5. EXCEPTION REPORT: 30-day emergency readmissions	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

The number of emergency readmissions within 30 days of a previous discharge, rated against a target measured as a percentage of all discharges in the period. The target is an improvement on the previous year's level of emergency readmissions (i.e. 2013/14), which for 2014/15 equates to an emergency readmission rate of 2.70%

Performance in the period, including reasons for the exception:

In January there were 348 emergency readmissions within 30 days of discharge, which equates to 3.06% of discharges. This is 0.36% above the target level of readmissions of no more than 2.70%. The rate of readmissions is 0.1% above the 2.7% target for the year to date. The Trust continues to review any specialties which are identified through benchmarking reports as having a higher than expected readmission rate, relative to national and clinical peers.

Recovery plan, including expected date performance will be restored:

- Reviews of the causes of any specialties identified as having a high emergency readmission rate, relative to the national average and clinical peer group, to continue to be commissioned by the Quality Intelligence Group. These reviews include the following:
  - Clinical coding review of the readmissions (including an assessment of whether the type of admissions has been correctly classified) that happened during any period for which levels of readmissions were identified as being statistically high;
  - Following any amendments to clinical coding, the revised data to be reviewed to assess whether the specialty is still showing as an outlier from the national average and clinical peer group level, with the corrected data;
  - Where the clinical coding data changes have not addressed the variance, the initiation of a formal clinical review of the readmission cases, to determine what the causes of readmissions were and whether there are any themes, in terms of avoidable reasons for readmission which need to be addressed.

QUALITY

Q6-7. EXCEPTION REPORT:	**RESPONSIBLE DIRECTOR: Medical Director**
• **Fractured neck of femur patients treated with 36 hours** • **Fractured neck of femur patients achieving best practice tariff**	

Description of how the standard is measured:

Best Practice Tariff (BPT) for patients with an identified hip fracture requires all of the following standards to be achieved:

1. Surgery within 36 hours from admission to hospital
2. Multi-disciplinary Team rehabilitation led by an Ortho-geriatrician
3. Ortho-geriatric review within 72 hours of admission
4. Falls Assessment
5. Joint care of patients under Trauma & Orthopaedic and Ortho geriatric Consultants
6. Bone Health Assessment
7. Completion of a Joint Assessment Proforma
8. Abbreviated Mental Test done on admission and pre-discharge

Performance in the period, including reasons for the exception:

February's Best Practice Tariff performance was **82.8%**, the highest achievement in 2014/15, but below the 90% standard. Five patients' care did not meet all eight best practice indicators. Three of the five patients did not receive surgery within 36 hours, and two of the five patients did not have an Ortho-geriatric review within 72 hours. However, 89.7%% of patients had their surgery with 36 hours of admission against the 90% standard – this is the best performance since February 2014 and is in line with the Recovery Trajectory. Further details regarding the reasons for non-achievement are given below:

- The two patients that were not reviewed by an ortho-geriatrician within 72 hours were both admitted during a week when two of the three ortho-geriatricans were absent (one due sickness), and despite significant attempts to secure a locum doctor, this was not achieved;
- Of the three patients that did not receive surgery within 36 hours, two of the three patients were scheduled to be operated on within the timeframe. However, on both days theatres over-ran due to the prior case being more complex than anticipated;
- The third patient was not fit for theatre on the day of their planned surgery and once fit, more clinically urgent cases were prioritised.

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

The Division of Surgery, Head & Neck continues to focus on improving performance in the time to theatre for hip fracture patients, including the following actions:

QUALITY

- Operational focus is currently on imbedding the new all-day weekend operating, and ensuring staffing can support this on an ongoing basis; this will include running these lists on Bank Holidays, starting at Easter. Funding for continuation of this model, from April onwards is included (as a cost pressure) in the Surgery, Head & Neck Operating Plan given the expectation that Resilience Funding will not continue in 2015/16;
- A new Trust-wide transformation programme has commenced, with a project specifically focussed on orthopaedic theatre utilisation and efficiency; including a specific work-stream on emergency pathways;
- Further job plan changes have been agreed which will improve the spread of trauma time across the week and enable an additional hip fracture case to the start of planned limb reconstruction theatre lists;
- Enhancement of theatre staffing in the evening to allow for two "planned over-runs" as opposed to the current one, in light of the frequency of this occurrence – had this been in place in February, two of three breaches could have been avoided.

The Recovery Trajectory below for time to theatre shows that the actual number of breaches in February is in line with the recovery plan.

Month (of patient discharge)	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Total patients	31	27	15	30	23	29	30
Expected 36 hour breaches	**7**	**7**	**6**	**5**	**5**	**3**	**3**
Performance trajectory	**77%**	**77%**	**80%**	**83%**	**83%**	**90%**	**90%**
Actual 36 hour breaches	12	6	4	9	5	3	
Actual performance	**61%**	**78%**	**73%**	**70%**	**78%**	**89.7%**	

QUALITY

Q8. EXCEPTION REPORT: Percentage of Normal Births	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Performance against this indicator is calculated as the percentage of all births at St Michael's that are "normal". Normal is defined as women whose labour starts spontaneously, progresses spontaneously without drugs, and who give birth spontaneously.

Women who experience any one or more of the following are excludes induction of labour (with prostaglandins, oxytocics or Artificial Rupture of Membranes), epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section, or episiotomy."

This data is taken from Medway Maternity each month via an analyst using the above criteria it includes birth in all clinical settings both in the hospital and at home whether planned or by accident

Performance in the period, including reasons for the exception:

In January normal births were at 59.8%, 1.2% below the amber target of 61% and 4.2 % below the green target of 64%.

The number of non-operative vaginal births was 61.3% (which also remains below target, but is a different indicator).

We have noted that in the last month there has been an increase in the operative vaginal delivery rate which would account for the fall in normal births, but a reassuring fall in the Caesarean section rate and an increase in women successfully undergoing Vaginal Birth After Caesarean Section (VBAC).

There is concern that the reduced normal birth rate is related to the high induction of labour rate at 30% due to the use of oxytocin and artificial rupture of membranes. Even if these women progress to a normal birth without drugs, or intervention they are excluded for these reasons. There are many high risk women who have to give birth at St. Michael's due to maternal and fetal clinical reasons, and referrals from across the South West area as their babies require surgical input once born. Many of these women and babies require induction and assistance due to their complications, resulting in a slightly higher percentage than other units would expect.

Recovery plan, including expected date performance will be restored:

- We are always considering normal birth and encouraging women both during the ante-natal and intra-partum period to birth normally, this will continue.
- We are reviewing our clinical guidelines in line with the NICE Intrapartum Care guideline which may alter the proportion of women encouraged to give birth in the Midwife Led Unit; there have been significant changes to the recommendations for fetal monitoring in labour which may reduce the number of cardiotocographs classified as pathological and thereby reduce the intervention rates.

QUALITY

- A high percentage of inductions is noted here at St. Michael's and there is an audit underway to review the induction of labour pathway, including the indication for induction of labour. Induction of labour will undoubtedly affect our normal birth rate as induction includes use of oxytocin and Artificial Rupture of Membranes, hence this 30% of women are excluded each month from our target group of women from the outset. Women undergoing induction of labour are also more likely to require epidural anaesthesia and as a result of this require an instrumental delivery;
- There has been a significant change to the maternity population in recent years with a much greater proportion of higher risk women such as those with Type 2 and gestational diabetes, or who conceive over the age of 40 where induction of labour may be advised due to evidence of increased perinatal mortality in late pregnancy. Significant changes in Royal College of Obstetricians and Gynaecology guidelines have also resulted in a greater proportion of women undergoing induction of labour with reduced fetal movements in late pregnancy;
- Monitor high risk women who birth here due to fetal reasons and referral from other South West areas due to the Neonatal Intensive Care Unit and neonatal surgical facilities, which will affect our normal birth figures as caesarean section and induction will be the safest mode of delivery for many of these women and babies;
- The Practice Development Team is working with the Band 7 co-ordinators in the Central Delivery Suite to re-start the normal birth progress charts, which are updated throughout the month and can demonstrate to staff how well we are, or are not, doing. These charts have been of value in the past when attempting to achieve the CQUIN for normal birth;
- The unit holds a Normal Birth Study day, the next date for this is the 18th March, this is a popular well attended day and should galvanise efforts within the clinical areas;
- It is noted on reviewing the local dashboard that there is an annual trend of lower non-operative vaginal births in the winter months; particularly December – February and again in August – September. There are many reasons for this which may be patient factors – women do not choose a vaginal birth after a previous caesarean section in December as they wish certainty in delivery date around Christmas. There may be seasonal illnesses which mean women (and foetuses) are less able to withstand labour. This pattern of births could also be related to staffing – there has been a recent intake of junior midwives and there are annual rotations of medical staff which coincide with the peak months;
- The team will also explore the definition they are using because the giving of drugs as pain relief, or an artificial rupture of membranes in a spontaneous labour and normal birth, should not necessarily be excluded as part of the definition of a 'normal' birth. So work will be undertaken with the data collection team to understand the data in more detail;
- The Normal Birth Working Group is to be re-established to look at how best to improve the rates. It is likely to not be a single area of focus, but several that will make small gains, to enable us to achieve the target currently set.

QUALITY

Q9. EXCEPTION REPORT: Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	RESPONSIBLE MANAGER: Medical Director

Description of how the target is measured:

Proportion of all the "Stroke" Consultant Episodes where the patient had more than 90% of their bed-days on a Stroke Unit. A "Stroke" spell is one where the primary diagnosis (Clinical Coding) indicates a Stroke.

Performance during the period, including reasons for exception:

Performance in January was 75.0% against a target of 90%, which equates to 10 out of 40 patients discharged in January not spending at least 90% of their time on a stroke unit. Four of the ten patients were originally admitted in December As previously reported, some patients admitted in December could not be directly admitted due to the Stroke Unit being closed with due to Norovirus. However, the more detailed breach reasons for the breaches of standard for these 10 patients is as follows:

- Seven patients were directly admitted to the Medical Assessment Unit who should have gone direct to the Stoke Unit;
- One patient was appropriately admitted to Oncology instead, for clinical reasons;
- One patient had a discharge diagnosis of stroke included in discharge summary, but was not referred to stroke team during their admission;
- One patient had a delayed stroke diagnosis due to their dementia (the stroke was not clearly identifiable).

Recovery plan, including expected date performance will be restored:

- Work is in progress to ensure the Medical Assessment Unit refer direct to the Stroke Unit and remove this step in the journey. The Stroke Unit is also now accessing the Emergency Department screen and medical take list, to ensure they are aware of all stroke admissions via the Emergency Department;
- A key expected improvement is the embedding of protected stroke bed model and agreed process for transfer out of non-stroke patient following each admission to release the next protected stroke bed (ghost bed on ward);
- The re-writing of the Protected Bed Standard Operating Procedure and Operational Policy is in progress, to clarify the process for escalation if bed not available;
- A protected bed is now identified for use in black escalation and potential 12-hour Emergency Department trolley waits situations, but importantly will not be used before this level of escalation has been reached.

QUALITY

Q10. EXCEPTION REPORT: High Risk TIA Patients Starting Treatment Within 24 Hours	RESPONSIBLE MANAGER: Medical Director

Description of how the target is measured:

High Risk patients are those with an ABCD (Age, Blood, Clinical Features, Duration of symptoms) Score of 4 or above. Treatments (Aspirin, Statin, Control of blood pressure, referral for carotid intervention) should be commenced and relevant investigations (e.g. Blood tests, ECG, Brain scan) completed within the 24 hour window. The 24 hour window starts at first contact with any health professional. Only counts patients who attend as Outpatients, not those who are admitted to hospital.

Performance during the period, including reasons for exception:

Performance in February was 57.1% against a target of 60%, which equates to six out of fourteen TIA patients in February not starting treatment within 24 hours. The reasons for this are:

- One patient was ill with campylobacter and unable to attend;
- One patient declined an earlier appointment;
- One patient was referred on Saturday at 19:00 by the BRI Emergency Department, picked up 01:00 on Sunday by the Stroke Clinical Nurse Specialist at UH Bristol, therefore too late for onward referral to North Bristol Trust;
- One patient was discharged from the Medical Assessment Unit, but not referred to the Stroke Clinical Nurse Specialist on Saturday, and the referral picked up too late on Sunday morning for onward referral to North Bristol Trust;
- One patient declined to come into hospital;
- One patient was referred late from their GP.

Recovery plan, including expected date performance will be restored:

- Two patient delays occurred at weekends. Our commissioner for stroke care has been invited to Executive Stroke Steering Group to review weekend TIA referrals as North Bristol Trust's process limits weekend referrals from UH Bristol. North Bristol Trust currently only access their weekend referrals at 07:00 hours, and therefore referrals for patients sent over after this time mean these patients are unable to access the weekend TIA service at North Bristol Trust;
- Changes are being made to the ICE (Order Communications) system for weekend TIA referrals to make it clear all weekend referrals need to go direct to North Bristol Trust, rather than via the Stroke Clinical Nurse Specialist 7-day service, which can cause a slight onward delay in referral
- No additional actions required for those patient who refuse or choose not to attend within the appropriate timescale

QUALITY

Q11. EXCEPTION REPORT: Dementia: Stage 1 - Find	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Green rating 90% or above / Amber rating 80% - 89% / Red rating below 80%

The National Dementia Clinical Quality Indicator (CQUIN), "Find, Assess and Investigate, Refer (FAIR)" occurs in three parts:

1. **Find**
   The case finding of at least 90% of all patients aged 75 years and over following emergency admission to hospital, using the dementia case finding question and identification of all those with delirium and dementia. This has to be completed within 72 hours of admission
2. **Assess and Investigate**
   The diagnostic assessment and investigation of at least 90% of those patients who have been assessed as at-risk of dementia from the case finding question and/or presence of delirium.
3. **Refer**
   The referral of at least 90% of clinically appropriate cases to General Practitioner to alert that an assessment has raised the possibility of the presence of dementia

The CQUIN payment for 2014/15 has identified milestones for achievement for each quarter. As a provider we need to achieve 90% or more for each element of the indicator for each quarter taken as a whole with a weighting of 25% for each quarter.

Performance in the period, including reasons for the exception:

Stage 1- Find – status RED

Performance in February for stage 1 was 77.3 % against a target of 90%, compared with 78.3% in January.

Divisional performance

Medicine 78.3%; Surgery Head & Neck 73.5%; Specialised Services 75%

Recovery plan, including expected date performance will be restored:

Since the introduction of the electronic solution in January, compliance levels in all three stages of the dementia CQUIN have stayed consistent this month. The Project Nurse will continue to focus on training and supporting ward areas with the aim of embedding this process into everyday practice.

QUALITY

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

- Embedding of the IM&T system to flag, record and monitor all stages of the FAIR process across the Trust. This continues to be widely advertised and support received from all senior divisional teams to ensure the system is used;
- Project Nurse (two year secondment / fixed term project post holder) continues to work closely with the Medical and multi-disciplinary teams across the admission areas to ensure the timely screening, assessment and referral on where appropriate. There is targeted support for wards currently performing less well against the CQUIN such as the Medical Assessment Unit by the Project Nurse, with improvement expected next month;
- A continued step change in improvement is anticipated in all three stages Trust wide in March.

QUALITY

Q12. EXCEPTION REPORT: Percentage of complaints per patient attendance in the month	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of complaints received by the Trust and either managed by a formal or informal resolution process in agreement with the complainant, as a percentage against the number of patient attendances within the month. This excludes concerns raised and immediately dealt with by front line staff, and which are recorded within the Division. A green rating on the dashboard = <0.21%.

Performance in the period, including reasons for the exception:

In February 2015, complaints received represented 0.29% of clinical activity (approximately one in every 340 patient episodes of care). This is an increase on the 0.27% reported in January 2015; the number of complaints received also increased from 165 in January to 171 in February 2015. Of the complaints received in February, 79 are being progressed through formal resolution. There were no notable changes to the numbers of complaints received by each Division compared to January, although there were notable increases in all Divisions when compared with the same period last year (February 2014).

The divisional breakdown is shown below:

DIVISION	TOTAL COMPLAINTS RECEIVED IN FEBRUARY 2015	% OF PATIENT ACTIVITY	AREAS WITH HIGHEST NUMBER OF COMPLAINTS IN DECEMBER 2014
Diagnostics & Therapies	5 (7 in January)	Not recorded for this Division	Audiology x 2
Surgery, Head & Neck	66 (66 in January)	0.25%	Bristol Eye Hospital x 20 Bristol Dental Hospital x 15 Ear, Nose & Throat Outpatients x 7 Trauma & Orthopaedics x 6
Medicine	29 (30 in January)	0.23%	Emergency Department x 9 Ward C808 x 3 Ward A518 x 2
Women & Children	32 (30 in January) Bristol Children's Hospital – 24 St Michael's Hospital – 8	0.26%	Paediatric Orthopaedics x 7 Paediatric Neurology x 5
Specialised Services	32 (26 in January)	0.45%	Bristol Heart Institute Outpatients x 15

	Bristol Heart Institute – 25 Bristol Haematology & Oncology Centre - 7		Ward C708 x 4

In the Division of Surgery Head & Neck, the number of complaints received by Bristol Eye Hospital remained high at 20 complaints (equal to January 2015). Of these 20 complaints, nine were in respect of cancelled or delayed appointments/operations, three were about failure to answer the telephone and two were in respect of long waiting times in clinic.

There was a further small increase in complaints received by the Bristol Dental Hospital, with 15 complaints in February compared to 14 in January 2015. Of these 15 complaints, eight were in respect of cancelled or delayed appointments/operations, two were about attitude of staff and two were in respect of failure to answer telephones.

In the Division of Medicine, there was an increase in the number of complaints received by the Emergency Department, with nine being received in February 2015 (five in January). Three complaints each were received by Ward A518 and Ward C808. There were no discernible patterns or trends in the reasons for these complaints.

In the Division of Specialised Services, there was a further increase in the number of complaints received by the Bristol Heart Institute Outpatients Department, with 15 complaints in February 2015 (11 in January). Of these 15 complaints, eight were about cancelled or delayed appointments and two were in respect of unanswered telephones. There were four complaints received for Ward C708.

In the Divisions of Women's & Children's Service and Diagnostics & Therapies there were no discernible trends other than shown in the table above.

Recovery plan, including expected date performance will be restored:

February and March 2015 complaints data will be discussed in detail by Heads of Nursing at the Trust's Patient Experience Group meeting on 16th April 2015.

QUALITY

Q13. EXCEPTION REPORT: Number and percentage of complaints resolved within Local Resolution Plan timescale	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

In February 2015, 36 responses out of the 43 which had been due in that month were posted to the complainant by the date agreed (83.7% compared to 84.8% in January). Of the seven breaches, only two were attributable to delays in Divisions (both in the Division of Women's & Children's Services). Three of the remaining breaches were due to delays during the Executive sign-off process, and the remaining two were due to delays in other trusts sending us their comments to input into our response.

The Divisions of Diagnostics & Therapies and Specialised Services recorded zero breached deadlines in February 2015.

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

Recovery plan, including expected date performance will be restored:

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

QUALITY

Q14. EXCEPTION REPORT: Average Number of Ward Moves	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

This is one of our quality objectives for 2014/15 and is defined as the average number of ward moves per patient spell. This measure includes only spells where patient has had at least 2 overnight stays and is calculated as total ward moves divided by total spells.

We are aiming to achieve a 15% reduction by quarter 4 2014/15, from a 2013/14 baseline of 2.26. We have calculated seasonally-adjusted quarterly targets of 2.32 (Quarter 1), 2.20 (Quarter 2), 2.09 (Quarter 3) and 1.97 (Quarter 4).

Performance in the period, including reasons for the exception:

In the month of February 2015 there was an average of 2.28 ward moves per patient.

Recovery plan, including expected date performance will be restored:

- The lay-out of the wards and increase in single rooms in the new build should decrease the necessity to move patients to address gender, specialty, acuity and isolation requirements;
- Actions taken to improve patient flow, as detailed in the A&E 4-hour Exception Report in the Access section of this report, should also help to ensure patients get to the right bed, following any assessment period they need, and do not necessitate a further move;
- A specification for a ward moves report has been agreed with the Performance Information Team. This report will include information on how many ward moves each patient has undergone on their current admission. This will support the dynamic risk assessments made by the Clinical Site Team on patient placement.

1.6 SUPPORTING INFORMATION

1.6.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the **Trust Services Division:**

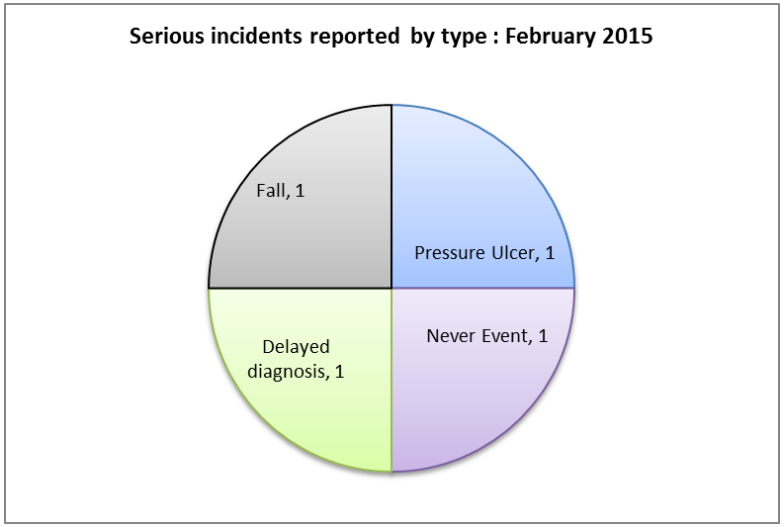
A number of posters celebrating successes in quality and patient safety improvements across the Trust have been accepted for display at a regional quality and patient safety conference on 16th April. These are:

- Escalation of parental concerns: Dr Caroline Haines et al, Division of Women's & Children's
- "How to WHO"- improving use of the WHO surgical safety checklist: Dr Mat Molyneux et al, Division of Surgery Head & Neck
- Improving Safety in Oxygen Therapy: Dr Giles Dixon et al: Division of Medicine;
- Analgesia prescribing in Acute Adult Admissions with Renal Impairment: Dr Nilesh Chauhan et al, Division of Surgery Head & Neck

At the same conference, Dr Emma Redfern, Consultant in Emergency Medicine and Associate Medical Director for Patient Safety will be presenting work to date on our "Southwest STAR project focussed in the Emergency Department. This project comprises a safety 'checklist' to encompass safety, assessment and triage, particularly when patients are in the queue; and an information technology innovation that helps the clinical site team to place inpatients in the most appropriate bed. The project aims to enhance patient safety and outcomes in a cost effective and demonstrable way.

1.6.2 SERIOUS INCIDENT THEMES

There were four serious incidents reported in February as shown below:



Further details are provided in the table below:

Date of Incident	SI Number	Division	Incident Details	Investigation
03/02/2015	2015 4641	Surgery, Head and Neck	Never event: "Wrong (no) gas administered". A patient requiring non-invasive ventilation was transferred to an appropriate ward without the oxygen being connected. The patient subsequently died.	Investigation underway
10/02/2015	2015 5984	Women and Children	Diagnosis of brain tumour seven months post initial presentation.	Investigation underway
16/02/2015	2015 6408	Medicine	Patient fall resulting in fracture.	Investigation underway
21/02/2015	2015 7428	Medicine	Grade 3 Pressure Ulcer	Investigation underway

WORKFORCE

2.1 SUMMARY

The indicators included in the monthly performance review are summarised in the dashboard below.

 **Achieving**	 **Underachieving**	 **Failing**
		- Workforce expenditure - compared with budget - Workforce numbers - compared with budgeted establishment - Bank and agency usage - compared with target - Vacancies - compared with target - Turnover - compared with target - Sickness absence – compared with target

2.2 EXCEPTION REPORTS

Although it is recognised that many of the contributory factors are impacting on more than one workforce Key Performance Indicator (KPI), an exception report is provided for each of the RED-rated indicators, which in February 2015 were as follows:

- Workforce expenditure - compared with budget
- Workforce numbers - compared with budgeted establishment
- Bank and agency usage – compared with target
- Vacancies – compared with target
- Turnover - compared with target
- Sickness – compared with target

Key Performance Indicators (KPIs) in the quarterly workforce report, which is next due in May, include appraisal, essential training, health and safety measures and junior doctor new deal compliance, in addition to those which form part of the monthly performance report.

Targets for sickness absence, turnover and bank and agency are agreed with Divisions as part of the annual Operating Plan process. For those targets which are below plan, exception reports are provided which detail performance against target. Graphs in the Supporting Information section are continuous from the previous year to provide a rolling perspective on performance.

KPI thresholds were determined on the basis of previous years' performance and through benchmarking with other comparable Trusts. Some ambition was built into the thresholds to move UH Bristol to the upper quartile in respect of staff experience. During March 2015, Divisions have developed operating plans for 2015/16, which include workforce KPIs, which come into effect from April 2015, in the report produced in May.

Detailed programmes of work to underpin delivery of workforce KPIs are described in the Quarterly Workforce Report. This exception report provides a summary update on progress and issues arising from the latest report covering the period October to December 2014.

WORKFORCE

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

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

Performance in the period, including reasons for the exception:

During February, there was an adverse variance on the pay expenditure compared to budget of 2.0% compared with 0.2% below budget in January with a cumulative year to date overspend of 1.3%.

	UH Bristol	Diagnostics and Therapies	Medicine	Specialised Services	Surgery Head and Neck	Women's and Children's	Trust Services (exc Estates and Facilities)	Facilities and Estates
February 2015	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Planned Expenditure	29,264	3,398	4,487	3,344	6,004	7,379	1,894	1,647
Actual Expenditure	29,846	3,407	4,500	3,558	6,398	7,450	1,911	1,658
variance target +/-	(582)	(9)	(13)	(214)	(393)	(71)	(17)	(10)
Percentage variance	(2.0%)	(0.3%)	(0.3%)	(6.4%)	(6.6%)	(1.0%)	(0.9%)	(0.6%)

Trust-wide, there was an adverse variance of £582k. Last month`s favourable variance of £47k was due in part to the release of accrued bank expenses. Total spend on agency reduced by £12k, but bank increased by £290k, and substantive staffing increased by £303k, due to recruitment and overtime and other additional payments.

Budgets since October have included Operational Capacity & Resilience funding, which has been agreed by NHS England for a range of providers, in recognition of the additional capacity pressures the NHS is facing on a national level. UH Bristol has been granted a total of £3.8 million Operational Capacity and Resilience funding, of which £2.5 million had contributed to the pay budget between October and February 2015.

All Divisions, except Trust Services, had an adverse variance in pay spend in month with the largest overspend in the following Divisions:

Specialised Services**:** adverse variance increased by £109k to £214K largely due to increases in cardiology, oncology and haematology medical pay for a variety of reasons, including pay arrears, and vacancy cover.

Surgery Head & Neck**:** adverse variance increased in month by £85k to £393k, mainly due to increased consultant payments to reduce waiting lists including in theatres, combined with increased nursing bank and agency.

WORKFORCE

Women`s and Children`s Division: there was an adverse variance of £71k compared with favourable variance of £131k last month. Nursing bank and agency spend has continued despite vacancies in theatres and paediatric intensive care unit being filled, and budget holders are working to return to funded levels, and there has also been medical agency usage to cover neonatal intensive care and paediatric junior doctors.

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

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

WORKFORCE

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

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

Total workforce numbers (substantive and bank and agency) were 2.2% above budgeted FTE, compared with 1.0% in January, largely due to the continued high usage of bank and agency staff.

Total workforce numbers including bank and agency	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates and Facilities)	Facilities & Estates
February 2015	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE
Actual Employed	7499.1	930.6	1062.0	792.7	1661.0	1681.3	653.2	718.4
Bank and Agency	589.5	20.1	188.0	69.5	98.9	92.2	47.0	73.7
Total Workforce Numbers	8088.6	950.7	1250.0	862.2	1759.9	1773.4	700.2	792.1
Budgeted Numbers	7912.4	945.4	1177.5	824.9	1714.6	1765.3	699.9	784.8
variance target +/-	(176.2)	(5.3)	(72.5)	(37.3)	(45.3)	(8.2)	(0.4)	(7.3)
Percentage variance	(2.2%)	(0.6%)	(6.2%)	(4.5%)	(2.6%)	(0.5%)	(0.1%)	(0.9%)

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

When this estimated adjustment for the Operational Resilience funding is made, which has been based on average agency and bank costs provided by Finance Department, workforce numbers are within 0.8% of budgeted FTE.

WORKFORCE

Total workforce numbers including bank and agency	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates and Facilities)	Facilities & Estates
February 2015	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE
Actual Employed	7499.1	930.6	1062.0	792.7	1661.0	1681.3	653.2	718.4
Bank and agency actual (FTE) **minus** usage funded by Operational Resilience	473.6	15.6	91.1	63.1	97.7	85.4	47.0	73.7
Total Workforce Numbers	7972.8	946.2	1153.1	855.8	1758.7	1766.7	700.2	792.1
Budgeted Numbers	7912.4	945.4	1177.5	824.9	1714.6	1765.3	699.9	784.8
variance target +/-	60.4	0.8	(24.4)	30.8	44.1	1.4	0.4	7.3
Percentage variance	0.8%	0.1%	(2.1%)	3.7%	2.6%	0.1%	0.1%	0.9%

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

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

WORKFORCE

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

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

During February, temporary staffing comprised 7.3% of total staffing numbers (FTE) compared with 6.4 % last month, and an annual average of 6.5%. Agency staffing accounted for 1.9% of total staffing for January, compared to the annual average of 1.5%. Agency usage has increased by 18.4 FTE and bank usage has increased by 58.3 FTE. The overview below by Division shows usage for bank and agency against the original thresholds set by Divisions.

Bank (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Bank February 2014	329.6	8.9	107.4	41.1	64.4	49.7	31.0	27.1
Target set by division	254.0	11.0	80.0	19.7	55.5	46.4	28.2	13.2
Bank February 2015	432.2	11.6	132.0	47.5	77.5	69.5	36.1	58.0
Variance from target (FTE)	(178.2)	(0.6)	(52.0)	(27.8)	(22.0)	(23.1)	(8.0)	(44.8)

Agency (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Agency February 2014	79.8	1.5	28.5	26.6	6.3	8.9	8.1	1.4
Target set by division	37.2	1.5	8.3	3.5	6.9	8.2	4.9	3.9
Agency February 2015	157.3	8.6	56.1	22.0	21.4	22.6	10.9	15.7
Variance from target (FTE)	(120.1)	(7.1)	(47.8)	(18.5)	(14.5)	(14.4)	(6.0)	(11.9)

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

- Workload and clinical needs, increased acuity, extra capacity and administrative workload increased to 42.1% from 41.5% of overall usage;
- Cover for vacancies increased to 27.3% from 26.2 %;
- Cover for sickness absence increased to 14.4% from 12.4%;

WORKFORCE

- Nursing assistant one-to-one care reduced to 8.6% from 9.1% of usage.

At the end of February, there were 43 additional capacity beds open, of which 27 were unplanned. As a result of changes to the way reasons for bank and agency usage are recorded at the point of booking, there is clearer information about the respective impact of increased patient acuity and bed capacity on bank and agency usage. 4.5% of usage was due to additional bed capacity and in addition and 15.7% increased acuity and dependency, reflecting the increased operational pressures.

The table below shows bank and agency usage when Operational Resilience funded FTE is excluded, based on a notional calculation from money to FTE.

Bank & agency usage (excluding operational resilience funded) FTE	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services (exc Facilities & Estates)
October 2014	517.58	15.24	163.08	62.93	93.61	80.39	63.13	39.21
November 2014	522.65	21.50	161.64	63.94	96.02	80.47	62.52	36.56
December 2014	489.13	14.25	141.06	54.45	99.68	65.08	67.66	46.95
January 2015	433.60	9.98	107.68	51.66	80.67	60.85	61.78	42.35
February 2015	494.41	15.60	91.05	63.07	97.71	85.45	73.73	47.03

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

The Bank and Agency Action Plan will be regularly reviewed by the Recruitment and Retention Group. Progress this month is summarised below:

Enhanced Rostering, Operational and Workforce Planning:

- Further Key Performance Indicators have been added to monitor requests, covering more areas in February and March.

Reducing requests due to clinical need and enhanced observation

- The Standard Operating Procedure continues to ensure all agency requests are appropriately approved, with controls in place to monitor this.

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

- The NHS Net texting service, which is important in advising nursing bank staff of shifts to be filled, is no longer available from April 1st. The replacement system, already in use in the Bristol Children`s Hospital, has an added functionality that staff can text back to fill a shift, rather than needing to ring or email. This service will be extended to other bank staff including admin and clerical, interpreters and Estates & Facilities;
- Senior Leadership team and the Pay Assurance Group agreed that the intensity bonus for staff with bank-only contracts would be increased. Following a review of bonus terms, the Trust has agreed to reduce the number of qualifying hours and increase the bonus percentage. This

change is in recognition of our temporary workforce's dedication and hard work throughout the year and will come into effect from April 1st.

- The Trust has reviewed the current pay processes for substantive staff who work additional bank hours. Shifts can now be paid at the end of the month they are worked, encouraging substantive staff to undertake additional hours;
- There will be a revised re-appointment process following process mapping in February. The new process will be more efficient and streamlined when leaving a substantive post and retaining a bank position with the Trust;
- Divisions have been asked to review bank administrative and clerical contracts which have exceeded 12 weeks with a view to releasing bank capacity if appropriate. The same approach will be undertaken for long term admin and clerical agency usage.

WORKFORCE

W4. EXCEPTION REPORT: Vacancy Levels	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

Vacancies have shown a clear reduction in month, reducing from 5.5% to 5.2%, with a reduction in all Divisions except Specialised Services.

Vacancy Levels by Division	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
February 2014	3.7%	3.7%	1.5%	2.2%	3.2%	2.4%	9.1%	7.0%
Actual February 2015	5.2%	1.6%	9.8%	3.9%	3.1%	4.8%	6.7%	8.5%
FTE vacancy February 2015	413.3	14.8	115.5	32.2	53.6	84.0	46.7	66.4

There are about 8 FTE more staff employed this month than in February, but 26 less registered nurses. Registered nurse vacancies have increased from 6.2% (147 FTE) to 7.3% (171 FTE). Ancillary vacancies have reduced again this month to 6.7% (52.7 FTE) and are at their lowest since last May. There continue to be "hot spots" of high vacancies, including Paediatric and Neonatal Intensive Care Units, Medicine Wards, and key medical posts in Diagnostics & Therapies and Specialised Services Divisions.

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

Progress on the agreed recruitment action plan is as follows:

Increased speed of recruitment - Conversion to hire

- The agreed escalation process to speed-up health assessment clearances continues to be implemented;

IT infrastructure within the end-to-end recruitment process

- Approval was provided by IM&T (Information Management & Technology) Board in February to proceed with the successful supplier for a recruitment system with a target go-live date of May 2015. A full project plan is being compiled with support from IM&T to formally implement the system. Resources within the recruitment service have been identified to support the implementation;

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

- The Recruitment team structure has been strengthened and training is taking place to improve service resilience. Funding as part of the Operating Plan process will support further investment, to sustain the additional resource, including the nurse placement manager, on a non recurring basis;

Marketing campaign to target the national UK market

- The marketing campaign continued with a range of activities including UH Bristol Recruitment representation at a careers fair at Bristol City College to raise awareness about careers in the NHS and promote vacancies for domestic and nursing assistants, and Administrative & Clerical staff;

Overseas Recruitment

- It has been agreed that UH Bristol representatives will attend the careers fairs in Dublin and Belfast, similar to April 2013, where 9 Irish nurses were recruited, all of whom continue to work at the trust.

The newly established Recruitment and Retention sub-group will be managing this programme of work and will report back to the Workforce & Organisational Development Group on a regular basis.

Progress in February with respect to staff groups where vacancies are particularly high is described below:

Ancillary (Cleaning, Catering and Portering) Recruitment

At the beginning of May there were 15 Domestic Assistant vacancies Trust-wide. However, in light of continued changes in relation to the BRI Redevelopment, there are now a further 27 vacancies, together with an additional 5 vacancies due to ongoing turnover, resulting in a total of 47 vacancies. There are 22 posts with recruitment already in the pipeline. The plan to address the gap includes an Open Day in March.

Nurse Recruitment

28 final offers were made in February for registered nurses and 35 were made to Nurse Assistants. Activities include the following:

- A Nursing Open Day was held on 26 February 2015. A total of 50 enquiries were received from registered nurses, and students qualifying in the summer coming from across the UK, and a total of 12 offers made and 17 others will be invited either for interview or to attend a tour in the future;
- Assessment centres were held for registered and unregistered nursing, resulting in a number of offers, (17 unregistered, 26 registered) including a significant proportion for the bank;
- The third of the Trust's Return to Practice cohorts is planned to start on 18 May. The Trust hopes to recruit to 10 placements. The advert for this went live in February with short-listing and interviews to take place in March.

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W5. EXCEPTION REPORT: Rolling Turnover	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

Turnover is measured as the total (FTE) permanent employees who have left, as a percentage of the 12 month average total (FTE) permanent staff in post, presented as a cumulative, rolling 12 month figure compared with a Trust wide trajectory to achieve 10% by the end of 2014/15.

Performance in the period, including reasons for the exception:

Rolling turnover continues to exceed 13% at 13.8% in February, compared with 13.7% in January and 11.2% a year ago. Rates by Division are shown in the table below:

Turnover by Division	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Cumulative Rolling Turnover February 2014	11.2%	8.6%	14.0%	12.7%	12.1%	9.4%	10.9%	10.9%
Actual Cumulative Rolling Turnover February 2015	13.8%	10.8%	13.6%	16.9%	15.0%	12.0%	15.0%	14.7%
Approximate leavers (FTE) over previous 12 months	880	90	123	115	199	167	83	103

Permanent staff leaver numbers increased in February to 122 compared with 118 one year ago. The biggest increase this month was in Women`s & Children`s which rose from 11.1% to 12%. The turnover rate in Specialised Services continues to be the highest Divisional level, but has reduced this month from 17.1% to 16.9%.

Retirements were below average this month, 4 compared with a monthly average (financial year to date) of 10.2. Numbers leaving due to "work life balance" have reduced for the third successive month, with 17 compared with an average of 22.6. Relocation is the reason most often given for staff leaving voluntarily, with 19 this month (average 23.5). The highest turnover continues to be amongst unregistered nursing, although this has reduced slightly this month, from 23.6% to 23.5%.

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

Progress against the priorities agreed with Senior Leadership Team is as follows:

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Nursing/Midwifery Assistants

- *Communication* – work to develop a Trust-wide Nursing/Midwifery Assistants Forum and a number of listening events is being taken forward by Divisions – for example, the Division of Medicine has their second event planned for March, having held two events in February, where the lack of progression opportunities from band 2 was highlighted;
- *Pre and post-induction support* – the Trust is currently reviewing both induction and appraisal processes and Nursing leads are specifically focusing on how local ward induction can be improved;
- *Career Progression* – Corporate nursing leads are ensuring there are clear competence requirements supported by training for each role within nursing job descriptions, to be included as part of a nursing website to demonstrate opportunities for development and career progression for registered and unregistered nurses at UH Bristol;
- *Revised nursing assistant pathways* – an evaluation of the nursing pathways introduced in July 2014 has taken place. Evidence shows that whilst turnover generally amongst nursing assistants has increased between July 2014 and February 2015, there are lower numbers of leavers among the cohort recruited through the new pathway compared with those recruited during the same period in the previous year.

Incentives

A paper describing options for staff groups where there are particular recruitment and retention difficulties was presented to the Trust Executives and Senior Leadership Team in February. It was agreed that up financial support for accommodation costs could be made available for new recruits within defined shortage occupations, and the Refer a Friend scheme was also agreed. Additional staff benefits, including staff recognition schemes, are still under review.

Staff Engagement

The comprehensive programme of staff engagement work continues with key headlines this month including:

- Organisational Development training for team coaches provided by Aston University commenced in early March. Two cohorts of coaches are being trained, with the first cohort between March and May and the second May to July. Coaches work with team leaders, using a systematic, evidence-based approach, to support team development;
- A survey on nursing staff views on shift patterns was run during December and January, and was followed by a series of focus groups in February. Findings are currently under review and a report will be presented to the Trust Executive Group in April;
- The first draft of a revised Speaking Out Policy, Frequently Asked Questions and extensive management and staff guidance has been prepared and will be reviewed by Trust Board prior to formal ratification and an implementation programme;
- The staff survey results have been received and analysed. The report will be presented to Senior Leadership Team and the Workforce and Organisational Development Group in March. Divisions have been given their local survey results and are being asked to carry out a range of discussions/listening events/focus groups to obtain richer data and seek collaborative solutions with staff to inform divisional action plans.

WORKFORCE

W6. EXCEPTION REPORT: Sickness compliance	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured:

Sickness absence figures are shown as percentage of available FTE (full time equivalent) absent.

Performance in the period, including reasons for the exception:

Sickness rates have reduced slightly from 4.7% to 4.6%. There is a large variation between divisions in changes over the last month. Diagnostics & Therapies Division, which generally has the lowest level with an annual average to date of 2.9%, reached 4.2% this month and the rate in Surgery Head & Neck Division, with an annual average of 3.8%, was 4.4%. By contrast, absence in Specialised Services was 3.2% which is their lowest rate for more than two years.

The top three reasons for absence showed a slight increase in January compared with December (see section 2.3.1), but there has been a slight decrease in February. Cold and flu related absence in February was lower than in January or December, which is consistent with the usual seasonal pattern. However, the impact of colds and flu has been much greater this year than in the previous year. During February 2015, there were 32% more days lost to colds and flu compared with a year ago, and 36% more days lost due for this reason during the winter of 2014/15 than the same period in 2013/14.

Detail by Division is provided in the following table:

	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Absence February 2013	4.2%	2.4%	4.5%	4.1%	4.2%	4.1%	3.3%	7.6%
Target February 2014	3.6%	2.8%	4.2%	4.0%	3.3%	3.4%	2.7%	5.3%
Absence February 2015	**4.6%**	**4.2%**	**5.7%**	**3.2%**	**4.4%**	**4.4%**	**4.1%**	**6.9%**
Cumulative absence February 2014	4.1%	2.9%	5.0%	3.9%	3.8%	4.0%	3.3%	6.5%
	1.0%	1.4%	1.6%	-0.8%	1.1%	1.0%	1.4%	1.5%

Progress against recovery plan

In the context of our overall health and well-being programme, key activity is highlighted below.

Influenza

4168 staff, including 3444 frontline staff, have been vaccinated to date, representing 60% of frontline staff and showing a 9% improvement from 2013/14.

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Stress Management/ Health and well-being

- Hot spots have been identified in partnership with Divisional HR Business Partners to identify where there are high incidences of indicators such as sickness absence, turnover, Occupational Health counselling referrals, discipline and grievance cases, etc;
- Smoke free secondary care practitioners will be recruited for a fixed term of a year from April 2015. Duties will include the implementation of a revised smoke free policy and providing cessation support for staff, patients and visitors (funded by public health, Bristol City Council);
- The revised staff Health & Wellbeing Group (a sub group of the Workforce & Organisational Development Group) has been set up to reinvigorate the Trust Well Being approach;
- 10 extended modules of 'Making Change' and 'Identifying and Managing Work Related Stress' have been made available to staff from hot spots identified as part of the "Lighten-up" programme. There are up to 300 places for staff (150 each module) concluding in April 2015 when evaluation will be completed;
- The second Schwartz round took place in March which was well attended;
- Use of the Care First Employee Assistance Programme in Women`s & Children`s Division increased between November and January. 70% of contacts were made after recommendations from other staff who had used the service.

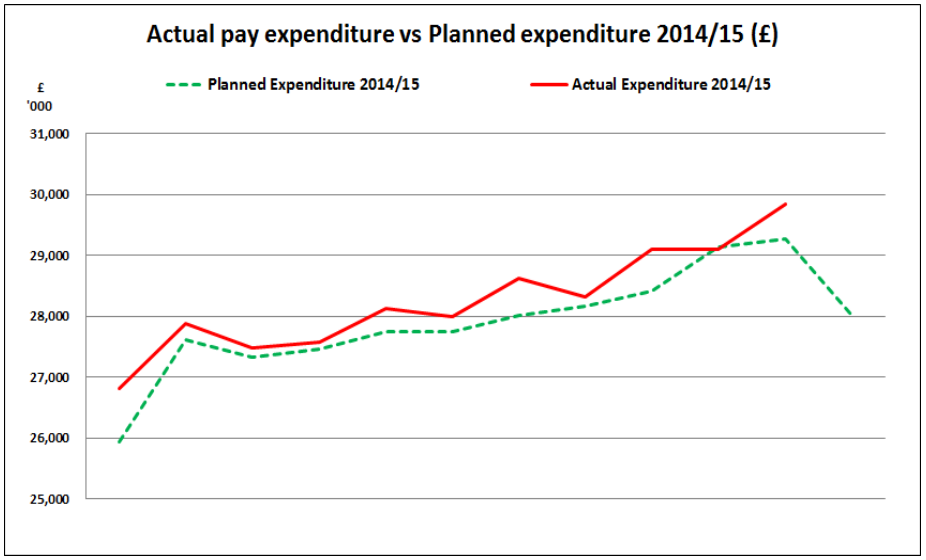
Musculo-skeletal

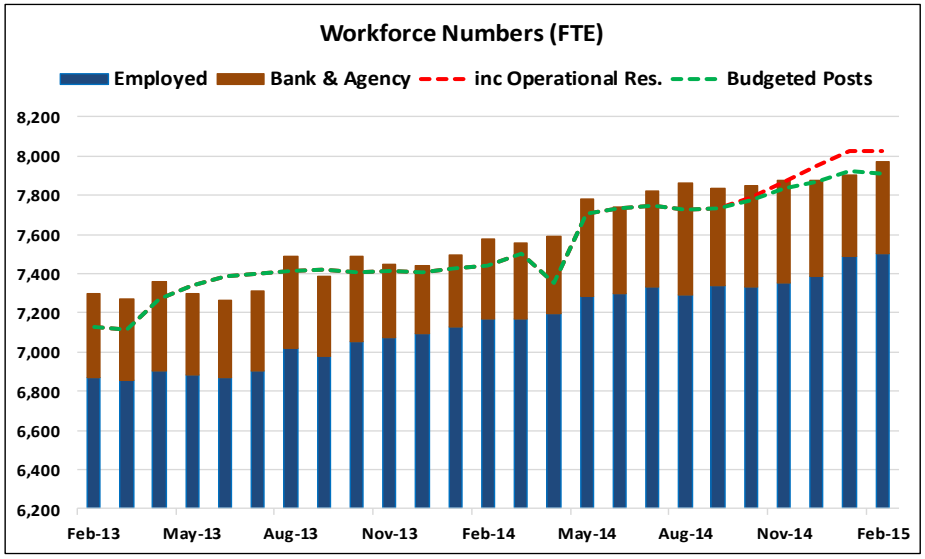
- Physio Direct consultations increased in February to 77 from 65 in January;
- Musculo skeletal manager-referral clinics have been running to full capacity;
- The manual handling team provided more than 100 individual in-loco staff follow-up visits to advise and assess on best practice, musculo and skeletal wellbeing and patient safety and provided more than 20 individual Workstation / advisory visits related to wellbeing.

2.3 SUPPORTING INFORMATION

2.3.1 Performance against key workforce standards

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





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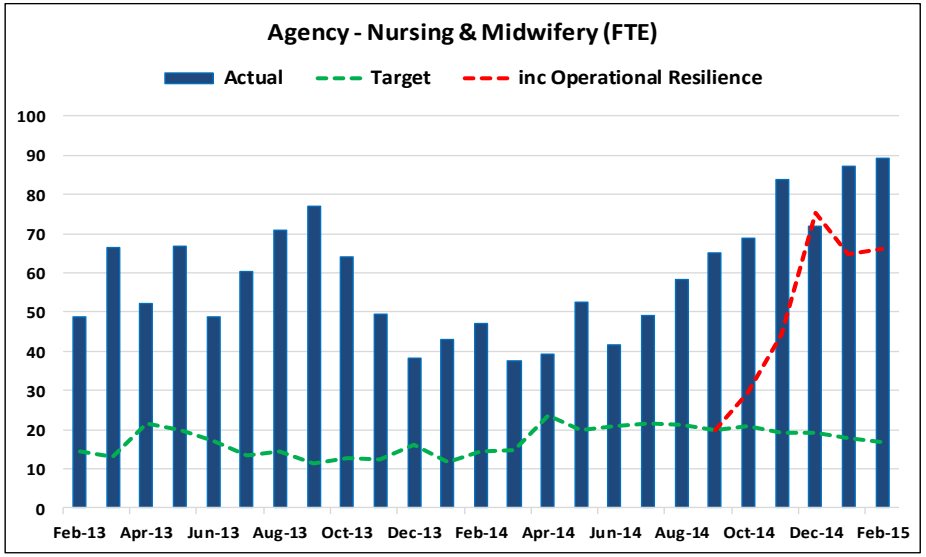
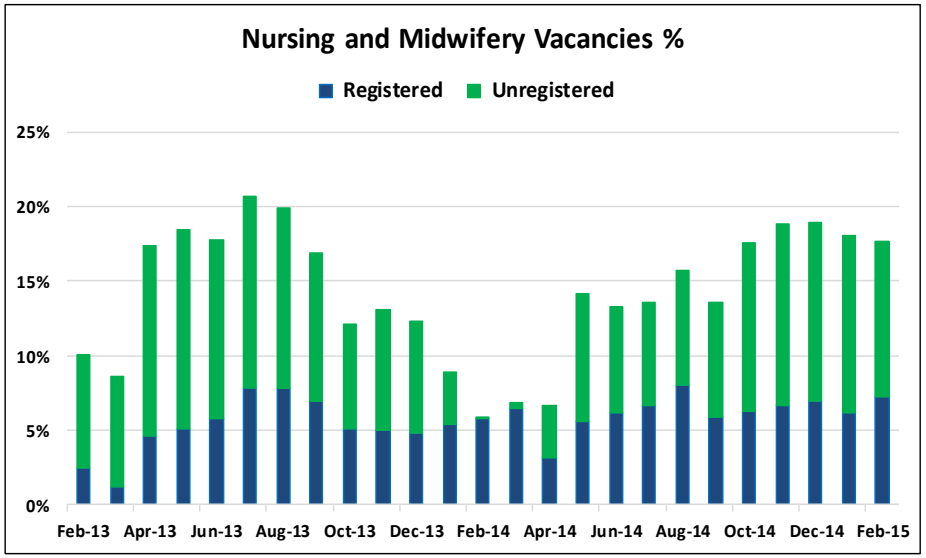
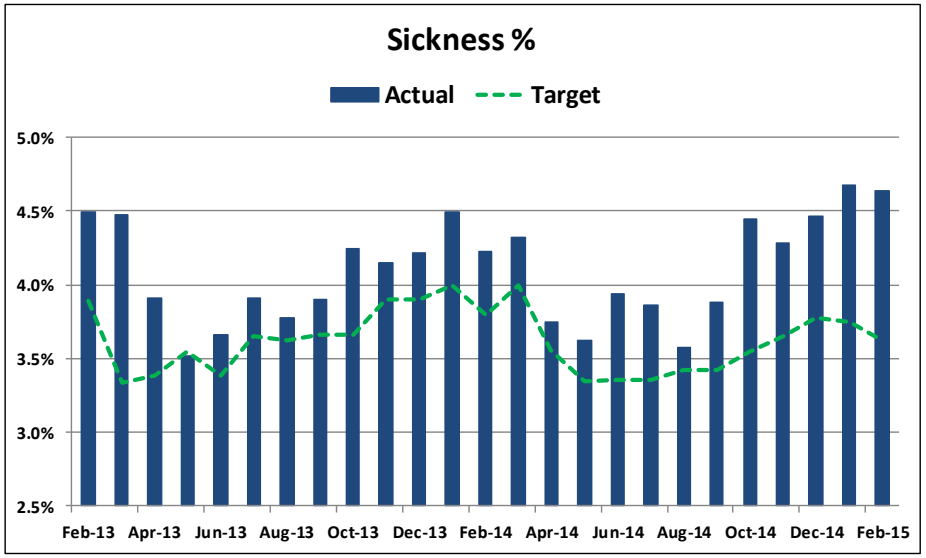
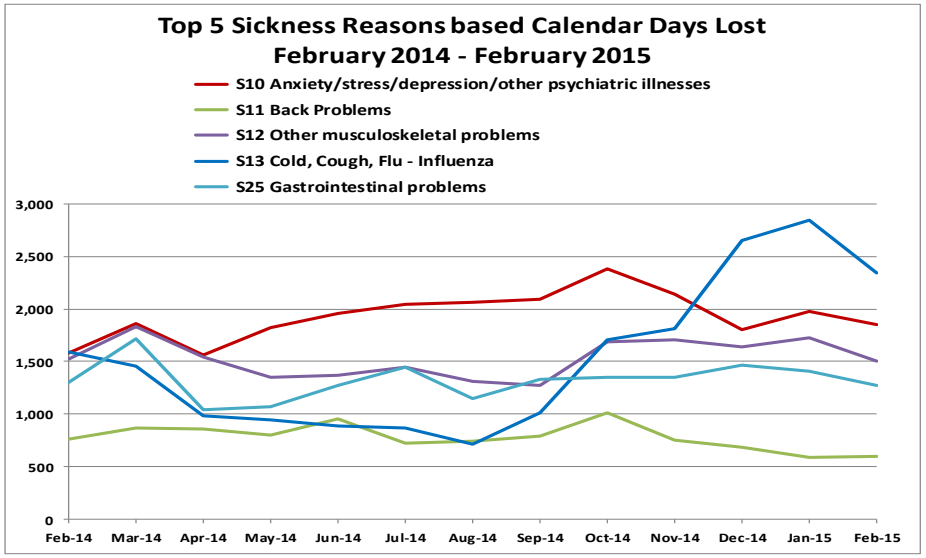
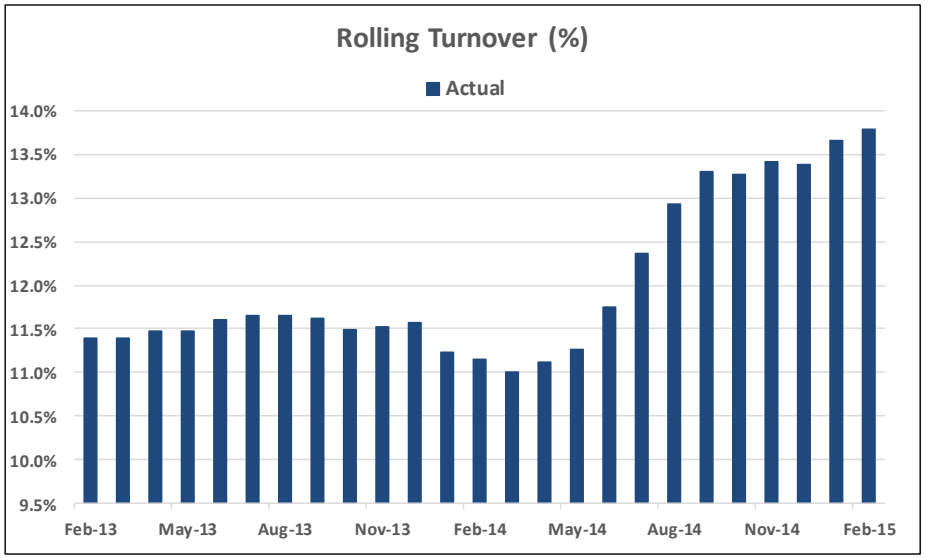

Agency - Nursing & Midwifery (FTE)
Actual
Target
inc Operational Resilience
100
90
80
70
60
50
40
30
20
10
0
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15


Nursing and Midwifery Vacancies %
Registered
Unregistered
25%
20%
15%
10%
5%
0%
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15


Sickness %
Actual
Target
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15

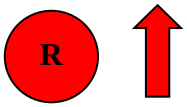
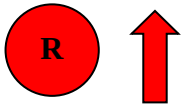
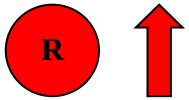
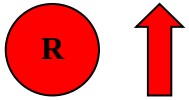
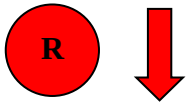
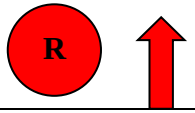
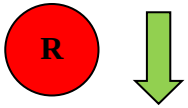

Top 5 Sickness Reasons based Calendar Days Lost
February 2014 - February 2015
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
3,000
2,500
2,000
1,500
1,000
500
0
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15

WORKFORCE


Rolling Turnover (%)
Actual
14.0%
13.5%
13.0%
12.5%
12.0%
11.5%
11.0%
10.5%
10.0%
9.5%
Feb-13
May-13
Aug-13
Nov-13
Feb-14
May-14
Aug-14
Nov-14
Feb-15

2.3.3 Changes in the period

Performance is monitored for workforce expenditure, workforce numbers, bank and agency usage, sickness and turnover. The following dashboard shows key workforce information indicators RAG (Red, Amber, Green) rated for the month of January. Red rated indicators are outside tolerance limits and exception reports are provided for these.

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Expenditure (£)		Workforce expenditure adverse variance from budget increased from 0.2% below budget to 2.0% above budget in month compared with January 2015.	See summary, supporting information and exception report.
Workforce Numbers (FTE)		Total workforce numbers including bank and agency increased by 84.5 FTE compared with the previous month. Workforce numbers were 2.2% above budgeted FTE. This compares with January 2015, when numbers were 1.0% above budgeted establishment.	See summary, supporting information and exception report.
Bank (FTE)		Bank increased by 58.3 FTE to 432.2 FTE (compared with a target of 254.0 FTE) in February 2015. Operational Resilience Pressures funding equated to 8.3% (35.7 FTE) of total bank FTE in February 2015.	See summary, supporting information and exception report.
Agency (FTE)		Agency increased by 18.4 FTE to 157.3 FTE (compared with a target of 37.2 FTE) in February 2015. Operational Resilience Pressures funding equated to 37.7% (59.3 FTE) of total agency FTE in February 2015.	See summary, supporting information and exception report.
Sickness absence (%)		Sickness absence reduced to 4.6% in February; compared to 4.7% in January (updated figure).This is 1.0 percentage points above the monthly target of 3.6%.	See summary, supporting information and exception report.
Turnover (%)		Rolling turnover (excluding fixed term contracts, junior doctors, and bank) increased from 3.7% to 13.8% compared a target of 10.1%.	See summary, supporting information and exception report.
Vacancy (%)		Vacancies reduced to 5.2% this month, compared with a target of 5%.	See summary, supporting information and exception report.

Note: RAG (Red, Amber, and Green) rating reflects whether the indicator has achieved the target. The direction of the arrow shows the change from last month. The colour of the arrow reflects whether actual this month is better in relation to the target (green) or further from the target than last month (red). Sickness and bank and agency targets are set by Divisions, and appraisal is a Trust wide target.

2.3.4 Monthly forecast and overview

Measure	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	February 15 Target
Budgeted Posts (FTE)	7442.0	7499.3	7355.2	7709.5	7732.9	7744.9	7729.1	7733.4	7775.8	7833.6	7872.4	7927.2	7912.4	7780.4
Total Staffing (FTE)	7578.1	7556.5	7588.1	7780.7	7739.6	7821.9	7864.8	7835.5	7859.9	7910.8	7954.2	8004.1	8088.6	7499.1
Bank (FTE) Admin & Clerical	67.4	64.9	71.3	89.2	83.7	88.8	103.5	86.4	95.8	93.5	102.5	89.1	101.0	64.0
Bank (FTE) Ancillary Staff	35.2	34.6	38.0	54.6	51.8	51.9	73.3	59.0	55.6	47.5	57.4	51.5	62.7	17.6
Bank (FTE) Nursing & Midwifery	220.2	197.4	203.6	249.5	220.8	241.8	274.2	233.7	247.2	245.0	254.8	227.2	257.5	156.7
Agency (FTE) Admin & Clerical	27.1	25.7	23.4	22.4	21.1	19.3	27.7	26.4	29.9	49.0	52.9	25.2	39.2	12.1
Agency (FTE) Ancillary Staff	0.0	8.3	0.0	6.8	4.9	15.0	12.1	7.6	7.9	14.3	9.7	12.1	11.5	3.5
Agency (FTE) Nursing & Midwifery	47.2	37.5	39.2	52.4	41.6	49.1	58.3	65.0	68.9	83.7	71.9	87.2	89.3	16.9
Overtime	54.7	83.7	76.4	48.2	62.3	49.6	67.5	60.2	78.9	64.3	76.9	47.0	65.8	47.9
Sickness absence[1] Rate (%)	4.2%	4.3%	3.7%	3.6%	3.9%	3.9%	3.6%	3.9%	4.4%	4.3%	4.5%	4.7%	4.6%	3.6%
Appraisal (%)	87.9%	85.9%	87.1%	86.3%	87.2%	86.3%	86.9%	85.3%	84.4%	83.5%	85.1%	83.7%	84.4%	85.0%
Consultant Appraisal[5] (%)	0.0%	0.0%	89.1%	89.2%	83.0%	85.5%	88.8%	89.1%	88.4%	90.3%	89.0%	89.7%	90.6%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	18.0%	17.8%	17.8%	18.0%	18.6%	19.0%	19.4%	19.7%	19.5%	19.6%	19.4%	19.7%	19.6%	
Rolling Average Turnover[3] (with exclusions) (%)	11.2%	11.0%	11.1%	11.3%	11.7%	12.4%	12.9%	13.3%	13.3%	13.4%	13.4%	13.7%	13.8%	10.1%
Vacancy[4] Rate (%)	3.7%	4.4%	2.2%	5.5%	5.6%	5.4%	5.6%	5.1%	5.7%	6.1%	6.1%	5.5%	5.2%	≤5%

1. Sickness absence is expressed as a percentage of total whole time equivalent staff in post.
2. Turnover measures the number of leavers expressed as a percentage of the average number of staff in post in the period. Turnover (all reasons) excludes bank, locum and honorary staff.
3. Turnover (with exclusions) excludes bank, locum, honorary and fixed term staff together with junior doctors.
4. Vacancy measures the number of vacant posts as a percentage of the budgeted establishment.
5. Consultant appraisal process allows 15 months before counting as non-compliant

ACCESS STANDARDS

3.1 SUMMARY

The following section provides a summary of the Trust's performance against key national access standards at the **end of February 2015**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 4)***, and/or the ***month***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS operating framework and NHS Constitution.

Achieving (10)	**Underachieving (2)**
- 31-day diagnosis to treatment cancer standard - *subsequent drug* - 31-day diagnosis to treatment cancer standard – *subsequent radiotherapy* - 31-day diagnosis to treatment cancer standard - *subsequent surgery* - 31-day diagnosis to treatment cancer standard - *first treatment* - 2-week wait urgent GP referral cancer standard - A&E Time to Initial Assessment - A&E Left without being seen rate - A&E Time to Treatment - A&E Unplanned re-attendance - Reperfusion times (door to balloon time of 90 minutes)	- Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved* - Ambulance hand-over delays over 30 minutes (year-on-year reduction)
Failing (10)	**Not reported/scored (0)**
- A&E Maximum waiting time (4-hours) - Delayed Discharges - Referral to Treatment Time for non-admitted patients - Referral to Treatment Time for admitted patients - Referral to Treatment Time for incomplete pathways - 62-day referral to treatment cancer standard – *GP referred* - 62-day referral to treatment cancer standard - *Screening referred* - Last-minute cancelled (LMC) operations + 28-day readmission - 6-week wait for key diagnostic tests	

*Please note: Performance for the cancer standards is reported by all trusts in the country two months in arrears. The current cancer performance figures shown include the reported figures for January, and draft figures for the quarter to date. Indicators are shown as being **failed** where the required standard is not achieved for the quarter to date. Indicators are shown as being **underachieved** if there has been a failure to achieve the national target in the current month, but the quarter is currently being achieved, or where a local standard is not being met.*

3.2 ACCESS DASHBOARD

Access Standards - dashboard

		Thresholds		Previous YTD	Year to date (YTD)	Month												Quarter				
	Target	Green	Red			Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	96.5%	95.8%	98.4%	97.1%	97.0%	96.0%	97.0%	93.2%	94.8%	94.7%	96.3%	97.5%	94.3%	Cancer standards report two months in arrears	97.4%	96.7%	95.0%	96.1%	94.3%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.3%	96.7%	97.8%	97.5%	97.9%	96.2%	96.8%	96.2%	96.2%	95.7%	94.0%	98.5%	97.8%		96.0%	97.2%	96.4%	96.2%	97.8%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.7%	99.7%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	99.0%		99.7%	99.7%	100.0%	99.6%	99.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.9%	94.8%	91.8%	97.9%	93.2%	93.5%	94.0%	97.8%	91.7%	96.4%	92.3%	95.0%	95.5%		94.1%	94.9%	94.6%	94.8%	95.5%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.4%	97.7%	95.6%	97.9%	98.9%	95.1%	97.6%	98.4%	97.4%	98.2%	99.5%	97.2%	96.4%		95.7%	97.2%	97.8%	98.3%	96.4%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	81.0%	79.7%	74.8%	75.3%	81.1%	85.1%	79.4%	77.6%	74.3%	78.8%	81.4%	84.6%	80.0%		75.1%	80.4%	76.8%	81.6%	80.0%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	93.6%	89.4%	88.9%	90.3%	90.2%	90.9%	90.2%	94.3%	83.3%	73.3%	100.0%	90.9%	66.7%		94.4%	90.4%	90.8%	84.4%	66.7%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	90.7%	90.0%	97.0%	97.5%	86.1%	100.0%	86.7%	70.0%	89.3%	85.7%	100.0%	90.5%	84.4%		85.3%	95.3%	83.1%	90.4%	84.4%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	92.9%	85.4%	90.5%	91.9%	91.8%	90.1%	87.2%	84.4%	82.4%	85.2%	83.1%	84.3%	80.5%	80.4%	92.0%	91.2%	84.7%	84.3%	80.4%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	93.1%	90.4%	93.1%	93.6%	94.0%	92.8%	89.7%	90.0%	89.0%	89.2%	88.8%	89.9%	88.9%	89.3%	92.6%	93.4%	89.5%	89.3%	89.1%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.5%	90.4%	93.1%	92.7%	92.5%	92.1%	92.0.%	91.1%	90.0%	89.4%	88.7%	87.5%	88.9%	89.4%	92.7%	92.4%	91.0%	88.5%	89.1%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	93.8%	92.0%	92.1%	94.5%	94.3%	95.2%	92.4%	93.7%	92.4%	93.8%	88.6%	86.3%	90.9%	89.5%	91.3%	94.7%	92.8%	89.6%	90.2%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	15	13	15	14	12	11	13	12	11	12	12	36	14	14	14	12	12	15	14
	A&E Time to treatment decision (median) - in minutes	60	60	52	54	54	53	57	55	59	47	55	51	59	57	48	50	51	55	54	55	49
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	1.5%	2.3%	2.4%	2.7%	2.2%	2.4%	0.2%	2.5%	2.6%	2.5%	2.6%	2.4%	2.7%	2.5%	2.5%	2.4%	1.7%	2.5%	2.6%
	A&E Left without being seen	5%	5%	1.8%	1.8%	1.7%	1.5%	1.9%	1.4%	2.2%	2.0%	2.0%	1.5%	2.3%	1.6%	1.6%	1.5%	1.8%	1.6%	2.1%	1.8%	1.5%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.00%	1.08%	0.92%	0.98%	0.96%	1.10%	1.35%	0.97%	1.14%	0.84%	1.96%	0.73%	1.00%	0.85%	1.17%	1.02%	1.16%	1.16%	0.93%
	28 Day Readmissions	95%	85%	89.6%	89.5%	89.7%	94.2%	85.2%	94.4%	95.3%	90.5%	85.2%	85.3%	90.4%	87.0%	82.9%	94.8%	90.3%	91.3%	90.6%	87.3%	89.9%
	6-week wait for key diagnostics	99%	99%	98.5%	97.4%	99.2%	98.3%	96.6%	97.3%	97.7%	97.0%	98.1%	99.1%	98.3%	95.8%	95.5%	97.9%	98.8%	97.4%	97.6%	97.8%	96.7%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	82.4%	78.7%	77.1%	78.6%	78.3%	82.1%	80.6%	76.9%	81.8%	79.4%	73.8%	80.0%	78.3%		78.9%	79.4%	78.7%	76.3%	78.3%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	93.0%	92.2%	91.7%	96.4%	93.5%	96.4%	88.9%	94.9%	90.9%	94.1%	81.0%	92.0%	95.7%		91.1%	95.1%	92.0%	88.1%	95.7%
	Delayed discharges (Green to Go List)	30	41	Not applicable	52.2	58	56	51	58	50	53	57	44	55	42	59	49	63.7	55.0	53.7	47.0	54.0
	Ambulance hand-over delays (over 30 minutes) - 10% reduction on 13/14	0	91.2	100.0	111.9	105	96	100	79	139	144	100	77	131	168	119	78	112.0	91.7	127.7	125.3	98.5

Please note:
Where the threshold for achieving the standard has changed between years, the latest threshold for 2014/15 has been applied in the Red, Amber, Green ratings.
The A&E Time to Initial Assessment figures exclude the Bristol Children's Hospital performance, due to problems with reporting accurate figures from Medway Patient Administration System (PAS). Work is ongoing to address the data issues.
The thresholds for Ambulance hand-over delays are a percentage reduction on the same period last year, in order to take account of seaonal changes in demand.
The standard for Primary PCI 150 Call to Balloon Time only applies to direct admissions - the local target is shown as the GREEN threshold and the national target as the RED.
All **CANCER STANDARDS** are reported nationally two months in arrears. Monthly figures are indicative, until they are finalised at the end of the quarter. The figures shown are those reported as part of the National Cancer Waiting Times data-set. They do not reflect any breach reallocation for late referrals, which is only allowable under Monitor's Compliance Framework.

3.3 CHANGES IN THE PERIOD

Performance against the following national standards changed significantly relative to the last reported period:

- Cancer 62-day Screening referral to treatment ↓ (down from 90.9% in December to 66.7% in January);
- Last-minute cancelled operations ↓ (down from 1.0% in January to 0.85% in February);
- 28-day readmissions following a last-minute cancelled operation ↑ (up from 82.9% in January to 94.8% in February);
- Ambulance hand-over delays over 30 minutes ↓ (down from 119 in January to 78 in February);

Please note the above performance figures only show the final reported position and do not show the draft performance against the cancer standards for the current quarter, although additional information is noted where the draft figures have been validated.

3.4 EXCEPTION REPORTS

Exception reports are provided for nine of the RED rated performance indicators. Please note that the number of Delayed Discharge patients in hospital at month-end is now reported as one of the access key performance indicators, along with Ambulance hand-over delays over 30 minutes. As key measures of patient flow, Delayed Discharges and Ambulance Hand-over delay performance will be reported as part of the A&E 4-hour Exception Report, in months where the 95% standard isn't achieved.

1) Last-minute cancellations (LMC)
2) 28-day readmission following a last minute cancellation
3) 62-day referral to treatment cancer standard – GP referred
4) 62-day referral to treatment cancer standard – Screening referred
5) Referral to Treatment Time (RTT) Admitted pathways standard
6) Referral to Treatment Time (RTT) Non-admitted pathways standard
7) Referral to Treatment Time (RTT) Incomplete pathways standard
8) A&E 4-hour maximum wait
9) Six-week diagnostic wait

ACCESS STANDARDS

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

Description of how the target is measured:

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

This standard remains part of the NHS Constitution.

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

There were 46 last-minute cancellations (LMCs) of surgery in February (0.85% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in February were as follows:

- 24% (11 cancellations) were due to a lack of theatre time due to clinically complicated patients needing more time in theatre than expected, and/or the morning theatre session running over;
- 20% (9 cancellations) were due to no high dependency bed/intensive therapy unit bed being available to admit a patient to;
- 13% (6 cancellations) were due to a surgeon or anaesthetist being unwell or unavailable;
- 9% (4 cancellations) were due to an emergency patient being prioritised;
- 9% (4 cancellations) were due to booking errors;
- 7% (3 cancellations) were due to no ward beds being available;
- 20% (9 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging.

Of the 46 cancellations, 15 were day-cases and 41 were inpatients (33% day-cases). On average, seventy percent of the Trust's admissions in a month are day-cases. The higher cancellation rate for inpatient procedures is likely to be a result of one of the main causes of cancellation being lack of a bed on high dependency bed/intensive therapy unit. Day-case procedures do not require high dependency bed/intensive therapy unit beds, and are also less likely to be cancelled due to cases running over because they were more complicated than expected.

In February 94.8% of patients cancelled in the previous month were readmitted within 28 days of the cancellation, against a national standard of 95%. This represents a significant improvement of January's performance of 82.9%. There were three breaches of 28-day readmission standard in the month, of which two patients were due for readmission for procedures within the Bristol Children's Hospital, and one patient needed to be readmitted for a procedure within the Bristol Royal Infirmary. In all three cases, the patients could not be re-admitted within 28-days due to more clinically urgent patients requiring admission.

ACCESS STANDARDS

Recovery plan, including expected date performance will be restored:

The following actions continue to be taken to reduce last-minute cancellations and support achievement of the 0.8% standard:

- Ongoing implementation of 4-hour plans, the actions from which should reduce cancellations related to bed availability (see A&E 4-hour Exception Report – A8);
- Escalation of all LMCs not re-booked within 7 days of cancellation (ongoing); patient list now also being reviewed at the weekly or fortnightly Referral to Treatment Time (RTT) meetings with Divisions;
- Monthly validation of all potential LMCs re-established, to ensure we are not inappropriately reporting last-minute cancelled operations, or failures to re-admit within 28 days, and that we understand the reasons for cancellations (ongoing);
- Outputs of the weekly scheduling meeting are reviewed by Surgery, Head & Neck team, to be clear on the accountability for making sure theatre lists are appropriately booked (i.e. will not over-run), and the necessary equipment/staffing are available (ongoing);
- Weekly reviews of future week's operating lists continue, to ensure the demand for critical care beds is spread as evenly as possible across the week; daily reviews of current demand for critical care beds, and flexible critical care bed-usage across Divisions to minimise cancellations (ongoing);
- Daily e-mails circulated of all on-the-day cancellations within the Bristol Royal Infirmary by the nominated Patient Flow Co-ordinator, to help ensure patients are re-booked within target (ongoing);
- The opening of the new adult Intensive Therapy Unit (ITU) will provide greater flexibility to manage a higher proportion of patients needing higher levels of clinical input, thereby reducing the likelihood of a patient needing to be cancelled due to not ITU bed being available;
- Elective activity is routinely discussed at every 08:30 Site Team and the 16:45 Silver Command patient flow meetings. No patients are cancelled without a cross Divisional discussion to ensure other options have been explored.
- Specialty specific plans are shown below:

Specialty	Action
Upper GI, Trauma & Orthopaedics & Maxillo-facial Surgery	Implement managed beds for surgical elective admissions to reduce cancellations due to lack of ward beds/lack of High Dependency Unit beds. **Commenced 6/10/2014**
Ophthalmology	Working group in place to improve Pre-Operative Assessment processes, reducing clinical cancellation and allowing for more accurate time allocation. Lists currently booked assuming lowest level of emergency admissions to maximise time available to clear Referral to Treatment Times backlog, although list space remains allocated for admissions through clinic.
All Paediatric	Through the Winter Planning Project within the Children's Flow Programme, increase medical bed capacity throughout winter to reduce impact on surgical bed capacity and thus last-minute cancellations

ACCESS STANDARDS

	(LMCs) **At Risk - Recruitment/Retention Challenges and staff sickness absence**
All Paediatric	Through the Elective Processes Project in the Children's Flow Programme, improve planning, communication and decision-making to reduce LMCs; decision taken to cancel a number of elective theatre lists during the winter months, as patients booked onto these lists were routinely having to be cancelled at last minute due to emergencies.
Paediatric plastics, Maxillo-facial and Trauma & Orthopaedics	Following transfer of Specialist Paediatric services in May this year, there has been a period of settling in to reach optimum operating capacity and efficiency. Work needs to continue to support this.

Progress against the recovery plan:

The national standard of less than 0.8% of operations being cancelled at last-minute for non-clinical reasons was not achieved in February, although performance improved by 0.15% relative to January.

Performance against the 28-day readmission standard also improved in February, with the 95% standard being missed by 0.2% (less than 1 patient).

Maintaining a lower level of ward-bed related cancellations remains the minimum requirement for achievement of both the last-minute cancelled operations and the 28-day readmission standards. The actions described in Exception Report A8 (A&E 4-hours) should reduce levels of last-minute cancelled operations and improve performance against the 28-day readmission standard.

ACCESS STANDARDS

A3 – A4. EXCEPTION REPORT: 62-day referral to treatment cancer standard for GP and Screening referred patients	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients with confirmed cancers treated within 62 days of referral, as a percentage all cancer patients treated during the period under that standard. There are separate targets for GP and Screening referred patients, although Monitor treats this as a combined standard for the purposes of scoring.

Monitor measurement period: All cancer standards are measured Quarterly (weighted 1.0 in the Risk Assessment framework)

Performance during the period, including reasons for exceptions:

62-day GP referred

Performance in January was 80.0% against the 85% standard. This was below the recovery trajectory for the month of 84.8%. There were 4.9 more breaches in the month than 'expected' in the plan. The main variances were in the number of breaches due to late referrals (3.4 more than expected) and Delayed Outpatient appointments (0.7 more than expected). Activity was higher than forecast, which off-set some of the additional breaches.

Performance for internally managed pathways was 92.0% against the 85% standard. Performance for shared pathways was 58.2%. If the breaches for those referrals received late (i.e. on or after day 42 in the pathway) were re-allocated in full to the referring provider, performance would have been 90.3%, and above the 85% standard.

Breach reasons - January	Trajectory ('expected' number)	Actual number	Variance	Percentage of breaches (actual)
Late referral	4.7	8.0	3.4	52%
Medical deferral/Clinical complexity	2.7	3.0	0.3	19%
Patient choice to delay	0.9	1.0	0.1	6%
Delayed pre-operative assessment	0.0	0.0	0.0	0%
Elective capacity	0.2	0.5	0.3	3%
Elective cancellation	0.1	0.5	0.4	3%
Delayed outpatient appointment	0.3	1.0	0.7	6%
Administrative delay/pathway management	0.3	0.5	0.2	3%
Delays at other provider	1.0	1.0	0.0	6%
Other	0.5	0.0	-0.5	0%
	10.6	**15.5**	**4.9**	**100%**

84% of breaches were due to primarily unavoidable reasons, including late referral, medical deferral, clinical complexity and delays at other providers.

There were 4 breaches (26%) relating to internally managed pathways and 11.5 breaches (23 pathways x 0.5 accountability) relating to shared pathways.

The transfer of breast and urology services to North Bristol Trust has left the Trust with a challenging group of pathways to meet the 62-day GP

standard. This is because breast cancers are relatively easy to treat within 62-day of referral because the diagnostic pathways are simple and patients are usually fit enough to proceed to treatment without further intervention. In January 2015, the 85% standard was only achieved for breast and skin cancers at a national level, with all other tumour sites performing at or below 80%. The national average performance across all tumour sites was 81.1%. The Trust is now the only acute provider in the country that provides neither breast nor urology cancer outpatients or surgical services. It is calculated that the impact of our tumour site case-mix equates to a 3.5% reduction in expected performance. This figure is without any adjustment for the tertiary nature of our services.

The improvement work on the high volume tumour sites is ongoing. The focus of this work is informed by monthly breach reviews, and also structured telephone-based interviews which have been carried-out with better performing equivalent providers, to identify good practice from elsewhere. Whilst the telephone interviews provided assurance that there were no obvious differences in the diagnostic or treatment pathways that other providers had in place to treat cancer patients, disappointingly few pathway improvement opportunities were identified through these discussions.

62-day GP Screening

Performance in January was 66.7% against the 90% 62-day screening standard. Performance of breast and gynaecology screening pathways was above the national standard in the month. Performance for bowel screening referred cancers was 33.3%, with one breach in the period due to patient choice. The loss of the majority of Breast Screening treatments in quarter 2 2014/15, following the transfer of Avon Breast Screening (ABS) to North Bristol Trust, has, as expected, had a significant impact on performance. Bowel is now the highest volume tumour site for 62-day screening treatments (shared and internal pathways) reported by the Trust. Nationally, bowel screening pathways performed at 71.1% against the 90% standard in January.

Recovery plan, including expected date performance will be restored:

A fortnightly cancer performance improvement group is taking forward further improvement priorities. These are identified from reviews of breaches, good practice from other providers, and in response to potential risks e.g. awareness campaigns. A specific action plan for cancer performance is maintained by the group and is also monitored at the Cancer Board and Service Delivery Group. The action plan is updated with new actions on an ongoing basis as these are identified, and all actions have an expected impact assigned to them which link through to the trajectory for performance improvement. The impact of some actions may take two months (i.e. the length of a pathway) to show the full effect, depending on the stage of the pathway they relate to. The action plan covers all cancer access targets, but with the primary focus being on those actions that will support delivery of the 62 day GP standard. The current/recently completed key actions are as follows:

The current/recently completed key actions are as follows:

- Implement joint clinics between respiratory physicians and thoracic surgeons, both internally and at referring providers, effectively removing the need for a second outpatient appointment. This has been implemented at UH Bristol and North Bristol Trust. An innovative project trialling remote pre-operative assessment via Skype technology has also started to support this clinic. Taunton clinics are due to start,

followed by Yeovil and Weston. Discussions will also be held with Gloucester and Bath hospitals with a view to rolling-out there;

- Reduce maximum wait for 2-week wait step to 7 days for 90% patients in six specialities where this will likely make a material difference to pathways. Patient choice does affect achievement of this standard in some specialties. All areas have made and sustained significant progress on this, with several consistently hitting the target and others coming very close;
- A specific pathway improvement project for Head and Neck, most of which has now completed. The implementation of this project's actions has seen a three-fold reduction in breaches for this speciality and the learning from this project is being applied elsewhere;
- Additional capacity for thoracic surgery, hepato-pancreato biliary surgery and Ear, Nose & Throat minor procedures has been created, following the move of vascular services to North Bristol Trust. This has considerably improved capacity problems in these specialities, particularly thoracic surgery, and has also reduced the impact of cancellations;
- Revisions to the colorectal two-week wait pathway are in progress, to support improved pathways for patients (fewer appointments) and ongoing attainment of waiting times standards in a time of rising demand. This work is being coordinated by the Strategic Clinical Network and Commissioning Support Unit, and has external funding and support from the 'ACE' Earlier Diagnosis of Cancer initiative, and is being carried out in conjunction with North Bristol Trust;
- Improved referral to reporting times of CT colonoscopies; with a change to the organisation of reporting by radiologists and a review of the timings of lists and reporting sessions to ensure optimum timings. There have been no patients identified waiting over a week for their results since these changes were implemented in November;
- Competency based training and assessment for Multi Disciplinary Team (MDT) co-ordinators and all administrative staff involved in booking cancer patients (both at start of post and on an ongoing basis) has been devised and rolled-out to reduce risk of administrative errors. The first new coordinators have been trained according to this programme and all existing staff will be assessed against the competencies as part of appraisal;
- Pathways with optimum timescales for lung and oesophago-gastric (OG) cancer (complex, relatively high volume specialities) are being developed and good progress is being made. The OG pathway was discussed at the Network Site Specific Group and received strong clinical engagement and support. Audit of actual against ideal performance is now being undertaken at all trusts to identify how we can implement the pathway. The Lung pathway is now being supported by North Bristol Trust, and colleagues from UH Bristol and North Bristol are working together on its further development. Some changes have already been implemented as a result of the work on this pathway, for example introduction of protected PET scan slots for patients had highest risk of complex pathways. The ultimate aim is for these pathways to be adopted across the South West and this has been discussed at several regional meetings;
- Pathway work for patients with lymphomas of the neck, who commonly have lengthy pathways due to passing between specialities, to design a smooth timely pathway. The pathway is now designed in draft and subject to clinical discussions as several of the elements would require a change of practice. The pathway aims to get patients onto the most appropriate pathway at an earlier stage;
- Additional bronchoscopes have been purchased, reducing risks of delays due to equipment failure and enabling the Trust to carry out in-house certain types of bronchoscopy which previously had to be sent to other providers;

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- Implementation of the plan to manage impact of the 2015 national awareness campaign for oesophago-gastric cancer, which started on January 26th. Work has been undertaken by the Trust based on information obtained from trusts who participated in the regional pilot of the campaign has enabled impact on services post two week wait referral to be estimated and planned for;
- Subject to agreement from commissioners, introduce direct booking of two week wait referrals via choose and book, which should increase the likelihood of patients attending their first appointments and doing so in a timely way, as well as having safety and patient experience benefits. This is particularly important in light of forthcoming changes to NICE guidance for cancer referrals. Other trusts who successfully use this system have been identified, and it is hoped we can work with them to demonstrate how the system works and thus allay the concerns held by some GPs about this;
- Developing an improved system for providing theatre time in main theatres to the gynaecology team within shorter timescales, for high risk patients requiring intensive care/high dependency care. A protocol has been drafted for this and is under discussion;
- Improving proactive management systems for fast track patients in radiology and pathology. The radiology system is in place and has reduced the number of queries for radiology, and the pathology system developments have been incorporated into the work surrounding the service transfer.

Progress against the recovery plan:

62-day GP

The following improvement trajectory has been agreed, on the basis of the actions identified and expected impact of these actions. The figures for October to December are now confirmed following the completion of quarter 3 reporting. The reported performance for January is shown, but may be subject to change when the whole quarter's data is submitted at the beginning of May.

	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	Dec-14	Q3	Jan-15	Feb-15	Mar-15	Q4
Trajectory	75.7%	80.5%	65.0%	75.3%	79.9%	82.1%	81.8%	81.3%	86.4%	85.1%	84.1%	85.3%	84.8%	85.4%	87.0%	85.8%
Actual	75.5%	81.6%	85.1%	80.4%	79.4%	77.6%	74.3%	76.8%	79.0%	81.2%	84.6%	81.6%	80.0%			

62-day screening

The 90% standard was failed in January, with a single breach of the standard due to patient choice.

ACCESS STANDARDS

A5-A7. EXCEPTION REPORT: Referral to Treatment Time (RTT) admitted, non-admitted and ongoing pathways standards	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

Waiting times for these standards are measured from the date of a referral made with an expectation of treatment, through to the commencement of first definitive treatment. A referral can be made by a GP or any other healthcare professional. A referral onto an 18-week pathway can also be made when a patient's condition has been monitored and a decision has been made that treatment is now required.

There are three different standards relating to Referral to Treatment Times (RTT). The first two measure the percentage of patients treated within 18 weeks for patients not needing an admission for their treatment (Non-admitted pathways), and those patients needing an admission (Admitted pathways). The targets for these are 95% and 90% respectively. The final standard measures the percentage of patients waiting under 18 weeks at month-end. This is referred to as the ongoing or incomplete pathways standard. The target is for at least 92% of patients to be waiting less than 18 weeks from referral. Failure of this standard is an indication that the number of non-admitted and/or admitted patients waiting over 18 weeks is higher than the sustainable level for achievement of the admitted and non-admitted standards. Failure of the ongoing/incompletes standard usually therefore results in failure of one or both of the non-admitted and admitted standards, until the number of over 18-week waiters is reduced.

Monitor measurement period: Monthly achievement required but quarterly monitoring. Performance is assessed by Monitor at an aggregated Trust level, rather than an RTT specialty level.

Performance during the period, including reasons for exceptions:

The Trust continued to under-perform against the three RTT pathways standards in February as expected, due to the volumes of long waiting patients treated in the period. The number of patients waiting over 18 weeks on admitted and non-admitted pathways remains higher than the sustainable level to support achievement of the admitted and non-admitted standards. But importantly, the backlog reduction trajectory targets were met in the period (see final section of the exception report).

The RTT waiting list has also been affected by data quality issues, as a result of a combination of the way the Patient Administration System (Medway) works following recent upgrades, and the way staff are using the system. The ongoing RTT over 18-week waiting list has not been validated in full for several months, and the validation that used to take place was also not undertaken by staff that specialised in this role. The lack of a 'clean' operational RTT waiting list has also limited the impact of improvements being made to 'picking' patterns and booking practices.

The impact of the validation work of the recently appointed team of validators, along with the work of the national team, continued to be felt in February. In combination with the additional capacity put in place to treat more long waiters, this resulted in a further reduction, for both the admitted and non-admitted pathways, in the number of patients waiting over 18-weeks at month-end. As a result, performance against the RTT Ongoing pathways standard in February also improved by 0.5%, from 88.9% to 89.4%.

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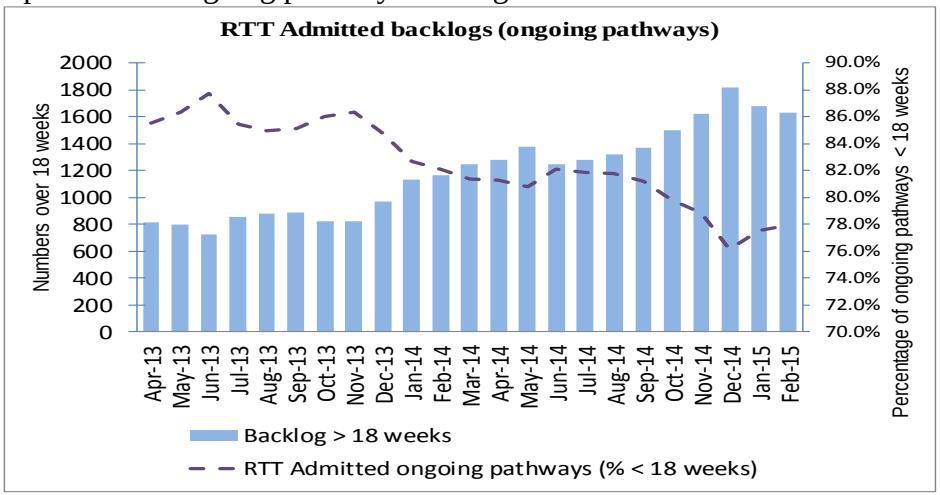
Graph 1 – RTT Admitted backlogs versus the percentage of patients on ongoing pathways waiting under 18 weeks.



Graph 2 – RTT Non-admitted backlogs versus the percentage of patients on ongoing pathways waiting under 18 weeks.

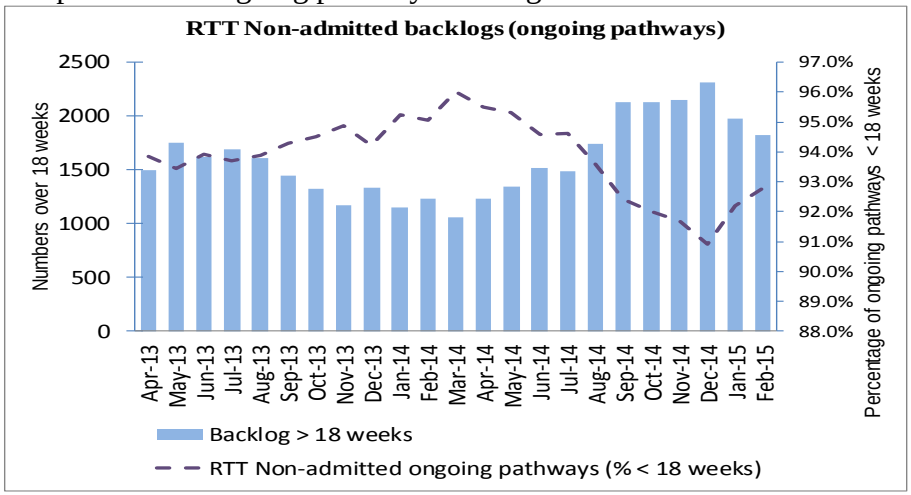


Table 1: Performance against the RTT Admitted standard at a national RTT specialty level in February.

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
Cardiology	170	89	259	**65.6%**
Cardiothoracic Surgery	37	21	58	**63.8%**
Dermatology	127	51	178	**71.3%**
E.N.T.	183	8	191	**95.8%**
Gastroenterology	70	4	74	**94.6%**
General Medicine	8	1	9	**88.9%**
Gynaecology	144	21	165	**87.3%**
Ophthalmology	625	113	738	**84.7%**
Oral Surgery	266	51	317	**83.9%**
OTHER	708	234	942	**75.2%**
Plastic Surgery	1	0	1	**100.0%**
Rheumatology	77	0	77	**100.0%**
Thoracic Medicine	14	0	14	**100.0%**
Trauma & Orthopaedics	53	11	64	**82.8%**
TOTAL	**2483**	**604**	**3087**	**80.4%**

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In February, five of the fourteen specialties achieved the 95% standard, compared with six in January. As in January, a high number of long waiting patients were treated in the month, reflecting the focus on picking patterns and treating as many long waiting patients as possible.

The performance of the top eight highest volume specialties for admitted pathways within 'Other' was as follows, in order of volume of clock stops:

- Upper GI surgery – 55.2%
- Paediatric Ear Nose Throat – 50.4%
- Clinical Oncology - 100%
- Thoracic surgery 85.7%
- Colorectal Surgery – 79.6%
- Maxillo facial surgery – 90.0%
- Paediatric surgery – 63.8%
- Paediatric urology – 62.2%

Table 2: Performance against the RTT Non-admitted standard at a national RTT specialty level in February.

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
Cardiology	104	50	154	**67.5%**
Cardiothoracic Surgery	27	6	33	**81.8%**
Dermatology	527	50	577	**91.3%**
E.N.T.	708	40	748	**94.7%**
Gastroenterology	59	22	81	**72.8%**
General Medicine	134	0	134	**100.0%**
Geriatric Medicine	56	0	56	**100.0%**
Gynaecology	320	23	343	**93.3%**
Neurology	67	8	75	**89.3%**
Ophthalmology	843	56	899	**93.8%**
Oral Surgery	259	54	313	**82.7%**
OTHER	2825	423	3248	**87.0%**
Rheumatology	106	5	111	**95.5%**
Thoracic Medicine	314	2	316	**99.4%**
Trauma & Orthopaedics	87	32	119	**73.1%**
TOTAL	**6436**	**771**	**7207**	**89.3%**

In February, four out of the fifteen specialties achieved the 95% non-admitted standard, compared with seven in January. A low level of performance is planned during this period of recovery, reflecting the need for more long waiting patients to be treated in the month.

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The performance of the top eight highest volume specialties for admitted pathways within 'Other' was as follows, in order of volume of clock stops:

- Restorative dentistry – 63.3%
- Maxillo facial surgery – 88.0%
- Paediatric ophthalmology – 74.2%
- Colorectal Surgery – 95.0%
- Radiotherapy treatments – 100%
- Oral medicine – 85.4%
- Paediatric ENT – 95.9%
- Upper GI – 90.4%

Table 3: Performance against the RTT Ongoing pathways standard at a national RTT specialty level in February.

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Ongoing	Percentage Under 18 Weeks
Cardiology	1886	400	2286	82.5%
Dermatology	1768	129	1896	93.2%
E.N.T.	2147	27	2174	98.8%
Gastroenterology	447	43	490	91.2%
General Medicine	110	0	110	100.0%
Gynaecology	1132	82	1214	93.2%
Neurology	270	65	335	80.6%
Ophthalmology	4290	269	4559	94.1%
Oral Surgery	2264	126	2390	94.7%
OTHER	12425	2231	14651	84.8%
Rheumatology	344	1	345	99.7%
Thoracic Medicine	600	6	606	99.0%
Trauma & Orthopaedics	1020	35	1055	96.7%
Cardiothoracic Surgery	227	32	259	87.6%
Geriatric Medicine	158	0	158	100.0%
TOTAL	**29088**	**3446**	**32528**	**89.4%**

In February, ten of the fifteen specialties achieved the 92% ongoing standard, compared with eleven in January.

The performance of the top eight highest volume specialties for admitted pathways within 'Other' was as follows, in order of total pathway volumes:

- Restorative dentistry – 80.7%
- Clinical Genetic – 79.3%

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- Paediatric ENT – 69.4%
- Paediatric T&O – 70.7%
- Oral medicine – 97.8%
- Upper GI – 78.0%
- Colorectal surgery – 88.0%
- Paediatric dentistry – 90.6%

The number of patients waiting over 40-weeks from referral to treatment increased from 160 at the end of January to 161 at the end of February, but was below the trajectory of 194. There were 11 over 52-week RTT waiters were reported at February month-end, compared with 9 at the end of January. This was above the forecast number of eight. All eleven were within paediatric specialties due to demand being significantly higher than capacity within these services (i.e. 6 for Paediatric Plastic Surgery, 4 for Paediatric Trauma & Orthopaedics and 1 Paediatric Ear, Nose & Throat). All expected over 52-week waiters for the end of March have had dates for treatment booked.

Recovery plan, including expected date performance will be restored:

- Continued weekly focus from the weekly RTT Operational Group on treating longest waiting patients and improving 'picking' patterns to make best use of available capacity to reduce waiting times;
- Full demand and capacity modelling has been completed for all under-performing specialties, with the help of the Interim Management and Support (IMAS) team; these models take into account the level of capacity needed to meet the additional recurrent demand we are seeing, in addition to the capacity needed to clear the backlog; the modelling has been shared with the commissioners and Monitor, and has informed contract discussions for 2015/16; the outputs of this work have also resulted in the recovery trajectories shown in the next section of this Exception Report;
- Divisions are continuing to refer patients to external providers where possible, with Diagnostics & Therapies having already outsourced 330 patients' scans and treatment (see Exception Report A9);
- A monthly RTT Steering Group is overseeing the progress of the Operational Group as well providing a more strategic oversight of RTT performance. This group is responsible for ensuring all the milestones of the project are met as well as overseeing risks, reviewing benchmarking information, providing cross divisional oversight and recognising / promoting best practice;
- To provide external assurance that our recovery plan is 'fit for purpose', the national Interim Management and Support (IMAS) was asked to undertake a review of our action plan, to ensure it is robust as well as to share best practice from other organisations. Following the original visit in April and further visits to the Trust in June and July, a final report was agreed and the recommendations form the basis of a detailed recovery plan. The actions are now in the process of being implemented.
- The Trust now has in place a team of external validators, to facilitate validation of all patients in the RTT backlogs. This has been

supplemented by support from a national team; a significant number of ongoing pathways are being closed down as a result of this validation;

- A local (community-wide) Patient Access Policy has recently been reviewed and has been implemented; the new Policy will enable the Trust to take appropriate action when patients delay their outpatient appointments or elective admissions, and where funding decisions are not made within an acceptable time period.

Progress against the recovery plan:

The trajectories below have been informed by the IMAS capacity and demand modelling. Performance trajectories for admitted and non-admitted pathways have been added this month. Progress against these will be reported on a monthly basis. The Trust is currently on trajectory with all elements of the recovery plan.

Please note: A green RAG (Red, Amber, Green) rating indicates where the recovery trajectory is being met.

Over 18-week waiters	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Non-admitted (plan)	2455	2044	1812	1636	1506	1386	1338	1265	1200	1151	1119	1100	1059	1022	985
Non-admitted (actual)	1972	1819													
Admitted (plan)	1857	1819	1772	1659	1498	1351	1178	1048	913	795	748	651	590	521	465
Admitted (actual)	1677	1627													
Ongoing performance (plan)	87.0%	88.1%	88.0%	88.5%	89.4%	90.4%	91.1%	91.9%	92.7%	93.3%	93.7%	94.3%	94.7%	95.0%	88.1%
Ongoing performance (actual)	88.9%	89.4%													
Admitted performance (plan)		80.0%	80.0%	80.2%	80.8%	80.8%	80.8%	82.1%	84.3%	86.5%	87.2%	88.6%	89.5%	89.8%	90.3%
Admitted performance (actual)		80.4%													
Non-admitted performance (plan)		89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	90.2%	91.8%	92.4%	93.6%	95.0%	95.1%	95.2%	95.2%
Non-admitted performance (actual)		89.3%													

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A8. EXCEPTION REPORT: A&E maximum wait 4 hours	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 no longer included in the performance figures. .

Monitor measurement period: Quarterly

Performance during the period, including reasons for exceptions:

At a Trust level performance against the 4-hour standard declined from 90.9% in January to 89.5% in February. This was mainly due to a decline in performance at the Bristol Royal Infirmary (BRI).

Within the BRI, levels of emergency admissions were lower than in January (down 9.2%), but slightly higher than the same period last year (up 2.0%). Ambulance arrivals were 6% lower than the same period last year, which in combination with the higher levels of admission, indicates a higher rate of conversion to admission. It is unclear whether this higher rate of admissions is due to acuity or admitted practice. Disappointingly, fewer patients waited less than 4 hours compared with January and the same period last year.

Table 1 – The number of BRI Emergency Department (ED) attendances, admissions and ambulance arrivals in the current and the previous months, and the same period last year.

	Jan-15	Feb-15	Feb -14
Attendances	5228	4866	4971
Emergency admissions via the ED	1881	1708	1674
Ambulance arrivals	2289	1952	2078
Performance against 4-hour standard	86.6%	82.9%	85.3%
Numbers of patients waiting less than 4 hours	4525	4034	4238

Performance against the 4-hour standard at the BCH improved between January and February, with the 95% standard being achieved. This reflected the lower levels of emergency attendances and admissions seen in the period. Activity levels were, however, significantly higher than the same period last year, consistent with the expected level of transfer of emergency work following the closure of Frenchay Emergency Department and the Centralisation of Specialist Paediatrics earlier in the year. Despite this, performance was also higher than in February 2014.

Table 2 – The number of BCH Emergency Department (ED) attendances, admissions and ambulance arrivals in the current and the previous months, and the same period last year.

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	Jan-15	Feb-15	Feb -14
Attendances	2841	2683	2305
Emergency admissions via the ED	787	654	527
Ambulance arrivals	621	586	537
Performance against 4-hour standard	93.8%	95.6%	94.9%
Numbers of patients waiting less than 4 hours	2664	2565	2188

There were significantly fewer over 30 minute ambulance hand-over delays in the BRI ED in the period, reflecting the lower levels of ambulance arrivals. Performance against a number of the other measures of patient flow also improved, such as the number of delayed discharges, bed-days spent by patients outlying from their specialty ward, discharges before midday and out of hours discharges. Although Length of Stay decreased in the period, this was related to fewer long stay patients being discharged in the month. So although the level of delayed discharges reduced, we saw the highest level of over 14 day stays in hospital at month-end, seen since June 2014. For this reason, bed occupancy stayed high and resulted in poor performance against the 4-hour standard.

Table 1 – Number of Delayed Discharges on the Green to Go list at the end of February 2015 compared with the previous month-ends

Month	Total number of Green to Go (Delayed Discharge) patients at month-end
February 2014	73
March 2014	58
April 2014	56
May 2014	51
June 2014	58
July 2014	50
August 2014	53
September 2014	57
October 2014	44
November 2014	55
December 2014	42
January 2015	59
February 2015	**49**

Recovery plan, including expected date performance will be restored:

A whole system operational resilience plan has been developed with partner organisations, for improving emergency access and delivering the 4-hour

target. The core elements of this plan are as shown below:

A) Front Door – including the 'protection' of the clinical management of minor injury/illness patients to deliver high levels of performance for this stream of patients; Care of the Elderly consultant-led rapid assessment of patients in the Emergency Department and Older Persons Assessment Unit; extension of the South Bristol Urgent Care Centre opening hours; BrisDoc out of hours service supporting the ED minors pathway; GP working in the Bristol Children's Hospital Emergency Department;

B) Admission avoidance – including establishment of a virtual multi-disciplinary team and a rapid assessment clinic at South Bristol Community Hospital, for frail elderly patients in the community; nursing and residential homes having access to dietetics and speech and language therapy input;

C) Flow – Enhanced recovery pathways for elderly patients; increased therapist cover across weekends; increased consultant physician cover across weekends; improved general surgical and trauma theatre access at weekends; increased liaison psychiatry cover across winter months;

D) Discharge – pathways for non weight-bearing patients, pathways for patients needing percutaneous endoscopic gastrostomy (PEG) management; additional interim community bed capacity for patients needing long-term care placements or patients with dementia; additional community rehabilitation bed capacity, increased cardiac diagnostics at weekends; paediatric home intravenous (IV) services; additional ward rounds at the Children's Hospital at weekends;

E) System governance – improved robustness of breach analysis; improved clarity of the reasons for delayed discharges to support system planning/resilience; community services inclusion criteria in which all patients are accepted to assess for appropriate need.

In addition, the Trust takes part in the daily sector teleconference calls managed through ALAMAC. A full review of the previous day's 4 hour performance, key performance indicators, (included in the ALAMAC "kitbag"), and actions to improve performance are discussed and further actions agreed. The key areas for action have included reduction in the Trust's "Green to Go" list and addressing other operational constraints which impact on flow, which when addressed will help to improve performance.

Additional actions are being taken in response to the issues highlighted in the Care Quality Commission (CQC) report. An internal action for the Trust is the development of an electronic CM7 form for health needs assessment, which is the means through which a referral is made to the local authority for social work assessment. The current paper-based system can result in a number of days delay to the referral and assessment process being commenced.

Progress against the recovery plan:

The expected impact of both the internal and partner organisations actions' in reducing 4-hour breaches of standard has been assessed. This has been used to create an A&E 4-hour performance trajectory using the last 12 month's activity and performance as a baseline, with best case and realistic scenarios. Using historical performance and activity as a baseline has allowed seasonal pressures to be factored-in. The most recent revision to the trajectory, as shown below, reflects changes in the assessment of the impact of the actions in the plan, and is informed by the continued decline in national performance.

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Key Performance Indicators (KPIs) have been established to enable the delivery against the individual elements of the above plan to be monitored, and to enable analysis of which actions are not delivering the expected outcomes to be undertaken. A sub-set of the KPIs, together with the last six week's performance, is shown below:

	Indicator	Threshold	2/2/15	9/2/15	16/2/15	23/2/15	2/3/15	9/3/15
Front door	Minors performance (ESC 1 and 2)	>=98.0%	97.5%	98.1%	96.9%	94.0%	96.0%	98.0%
	Time to Treatment (60 minutes)	>=50.0%	50	58	51	47	49	53
	Number of emergency admissions (BRI)	<= 463	544	509	534	541	545	530
Admission avoidance	Bed occupancy (BRI)	< = 91.5%	95.9	96.4	95.5	97.0	92.0	90.0
	BRI ED conversion rate %	TBC	36	32	35	40	30	30
	Increase 0 to 1 day stays > 75 year olds	250	244	238	245	266	255	256
Flow	Weekly average Length of Stay emergency patients (Medicine)	4.9	4.4	6.1	4.0	4.2	5.5	4.5
	Number patients > 14 days Length of Stay BRI	<=99	101	114	103	118	133	122
	Total number of weekend discharges	TBC	158	140	136	126	159	146
Discharges	Green to Go Delayed Discharges (Medicine)	30	47	60	48	51	45	37
	Number of discharges by 10:00	>=15	6	5	10	9	7	7
	Percentage discharges by 14:00	>=75%	32	35	31	31	35	33

The new patterns of emergency admissions following the Frenchay Emergency Department closure are still emerging, in particular increases in ambulance arrivals at the weekend and earlier in the day. In conjunction with the increasing ago-profile of patients admitted to the Trust, this pose risks to achievement of the 95% standard over the winter, which may be difficult to mitigate fully, as reflected in the Realistic scenario.

Scenario	Jan-15	Feb-15	Mar-15	Q4	Apr-15	May-15	Jun-15	Q1	Jul-15	Aug-15	Sep-15	Q2
Best case	91.9%	91.5%	94.0%	**92.5%**	94.7%	94.5%	96.4%	**95.2%**	97.3%	95.8%	94.2%	**95.8%**
Realistic	91.5%	90.6%	92.8%	**91.7%**	94.4%	94.2%	95.8%	**94.8%**	96.0%	95.1%	93.9%	**95.0%**
Actual	90.9%	89.5%										

Performance in February was 1.1% below trajectory. However, performance for the quarter to date as a whole (as at the 19th March) has improved since the end of February, and is now 91.2% against the target of 91.7%. Achievement of the trajectory target for the quarter is still considered possible.

ACCESS STANDARDS

A9. EXCEPTION REPORT: 6-week wait for key diagnostic tests	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients waiting over 6 weeks for one of the top 15 key diagnostic tests at each month-end, shown as a percentage of all patients waiting for these tests. The figures include patients that are more than 6 weeks overdue a planned diagnostic follow-up test, such as a surveillance scan or scoping procedures. The national standard is 99%.

Monitor measurement period: Not applicable; the monitoring period nationally is monthly.

Performance during the period, including reasons for exceptions:

Performance in February was 97.9% against the 99% national standard for 6-week diagnostic wait. This is above the recovery trajectory of 97.6% and a 2.4% improvement on January's reported position. There were 145 breaches of the 6-week standard at month-end, of which 66 were waiting for echocardiography scans (down from 71 in February), 3 for audiology tests (down from 126), 37 were for MRI scans (down from 68), 37 were for paediatric gastrointestinal endoscopies (up from 35), and 2 for ultrasound scans.

Demand in many diagnostic services has been out-stripping capacity. This is partly due to underlying demand rising, but also additional demand arising from work being undertaken to reduce the number of long waiting RTT patients. The ability to continue to meet the 6-week maximum wait has also been impacted by short and long-term staff absences, some of which were unforeseen.

A recovery trajectory has now been developed based upon detailed capacity and demand modelling for each diagnostic test, using a model provided by the Interim Management and Support (IMAS) team. The modelling takes account of the most recent level of demand for the service as well as the normal variation in capacity month on month. Capacity plans have now been developed to fill the gaps, with forecast achievement of the 6-week standard, on a sustainable basis from the end of June 2015.

Recovery plan, including expected date performance will be restored:

The following actions are being taken to improve performance against the 6-week wait standard in quarter 1. *Please note: actions completed in previous months have been removed from the following list*:

- Month on month capacity plans have been developed for each test, to fill the identified gap in capacity;
- A locum audiologist came into post at the end of January; the forecast is to have fewer than 10 Audiology over 6 week waiters at the end of February (**Action complete** – 3 long waiters reported at the end of February);
- Short-term in-house capacity solutions being put in place to manage the peaks in demand through locums and additional sessions – cardiac

stress echo, audiology, MRI;

- Additional cardiac stress echo sessions are being sourced from clinicians in other trusts where possible;
- Clinical validation of the appropriateness of referrals where demand is higher than expected is being undertaken;
- Routine MRI scans and musculo-skeletal ultrasound guided injections are now being provided by the Chesterfield Hospital, with a plan in place to outsource a total of 500 cases before the end of March (with just over 330 patients having already been transferred as of the 13th March);
- Audiology patients are being offered appointments in community settings where capacity is available before hospital-based appointments;
- A consultant paediatric gastroenterologist post has been recruited; the successful applicant will now be in post towards the end of quarter 4; additional sessions will be run during the quarter, with the aim of clearing the majority of the backlog by the end of Quarter 1 2015/16.

Progress against the recovery plan:

Performance against the revised trajectory below will be reported on a monthly basis.

Month	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Total > 6 weeks	161	152	130	106	63	55	63	60
Performance trajectory	**97.6%**	**97.7%**	**98.0%**	**98.4%**	**99.1%**	**99.2%**	**99.1%**	**99.1%**
Actual total > 6 weeks	145							
Actual performance	**97.9%**							
Trajectory achieved	**Yes**							

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Tuesday 31 March 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
8. Preparation for Annual Quality Report (Quality Account) including draft Corporate Quality Objectives for 2015/16
Sponsor and Author(s)
Sponsor – Chief Nurse, Carolyn Mills Authors – Chris Swonnell, Head of Quality (Patient Experience & Clinical Effectiveness)
Intended Audience

Board members	√	Regulators		Governors		Staff		Public	

Executive Summary
Purpose The purpose of this report is to inform the Board of the ongoing process and outcomes for developing the annual Quality Report (also known as the Quality Account), including confirmation of proposed corporate quality objectives for 2015/16. Key issues to note The attached report includes: - A description of preparation in advance of the annual Quality Report - Proposed content/topics for the Quality Report - Confirmation of external audit indicators - Draft corporate quality objectives for 2015/16 (updated since February) - An outline timetable for the production of the report SLT has approved the nine quality objectives, subject to the following amendments: - Objective 2 (patient moves) – agreement that the focus should be on *inappropriate* – ideally this should reflect the place as well as the time of the move (potential measures to be reviewed). - Objective 4 (TTA medications) – to become a sub-objective of a wider objective related to improving discharge; also an additional sub-objective to reinforce a discharge aspect of safer bundles (Chief Nurse to discuss with Director of Transformation). - Objective 5 (communication) – to include a specific sub-objective to fully implement Duty of Candour - Objective 9 (informing patients about OPD waits) – to become a sub-objective of a wider objective to reduced actual delays
Recommendations
Board to receive assurance regarding the process and outcome of developing the quality objectives and choosing the external audit indicators for quality for 2015/16.
Impact Upon Board Assurance Framework
The annual Quality Report will include reports relating to achievement (and non-achievement) of corporate quality objectives for 2014/15 as set out in the Board Assurance Framework.

Impact Upon Corporate Risk
Nil specific - delivery of quality objectives will be an annual objective in the Board Assurance Framework and risk to delivery will be monitored via review of the BAF
Implications (Regulatory/Legal)
The Quality Report forms part of the Trust's Annual Report and is a Monitor requirement.
Equality & Patient Impact
The choice of quality objectives for 2015/16 takes account of feedback received from patients, staff, governors and the public.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
			18/3/15	Clinical Quality Group, 9/3/15 Quality Outcomes Committee, 26/3/15

University Hospitals Bristol NHS
NHS Foundation Trust

Subject: **Preparation for annual Quality Report (Quality Account) including draft corporate quality objectives for 2015/16**

Report to: **Senior Leadership Team**

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

Date: **12th March 2015**

1. Introduction

This report summarises preparation for the annual Quality Report – also known as the Quality Account – including draft quality objectives for 2015/16.

According to NHS Choices, "A Quality Account is a report about the quality of services by an NHS healthcare provider… Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided… The Department of Health requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year."

Quality Reports are a variant of the Quality Account required by Monitor and form part of Foundation Trust Annual Reports. Rather than publish two separate and near-identical documents, the Trust publishes a single document, entitled "Quality Report" which fulfills the requirements of both the Department of Health and Monitor.

UH Bristol's annual Quality Report is largely written in April of each year, following the end of the preceding financial year. Preparation for the report takes place during February and March; this includes consultation with stakeholders on the development of annual corporate quality objectives, and earlier discussions with external auditors.

This report includes:

- A description of preparation to date
- Proposed content/topics for the Quality Report
- Confirmation of external audit indicators
- Draft corporate quality objectives for 2015/16
- An outline timetable for the production of the report

2. Preparation for the Quality Report

In preparation for the Quality Report, the Trust held a membership consultation evening on 19th January, hosted by the Chief Nurse and Medical Director. This event, which was attended by approximately 30 members and governors, plus stakeholder representatives including Bristol CCG, gave attendees the opportunity to talk about the things that mattered most to them in relation to the hospital care. We then used common themes from this event to inform our choice of draft corporate quality objectives for 2015/16. This choice was also informed by feedback received from an on-line survey (we received approximately 50 responses, evenly split between staff and public) and an extraordinary meeting of the Governors' Quality Focus Group.

Early draft quality objectives were shared with Clinical Quality Group in February and have been discussed at the Chief Executive's senior management forum.

As well as contributing to the discussion about possible corporate quality objectives for 2015/16 and suggesting a number of quality themes for inclusion in the Trust's account of 2014/15, the Governors have a formal role to choose one of three quality indicators from the Quality Report which will be the subject of external audit (see below).

3. Proposed structure and content of the Quality Report

It is proposed to adopt a broadly similar presentational format to the one used by the Trust in recent years. The sequence in which the various sections of the Quality Report appear does not adhere strictly to the published guidance, instead following a pattern which we feel is more logical and readable. However a statement on the opening page of the report, agreed with external auditors, will explain how any formal reporting requirements for the Quality Reports are satisfied.

Proposed content for the 2015/16 Quality Report is as follows:

Section of Quality Report	**Comments**
Statement from the Chief Executive	To include Robert's reflections on the Care Quality Commission's comprehensive inspection.
CQC inspection	It is suggested that the report then moves immediately into an extended item on the CQC's comprehensive inspection, focussing on areas of outstanding practice, key challenges and actions (note governor interest in reducing discharge delays and end of life care – they have asked for these aspects of care to be mentioned within our precis). The broad nature of the inspection means that it creates a good foundation for the detailed quality reporting that follows.
Performance against quality objectives for 2014/15	This year, it is proposed to report on our quality objectives in a dedicated section of the report (i.e. as per guidance), rather than under the separate thematic headings of Safety, Effectiveness and Experience: this is because our choice of objectives focussed on patient flow, which straddles these agendas and also follows on naturally from the key findings of the CQC's report. Our objectives were: - Reducing numbers of cancelled operations (not achieved) - Reducing patient moves (not achieved)

	- Right patient, right ward (not achieved) - Reducing out of hours discharges (likely to be achieved) - Developing new approach to PPI (achieved)
Mandatory national comparative indicators	Since 2012, trusts have been required to report on a set of mandated comparative indicators: - VTE risk assessment - C Diff rate per 100,000 bed days - Patient safety incidents per 100 admissions - Patient safety incidents resulting in severe harm or death - Percentage of staff who would recommend the provider (staff survey) - Responsiveness to patients' needs (patient survey) - SHMI (mortality) - Percentage of deaths with palliative medicine coding - Patient Reported Outcome Measures (PROMs) - Emergency readmission with 28 days of discharge (0-15 and 16+) Note: this is a table of mandated data, not supported by narrative commentary – however a number of the quality themes are covered later in the relevant sections of the report.
Patient Safety	- Falls - Pressure Ulcers - VTE risk assessment - Infection control (at request of governors, report to include story of continued focus on IV line care) - Medication errors - Identification of deteriorating patients - Incident reporting rate - Serious Incidents (governors have asked that this focusses on learning) - Never events - How we track clinical/medical equipment – item requested by governors: how we ensure this is in-date, fit for purpose and that staff have received appropriate training to use
Patient Experience	- Friends and Family Test scores - Headline local patient survey scores (e.g. board tracker) + quotes - National patient surveys results during the year (governors have asked that we make it clear what actions are being taken in response to the findings of the national cancer survey) - National staff survey results (governors have asked for this to be focussed on how we are responding and changing our practice; quoting benchmarked data where possible. Staff retention is key theme from governors' perspective); note that there may be a national requirement to report on staff FFT results (NHS England guidance has not yet been published) - Complaints (governors have asked that this item talks about learning from complaints, and also that we also make reference to compliments) - Progress of carers strategy (at the request of governors: a

	theme which we last reported in 2011/12; in particular how we identify and support carers)
Clinical Effectiveness	- Mortality data - Cardiac mortality data (we publish this every year) - 28 day readmissions - Hip fracture best practice tariff (governors have specifically asked that we include again this year) - Dementia (at request of governors)
Performance against key national priorities	See appendix A. - To include extended narrative on national access targets including 18 week RTT. As part of this, governors have asked that the data presented makes it clear what the "tail" of waits is like, i.e. how long are patients waiting after they have breached?
Statements of assurance from the Board	- 'Review of services' (mandated statement) - Clinical audit - CQUINs performance - CQC registration and reviews (brief summary only – extended piece above) - Data quality
Objectives for 2015/16	(see below)
Stakeholder feedback	- Council of Governors - Healthwatch - South Glos OSC - Bristol OSC - Bristol CCG
Performance indicators subject to external audit	(see below)
Statement of Directors' Responsibilities	Mandated statement
External audit opinion	Provided by PwC

4. Proposed external audit indicators for 2014/15 Quality Account/Report

Indicator mandated by monitor: Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways.

Indicator chosen by the Trust (from two options): Emergency waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Indicator chosen by the governors: Dementia FAIR (Find, Assess, Investigate, Refer)[1].

[1] The likelihood is that auditors will only have scope to look at one element of FAIR and that they will focus on the 'Find' indicator – to be confirmed in discussion with the Deputy Chief Nurse

5. Proposed corporate quality objectives for 2015/16

	Objective	Rationale	Measure
1	Reduce cancelled operations	Corporate quality objective not achieved in 2014/15 – therefore carried forward	Chief Operating Officer / Head of Performance Improvement to advise. Revised targets need to take account of any shortfall in 2014/15 performance.
2	Reduce inappropriate patient moves between wards	Corporate quality objective not achieved in 2014/15 – therefore carried forward	Chief Operating Officer / Head of Performance Improvement to advise. Will need to able to capture data for *inappropriate* moves.
3	Right patient, right ward	Corporate quality objective not achieved in 2014/15 – therefore carried forward	Chief Operating Officer / Head of Performance Improvement to advise.
4	Improving the speed of prescribing TTA medications	Very strong consensus from staff/public survey that delays in patients receiving TTA medications needed to be a focus for improvement. Subsequent discussions have highlighted that delays are usually in prescribing, i.e. not pharmacy delays.	Medical Director to advise.
5	Improving how the Trust communicates with patients	A large proportion of complaints received by the Trust are due to failures in some form of communication – this includes face-to-face contact, written letters/information and electronic communications. The executive team has commissioned a trust-wide review of trust-patient communications.	Measures to be identified following detailed scoping of this project.
6	Improving the management of sepsis	Patient safety collaborative objective.	Targets will be advised by the collaborative.
7	Improving the experience of cancer patients	Objective requested by governors in response to the Trust's disappointing national cancer survey results.	The Trust will: - Carry out a series of patient engagement and involvement activities with cancer patients, to fully understand their experience of our services - Work with high-performing Acute NHS Trusts, local health and social care partners, patient advocate organisations, and our own staff to identify and implement improvements to our cancer services - Monitor the actions identified

			and wherever possible undertake regular measurement to provide assurance of progress/completion/impact Cancer Board to advise/own. Measures will need to look beyond the national survey, the timescales of which is unlikely to fit with our own improvement goals.
8	Improving the quality of our complaints responses and reducing the number of dissatisfied complainants	Too many complainants tell us that they are dissatisfied with our complaints responses. Our response letters are consistently detailed and professional but often lack empathy and occasionally fail to address key issues. The choice of objective is supported by feedback from Bristol CCG quarterly reviews and the findings of an independent review by the Patients Association.	To be defined in discussion with the Patient Support and Complaints Team – but will include a defined reduction in the number of dissatisfied complainants as reported to the board via the monthly quality dashboard.
9	Keeping patients who are waiting in outpatient clinics informed about any delays to their appointment time	A large number of recommended improvement actions arising from the Trust's CQC inspection are about outpatient services. There is consensus amongst senior Trust staff that this should be reflected in our corporate objectives – and communication about waiting times is something that our patients consistently tell us that we can do better (also reflected in feedback from our on-line survey).	Chief Operating Officer to advise.

Measures/targets will need to be identified and confirmed as part of the ongoing development of the draft Quality Report, prior to its approval by the Board in May.

6. Quality Report timetable

2nd March	Planning meeting with external auditors (completed)
By Friday 6th March	Notify all proposed contributors of reporting requirements and deadlines (completed)
9th March	This planning report is received by Clinical Quality Group (completed)
12th March	Executive team to discuss draft quality objectives prior to SLT
18th March	Senior Leadership Team receives draft quality objectives for approval
9am on Tuesday 7th April	**Deadline for all initial contributions to QR.** These are needed at this point so that we can release a draft QR for CCG to comment allowing them a 30 day statutory window to review and comment (in practice, the window is

	almost impossible to achieve, but we work closely with the CCG to get as close to this as we can).
w/c 30th March	(CS annual leave)
7th – 17th April	**Intensive work on draft Quality Report**
10th April	Deadline for slides to be sent to Bristol OSC CS to prepare presentation slides for OSCs and gain agreement from Medical Director / Chief Nurse / Chief Operating Officer about content (note that imposed timescale does not allow us to submit the actual QR to our OSCs – just a summary of key quality issues, plus our objectives for the year ahead).
13th April	Trust attends Bristol OSC
13th April	Deadline for slides to be sent to S.Glos OSC (so there will be an opportunity to update the slides from the version we present to Bristol OSC).
Friday 17th April	**Completion of first draft** – release to CCG (informally) – need to ask for their statement by 7th May; but if they have comments which would influence content, we need to know by Friday 24nd April. Also propose we release a draft to our Governors at the same time, to enable their own preparation.
20th April – 5th May	Second-stage editing, taking account of any feedback from OSC visits. To include CEO's introduction.
w/c 20th April	External auditors on site – will want to complete indicator testing by first week of May
22nd April	Trust attends S Glos OSC
By end of April	**Completion of second-stage editing.** Upon completion, we need to release the draft QR to OSCs and Healthwatch. Propose that we release draft to all Board members at the same time (for their information/awareness).
5th May	Latest date for inclusion in CQG papers
7th May	Draft Quality Report received by Clinical Quality Group
14th May	Deadline for SLT papers (by this time, all stakeholder statements need to have been received).
19th May	Possible deadline for Audit Committee, but note that submission will need to be delayed until after SLT (20th) and any subsequent final amendments.
20th May	SLT meets to review draft
26th May	Audit Committee meets (technical sign-off of the QR and external audit)
27th May	Private board to receive QR as part of the Annual Report.
Noon on 29th May	Monitor deadline for submission of QR with our Annual Report
After 29th May	Release QR to Communication Team to facilitate transformation into document for publication.
By 30th June	Send QR to Secretary of State and publish on web site

Appendix - Performance against national standards – as reported in UH Bristol Quality Report for 2013/14

National standard	2011/12	2012/13	2013/14 Target	2013/14[2]	Notes
A&E maximum wait of 4 hours	96.0%	93.8%	95%	93.7%	Target met in 1 quarter in 2013/14 (Q2)
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes	26	57	15 mins	15	Target met in 3 quarters in 2013/14 (not Q1)
A&E Time to Treatment (minutes) median within 60 minutes	20	53	60 mins	52	Target met in every quarter in 2013/14
A&E Unplanned re-attendance within 7 days	1.7%	2.6%	< 5 %	1.6%	Target met in every quarter in 2013/14
A&E Left without being seen	1.0%	1.9%	< 5%	1.8%	Target met in every quarter in 2013/14
MRSA Bloodstream Cases against trajectory	4	10	Trajectory	2	One of the two cases was a contaminated sample only
C. diff Infections against trajectory*	54	48	Trajectory	38	Cumulative target failed in each quarter in 2013/14
Cancer - 2 Week wait (urgent GP referral)	95.9%	95.0%	93%	96.6%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (First treatment)	98.1%	97.0%	96%	96.9%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	96.7%	94.9%	94%	95.1%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.9%	99.8%	98%	99.8%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	99.3%	98.7%	94%	97.6%	Target met in every quarter in 2013/14
Cancer 62 Day Referral To Treatment (Urgent GP Referral)*	87.0%	84.1%	85%	80.7%	Target met in 2 quarters in 2013/14 (not Q2 or Q4)
Cancer 62 Day Referral To Treatment (Screenings)	94.4%	90.0%	90%	93.7%	Target met in every quarter in 2013/14
18-week Referral to treatment time (RTT) admitted patients	91.7%	92.6%	90%	92.7%	Target met in every month in 2013/14
18-week Referral to treatment time (RTT) non-admitted patients	97.9%	95.7%	95%	93.1%	Target met in every month in 1 Q1 2013/14
18-week Referral to treatment time (RTT) incomplete pathways	N/A	92.2%	92%	92.5%	Target met in every month in 2013/14
Number of Last Minute Cancelled Operations	0.87%	1.13%	0.80%	1.02%	Target failed in each quarter in 2013/14
28 Day Readmissions *(following a last minute cancellation)*[3]	93.3%	91.1%	95%	89.6%	Target failed in each quarter in 2013/14
6-week diagnostic wait	99.5%	89.7%	99%	98.6%	Target failed in 3 quarter in 2013/14 (achieved in Q3)
Primary PCI - 90 Minutes Door To Balloon Time	91.0%	91.7%	90%	92.9%	Target met in every quarter in 2013/14
Infant Health - Mothers Initiating Breastfeeding[4]	76.2%	80.6%	76.3%	81.6%	Target met in every quarter in 2013/14

* defined in Appendix C

Achieved for the year and each quarter

Achieved for the year, but not each quarter

Not achieved for the year

Target not in effect

[2] Due to the timing of this report the figures shown in the above table are for the year to date ending March 2014, with the exception of cancer and primary PCI, which are up to and including February 2014.

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

[4] The Infant Health standard shown is a target set by the Trust

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Tuesday 31 March 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
9. Quarterly Complaints and Patient Experience Reports
Sponsor and Author(s)
Sponsor: Chief Nurse, Carolyn Mills Authors: Paul Lewis, Patient Experience Lead (Surveys and Evaluation) Tanya Tofts, Patient Support & Complaints Manager Chris Swonnell, Head of Quality (Patient Experience & Involvement) Jane Palmer, Head of Nursing, Surgery Head & Neck Division Sarah Windfeld, Head of Midwifery

Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

This quarterly agenda item covers the following reports:

- Quarter 3 Complaints Report
- Quarter 3 Patient Experience Report

It includes additional assurance reports in response to areas of performance variance:

- A report from Maternity Services, prompted by patient-reported "kindness and compassion" scores which have been consistently below the Trust norm.
- A report from Bristol Eye Hospital, prompted by persistent patterns of complaints received by the hospital

Key issues to note

Patient Experience

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

Complaints

- 421 complaints were received in Q3 (0.23% of activity) – a reduction compared to 518 (0.29%) in Q2
- The Trust's performance in responding to complaints within the timescales agreed with complainants

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

Triangulation
- As reported in Q2, Ward B301 (old Ward 7, care of the elderly) receives consistently low scores on key patient experience metrics. A wider quality review by the Head of Nursing for the Medical Division has found no evidence of wider care failings and the majority of feedback received by the ward is positive. *Face-to-face* interviews are also being carried out in February (delayed from January). This information will then be used to inform a decision about whether and when to adopt the Trust's *Patient experience at heart* co-design methodology to support the ward to explore patient experience in greater depth (either before or after the ward is relocated in 2015).
- Q3 patient experience scores from Ward A605 were also low, however this was not reflected in complaints data. The likelihood is that lower survey scores have resulted from ward moves (old Ward 6 moved out in August; old Ward 9 moved in in October) and a large number of medical outliers on the ward. The ward will close altogether in March.

Maternity Services
- The report provides an analysis of recent complaints and survey data. Although "kindness and understanding" scores in maternity services are below the Trust norm, the service performed well in the last national survey on this question (i.e. scores are good compared to other Trusts) and has received very positive feedback from the CQC. The report outlines actions being taken as part of a continuous drive to improve patient experience.

Bristol Eye Hospital
- The report demonstrates that, as a proportion of patient activity, the number of complaints received by the Bristol Eye Hospital is significantly less than the Trust norm. Nonetheless, the report provides assurances of ongoing activity designed to improve patient experience.

Recommendations

The Board is recommended to receive these reports for assurance.

Impact Upon Board Assurance Framework

The Quarter 3 complaints report supports achievement of the objective, "To establish an effective and sustainable complaints function to ensure patients receive timely and comprehensive responses to the concerns they raise and that learning from complaints inform service planning and day to day practice."

The Quarter 3 patient experience report supports achievement of the objectives, "To implement the Friends and Family Test in outpatient and day-case settings" and "To increase monthly [FFT] response rate to meet national [CQUIN] targets".

Impact Upon Corporate Risk

The Quarter 3 Complaints Report provides assurances that the Trust's Patient Support & Complaints Team is continuing to respond to enquiries with appropriate timescales, i.e. with a sustained 'no backlog' position (previously a corporate risk).

Implications (Regulatory/Legal)
The Quarter 3 Complaints report supports compliance with the Care Quality Commission's Fundamental Standard for complaints, Regulation 16.
Equality & Patient Impact
A new addition to the quarterly Complaints report is data describing the known 'protected characteristics' of people who complaint about our services. Going forward, the intention is to develop and use this data to help make our complaints service more accessible to all patients.
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

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

Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
			18/3/15	Patient Experience Group, 26/2/15 Quality and Outcome Committee, 26/3/2015

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 3, 2014/2015

(1 October to 31 December 2014)

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

1. Executive summary

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

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

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

This report includes an analysis of the themes arising from complaints received in Q3, possible causes, and details of how the Trust is responding.

2. Complaints performance – Trust overview

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

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

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

2.1 Total complaints received

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

We received 421 complaints in Q3, which equates to 0.23% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]; the figures do not include concerns which may be raised by patients and dealt with immediately by front line staff. The volume of complaints received in Q3 represents a decrease of approximately 19% compared to Q2 (518) but still a 26% increase on the corresponding period a year ago.

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

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

Table 1 – Complaints performance

Items in italics are reportable to the Trust Board.

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

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Total complaints received (inc. TS and F&E from April 2013)	104	127	124	164	131	130	166	178	170	170	148	140	133
Formal/Informal split	55/49	55/72	62/62	89/75	60/71	64/66	64/102	79/99	73/97	86/84	68/80	61/79	52/81
Number & % of complaints per patient attendance in the month	*0.20% 104 of 52194*	*0.21% 127 of 59288*	*0.23% 124 of 54507*	*0.28% 164 of 58180*	*0.24% 131 of 54981*	*0.23% 130 of 57463*	*0.28% 166 of 60027*	*0.28% 178 of 63,039*	*0.32% 170 of 52,879*	*0.27% 170 of 63,794*	*0.22% 148 of 66,104*	*0.25% 140 of 55,703*	*0.22% 133 of 59,487*
% responded to within the agreed timescale (i.e. response posted to complainant)	*88.1% (37 of 42)*	*76.1% (51 of 67)*	*92.0% (46 of 50)*	*88.7% (47 of 53)*	*93.1% (54 of 58)*	*82.5% (47 of 57)*	*83.3% (50 of 60)*	*91.5% (65 of 71)*	*88.3% (53 of 60)*	*88.1% (52 of 59)*	*84.4% (65 of 77)*	*82.9% (58 of 70)*	*82.9% (58 of 70)*
% responded to by Division within required timescale for executive review	57.1% (24 of 42)	77.6% (52 of 67)	86.0% (43 of 50)	71.7% (38 of 53)	82.8% (48 of 58)	86.0% (49 of 57)	91.7% (55 of 60)	76.1% (54 of 71)	83.3% (50 of 60)	81.4% (48 of 59)	77.9% (60 of 77)	78.6% (55 of 70)	87.1% (61 of 70)
Number of breached cases where the breached deadline is attributable to the Division	3 of 5	7 of 16	2 of 4	3 of 6	2 of 4	2 of 10	6 of 10	4 of 6	4 of 7	6 of 7	6 of 12	6 of 12	1 of 12
Number of extensions to originally agreed timescale (formal investigation process only)	9	16	13	11	5	21	8	19	5	17	20	15	11
Number of Complainants Dissatisfied with Response	*6* 6***	*6* 3***	*3* 5***	*5* 2***	*6* 10***	*4* 2***	*11* 4***	*8* 2***	*4* 5***	*2* 4***	*7* 2***	*9* 3***	*8* 2***

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

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

Figure 1: Number of complaints received

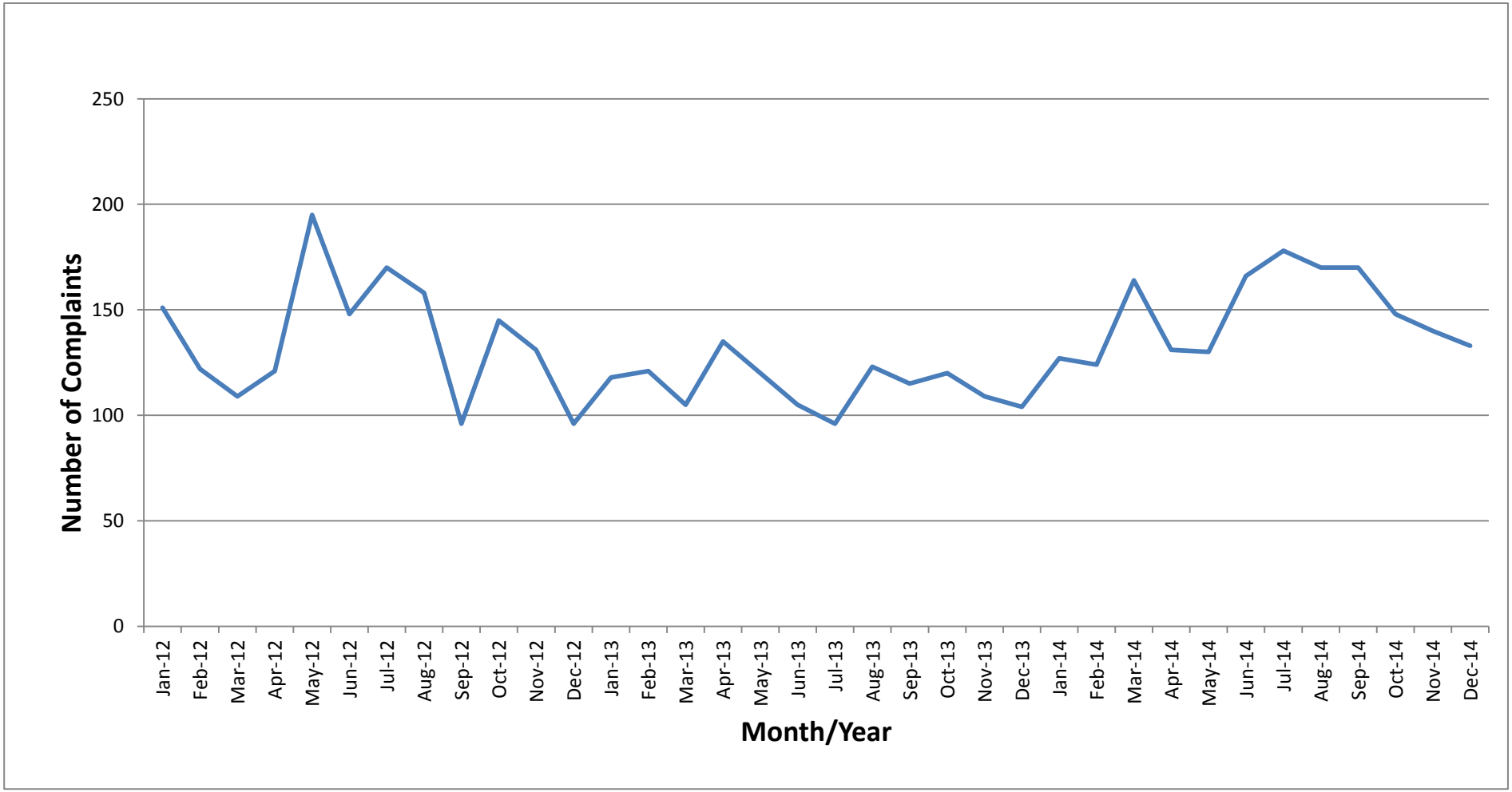
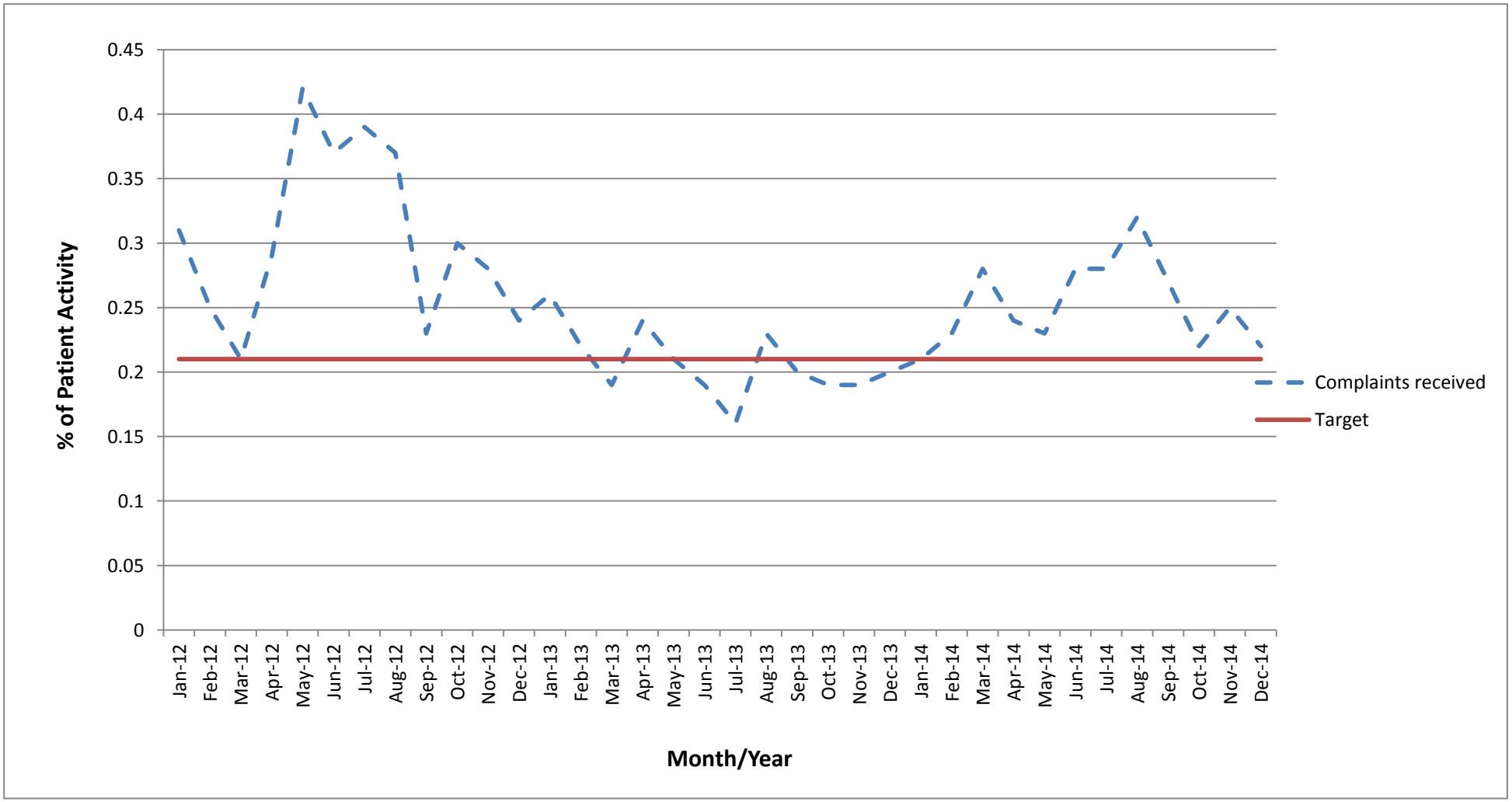


Figure 2: Complaints received, as a percentage of patient activity

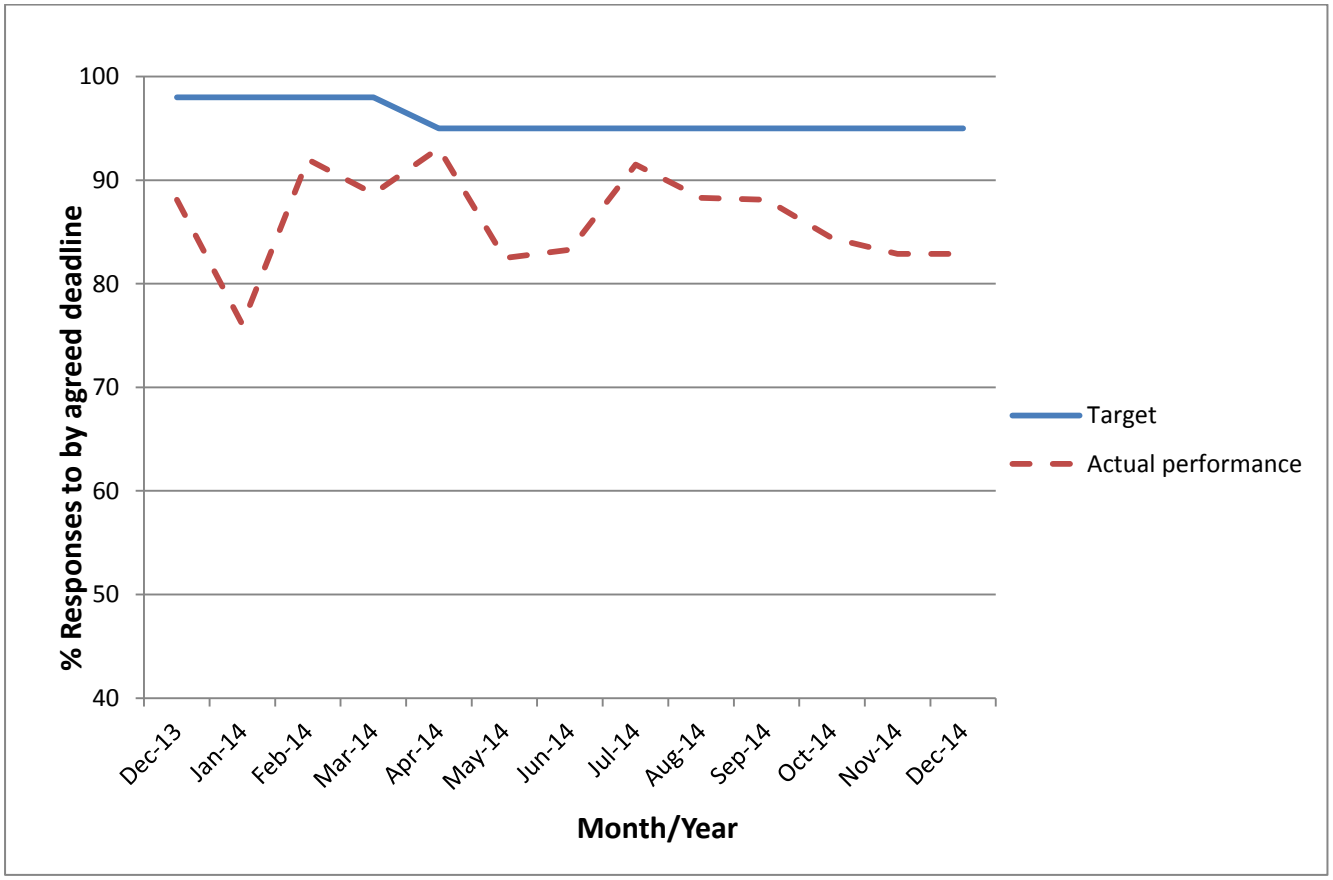


2.2 Complaints responses within agreed timescale

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

Prior to April 2014, our target was to respond to at least 98% of complainants within the agreed timescale. Since 1st April, this target has been adjusted slightly downwards to 95%. The end point is measured as the date when the Trust's response is posted to the complainant. In Q3, 83.4% of responses were made within the agreed timescale, compared to 89.5% in Q2. This represents 36 breaches out of 217 formal complaints which were due to receive a response during Q3[5]. Divisional management teams remain focussed on improving the quality and timeliness of complaints responses. Figure 3 shows the Trust's performance in responding to complaints since December 2013.

Figure 3. Percentage of complaints responded to within agreed timescale



[2] Based on experience, due to relative complexity and numbers received
[3] 25 working days used to be an NHS standard
[4] Discussed and agreed by Patient Experience Group, December 2014
[5] Note that this will be a slightly different figure to the number of complainants who *made* a complaint in that quarter.

2.3 Number of dissatisfied complainants

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

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

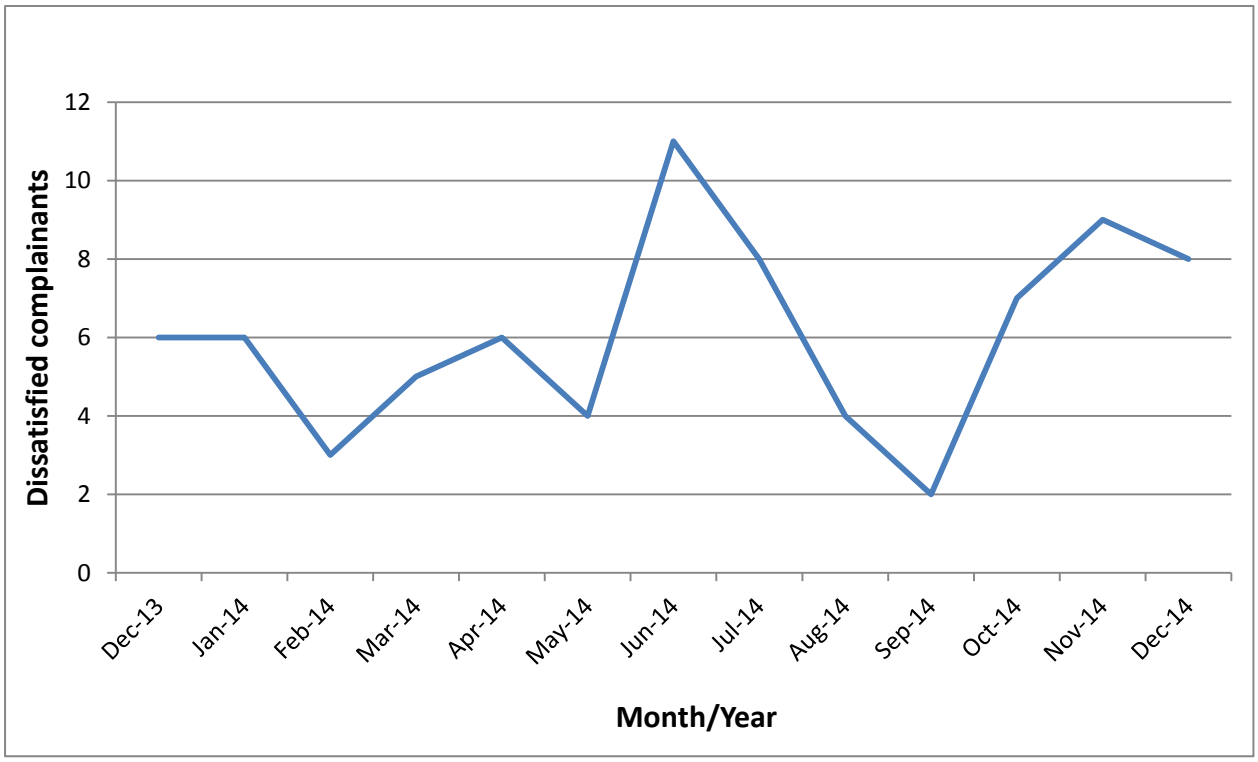
The 24 cases where the complainant was dissatisfied were associated with the following lead Divisions:

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

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

The number of dissatisfied complainants has increased significantly in Q3, with the largest increase being seen in the Division of Surgery, Head & Neck. Actions agreed to address this increase are detailed in section 3.6 of this report.

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



2.4 Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of six major themes. The table below provides a breakdown of complaints received in Q3 compared to Q2. Complaints about all category types decreased in Q3 in real terms, although 'attitude & communication', 'clinical care', 'access' and 'information & support' all showed a slight decrease when measured as a proportion of complaints received.

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

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

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

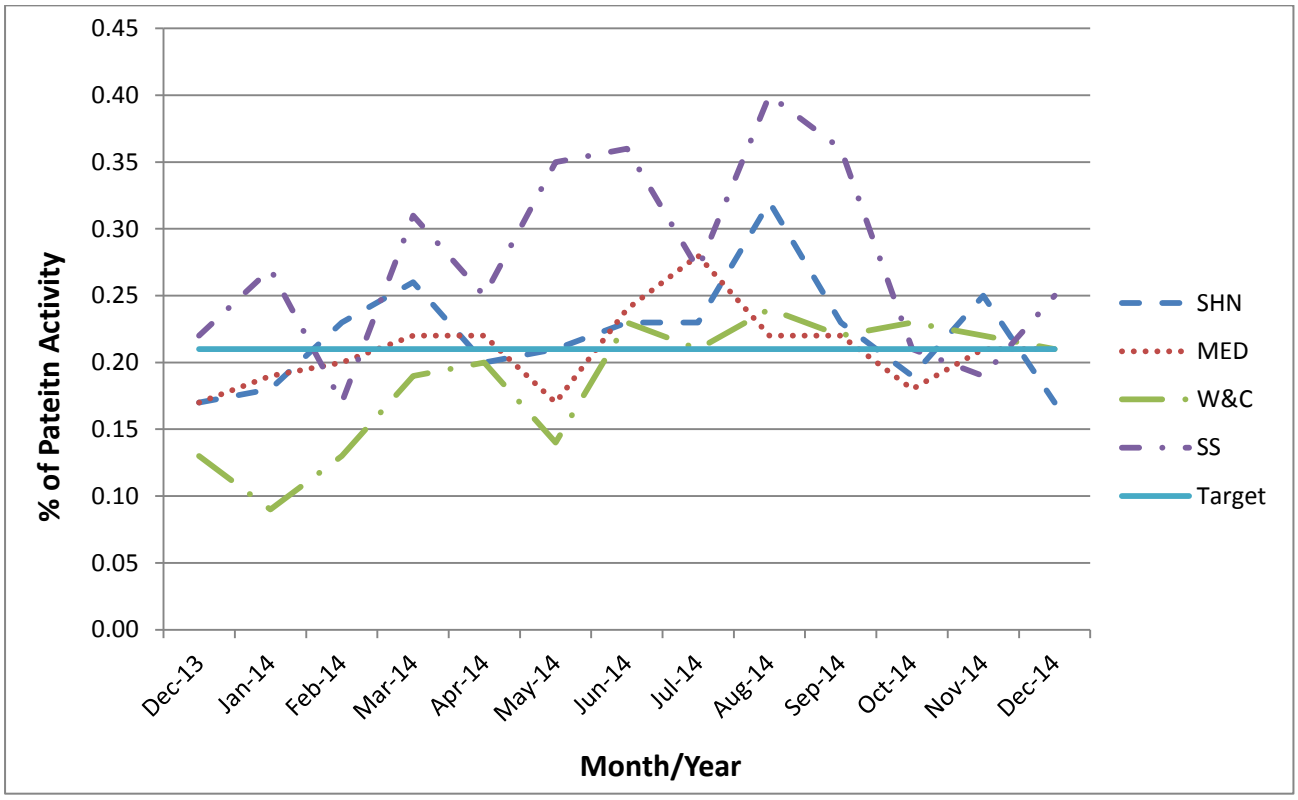
Most notably, the issue of cancelled or delayed appointments and operations has seen a sizeable decrease in Q3 after this was highlighted in the Care Quality Commission's recent inspection report. The Trust, working in conjunction with local health and social care partners, has been tasked by the CQC and Monitor with developing a robust action plan to deliver transformational change to patient flow during the final quarter of 2014/15; the Trust's Chief Operating Officer is leading this work on behalf of the Board. There has been a further increase in complaints about failure to answer telephones – this trebled between Q1 and Q2 (although numbers were relatively small) and there has been a further 58% increase in Q3.

3. Divisional performance

3.1 Total complaints received

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

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



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

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

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

3.2 Divisional analysis of complaints received

Table 3 provides an analysis of Q3 complaints performance by Division. The table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 3.

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

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

3.3.1 Division of Surgery, Head & Neck

Complaints by category type[6]

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

Top sub-categories

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

Divisional response to concerns highlighted by Q3 data

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

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

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

3.3.2 Division of Medicine

Complaints by category type

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

Top sub-categories

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

Divisional response to concerns highlighted by Q3 data

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

3.3.3 Division of Specialised Services

Complaints by category type

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

Top sub-categories

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

Divisional response to concerns highlighted by Q3 data

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

3.3.4 Division of Women & Children

Complaints by category type

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

Top sub-categories

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

Divisional response to concerns highlighted by Q3 data

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

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

3.3.5 Division of Diagnostics & Therapies

Complaints by category type

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

Top sub-categories

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

Divisional response to concerns highlighted by Q3 data

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

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

Complaints by hospital site

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

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

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

Q3 2014/15

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

3.5 Complaints responded to within agreed timescale

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

	Q3 2014/15	**Q2 2014/15**	**Q1 2014/15**	**Q4 2013/14**
Surgery Head and Neck	12 (14.6%)	5 (7.1%)	9 (14.3%)	8 (11%)
Medicine	10 (23.8%)	4 (11.1%)	7 (21.2%)	7 (21.2%)
Specialised Services	4 (15.4%)	1 (4.3%)	2 (8.7%)	0
Women and Children	6 (12.5%)	8 (17%)	6 (19.4%)	9 (36%)
Diagnostics & Therapies	0 (0%)	1 (11.1%)	0 (0%)	1 (8.3%)
All	**32 breaches**	**19 breaches**	**24 breaches**	**25 breaches**

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

Breaches of timescale were caused either by late receipt of final draft responses from Divisions which did not allow adequate time for Executive review and sign-off, delays in processing by the Patient Support and Complaints team, or by delays in during the sign-off process itself. Sources of delay are shown in the table below. It should be noted that in addition to the figures shown in the table below, there were two breaches by the Division of Facilities & Estates and one breach by the Division of Trust Services, giving a total of 36 (see section 2.2). The column headed "Other" relates to other sources of delay. In Q3, both of these breaches were due to delays in other organisations providing their input to the Trust's response.

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

Actions agreed via Patient Experience Group:

- New KPIs have been agreed in respect of turnaround times for the Patient Support and Complaints Team and for the Executives, in addition to the four working days allowed for the Divisions. The Patient Support and Complaints Team must send the response letter to the Executives for signing within 24 hours of receipt from the Division. The Executives then have up to three working days (maximum) to review, sign and return the response to the Patient Support and Complaints Team.
- Divisions have been reminded of the importance of providing the Patient Support and Complaints Team with draft final response letters at least four working days prior to the date they are due with the complainant.
- The Patient Support and Complaints Team continue to actively follow up Divisions if responses are not received on time; Divisional staff are also reminded of the need to contact the complainant to agree an extension to the deadline if necessary.
- Longer deadlines are agreed with Divisions if the complainant requests a meeting rather than a written response. This allows for the additional time needed to co-ordinate the diaries of clinical staff required to attend these meetings. (Note that deadlines agreed with Surgery, Head and Neck, Medicine and Specialised Services are longer than for the other Divisions, to reflect the larger patient numbers and subsequent complaints received by these Divisions).
- An escalation process is in place, to be followed by the Patient Support & Complaints Team in the event that divisional staff fail to respond by agreed deadlines to requests for assistance in resolving informal complaints. The agreed process is that the PSCT caseworker will chase the relevant person once if they have not responded (or updated on progress) by the agreed date, and they will then escalate to the relevant Head of Nursing. If the Head of Nursing fails to respond, the PSCT caseworker will again chase them once before escalating to the relevant Divisional Director. If there is still no response, the PSCT caseworker will chase the Divisional Director once and then escalate to the Chief Nurse. Of course sense and discretion should be used when invoking this process, to allow for the possibility that someone may be on annual leave, off sick or otherwise unavailable.
- Ongoing vigilance to avoid any delays by Patient Support and Complaints Team.

3.6 Number of dissatisfied complainants

As reported in section 1.3, there were 24 cases in Q3 where complainants were dissatisfied with the quality of our response: a return to levels reported in Q1 following an improvement in Q2.

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

Actions agreed via Patient Experience Group:

- Divisions are notified of any case where the complainant is dissatisfied. The 24 cases recorded in Q3 have now either been responded to in full, or have had revised response deadlines agreed with the complainants.
- The Patient Support and Complaints Team continues to monitor response letters to ensure that all aspects of each complaint have been fully addressed – there has recently been an increase in the number of draft responses which the Patient Support and Complaints Team has queried with the Division prior to submitting for sign-off.
- Trust-level complaints data is replicated at divisional level to enable Divisions to monitor progress and identify areas where improvements are needed. This data will also be used for quarterly Divisional performance reviews.

- Response letter cover sheets are sent to Executive Directors with each letter to be signed off. This includes details of who investigated the complaint, who drafted the letter and who at senior divisional letter signed it off as ready to be sent. The Executive signing the responses can then make direct contact with these members of staff should they need to query any of the content of the response.
- Training on writing response letters has being delivered to key staff across all Divisions with input from the Patients Association. This training was well received and further training on this subject matter is being planned. A draft training plan has now been drafted and work is underway for the Patient Support & Complaints Team to roll out a series of focussed training sessions over the coming year.

4. Information, advice and support

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

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

In Q3, the team dealt with 135 such enquiries, compared to 132 in Q2. These enquiries can be categorised as:

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

5. PHSO cases

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

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

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
16353	AH	CH	24/07/2014	BRCH	Paediatric Orthopaedics	Women & Children
14650	CF	MS	23/12/2013	BRI	Upper GI	Surgery, Head & Neck
10805	AJ	MM-L	17/05/2012	BRI	Ward 9	Surgery, Head & Neck
Closed: The PHSO's final report stated that the complaint regarding clinical care and treatment and about the handling of the complaint had not been upheld and that the Trust acted appropriately and proportionately in all respects.						
13987	AB	DJ	10/09/2013	BRI	QDU (Endoscopy)	Surgery, Head & Neck
Open: The PHSO's final report states that the complaint made is partially upheld. A request has been made of the Trust for a letter of apology and a payment of £250 to be sent to the patient, and an Action Plan prepared detailing what has been done and will be done to avoid a recurrence.						

6. Protected Characteristics

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

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

6.1 Age

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

6.2 Ethnic Group

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

6.3 Religion

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

6.4 Civil Status

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

6.5 Gender

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

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

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

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

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

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

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

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

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Experience Report

Quarter 3, 2014/15

(1 October to 31 December 2014)

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

1. Executive Summary

This report presents quality assurance data arising from the UH Bristol patient experience survey programme, principally: the Friends and Family Test survey, the monthly inpatient/parent and maternity postal surveys, and the national patient surveys. Summary analysis is provided which draws on discussions held at the Trust's Patient Experience Group, where the data is reviewed at each meeting. The key headlines from Quarter 3 (October-December 2014) are:

- The Trust continued to achieve "green" ratings in the Trust Board Quality Dashboard: reflecting the provision of a high quality patient experience at UH Bristol.
- Improved "communication" and reducing waiting/delays were key themes arising from the written feedback received from patients.
- There continues to be significant variation in patient-reported experience between wards within the Trust. Detailed analysis of the survey data suggests that these differences are primarily a reflection of differing patient populations, rather than an indication of deeper care failings.
- The Friends and Family Test was introduced to UH Bristol's day case areas in October 2014. We do not have national benchmarks yet (these will be available from May 2015) but, as an interim guide, the day case scores that the Trust has received to date exceed the equivalent inpatient scores.
- UH Bristol received a good set of results of the 2014 National Accident and Emergency patient experience survey, comparing favourably with local and national peer Trusts.

2. Overview of patient experience at UH Bristol

Overall, the feedback received via the UH Bristol corporate patient experience survey programme shows that a positive experience is provided to the majority of patients. However, there is significant variation between wards, and also between individual patients (as demonstrated by the compliments and complaints that the Trust receives - see the linked Quarter 3 Complaints report). By far the most frequent form of feedback from patients conveys praise for UH Bristol staff, but this praise is often accompanied by suggestions for improvement: most typically relating to better communication and reducing waiting/delays. The Trust broadly performs in line with the national average in patient experience surveys, with the exception of the 2013/14 National Cancer Survey where a number of below-average scores were received[1].

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

3. Trust-level patient experience data

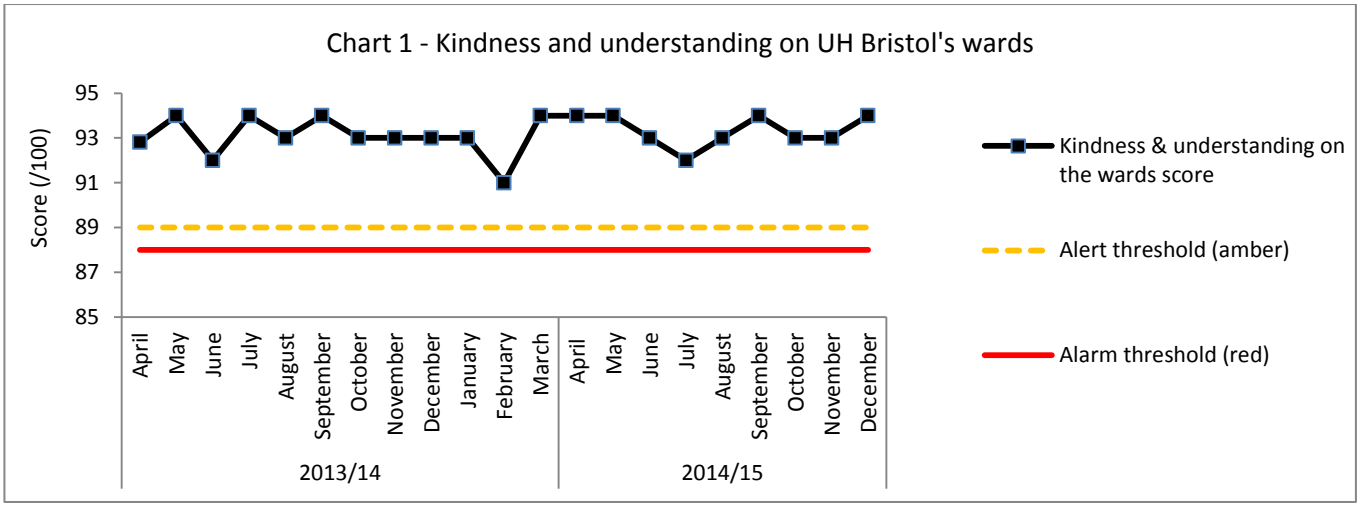
Charts 1 to 4 (over) show the four headline metrics that are used by the Trust Board to monitor the overall quality of patient-reported experience at UH Bristol[2]. These scores have been consistently rated "green" in the periods shown[3], indicating that a high standard of patient experience is being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

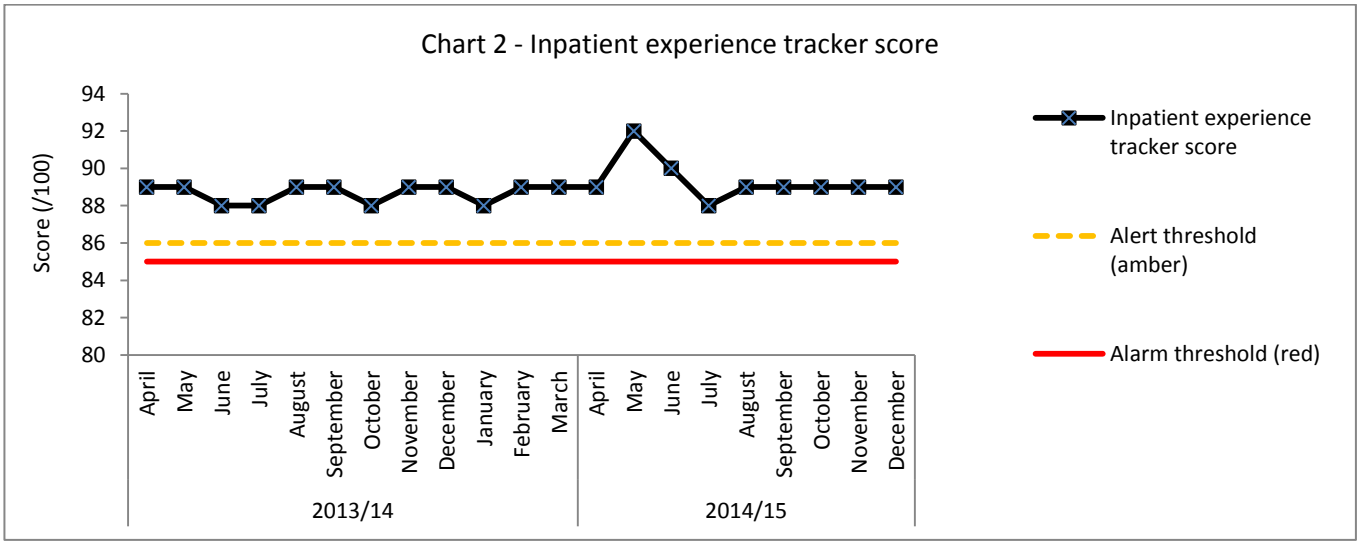
[1] A programme of engagement with patients of the Trust's cancer services is currently being undertaken to fully explore these survey results. The outcomes of this activity will inform a substantive improvement plan.

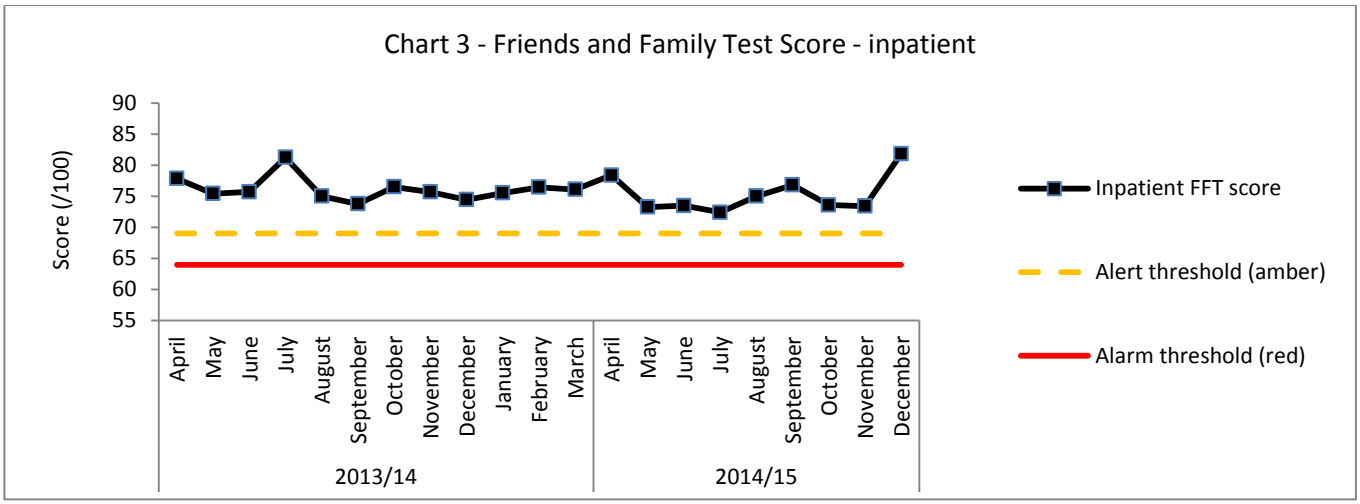
[2] Kindness and understanding is used as a key measure, because it is a fundamental component of compassionate care. The "patient experience tracker" is a broader measure of patient experience, made up of five questions from the UH Bristol monthly postal survey: ward cleanliness, being treated with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

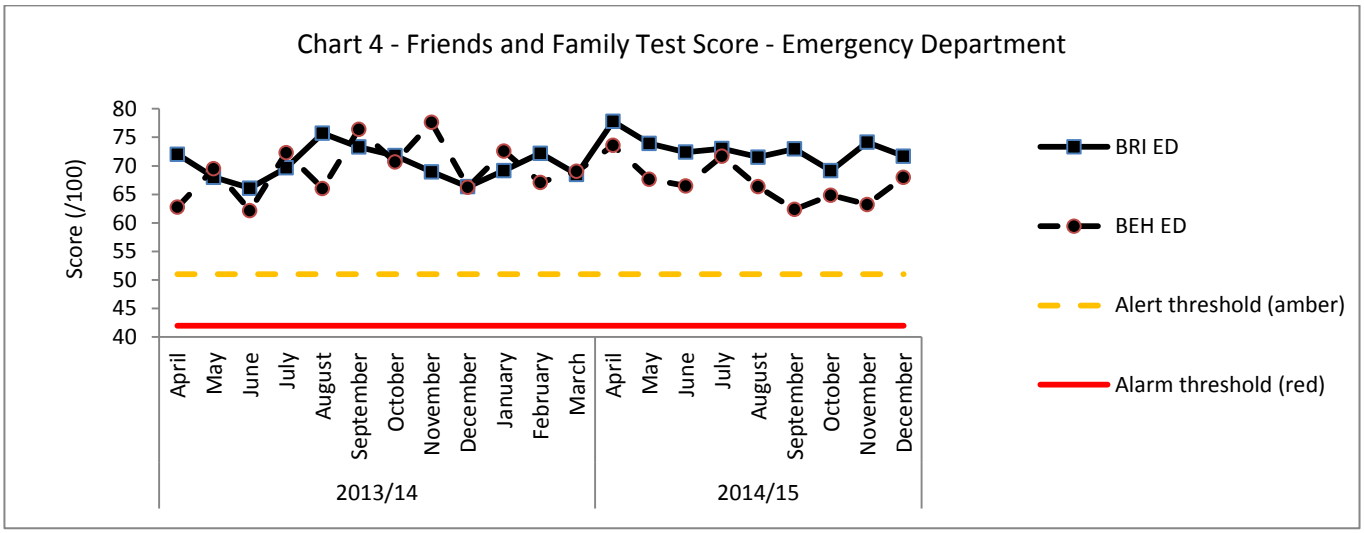
[3] Note: the Friends and Family Test data is available around one month before the postal survey data.

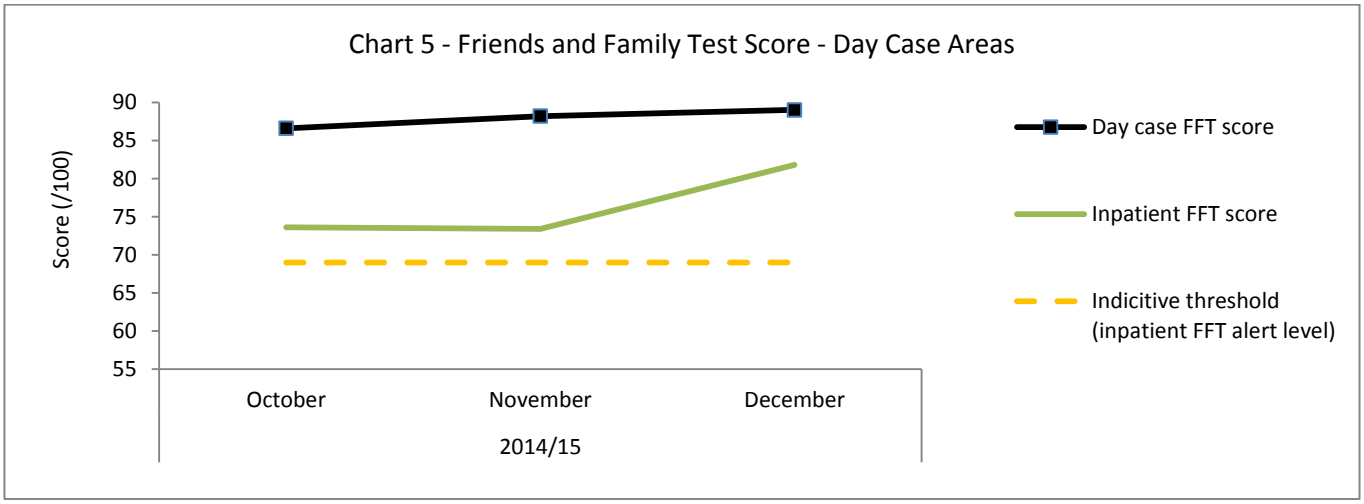
would turn “amber” or “red” if they fell significantly, alerting the senior management team to a deterioration in this position. Chart 5 (page 4) shows the results from the Trust’s new Day Case Friends and Family Test survey (see Appendix D for further information about the Friends and Family Test).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







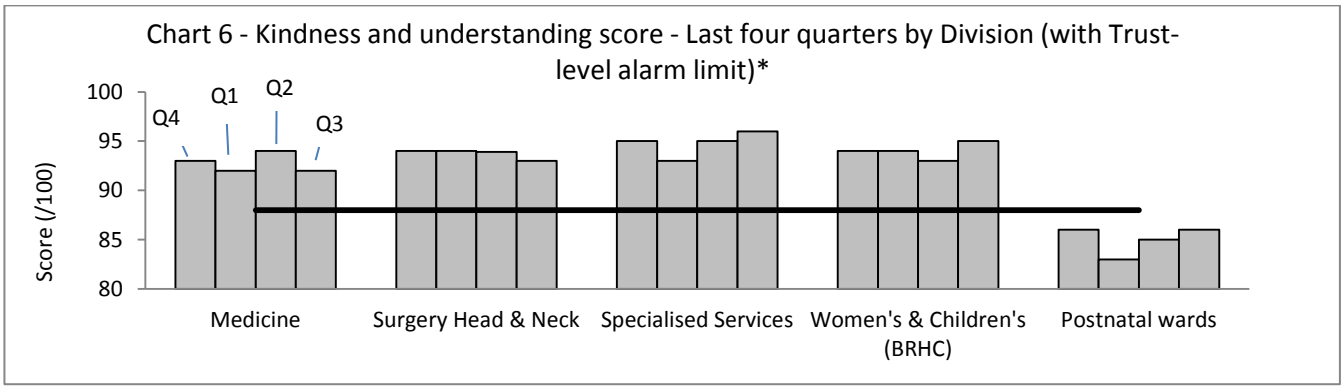


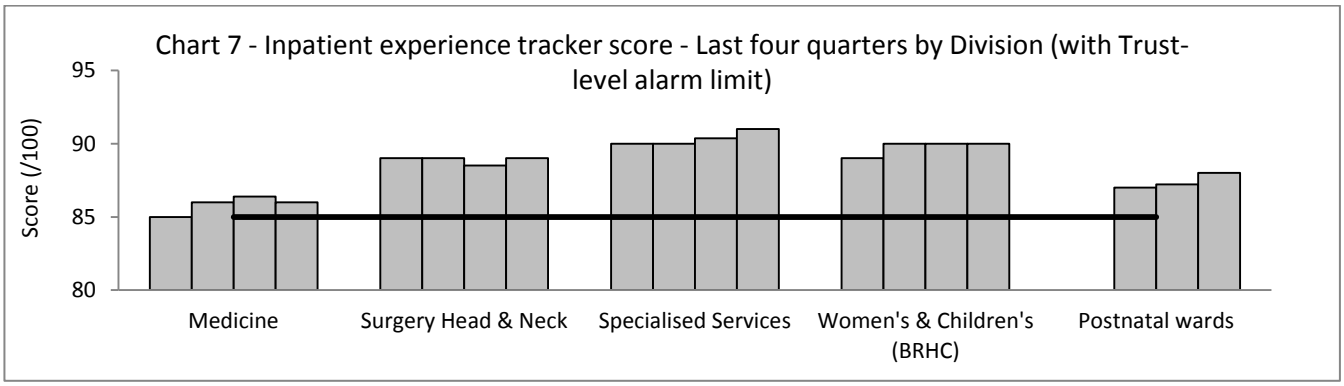


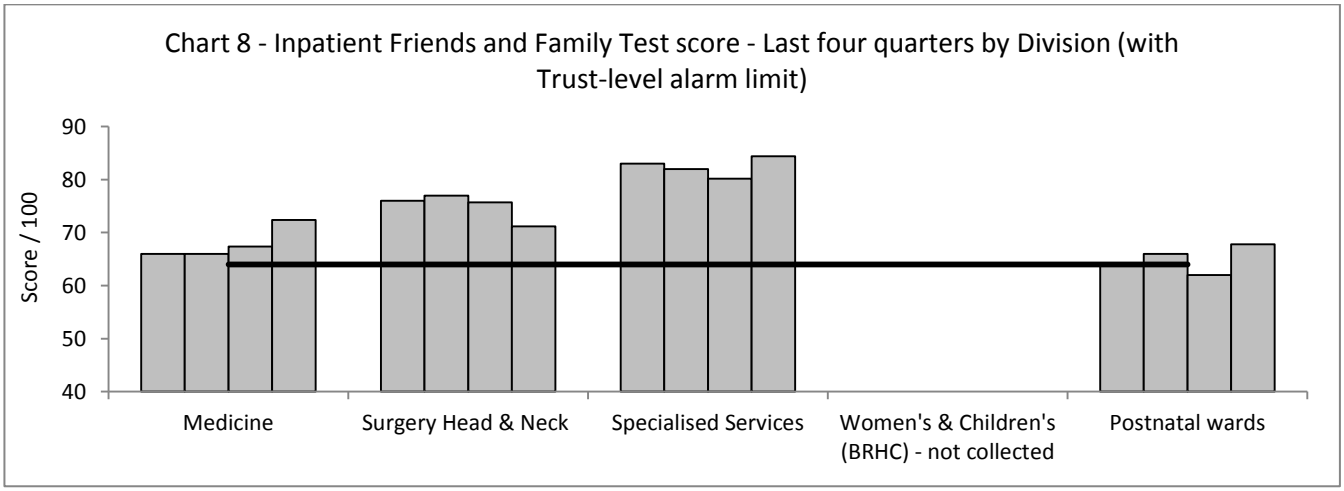
4. Divisional-level patient experience data

Charts 6-8 (over) split the headline patient experience metrics by UH Bristol Division. The Trust-level "alarm threshold" is shown in these charts, but this is a guide only - caution is needed in applying this directly because there is a higher margin of error in the data at this level. The Specialised Services Division tends to receive the highest (best) patient experience ratings, with the Division of Medicine attracting slightly lower survey ratings. An important factor here is that the Division of Medicine cares for a relatively high proportion of elderly patients with chronic, complex conditions: research has shown that this affects patient experience ratings over and above the quality of the care provided[4]. Nevertheless, these scores are reflective of the experience as the survey respondents saw it, and the Division of Medicine are carrying out a number of monitoring and improvement activities in this respect (see Sections 5 and 6). Postnatal maternity care also attracts lower survey ratings: although these scores are in line with (or better than) the national maternity average, improvement initiatives continue to be carried out in the service to improve these scores (see Section 5)[5].

[4] http://www.pickereurope.org/wp-content/uploads/2014/10/Multi-level-analysis-of-inpatient-experience.pdf
[5] The FFT is not currently in paediatric inpatient wards (it will be implemented by March 2015). The Patient Experience Tracker has been collected for postnatal wards since April 2014.







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

5. Hospital-level patient experience data

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

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

South Bristol Community Hospital (Wards 100 and 200)

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

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

Postnatal wards (71,74,76)

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

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

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

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

Chart 10: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

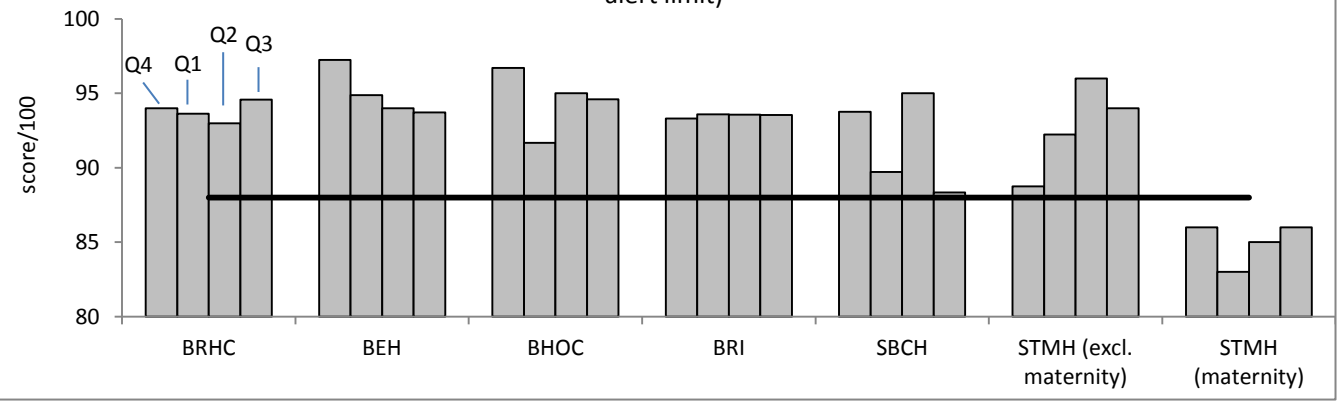


Chart 11: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

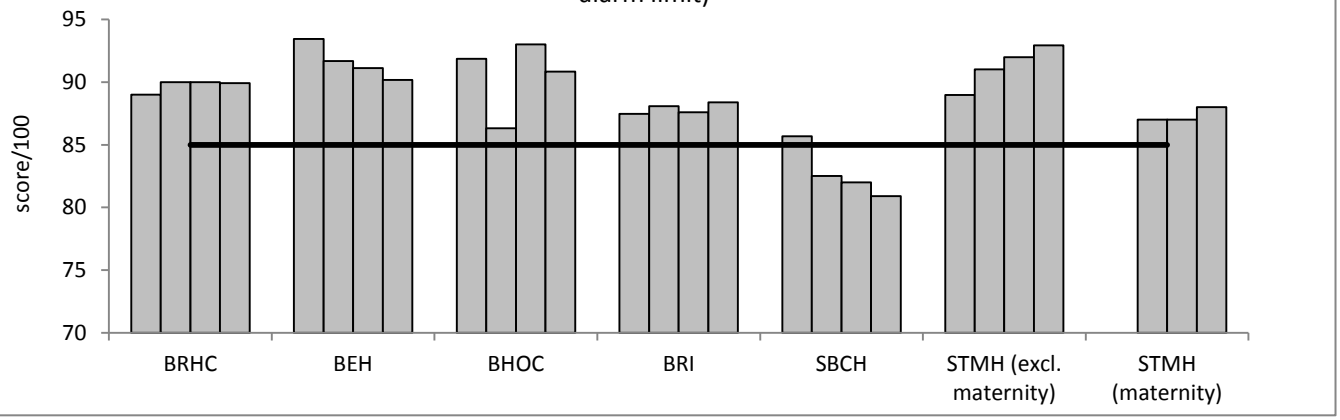
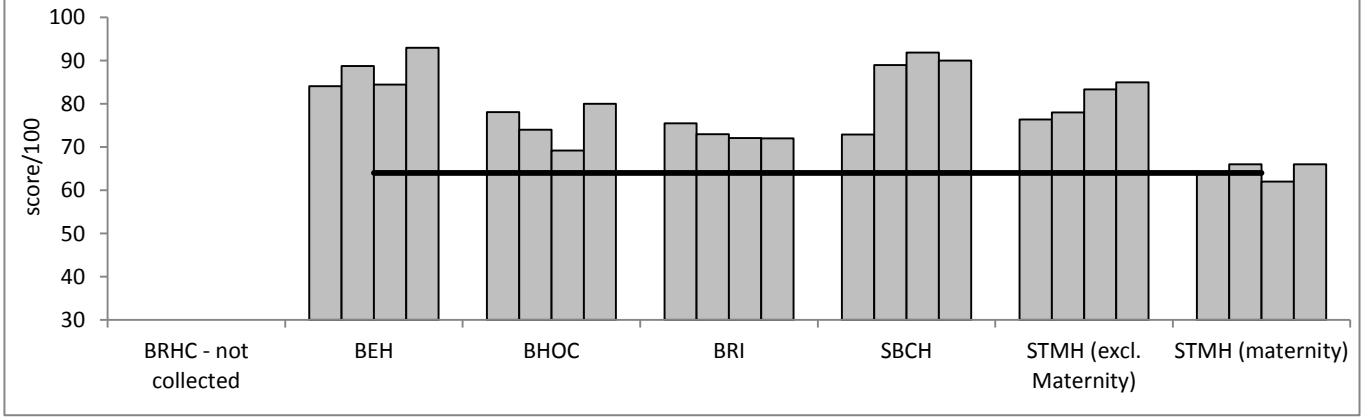


Chart 12: Friends and Family Test score by hospital (with Trust-level alarm threshold)



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

6. Ward-level data

The ward-level inpatient survey and Friends and Family Test data is presented in charts 11 to 13 (over). The sample sizes are relatively small at this level, decreasing the levels of accuracy in the data. Furthermore, a large number of the ward moves / refurbishments / closures are currently taking place within the Trust. Efforts have been made within the following analysis to take into account these moves, but ultimately it is very difficult to do this with a great degree of accuracy. In short: even more caution that usual should be attached to the ward-level data in this report but, even so, some consistency across the surveys does emerge:

- The Coronary Care Unit (CCU) consistently achieves the highest scores.
- The postnatal wards tend to receive lower scores (see the previous discussion in Section 5).
- Ward B301 (formally Ward 7), which is primarily provides care for an elderly patient population, received relatively low patient experience ratings in the period shown. As with South Bristol Community Hospital, this is in many ways a realistic reflection of the challenges in caring for this patient group. A theme also emerges in the Friends and Family Test feedback for ward B301 around noise and disruption from other patients. This is likely to be because some patients on the ward will have severe Dementia: early discussions are taking place within Division of Medicine around whether it remains appropriate to care for these patients on the same ward(s) as patients with mild or no Dementia. Despite these challenges, the feedback for Ward B301 contains very high levels of praise for the staff and the care provided. Furthermore, no evidence of deeper care failings has been found in a wider review of quality data for the ward that was carried out by the Head of Nursing for the Division of Medicine. This assurance will be further tested in February 2015, when the ward is a focus for the Trust's *Face2Face* interview survey (see Appendix C).
- Ward A605 received the lowest Friends and Family Test score (Chart 13) and a relatively low patient experience tracker score (Chart 12). This ward hasn't been flagged in this Quarterly report before, and there hasn't been a corresponding rise in complaints or concerns in other quality data. Furthermore, the great majority of written comments received from patients contain praise for the staff, and 94% said that they would be likely to recommend the ward to friends and family. Nevertheless, two separate surveys are showing that satisfaction scores were *relatively* low compared to other wards. During the period covered in the data, there were some ward moves involving A605: the previous specialty (Thoracic) moved to a new location, with a new specialty (Vascular) being temporarily housed on the ward until it closes altogether in March 2015. This is the only major contributing factor that we have been able to correlate with the survey results.

Chart 11: Kindness and understanding ratings by ward (October to December 2014), with Trust-level alarm threshold)

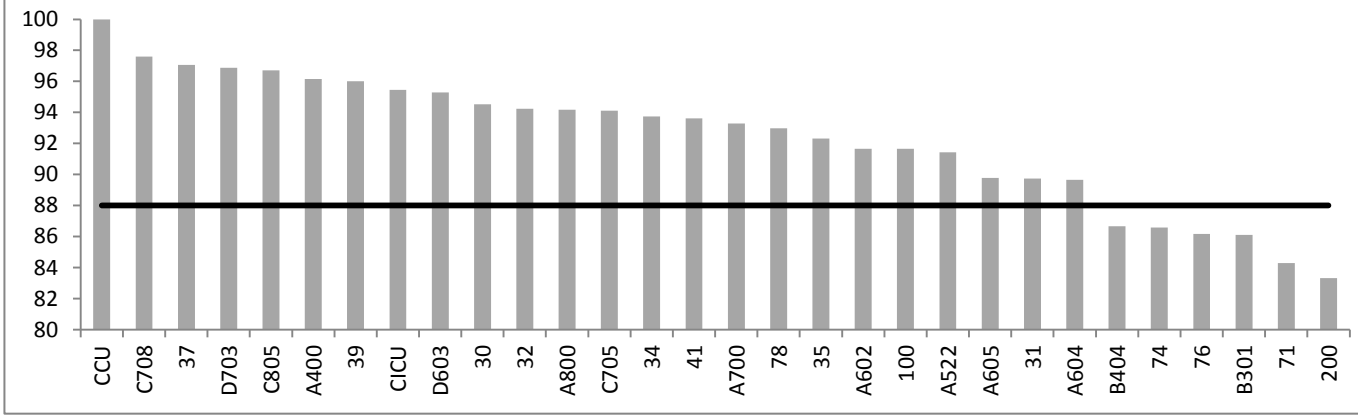


Chart 12: Patient Experience Tracker score by ward (October to December 2014), with Trust-level alarm threshold)

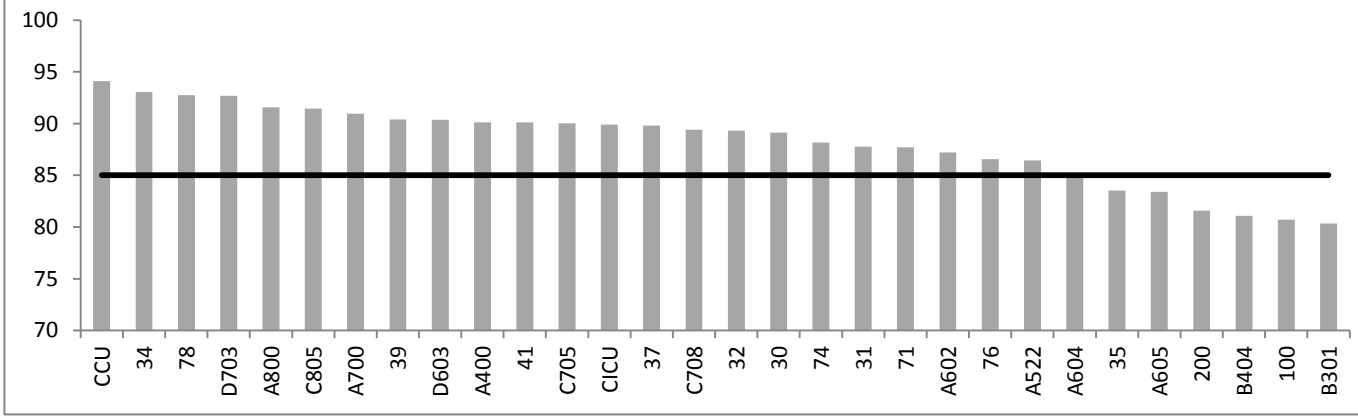
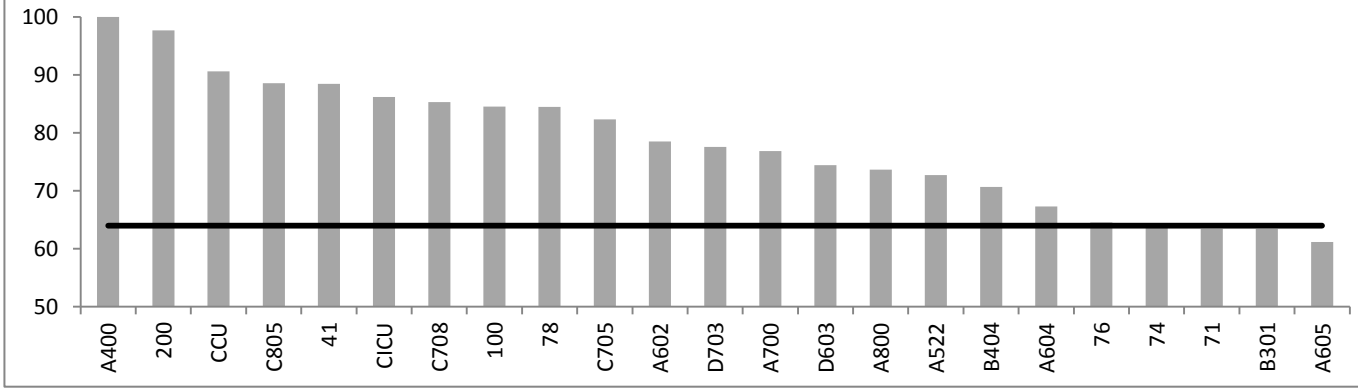


Chart 13: Friends & Family Test inpatient results by ward (October to December 2014, with Trust-level alarm threshold) - no data is available for the Bristol Royal Hospital for Children



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

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

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

All inpatients/parent comments (excluding maternity)

Theme	Valence	% of comments[8]	
Staff	Positive	60%	*61% of the comments received contained praise for UH Bristol staff, making this by far the most common theme. Improvement themes centre on communication, staff, waiting/delays, and food.*
Communication	Negative	14%	
Waiting/delays	Negative	9%	
Staff	Negative	9%	
Food/catering	Negative	8%	

Division of Medicine

Theme	Valence	% of comments	
Staff	Positive	56%	*Negative comments about "staff" are often linked to other thematic categories (e.g. poor communication from a member of staff). This demonstrates that our staff are often the key determinant of a good or poor patient experience.*
Communication	Negative	10%	
Waiting/delays	Negative	8%	

Division of Specialised Services

Theme	Valence	% of comments	
Staff	Positive	60%	*Negative comments about staff also often relate to a one-off experience with a single member of staff, showing how important each individual can be in a patient's experience of care.*
Communication	Negative	14%	
Food/catering	Negative	10%	

Division of Surgery, Head and Neck

Theme	Valence	% of comments	
Staff	Positive	59%	*Improving patient flow (including delays at discharge) is a key priority for the Trust. A number of major projects are being undertaken in relation to this during 2014/15.*
Communication	Negative	14%	
Staff	Negative	10%	

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

Theme	Valence	% of comments	
Staff	Positive	65%	*This data includes feedback from parents of 0-11 year olds who stayed in the Bristol Royal Hospital for Children. Again the themes are similar to other areas of the Trust.*
Communication	Negative	17%	
Staff	Positive	11%	

Maternity comments

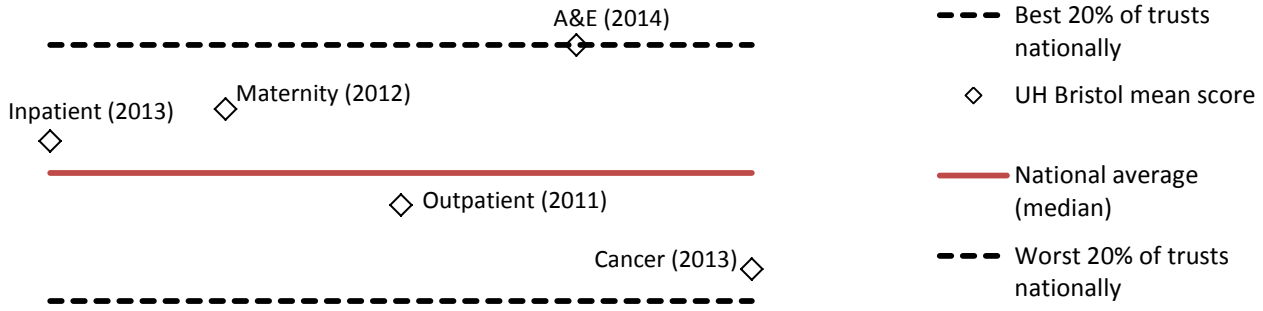
Theme	Valence	% of comments	
Staff	Positive	62%	*For maternity services, the two most common themes relate to praise for staff and praise for care during labour and birth.*
Care during labour	Positive	29%	
Information/advice	Negative	18%	

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

7. National patient survey programme

Along with other English NHS trusts, UH Bristol participates in the Care Quality Commission (CQC) national patient survey programme. This provides useful benchmarking data - a summary of which is provided in chart 14 below[9] and Appendix A. It can be seen that UH Bristol broadly performs among the mid-performing trusts nationally. The main exception here is the 2012 national Accident and Emergency survey[10], where UH Bristol performed well above the national average. The national cancer survey (NCS) on the other hand tends to produce scores for UH Bristol that are lower than the national average. The latest set of NCS results were received during Quarter 2 (although the sample of patients surveyed had attended UH Bristol in late 2013). Despite a large number of service improvement actions at the Trust, the scores had not improved significantly from previous NCS results. A comprehensive engagement programme with patients receiving cancer services will be carried out by the Trust, in collaboration with the Patient's Association, to fully understand these results and inform the substantive action plan. In addition, the Trust will participate in an NHS England programme which will involve working closely with a peer Trust that performs consistently well in the NCS. These activities will lead to the development of a comprehensive and far-reaching action plan during 2015.

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



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

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

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

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

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

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan progress reviewed by Patient Experience Group*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2013 National Inpatient Survey	59/60 scores were in line with the national average. One score was below the national average (privacy in the Emergency Department)	May 2014	Quarterly	• Privacy in the Emergency Department • Awareness of the complaints process • Delays at discharge • Explaining potential medication side effects to patients at discharge	March 2015
2013 National Maternity Survey	14 scores were in line with the national average; 3 were better than the national average	January 2014	Six-monthly	• Continuity of antenatal care • Communication during labour and birth • Care on postnatal wards	January 2016
2013 National Cancer Survey	30/60 scores were in line with the national average; 28 scores were below the national average; 2 were better than the national average	November 2014	Six-monthly	• Providing patient-centred care • Validate survey results • Understanding the shared-cancer care model, both within UH Bristol and across Trusts	September 2015
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	December 2014
2011 National Outpatient Survey	All UH Bristol scores in line with the national average	March 2012	Six monthly	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments • Copy patients in to hospital letters to GPs	No longer in the national survey programme

Appendix B: Full quarterly Divisional-level inpatient/parent survey dataset (Quarter 3 2014/15)

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

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

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

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

Appendix C – UH Bristol corporate patient experience programme

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

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

Appendix D: survey scoring methodologies

Postal surveys

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

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

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

Friends and Family Test Score

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

The FFT score is calculated as follows:

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

Minus

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

Division of Surgery, Head and Neck – Bristol Eye Hospital complaints update

Report for Quality and Outcomes Committee

Introduction

In response to concerns raised by the Committee regarding the numbers of complaints received by the Bristol Eye Hospital (BEH), the hospital managers have undertaken a review of the current situation in order to provide both assurance and context.

Looking back over the past four quarters, numbers of complaints have remained fairly stable, with the exception of quarter four 2013/14 when 60 complaints were received: this quarter corresponded with the change in pharmacy services for the hospital and as a result a significant number of the complaints related to this. In the three quarters so far in 2014/15, as part of the work around reducing backlogs, on-hold patients and meeting referral to treatment targets, the number of patient attendances has reached 41,000 per quarter. This number includes accident and emergency cases, elective day cases, elective and non-elective inpatients, as well as outpatient attendances across the three current sites – BEH, South Bristol Community Hospital and a GP practice in Worle, Weston-Super-Mare. This number of attendances is likely to rise further in 2015/16 and we hope to have a service in the South Gloucester area by the end of 2015.

Volume of complaints received by Bristol Eye Hospital
Q4 2013/14 = 0.21% of total patient episodes for the hospital and outreach services (60 complaints)
Q1 2014/15 = 0.13% (38 complaints)
Q2 2014/15 = 0.15% (46 complaints)
Q3 2014/15 = 0.12% (36 complaints)

This data demonstrates that when complaints are measured as a proportion of clinical activity (which is the way that complaints are reported to the Board), Bristol Eye Hospital performs significant <u>better</u> than the Trust norm (for example, the Trust rate for Q3 was 0.29%). In other words, the fact that the Eye Hospital receives relatively large numbers of complaints in absolute terms is mostly a reflection of the high volume of clinical activity at this hospital.

The key areas where we see the consistently largest number of complaints are:

Bristol Eye Hospital

Concern	Explanation	Action
<u>Appointments & Admissions:</u> Of the 36 complaints received in Q3, 12 commented on access to appointments, cancellations and delayed appointments	We are very aware of the issues, particularly with the medical retinal and glaucoma services, that have led to patients experiencing significant delays and cancellations in their follow up appointments.	Work is ongoing to address the on-hold situation, each case is addressed appropriately as they arise; incident forms are submitted and investigated to ensure that all lessons are learnt about the process and any system fragility that still exists. Recruitment is ongoing to address the medical retinal service; two new nurse practitioners have been appointed to carry out both intra-vitreal injections and laser treatments – both areas where we know there is significant delay but also that they generate complaints about communication. We have found that the nurse practitioners have a much greater

		focus on patient experience and they receive vast numbers of informal compliments. Further work is ongoing to provide an additional outreach service in South Gloucestershire during 2015 as we are aware that patients from this area struggle to access our services at SBCH due to transport issues. The glaucoma service has developed an outreach centre at SBCH to help manage the patients with a stable condition that requires infrequent reviews. Further feasibility work is ongoing regarding a facility in South Gloucestershire. A few complaints mentioned delays once in clinics; this has decreased considerably, due to the ongoing recruitment of very high quality outpatient clinical staff. Patients are kept informed of delays both verbally and visually through the use of a white board. This is reinforced to staff on a regular basis as they can forget to update patients when involved in the clinical role. A small number of complaints related to cancelled operation; these were in relation to the specialties where emergencies and cancer patients are likely to present requiring surgery at very short notice. Staff working in these specialties have been asked to advise patients that, where their surgery is not time critical, there is a potential for cancellation for this reason.
<u>Clinical Care:</u> Of the 36 complaints received in Quarter 3, 7 relate to clinical care.	The number of complaints received relating to clinical care is not increasing. There is also no obvious pattern of complaints within this category.	On receipt of a complaint, the team/s involved receive a copy and are asked to reflect on their practice, learn lessons and take action, where appropriate to make changes. One complaint in Q3 related to an incorrect medication being prescribed for a patient to take home; this error was not picked up through the normal checking process, the error was rectified immediately it was noted and an apology was made to the patient. None of the other complaints related to errors but to a failure to manage patients' expectations regarding likely outcomes of surgery. This will be discussed further at the BEH executive group however staff have been reminded to be as explicit as possible where the predicted outcome may be no improvement or deterioration – in each case the

		consent form has identified the potential poor outcome, the majority of patients had been given the pink copy of their form. Further discussion is required around copying patients into correspondence which may be helpful for them to understand their condition.
Attitude and communication: Of the 36 complaints 10 were in this category	Two complaints related specifically to the approach of one member of administrative staff. The remaining eight complaints relate to various issues around outcomes from treatments not being as the patient/families expected.	The concerns relating to the member of administration staff have been addressed directly with the individual concerned and their behaviour is being monitored supportively. Further complaints were received in this category relating to the pharmacy service; additional signage has been placed in the outpatients and accident and emergency departments to advise patients of the change in service. Each complaint was reviewed and on each occasion documentation existed to support that the outcomes were discussed with the patient. We understand that patients do not always take in the information that is given to them, particularly when they are receiving bad news about their health. The new patient support and liaison nurse has been in post for four months and has significantly improved communication between clinical staff and patients; next steps are to provide her with a mobile telephone (so that staff/patients can contact her when she is away from the office) and to provide business cards to inform patients of her role and that of the Eye Clinic Liaison Officer who manages the process to register a patient as severely sight impaired. We plan to have these in all departments.
Facilities and environment: A further four complaints relate to this category	The theme of these complaints was access to and timeliness of hospital transport arrangements.	All complaints were investigated by the ambulance service. We have asked for some patient information to help manage patients' expectations regarding the use of hospital transport as BEH staff have no influence over this other than to book appropriately and inform the service in a timely manner when patients are ready for collection.

The Division is aware of the ongoing level of complaints and has reviewed the evidence with teams in the Bristol Eye Hospital. Complaints are a standing agenda item at the BEH clinical governance and Clinical Executive groups. The matron receives all complaints as soon as they are received by the Division to investigate; she manages the process to ensure that responses are discussed with any individual mentioned and that any themes are identified and addressed. A member of the divisional management team reviews all final responses before one of the trust executives signs them off; formal action plans are in place to help retain focus on issues.

Patient experience has a high profile in the Division, with complaints responded to promptly. The figures demonstrate that, as a percentage of patient attendances, there are very few reported complaints and concerns, and we anticipate that the mitigation put in place will maintain or reduce this further. Given the already very small numbers of complaints it is unlikely that we will make a significant impact upon the numbers but the hospital managers will continue to oversee the process appropriately for our patients.

Maternity Services report for the Quality and Outcomes Committee

Purpose

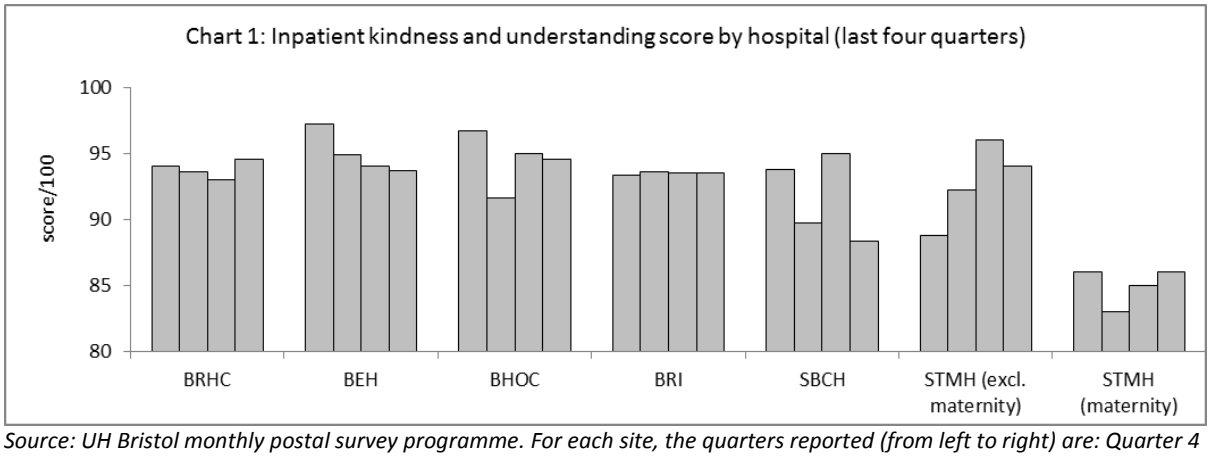
This report to the Quality and Outcomes Committee has been prompted by questions raised by the committee about why patient-reported 'kindness and understanding' survey scores in maternity services continue to be lower than the Trust norm, and how the service is responding.

Introduction

The Trust Board Quality Dashboard includes a patient-reported measure of whether UH Bristol's inpatients are treated with kindness and understanding. In the Trust's Quarterly Patient Experience Report, this metric is further broken down by ward. Typically, the kindness and understanding rating for UH Bristol's postnatal maternity wards is lower than for inpatient wards[1]. It should be noted that directly comparing maternity and inpatient wards is problematic, given the differences in service-user demographic s and the type of care being provided. Furthermore, the most recent National Maternity Survey (2012) found that UH Bristol's postnatal wards were among the best performing trusts on the kindness and understanding question[2], and a detailed inspection by the Care Quality Commission in the autumn of 2014 rated the Trust's maternity services as "good". Nevertheless, the maternity service recognises that there is room for improvement in the kindness and understanding score and staff have been fully engaged in carrying out actions to improve this.

Survey data

Chart 1 demonstrates that the postnatal ward scores, which are on far the right hand side of the chart, are typically lower than for other inpatient areas at the Trust. The scores[3] in the period shown in Chart 1, equate to 73% of women stating that they were always treated with kindness and understanding, 23% stating that they were "sometimes", and 3% that they were not.



Source: UH Bristol monthly postal survey programme. For each site, the quarters reported (from left to right) are: Quarter 4 (January-March 2014); Quarter 1 (April-June 2014); Q2 (July-September 2014); Quarter 3 (October to December 2014).

[1] Conversely, the equivalent score in the Central Delivery Suite / Midwifery Led Unit are among the highest in the Trust.

[2] The next national maternity survey will take place during 2015.

[3] The scoring approach follows the methodology used in the Care Quality Commission's National Patient Surveys – assigning a weighted value to each of the three response categories.

BRHC = Bristol Royal Hospital for Children; BEH = Bristol Eye Hospital; BHOC = Bristol Haematology and Oncology Centre; BRI = Bristol Royal Infirmary; SBCH = South Bristol Community Hospital; STMH (excl. maternity) = St. Michaels Hospital Gynaecology; STMH (maternity) = Postnatal Wards

A review has been undertaken of the written comments received from women via the UH Bristol maternity survey[4]. A key factor identified in the relatively low kindness and understanding score between labour / delivery areas and postnatal wards (see Footnote 1), was that relatively fewer staff were available on the wards. Although Midwifery staffing levels for UH Bristol are in line with Birth rate Plus (A recognised workforce tool for Midwifery) , this is perception is understandable: women will go from 1:1 care during labour / deliver, to the postnatal ward, which has an emphasis on mobilising women early after child birth and encouraging them to care for themselves / baby wherever possible.

Complaints

Between April 2014 and March 2015[5], the maternity service received 31 complaints. This equates to approximately 0.13% of women who used the maternity service (approximately 1 in 770 patients), compared to approximately 0.26% for the Trust as a whole during the same period. The number of complaints received each month is shown in Table 1. It can be seen that there is significant variation from one month to the next – in some cases "spikes" in complaints can be correlated with specific events (e.g. September 2014, when the department was short staffed); but in other cases, no single attributable cause is apparent.

Table 1: maternity service complaints April 2014 to March 2015

April	May	June	July	August	Sept.	Oct.	Nov.	Dec.	January	February	March*
0	2	0	3	1	7	2	7	1	2	6	0

*to date

Table 2 below looks in more detail at the type of complaint received during 2014/15. It can be seen that similar numbers of complaints were received about clinical care (i.e. related to any medical interventions), and issues broadly related to the kindness and understanding theme (e.g. lack of support, staff attitude, communication issues).

Table 2: maternity service complaints April 2014 to March 2015

Clinical care	15
Kindness and understanding - labour / delivery	5
Kindness and understanding - postnatal ward	4
Kindness and understanding - general	5
Other	2

[4] This review covered the period to March 2011. Although this analysis is now aged, the broad themes identified remain valid to any discussion of the postnatal ward service-user experience.
[5] To the date that this report was written: 11 March 2015

Improving service-user experience of maternity services

The discrepancy in postnatal and inpatient ward scores has been apparent for some time, and so a number of activities have already been undertaken in relation to the issues raised in this report, including increases in the number of midwifery posts, and an ongoing series of staff workshops relating to service-user experience. Some more recent and planned examples of activity include:

- The Practice Development Midwifery Team is engaging with the community midwives, to ensure that pregnant women are given a realistic view of the differences between care during labour / birth and the postnatal wards. This is intended to set clear expectations before women come in to hospital.

- "Comfort rounds" now take place three times a day, where all women admitted to the postnatal ward are told about facilities available and asked if they have any issues that they would like help with.

- There is now increased flexibility around partners spending the night on the wards, although this is still constrained by the physical space available and the privacy of other women on the wards.

- Increased senior midwife (Band 7) presence on the wards. The large joint ward has now two full time equivalents, following a rotation of Band 7s to the delivery suite and from the community.

- An emphasis on the "six Cs" when recruiting new staff[6].

- Planned refurbishment of the postnatal wards in 2016.

- Supervisors of Midwives doing regular walkabouts to obtain feedback from women.

- Lay representatives from Maternity Voices (The Maternity Services liaison committee) will also be carrying out walkabouts on the wards to obtain feedback from women.

Sarah Windfeld
Head of Midwifery

[6] The Chief Nurse of England's Vision and Strategy for Nurses and Midwives, the 6 Cs - Care, Compassion, Competence, Courage and Commitment - are what nurses and midwives should embed in all they do.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Tuesday 31 March 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
10. National Staff Survey Results
Sponsor and Author(s)
Sue Donaldson, Director of Workforce and OD (Executive Sponsor)

Intended Audience									
Board members	**X**	Regulators		Governors	**X**	Staff	**X**	Public	**X**

Executive Summary

The National Staff Survey was undertaken by Quality Health for the University Hospitals Bristol NHS Foundation Trust between September 2014 and December 2014.

For the first time questionnaires were sent on a census basis to all substantively employed staff across the Trust. Historically we have only sampled 850 staff, in line with national requirements. The invitation to include all staff appears to have been received well as over 3,600 colleagues across the Trust participated in the survey. This is a response rate of 47% which is above the average for acute Trusts in England, many of which only run a sample survey, in line with the national requirements.

The attached paper provides an overview of the National Survey results which were published on 24th February 2015. This document indicates that there are a number of areas where respondents have signified decreased satisfaction between 2013 and 2014 and where UH Bristol's performance against that of other acute Trusts is below average. Areas of concern are our overall staff engagement score; staff motivation; work pressure and stress felt by staff; satisfaction with the quality or work and patient care; staff witnessing potential harmful errors; and staff receiving health and safety and equality and diversity training.

A detailed programme to improve Staff Engagement and Experience is already underway across the Trust. This work is being directed both centrally by the Senior Leadership Team and locally by Divisional Management Teams. It includes a focus on improving two way communications; team building; training programmes for managers/supervisors; recognition events; a wide range of health and wellbeing initiatives; targeted action to address harassment and bullying; a revision and re-launch of the 'Speaking Out' process; and encouragement of staff forums and reverse mentoring.

Despite this work, it is clear that there is more to do to improve the experience of staff working at the Trust and the Senior Leadership Team are currently re-examining the overall approach, with a particular emphasis on more direct involvement of staff; and greater collaboration between local managers and their teams in drawing up action plans. This is easier to facilitate as each Division and department has been given a fuller breakdown of their own survey results than has been previously been possible given the census approach to the survey. Managers are also being encouraged to look at other key areas, such as staff turnover rates, feedback from exit interviews, sickness absence rates and

causes, etc.

Details of this review being undertaken by the Senior Leadership Team and the steps agreed will be shared with the Quality and Outcomes Committee and Trust Board during April. This work will actively consider the Kings Fund publications, including 'Staff Engagement – Six building blocks for harnessing the creativity and enthusiasm of NHS Staff'. (February 2015). This draws on extensive work on organisational culture carried out by the Kings Fund and Professor Michael West. We will also draw from the experience of other NHS Trusts who have made sustained improvements to their staff experience.

It would appear from benchmarking information that staff survey results across the country have been affected by the current challenges facing the NHS and it is also thought that recent decisions on national pay and pension arrangements has had an impact on staff morale.

Recommendations
Trust Board is invited to receive this report for information.
Impact Upon Board Assurance Framework
Improving staff engagement scores is a key Trust objective – BAF Reference 3.
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
Equality & Patient Impact

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

2014 National NHS staff survey

Brief summary of results from University Hospitals Bristol NHS Foundation Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2014 national NHS staff survey conducted in University Hospitals Bristol NHS Foundation Trust.

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

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 29 Key Findings.

These sections of the report have been structured around 4 of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus two additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme: Staff satisfaction
- Additional theme: Equality and diversity
- Additional theme: Patient experience measures

Please note that the NHS pledges were amended in 2014, however the report has been structured around 4 of the pledges which have been maintained since 2009. For more information regarding this please see the “Making Sense of Your Staff Survey Data” document.

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

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

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

A longer and more detailed report of the 2014 survey results for University Hospitals Bristol NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q12a - 12d and the weighted score for Key Finding 24. The percentages for Q12a – Q12d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

The Q12d score is related to CQUIN payments for Acute trusts participating in the National NHS Staff Survey. 2013/2014 guidance on CQUIN payments can be found via the following link https://www.supply2health.nhs.uk/eContracts/Documents/cquin-guidance.pdf.

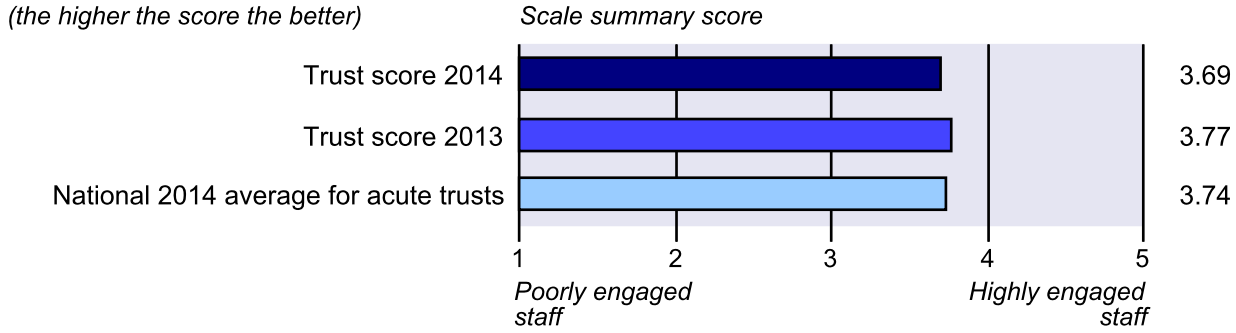
Q12a, Q12c and Q12d feed into Key Finding 24 “Staff recommendation of the trust as a place to work or receive treatment”.

		Your Trust in 2014	Average (median) for acute trusts	Your Trust in 2013
Q12a	"Care of patients / service users is my organisation's top priority"	70	70	69
Q12b	"My organisation acts on concerns raised by patients / service users"	71	71	72
Q12c	"I would recommend my organisation as a place to work"	56	58	60
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	70	65	74
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.68	3.67	3.76

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

The figure below shows how University Hospitals Bristol NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.69 was below (worse than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 22, 24 and 25. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 22); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 24); and the extent to which they feel motivated and engaged with their work (Key Finding 25).

The table below shows how University Hospitals Bristol NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2013 survey.

	Change since 2013 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	! Decrease (worse than 13)	! Below (worse than) average
KF22. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Below (worse than) average
KF24. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)*	• No change	• Average
KF25. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	! Decrease (worse than 13)	! Lowest (worst) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2014 Key Findings for University Hospitals Bristol NHS Foundation Trust

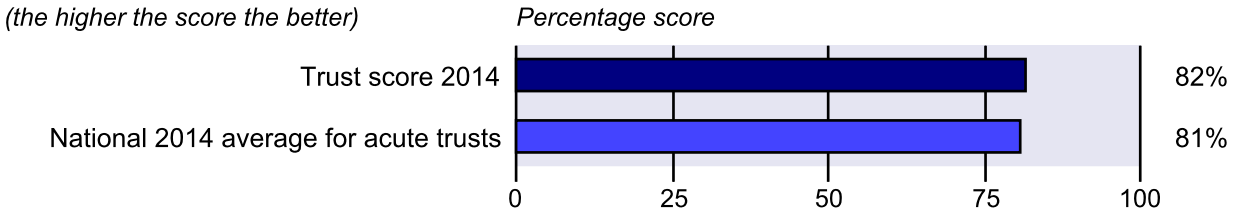
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which University Hospitals Bristol NHS Foundation Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

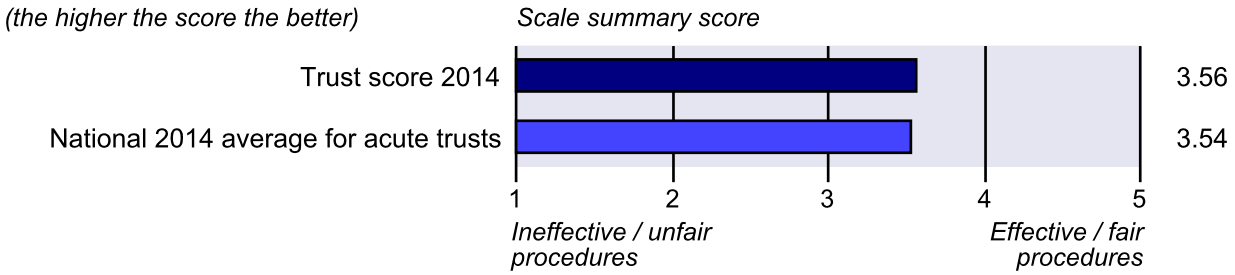
✓KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months

(the higher the score the better)



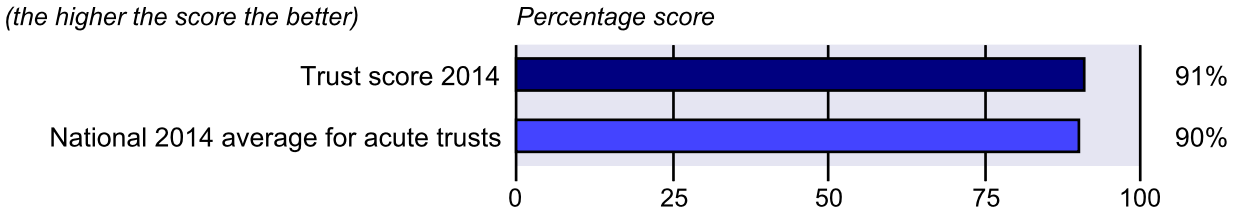
✓KF14. Fairness and effectiveness of incident reporting procedures

(the higher the score the better)



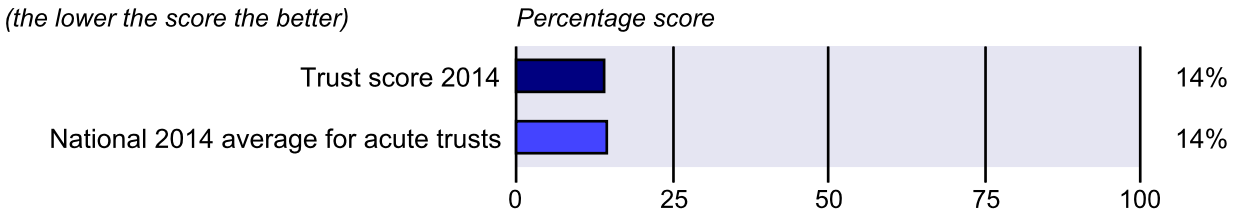
✓KF13. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)

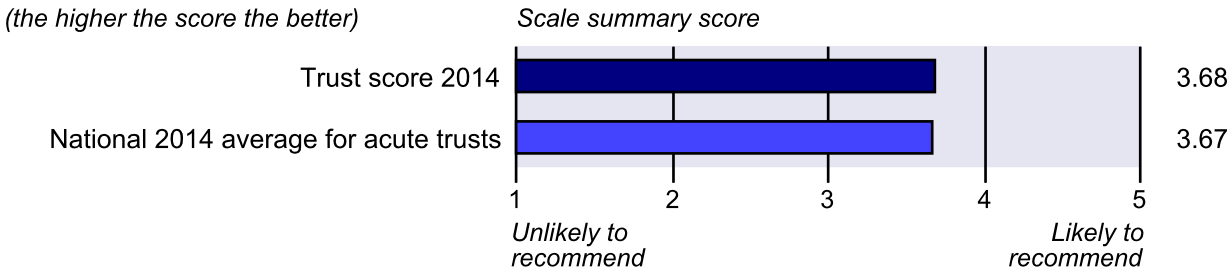


✓KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



✓KF24. Staff recommendation of the trust as a place to work or receive treatment



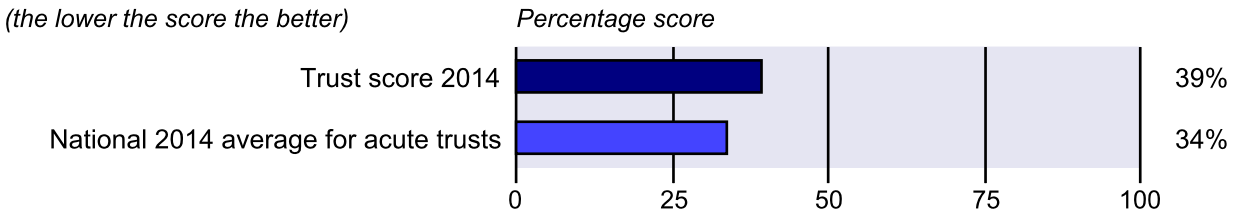
For each of the 29 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 138 (the bottom ranking score). University Hospitals Bristol NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which University Hospitals Bristol NHS Foundation Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

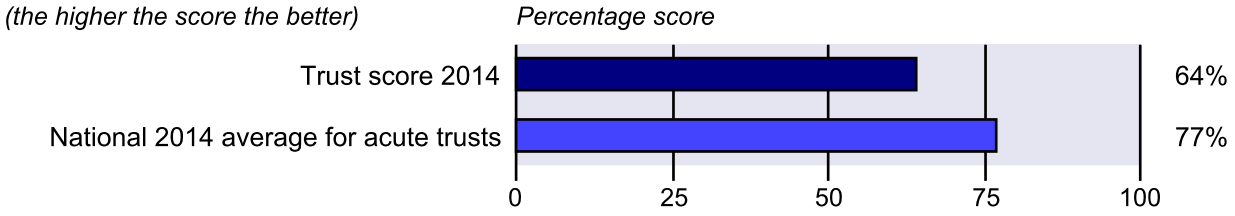
! KF12. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



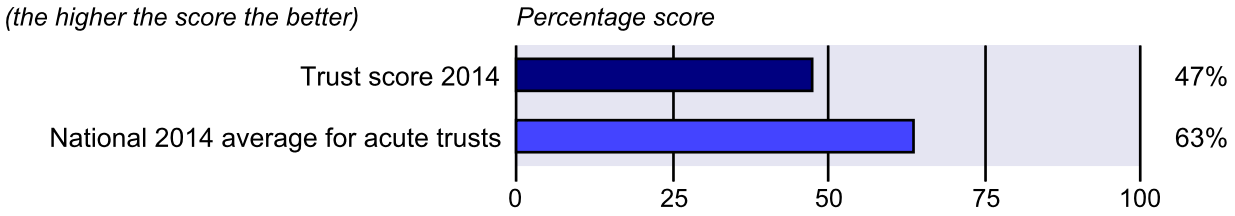
! KF10. Percentage of staff receiving health and safety training in last 12 months

(the higher the score the better)



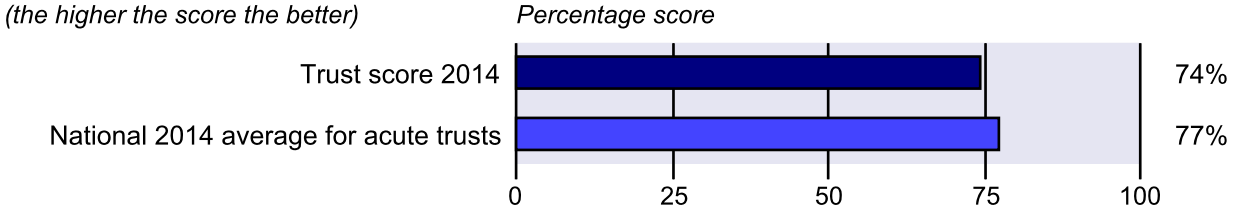
! KF26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



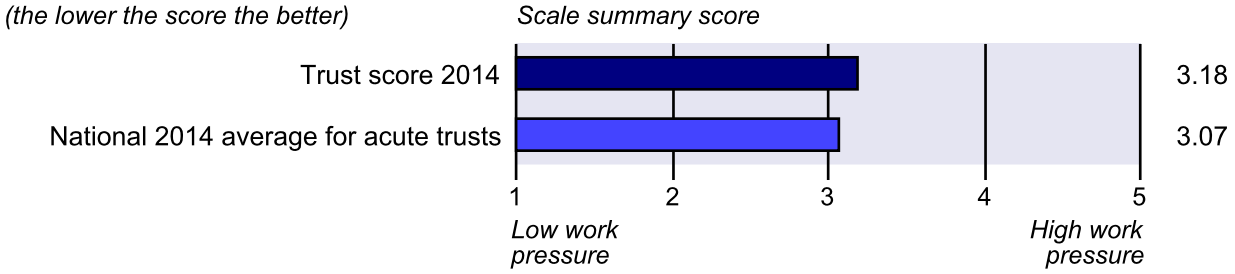
! KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)



! KF3. Work pressure felt by staff

(the lower the score the better)



For each of the 29 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 138 (the bottom ranking score). University Hospitals Bristol NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 138. Further details about this can be found in the document ***Making sense of your staff survey data***.

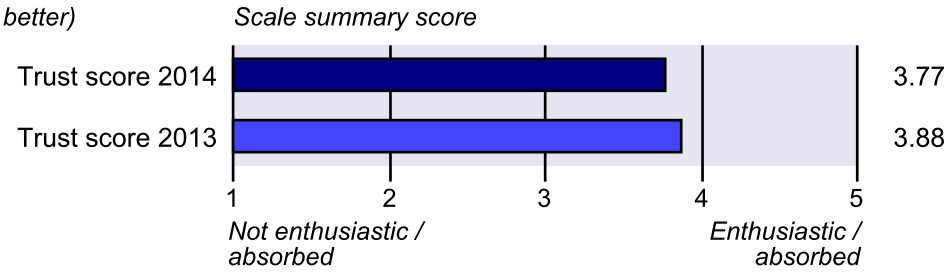
3.2 Largest Local Changes since the 2013 Survey

This page highlights the two Key Findings where staff experiences have deteriorated since the 2013 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

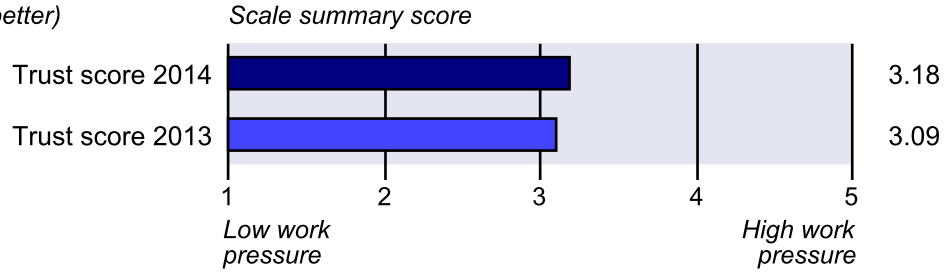
! KF25. Staff motivation at work

(the higher the score the better)



! KF3. Work pressure felt by staff

(the lower the score the better)



3.3. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust

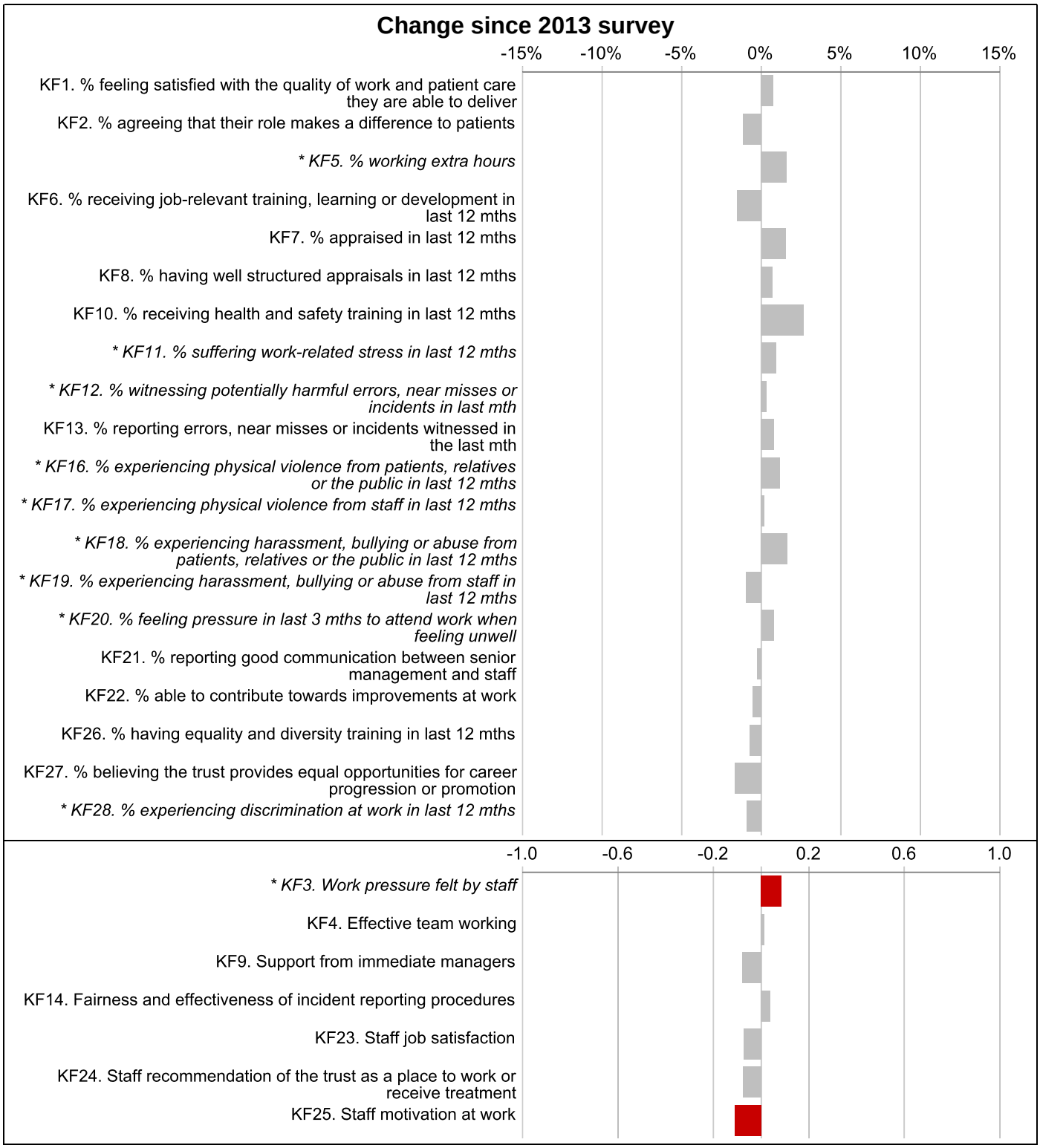
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2013 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2013 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2013 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust

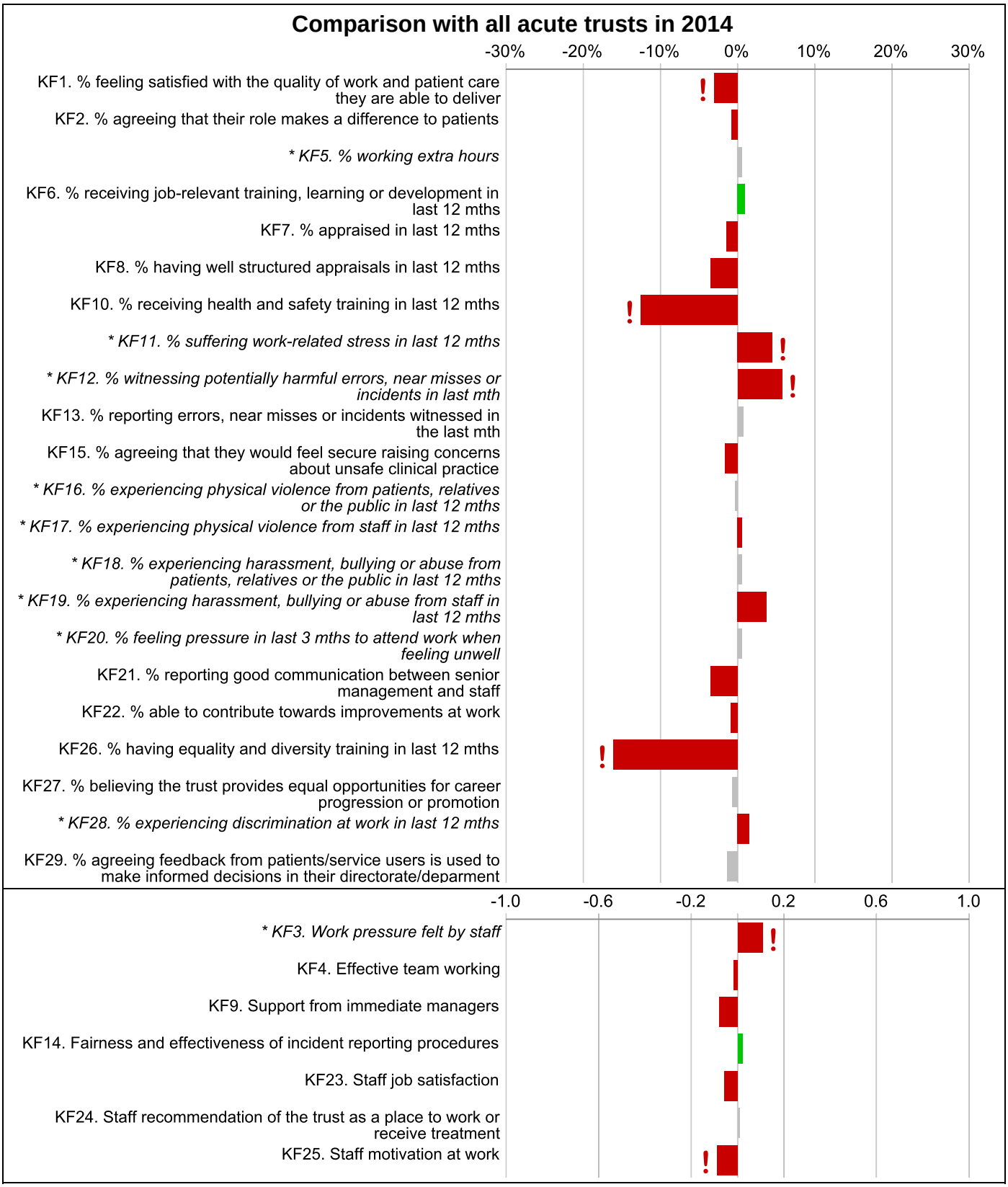
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than avearge. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.4. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2013.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2013.

'Change since 2013 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2013 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2013 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.

	Change since 2013 survey	Ranking, compared with all acute trusts in 2014
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	• No change	! Lowest (worst) 20%
KF2. % agreeing that their role makes a difference to patients	• No change	! Below (worse than) average
* *KF3. Work pressure felt by staff*	! Increase (worse than 13)	! Highest (worst) 20%
KF4. Effective team working	• No change	! Below (worse than) average
* *KF5. % working extra hours*	• No change	• Average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF6. % receiving job-relevant training, learning or development in last 12 mths	• No change	✓ Above (better than) average
KF7. % appraised in last 12 mths	• No change	! Below (worse than) average
KF8. % having well structured appraisals in last 12 mths	• No change	! Below (worse than) average
KF9. Support from immediate managers	• No change	! Below (worse than) average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF10. % receiving health and safety training in last 12 mths	• No change	! Lowest (worst) 20%
* *KF11. % suffering work-related stress in last 12 mths*	• No change	! Highest (worst) 20%
Errors and incidents		
* *KF12. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Highest (worst) 20%
KF13. % reporting errors, near misses or incidents witnessed in the last mth	• No change	• Average
KF14. Fairness and effectiveness of incident reporting procedures	• No change	✓ Above (better than) average
KF15. % agreeing that they would feel secure raising concerns about unsafe clinical practice	--	! Below (worse than) average

3.4. Summary of all Key Findings for University Hospitals Bristol NHS Foundation Trust (cont)

	Change since 2013 survey	Ranking, compared with all acute trusts in 2014
Violence and harassment		
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF17. % experiencing physical violence from staff in last 12 mths*	• No change	! Above (worse than) average
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
Health and well-being		
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	• Average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF21. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF22. % able to contribute towards improvements at work	• No change	! Below (worse than) average
ADDITIONAL THEME: Staff satisfaction		
KF23. Staff job satisfaction	• No change	! Below (worse than) average
KF24. Staff recommendation of the trust as a place to work or receive treatment	• No change	• Average
KF25. Staff motivation at work	! Decrease (worse than 13)	! Lowest (worst) 20%
ADDITIONAL THEME: Equality and diversity		
KF26. % having equality and diversity training in last 12 mths	• No change	! Lowest (worst) 20%
KF27. % believing the trust provides equal opportunities for career progression or promotion	• No change	• Average
* *KF28. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average
ADDITIONAL THEME: Patient experience measures		
Patient/Service user experience Feedback		
KF29. % agreeing feedback from patients/service users is used to make informed decisions in their directorate/deparment	--	• Average

4. Key Findings for University Hospitals Bristol NHS Foundation Trust

3641 staff at University Hospitals Bristol NHS Foundation Trust took part in this survey. This is a response rate of 47%[1] which is above average for acute trusts in England, and compares with a response rate of 52% in this trust in the 2013 survey.

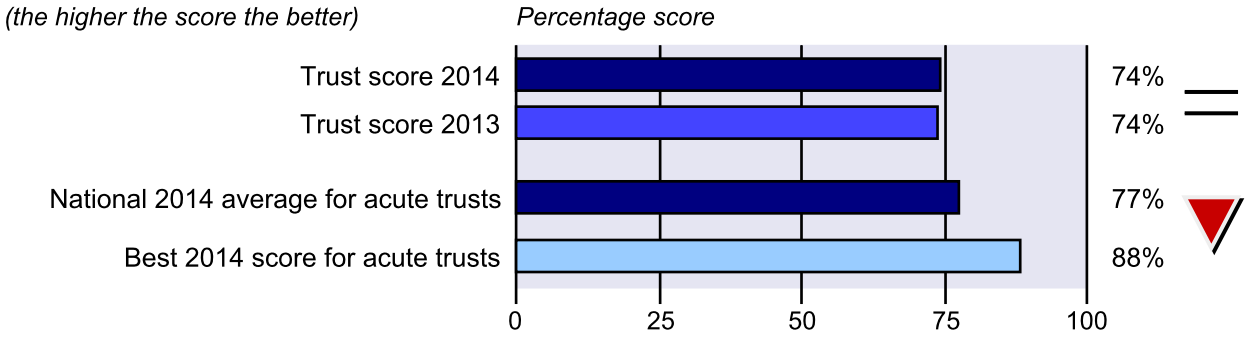
This section presents each of the 29 Key Findings, using data from the trust's 2014 survey, and compares these to other acute trusts in England and to the trust's performance in the 2013 survey. The findings are arranged under six headings – the four staff pledges from the NHS Constitution, and the two additional themes of staff satisfaction and equality and diversity.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2013). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2013). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

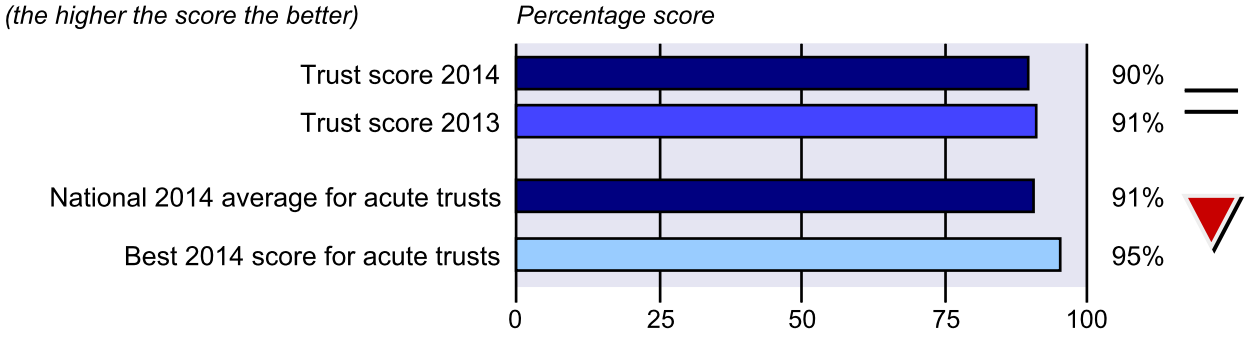
KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)



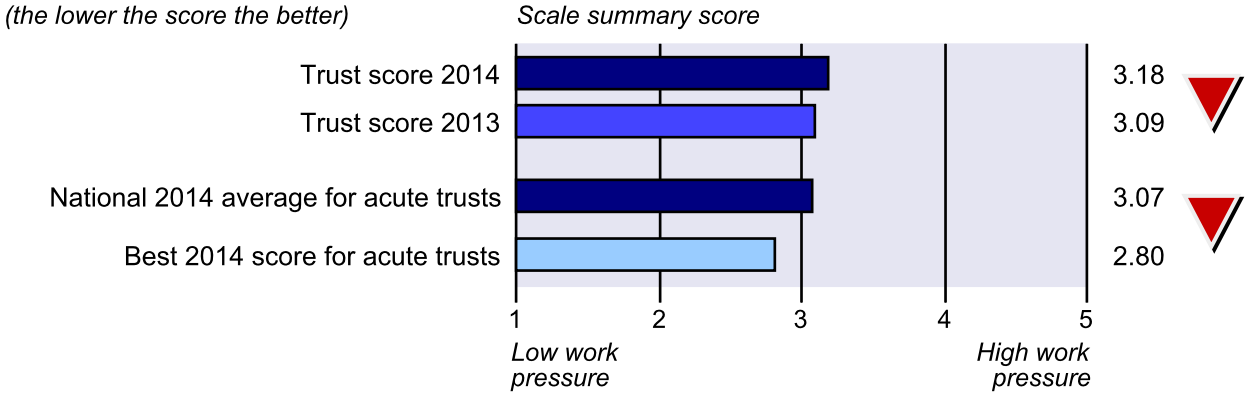
KEY FINDING 2. Percentage of staff agreeing that their role makes a difference to patients

(the higher the score the better)

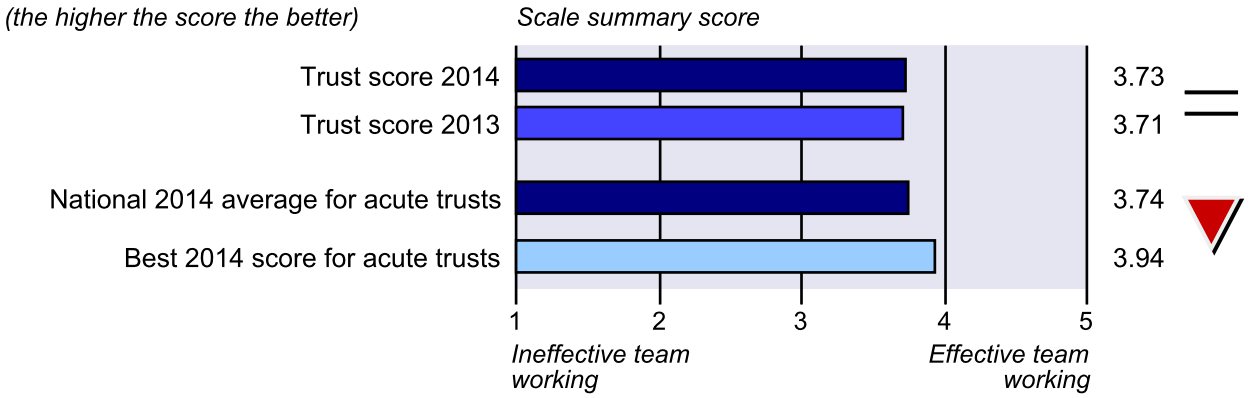


[1]Questionnaires were sent to all 7797 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

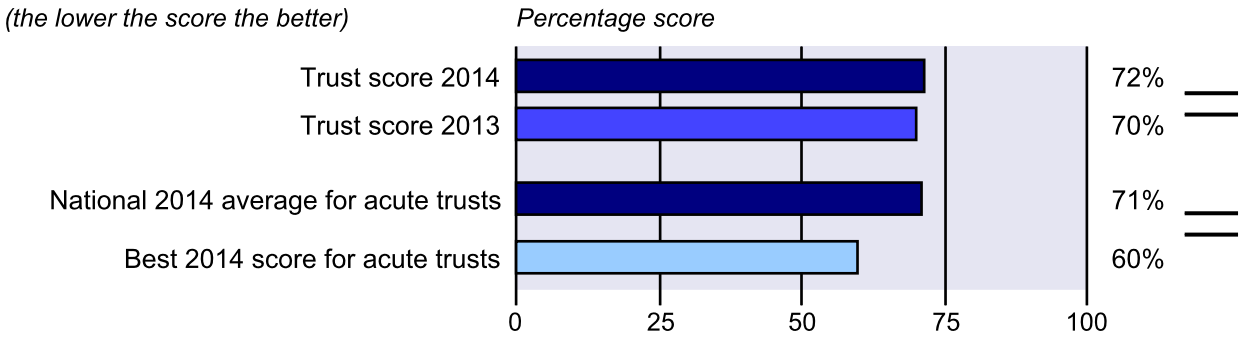
KEY FINDING 3. Work pressure felt by staff



KEY FINDING 4. Effective team working

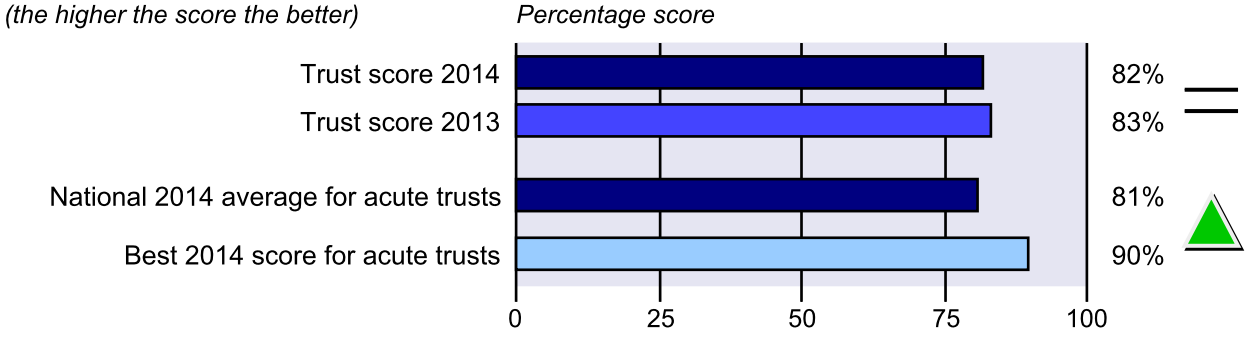


KEY FINDING 5. Percentage of staff working extra hours



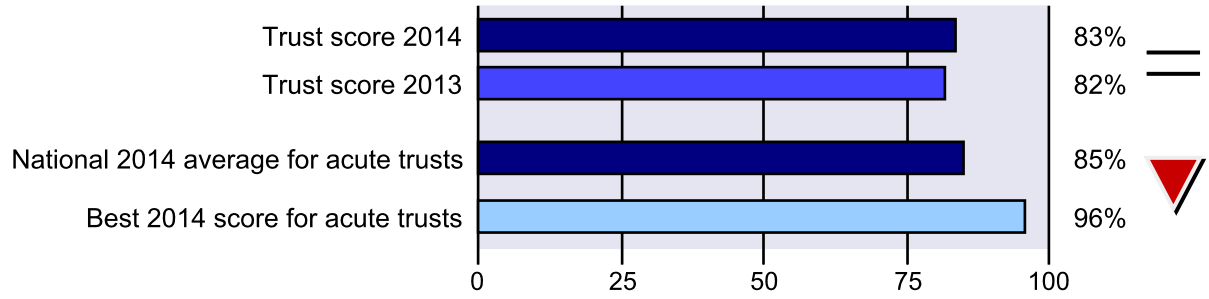
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

KEY FINDING 6. Percentage of staff receiving job-relevant training, learning or development in last 12 months



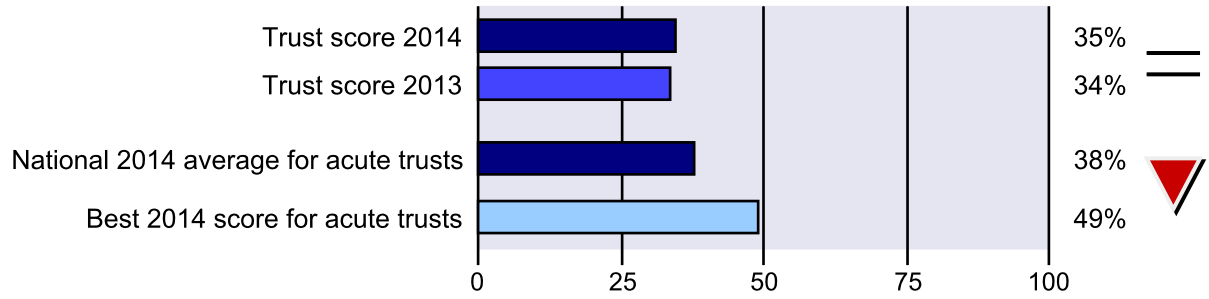
KEY FINDING 7. Percentage of staff appraised in last 12 months

(the higher the score the better) *Percentage score*



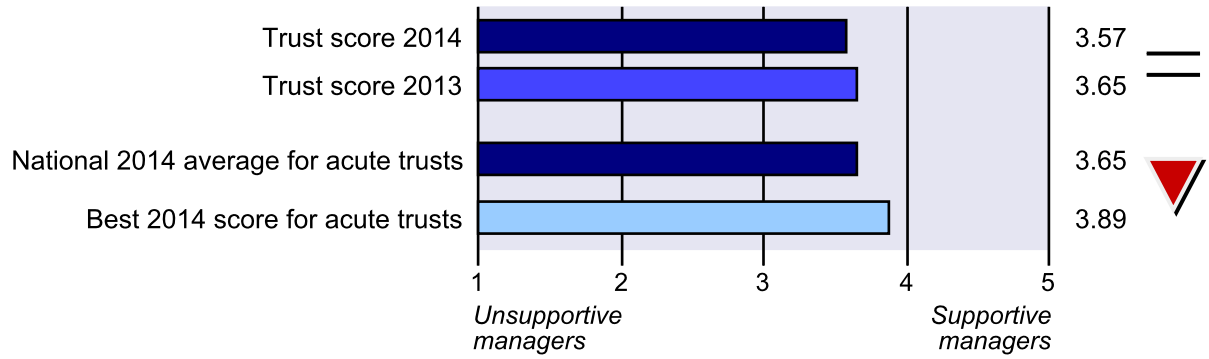
KEY FINDING 8. Percentage of staff having well structured appraisals in last 12 months

(the higher the score the better) *Percentage score*



KEY FINDING 9. Support from immediate managers

(the higher the score the better) *Scale summary score*

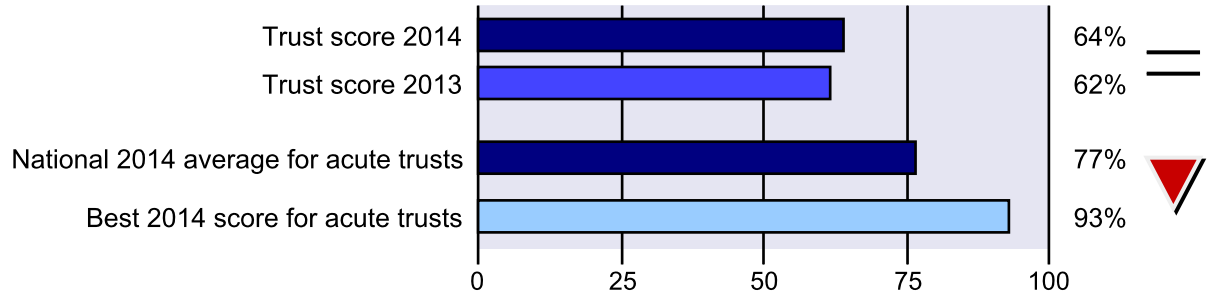


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Occupational health and safety

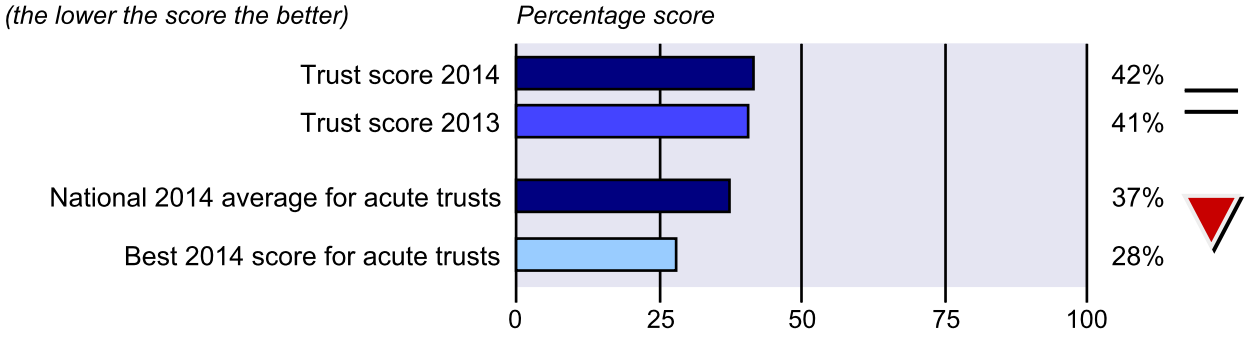
KEY FINDING 10. Percentage of staff receiving health and safety training in last 12 months

(the higher the score the better) *Percentage score*



KEY FINDING 11. Percentage of staff suffering work-related stress in last 12 months

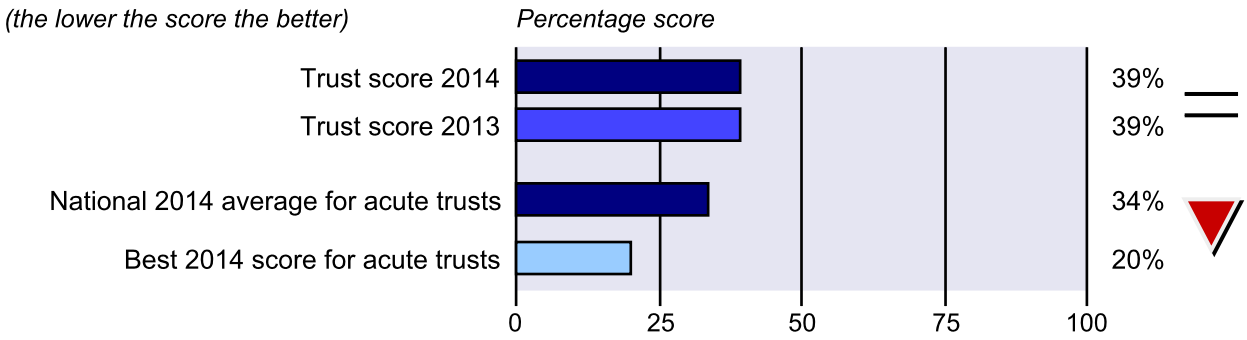
(the lower the score the better)



Errors and incidents

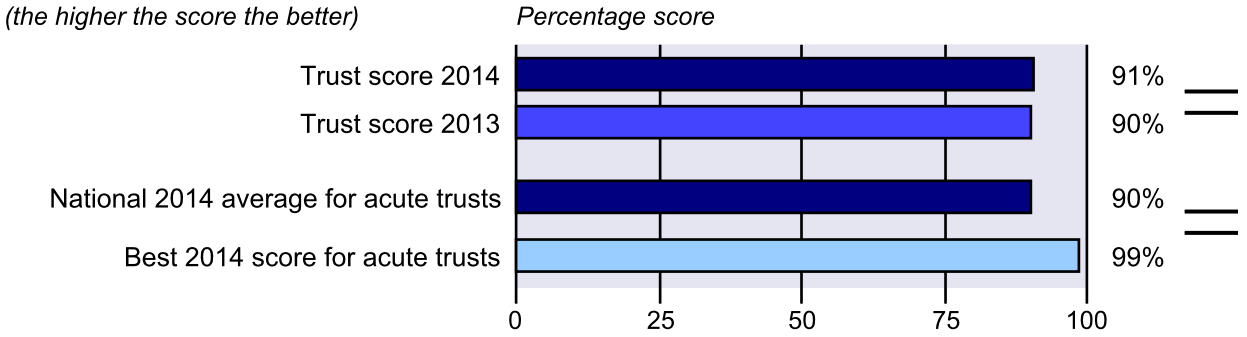
KEY FINDING 12. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



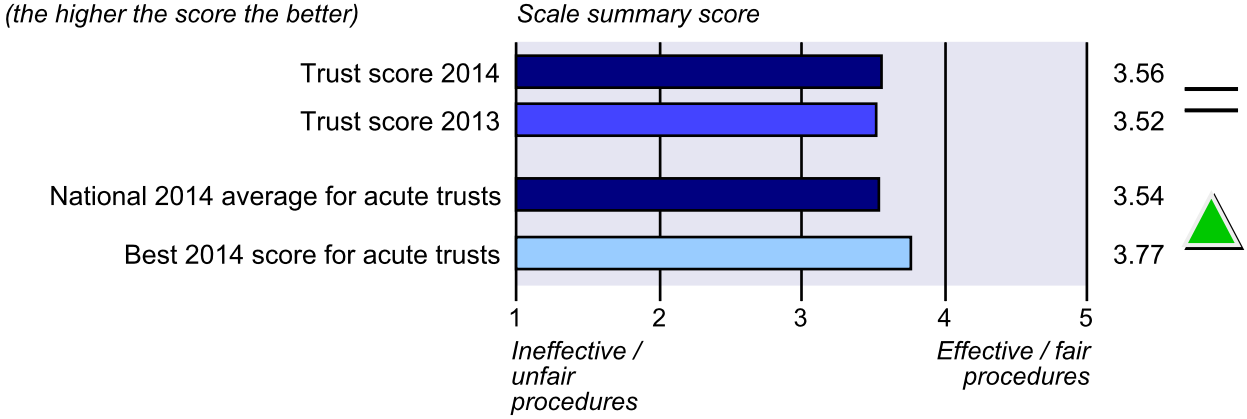
KEY FINDING 13. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



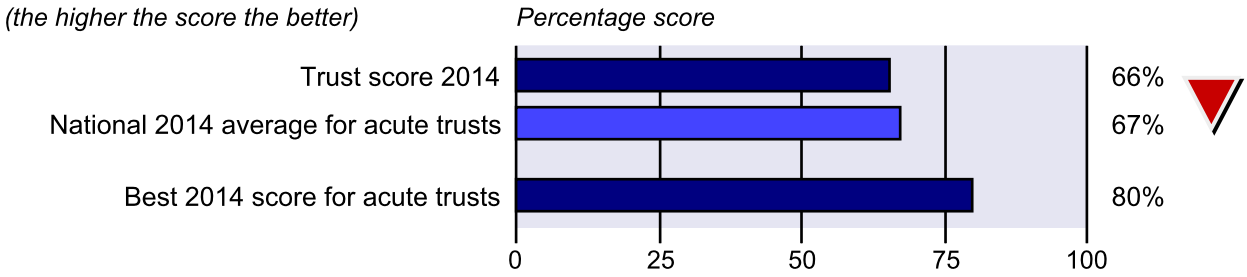
KEY FINDING 14. Fairness and effectiveness of incident reporting procedures

(the higher the score the better)



KEY FINDING 15. Percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice

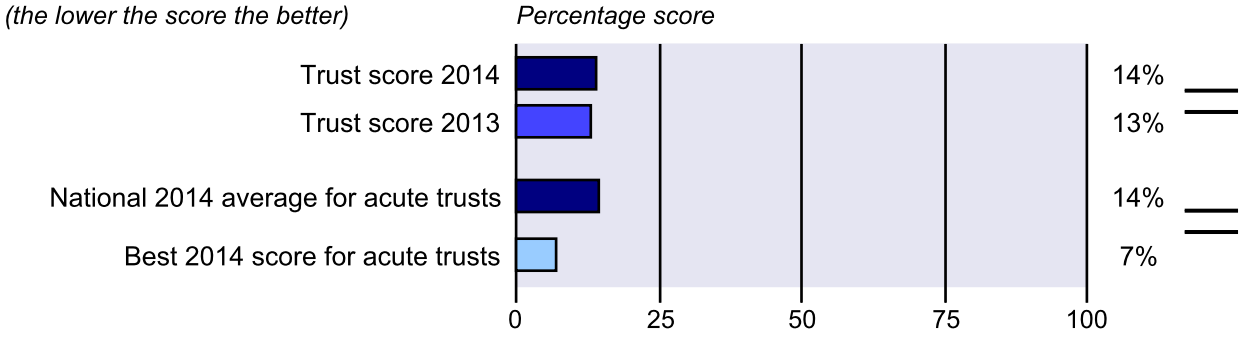
(the higher the score the better)



Violence and harassment

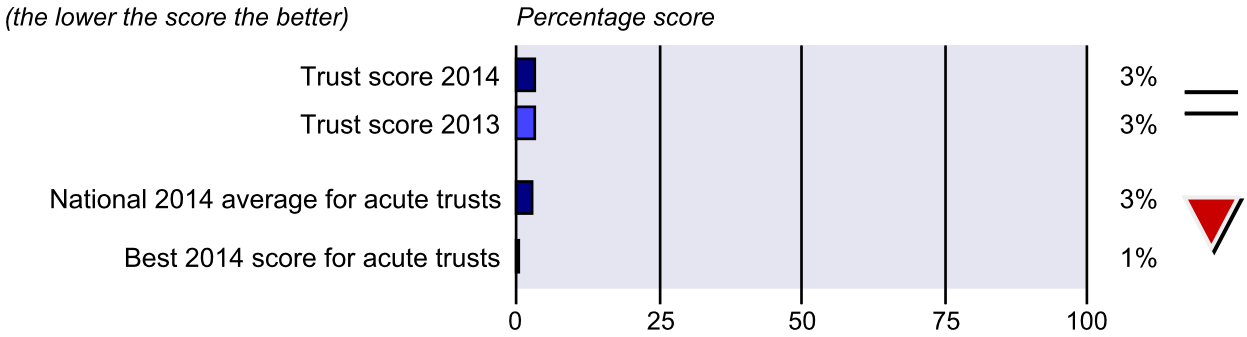
KEY FINDING 16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



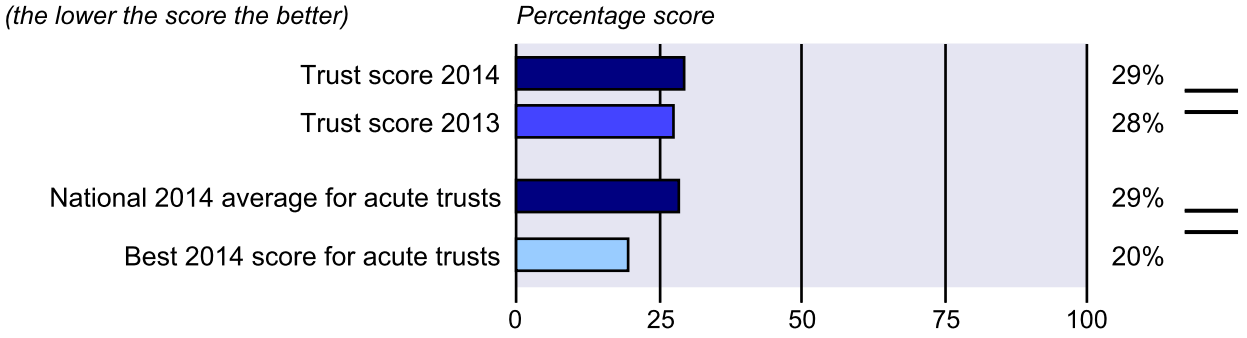
KEY FINDING 17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



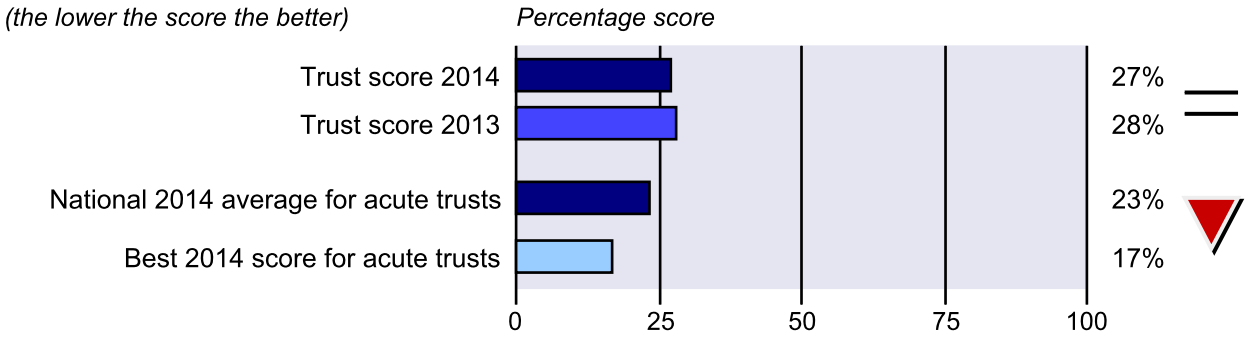
KEY FINDING 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



KEY FINDING 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

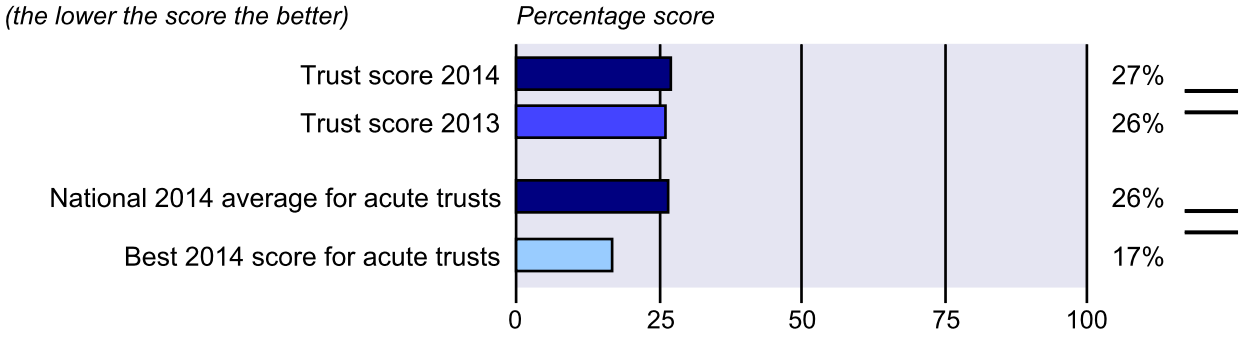
(the lower the score the better)



Health and well-being

KEY FINDING 20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

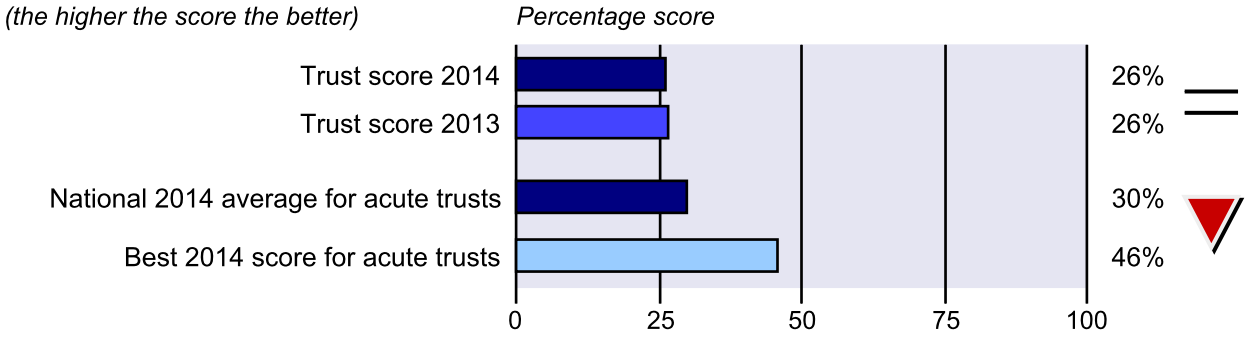
(the lower the score the better)



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

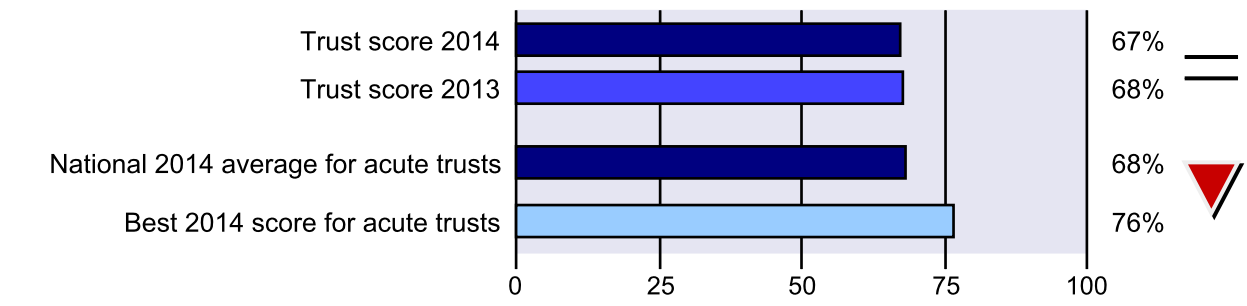
KEY FINDING 21. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 22. Percentage of staff able to contribute towards improvements at work

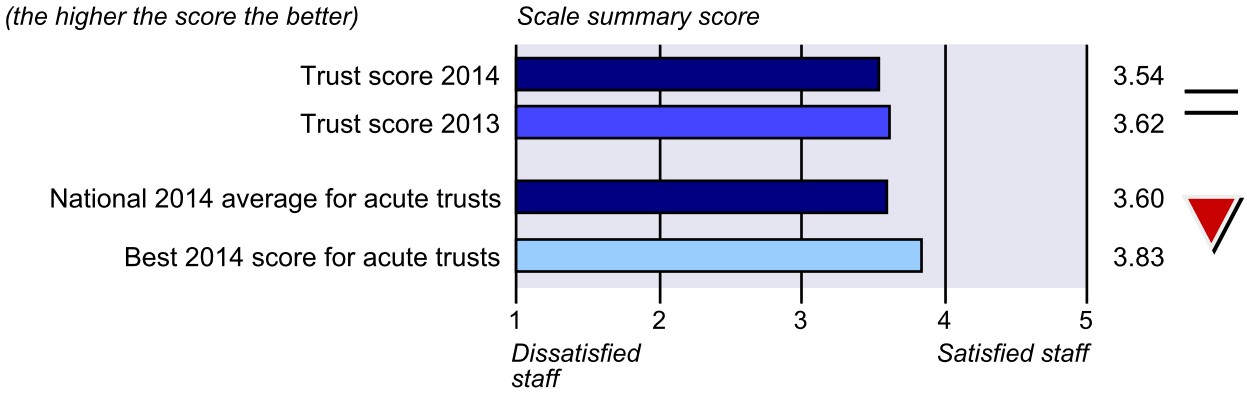
(the higher the score the better)



ADDITIONAL THEME: Staff satisfaction

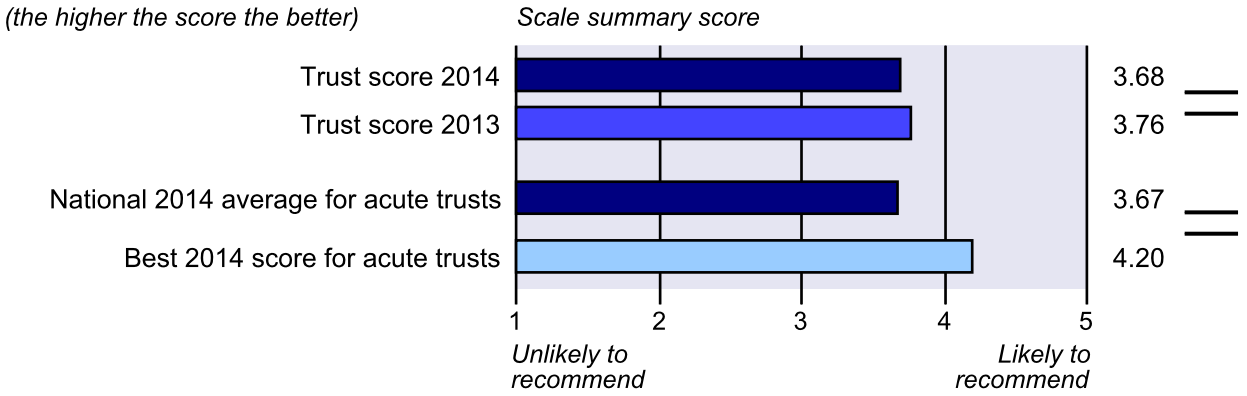
KEY FINDING 23. Staff job satisfaction

(the higher the score the better)



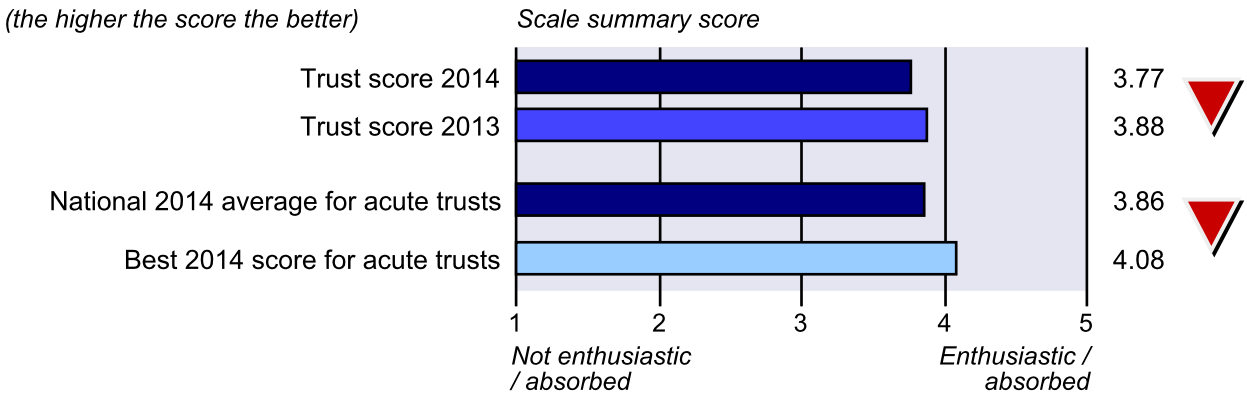
KEY FINDING 24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



KEY FINDING 25. Staff motivation at work

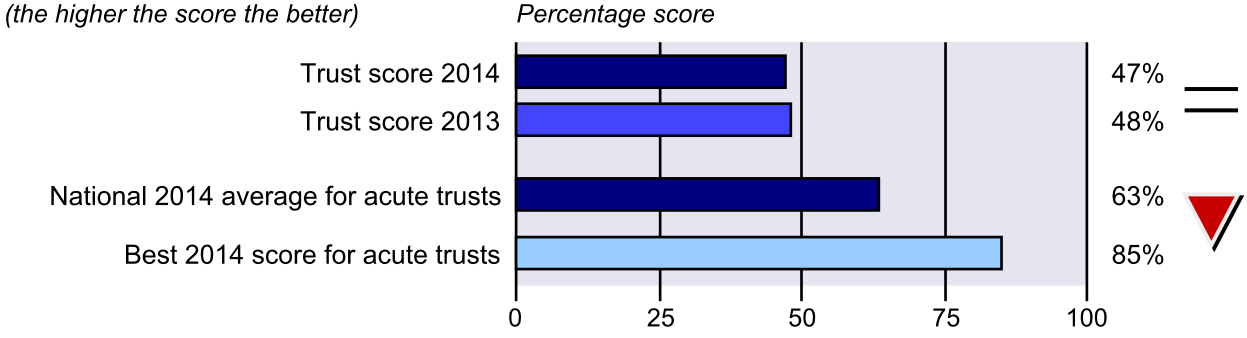
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

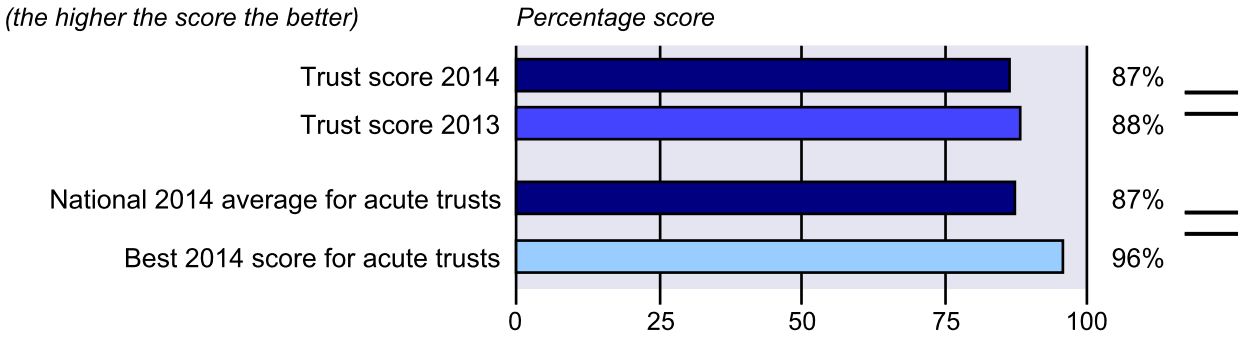
KEY FINDING 26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



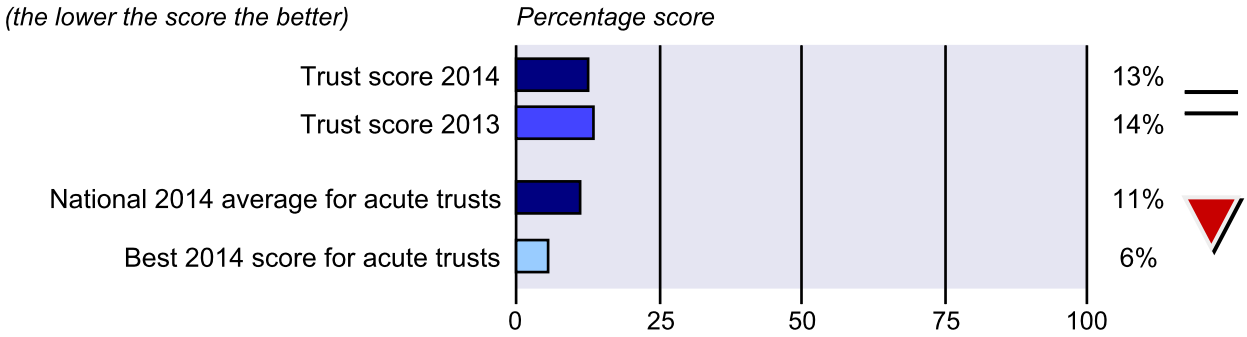
KEY FINDING 27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion

(the higher the score the better)



KEY FINDING 28. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)

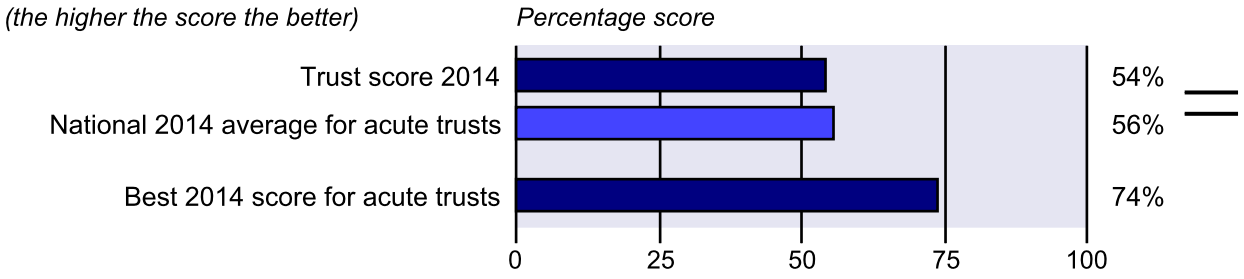


ADDITIONAL THEME: Patient experience measures

Patient/Service user experience Feedback

KEY FINDING 29. Percentage of staff agreeing that feedback from patients/service users is used to make informed desisions in their directorate/department

(the higher the score the better)



University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 31st March 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
11. Finance Report									
Sponsor and Author(s)									
Paul Mapson									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To report to the Board on the Trust's financial position and related financial matters which require the Board's review.

Key issues to note

The summary income and expenditure statement shows a surplus of £6.904m (before technical items) for the eleven month period to 28th February 2015. This represents a favourable variance of £1.587m against plan to date. The Divisional position has deteriorated further by £1.143m in February to a cumulative overspending of £9.966m. This is offset, in line with practice reported in recent months, by the net underspending in February on the corporate share of service agreement income, reserves, capital charges and financing costs. The position reported for February includes the beneficial impact (£0.726m) relating to the waiving of Referral to Treatment (RTT) penalties for the period December – February. This waiver is also to apply for March and is in line with advice published jointly by Monitor and NHS England.

The Trust's income for 'Operational Resilience' is £3.942m. For February a further £0.851m has been recognised as income to meet additional capacity costs incurred. It is expected that this funding will be fully utilised by 31 March 2015 and will not therefore contribute to the year-end financial position.

Recommendations
The Board is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
None
Impact Upon Corporate Risk
None in 2014/15
Implications (Regulatory/Legal)
None
Equality & Patient Impact
None

Resource Implications							
Finance			x	Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	x	For Approval		For Information	

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

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £6.904m (before technical items) for the first eleven months of 2014/15. This represents a favourable variance of £1.587m against plan year to date. The divisional overspend has increased by £1.143m in February, resulting in a year to date overspending of £9.966m. This month's report includes Operational Resilience income of £0.851m that has been recognised to meet additional costs incurred in February.

This is offset by the following in February:

	£'m
• Service Agreements – Corporate share	0.218
• RTT penalties waived	0.726
• Reserves	0.421
• Financing costs	0.373

Therefore, the overall favourable variance increases from £0.992m to £1.587m.

The position reported for February includes the beneficial impact (£0.726m) relating to the waiving of Referral to Treatment (RTT) penalties for the period December – February. This waiver is also to apply for March and is in line with advice published jointly by Monitor and NHS England.

The table below shows the Trust's income and expenditure position setting out the variances on the four main income and expenditure headings. This generates an overspending against divisional budgets of £9.966m.

Divisional Variances	Variance to 31 January	February Variance	Variance to 28 February
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Pay	(2,964)	(663)	(3,627)
Non Pay	2,429	(748)	1,681
Operating Income	431	109	540
Income from Activities	(3,945)	53	(3,892)
Sub Totals	(4,049)	(1,249)	(5,298)
Savings Programme	(4,774)	106	(4,668)
Totals	**(8,823)**	**(1,143)**	**(9,966)**

Pay budgets have an overspending of £0.663m in the month and a cumulative overspending of £3.627m. Substantive staff pay costs increased by £0.303m in February to £26.987m. Agency staff expenditure of £1.314m represented a reduction of £12k when compared with January. For the Trust as a whole, bank, overtime, waiting list initiative and other payments decreased by £0.462m to £1.545m in February (cumulative expenditure £15.1m).

N**on-pay budgets** show an adverse variance of £0.748m in the month thereby reducing the cumulative favourable variance to £1.681m for the 11 months to 28st February. The underspending to date relates in the main to the proportion of contract transfer funding which has yet to be used – in effect offsetting the income from activities under performance.

Operating Income budgets show a favourable variance of £109k for the month, and a cumulative underspending of £0.540m.

Income from Activities shows a net favourable variance of £53k in the month. This reduces the cumulative under performance to £3.892m. The principal variances are the in-month over performance recorded for Medicine (£114k), Surgery, Head & Neck (£228k), partially offset by activity being lower than planned for Specialised Services (£142k) and Women's and Children's Services (£136k).

The table below summarises the financial performance in February for each of the Trust's management divisions.

	Variance to 31 January	February Variance	Variance to 28 February
	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)
Diagnostic and Therapies	(149)	(112)	(261)
Medicine	(1,351)	(118)	(1,469)
Specialised Services	(919)	(208)	(1,127)
Surgery, Head and Neck	(4,666)	(462)	(5,128)
Women's and Children's	(2,409)	(241)	(2,650)
Estates and Facilities	126	11	137
Trust HQ	187	16	203
Trust Services	358	(29)	329
Totals	**(8,823)**	**(1,143)**	**(9.966)**

The results to 28 February are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 4.0, January 4.0). Further information on the financial risk rating is given in section 5 below and appendix 6.

2. Savings Programme

The Trust's Savings Programme for 2014/15 is £20.771m. Savings of £14.372m have been realised for the eleven months to 28 February (79% of Plan), a shortfall of £3.724m against divisional plans. The forecast outturn for savings this year is £16.482m – equivalent to 79% of the planning assumption of £20.771m. The Finance Committee will receive a more detailed report on the Savings Programme under item 5.4 on this month's agenda.

	Savings Programme to 28 February			1/12ths Phasing Adj Fav / (Adv)	Total Variance Fav / (Adv)
	Plan	Actual	Variance Fav / (Adv)		
	£'000	£'000	£'000	£'000	£'000
Diagnostics and Therapies	1,571	1,774	203	(41)	162
Medicine	2,560	2,038	(522)	(225)	(747)
Specialised Services	2,015	2,054	39	(405)	(366)
Surgery, Head and Neck	4,377	2,124	(2,253)	(138)	(2,391)
Women's and Children's	3,182	1,961	(1,221)	(100)	(1,321)
Estates and Facilities	972	1,033	61	(36)	25
Trust HQ	953	965	12	1	13
Other Services	2,466	2,423	(43)	-	(43)
Totals	**18,096**	**14,372**	**(3,724)**	**(944)**	**(4,668)**

3. Income

Contract income is £1.96m lower than plan for the 11 month period to 28 February. Activity based contract performance at £376.34m is £3.18m less than plan. Contract rewards / penalties at a net income of £5.25m is £0.67m greater than plan. Income of £55.52m for 'Pass through' payments is £0.55m higher than Plan.

Clinical Income by Worktype	**Plan** £'m	**Actual** £'m	**Variance** £'m
Activity Based			
Accident & Emergency	12.53	12.20	(0.33)
Emergency Inpatients	66.16	67.64	1.48
Day Cases	33.87	32.30	(1.57)
Elective Inpatients	47.34	44.46	(2.88)
Non-Elective Inpatients	15.42	13.98	(1.44)
Excess Bed days	6.65	6.82	0.17
Outpatients	67.44	67.72	0.28
Bone Marrow Transplants	7.78	8.29	0.51
Critical Care Bed days	38.96	38.34	(0.62)
Other	83.37	84.59	1.22
Sub Totals	**379.52**	**376.34**	**(3.18)**
Contract Rewards / Penalties	4.58	5.25	0.67
Pass through payments	54.97	55.52	0.55
Totals	**439.07**	**437.11**	**(1.96)**

4. Expenditure

In total, Divisions have overspent by £1.143m in February. Further analysis of the variances by pay, non-pay and income categories is given at Appendix 2.

Three divisions are red rated[1] for their financial performance for the year to date.

The **Division of Medicine** has an adverse variance of £1.469m for the eleven months to 28 February, an adverse variance in the month of £118k. The Division continues to benefit significantly from the release of Operational Resilience moneys.

The Division has an overspending of £0.516m to date on pay budgets, an overspending in the month of £45k. There were overspendings on each of the staff groups with a partial in-month offset by the division's pay reserves budget. To date medical staff budgets are underspent by £0.835m whilst cumulative overspendings are recorded against nursing staff (£0.532m), clinical staff (£0.316m) and non clinical staff (£0.205m).

Non-pay budgets have an adverse variance of £0.333m in the month and a cumulative overspending of £0.321m. The principal in-month adverse variances were recorded against drugs (£0.240m) and clinical supplies (£0.175m). The drugs overspending is activity related together with an accrual for 'healthcare at home' services. Clinical supplies expenditure is similarly activity related with, for example, additional clinics run in the Sleep Unit leading to an increased use of masks and other consumables.

[1] Division has an annualised cumulative overspending greater than 1% of approved budget.

The Division reports a cumulative favourable variance of £0.241m on its Operating Income budgets. Income from Activities shows an over achievement of £114k in the month and a cumulative adverse variance of £0.126k.

The Surgery, Head and Neck Division reports an adverse variance of £5.128m for the eleven months to 28 February, an overspending of £0.462m in the month.

Pay budgets are overspent by £3.104m to date, an increase of £0.417m in February. The overall position represents the pay proportion of the Division's underlying deficit (£3.572m) offset by a net underspending on other pay headings (£0.468m).

Non pay budgets are overspent by £0.278m in the month. The cumulative overspending of £24k is net of the release of 11/12th of the non-recurring funding allocated at the start of the year, the further non recurring funding allocated and the release of reserves to offset contract underperformance.

Income from Activities shows a favourable variance in February of £0.228m thereby achieving a cumulative favourable position of £0.257m. Ophthalmology services continue to record higher than planned activity in the month (£0.176m). In total other clinical services income headings are higher than plan for the month, by a net £24k. The Division has received a higher than planned share of income (£28k) for activities provided by other Divisions in February.

Operating Income budgets show a favourable variance of £79k in the month and a cumulative underspending of £134k.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £2.650m for the eleven months to 28 February, an increase of £0.241m in the month.

Pay budgets overspent by £84k in the month and now show a cumulative adverse position of £0.180m. Nursing and midwifery staff expenditure was £89k overspent mainly because of recruitment to vacancies and continued overspendings in other areas. Budget managers in overspending areas are working to return staffing to funded levels.

Non-pay budgets show an underspending of £14k in the month and an underspending of £1.880m to date. This includes an underspending against the funding linked to the contract transfer, where the higher levels of activity have yet to be delivered, and non recurrent Trust support moneys.

Income from Activities shows an adverse variance of £3.068m to date, a deterioration of £136k in the month. The principal adverse variances are shown against maternity (£0.676m), paediatric cardiac (£0.945m), paediatric medicine (£0.374m). In addition there are other significant variances such as CSP related services (£0.916m adverse), hearing implants (£0.503m favourable) and renal services (£0.223m favourable).

Income from Operations budgets show a favourable variance of £41k in February to give a cumulative underspending of £39k.

One Division is amber / red rated

The **Division of Specialised Service** reports an adverse variance on its income and expenditure position of £1.127m for the eleven months to 28 February, an overspending of £0.208m in the month.

Pay budgets show an overspending of £0.217m for the month, cumulative overspending £1.389m. The overspending in February on nursing staff was £50k (agency staffing, BMT services support and higher levels of activity for the Teenage and Young Adult oncology service), cumulatively £0.703m adverse. Medical staff costs were higher than planned £159k in the month and cumulatively by £0.523m. Agency consultant costs of £40k per month are being incurred in Oncology to cover temporary vacancies. Junior doctor agency spend in Haematology has increased in response to the need to cover gaps in the medical rota.

Non pay budgets have underspent by £169k in February thereby increasing the favourable variance to date to £0.734m. Adverse activity related variances were recorded in February against blood and blood products (£61k) and clinical supplies (£69k). The non pay budget heading is supported by favourable variances on the allocation of contract transfer funds (£0.319m) and Trust support funding (£1.302m).

Income from activities shows an adverse variance in month of £142k to give a cumulative adverse variance of £0.486m. Cardiac surgery was less than plan by £11k, cumulatively now £0.600m adverse. Cardiology services have under-performed in February against the service level agreement activity thereby increasing the cumulative under performance by £10k to £0.465m. Operating income shows a small overspending in the month with a cumulative underspending of £0.380m to date.

One Division is amber / green rated

The **Diagnostic and Therapies Division** reports an overspending for the month of £0.112m and a cumulative overspending of £0.261m. The underspending on pay budgets is unchanged at £154k.

The overspending in February on non-pay headings of £179k reflects higher than planned spend on high tech homecare drugs (offset by income from activities), part pack wastage identified in Pharmacy arising from the recent quarterly stocktake and a high number of low value external pathology specimen testing.

Income from Activities shows a favourable variance of £6k in the month thereby reducing the cumulative adverse variance to £0.256m. Operating income was adverse to plan by £33k and now shows a year to date favourable variance of £0.340m.

Two divisions are green rated.

The Facilities and Estates Division reports a £11k surplus for the month thereby increasing its cumulative underspending to £137k.

Trust Headquarters Services report a £16k underspending in February and a cumulative underspending of £203k. The principal reason for the improvement is additional income following a review of VAT recovery and an increase in external Occupational Health income.

5. Continuity of Service Risk Rating

The Trust's overall financial risk rating, based on results for the 11 months ending 28 February is 4. The actual financial risk rating is 4.0 (January 4.0). The actual value for each of the metrics is given in the table below together with the bandings for each metric.

Further information showing performance to date is given at Appendix 6.

	March	December	January	February	Annual Plan 2014/15
Liquidity					
Metric Performance	2.71	5.45	7.92	8.87	2.53
Rating	4	4	4	4	4
Capital Service Capacity					
Metric Performance	3.04	2.75	2.89	2.92	2.51
Rating	4	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**	**4**

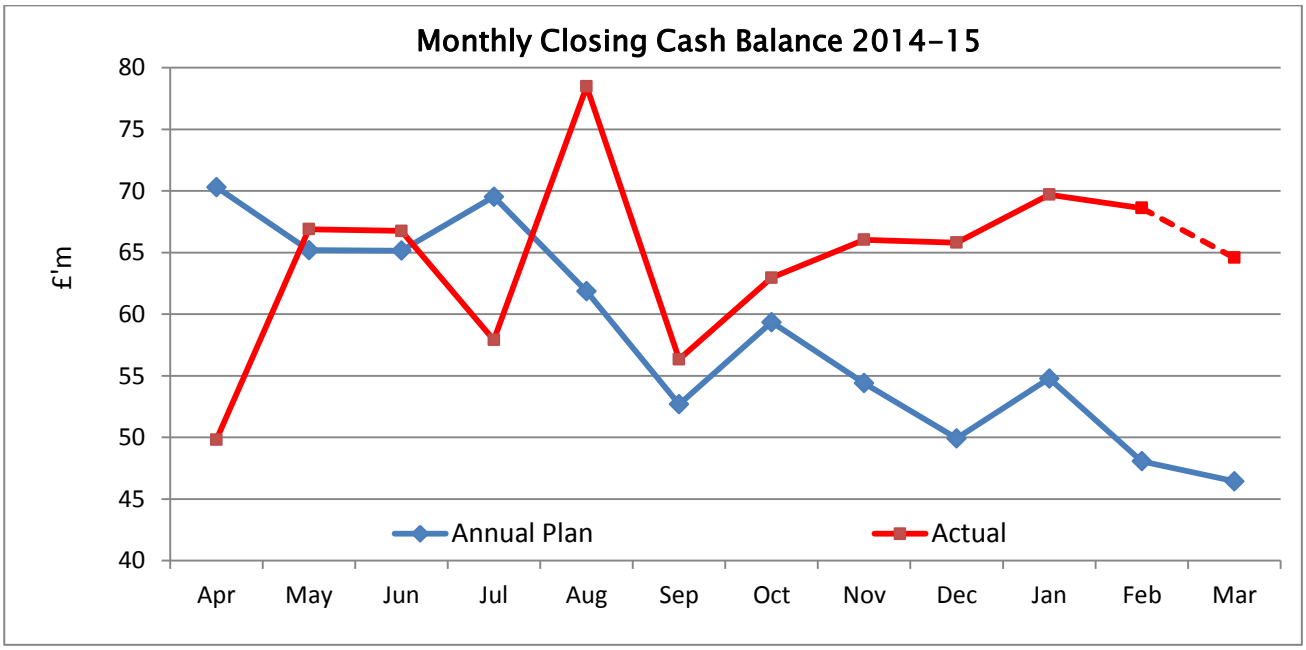
6. Capital Programme

A summary of income and expenditure for the eleven months to 28 February is given in the table below. Expenditure for the period of £39.574m equates to 97% of the current capital expenditure plan. The year-end forecast shows slippage / underspending of £12.796m (22.6%).

	Annual Plan	**Eleven Months Ending 28 February**			**Forecast Outturn**
		Plan	**Actual**	**Variance Fav / (Adv)**	
	£'000	£'000	£'000	£'000	£'000
Sources of Funding					
Public Dividend Capital	2,625	609	609	-	2,625
Donations	10,763	8,399	8,399	-	8,763
Retained Depreciation	19,181	16,769	16,739	(30)	18,312
Prudential Borrowing	20,000	20,000	20,000	-	20,000
Sale of Property	700	700	700	-	700
Recovery of VAT	954	-	-	-	-
Cash balances	2,452	(5,841)	(6,873)	(1,032)	(6,521)
Total Funding	**56,675**	**40,636**	**39,574**	**(1,062)**	**43,879**
Expenditure					
Strategic Schemes	(29,957)	(24,092)	(24,180)	(88)	(25,200)
Medical Equipment	(5,503)	(3,602)	(3,256)	346	(3,950)
Information Technology	(8,176)	(5,335)	(5,380)	(45)	(6,466)
Roll Over Schemes	(2,933)	(1,882)	(1,740)	142	(2,178)
Operational / Other	(10,106)	(5,725)	(5,018)	707	(6,085)
Total Expenditure	**(56,675)**	**(40,636)**	**(39,574)**	**1,062**	**(43,879)**

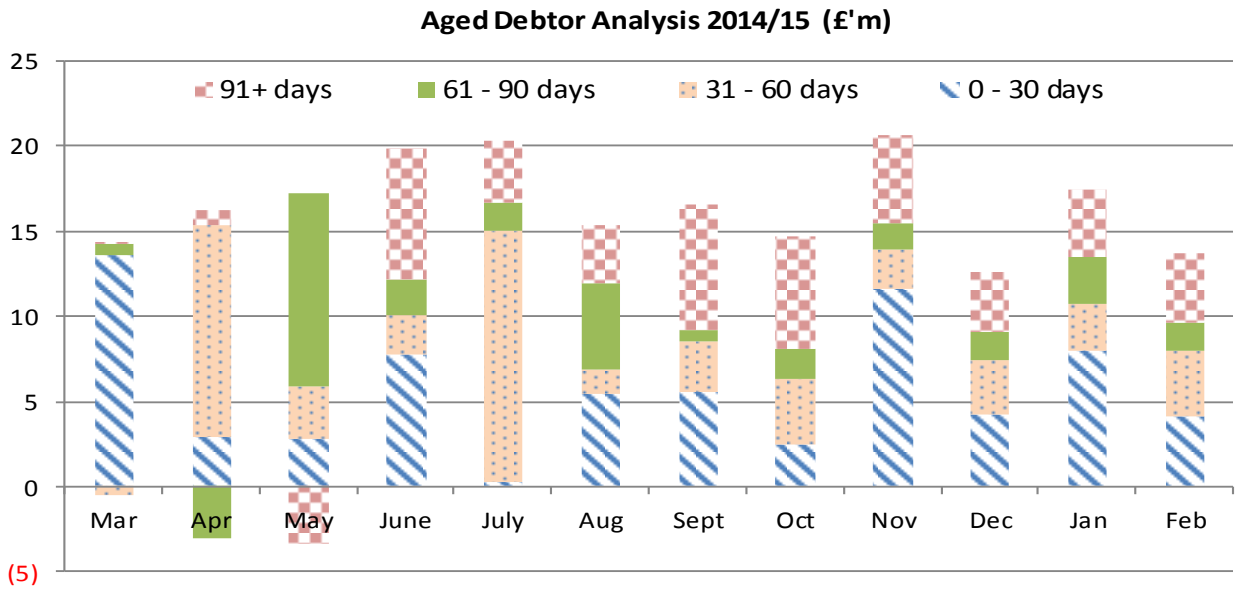
7. Statement of Financial Position (Balance Sheet) and Cashflow

Cash - The Trust held a cash balance of £68.724m as at 28 February.

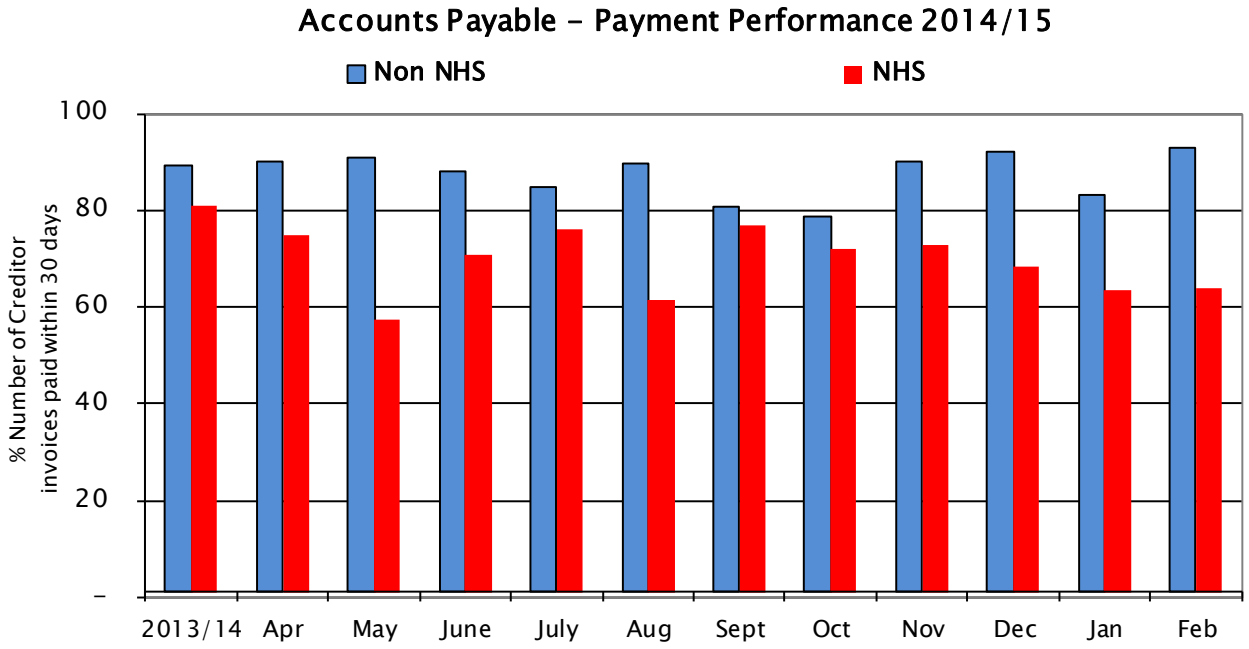


The higher forecast cash balance is due to some slippage on the Capital programme and a high level of provisions (mainly re employment issues).

Debtors - The total value of invoiced debtors has decreased by £3.680m during February to a closing balance of £13.686m. The total amount owing is equivalent to 8.6 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In February the Trust achieved 64% and 93% compliance against the Better Payment Practice Code for invoices paid for NHS and Non NHS creditors. The Trust continues to operate strict financial controls around supplier price increases.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2a – Divisional Income and Expenditure Statement
Appendix 2b – Divisional I&E Projection Graphs
Appendix 3 – Monthly Analysis of Pay Expenditure
Appendix 4 – Executive Summary
Appendix 5 – Financial Risk Matrix
Appendix 6 – Continuity of Service Risk Rating
Appendix 7 – Release of Reserves February 2015

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report February 2015 – Summary Income & Expenditure Statement

Approved Budget / Plan 2014/15	Heading	Position as at 28th February			Actual to 31st January
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
488,680	From Activities	445,421	445,093	(328)	403,831
91,951	Other Operating Income	83,961	84,274	313	76,173
580,631	**Sub totals income**	**529,382**	**529,367**	**(15)**	**480,004**
	Expenditure				
(334,842)	Staffing	(306,836)	(310,795)	(3,959)	(280,949)
(199,567)	Supplies and Services	(181,128)	(184,384)	(3,256)	(168,388)
(534,408)	**Sub totals expenditure**	**(487,964)**	**(495,179)**	**(7,215)**	**(449,337)**
(5,995)	Reserves	(4,629)	–	4,629	–
40,228	**EBITDA**	**36,789**	**34,188**	**(2,601)**	**30,668**
	Financing				
(23)	Profit/(Loss) on Sale of Asset	(23)	(23)	–	(23)
(21,937)	Depreciation & Amortisation – Owned	(20,061)	(16,739)	3,322	(15,246)
150	Interest Receivable	138	230	92	209
(338)	Interest Payable on Leases	(310)	(317)	(7)	(288)
(3,117)	Interest Payable on Loans	(2,820)	(2,897)	(77)	(2,642)
(9,160)	PDC Dividend	(8,396)	(7,538)	858	(6,853)
(34,425)	**Sub totals financing**	**(31,472)**	**(27,284)**	**4,188**	**(24,843)**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**5,317**	**6,904**	**1,587**	**5,825**
	Technical Items				
8,588	Donations & Grants (PPE/Intangible Assets)	8,399	8,399	–	8,399
(24,204)	Impairments	(2,923)	(2,923)	–	(2,923)
1,232	Reversal of Impairments	–	–	–	–
(1,219)	Depreciation & Amortisation – Donated	(1,106)	(1,149)	(43)	(982)
(9,800)	**SURPLUS / (DEFICIT) after Technical Items**	**9,687**	**11,231**	**1,544**	**10,319**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report February 2015 – Divisional Income & Expenditure Statement

Approved Budget / Plan 2014/15	Division	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st January
			Pay	Non Pay	Operating Income	Income from Activities	CRES		
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements								
481,314	Service Agreements	439,074	–	–	1	(1)	–	–	–
(3,886)	Overheads	(664)	–	(1,414)	–	4,242	–	2,828	1,884
40,931	NHSE Income	37,300	–	–	–	–	–	–	–
518,359	**Sub Total Service Agreements**	**475,710**	**–**	**(1,414)**	**1**	**4,241**	**–**	**2,828**	**1,884**
	Clinical Divisions								
(48,963)	Diagnostic & Therapies	(44,846)	154	(661)	340	(256)	162	(261)	(149)
(68,576)	Medicine	(64,039)	(516)	(321)	241	(126)	(747)	(1,469)	(1,351)
(81,411)	Specialised Services	(75,505)	(1,389)	734	380	(486)	(366)	(1,127)	(919)
(97,317)	Surgery Head & Neck	(93,740)	(3,104)	(24)	134	257	(2,391)	(5,128)	(4,666)
(109,749)	Women's & Children's	(102,967)	(180)	1,880	39	(3,068)	(1,321)	(2,650)	(2,409)
(406,016)	**Sub Total – Clinical Divisions**	**(381,097)**	**(5,035)**	**1,608**	**1,134**	**(3,679)**	**(4,663)**	**(10,635)**	**(9,494)**
	Corporate Services								
(35,423)	Facilities And Estates	(32,640)	129	84	(86)	(15)	25	137	126
(24,405)	Trust Services	(22,202)	514	(558)	142	–	13	111	103
(6,292)	Other	(5,583)	765	455	(650)	(198)	(43)	329	358
(66,120)	**Sub Totals – Corporate Services**	**(60,425)**	**1,408**	**(19)**	**(594)**	**(213)**	**(5)**	**577**	**587**
(472,136)	**Sub Total (Clinical Divisions & Corporate Services)**	**(441,522)**	**(3,627)**	**1,589**	**540**	**(3,892)**	**(4,668)**	**(10,058)**	**(8,907)**
(5,995)	Reserves	–	–	4,629	–	–	–	4,629	4,208
(5,995)	**Sub Total Reserves**	**–**	**–**	**4,629**	**–**	**–**	**–**	**4,629**	**4,208**
40,228	**Trust Totals Unprofiled**	**34,188**	**(3,627)**	**4,804**	**541**	**349**	**(4,668)**	**(2,601)**	**(2,815)**
	Financing								
(23)	(Profit)/Loss on Sale of Asset	(23)	–	–	–	–	–	–	–
(21,937)	Depreciation & Amortisation – Owned	(16,739)	–	3,322	–	–	–	3,322	3,020
150	Interest Receivable	230	–	92	–	–	–	92	84
(338)	Interest Payable on Leases	(317)	–	(7)	–	–	–	(7)	(6)
(3,117)	Interest Payable on Loans	(2,897)	–	(77)	–	–	–	(77)	(71)
(9,160)	PDC Dividend	(7,538)	–	858	–	–	–	858	780
(34,425)	**Sub Total Financing**	**(27,284)**	**–**	**4,188**	**–**	**–**	**–**	**4,188**	**3,807**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**6,904**	**(3,627)**	**8,992**	**541**	**349**	**(4,668)**	**1,587**	**992**
	Technical Items								
8,588	Donations & Grants (PPE/Intangible Assets)	8,399	–	–	–	–	–	–	–
(24,204)	Impairments	(2,923)	–	–	–	–	–	–	–
1,232	Reversal of Impairments	–	–	–	–	–	–	–	–
(1,219)	Depreciation & Amortisation – Donated	(1,149)	–	(43)	–	–	–	(43)	47
(15,603)	**Sub Total Technical Items**	**4,327**	**–**	**(43)**	**–**	**–**	**–**	**(43)**	**47**
(9,800)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**11,231**	**(3,627)**	**8,949**	**541**	**349**	**(4,668)**	**1,544**	**1,039**

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14	2014/15													2013/14	2013/14
		Total	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Total	Mthly Average	Mthly Average	Mthly Average	Mthly Average
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	%	£'000	%
Diagnostic & Therapies	Pay budget	39,526	10,162	3,411	3,362	3,293	10,066	3,356	3,317	3,364	10,037	3,362	3,398	37,025	3,366		3,294	
	Bank	306	64	25	39	27	91	27	26	33	86	14	32	287	26	0.8%	26	0.8%
	Agency	340	79	78	93	13	184	178	103	106	387	101	139	890	81	2.4%	28	0.9%
	Waiting List initiative	225	45	23	8	15	46	19	16	30	65	47	34	237	22	0.6%	19	0.6%
	Overtime	314	102	36	35	23	94	36	33	41	111	30	34	370	34	1.0%	26	0.8%
	Other pay	38,153	9,772	3,151	3,143	3,140	9,435	3,176	3,170	3,329	9,675	3,178	3,169	35,228	3,203	95.2%	3,179	97.0%
	Total Pay expenditure	39,339	10,062	3,312	3,319	3,218	9,850	3,436	3,348	3,540	10,324	3,370	3,407	37,013	3,365	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	187	100	99	43	75	216	(79)	(31)	(177)	(287)	(8)	(9)	12	1		16	
Medicine	Pay budget	44,151	11,591	3,920	3,969	3,991	11,880	3,970	4,191	4,345	12,507	4,359	4,487	44,823	4,075		3,679	
	Bank	3,305	805	264	319	287	870	306	316	397	1,019	229	299	3,222	293	7.1%	275	6.9%
	Agency	2,354	451	167	193	270	630	322	378	359	1,058	455	402	2,996	272	6.6%	196	4.9%
	Waiting List initiative	151	26	12	17	10	39	11	13	10	34	14	75	188	17	0.4%	13	0.3%
	Overtime	197	36	6	12	2	19	5	3	8	16	3	5	79	7	0.2%	16	0.4%
	Other pay	41,743	10,704	3,526	3,502	3,371	10,398	3,441	3,486	3,660	10,587	3,699	3,720	39,109	3,555	85.8%	3,479	87.4%
	Total Pay expenditure	47,751	12,022	3,974	4,042	3,940	11,957	4,084	4,196	4,435	12,715	4,401	4,500	45,595	4,145	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(3,600)	(431)	(55)	(73)	51	(77)	(114)	(5)	(90)	(209)	(42)	(13)	(772)	(70)		(300)	
Specialised Services	Pay budget	36,718	9,577	3,177	3,215	3,261	9,653	3,223	3,233	3,271	9,727	3,250	3,344	35,550	3,232		3,060	
	Bank	1,184	309	108	104	123	335	110	113	134	357	58	116	1,175	107	3.2%	99	3.1%
	Agency	1,882	509	255	183	225	664	223	218	237	677	274	273	2,397	218	6.5%	157	5.0%
	Waiting List initiative	379	91	34	31	25	90	48	51	34	133	44	80	438	40	1.2%	32	1.0%
	Overtime	182	55	14	20	6	40	8	7	6	22	11	10	138	13	0.4%	15	0.5%
	Other pay	34,079	8,811	2,886	2,990	3,018	8,894	3,017	3,025	2,986	9,027	2,968	3,079	32,779	2,980	88.8%	2,840	90.4%
	Total Pay expenditure	37,705	9,775	3,296	3,329	3,397	10,022	3,406	3,413	3,396	10,216	3,355	3,558	36,926	3,357	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(988)	(199)	(119)	(114)	(136)	(369)	(182)	(181)	(125)	(488)	(106)	(214)	(1,376)	(125)		(82)	
Surgery Head and Neck	Pay budget	70,927	17,951	5,876	6,130	6,020	18,025	6,114	6,030	6,044	18,188	6,017	6,004	66,185	6,017		5,911	
	Bank	1,859	463	173	172	167	511	204	152	231	587	133	167	1,862	169	2.7%	155	2.5%
	Agency	808	226	120	102	105	327	79	91	106	275	110	120	1,059	96	1.5%	67	1.1%
	Waiting List initiative	1,394	366	133	162	161	456	146	136	164	446	113	137	1,518	138	2.2%	116	1.9%
	Overtime	485	184	37	65	12	114	14	12	13	40	10	13	360	33	0.5%	40	0.7%
	Other pay	69,195	17,465	5,660	5,863	5,876	17,400	5,965	5,780	5,894	17,639	5,959	5,961	64,424	5,857	93.1%	5,766	93.8%
	Total Pay expenditure	73,741	18,704	6,123	6,364	6,321	18,808	6,408	6,172	6,408	18,988	6,326	6,398	69,223	6,293	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(2,814)	(753)	(247)	(235)	(301)	(783)	(294)	(142)	(363)	(800)	(309)	(393)	(3,038)	(276)		(235)	

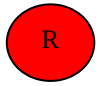
Analysis of pay spend 2013/14 and 2014/15

Division		2013/14	2014/15													2013/14	2013/14
		Total £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Jan £'000	Feb £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	73,478	20,433	7,117	7,161	7,243	21,521	7,301	7,317	7,327	21,945	7,283	7,379	78,561	7,142		6,123	
	Bank	1,813	530	151	172	162	485	222	216	193	631	126	214	1,986	181	2.5%	151	2.5%
	Agency	1,398	384	159	70	168	397	145	163	104	411	175	199	1,567	142	2.0%	117	1.9%
	Waiting List initiative	365	88	28	30	29	87	13	27	36	76	21	57	329	30	0.4%	30	0.5%
	Overtime	226	82	20	36	23	78	33	34	28	95	25	32	312	28	0.4%	19	0.3%
	Other pay	70,112	19,455	6,734	6,832	6,863	20,429	7,012	6,882	6,981	20,875	6,805	6,947	74,511	6,774	94.7%	5,843	94.9%
	Total Pay expenditure	73,913	20,539	7,092	7,140	7,244	21,476	7,425	7,322	7,341	22,088	7,152	7,450	78,705	7,155	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(435)	(106)	25	22	(1)	45	(125)	(4)	(15)	(144)	131	(71)	(144)	(13)		(36)	
Facilities & Estates	Pay budget	18,435	4,638	1,616	1,679	1,621	4,916	1,619	1,614	1,699	4,931	1,604	1,647	17,736	1,612		1,536	
	Bank	555	228	82	133	102	316	96	72	103	271	84	99	998	91	5.6%	46	3.0%
	Agency	346	80	29	46	40	115	33	68	32	133	21	96	445	40	2.5%	29	1.9%
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	895	245	76	103	76	255	98	90	85	273	59	71	902	82	5.1%	75	4.9%
	Other pay	16,397	4,109	1,361	1,416	1,351	4,129	1,441	1,376	1,456	4,274	1,422	1,393	15,327	1,393	86.7%	1,366	90.1%
	Total Pay expenditure	18,193	4,662	1,548	1,698	1,569	4,815	1,669	1,607	1,676	4,951	1,586	1,658	17,671	1,606	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	242	(24)	68	(19)	53	101	(49)	7	23	(20)	18	(11)	66	6		20	
Trust Services (Including R&I and Support Services)	Pay budget	29,492	6,524	2,351	2,236	2,316	6,903	2,423	2,468	2,367	7,257	3,266	3,005	26,955	2,450		2,458	
	Bank	680	165	50	48	56	154	64	38	87	189	55	64	627	57	2.4%	57	2.4%
	Agency	375	135	64	34	40	139	72	47	35	154	189	86	702	64	2.7%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	114	31	8	11	7	27	10	10	12	33	6	7	104	9	0.4%	9	0.4%
	Other pay	27,425	6,061	2,104	2,135	2,195	6,433	2,045	2,160	2,156	6,362	2,654	2,719	24,229	2,203	94.4%	2,285	95.9%
	Total Pay expenditure	28,595	6,392	2,226	2,229	2,299	6,754	2,191	2,255	2,290	6,737	2,904	2,876	25,662	2,333	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	897	132	125	6	17	149	231	212	77	520	362	128	1,293	118		75	
Trust Total	Pay budget	312,726	80,876	27,467	27,752	27,745	82,964	28,006	28,169	28,417	84,593	29,140	29,264	306,836	27,894		26,060	
	Bank	9,702	2,564	852	988	923	2,762	1,029	933	1,178	3,140	700	990	10,157	923	3.3%	809	3.0%
	Agency	7,506	1,865	872	722	862	2,455	1,051	1,067	978	3,096	1,326	1,314	10,057	914	3.2%	625	2.4%
	Waiting List initiative	2,514	616	230	248	240	718	237	243	274	754	239	383	2,710	246	0.9%	210	0.8%
	Overtime	2,413	734	196	282	149	628	205	190	193	589	144	172	2,266	206	0.7%	201	0.8%
	Other pay	297,103	76,378	25,422	25,882	25,813	77,117	26,097	25,880	26,463	78,440	26,684	26,987	285,606	25,964	91.9%	24,759	93.1%
	Total Pay expenditure	319,238	82,157	27,571	28,121	27,987	83,681	28,619	28,313	29,086	86,019	29,093	29,846	310,796	28,254	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(6,514)	(1,281)	(104)	(369)	(243)	(717)	(613)	(144)	(669)	(1,426)	47	(582)	(3,959)	(360)		(543)	

NOTE: Other Pay includes all employer's oncosts.

<table>
<tr><th>Key Issue</th><th>RAG</th><th>Executive Summary</th><th>Table</th></tr>
<tr><td>Financial Risk Rating</td><td>G</td><td>The surplus before technical items for the eleven months to 28 February is £6.904m. This represents an over performance of £1.587m when compared with the planned surplus to date of £5.317m. Total income of £529.367m is £15k lower than Plan. Expenditure at £495.179m is higher than Plan by £2.586m. Financing costs are £4.188m lower than Plan.

The Trust's overall Continuity of Services financial risk rating for the eleven months ending 28 February is 4 (actual score 4.0, January = 4.0).</td><td>Agenda Item 5.1 App 6</td></tr>
<tr><td>Service Level Agreement Income and Activity</td><td>A</td><td>Contract income is £1.96m lower than plan for the 11 month period to 28 February. Activity based contract performance at £376.34m is £3.18m less than plan. Contract rewards / penalties at a net income of £5.25m is £0.67m greater than plan. Income of £55.52m for ‘Pass through’ payments is £0.55m higher than Plan.
<table>
<tr><th rowspan="2">Clinical Service</th><th rowspan="2">Activity to 28 February</th><th colspan="2">Higher than Plan</th><th colspan="2">Lower than Plan</th></tr>
<tr><th>Number</th><th>%</th><th>Number</th><th>%</th></tr>
<tr><td>A&E Attendances</td><td>108,784</td><td></td><td></td><td>2,311</td><td>2.1</td></tr>
<tr><td>Emergency</td><td>35,245</td><td>735</td><td>2.4</td><td></td><td></td></tr>
<tr><td>Non Elective</td><td>2,236</td><td></td><td></td><td>286</td><td>11.3</td></tr>
<tr><td>Elective</td><td>12,553</td><td></td><td></td><td>1,181</td><td>8.6</td></tr>
<tr><td>Day Cases</td><td>49,348</td><td>235</td><td>0.5</td><td></td><td></td></tr>
<tr><td>Outpatient Procedures</td><td>51,315</td><td>381</td><td>0.7</td><td></td><td></td></tr>
<tr><td>New Outpatients</td><td>141,427</td><td></td><td></td><td>10,170</td><td>6.7</td></tr>
<tr><td>Follow up Outpatients</td><td>286,548</td><td></td><td></td><td>20,016</td><td>6.5</td></tr>
</table>
An income analysis by commissioner is shown at Table INC 2.
Information on clinical activity by Division, specialty and patient type is provided in table INC 3.</td><td>Agenda Item 5.2 INC 1</td></tr>
<tr><td>Savings Programme</td><td>R</td><td>The 2014/15 Savings Programme totals £20.771m. The forecast outturn has been reduced to £16.482m – equivalent to 79% of the Plan for the year. Actual savings achieved for the eleven months to 28 February total £14.372m (79% of Plan before the 1/12ths phasing adjustment), a shortfall of £3.724m against divisional plans.</td><td>Agenda Item 5.4</td></tr>
</table>

Key Issue	RAG	Executive Summary	Table
Diagnostic & Therapies		The Division reports an overspending of £0.112m for February thereby increasing the cumulative adverse variance to £0.261m.	Agenda Item 5.3
Medicine		Cumulative overspending is £1.469m, a deterioration of £118k in the month. The principal areas of overspending are on nursing staff (£0.532m), clinical supplies (£0.264m), under performance on SLA activity (£0.126m) and savings (£0.747m).	
Specialised Services		An overspending of £0.208m increases the cumulative overspending to £1.127m. The position reflects overspendings on pay budgets (nursing and medical staff include a high volume of agency staff) non-achieved savings (£0.366m) and SLA underperformance (£0.486m).	
Surgery, Head & Neck		Overspending to date of £5.128m includes an overspending of £0.462m in February. Causal factors are historical non achievement of savings programme and an underachievement of planned activity to date. The Division delivered higher than planned activity (by £228k) in the month.	
Women's & Children's		Overspending to date totals £2.650m, an increase of £0.241m in February. Principal factors are underperformance on income from activities (£3.068m) and non achievement of savings programme (£1.321m).	
Facitities & Estates		The cumulative underspending is £137k, an improvement of £11k in the month.	
THQ		The underspending of £16k in February increases the cumulative underspending to £0.203m.	
Capital		The Monitor capital expenditure performance target is to deliver the programme within 85% -115% of the Annual Plan. Expenditure for the first eleven months totals £39.574m – this equates to 97% of the current plan for the period. The forecast outturn is for total expenditure of £43.879m i.e. 77% of the Annual Plan submission to Monitor.	Agenda Item 6
Statement of Financial Position and Treasury Management		The cash balance on 28 February was £68.7m. The balance on Invoiced Debtors has decreased by £3.680m in the month to £13.686m. The invoiced debtor balance equates to 8.6 debtor days. Creditors and accrual account balances total £83.75m. Invoiced Creditors - payment performance for the month for Non NHS invoices and NHS invoices within 30 days was 93% and 64% respectively. Payment performance to date by invoice value is 86% for Non NHS and 83% for NHS invoices.	Agenda Item 7

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report February 2015 - Risk Matrix

Risk Register Ref.	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Residual Risk	
		Risk Score	Value			Risk Score	Value
			£'m				£'m
741	Savings Programme	High	10.0	Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed.	JR	High	5.0
962	Delivery of Trust's Financial Strategy in changing national economic climate.	High	-	Long term financial model and in year monitoring of financial performance by Finance Committee and Trust Board.	PM	High	-
2116	Non delivery of contracted activity	High	10.0		JR	High	8.0
1240	SLA Performance Fines	High	3.0	Regular review of performance. RTT fines increasing during the year.	DL	High	2.0
	Commissioner Income challenges	Medium	3.0	Maintain reviews of data, minmise risk of bad debts	PM	Medium	2.0
1623	Risk to UH Bristol of fraudulent activity.	Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	Low	-

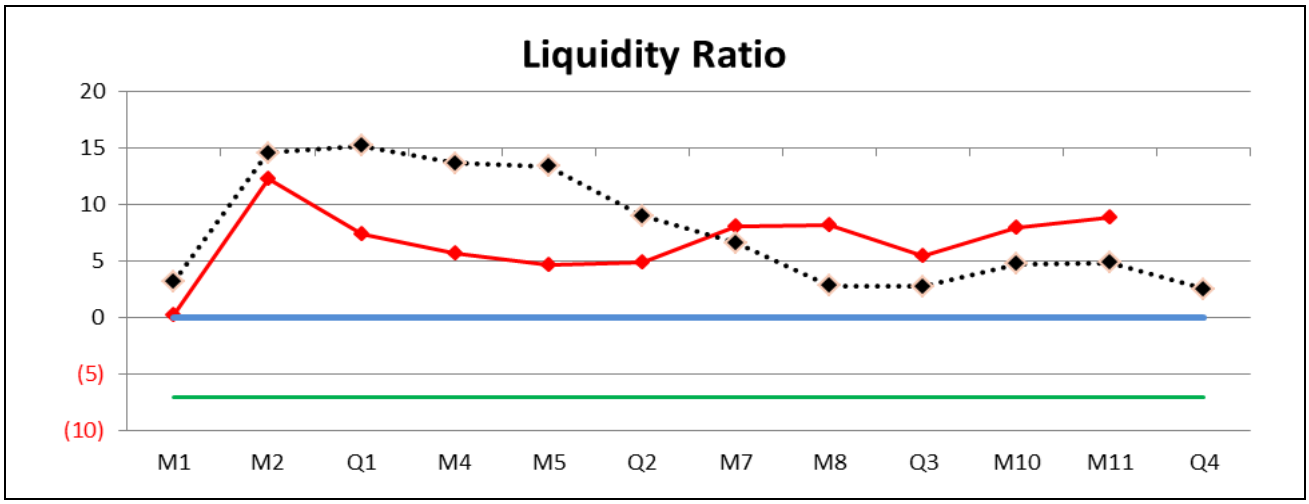
University Hospitals Bristol NHS
NHS Foundation Trust

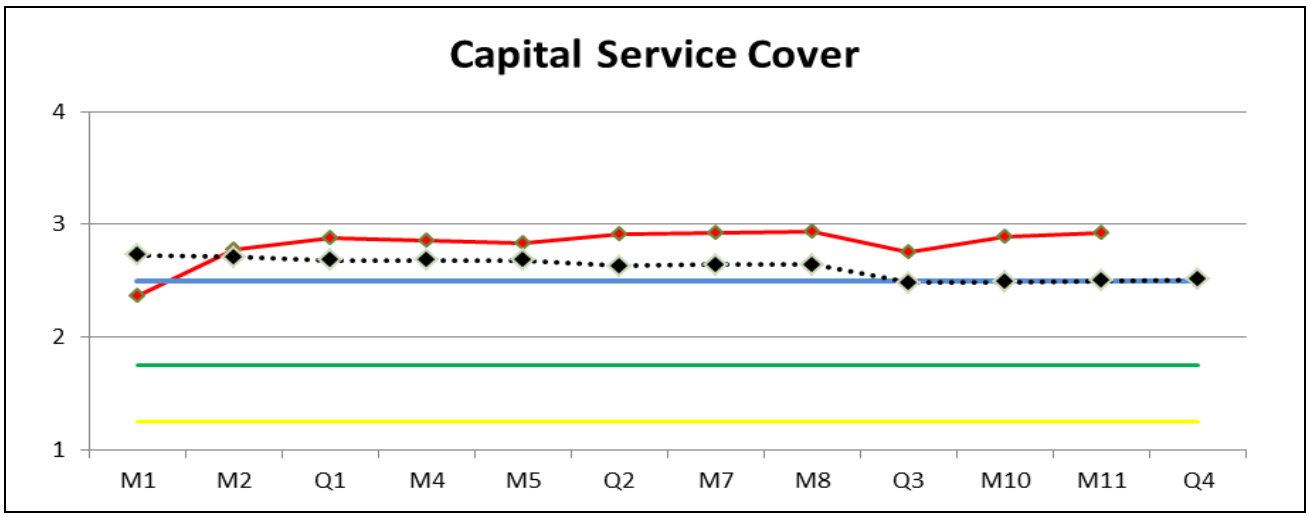
Appendix 6

Continuity of Services Risk Rating – February 2015 Performance

The following graphs show performance against the 2 Financial Risk Rating metrics. The 2014/15 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 4 (blue line)**; **FRR 3 (green line)** and **FRR 2 (yellow line)**.

	March 2014	Plan March 2015	September	December	January	February
Liquidity						
Metric Performance	2.71	2.53	4.90	5.45	7.92	8.87
Rating	4	4	4	4	4	4
Capital Service Cover						
Metric Performance	3.04	2.51	2.91	2.75	2.89	2.92
Rating	4	4	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**	**4**	**4**





Release of Reserves 2014/15 **Appendix 7**

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Provision as per Resources Book	2,000	4,468	59,894	(108)	12,885	3,750	82,889									
Fund technical items			(8,588)				(8,588)									
Adjustments to V7		(98)	5,339				5,241									
Revised provision	2,000	4,370	56,645	(108)	12,885	3,750	79,542									
April Movements	(199)	161	(29,944)	595	(7,954)	(1,052)	(38,393)	1,342	5,986	9,901	9,368	7,467	752	6,158	(2,581)	38,393
May Movements	(36)	(962)	(19,133)	-	(533)	(8)	(20,672)	1,622	154	205	1,326	12,583	989	345	3,448	20,672
June Movements	(65)	117	(2,146)	-	386	(1,028)	(2,736)	(72)	113	282	124	151	51	90	1,997	2,736
July Movements	(117)	(34)	(97)	-	(339)	(24)	(611)	22	5	95	287	7	33	124	38	611
August Movements	(12)	(321)	(242)	-	(431)	(25)	(1,031)	260	86	80	140	229	74	70	92	1,031
September Movements	(68)	(131)	(1,384)	-	(574)	(14)	(2,171)	181	198	222	598	353	483	85	51	2,171
October Movements	(225)	(105)	(144)	-	378	(453)	(549)	37	218	55	112	532	19	196	(620)	549
November Movements	(35)	(90)	3,313	-	(434)	(69)	2,685	94	319	50	58	197	233	128	(3,764)	(2,685)
December Movements	(35)	(94)	(307)	(824)	32	(162)	(1,390)	114	496	68	120	232	27	143	190	1,390
January Movements	(40)	(97)	(1,032)	-	(369)	(123)	(1,661)	41	584	63	106	183	291	36	357	1,661
Month 10 balances	1,168	2,814	5,529	(337)	3,047	792	13,013	3,641	8,159	11,021	12,239	21,934	2,952	7,375	(792)	66,529
Month 11 Movements																
Incremental drift funding		(78)					(78)	13	8	9	13	26	2	7		78
EWTD					(127)		(127)	9	27	18	23	47	1	1	1	127
MARS						(7)	(7)								7	7
BRI Redeveopment					(115)		(115)						115			115
Resilience Funding			(815)				(815)	40	610	38	22	128	10	1	(34)	815
Other	(81)	(17)			41	(24)	(81)	34	(3)	103	(41)	(6)	30	79	(115)	81
Month 11 balances	1,087	2,719	4,714	(337)	2,846	761	11,790	3,737	8,801	11,189	12,256	22,129	3,110	7,463	(933)	67,752

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Tuesday 31 March 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
13. Monitor feedback on Quarter 3 Risk Assessment Framework Submission
Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive Author: Debbie Henderson, Trust Secretary

Intended Audience									
Board members	**X**	Regulators	**X**	Governors	**X**	Staff	**X**	Public	**X**

Executive Summary

Purpose

The purpose of this report is to inform the Trust Board of Directors of Monitor's analysis of the Trust's Quarter 3 submission. Monitor's analysis of the quarter 3 submission is based on the Trust's risk ratings relating to Continuity of Services and Governance, which the Trust submission as follows:

- Continuity of Services Risk Rating – 4
- Governance Risk Rating – Under Review

Key issues to note

These rating will be published on Monitor's website in March reflecting the Trust's failure to meet targets relating to: Referral to Treatment times for admitted, non-admitted and incomplete pathways; A&E four-hour waiting times; and cancer 62 day waits for first treatment (from NHS Cancer Screening Service referral and urgent GP referral).

Monitor had confirmed that this submission had triggered consideration for further regulatory action. Monitor continues to work closely with the Trust to ensure improvements in these areas.

Recommendations

The Board is recommended to receive the report to note

Impact Upon Board Assurance Framework

Annual Objective to improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model – this report results in no change to the Board Assurance Framework

Impact Upon Corporate Risk
Corporate Risk Number 2479 – Performance risk to Monitor Green Rating – this report results in no change to the Corporate Risk Register.
Implications (Regulatory/Legal)
Possible breach of the Health and Social Care Act 2012 if the Trust does not comply with the conditions of the licence.
Equality & Patient Impact
There are no equality implications as a result of this report. Potential impact on patient experience as a result of the Trust's failure to meet targets.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	**X**

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

5 March 2015

Mr Robert Woolley
Chief Executive
University Hospitals Bristol NHS Foundation Trust
Trust HQ
Marlborough Street
Bristol
BS1 3NU

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Making the health sector work for patients

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Dear Robert

Q3 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q3 submissions is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 4
- Governance risk rating - Under Review

These ratings will be published on Monitor's website later in March.

The Trust has failed to meet the following targets in Q3:

- Referral to Treatment admitted;
- Referral to Treatment non admitted;
- Referral to Treatment incomplete;
- A&E four hour waiting time;
- Cancer 62 day waits for first treatment (from NHS Cancer Screening Service referral); and
- Cancer 62 day waits for first treatment (from urgent GP referral).

These failures have triggered consideration for further regulatory action, as set out in our letter dated 29 January 2015. For this reason the Trust's governance risk rating is "Under Review- Monitor is requesting further information following multiple breaches of the A&E, referral to treatment and cancer waiting time targets, before deciding next steps".

Monitor uses the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the Trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the Health and Social Care Act 2012, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[1].

[1] www.monitor-nhsft.gov.uk/node/2622

Monitor set out its position and expectations of the Trust, and its system partners, in its letter dated 29 January 2015 and will review the progress against these actions. The Trust's governance risk rating will remain Under Review until we have concluded our considerations for further regulatory action, at which point we will write to you again.

A report on the FT sector aggregate performance from Q3 2014/15 is now available on our website[2] which I hope you will find of interest.

We have also issued a press release[3] setting out a summary of the key findings across the FT sector from the Q3 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 0203 747 0485 or by email (Amanda.Lyons@Monitor.gov.uk).

Yours sincerely

Amanda Lyons
Senior Regional Manager

cc: Dr John Savage, Chairman
Mr Paul Mapson, Finance Director

[2] www.monitor.gov.uk/raf
[2] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-3-201415
[3] https://www.gov.uk/government/news/nhs-foundation-trusts-tackle-rising-patient-demand

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Tuesday 31 March 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
15. Governor's Log of Communication									
Sponsor and Author(s)									
Sponsor: John Savage, Chairman		Author: Amanda Saunders, Head of Membership & Governance							
Intended Audience									
Board members	**X**	Regulators		Governors	**X**	Staff	**X**	Public	**X**
Executive Summary									
Purpose: The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. Key issues to note: N/A									
Recommendations									
The Board is asked to receive this report to note.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									
Equality & Patient Impact									
N/A									
Resource Implications									
Finance				Information Management & Technology					
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	X		

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
					Executive Directors 25.03.15

Governors' Log of Communications

24 March 2015

ID Governor Name

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

Query 03/03/2015

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

Response 03/03/2015

Assigned to Executive Lead 16/3/2015

Status *Assigned to Executive Lead*

114 Angelo Micciche **Title: Ward moves - transfer of cystic fibrosis nursing staff**

Query 10/02/2015

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

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

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

Response 16/03/2015

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

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

Specific actions put in place ahead of the planned change:
•The CF Clinical Nurse Specialists (CFCNS) set up a band 5 nurse rotation to allow staff from the inpatient ward to rotate for half their hours between the ward and the CF nursing team. This was to develop their skills and knowledge in CF and allow them to feed these skills back into the ward where they worked. This worked well and it also meant that patients that may not be regularly admitted also became familiar with the ward staff in the outpatient setting. This 'placement' recognised the need to prepare the RN's who would be working on A900 for their role as the specialist CF ward in the future
•One of the band 5 nurses from C808 was successful at interview and moved to be the Senior Staff Nurse a number of months before the ward moved to share clinical skills and CF models of care
•During the opening week on A900 the CF nurses planned their workload to ensure there was at least one CFCNS present on the ward to welcome patients and work alongside the ward staff. Two of the CF CNS' came in out of hours at the weekend to support the staff with IV antibiotics and in addition have drawn up a detailed user guide of regular IV antibiotics and their administration specifically for CF patients
•Since A900 opened there has been a CF CNS up on the ward on a daily basis and the ward made aware they are contactable Monday to Friday. When there are teaching opportunities such as port training, the CFCNS support nursing staff to become competent and where possible, organise this to allow these opportunities to fall within working hours
•A week before the actual move there was multi-professional study day for all Ward A900 staff of which all but 2 staff attended from the A900 team. It was organised as 2 half day sessions to allow maximum attendance. The physiotherapy team are also delivering weekly teaching. There are additional planned teaching sessions with input from all members of the MDT on a rotational basis
•2 RN's from ward C808 have been allocated to work on A900 until the end of the summer on a rotational basis (1 on nights and 1 days)
•During the first few weeks following the move and for as long as required, senior staff from C808 have made themselves available on a daily basis to support A900 staff, either by visiting or on the telephone
•A weekly operational meeting has been set up to review the progress of the transfer and manage any issues (should they arise) swiftly

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

Status *Assigned to Executive Lead*

ID Governor Name

113 Angelo Micciche **Title: Staffing levels**

Query 06/02/2015

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

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

Response 11/02/2015

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

Status *Responded*

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

Query 30/01/2015

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

Response 11/02/2015

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

Status *Responded*

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

Query 30/01/2015

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

Response 06/02/2015

Assigned to Executive Lead.

Status *Assigned to Executive Lead*