University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for the Meeting of the Trust Board of Directors held in Public to be held on 30 September 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 agenda	Chairman	_
3. Minutes from previous meeting To approve the Minutes of the Board of Directors Meeting held in public on 30 July 2015	Chairman	3
4. Matters Arising (Action log) To review the status of actions agreed	Chairman	14
5. Chief Executive's Report To receive the report to note	Chief Executive	15
Delivering Best Care and Improving Patient Flow		
6. Patient Experience Story To receive the Patient Experience Story for review	Chief Nurse	19
7. Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Chief Operating Officer/Deputy CEO	23
8. Quality and Outcomes Committee Chair's report To receive the report for assurance	Quality & Outcomes Committee Chair	To follow
9. Referral to Treatment Times Recovery Trajectories To receive the report for approval	Chief Operating Officer/Deputy CEO	72
10. Cancer Waiting Times Improvement Plan submission To receive the report to note	Chief Operating Officer/Deputy CEO	78
11. Quarterly Complaints and Patient Experience reports To receive the reports for assurance	Chief Nurse	93
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Building Capability		
14. Quarterly Workforce Report To receive the report for assurance	Director of Workforce & OD	204

Delivering Best Value		
15. Finance Report To receive the report for assurance	Director of Finance & Information	243
16. Finance Committee Chair's Report To receive the report for assurance	Finance Committee Chair	To follow
Leading in Partnership		
17. Clinical Research Network Annual Report 2014/15 and Annual Plan 2015/16 To receive the Annual Report and approve the Annual Plan for 2015/16	Medical Director	273
Compliance, Regulation and Governance		
18. Audit Committee Chair's Report To receive the report for assurance	Audit Committee Chair	341
19. Governor Expenses Policy To approve the Governors Expenses Policy	Chief Operating Officer/Deputy CEO	347
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20. Monitor feedback on the 2014/15 annual report & accounts Process To receive the correspondence to note	Chief Executive	357
21. Monitor feedback on Q4 monitoring submission and 2015/16 Annual Plan Review To receive the correspondence to note	Chief Executive	362
22. Monitor feedback on Q1 monitoring submission To receive the correspondence to note	Chief Executive	367
23. Governors' Log of Communications To receive the Governors' log to note	Chairman	371
24. 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 October 2015, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU		

University Hospitals Bristol NHS
NHS Foundation Trust

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

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

Present or in attendance:
Debbie Henderson – Trust Secretary
Fiona Reid – Head of Communications
Anita Randon – incoming Interim Director of Strategy and Transformation
Amanda Saunders – Head of Membership and Governance
Sarah Murch – Membership & Governance Administrator (Minutes)
Tony Watkin – Patient Experience Lead (Engagement and Involvement) (Items 1-6 only)
Sophie Jenkins -Vice-Chair of Joint Union Committee
Clive Hamilton – Public Governor
Bob Bennett – Public Governor
Mo Schiller – Public Governor
Sue Silvey – Public Governor
Tony Tanner – Public Governor
Angelo Micciche – Patient Governor
Sue Milestone – Patient Governor
Tony Rance – Patient Governor
John Steeds – Patient Governor
Pam Yabsley – Patient Governor
Florene Jordan – Staff Governor
Jeanette Jones – Appointed Governor
Garry Williams – Foundation Trust Member
Martyn Dury – Member of the public (Items 1-6 only)

63/07/15 Chairman's Introduction and Apologies
John Savage, Chairman extended a particular welcome to Martyn Dury, a patient in attendance to discuss his recent experience of care at the Trust under Agenda Item 6. John also extended a welcome to Anita Randon who had been appointed to undertake the role of Interim Director of Strategy and Transformation in place of James Rimmer from August.

John announced James' appointment as interim Chief Executive of Weston Area Health Trust, and would be seconded from UH Bristol from the end of July until the end of March 2016. The Board took an opportunity to thank James and wish him well in his new role.

Apologies for absence were received from John Moore, Non-executive Director.

64/07/15 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. James Rimmer's appointment at Weston Area Health Trust was noted. No further declarations of interest were received.

65/07/15 Minutes and Actions from Previous Meeting
The Board considered the minutes of the meeting held in public on 30 June 2015. Under Item 49/06/15 it was agreed to amend the phrase '800 managers had attended courses in 2014' to '800 staff with management responsibilities had attended courses in 2014'.

It was agreed to amend the action under item 55/06/15 to reflect the fact that a business case for the redevelopment of Trust Headquarters and the land around Marlborough Hill as a whole, including proposals for car parking, would be presented to the Trust Board in September. It was:

RESOLVED:
- **That the minutes of the meeting held 30 June 2015 be agreed as an accurate record of proceedings, subject to the amendments outlined in the minutes**

66/07/15 Matters Arising
Matters arising and actions completed were noted by the Board.

67/07/15 Chief Executive's Report
The Board received a written report of the main business conducted by the Senior Leadership Team in July 2015. Robert Woolley, Chief Executive, provided a verbal report of matters of topical importance to the Trust.

With regard to cancer standards, Robert referred to the announcement from Monitor, NHS England, and the Trust Development Authority regarding the establishment of a national delivery group to improve 62-day Referral-to-Treatment Times for cancer. Every Trust would be required to produce an improvement plan by the end of August, weekly reporting of the prospective patient treatment list was required, and every health system had to provide a plan for dealing with cancer demand going forward. The Trust Board would receive reports of progress in this area at future meetings.

There had been a major policy commitment by the Department of Health to increase the level of seven-day working in the NHS as a whole. UH Bristol was therefore required by Monitor, NHS England, and the Trust Development Authority to submit baseline data about its current performance in relation to seven-day working by the start of September. Further updates would be provided to the Board on progress.

Robert took an opportunity to remind Board members that NHS England had invited organisations and partnerships to apply to become 'vanguard' sites, which would lead the development of new care delivery models at a local level. Robert reported that the

Commissioner-led application to the Urgent and Emergency Care Vanguard Programme had been unsuccessful. The Trust had considered submission of an expression of interest jointly with North Bristol Trust in July to an Acute Care Vanguard programme to sustain and improve local joined-up acute care. Robert reported that the two Trusts had now agreed the basis for an application to be submitted by 31st July.

With regard to the NHS England Review of Congenital Heart Services, Robert reported that the findings from the 2014 review into adult and children's care had now been published and called for a three-tier model of care. This would include regional centres that would provide specialist surgery, cardiology centres in some networks, and a final tier of local centres. Standards had been approved and implementation would commence at end of October. Further updates would be provided with regard to the impact on the Trust at future Board meetings.

Robert provided an update on the Independent Review of Children's Congenital Heart Services in Bristol and provided assurance that the Trust was fully co-operating with the review which was now going through an intensive process of information-gathering. There was as yet no indication of when the review would conclude.

David Armstrong, Non-executive Director, referred to the work to update terms of reference of Senior Leadership Team groups and asked if these were being updated in line with the Well-led Governance Review. Robert responded that consideration had been given to this, but to avoid delaying good governance practice, it had been decided to continue to meet the annual programme of reviewing and updating terms of reference where appropriate, while acknowledging that they may require further review in due course in line with the recommendations from the review.

Emma Woollett requested an update on the transfer of cellular pathology to North Bristol Trust. Robert responded that there was now increased certainty regarding the timetable for the physical aspects of implementation, particularly with regard to the new laboratory building and laboratory information management system. The transfer was now scheduled for 1 April 2016. There had been improvements in sample turnaround time. The Trust was now seeking to work proactively and collaboratively with NBT in co-leading the project. However, the Board were advised that following the resignation of Joint Clinical Lead, Dr Robert Pitcher, interim leadership arrangements would be required during the replacement process to be undertaken by North Bristol. It was:

RESOLVED:

- **That the Board note the report from the Chief Executive**

68/07/15 Patient Experience Story

Carolyn Mills introduced the Patient Experience Story, presented to Board members in order to set a patient-focussed context for the meeting, and introduced the patient who told the Board his story.

The patient had been referred directly to the Bristol Royal Infirmary Surgical Assessment Unit by his GP. Despite experiencing considerable pain, he had been turned away from the unit on arrival as the GP's referral had not been received by the department prior to the patient's arrival. Due to his persistence and help from staff in other areas of the hospital he was admitted. He had been very pleased with the care he had received once admitted, but his initial experience had caused him considerable anxiety.

The Board discussed the case and the response from the Division of Surgery, Head and Neck. The Board provided assurance to the patient that the level of service he had received was not acceptable and explained the actions that were due to be taken as a result of his experience.

Non-executive Directors sought assurance that adequate customer service training was provided to staff, particularly in dealing with unexpected circumstances and variants from the standard process, and also around communication and listening to the patient. Environmental factors were also noted adversely affecting staff-patient communications, for example, the shape of the wards and position of intercoms.

The Chairman thanked the patient for attending and for taking the time to share his story with the Board.

Non-executive Directors emphasised the importance of patient feedback which would not be identified via the formal complaints process and asked that Trust consider making it clearer to staff ways in which they could communicate incidents to enable actions to be addressed immediately. It was:

RESOLVED:

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

69/07/15 Quality and Performance Report

Overall Performance

Deborah Lee introduced the monthly report which reviewed the Trust's performance in relation to Quality, Workforce and Access standards and referred to the achievement of the 95% standard for the A&E 4-hour wait, delivery of the 6-week diagnostic 99% national standard for the first time since October 2014, and further reductions in both the total number of patients waiting over 18 weeks from Referral to Treatment (RTT) and the longest waiting patients.

It was acknowledged that challenges remained in a number of areas, in particular meeting cancer waiting times standards, due to the nature of the case mix and the volume of late referrals from other providers. During the period, there had been an unprecedented level of cancelled operations for patients on cancer pathways due to pressures in Intensive Therapy Units.

The waiting times risk profile was growing particularly with regard to increased demand, which had been consistently above expected levels and had an adverse impact on the continued reduction in backlogs. Deborah provided assurance to the Board that the Trust was in regular communication with regulators and commissioners regarding the challenges.

Deborah noted the sustained strong performance in relation to the vast majority of quality metrics, including falls, pressure ulcers and mortality rate. Sean O'Kelly highlighted that the new quality and performance report now included Care Quality Commission intelligent monitoring, and the Board were pleased to note that the report had placed the Trust in a low risk band 5, band 6 being the lowest risk category.

Sue Donaldson cautioned the Board that the Trust was still carrying a significant risk relating to the workforce agenda but briefed the Board on the significant amount of work, energy and focus to reduce the risk, which had been reflected in the new re-formatted report. Sue

provided assurance that action plans had been implemented to reduce vacancies and sickness absence, and to support divisional efforts on an ongoing basis. It was:

RESOLVED:

- **That the Board receive the Quality and Performance Report and acknowledge and support the new format of reporting**

70/07/15 Quality and Outcomes Committee Chair's Report

Alison Ryan presented the report for members of the Board on the business of the Quality and Outcomes Committee meeting held on 28 July 2015. The Committee brought to the attention of the Board: increasing numbers of outpatient referrals, associated pressure on waiting lists and capacity to reduce backlog; increasing number of cancelled operations; increasing vacancy and turnover rates; and sickness absence rates.

Guy Orpen welcomed the new format of the quality and performance report, but referred to the absence of research indicators. Deborah Lee confirmed that the report would be supported by a detailed quarterly report which would include research and innovation metrics.

In response to a further request by Guy for greater visibility of performance regarding staff development, Sue Donaldson noted that the Education, Learning and Development Strategy previously presented to the Board in June had defined key performance indicators, which could be built into the reporting process.

David Armstrong referred to the Green rating on patient experience and enquired whether a postal survey was the optimal way of ascertaining satisfaction and experience. Carolyn Mills advised that the postal survey was one of several methods used to gather patient feedback and Alison Ryan confirmed that the Quality and Outcomes Committee reviews the methodology for obtaining patient feedback regularly and she believed that Trust used particularly varied set of methods and extremely robust mechanisms. The results of the feedback are reported to Quality and Outcomes Committee on a quarterly basis.

In response to a question from Mo Schiller, Carolyn Mills confirmed that the University of the West of England had increased the number of places for student nurses and Oxford Brookes had increased its places for medical practitioners.

Clive Hamilton welcomed the new format of the quality and performance report and suggested that further metrics be rated in percentage terms as well as the level of activity. Clive also noted the additional assurance provided with regard to Fractured Neck of Femur targets and expressed appreciation of the improvements around Dementia Care and Pressure Ulcers.

The Chairman led the Board in acknowledging the efforts of Xanthe Whittaker, Associate Director of Performance and her team in producing the new report, which represented a significant amount of work and a great improvement. It was:

RESOLVED:

- **That the Board note the Quality and Outcomes Committee Chair's Report**

71/07/15 Transforming Care Report
Robert Woolley introduced the report advising that the scope of the programme had been revised to ensure it supported the operational plan and the quality objectives in relation to patient communications, supporting administrative staff with training and support, and staff engagement and experience. Robert noted the significant amount of work to improve staff engagement and experience and was pleased to report that the latest quarterly staff Friends and Family Test had seen an improvement in the numbers of staff recommending the Trust as place to work or receive care.

Jill Youds requested assurance that the breadth of work and the timescales for completion were realistic. Robert Woolley responded that the scope of the project had been subject to detailed discussion, and work had already been taken forward by divisional leaders. It was agreed that it would be useful to include further detail in the report on timescales for particular initiatives and progress reports. Sue Donaldson reported progress in the area of staff experience which included workshops with staff to obtain their views on improving communication. Staff governors were encouraged to attend the workshops. It was:

RESOLVED:
- **That the Board receive the Transforming Care Report for assurance**

72/07/15 Complaints Annual Report 2014/15
Carolyn Mills presented the report which provided a detailed analysis of the nature and number of complaints during 2014/2015. Patient complaints had averaged 157 per month. The volume of complaints received by the Trust as a proportion of patient activity was 0.26%: an increase on 2013/14, when 0.21% of patient episodes resulted in a complaint. The main themes had been admissions and clinical care, particularly delayed or cancelled appointments or operations.

Lisa Gardner asked if there had been a trend identified regarding the increase in complaints year-on-year in Specialised Services. Carolyn advised that the complaints related primarily to delayed or cancelled operations, and issues in outpatients departments which had now been resolved.

Garry Williams, Foundation Trust Member, asked whether it was possible to generalise about the nature of complaints in terms of desired outcome. It was acknowledged that there would be many reasons for submitting a complaint including: wanting to improve the service; dissatisfaction; and desire for reparation. It was:

RESOLVED:
- **That the Board receive the Complaints Annual Report for assurance**

73/07/15 National In-Patient Survey Results 2014
Carolyn Mills presented the report outlining the findings of the 2014 National Inpatient Survey. The report included a local analysis report providing detailed analysis of the Trust's performance and outlining service improvement activity in relation to the key issues identified, and the Care Quality Commission Benchmark report.

It was acknowledged that the Trust performed in line with the national average on 57 out of 60 survey questions. The Trust performed better than the national average in the domains of explaining risks and benefits of operations and discussing post-hospital care needs with

patients. The Trust received a below-national average score on availability of hand gels. Carolyn felt the findings were largely positive.

David Armstrong referred to low scores on two questions regarding opportunity to give views on the quality of care and provision of information on how to complain, and requested that actions would be identified to address the issues. Jill Youds asked that the Trust focus not just on lower-scoring areas, but also on areas where it had the potential to excel. Carolyn Mills stated that the Trust's ambitions would be included in the Patient Experience strategy when it was reviewed. It was:

RESOLVED:

- **That the Board receive the National In-Patient Survey Results 2014 for assurance**

74/07/15 Speaking Out Policy

Sue Donaldson presented the policy which had been developed following a response to the recommendations from the Francis Freedom to Speak Up Review (February 2015). The policy had been submitted in draft form to the Board and the Quality and Outcomes Committee for comment.

Sue confirmed that there had been extensive benchmarking and wide stakeholder involvement in the development of the policy. In addition, the Policy had been reviewed by the National Whistleblowing Helpline Policy Manager and had received very positive feedback. Work would continue to develop and promote awareness of the supporting documents.

Julian Dennis welcomed the improvements made to the policy but suggested minor changes to the tone. Sue asked for suggestions to be communicated to her outside the meeting.

Sue Milestone, Patient-Carer Governor, enquired about the meaning of the phrase 'Protected Disclosure' and it was agreed that Sue Donaldson would provide a written explanation into the policy. It was:

RESOLVED:

- **That the Board approve the Speaking Out Policy subject to minor alterations to the language and the inclusion of the definition of 'Protected Disclosure'**

75/07/15 Annual Revalidation Report 2014/15

Sean O'Kelly presented the report which provided assurance and compliance with the NHS England requirements on revalidation.

Sean advised that revalidation of a doctor's General Medical Council (GMC) licence to practice had now been operational for two years. Revalidation was based on annual appraisal with evidence consistent with good medical practice. Each designated body was responsible for making one of three recommendations to the GMC regarding medical practitioners; positive recommendation; deferral; and non-engagement. Sean reported 194 positive recommendations, 24 deferrals (11%) and no non-engagement notifications. Internal audit had considered the processes and concluded that sound procedures were in place that were evidence-based and fully in line with GMC requirements.

In the discussion that followed there was some concern expressed in relation to the data for clinical fellows and SAS doctor groups. Sean noted that this was a transient population with a high turnover rate, and there were often difficulties in establishing whether they had informed the GMC that they were working for the Trust, which led to delays in asking the Trust to prepare them for revalidation. Following a request for assurance from Non-executive Directors, Sean provided assurance that they could not be revalidated unless they had evidence of annual appraisal. Sue Donaldson provided additional assurance that the HR team ensure procedures had been followed in terms of reporting, regardless of designation. It was:

RESOLVED:

- **That the Board receive the Annual Revalidation Report 2014/15 for assurance**

76/07/15 Finance Report

Paul Mapson presented the report on the Trust's financial position at the end of June 2015 and noted a surplus of £0.443m (before technical items). As the financial position to date suggested that the Trust had significantly improved its performance since the original plan was agreed and submitted to Monitor, it was recommended that the Trust Board approve a revised financial plan to be submitted to Monitor of a break-even position for the end of the financial year (before technical items). Paul cautioned that the outlook was still challenging, and there was still a risk of significant capital slippage, though the Trust was trying to improve the phasing of the capital programme. It was:

RESOLVED:

- **That the Board receive the Financial Report**
- **That the Board approve the submission of a revised financial plan to Monitor, reflecting a break-even position (before technical items) for the financial year-end 2015/2016**

77/07/15 Finance Committee Chair's Report

Jill Youds presented the report of the business discussed at the meeting of the Finance Committee on 24 July 2015, as interim chair. The Committee had received a report considering the recently published interim report on Operational Productivity in NHS Providers by Lord Carter. The report focused on a few key areas for savings, one or two of which may be an opportunity for the Trust, but this would become clearer when the final report is produced by Lord Carter.

The Committee had discussed the Quarter 1 finance report in depth. In particular the Committee had noted the slowing down of early overspends in some divisions and encouraging signs of financial grip and control in most divisions. The proposal to submit a revised financial plan had been discussed in some detail by the Committee and they had agreed to support the Director of Finance's recommendation to submit a break-even plan to Monitor.

The Committee had expressed concern about the savings pipeline and had requested that the Board spend some time at a future seminar examining the Trust's approach to transformation and savings.

Julian Dennis enquired whether there was a risk to the Trust in being behind schedule on expenditure on medical equipment. Deborah Lee acknowledged that this was not without impact, but the associated risks had been controlled due to close working with Divisions.

Alison Ryan referred to the impact on activity of challenges relating to recruitment and retention of staff and requested that this risk be quantified. Paul Mapson advised that a report on recruitment would be submitted to the August Finance Committee meeting. Deborah Lee suggested that the report include further detail from divisions to give a sense of the scale of the risk, and drew the Board's attention to work ongoing to identify elements of the operating plan which were linked to workforce risks and measures to control and mitigate such risks. It was:

RESOLVED:

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

78/07/15 Quarterly Capital Projects Status Report

Deborah Lee presented the report and highlighted risks that had been identified around programme timings, particularly related to the impact of the histopathology transfer, and the moves that need to take place in order to ensure the timely transfer of services out of the Old Building prior to sale. Contingency plans were being developed to ensure there would be no delay to plans for disposal of the building. This would impact on some members of staff, who would need to be housed in temporary office accommodation for up to a year.

Deborah made reference to further pressures regarding the increased costs over budget for the Level 8 and 9 works following a change in scope, and the likelihood of an increase in the proposed cost for the King Edward Building refurbishment by approximately 5%. It was:

RESOLVED:

- **That the Board receive the Quarterly Capital Projects Status Report for assurance**

79/07/15 Clinical Research Network Annual Plan 2015/16

Sean O'Kelly advised that this item be withdrawn in order to present the Annual Plan for 2015/16 with the Annual Report 2014/15, which was yet to be received.

Robert Woolley reminded those present that as the host organisation for the West of England Clinical Research Network, UH Bristol would be required to approve the annual plan on behalf of the member organisations, and emphasised the expectation that the Board would be required to approve the plan prior to submission. Robert agreed to clarify the approval process outside of the meeting, but noted that both documents would be received by the Board in September. It was:

RESOLVED:

- **That the Board defer the Clinical Research Network Annual Plan 2015/16 to the September meeting**

80/07/15 Q1 Risk Assessment Framework Declaration Report

Robert Woolley referred to the proposed declaration against Monitor's Risk Assessment Framework for quarter 1 and highlighted the standards failed in quarter 1 to be the RTT non-admitted, admitted and ongoing pathways standards, the A&E 4-hour standard, the 62-day GP and 62-day screening cancer standards. The report also recommended that the planned ongoing failure of the RTT standards as part of the agreed recovery trajectory would be flagged to Monitor, along with specific risks to achievement of the 62-day screening and 62-

day GP cancer standards, and the A&E 4-hour standard, as part of the narrative that accompanies the declaration. It was:

RESOLVED:
- **That the Board approve the Q1 Risk Assessment Framework Declaration Report for submission to Monitor**

81/07/15 Board Assurance Framework
Robert Woolley introduced the Board Assurance Framework, which was used to track progress against the Trust's strategic objectives and specifically to track progress against the annual objectives which were derived as part of the 2015/16 annual planning cycle.

Robert explained that greater emphasis had been applied to the provision of detail of current risks to achieving the annual objectives. Of the 36 annual objectives, as at 30 July 2015, there were 20 objectives where delivery was forecast with a residual rating of Green and 16 Amber rated objectives.

Alison Ryan questioned why the achievement of objectives relating to staff turnover had received an amber rating as opposed to Red, given the acknowledgement of high risks of achievement workforce key performance indicators. Sue Donaldson responded that the review of the actions outlined in the previous discussion on Quality and Performance would provide clarification on likely areas of progress, but agreed to re-evaluate the rating. It was:

RESOLVED:
- **That the Board receive the Board Assurance Framework for assurance**
- **That the residual rating relating to achievement of annual objectives for workforce be re-evaluated prior to the October submission**

82/07/15 Corporate Risk Register
Robert Woolley referred to the corporate risk register and noted that there were only two very high risks reflecting the success in mitigating the highest risks across the organisation. Robert acknowledged that as a result of the improved management of very high risks and the increased level of detail for risks included in the Board Assurance Framework, the Board oversight of organisational high risks should be increased. A more detailed corporate risk register would therefore be submitted to the Board from Quarter 2 onward to enhance Board sightedness on the Trust's management of high risks across the organisation.

David Armstrong enquired why risks identified in the Quarterly Capital Projects Status Report were not reported. Deborah Lee clarified that they were reported on the Trust Services Risk Register as they presented a divisional risk as opposed to corporate risk.

In response to a query from Alison Ryan and Emma Woollett regarding the timeliness of risk reporting, particularly the risk dating back to 2004, Deborah Lee advised that although documented as a risk, the risk had been controlled at divisional level until the present. Deborah provided assurance that a significant investment had now been agreed to mitigate the risk and took an opportunity to note that the risk was one to quality, and not patient safety. It was:

RESOLVED:
- **That the Board receive the Corporate Risk Register for assurance**

83/07/15 Board of Directors Register of Interests
John Savage referred to the register of interests for the Trust Board of Directors. Emma Woollett asked for assurance that a similar process would be undertaken for divisional Boards. Debbie Henderson confirmed that the trust wide register of interests would be submitted to the Audit Committee in September. It was:

RESOLVED:
- **That the Board receive the Board of Directors Register of Interests for assurance**

84/07/15 Register of Seals
John Savage referred to the report outlining the application of the Trust Seal as required by the Foundation Trust Constitution. It was:

RESOLVED:
- **That the Board receive the Register of Seals for information**

85/07/15 West of England Academic Health Science Network Board Report June 2015
John Savage referred to the report providing an update to the Boards of member organisations of the West of England Academic Health Science Network of the decisions, discussion and activities of the Network Board. It was:

RESOLVED:
- **That the Board receive the West of England Academic Health Science Network Board Report for information**

86/07/15 Governors' Log of Communications
John Savage referred to the Governors' Log providing the Trust Board with an update on governors' questions and responses from Executive Directors. It was noted that a response had now been received for Item 123. It was:

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

87/07/15 Any Other Business (Item 25)
The Chairman formally thanked James Rimmer on behalf of the Trust Board, and wished him well in his new role as interim Chief Executive of Weston Area Health Trust. Clive Hamilton added his good wishes on behalf of the Council of Governors and his North Somerset constituents.

Meeting close and Date and Time of Next Meeting
There being no other business, the Chair declared the meeting closed at 13:17.
The next meeting of the Trust Board of Directors will take place on Wednesday 30 September 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 30th July 2015
Action tracker

Outstanding actions following meeting held 30th June 2015					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	**81/07/15**	Review residual rating on the Board Assurance Framework relating to achievement of annual objectives for workforce prior to the October submission	Director of Workforce & OD	October 2015	N/A
2	**55/06/15**	The car parking business case to be submitted to the Board	Chief Operating Officer/ Deputy CEO	October 2015	N/A
3	**49/06/15**	A report to be provided on the detailed action plan arising from the Education, Learning and Development Strategic priorities	Director of Workforce & OD	November 2015	N/A
4	**31/05/15**	Explore options to include number of staff leavers, those who have completed exit interviews and at what stage of the process in future quarterly workforce reporting	Director of Workforce & OD	September 2015	N/A
Completed actions following meeting held 30th July 2015					
		NO COMPLETED ACTIONS TO NOTE			

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
05. Chief Executive's Report									
Sponsor and Author(s)									
Author - Robert Woolley, Chief Executive Sponsor – Robert Woolley, Chief Executive									
Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team. Key issues to note The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in August and September.									
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 – SEPTEMBER 2015

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in August and September 2015.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **approved** revised Referral to Treatment backlog reduction trajectories and **supported** the Referral to Treatment Medway migration plan, for onward submission to the Trust Board.

The group **noted** the Bristol response submission to the Tri-partite on preparations for winter, developed by the Urgent Care Working Group, with input from UH Bristol.

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

The group noted the Quarter 1 Complaints and Patient Experience report for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **noted** the Quarter 1 update on Corporate Quality Objectives.

The group **received** the Quarterly workforce report.

The group **approved** the closure of the Care Quality Commission inspection action plans, noting arrangements for monitoring of the few outstanding actions at the relevant committees.

3. STRATEGY AND BUSINESS PLANNING

The group **approved** the interim arrangements put forward, in respect of the planned homeopathy service transfer.

The group **noted** updates with regards to the review of the business planning process.

The group **received** a report on the baseline establishment for four key standards for Seven-Day services and Divisions were asked to consider what steps and actions were required to address any areas where current performance did not meet the specification and how they would monitor compliance.

The group **approved** the recommendations put forward with regards to next steps in relation to sickness absence management and staff retention.

The group **approved** the continuation of the Patient Mailing programme on behalf of Above & Beyond.

The group **agreed** on further work to review and standardise the payments and practices across the Trust relating to medical staffing locum rates and premium payments such as waiting list initiatives.

The group **noted** national guidance in respect of the National Clinical Excellence Award Renewal process and **agreed** an option for recommendation to the Local Negotiating Committee.

4. RISK, FINANCE AND GOVERNANCE

The group **received** an update on the status of the transfer of Cellular Pathology to North Bristol Trust.

The group **approved** twelve recommended Divisional schemes for the Trust-wide in-year retention initiative, amounting to approximately £170,000.

The group **received** the four-monthly Partnership Report.

The group **noted** six low impact Internal Audit Reports in relation to Doctor Revalidation, Workforce Planning and Business Planning, Capital Prioritisation, Medway Access Controls, Patient Experience – Dementia and Accuracy and Timeliness of Patient Information, and three medium impact Internal Audit Reports in relation to financial sustainability and cost improvement plans, Estate Management and Medical Staff Leave.

The group **approved** revised terms of reference for the Clinical Quality Group.

The group **received** the Quarterly Benchmarking Report for Access and Quality Standards.

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

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

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

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
September 2015

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30th September 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
06. Patient Experience Story									
Sponsor and Author(s)									
Sponsor: Carolyn Mills – Chief Nurse Author: Gloria Clark – Patients Association, Ruth Hendy Lead Cancer Nurse/ Tony Watkin –Patient Experience Lead (Engagement and Involvement)									
Intended Audience									
Board members	**x**	Regulators		Governors		Staff		Public	

Executive Summary

Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality.

This story is presented by the Patients Association who have worked in partnership with the Trust to understand our patients' and their family's lived experience of receiving treatment for cancer at UH Bristol and how this could be improved in light of poor performance in the National Cancer Patient Experience Survey.

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

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

Context

The annual National Cancer Patient Experience Survey has consistently presented UH Bristol as scoring below the national average. These results have been both disappointing and perplexing as they are contrary to other UH Bristol patient experience scores and also appeared to remain unresponsive to numerous improvement initiatives.

Following the 2014 report, UH Bristol Trust Board and Cancer Steering Group (formerly Cancer Board) supported a wider reaching medium term plan to undertake an extensive local cancer patient engagement project, resulting in the development of an informed action plan. It was agreed that the 2015 UH Bristol Patient Association project would be linked to this work.

From December 2014 – May 2015, the cancer patient engagement activity included:

- Patient Association project - five focus groups and 4 telephone interviews
- Repeat of local cancer survey – 309 responses
- UH Bristol facilitated 'listening event'
- 35 additional telephone interviews
- Staff survey – 106 responses

Patient Association project report highlights:

- Delivery of cancer care is highly complex and frequently involves many different organisations

- Overall UH Bristol, "can take much comfort from the findings of this work" especially in terms of the appreciation patients showed for the quality and dedication of staff
- Patients' main priorities for an excellent patient experience were:
    - Supportive care coupled with clinical excellence
    - Well-planned and coordinated care
    - Timely delivery of care / treatment (avoidance of delays / cancellations)

Recommendations from the Patient Associations report:

- All patients diagnosed with cancer should have access to a Clinical Nurse Specialist
- Review training in giving bad news
- Ensure information provided is relevant and tailored to personal need
- Work with GPs to encourage ongoing involvement in care
- Improve after care support
- Try to avoid cancellation of operations / delays in processes and delivery of care
- Investigate why processing and administration (of appointments) breaks down too often
- Work with partner providers to ensure treatment, tests or follow-up is delivered as near to people's homes as possible.

All these recommendations have been accepted and endorsed by the Cancer Steering Group (having governance responsibility for over-sight of this process) and they have been incorporated into the collaborative detailed action plan generated from all the recent cancer patient experience engagement activity.

Recommendations
To receive the patient story, and note the context from which it was generated.
Impact Upon Board Assurance Framework
Implementation of the learning associated with this story supports achievement of the Trust's corporate quality objective to improve communication with patients.
Impact Upon Corporate Risk
No links to corporate risks.
Implications (Regulatory/Legal)
Learning from feedback supports compliance with CQC's fundamental standards – regulation 9, person centred care; regulation 10, dignity and respect; regulation 12, safe and appropriate treatment; regulation 17, good governance.
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Patient Story

Trust Board – 30th September 2015

Our experience of care

Introduction

Unusually, this month's story - two patient stories in fact - brings together the reported experiences of approximately 40 patients who participated in the Patients Association cancer project. Both 'patients' are fictional however their stories draw upon the real experiences and feelings described by participants, in an attempt to paint a picture of the 'composite experience' and describe the key themes for patients.

At the Board meeting we will introduce:

- Paula, a 53 year old woman from Somerset who received cancer care from two hospitals
- Bernard, a 65 year old man from Bristol whose cancer care was exclusively at UH Bristol.

Through their stories we will bring out some of the information and insight gained from the people of all ages and cancer conditions who participated in the Patients Association focus groups and telephone interviews to discuss their experience of cancer treatment at UH Bristol during 2014.

There were a number of critical factors which emerged as important for patients. The themes we will explore through the words of Paula and Bernard are vital to patients and in some cases, when they go wrong, can 'colour' the whole experience. These are:

- Speed/ease of diagnosis
- How the news that you have cancer is broken to you
- Quality of support and care overall, including the pivotal role of the Clinical Nurse Specialist
- Coordination and planning of care and how well and quickly it is executed
- Clinical care
- The role of the GP
- After-care advice and support

Through these two patients we will also highlight the difference it makes to patients when care is shared with other hospitals. Their experience, particularly when involving another hospital outside Bristol, tends to be less good in terms of support, coordination and sheer inconvenience.

Summary - Key learning

The key learning from patients was:

- For many people their diagnosis was quickly achieved; however some patients had a tortuous time, often involving several different health providers.
- People like the news that they have cancer to be delivered in a clear, straight-forward but hopeful way. A few people did not receive the news this way – they felt badly when it was unclear, pessimistic or lacking in empathy.
- There was mostly a resoundingly positive description of the kindness and dedication of staff. However one-off harsh words or lack of sensitivity reverberate at such a vulnerable time. People talked of the support they felt by referring to a 'cancer club'. This seemed often to be built up in the chemotherapy department which was widely praised.
- The role of the clinical nurse specialist (CNS) was described as vital both for support and for smoothing and ensuring the process– *'the glue in the system'*. Where no UH Bristol CNS was involved the experience was notably less good.
- Many patients described smooth planning and organisation; however for others there were significant problems. Patients know that time is important in cancer care and so any delays are worrying. The inconvenience of delayed or cancelled appointments and treatments are all the more problematic when long distances have been travelled.
- There was widespread appreciation of clinical expertise. There was a strong desire for continuity of clinical consultant.
- Information was mostly considered sufficient; a timely balance of verbal and written information is needed, which takes account of very varying levels of requirement for quantity and detail.
- The role of the GP varied enormously. Ongoing GP involvement seemed to improve the quality of patients' experience.
- Many people wanted more support and advice after the end of their main treatment.

Recommendations

The recommendations from this work are outlined in the cover report paper. Through the creation of Paula and Bernard's stories we hope to do justice to the experiences described to us by patients who have experienced cancer care at UH Bristol.

Gloria Clark
Patients Association

The Patients Association
listening to patients
speaking up for change

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

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

Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose To review the Trust's performance on Quality, Workforce and Access standards.
Recommendations
The Board is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
Links to achievement of the standards in Monitor's Risk Assessment Framework.
Impact Upon Corporate Risk
As detailed in the individual exception reports.
Implications (Regulatory/Legal)
Links to achievement of the standards in Monitor's Risk Assessment Framework.
Equality & Patient Impact
As detailed in the individual exception reports.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
28/8/15 28/09/15					

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

September 2015

Executive Summary

System pressures have resurfaced this month and impacted on many of the headline indicators reported here. However, progress continues to be made in some of the most challenged areas of the Trust's performance. These include a further reduction in the total number of patients waiting over 18 weeks from Referral to Treatment (RTT) and a significant reduction in the number of last-minute cancelled operations. Further successes for the month are detailed on the Over-view page of this report, alongside the priorities, risks and threats for the coming months. The ongoing pressure from heightened levels of demand, however, will continue to constrain the speed of recovery without plans being re-set and further mitigating actions being taken. Such a re-set has taken place for the achievement of the RTT Ongoing pathways standard, for which the Quality & Outcomes Committee and Trust Board have received a separate briefing.

The discharge of patients out of the BRI continues to be slow, with circa 70 medically fit patients awaiting discharge at any point in time. Relative to the levels of delayed discharges seen at the start of 2015/16, this represents one and a half additional wards' worth of patients occupying BRI beds. Bed occupancy has increased since April, for this reason, which has resulted in an increase in patients waiting longer than 4 hours in the Emergency Department, and the 95% national standard being narrowly missed in the period.

The increase in delayed discharges is primarily a result of the recommissioning of domiciliary care packages, with the new providers still to come up to full capacity and the acute shortage of social workers. This was previously flagged as a risk to 4-hour achievement to the Trust Board and Monitor. The increased pressure on ward bed availability has resulted in a worsening of performance against a number of the Trust's Quality Objectives over the last two months. These include the days patients spend outlying from their correct specialty ward, the average number of ward stays (I.e. ward moves) per patient, and out of hour discharges. Despite a reduction in available ward beds, encouraging progress has been made in reducing the number of operations cancelled at last minute for non clinical reasons, which in August was at the lowest level reported since September 2011. This is in part due to the acuity of patients being admitted reducing, as can also be seen through one of our assurance metrics, which shows a reduction in patients aged 75 years and over being admitted in the period relative to that seen in previous summers. However, improvements have also been realised through actions being taken to improve staffing levels in the units, with a further focus on recruitment and retention efforts. In time, this will also help to ensure more beds can be kept open when patient acuity rises again.

Despite these system pressures, performance against many of the quality metrics continues to be strong, especially in terms of patient safety and experience, and provides good assurance of the quality of the services the Trust is delivering. These includes patient falls with harm, for which no falls with harm were reported in the period, and for the first time, green ratings across all three dementia key performance indicators.

System pressures continue to provide context to the current workforce challenges, especially bank and agency spend. There remains a strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand ahead of the seasonal winter peaks. We also continue to work in partnership with other organisations within the community to mitigate these system risks, and improve the responsiveness of the Trust's services.

Performance Overview

External views of the Trust

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

Care Quality Commission

Intelligence Monitoring Report

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

Band 6 represents the lowest risk band.

Overall risk score = 5 points (2.69%) – **band 5** (not published as recently inspected) – **as reported last month**

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

Current scoring

Risks

Safe:	Never Event Incidence
Effective:	SSNAP Domain (Stroke) team-centred rating score
Responsive:	Referral to Treatment Time (composite indicator) Ratio of days delayed in transfer from hospital to total occupied beds (delayed discharges)
Well-led:	Monitor Governance Risk Rating(see next page)

Elevated risks:

None

NHS Choices

Website

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

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

Stars – maximum 5
OK = Within expected range
✓ = Among the best
! = Among the worst
Please refer to appendix 1 for our site abbreviations.
Please note – there have been no changes in ratings since last month's report

Monitor's Risk Assessment Framework

At the end of August the Trust was achieving all except three of the standards in Monitor's 2015/16 Risk Assessment Framework, as shown in the table below. Overall this gives the Trust a Service Performance Score of 2.0[1] against Monitor's Risk Assessment Framework. Monitor restored the Trust to a GREEN risk rating last quarter, following its review of actions being taken to recover performance against the RTT, Cancer 62-day GP and A&E 4-hour standards and an acceptance of the factors continuing to affect Trust performance, which are outside of its control.

Monitor's Risk Assessment Framework - dashboard

Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework: Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16*	Q2 15/16*	Q2 Forecast	Notes	Q2 Current Risk Assessment Risk rating
1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	3	✓	✓	✓	✓	TBC**	✓	Limit 21 avoidable for end Q2	Achieved
2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.3%	✓	✓	✓	✓	98.6%	✓		Achieved
2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	94.5%	✓	✓	✓	✓	94.4%	✓		
2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	96.6%	✓	✓	✓	✓	97.2%	✓		
3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	79.0%	✗	✗	✗	✗	81.5%	✗	Most of the 62-day screening standard breaches outside of the control of the Trust.	Not achieved
3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	78.0%	✓	✗	✗	✗	73.9%	✗		
4	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	90.4%	Not achieved	Not achieved	Not achieved	Not achieved	90.5%	✗		Not achieved (see notes)
5	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	96.9%	✓	✓	✓	✓	96.4%	✓		Achieved
6a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	95.5%	✓	✓	✓	✓	96.4%	✓		Achieved
6b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
7	A&E Total time in A&E 4 hours	1.0	95%	94.8%	✗	✗	✗	✗	95.2%	✓	At risk, but can still be achieved for the quarter as a whole.	Achieved
8	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
	CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
				Risk Rating	Triggers further investigation	Triggers further investigation	GREEN	To be confirmed	To be confirmed	Triggers further investigation		2.0 To be confirmed (see narrative)

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

***Q2 Cancer figures based upon confirmed figures for July and draft for August.**
**** C. diff cases from July still subject to commissioner review, but well within limit**

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

Summary Scorecard

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

Key changes in indicators in the period:

RED to AMBER:
- Diagnostic waits

AMBER to GREEN:
- Cancelled operations
- Mortality

GREEN to RED:
- Infection Control
- Never Events
- Safety Thermometer
- Outliers

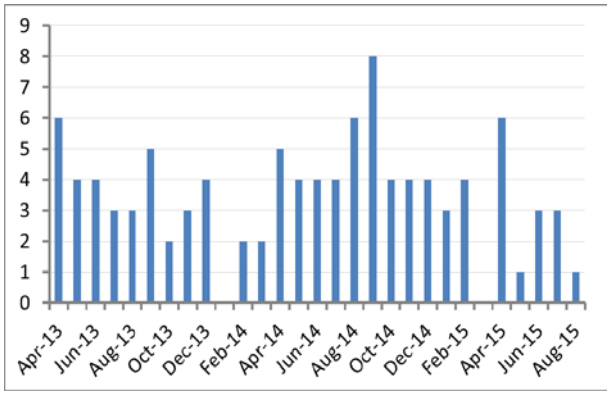
GREEN to AMBER:
- A&E 4-hours

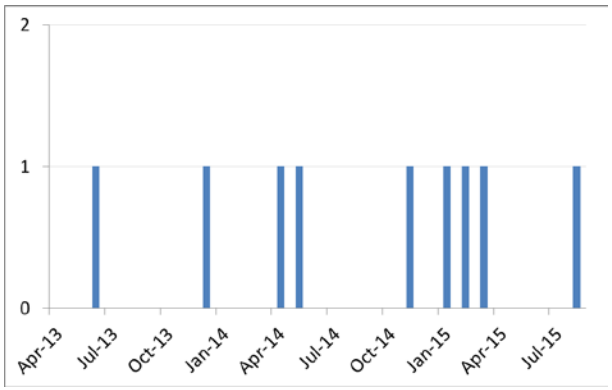
Please note: The RAG rating for Sickness Absence was revised to RED for July (the same as August's rating)

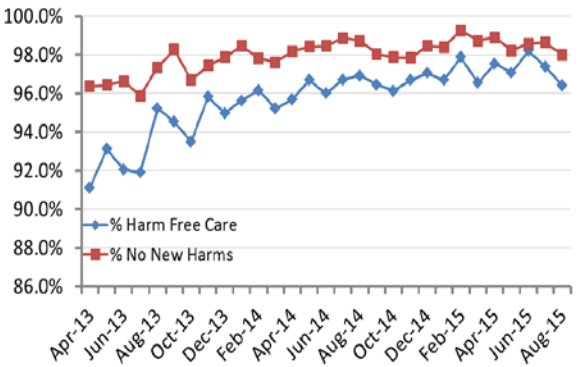
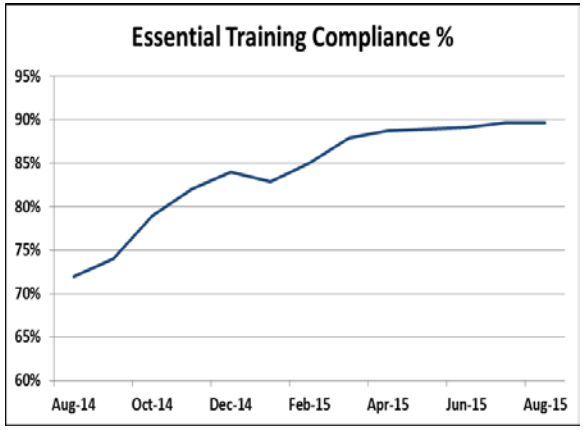
Overview

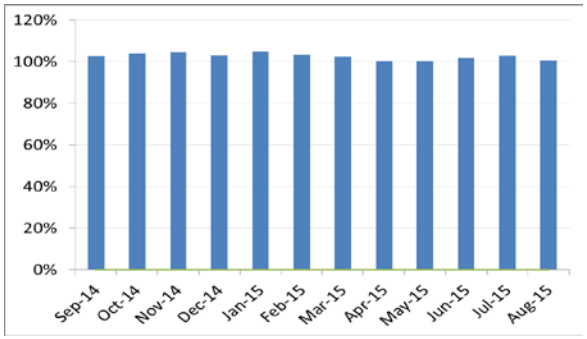
The following summarises the key successes in August 2015, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 2 2015/16

Successes	Priorities
• Four Staff Experience workshops have taken place, with more planned. Key themes on improving staff experience will be taken to Senior Leadership Team in October; • No patient falls which resulted in moderate or severe harm occurred in August; • 100% of patients who were at high risk of Transient Ischaemic Attack started treatment within 24 hours; • Reduction in last-minute cancelled operations for non-clinical reasons to 0.46% (25 patients) in August; • Improvement in all three dementia metrics, including 100% of patients with dementia being referred for follow up care.	• Increasing outpatient and elective activity to deliver revised trajectories for the reductions in numbers of patients waiting over 18 weeks RTT; • Implementing ideal timescale pathways for high volume cancer tumour sites, during the remainder of quarter 2 and quarter 3; • Improving staff experience and staff retention; • Sustaining recruitment effort through national recruitment campaigns for nursing and theatres staff; • Reducing sickness absence; • Improving the response rate for Friends and Family Test for inpatients and the emergency department; • Improve performance in quality objectives relating to flow and notably discharge and right bed.
Opportunities	**Risks & Threats**
• Additional investment, as a Spend to Save scheme, has been agreed to support staff development, provided it will have a direct and demonstrable impact on reducing staff turnover during 2015/16; • Never events: to review subcontracting arrangements with private providers.	• Increase in demand for the Trust's services, in excess of the capacity being delivered to treat patients within national access times (RTT and cancer); • Continuing high levels of Green To Go patients represent an ongoing threat to achievement of the quality objectives and A&E 4-hour standard, not least as no immediate resolution is in sight; • Risk of not achieving target annual reduction in staff turnover, agreed during Operating Planning Process; • Two grade 3 pressure ulcers reported in August (and one in each of previous two months). New risk added to Trust wide risk register to support sustained focus on mitigating actions. Risk score 9.

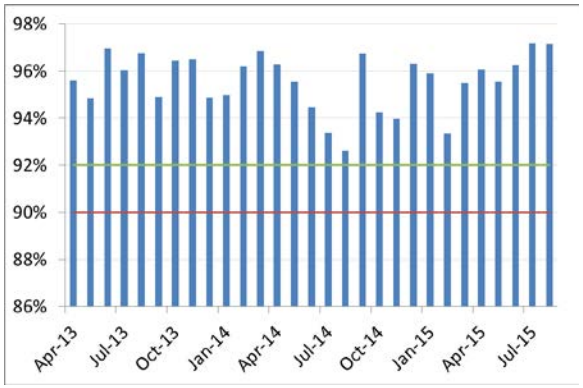
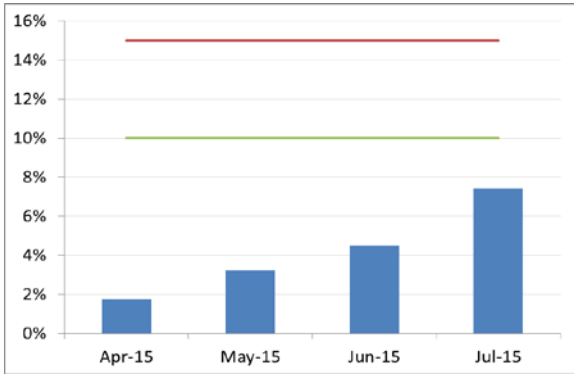
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Infection control
The number of hospital-apportioned cases of Clostridium difficile infections and the number of MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias.
The Trust limit for 2015/16 is 45 avoidable cases of clostridium difficile and zero cases of MRSA.</td>
<td>One case of clostridium difficile (C. diff) was reported in August and has been assessed as unavoidable by the Trust. However, this still needs to be agreed with the Clinical Commissioning Group (CCG).
<table>
<tr><th></th><th>C. diff</th><th>MRSA</th></tr>
<tr><td>Medicine</td><td>1</td><td>0</td></tr>
<tr><td>Surgery</td><td>0</td><td>0</td></tr>
<tr><td>Specialised Services</td><td>0</td><td>1</td></tr>
<tr><td>Women’s & Children’s</td><td>0</td><td>0</td></tr>
</table>
One MRSA bacteraemia occurred in a patient who had a pacemaker fitted 10 days earlier and had been discharged. It has yet to be decided if this was hospital or community acquired, but has been included in our numbers.</td>
<td>Total number of C. diff cases per month
 

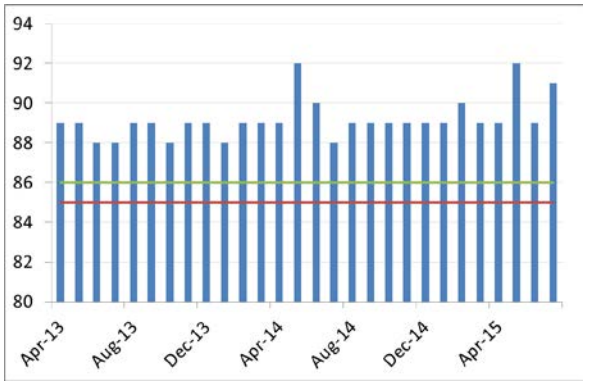
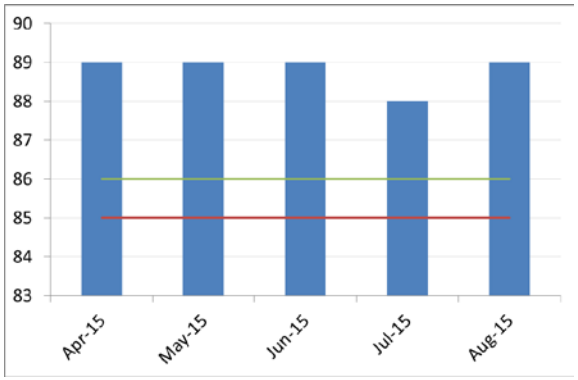
A total of 14 cases (unavoidable + avoidable) have been reported in the year to date (April to August). The limit for avoidable cases for the end of Quarter 2 (September) is 23.</td>
<td>The multidisciplinary Post Infection Review meeting for the case of MRSA which occurred at the end of August is yet to be held. This meeting will identify any learning and preventative actions to be in place if required. (Action 1).</td>
</tr>
<tr>
<td>Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. There are currently 14 different categories of Never Events listed by NHS England.</td>
<td>There was one Never Events reported in August 2015, as mentioned in last month’s Board report.
This involved a consultant from another Trust working in private capacity at a private provider who removed a wrong mole from one of our dermatology patients, adjacent to the intended mole.
This has been attributed to our Trust because it was our patient being treated under a sub-contracting arrangement.</td>
<td>Number of never events per month
 
</td>
<td>This incident remains under investigation the outcome of which will be reported to the Quality & Outcomes Committee in due course. Meanwhile, a review of sub-contracting arrangements is underway.</td>
</tr>
</table>

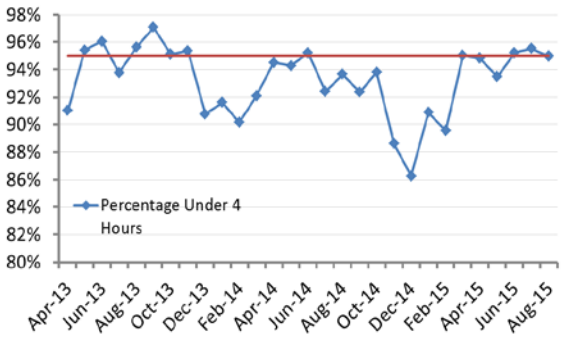
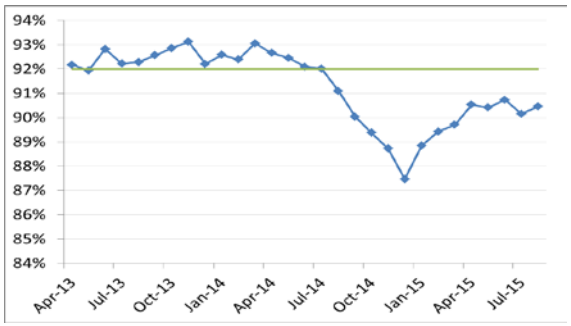
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In August, the percentage of patients with no new harms was 98.0%, against an upper quartile target of 98.26% (GREEN threshold) of the NHS England Patient Safety peer group of trusts. This is a slight reduction compared with July's performance. The main increase in new harms is in catheter associated urinary tract infections, which increased from 3 in July to 8 in August out of 752 patients audited. **Catheter associated urinary tract infections** Medicine: 5 Surgery: 1 Specialised Services: 2 Women's & Children's: 0	**The percentage of patients surveyed showing No New Harm each month** 	The Safety Thermometer national audit tool is designed to measure the burden of harm on patients. It is a point prevalence audit and not a measure of incidence. The definition of catheter associated urinary tract infections requires inclusion of the number of patients with urinary catheters and new urinary tract infections, although it is recognised that presence of both does not necessarily mean cause and effect. (Action 2).
Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%.	Compliance at the end of August was 89.7% against the 90% threshold for core Essential Training. Three Divisions achieved the 90% target this month. **August 2015** / **Compliance Rate** **UH Bristol: 89.7%** Diagnostics & Therapies: 89.6% Medicine: 89.1% Specialised Services: 91.6% Surgery Head & Neck: 89.5% Women's & Children's: 87.5% Trust Services: 92.1% Facilities And Estates: 95.2%	**The percentage of core Essential Training completed by month** 	Compliance exceeded 89% for the third consecutive month. There has been continued improvement in Safeguarding Adults/Children with 90% being achieved for adult safeguarding level 1 and child protection level 1. Resuscitation and other safeguarding levels continue to be below target, but have detailed plans in place to achieve 90% (Actions 3A and 3B).

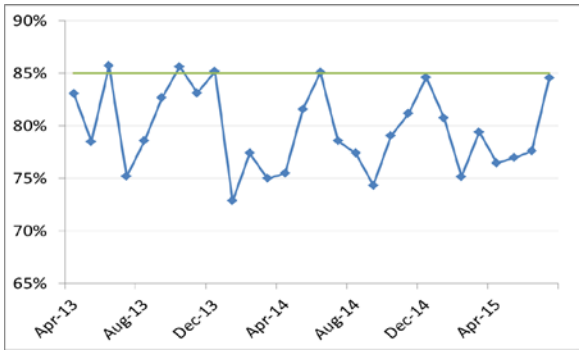
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in August the Trust had rostered 212,936 expected nursing hours, with the number of actual hours worked of 213,941. This gave an overall fill rate of 100.5%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Differen</th></tr>
<tr><td>Medicine</td><td>66,494</td><td>62,637</td><td>3857</td></tr>
<tr><td>Specialised Services</td><td>37,573*</td><td>39,877</td><td>-2304</td></tr>
<tr><td>Surgery Head & Neck</td><td>45,257</td><td>42,453</td><td>2804</td></tr>
<tr><td>Women’s & Children’s</td><td>64,618**</td><td>67, 968</td><td>-3351</td></tr>
<tr><td>Trust - overall</td><td>213,941</td><td>212,936</td><td>1005</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month
 

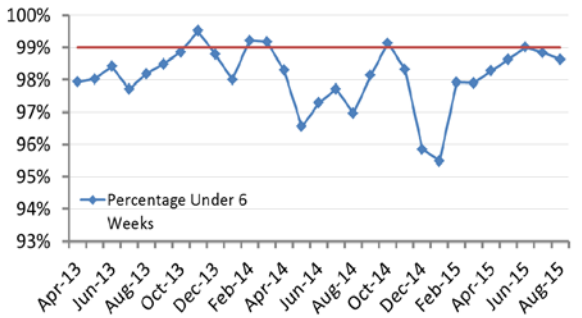
*There was a reduction on overall acuity in Cardiac Intensive Care Unit requiring less Registered Nurses
** There was a technical issue in recording all shifts in maternity services due to the flexible management of staffing not being captured on the electronic roster system. This will be resolved for the September return.</td>
<td>There was an overall deficit of hours within Specialised Services and Women’s & Children’s Divisions. This was due to vacancies in some wards particularly in the Children’s Hospital and St. Michael’s Hospital. Beds were closed on some wards in the Children’s Hospital to help manage this. In other areas, lower patient acuity and activity levels reduced the requirement for registered nurses and enabled wards to be flexibly staffed. Robust plans are in place to mitigate the current shortfall (Action 4A and 4B). Further details can be found in the separate monthly report.</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Friends & Family Test inpatient score is a measure of how many patients said they were ‘very likely’ to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.</td>
<td>Performance for August 2015 was 97.2%. This metric combines Friends and Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services. A breakdown of the scores by site shown below*:
<table>
<tr><th>Site</th><th>Inpatient FFT score</th></tr>
<tr><td>Bristol Children’s Hospital</td><td>98%</td></tr>
<tr><td>Bristol Dental Hospital</td><td>100%</td></tr>
<tr><td>Bristol Eye Hospital**</td><td>67%</td></tr>
<tr><td>Bristol Haem. & Oncology Centre</td><td>100%</td></tr>
<tr><td>Bristol Royal Infirmary</td><td>96%</td></tr>
<tr><td>South Bristol Community Hospital</td><td>100%</td></tr>
<tr><td>St Michael’s Hospital</td><td>98%</td></tr>
<tr><td>Bristol Dental Hospital</td><td>100%</td></tr>
</table>
*Final mapping of day-case responses to divisions underway. **Based on 3 responses.</td>
<td>Inpatient Friends & Family scores each month
 
</td>
<td>The scores for UH Bristol are in line with national norms, and a very high proportion of the Trust’s patients would recommend the care that they received to their friends and family. These results are shared with ward staff and are displayed publically on the wards.</td>
</tr>
<tr>
<td>Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.</td>
<td>For the month of July 2015, performance was 7.4%. The first milestone is to achieve 10% in the first six months of 2015/16.
In July, we sent out 54 responses to complaints. By the 11th September we had received 4 responses back from complainants indicating they were dissatisfied with the Trust’s response = 7.4%.</td>
<td>Percentage of compliantaints dissatisfied with the complaint response each month
 
</td>
<td>Improving the quality of written complaint responses is one of our quality objectives for 2015/16.
Actions being taken to achieve this are described in the improvement plan section of this report (Actions 5A to 5C).</td>
</tr>
</table>

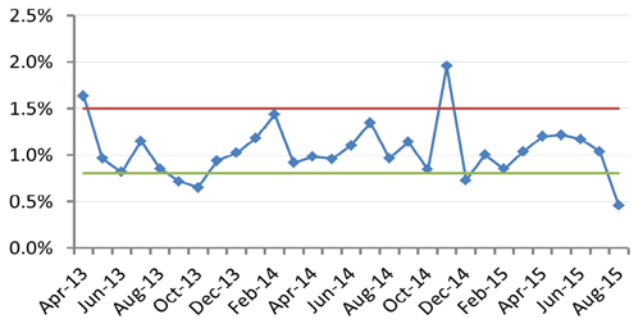
Description	Current Performance	Trend	Comments
Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via analysis and focus groups.	For the month of July 2015, the score was 91 out of a possible score of 100. Divisional scores are broken down at the end of each quarter as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.	**Inpatient patient experience scores (maximum score 100) each month** 	The Trust's performance is in line with national norms in terms of patient-reported experience. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.
Outpatient experience tracker comprises four scores from the Trust's monthly survey of outpatients (or parents of 0-11 year olds): 1) Cleanliness 2) Being seen within 15 minutes of appointment time 3) Being treated with respect and dignity 4) Receiving understandable answers to questions.	This metric is derived from a new survey that the Trust introduced in April 2015. For the month of August 2015, the score was 89 out of a possible score of 100. Please note that there is a relatively rapid turnaround time on this metric compared to the inpatient tracker, as the survey sample is taken from a single day near the start of the month and only one mail-out is sent (the inpatient survey covers the whole month and also features a reminder letter to non-responders). This means that the outpatient tracker is one month "ahead" of the inpatient data. Given the relatively small sample sizes for this survey, a rolling three-month score is provided.	**Outpatient Experience Scores (maximum score 100) each month** 	This metric is derived from a new survey and would turn red if patient experience at the Trust began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the Trust score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.

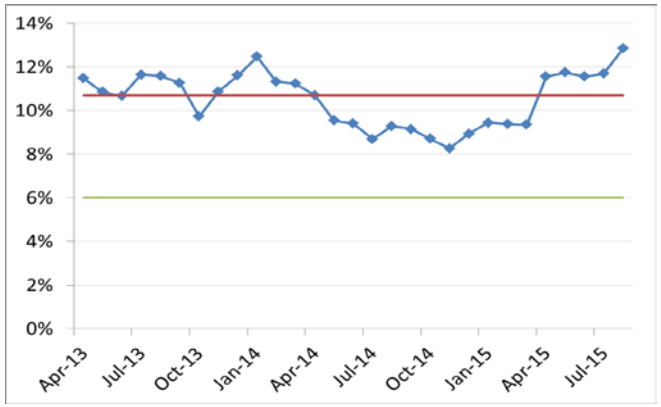
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was narrowly missed in August, with performance for the Trust as a whole reported at 94.95%. Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Aug 2014</th><th>Jul 2015</th><th>Aug 2015</th></tr>
<tr><td>Attendances</td><td>5461</td><td>5645</td><td>5529</td></tr>
<tr><td>Emergency Admissions</td><td>1880</td><td>1789</td><td>1702</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4885
89.5%</td><td>5294
93.8%</td><td>5166
93.4%</td></tr>
<tr><th>BCH</th><th>Aug 2014</th><th>Jul 2015</th><th>Aug 2015</th></tr>
<tr><td>Attendances</td><td>2249</td><td>2917</td><td>2547</td></tr>
<tr><td>Emergency Admissions</td><td>554</td><td>731</td><td>718</td></tr>
<tr><td>Patients managed < 4 hours</td><td>2229
99.1%</td><td>2801
96.0%</td><td>2419
95.0%</td></tr>
</table>
</td>
<td>Performance against the A&E 4-hour standard
 
</td>
<td>Although August's performance was just below 95%, performance for the quarter to date was above 95%. Levels of emergency admissions into the Bristol Children's Hospital (BCH) were significantly above the levels seen during the same period last year (Action 6A). Recovery of performance continues to be supported by the community-wide resilience plan and internal transformation efforts focusing on Bristol Royal Infirmary and BCH patient flow (Actions 6B and 6C).</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) is a measure of the length of wait from referral through to treatment. The target is for at least 92% of patients, who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), to be waiting less than 18 weeks at month-end.</td>
<td>Although the backlog reduction trajectory was not achieved at the end of August, the total number of patients waiting over 18 weeks was lower than at the end of July (see Appendix 3). The admitted backlog is now the lowest it has been since January 2014.
There was a decrease in the number of patients waiting over 40 weeks RTT at month-end against trajectory (in brackets). No 52-week waiters were reported.
<table>
<tr><th></th><th>Jun</th><th>Jul</th><th>Aug</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>38
(72)</td><td>45
(35)</td><td>38
(15)</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>0
(0)</td><td>0
(0)</td><td>0
(0)</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 
</td>
<td>The main reasons for the variance from the recovery trajectory are 1) higher levels of outpatient referrals than assumed in the capacity models/plans, and 2) delays in appointments to clinical posts. Specialities not achieving their backlog reduction trajectories have now produced a revised capacity plan and associated trajectory forecast. The proposed revised trajectories are provided in a separate briefing (Action 7A and 7B).</td>
</tr>
</table>

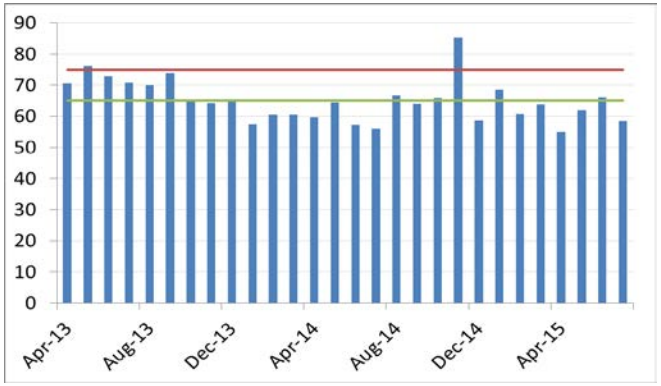
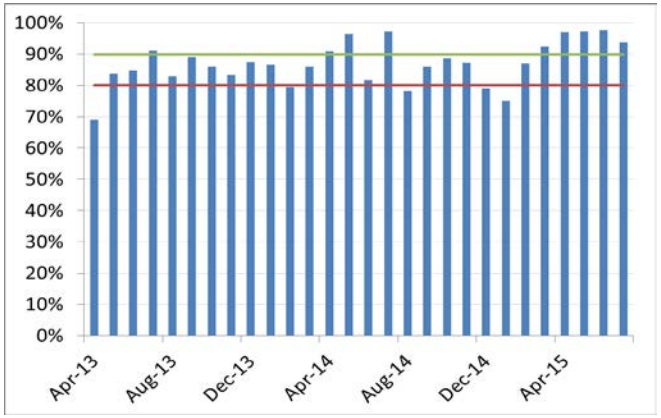
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.</td>
<td>Performance against the 85% 62-day GP standard was 84.6% in July. Performance against the 90% 62-day screening standard was 76.9%. The main reasons for failure to achieve the 85% national 62-day GP standard were as shown below, with late referral from other providers remaining the highest single cause of breaches
<table>
<tr><th>Breach reason</th><th>July</th></tr>
<tr><td>Late referral by other provider</td><td>7.5</td></tr>
<tr><td>Medical deferral/clinical complexity</td><td>2.5</td></tr>
<tr><td>Insufficient surgical capacity</td><td>2.0</td></tr>
<tr><td>Delayed outpatient appointment</td><td>2.0</td></tr>
<tr><td>Other (no significant themes)</td><td>1.5</td></tr>
<tr><td>TOTAL</td><td>15.5</td></tr>
</table>
</td>
<td>Percentage of patients treated within 62 days of GP referral
 

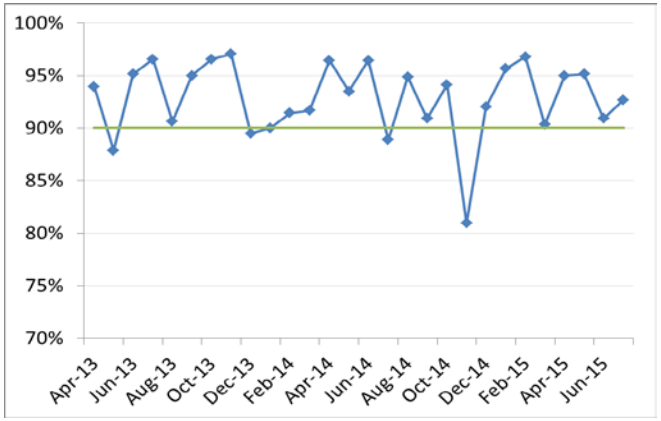
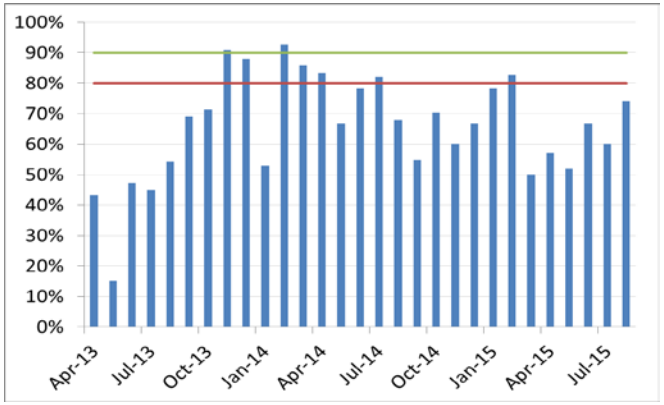
The 1.5 x 62-day screening pathway breaches in the period were due to patient choice and late referral to the Trust, and therefore continued to be outside of the control of the Trust.</td>
<td>Internal priorities for improving the Trust’s performance against the 62-day GP cancer standard continue to be the implementation of implementation of ideal timescale pathways, and a 7-day wait for the first step in the pathway (Action 8). External support has been sought for agreeing milestones for timely referral with other providers. The above areas of focus are part of wide ranging action plan, to be submitted to NHS England at the end of August.</td>
</tr>
<tr>
<td>Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.</td>
<td>The 99% national standard wasn’t achieved at the end of August, although performance was 1.6% above the forecast position of 97% (and for this reason the indicator is rated AMBER). The number and percentage of over 6-week waiters at month-end, is shown in the table below:
<table>
<tr><th>Diagnostic test</th><th>Jun</th><th>Jul</th><th>Aug</th></tr>
<tr><td>MRI</td><td>0</td><td>1</td><td>15</td></tr>
<tr><td>Echo</td><td>34</td><td>51</td><td>38</td></tr>
<tr><td>Ultrasound</td><td>0</td><td>8</td><td>1</td></tr>
<tr><td>Endoscopies</td><td>26</td><td>21</td><td>33</td></tr>
<tr><td>Other</td><td>10</td><td>2</td><td>3</td></tr>
<tr><td>TOTAL</td><td>70</td><td>83</td><td>90</td></tr>
<tr><td>Percentage</td><td>99.0%</td><td>98.8%</td><td>98.6%</td></tr>
<tr><td>Trajectory</td><td>99.0%</td><td>99.0%</td><td>97.0%</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 6 weeks at month-end
 

Forecast performance for September = 99.0% (i.e. a return to achievement of the standard).</td>
<td>Work continues to reduce the number of patients waiting over 6 weeks for a stress echo following departures within the team. There was a forecast rise in the number of patients waiting over 6 weeks for a routine adult gastro-intestinal (GI) endoscopy due to a short-term loss of capacity. The number of routine over 6 week waiters for paediatric GI endoscopies remains above plan, with actions in progress to eliminate the backlog by the end of December (Action 9).</td>
</tr>
</table>

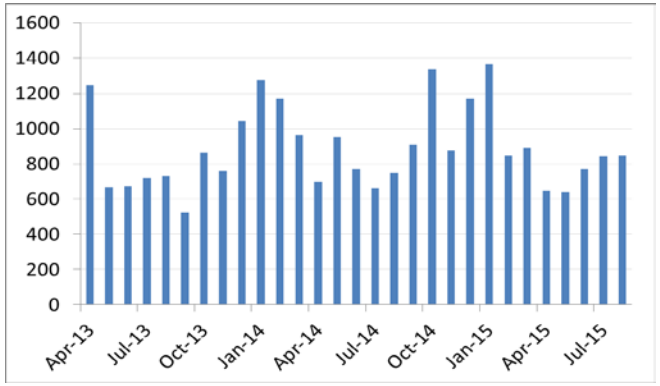
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In August, the Trust cancelled 0.46% of operations at last-minute for non-clinical reasons, meeting both the quality target and the national 0.8% standard. There were 25 last minute cancellations, the reasons for which are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number/ percentage</th></tr>
<tr><td>Emergency patient prioritised</td><td>7 (28%)</td></tr>
<tr><td>Ran out of time</td><td>7 (28%)</td></tr>
<tr><td>Other causes (no themes)</td><td>11 (13%)</td></tr>
</table>
</td>
<td>Percentage of operations cancelled at last-minute
 

93.5% of patients cancelled in July were readmitted in August, within the required 28 days. Four patients were not readmitted within 28 days. Three of the four patients failed to be readmitted within 28 days due to more urgent patients taking priority.</td>
<td>There was a significant reduction in the level of last-minute cancellations between July and August. This has been attributed to a reduction in the number of cancellations due to a lack of an ITU or HDU bed, and also ward-bed related cancellations. The improvement in access to ITU and HDU beds is in part due to a drop in acuity, along with actions being taken to improve staffing levels, and as a consequence, reduce excessive agency spend (Actions 10A and 10B).</td>
</tr>
<tr>
<td>Outpatient appointments cancelled is a measure of the percentage of outpatient appointments that were cancelled by the hospital. This includes appointments cancelled to be brought forward, to enable us to see the patient more quickly.</td>
<td>In August 12.8% of outpatient appointments were cancelled by the hospital. This is above the levels reported in June and July.
The higher level of hospital cancellation of outpatient appointments continues to be due to a high proportion of patients' appointments being brought forward when booked too far ahead. This is due to capacity being put-on after patients have booked their appointments via eReferrals.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Whilst it's positive for patients to be offered earlier appointments, if the right capacity is established in the first place, patient's appointments do not need to be moved, both reducing administrative workload and improving patient experience. Ensuring outpatient capacity is effectively managed is a core part of the work to improve the efficiency of the Trust's outpatient services as being overseen by the Outpatients Steering Group (Action 11).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator (in hospital deaths) is the ratio of the actual number of patients who died in hospital and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other factors.	Summary Hospital Mortality Indicator for July 2015 was 58.5 against an internally set target of 65.	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	This is a high level indicator of the effectiveness of the care and treatment we provide.
Stroke care. This indicator is a measure of what percentage of a stroke patient's stay was spent on a designated stroke unit. The target is for 90% of patients to spend at least 90% of their stay in hospital on a stroke unit, so that they receive the most appropriate care for their condition	Performance in July 2015 was 93.8% (latest data) against a target of 90%. There were 32 patients discharged in July, of which 30 had spent at least 90% of their stay on the stroke unit.	**The percentage of stroke patients spending 90% of their stay on a stroke unit by month** 	The two patients who did not spend 90% of their time on a stroke unit were admitted to other wards because their presenting symptoms were more suggestive of alternative diagnoses. Subsequent diagnostic investigations identified a stroke.

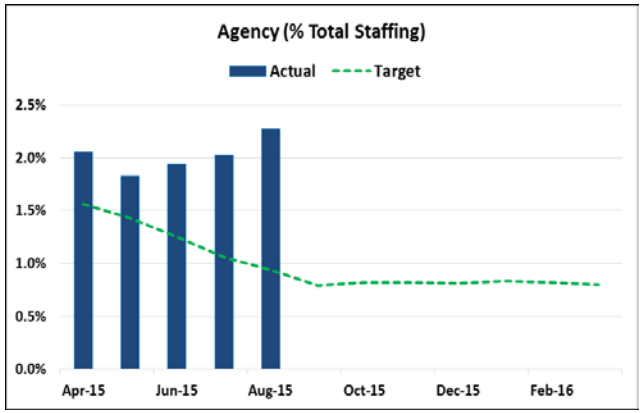
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Door to balloon times measures the percentage of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Heart Institute.</td>
<td>In July (latest data), 38 out of 41 patients (92.7%) were treated within 90 minutes of arrival in the hospital, meeting the 90% standard.</td>
<td>Percentage of patients with a Door to Balloon Time < 90 minutes by month
 
</td>
<td>Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. The 90% standard continues to be met for the year as a whole.</td>
</tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In August we achieved 70.4% overall performance in Best Practice Tariff. There were 27 patients eligible for Best Practice Tariff in the period, 8 of which did not meet all eight standards. Five patients were not operated on within 36 hours. Four patients (including one also not meeting the time to theatre standard) were not reviewed by an Ortho-geriatrician within 72 hours due to sickness and planned leave.
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number</th></tr>
<tr><td>Not well enough for theatre</td><td>1</td></tr>
<tr><td>Lack of theatre capacity</td><td>2</td></tr>
<tr><td>Required specialist operator</td><td>1</td></tr>
<tr><td>Theatre staff sickness</td><td>1</td></tr>
</table></td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>Of the two patients who breached due to theatre capacity, one was delayed to a previous complex patient taking longer than anticipated and the delayed patient subsequently became too unwell for theatre and required further clinical optimisation.

Actions, in addition to those previously reported, are shown in the improvement plan and focus on two key areas: 1) improving access to theatres and 2) reducing delays to Ortho-geriatrician review (Actions 12A and 12B).</td>
</tr>
</table>

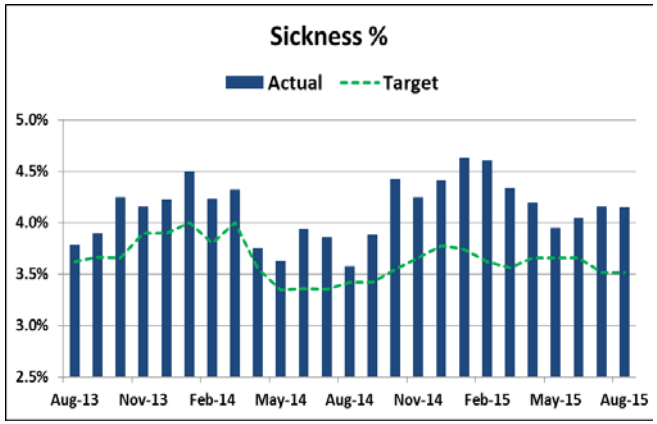
Description	Current Performance	Trend	Comments
Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.	In August there were 845 outlier bed-days against a Quarter 2 (Q2) monthly target of 562. **Outlier bed-days** / **August 2015** Division of Medicine: 279 Division of Surgery, Head & Neck: 480 Division of Specialised Services: 56 Women's & Children's Division: 30 Total: 845	**Number of days patients spent outlying from their specialty wards** 	The reduction in the number of medical outliers has been sustained. Although, the number of outliers in the Division of Surgery, Head & Neck has decreased by 20 since July, it remains above the divisional target of 152 a month for Q2, which is a reflection of pressures on the surgical bed base and a number of delayed patients awaiting discharge. Actions being taken to improve performance in Surgery Head and Neck are described in the actions section of this report (Actions 13A and 13B)

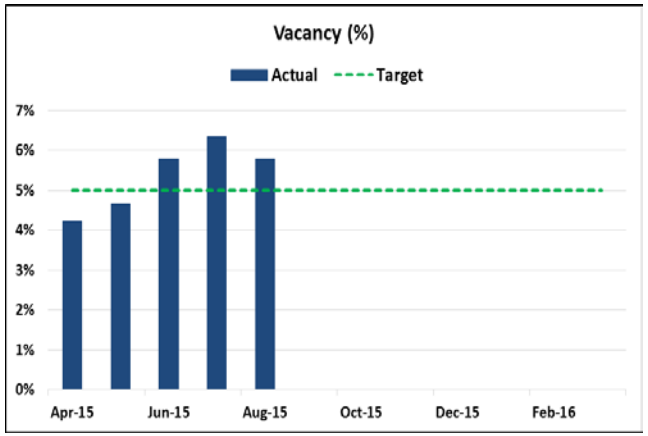
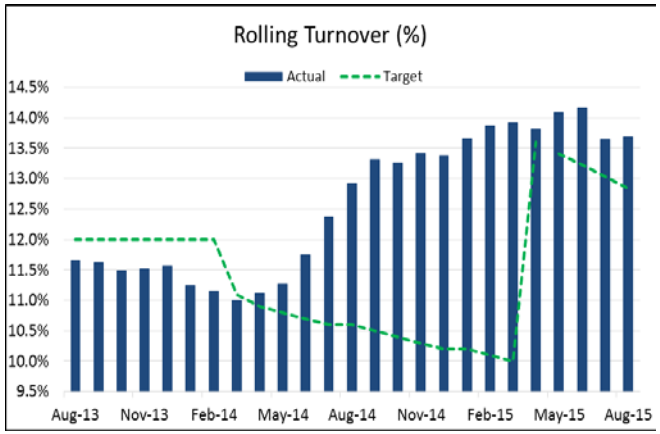
Description	Current Performance	Trend	Comments
Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.	Agency usage increased by 21.7 FTE. The largest increase (6.3 FTE) was in agency to cover enhanced observation/increased acuity and dependency, although there were small increases due to vacancies/sickness absence.	**Agency usage as a percentage of total staffing by month**	The agency action plans continue to be implemented and the headlines are in the improvement plan (Action 14).
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.	Current Trust-wide performance remains unchanged from last month. There were reductions in Facilities & Estates and Medicine and slight increases in Surgery, Head & Neck and Trust Services.	**Sickness absence as a as a percentage of full time equivalents by month**	There has not been the usual August dip in sickness absence due largely to an increase (38%) in days lost to colds and flu. There was also an 18% increase in back/musculo skeletal absence, and a 7% increase in stress related absence. The Senior Leadership Team (SLT) endorsed the recommendations made by Workforce and Organisational Development Group (Action 15).

August 2015	FTE	%	KPI
UH Bristol	**185.2**	**2.3%**	**0.9%**
Diagnostics & Therapies	12.3	1.3%	0.7%
Medicine	43.9	3.5%	1.2%
Specialised Services	22.8	2.7%	2.0%
Surgery, Head & Neck	39.4	2.2%	0.8%
Women's & Children's	33.2	1.8%	0.5%
Trust Services	16.1	2.4%	0.7%
Facilities & Estates	17.6	2.3%	1.0%



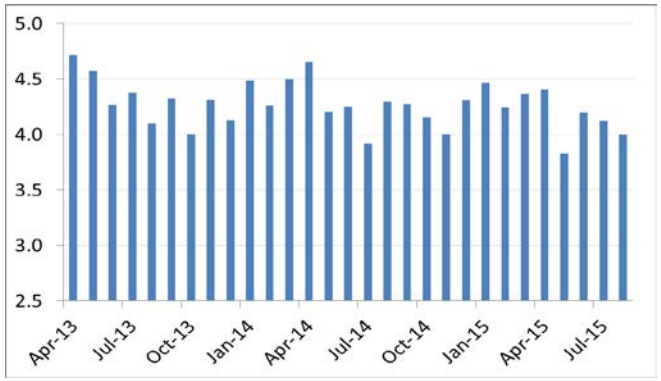
August 2015	Actual	KPI
UH Bristol	**4.2%**	**3.5%**
Diagnostics & Therapies	3.0%	2.8%
Medicine	5.3%	4.1%
Specialised Services	3.9%	3.7%
Surgery, Head & Neck	4.5%	3.4%
Women's & Children's	3.6%	3.4%
Trust Services	3.6%	2.4%
Facilities & Estates	5.2%	5.0%



Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Vacancies reduced from 6.3% (507.9 FTE) to 5.8% (465.1 FTE) against a target of 5%. Registered nursing vacancies increased by 21.4 FTE, across Specialised Services, Surgery Head & Neck and Women`s & Children`s. Hot spots include Theatres, paediatric ICU, adult trauma and orthopaedics, oncology and haematology.	**Vacancies rate by month** 	Ongoing recruitment plans are described in the improvement plan (Action 16).
Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 11.5% by the end of 2015/16. The red threshold is 10% above monthly trajectory**.**	Trust-wide, turnover is unchanged at 13.7%, and registered nurse turnover remains at 13.3%. Turnover has reduced slightly in bed-holding Divisions, but increased in Diagnostic & Therapies and Facilities & Estates.	**Staff turnover rate by month** 	Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 17).

August 2015	Rate
UH Bristol	**5.8%**
Diagnostics & Therapies	4.6%
Medicine	6.9%
Specialised Services	7.2%
Surgery, Head & Neck	4.3%
Women's & Children's	5.2%
Trust Services	5.4%
Facilities & Estates	9.4%

August 2015	Actual	Target
UH Bristol	**13.7%**	**12.8%**
Diagnostics & Therap.	12.4%	11.3%
Medicine	12.3%	13.2%
Specialised Services	16.7%	14.9%
Surgery, Head & Neck	14.5%	14.0%
Women's & Children's	12.3%	11.1%
Trust Services	15.4%	13.2%
Facilities & Estates	14.1%	13.4%

Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In August the average length of stay for inpatients was 4.00 days. This is a small decrease on the previous month, when patients stayed an average of 4.12 days. However, Length of Stay remains above plan, and for this reason is RED rated. The average LOS for patients discharged in the month is often a reflection of the number of long stay patients discharged in the period. However similar to last month, despite a decrease in the LOS (suggesting fewer long stay patients being discharged), the overall number of patients in hospital at month-end that had stayed 14 days or more, remained largely unchanged	**Average length of stay (days)** 	The number of surgical outliers and long stay patients has increased in recent weeks (Action 18). Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide resilience plan. During August there was a sharp rise in delayed discharges, and patients staying over 14 days. This is a result in the change in providers of domiciliary care packages.

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Infection control: MRSA case August 2015	1	Set-up multidisciplinary team meeting to discuss and investigate case and develop action plan as appropriate.	October 2015.	Action plan to be taken to infection control group.	No further cases of a similar type.
Safety Thermometer – No new harm: 8 catheter associated urinary tract infections	2	Matrons for the wards concerned to review the cases and identify if there is any learning. If so, this will be disseminated via the local safety brief.	September 2015	Outcome of Matrons review of cases and local safety brief records.	Small numbers will be subject to normal variation. Plan to have no upward trend of numbers of catheter associated urinary tract infections in subsequent months in 2015/16.
Essential Training	3A	Continue to drive compliance of core topics, including increasing e-learning	Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group	Trajectory linked to action plans to achieve compliance and sustain 90%.
	3B	Detailed plans to improve compliance of Safeguarding and Resuscitation	September 2015	Oversight of safeguarding training compliance by Safeguarding Board	Trajectory linked to action plans to achieve compliance by end of September 2015.
Nursing and Midwifery staffing levels: 3351 hours deficit in Women's and Children's division	4A	Beds closed on Ward 31 and 34 in the Children's Hospital	August/ September 2015	Future staffing reports.	Plans to re-open beds once recruited staff are in post.
Monthly Staffing levels	4B	Posts have been recruited to, with start dates of September.	September 2015	Future staffing reports.	N/A
Caring					
Dissatisfied Complainants	5A	Training is being delivered to all Divisions in relation to the quality	Completion by October 2015	Completion of training signed-off by Patient Support &	10% by October 2015, then 5% by March 2016.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		objective to improve the quality of written complaint responses.		Complaints Team and Divisions.	
	5B	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the caseworker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality (Patient Experience & Clinical Effectiveness) also checks a selection of response letters each week. All responses are then sent to the Executives for final approval and sign-off.	Ongoing	Senior Managers responsible for drafting and signing off response letters before they leave the Division are named on a Response Letter Checklist that is sent to the Executives with the letter. Any concerns over the quality of these letters can then be discussed individually with the manager concerned and further training provided if necessary.	As above.
	5C	Dissatisfied complaints responses are now shared routinely with the Head of Quality (Patient Experience and Clinical Effectiveness) to identify potential learning which is fed back to relevant contributors to inform a second response.	Implemented September 2015	Monthly Board Reports	Maintain green RAG rating for this KPI
Responsive					
A&E 4-hours	6A	Analysis of the causes of the unexpected rise in emergency admissions into the BCH. Work with commissioners to mitigate expected winter rise in admissions.	Completed. Ongoing	Urgent Care Board	Achievement of recovery trajectory over winter, when emergency admissions increase as a result of respiratory viruses.
	6B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of 95% for Q2, as per the recovery trajectory

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	6C	Working with partners to mitigate any impact of planned recommissioning of domiciliary care packages providers and bed closures in other acute trusts	Ongoing	Urgent Care Board	Achievement of 95% for quarter 2, as per the recovery trajectory
Referral to Treatment Time (RTT)	7A	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting patients through RTT Operations Group	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Achievement of the RTT Incomplete/Ongoing pathways standard as per revised trajectories.
	7B	Capacity plans being revised for under achieving specialties, to address referral growth and where capacity is below original planning assumptions; new forecasts for timescale for restoring performance to be developed.	Complete	Divisional Review meetings in September, with revised forecasts to be presented to the Board in the month.	Progress with backlog reduction restored.
Cancer waiting times	8	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments (copy of plan provided to the Quality & Outcomes Committee as a separate paper in August; and Trust Board in September)	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Restore internal pathway performance to above 85% for quarter 3. Achieve 85% across shared and internal pathways combined by March 2016.
Diagnostic waits	9	Weekly monitoring of waiting list to inform capacity planning, with particular focus on cardiac stress echo, paediatric and adult gastrointestinal endoscopy long	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Forecast for 99% standard to be restored from the end of September (revised from October).

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		waiters.			
Last minute cancelled operations	10A	Continued focus on recruitment and retention of staff to enable all adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited but now in pipeline before starting.	Ongoing	Monthly Divisional Review Meetings;	Improvement to be evidenced by a reduction in cancellations for this reason (as seen in August). Ongoing achievement of quality objective on a quarterly basis, with achievement of national standard of 0.8% in quarter 4 2015/16.
	10B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.
Outpatient appointments cancelled by hospital	11	Reductions in cancellation rates to be realised through improvements in booking practices and appointment slot management	March	Oversight of programme of work, which this is a core part, by the Outpatients Steering Group.	Green target level achieved.
Effective					
Fractured Neck of Femur (NOF) Best Practice Tariff	12A	Live flow tracker in situ across Division to increase visibility and support escalation standards.	September 2015	Inclusion of three new fields to include all trauma patients waiting without a plan, all fractured NOF patients waiting and all fractured NOF patients over 24 hours.	Tracker in place.
	12B	Confirm cover arrangements for current 1 WTE gap in ortho-geriatric establishment due to sickness.	September	Locum post starting on 14th September 2015.	Improve Ortho-geriatrician review to 100%.
Ward Outliers	13A	Work is in progress to map surgical patient pathways to decrease the length of stay and achieve “Right	October 2015	Through surgical patient pathway Transformation Sub-	To be confirmed.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		patient, Right bed'.		group	
	13B	Implement Discharge to Assess pathways, to move the patient from hospital to a community bed for assessment to take place. Spot purchase beds as appropriate directly by Bristol CCG. Extra Social Work support to be commissioned for the BRI by Bristol city Council.	Complete Ongoing Complete	Weekly multi-agency patient progress meeting held, chaired by the Divisional Director for Medicine. Daily ALAMAC calls with acute and community partners to escalate relevant issues and enhance communication.	'Green to go' trajectory or no more than 30 patients Length of stay reduction to meet bed model by 31st August 2016
Well led					
Agency Usage	14	Key actions driven corporately for Agency are: <u>Nursing and midwifery</u> • Divisional weekly meetings to monitor bank/agency activity to ensure there are appropriate controls; • Disseminate FAQs, building on information previously distributed on pay arrangements for additional hours; • Close work with wards continues to maximise the functionality of Rosterpro to support bank staff booking and payment processes. A trial for direct booking at ward level is commenced in Sept 2015.	Ongoing September 2015 September 2015	Oversight by Savings Board (Nursing Agency) and Medical Efficiencies Group (Medical Agency)	The full achievement of agency reduction trajectories are dependent on vacancy levels being below the 5% KPI. Trajectories will be reviewed at mid-year review.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		<u>Admin & Clerical</u> • A review of the bank recruitment process has taken place. Changes include publicising available bank staff and improved alignment of supply with peaks in demand. <u>Medical agency usage</u> • Reduce costs by agreed locum rates and procurement of a Master Vend supplier for locums – contract awarded, go-live October. • Rolling out the Envoy Texting system (currently used by the TSB) in the Division of Medicine to improve the speed and efficiency of seeking internal locum solutions • Work is being undertaken to develop an internal locum bank replicating existing bank arrangements for other staff groups. Feasibility study of appropriate systems to support this commences.	September 2015 October to December 2015 October to December 2015 Review commences October 2015		
Sickness Absence	15	Senior Leadership Team endorsed the recommendations made last month by Workforce and Organisational Development Group. Detailed plans with timescales have been developed		Oversight by Workforce and OD Group via the Staff Health and Well Being Sub Group	The Trust is currently red rated against a target of 3.5%. Given the usual seasonal reduction in absence has not been evident in June, July or August, it is anticipated that out turn will

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		and will be implemented during the next quarter. • Self-certification for absences of less than four days; • Audit and raise the profile of return to work interviews; • Contacting employees who are taking sickness absence on the 1st, 3rd and 7th day of absence, phased roll-out; • Managers in "hot spots" to receive coaching; • Occupational health triage service to be promoted; • Extension of system to alert managers to sickness stages, currently used in Diagnostic and Therapies. Continued implementation of the Staff Health and Well Being action plan: *Stress, anxiety and depression* • The Resilience Building Programme providing tools and techniques to build resilience and prevent absence for psychological reasons. *Musculo-skeletal* • Review of Occupational Health to Physiotherapy Bristol Royal Infirmary pathway to improve	September to December 2015 August 2015 to July 2016 November 2015		be 3.9% which is above the 2015/2016 target of 3.7%. This will be rigorously reviewed at quarterly and monthly reviews with Divisions

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		the focus on prevention and keeping staff at work. • Continued targeted intervention by Occupational Health Musculo-skeletal services, Physio direct, and Manual Handling Team. *Infection prevention and control* • Audit South West has commenced a risk-based systems audit of the 'Immunisation status' of existing staff. The impact of this is likely to be improved compliance with immunisation requirements. A draft action plan will then be produced with dates for completion and presented to the audit committee. *Cold and flu* • The seasonal flu vaccination campaign for all Trust staff will begin on 5 October 2015, building on best practice from last year. The Trust is aiming to achieve the 75% target coverage set by NHS England.	Ongoing August 2015 to November 2015 October 2015 to end February 2015	Flu Steering Group	
Vacancies	16	Recruitment action plan includes the following ongoing activities: • A schedule of recruitment and advertising activity has been developed utilising the agreed	September 2015 to March 2016	Oversight by Workforce and Organisational Development Group via the Recruitment Sub Group.	Improvement is focussed on staff groups where vacancy levels are above target including nursing and midwifery. Recruitment is

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		funding for 2015/16 to target the national market for hard to fill posts including nursing and midwifery; • A Trust-wide senior lead commences October 2015 to provide a strategic steer for nursing recruitment; • Service level agreements and KPIs for recruitment will be developed when the TRAC recruitment system has been implemented for three months. This will measure performance and support improvement of conversion to hire rates and benefits realisation. • Newly appointed Recruitment and Retention lead for Facilities will aim to reduce vacancies.	October 2015 October 2015 October 2015		currently below trajectory for nursing and midwifery.
Turnover	17	Key corporate and divisional actions include: • As part of the Staff Experience Programme 4 workshops have taken place, with more workshops now planned for different sites such as South Bristol Community Hospital, to agree how we improve communications between our managers and teams with an outcome of improving staff experience. A full report will be	July – October2015	Oversight of Staff Experience Programme by Transformation Board.	The current trajectory indicates that the annual target will be exceeded, with an anticipated out turn of 14.3%, assuming that the numbers of monthly leavers continue at the present level.

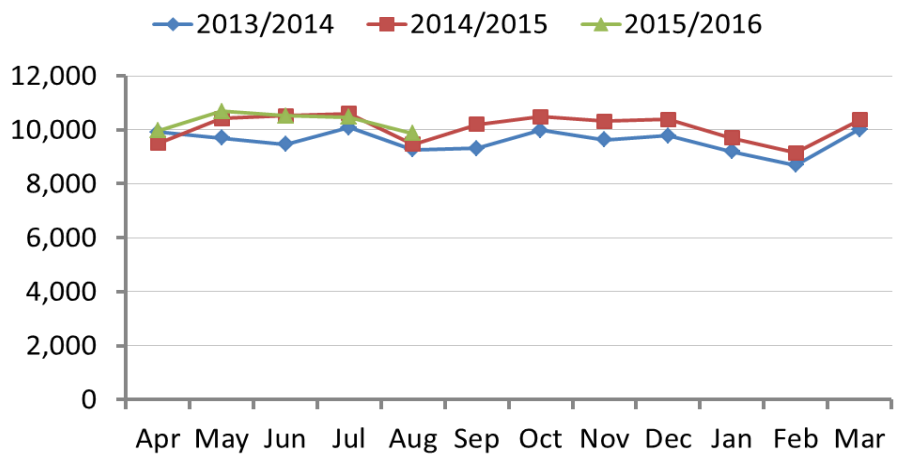
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		made to Senior Leadership Team in October. • Pilot preceptorship programmes to support newly qualified nurses in their transition from student to registered nurses; • Innovative training and development programme being developed for theatres and critical care staff. Senior Leadership Team endorsed the recommendations made by Workforce and Organisational Development (OD) Group in respect of turnover. Detailed action plans with timescales will be agreed by Workforce and OD Group at the end of September. Actions include: • Audit training and development resources; • Additional investment as a Spend to Save to reduce turnover (to support the reduction of agency usage) has been agreed, with bids by Divisions to be reviewed at the end of September; • Introduce role competency and career frameworks, and offer career advice and support; • Improve the quality and	September 2015/ February 2016 October 2015 September 2015 – March 2016	Oversight by Workforce and Organisational Development Group Surgery Head and Neck Divisional board Workforce and Organisational Development Group	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		application of staff appraisals, to include focus on professional and personal development requirements.			
Length of stay	18	See actions described under Outlier bed-days (Actions 13A and B), focusing on Surgery Length of Stay and Delayed Discharges.			

Operational context

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

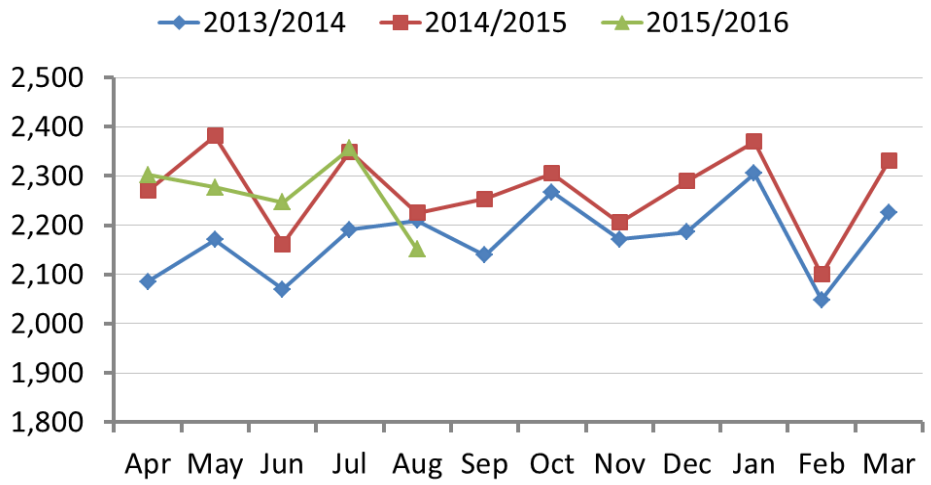
A&E attendances



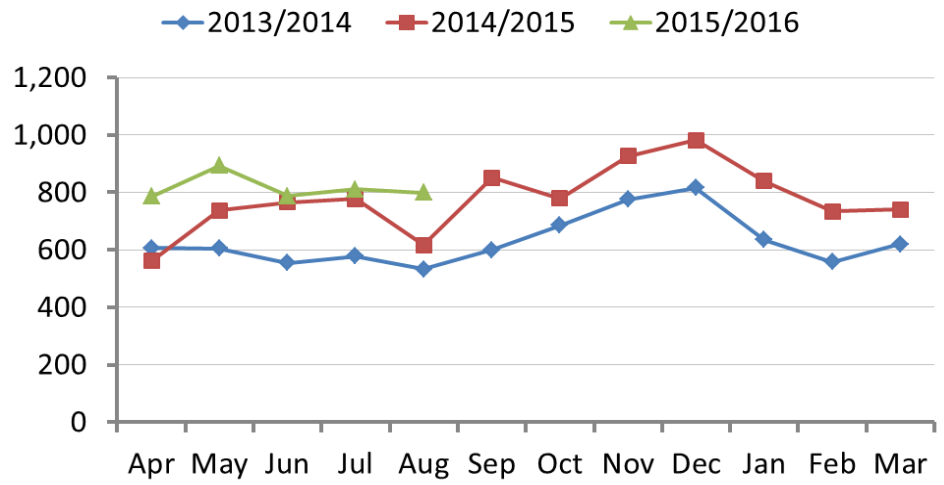
Summary points:

- The level of emergency admissions into the BRI remains consistent with the seasonal norms; the level of emergency admissions into the BCH is significantly above the same period last year;
- Levels of elective admissions has returned to seasonal norms; however, as will be seen in the Assurance and Leading Indicators summary, there has been a decrease in the number of patients on elective waiting list, and in the numbers of patients waiting over 18 weeks from referral to treatment;
- Levels of outpatient attendances have remained at seasonal norms, resulting in the number of patients waiting for a new outpatient appointment remaining similar to last month.

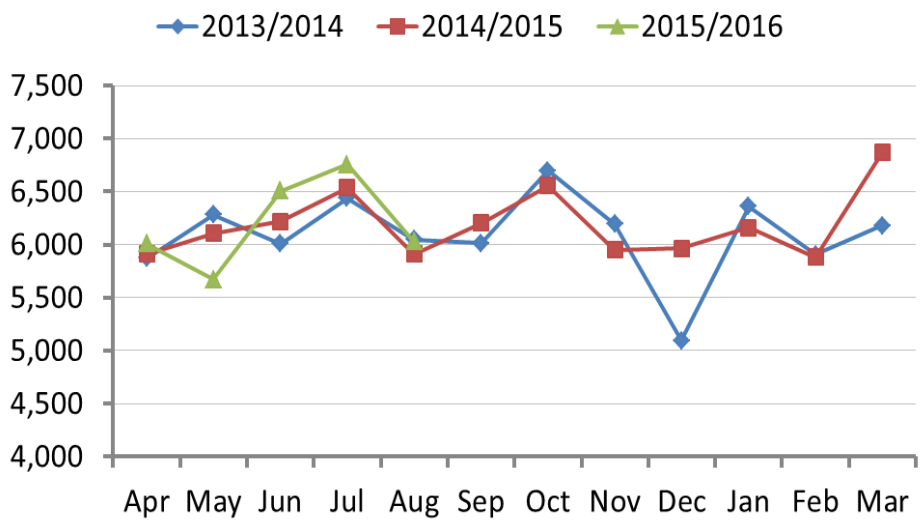
Emergency admissions (BRI)



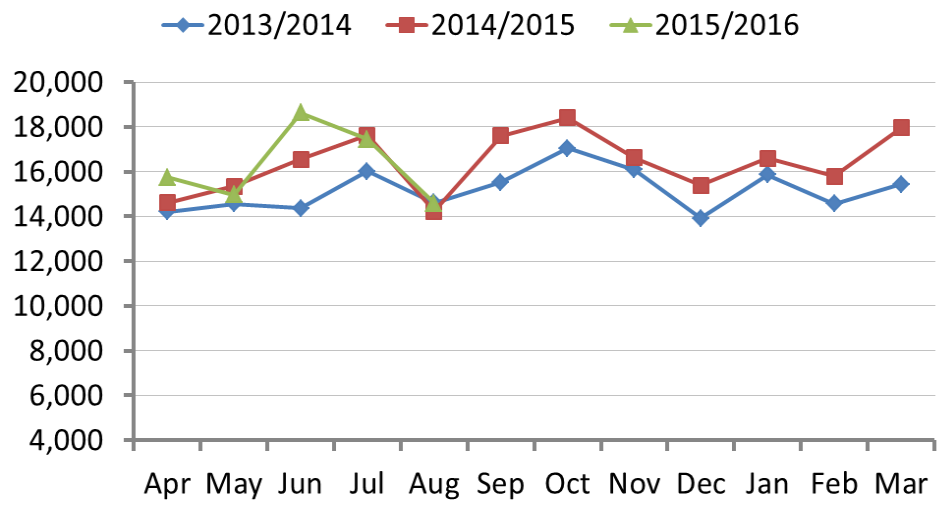
Emergency admissions (BCH)



Elective admissions



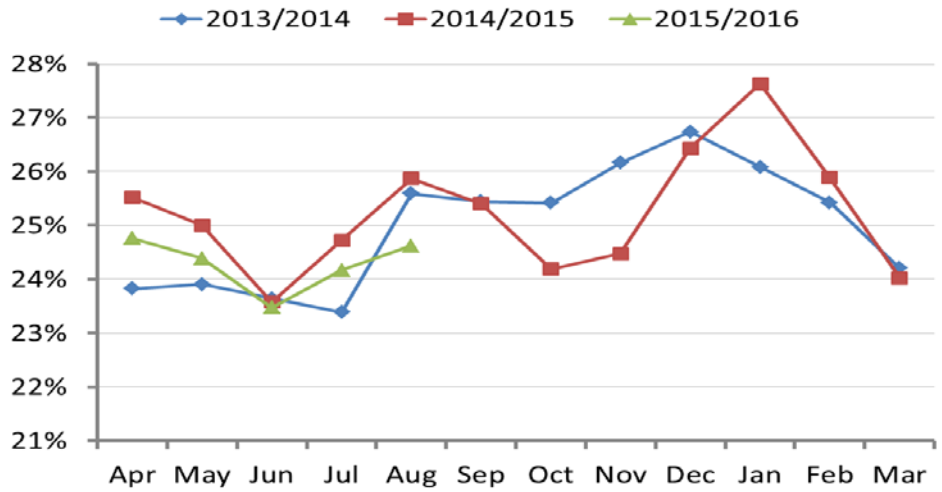
New outpatient attendances



Assurance and Leading Indicators

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

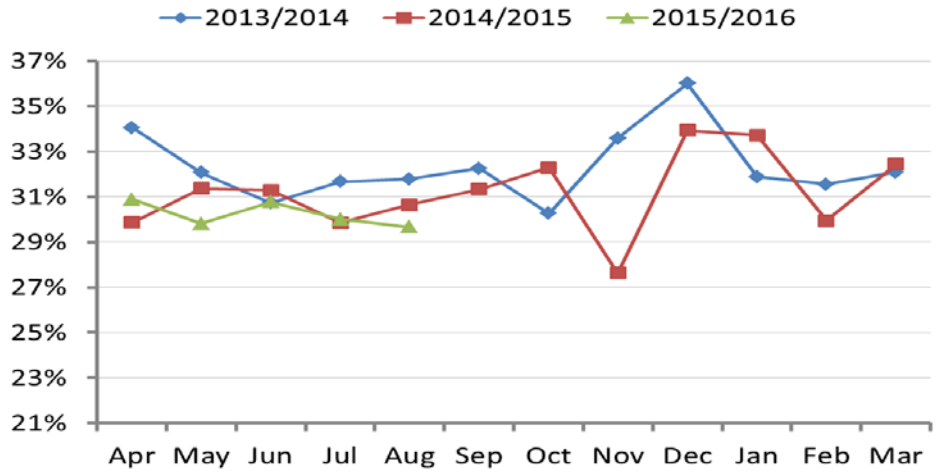
Percentage ED attendances resulting in admission



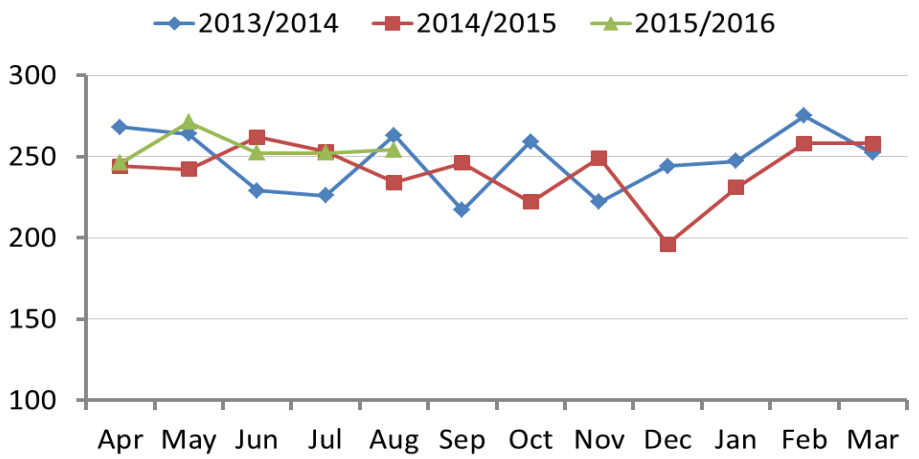
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission, and the percentage of patients admitted aged 75 years and over, was below the seasonal norm in August;
- Over 14 day stays stayed at a similar level to that in June and July; delayed discharges levels, however**,** increased, with significant peaks observed in-month;
- Numbers of patients on the elective waiting list has continued to reduce, which is consistent with the reduction in the number of RTT patients waiting over 18 weeks on an admitted pathway; but due to the increase in outpatient referrals experienced in recent months, the number of patients on the new outpatient waiting list remains high;
- Numbers of patients being referred by their GP for a suspected cancer, and then treated, remains high, and poses a further challenge to meeting the cancer waiting times standards.

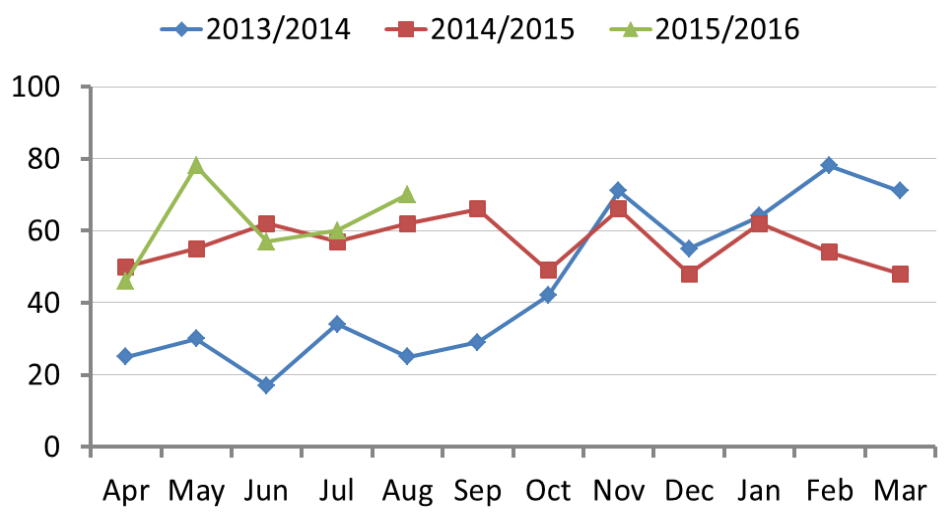
Percentage of Emergency BRI spells patients aged 75 years and over



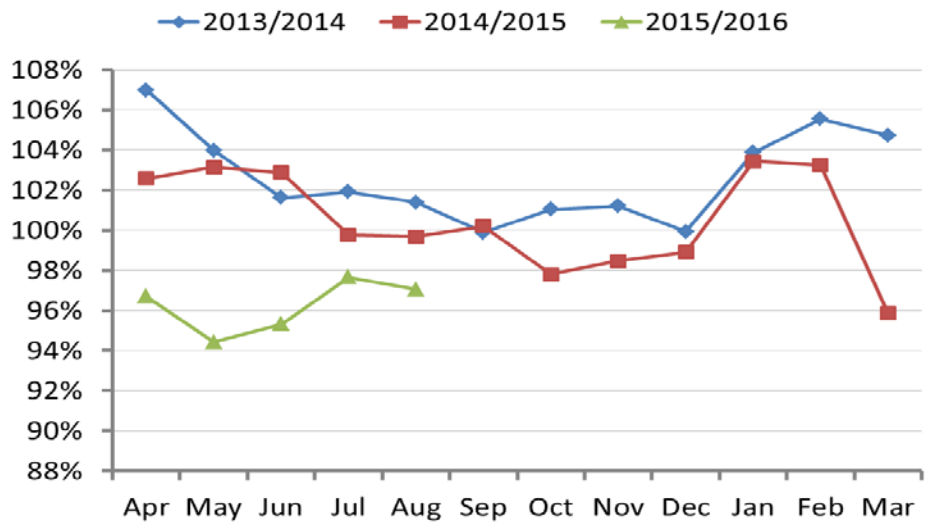
Over 14 day stays



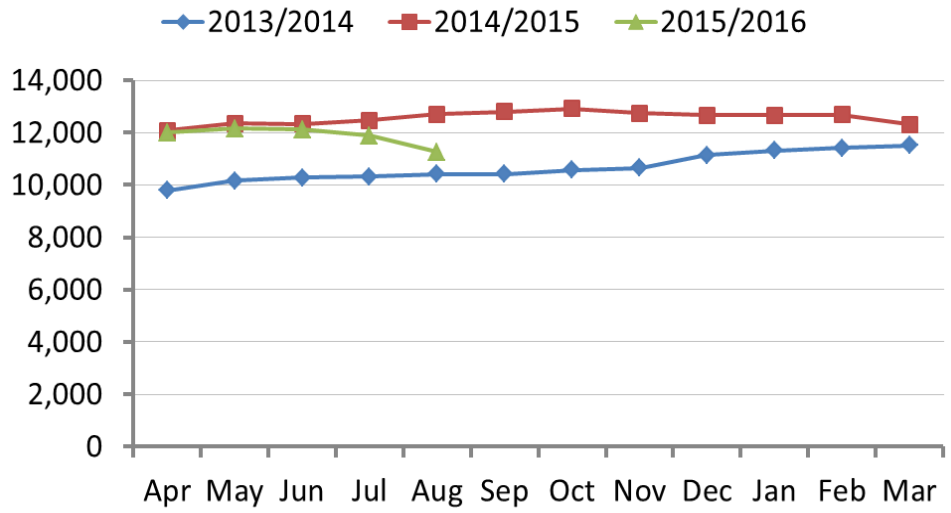
Delayed discharges



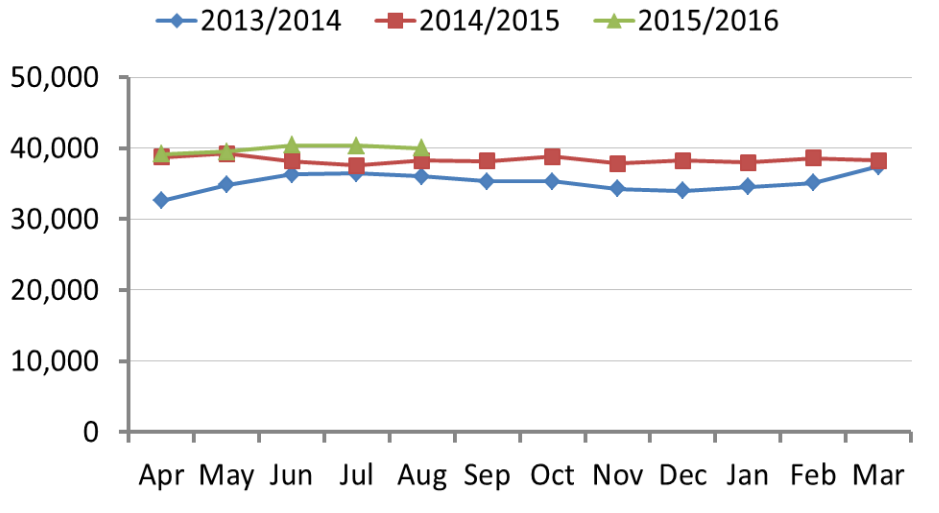
BRI Bed Occupancy



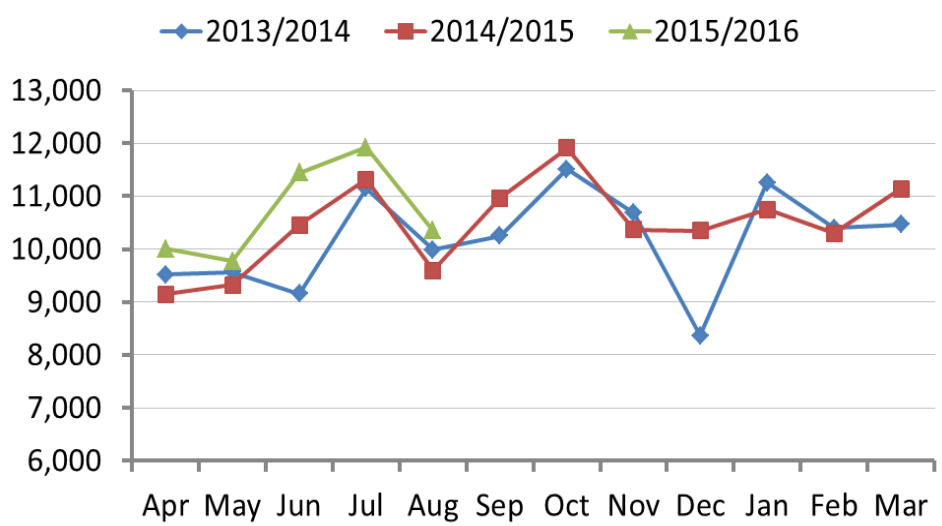
Elective waiting list size



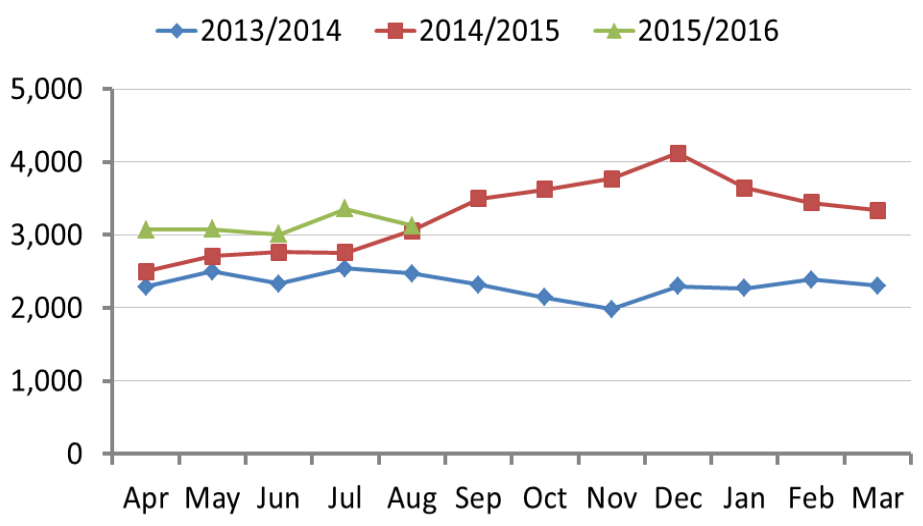
Outpatient waiting list size



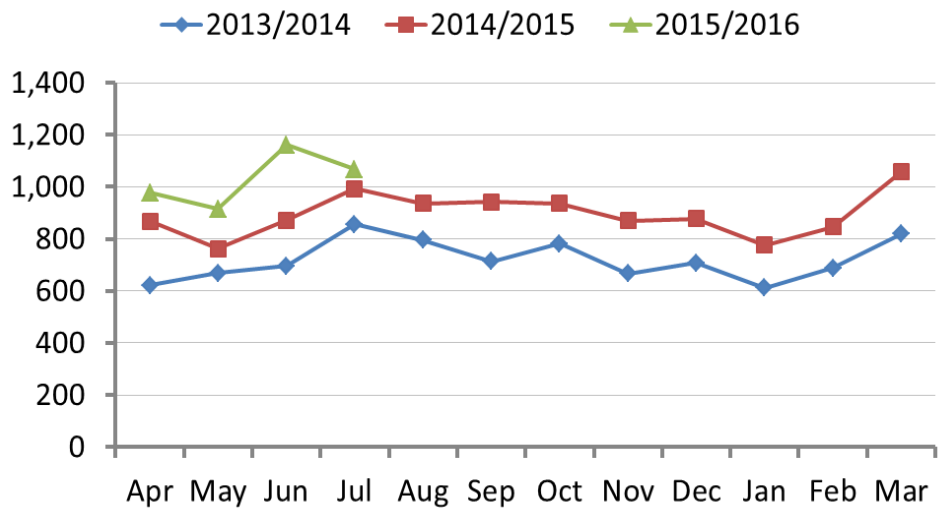
Number of RTT pathways stopped (i.e. treatments)



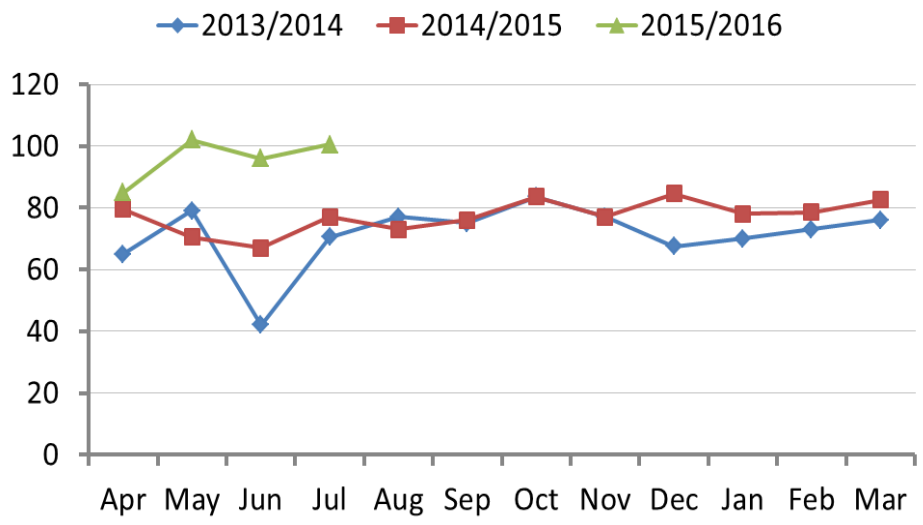
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day treatents



Trust Scorecards

QUALITY

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Quarterly Totals 14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	5	3	3	3	3	4	4	5	5	1	1	2	2	3	4	5	2	3
	DA01	MRSA Bloodstream Cases - Monthly Totals	5	3	0	0	0	1	0	1	0	1	0	1	0	1	1	1	2	1
	DA03	C.Diff Cases - Monthly Totals	50	14	8	4	4	4	3	4	0	6	1	3	3	1	12	7	10	4
	DA02	MSSA Cases - Monthly Totals	33	14	4	1	3	4	3	2	4	4	1	4	2	3	8	9	9	5
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	8	3	5	6	6	6	7	8	8	2	2	3	-	-	6	8	3	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.2%	97.4%	97.1%	96.3%	97.2%	97.6%	97.1%	97.4%	97.6%	97%	96.9%	97.6%	97.7%	97.7%	97%	97.4%	97.2%	97.7%
	DB02	Antibiotic Compliance	89.3%	89.6%	88.5%	90.3%	91.2%	89.1%	90.6%	88.8%	88.8%	90.7%	90.9%	88.9%	88.3%	-	90.3%	89.4%	90.1%	88.3%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	96%	95%	95%	94%	95%	96%	96%	96%	95%	95%	93%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	97%	98%	98%	98%	98%	98%	98%	98%	98%	97%	96%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	95%	96%	95%	95%	96%	96%	97%	97%	95%	94%	93%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	78	27	7	10	6	8	7	4	6	6	6	4	3	8	24	17	16	11
	S02a	Number of Confirmed Serious Incidents	69	8	6	8	5	7	5	4	6	4	3	1	-	-	20	15	8	-
	S02b	Number of Serious Incidents Still Open	4	18	-	1	0	1	2	0	0	1	3	3	3	8	2	2	7	11
	S03	Serious Incidents Reported Within 48 Hours	88.5%	77.8%	100%	80%	83.3%	100%	100%	100%	83.3%	100%	100%	25%	100%	62.5%	87.5%	94.1%	81.3%	72.7%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	73.3%	83.3%	100%	50%	66.7%	37.5%	80%	66.7%	100%	75%	85.7%	66.7%	100%	100%	46.7%	76.2%	78.6%	100%
Never Events	S01	Total Never Events	6	1	0	0	1	0	1	1	1	0	0	0	0	1	1	3	0	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	12712	4465	1258	1151	1028	1073	1017	1022	1124	1087	1139	1216	1023	-	3252	3163	3442	1023
	S06b	Patient Safety Incidents Per 1000 Beddays	41.32	43.1	49.62	44.91	40.6	41.66	37.64	41.85	43.14	42.65	43.43	47.3	39.07	-	42.4	40.81	44.46	39.07
	S07	Number of Patient Safety Incidents - Severe Harm	89	40	16	3	12	6	12	7	6	7	5	5	23	-	21	25	17	23
Patient Falls	AB01	Falls Per 1,000 Beddays	4.8	4.06	4.26	5.23	4.5	5.59	4.89	4.91	4.53	3.61	4.46	3.81	3.82	4.6	5.11	4.77	3.97	4.21
	AB06a	Total Number of Patient Falls Resulting in Harm	28	7	5	2	4	1	2	1	2	2	2	0	3	0	7	5	4	3
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.387	0.278	0.394	0.312	0.553	0.388	0.37	0.45	0.269	0.353	0.267	0.311	0.229	0.232	0.417	0.361	0.31	0.231
	DE02	Pressure Ulcers - Grade 2	110	32	10	8	13	8	9	10	5	9	7	7	5	4	29	24	23	9
	DE03	Pressure Ulcers - Grade 3	9	4	0	0	1	2	1	1	2	0	0	1	1	2	3	4	1	3
	DE04	Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.8%	99.2%	98.9%	98.7%	99%	99%	99.1%	99.4%	99.2%	99.1%	99.3%	99.1%	99.4%	99.3%	98.9%	99.2%	99.2%	99.3%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.4%	94.8%	93.2%	92.6%	92.3%	96.7%	92.4%	92.9%	96%	93.9%	93%	94.3%	96.6%	95.2%	93.8%	93.8%	93.8%	96.1%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	88.9%	90.1%	93.1%	88.3%	87.2%	87.8%	87.4%	88.4%	87.9%	86.8%	93%	92.3%	90.7%	86.6%	87.8%	87.9%	90.9%	88.8%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.9%	99.6%	99.7%	99.6%	99.4%	100%	100%	100%	100%	99.7%	100%	100%	100%	99.6%	100%	99.9%	100%

QUALITY (continued)

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Quarterly Totals 14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Patient Safety																				
Medicines	WA01	Medication Errors Resulting in Harm	0.45%	0.14%	0.56%	0%	0.57%	0%	0%	0%	0.54%	0%	0.56%	0%	0%	-	0.2%	0.21%	0.18%	0%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.01%	0.89%	0.69%	1.21%	0.86%	0.37%	1.55%	1.54%	0.52%	0.63%	1.43%	0.96%	0.83%	0.73%	0.84%	1.23%	0.96%	0.78%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	96.6%	97.3%	96.5%	96.1%	96.7%	97%	96.7%	97.9%	96.5%	97.5%	97.1%	98.2%	97.4%	96.4%	96.6%	97%	97.6%	96.9%
	AK04	Safety Thermometer - No New Harms	98.4%	98.5%	98%	97.9%	97.8%	98.5%	98.4%	99.3%	98.7%	98.9%	98.2%	98.6%	98.6%	98%	98.1%	98.8%	98.6%	98.3%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	89%	93%	88%	88%	86%	83%	92%	96%	88%	90%	96%	91%	98%	90%	85%	91%	92%	94%
Out of Hours	TD05	Out of Hours Departures	10.4%	10.8%	10%	9.3%	8.5%	9.5%	10.7%	9%	10.4%	9%	11.7%	11.6%	10.1%	11.7%	9.1%	10.1%	10.8%	10.9%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	19.5%	19.1%	18.4%	18.9%	16.9%	19%	18.5%	22.3%	20.6%	20.4%	19%	18.6%	19.9%	17.8%	18.3%	20.4%	19.3%	18.9%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9862	4089	791	829	726	800	809	877	873	845	838	789	879	738	2355	2559	2472	1617
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	97.9%	100%	100%	85.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%
	CS03	Number of CAS Alerts Overdue At Month End	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.6%	101.2%	102.7%	104%	104.6%	103.1%	104.6%	103.4%	102.4%	100.4%	100.3%	101.8%	102.8%	100.5%	103.9%	103.5%	100.8%	101.6%
Clinical Effectiveness																				
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital Deat	64.1	60.3	64.1	65.9	85.4	58.5	68.6	60.8	63.9	54.8	62	66	58.5	-	68.7	64.8	60.9	58.5
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	96.5	-	95.8	-	-	97.8	-	-	-	-	-	-	-	-	97.8	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline	68.3	61.8	73.9	70.4	89.7	63.3	70.3	57.8	68.6	56.5	70.9	64.7	56.4	-	73.1	66.1	63.8	56.4
Readmissions	C01	Emergency Readmissions Percentage	2.82%	2.95%	2.96%	2.45%	2.39%	2.99%	3.06%	2.83%	2.96%	2.89%	3.55%	2.69%	2.72%	-	2.61%	2.95%	3.04%	2.72%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	61.5%	61.7%	63.8%	58.9%	65.5%	59.6%	60%	59.8%	57.9%	60.9%	63.4%	64.1%	57.3%	62.6%	61.3%	59.3%	62.8%	59.9%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	76%	73.5%	61.3%	77.8%	73.3%	70%	78.3%	89.7%	72.7%	71.4%	72%	66.7%	76%	81.5%	73.6%	81.1%	70.2%	78.8%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	93.4%	80.1%	93.5%	88.9%	86.7%	93.3%	95.7%	93.1%	86.4%	77.1%	68%	91.7%	80%	85.2%	90.3%	91.9%	78.6%	82.7%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	70.1%	61%	54.8%	70.4%	60%	66.7%	78.3%	82.8%	50%	57.1%	52%	66.7%	60%	70.4%	66.7%	71.6%	58.3%	65.4%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	54.1	41.5	41.3	57.5	45.5	47.2	47.6	45.5	57.4	56.8	52.3	33.2	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	56.5%	58.7%	61.1%	62.8%	59%	62.8%	55%	66.7%	60%	68.6%	65.7%	56.1%	43.8%	-	61.6%	61.2%	63.1%	43.8%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	86.4%	96.5%	86.1%	88.6%	87.2%	79.1%	75%	87%	92.5%	97.1%	97.2%	97.6%	93.8%	-	84.9%	85.1%	97.3%	93.8%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.2%	65.6%	66.7%	58.8%	73.3%	64.7%	50%	57.1%	50%	69.2%	83.3%	30.8%	58.8%	100%	65.3%	52.8%	60.5%	73.1%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	65%	86%	66.6%	61.4%	63.7%	62.9%	78.3%	77.3%	81.6%	83.9%	88.4%	82.7%	83.3%	92.5%	62.6%	79.3%	84.9%	87.7%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	84.1%	94.9%	87.3%	87.1%	92.2%	82.2%	90.7%	88.5%	94.2%	98.6%	100%	92.8%	90%	92.3%	86.3%	91.7%	97%	91.1%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	58.5%	90.8%	35.9%	78.3%	73.3%	68%	82.4%	81.3%	90.5%	90%	92.3%	92.9%	80%	100%	74.3%	85.2%	91.5%	88.9%
	AC04	Percentage of Dementia Carers Feeling Supported	75.2%	90.5%	70%	80%	88.9%	64.3%	87.5%	81.8%	-	90.9%	100%	93.3%	92.3%	76.9%	78.7%	85.2%	94.6%	84.6%
Outliers	J05	Ward Outliers - Beddays	11216	3740	908	1338	876	1169	1364	847	889	647	638	769	841	845	3383	3100	2054	1686

QUALITY (continued)

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Quarterly Totals 14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	89	89	89	89	89	90	89	89	92	89	91	-	89	89	90	91
	P01g	Patient Survey - Kindness and Understanding	-	-	94	93	93	94	93	93	93	94	96	93	93	-	93	93	94	93
	P01h	Patient Survey - Outpatient Tracker Score	-	-	-	-	-	-	-	-	-	89	89	89	88	89	-	-	89	-
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	38.7%	16.9%	33.1%	36.1%	41.3%	29.5%	37.9%	33.9%	59.3%	17.4%	19.7%	16.2%	20.5%	10.4%	35.5%	44%	17.7%	15.8%
	P03b	Friends and Family Test ED Coverage	20.8%	9.4%	26.2%	20.2%	14.9%	16%	17.3%	22.5%	37.1%	6.6%	6.7%	7%	12.3%	14.7%	17.1%	26.1%	6.7%	13.5%
	P03c	Friends and Family Test MAT Coverage	28.9%	23.8%	32.4%	18.9%	54.3%	29.2%	26.9%	22.5%	35%	23.9%	33.7%	20.1%	22.1%	18.3%	33.7%	28.2%	26.1%	20.3%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	94.9%	96.4%	96.7%	94.3%	94%	96.3%	95.9%	93.3%	95.5%	96.1%	95.5%	96.3%	97.2%	97.2%	94.7%	95.1%	96%	97.2%
	P04b	Friends and Family Test Score - ED	92.7%	75.3%	91.2%	90.5%	92.4%	92.1%	93.4%	89.9%	93.5%	80.7%	66.3%	70.4%	78.1%	77.3%	91.5%	92.5%	72.2%	77.7%
	P04c	Friends and Family Test Score - Maternity	94.2%	96.4%	93%	97.1%	95.8%	92%	97.1%	97.1%	91.5%	97.3%	93.3%	97.8%	98.7%	97.1%	95%	94.9%	95.6%	98%
Patient Complaints	T01	Number of Patient Complaints	1883	834	170	148	140	133	165	171	181	158	147	154	207	168	421	517	459	375
	T01a	Patient Complaints as a Proportion of Activity	0.261%	0.272%	0.266%	0.224%	0.251%	0.224%	0.267%	0.291%	0.273%	0.266%	0.25%	0.231%	0.315%	0.302%	0.232%	0.277%	0.249%	0.309%
	T03a	Complaints Responded To Within Trust Timeframe	85.9%	84.7%	88.1%	84.4%	82.9%	82.9%	84.8%	83.7%	85.3%	89.5%	83.9%	82.1%	87%	80.9%	83.4%	84.7%	84.9%	84.2%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	94.1%	81.4%	77.9%	78.6%	87.1%	87.9%	81.4%	92.6%	93%	91.9%	94%	98.1%	93.6%	81.1%	88.1%	93%	96%
	T04c	Percentage of Responses where Complainant is Dissatisfied	-	4.17%	-	-	-	-	-	-	-	1.75%	3.23%	4.48%	7.41%	-	-	-	3.23%	7.41%
Ward Moves	J06	Average Number of Ward Stays	2.32	2.24	2.42	2.32	2.37	2.25	2.24	2.28	2.24	2.31	2.18	2.19	2.25	2.28	2.31	2.25	2.22	2.27
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.08%	1.02%	1.14%	0.84%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.04%	0.46%	1.16%	0.97%	1.19%	0.76%
	F01a	Number of Last Minute Cancelled Operations	749	286	68	52	108	41	58	46	66	66	63	70	62	25	201	170	199	87

ACCESS

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	14/15	15/16 YTD	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Referral to Treatment (RTT)	A01	Referral To Treatment Admitted Under 18 Weeks	90%	90%	84.9%	82.3%	82.4%	85.2%	83.1%	84.3%	80.5%	80.4%	80.5%	79.9%	81%	80.4%	84.2%	85.1%	84.3%	80.5%	80.4%	84.6%
	A02	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	90.3%	90.1%	89%	89.2%	88.8%	89.9%	88.9%	89.3%	90%	90.2%	91.4%	90.7%	89.2%	88.9%	89.3%	89.4%	90.8%	89.1%
	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	90.4%	90.4%	90%	89.4%	88.7%	87.5%	88.8%	89.4%	89.7%	90.5%	90.4%	90.7%	90.2%	90.5%	88.5%	89.3%	90.6%	90.3%
Referral to Treatment (RTT) Ongoing Volumes	A03A	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3497	3622	3766	4117	3641	3440	3339	3069	3078	3010	3357	3128	-	-	-	-
	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	59	5	1	6	8	13	9	11	4	4	1	0	0	0	27	24	5	0
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	1842	326	170	140	117	177	160	161	119	116	89	38	45	38	434	440	243	83
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.5%	95.5%	94.8%	94.7%	96.3%	97.5%	94.3%	95.8%	93.1%	94.2%	94.9%	95.3%	97.3%	-	96.1%	94.3%	94.8%	97.3%
	E01b	Cancer - Breast Symptom Referrals Seen In Under 2 Weeks	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.9%	96.9%	96.2%	95.7%	94%	98.5%	97.9%	98.4%	97%	95.8%	99.5%	95.3%	96.7%	-	96.2%	97.7%	96.9%	96.7%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.6%	99.3%	100%	100%	98.9%	100%	99%	98.1%	100%	100%	97.8%	100%	99.1%	-	99.6%	99%	99.3%	99.1%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.9%	94.5%	91.7%	96.4%	92.3%	95%	95.6%	94.4%	95.9%	94.1%	97.4%	97.9%	88.9%	-	94.8%	95.4%	96.4%	88.9%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.6%	96.6%	97.4%	98.2%	99.5%	97.2%	96.5%	97.7%	97.2%	97.5%	98.1%	94.7%	96.1%	-	98.3%	97.1%	96.7%	96.1%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	79%	74.3%	79%	81.2%	84.6%	80.8%	75.2%	79.4%	76.5%	77%	77.6%	84.6%	-	81.6%	78.5%	77%	84.6%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	89%	78%	83.3%	73.3%	100%	90.9%	71.4%	60%	100%	100%	81.3%	62.5%	76.9%	-	84.4%	80.6%	78.6%	76.9%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	90.1%	84.7%	89.3%	85.7%	100%	90.5%	84.4%	94.4%	87.2%	100%	83.3%	76.9%	83.3%	-	90.4%	88.8%	85.2%	83.3%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	1.5%	1.08%	1.02%	1.14%	0.84%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.04%	0.46%	1.16%	0.97%	1.19%	0.76%
	F02B	Number of LMCs Re-admitted Within 28 Days	699	699	660	282	46	58	47	94	34	55	43	56	54	51	63	58	199	132	161	121
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	79.7%	78.5%	81.8%	79.4%	73.8%	80%	78.3%	87.1%	83.9%	77.5%	80.5%	86.4%	73.2%	-	77.2%	82.4%	80.6%	73.2%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	92.4%	93.8%	90.9%	94.1%	81%	92%	95.7%	96.8%	90.3%	95%	95.1%	90.9%	92.7%	-	88.1%	94.4%	94.2%	92.7%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.47%	98.68%	98.13%	99.14%	98.32%	95.85%	95.48%	97.92%	97.9%	98.27%	98.63%	99%	98.83%	98.63%	97.8%	97.11%	98.64%	98.73%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	9.2%	11.9%	9.1%	8.7%	8.3%	8.9%	9.4%	9.4%	9.4%	11.6%	11.7%	11.6%	11.7%	12.8%	8.6%	9.4%	11.6%	12.2%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	54	44	59	43	49	43	39	30	58	51	41	59	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	12	5	7	5	13	11	9	16	20	6	19	11	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	3.7	3.7	4.26	4.11	4.28	4.16	4	4.31	4.46	4.24	4.36	4.41	3.83	4.2	4.12	4	4.16	4.36	4.14	4.06

ACCESS (continued)

additional reports

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 14/15	Annual 15/16 YTD	Monthly Totals Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Quarterly Totals 14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	92.23%	94.78%	92.37%	93.81%	88.62%	86.27%	90.87%	89.53%	95.01%	94.81%	93.47%	95.2%	95.51%	94.95%	89.59%	91.92%	94.48%	95.24%
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	10	0	0	0	0	0	10	0	0	0	0	0	0	0	0	10	0	0
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95%	95%	97.2%	89.9%	100%	100%	99%	87.8%	99.7%	99.8%	87.9%	87.9%	88.3%	89.3%	92.1%	92%	95.6%	95.1%	88.5%	92%
	B02a	ED Time to Initial Assessment - 95th Percentile	15	15	14	26	11	12	12	38	14	14	29	30	30.4	28	23	21	15	15	30	22
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	78.3%	92.6%	77.9%	78.4%	71.9%	70.3%	77.7%	76.1%	94.5%	93.2%	92.2%	92.3%	93.4%	91.6%	73.5%	83%	92.6%	92.5%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	55.4%	56.4%	54.3%	58.1%	50.9%	53%	60.6%	59.6%	56.3%	57.2%	53.5%	53.9%	57.5%	60.4%	54%	58.8%	54.8%	58.9%
	B03a	ED Time to Start of Treatment - Median	60	60	54	52	55	51	59	57	48	50	53	51	56	56	52	48	55	50	54	50
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	99.3%	99%	99.2%	99.3%	99%	99.3%	99.5%	99.5%	99.3%	99.3%	99.1%	98.5%	99.1%	99.2%	99.2%	99.4%	99%	99.1%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.3%	2.8%	2.6%	2.5%	2.6%	2.4%	2.7%	2.5%	2.5%	2.7%	3%	2.6%	2.9%	2.5%	2.5%	2.6%	2.8%	2.7%
	B05	ED Left Without Being Seen Rate	5%	5%	1.8%	2.3%	2%	1.5%	2.3%	1.6%	1.6%	1.5%	1.6%	1.9%	2.4%	2.9%	2.3%	2%	1.8%	1.6%	2.4%	2.2%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	1032	1032	1287	195	100	77	131	168	119	78	49	46	46	29	38	36	376	246	121	74

WORKFORCE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			14/15	15/16 YTD	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Sickness	AF02	Sickness Rate	4.2%	4.1%	3.9%	4.5%	4.4%	4.5%	4.7%	4.6%	4.3%	4.2%	4%	4.1%	4.2%	4.2%	4.5%	4.5%	4.1%	4.2%
Staffing Numbers	AF08	Funded Establishment FTE	-	-	7733.4	7775.8	7833.6	7872.4	7927.2	7912.4	7958.8	7976.8	8011.6	8088.3	8096.3	8110.8	-	-	-	-
	AF09A	Actual Staff FTE (Including Bank & Agency)	-	-	7835.5	7859.9	7910.8	8022.7	8004.1	8088.6	8130.6	8080.5	8123.2	8114.4	8069.3	8149.2	-	-	-	-
	AF13	Percentage Over Funded Establishment	-	-	1.3%	1.1%	1%	1.9%	1%	2.2%	2.2%	1.3%	1.4%	0.3%	-0.3%	0.5%	-	-	-	-
Bank Usage	AF04	Workforce Bank Usage	-	-	384.9	407.1	392.6	489.6	373.9	432.2	416.2	368.6	424.2	423.5	395	399.2	-	-	-	-
	AF11A	Percentage Bank Usage	-	-	4.9%	5.2%	5%	6.1%	4.7%	5.3%	5.1%	4.6%	5.2%	5.2%	4.9%	4.9%	-	-	-	-
	Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive)																			
Agency Usage	AF05	Workforce Agency Usage	-	-	108.4	120.7	165.9	144.5	138.9	157.3	170.3	165.8	148.3	157.3	163.5	185.2	-	-	-	-
	AF11B	Percentage Agency Usage	-	-	1.4%	1.5%	2.1%	1.8%	1.7%	1.9%	2.1%	2.1%	1.8%	1.9%	2%	2.3%	-	-	-	-
	Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive)																			
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	-	-	391.2	443.7	481.3	483.9	435.8	413.3	414.7	333.2	368.5	463.6	507.9	465.1	-	-	-	-
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	-	-	5.1%	5.7%	6.1%	6.1%	5.5%	5.2%	5.2%	4.2%	4.7%	5.8%	6.3%	5.8%	-	-	-	-
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	2415	982	275	133	154	147	162	239	199	121	174	156	147	384	434	600	451	531
	AF10	Workforce Turnover Rate			13.3%	13.2%	13.4%	13.5%	13.7%	13.8%	13.9%	13.8%	14.1%	14.1%	13.7%	13.7%				
	Turnover is a rolling 12 months. It's number of permanent leavers over the 12 month period, divided by average staff in post over the same period. Average staff in post is staff in post at start PLUS stafff in post at end, divided by 2.																			
Training	XX	Compliance with Core Essential Training			74%	79%	82%	84%	83%	85%	88%	89%	89%	89.1%	89.7%	89.7%				

Appendix 1

Glossary of useful abbreviations, terms and standards

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

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

Appendix 2

Other Essential Training Compliance Figures for August 2015

Safeguarding Adults:

Level 1: 90.1% (previous month 88.1%)
Level 2: 81.5% (previous month 79.2%)

Safeguarding Children:

Level 1: 90.1% (previous month 87.3%)
Level 2: 88.5% (previous month 85.9%)
Level 3: 81.7% (core) (previous month 79.8%)
Level 3: 79.6% (specialist) (previous month 77.4%)

Resuscitation: 75.5% (previous month 75.6%)

Appendix 3

Access standards – further breakdown of figures

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

Tumour Site	UH Bristol	Internal operational target	National
Breast	100%	-	95.0%
Gynaecology	88.9%	85%	80.6%
Haematology (excluding acute leukaemia)*	50.0%	85%	77.5%
Head and Neck	95.5%	79%	64.9%
Lower Gastrointestinal	73.9%	79%	72.8%
Lung	70.6%	79%	74.3%
Other*	71.4%	-	67.4%
Sarcoma*	100%	-	79.6%
Skin	96.8%	96%	95.5%
Upper Gastrointestinal	86.7%	79%	74.6%
Urology*	0.0%	-	73.3%
Total (all tumour sites)	**84.6%**		**81.7%**
Monthly trajectory target	**82.5%**		

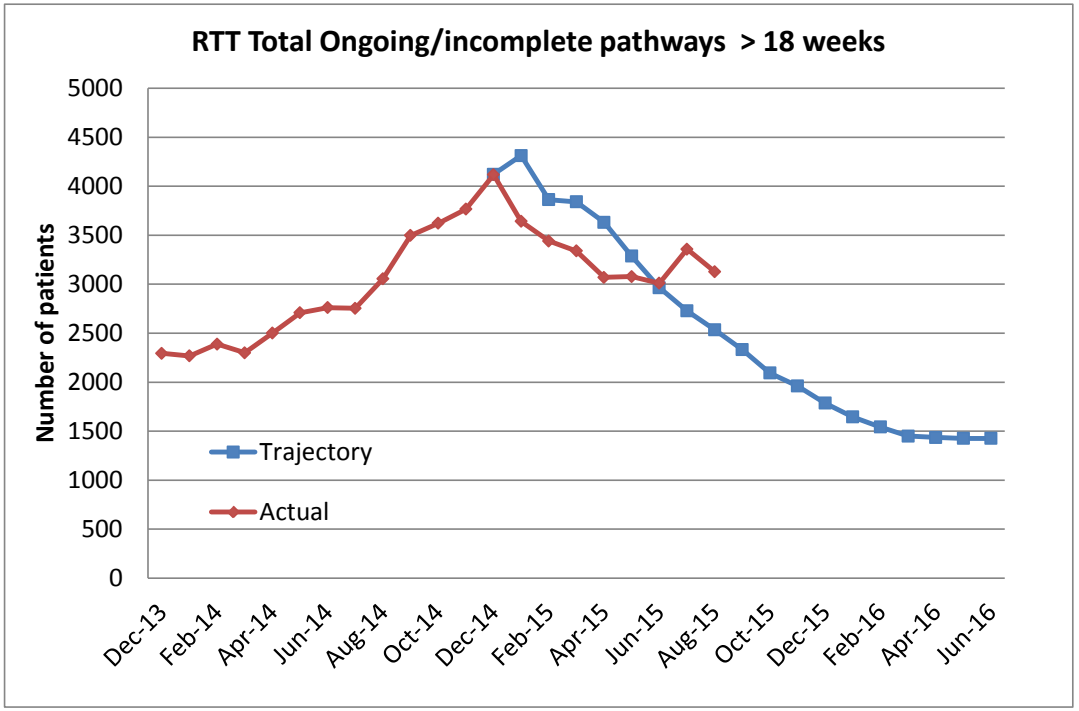
*= 5 or fewer patients treated in accountability terms

Appendix 3 (continued)

Access standards – further breakdown of figures

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

RTT Specialty	Ongoing Pathways Over 18 weeks	Ongoing Pathways	Ongoing Performance
Cardiology	435	2,339	81.4%
Cardiothoracic Surgery	22	293	92.5%
Dermatology	76	1,690	95.5%
E.N.T.	64	2,171	97.1%
Gastroenterology	17	469	96.4%
General Medicine	0	84	100.0%
Geriatric Medicine	0	120	100.0%
Gynaecology	69	1,315	94.8%
Neurology	135	380	64.5%
Ophthalmology	221	4,543	95.1%
Oral Surgery	104	2,494	95.8%
Other	1,936	14,964	87.1%
Rheumatology	2	399	99.5%
Thoracic Medicine	8	665	98.8%
Trauma & Orthopaedics	39	828	95.3%
Urology	0	2	100.0%
Grand Total	**3,128**	**32,756**	**90.5%**



In July five RTT specialties were failing the 92% standard, compared with three in August.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
09. RTT Recovery Trajectories update									
Sponsor and Author(s)									
Sponsor: Deborah Lee, Chief Operating Officer/Deputy Chief Executive Author: Xanthe Whittaker, Associate Director of Performance									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

This briefing provides an update on the trajectories for reducing the numbers of patients waiting over 18 weeks from Referral to Treatment (RTT), in light of additional demand and delays to capacity coming on line.

The Trust is currently not meeting the original reduction trajectories for patients with an Ongoing/Incomplete pathway waiting over 18 weeks RTT (Referral to Treatment) at month-end. The variance from the original non-admitted and admitted 18 week backlog trajectories is explained by variances in cardiology, ophthalmic neurology and dental specialties, and is due to the following reasons:

1) Higher outpatient demand than forecast (impacting in particular on cardiology, restorative dentistry and neurology) – see Appendix 1

2) Capacity coming on line later than assumed in the plans, due to delayed appointments to consultant and other clinical posts (neurology and dental specialties)

The national change in the RTT standards, with the abandonment of the admitted and non-admitted (in-month treatments) standards, also brings with it an opportunity to re-focus the Trust's RTT plans. It is important that the number of over 18-week waiting patients for both non-admitted and admitted pathways continues to reduce, however, the single national measure of Referral to Treatment waiting times is now the percentage of patients waiting under 18 weeks at each month-end. Hence, it is the total number of patients waiting over 18 weeks RTT at each month-end (i.e. the total admitted and non-admitted 18-week backlog) which is the most important determinant of overall achievement of the RTT standard.

For this reason, the specialties not meeting the current backlog reduction trajectory have reviewed the opportunities to make more rapid progress in reducing the total number of patients waiting over 18 weeks at each month-end, by changing the relative focus of their plans between non-admitted (outpatient) and admitted pathways.

In summary, the Trust is forecasting achievement of the national RTT standard from January 2015; this is two months ahead of the original trajectory which required achievement of all three of the former standards.

A view from Monitor on this proposal is awaited.

Recommendations

The Board is asked **to approve** the revision to these trajectories.
Impact Upon Board Assurance Framework
Achievement of the RTT standard, which contributes to the Trust Risk Assessment Framework rating.
Impact Upon Corporate Risk
None – Overall timescale for achievement of RTT standards remains unchanged.
Implications (Regulatory/Legal)
Monitor's view of the planned change to the RTT trajectories is currently being sought.
Equality & Patient Impact
None.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	**X**	For Information	

Date the paper was presented to previous Committees

Finance Committee	Quality & Outcomes Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
	28th September 2015			September 23rd 2015	RTT Steering Group 17th September 2015

BRIEFING: Proposed revision to RTT backlog reduction trajectories

1. Background

The Trust is currently not meeting the original reduction trajectories for patients with an Ongoing/Incomplete pathway waiting over 18 weeks RTT (Referral to Treatment) at month-end. The variance from the original non-admitted and admitted 18 week backlog trajectories is explained by variances in cardiology, neurology and dental specialties, and is due to the following reasons:

1) Higher outpatient demand than forecast (impacting in particular on cardiology, restorative dentistry and neurology) – see Appendix 1

2) Capacity coming on line later than assumed in the plans, due to delayed appointments to consultant and other clinical posts (neurology and dental specialties)

For this reason, specialties not meeting the current backlog reduction trajectory have reviewed and revised their original capacity plans, from which a new set of RTT backlog reduction trajectories have been developed.

2. Approach to trajectory revision

The national change in the RTT standards, with the abandonment of the admitted and non-admitted (in-month treatments) standards, has brought with it an opportunity to re-focus the Trust's RTT plans. It is important that the number of over 18-week waiting patients for both non-admitted and admitted pathways continues to reduce. However, the single national measure of Referral to Treatment waiting times is now the percentage of patients waiting under 18 weeks at each month-end. Hence, it is the total number of patients waiting over 18 weeks RTT at each month-end (i.e. the total admitted and non-admitted 18-week backlog) which is the most important determinant of overall achievement of the RTT standard.

For this reason, those specialties that needed to revised their trajectories have taken account of opportunities to make more rapid progress in reducing the <u>total</u> number of patients waiting over 18 weeks at each month-end, by changing the relative focus of their plans between non-admitted (outpatient) and admitted (elective admission) pathways. These trajectories have been approved by the Senior Leadership Team (SLT).

3. Impact on achievement of RTT standards

Through the delivery of the original backlog reduction trajectories the Trust was planning to achieve all three RTT standards by March 2016, with the non-admitted and admitted standards being achieved in December 2015 and March 2016 respectively.

The revised trajectories forecast achievement (Table 1), of the RTT Ongoing/Incomplete pathways standard in January 2016, instead of the September 2015 (Table 2). The Trust will, therefore, still be compliant with the RTT standards by the end of quarter 4 as planned.

4. Recommendation

The Trust Board is recommended **to approve** the revision to these trajectories.

Table 1 – Revised RTT Over 18-week trajectory (total admitted and non-admitted pathways)

	TOTAL INCOMPLETE/ONGOING (Admitted & Non-admitted) - Monthly backlog size									
RTT/PAS specialty	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Paediatric ENT	237	207	175	155	120	90	70	40	25	13
Paediatric medicine	19	19	19	19	19	19	19	19	19	19
Paediatric respiratory medicine	11	11	11	11	11	11	11	11	11	11
Paediatric T&O	150	125	105	90	73	54	43	37	31	31
Paediatric surgery and urology	155	140	145	91	70	56	38	38	38	38
Paediatric dermatology	16	16	16	16	16	16	16	16	16	16
Paediatric cardiology	70	60	50	40	25	17	17	17	17	17
Paediatric gastroenterology	10	10	10	10	10	10	10	10	10	10
Paediatric neurology	9	9	9	9	9	9	9	9	9	9
Paediatric plastic surgery	102	90	77	74	61	46	26	19	15	15
Paediatric Max Facs	14	10	8	8	7	4	1	1	1	1
Paediatric Cardiac Surgery	7	6	5	5	4	3	3	3	3	3
Paediatric Cleft	32	30	28	28	26	24	22	22	22	22
Gynaecology	26	26	26	26	26	26	26	26	26	26
Clinical genetics	100	90	80	70	60	50	40	40	40	40
Dermatology	98	98	98	98	98	98	98	98	98	98
Gastroenterology	24	24	24	24	24	24	24	24	24	24
Colorectal	40	45	45	45	40	30	20	10	10	10
ENT	70	70	70	70	70	70	70	70	70	70
Upper GI	29	15	15	15	15	15	15	15	15	15
Maxillo facial	53	46	39	32	26	24	24	24	24	24
Ophthalmology	258	258	258	258	246	236	226	226	226	226
Neurology	135	135	135	135	135	135	135	135	135	135
Oral Medicine	228	239	204	185	159	98	62	42	22	22
Oral Surgery	149	154	149	129	121	111	101	101	101	101
Orthodontics	50	37	26	26	26	26	26	26	26	26
Paediatric ophthalmology	22	22	22	22	22	22	22	22	22	22
Paediatric dentistry	93	52	46	40	28	23	18	18	18	18
Thoracic surgery	11	11	11	11	11	11	11	11	11	11
Periodental	163	149	144	140	99	76	56	46	26	26
Physiology	15	15	15	15	15	15	15	15	15	15
Restorative dentistry	277	245	237	228	192	134	104	74	74	74
Pain Relief	13	13	13	13	13	13	13	13	13	13
Orthopaedics	55	55	55	55	55	55	55	55	55	55
Cardiology (including GUCH)	463	441	417	378	355	346	328	300	273	246
Cardiac Surgery	12	12	12	12	12	12	12	12	12	12
Other paediatric	62	62	62	62	62	62	62	62	62	62
Other adult	108	108	108	108	108	108	108	108	108	108
Impact of validation	-244	-101	-46	-43	-38	-34	-31	-29	-28	-28
TOTAL backlog	3142	3054	2923	2710	2430	2145	1925	1786	1695	1656
TOTAL pathways	33500	33500	33000	32500	32000	31750	31500	31500	31500	31500
Percentage Incomplete < 18 weeks	90.6%	90.9%	91.1%	91.7%	92.4%	93.2%	93.9%	94.3%	94.6%	94.7%

Table 2 – Original RTT Over 18-week trajectory (total admitted and non-admitted pathways)

	RTT ONGOING performance											
RTT/PAS specialty	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
Trust total backlog	3631	3287	2964	2727	2535	2332	2093	1961	1786	1646	1543	1450
Trust total ongoing pathways (estimate)	31750	31500	31300	31150	31050	31000	31000	31000	31000	31000	31000	31000
Trust level RTT Ongoing performance	88.6%	89.6%	90.5%	91.2%	91.8%	92.5%	93.2%	93.7%	94.2%	94.7%	95.0%	95.3%

Appendix 1 – Outpatient Referral Growth vs. Non-admitted RTT backlog changes

	A	B	Y	Z					
PAS Specialty	**Oct 13-Feb 14 total**	**Mar 14-July 14 total**	**Oct 14-Feb 15 total**	**Mar 15-July 15 total**	**Growth A to Y**	**Growth B to Z**	**Change RTT Non-admitted backlog (Mar 15-Jul 15)**	**Total RTT Non-admitted pathways Jul 15**	**RTT Non-admitted Backlog growth (% of pathways)**
Cardiac Surgery	781	807	878	873	12.4%	8.2%	6	132	4.5%
Cardiology	4,258	4,454	5,031	4,698	18.2%	5.5%	184	1283	14.3%
Colorectal Surgery	1,215	1,282	1,295	1,294	6.6%	0.9%	7	445	1.6%
Dermatology	3,912	4,520	5,306	5,787	35.6%	28.0%	-34	1494	-2.3%
E.N.T.	6,668	6,407	6,570	7,084	-1.5%	10.6%	30	1803	1.7%
GUCH	389	402	427	439	9.8%	9.2%	17	294	5.8%
Gynaecology	3,798	3,908	3,850	4,015	1.4%	2.7%	29	1160	2.5%
Maxillo Facial Surgery	1,482	1,311	1,311	1,407	-11.5%	7.3%	3	298	1.0%
Neurology	319	450	418	404	31.0%	-10.2%	64	316	20.3%
Ophthalmology	9,768	10,443	10,413	11,580	6.6%	10.9%	5	3200	0.2%
Oral Medicine	1,565	1,218	1,308	1,359	-16.4%	11.6%	130	816	15.9%
Oral Surgery	5,778	5,312	4,962	4,985	-14.1%	-6.2%	-7	1753	-0.4%
Orthodontics	1,013	904	954	954	-5.8%	5.5%	-14	460	-3.0%
Paediatric Cardiac Surgery	84	97	63	66	-25.0%	-32.0%	-1	3	-33.3%
Paediatric Cardiology	753	768	675	781	-10.4%	1.7%	1	404	0.2%
Paediatric Dentistry	1,387	1,415	1,421	1,186	2.5%	-16.2%	36	610	5.9%
Paediatric Dermatology	605	625	581	788	-4.0%	26.1%	-17	281	-6.0%
Paediatric ENT	1,359	1,550	1,563	1,664	15.0%	7.4%	0	315	0.0%
Paediatric Gastroenterology	195	248	212	295	8.7%	19.0%	-9	165	-5.5%
Paediatric Rheumatology	176	159	173	198	-1.7%	24.5%	-7	80	-8.8%
Paediatric Surgery	472	553	471	503	-0.2%	-9.0%	-18	165	-10.9%
Paediatric Urology	364	371	390	394	7.1%	6.2%	-11	160	-6.9%
Pain Relief	414	432	426	383	2.9%	-11.3%	5	274	1.8%
Periodontal	778	726	706	644	-9.3%	-11.3%	56	531	10.5%
Physiology	546	563	430	437	-21.2%	-22.4%	-43	162	-26.5%
Respiratory	2,506	2,631	2,855	2,933	13.9%	11.5%	3	666	0.5%
Restorative Dentistry	2,559	2,559	3,231	2,826	26.3%	10.4%	40	1437	2.8%
Rheumatology	745	921	953	1,028	27.9%	11.6%	2	404	0.5%
Thoracic Surgery	418	440	396	398	-5.3%	-9.5%	0	70	0.0%
Trauma and Orthopaedics	5,505	5,415	4,785	5,033	-13.1%	-7.1%	8	825	1.0%
Upper GI Surgery	948	984	983	879	3.7%	-10.7%	22	260	8.5%
Grand Total	**60,760**	**61,875**	**63,037**	**65,315**	**3.7%**	**5.6%**	**487**	**20266**	**2.4%**

Specailties with significant variances from RTT backlog reduction plan

* Figures include the Weston service transfer (although significant growth seen in South Glos, BANES and Bristol CCGs as well).

The analysis is based upon five-month time bands, working back from the most recent month's data. The time bands broadly align with 18 week pathways. Referrals from each time band should therefore be impacting on the backlog from the end of that period. Each time band is compared with the same period in previous year (to address seasonality). The oldest time band should have already hit the RTT Non-admitted backlog up to the end of July. The next time band will start to hit from August onwards. So the logic is the growth in the first time band would impact on the existing RTT Non-admitted variances (shown as the difference between the July and Feb RTT Non-admitted backlogs).

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
10. Improving and Sustaining Cancer Performance – Monitor Submission									
Sponsor and Author(s)									
Sponsor: Deborah Lee, Chief Operating Officer/Deputy Chief Executive Author: Xanthe Whittaker, Associate Director of Performance									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To brief the Board on the submission the Trust made on the 31st August 2015, on plans to improve 62-day GP cancer waiting times performance. The submission and plans were approved by the Quality and Outcomes Committee via delegated authority of the Board.

Key issues to note

All Trusts are required to meet the 85% standard by March 2016 at the latest.

Many of the drivers of the Trust's poor performance against the 62-day GP standard are outside of the Trust's control, including late referral from other providers, clinical complexity/medical deferral and high growth in demand.

The Trust is highly unlikely to achieve the 85% standard without significant improvements in the timeliness of referrals received from other providers.

Recommendations

The Board is asked to note the Trust's submission of the action plan with its associated improvement trajectory and the declaration of compliance against the eight standards of good practice

Impact Upon Board Assurance Framework

Retaining a GREEN risk rating for Monitor's Risk Assessment Framework

Impact Upon Corporate Risk

Links to risk on the Risk Register – 1412 - Risk of failing one or more cancer access standards

Implications (Regulatory/Legal)

62-day GP standard is part of the Monitor Risk Assessment Framework.

Equality & Patient Impact

None

Resource Implications

Finance		Information Management & Technology	

Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	For Information	
Date papers were presented to previous committees							
Finance Committee	**Quality & Outcomes Committee**		**Audit Committee**	**Remuneration & Nomination Committee**		**Senior Leadership Team**	**Other (specify)**
	28/8/15						

BRIEFING: Cancer Waiting Times Improvement Plan submission

1. Background

Due to the ongoing national decline in performance against the 62-day GP cancer waiting time standard, all trusts were sent a letter on the 14th July, requesting submission of an improvement plan, recovery trajectory, and a declaration of compliance against eight recently published standards of good practice. All Trusts are required to meet the 85% standard by March 2016 at the latest.

The 62-day GP cancer standard covers patients referred by their GP with a suspected cancer that go on to have a cancer diagnosed. The operational standard set nationally is that 85% of patients should receive any treatment they need within 62 days of referral by their GP. All 62-day GP pathways commence with a GP making an urgent referral for a suspected cancer under the 2-week wait standard (i.e. patients should be seen by a specialist within 14 days of being referred).

This briefing provides a summary of the Trust's submission against the three requirements set-out in the letter of the 14th July, the format for which was prescribed via a two submission templates (Appendices 1 and 2). Importantly, it also includes the rationale behind the actions included in improvement plan submission, by specifying the drivers for the Trust's current sub-optimal performance against the 62-day GP waiting times standard, and the way the Trust is aiming to tackles these.

2. Factors impacting on 62-day GP performance

The following information is based upon analysis conducted on 62-day cancer treatments undertaken by the Trust over the last three years. It highlights the main factors impacting on performance against the 85% standard, and the hurdles the Trust needs to get over in order to materially improve 62-day performance. Whilst the main focus of this briefing is how the Trust improves performance against this waiting times standard, it is clear that there are likely to be significant benefits in terms of patient experience and potentially clinical outcome, in terms of treating people more quickly via a more streamlined and pre-planned process. In each of the following sections, in addition to describing the impact various factors is having on Trust performance, rationale is provided as to the focus of the work-streams detailed in the associated action plan (Appendix 1).

Case-mix

The 62-day GP standard applies to all types of cancer and to all groups of patients. However, the national Cancer Waiting Times guidance acknowledges that it will not be possible to meet the 85% operational standard for all types of cancer.

"These operational standards are for all tumours taken together. Some tumour areas will exceed these standards, others (where there are complex diagnostic pathways and treatment decisions to make) are likely to be slightly below these operational standards. However when taking a Provider's casemix as a whole the operational standards should be achievable…"

The Trust has a highly unusual case-mix, in that it provides neither breast nor urological cancer services, other than those oncological treatments carried-out at the Bristol Haematology & Oncology Centre (BHOC). Only breast, skin and the small number of brain cancer treatments undertaken across the country, have a national average performance of above the 85% standard. To put this into context for what this means for the case-mix of UH Bristol, in quarter 1 2015/16, this is what our analysis shows:

- 72% of the patients we treated had cancers that nationally the average performance was below the 85% standard (referred to below as 'non-achieving tumour sites');
- The average performance for these non-achieving tumour sites, based upon the numbers of patients we treated, was 73.5% - our performance was 70.5%;
- Had we achieved the national average of 73.5% for these tumour sites, our other tumour sites would have had to perform at 115.2% to compensate for the case-mix;
- To achieve the 85% standard for the Trust as a whole, these non-achieving tumour sites need to perform at a minimum of 81.2% (i.e. a 7.7% improvement on the national average).

This analysis suggests it is not possible for the Trust to achieve the 85% standard overall, simply by over-performing in tumour sites, such as skin, for which it is more readily possible to treat patients within 62 days. Our performance against national average performance for each tumour site (Table 1), however, provides a useful guide as to the level of performance that is potentially realisable, and which overall would result in Trust level compliance against the 85% standard. It should be noted though, that to achieve a standard of performance above that of the national average represents a significant challenge for tumour sites such as Lung and Upper GI, within which a high proportion of patients are referred to the Trust for specialist treatment, and are therefore more likely to subject to the issues identified below, including clinical complexity, medical deferral and late referrals.

Table 1 – Performance against the 85% standard at a tumour-site level for quarter 1 as a whole, including national average performance for the same tumour site

Tumour Site	UH Bristol	National average	Proposed operational standard
Brain*	100%	88.5%	No target set
Breast	90.5%	96.6%	No target set
Gynaecology	82.6%	78.8%	85%
Haematology (excluding acute leukaemia)	82.7%	80.5%	85%
Head and Neck	66.1%	66.4%	79%
Lower Gastrointestinal	71.7%	71.5%	79%
Lung	57.9%	71.4%	79%
Other*	94.1%	76.4%	No target set
Sarcoma*	91.7%	75.1%	No target set
Skin	94.7%	95.7%	96%
Upper Gastrointestinal	65.2%	74.6%	79%
Urology*	33.3%	74.8%	No target set
Total (all tumour sites)	**77.0%**	**81.8%**	**85%**

*= 10 or fewer patients treated in accountability terms

There is no obvious solution to the challenge posed by the case-mix the Trust now has. However, the proposed operational standards for each tumour sites provides a guide as to the level of performance we need to be aiming for, by tumour site, in order to achieve the 85% standard at a Trust level. Please note, that no operational standard has been proposed for the tumour sites that are low in treatment volumes, and/or the performance of which is almost solely dictated by the management of these pathways by other providers.

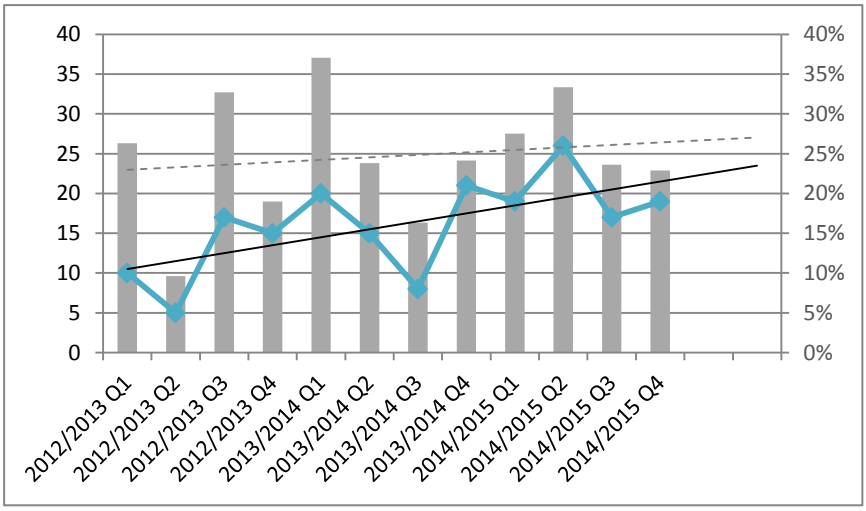
Clinical complexity and medical deferral

The pathways of patients that we have not been able to treat within 62 days of referral are reviewed in detail before each monthly upload of data as part of the national data submission. This allows us to understand what the causes of the breaches of the waiting times standard are.

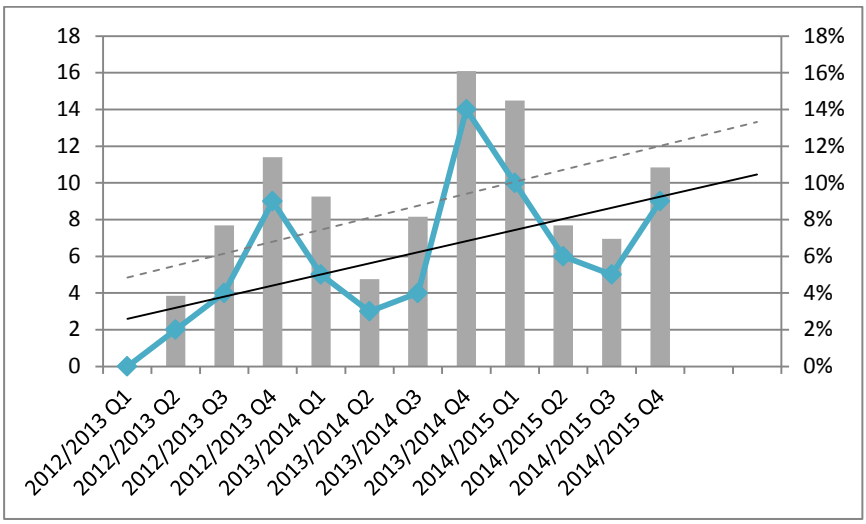
Analysis of these breach reasons has highlighted that the number of breaches classified as resulting from clinical diagnostic complexity (Graph 1), and medical deferral (Graph 2), when another medical condition delays the patient's diagnosis or treatment, have increased significantly over the last three years in percentage terms.

In numbers terms, breach volumes for these two reasons have risen by 23% in the last year. This provides evidence to support the previously anecdotal belief that we treating more clinically complex patients, in terms of both the cancers patients are presenting with, but also their underlying health. It's important to note that over this three-year time period, the rules for classifying clinical diagnostic complexity and medical deferral have been consistently applied and the two managers conducting these reviews have been the same.

Graph 1 – The number (grey bars; dotted trend line) and percentage (blue line; solid trend line) of breaches of the 62-day GP standard, identified as being due to clinical diagnostic complexity



Graph 2 – The number (grey bars; dotted trend line) and percentage (blue line; solid trend line) of breaches of the 62-day GP standard, identified as being due to medical deferral.



It is clear from this analysis that the breaches of the 62-day standard due to clinical complexity and medical deferrals are likely to continue to increase. The proposed tactical solutions to managing this challenge is the introduction of pre-planned and booked (Ideal Timescale) pathways, whereby the

majority of patients go through predetermined steps for which service capacity has been ring-fenced, and, measures which support the early identification of health problems.

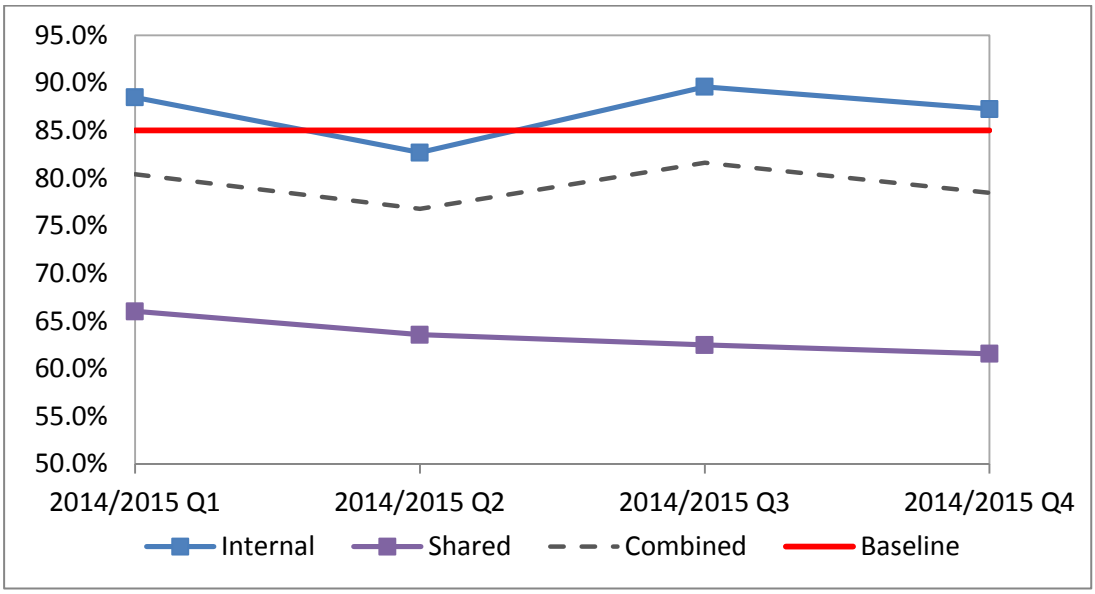
How is this being addressed in the improvement plan?

- Early assessment of patient fitness to enable proactive management of patient fitness
- Ideal Timescale Pathway implementation, to allow as much time as possible to address unforeseen eventualities within diagnostic complexity or co-morbidities
- Reducing the 2-week wait step down to 7 days for key tumour sites

Late referrals

In 2014/15, 32% of breaches of the 62-day GP standard resulted from referrals received from other providers, on or after day 42 on a 62-day pathway. Half the patients the Trust treats came via another provider. Analysis of internally managed versus shared pathways highlights the combined impact late referrals and clinical complexity has on performance, with the Trust internal performance reported at 87.6%, dropping to 63.4% for shared pathways. The general trend for performance of shared pathways is one of deterioration.

Graph 3 – Performance against the 62-day GP standard for internal and shared pathways



Patients are often referred for specialist treatment, following a diagnosis of cancer having been made, but also can be referred with part of their diagnostic pathway still to be completed (i.e. a cancer not yet diagnosed). Referral on or after day 42 makes treatment within 62 days challenging, even when a cancer has already been diagnosed and the Trust is only responsible for the treatment phase. Patients often still need to be seen in outpatients to discuss and consent to the planned treatment, the patient's fitness, especially for Surgery, needs to be checked, and the treatment then needs to be planned and undertaken. Completing all of these steps within the 20 days remaining on a 62-day pathway, can prove difficult, and provides little room for unforeseen circumstances or patient choice.

Patients are referred to the Trust from a number of different providers across the region, including North Bristol Trust, Royal United Hospital Bath, Weston Area Health Trust, Taunton & Somerset, Yeovil and Gloucester Hospitals. Given the challenge posed in agreeing milestones for timely referral with this number of providers, the Trust has sought support from the Interim Management & Support (IMAS) team, to facilitate sessions to broker these agreements.

How is this being addressed in the improvement plan?

• Agreeing milestones for referral by referring providers, supported by the IMAS

Increasing demand

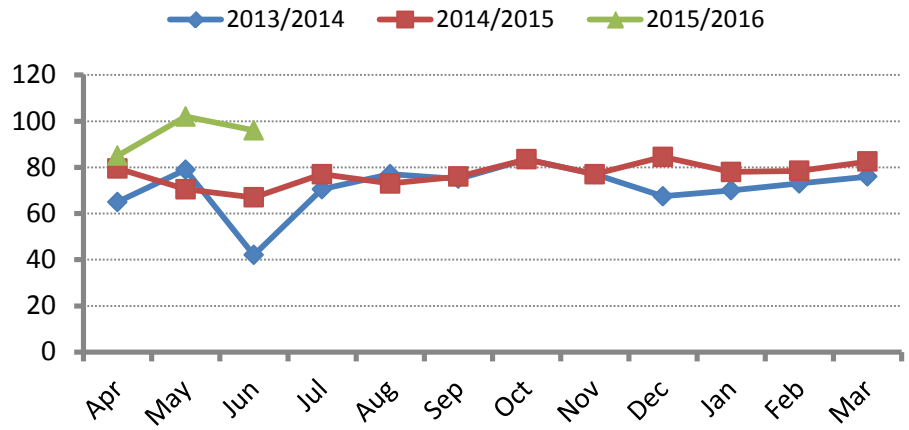
During the past year the Trust has taken-over the management of the skin cancer service from Weston Area Health Trust. However, the Trust has also seen a significant increase in the level of demand across a range of other tumour sites (Table 2, Graph 4 and Graph 5), including upper GI, which has been fed by the national awareness raising campaign in quarter 4 2014/15. Whilst the upper GI campaign was known about and planned for within the constraints of the available pilot data, the growth in referrals experienced across a range of services has in some instances impacted on service delivery and timeliness due to the scale of these increases.

Table 2 – The number of patients treated under the 62-day GP standard in quarter 1 2014/15 and quarter 1 2015/16

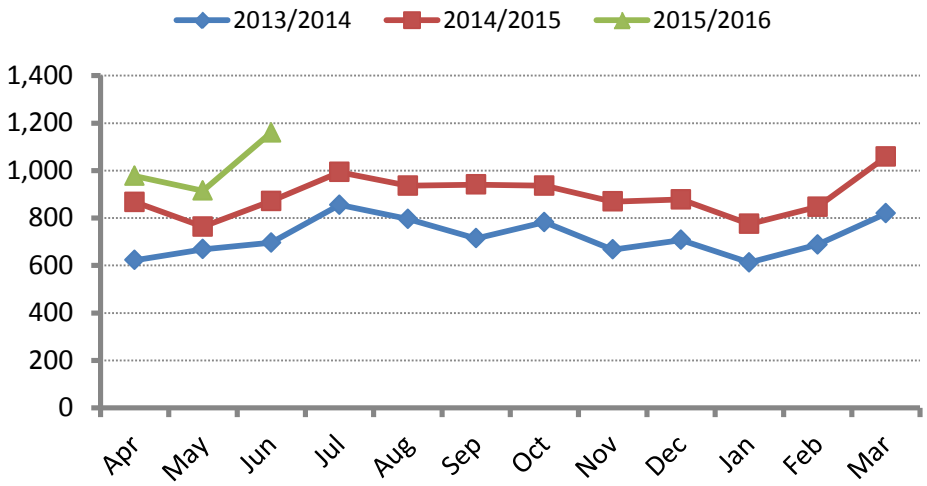
Tumour Type	Quarter 1 2014/15	Quarter 1 2015/16	Change	Percentage Change
Brain/Central Nervous System	0.5	1	0.5	100.0%
Breast	12	10.5	-1.5	-12.5%
Gynaecological	25.5	23	-2.5	-9.8%
Haematological (Excluding Acute Leukaemia)	16	26	10	62.5%
Head & Neck	22.5	29.5	7	31.1%
Lower Gastrointestinal	24.5	30	5.5	22.4%
Lung	49	47.5	-1.5	-3.1%
Other	3	8.5	5.5	183.3%
Sarcoma	1	6	5	500.0%
Skin	33	66.5	33.5	101.5%
Upper Gastrointestinal	28.5	33	4.5	15.8%
Urological (Excluding Testicular)	1.5	1.5	0	0.0%
Totals	**217**	**283**	**66**	**30.4%**
Totals (excluding skin)	**184**	**216.5**	**32.5**	**17.7%**

Although performance in quarter 1 2015/16 represents a deterioration on that of previous quarters, the number of patients treated within target was 25% higher than in quarter 1 2014/15 (218 versus 174.5 including the additional skin treatments following the service transfer).

Graph 4 – The number of 62-day GP treatments (in accountability terms)



Graph 5 – The number of 2-week wait urgent GP referral patients seen



Graphs 4 and 5 demonstrate that the increase in 62-day GP treatments is largely arising from an increase in 2 week wait referrals directly to the Trust (i.e. internal pathways). Whilst this provides an opportunity to improve performance as more pathways are within the Trust's control, this will only be the case if the Trust can increase its service capacity to respond to this scale of growth, which is why the main focus of the relevant actions in the action plan are around understanding and responding to demand, as well as ways of mitigating future unsustainable rises in demand through the implementation of the NICE guidance.

How is this being addressed in the improvement plan?

- Capacity & demand modelling for hot-spot areas of high growth
- Planning for the impact of the NICE guidance changes
- Use of tools developed from sustainable waiting list size modelling, to provide advance warning of increases in demand

Avoidable breaches

Analysis of the breaches of the 62-day cancer standard in 2014/15 suggests that 21% of breaches were due to range of reasons that were potentially amenable to improved management via the proposed pre-planned, ideal timescale pathways. This includes poor pathway planning and management, and capacity constraints.

How is this being addressed in the improvement plan?

- Ideal Timescale Pathway implementation, to allow as much time as possible to address unforeseen eventualities
- Reducing the 2-week wait step down to 7 days for key tumour sites
- Capacity & demand modelling for hot-spot areas of high growth

3. Improvement trajectory

From the Trust's breach analysis, estimates have been made as to the number of breaches that will be 'saved' as a result of the implementation of each action. Using a baseline of 2014/15, with growth in

treatment volumes factored-in, an improvement trajectory has been developed. This is shown at the top of the action plan (Appendix 1). It must be noted that by necessity of the volume of breaches attributable to late referral, this improvement trajectory assumes a 3.5% improvement in performance in quarter 4, solely attributable to improvements in the timeliness of referrals from other providers.

4. Summary & recommendations

The Quality & Outcomes Committee signed-off the Trust's submission in August, on behalf of the Board, which included the action plan with its associated improvement trajectory (Appendix 1), along with the required declaration of compliance against the eight standards of good practice (Appendix 2).

The above analysis is intended to provide assurance that the Trust understands the reasons for its under-performance against the 62-day GP standard, and that the action plan the Trust submitted at the end of August had the right focus. The Board is therefore asked to receive this briefing for **information** and **assurance**.

Appendix 1 – Cancer Improvement Plan

62 Day Cancer Standard Improvement Plan

This plan is intended to capture the key reasons for non-compliance with the 62 Cancer Standard trajectory of 85% and describe the actions your trust are undertaking to meet the standard at the earliest possible opportunity and by 31 March 2016 at the latest.

The plan is in addition to the statement that your trust must complete to provide assurance on implementation of the 8 Improving and Sustaining Performance Priorities for the 62 Day Cancer Standard.

Submission Details		
NHS Trust Name		University Hospitals Bristol
Submission Date		28-Aug-15
Date agreed by Trust Board		28-Aug-15
Completed by	Name Role	Xanthe Whittaker Associate Director of Performance
Contact details	Telephone E-mail	0117 342 3776 Xanthe.Whittaker@uhbristol.nhs.uk
Signed off by Acute Trust Chief Executive	Name	Robert Woolley
Signed off by CCG Accountable Officer	Name	Jill Shepherd

Please submit the completed template to the following e-mail account: england.me-ops@nhs.net by 31 August 2015

If you have any queries regarding the completion of the template please contact your TDA/Monitor/NHS England account manager.

Section 1 - Expected date of achievement of the overall 62 Day Cancer Standard:
Please provide the expected date of achievement of the 62 Day Cancer Standard

Cancer standard	Specific recovery date (DD-MM-YY)	Has this been agreed with commissioners in a Remedial Action Plan?	Comments
62 Day Cancer Standard	31-Mar-16	YES	

Section 2 – Month by month trajectory for achievement of the 62 Day Cancer Standard

Please complete the table detailing the month by month trajectory for achievement of the 62 Day Cancer Standard. NB: This should not be back loaded and should show steady improvement as agreed with commissioners.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	
Overall Cancer 62 Day Standard - Trajectory for Achievement				82.5%	77.0%	75.0%	78.0%	79.0%	82.0%	80.0%	83.0%	85.0%	
Trajectory for Achievement (without improvements in late referrals)				82.5%	77.0%	75.0%	78.0%	78.0%	80.2%	77.0%	79.1%	81.3%	
Has the CCG agreed to this recovery trajectory?	YES												
Is this trajectory formalised in a Remedial Action Plan?	YES												

Section 3 - Reasons for non-compliance with the 62 Day Cancer Standard

Please briefly and clearly outline the key reasons for non-compliance with the 62 Day Cancer Standard. You should be able to provide evidence for the reasons identified and if you have had a recent review by the Cancer IST or the Cancer Clinical Network, your response should incorporate the key findings.

1 Case-mix - 72% of patients treated by the Trust are within tumour sites that nationally perfom 4.5 to 18.6% below the 85% standard (Q1 15/16 CWT data source)
2 Late referrals - single highest cause of 62-day breaches representing 32% of breaches in 2014/15; internally managed pathways = 87.6% performance (63.4% for shared)
3 Medical deferral/clinical complexity - number of 62-day breaches due to clinical complexity or medical deferral has increased by 23% over the last year
4 Increasing demand - 30% increase in 62-day GP treatments between Q1 2014/15 and Q1 2015/16 (17.7% increase even with skin transfer excluded)
5 Avoidable breaches - 21% of breaches in 2014/15 due to a range of pathway planning, capacity and management issues (potentially amenable to timed pathway redesign)

Section 4 - Key Actions to address performance issues raised in sections 1 to 3 above

Please use the table below to detail the key actions you are taking to address performance issues in sections 1 and 2. Where the actions are in response to a Cancer IST or Cancer Clinical Network recommendation, please reference this.

Key actions (prioritised list)	Owner	Key milestones	Completion date	How will you measure progress/delivery?	Expected outcomes/impact	Which tumour sites do the actions relate to?
1 Agree referral milestones with referring providers, for all key teriary pathways	IMAS/Cancer Manager (CM)/Associate Director of Performance (ADP)	Timescales agreed, new pathways implemented by referring providers to reflect these.	31/10/2015 (agreeing milestones) 31/12/15 (new pathways implemented)	Monitoring of day of receipt of referral against agreed milestones per tumour site.	12 breaches saved per quarter (which excludes likely numbers of 'unavoidable' late referrals)	Lung; Upper GI OesophagoGastric; Gynaecology, Hepatobiliary; Breast; Urology
2 Implement the ideal timescales for typical oesophagogastric cancer pathways, to help deliver these complex pathways within 62 days and reduce impact of medical deferral	Specific Working Group (chaired by CM or ADP)	Implementation plan agreed, new service arrangements in place	30/09/2015	Performance against the 62 day standard. Root Cause Analysis of all breaches including mapping against the ideal timescales. PTL management to check actual pathway day of each patient against ideal as they progress through their pathway	2 breaches saved per quarter, together with action 16.	Upper GI - OesophagoGastric
3 Implement the ideal timescales for typical lung cancer pathways, to help deliver these complex pathways within 62 days and reduce impact of medical deferral	Specific Working Group (chaired by CM or ADP)	Implementation plan agreed, new service arrangements in place	31/10/2015	Performance against the 62 day standard. Root Cause Analysis of all breaches including mapping against the ideal timescales. PTL management to check actual pathway day of each patient against ideal as they progress through their pathway	2 breaches saved per quarter, together with action 15.	Lung
4 Develop and implement ideal timescales for typical colorectal cancer pathways, to reduce impact of medical deferral and clinically complex treatment options that require more planning time	Specific Working Group (chaired by CM or ADP)	Implementation plan agreed, new service arrangements in place	31/12/2015	Performance against the 62 day standard. Root Cause Analysis of all breaches including mapping against the ideal timescales. PTL management to check actual pathway day of each patient against ideal as they progress through their pathway	Timescales produced; 2 breaches saved per quarter once implemented	Colorectal
5 Develop and implement 'ideal' pathway timescales for hepatopancreatobiliary cancers to help deliver these complex pathways within 62 days and reduce impact of medical deferral	Cancer Manager	Implementation plan agreed, new service arrangements in place	31/12/2015	Performance against the 62 day standard. Root Cause Analysis of all breaches including mapping against the ideal timescales. PTL management to check actual pathway day of each patient against ideal as they progress through their pathway	Timescales produced; 0.5 breach saved per quarter once implemented	Upper GI - Hepatopancreatobiliary
6 Consider further roll out of post-multi-disciplinary team meeting respiratory/throacic clinics to RUH Bath and Gloucester, to help reduce timescales of complex pathways and improve timeliness of referral	Lead Thoracic Surgeon/Assistant General Manager Surgery	Decision and options appraisal on benefits of this approach, with implementation plan if relevant (with timescale agreed for this)	31/08/2015	Report to Cancer Performance Improvement Group	Decision and implementation plan if relevant	Lung
7 Further work on capacity and demand in pre-operative assessment, to ensure reliable on the day-assessment, in order to reduce impact of medical deferrals	Assistant General Manager Surgery	Completed demand and capacity analysis; action plan to implement any changes; changes implemented	30/09/2015	Report to Cancer Performance Improvement Group	Enabler to Ideal Timescale Pathways (higher impact on 31 day access standards)	All
8 As part of the region-wide project to update proformas for suspected cancer referrals, include more information on patient fitness, to help manage impact of medical deferrals and complexity	Cancer Manager in association with external partners	Final forms complete with requisite information included	31/10/2015, unless advised otherwise externally	Reports to Cancer Steering Group	Completed forms	All
9 Investigate and implement ways to introduce electronic flagging of patients who fail Pre-Operative Assessment Clinic, to enable a faster response and reduce the impact of medical deferral	Assistant General Manager Surgery	Finished summary of methods to do this, system in place	31/10/2015	Report to Cancer Performance Improvement Group	Finished summary of methods to do this, system in place	All
10 Introduce direct booking of 2 week wait referrals (i.e. patient or GP books own appointment) as used successfully in other areas, to reduce impact of patient choice and help with complex pathways	Commissioners	Commissioners and GPs confirm issues in primary care are resolved; Direct booking in place.	31/12/2015 (subject to agreement with other providers and NHS England)	Report to Cancer Working Group (meeting of local providers and commissioners) as action is entirely with commissioners now	Enabler to Ideal Timescale Pathways	All

11 Ensure 90% first appointments booked in 7 days - Head and Neck. To help reduce the overall length of complex pathways.	Assistant General Manager Surgery	90% first appointments booked in 7 days	31/10/2015	Weekly report on waiting times, reviewed at Cancer Performance Improvement Group	Enabler to Ideal Timescale Pathways	Head and Neck
12 Ensure 90% first appointments booked in 7 days - Gynaecology. To help reduce the overall length of complex pathways.	General Manager Gynaecology	90% first appointments booked in 7 days	31/10/2015	Weekly report on waiting times, reviewed at Cancer Performance Improvement Group	1 breach saved per quarter	Gynaecology
13 Ensure 90% first appointments booked in 7 days - Haematology. To help reduce the overall length of complex pathways.	General Manager Bristol Haematology and Oncology Centre	90% first appointments booked in 7 days	31/10/2015	Weekly report on waiting times, reviewed at Cancer Performance Improvement Group	2 breaches saved per quarter	Haematology
14 Ensure 90% first appointments booked in 10 days - Lung. To help reduce the overall length of complex pathways.	Speciality Manager Lung	90% first appointments booked in 10 days	31/10/2015	Weekly report on waiting times, reviewed at Cancer Performance Improvement Group	Enabler to Ideal Timescale Pathways	Lung
15 Ensure 90% first appointments booked in 7 days - oesophagostric. To help reduce the overall length of complex pathways.	Assistant General Manager Surgery	90% first appointments booked in 7 days	31/10/2015	Weekly report on waiting times, reviewed at Cancer Performance Improvement Group	Enabler to Ideal Timescale Pathways	Upper GI - OesophagoGastric
16 Establish direct access endoscopy to improve early colorectal pathways, reducing the impact of medical deferral, patient choice and complex treatment pathways in this area	Assistant General Manager Surgery	Direct access operational and GPs referring this way	31/10/2015	Report to Cancer Steering Group	Enabler to Ideal Timescale Pathways	Colorectal
17 Identify and agree any areas requiring additional capacity and demand modelling, in face of increasing demand; undertake modelling	Cancer Performance Improvement Group	Identification of areas with timescales for completion of work on each	31/10/2015	Report to Cancer Performance Improvement Group	Identification of areas with timescales for completion of work on each; modelling completed and informing service capacity decisions.	To be confirmed
18 Management of the impact of new NICE referral guidance, to manage the expected increased demand and changes to pathways which could affect complexity	Cancer Manager in association with external partners	Completed gap analysis and plan, in line with regional and national work	31/12/2015	Report to Trust Clinical Quality Group and to Network	Completed gap analysis and plan, in line with regional and national work	All, in particular lung, colorectal, oesophagogastric
19 Work with commissioners on demand management options in dermatology to ensure sustainability of service in face of rapidly rising demand (both routine and cancer)	Speciality Manager Skin, Commissioners	Agreement on appropriate demand management options and plan to implement	31/12/2015	Report to Divisional Board	Agreement on appropriate demand management options and plan implemented	Skin
20 Clinical review of pathway for shared haematology/head and neck cases, to potentially reduce steps in this clinically complex pathway	Cancer Manager and Clinical Teams	Completion of clinical audit; team discussion of audit results and decision on any appropriate changes; implementation of agreed changes	31/12/2015	Report to Cancer Performance Improvement Group	2 breaches saved per quarter, assuming clinically safe revised model can be found	Haematology, head and neck
21 Develop and implement ideal timescales for typical head and neck cancer pathways, to reduce impact of medical deferral and clinically complex treatment options that require more planning time	Specific Working Group (chaired by CM or ADP)	Implementation plan agreed, new service arrangements in place	31/12/2015	Performance against the 62 day standard. Root Cause Analysis of all breaches including mapping against the ideal timescales. PTL management to check actual pathway day of each patient against ideal as they progress through their pathway	Timescales produced; 3 breaches saved per quarter once implemented	Head and Neck
22 Modelling to enable ongoing assessment of sustainable cancer waiting list size fro each tumour site	Senior Business Planning Analyst	Assessment completed and integrated into tool for ongoing use	31/08/2015	Report to Cancer Steering Group	Assessment complete and in ongoing use	All
23 Enhance existing PTL (Patient Tracking List) management using tools based on the modelling of sustainable list size and weekday planning developed via the ideal pathway timescales, thus giving earliest warning of underlying issues and changing patterns of demand	Cancer Manager, Associate Director for Performance	New tools in use along with conventional PTL management arrangements already in place	30/09/2015	Report to Cancer Steering Group	3 breach saved per quarter	All

24 Refresh training for MDT coordinators and booking teams on key competencies, continue standard training programme for new coordinators being appointed autumn 2015	Cancer Quality and Assurance Manager	Training completed, competencies reassessed, new coordinators signed off as fully competent	31/10/2015	Competency checklists complete, appraisal documentation - check by Cancer Manager	Completed training	All
25 Increase flexibility around critical care unit capacity at times of high acuity on the unit, to ensure elective cases can be accommodated in addition to emergencies and existing patients requiring critical care support	Divisional Director and Clinical Chair, Surgery, Head and Neck	Plan in place to mitigate risk of high acuity preventing admissions	30/09/2015	Report to Cancer Steering Group	0.5 breaches saved per quarter (higher impact on 31 day targets)	Upper GI - OesophagoGastric, Lung, Hepatobiliary, Colorectal, Gynaecology
26 Implement process to identify patients on anti-coagulants earlier in the pathway and ensure this information is recorded and taken into account when planning surgery	General Manager, Surgery, Head and Neck	Agreed process in place, addition to 2WW forms (see action 8)	30/09/2015 (plus action 8)	Report to Cancer Performance Improvement Group	See action 8	All, in particular lung, colorectal, oesophagogastric

Section 5 – Support requirements

Please identify the specifc support requirements from the IST/Cancer Network or other bodies to deliver your improvement plan.

Support requirement	Which body would provide this support?
1 Agreeing referral milestones for tertiary pathways	**IMAS**
2 Performance managing providers against agreed referral timescales	**CCGs**
3 Implementing Direct Choose & Book of 2-week wait appointments by end Oct 15	**CCGs**

Section 6 – Governance and programme management arrangements

Please use this space to describe the governance and programme management arrangements in place to ensure this improvement plan will be implemented and achieve the standard by the date provided in Section 1 above. Please highlight any vacant posts and workforce recruitment issues in the structure.

Governance:
Cancer Improvement Plan to continue to be delivered through the Trust's Cancer Performance Improvement Group (CPIG), with progress reports and escalation to the Trust's Cancer Steering Group/Trust Senior Leadership Team.
Issues related to operational capacity to be identified through the corporately managed Cancer PTL Meeting and escalated to Divisional Directors/Chief Operating Officer.

Programme Management:
Associate Director of Performance is the Programme Manager, with the Cancer Services Manager acting as the Business Change Manager, supported by project managers.
There are currently no vacancies within the funded Performance/Cancer Services Team. However, the Trust is seconding staff in to support pathway improvement work (project managers) within its high volume tumour sites (1 day per week x 5 x 3 months), which will need backfill (still to be identified).

Appendix 2 – Compliance with the eight standards

		Trust Response - Yes/No	Please provide appropriate supporting narrative for each question. Where you have given a "No" response could you please include in your narrative when you expect to be compliant.
1	**Does the Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards?**	**Yes**	Named Exectuive Director is Deborah Lee
2	**Does the Board receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average?**	**Yes**	The monthly Quality & Performance Report includes a summary of the following information, along with an appendix that sets-out tumour site level performance in the reported month, against the national average performance.
3	**Does the Trust have a cancer operational policy in place and approved by the Trust Board?** This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.	**Yes**	The Trust has an operational policy in place which includes all the listed elements and has been approved by the Quality and Outcomes Committee as the responsible sub-committee of the Trust Board
4	**Does the Trust maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast?** These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.	**No**	The Trust has a timed pathway for lung, and is developing a pathway for colorectal cancer, with the finalised timescales expected to be complete by end of October 2015 (for implementation by the end of December 2015). The Trust does not manage prostate and breast cancer patients other than to provide oncological treatments. Therefore, pathways for these sites are being developed by North Bristol Trust. All pathways developed to date have been shared with referring providers and commissioners, and comments from them have been incorporated into the finalised timescales as far as possible. The Trust is therefore expceting to be fully compliant by October 2015, provided there are no major disagreements from other providers with the colorectal pathway.
5	**Does the Trust maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance?** The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.	**Yes**	The Trust has a cancer specific PTL which is reviewed at least weekly both within divisions and at Trust level. The PTL updates twice daily and snapshots are saved weekly to provide an audit trail. The Trust holds a Trust-wide weekly cancer PTL meeting to go through challenging cases and gain assurance from Divisions that patients are being managed in an appropriately timely way.

		Trust Response - Yes/No	Please provide appropriate supporting narrative for each question. Where you have given a "No" response could you please include in your narrative when you expect to be compliant.
6	**Is root cause breach analysis carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching)?** These should be reviewed in the weekly PTL meetings.	**Yes**	All 62 and 31 day breaches have a full root cause analysis undertaken, regardless of the pathway type. Reports are shared with relevant Divisions, through the Cancer Performance Improvement Group and other fora. Each breach analysis is also reviewed by the Associate Director of Performance on a monthly basis. Selected reports, highlighting important issues, are shared with Cancer Steering Group. The Trust does not review near misses, due to the high volume of breach analaysis it currently already undertakes, but believed the model it has in place to be suitably robust to consider itself compliant with this standard.
7	**Is capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) carried out?** There should also be an assessment of sustainable list size at this point.	**Yes**	The Interim Management and Support (IMAS) team supported the Trust in late 2014 to carry out demand and capacity modelling for all specialities. This modelling included the demand for cancer servives within each specialty. An assessment of sustainable waiting list size for the cancer PTL is being undertaken by a senior data anlayst in the Trust, and will be completed by the end of August.
8	**Is an Improvement Plan prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard.** This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.	**Yes**	The Trust maintains a Cancer Performance Improvement Plan which covers every pathway including but not limited to those that have recently not met the standard. The plan is updated at least fortnightly by the Cancer Performance Improvement Group and is reviewed by the Trust's Cancer Steering Group at all of its meetings.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
11. Quarterly Complaints and Patient Experience Reports

Sponsor and Author(s)
Sponsor: Carolyn Mills, Chief Nurse Authors: Paul Lewis, Patient Experience Lead (surveys and evaluation); Tanya Tofts, Manager, Patient Support and Complaints Team

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

These reports provide a summary of patient-reported experience received via the Complaints Team and the Trust's patient survey programme.

Key issues to note

Patient Experience Report

- The Trust continued to achieve "green" patient satisfaction ratings in the Trust Board Quality Dashboard: reflecting the provision of a high quality patient experience at UH Bristol.
- Negative outliers in respect of patient reported experience in this period include:
    - Waiting times in outpatient clinics at the Bristol Eye Hospital and Bristol Royal Hospital for Children.
    - Kindness and understanding ratings on postnatal wards (although these scores are in line with maternity service norms nationally).
    - Inpatient experience tracker scores at the South Bristol Community Hospital. It is the "communication" (rather than "caring") elements of the tracker that affect this score. Our evidence strongly suggests this is a realistic reflection of the challenges in caring for this patient group, rather than an indication of deeper care failings.
    - Low Friends and Family Test scores for the Bristol Royal Hospital for Children Emergency Department. This is likely to be due to the methodology being used (touchscreens as opposed to exit cards): the optimal location of the screens, and the appropriate blend of exit card / automated data collection, is currently being explored.
    - Relatively low patient satisfaction on ward A900. This primarily reflects concerns raised by patients with Cystic Fibrosis. The Division has started a wider piece of engagement work with these patients. So far this work suggests that there might be some specific aspects of clinical care to address, but that the fundamental issue is the need to build relationships between patients and staff –this patient group are regular / long-term attenders and have recently moved to a new ward location (A900) with a new care team in place.

Complaints Report

- 459 complaints were received in Q1 (0.25% of activity) – a reduction compared to 517 (0.28%) in Q4
- The Trust's performance in responding to complaints within the timescales agreed with complainants was 84.9% compared to 84.7% in Q4.
- The number of cases where the original response deadline was extended rose in Q1 to 44 cases, after decreasing to 27 in Q4 of 2014/15 compared with 46 in Q3.
- The way in which the Trust reports the number of complainants who tell us that they are unhappy

with our investigation of their concerns has changed with effect from Q1. "Dissatisfied" cases are now reported as a percentage of the total number of responses sent out in a given month. Performance for Q1 is 3.2% (i.e. of the 186 responses sent out during Q1, six complainants have told us that they were dissatisfied).

- In Q1, complaints relating to appointments and admissions continued to account for over a third (124) of the total complaints received by the Trust, in line with each quarter of 2014/15.
- Complaints about failure to answer telephones rose again in Q1.

Links between complaints and survey data in Quarter 1

- The Bristol Royal Hospital for Children Emergency Department had a low Friends and Family Test score in Quarter 1. This score is likely to be attributable to the methodology used to collect the data, but it is noted that the Department is also flagged as having a relatively high number of complaints in Quarter 1.
- The Bristol Heart Institute had a relatively high number of Complaints in Quarter 1, but this trend was not apparent in the survey data (which was largely positive). One possible explanation is that the complaints tended to relate to important peripheral aspects of care (e.g. telephone contact, cancelled appointments etc.), whereas the surveys mainly focus on the experience in hospital.
- Although the themes emerging from survey comments and complaints are not directly comparable, the highest number of complaints fell into the "attitude and communication" and "appointments and admissions" complaints categories – these are broadly in line with the survey data where communication, staff, and waiting times are the most common improvement themes raised by respondents.

Recommendations

The Board is recommended to receive the report for **assurance.**

Impact Upon Board Assurance Framework

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

Impact Upon Corporate Risk

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

Implications (Regulatory/Legal)

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

Equality & Patient Impact

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

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees

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

			Committee		
28/09/15				23/9/2015	Patient Experience Group 27/8/2015

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Experience Report

Quarter 1, 2015/16

(1 April to 30 June 2015)

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

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

This report presents quality assurance data from the UH Bristol patient experience survey programme, principally: the Friends and Family Test, the monthly postal surveys, and the national patient surveys. The key headlines from Quarter 1 (April–June 2015) are:

- The Trust continued to achieve "green" patient satisfaction ratings in the Trust Board Quality Dashboard: reflecting the provision of a high quality patient experience at UH Bristol (see Appendix C and D for a description of the surveys and scoring mechanisms used in this report).
- Praise for UH Bristol staff continues to be the most frequent form of written comment received via the Trust's corporate patient experience surveys - easily exceeding the top five negative themes combined. The negative themes that emerge most frequently are around communication, waiting / delays, food, and staff behaviour (often an isolated incident within an otherwise good hospital experience).
- The Trust commenced a new survey of outpatients in April 2015. The first quarterly data from the survey is presented in this report and indicates that a high quality outpatient experience is being provided. Of the four key survey questions used to derive the UH Bristol outpatient experience "tracker", the lowest score was around waiting times in clinic (improving this score is a Trust Quality Objective for 2015/16).
- The Friends and Family Test (FFT) was formally extended to day-case services in April 2015. This new data is aggregated with the inpatient FFT data to give a single metric, with both services receiving similarly positive scores (typically around 95% of patients saying that they would recommend the care).
- The Friends and Family Test (FFT) was also extended to paediatric services in April 2015. As part of this extension, survey touchscreens were installed in the Bristol Royal Hospital for Children's Emergency Department to automate the data collection. This technology has enabled the Department to meet the challenging response rate targets associated with this survey with minimal impact on staff time, but has generated very low FFT scores – primarily because people are giving feedback at all stages of their "journey", rather than just at the end. (This technology was introduced into the two adult Emergency Departments in July 2015 and has had a similar effect on the response rates and scores). Although these are methodological issues, rather than a reflection of service quality, these lower scores are a concern because they are publically available and intimate that the Trust is performing poorly in respect of patient experience. As such, the Emergency Department element of the FFT is currently in a re-development phase: optimal placing of the screens in the Departments is being explored, and feedback will continue to be captured using FFT "postcards" at discharge (albeit at a lower volume) alongside the screens, in order to ensure a rounded view of patient experience is captured.
- UH Bristol performs in line with national norms in most of the national patient experience surveys. The exception here is the national cancer survey, where a number of low scores were achieved by the Trust. A significant programme of patient engagement has been undertaken by the Trust in order to triangulate and better understand these results. This programme (which included a series of focus groups carried out independently by the Patients Association) found that UH Bristol provides a good patient experience for people with cancer, but that the broad areas for improvement identified via the national cancer survey were valid (e.g. communication / information provision, continuity of care between organisations). An action plan in response to these findings has been developed and is being overseen by the Trust's Cancer Steering Group.
- The variations seen in UH Bristol's hospital site and ward-level survey scores also reflect national trends, with postnatal wards and wards providing long-term care for chronic conditions generally receiving lower patient satisfaction ratings. A large number of service improvement activities continue to be carried out at the Trust that will have a positive impact on patient experience.

2. Trust-level patient experience data

Charts 1 to 6 (over) show the six headline metrics used by the Trust Board to monitor patient satisfaction at UH Bristol[1]. These scores have been consistently rated "green" in the periods shown[2], indicating that a high standard of patient experience is being maintained at the Trust. The scores would turn "amber" or "red" if they fell significantly, alerting the senior management team to the deterioration.

The most frequent form of written feedback via the surveys is praise for staff. Communication, delays, food and staff are the most cited areas for improvement. It is clear from this feedback that UH Bristol's staff are the main determinant of a positive or negative patient experience. Whilst this "people" aspect of care is in general very positive – a single negative experience in this respect often has a detrimental effect on the patient's entire experience of being in hospital.

A new UH Bristol outpatient survey started in April 2015. This is sent by post to approximately 500 patients (or parents of 0-11 year olds) per month. From this data an "outpatient tracker score" is now provided to the Trust Board (Chart 3) [3]. This aggregates four survey scores relating to cleanliness, treating patients with respect and dignity, waiting times in clinic, and communication. Among this group of four questions, waiting times in clinic achieved the lowest (i.e. worst) score in Quarter 1 – although it should be noted that the majority of respondents (73%) reported that they were seen on time or within fifteen minutes of their appointment time. Reducing delays in clinic is currently one of UH Bristol's corporate Quality Objectives and so will be a major focus of improvement at the Trust in 2015/16.

UH Bristol's Friends and Family Test (FFT) for Emergency Departments does not currently have a minimum target score threshold associated with it (Chart 5). A number of methodological changes are currently taking place with this element of the Trust's FFT – in particular its extension to the Bristol Royal Hospital for Children Emergency Department (BRHC ED) from April 2015, and the implementation of touchscreen technology to support data collection. During Quarter 1, the BRHC ED was the only UH Bristol Emergency Department collecting FFT data using touchscreens, with the two adult EDs maintaining their approach of administering an FFT card to patients at discharge. Since then, touchscreens have been introduced into the Bristol Royal Infirmary and Bristol Eye Hospital Emergency Departments. Whilst these changes open up more feedback opportunities for patients / parents and reduce the administrative burden on staff, they affect the scores: the relatively low score for the BRHC ED in Quarter 1 was principally because feedback via the touchscreens is received at all stages of the patient journey, not just at the end (when people are usually feeling more positive). The optimal positioning of the screens and appropriate blend between touchscreen and card collection is currently being explored, before a target threshold is set (with the aim of having this in place during Quarter 3).

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

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

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

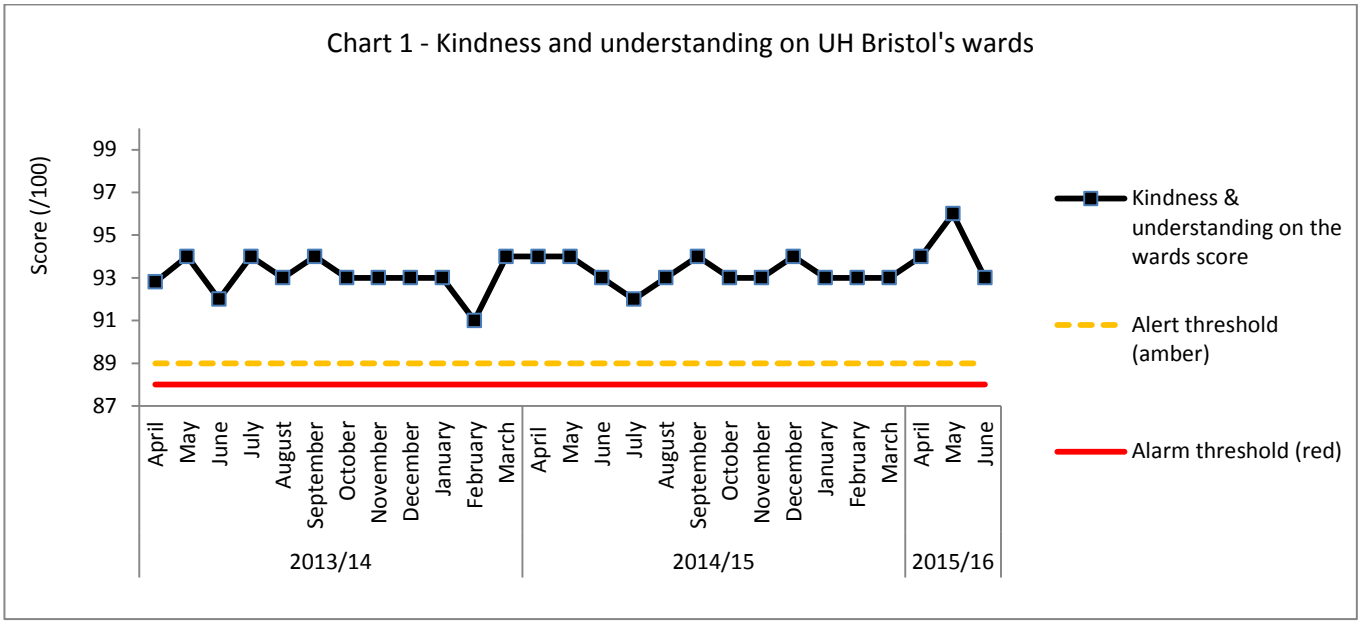


Chart 1 - Kindness and understanding on UH Bristol's wards
Score (/100)
99
97
95
93
91
89
87
April May June July August September October November December January February March April May June July August September October November December January February March April May June
2013/14
2014/15
2015/16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

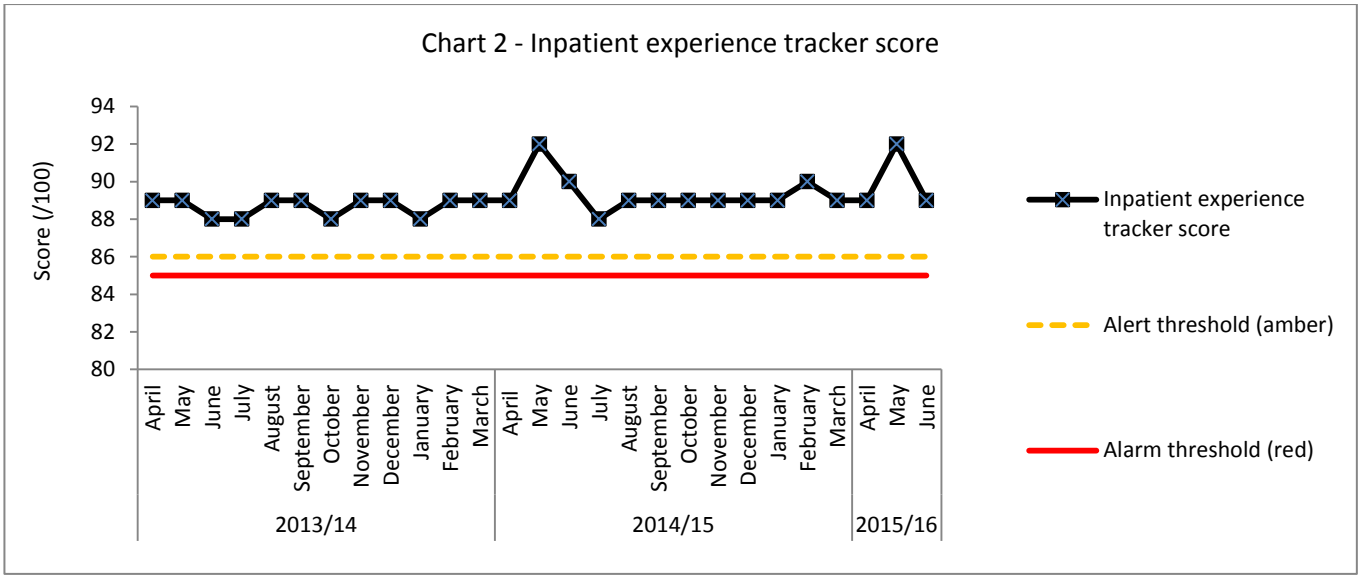


Chart 2 - Inpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April May June July August September October November December January February March April May June July August September October November December January February March April May June
2013/14
2014/15
2015/16
Inpatient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

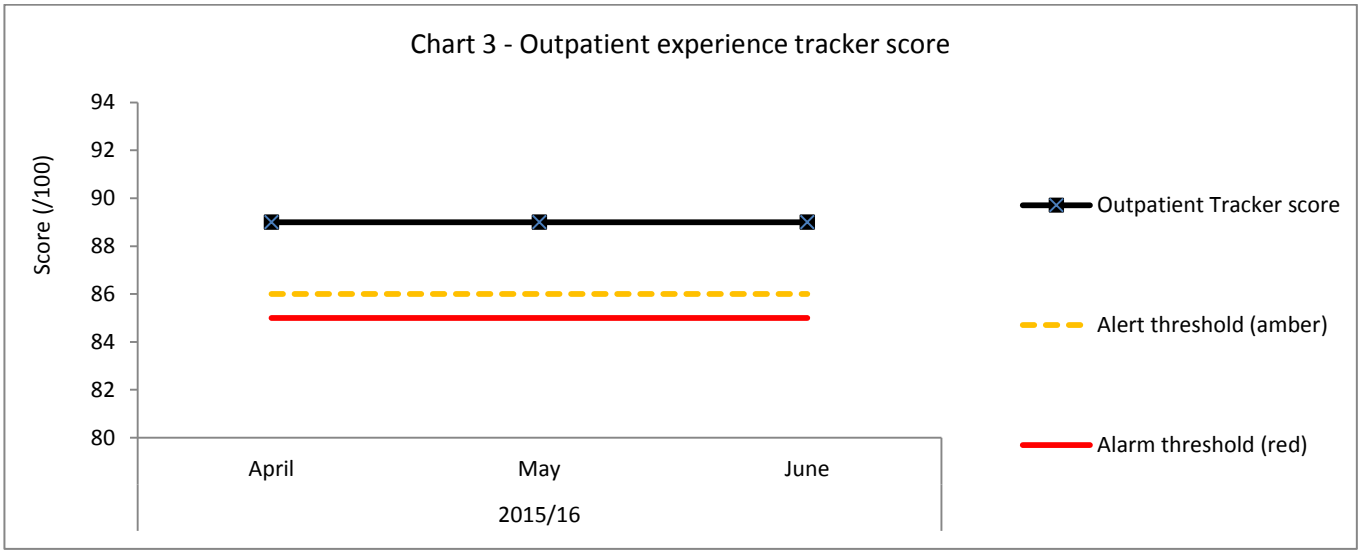
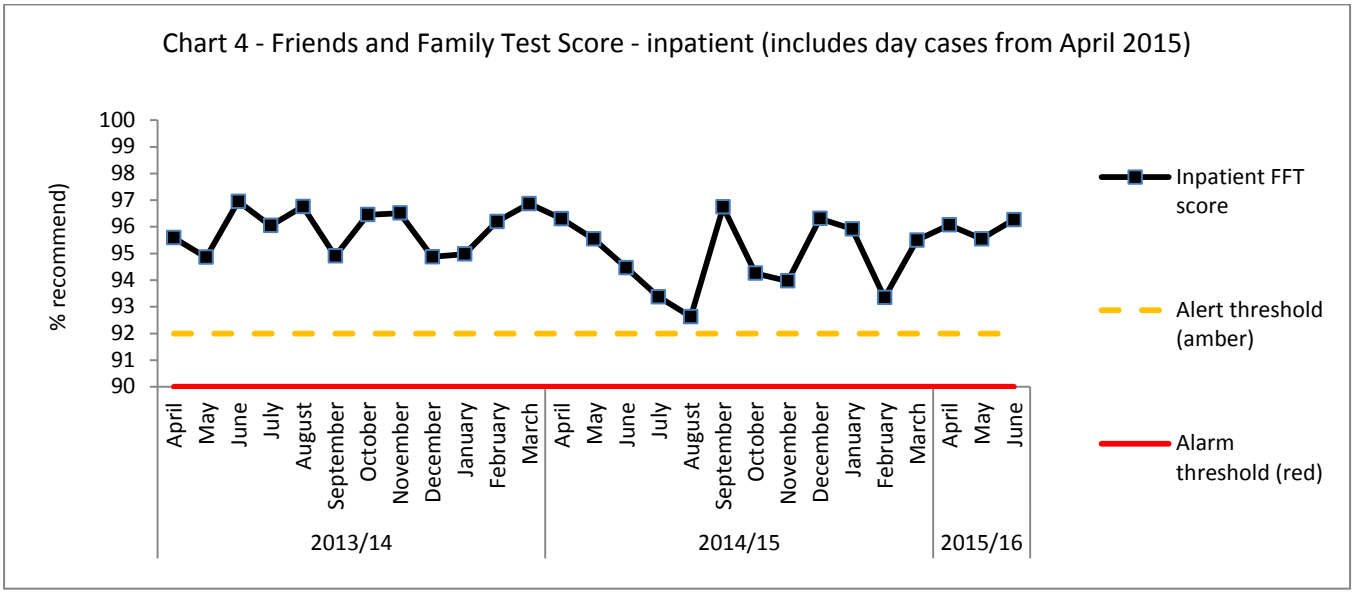
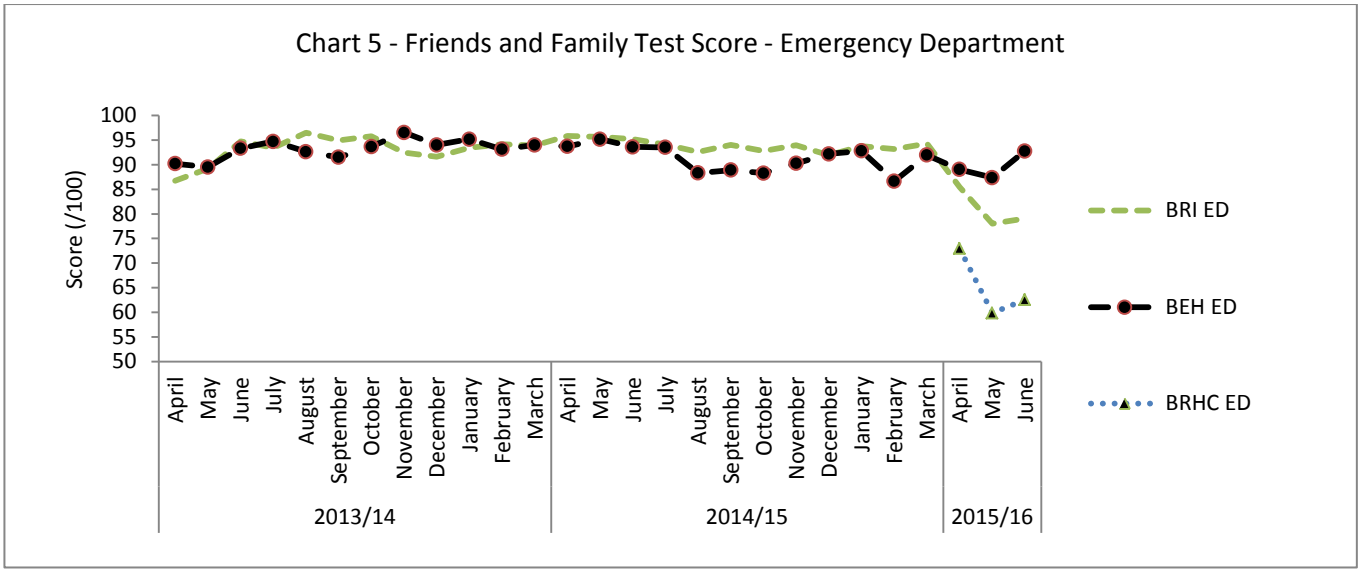
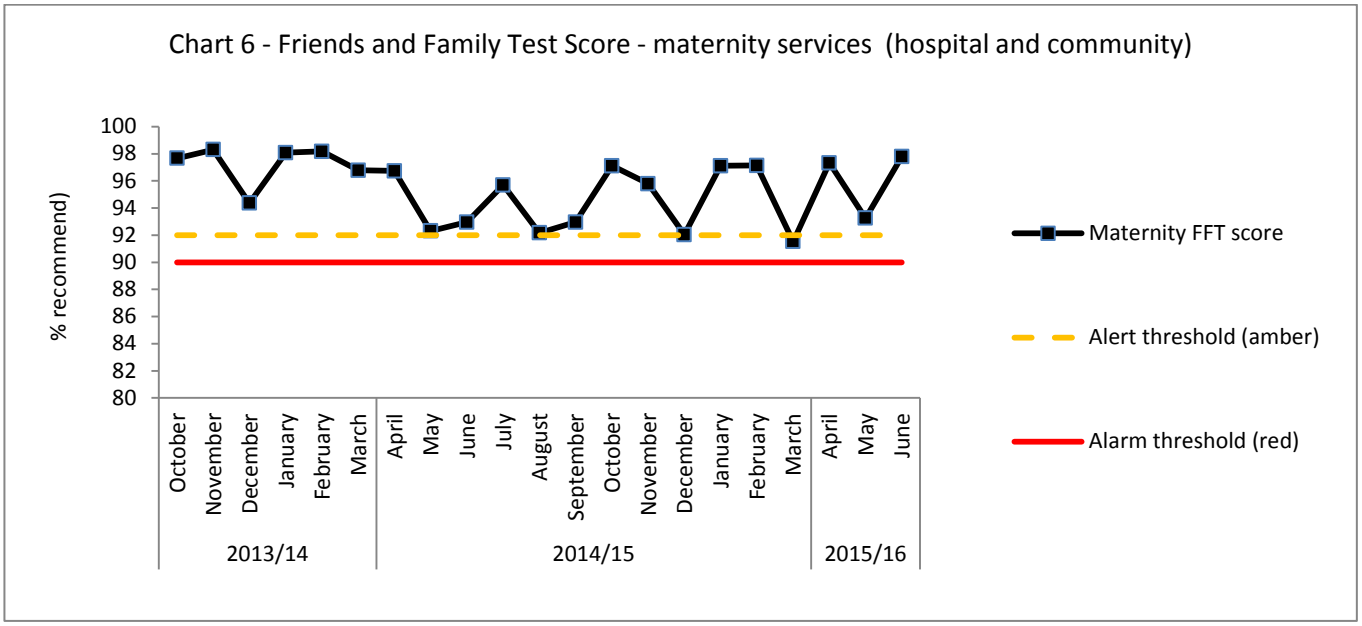


Chart 3 - Outpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
2015/16
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)







3. Divisional and hospital-level patient experience data

Charts 7 to 10 (page 7) show 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 threshold because there is a higher margin of error in the data at this level.

Postnatal wards tend to attract lower survey ratings for kindness and understanding (Chart 7) and in the Friends and Family Test (Chart 9). Directly comparing these scores with other inpatient wards is problematic because the demographics of respondents from maternity services are different to the rest of the Trust. It is important to note that the Trust's maternity scores are in line with (or better than) their national benchmarks (see section 6 of this report). However, the maternity services management team and staff remain committed to acting on service-user feedback, for example –

- To improve the experience of women having an induced labour there has been a reconfiguration of the maternity wards and staff rotas. This includes allocating dedicated staff and space within the ward (including six single rooms) women having inductions.
- Capital funding has been secured to improve the lay out of the post-natal ward and reception area.
- A housekeeper has been appointed to ensure that women are orientated to the ward and are able to obtain food / refreshments as required.
- The Supervisors of Midwives have set up a contact telephone number for patients to contact them with any concerns about their care.
- Setting realistic expectations for future service users is also important. Work has being carried out with the community midwifery teams to ensure that women coming into hospital who have a normal birth know that they won't be treated as patients: they will be encouraged to mobilise soon after birth and to care for their baby.
- Patient experience and feedback from patients is discussed within the midwifery patient safety day, which is mandatory for midwives to attend.

Charts 11 to 14 (page 8) show the headline survey results by hospital. Again, the Trust-level alarm threshold is shown, but should be applied with caution due to the higher margin of error in the data at this level.

The South Bristol Community Hospital (SBCH) receives positive patient ratings for outpatient services (Chart 14) and for the "caring" aspects of inpatient care (Charts 11 and 13). However two elements of the "inpatient tracker" bring down the overall score on this metric (Chart 12): involvement in care decisions and communication (receiving understandable answers to questions put to doctors and nurses). The management team at SBCH are aware of these scores and are constantly striving to improve the service provided to patients and their carers / families, but as a large proportion of inpatients at SBCH are elderly with long-term medical / care needs (e.g. rehabilitation from stroke), these lower "communication" scores are in many ways a realistic reflection of the challenges in caring for this group of patients. This is a trend seen at both national-level[4] and within UH Bristol's own survey data.

Two hospitals had relatively low scores on the new outpatient experience tracker (Chart 14): the Bristol Royal Hospital for Children and the Bristol Eye Hospital. The main reason for these lower scores is that patients in these hospitals reported longer waiting times in clinic. As we have not yet collected sufficient data to establish trends in this new dataset, this may have been a temporary issue during Quarter 1. The Trust has a Quality Objective associated with reduced waiting times and so this information will be fed into the project team.

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

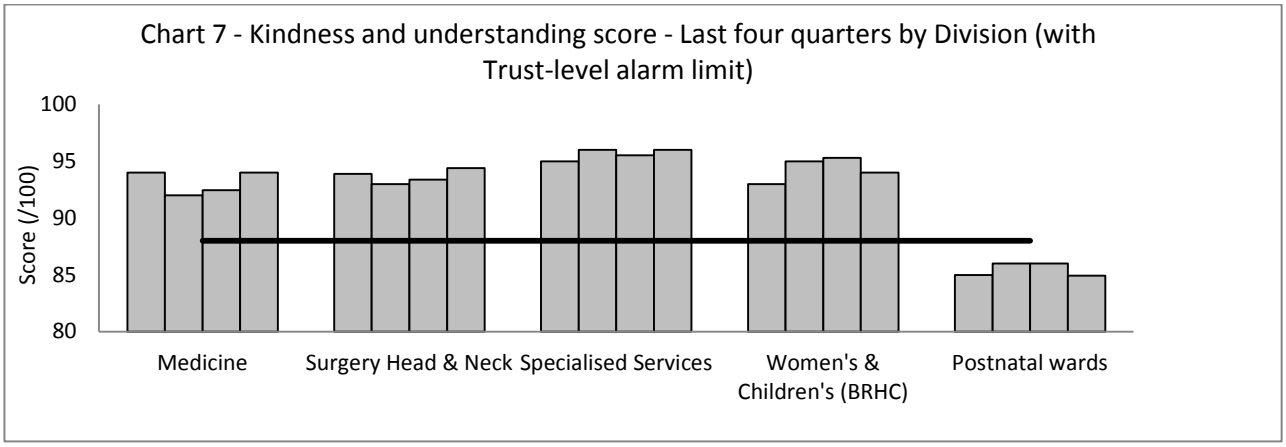


Chart 7 - Kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)
Score (/100)
100
95
90
85
80
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Postnatal wards

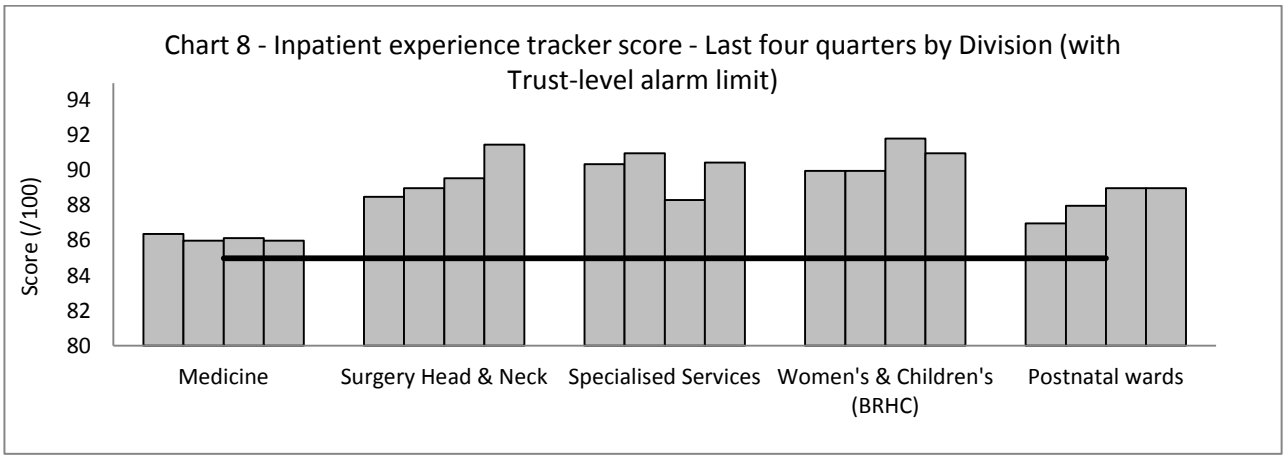


Chart 8 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)
Score (/100)
94
92
90
88
86
84
82
80
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Postnatal wards

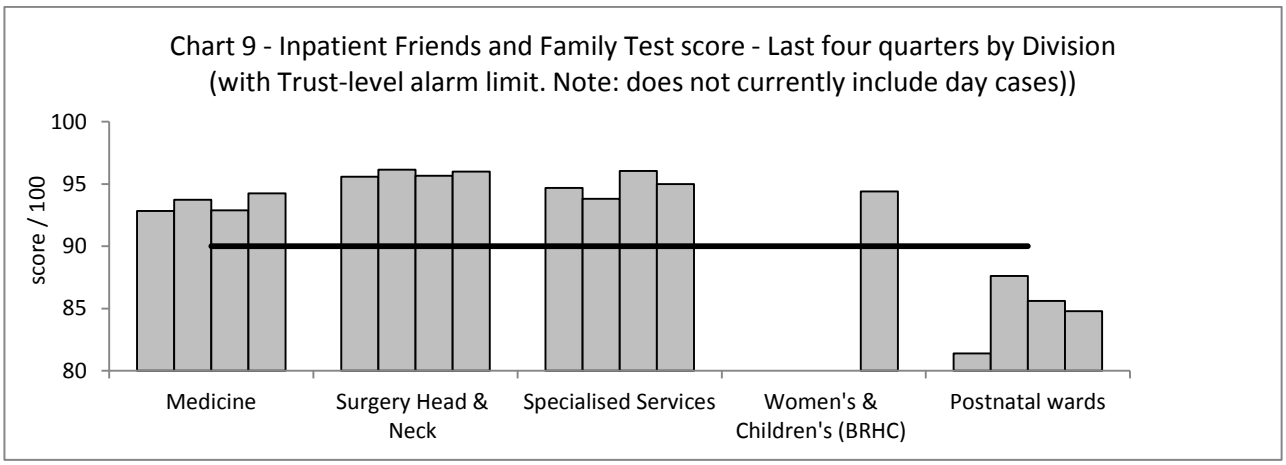


Chart 9 - Inpatient Friends and Family Test score - Last four quarters by Division (with Trust-level alarm limit. Note: does not currently include day cases))
score / 100
100
95
90
85
80
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Postnatal wards

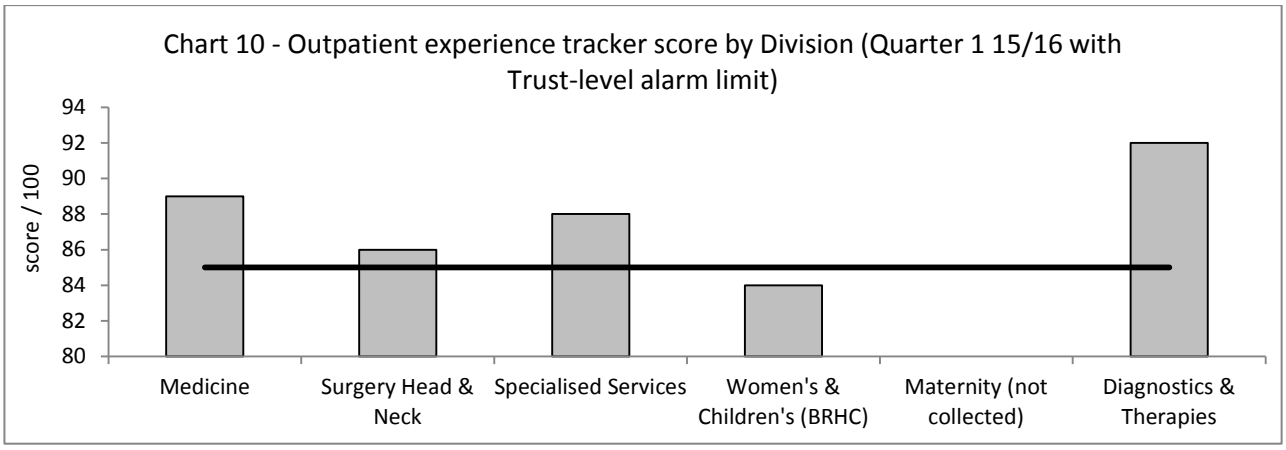


Chart 10 - Outpatient experience tracker score by Division (Quarter 1 15/16 with Trust-level alarm limit)
score / 100
94
92
90
88
86
84
82
80
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Maternity (not collected)
Diagnostics & Therapies

Chart 11: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

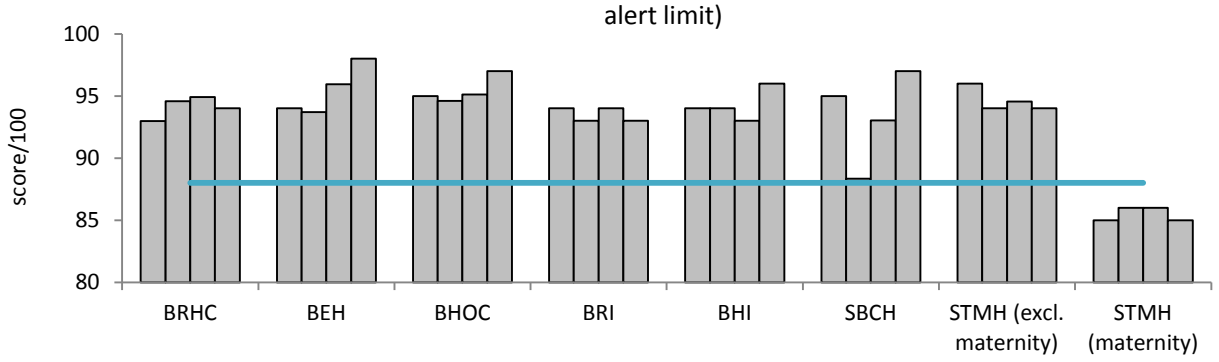


Chart 12: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

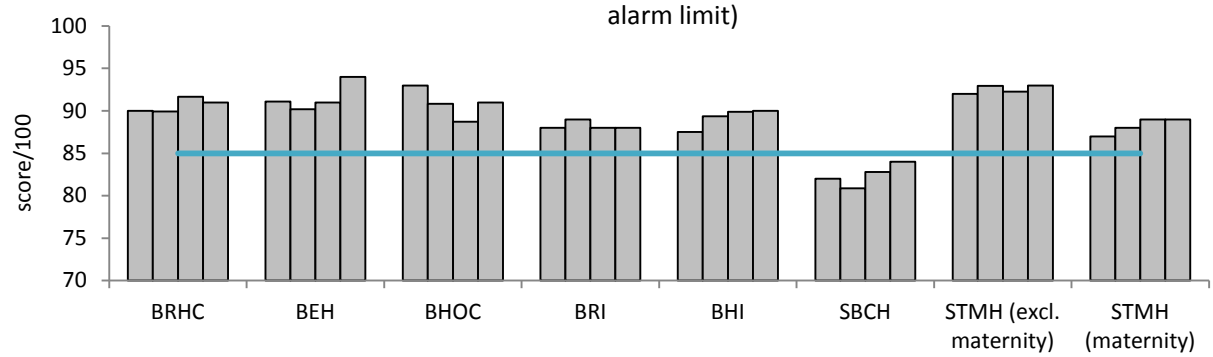


Chart 13: Inpatient and day case Friends and Family Test (last four quarters; with Trust-level alarm limit)

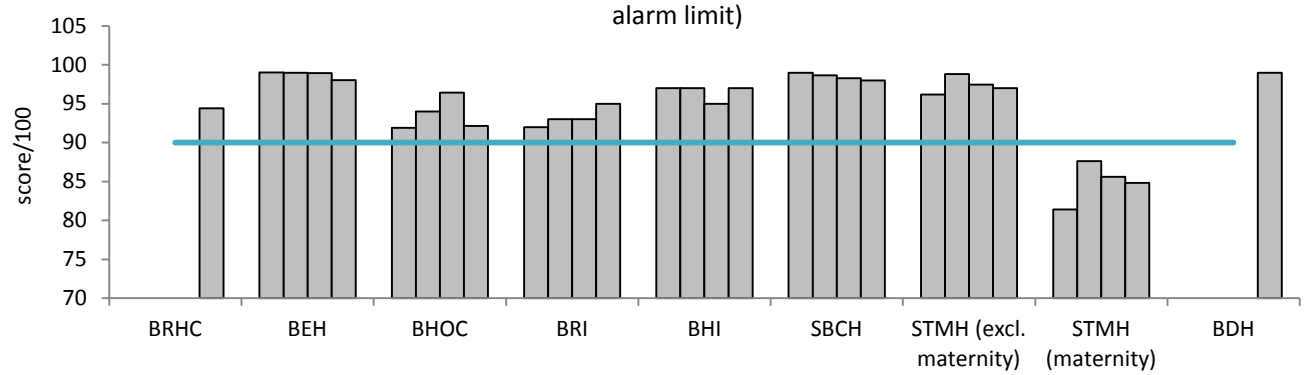
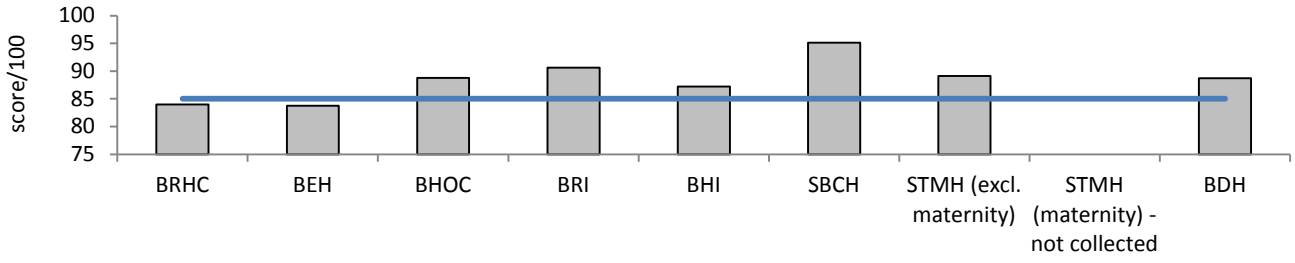


Chart 14: Outpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)



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

4. Ward-level data

Ward-level inpatient survey and Friends and Family Test data is presented in charts 15 to 17 (over)[5]. The quality of this ward-level data has been adversely affected by the ward moves occurring within the Bristol Royal Infirmary. To minimise the effect of these moves on the data, scores from a single Quarter are presented here – but this significantly reduces the sample sizes, which has a detrimental effect on the reliability of the data (ideally we would aggregate this data to a six-monthly view). Furthermore, in the Friends and Family Test, a number of new ward areas went "live" in April 2015 (principally at the Bristol Royal Hospital for Children): these wards have not yet gained full traction in terms of generating high response rates, and so at present the FFT is particularly unreliable at this level. These issues will resolve over the coming months, but caution should be applied to the survey scores presented in this section of the report.

At a ward-level it is important to look for consistent trends across the surveys (particularly given the issues described above) and to draw on wider quality data /research to help interpret the results:

- In Chart 15, the kindness and understanding score for postnatal wards (71,74,76) has been discussed in Section 3 of this report. Whilst the Friends and Family Test survey also tends to be slightly lower for postnatal wards, In Quarter 1 Ward 74 achieved a very low score (Chart 17). The maternity FFT data is particularly prone to fluctuation at a ward level, as the number of responses is generally quite low at this level. However this particular score was mainly attributable an unusually high number of "don't know" responses for Ward 74 in Quarter 1: these are included in the FFT score calculation and so serve to reduce the percentage of respondents stating that they would recommend the care. It is not clear why there were such a large proportion of these responses in Quarter 1 for this ward.

- Ward A900 had the lowest "kindness and understanding" rating and among the lowest scores on the inpatient tracker in Quarter 1. Ward A900 is a new ward at the Bristol Royal Infirmary that provides specialist care for patients admitted with gastro and respiratory problems. It also houses the inpatient beds for the Bristol Adult Cystic Fibrosis Centre, which is an adult specialist centre providing multidisciplinary care to adults with Cystic Fibrosis (CF) in the region. Whilst in general the patient feedback is positive about the ward, some CF patients have expressed concerns about their care. In order to better understand these issues, an analysis of patient feedback about the ward was carried out and the Trust's *Face2Face* survey volunteers visited the ward in September 2015 to talk specifically to CF patients. As frequent users of UH Bristol's services (and often experts in their own care), it is clear that the move to a new environment, with a new care team, poses challenges and requires new relationships and confidence to be built. The outcomes of this exercise are currently being reviewed by the Head of Nursing and ward team, and will be used to target improvements in the experience for these patients.

- B501 (care of the elderly) and B504 (acute stroke) in the Bristol Royal Infirmary had the lowest inpatient tracker scores in Quarter 4. This was primarily due to the communication and involvement in care elements of this aggregate score. As discussed in relation to South Bristol Community Hospital, this is a realistic reflection of the challenges in caring for these patient groups and reflects research findings at a national level. The Divisional Head of Nursing continues to monitor the survey scores and to triangulate them with other data sources, to ensure that a high quality of care is maintained.

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

Chart 15: Kindness and understanding ratings by ward (April to June 2015), with Trust-level alarm threshold)

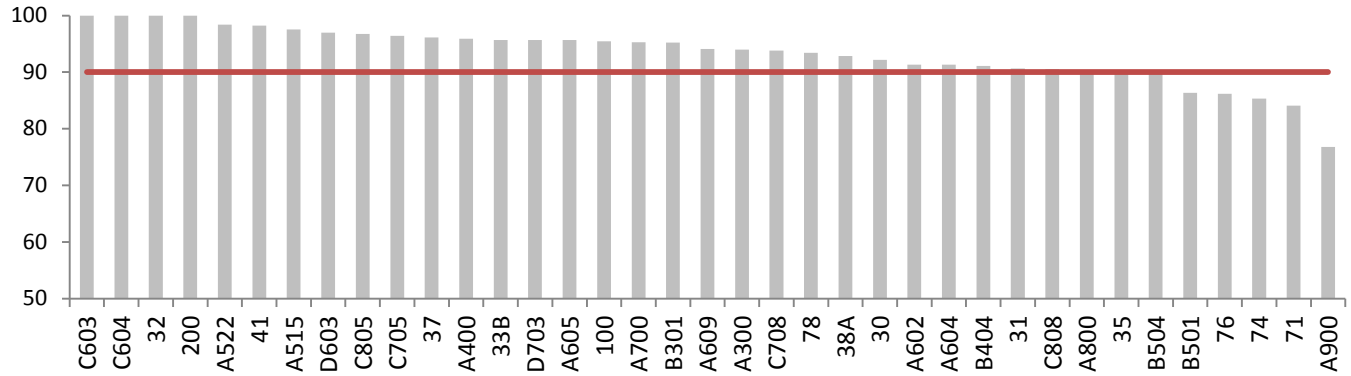


Chart 16: Patient Experience Tracker score by ward (April to June 2015), with Trust-level alarm threshold

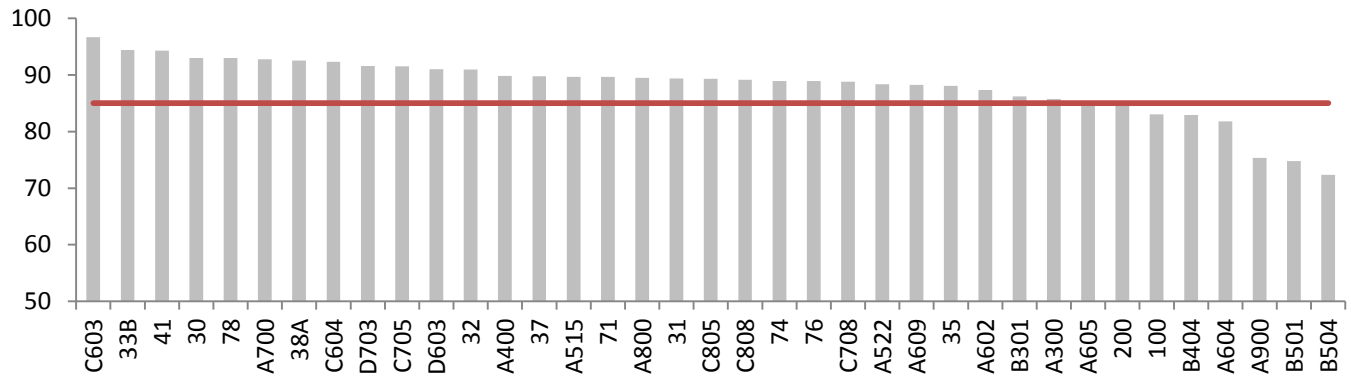
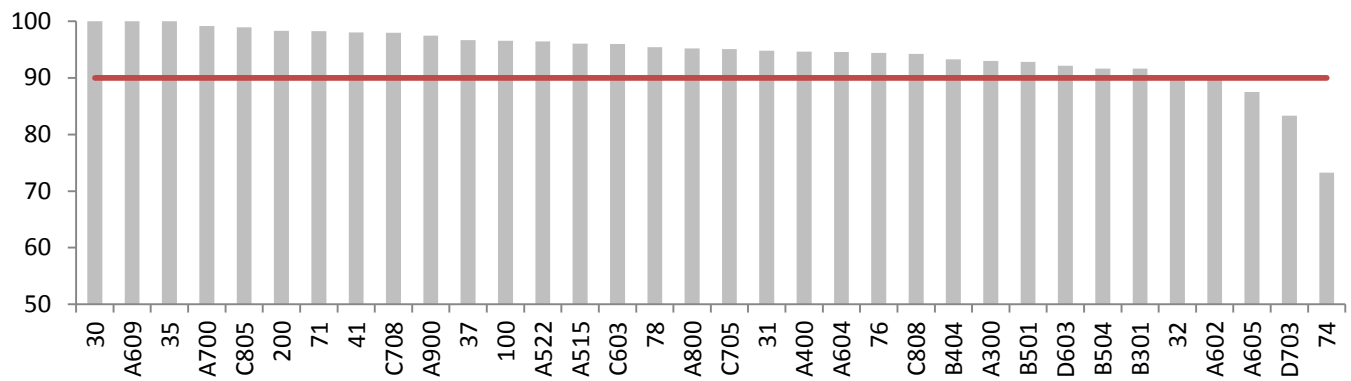


Chart 17: Friends & Family Test inpatient results by ward (April to June 2015), with Trust-level alarm threshold) - no data is available for the Bristol Royal Hospital for Children



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

At the end of our postal survey questionnaires, patients are invited to comment on any aspect of their stay – in particular anything that was worthy or praise or that could have been improved. In the twelve months to 30 June 2015, around 5,000 written comments were received in this way. All comments are categorised, reviewed by the relevant Heads of Nursing, and shared with ward staff for wider learning. The over-arching themes from these comments are provided below. Please note that "**valence**" is a technical term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed).

All inpatient /parent comments (excluding maternity)

Theme	Valence	% of comments[6]	
Staff	Positive	61%	*61% of the comments received contained praise for UH Bristol staff. Improvement themes centre on communication, staff, waiting/delays, and food. "Food" generates strong feelings, but the majority of patients (65%) rate it as "very good" or "good"*
Communication	Negative	14%	
Waiting/delays	Negative	10%	
Staff	Negative	9%	
Food/catering	Negative	9%	

Division of Medicine

Theme	Valence	% of comments	
Staff	Positive	57%	*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	13%	
Staff	Negative	10%	

Division of Specialised Services

Theme	Valence	% of comments	
Staff	Positive	63%	*Negative comments about staff also often relate to a one-off negative experience with a single member of staff, showing how important each individual can be in shaping a patient's experience of care.*
Communication	Negative	15%	
Waiting / delays	Negative	10%	

Division of Surgery, Head and Neck

Theme	Valence	% of comments	
Staff	Positive	60%	*Communication is a key issue, but it is a very broad theme which includes ease of contacting the trust, patient information, clinic letters, and face-to-face discussions with individual staff.*
Communication	Negative	16%	
Waiting/delays	Negative	10%	

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

Theme	Valence	% of comments	
Staff	Positive	68%	*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	14%	
Waiting/delays	Positive	11%	

Maternity comments

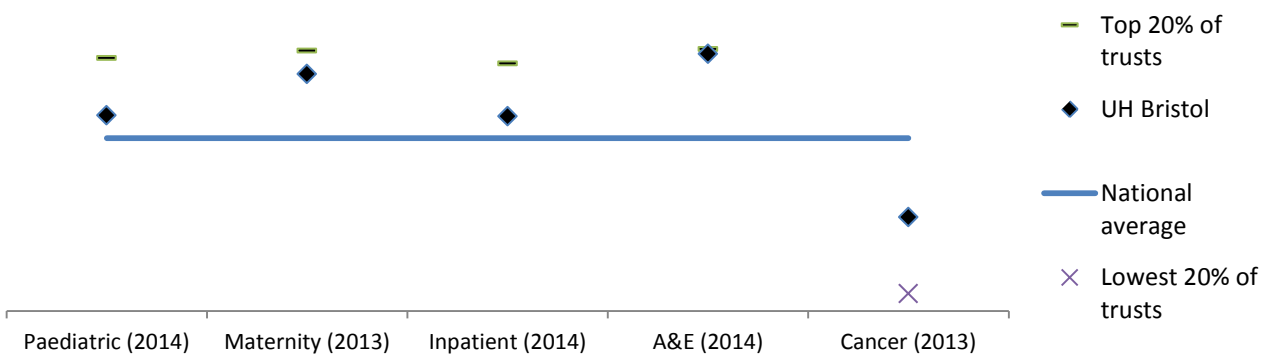
Theme	Valence	% of comments	
Staff	Positive	61%	*For maternity services, the two most common themes relate to praise for staff and praise for care during labour and birth.*
Care during labour	Positive	24%	
Staff	Negative	13%	

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

6. National patient survey programme

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 18 below[7] and Appendix A. It can be seen that UH Bristol broadly performs among the mid-performing trusts nationally. The main exception is the 2014 national Accident and Emergency survey, where UH Bristol performed well above the national average. The national cancer survey (NCS) on the other hand tends to produce scores for UH Bristol that are lower than the national average, despite a large number of service improvement actions at the Trust to try and redress this. A comprehensive engagement programme with patients receiving cancer services at UH Bristol has been carried out, in collaboration with the Patient's Association. In addition, the Trust is participating in an NHS England programme which involves working closely with a peer Trust that performs consistently well in the NCS. These activities have formed the development of a service-improvement plan which was received by the Trust's Cancer Steering Group in Quarter 2 (2015/16).

Chart 18: Comparison of UH Bristol's national patient experience survey results against the national average (year in brackets / nearest quintile threshold shown)



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)	0.3%	1%
1 to 4	6%	6%
5 to 7	18%	21%
8 and 9	50%	46%
10	26%	27%

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

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

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)*
2014 National Inpatient Survey	57/60 scores were in line with the national average. One score was below (availability of hand gels) and two were above (explaining risks and benefits and discharge planning)	July 2015	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Explaining potential medication side effects to patients at discharge	May 2016
2013 National Maternity Survey	14 scores were in line with the national average; 3 were better than the national average	January 2014	Six-monthly	• Continuity of antenatal care • Communication during labour and birth • Care on postnatal wards	January 2016
2013 National Cancer Survey	30/60 scores were in line with the national average; 28 scores were below the national average; 2 were better than the national average	November 2014	Six-monthly	• Providing patient-centred care • Validate survey results • Understanding the shared-cancer care model, both within UH Bristol and across Trusts	September 2015
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	December 2014
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 survey dataset (Quarter 1 2015/16)

The following table contains a full update of the inpatient and parent data for January to March 2015. Where equivalent data is also collected in the maternity survey, this is presented also. All scores are out of 100 (see Appendix D), with 100 being the best. Cells are shaded amber if they are more than five points below the Trust-wide score, and red if they are ten points or more below this benchmark. See page 14 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?	90	92	94	91	n/a	92
How would you rate the hospital food you / your child received?	63	62	61	60	59	61
Did you / your child get enough help from staff to eat meals?	78	84	81	70	n/a	79
In your opinion, how clean was the hospital room or ward you (or your child) were in?	94	96	95	92	89	95
How clean were the toilets and bathrooms that you / your child used on the ward?	91	93	91	91	83	92
Were you / your child ever bothered by noise at night from hospital staff?	79	85	85	86	n/a	84
Do you feel you / your child was treated with respect and dignity on the ward?	94	95	97	96	91	96
Were you / your child treated with kindness and understanding on the ward?	94	94	96	94	85	94
How would you rate the care you / your child received on the ward?	85	89	89	89	83	88
When you had important questions to ask a doctor, did you get answers you could understand?	80	88	87	91	88	86
When you had important questions to ask a nurse, did you get answers you could understand?	83	89	87	90	91	87
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	69	71	71	73	77	71
If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so?	79	84	85	86	86	83
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	78	85	86	88	87	84
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	86	88	89	86	n/a	87
Did you / your child find someone to talk to about your worries and fears?	68	73	75	76	78	73
	MDC	**SHN**	**SPS**	**WAC (Excl.**	**Maternity**	**Trust**

				Maternity)		(excl Mat.)
Staff explained why you needed these test(s) in a way you could understand?	80	87	86	93	n/a	86
Staff tell you when you would find out the results of your test(s)?	68	68	68	82	n/a	71
Staff explain the results of the test(s) in a way you could understand?	73	78	78	86	n/a	78
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	82	93	90	95	n/a	91
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	72	79	76	87	n/a	79
Staff were respectful any decisions you made about your / your child's care and treatement	88	93	94	94	n/a	92
During your hospital stay, were you asked to give your views on the quality of your care?	22	23	25	25	32	23
Do you feel you were kept well informed about your / your child's expected date of discharge?	84	90	88	91	n/a	88
On the day you / your child left hospital, was your / their discharge delayed for any reason?	65	61	57	67	60	62
% of patients delayed for more than four hours at discharge	21	19	12	20	30	18
Did a member of staff tell you what medication side effects to watch for when you went home?	51	66	59	68	n/a	61
Total responses	448	526	389	366	246	1975

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

Appendix C – UH Bristol corporate patient experience programme

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

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	Before leaving hospital, all adult inpatients, day case, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity surveys, annual outpatient and day case surveys)	These surveys, which each month are sent to a random sample of approximately 1500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level. A new monthly outpatient survey commenced in April 2015, which is sent to around 500 patients / parents per month.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view.
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

Appendix D: survey scoring methodologies

Postal surveys

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

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

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

Friends and Family Test Score

The inpatient and day case Friends and Family Test (FFT) is a card given to patients at the point of discharge from hospital. It contains one main question, with space to write in comments: How likely are you to recommend our ward to Friends and Family if they needed similar care or treatment? The score is calculated as the percentage of patients who tick “extremely likely” or “likely”.

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

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 1, 2015/2016

(1 April to 30 June 2015)

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

1. Executive summary

- 459 complaints were received in Quarter 1 of 2015/16 (Q1), representing 0.25% of activity, compared to 517 complaints (0.28%) in Quarter 4 of 2014/15 (Q4) and 421 (0.23%) in Quarter 3 (Q3).
- In Q1, of the 459 complaints received, 175 (38%) were dealt with through the formal complaints process, whilst the majority, 284 (62%), were resolved informally. This compares to 237 (46%) formal and 280 (54%) informal in Q4.
- The Trust's performance in responding to complaints within the timescales agreed with complainants was 84.9% in Q1 compared to 84.7% in Q4 and 83.4% in Q3. 85.7% of breaches (24/28) were attributed to Divisions in Q1 compared to 63% (17/27) in Q4.
- The number of cases where the original response deadline was extended rose to 44 in Q1, compared to 27 cases in Q4 and 46 in Q3.
- The way in which the Trust reports the number of complainants who tell us that they are unhappy with our investigation of their concerns has changed with effect from Q1. "Dissatisfied" cases are now reported as a percentage of the total number of responses sent out in a given month. At the time of completing this report (11th August 2015), performance for Q1 is 3.2% (i.e. by this date, of the 186 responses sent out during Q1, six complainants had told us that they were dissatisfied).
- In Q1, complaints relating to appointments and admissions continued to account for over a third (37%) of the total complaints received by the Trust, in line with each quarter of 2014/15. Complaints about cancelled or delayed appointments and operations decreased in Q1 (124) having previously increased in Q4 (140).
- Complaints about failure to answer telephones rose for the fifth consecutive quarter, from 26 in Q4 to 34 in Q1.
- Complaints about Bristol Eye Hospital remained the same in Q1 as in Q4 at 71 complaints, having increased from 38 in Q3.
- There was a significant decrease in complaints about outpatient services in the Bristol Heart Institute, from 41 in Q4 to 21 in Q1.

This report includes detailed performance data regarding the handling of complaints and an analysis of the themes arising from complaints received in Q1, possible causes, and details of how the Trust is responding.

2. Complaints performance – Trust overview

Until now, the Board has monitored 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

In Q1, a change was made to way that the third of these indicators is calculated. "Dissatisfied" cases are now reported as a percentage of the total number of responses sent out in a given month. This indicator will be reported one month in arrears to allow complainants the opportunity to express their dissatisfaction should they wish. For example, in May 2015 the Trust sent out 62 response letters. By the cut-off date of 14th July 2015, two complainants of the 62 who received their responses in May had told us they were dissatisfied with our response. This data will be reported to the Board as a 'headline indicator' each month.

The table on page 4 of this report provides a comprehensive 13 month overview of complaints performance including all three key indicators, with the change to the way in which dissatisfied cases are recorded shown with effect from April 2015.

2.1 Total complaints received

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

We received 459 complaints in Q1, which equates to 0.25% 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 Q1 represents a decrease of approximately 11% compared to Q4 (517) and a 7% increase on the corresponding period a year ago.

[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.

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Total complaints received (inc. TS and F&E from April 2013)	166	178	170	170	148	14	133	165	171	181	158	147	154
Formal/Informal split	64/102	79/99	73/97	86/84	68/80	61/79	52/81	70/95	79/92	88/93	72/86	46/101	57/97
Number & % of complaints per patient attendance in the month	*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*	*0.27% 165 of 61,683*	*0.29% (171 of 58,687)*	*0.27% (181 of 66,317)*	*0.27% (158 of 59,419)*	*0.25% (147 of 58,716)*	*0.23% (154 of 66,548)*
% responded to within the agreed timescale (i.e. response posted to complainant)	*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)*	*84.8% (56 of 66)*	*83.7% (36 of 43)*	*85.3% (58 of 68)*	*89.5% (51 of 57)*	*83.9% (52 of 62)*	*82.1% (55 of 67)*
% responded to by Division within required timescale for executive review	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)	87.9% (58 of 66)	81.4% (35 of 43)	92.6% (63 of 68)	87.7% (50 of 57)	91.9% (57 of 62)	94.0% (63 of 67)
Number of breached cases where the breached deadline is attributable to the Division	6 of 10	4 of 6	4 of 7	6 of 7	6 of 12	6 of 12	1 of 12	7 of 10	2 of 7	8 of 10	3 of 6	9 of 10	12 of 12
Number of extensions to originally agreed timescale (formal investigation process only)	8	19	5	17	20	15	11	16	4	7	7	21	16
Percentage of Complainants Dissatisfied with Response											*1.8% (1 case)*	*3.2% (2 cases)*	*4.5% (3 cases)*

Figures 1 and 2 show the decrease in the volume of complaints received in Q1 (2015/16) compared to Q4 (2014/15) and also when compared to the corresponding period last year.

Figure 1: Number of complaints received

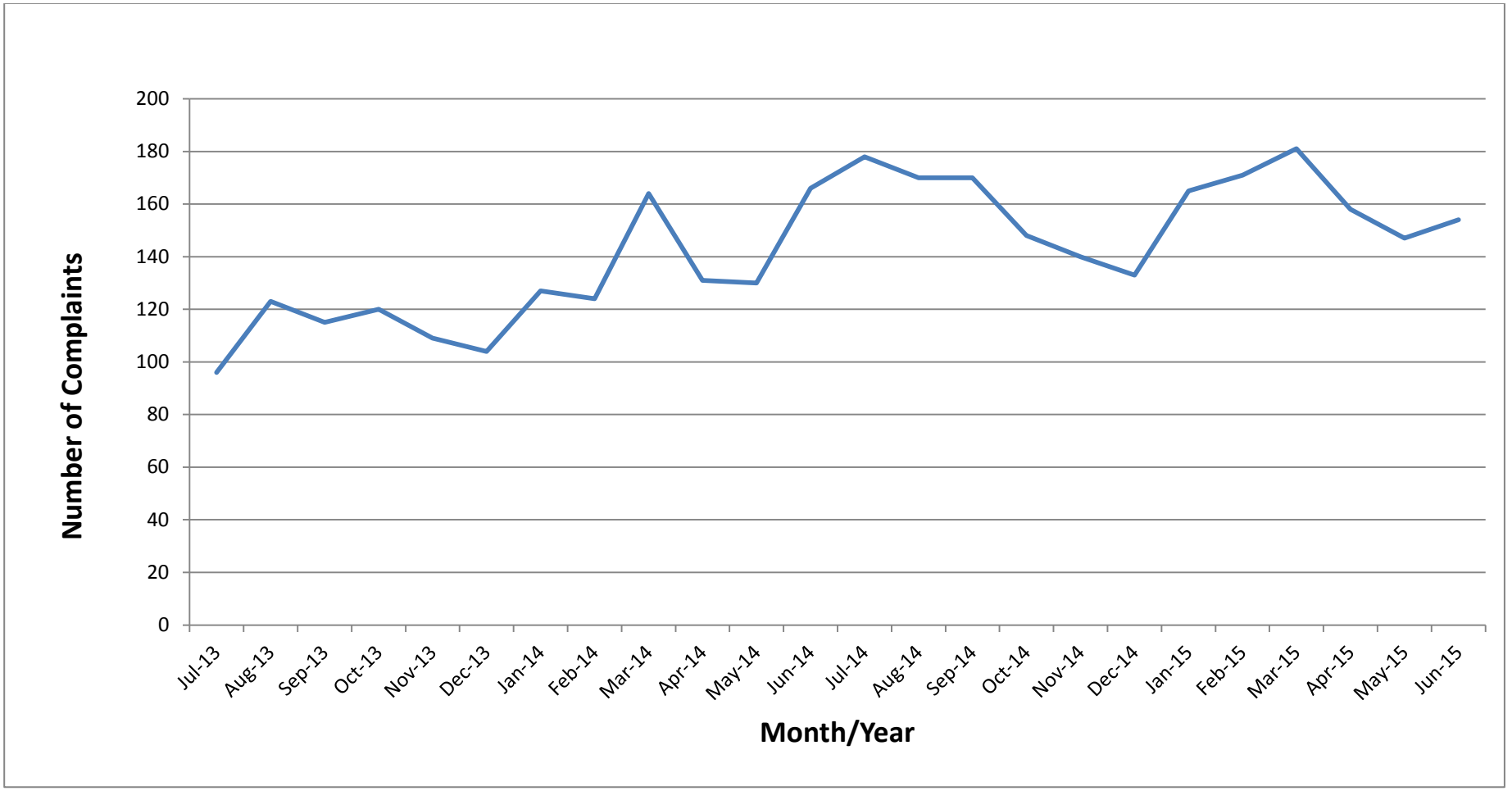
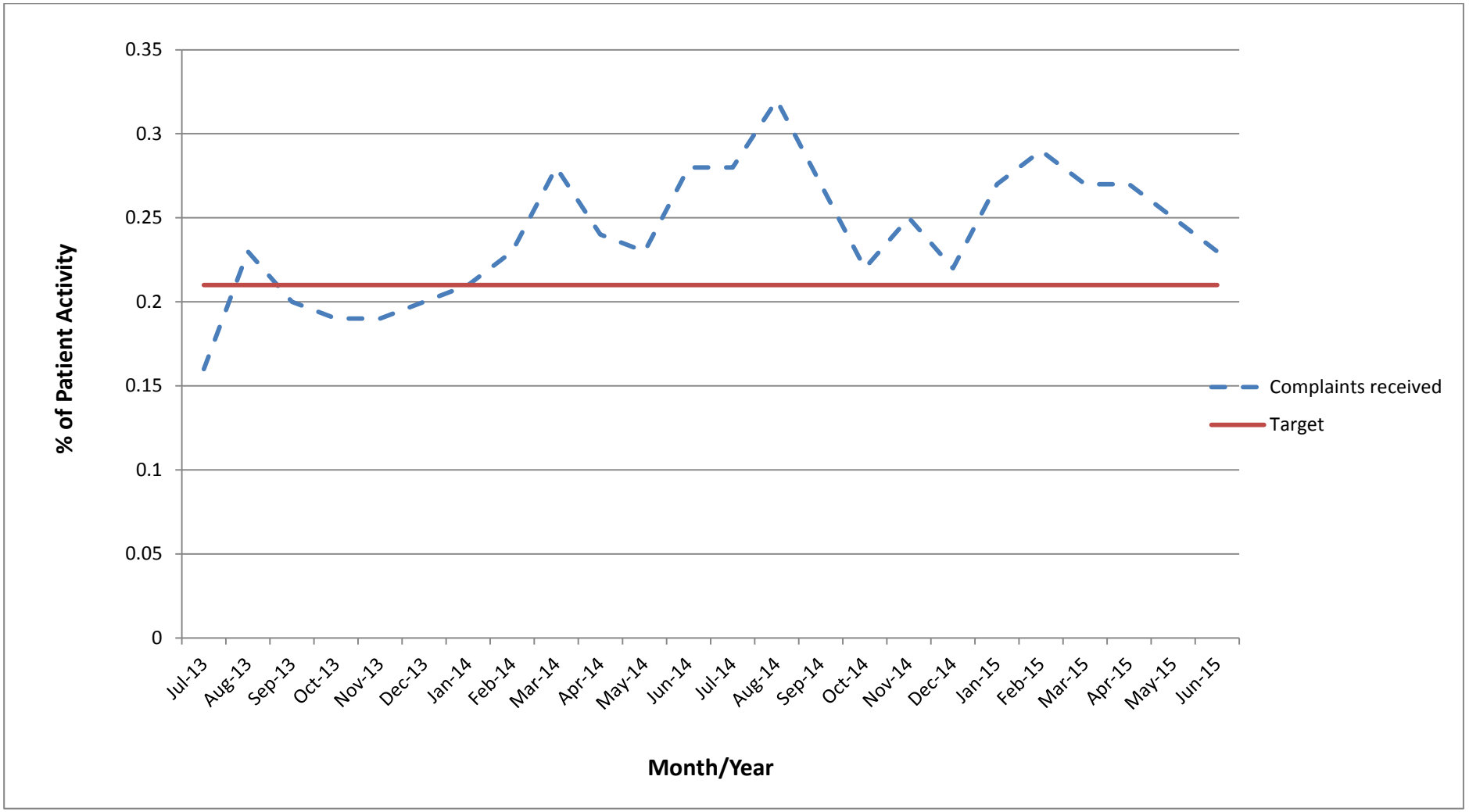


Figure 2: Complaints received, as a percentage of patient activity



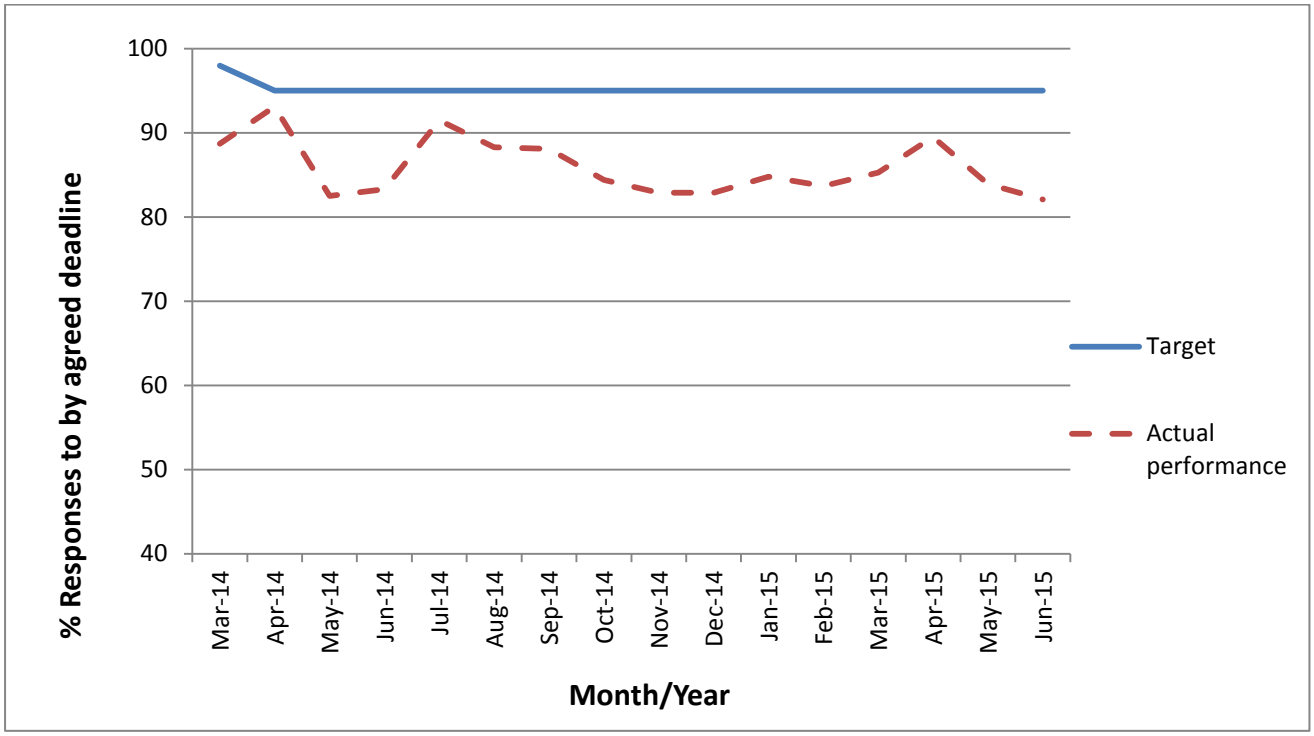
2.2 Complaints responses within agreed timescale

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

The Trust's target is to respond to at least 95% of complainants within the agreed timescale (prior to April 2014 this was 98%). The end point is measured as the date when the Trust's response is posted to the complainant. In Q1, 84.9% of responses were made within the agreed timescale, compared to 84.7% in Q4. This represents 28 breaches out of 186 formal complaints which were due to receive a response during Q1[2]. Figure 3 shows the Trust's performance in responding to complaints since March 2014.

Although overall performance in Q1, Q4 and Q3 was very similar, there was a large increase in the proportion of these breaches that were attributable to the Divisions: 85.7% (24/28) in Q1; 63% (17/27) in Q4; and 36% (13/36) in Q3.

Figure 3. Percentage of complaints responded to within agreed timescale



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

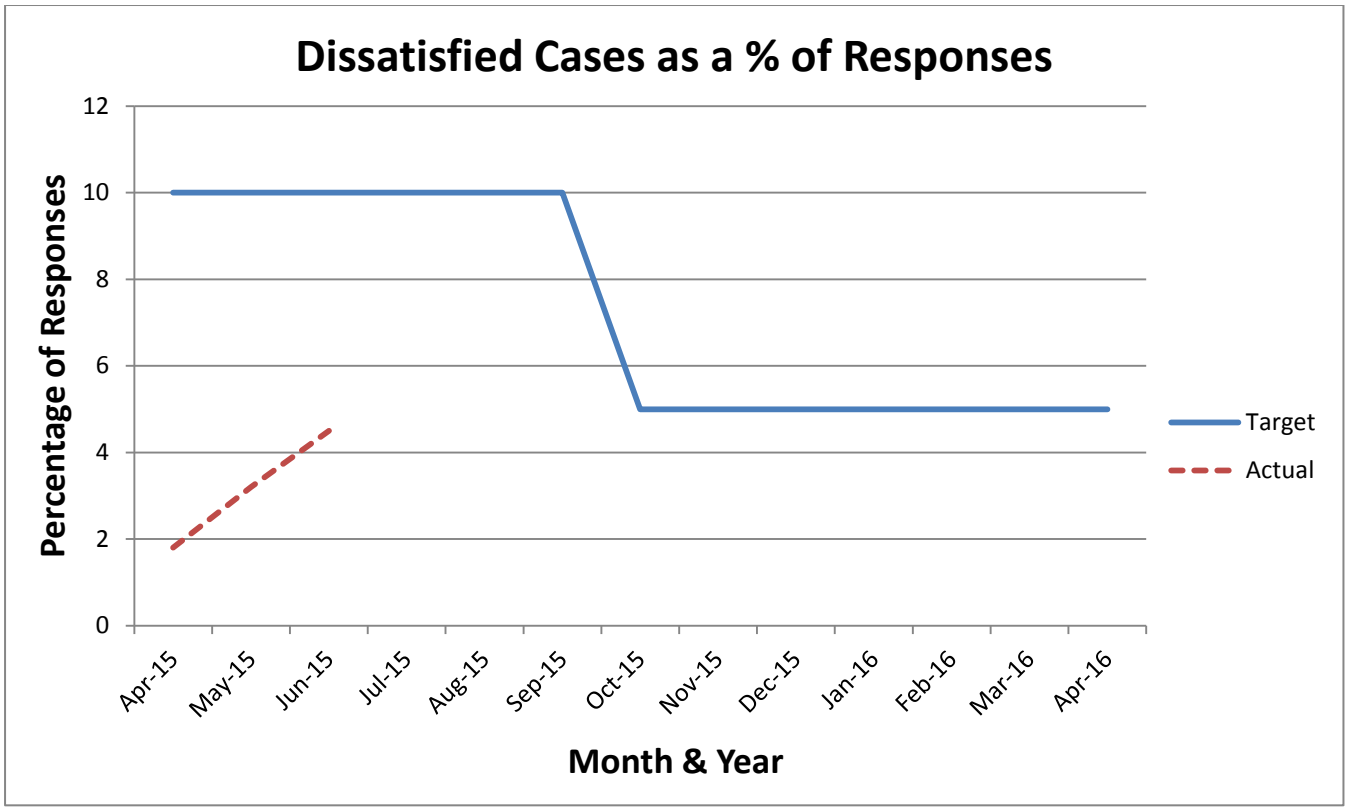
2.3 Dissatisfied complainants

Reducing numbers of dissatisfied complainants is one of the Trust's nine corporate quality objectives for 2015/16. We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are dissatisfied with the quality of our investigation of their concerns. For every complaint we receive, our aim is to identify whether and where we have made mistakes, to put things right if we can, and to learn as an organisation so that we 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. As noted earlier in section 2 of this report, the way in which dissatisfied cases are reported is now expressed as a percentage of the responses the Trust has sent out in any given month. In Q1 and Q2 of 2015/16, our target is for less than 10% of complainants to be dissatisfied, reducing to less than 5% from Q3 onwards.

In Q1, a total of 186 responses were sent out. By the cut-off point of 11th August 2015 (the date on which the complaints data for June was finalised), six people had contacted us to say that they were dissatisfied with our response. This represents 3.2% of the responses issued during that period.

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.

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



2.4 Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of six major themes. The table below provides a breakdown of complaints received in Q1 compared to Q4. Complaints about all category types decreased in Q1 in real terms, although 'appointments and admissions', 'attitude and communication' and 'clinical care' all showed a slight increase when measured as a proportion of complaints received.

Category Type	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Appointments & Admissions	170 (37% of total complaints) ↓	186 (36% of total complaints) ↑
Attitude & Communication	127 (28%) ↓	129 (25%) ↑
Clinical Care	118 (26%) ↓	124 (24%) ↑
Facilities & Environment	12 (3%) ↓	26 (5%) ↑
Access	8 (2%) ↓	21 (4%) ↑
Information & Support	24 (4%) ↓	31 (6%) ↑
Total	**459**	**517**

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 62% of the complaints received in Q1 (285/459).

Sub-category	Number of complaints received – Q1 2015/16	Q4 2014/15	Q3 2014/15	Q2 2014/15
Cancelled or delayed appointments and operations	124 ↓ (11% decrease *compared to Q4*)	140	124	152
Clinical Care (Medical/Surgical)	49 ↓ (37% decrease)	78	58	62
Communication with patient/relative	33 ↑ (27% increase)	26	28	35
Clinical Care (Nursing/Midwifery)	24 ↓ (8% decrease)	26	26	34
Attitude of Nursing/Midwifery	10 =	10	14	22
Attitude of Medical Staff	11 ↓ (48% decrease)	21	15	21
Failure to answer telephones	34 ↑ (31% increase)	26	19	12

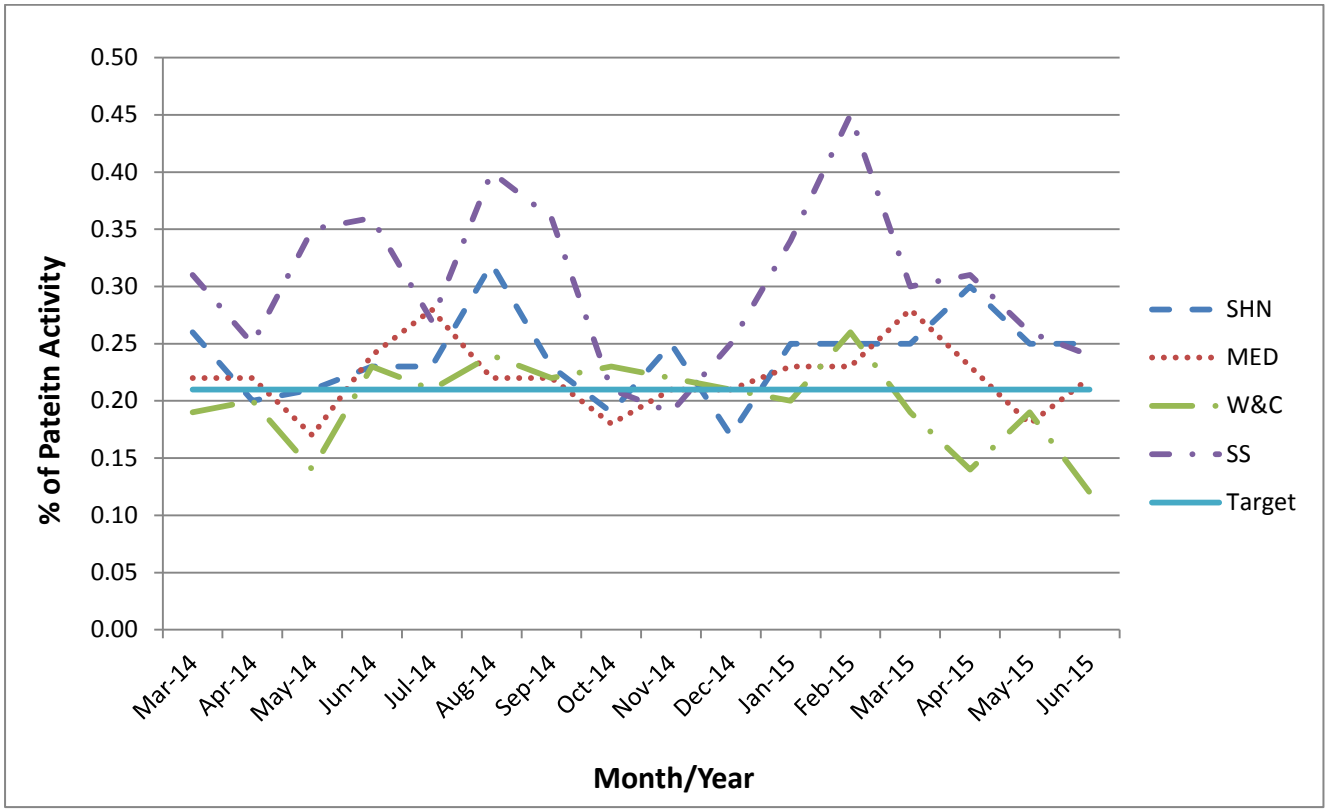
The issue of cancelled or delayed appointments and operations has seen an 11% decrease in Q1, following a significant increase in the previous quarter. There have been significant decreases in complaints about clinical care and attitude of medical staff. Complaints regarding the failure to answer telephones has seen a 31% increase, the fifth successive quarterly increase.

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 downturn in the volume of complaints received in the bed-holding Divisions during Q1, although the Division of Surgery, Head & Neck did show a slight upturn compared to Q4.

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 July 2014

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Number of complaints received	17	6	10	7	7	8	7	5	11	2	5	7

3.2 Divisional analysis of complaints received

Table 3 provides an analysis of Q1 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	208 (204) ↑	85 (98) ↓	61 (82) ↓	65 (90) ↓	14 (23) ↓
Total complaints received as a proportion of patient activity	0.26% (0.25%) ↑	0.21% (0.25%) ↓	0.27% (0.36%) ↓	0.15% (0.22%) ↓	N/A
Number of complaints about appointments and admissions	101 (93) ↑	19 (30) ↓	26 (34) ↓	22 (23) ↓	3 (4) ↓
Number of complaints about staff attitude and communication	56 (46) ↑	25 (29) ↓	18 (25) ↓	16 (22) ↓	5 (6) ↓
Number of complaints about clinical care	45 (42) ↑	34 (22) ↑	14 (11) ↑	24 (39) ↓	2 (9) ↓
Areas where the most complaints have been received in Q1	Bristol Eye Hospital – 71 (71) = Bristol Dental Hospital – 33 (37) ↓ Ear Nose and Throat – 25 (16) ↑ Upper GI – 11 (16) ↓ Trauma & Orthopaedics – 18 (13) ↑ Lower GI – 10 (4) ↑ Ward A609 (STAU) – 6 (1) ↑ Ward A700 – 6 (3) ↑	A&E – 18 (18) = Dermatology – 14 (7) ↑ Gastroenterology & Hepatology – 8 (8) = Ward A300 (MAU) – 4 (9) ↓ Ward C808 – 4 (2) ↑	BHI Outpatients – 21 (41) ↓ Chemo Day Unit / Outpatients – 16 (9) ↑ Ward C708 – 6 (9) ↓	Paediatric Orthopaedics – 9 (12) ↓ Children's ED & Ward 39 - 6 (7) ↓ Gynaecology Outpatients – 4 (5) ↓ Ward 78 (Gynaecology) – 4 (2) ↑ Paediatric Neurology – 2 (7) ↓ Ward 31 – 0 (6) ↓	Adult Therapy – 3 (4) ↓ Audiology – 1 (3) ↓

Notable deteriorations compared to Q4	Bristol Eye Hospital – 71 (71) (no improvements seen rather than being a notable deterioration this quarter) Ear Nose & Throat – 25 (16) Trauma & Orthopaedics – 18 (13)	Dermatology – 14 (7)	Chemo Day Unit / Outpatients – 16 (9)	Ward 78 (Gynaecology) – 4 (2)	None
Notable improvements compared to Q3	Upper GI – 11 (16)	Ward A300 (MAU) – 4 (9)	BHI Outpatients – 21 (41)	Paediatric Neurology – 2 (7) Ward 31 – 0 (6)	Audiology – 1 (3) ↓

3.3 Areas where the most complaints were received in Q1 – additional analysis

3.3.1 Division of Surgery, Head & Neck

Complaints by category type[3]

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	1 (0.5% of total complaints) ↓	6 (2.9% of total complaints) ↑
Appointments & Admissions	101 (48.6%) ↑	93 (45.6%) ↑
Attitude & Communication	56 (26.9%) ↑	46 (22.5%) ↑
Clinical Care	45 (21.6%) ↑	42 (20.6%) ↑
Facilities & Environment	1 (0.5%) ↓	11 (5.4%) ↑
Information & Support	4 (1.9%) ↓	6 (2.9%) ↑
Total	**208**	**204**

Top sub-categories

Sub-category	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Cancelled or delayed appointments and operations	79 (2.6% increase compared to Q4) ↑	77 (67.4% increase compared to Q3) ↑
Clinical Care (Medical/Surgical)	18 (14.3% decrease) ↓	21 (12.5% decrease) ↓
Communication with patient/relative	17 (88.9% increase) ↑	9 (35.7% decrease) ↓
Attitude of Medical Staff	1 (85.7% decrease) ↓	7 (16.7% increase) ↑
Attitude of Nursing/Midwifery	4 (20% decrease) ↓	5 (66.7% increase) ↑
Clinical Care (Nursing/Midwifery)	6 (33.3% decrease) ↓	9 (125% increase) ↑
Failure to answer telephones	17 (54.5% increase) ↑	11 (22.2% increase) ↑

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Across the Division as a whole, complaints regarding a failure to answer telephones saw a further significant increase in Q1.	Site-specific actions explanations and actions are listed below. It should be noted that for all of these sites, the number of complaints in this category are minimal compared to the large numbers of calls they each receive.	Benchmarking work is being undertaken. The Division will work with Candice Tyers, Outpatients Manager, to identify appropriate workforce for all call centre functions.
Assurances were provided in the Q3 and Q4 Complaints Reports that Bristol Dental Hospital had appointed further call centre staff and hoped to see a decrease in complaints in this category, however they increased from	Two additional medical records-specific staff have been recruited, which will remove the requirement for reception staff to leave the desk to retrieve notes. All reception vacancies have now been recruited to (or are at	Take advantage of better call centre performance information that allows us to review how long each call takes to answer and subsequently the length of time to manage the patient query – this will enable us to monitor staff efficiency (i.e. does it take some staff longer than others

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

four in Q4 to six in Q1.	least out to advert).	and, if so, what training and support can be offered). Staffing levels will also be reviewed regularly. Daily figures are currently monitored but there is a need to look at one to two months' data to gain intelligence on trends and ensure appropriate operational responses.
Complaints in this category for Bristol Eye Hospital decreased slightly from six in Q4 to five in Q1. ENT, having improved in this category with just one case in Q4, saw an increase to four in Q1.	Complaints remain in this area as BEH staffing to call volume ratio outstrips what is available in the BRI call centres as the workload for the BEH is very high. Call centre software now in place which will facilitate increased transparency and better performance reporting. New staff recruited and improved phones ordered.	
A significant increase in complaints regarding cancelled or delayed appointments and operations was recorded in Q3 (46) and Q4 (77) of 2014/15. There was a further slight increase to 79 complaints in Q1. Of particular note were the 35 complaints in this category received by Bristol Eye Hospital (compared to 24 in Q4); 13 by Bristol Dental Hospital (12 in Q4); and 10 in ENT (the same number as for Q4).	Cancellations and delayed treatment/clinics have been largely due to three issues: - Staff sickness in two key areas (oral surgery and oral medicine). - Access to high dependency beds, impacting mainly on MaxFax cases. - Access to Pre-Op Assessment Significant loss of cataract capacity at the beginning of the quarter caused a shortfall in the availability of appointments that could be booked through Choose and Book. This resulted in circa 600 patients being unable to access our services.	Central Pre-Op have now addressed their capacity issues and dental services have put in place dental - specific pre-op capability for low acuity cases. Dental services have responded to staff absence by recruiting to a variety of posts, ranging from temporary locum to addressing substantive vacancies. The division is working to improve 'step down' processes, where patients transition from ITU to HDU to ward bed as their condition improves, to increase the availability of ITU/HDU beds. Additional capacity was provided in June and complaints decreased over the course of this month. Some capacity challenges remain and recruitment and capacity planning work is ongoing to provide this within the substantive workforce so that consistent additional pre-

		operative assessment and theatre slots can be provided.
There was an increase in Q1 in the number of complaints under the Category Type "Attitude & Communication" with 56 complaints, compared with 46 in Q4. The majority of complaints in this category type were for Bristol Eye Hospital, with 17 complaints (compared to 18 in Q4), followed by Bristol Dental Hospital with 13 (11 in Q4). There were also seven complaints in this category type received by the ENT Outpatients Clinic. Whilst there was a noticeable decrease in complaints regarding the attitude of medical and nursing staff, there were a significant number of complaints received under the categories of Communication with Patients/Relatives (17) and Administrative (12), as well as Failure to Answer Phone (17) (see above).	A significant number of the complaints relating to communication with patients and relatives relate to the lack of ability to keep all patients informed of the delays to follow-up appointments and how we are addressing this. This links to the administrative and telephone answering complaints, as patients cannot get through to speak with staff to query their appointments. We did see a sharp rise in informal complaints on this matter over this quarter due to the capacity problems discussed in previous sections.	The Administrative Standards Manager joined the Division on 3rd August. They will be working on the following as part of that role: • Training of all current administrative staff, including training on strong communication and ongoing monitoring of standards. • Implementing a standardised recruitment and induction process for administrative staff that ensures they have the requisite skills for the role, including a telephone test. • Reviewing all correspondence, to include direct patient involvement and feedback to improve clarity and tone of written information received. • We are able to listen back to all calls taken by the hospital call centres, in order to identify where challenges have arisen and, where appropriate, work with staff to help them develop their communication skills to avoid a recurrence. • Recruitment to the additional clinical staff funded for this year is ongoing but it has proven challenging to recruit appropriately qualified and experienced clinicians, which has delayed plans to add additional activity. The recruitment process continues and, in the meantime, we continue with additional out of hours working to maintain patient throughput as far as possible.

3.3.2 Division of Medicine

Complaints by category type

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	0 (0% of total complaints) ↓	4 (4.1% of total complaints) ↑
Appointments & Admissions	19 (22.4%) ↓	30 (30.6%) ↑
Attitude & Communication	25 (29.4%) ↓	29 (29.6%) ↑

Clinical Care	34 (40%) ↑	22 (22.4%) ↓
Facilities & Environment	2 (2.4%) ↓	7 (7.1%) ↑
Information & Support	5 (5.8%) ↓	6 (6.1%) ↑
Total	**85**	**98**

Top sub-categories

Category	**Number of complaints received – Q1 2015/16**	**Number of complaints received – Q4 2014/15**
Cancelled or delayed appointments and operations	9 (18.2% decrease compared to Q4) ↓	11 (42.1% decrease compared to Q3) ↓
Clinical Care (Medical/Surgical)	12 (9.1% increase) ↑	11 (22.2% decrease) ↑
Communication with patient/relative	8 (33.3% increase) ↑	6 (14.3% decrease) ↓
Attitude of Medical Staff	4 (42.9% decrease) ↓	7 =
Attitude of Nursing/Midwifery	2 =	2 (60% decrease) ↓
Clinical Care (Nursing/Midwifery)	14 (133.3% increase) ↑	6 (40% decrease) ↓
Failure to answer telephones	4 (33.3% decrease) ↓	6 (500%) ↑

Divisional response to concerns highlighted by Q1 data

Concern	**Explanation**	**Action**
Whilst complaints regarding the category type of Attitude & Communication have decreased overall in Q1, there has been an increase in the number of complaints categorised as Communication with Patient/Relative (6).	Having reviewed the complaints within this category, there are no significant concerns, although appointment changes and liaison between health care professionals comes up more than once, particularly in Dermatology. The service is rapidly expanding and covering services at Weston and communication has been difficult. This is being addressed. This included feedback about a lack of interpreting at a planned appointment, communication challenges with a Next of Kin in Australia and a husband who did not feel included in his wife's discharge plans.	The administrative staff in the outpatient departments are undergoing some bespoke values based training to support an improvement in their communication skills. Complex discharges in Medicine and ensuring timely and accurate communication in complex discharge cases, is being addressed via ward based multi-professional workshops, aimed at smoothing discharge planning and ensuring this is timely. Communication remains a focus of these workshops.
There has been an increase in the number of complaints received regarding Clinical Care (34 compared to 22 in Q4). In particular, there has been a significant increase in complaints specifically about nursing care (14 compared to 6 in Q4).	There are nine complaints in this quarter relating to the Emergency Department and diagnosis/treatment in the department. These are being explored in more detail by the senior team in the department.	A further review of these incidents is currently being undertaken to determine whether there is any additional learning.

These complaints were spread across various wards and departments, with the highest amount being in the Emergency Department (8); Ward A522 – Respiratory (3); Ward A605 (3); and Dermatology (3).	There were different clinical care concerns in other areas relating to different professions including therapies, medical staff and nursing. There are no common themes, however the Division will continue to monitor.	

3.3.3 Division of Specialised Services

Complaints by category type

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	0 (0% of total complaints) ↓	3 (3.7% of total complaints) ↑
Appointments & Admissions	26 (42.6%) ↓	34 (41.5%) ↑
Attitude & Communication	18 (29.5%) ↓	25 (30.5%) ↑
Clinical Care	14 (23%) ↑	11 (13.4%) ↓
Facilities & Environment	2 (3.3%) ↓	3 (3.7%) ↑
Information & Support	1 (1.6%) ↓	6 (7.3%) ↑
Total	**61**	**82**

Top sub-categories

Category	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Cancelled or delayed appointments and operations	18 (30.8% decrease compared to Q4) ↓	26 (85.7% increase compared to Q3) ↑
Clinical Care (Medical/Surgical)	6 (14.3% decrease) ↓	7 (12.5% decrease) ↓
Communication with patient/relative	4 = ↑	4 (300% increase) ↑
Attitude of Medical Staff	1	0 (100% decrease) ↓
Attitude of Nursing/Midwifery	1 (50% decrease) ↓	2 =
Clinical Care (Nursing/Midwifery)	0 =	0 (100% decrease) ↓
Failure to answer telephones	9 =	9 (200% increase) ↑

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
16 complaints were around the care and management of patients within the Bristol Haematology & Oncology (BHOC) Outpatients Department. Themes include delays with chemotherapy administration, unanswered telephones, delays in receiving typed letters and general issues with		The Division recognises the issues within the BHOC Outpatients Department and is working with the transformation team to improve the processes currently in place and therefore reduce the incidence of delays to the patient's journey.

typed letters.		
21 complaints were reported in the Bristol Heart Institute (BHI) Outpatients Department, which reflected issues with unanswered telephones, cancellation of appointments on multiple occasions, and delays in referrals and follow ups	Complaints in this category halved in Q1 compared to Q4, so there is evidence of positive progress.	The BHI has undertaken focussed work in relation to the administrative and clerical issues within the outpatient areas. The department's workload has been reviewed and adjusted in order to free up more staff to answer telephones. A specific e-mail address has also been established for patients to use.
Six complaints were received in relation to Ward C708. Two of these complaints specifically reflected concerns over the discharge experience and four also contained queries around the management of medical care and surgical procedures undertaken.	Of the complaints received regarding C708, two have been formally investigated within the formal complaints process. In total, five complaints were received which reflected a less than satisfactory discharge process for patients.	Discharge arrangements are currently under review with the Division, with a view to formulating a formal action plan to be supported and delivered by the Ward Sisters.

3.3.4 Division of Women & Children

Complaints by category type

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	1 (1.5% of total complaints) ↓	4 (4.4% of total complaints) ↑
Appointments & Admissions	22 (33.9%) ↓	23 (25.6%) ↓
Attitude & Communication	16 (24.6%) ↓	22 (24.4%) ↑
Clinical Care	24 (37%) ↓	39 (43.3%) ↑
Facilities & Environment	1 (1.5%) ↑	0 (0%) ↓
Information & Support	1 (1.5%) ↓	2 (2.2%) ↑
Total	**65**	**90**

Top sub-categories

Category	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Cancelled or delayed appointments and operations	18 (25% decrease compared to Q4) ↓	24 (20% decrease compared to Q3) ↓
Clinical Care (Medical/Surgical)	13 (23.5% decrease) ↓	17 (10.5% decrease) ↓
Communication with patient/relative	3 (50% decrease) ↓	6 (100% increase) ↑
Attitude of Medical Staff	5 (28.6% decrease) ↓	7 (600% increase) ↑
Attitude of Nursing/Midwifery	3 =	3 (25% decrease) ↓
Clinical Care (Nursing/Midwifery)	4 (66.7% decrease) ↓	12 (9.1% increase) ↑

Failure to answer telephones	0 =	0 (100% decrease) ↓

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Six complaints were received by Children's ED and Ward 39 - these were a mixture of complaints about Attitude & Communication and Clinical Care.	A variety of complaints were received by Children's ED, with no single theme emerging. The department experienced an unusually high level of attendances in the early part of Q1 (10% more patients than for the same period last year).	Useful learning has been generated from these complaints, including improvements to how samples delivered to the department are handled.
27 complaints were received in total for Paediatric outpatient services – in particular, nine for Paediatric Orthopaedics.	The General Manager for Outpatients at the Children's Hospital has highlighted a concern that "outpatients" has become an umbrella term for the many different types of complaints received and that it is not a fair reflection of the issues raised in some cases.	The General Manager is working with the Trustwide Outpatient Manager and the Patient Support & Complaints Team to refine the categorisation of complaints currently allocated to Outpatients. This will help to monitor trends and direct actions appropriately to improve services offered. The Trauma & Orthopaedics Team is working on increasing capacity to meet demand. Trauma is seasonally busier in the summer months.
Four complaints were received for Gynaecology Outpatients and four complaints for Ward 78 (Gynaecology).	Three of the complaints for Gynaecology Outpatients related to communication issues and one was about a delayed appointment. Of the four complaints received by Ward 78, three related to clinical care and one was about discharge arrangements.	No consistent themes have been identified – the complaints reflect the complex and delicate issues related to the clinical care of this cohort of patients.

3.3.5 Division of Diagnostics & Therapies

Complaints by category type

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	2 (14.3% of total complaints) =	2 (8.7% of total complaints) =
Appointments & Admissions	3 (21.4%) ↓	4 (17.4%) ↓
Attitude & Communication	5 (35.7%) ↓	6 (26.1%) =
Clinical Care	2 (14.3%) ↓	9 (39.1%) ↑
Facilities & Environment	0 ↓	1 (4.3%) ↑
Information & Support	2 (14.3%) ↑	1 (4.3%) ↓
Total	**14**	**23**

Top sub-categories

Category	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Cancelled or delayed appointments and operations	5 =	5 ↓ (16.7% decrease compared to Q2)
Clinical Care (Medical/Surgical)	2 ↑	0 ↓ (100% decrease)
Communication with patient/relative	4 ↑ (33.3% increase)	3 ↑ (50% increase)
Attitude of Medical Staff	1 ↑	0 ↓ (100% decrease)
Attitude of Nursing/Midwifery	0 =	0 =
Clinical Care (Nursing/Midwifery)	0 =	0 =
Failure to answer telephones	0 ↓ (100% decrease)	1 ↓ (66.7% decrease)

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Radiology received three complaints in Q1. Two of these related to Attitude & Communication and one related to Appointments & Admissions.	The complaint regarding Attitude & Communication related to a patient who was refused help to weight bear whilst attending an x-ray appointment. The second complaint related to a patient's mother who was unable to get through to the cardiac MRI clerk by phone, despite ringing the department between 08:30 and 09:00. When the patient subsequently attended the department, they found the staff member (radiographer helper) very rude. The complaint regarding Appointments & Admissions related to a GP who referred a patient to St Michael's Hospital for an ultrasound scan. The GP had advised the patient that it was a drop in clinic, which it is not. On arrival, the patient was advised that scans were provided by appointment only, and they were given a date to return.	The complaint was discussed with the Radiographer involved, who asked for their apologies to be passed on to the patient. They had not fully understood the concerns the patient had about falling, and it is standard practice to support patients with weight bearing when required. The patient was contacted to rearrange the scan date. They were happy with this and an appointment letter was sent out. The patient and staff member involved did not wish to take the incident any further. The patient's GP had provided them with incorrect information. The service will confirm the correct referral process with the GP.
Pharmacy received three complaints in Q1, two of	The first complaint regarding access related to the closure of	The enquirer did not want a response. The department will

which related to access and one to clinical care.	the pharmacy provision at the Bristol Eye Hospital. Patients now collect their medication at the main Bristol Royal Infirmary site. The second complaint related to Boots pharmacy not being open at weekends and patients having to go to external pharmacies. Difficulties have arisen where a consultant signature has not been accepted externally, resulting in patients having to come back to the hospital. The third complaint related to clinical care. The patient had an in-date (within six months) prescription which they handed into Boots Pharmacy. Boots did not have the prescription in stock and had to order it in, resulting in the prescription falling outside of its six month timeframe. Boots would not honour the prescription and informed the patient they would need to get a new prescription.	however feed the comments into the regular review meeting held between the UH Bristol Pharmacy Management team and the Boots teams to ensure that it is recorded on the issues log. This complaint is under investigation by the Pharmacy Operational Manager. The feedback from patients and carers is addressed with the Boots management at monthly review meetings and this issue will be raised at the August meeting. Boots is currently open from 09.00am until 13.00pm each Saturday and the number of customers is very low. The hospital dispensary is open for urgent prescriptions from 09.00am until 15.00pm each Saturday and from 11.00am until 15.00pm each Sunday. A member of the Boots team telephoned the patient to apologise for their poor experience. Boots have acknowledged, having established the reason for the late presentation of the prescription, that they should have supported the patient by sourcing a replacement prescription. The patient was happy to hear that there was learning from the incident and to have received an apology from Boots.
Orthotics received one complaint, relating to Attitude & Communication.	This complaint related to inadequate staffing in the department and the attitude of a temporary staff member in particular.	Staffing levels changed in Q1 due to the retirement of two part time staff members. The temporary staff member in question was employed in the interim for a few weeks in April, and has since left the department. The service lead has fed back to the bank their concerns over the staff member's behaviour. A new full time staff member came into post in late April and no further complaints have been received.
Therapies received two	The first complaint related to a patient who had problems	The patient was contacted and advised that on the occasion they

complaints, relating to Attitude & Communication and Information & Support.	getting through on the telephone to the Physiotherapy Department to book an appointment. The patient also expressed concern about the wording of their appointment letter, as it stipulated that failure to make an appointment would result in them being removed from the waiting list. The second complaint related to an in-patient seen by an Occupational Therapist (OT) on Ward 604 prior to discharge. The OT should have referred the patient for adaptations at home but the patient had heard nothing further.	rang there were staffing issues. They were advised that a new telephone system is being considered to better manage the demand for calls. The service will also review the wording of their letters. They are also taking part in the Trust's outpatient letters audit taking place during the week commencing 3rd August. The patient's referral was completed and they were contacted by an external agency (whose support they subsequently declined due to charges). The Therapy service has since contacted the community team to advise them that the patient will need to have a reassessment.
Laboratory Medicine received one complaint, relating to Information & Support.	This complaint related to a patient who had been contacted by a Consultant asking the patient to call them back; however they did not leave any contact details.	The Patient Support & Complaints Team arranged for the Consultant to call the patient back when he was next in work.

3.3.6 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 – Q1 2015/16**	**Number and % of complaints received – Q4 2014/15**
Bristol Royal Infirmary (BRI)	183 (39.9% of total complaints) ↓	192 (37.1% of total complaints) ↑
Bristol Eye Hospital (BEH)	71 (15.5%) =	71 (13.7%) ↑
Bristol Dental Hospital BDH)	33 (7.2%) ↓	37 (7.2%) ↑
St Michael's Hospital (STMH)	46 (10%) ↓	50 (9.7%) ↓
Bristol Heart Institute (BHI)	43 (9.4%) ↓	67 (13%) ↑
Bristol Haematology & Oncology Centre (BHOC)	28 (6.1%) ↑	21 (4.1%) ↑
Bristol Royal Hospital for Children (BCH)	44 (9.5%) ↓	71 (13.7%) ↑
South Bristol Community Hospital (inc. Homeopathic Outpatients) (SBCH)	11 (2.4%) ↑	8 (1.5%) ↑
Total	**459**	**517**

The table below breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints a hospital site receives is broadly in line with its proportion of attendances. For example, in Q1, St Michael's Hospital (STMH) accounted for 11.6% of the total attendances and received 10% of all complaints

Site	No. of Complaints	No. of Attendances	Complaints Rate	Percentage of Attendances	Percentage of Complaints
BRI	183	56,347	0.32%	30.6%	39.8%
BEH	71	29,892	0.24%	16.2%	15.5%
BDH	33	19,536	0.17%	10.6%	7.2%
STMH	46	21,425	0.21%	11.6%	10%
BHI	43	4,487	0.96%	2.4%	9.4%
BHOC	28	16,378	0.17%	8.9%	6.1%
BRHC	44	28,857	0.15%	15.7%	9.6%
SBCH	11	7,377	0.15%	4%	2.4%
TOTAL	**459**	**184,299**	**0.25%**		

This analysis shows that the Bristol Royal Infirmary and Bristol Heart Institute receive the highest rates of complaints and a disproportionately high volume of complaints compared to their respective shares of patient activity; the share of complaints in all other hospital sites is proportionately less than their respective shares of patient activity.

3.5 Complaints responded to within agreed timescale

All of the clinical Divisions reported breaches in Quarter 1, totalling 28 breaches, which represents an increase on those reported in Q4.

	Q1 2015/16	Q4 2014/15	Q3 2014/15	Q2 2014/15
Surgery Head and Neck	9 (12.9%)	8 (11.6%)	12 (14.6%)	5 (7.1%)
Medicine	9 (20%)	5 (14.7%)	10 (23.8%)	4 (11.1%)
Specialised Services	2 (11.1%)	1 (5.6%)	4 (15.4%)	1 (4.3%)
Women and Children	7 (17.1%)	11 (23.9%)	6 (12.5%)	8 (17%)
Diagnostics & Therapies	1 (10%)	0 (0%)	0 (0%)	1 (11.1%)
All	**28 breaches**	**25 breaches**	**32 breaches**	**19 breaches**

(So, as an example, there were 9 breaches of timescale in the Division of Medicine in Q1, which constituted 20% *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 during the sign-off process itself. Sources of delay are shown in the table below. The column indicating 'other' breaches relate to delays in other organisations providing their input to the Trust's response.

	Source of delays (Q1, 2015/2016)			Totals
	Division	**Patient Support and Complaints Team**	**Executive sign-off**	
Surgery Head and Neck	9	0	0	**9**
Medicine	8	0	1	**9**
Specialised Services	2	0	0	**2**
Women and Children	5	1	1	**7**
Diagnostics & Therapies	1	0	0	**1**
All	25 breaches	1 breach	2 breaches	**28**

The majority of divisional delays have resulted from increased scrutiny of draft responses. The vast majority of responses were prepared by Divisions within the agreed timescale (170 out of 186 responses or 91.4%),

however the need for significant changes/improvements following executive review led to 28 cases breaching the deadline by which they were sent to the complainant.

Ongoing actions previously agreed via Patient Experience Group:

- The Patient Support and Complaints Team continue to monitor response letters to ensure that all aspects of each complaint have been fully.
- All response letters, as well as being checked by the individual caseworker, are now also checked by the Patient Support & Complaints Manager, prior to being sent to the Executives for final sign-off.
- A random selection of two or three draft responses per week are also sent to the Head of Quality (Patient Experience and Clinical Effectiveness) for an additional level of checking prior to Executive sign-off.
- Response letter cover sheets are sent to Executive Directors with each letter to be signed off. This includes details of who investigated the complaint, who drafted the letter and who at senior divisional letter signed it off as ready to be sent. The Executive signing the responses can then make direct contact with these members of staff should they need to query any of the content of the response.
- Training on investigating complaints and writing response letters has been delivered to at least one group from each Division, with the exception of Surgery, Head & Neck, whose first session is booked for 14th September 2015. The training delivered so far has been well received, with positive feedback from attendees.

3.6 Number of dissatisfied complainants

As reported in Section 1 of this report, the way in which the Trust reports the number of complainants telling us that they were unhappy with our investigation of their concerns has changed with effect from Q1. In Q1, a total of 186 responses were sent out. By the cut-off point of 11th August 2015 (the date on which the complaints data for June was finalised) six people had contacted us to say that they were dissatisfied with our response. This represents 3.2% of the responses issued during that period.

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

4. Information, advice and support

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

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

In Q1, the team dealt with 171 such enquiries, compared to 178 in Q4. These enquiries can be categorised as:

- 100 requests for advice and information (110 in Q4)
- 65 compliments (49 in Q4)
- 6 requests for support (19 in Q4)

5. PHSO cases

During Q1, the Trust has been advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in three new complaints (compared to four in Q4 and two in Q3) as follows:

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
16120	CL	LW	30/06/2014	BHI	Coronary Care Unit (CCU)	Specialised Services
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from the PHSO.						
17608	JR	AH	19/12/2014	BRI	Ward A604	Surgery, Head & Neck
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. PHSO wrote to Trust in July 2015 confirming their intention to carry out an investigation. Currently awaiting further contact from the PHSO.						
15952	KH	JH	09/06/2014	BRI	Ward 11	Medicine
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Advised PHSO that some issues complainant raised with them had not previously been raised with the Trust. PHSO advised Trust in July 2015 that the case is currently waiting to be allocated to an investigator. Currently awaiting further contact from the PHSO.						

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

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
15213	WE	VE	10/03/2014	BHOC	Chemotherapy Outpatients	Specialised Services
Copy of complaint file, correspondence and medical records sent to PHSO. Received further request from PHSO for patient's oncology records, which were sent to them in August 2015. Currently awaiting further contact from the PHSO.						
12548		CM	05/02/2013	BRI	Upper GI	Surgery, Head & Neck
Copy of complaint file, correspondence and medical records sent to PHSO and acknowledged by them. Letter from PHSO received in July 2015 advising that they will be carrying out an investigation and will contact the Trust in due course. Currently awaiting further contact from the PHSO.						
12124 & 11500		SM	21/11/2012 & 13/08/2012	BRI & BHI	Urology & Cardiology (GUCH)	Surgery, Head & Neck & Specialised Services
Copy of complaints file and medical records sent to PHSO in May 2015. Further contact from PHSO received in July advising that they now have all the information they require and will contact us in due course with their provisional report and findings. Currently awaiting further contact from the PHSO.						

6. Protected Characteristics

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

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

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

6.1 Age

Age Group	Number of Complaints Received – Q1 2015/16
0-15	52
16-24	22
25-29	17
30-34	35
35-39	17
40-44	22
45-49	23
50-54	26
55-59	32
60-64	34
65+	179
Total Complaints	**459**

6.2 Ethnic Group

Ethnic Group	Number of Complaints Received – Q1 2015/16
Any Other Asian Background	1
Any Other Ethnic Group	1
Any Other White Background	13
Asian or British Asian	4
Bangladeshi or British Bangladeshi	2
Black or Black British – African	3
Black or Black British – Caribbean	6
Chinese	2
Indian	2
Mixed – White and Black Caribbean	3
Pakistani	4
Pakistani or British Pakistani	2
White - British	366
White – Irish	2
Not Collected At This Time	36
Not Stated/Given	12
Total Complaints	**459**

6.3 Religion

Religion	**(Christian denomination)**	**Number of Complaints Received – Q1 2015/16**
Christian	Anglican	1
	Baptist	3
	'Christian'	21
	Church of England	162
	Church of Scotland	1
	Methodist	10
	Protestant	3
	Roman Catholic	22
	Salvation Army	1
	United Reform	2
	(Total Christian)	*(226)*
Agnostic		2
Atheist		3
Buddhist		3
Muslim		4
No Religious Affiliation		104
Sikh		2
Spiritualist		1
Unknown		114
Total Complaints		**459**

6.4 Civil Status

Civil Status	**Number of Complaints Received – Q1 2015/16**
Co-habiting	18
Divorced/Dissolved Civil Partnership	21
Married/Civil Partnership	179
Separated	3
Single	126
Widowed/Surviving Civil Partner	26
Unknown	86
Total Complaints	**459**

6.5 Gender

Of the 459 complaints received in Q1 2015/16, 232 (51%) of the patients involved were female and 227 (49%) were male.

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Board Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
12. Infection Prevention and Control Annual Report
Sponsor and Author(s)
Sponsor: Carolyn Mills, Chief Nurse Author: Dr Richard Brindle, Director of Infection and Prevention Control (DIPC) and Joanna Hamilton-Davies, Deputy DIPC

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

Executive Summary
Purpose: The purpose of the report is to inform patients, public, staff, the Trust board members and Bristol Clinical Commissioning Group of the infection prevention and control activities undertaken in 2014/15 within University Hospitals Bristol NHS Foundation Trust and progress against performance targets. The report corresponds with requirements set out in the Health and Social Care Act 2008. Key issues to note: 1. The Trust has continued compliance with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code). 2. The team have continued to report, investigate and learn from cases and outbreaks of healthcare associated infections. 3. Continue to focus on reducing the incidence of infections (specifically MRSA and MSSA blood stream infections and *Clostridium difficile*). 4. Have started to develop a Surgical Site Infection Surveillance programme and will continue this programme in the coming year. 5. The team have develop strong collaborative working and supportive relationships with our community colleagues. 6. The team have continued to monitor carbapenemase producing enterobacteriaceae and ensure appropriate control measures are in place.
Recommendations
Committee to receive the report for assurance
Impact Upon Board Assurance Framework
The report supports the achievement of objective "to deliver all quality objectives and exceed national standards".
Impact Upon Corporate Risk
The infection control report provides assurance that the Trust's Infection Control Team is continuing to respond to infection control issues and risks within appropriate timescales.
Implications (Regulatory/Legal)
This report supports compliance with the Care Quality Commissions Regulation 12 – Safe and appropriate care and treatment.
Equality & Patient Impact
Nil specific.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date submitted to sub-committee (if applicable)					
Finance Committee	**Quality & Outcomes Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
	28/7/15				Infection Control Committee 08/09/15

University Hospitals Bristol NHS
NHS Foundation Trust

INFECTION CONTROL ANNUAL REPORT 2014 – 2015

STATEMENT FROM THE CHIEF NURSE

High standards of infection control are crucial to ensure prevention of infection in healthcare facilities. The organisation has a statutory responsibility under the Health and Social Care Act, 2008 (the Hygiene Code) to produce and publish an infection control annual report.

This report summarises the key infection prevention and control activities carried out on behalf of University Hospitals Bristol NHS Foundation Trust from April 1st 2014 to March 31st 2015 and provides an overview of all infection prevention and control activities in the past year, highlighting service achievements and progress made against national and local priorities related to infection control.

Our focus on working to reduce the incidence of hospital acquired infections is continuous. I would personally like to thank all staff for their efforts and support in this important area of clinical care.

Carolyn Mills
Chief Nurse

CONTENTS

1. INTRODUCTION

The purpose of the report is to inform patients, public, staff, the Trust board members and Bristol Clinical Commissioning Group of the infection prevention and control activities undertaken in 2014/15 within University Hospitals Bristol NHS Foundation Trust and progress against performance targets. The report corresponds with requirements set out in the Health and Social Care Act 2008.

Healthcare associated infections remain an important priority for the patients, public and staff. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources, therefore investment in infection prevention and control is necessary and cost effective. The resources committed to infection prevention and control by University Hospitals Bristol NHS Foundation Trust is visible in the content of this report.

The authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on decontamination, cleanliness, antimicrobial prescribing and vascular access.

2. OVERVIEW OF PROGRESS FOR 2014/15

The Infection Prevention & Control Teams' goal in 2014/15 was to continue to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of acquiring an infection, as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection. To achieve this, the following objectives were identified:

1. Compliance with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code).
2. Report, investigate and learn from cases and outbreaks of healthcare associated infection as mandated.
3. Reduce the incidence of infections (specifically MRSA and MSSA blood stream infections and *Clostridium difficile*).
4. Develop a Surgical Site Infection Surveillance programme.
5. Develop strong collaborative working and supportive relationships with our community colleagues.
6. Monitor carbapenemase producing enterobacteriaceae and ensure appropriate control measures are in place.

3. COMPLIANCE TO THE HYGIENE CODE

3.1. Have systems in place to manage and monitor the prevention and control of infection, using risk assessment to consider individual and environmental risks.

- We have a fully established infection control team that consists of an Infection Control Doctor, seven Infection Control Nurses (which includes the Deputy Director of Infection Prevention & Control), an Intravenous Access Co-ordinator, an Antimicrobial Pharmacist, an Analyst and Administrative Support.
- The Director of Infection Prevention and Control leads the team and reports directly to the Chief Nurse and Medical Director in regard to infection prevention and control issues.
- The Chief Nurse is the Executive Lead and chairs the Infection Control Group, which has met bi-monthly in 2014/15 and includes partner organisation representatives.
- The Trust Board has received monthly infection control exception reports within the quality report for key performance indicators related to infection.
- The Quality Outcomes Committee (Board sub-committee) has received quarterly infection control update reports.
- The Infection Control Group has monitored all relevant risks at each bi-monthly meeting. There are four risks being monitored by Infection Control Group, these are:

    1. Relates to isolation facilities in the Trust. With the opening of the new ward block this risk has reduced. The risk will continue to be monitored until the King Edward Building, which has Nightingale wards, has been closed to inpatients.
    2. Relates to Norovirus and the impact on the Trust if wards are closed. Due to the increase in isolation room capacity the Trust is able to isolate more patients with symptoms of diarrhoea and vomiting. The Trust manages patients in accordance with the National Norovirus Tool Kit. Guidelines are in place for staff that are also affected.
    3. Relates to infection prevention and control training. The Trust target for infection prevention and control training is 90% compliance. At the end of March 2015 compliance was at 86%. The team teach on the Trust induction, clinical and non-clinical essential training days. All infection prevention and control training is reviewed regularly and all staff has access to E-learning packages.
    4. Relates to surgical site infection surveillance. The Trust is not routinely undertaking surgical site infection surveillance within all the Public Health England surveillance categories and therefore may not be sighted on any risks associated with specific surgical procedures.

- Only Orthopaedic surgery continue with the mandatory reporting of cases and the paediatric surgical cardiac team have started to report their cases via the Public

Health England data capture system. Both specialities undertake 30 day post-surgery reviews. The development of a surgical site infection surveillance programme will be included in the 2015/16 infection prevention and control annual programme.

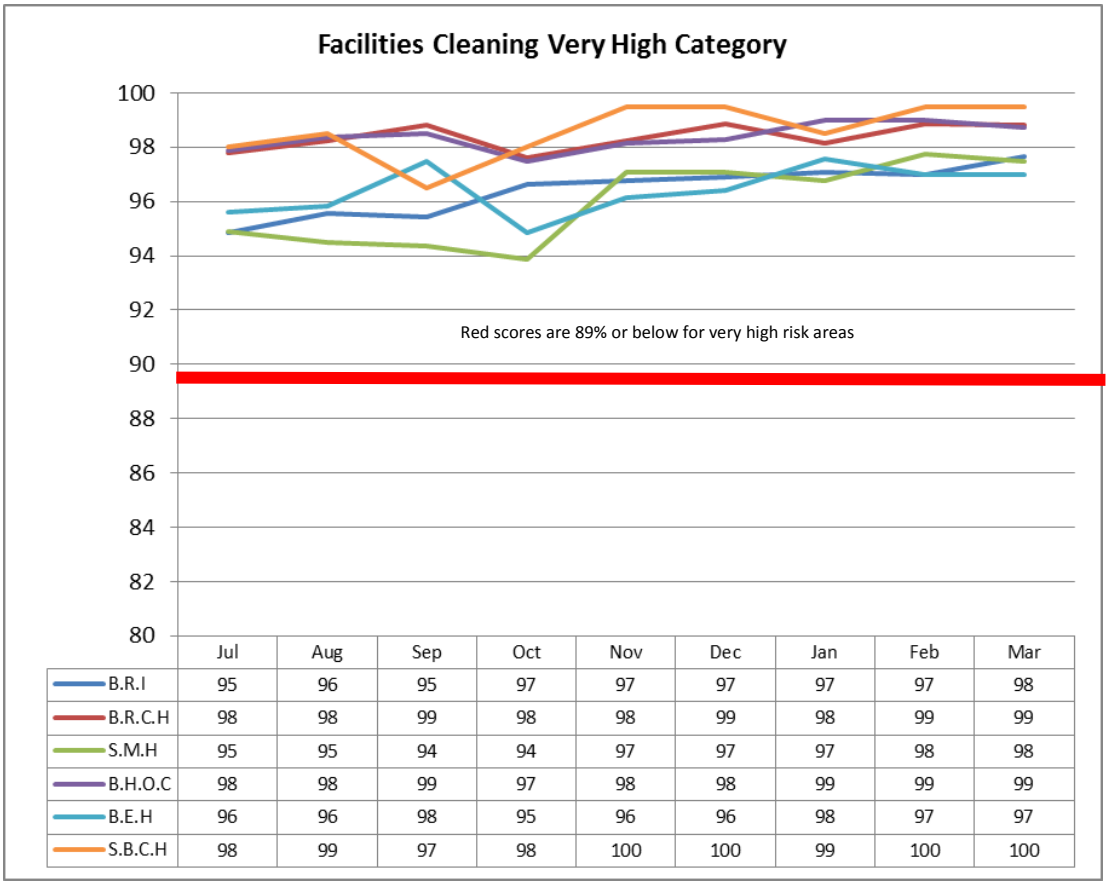
- The Infection Prevention and Control Team work to an Infection Control Annual Programme, delivery of which is monitored by the Infection Control Group.

3.2. Provide and maintain a clean and appropriate environment:

- There is a designated operational lead in the Trust for cleanliness (Deputy General Manager, Facilities) and a lead for decontamination (Surgery, Head and Neck, Divisional Director).
- The Trust's scoring system for cleanliness is in line with the National Specifications for Cleanliness 2007 and is weighted according to each hospital's bed numbers and number of risk areas.
- There are three elements to the cleaning audit; facilities cleaning, clinical cleanliness, and estates cleanliness.
- The monthly scores are distributed in two formats: by Hospital and Division.
- The scores are shared with the Ward Sisters, Matrons, Heads of Nursing, Service Leads, Estates, Infection Control, Facilities Hotel Services Managers and members of the Trust Executive Team.

Figure 1

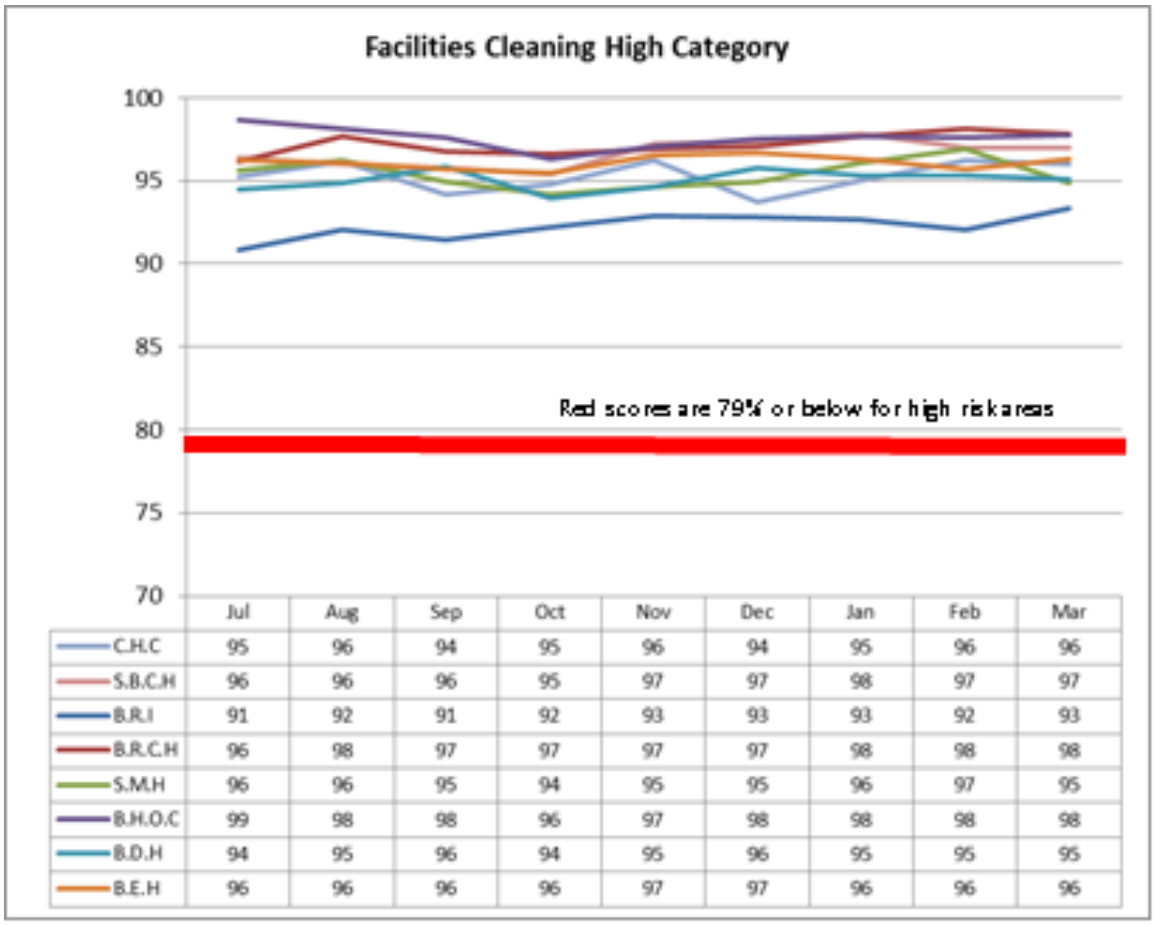
University Hospital's Bristol – component hospitals with their cleanliness score within very high risk areas (e.g. theatres) since July 2014. The Trust RAG rating for Very High category areas is 98% for Green, 90-97% for Amber and 89% or below for Red.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
B.R.I	95	96	95	97	97	97	97	97	98
B.R.C.H	98	98	99	98	98	99	98	99	99
S.M.H	95	95	94	94	97	97	97	98	98
B.H.O.C	98	98	99	97	98	98	99	99	99
B.E.H	96	96	98	95	96	96	98	97	97
S.B.C.H	98	99	97	98	100	100	99	100	100

Figure 2

University Hospital's Bristol – component hospitals with their cleanliness score within high risk areas (e.g. wards) since July 2014. The RAG rating for High Risk category areas is 95% for Green, 80-94% for Amber and 79% or below of Red.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C.H.C	95	96	94	95	96	94	95	96	96
S.B.C.H	96	96	96	95	97	97	98	97	97
B.R.I	91	92	91	92	93	93	93	92	93
B.R.C.H	96	98	97	97	97	97	98	98	98
S.M.H	96	96	95	94	95	95	96	97	95
B.H.O.C	99	98	98	96	97	98	98	98	98
B.D.H	94	95	96	94	95	96	95	95	95
B.E.H	96	96	96	96	97	97	96	96	96

3.3. Provide suitable and accurate information on infections to service users and their visitors.

- All patient and visitor Infection Prevention and Control Information Leaflets have been updated when national guidance has been released and reviewed. Staff explain contents of leaflets to patients when required.

3.4. Provide suitable and accurate information on infections to any person concerned with further support including nursing/medical care in a timely manner.

- Adult and Paediatric patients that have been discharged and have a positive Meticillin Resistant *Staphylococcus aureus* and positive *Clostridium difficile* result are informed by letter of their result. Their General Practitioners are also informed.
- A re-audit looking at discharge summaries to check that the infection status of patients is included, has been completed. The audit demonstrated that there had been an improvement in the documentation regarding clinical information and

specific instructions included in the discharge letter. To ensure continual improvement, a re-audit will be undertaken in 2015/16.

- All infection prevention and control policies/guidelines are available on the Trusts' Document Management System and the Infection Prevention and Control Team's Connect site.

3.5. Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care:

- An assessment for risk of infection is carried out for all patients when they are admitted.
- The Infection Prevention and Control Team ensure the clinical teams are informed of any positive results.
- The Infection Prevention and Control Team follow up positive Meticillin Resistant *Staphylococcus aureus* and *Clostridium difficile* patients (and patients who are diagnosed with any multi-resistant organisms), ensuring appropriate management and treatment is commenced.
- Management of the adult and paediatric cubicle tracker by the Infection Prevention and Control Team and Clinical Site Team ensures patients are isolated appropriately.
- The Infection Prevention and Control Team have screened elective and emergency patients before surgery for Meticillin Resistant *Staphylococcus aureus*. Our target for 2014/15 was 100% compliant for elective patients and 95% for emergency patients. The Trust was slightly below the compliance target for emergency patients.
- The Infection Prevention and Control Team have screened inpatients every 14 days for Meticillin Resistant *Staphylococcus aureus* during 2014/15.

Trust wide	Apr 2014 – March 2015
Meticillin Resistant *Staphylococcus aureus* Pre-Op Elective Screenings	100%
Meticillin Resistant *Staphylococcus aureus* Emergency Screenings	94.07%

3.6. Ensure all staff are fully involved in the process of preventing and controlling infection

- All bed holding Divisions have leadership for infection control through the Heads of Nursing, a designated Medical Lead and Matrons. Divisions all have effective link practitioner systems.

- All induction, mandatory and update infection prevention and control training has been reviewed – this has been reviewed quarterly to reflect target requirements and achievements. E-Learning packages have been developed and all clinical updates (including paediatrics) are now being delivered through this route. Non-clinical staff will have a mixture of E-Learning and face to face sessions. Medical staff will continue with face to face sessions and with an E-Learning package which has been developed specifically for medical staff.
- The Infection Prevention and Control Team are involved in ad hoc training on a regular basis. 30 volunteers have received infection control training and the school teachers based at the Bristol Royal Children's Hospital have been trained in hand hygiene and are now undertaking sessions with the children that attend the school room.
- A joint annual Infection Prevention and Control Study Day was held for the tenth consecutive year and included staff from North Bristol Trust.

3.7. Provide adequate isolation facilities

- Improved isolation facilities have been completed as part of the new build, increasing isolation facilities from 12% to 33% of beds. The Trust has seven specialist ventilation rooms including three in the new intensive care unit.

3.8. Secure adequate access to laboratory facilities

- Laboratory services are provided by Public Health England laboratory in line with the contract.

3.9. Have and adhere to policies that will prevent and control infection

- All infection prevention and control policies have been monitored and updated with national guidelines and up to date evidence as required.
- The Infection Prevention and Control Team have audited hand hygiene compliance monthly with a standard of 97.2% achieved at the end of year, against a target of 95%.
- The Infection Prevention and Control Team have quality assured on a bi-monthly basis that staff are adhering to the correct clinical guideline for wearing personal protective equipment. Results are fed back to Ward Staff, Heads of Nursing and Matrons, at the bi-monthly Infection Control Group. The majority of scores reached in each area are 100%; however isolation signs outside of cubicles and the changing of gloves between tasks are not always performed. These issues are picked up immediately with the ward staff.

- The annual audit of sharps management has been completed by Daniel's, the company that supply the sharps bins to University Hospitals Bristol NHS Foundation Trust. The results are broken down into department and ward area and fed back to Divisions, along with any recommendations. Departments and ward areas devise an action plan where appropriate.
- Environmental and equipment audits have been carried out by the Infection Prevention and Control Team trust-wide. Results and recommendations are fed back to each ward area. Action plans are developed by the ward staff.
- An audit of commode cleaning demonstrated an improvement in compliance and highlighted areas still needing further work to ensure standards for cleaning and maintenance are continuously achieved.

3.10. Ensure that healthcare workers are free of and protected from exposure to infections and that all staff are suitably educated in the prevention of cross infection. To develop a system in conjunction with Occupational Health and Human Resources for identifying members of staff who have been visiting (on annual leave/secondment) a high risk Pulmonary Tuberculosis country for more than 3 months or who have worked and lived with Pulmonary Tuberculosis patients for more than one month.

- All staff are screened for infection when they begin work at the Trust and are offered appropriate vaccinations against infectious diseases.
- The Occupational Health department use the OPAS system (Occupational Health IT system) to remind staff when their immunisations are due.
- Staff immunisation status is now included in staff appraisals.
- Occupational Health now receives a list of new starters on a monthly basis and text messages are sent to respective individuals with a date and time to attend the department.
- There is a new process in place via the Health @ Work portal, whereby Employee Services can now track the status of a staff members' health clearance.
- Additional health screening continues for staff members that spend long periods in specific countries abroad, for either work of personal reasons.
- The Infection Prevention and Control Team continue to provide infection control induction and update training for all staff.

4. STATUTORY AND NATIONAL REQUIREMENTS

4.1. Further reduce the incidence of infections, specifically Meticillin Resistant *Staphylococcus aureus* and Meticillin Sensitive *Staphylococcus Aureus* blood stream infections and *Clostridium difficile.*

Clostridium difficile

A new process was introduced by Public Health England for assessing patients with *Clostridium difficile* in April 2014. The Infection Prevention and Control Team have to assess whether our patients acquisition of *Clostridium difficile* was avoidable or unavoidable. The standard is measured by patients who are in hospital for 3 days or more. The Bristol Clinical Commissioning Group also has to assess in conjunction with Infection Prevention and Control Team that they agree with our assessment of each case. The Infection Prevention and Control Team meet the Bristol Clinical Commissioning Group on a monthly basis to discuss each case. The limit assigned to the Trust for 2014/15 was forty avoidable cases; the Trust reported eight.

Overall, however, the Trust has experienced an increase in 2014/15 with the total cases of *Clostridium difficile* being 50, (see figure 3) compared to 38 in 2013/14. There are a number of possible reasons for this increase including:

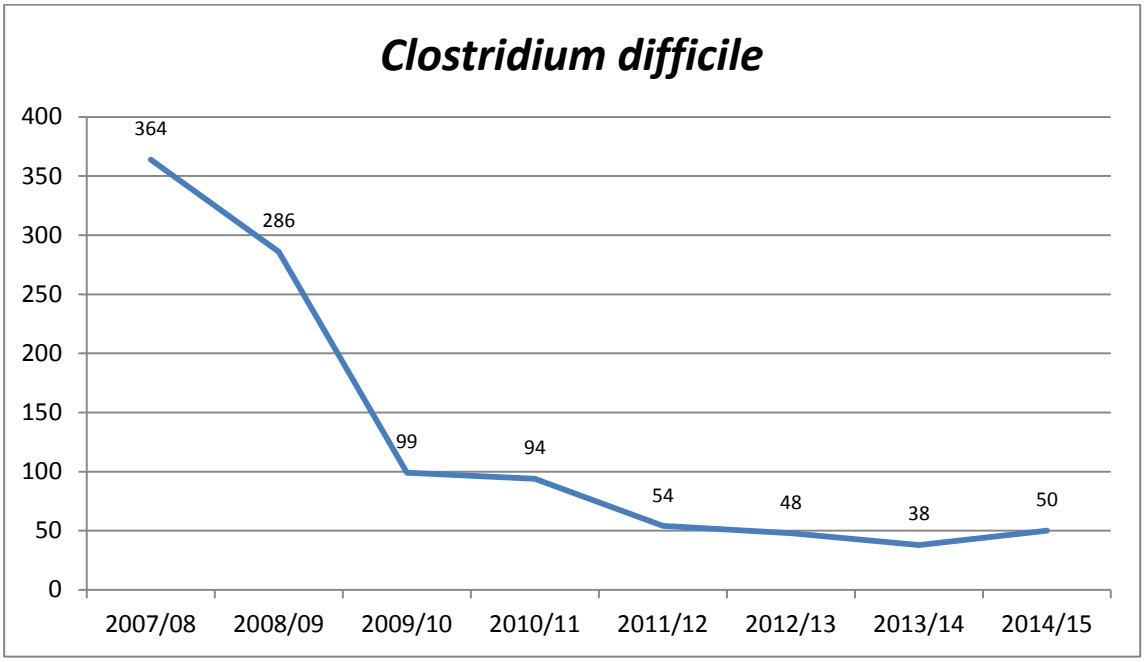
- Slowly increasing mean age of patients with significant co-morbidities and immobility.
- Increased bed-occupancy which reduces time for bed-space cleaning.
- Increased exposure to antibiotics because of respiratory and urinary tract infections in the hospital and community population.

We continue to manage the patients on a case by case basis.

- Diarrhoeal stool samples submitted to the microbiology laboratory are examined for presence of *Clostridium difficile* toxin in accordance with the Department of Health updated guidance on the diagnosis and reporting which was published in March 2012. Process implemented in 2012.
- All patients are visited on the next working day of the positive result by an infection control nurse, medical microbiologist and anti-infective pharmacist. They assess that the Trust protocols have been followed and if the case is avoidable or non-avoidable.
- Timelines are completed on all patients. Any issues are reported to the bi-monthly Infection Control Group.
- Antimicrobial prescribing is monitored on a monthly basis. Reported to the bi-monthly Infection Control Group.
- Patients have been managed in the cohort ward (26A) and then on Ward A800 until March 2015 – in the future, patients will be managed on Ward A900.

Figure 3

Trust *Clostridium difficile* cases since 2007



MRSA Bacteraemia

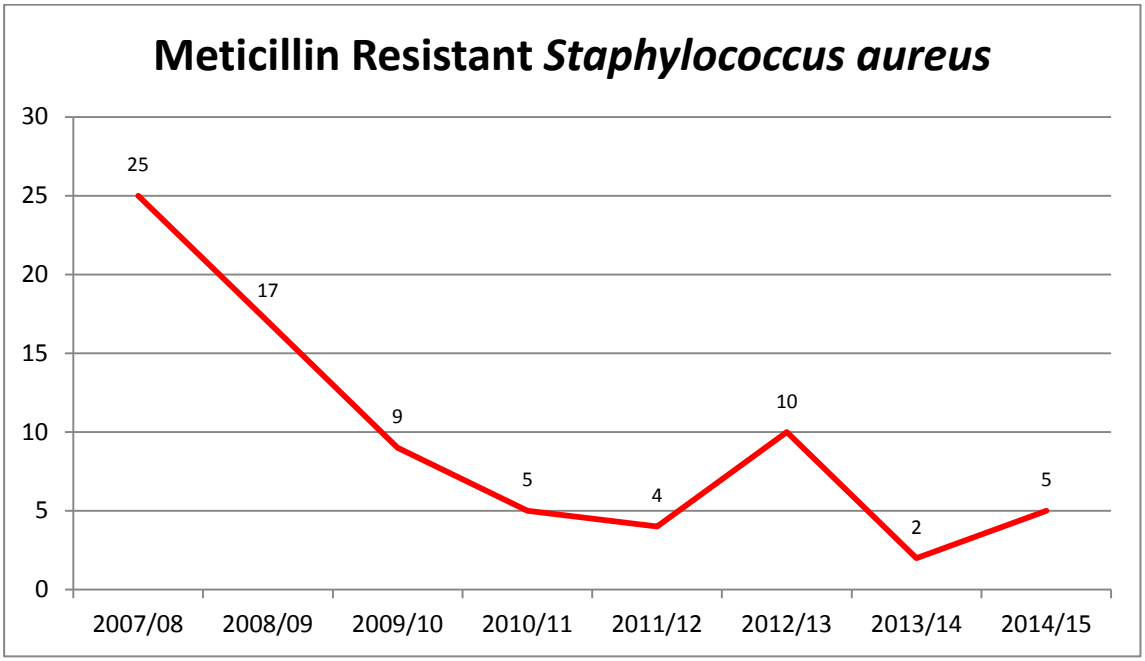
Number of cases

The standard is measured by patients in hospital for more than 2 days. The target for 2014/15 was zero tolerance to avoidable Meticillin Resistant *Staphylococcus aureus* bacteraemia. This target has no financial penalties but does contribute to MONITOR's compliance framework. By the end of March 2015 there were five MRSA bacteraemia attributed to University Hospitals Bristol NHS Foundation Trust – plus one case that was attributed to another organisation. The five cases (figure 4) include one case that was reported as a contamination of blood culture, not a patient infection.

- Mandatory reports are made to Public Health England on a case by case basis. All cases have to be reported and investigated even if not deemed an infection.
- The Public Health England investigation process was completed for all cases.
- Multidisciplinary meetings were held for each case. Each case was discussed and action plans instigated.
- Cases are discussed at the bi-monthly Infection Control Group.

Figure 4

Trust Meticillin Resistant *Staphylococcus aureus* blood stream infections since 2007



Meticillin Sensitive *Staphylococcus Aureus* Bacteraemia

The standard is measured by patients in hospital for more than 2 days. The Trust target was no more than 25 cases in the year. This target has no financial penalties and does not contribute to MONITOR's compliance framework. The Trust reported 35 cases. This was an increase from the previous year. The actions to reduce Meticillin Sensitive *Staphylococcus Aureus* are the same as for Meticillin Resistant *Staphylococcus aureus*, because both organisms are responsible for intravascular access and surgical site infections. A report from the Vascular Access Co-ordinator is included in this report.

E. Coli

There has been no target set for E. coli bacteraemia. However we report these blood stream infections to Public Health England – which is a National requirement.

4.2. Report and investigate cases of healthcare associated infection and outbreaks.

Multi antibiotic resistant gram negative bacteria including carbapenemase producing enterobacteria

There has been a steady increase in antibiotic resistance levels. A recent re-look at resistance to antibiotics within haematology and oncology showed rises in every measured instance.

Carbapenem antibiotics are a powerful group of *B*-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been antibiotics doctors could rely on, when other antibiotics have failed to treat infections caused by gram-negative bacteria. The Trust manages cases in accordance with the Acute Trust Toolkit for the Early Detection, Management and Control of Carbapenemase-Producing Enterobacteriaceae (Public Health England 2013).

There was one paediatric confirmed case in May 2014 and one confirmed adult case in July 2014. Patients were screened and managed as per national guidelines.

Tuberculosis

The Infection Prevention and Control Team received notification of a member of staff in the Neonatal Intensive Care Unit with smear–negative pulmonary Tuberculosis. A meeting was held with Neonatal Intensive Care Unit staff, Occupational Health, Public Health England, Paediatric Infectious Diseases Team and the Trust Communications Team. The decision was made to contact trace and offer clinic appointments to all potentially exposed babies in view of their extreme vulnerability. Letters were sent to all families. The Neonatal Network was informed to facilitate babies from out of area to be seen locally. Clinics arranged and babies were seen and where necessary treatment given. An information phone line was set up for parents to call if they had any concerns. Feedback from staff was that the phone line was predominantly used to change clinic appointments. A meeting will be held in July 2015 to close this incident down and discuss if there are any lessons to be learned from the process that was instigated.

An adult patient was diagnosed with pulmonary Tuberculosis. Patients were contact traced and letters were sent to General Practitioners and patients to inform them of their exposure. Patients who were thought to be at risk have been offered screening within the Trust respiratory department.

Parainfluenza Type 3

A number of babies in the Neonatal Intensive Care Unit were diagnosed with Parainfluenza Type 3. Neonatal Intensive Care Unit was closed to admissions. A meeting was held with the Director of Infection Prevention and Control, the Infection Prevention and Control Team and staff from Neonatal Intensive Care Unit. It was agreed that all admissions were to be assessed on a case by case basis and all common areas such as parent's sitting room closed with immediate effect. The families were informed and all siblings were excluded. Parents were asked to report viral symptoms promptly to staff.

The number of babies with symptoms increased and an outbreak meeting was called. An Incident Form was completed. A plan to manage the unit until it was fully reopened was put in place, in conjunction with the Neonatal Network. This was reported as a Serious Untoward Incident and a Root Cause Analysis has been completed by the Division. The Root Cause Analysis will be discussed at the bi-monthly Infection Control Group.

Group A Streptococcus

An outbreak of Group A Streptococcus was declared in March 2015 on Ward 200. The outbreak was managed as per national guidelines. All staff and patients were screened on the ward and three staff and four patients were positive. Positive staff and patients were treated with antibiotics and staff returned to work after 48 hours of treatment, monitoring of the ward continues.

Norovirus Outbreak Activity

The Trust has seen a marked decline in the number of Norovirus outbreaks this year, which is most likely due to the increase in isolation rooms available in the Trust and good management by staff. Samples are sent to the Virology Laboratory and the Trust complies with the National Norovirus Tool Kit in the Management of Outbreaks.

	Wards Closed	Bays Closed	Bed days lost
2013-14	16	32	524
2014-15	6	19	161

Ebola

The Trust adhered to Public Health Guidance in preparing for the possibility of managing a patient suspected of Ebola. No patient presented.

5. DEVELOPMENTAL OBJECTIVES 2014/15

During 2014/15 the Infection Prevention and Control Team developed and delivered study sessions for local General Practitioners and nursing homes. This included management of patients with *Clostridium difficile* and antibiotic prescribing. The sessions were a success and more sessions will be arranged for 2015/16.

The Infection Prevention and Control Team have developed collaborative working relationships with the Bristol Clinical Commissioning Group, which has enabled a greater mutual understanding between both organisations. The Infection Prevention and Control Team will continue to work with the Bristol Clinical Commissioning Group and to have engagement where possible with any projects they develop.

Surgical Site Infection Surveillance

Paediatric Cardiac Surgery have started to input data with their first quarter report (Jan – March 2015) now available.

- There were 37 cases input into the Public Health England database, however as this is the first report generated from the database we cannot compare data.
- There were approximately 20 patients who underwent cardiac surgery through a sternotomy wound whom should have been included in the surveillance however for inputting reasons they could not be included in the results. None of these has surgical site infections; therefore our accurate percentage of patients contracting surgical site infections would actually have been 1.75% for this last quarter which would be in line with other centres represented in the report.
- Trauma & Orthopaedics continue with Surgical Site Infection Surveillance utilising the national Public Health England programme. During 2014/15 there were no infections reported for patients who underwent hip surgery in the Trust.
- Of the 234 patients who underwent surgery for repair of fractured neck of femur, four (2.1%) patients acquired an infection. This is slightly above the national percentage of 1.6%.

Vascular Access Devices

In August 2013 the Trust appointed a Vascular Access Co-ordinator, to cover Adult, Paediatric and Neonatal services.

The aim of the role was to establish the Trust's position regarding vascular access device practice from the point of insertion, management of the device and removal. This involved reviewing the Trust's current guidelines and policies against current national standards, education and training, clinical practice and standardisation.

Specific Objectives

To achieve this, the following 7 specific objectives were identified:

1. Review current standards set within University Hospitals Bristol NHS Foundation Trust to ensure they are in line with and promote current national standards for vascular access devices.
2. Review educational programmes within University Hospitals Bristol NHS Foundation Trust regarding vascular access devices.
3. Review practice and standards on insertion, maintenance and removal of vascular access devices.
4. Capture data on lines inserted and removed.
5. Capture and respond to all Catheter Related Blood Stream Infections.

6. Transfer to electronic systems where possible.
7. Standardisation of intravenous lines used

Progress Against Objectives

A trust-wide action plan was introduced in September 2014 to include all Clinical Staff. This was developed to reinforce the importance of Aseptic Non Touch Technique and the following actions were achieved:

- Aseptic Non Touch Technique on Trust induction and E-Learning.
- Aseptic Non Touch Technique Champions who will audit standards quarterly.
- Aseptic Non Touch Technique workshops trust-wide.
- Launch of Aseptic Non Touch Technique poster designed to be displayed in clinical areas.
- Development and launch of Aseptic Non Touch Technique educational videos.

Trust Policies, Patient Information Leaflets, Clinical Guidelines, Standard Operating Procedures, Inpatient Pro Forma and Vascular Access Devices Competency Booklet have been developed, all of which incorporate current national guidelines for vascular access devices.

Data on lines inserted across the Trust are captured via databases. These include Clinical Information System Suite, Medway and Phillips Intellispace.

University Hospital Bristol NHS Foundation Trust has been capturing Catheter Related Blood Stream Infections rates since September 2013. 2014/2015 is the first year the Trust can officially report rates back to the Divisions for any actions to be implemented.

6. ANTIBIOTIC PRESCRIBING

Antibiotic lead structures

The Trust Anti-infective Committee has continued to meet under the leadership of Dr Sean O'Kelly with representatives from each division, microbiology and pharmacy. The Committee is responsible for the antibiotic stewardship within University Hospital Bristol NHS Foundation Trust.

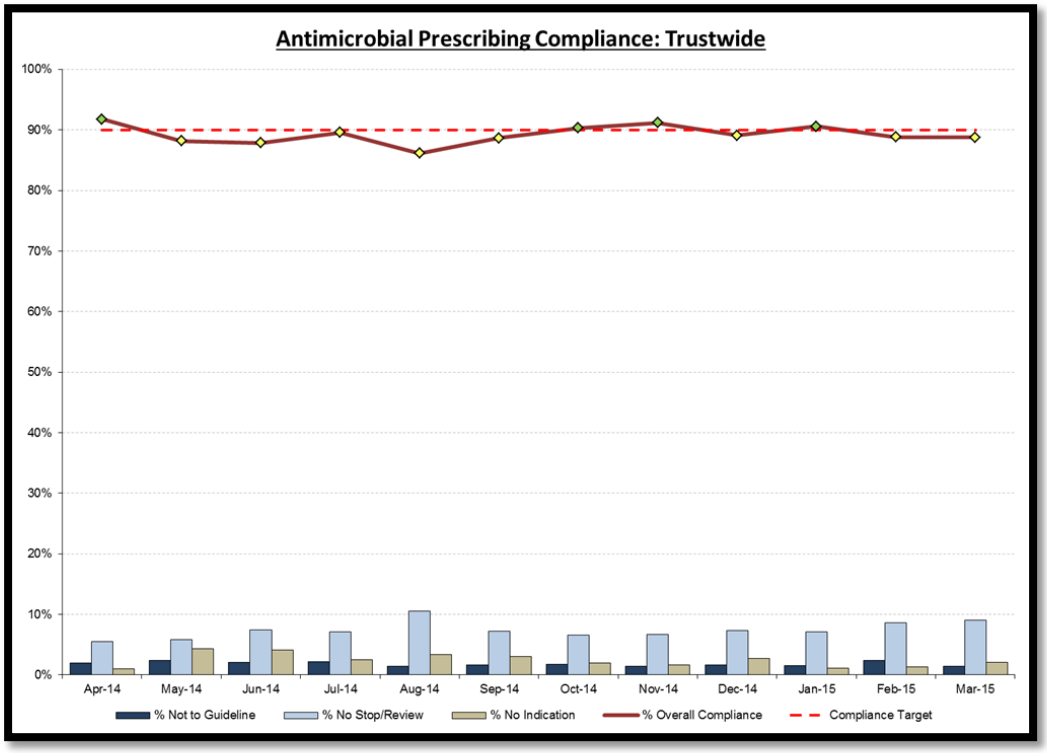
Antibiotic ward reviews

Antibiotic ward reviews continue across the Trust. There has been an increase in joint reviews with microbiology and pharmacy totalling 11 multidisciplinary ward rounds (22

wards) each week; these joint rounds have been expanded to cover oncology and haematology.

All other wards not covered are reviewed fortnightly by an antimicrobial pharmacist. On a weekly basis, Divisions receive a summary report of compliance by ward and monthly by specialist teams.

The tables below summarise the trust-wide results.



The compliance with the antibiotic prescribing care bundle continued to rise during the year with the 90% target being achieved on 4 occasions. Work continues to ensure continued improvement in 2015/16.

University Hospital Bristol NHS Foundation Trust came first in the regional point prevalence study in February 2015 for antimicrobial prescribing compliance. This study has been carried out annually for 9 years.

Antibiotic guidelines

A continued review of antibiotic guidelines has been undertaken, with all areas covered by a guideline or having a guideline under production. Work has begun to develop joint guidelines with North Bristol. Data from microguide usage shows University Hospital Bristol NHS Foundation Trust in the top 5 in the country for accessing the APP.

7. DECONTAMINATION

Risks

Risk around occurrence of mycobacteria in the final rinse water in the Automatic Endoscopic Re-processors at the Day Surgery Endoscopy Unit at South Bristol Community Hospital has been significantly reduced due to the actions that have been undertaken. Water testing for mycobacteria has returned to quarterly in line with Choice Framework for local Policy and Procedures (CFPP)-0101 guidance and mycobacteria has not been present since April 2014.

Bristol Dental Hospital Reversed Osmosis Plant continued to be unreliable during 14/15 with 4 breakdowns which lead to significant service disruption. Capital monies were secured for replacement of the plant and these works took place March/April 2015.

Queens Day Unit Automatic Endoscopic Re-processors continued to experience numerous breakdowns during the year. Capital monies were secured to support replacement of the unreliable Automatic Endoscopic Re-processor in Queens Day Unit. Tender process undertaken and award made to MMM Medical Equipment UK Limited in March 2015. As installation of new machines will be within live unit it is anticipated that it will be over 6 months in order to maintain endoscopy service provision as well as meet installation and commissioning requirements as per CFPP-0101 guidance.

Reliability of Reversed Osmosis Plant plant – level 3, Bristol Royal Children's Hospital continues to be a concern due to age profile being over 13 years old. A fully comprehensive service and maintenance contract that includes emergency call outs is in place, but the plant and hence the service remains vulnerable. Plan is to apply for capital monies for 15/16.

E3 steriliser in Bristol Eye Hospital Theatre Sterile Supply Unit had been condemned following pressure leak. Following further investigation by the manufacturer it was determined that the machine could be repaired. This was undertaken and machine returned into service September 2014.

All decontamination machinery/plant installed in Bristol Eye Hospital Theatre Sterile Supply Unit is over 13 years old. A number of breakdowns across the plant during the past 12 months has led to much disruption to service. A number of parts have been replaced when required and estates have now procured a number of critical spares in order to be able to repair these items quickly at times of failure. Due to the long-term plan of closing this facility (2016-17) it is not financially viable to replace these items. Work can and is transferred to the Kingsdown Central Sterile Supply Department unit at times of plant failure in order to keep Bristol Eye Hospital theatres supplied with a service.

Age profile of a number of items of decontamination machinery across the Trust now renders them due for replacement. Full service contracts are in place to support service delivery and capital bids will be submitted in an effort to secure monies for replacement. Trust decontamination engineering team are excellent in responding to breakdown calls and provide a first line repair response in an effort to get machinery working quickly for the end user.

Project of works for 2015/16

Installation and replacement of Queens Day Unit Automatic Endoscopic Re-processors – summer – autumn 2015 as tender awarded

Installation and replacement of Bristol Dental Hospital Reversed Osmosis Plant – spring 2015

Installation of additional ENT Outpatient Department Automatic Endoscopic Re-processors – April 2015

Installation of 2 High-efficiency Particulate Arrestance filtered drying cabinets Queens Day Unit – April 2015

Refurbishment of Central Sterile Supply Department – year 3. Plan to replace air handling unit and install clean steam during 2015/16 has Trust support and the aim is that all works will be complete within the 15-16 financial year.

Creation of new decontamination unit on level E, St Michael's Hospital to support the manual decontamination of ultrasound probes.

Purchase of at least 1 steam steriliser for Central Sterile Supply Department.

Removal of 3 steam sterilisers and 1 hot oven from Pathology labs, level 8, following transfer of city wide Pathology services to North Bristol NHS Trust.

Installation of sink in clean room and additional sockets in decontamination room at Day Surgery Endoscopy Unit (South Bristol Community Hospital) – required as part of Joint Advisory Group accreditation

Apply for capital monies to support the replacement of community dental decontamination washer (Southmead clinic).

Cease provision of decontamination service at dental South Bristol Community Hospital and re-provide at Bristol Dental Hospital.

Successes for 2014/ 15

Installation and replacement of Queens Day Unit Reversed Osmosis Plant – completed autumn 2014.

Installation of 1 new Automatic Endoscopic Re-processors for Bristol Royal Children's Hospital Day Case Theatres – autumn/winter 2014/15.

Completion of creation of decontamination room, Radiology, level 2, Bristol Royal Infirmary – winter 2014-15.

Purchase and installation of an automated decontamination machine for Radiology – winter 2014-15.

Upgrade works to ventilation system in Queens Day Unit and application of film to windows in order to reduce heat gain – thus making the decontamination working environment much more pleasant and compliant to CFPP-0101 decontamination guidelines – this in turn led to the unit being awarded renewal of their Joint Advisory Group status.

Conversion from enzymatic detergents for endoscopy manual cleaning to non-enzymatic detergents in the interests of health and safety for staff.

Purchase of two scope buddy's (Queens Day Unit and Day Surgery Endoscopy Unit) to assist the manual decontamination cleaning process and reduce the incidence of repetitive strain injury for staff.

Securing capital monies for purchase of additional nasendoscopes to support ENT Outpatient Department service.

Securing of monies to purchase 1 x decontamination machine to support the re-processing of nasendoscopes in ENT O Outpatient Department.

8. CLEANLINESS REPORT

Current Year (2014/15)

The Facilities department has made continual improvements to performance and working strategy to ensure the best patient environment experience. Actions and initiatives during 2014/15 included:

Facilities Cleaning

The successful implementation of the new ride-on machine for cleaning the floors in the corridors within the Bristol Royal Infirmary/Bristol Heart Institute has improved efficiency and enhanced cleaning standards. A further two machines have been purchased for the Welcome Centre and Terrell Street corridors.

Further 'state of the art' cleaning equipment has been purchased for the new build in Terrell Street. The equipment includes a 'Taski Scrubber', electronic scrubber dryer machines, industrial steam cleaning machines, rota-wash machines and the implementation of the microfiber mop trolley system. This equipment will support our Hotel Service Assistants in delivering and maintaining the required cleanliness standards.

As part of the Bristol Royal Infirmary Redevelopment Programme, a 14-stage phased consultation process with our Health Service Assistant staff was successfully completed prior to them moving into their new wards and adopting their new rotas in Terrell Street and wards within the King Edward Building.

Facilities are implementing Service Level Agreements for catering and cleaning at ward level. They will be working in partnership with Matrons and Ward Managers who will sign off the Service Level Agreements.

The Facilities team continue to support infection prevention and control with deep cleans of bed spaces, cubicles, rooms and whole ward areas. This cleaning is in addition to regular cleaning and is carried out in response to individual cases of infection, as well as outbreaks. A total of 4,965 deep cleans were performed in 2014-15, an increase of 14% from the previous year. During 2014-15, the Deep Clean Team disinfected areas using hydrogen peroxide vapour machines 345 times (an average of 6.6 times per week). Compared to the year before, this represents an increase of 5%.

A Facilities Standard Operating Procedure for remedial actions required in areas not achieving a 'green rating' for cleanliness is in place. The process for re-audits is designed to improve the scores within an area, to ensure it reaches a compliant 'green score'.

Quality Assurance for Cleanliness

Internal:

- The Trust receives assurance on cleanliness by cleanliness being monitored on a daily basis by an independent Audit Team.
- From 1 July 2014, the Trust adopted the National Specifications for Cleanliness 2007 and monitored three elements: Facilities cleaning, Clinical team cleaning and Estates cleaning. The catering element is reported separately.
- Each area is assigned a risk category (very high, high, significant or low risk) and a RAG rating (red, amber or green). Very High risk areas such as Intensive Care Units and Theatres (where patients are more vulnerable to infection) are audited on a monthly basis if the areas are performing to a Green RAG rating. Should any Very High Risk Areas fall into an amber or red RAG rating, the area can be audited weekly. The green RAG rating for the very high risk areas increased from 95 to 98%.
- The risk category associated with each functional area has been reviewed with the Chief Nurse, Heads of Nursing representatives and Infection Control.

External:

- Successful completion of the Patient-Led Assessment of the Care Environment assessments in 2014 at six hospitals. The elements assessed included cleanliness, privacy, dignity & wellbeing, food and condition & appearance. The assessment teams included representatives from Clinical areas, Facilities and Estates, led by patient representatives including governors, volunteers, patients and HealthWatch.

Training

Training for all new Substantive and Bank Hotel Service Assistants, Supervisors and Managers continues to take place at Tyndall's Park Training Centre. A total of 250 staff were trained during 2014, of which 166 were Substantive and 84 were Bank staff. This is an increase of 13.6% over the numbers of staff trained in 2013. Staff receive further training on-site within their work areas, which involves a week undertaking cleaning tasks and a week undertaking food duties. All Hotel Service Assistants have their competency assessed within six weeks of commencing their role. Any shortfalls in performance are noted on an action plan, with a review date and are followed up by the Supervisor. Our challenge for 2015 is to further improve food service training with the aim being to introduce a consistent standard and process across all of our wards.

Next Financial Year (2015/16)

Facilities Cleaning

Microfibre mops and trolleys are now in use as at April 2015 for the Bristol Royal Infirmary Queens Building and Bristol Heart Institute. Training has been undertaken from Vileda and feedback from Hotel Service Assistants has been very positive. This new equipment will

improve the standard of cleanliness further through the provision of a more efficient and effective mopping system.

A spend-to-save bid will be completed to fund the roll-out of the Microfibre mop system across all other Trust sites.

Restaurant

A new staff restaurant has opened on the 11th May 2015 on Level 9 of the Bristol Royal Infirmary Queens Building and is run by the Contractor, Medirest.

Patient-Led Assessment of the Care Environment

The number of Patient-Led Assessment of the Care Environment assessments across the Trust have been increased to cover all 6 hospitals and the assessments now include a new element for Dementia.

The process for completing the actions associated with the assessments has been reviewed to ensure they are completed in a timely manner, within budget.

Patient-Led Assessment of the Care Environment scores will be released in August 2015.

Internal mini Patient-Led Assessment of the Care Environment assessments will be completed on a regular basis.

Cleanliness Monitoring

Facilities are working with the Deputy Head of Business Intelligence on corporate reporting for cleanliness monitoring.

Exception reports for 2 consecutive red ratings over 2 consecutive months are presented to the Infection Control Group, together with an action plan to rectify the scores.

Facilities and Estates reports for the Infection Control Group will be reviewed to reflect a corporate image.

9. NEXT STEPS

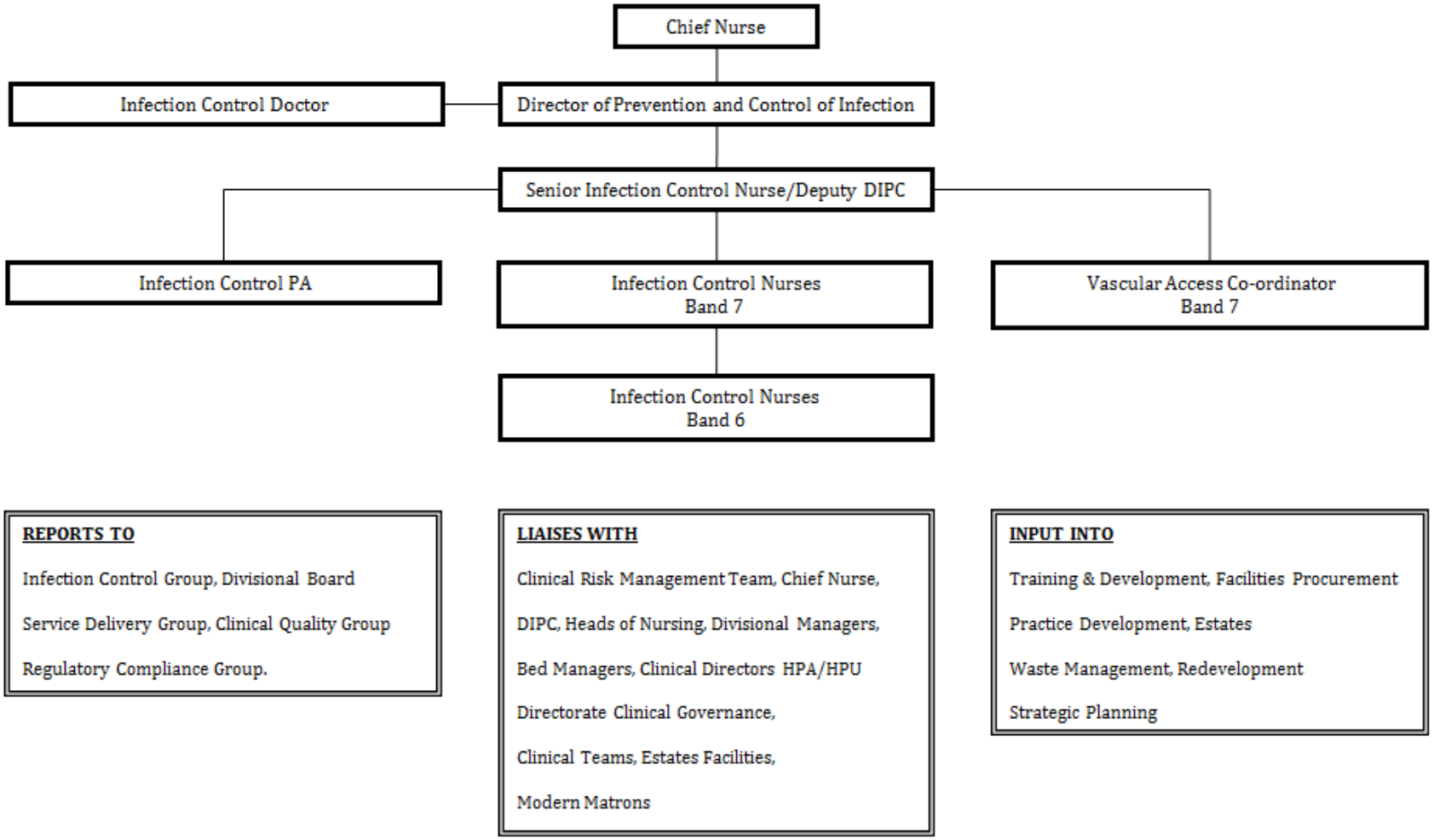
The Infection Prevention and Control Teams' goal in 2015/16 remains to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of infection as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection.

The Infection Prevention and Control Team will:

- Comply with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code).
- Report and investigate cases and outbreaks of healthcare associated infection as mandated.
- Reduce the incidence of infections (specifically Methicillin-resistant *Staphylococcus aureus* and Meticillin-sensitive *Staphylococcus aureus* blood stream infections and *Clostridium difficile)*.
- Continue to develop and drive the surgical site infection surveillance programme – there needs to be more surgical site infection surveillance in the Trust as this influences Methicillin-resistant *Staphylococcus aureus* and Meticillin-sensitive *Staphylococcus aureus* targets..
- Implement a rolling annual programme for Aseptic Non Touch Technique workshops across all Divisions.
- Develop working and supportive relationships with our community partners, as well as industry colleagues via means of the South West and Wales IV Forum.
- Re-configure and develop a cohesive Trust-wide Intra Vascular Team.

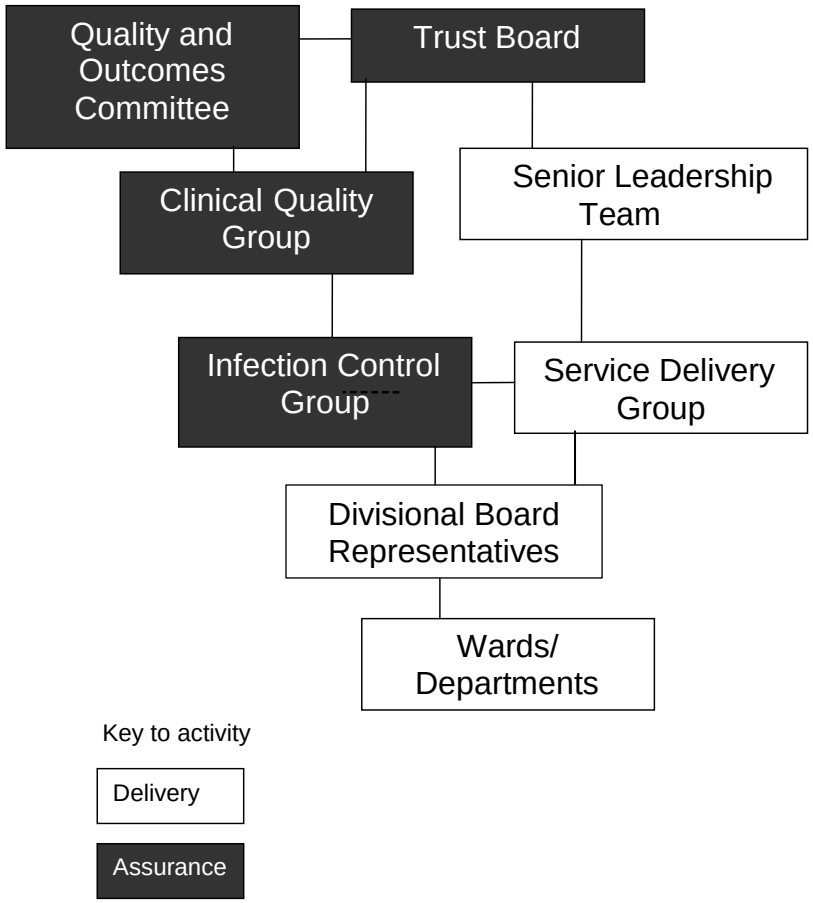
10. APPENDIX A

Infection Control Organogram



11. APPENDIX B

Infection Prevention and Control Reporting/Governance Structures



- The Chief Nurse is the Executive Lead and chairs the Infection Control Group, which has met four times and includes Governor and partner organisation representatives.
- The Trust Board has received infection control reports within the quality report monthly and a detailed report quarterly.
- The Infection Control Group has monitored all relevant risks at each meeting and has assessed compliance to the hygiene code quarterly at each Infection Control Group. The Trust Infection Prevention and Control risks include training compliance. There is a Trust wide action plan and this plan is being monitored at Service Delivery group. Isolation capacity, which will be removed from the risk register once the new ward block has been completed and opened. Norovirus outbreaks which is an ongoing risk and will continue to be monitored. Occupational Health Clearance regarding immunisations and infectious diseases which has ongoing monitoring and actions in place.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Board Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
13. Safeguarding Annual Report 2014/15									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse Author: Carol Sawkins, Nurse Consultant, Safeguarding Children/Named Nurse									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The purpose of this annual report is to provide both assurance and evidence to the that the Trust is fulfilling its statutory responsibilities to safeguarding adults, children and young people.

The annual report details the work over the last year to ensure that UH Bristol has made in fulfilling its statutory responsibilities to safeguarding adults, children and young people, as set out under Section 11 of the Children Act, 2004 and the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs). This report reviews the Trust's progress on meeting national and local priorities.

The report sets out the evidence available and measures the effectiveness of safeguarding arrangements for adults, children and young people within the Trust during 2013-2014.

Key issues to note

The report illustrates that the Local Safeguarding Boards, continue to facilitate the co-operation of local agencies to safeguard and promote the welfare of adults and children.

The report illustrates that safeguarding activity of Trust staff illustrating that previous increases in activity have been sustained.

The report illustrates that governance arrangements are robust, with Board representation and a team of safeguarding professionals in post, including a Named Doctor and Named Nurse for Children.

The report illustrates that a number of policies have been reviewed and updated during the reporting period and an audit programme in place to gain assurance around implementation of policy practice standards.

A number of activities are detailed re further improvements in the safeguarding of adults children and young people within the Trust.

There are two risks in relation to safeguarding adults and children on the Trust Risk Register, each are clearly defined with controls and action plans in place to mitigate risk rating (where possible).

Risk 1405 – detail in report, pate 9.

Risk 3044 – detail in report page 9.

Recommendations

The Trust Board is asked to note the report

Impact Upon Board Assurance Framework

The report supports the achievement of objective "to deliver all quality objectives and exceed national standards".

Impact Upon Corporate Risk

Corporate risk related to non-compliance with essential training.

Implications (Regulatory/Legal)

Supports CQC regulation no: 13.

Equality & Patient Impact

Nil specific

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	**X**	For Approval		For Information	

Date papers were presented to previous committees

Finance Committee	Quality & Outcomes Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
	28/9/15				Safeguarding Children's Board

University Hospitals Bristol NHS
NHS Foundation Trust

Safeguarding Annual Report

April 2014 – March 2015

1. Introduction

This annual safeguarding report aims to provide University Hospitals Bristol Trust Board, Bristol Clinical Commissioning Group and Local Safeguarding Boards with an overview of safeguarding for both children and adults for April 2014 to March 2015. The report will review key safeguarding activity, achievements and risks across the year, providing assurance that the Trust has fulfilled its statutory responsibilities to safeguard the welfare of children and adults across all areas of service delivery.

The report will outline national and local issues which have impacted on the Trust safeguarding agenda during this reporting period; including changes to the safeguarding children's arrangements across the city, the introduction of the Care Act 2014 and the review of the NHS Safeguarding and Accountability Assurance Framework, as a consequence of the Jimmy Savile investigation. The national reviews which have followed Child Sexual Exploitation (CSE) investigations in Rotherham, Greater Manchester, Oxford and most significantly for the Trust, the Bristol CSE case have also been considered and resulting actions incorporated into both the children's and adults work plans.

During this reporting period the Trust's safeguarding arrangements were inspected by the Care Quality Commission, whilst some areas for improvement were highlighted, safeguarding at the Children's Hospital was judged to be outstanding. The Bristol city wide 'Inspection of services for children in need of help and protection, children looked after and care leavers' by OFSTED, resulted in an overall judgment of ' Requires Improvement,' highlighting the need for a strategic plan to address Child Sexual Exploitation. Bristol was included as one of eight selected Local Authorities in the OFSTED thematic inspection 'The sexual exploitation of children: it couldn't happen here could it?' following which a number of recommendations relating to CSE were made. The Trust will continue to work in partnership with other agencies across the city to address areas of concern.

The Trust safeguarding agenda, for both children and adults, continues to be monitored through robust governance arrangements directed by the Safeguarding Steering Group, chaired by the Chief Nurse as the Executive lead for safeguarding, reporting directly to the Trust Board. The Steering Group is supported by Children's and Adults Operational Groups with representation from all Divisions. A team of well-established and experienced safeguarding professionals remains in place, providing expert advice, support and supervision to practitioners across the Trust.

2. Brief Update of National and Local Safeguarding Drivers

During this reporting period the statutory safeguarding duties of the Clinical Commissioning Groups and the role and responsibilities of NHS provider Trusts have been clarified through the review of the Accountability and Assurance Framework: Safeguarding Vulnerable People in the Reformed NHS (NHS England 2013). The Framework requires that NHS providers must have effective arrangements in place to safeguard children and vulnerable adults and to assure themselves and their regulators and commissioners that these are working.

These arrangements include:

- Safe recruitment , effective training of all staff, effective supervision arrangements, working in partnership with other agencies and the identification of a named doctor, named nurse and midwife for safeguarding children and a named lead for adult safeguarding.

- The requirement to be licensed by Monitor and registered with the Care Quality Commission (CQC).

Furthermore in order to be registered with the CQC, health providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported, and can demonstrate that they have safeguarding leadership and commitment at all levels of their organisation and that they fully engage in local accountability and assurance structures. Most importantly they must ensure that a culture exists where safeguarding is everyone's business and poor practice is identified and tackled.

Locally the re-modelling of social work in Bristol has seen significant changes to the safeguarding children's arrangements across the city. From January 2015 the system of locality duty teams, which included the Hospital Social Work team, was replaced by the implementation of 27 small social work units across the city. All referrals from the central access point, First Response, are now allocated to one of the units, led by a Consultant social worker. The loss of the Hospital Social Work team has had a significant impact on the number of contacts to the Child Protection Nursing Team. The full impact of these changes including capacity to respond to this increase in demand will be fully considered in the next reporting.

The statutory guidance in 'Working Together to Safeguard Children' (2015) has also been revised in this reporting period. The revised guidance reinforces the statutory requirements for NHS provider Trusts and amended guidance to specific areas of practice including introducing a broader learning framework to be followed for any child death or serious injury as the result of abuse or neglect.

Additional significant changes in legislation during this reporting period include:

- Anti-social Behaviour, Crime and Policing Act 2014

Part 10 of this Act has made forced marriage an offence in England, Wales and Scotland giving additional powers to the police and the forced marriage unit to help prevent forced marriage and to press charges where appropriate. This law has also tightened the legislation in relation to sexual violence and the prevention of sexual exploitation with new powers for things such as reviewing hotel occupancy records.

- Counter-Terrorism and Security Act 2015

Following agreement by both Houses on the text of the Bill it received Royal Assent on 12 February 2015. Among other provisions, the act places the Prevent programme on a statutory footing. This means that from the 1st July 2015 every Trust/local authority/police authority etc will have a legal duty to, "when exercising its functions, have due regard to the need to prevent people from being drawn into terrorism". Prevent is one of four strands of the government's "CONTEST" counter-terrorism strategy, and aims to stop people becoming terrorists or supporting terrorism. The implications of this change will be considered as part of the Safeguarding work plan for 2015-17.

- The Serious Crime Act 2015

This Act received Royal Assent on 3 March 2015. It clarifies the offence of child cruelty, in section 1 of the Children and Young Persons Act 1933, in particular, to make it explicit that the offence covers cruelty which causes psychological suffering or injury as well as physical harm. It replaces anachronistic references to child prostitution and child pornography in the Sexual Offences Act 2003 and restricts the offence of loitering or soliciting for the purposes

of prostitution to adults. It introduces a new offence of sexual communication with a child and creates a new offence making it illegal to possess paedophile manuals.

It brings in new provisions to tackle Female Genital Mutilation (FGM) by:

- extending the extra-territorial reach of the offences in the Female Genital Mutilation Act 2003 so that they apply to habitual as well as permanent UK residents
- introducing a new offence of failing to protect a girl from risk of FGM
- granting lifelong anonymity to victims
- bringing in a civil order ('FGM protection orders') to protect potential victims
- introducing a duty on healthcare professionals, teachers and social care workers, to notify the police of known cases of FGM carried out on a girl under 18
- criminalises patterns of repeated or continuous coercive or controlling behaviour where perpetrated against an intimate partner or family member
- allows people suspected of committing an offence overseas under sections 5 (preparation of terrorism acts) or 6 (training for terrorism) of the Terrorism Act 2006 to be prosecuted in the UK

In addition the Department of Health is introducing new requirements for all Acute Trust to record and report the following data centrally to the Department of Health from September:

- If a patient has had FGM
- If there is a family history of FGM
- If an FGM related procedure has been carried out on a woman (deinfibulation).

This is recognised to be the first stage in a wide ranging Government programme of work aiming to improve the way in which the NHS responds to the health needs of women and girls who have suffered FGM and to actively prevent FGM. This will be strengthened by the proposed changes to the legislation, outlined within the Serious Crime Bill (2015), including a mandatory duty for health practitioners to report. These changes will be addressed as a specific work stream in the Safeguarding work plan for 2015- 17.

- Modern Slavery Act 2015

Received Royal Assent and became law on 26 March 2015. It increases the maximum jail sentence for the most serious offences in relation to slavery and human trafficking from 14 years to life. It makes Human Trafficking an offence and makes arrangements for things such as independent advocates for children and access to civil and legal aid. It has been criticised in that it requires adults to initially challenge the situation themselves and to leave the situation of their own volition.

- The Care Act 2015

Following agreement by both Houses on the text of the Bill it received Royal Assent on 14 May and as such "the law" however it will not come into force until April 2015. Given this there has still been much preparation work needed during this year to enable to Trust to be ready for this legislative change. The safeguarding team have been working to this end both internally and with partner agencies. Policies require updating to reflect the changes and it has been necessary to complete the multi-agency Bristol policy updates first to ensure that the Trust local policies correctly reflect the multi-agency policy. The Trust has also reviewed and updated all of the adult safeguarding training modules that it delivers to ensure compliance with the law. Team members have also attended additional training.

- Deprivation of Liberty Safeguards (DOLS)

The changes following the 19 March 2014 Supreme Court judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council" which significantly reduced the threshold for the need to make an application for DOLS, as anticipated in last year's annual report, have made a significant impact on the number of DOLS applications being made by the Trust. There has also been other unanticipated consequences the most notable being the impact on the Local Authority DOLS teams who have been inundated with applications resulting in large backlogs for reviewing applications. This has resulted in a good number of patients detained under a DOLS at the Trust never being reviewed and the DOLS application not being approved. Following advice from the Local Authority the Trust has continued to detain these people as it is in their best interests and the Local Authority have said that the legal responsibility will lie with them.

3. Summary of current Arrangements for Safeguarding within University Hospitals Bristol NHS Foundation Trust (UHBristol)

The UHBristol Trust Board continues to hold ultimate accountability for ensuring that safeguarding responsibilities for both children and adults are met, led by the Chief Nurse as Executive Lead for Safeguarding. The Trust's duties and responsibilities for Safeguarding Children are set out in Section 11 of the Children Act 2004 underpinned by the accompanying statutory guidance in 'Working Together to Safeguard Children (2015). The new Care Act 2015 provides a new legislative framework to guide Safeguarding Adults activity.

Day to day safeguarding activities continue to be supported by teams of well-established and experienced safeguarding professionals, who provide expert advice, support and supervision to practitioners across the Trust. Whilst there are many pieces of legislation, policy and guidance from multi agencies in the area of safeguarding, the principles of empowerment, protection, prevention, proportionality, partnership and accountability remain the same for all.

Monitoring of safeguarding arrangements and activity forms part of the Trust's governance arrangements and is reported quarterly to the Trust Safeguarding Steering Group , and includes data required by the NHS commissioning contracts and the Local Safeguarding Boards. During this year (2014/15) the Trust has augmented the management and governance framework for safeguarding with the introduction of two operational groups; one for Children's Safeguarding and one for Adult Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards.

In addition new strategic leads have been identified; the Head of Nursing for Women's and Children's Division for Children's Safeguarding and the Deputy Chief Nurse for Adult Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards. These groups report directly to the Safeguarding Steering Group.

All divisions are represented at the Operational Groups as are Allied Health Professionals and Medical staff. The Operational Groups have the responsibility for actioning the Trust Safeguarding Work-plan, monitoring activity, reviewing trends, receiving assurance from the divisions regarding safeguarding activity, monitoring training and the dissemination of learning and information through Divisions. Additionally action plans from local Serious Case and Homicide Reviews are actioned and monitored as part of these arrangements

The safeguarding teams work collaboratively with other safeguarding professionals both in a multi-agency and multi-professional approach, locally and across the region. This includes representation at the Bristol, North Somerset and South Gloucestershire Safeguarding Children Boards and the Bristol Safeguarding Adults Board.

The Trust also has in place safeguarding children and adult policies and procedures to guide staff through their contractual responsibilities to protect vulnerable patients which includes, for example, guidance on information sharing, making a referral and how to manage a professional difference of opinion. These policies and procedures are based on current national and local guidance and are reviewed regularly.

4. Safeguarding Assurance including Performance Monitoring, and Audit

The Trust has in place a robust performance management framework through which safeguarding activities for both adults and children are monitored. This framework provides assurance both internally to the Trust Board and externally to Local Safeguarding Boards and Clinical Commissioning Groups that the Trust continues to meet its contractual safeguarding requirements. However concern remains about the slow rate of improvement with safeguarding training compliance, which is recognised to be an area or risk which continues to be addressed as a matter of priority (detailed in 4.2 & 6.0).

During this reporting period the Trust's safeguarding arrangements and activities for both children and adults have continued to be safe and effective with areas of risk clearly identified and reviewed regularly (detailed in 4.2) The Care Quality Commission (CQC) inspection served to provide further assurance, judging safeguarding arrangements at the Children's Hospital as 'Outstanding' (detailed in 4.1).

Key safeguarding assurance evidence includes:

- Minutes from the Safeguarding Steering Groups and both Operational Groups providing detail of on-going quality assurance and monitoring activity.
- Completion of actions detailed in the 2014-15 Safeguarding work plans (summarised in 5.0).
- Quantitative safeguarding children data reported quarterly to Bristol and South Gloucestershire Local Safeguarding Children Boards and NHS Bristol and part of contractual requirement specified within the 'Safeguarding Children: Standards for providers of health services' (2014-15).
- Monitoring of allegations, complaints, risks and clinical incidents by the safeguarding teams for further actions to be taken. This enables recognition of possible patterns and trends, which in turn informs supervision practice and teaching content.
- Annual audit plans, for both safeguarding children and adults, are monitored quarterly through the safeguarding steering groups
- The Safeguarding Team has been involved with the Trust's internal Auditors in completing an audit relating to patient experience for patients with dementia which also looked at the implementation of the Mental Capacity Act, 2005 for this patient group
- A second audit was completed by Audit South West under the safeguarding umbrella, looking specifically at 'Consent and Speaking Out'. The audit highlighted that despite low training compliance staff were found to be knowledgeable of the principles of safeguarding and speaking out.

4.1 Safeguarding and Care Quality Commission (CQC) Regulation

Safeguarding is a key priority for the Care Quality Commission (CQC) who state that for both adults and children their overarching objective is enabling people to live their life free from abuse.

As the regulator of health and adult social care services, the CQC's primary role is to make sure that providers have appropriate systems in place to safeguard people who use the service, and that those systems are implemented and followed in practice to ensure good outcomes for people who use the service. Where regulatory information suggests a breach of regulations or the registered person not being fit for the role, the CQC will consider what regulatory action is needed and undertake that work, where necessary, in partnership with other agencies.

The Health and Social Care Act 2008 introduced a new, single registration system that applies to all health care and adult social care services. The registration system is based on ongoing assessment of the ability of providers to ensure the quality of people's experiences of the care they receive, including safeguarding and safety.

Although there are specific standards that relate to safeguarding and safety, effective safeguarding also requires compliance with a range of other standards as well. For example: robust recruitment and vetting processes for staff; having enough well-trained, competent and supported staff; providing effective and appropriate treatment; having systems in place to enable people who use services and their representatives to feedback concerns; and ensuring that people using the service are respected and as fully involved as possible in their care and support. Meeting the full range of standards should result in positive outcomes for people, where the risk of abuse, neglect or harm is far less likely to arise in the first place.

The Trust underwent a CQC inspection during this reporting period, and there was one area of improvement identified in relation to safeguarding identified by the CQC, which was the Trust compliance with safeguarding adults and children training. The Safeguarding Steering Group is aware of the current challenges in meeting the compliance standards for all safeguarding training. This is on the Trust risk register with a clear action plan to improve compliance, through delivering against the improvement trajectories which will be monitored by the Safeguarding Steering Group and the Workforce and OD Group.

4.2 Safeguarding Risks

Any safeguarding areas of concern are monitored robustly through the Trust's internal risk management arrangements. The following areas of concern are recorded on the Trust risk register to ensure that they are regularly reviewed by the Safeguarding Operational Groups and mitigated as far as possible:

- 1483 - The potential risk to a child through the use of multiple sets of notes across Trust hospital sites. Progress continues to be made in addressing this long term risk through the implementation of Electronic Patient Records which will reduce this risk. A plan is in place to introduce a single set of electronic patient records starting with St Michaels Hospital in the next reporting period.

- 1405 – The failure to reach 90% compliance for Essential Training, including Safeguarding Children and Adults training, for all Trust Staff. A training recovery plan is in place which includes the provision of additional training and monitoring compliance report.

- 3044 – Since March 2014 the Trust has been partially non – compliant with the DOLS legislation due to a court ruling that changed the interpretation of the legislation. During the year progress has been made towards meeting the new legal requirements and Trust staff have been updated with the new requirements included in essential training.

5. Summary of Key Safeguarding Achievements of 2014/15

During this reporting period the Trust has made significant progress in delivering key objectives included in the work plans for 2014-15 and areas of ongoing work have been incorporated into the next year's plans.

Key achievements include:

- Safeguarding Children's Arrangements rated as 'outstanding' at the Children's Hospital as part of the Care Quality Commission inspection.
- A robust process of monitoring incidents, complaints and risks has been implemented through a process of quarterly reporting with involvement from all Divisions through the production of a Divisional report. This has resulted in a range of learning and changes to practice, such as the implementation of a Trust wide 'Missing Persons Policy'.
- Significant progress has been made towards the introduction of Electronic Patient Records which it is hoped will address the long standing risk within the Trust of non-compliance with Laming recommendation for a single set of patient records.
- A cross Local Authority ' Non - Mobile Baby multi- agency protocol' has been introduced in response to a local Serious Case Review, which incorporates the Trusts Best Evidence Safeguarding Tool developed by the Nurse Consultant for Safeguarding Children. The potential impact on the Children's Emergency Department will be monitored in the next reporting period.
- Formation of a short life working group to consider the Child Sexual Exploitation requirements also contributing to the wider Bristol multi agency strategy.
- Continued support to Transitional Care arrangements for all specialities, from Children's to Adult Services with a safeguarding perspective.
- The Trust has continued to actively support the Serious Case Review and Domestic Homicide Review Process in Bristol and to action all relevant recommendations.
- A new Trust wide Supervision Policy has been developed which includes specific reference to safeguarding supervision and is due to be ratified early next year.
- The Trust safeguarding pages on CONNECT have been reviewed and enhanced over the course of the year giving much more information for the use of staff, patients or their representatives.
- In collaboration with partners the local multi-agency adult safeguarding procedures have been updated and re issued. In addition a skills and competency framework for Adult Safeguarding and the Mental Capacity Act (2005) has been ratified by Bristol Safeguarding Adults Board

- The Adult Safeguarding Team has provided updated training for staff to ensure that they are aware of the new thresholds pertaining to the Deprivation of Liberty Safeguards and have continued to work towards full implementation of the new thresholds.
- The safeguarding teams have delivered training to more than five thousand staff over the course of the year. E-learning modules have been introduced into the Trust for staff to complete update training.
- A Female Genital Mutilation (FGM) Working Group has been established to facilitate the requirements of the new legislation and the data recording and reporting process required by the Department of Health.

6. Safeguarding Activity Data

A summary of safeguarding activity for both children and adults across the Trust is detailed below.

6.1 Safeguarding Children Activity Data

6.1.1 Safeguarding Children Referrals

Historically Safeguarding children referrals were made directly from individual practitioners to the Hospital Social Work Team or other Local Authority allocated social workers. As part of the re- organisation of Bristol's Safeguarding Children arrangements a central referral point called 'First Response' was introduced in 2014, alongside a new referral from called the 'Request for Help' form. In practice this resulted in a significant change to the safeguarding referral process within the Trust following which all referrals are now sent directly to the child protection team in the first instance.

This has allowed referral activity data to be monitored and evaluated more robustly by the Child Protection Operational Group during this reporting period and going forward will be used to monitor patterns, trends or areas of concern. The data reflects a significant increase in safeguarding activity over the winter months in line with the winter pressures seen across the Trust. (Table Three)

It can be also be seen that approximately 50% of contacts to the Child Protection Nursing team, for advice and support, do not result in an onward referral to Children's Social Care. This is most often as a result of further information gathering and analysis, with reference to the Bristol Safeguarding Children Board Thresholds Guidance (2014), following which the outcome will be to share information with the child's Primary Health Care Team for ongoing support and monitoring (Table One).

Table 1: Safeguarding Referrals to First Response

	Calls to Child Protection Team	Referrals to First Response
Quarter 1	172	87
Quarter 2	184	70
Quarter 3	230	80
Quarter 4	209	166
Total	795	403

A more detailed analysis of safeguarding children referrals made from across the Trust has been completed for quarter four with the results detailed below (figure 1- 4).
This highlights that safeguarding referrals continue to be made from a wide range of areas within the Children's Hospital with the largest number of referrals from Midwifery services referrals for unborn babies as expected.

Figure 1: Source of safeguarding referral

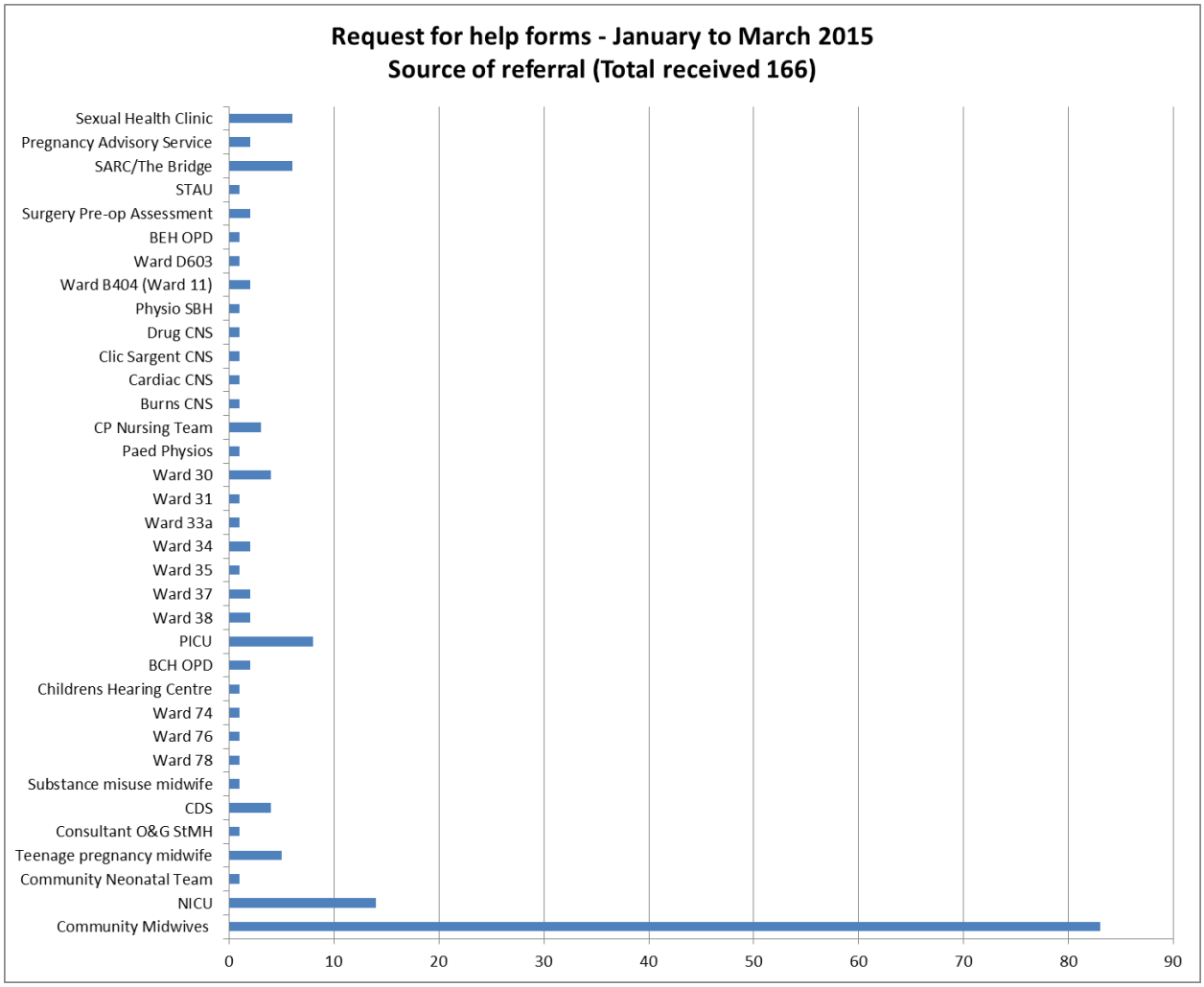


Figure 2: Reason for safeguarding referral

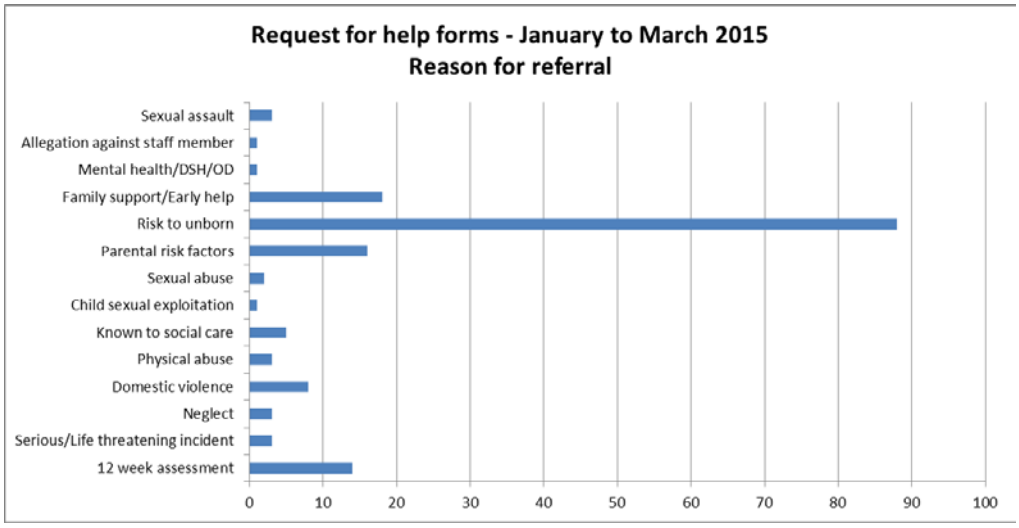


Figure 3: Reason for safeguarding referral for unborn babies.

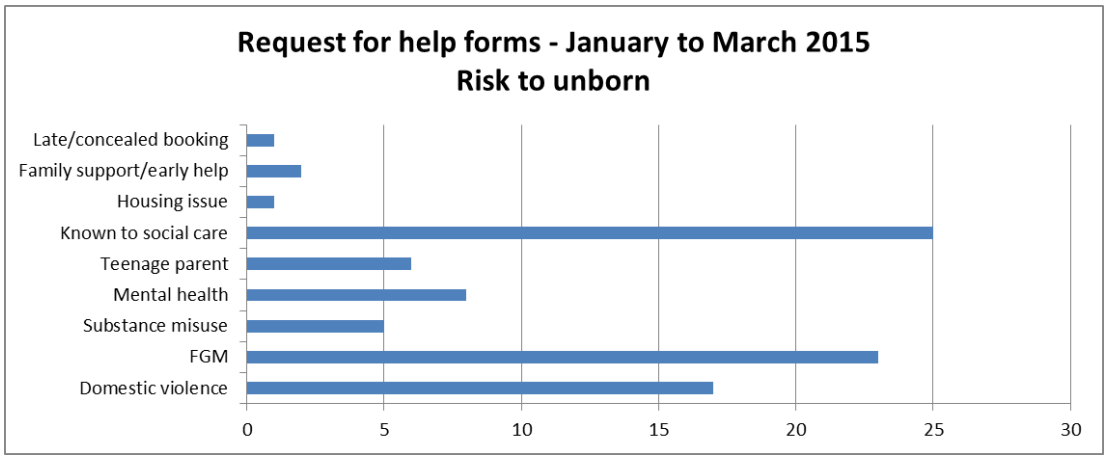
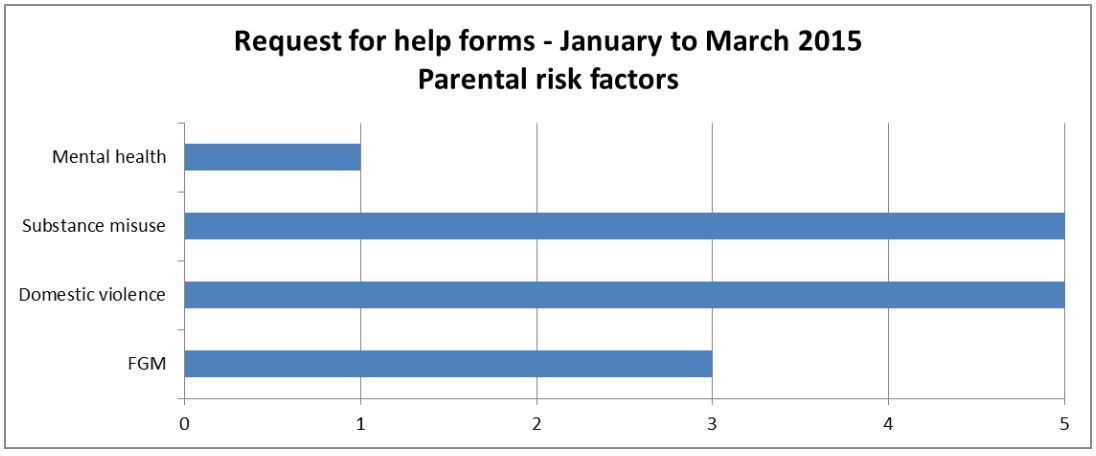


Figure 4: Breakdown of referrals for parental risk factors/ think family.



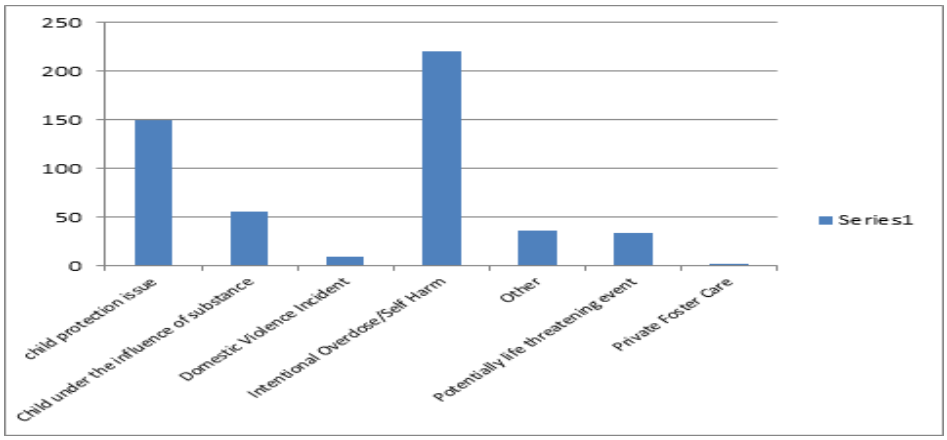
A significant number of notification and referrals continues to be made by practitioners in the Trust Emergency Departments to Children's Social Care (detailed in Table Two)

Table 2: Emergency Department Safeguarding Referrals / Information Sharing

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
BCH ED	609	891	1041	1172	885	1275	1362
BRI ED	225	284	330	514	462	488	593

Of the 1362 forms completed by the Children's Emergency department 854 were completed for the purpose of sharing information with Children's Social Care, for example if a child presented with an appropriate medical attendance but was noted to have an allocated social worker. Further breakdown of the remaining 508 safeguarding referrals form the Children's Emergency Department is detailed in Figure 5.

Figure 5: Children's Emergency Department Safeguarding Referrals



6.1.2 Safeguarding Advice and Supervision given by the Child Protection Nursing Team

The ability to recognise safeguarding risks to the unborn baby, children and young person and to know 'what to do' next is an essential component of the Trust's mandatory safeguarding training. Staff are advised during safeguarding training to contact the Child Protection Nursing Team if they require advice, support and supervision to manage cases.

The provision of safeguarding supervision for staff, both on an ad-hoc and regular basis, is frequently noted to be essential to support staff in effectively protecting children from harm, especially when they are managing complex and challenging cases (Sidebotham *et al*., 2010). A new Trust wide Supervision Policy has been developed which includes specific reference to safeguarding children supervision is due to be ratified early next year.

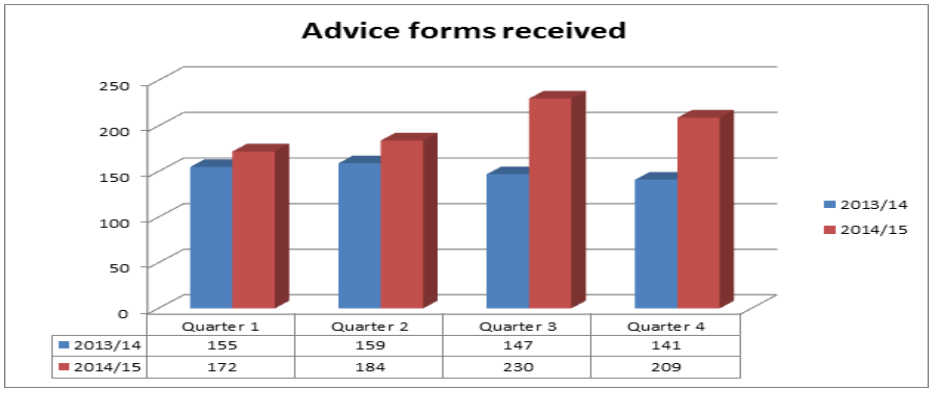
This reporting period has seen a significant increase in the number of recorded ad- hoc contacts to the Child Protection Nursing Team, from practitioners requesting advice and case supervision, detailed below in Table 3 and 4. This is likely to reflect the impact and change in practice resulting from the remodelling of Bristol Social Care arrangements and

the loss of the Hospital Social Work Team. The centralisation of specialist paediatric services, during this quarter has also impacted on the activity data.

Table 3: Safeguarding Advice / Case Supervision given by the Child Protection Team

	2013/14	2014/15	% increase
Quarter 1	155	172	11.0
Quarter 2	159	184	15.7
Quarter 3	147	230	56.5
Quarter 4	141	209	48.2
Total	602	795	32.1

Table 4: Safeguarding Advice / Case Supervision given by the Child Protection Team



The Child Protection Nursing Team, supported by the Named Doctor and Midwife continue to provide regular safeguarding supervision to a range of practitioners who are responsible for managing their own caseloads, such as the Paediatric Clinical Nurse Specialists as well as to individual clinical areas such as the Paediatric Intensive Care Unit and the Children's Emergency Department. Safeguarding Midwifery Supervision has been regularly provided to the Community Midwives.

The Named Professionals will continue to focus on strengthening the supervision practice during the next reporting period; this will include the development of a more formalised system which will allow for a greater degree of monitoring and reporting. This has been included as an objective in the Safeguarding work plan going forward.

6.1.3 Child Protection Medicals

As part of the process to centralise specialist paediatric services, a new Child Protection Clinic has been established to examine children who require a child protection medical in a timely fashion and in an appropriate environment. During this reporting period 82 child

protection medicals have been completed by the Consultant Community Paediatricians with the support of the Child Protection Nursing Team or the Children's Outpatient nurses. The impact of this new activity will continue to be monitored going forward into the next reporting period.

6.2 Safeguarding Adults Activity Data

During the course of this year the number of alerts has continued to grow from last year. During 2013/14 we received 652 alerts and in this reporting period 670 alerts have been received. It has been noted by the adult safeguarding team that the quality and suitability of the alerts received from Trust staff continues to improve and very few are received that are not appropriate. The Division of Medicine continues to make the most referrals a picture which is echoed nationally.

The team has continued to promote the safeguarding of vulnerable adults across different areas of the Trust and it is of note that although the majority of alerts continue to be generated by the Trust clinical staff there has also been an increase in the volume of alerts received from other areas such as Human Resources and Pharmacy.

This year has also seen an increase in the number of internal safeguarding cases from 44 in 13/14 to 62 this year. However it is important to note that this is viewed by our partner agencies including Bristol Local Authority and the Clinical Commissioning Group as a positive indicator that the Trust continues to improve in its recognition of what constitutes an adult safeguarding issue and we are applauded by our partners for our continued transparency plus our willingness to share and to learn lessons when appropriate. Of the 62 internal cases this year only 11 have been either substantiated or partially substantiated. For each of these 11 cases learning has occurred along with relevant changes in practice and through the Trust governance structure this has been shared and disseminated across all the divisions. Examples include: -

- The review and writing of the missing persons policy which has also been extended to cover children due to the joint working with adults and children's safeguarding
- The introduction of a "transfer of care document" for patients who are leaving hospital and going to residential or nursing home care to ensure that detailed information is conveyed to the receiving home which provides better more joined up care for our patients
- Pre discharge check lists have been introduced into some areas to assist staff in complex discharges
- Staff have received additional training in some topics including caring for people with dementia and pressure area care
- Staff safety briefings have been used as a reminder of the importance of checking and removing cannulas prior to the discharge of all patients

- The data below includes data about the number of Deprivation of Liberty Safeguards applications that have been submitted to the Local Authority. As anticipated the Trust saw a dramatic increase in applications going from 36 in 13/14 to 137 this year.

Figure 6: Number of Referrals Received Per Quarter

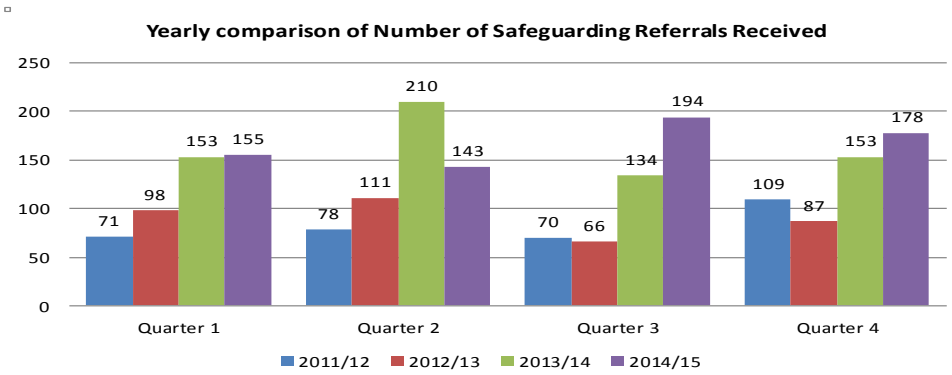


Figure 7: Category of referrals

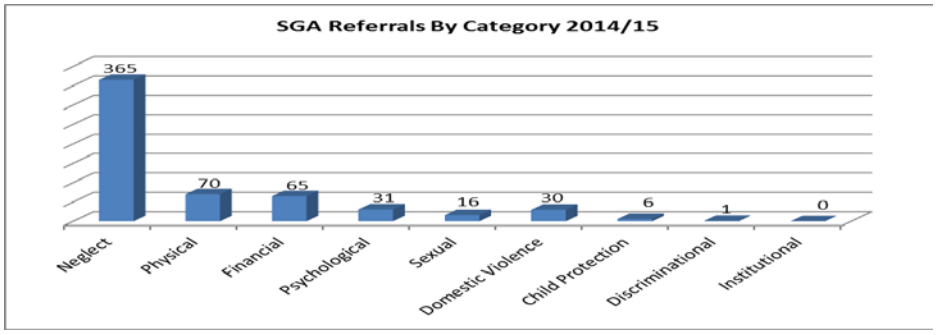


Figure 8: Total Referrals Received by Age

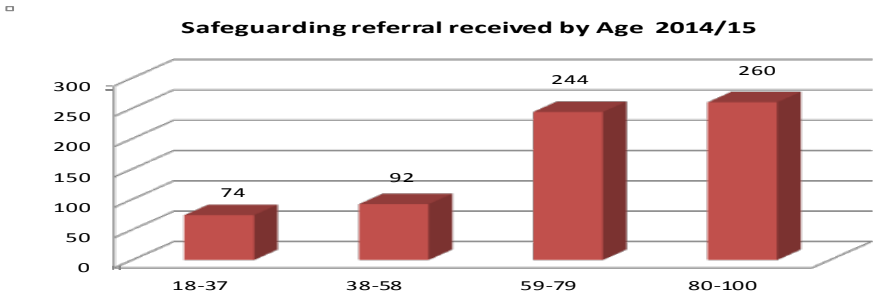


Figure 9: Safeguarding Referrals by Division

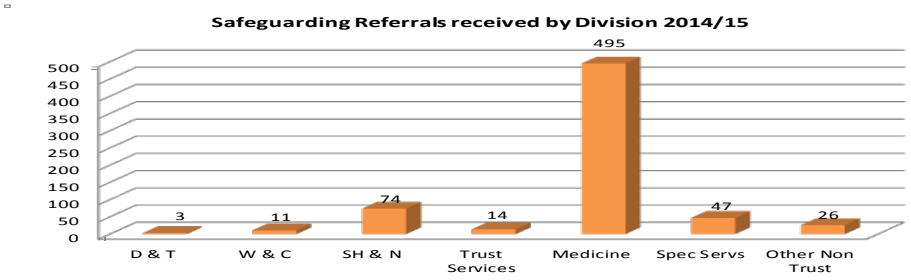


Figure 10: Internal Safeguarding Alerts Received Per Quarter

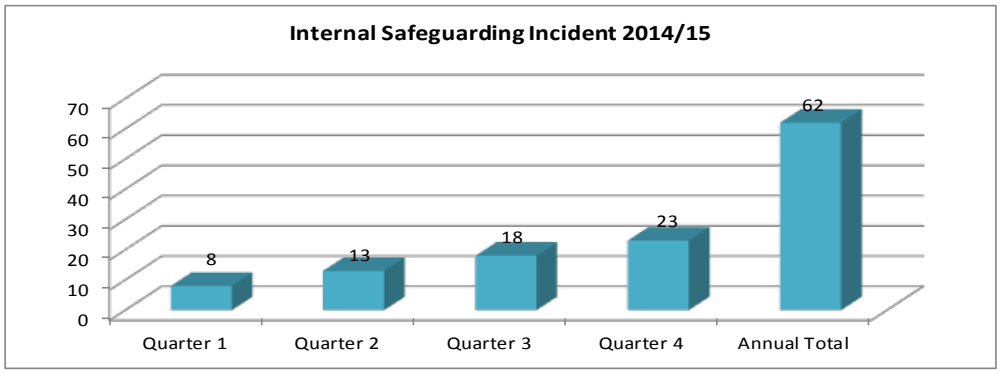


Figure 11: Annual Internal Safeguarding Referrals by Category

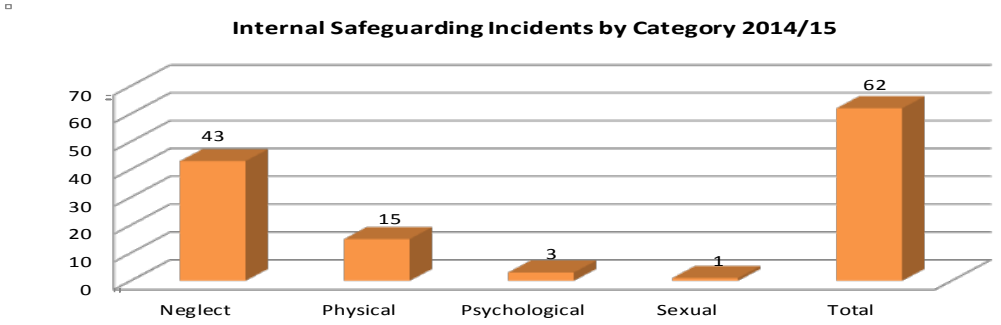


Figure 12: Annual Internal Safeguarding Referrals by Division

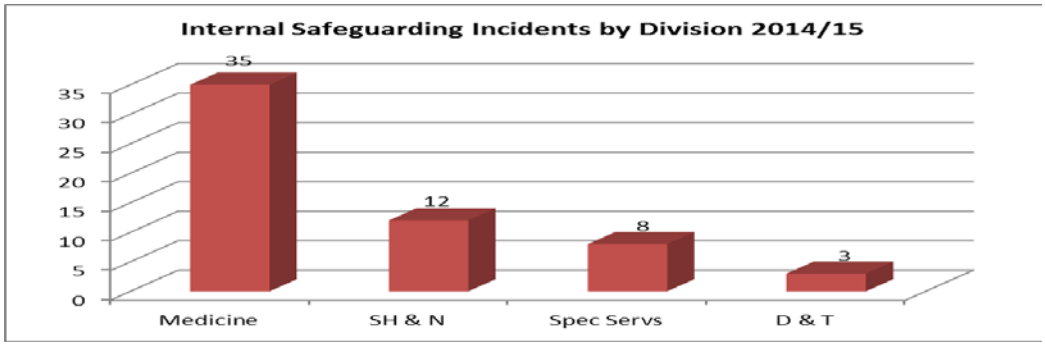


Figure 13: Outcome of internal Safeguarding investigations

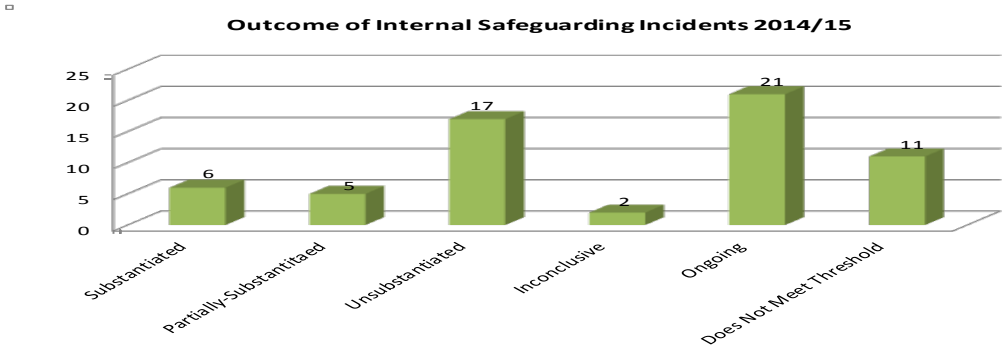


Figure 14: Number of Deprivation of Liberty Safeguards Applications per Quarter

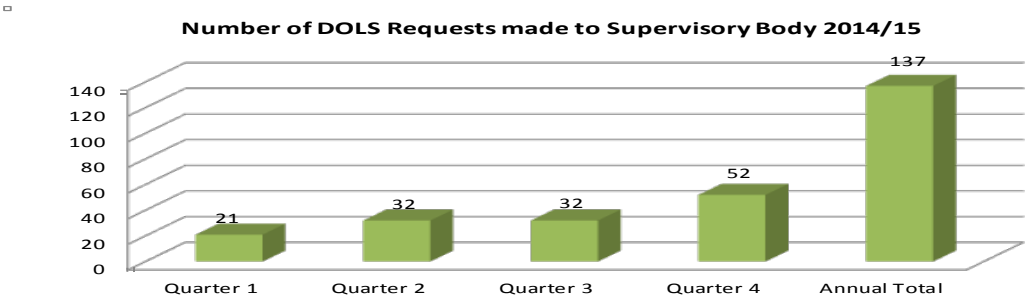
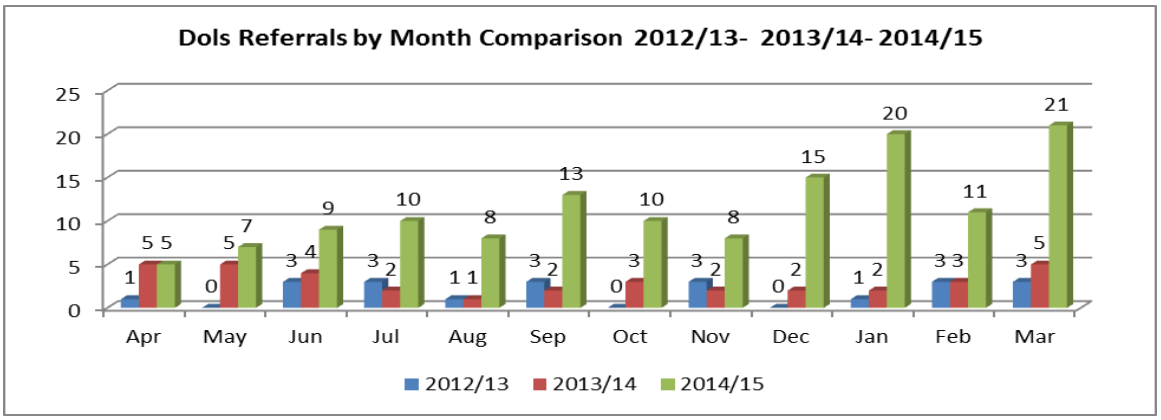


Figure 15: Deprivation of Liberty Safeguards Applications by Month Comparison



7. Safeguarding Children and AdultsTraining

The provision and delivery of both children and adults safeguarding training remains a key priority for the Trust, ensuring that all staff are provided with the appropriate level of training according to their role and responsibility. The aim of the training is to ensure that every member of staff is aware of how to recognise abuse and to feel confident in knowing what to do, as a minimum requirement.

For safeguarding children's training these requirements are underpinned by the competencies specified within the revised Intercollegiate Documents (2014). This third edition of the ‘safeguarding children and young people: roles and competences for health care staff’ has been updated to emphasize the crucial safeguarding role of Executive Teams and Board members, whilst also taking into account the structural changes which have occurred across the NHS.

Level 1 and 2 training for both children and adults is now incorporated into all clinical and non-clinical induction and all staff are required to complete updates at a minimum of three yearly. New this year is the addition of e-learning as an option for staff to complete to their update training; face to face update training also continues to be delivered.

The Bristol Clinical Commissioning Group (CCG) requires that the trust achieves and maintains a 90% compliance target for all levels of safeguarding training. This is specified within the annual Safeguarding Standards which are monitored both on a quarterly and annual basis.

The Trust has not yet managed to achieve the required target and as a result in May 2014 the Trust received a Contract Query Notice to provide assurance to the CCG of a remedial action plan to address safeguarding training as a matrer of urgency and to achieve the required target by the end of March 2015. Level 3 safeguarding children's training, the level required by staff regularly working with children, young people and the unborn baby, was highlighted as a particular area of concern by the CCG.

A remedial training recovery plan was developed and agreed by the Trust Senior Leadership Team (SLT) and the Safeguarding Steering Group. Compliance reporting has been closely monitored on a monthly both by SLT and a Divisional level. Much progress has been made over the proceeding twelve months and the final compliance position is detailed below in Table Five.

Table 5: Compliance data March 2015

	Level 1	Level 2	Level 3 Core	Level 3 Spec
Adults	**84.4 %**	**68.5 %**	**N/A**	**N/A**
Children	**81 %**	**81.6 %**	**72.9 %**	**63.8 %**

The Trust data reporting system does not allow for a refined level of data analysis, for example all new starters are included within the Level 3 total. In effect this means that a new member of staff, who according to the Trust Matrix is required to complete Level 3 training within 6 months of commencing employment with the Trust, will be recorded as non – compliant from their first working day.
For the purpose of this report a more detailed data analysis (a manual exercise) has been completed for the Level 3 target audience which involved the identification of new starters and staff on long term sick. These adjusted results are detailed in Table Six.

Table 6: Adjusted compliance data March 2015

	Adjusted
Level 3 Core	**81.2 %**
Level 3 Specialist	**73.2 %**

Whilst progress has been made towards achieving the required 90% target with all levels of training, it can be seen that the required target has not been achieved. A number of factors have contributed to the challenging position the Trust is in at the end of this reporting period. This included the impact of a new training data base in 2013, resulting in a prolonged period of time when compliance activity data could not be reported as well as unprecedented winter pressure of 2014-15 impacting on the ability particularly of front line clinical areas to release staff to attend training.

Going forward the Trust will continue to address training compliance as a matter of urgency, working closely with the CCG to achieve the required 90% target. It is also recognised that once the target has been reached maintaining this position will be equally as challenging. As such a more detailed training needs analysis will be completed, as well as a Local Safeguarding Children Board quality evaluation of training, as it is also recognised that the delivery of high quality, effective training is essential to improving outcomes. Importantly evidence that safeguarding practice within the Trust is effective is detailed within the safeguarding children's activity data for this reporting period.

7.1 Restrictive Physical Interventions (Clinical Holding / Restraint) Training

University Hospital Bristol NHS Foundation Trust is committed to providing a safe environment for its patients, staff and others, as well as recognising the needs and respecting the dignity of the individuals for whom it provides care.

The Policy for Restraint / clinical holding now referred to under the new title of 'Restrictive Physical Interventions' (DOH 2014), falls within the umbrella of safeguarding and is due to be reviewed in October 2015.

Clinical holding training is available to practitioners in high-risk areas across the Trust, identified from a Training Needs Analysis, which was updated in March/April 2015 by the safeguarding team, taking into account the most recent clinical incident reports. Attendance at clinical holding training has continued to be a challenge during this reporting period as staff frequently cannot be released from their duties to attend. As a result, the low attendance numbers of staff at training events is currently reported via the Trust's risk register.

7.2 Prevent Training

The Prevent strategy (HM Government 2011) sets out the government's commitment to understand factors which encourage people to support terrorism and then to engage in terrorism – related activity. Prevent is part of the country's counter-terrorism strategy, CONTEST. Its aim is to stop people becoming terrorists or supporting terrorism. Health organisations are required to work with partner organisations to contribute to the prevention of terrorism by the safeguarding and protecting of vulnerable individuals. This includes ensuring that staff are able to identify when people might be being radicalised into violent extremism and to make appropriate referrals. Training has been updated to incorporate PREVENT for all staff and is a part of the Trust's essential training syllabus being combined into induction and update safeguarding levels 1 & 2 and from next year WRAP training will be resumed for appropriate staff groups.

8. Serious Case Reviews, Management Reviews and Domestic Homicide Reviews

Serious Case Reviews are local enquiries conducted following the death or serious injury of a child where abuse or neglect is a known or suspected factor. They are commissioned by the Local Safeguarding Children Board under the statutory framework of the Children Act 2004.

Health is involved in most case reviews as a provider of universal services. During this reporting period the Trust were asked to contribute to a number of case reviews, including two Domestic Homicide Reviews (DHR), which became statutory in 2011. We are not able to comment here on either case yet as they have not been made available to the public, however the Trust has taken forward all actions identified and reported back upon completion of these actions. In each case the management review and chronologies were completed within the specified time scales. A brief update of on-going serious case reviews is detailed below:

- Child C – South Gloucestershire following the death of a 17 week old baby. Has been published during this reporting period and has resulted in the implementation of the Non – Mobile Baby protocol.
- Child T - Bristol Serious Case Review following the death of a baby, published in this reporting period.
- Information has been submitted towards Serious Case Reviews Commissioned in Somerset, Oxford and Gloucester for Children who received care at the Children's Hospital or St Michaels.
- A number of high profile case reviews are currently anticipated or underway in Bristol, including a complex Serious Case Review following a case of Child Sexual Exploitation which was heard in court in November 2014 and resulted in the conviction of a number of Somalian males which was widely reported in the media.

The resulting action plans from these case reviews are monitored by the Child Protection Operational Group, overseen by the Trust Safeguarding Steering Group.

9. Midwifery and the Unborn Baby

University Hospitals Bristol Maternity services continues to deal with a high number of serious and complex adult and child safeguarding issues relating to unborn babies and their mothers/carers. This is reflected in the fact that the Community Midwives are the staff group, apart from the Emergency Departments, who make the most referrals to First Response for information sharing and Child protection concerns. Midwifery staff discuss with all women at their booking appointment Domestic Abuse and FGM (Female Genital Mutilation) and refer mothers as appropriate when necessary. Midwifery staff are pro- active in ensuring women are aware that FGM is illegal in this country and that it has serious health consequences for the individuals on who it is performed. The FGM status of all pregnant women is recorded on the Maternity Computer data base "Maternity Medway" and the information is shared with the Health Visitor and GP.

A standard operating procedure (SOP) has been written for pre- birth planning meetings to ensure all important planning issues are covered. This has helped with ensuring clear, workable plans are in place and that Children and Young People Services (CYPS) understand what is required for these meetings. This has been required because the locality social workers are not always aware of procedures in the hospital and what midwifery services can realistically provide. With the loss of the hospital social work team who acted as liaison with the locality social work teams and hospital staff , there are still problems with CYPS understanding how Maternity Services work but the Named Midwife is working with First Response and locality social workers to improve communication and understanding of the issues both services face.

The Trust "People who Pose a Risk" policy has been updated in collaboration with CYPS in line with changes to the structure of CYPS. This has been ratified by the Trust and is awaiting ratification by CYPS.

In order to ensure Midwives are able to maintain their safeguarding children knowledge and skills, a session has been incorporated into the Midwife specific Patient Safety Training Day which is mandatory for all Midwives every two years.

There is a Midwifery Specific Child Protection Meeting held every 2 months, with attendance by the Trust's Named Midwife or deputy and their counterparts at North Bristol Trust and Weston Area Health Trust. The meeting allows the sharing of information across the services which is important due to women being able to choose where they give birth. It is also a forum where new policies and guidelines can be discussed, communication issues reviewed and where learning from Incidents and Serious Case Reviews can be disseminated.

The Drug Liaison Midwives have recently seen a change in the nature of their caseload and are seeing more women in whom there are concerns about alcohol misuse rather than Heroin use. The overall number of women referred to the Drug Liaison midwives for specialist support during pregnancy remains relatively consistent with approximately 50 per year.

10. Safeguarding and Domestic Violence

The need to protect both children, including the unborn baby, and adults from the risks and consequences of domestic abuse, remains a key priority for the safeguarding teams. The prevalence, characteristics and the associated risks for both adults and children are highlighted as part of the 'Think Family' approach through safeguarding training.

10.1 Multi-Agency Risk Assessment Conferences (MARAC)

The Trust continue to engage fully with the process of Multi-Agency Risk Assessment Conferences (MARAC) which shares information about the risk of serious harm or homicide to people experiencing domestic abuse and their children. Following the expansion of the Child Protection Nursing team, facilitated by Bristol Public Health funding, a dedicated MARAC nurse has been in post since July 2013. Attendance both at the North and South Bristol MARAC continues.

This reporting period has seen a significant increase in the number of high risks domestic abuses cases meeting the MARAC threshold. Due to limited capacity within all partner agencies, an increasing number of high risk cases are being considered at a 'Pre MARAC'. There is a potential risk that the Pre MARAC cases may be receiving a different level of service, this situation is being considered both by the Bristol MARAC Steering Group andthe Bristol Safeguarding Children Board. MARAC data for 2014/15 is detailed below in Table Seven.

Table 7: MARAC Data

Year	MARAC's attended	Cases discussed
2009-2010	12	258
2010-2011	12	249
2011-2012	12	340
2012-2013	12	285
2013-2014	22	544
2014-2015	24	535

The MARAC nurse and child protection team have successfully completed and continue to deliver MARAC awareness training across the Trust. This post has also led to the formation of a Domestic Abuse Steering Group, which will aim to strengthen the process of implementing and monitoring action plans from Domestic Homicide Reviews.

10.2 Independent Domestic and Sexual Violence Advisor (IDSVA) Service

The Independent Domestic & Sexual Violence Advisor (IDSVA) service located in the Bristol Royal Infirmary (BRI) continues into its fifth year of operation to address the safety of domestic abuse victims presenting within the Emergency Department (ED) and Trust-wide. The service specification remains the same as previous years - working to safeguard those patients (and their children) experiencing domestic abuse from intimate partners, ex-partners and family members.

The BRI IDSVA team work from the point of crisis with victims, providing expert advice, advocacy and support (typically short to medium term) and compile individual, structured safety plans to manage the risk faced by each patient. Key activity data is detailed below in Table Eight.

Table 8: IDVA Activity Data

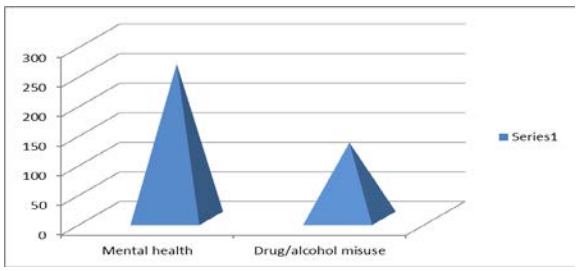
Service/Activity	**Targets**
Number of patients aged 16 and above referred following disclosure of DVA	300 from ED 25 from elsewhere in hospital
Numbers of patients referred who receive advice and safety planning from an advisor	75%
Number of patients referred to the IDSVAs who are **not** high risk on DASH Risk assessment	50%
Number of referrals onto generic or specialist services	75%
Number of service users satisfied with the support they received.	80%
Number of service users who report feeling safer on case closure.	80%
Number of repeat attendance to ED with domestic violence - post intervention	Maximum 40% of those who have seen IDSVA
Number of health professionals receiving training on identification of DVA	50

351 of patients reported being in heterosexual relationships, 6 being in same-sex relationships (8 not wanting to disclose their sexual orientation/not recorded).

The relationship dynamics of referrals to the IDSVA team are more diverse than previous years with 75.3% of referrals involving domestic abuse from a partner or ex-partner and the remaining referrals reporting abuse from family members including parents, siblings, or extended family members.

Patients referred to the IDSVA team suffering mental health issues remains high: 72.5% and drug/alcohol misuse issues stands at 35.5% (See figure 16). The IDSVA team assist victims of domestic abuse to access immediate support from the Trust Alcohol Liaison Nurse (ALN), drug specialist nurses as well as colleagues within the Trust Psychiatry Liaison team (clinic 7) to ensure collaborative care pathways are implemented prior to patients being discharged from hospital.

Figure 16: Percentage of cases with drug and alcohol issues



SafeLives (formerly CAADA) Insights data

Children: A total 252 children and 10 unborn were identified as living within abusive households, generating 145 Cause for Concern forms or referrals to First response/CYPS. Following a change to the online Cause for Concern form, all members of staff reporting domestic abuse to the Safeguarding Adults Team, will now be prompted to refer to the IDSVA service upon receiving patient consent.

Survivor feedback

"…… I felt very supported constantly [by the IDSVA], even at weekends. When not available, always got back to me really quick. Telephoned Police and other agencies that I could not face and kept me up to date and attended short notice appointments. Housing support and explained Court and Restraining Order really clearly."

"I found advisors to be very understanding & supportive. They were very knowledgeable and offered lots of important and useful information regarding DV and process & procedures. Overall a very useful and helpful service – the lipbalm with tel. no is a very good idea too".

11. Safeguarding Resourcing Group

The purpose of the Safeguarding Resourcing Group is to ensure the Trust's safeguarding duties for both adults and children's, relating to all resourcing matters, are fully considered. The group reports to the Safeguarding Steering Group, is chaired by the Head of the HR Service Centre and supported by Lead Safeguarding and HR practitioners. The group continues to have formal oversight of the Trust's protocol for approving appointments where there is an adverse disclosure to ensure ongoing rigour, consistency and equity.

All objectives detailed in the group's annual programme of work have been successfully completed during this reporting period. Key achievements have included completion of a self-assessment against the 'Themes and Lessons learnt from the NHS investigations into matters relating to Jimmy Saville', promoting awareness of the process to be followed for

any safeguarding allegation relation to a Trust employee and an audit of agency staff compliance with safeguarding training.

A programme of work for 2015/16 has been agreed and progress will be monitored by the Safeguarding Steering Group.

12. Child Death Overview Panel (CDOP)

Since 2008 there has been a statutory responsibility for all Local Safeguarding Children Boards to be informed of both expected and unexpected deaths of all children and young people up to the age of 18 years, who live in the Local Authority area. This includes the requirement to have a Child Death Overview Panel (CDOP). The Trust's, including the safeguarding teams continue to be fully engaged with this process.

During this reporting period data from 2013-14 has been published. 111 children under the age of 18 years from the West of England died during this time period, including 33 children from Bristol. A large percentage of the deaths occurred within the Trust Paediatric and Neonatal Intensive Care Units and were expected for a variety of medical causes such as genetic or congenital abnormalities.

The report focused in particular on sudden unexpected death in infancy with 20 deaths described in this category, 65% of these deaths involved co- sleeping. For 10 out of 13 babies that died, there were additional risk factors of smoking in the household, alcohol / substance misuse by the parent or carer on the night the baby died or concerns about the location of the baby within the co - sleeping environment. The report also highlighted a lack of support and voice for the families of the child who has died and the need for more training for professionals involved in the Child Death process.

Full details of the key findings from the Child Death Overview Panel will be published in the West of England Child Death Overview Panel Annual Report for 2013-14.

13. Safeguarding and the Disabled Children Working Group

Disabled children are recognised to be at particular risk from abuse and neglect. For more than three years, the Disabled Children's Working Group has been effectively developing strategic approaches to managing and supporting families with disabled children both through in-patients and out-patients departments in the hospital and across the region. Since the centralisation of specialist paediatric service in May 2014 the number of disabled children moving through the hospital has increased.

Past achievements for the Working Group include solutions as simple as a bedside information poster for families to specific case audits, the implementation of Safe Sides and, of course, the Hospital Passport and Disability Nursing Assessment (both nationally applauded by Contact-a-Family). Collaborative working with Bristol Parent Carers also has enabled "extra-curricular" activities which have led to greater community and social engagement with hospital families, including Gromit and Pirate Tours in summer holidays, an inclusive ice-skating session and our Fun day – you said, we did.

The success of the group as a strategic advocate and innovative solution finder for the needs of the disabled children and their families is due to the continued commitment of clinicians and nursing staff both in the hospital as well as community and the regional links with parent participation forums and local authorities.

This reporting period has been a particularly difficult time for the group due to a series of staff losses. Listening to the parents and the voice of the child a disability support worker has been appointed to provide hands on support and training to the staff, parent/carers and children on the wards during this period of change. The success of this post has been measured by the feedback received form families, parents/carers and children.

Given the current climate of change and rapid development of 0-25 Service, SEND Reforms and Children and Families Act (2014), this is a time when the Disabled Children's working group needs a strong, proactive group that will ensure that the needs of disabled children are being met in a practical, consistent and legal way. Therefore management and clinical teams at the Bristol Children's Hospital remain committed to providing children and their families with disabilities;

- High quality individual care, delivered with compassion;
- A safe, friendly and modern environment.
- Our commitment to continued partnership working with parent groups and other service providers.
- Implementing reasonable adjustments (The Equality Act 2010)
- Placing disability high on the agenda.
- Raising awareness and providing appropriately trained staff to develop and support the strategic disability agenda specific to the needs and development of care delivered to the disabled child and their families.

14. Learning Disabilities (Adults)

The population of the South West is approx. 5,229,346 people of which 2% (104, 835) are people with a learning disability (PWLD). Only approximately 22% of this population are known to statutory services. There are approximately 10 million disabled people in Great Britain covered by the Disability Discrimination Act, which represents around 18% of the wider population.

Our aim and commitment is to improve the health outcomes of PWLD and/or autism in a person-centred way, by maintaining momentum in improving care and outcomes. 'Death by Indifference' (Mencap 2007), which reported the deaths of six PWLD , deaths that the six families involved and Mencap believe were the result of failings in the NHS. Five years on (Mencap 2012) published 'Death by Indifference: 74 deaths and counting' which highlights that services providing health care have made some improvements, however there is still work to be done to ensure that services are accessible for PWLD and clear pathways are in place to minimise risk and improve patient experience.

Response to the above findings, The Department of Health funded the Norah Fry Research Centre; The Confidential Inquiry into the Deaths of People with Learning Disabilities (CIPOLD 2013) was tasked with investigating the avoidable or premature deaths of PWLD through a series of retrospective reviews of deaths. The aim was to review the patterns of care that people received in the period leading up to their deaths, to identify errors or omissions contributing to these deaths, to illustrate evidence of good practice and implement recommendations.

Where recommendations are appropriate the Trust has incorporated implementation plans into the Learning Disabilities Strategy group, for monitoring and action.

- Ensuring The Equality Act (2010) is recognised through training and service delivery by assessing the needs of PWLD and making `reasonable adjustments'
- Continually developing effective systems and processes, which include 'flagging systems'.
- Maintaining strong links and working partnerships with user groups and local authority in order to improve patient experience.

15. Dementia Care

Commissioned by the South West Dementia Partnership in 2010, an Expert Reference Group was established. The group developed and agreed a set of eight common standards with the aim of significantly improving services for patients and their carers/families and to provide a level of consistency in care wherever they are cared for.

During 2014/15 progress has continued to be made across the eight Southwest standards and continued focus to achieve the FAIR element of the National Dementia CQUIN. The Dementia care finding is now incorporated into the nursing admissions documentation. Performance data for Quarter 1(April – June 2015) for Indicator 3.1 (Find, Assess, Investigate, Refer) is detailed below in Table ten.

Table 10: Indicator 3.1 (Find Assess, Investigate, Refer) Quarter 1.

	Criteria	Status	Compliance
Stage 1	Find	Amber	82.7%
Stage 2	Assessment and Investigation	Green	92.8%
Stage 3	Referral on to GP	Green	92.9%

The CCG funded 1.0WTE Band 7 project post until August 2016, to focus on the admission areas to improve the timely screening and assessment of patients. The Project nurse and IM&T have developed a system specification that will flag, monitor and record all 3 stages of the CQUIN, which is incorporated into the e-handover system. This went live in December 2014 and is now embedded in practice.

Indicator 3.2: Clinical Lead & Training Programme

- A new Lead Dementia Practitioner came into post in November 2014, following the resignation of the Lead Nurse for Dementia in June 2014.
- Dementia awareness training provided on induction has been on the quality dashboard from June 2014. Compliance rate threshold of 85%. All UH Bristol staff will receive Dementia awareness training as part of the corporate induction; volunteers also receive the training on their induction. E-learning modules and a workbook are also available to staff. The Lead Dementia Practitioner also offers

bespoke training for wards / departments. There are two Dementia Champion study days per year, one held jointly with North Bristol NHS Trust.

Indicator 3.3 Carer Support

This indicator requires us to ensure that carers of people with Dementia feel supported. This requires a monthly survey of carers of people with Dementia. The CCG funded a 1.0WTE Band 3 Support Worker post to support the administration of the carer's surveys to ensure a minimum of 10 responses are obtained per month. This indicator will also be included on the quality dashboard from June 2014.

The care plan 'Caring for People with Cognitive Impairment' is in place across the adult in patient areas. The wards audit aspects of the care plan on a monthly basis, with a new electronic dashboard system being implemented July 2015.

16. Summary

Ensuring that the Trust continues to fulfil its contractual duty to safeguard children and adults remains a key priority and this report summarises the key safeguarding activities and achievements in this reporting period. Whilst there have been many achievements and examples of successful joint working across the safeguarding teams over the last twelve months, further work is needed to ensure that staff continue to receive the appropriate level of training for their role and responsibilities.

It has been essential to maintain the quality of safeguarding practice across the Trust during a challenging period of local change and continuing financial austerity. Multi-agency working in this current environment is difficult as the complexity and numbers of safeguarding cases increases.

Supporting staff in day to day practice through the delivery of high quality supervision is essential, underpinned by case management advice and regular supervision, which will be developed further in the next reporting period. Full details of the aims and objectives of both safeguarding teams going forward are detailed in work and audit plans for 2015 -2017 (Appendix One)

Appendix One. Safeguarding Work Plan 2015-17

Safeguarding Work Plan		Date Created	drafted 15/4/15
Plan Owner :	Helen Morgan Deputy Chief Nurse Hazel Moon Head of Nursing Women's & Children's Division Carol Sawkins – Named Nurse Child Protection Linda Davies Adult Safeguarding Lead	**Date last updated**	18/06/15 (version 8)
Core implementation Groups :	Children's Safeguarding Operational Group Adult Safeguarding & MCA Operational Group	**Next review due by - Group / Committee : Date :**	
Links to key documents			
Link to Corporate Risk Register - 3044	**Initial Risk Score = 10**	**Target Risk Score = 1**	

	Objective	Action	Lead	Time Scale	Update/ progress	Date complete	RAG
1	To achieve and maintain 90%compliance with all levels of safeguarding training for adults and children	Complete a training needs analysis to ensure sufficient training capacity to meet / maintain target for next 12 months	CS/LD/ OG	April 15			
		Complete evaluation of effectiveness of training (provide report to Trust Steering Group/ Children's LSCB)	CS OG	June 15			
		Update training to reflect the update in legislative requirements with the implementation of the Care Act 2014	LD OG	Sept 15			
		Develop, implement and review level 3 adult safeguarding/MCA training	LD OG	Dec 15			

		Review training matrix and strategy to ensure alignment with the new Intercollegiate guidance	CS/LD/ OG	Sept 15			
2	To ensure the Trust is fully engaged with Bristol's multi-agency FGM strategy	To form a short life working group to facilitate the implementation of the DOH requirements for mandatory reporting of FGM	CS/ FGM working group	April 15			
		To incorporate FGM training into appropriate levels of safeguarding training	FGM working group	July 15			
		To evaluate the effectiveness of the Trust FGM reporting process, report to Trust Steering Group	FGM working group	Feb 16			
3	To ensure the Trust is fully engaged with Bristol's multi-agency Domestic Abuse strategy	To review / formalise the Trust's arrangements to implement a robust strategy through the formation of a DVA steering group	CS/LD / Domestic Abuse Steering Group	May 15			
		To develop a robust process for Domestic Homicide Reviews and the associated action plans.	CS/LD / Domestic Abuse Steering Group	July 15			
		To review the process in place for Pre MARAC and if required add to Risk register	CS/LD / Domestic Abuse Steering Group	Aug 15			
		To provide an annual update to Steering Group	CS/LD / Domestic Abuse Steering	Feb 16			

			Group				
4	To ensure the Trust is fully engaged with Bristol's multi-agency strategy for Child Sexual Exploitation, Human Trafficking and Slavery	To form a short life working group to facilitate the implementation of a process to 'flag' children and young people at risk of CSE.	CS/ Working group	June 15			
		To include CSE, Human trafficking and Slavery into appropriate levels of safeguarding training	CS/ Working group	Sept 15			
		To ensure UHB policies and procedures are in line with Bristol CSE, Human trafficking and Slavery strategies.	CS/ Working group	Jan 16			
5	To ensure all staff have access to safeguarding supervision or reflective practice appropriate to their role.	To continue to raise awareness of the Safeguarding Supervision guidance (link to Trust Supervision policy) across the Trust (include in training)	OG	June 15			
		To consolidate the process of regular formal supervision for specific staff groups including Paediatric CNS and high risk clinical areas.	CS/ OG	Jan 16			
		To increase the accuracy of supervision reporting to Bristol CCG	CS/ OG	March 16			
6	To ensure there is a robust process in place to disseminate the learning from incidents, allegations, risks and Case Reviews to relevant areas across the Trust	Incidents, allegations, risks and case review to be a standing agenda item at OG	OG	April 15			
		Safeguarding reports from Divisions to be standing agenda item at OG	OG	Sept 15			
		To utilise Trust wide systems for the dissemination of key messages e.g. News Beat, Patient Safety Briefing -	OG	On - going			
		A summary of key learning points to be include in Trust annual safeguarding report for 2016-17	OG	March 16			

7	To continue working towards reducing the risks posed by multiple sets of notes through the safe implementation of Electronic Patient Records (EVOLVE)	Safeguarding teams to meet regularly with EVOLVE / MEDWAY Leads to consider safeguarding systems and process	CS/LD/SG /AH	On going			
		Progress to be monitored 6 monthly by OG					
8	DOLS To continue to implement the changes in the interpretation of the Deprivation of Liberty Safeguards post Lady Hales judgement in the Cheshire West and Mig and Meg cases	To work with the Trusts IT department to find an electronic format which will record a DOLS application	LD/OG	Nov 15			
		To support ward areas to recognise the need for a DOLS application and to include in initial assessment on admission	LD/OG	June 16			
		To monitor the increase in activity, trends and impact to clinical areas and the safeguarding team. To feedback to the Operational Group for review quarterly.	LD/ OG	On - going			
9	To continue to promote the 'Think Family' agenda across the Trust	Implementation of joint adults / children Level 2 training package for Clinical Update "Think Family"	CS/LD	April 15			
		'Think Family' pathway to be piloted in DVT Clinic/ Drugs & Alcohol / Epilepsy CNS	CS/NG /OG	Sept 15			
		Pathway to be evaluated amended as required.	CS/NG /OG	Dec 15			
		Plan made for the further implementation of the pathway as part of Trust wide safeguarding process	CS/NG /OG	March 16			
10	To ensure Safeguarding information is accessible to staff and service users and to gain feedback from	To include safeguarding information into the Trust public web site	CS/LD/ OG/SR	Sept 15			
		To include a section in the children's safeguarding process advice leaflet for families for feedback	CS/ OG/SR	July 15			
		To Develop advice and information for staff directly	LD/OG	Sept			

	service users about the safeguarding process	involved in a safeguarding investigations		15			
		To review the 'What to Do about abuse leaflet'	CS/LD/ OG/SR	Dec 15			
		To ensure relevant information from 'friend and Family' tests etc. are considered by OG'S	CS/LD/ OG/SR	Sept 15			
11	To raise awareness of PREVENT to enable staff to recognise signs that someone has been or is being drawn into terrorism, to interpret those signs correctly, is aware of the support which is available in the Trust.	Re-establish delivery of Wrap training. Arrange a small working group to plan and deliver Wrap training. Report training numbers to DoH.	CS/LD/ Working group	Sept 15			
		Monitor channel referrals and feedback any themes to the OGs	CS/LD/	Sept 15			
		Attendance at new regional PREVENT forum (Birmingham) and feed back to the operational groups	LD/CS	Sept 15			
12	To engage service users into planning and service development	To explore the possibility of inviting a service user/expert patient or parent to join the Safeguarding Children's Operational Group	HM/CS	March 16			

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
14. Quarterly Workforce Report
Sponsor and Author(s)
Sponsor: Sue Donaldson, Director of Workforce & OD Author: Heather Toyne, Assistant Director of Workforce

Intended Audience									
Committee members	√	Regulators		Governors		Staff		Public	

Executive Summary
Purpose The Quarterly Workforce Report is intended to provide a more detailed and wide ranging update on our Workforce and Organisational Development agenda than is currently provided in the monthly performance reports. The report is based on the Key Performance Indicators (KPIs) which were agreed in May 2015 and includes a description of the current position for each indicator, progress on actions to improve performance, and the agreed KPIs for 2015/16. Key issues to note The KPIs which have demonstrated positive movement are workforce numbers, sickness absence, Staff Friends and Family Test (compared with a year ago), Essential Training, Appraisal and junior doctor compliance. KPIs where there has been little change are bank, agency and overtime usage. Performance has deteriorated this quarter in respect of vacancies (taking into account rebased measure) and turnover. Manual handling/stress risk assessments are based on existing assessments, and it is expected that the trajectory for the year will still be achieved when all the assessments have been submitted. The Quality and Outcomes Committee (QOC) have discussed this report in detail at a meeting held on 28 August 2015. The separate report from the Chair of QOC refers. The report is presented to the September meeting of the Trust Board as there is no meeting held during August.
Recommendations
The Trust Board is asked to receive the Quarterly Workforce report for assurance.
Impact Upon Board Assurance Framework
N/A
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
N/A

Equality & Patient Impact

None							
Resource Implications							
Finance		Information Management & Technology					
Human Resources		Buildings					
Action/Decision Required							
For Decision		For Assurance	√	For Approval		For Information	

Finance Committee	**Quality & Outcomes Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
	28/8/15				Workforce & OD Group

University Hospitals Bristol NHS
NHS Foundation Trust

QUARTERLY WORKFORCE REPORT – APRIL – JUNE 2015

Executive Summary

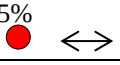
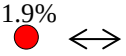
1. Introduction

The Quarterly Workforce Report is intended to provide a more detailed and wide ranging update on our Workforce and Organisational Development agenda than is currently provided in the monthly performance reports. The report is based on the Key Performance Indicators (KPI's) which were agreed in May 2015 and includes a description of the current position for each indicator, progress on actions to improve performance, and the agreed KPIs for 2015/16.

2. Overview

The table below provides an overview of each indicator agreed for 2015/16. KPIs were agreed as part of the Divisional Operating Planning process, and the aggregated Trust-wide KPIs were reviewed and endorsed at the Workforce and Organisational Development Group. We are continuing to work with the Association for United Kingdom University Hospitals to develop a more rounded set of benchmarks, pending agreement by member Trusts on the suite of indicators which will be gathered.

In the context of the work to improve performance reporting, the content and format of this quarterly report is under review.

Domain	Measure	KPI Description	Q1 KPI	Q1 Performance	Q4 Performance
Workforce costs /FTE	**Workforce numbers (FTE)**	Staffing numbers within 1% of establishment including bank and agency	>1%	1% over 	1.8% over
	Bank (FTE)	Percentage of total staffing (within 10% of target)	4.4%	5% 	5%
	Agency (FTE)	Percentage of total staffing (within 10% of target)	1.4%	1.9% 	1.9%
	Overtime	Percentage of total staffing (within 10% of target)	0.7%	0.8% 	0.8%
	Sickness absence rate (%)	Within 0.5% points of target	3.7%	4.1% 	4.5%
Staff Experience	**Vacancies**	Difference between budgeted establishment and in post	> 5%	4.9%* 	5.3%* (3.4% using rebased measure)
	Turnover	Trajectory to achieve target by March	13.2%	14%	13.8%
	Friends and Family Test	Percentage recommending UHB as a place to work (agree or strongly agree)	50%	61.7% 	56% (Q1 2014/15)
Staff Development	**All staff Appraisal (exc. medics)**	Appraisal of eligible staff on a rolling 12 month cycle	85%	86.1% 	85.6%
	Medical Staff Appraisal	Appraisal of eligible staff on a 15 month cycle – 5 within 5 years	85%	92.4%* 	90%*
	Essential Training	All staff completed relevant essential training topics (trajectory to achieve target by March)	90%	89% 	88%
Compliance Requirements	**Manual Handling Risk Assessment**	Risk assessments completed or reviewed within 12 month timeframe	Risk assessment completed /reviewed in last 12 months in +75% of cases	50% 	98%
	Stress Risk Assessment	Risk assessments completed or reviewed within 12 month timeframe	Risk assessment completed/ reviewed in last 12 months in + 75% of cases	40% 	95%
	Junior Doctor New Deal compliance	Junior doctor rotas compliant with New Deal requirements	90% or more of rotas compliant	90% 	89%

Whilst all KPIs are discussed in detail, this Executive Summary will concentrate on those areas which are most significant to overall Trust performance: recruitment, retention, and bank and agency usage, together with Staff Friends and Family, as a measure of staff experience and engagement.

3. Recruitment

The recruitment activity has continued, with 284 starters, including 55 registered nurses,

taking up employment in the last quarter. Vacancies this quarter were 4.9%, (291.3 average FTE) within the KPI of 5%. The way vacancies are calculated has changed to exclude bank and agency funded establishment; using the same way to calculate vacancies they have increased since last quarter, when they would have been 3.4% (270.5 average FTE). In part this increase is due to changes in the funded establishment.

Of Trusts which publish vacancy data, UH Bristol compares favourably, having an average vacancy rate of 4.2% Trust wide during April, compared with an average for the benchmarked group of 7.3%. Ancillary rates continue to be highest at 7.1% (59.8 FTE) average vacancies for the quarter. Nursing rates are 5.2% (155.8 average FTE), which is below published benchmarks, although there are "hot spots" such as Heygroves theatres, where vacancies stand at 10%. (26.9 average FTE).

There are 6 nurses still on track to join the Trust who were recruited at the careers event in Dublin in April 2015. Ireland is now offering longer contracts to their qualified nurses so initial interest to relocate outside of Ireland has reduced. As with the previous Irish cohort, the nurses will be invited over to visit the Trust, their wards and to see Bristol, in September before they take up their actual posts. This previously proved an extremely positive on-boarding approach.

Following a decision by the Executive Team not to undertake overseas recruitment during 2015/2016, primarily due to timescales and cost, the focus is on an advertising programme to target the national market for hard to fill posts particularly nursing and midwifery. This will be underpinned by a schedule of targeted recruitment campaigns including dates for in house open days between now and March 2016.

One of the key successes this quarter has been the new recruitment management system, TRAC, which went live in June 2015. Full implementation and handover to the Trust from the suppliers of TRAC at the end of July will enable conversion to hire rates to improve and benefits realised.

4. Retention/Turnover

Turnover at the end of June 2015 was 14% compared with 13.8% at the end of quarter 4, with 305 staff leaving the Trust in the quarter, of which 90 were registered nurses. Nursing Assistants are a particular focal point for turnover, as they have the highest rate at 23.3% compared with 24.1% in the previous quarter. Early information does suggest the new training and recruitment pathway for Nursing Assistants has had a positive impact. If Nursing Assistants with permanent contracts who left to go into education and training are excluded, turnover for the period would have been 13.7% rather than 14%.

Information produced by Health Education South West shows that the upward trend over the last year at UH Bristol is mirrored by the NHS organisations across the South West, with an average turnover rate (for all reasons except employee transfers) of 13.3% in March compared with 13% last December.

Retention has no single driver, and is therefore addressed through a number of work-streams. As part of the Staff Experience Programme a number of workshops for staff will take place in July and August to agree how we improve communications between our managers and teams with an outcome of improving staff experience. We are also communicating with staff about

the range of benefits which are available. In addition, there are a range of initiatives targeting the nursing and midwifery workforce, where high turnover rates have been combined with national shortages, resulting in difficulties in filling vacant posts. The action plan includes improved local induction processes and development of preceptorship for newly qualified staff, assessment centre approaches to recruitment to ensure the right staff are recruited and clarifying roles and expectations through the development of core job descriptions and competences. In addition to these trust wide programmes, there are focused divisional actions in areas of high turnover, including critical care and theatres.

Given the under achievement against KPI agreed within the Operating Planning Process (OPP) an assessment is being undertaken on the likelihood of recovering the position within 2015/2016 and the associated risks this presents for the Trust.

5. Bank and agency usage

There was little change in bank and agency usage during the quarter, with 5 FTE more agency and 5.9 FTE less bank used. The highest reason continues to be to cover vacancies with an increase from 26.3% (432.3 FTE) to 31.7% (514.5 FTE) of overall usage.

The agency action plan has been reviewed and refreshed this quarter. Governance has been improved with the nursing agency action plan being reporting to the Savings Board through the Chief Nurse and medical agency reporting to the Medical Efficiencies Group being through the Medical Director. Filling vacancies continue to be essential to managing agency for all staff groups, together with reducing costs of temporary staffing through improved supply and cost efficiencies. Available benchmarks indicate that agency usage at UH Bristol is below average, and the Trust is implementing most approaches recommended by the Department of Health in their recent regional workshops and supporting publications.

6. Staff Friends and Family Test

The Staff Family and Friends Test (FFT) is one of the measures used to evaluate the impact of Staff Experience/Engagement improvement activities. Unlike other measures, the comparison is with one year ago, which was the last “all staff” survey. The response rate improved from 19% to 20%. Positive responses to both FFT questions had improved, with 6% more respondents overall agreeing/strongly agreeing that they would recommend the Trust both as a place to receive care/treatment and as a place to work. Overall, 61.7% agreed or strongly agreed in Q1 that they would recommend as a place to work compared with 56%% in Q1 in 2014/15, compared with a KPI of 50%. Although this is encouraging, there is no room for complacency and the detailed work to improve staff experience continues.

7. Recommendation

Quality and Outcomes Committee are asked to:

- Note the contents of this report;
- Discuss any issues arising in relation to the areas reported.

QUARTERLY WORKFORCE REPORT – APRIL – JUNE 2015

1. INTRODUCTION

The Executive Summary has provided an overview of the KPI performance for quarter 1 and a brief update on programmes of work in relation to key areas. The report which follows provides detailed information in respect of each KPI. A summary dashboard of the KPIs is included in Appendix 1, and detail of performance at a Divisional level is in Appendix 2. A breakdown is provided by staff group in Appendix 3. Previous quarterly reports have included pay costs, but given the decision to consider at the Finance Committee, they are no longer included in this report, which now focuses on workforce numbers.

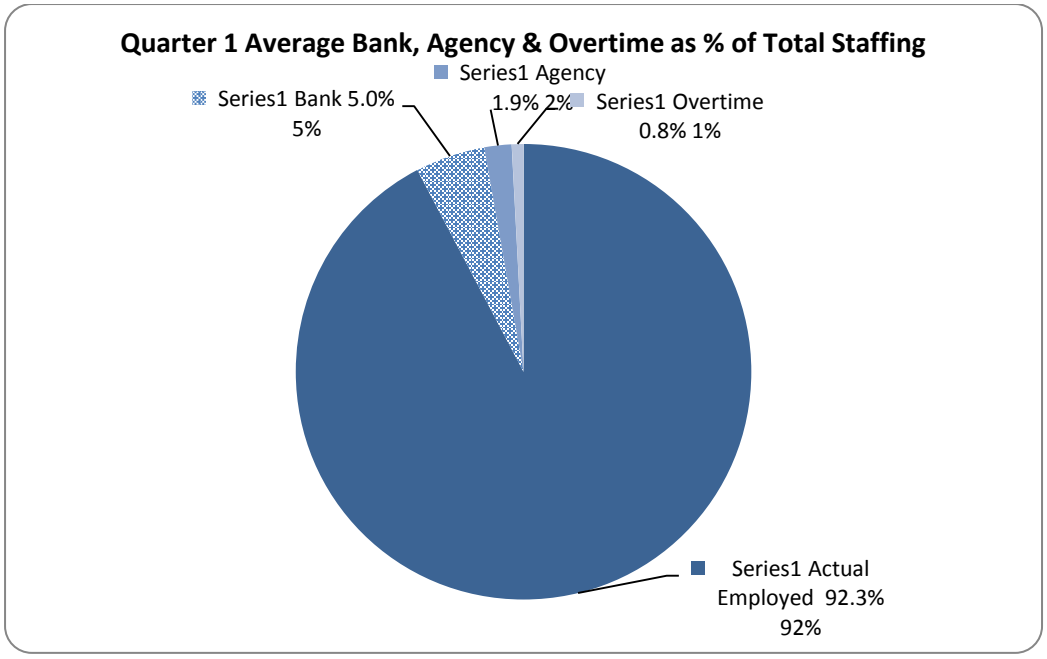
WORKFORCE NUMBERS

The average total FTE, including substantive, bank and agency staff, over the quarter was 8106.0 and was highest at the end of May when it reached 8123.2. The variance has reduced to 1.0% above budgeted establishment, compared with 1.8% last quarter. As at 30 June 2015, 7533.5 staff were substantively employed, approximately 10 FTE less than at 31 March 2015. Staffing levels in relation to funded establishment are shown graphically in Appendix 1.

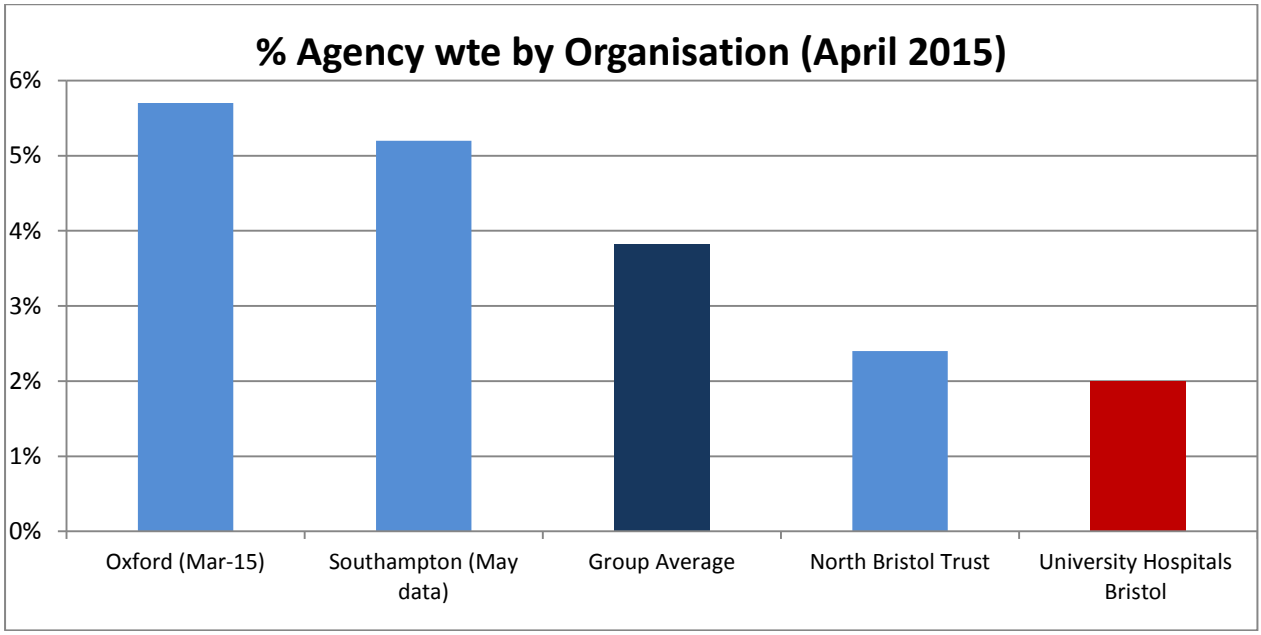
2. TEMPORARY WORKERS – BANK AND AGENCY STAFF AND OVERTIME WORKING (FTE)

The proportion bank and agency usage comprises of total staffing compared with last quarter has changed little, and is as follows:

- 5% of FTE (405.4 average FTE) against a KPI of 4.4% , unchanged since last quarter, were provided by bank (see pie chart below);
- 1.9% of FTE (157.1 average FTE), unchanged since last quarter, against a KPI of 1.4% were provided by agency.

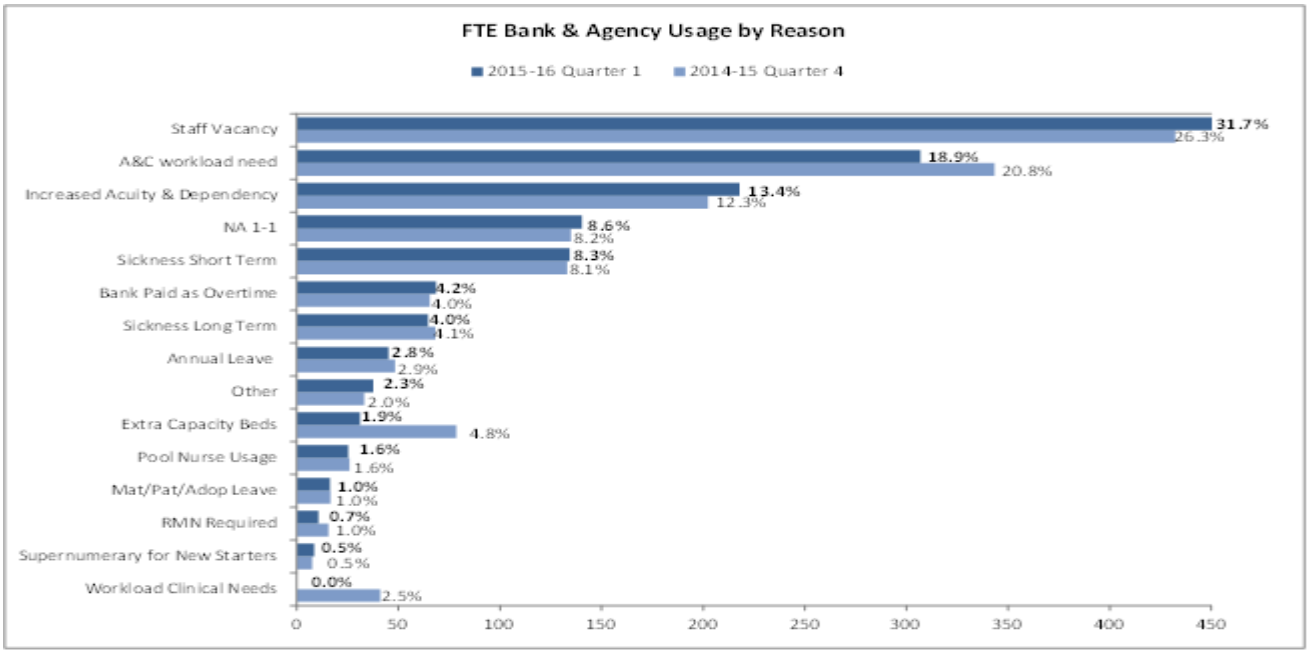


Few Trusts publish data in the Board reports on agency as a percentage of total staffing. UH Bristol compares favourably with the other 3 Trusts which were found to publish this data, with 2% for the month of April, compared with an average of 3.8%, as shown in the chart below.



A further 67.7 average FTE (0.8% of staffing) was provided through overtime working, which is a slight reduction on last quarter (68.1 average FTE). Facilities and Estates Division continues to be the highest user of overtime, accounting for 53.6% of all usage.

Reasons for using bank and agency are summarised in the table below, which shows that vacancies continue to be the main reason.



Actions to tackle agency are different for each staff groups. Progress this quarter is described below.

Nursing and midwifery agency usage

Nursing and midwifery agency forms the majority of agency usage. The agency action plan has been reviewed and updated during quarter 1, and performance against the agency action plan is now reported to the Savings Board through the Chief Nurse. Performance against the key elements of the action plan is as follows:

Controls/demand management

- Monthly performance management of e-rostering KPIs, "lost time" and ensuring that shifts are not covered inappropriately by temporary staff.
- Monthly review of actual Divisional agency usage compared with plan, understanding where and why performance is off trajectory, and agreeing any local actions via monthly Divisional Performance reviews.
- Close work with wards continues in order to maximise the functionality of Rosterpro to support booking and payment processes for bank staff.
- Benchmarking of tools used by a local Trust to manage staffing levels through RAG rated controls was undertaken in July 2015.
- A direct booking process based at ward level for temporary staff, commencing September 2015 is being trialed.
- Review of the Standard Operating Procedure by the end of August 2015 to ensure there are appropriate controls for approval and escalation to non-framework agencies.
- Weekly reviews commenced this quarter with bed holding divisions to assess temporary cover to identify issues and challenges.

Supply management

- In July, the Temporary Staffing Bureau and Communications team produced a simple guide on bank rates, options around points and associated pay arrangements for those staff working bank shifts.

- The Temporary Staffing Bureau has introduced a texting service to replace the recently withdrawn nhs.net service. Early evaluation indicates that this has been successful with non-nursing staff. Responses from nursing staff are currently being evaluated.
- Flexibility continues to be applied in filling shifts including long days being split if necessary and cancelling agency shifts if a bank nurse is available for part of the time.
- A marketing campaign to recruit to the Bank, including social media, internal communications, local radio and press, commenced in July 2015, aimed at extending the bank size, and increasing the range of specialist posts covered.
- The Bank recruitment process will be re-engineered to reduce the time to hire by September 2015.
- Bank staff will be provided with the functionality to view and book shifts remotely, via the web section of RosterPro, planned start November 2015.

Medical agency usage

The Medical Staff Efficiencies Group, led by the Medical Director, is responsible for the following actions:

Premium payment rates:

- Using benchmarking and best practice, the Premium Payments Sub-Group is drafting clear definitions of working practices within an additional hours policy and will be proposing revised rates for locums payments and waiting list initiatives. The anticipated outcomes are improved pay controls and potential reduction in medical locum costs.
- A Master Vendor supplier for locums contract is being awarded during July to improve cost efficiency and consistency.

Improved Supply

- A texting system will be implemented, similar to that successfully implemented for other staff groups such as Domestic Assistants and nursing and midwifery.

There is a continued Divisional focus on filling vacancies and gaps, which are the main reasons for medical agency.

Administrative/clerical and ancillary agency usage

Most administrative/clerical and ancillary agency usage was used to cover peaks in demand or vacancies. Actions include to address agency use for these staff groups include:

- An increased bank pool for Domestic Assistants, together with a new bank pool for Porters, both of which will support reduction in agency usage.
- Bank processes for administrative/clerical staff are under review and changes, which will impact by November 2015, are anticipated to improve the bank fill rate.

3. SICKNESS ABSENCE

Sickness absence has reduced to 4.1% this quarter (against a target of 3.7%), compared to 4.5% last quarter (target of 3.6%). The most recently available benchmark data shows that UH Bristol absence rates for Q4 were slightly lower than with comparable Trusts. In quarter 4 the figure of 4.1% for UH Bristol compared with 4.7% nationally for 40 other large acute Trusts and 4.2% for 33 University Hospitals (I*view* data).

Progress on programmes to target the main causes of sickness absence are described below. At this stage the aim remains to recover the sickness absence KPI by outturn 2015/2016 at 3.7%. However, this is being tested during Divisional Performance Reviews and is not without risk.

The highest levels of Divisional absence during quarter 1 were in Facilities and Estates (6.3%), and the lowest in Diagnostics and Therapies (2.9%) (Appendix 2). Highest rates by staff group continue to be unregistered nursing at 8.2% and estates and ancillary staff at 6.3% (Appendix 3). Long-term absence (29 calendar days or more) accounted for 51.7% of the total calendar days lost during the quarter, compared with 45.4% last quarter. The number of days lost has reduced by 15% since last quarter to 32,284.

Colds and flu have moved from the top reason to the fourth, reflecting the usual seasonal variation, with stress, anxiety and depression now in top place accounting for 19% of days lost to sickness absence. The top five reasons are shown in the table below.

	2014-15 Quarter 4		2015/16 Quarter 1	
Reason	**Days Lost**	**% Total Days Lost**	**Days Lost**	**% Total Days Lost**
Anxiety/stress/depression/other psychiatric illnesses	5972	17%	6214	19%
Other musculoskeletal problems	5185	14%	4950	15%
Gastrointestinal problems	4001	11%	4160	13%
Cold, Cough, Flu – Influenza	7162	20%	3446	11%
Injury, fracture	2081	6%	2465	8%

Stress, Anxiety and Depression

- *Lighten Up* Evaluation data is available from the extended Lighten up modules which took place between February and April 2015. 47 attended the "Making Changes" module, and 57 participated in the "Identifying and Managing Stress" module. Average satisfaction ratings for these modules were 8.84 and 8.78 (out of 10) respectively. The impact of the Lighten up programme pilots delivered in 2014 one year on will be measured by assessing whether actions individuals were to take post course have been implemented and sustained. As a result of the success of the programme to date, it will be rolled out across the Trust, rebranded as "Building Resilience". The 5 module programme will be offered over the next year, spread over 50 days with 3 sessions per day of 1.5 hrs per session.
- *Employee Assistance Programme* A pilot was completed in May in Women`s and Children`s Division. A full report and evaluation is being taken to Workforce and Organisational Development Group in August.

Flu – Influenza

- *Vaccination* A recent Flu workshop was organised by Public Health England, to review last year's campaign and plan this year's, and the UH Bristol campaign was seen as an exemplar. Compliance rates increased rate by 18% from 51% in 2013/14 to 60% in 2014/15. This placed UH Bristol amongst the top performing Trusts. The campaign for 2015/16 will incorporate lessons learnt from the previous year to further improve compliance and to establish the impact on sickness absence rates.

Musculoskeletal

- *Physio Direct* UH Bristol Physio Direct consultations took place, and 66% were referred on for Physiotherapy treatment, with the majority of urgent referrals being absent from work, or at risk of being off work or needing urgent assessment for neurological symptoms. New electronic individual exercise resources are now available, including videos of specific exercises following Physio Direct consultations.
- *Health Promotion* "Work out at work day" took place on June 12th 2015, with examples of staff participation within the trust promoted via Newsbeat.
- *Manual Handling Advice* The Manual Handling team provided more than 307 individual in-loco staff follow-up visits to advise and assess on best practice, musculoskeletal wellbeing and patient safety, and provided 48 individual Workstation/advisory visits related to wellbeing in quarter 1. This represents a 53% increase in musculoskeletal / Manual Handling visits in Quarter 4 and 220% increase for DSE / working environment visits.

Divisions continue to collaborate on areas for improvement in the management of sickness absence, including drop-in sessions, and focus sessions for managers, using a standard presentation, working in collaboration with Employee Services and Teaching and Learning.
In addition, regular monthly meetings with a network of HR Business Partners, Employee Services and corporate team members in Workforce Planning and Health, Safety and Wellbeing have been established to ensure a coordinated approach to managing sickness absence across the Trust. Some Divisions have other specific schemes, for example, Division of Women's and Children's Services has a Divisional based Wellbeing Group which held its second meeting in June 2015.

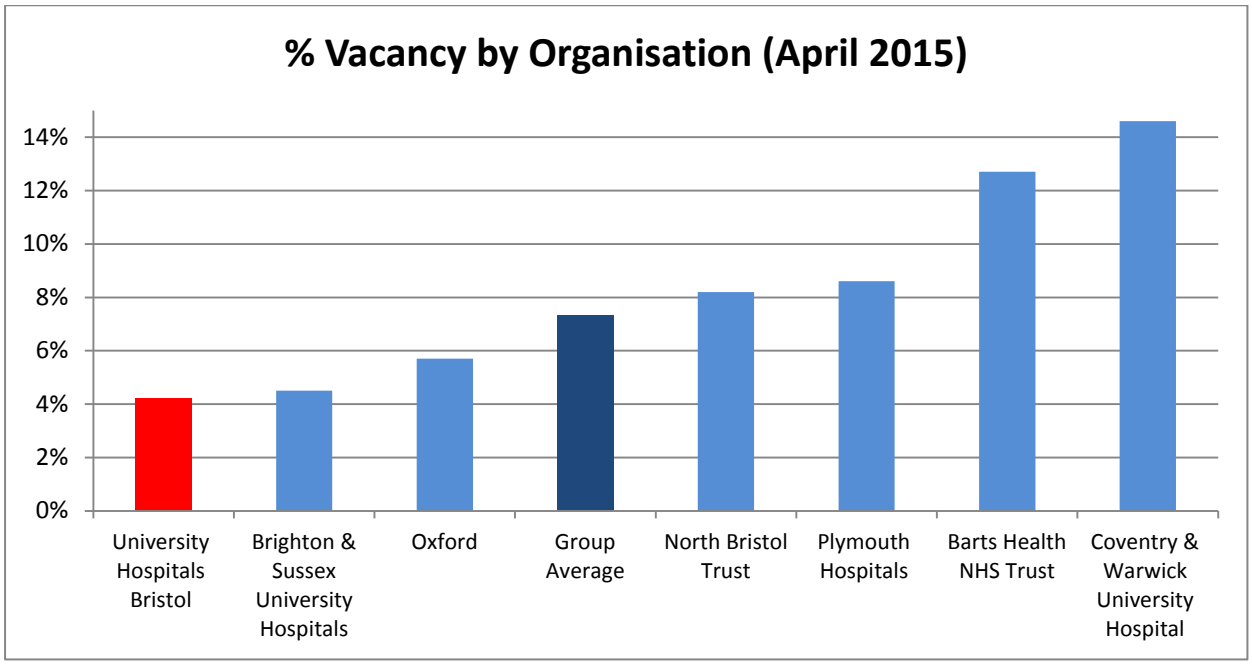
4. STAFF EXPERIENCE

A. VACANCIES

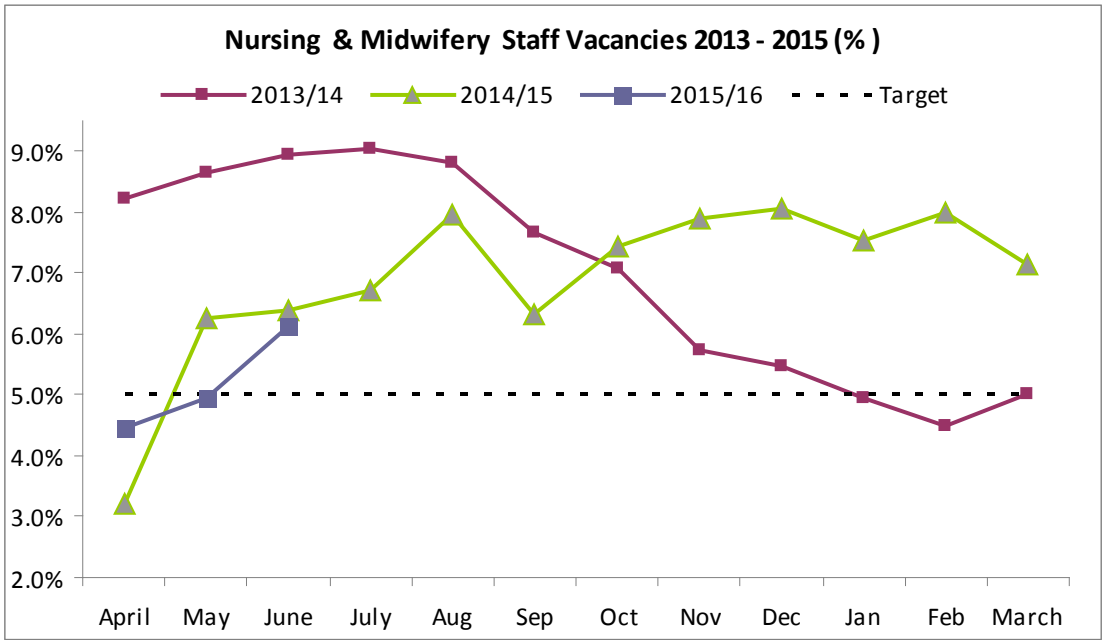
The KPI for 2015/16 continues to be 5%, although the measurement has changed to exclude posts which are intended to be filled by bank and agency. Vacancies this quarter were 4.9% (388.8 average FTE). Using the same methodology as this quarter, the vacancy rate last quarter would have been 3.4% (270.5 FTE). In part this change is due to increases in the funded establishment.

Despite this increase in funded establishment between March and June 2015 of 38.2 FTE, actual staff in post has reduced in the same period by 10.1 FTE. This is due in part to additional funded establishment being made available both as part of the contracting process, and due to some new research posts across the Trust.

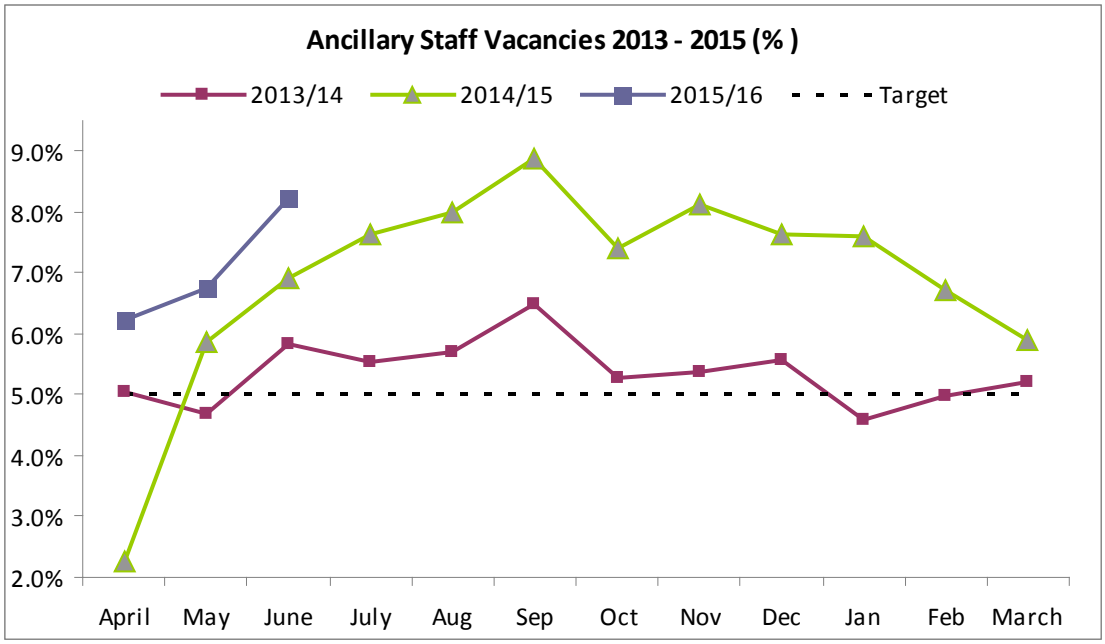
UH Bristol vacancy rates continue to be below average compared with those Trusts which publish them on their websites. UH Bristol vacancy rate in April was 4.2% Trust wide, (see graph below), compared with an average for the group of 7.3%.



Nursing and Midwifery The average vacancy this quarter was 5.2% (156.18). This compares with 3.7% (108.5 average FTE) last quarter (using the new methodology to calculate vacancies). Within this, there are pockets of vacancies, for example Heygroves theatres have a 10% vacancy rate (26.9 average FTE).



Ancillary vacancies The average vacancy FTE for this quarter was 7.1% (59.8 FTE) which compares with 52.8 FTE in the previous quarter.



Progress against the recruitment plan agreed with Senior Leadership Team is described below.

Increasing the speed of recruitment

There are two new systems being introduced during the next quarter which will support the reduction in delays in the recruitment process.

- The new recruitment management system, TRAC, went live in June 2015. This removes some administrative tasks, improves workflow management, and provides intelligence of recruitment in the pipeline by managers. Over the next quarter, conversion to hire rates will be closely monitored to inform revised Service Level Agreements and Key Performance Indicators.
- The new Occupational Health portal is planned to go live in October 2015. This offers an online work health assessments, improving efficiency for managers, candidates and the Recruitment/Occupational Health teams. It is currently being piloted in Surgery, Head and Neck.

Delivery of recruitment to support 2015/16 Operating Plans

Nursing recruitment
Following a decision by the Executive Team not to undertake overseas recruitment during 2015/2016, primarily due to timescales and cost, the focus is on an advertising programme to target the national market for hard to fill posts including nursing and midwifery. This will be underpinned by a schedule of targeted recruitment campaigns including dates for in house open days between now and March 2016.

Progress this quarter includes the following:

- 133 Registered Nurse offers and 93 Nursing Assistant offers were made in quarter 1.
- Return to Practice has been advertised again, 4 were shortlisted from 10 applicants.
- 13 attended and 13 appointments were made at an Open day in the Children Hospital

in May for registered nurses/theatres practitioners.
- A number of assessment centres were held, including 6 for nursing assistants and 3 for newly qualified.

In addition to the Trust wide programmes of work, there are specific Divisionally-led workstreams in key hot spots. This includes theatre nursing in Surgery Head and Neck, where there is a schedule of marketing activity and a planned divisional website to promote the opportunities and attractions available.

Facilities recruitment
Focused recruitment campaigns continue. A total of 16 Health Service Assistants were recruited this quarter. There have been 2 open days from which 25 Domestic Assistant vacancies were filled. There are 65 Trustwide cleaning, catering and portering vacancies, of which 27 have been offered.

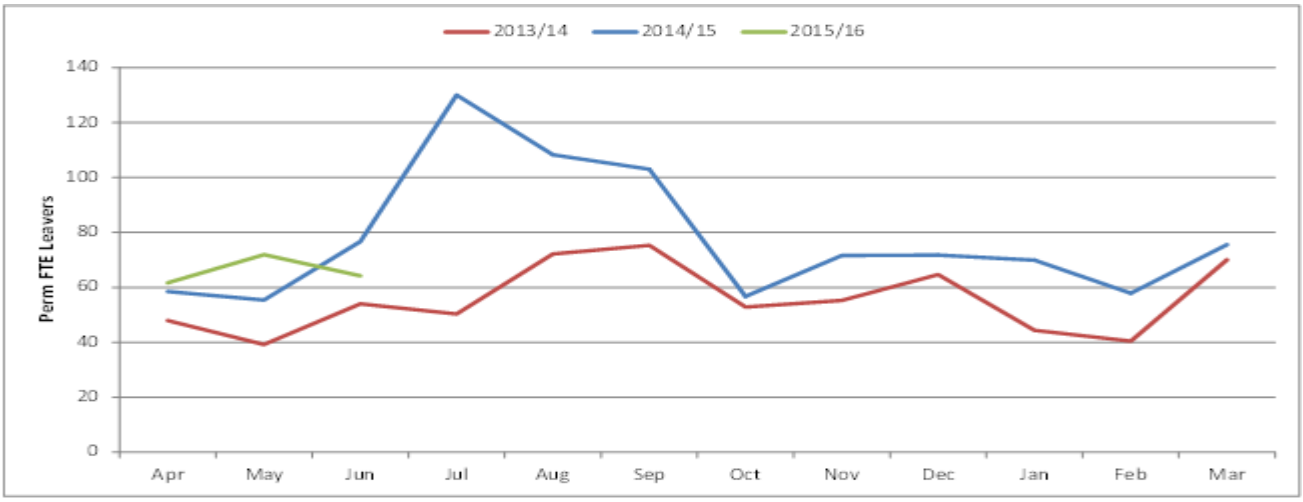
B. TURNOVER

Turnover at the end of the first quarter was 14.0%, against a target of 13.2% for the period. Turnover rates by Division are provided in Appendix 2. The biggest reduction was in Facilities and Estates which dropped from 14.2% to 13.2% and rates in Women`s and Children`s, Medicine and Specialised Services also reduced. By contrast, turnover increased in Surgery Head and Neck, Diagnostic and Therapies and Trust Services. Across staff groups, there was a significant increase in Allied Health Professionals turnover, which has traditionally been low, from 10.8% to 13.5%. Unregistered nursing, whilst still high at 22.2%, has reduced from 24.7% during the quarter.

There are also “hot spots” where there is particularly high turnover. Registered nurse rates, which pose a greater risk due to ongoing recruitment challenges, exceed 20% in the following large areas: ward D703 (oncology/haematology in specialised Services), Heygroves Theatres, and Intensive Care (Surgery Head and Neck).

Trust wide, average monthly leavers so far have totaled 65.9 FTE. If leaver numbers continued at the same monthly average, the out turn would be 12.2%. The maximum number of average monthly leavers to achieve our 11.5% KPI would be 61.3 FTE. However, historically, the first quarter has tended to be the lowest for leaver numbers and Q2 tends to be the highest so it may be too early to make reliable projections.

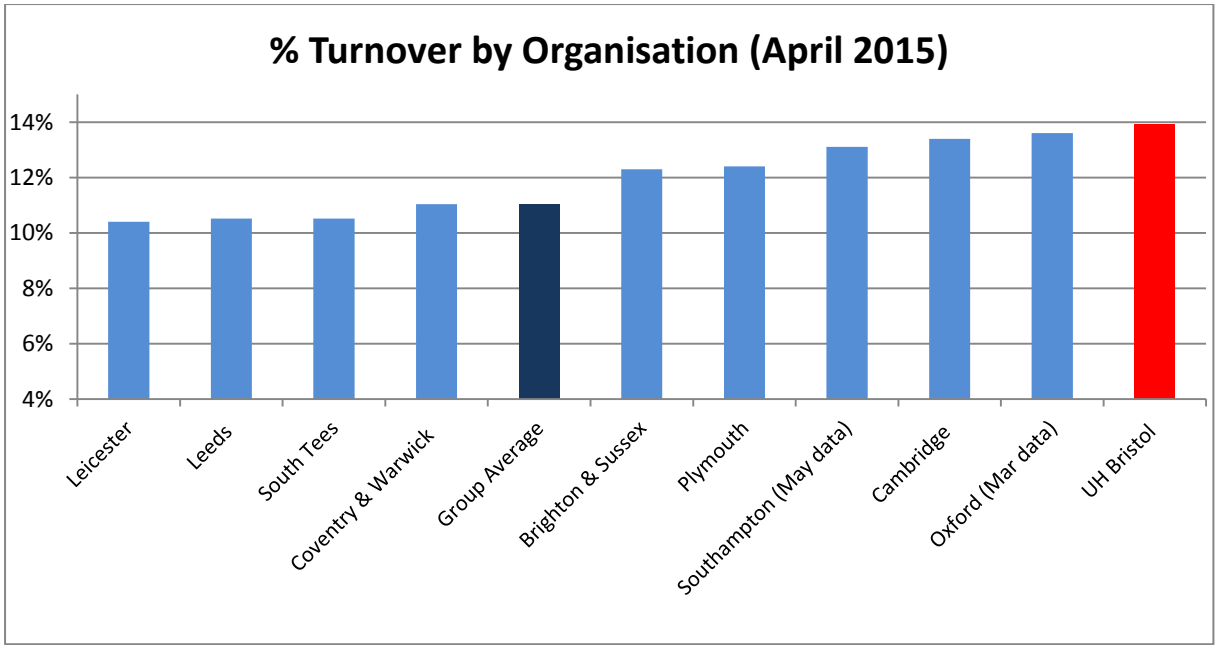
Permanent leaver numbers are shown in the graph below.



Given the under achievement against KPI agreed within the Operating Planning Process (OPP) an assessment is being undertaken on the likelihood of recovering the position within 2015/2016 and the associated risks this presents for the Trust.

Health Education South West, now produce average turnover and retention data for all the Trusts in the South West in the form of a chart (see below). The turnover calculation is slightly different to the ESR calculation, but it clearly shows an upward trend from 11.6% in March 2014 compared with 13.3% in March 2015 which mirrors the upward trend at UH Bristol.

In addition, turnover rates there are 11 Trusts identified which publish data on their websites, shown in the graph below. The UH Bristol rate of 13.9% is above the group average of 11%. Any Trusts which stated they used different exclusions to UH Bristol were not included in this analysis.



Data on reasons for leaving is available from the electronic termination forms completed by managers. Changes since last quarter are summarised below, (based on permanent leavers, excluding bank).

- There have been 14 more staff leaving due to Work Life Balance/Child Dependents / Adult Dependents this quarter than a year ago, and 4 more relocations;
- 19.9% of all leavers have been employed in the Trust for one year or less; this is a slight reduction on the same period last year, when it was 21.2%;
- The greatest change in 'destination' is in staff going to other NHS Organisations which has risen to 77 from 54, now accounting for 31% of leavers in the period; "No Employment" (where no future employment has been lined up or where the information is not completed by the manager), has been entered for under 40% of leavers in the period, compared with 26% for the same period last year;
- There has been a reduction in the percentage of staff moving to neighbouring trusts, from 13.7% of leavers to 9.3%; When compared with starters, UH Bristol is gaining similar numbers of starters from, and leavers to, neighbouring Trusts, across all staff groups.

Termination forms are only one source of information on reasons for leaving. Local managers in areas of high turnover such as critical care will be aware of the specific issues and drivers for turnover. In terms of formal sources of information on turnover, staff specific data is derived from the exit questionnaires and interviews in relation to the areas that leavers feel the trust could improve. The response rate this quarter was 30% (94) including 68 questionnaires, and 36 interviews. Work is being undertaken to ensure we receive termination forms at the point managers submit them to payroll to enable the Employee Services team to contact the employee earlier during their notice period to encourage participation in an interview or completion of the questionnaire.

An overview for the key staff groups using available sources of information is provided below:

Registered Nurses

- The data in respect of "reasons for leaving" does not identify a single driver, but continues to reflect the combination of "promotion/better reward package/work life balance/relocation", which combined, account for 59% of leavers within the period; this is a slight reduction on the same period last year, when they accounted for just over 60% of leavers;
- 20% of leavers have been in post for less than one year, a reduction compared with this quarter in 2014/15, when nearly a quarter left before completing a year's service;
- Around 41% of registered nurses are moving to other NHS organisations, which has increased slightly since last year, when it accounted for just under 30% of registered nurse leavers. We have a slight net loss between starters and leavers, with 7.4 FTE more nurses leaving for other Trusts, rather than coming from other NHS Trusts.

Feedback from registered nurses exit questionnaires continues to identify parking availability, staffing levels and also highlighted training opportunities.

Nursing Assistants

- There has been a reduction in the number of permanently employed unregistered nurse leavers compared with last year, reducing from 38 to 23;

- There was an increase in nursing assistants retiring compared with a year ago, accounting for 30.4% of leavers during the period (compared with 7.9% last year). Numbers leaving due to "Work Life Balance / Child Dependents / Adult Dependents" has reduced from 13 to 5.
- Of unregistered nursing leavers, the biggest numbers continue to be those going to no employment, which account for 43.5% of leavers;
- There is a net loss between starters and leavers going to other NHS Trusts, with 6.8 FTE leaving, and only 1 FTE joining the Trust from other NHS Trusts.

Areas in which the Trust could improve, identified in the exit questionnaires, as in last quarter, were described as staffing levels.

Nursing Assistants are a particular focal point for turnover, as they have the highest rate at 23.3% compared with 24.1% in the previous quarter. Early information does suggest the new training and recruitment pathway for nursing assistants has had a positive impact, as evidenced by the following:

- Of those recruited since the change was implemented a slightly lower proportion have left than in the same time period in the same period the year before. 15.6% of those recruited between July 2014 and June 2015 have left, compared with 17.1% of those recruited between July- June 2014.
- 8.7% of leavers have been in post for less than a year, which is an reduction compared with last year, when 28.9% left within a year.

Estates and ancillary staff

- "Work Life Balance / Child Dependents / Adult Dependents" continues to be the biggest reason for leaving, 45.2% of leavers; the biggest reduction in numbers of individuals leaving due to dismissal (2, compared with 9 last year);
- There has been an increase in the proportion of leavers who have been in post a year or less (22.6% compared with 17.1% last year);
- No individuals joined, from other NHS Trusts, but 4 FTE left to go to other NHS Trusts.

Feedback from the exit questionnaires is provided for HR Business Partners to share with divisional colleagues and address appropriately.

C. **RETENTION**

Turnover is being addressed through a number of programmes which will now be described.

Nursing and Midwifery Programmes

Nursing and midwifery-focused programmes aim to target a key staff group where turnover has increased particularly sharply in the last year.

Pre and post-induction support

- The Trust is currently reviewing nursing and midwifery induction processes. A designated lead for the work has been nominated. The first step will be to understand current practice and what a local induction should look like so that key milestones can be developed.

Revised nursing assistant pathways

- The new recruitment assessment centre process continues to receive excellent feedback from candidates and assessors. The National Fundamental Care Certificate will begin for all new substantive and bank nursing assistants from July onwards. The Certificate forms part of induction and will be completed within 3 months of joining the Trust. Although not mandatory it is being adopted by UH Bristol as best practice. This also provides a development opportunity for band 3 nursing assistants and assistant practitioners to act as assessors for the Care Certificate.

Competences and Career Progression

- The Nursing and Midwifery Committee is due to approve core job descriptions for nursing assistants at the end of July. This will ensure that there are clear competences and training for each role. After this, the focus will be on developing the Trust intranet to share and showcase the nursing role at UH Bristol.

Preceptorship for Newly Qualified nurses and midwives

- Funding has been made available from Health Education South West for one year to support the development of preceptorship in Trusts. A lead Project Nurse has been appointed to develop, pilot and evaluate a preceptorship programme for newly qualified registered nurses to run in September 2015 and February 2016. The programme will reflect the values and expectations of the organisation and support newly qualified nurses in their transition from student to registered nurse, with the aim of reducing turnover.

Focussed work in key areas

- Critical care is an example of an area where there are specific retention initiatives, including:
    - Working with staff to understand how they are feeling, develop stronger communication, and establish whether the organisation has met their aspirations, using a variety of tools, including local surveys and world café events.
    - Work more closely with Specialised Services on core Intensive care training skills as they are also experiencing retention issues.
    - Triangulation of data – review of staff survey, complaints, compliments and workforce data to target interventions and take corrective action.
    - Training and Education opportunities to provide incentives for staff to staff and develop their skills.

Incentives and Benefits

As part of the Reward and Performance Management element of the Workforce and Organisational Development Strategy, a "Staff Benefits Booklet" has been developed, to promote the considerable range of benefits which exist for Trust staff. This will be ready for distribution to wards and departments across the Trust by the end of July. The Division of Surgery, Head and Neck will be piloting the use of 'thank-you' cards at the end of July. The Trust also undertook a local survey on staff benefits, the results are currently being analysed and will be considered by the Workforce and Organisational Development Group in September.

Staff Engagement/Experience

The Staff Experience Programme continues across the Trust. This work is being directed both centrally by the Senior Leadership Team and locally by Divisional Management Teams. A key priority of the programme is the improvement of two-way communication. A number of workshops will be held during July and August with staff to look at practical solutions to enhance communications and improve staff engagement.

Friends and Family Test

The Staff Family and Friends Test (FFT) is one of the measures used to evaluate the impact of Staff Experience/Engagement improvement activities. The on line survey was distributed to all substantively employed members of Trust staff, via email in May and June 2015. The Response rate at UH Bristol was 20% (1,664 respondents from a survey population of 8,325) which exceeds our 18% target and is a slight improvement on the 19% participation rate in our previous census-based FFT in 2014-15. The responses to the all staff FFT in Q1 2014 and Q1 2015 have been compared and are shown in the table below. Positive responses to both questions had improved, with 6% more respondents overall agreeing/strongly agreeing that they would recommend the Trust both as a place to receive care/treatment and as a place to work.

Friends and Family comparison	Diagnostic and Therapies	Facilities and Estates	Medicine	Specialised Services	Surgery Head and Neck	Trust Services	Women`s and Children`s
Q1 2014/15	60%	53%	60%	59%	54%	55%	50%
Q1 2015/16	60%	59%	68%	61%	61%	63%	59%
Target (Compliance Framework)	50%	50%	50%	50%	50%	50%	50%
Differential between Q1 2014/15 and Q1 2015/16	⟺	⬆	⬆	⬆	⬆	⬆	⬆
	0%	6%	9%	2%	7%	8%	9%

The Division with the highest rate of "extremely likely" or "likely" responses to this question was Medicine (68%). Medicine, Women's and Children's and Trust Services showed the greatest improvement in positive responses, since the 2014 census FFT. All Divisions have exceeded the target for numbers of staff agreeing/strongly agreeing that they would recommend the Trust as a place to work, and five of six divisions have increased their positive score on this measure since the 2014 census based FFT. The results of the Survey were submitted to NHS England in July.

Trust wide Staff Engagement/Experience workstream:

Activity during this quarter as part of the Trust wide work programme includes:

- The Speaking Out Policy and procedure review process has taken place. The revised policy, FAQ and extensive management and staff guidance is being shared again with the Board and IRG during July. Following this, a full relaunch will take place.
- A survey regarding inpatient nursing staff views on shift patterns was rolled out during December and early January. The survey closed in January and was followed by focus groups throughout February. A report on findings and recommendations has been

presented to Workforce and Organisational Development Group in July 2015 and was presented to IRG in July 2015.

- Aston Organisational Development training for the second cohort of team coaches commenced in May 2015 and was completed in July. This training equips two cadres of team coaches to work with teams across the organisation using practical, research-based, diagnostic and development tools which will enable to the Trust to improve performance through the development of effective team based working and positive organisational cultures. Coaches from Cohort one began working with their initial practice teams during June 2015.

Divisional Staff Engagement/Experience Activities

The key actions within Divisions to improve staff engagement and experience include the following:

- Medicine have installed "Fix It" boxes around the division – a staff suggestion scheme whereby comments, are received and responded to in a timely way, to improve experience and services. Staff in the Division were invited to come to an engagement event to discuss the Operating Plans. Managers and the HR Business Partner used this opportunity to give people a forum to feed back regarding how they would like to be communicated with/engaged in future.
- Specialised Services have piloted a Staff Champions Scheme in Coronary Care Intensive Care Unit and in ward D703; they are also having individual meetings with 40 managers across the Division to discuss the staff survey results and to share the engagement plans, so that they are reflective of divisional views; additionally, they are carrying out bespoke training for Matrons and Ward managers on engaging and motivating staff. The Divisional board is also undertaking the Aston Team Journey.
- Women's' and Children's Division have shared their staff survey results very widely and, having considered the results, are designing, with the HR Business Partner and Head of Organisational Development, Bystandar Training – including some Forum Theatre methodologies for all staff to give them the confidence to speak up when they see practice/bullying/behaviours which they believe are wrong.
- Facilities and Estates have implemented newsletters, implemented a staff champions scheme, and are running listening events for all Facilities staff in July. Following this latter they plan to roll out the same kind of events in Estates.

5. STAFF DEVELOPMENT

A. APPRAISAL

Appraisal compliance has remained above target in quarter one, with a rate of 86.1% at 30th June 2015, slightly higher than at the end of quarter 4 (85.6%).

Medicine have recovered their position and are within the 85% KPI this quarter, but Surgery Head and Neck, and Women's and Children's, continue to be below target for their non-medical staff groups but have recovery plans in place.

Work continues to ensure that the quality of appraisal is improved. A paper was considered at the Workforce and Organisational Development Group during May, and further detail was requested by the Group to ensure the maximum impact and benefit for the organisation and staff. One of the aspects which required further work was an understanding of whether the

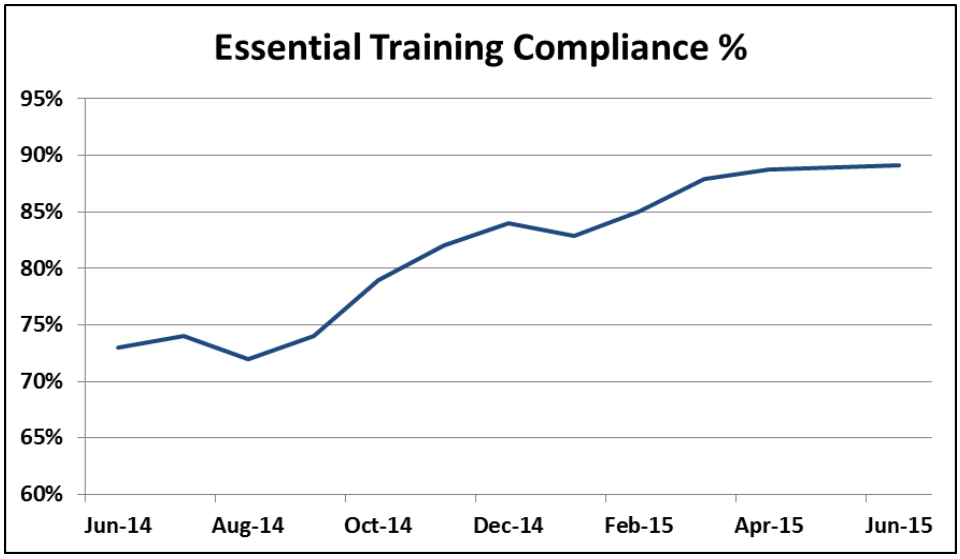
existing Teaching and Learning portal could meet all requirements for recording and scoring objectives. A proposal concerning all aspects of performance management including appraisal was considered in July, with an options appraisal on the systems issues going to the Workforce and Organisational Development Group on 11th August.

Consultant Appraisal and Revalidation
Consultant appraisal data is derived from the consultant revalidation database. Different parameters apply to medical staff, as revalidation requires five appraisals to take place in five years, rather than a strict annual requirement. For this reason, they are not considered overdue until 15 months have elapsed since the last appraisal, in contrast with other staff, for whom an annual appraisal is required. In quarter 1, 92.3% of consultants had been appraised within the required timeframe.

Revalidation of doctors' General Medical Council licence to practice has now been operational for two years. Revalidation is based on annual appraisal and with evidence consistent with good medical practice. Due to timescales for reporting of revalidation, Quarter 1 data will be reported in the next quarterly workforce report. During quarter 4, there were 32 consultants recommended for revalidation, and only one referral due to lack of evidence.

B. ESSENTIAL TRAINING

The position for ET (Core Training) at the end of June was 89% against a trajectory of 90%. There is a trajectory linked to action plans to achieve compliance by August 2015. Individual topics vary in terms of compliance with 6 reaching over 90% which is an improvement against the position last quarter where only 4 topics exceeded 90%. We continue to see a real month on month increase in the uptake of E-Learning which was launched in October which further supports staff to access learning through a blended approach.



The action plan includes:

- Continue to drive compliance of core topics, including increasing E learning.

- Divisions are working with local trajectory recovery plans to ensure the compliance gap is closed and additional training places continue to be available reflecting divisional demand.
- From July, all managers will receive an electronic notification of when compliance for their staff members expires.
- There are detailed plans in place to improve compliance for topics with the lowest rates which include safeguarding and resuscitation, all topics have improved their position since the last quarter, with further improvements anticipated during the next quarter.

6. COMPLIANCE REQUIREMENTS

A. HEALTH AND SAFETY

KPI's for risk assessment exceeded the trajectory of 93% for both topics by March 2015. Manual handling/stress risk assessments are based on existing assessments, and it is expected that the trajectory for the year will still be achieved when all the audits have been submitted, however to date we have only received 44% of the returns, therefore this measure will be fully reported in Q2. The issue is understood to be an absence of reporting to the Corporate Team, rather than a risk that the assessments are not happening. This is being actively followed up with the Divisions' Health and Safety representatives

B. JUNIOR DOCTOR NEW DEAL COMPLIANCE

The 'New Deal' refers to the Junior Doctors Terms and Conditions of Service. This includes rest and hours targets which must be met in order for a rota to be 'compliant'. At the end of June, there were 65 compliant and 8 non-compliant rotas. The divisional position is provided below:

	Number Non-Compliant	Number Compliant	Compliance	Anticipated Date for 100% Compliance
Diagnostics & Therapies	0	6	100%	
Medicine	0	12	100%	
Specialised Services	0	11	100%	
Surgery Head & Neck	2	23	92%	August 2015
Women's & Children's	6	13	74%	August 2015
UH Bristol	**8**	**65**	**90%**	

Each Division has a robust action plan, with dates to achieve compliance where necessary. Divisions are required to report progress against action plans at their Performance and Operations quarterly review meetings.

7. CONCLUSION

There has been some positive movement in a number of KPIs this quarter, including sickness absence; Staff Friends and Family Test (compared with a year ago); core essential training; appraisal compliance, and junior doctor rota compliance, which has now hit the 90% target.

However, there has been little change in bank, agency and overtime usage. Of particular concern is the ongoing upward trend in staff turnover. Turnover and work to retain staff and improve engagement will therefore continue to be a priority.

Quality and Outcomes Committee is asked to:

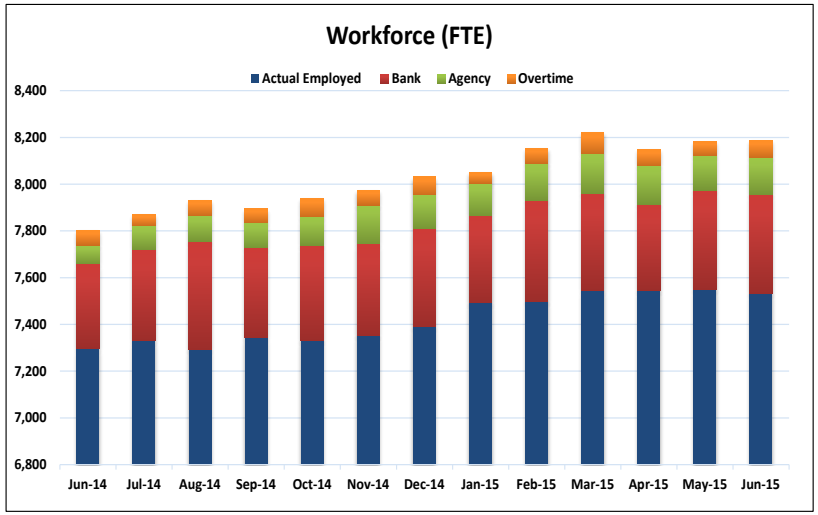
1. Note the contents of this report;
2. Discuss any issues arising in relation to the areas reported;
3. Note that this report is under review and a now format will be submitted next time, complementing the new monthly performance report.

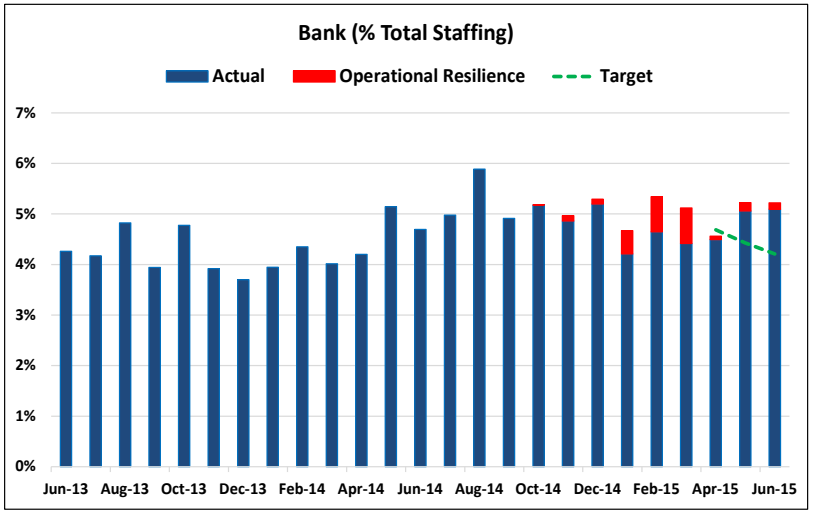
APPENDICES

Appendix 1 – Workforce Performance Dashboard
Appendix 2 – Divisional KPIs – Quarterly Comparisons
Appendix 3 – Staff Group KPIs – Quarterly Comparisons

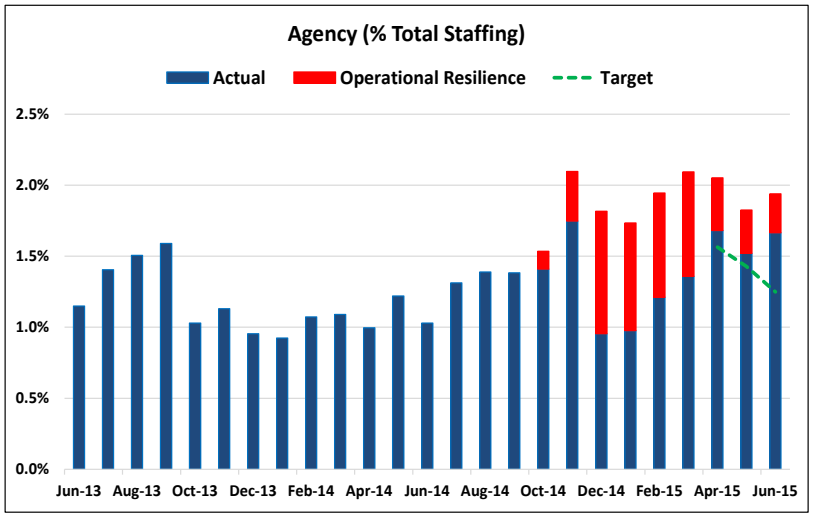
Appendix 1 – Workforce Performance Dashboard

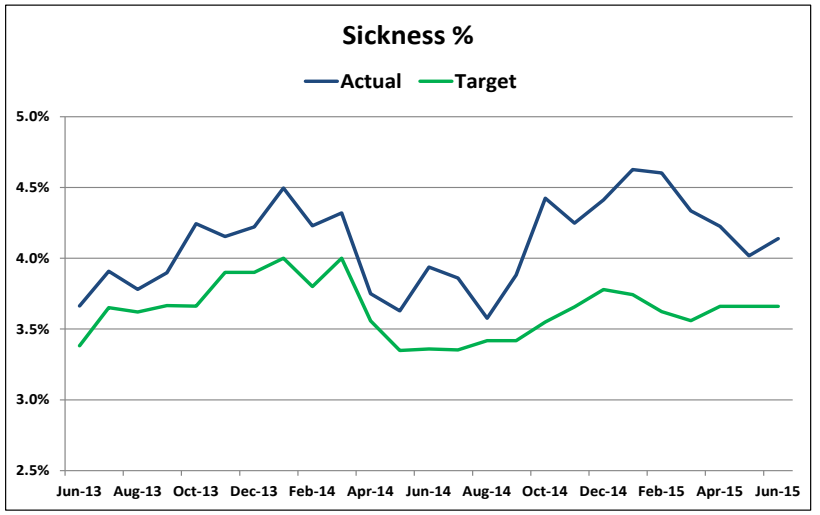
Workforce FTE



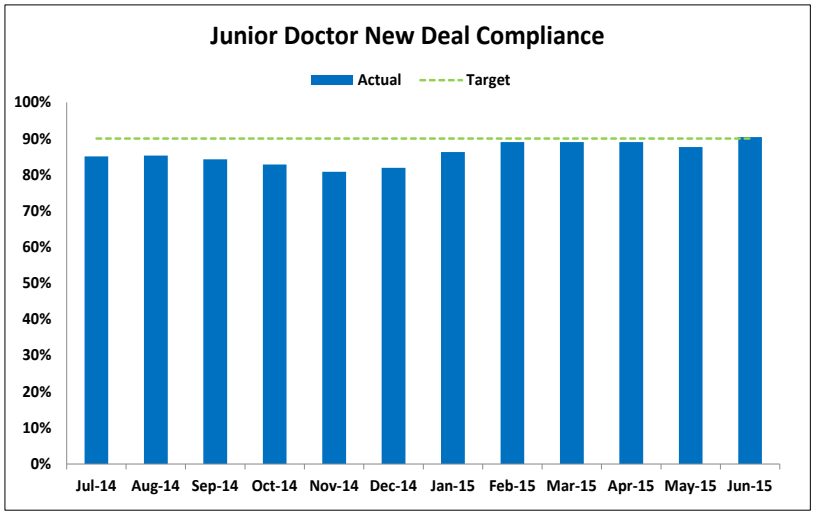


Workforce FTE

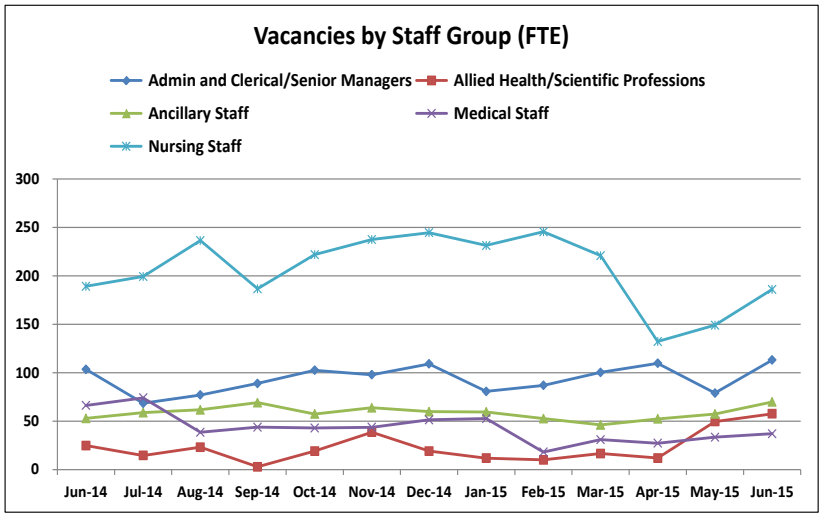


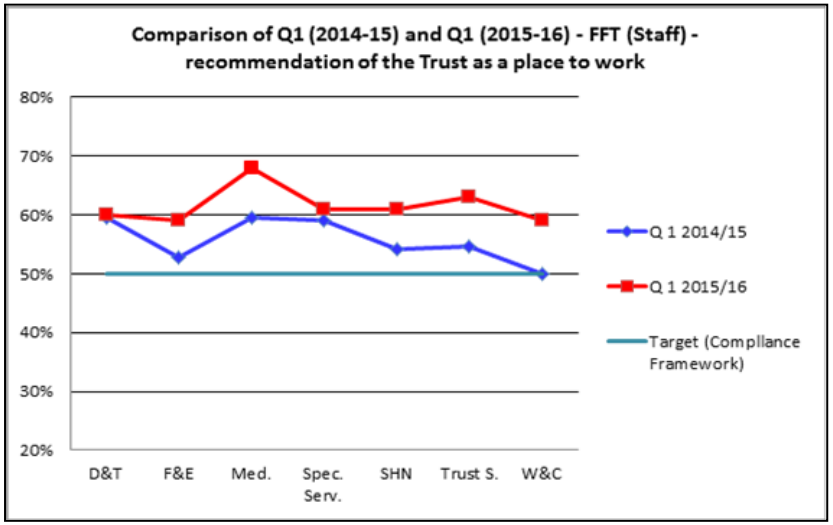


Workforce FTE

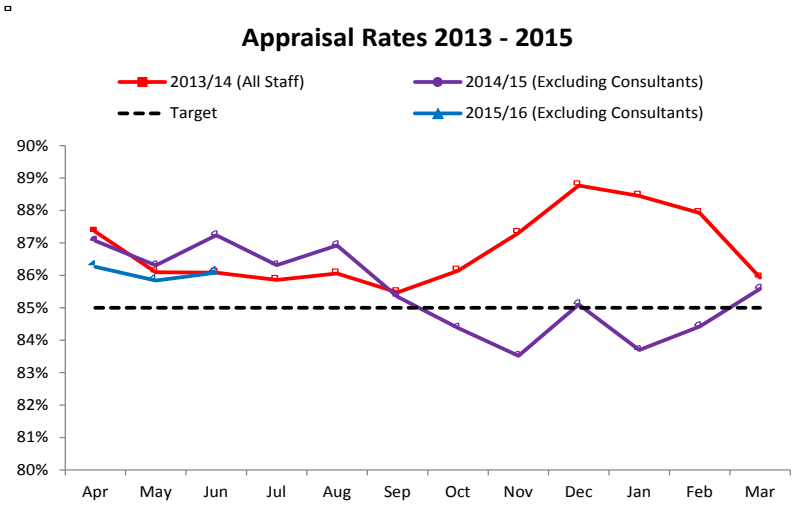


Staff Experience





Staff Development



Essential Training Compliance

Accreditation	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's	Compliance
Blood Transfusion	69%		85%	92%	87%	81%	86%	87%
Clinical Record Keeping	81%		86%	90%	86%	78%	83%	85%
Conflict Resolution Awareness	98%	99%	99%	98%	98%	96%	97%	98%
Conflict Resolution Training	85%		89%	91%	87%	78%	82%	86%
Consent	81%		83%	88%	86%	77%	83%	84%
Equality & Diversity	98%	99%	98%	98%	98%	97%	98%	98%
Fire Safety	99%	99%	99%	98%	98%	98%	98%	98%
Food Safety	98%	99%	98%	97%	97%	97%	97%	98%
Harassment & Bullying	99%	99%	99%	98%	98%	97%	98%	98%
Health & Safety	89%	84%	89%	91%	87%	92%	83%	87%
Infection Prevention & Contro	88%	83%	88%	91%	89%	91%	84%	87%
Information Governance	98%	98%	99%	98%	98%	98%	98%	98%
Manual Handling	84%	81%	87%	89%	86%	85%	83%	85%
Medical Devices	76%		78%	84%	81%	72%	76%	79%
Medicines Management	76%		78%	85%	83%	72%	78%	80%
Nutrition	76%		83%	85%	82%	72%	77%	80%
Patient Safety	76%		78%	84%	81%	73%	77%	79%
Patient Slips, Trips and Falls	79%		83%	87%	83%	77%	79%	82%
Pressure Ulcer Prevention	76%		87%	87%	84%	75%	79%	83%
Venous Thromboembolism	60%		82%	88%	84%	79%	80%	82%
ALL:	89%	93%	89%	91%	89%	92%	86%	89%

Induction	86%	88%	91%	86%	88%	80%	86%	87%
Local Induction Checklist	61%	82%	38%	45%	51%	54%	49%	52%
Resuscitation	73%		76%	80%	75%	78%	73%	75%
Safeguarding Adults L1	87%	83%	87%	90%	86%	88%	87%	86%
Safeguarding Adults L2	67%	61%	81%	84%	77%	70%	67%	74%
Safeguarding Adults L3								
Safeguarding Children L1	90%	82%	79%	83%	81%	85%	50%	84%
Safeguarding Children L2	81%	69%	84%	92%	85%	86%	77%	84%

Compliance Requirements

Jun-15	Manual Handling Risk Assessments	Stress Risk Assessments
Diagnostic & Therapies	28%	24%
Facilities & Estates	46%	46%
Medicine	65%	41%
Specialised Services	79%	67%
Surgery Head & Neck	57%	48%
Trust Services	33%	33%
Women's & Children's	41%	26%
Trust Wide	**50%**	**40%**

Appendix 2 Divisional KPIs – Quarterly Comparisons

Workforce FTE

WORKFORCE NUMBERS, INCL BANK & AGENCY (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	943.4	975.1	943.1	945.0
Facilities & Estates	783.7	785.4	786.7	785.6
Medicine	1268.5	1235.0	1260.4	1194.6
Specialised Services	877.9	837.2	855.8	823.4
Surgery, Head & Neck	1748.3	1716.6	1741.1	1727.8
Trust Services	667.2	653.4	701.9	697.7
Women's & Children's	1817.1	1822.8	1785.6	1758.7
Trust Total	**8106.0**	**8025.5**	**8074.4**	**7932.8**

BANK (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	1.1%	1.2%	1.0%	
Facilities & Estates	6.9%	6.0%	6.4%	
Medicine	9.7%	8.9%	10.7%	
Specialised Services	5.9%	4.6%	5.1%	
Surgery, Head & Neck	4.2%	4.2%	4.1%	
Trust Services	5.1%	1.9%	5.1%	
Women's & Children's	3.2%	3.5%	3.5%	
Trust Total	**5.0%**	**4.4%**	**5.0%**	

Workforce FTE

AGENCY (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	1.0%	1.0%	0.7%	
Facilities & Estates	1.5%	1.5%	2.3%	
Medicine	3.3%	3.4%	4.6%	
Specialised Services	2.9%	2.1%	2.4%	
Surgery, Head & Neck	1.6%	1.0%	1.2%	
Trust Services	1.6%	0.7%	1.5%	
Women's & Children's	1.7%	0.5%	1.1%	
Trust Total	**1.9%**	**1.4%**	**1.9%**	

OVERTIME (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	1.5%	1.0%	1.0%	
Facilities & Estates	4.4%	3.8%	4.3%	
Medicine	0.0%	0.1%	0.1%	
Specialised Services	0.3%	0.1%	0.3%	
Surgery, Head & Neck	0.2%	0.3%	0.2%	
Trust Services	0.4%	0.4%	0.9%	
Women's & Children's	0.4%	0.3%	0.5%	
Trust Total	**0.8%**	**0.7%**	**0.8%**	

Workforce FTE

SICKNESS ABSENCE (%)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	2.9%	3.0%	3.6%	2.7%
Facilities & Estates	6.3%	5.2%	6.6%	5.5%
Medicine	5.6%	4.2%	5.8%	4.2%
Specialised Services	3.7%	3.7%	3.2%	4.0%
Surgery, Head & Neck	3.8%	3.5%	4.5%	3.3%
Trust Services	3.3%	2.6%	4.0%	2.9%
Women's & Children's	3.7%	3.6%	4.2%	3.4%
Trust Total	**4.1%**	**3.7%**	**4.5%**	**3.6%**

Staff Experience

VACANCY (% FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	5.2%	5.0%	1.9%	5.0%
Facilities & Estates	8.5%	5.0%	8.6%	5.0%
Medicine	6.5%	5.0%	10.7%	5.0%
Specialised Services	3.5%	5.0%	3.9%	5.0%
Surgery, Head & Neck	3.4%	5.0%	4.6%	5.0%
Trust Services	4.8%	5.0%	6.0%	5.0%
Women's & Children's	4.3%	5.0%	3.2%	5.0%
Trust Total	**4.9%**	**5.0%**	**5.3%**	**5.0%**

TURNOVER (% FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	12.1%	11.3%	11.4%	9.0%
Facilities & Estates	13.2%	13.6%	14.0%	10.0%
Medicine	13.5%	13.4%	13.7%	10.2%
Specialised Services	16.4%	15.6%	16.6%	9.7%
Surgery, Head & Neck	16.0%	14.5%	15.1%	10.2%
Trust Services	16.4%	14.0%	15.3%	10.3%
Women's & Children's	12.1%	11.5%	12.0%	10.1%
Trust Total	**14.0%**	**13.2%**	**13.8%**	**10.0%**

Staff Experience

How likely are you to recommend the Trust to friends and family as a place to work?	Diagnostics And Therapies		Facilities And Estates		Medicine		Specialised Services		Surgery Head And Neck		Trust Services		Women's And Children's		UH Bristol	
Extremely Likely	31	14%	14	17%	36	15%	24	13%	50	16%	55	20%	64	18%	274	17%
Likely	104	46%	35	42%	125	54%	86	48%	140	45%	117	43%	146	41%	753	45%
Neither Likely or Unlikely	51	22%	13	16%	37	16%	37	21%	61	20%	49	18%	88	25%	336	20%
Unlikely	23	10%	11	13%	26	11%	22	12%	38	12%	31	11%	45	13%	196	12%
Extremely Unlikely	17	7%	10	12%	9	4%	6	3%	19	6%	18	7%	12	3%	91	5%
Don't Know	1	0%		0%		0%	4	2%	4	1%		0%	1	0%	10	1%
Total	**227**	100%	**83**	100%	**233**	100%	**179**	100%	**312**	100%	**270**	100%	**356**	100%	1660	**100%**

Staff Development

APPRAISAL COMPLIANCE (EXCL CONSULTANTS)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	89.0%	85.0%	89.4%	85.0%
Facilities & Estates	91.2%	85.0%	85.5%	85.0%
Medicine	86.5%	85.0%	83.8%	85.0%
Specialised Services	87.5%	85.0%	89.3%	85.0%
Surgery, Head & Neck	83.6%	85.0%	83.8%	85.0%
Trust Services	88.0%	85.0%	88.7%	85.0%
Women's & Children's	82.4%	85.0%	83.4%	85.0%
Trust Total	**86.1%**	**85.0%**	**85.6%**	**85.0%**

Appendix 3 Staff Group KPIs – Quarterly Comparisons

Workforce FTE

WORKFORCE NUMBERS, INCL BANK & AGENCY (FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	1649.1	1642.1	1668.6	1624.5
Scientific & Professional	1250.4	1274.8	1310.1	1313.4
Estates & Ancillary	856.3	847.3	800.5	783.5
Medical & Dental	1156.3	1177.0	1110.6	1130.6
Nursing & Midwifery	3193.9	3084.4	3184.6	3080.9
Trust Total	**8106.0**	**8025.5**	**8074.4**	**7932.8**

BANK (FTE)

	Quarter 1 Actual	**Quarter 4 Actual**
Administrative & Clerical	5.7%	5.8%
Scientific & Professional	0.8%	0.7%
Estates & Ancillary	7.1%	6.9%
Medical & Dental	0.0%	0.0%
Nursing & Midwifery	7.6%	7.7%
Trust Total	**5.0%**	**5.0%**

Workforce FTE

AGENCY (FTE)

	Quarter 1 Actual	Quarter 4 Actual
Administrative & Clerical	1.8%	2.2%
Scientific & Professional	0.6%	0.1%
Estates & Ancillary	1.1%	1.8%
Medical & Dental	1.6%	1.3%
Nursing & Midwifery	2.9%	2.8%
Trust Total	**1.9%**	**1.9%**

OVERTIME (FTE)

	Quarter 1 Actual	Quarter 4 Actual
Administrative & Clerical	0.4%	0.5%
Scientific & Professional	1.4%	2.4%
Estates & Ancillary	4.1%	0.0%
Medical & Dental	0.0%	0.9%
Nursing & Midwifery	0.2%	0.5%
Trust Total	**0.8%**	**0.8%**

Workforce FTE

SICKNESS ABSENCE (%)

	Quarter 1 Actual	Quarter 4 Actual
Add Prof Scientific & Technic	3.5%	4.1%
Additional Clinical Services	4.4%	5.8%
Administrative & Clerical	3.5%	4.2%
Allied Health Professionals	3.4%	3.2%
Estates & Ancillary	6.3%	6.8%
Healthcare Scientists	2.4%	2.6%
Medical & Dental	1.5%	1.1%
Nursing & Midwifery Registered	4.2%	4.9%
Nursing & Midwifery Unregistered	8.2%	8.0%
Trust Total	**4.1%**	**4.5%**

Staff Experience

VACANCY (% FTE)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	6.2%	5.0%	5.5%	5.0%
Scientific & Professional	3.1%	5.0%	1.0%	5.0%
Estates & Ancillary	7.1%	5.0%	6.7%	5.0%
Medical & Dental	2.8%	5.0%	3.0%	5.0%
Nursing & Midwifery	5.2%	5.0%	7.5%	5.0%
Trust Total	**4.9%**	**5.0%**	**5.3%**	**5.0%**

TURNOVER (% FTE)

	Quarter 1 Actual	**Quarter 4 Actual**
Add Prof Scientific & Technic	11.3%	11.2%
Additional Clinical Services	13.7%	12.5%
Administrative & Clerical	15.0%	14.9%
Allied Health Professionals	13.5%	10.8%
Estates & Ancillary	12.6%	13.5%
Healthcare Scientists	8.5%	9.8%
Medical & Dental	9.1%	8.2%
Nursing & Midwifery Registered	13.9%	12.9%
Nursing & Midwifery Unregistered	22.2%	24.3%
Trust Total	**14.0%**	**13.8%**

Staff Development

APPRAISAL COMPLIANCE (EXCL CONSULTANTS)

	Quarter 1		Quarter 4	
	Actual	**Target**	**Actual**	**Target**
Add Prof Scientific & Technic	86.2%	85.0%	75.3%	85.0%
Additional Clinical Services	90.1%	85.0%	89.8%	85.0%
Administrative & Clerical	85.3%	85.0%	86.5%	85.0%
Allied Health Professionals	88.3%	85.0%	91.5%	85.0%
Estates & Ancillary	91.8%	85.0%	83.4%	85.0%
Healthcare Scientists	81.4%	85.0%	88.5%	85.0%
Medical & Dental	83.2%	85.0%	94.7%	85.0%
Nursing & Midwifery Registered	84.5%	85.0%	83.8%	85.0%
Nursing & Midwifery Unregistered	87.3%	85.0%	84.5%	85.0%
Trust Total	**86.1%**	**85.0%**	**85.6%**	**85.0%**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
15. Finance Update									
Sponsor and Author(s)									
Sponsor: Paul Mapson, Director of Finance & Information									
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 Trust's reported financial position at the end of August 2015 is a deficit of £0.535m (before technical items). This is a significant deterioration from the surplus of £0.514m reported in July. With technical items (donated income, donated asset depreciation and impairments) included the deficit reduces to £0.042m.

The position is driven by the Clinical Divisions deteriorating from £1.991m deficit in July to £3.461m deficit in August. The greatest concern is with the rate of deterioration in Surgery, Head and Neck (from £1.531m deficit in July to £2.266m in August) and Medicine (from £0.296m deficit in July to £0.7m in August). Clinical Divisions are now £1.71m adverse to their Operating Plan trajectories.

The two key issues continue to be the delivery of clinical activity and rate of agency nursing expenditure.

Recommendations
The Board is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
None
Impact Upon Corporate Risk
None
Implications (Regulatory/Legal)
None
Equality & Patient Impact
None

Resource Implications			
Finance	**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)**
	25/9/15			23/9/15	

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a deficit of £0.535m (before technical items) for the first five months of the financial year. This compares to a surplus reported to July of £0.514m. After technical items the deficit decreases to a deficit of £0.042m.

The significant deterioration in August is of concern. The variance to the Monitor Annual Plan is now adverse £0.919m to August compared to a favourable variance of £0.1m to July.

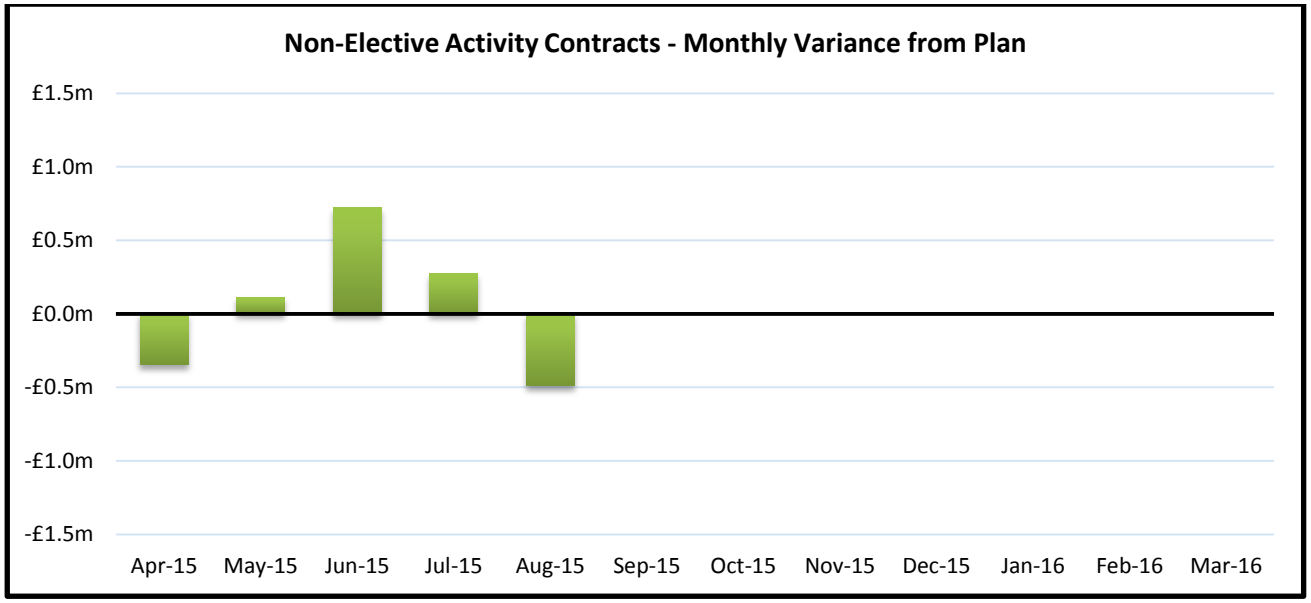
The position is driven by the Clinical Divisions deteriorating by £1.470m from £1.991m deficit to July to £3.461m to August. The deterioration is most concerning in Surgery, Head and Neck (£1.531m to July compared to £2.266m to August) and Medicine (£0.296m to July compared to £0.7m to August).

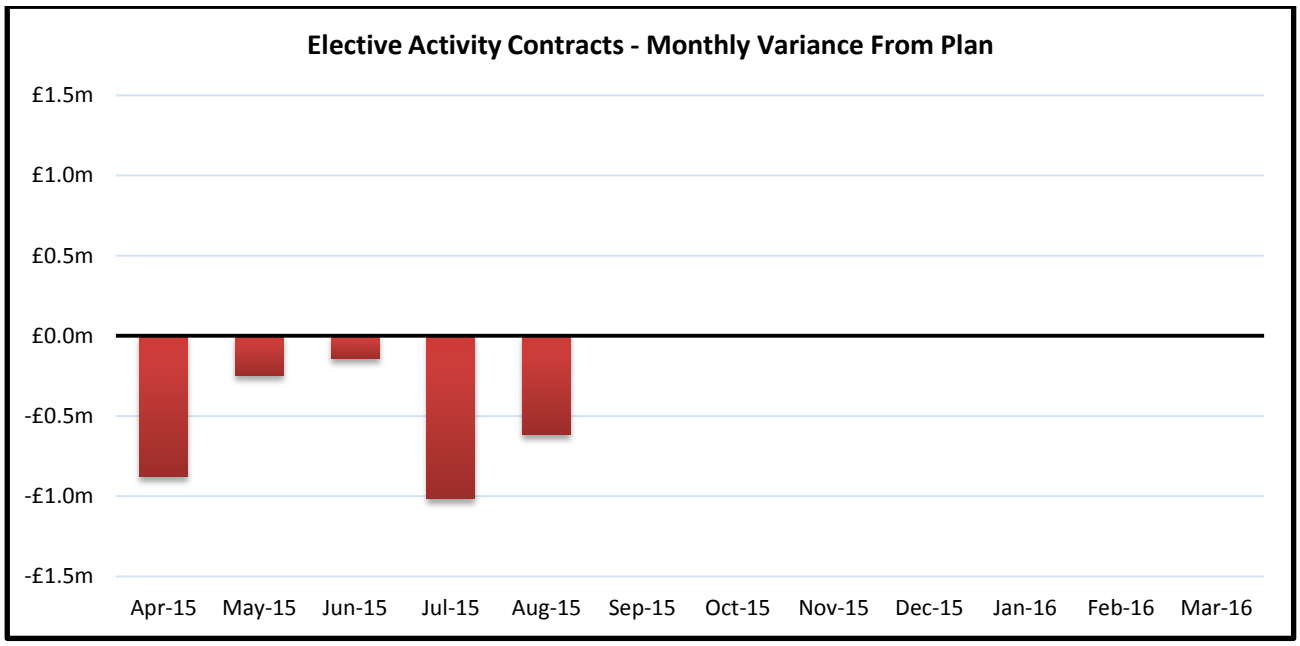
Clinical Divisions are now adverse to their Operating Plan trajectories by £1.71m compared to £0.33m to July. With the substantial improvements in the trajectories already being planned from September onwards the rate of adverse variance in July and August must be stopped to achieve the financial plan.

Recovery plans have been requested for the two Divisions and these will be reviewed and monitored in detail. The positions in Specialised Services and Women's and Children's will be reviewed after the monthly Finance and Operating Reviews in September.

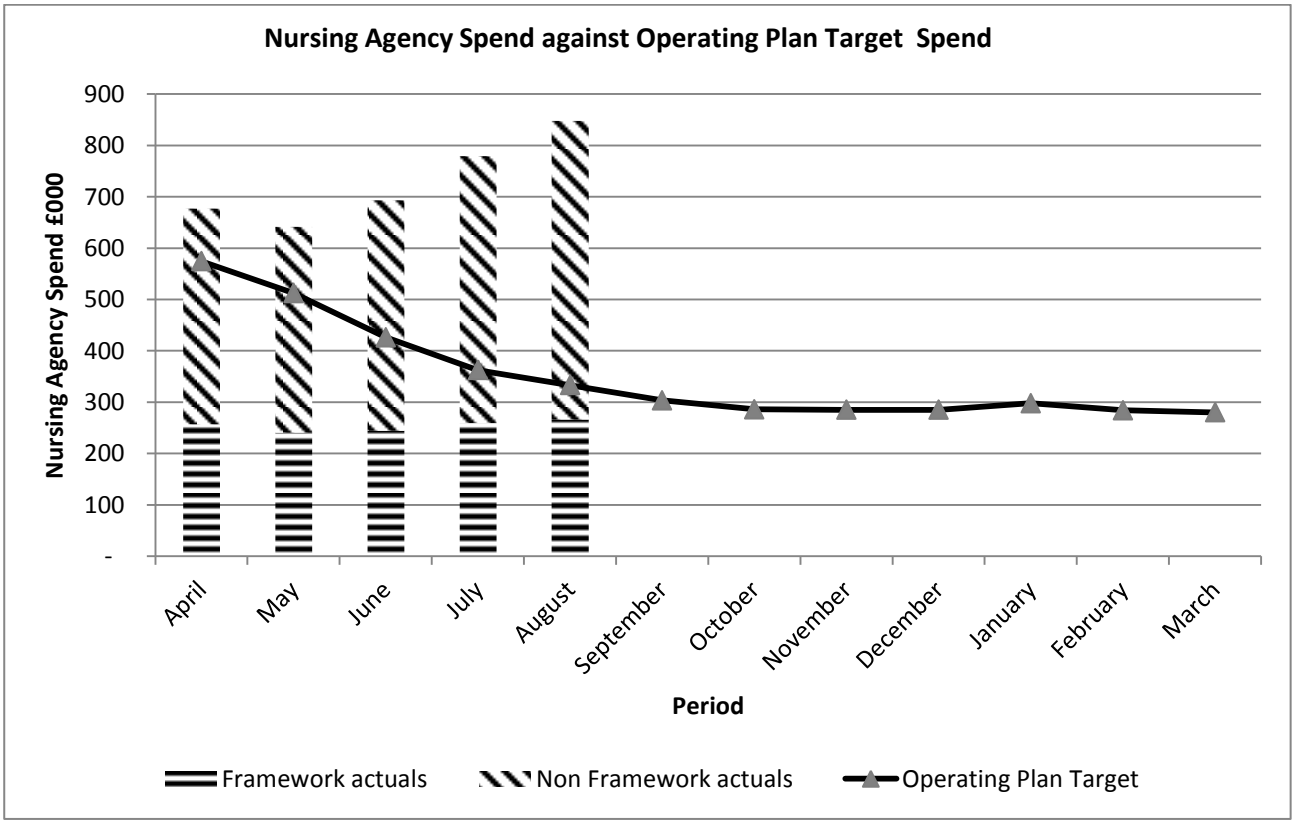
As highlighted in previous reports the two key issues continue to be the delivery of clinical activity and rate of nurse agency spending. Bar charts are shown below for each issue.

- Clinical activity delivery – two bar charts are shown, one for non-elective and one for elective activity. Both show significant adverse variances from plan in the two main summer months of July and August with emergency activity being particularly low in August. It is to be hoped that activity will be increased from September onwards.





- Nursing Agency spend – the level of agency spend continues to rise month on month in contrast to the Operating Plan trajectory where a month on month reduction was planned. The use of non-framework agency is particularly marked



On both areas the summer season in July and August is clearly a major contributor to the substantial deterioration experienced. Factors such as annual leave arrangements, sickness and other factors will be analysed to assess why the summer has been problematic with a view to ensuring that future holiday periods are as productive as other periods in the year.

The expectation remains that the position will improve from September to get the Trust's run rate back under control in preparation for the winter and more importantly the new financial year.

2. Divisional Financial Position

In total, the Clinical Divisions and Corporate Services overspend against budget increased by £1.470m in August to £3.461m cumulatively. The table overleaf summarises the financial performance in August for each of the Trust's management divisions against the budget and against their August operating plan target. Further analysis of the variances against budget by pay, non-pay and income categories is given at Appendix 2.

	Budget Variance to 31 July	Aug Budget Variance	Budget Variance to 31 Aug	Aug Operating Plan Target	Operating Plan Variance
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Diagnostic & Therapies	38	(120)	(82)	(29)	(53)
Medicine	(296)	(404)	(700)	(110)	(590)
Specialised Services	(325)	(19)	(344)	(48)	(296)
Surgery, Head & Neck	(1,531)	(735)	(2,266)	(1,366)	(900)
Women's & Children's	(96)	(229)	(325)	(366)	41
Estates & Facilities	52	10	62	(9)	71
Trust Services	26	(9)	17	0	17
Other Corporate Services	141	36	177	-	177
Totals	**(1,991)**	**(1,470)**	**(3,461)**	**(1,928)**	**(1,533)**

Variance to Budget:
The table below shows the Clinical Divisions and Corporate Services budget variances against the four main income and expenditure headings.

Divisional Variances	Variance to 31 July	Aug Variance	Variance to 31 Aug
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(518)	(158)	(676)
Non Pay	847	(81)	766
Operating Income	113	(4)	109
Income from Activities	(1,061)	(734)	(1,795)
Sub Totals	(616)	(977)	(1,596)
Savings Programme	(1,372)	(493)	(1,865)
Totals	**(1,991)**	**(1,470)**	**(3,461)**

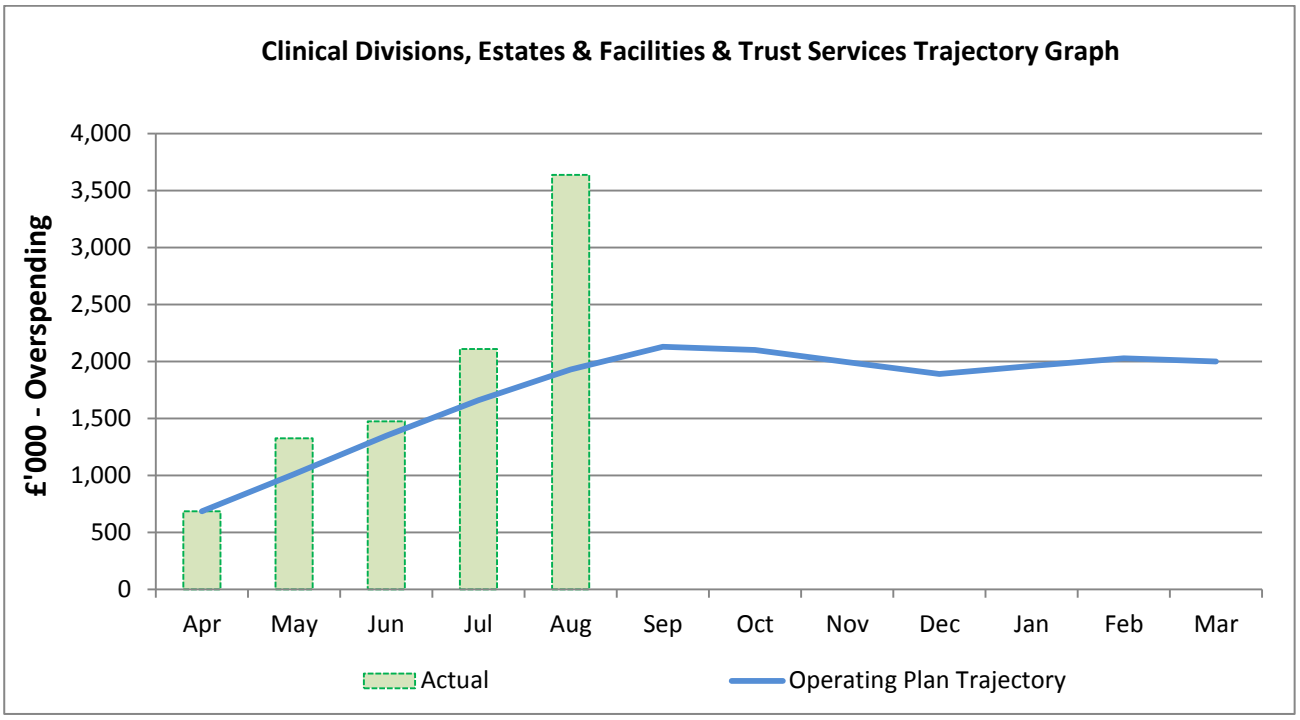
Pay budgets have overspent by £0.158m in the month increasing the cumulative overspend to £0.676m. The principal overspends are within Specialised Services (£0.346m) and Women's and Children's (£0.608m). For the Trust as a whole, agency spend is £5.683m to date. The average monthly spend of £1.137m compares with £0.967m for 2014/15. The greatest increases being in Surgery, Head and Neck which has increased from an average monthly spend of £106k in 2014/15 to £241k in 2015/16 and Women's and Children's which increased from £154k to £236k. Waiting list initiatives costs remain high at £1.407m in the first five months, of which £0.660m is within Surgery, Head and Neck.

N**on-pay budgets** have underspent by £0.081m in the month reducing the cumulative underspend to £0.766m. This relates in the main to divisional support funding and lower activity related expenditure. There has, however, been a further deterioration of the position within Surgery Head and Neck this month of which £0.167m.

Operating Income budgets show a favourable variance of £4k for the month to give a cumulative favourable variance of £0.109m.

Income from Activities budgets have overspent in the month by £0.7.4m increasing the cumulative overspend to £1.795m. The principal areas of under achievement to date are within Medicine (£0.613m), Surgery, Head and Neck (£0.660m), Specialised Services (£0.551m) and Diagnostics and Therapies (£0.132m) offset by an over achievement in Women's and Children's (£0.179m). The Diagnostic and Therapies position results from the share of the underachievement in other Divisions.

Variance to Operating Plan:
Clinical Divisions, Estates and Facilities and Trust Services are £3.638m overspent to date against a combined operating plan trajectory of £1.928m. The August position is £1.710m above trajectory as shown in the graph below.



Further detail is given in section 4 of this report and under agenda item 5.3 in the Finance Committee papers.

Savings Programme
The savings requirement for 2015/16 is £19.879m. This is net of the £4.476m provided non-recurringly to support the delivery of Divisional Operating Plans. Savings of £6.417m have been realised to date, a shortfall of £1.891m against divisional plans. The shortfall is a combination of the adverse variance for unidentified schemes of £1.473m and a further £0.418m for scheme slippage. The 1/12th phasing adjustment reduces the shortfall to date by £25k.

The year-end forecast outturn is a shortfall of £2.881m, (a deterioration of £0.059m from last month's forecast shortfall of £2.822m), which represents delivery of 85.5%. There remains significant risk with achieving this, particularly with regard to schemes relating to income and reductions in agency spend.

A summary of progress against the Savings Programme for 2015/16 is summarised below. A more detailed report is given under item 5.4 on this month's agenda.

	Savings Programme to 31st Aug 2015			1/12ths Phasing Adj Fav / (Adv) £'000	Total Variance Fav / (Adv) £'000
	Plan £'000	Actual £'000	Variance Fav / (Adv) £'000		
Diagnostics and Therapies	861	631	(230)	(33)	(263)
Medicine	858	971	113	(68)	45
Specialised Services	713	760	47	52	99
Surgery, Head and Neck	2,548	1,167	(1,381)	89	(1,292)
Women's and Children's	1,886	1,270	(616)	103	(513)
Estates and Facilities	444	464	20	(11)	9
Trust HQ	127	265	138	(95)	43
Other Services	871	889	18	(12)	6
Totals	**8,308**	**6,417**	**(1,891)**	**25**	**(1,866)**

3. Divisional Reports

Three Divisions are red rated for their financial performance for the year to date:

Division of Medicine

The Division reports an adverse variance to month 5 of £0.700m; this represents a significant deterioration from month 4 of £0.404m. The Division is £0.590m adverse to its operating plan target to date. Positively, the savings programme is currently overachieving by £45k to date.

The key reasons for the adverse variance against budget to date are:

- Underachievement on income from activities of £0.613m due to lower than expected emergency admissions which were lower by 148 (9%) in the month, equivalent to a 36% reduction in gross income received. There was also an underachievement in A&E attendances and outpatient attendances. Emergency admissions and A&E attendances are not amenable to recovery planning. The adverse variance on income from activities increased by £0.272m in August, a significant deterioration in the run rate. Significantly, emergency admissions were lower by 148 (9%) in the month, equivalent to a 36% reduction in gross income received (c.£1m). Admissions were 11% lower than SLA in month and are now 3% lower than the SLA to date.

- Pay overspends of £0.175m due to costs associated with agency nursing and medical staffing. It should be noted that despite lower recorded levels of activity, absolute pay expenditure increased by £0.323m (8%) in August, almost all of which was across nursing. This is a reversal of the downward trend in expenditure set in the preceding months and reflects higher usage of RMNs and 1:1 agency nurses across, primarily, three wards (A515 – Stroke, A400 – OPAU and A605 – delayed transfer of care).

The key reasons for the adverse variance against the operating plan target are:

- Broadly those for the year to date budget variance, however, it should be noted that pay is more favourable in terms of variance against operating plan.

Actions being taken to restore performance include:

- Recruitment to key posts to increase the capacity to deliver outpatient activity.
- Additional outpatient clinics to recover the shortfall on outpatient activity related income, pending successful recruitment.
- Continuation of an intensive nurse recruitment programme with further new starters anticipated throughout quarter 2, further reducing expenditure on agency nursing in line with the operating plan.

Key risks to delivery of the operating plan include:

- Failure of the recruitment strategy to deliver the required number of posts and hence the planned level of agency expenditure reductions are not achieved. The scale of this risk is currently being assessed.

Division of Specialised Services

The Division reports an adverse variance to month 5 of £0.344m, the rate of overspend has slowed significantly this month with a deterioration of £0.019m. The Division is £0.296m adverse to the operating plan target to date; a small improvement from last month. Delayed receipting accounted for an additional £0.099m of expenditure this month, without this the Division's position would have significantly improved in the month.

The savings programme is currently overachieving by £0.100m to date and the non pay budgets are underspending by £0.375m from support funding and unallocated contract transfer funding as well as a small favourable variance on blood. The key reasons for the adverse variance against budget to date are:

- Underachievement of income from activities of £0.551m due to lower than planned activity in cardiac surgery of £0.790m and radiotherapy of £0.166m, with smaller underachievements in other specialties. This is offset to some extent by a favourable variance in cardiology £0.128m, clinical haematology/haemophilia £0.129m and private patient income of £0.073m. The under performance on cardiac surgery is attributable to reduced access to cardiac intensive care beds arising from a peak in acuity (affecting length of stay) and staffing constraints resulting in fewer beds being opened over the period. Actual procedures performed in month have again been higher than those billed and 18 additional cases will be reflected in the September position.
- Nursing and midwifery pay overspends of £0.275m, particularly within the BHI. This continues to represent a slowing in the rate of overspending in this area.

The key reasons for the adverse variance from the operating plan target are:

- Lower than planned cardiac surgery activity £0.376m.
- Higher than planned nursing costs £0.141m.
- Lower than planned Radiotherapy and Gamma Knife activity £0.166m.

Actions being taken to restore performance include:

- A review of the scheduling of high acuity patients in order to address flow in CICU and mitigate the adverse impact of fines for non-booking of cancelled patients, which is currently significant.
- A review of nurse staff deployment, including rostering and controls for bank and agency staffing, overseen by the Chief Nurse.
- A recruitment and retention drive to improve the levels of permanent staff in CICU to ensure beds remain open at all times.
- Addressing the sickness levels in CICU.
- A focus on potential additional income in areas such as Cardiology, BMT and radiotherapy particularly Gamma Knife work.

Key risks to delivery of the operating plan include:

- Further loss of Cardiac Surgery activity due to shortage of staff, high acuity of patients or bed pressures during the winter period.
- An inability to recruit to vacant posts in nursing, resulting in continued agency expenditure.
- Non recruitment to medical staff vacancies within BHOC, particularly for Radiotherapy.
- Continued charges for unused chemotherapy drugs.
- Non delivery of expected savings.
- Reduction in referrals for BMT.

Division of Surgery, Head and Neck

The Division reports an adverse variance to month 5 of £2.266m; a deterioration from month 4 of £0.735m, a further significant increase in the rate of overspending over prior months. The Division is £0.900m adverse to its operating plan target to date, compared with £0.349m last month.

The key reasons for the adverse variance against budget to date are:

- Underachievement of income from activities of £0.660m due to lower than expected activity primarily in outpatient areas (oral surgery, ophthalmology and ENT) and emergency/ unplanned work in upper GI surgery and T&O – the latter two difficult to recover. A significant element of this is a share of the underperformance on cardiac surgery within Specialised Services (£0.197m), although this run rate has slowed.
- An adverse variance to date on non pay of £0.320m which is an in month deterioration of £0.167m. Whilst some of this is due to re-profiling and the divisional deficit, there is increased expenditure within theatres which is of significant concern.
- An underachievement of the savings programme, resulting in an adverse variance to date of £1.292m. The majority of which relates to unidentified plans of £1.155m with the balance mainly due to shortfalls on income related schemes. The most significant being income from the national Bowel Screening Programme (flexible sigmoidoscopy) which has been slowed down by the national programme and as such is not recoverable. The incoming Divisional Director is focussing upon the identification of further savings plans.

The key reasons for the adverse variance against operating plan are:

- Slippage on the savings programme, mainly flexible sigmoidoscopy scheme (income related), £0.226m.
- Underachievement of activity (including the share of cardiac surgery), £0.431m.
- Higher than planned agency costs £0.402m.

Actions being taken to restore performance include:

- Implementing a revised operating plan to improve utilisation rates within theatres, reducing the number of waiting list initiatives required.
- Increasing capacity within oral surgery and dental specialities by recruiting to the required levels of nursing and consultant staff.
- Increasing capacity at South Bristol Hospital including the scheduling of additional sessions in the evenings and at weekends.
- Implementing a recruitment and retention strategy to address areas where lack of permanent staff is causing high levels of agency usage and excessive turnover. The retention strategy will focus on the training, development and succession opportunities for staff in theatres and critical care based upon insights gained from recent exit interviews.

Key risks to delivery of the operating plan include:

- Continuing high usage of agency nursing if the recruitment strategy fails to deliver.

One Division is amber/green rated for its financial performance for the year to date:

The Division of Women's and Children's Services

The Division reports an adverse variance to month 5 of £0.325m, this represents significant deterioration from month 4 of £0.229m. The Division is however £0.041m favourable to the operating plan target to date.

The key reasons for the adverse variance against budget to date are:

- An adverse variance on pay of £0.608m due to higher than planned agency costs within medical staff (NICU cover) and nursing (including 1-1 care). Non clinical staff is overspending by £0.206m driven by requirements such as validating waiting lists and completion of missing outcomes.
- An underperformance on the saving programme, resulting in an adverse variance to date of £0.514m. The majority of which relates to unidentified savings.

Actions being taken to restore performance include:

- Concerted effort to identify further savings opportunities.
- Minimising agency payments through improved and efficient recruitment and retention.
- Actively managing private patients and commercial research plans.
- Improving cost control and budgetary performance including Profin compliance.

Key risks to delivery of the operating plan include:

- Maintaining elective flow through the winter months.
- Emergency admissions being paid at 70% tariff.

One Division is rated amber/green.

Diagnostic and Therapies Division

The Division reports an adverse variance to month 5 of £0.082m, which represents deterioration from month 4 of £0.120m. £0.104m of this relates to the Division's share of activity underperformance in other Divisions. The Division is £0.053m adverse to the operating plan target to date.

The key reasons for the adverse variance against budget to date are:

- An adverse variance on non-pay of £0.120m relating to radiology maintenance contracts (£0.138m) and the Microbiology Public Health England contract (£0.185m).
- An adverse variance on income from activities of £0.132m which relates to a favourable variance on D&T hosted services of £0.117m off-set by £0.249m adverse on services hosted by other divisions.
- An underachievement of the savings programme, resulting in an adverse variance to date of £0.262m of which £0.140m relates to unidentified plans.
- Vacant posts have contributed to a pay underspend of £0.225m which is offsetting the adverse variances.

Actions being taken to restore performance include:

- Developing the savings programme to address the shortfall.
- Challenging the LIMS costs with NBT.

Key risks to delivery of the operating plan include:

- Other Division's under-performance on contracted activity.
- Non-delivery or under-delivery of savings schemes currently forecast to achieve, such as those linked to the extension of the Roche Managed equipment service for laboratory medicine.
- Employing high cost agency / locums into hard to recruit to posts to ensure delivery of key performance targets and resilience in services such as radiology and laboratory medicine.

The remaining two Divisions are rated green.

The Facilities and Estates Division
The Division reports a favourable variance to month 5 of £0.062m, which represents an improvement from month 4 of £0.010m; the Division is £0.071m favourable to the operating plan target to date.

Trust Headquarters
The Division reports a favourable variance to month 5 of £62k, this represents a deterioration from month 4 of £1k; the Division is £17k favourable to the operating plan target to date, excluding financing items.

4. Income

Contract income was £1.05m lower than plan in August and £2.73m lower than plan for the year to date. Activity and penalties were lower than plan whilst pass through payments were higher than plan. The table below summarises the overall position which is described in more detail under agenda item 5.2.

Clinical Income by Worktype	**In Month Variance** Fav/(Adv)	**Year to Date Plan**	**Year to Date Actual**	**Year to Date Variance** Fav/(Adv)
	£'m	£'m	£'m	£'m
Activity Based				
Accident & Emergency	0.01	6.10	6.20	0.10
Emergency Inpatients	(0.31)	30.01	30.55	0.54
Day Cases	(0.10)	15.52	14.88	(0.64)
Elective Inpatients	(0.13)	21.86	20.53	(1.33)
Non-Elective Inpatients	(0.02)	6.63	6.09	(0.54)
Excess Bed days	(0.06)	2.90	3.26	0.36
Outpatients	(0.39)	32.68	31.51	(1.16)
Bone Marrow Transplants	0.00	3.88	4.00	0.11
Critical Care Bed days	(0.08)	17.43	17.56	0.13
Other	(0.02)	38.61	38.44	(0.17)
Sub Totals	**(1.10)**	**175.62**	**173.01**	**(2.62)**
Contract Rewards / Penalties	0.13	0.80	1.03	0.23
Pass through payments	(0.07)	29.73	29.73	(0.34)
Totals	**(1.05)**	**203.76**	**203.76**	**(2.73)**

The Trust has now signed contracts with the main NHS Commissioners for 2015/16. Early indications are that the Trust is performing well against the agreed CQUIN targets.

Significant activity underperformance continues within elective inpatients and outpatients. Key areas for the elective inpatient underperformance of £1.33m are cardiac surgery (£0.59m) and upper gastrointestinal surgery (£0.54m). Ophthalmology outpatient activity is £0.58m lower than plan resulting from reduced capacity whilst recruitment is underway.

Pass through payments are £0.34m lower than planned. Within this, drugs are £1.55m lower, reflecting an assessment of the anticipated use of new NICE treatments which have not yet fully materialised.

Performance at Clinical Divisional level is shown at appendix 4. Activity based contract performance is summarised as follows:

Divisional Variances	August Variance	Variance to date
	Fav/(Adv) £'m	Fav/(Adv) £'m
Diagnostic & Therapies	(0.11)	(0.21)
Medicine	(0.24)	(0.51)
Specialised Services	(0.01)	(0.83)
Surgery, Head and Neck	(0.21)	(0.91)
Women's and Children's	(0.19)	0.50
Facilities and Estates	(0.01)	(0.03)
Corporate	(0.32)	(0.62)
Totals	**(1.10)**	**(2.62)**

5. Risk Rating

The Trust's overall Financial Sustainability Risk Rating (FSRR) for the period ending 31st August is 3 (3.0 actual) against the planned FSRR of 4 (rounded up, 3.5 actual). The reduction in the FSRR against plan is due to the deterioration in the Trust's reported net income and expenditure position to a deficit of £535k (before technical items) against a planned surplus of £384k. The £919k adverse position against plan reduces the "capital servicing capacity" metric rating from a planned metric rating of 3 to an actual rating of 2. The adverse position also reduces the "variance in I&E margin" metric rating from a planned metric rating of 4 to an actual rating of 3. Further information showing performance to date and trajectories for each of the four metrics is given at Appendix 3. A summary of the position is provided in the table below.

		31st July 2015		31st August 2015		31st March 2016	
	Weighting	Plan	Actual	Plan	Actual	Plan	Forecast
Liquidity							
Metric Result – days		6.85	7.81	6.56	6.58	7.16	7.16
Metric Rating	25%	4	4	4	4	4	4
Capital Servicing Capacity							
Metric Result – times		1.66	1.68	1.78	1.66	1.83	1.83
Metric Rating	25%	2	2	3	2	3	3
Income & expenditure margin							
Metric Result		1.1%	1.2%	0.8%	0.5%	0.5%	0.5%
Metric Rating	25%	4	4	3	3	3	3
Variance in I&E margin							
Metric Result		0.0%	0.1%	0.0%	(0.3)%	0.0%	0.0%
Metric Rating	25%	4	4	4	3	4	4
Overall FSRR		**3.5**	**3.5**	**3.5**	**3.0**	**3.5**	**3.5**
Overall FSRR (rounded up)		**4**	**4**	**4**	**3**	**4**	**4**

6. Capital Programme

A summary of income and expenditure for the five months ending 31 August is given in the table below. Expenditure for the period is £8.128m against a revised plan of £8.371m. The revised plan to date and forecast outturn position reflects the conclusion of the re-profiling exercise. The Trust's forecast outturn is £30.075m which is 87.3% of the Monitor Annual Plan. Whilst this meets the Monitor target, the revised expenditure profiles for quarters 2 and 3 are below the performance target. Monitor may request an updated forecast for the remainder of the financial year.

The sale of the BRI Old Building has increased the forecast for disposals and the level of cash balances by an equivalent sum.

Current Annual Plan		**Month ended 31st August 2015**			
		Plan	**Actual**	**Variance**	**Forecast**
£'000		£'000	£'000	£'000	£'000
	Sources of Funding				
4,612	Donations	2,301	2,399	98	4,612
1,100	Disposals	1,100	1,100	-	14,025
1,130	Grants/Contributions	954	1,040	86	1,130
	Cash:				
20,814	Depreciation	8,572	8,619	47	20,814
12,127	Cash balances	(4,556)	(5,030)	(474)	(8,506)
39,783	**Total Funding**	**8,371**	**8,128**	**(243)**	**32,075**
	Expenditure				
(15,884)	Strategic Schemes	(4,439)	(4,583)	(144)	(11,853)
(7,604)	Medical Equipment	(912)	(769)	143	(5,958)
(3,230)	Information Technology	(853)	(500)	353	(3,188)
(2,947)	Estates Replacement	(509)	(833)	(324)	(2,887)
(10,118)	Operational Capital	(1,658)	(1,443)	215	(8,189)
(39,783)	**Total Expenditure**	**(8,371)**	**(8,128)**	**243**	**(32,075)**

The Finance Committee is provided with further information under agenda item 6.1.

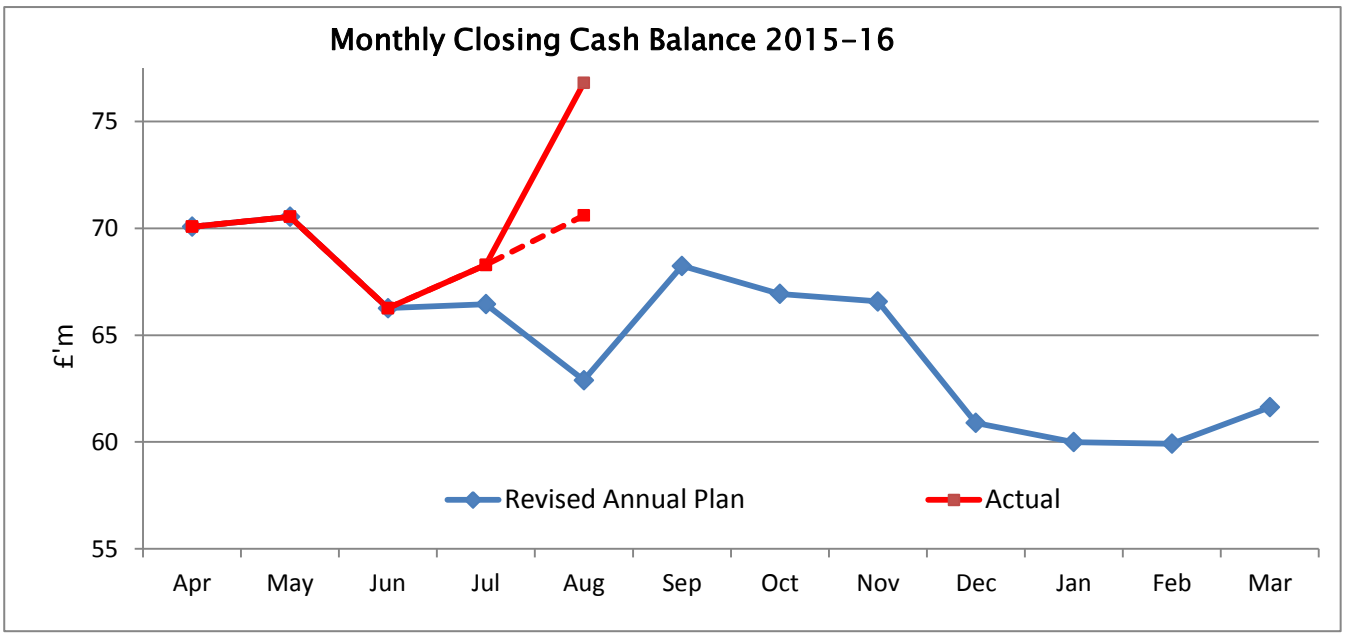
7. Statement of Financial Position and Cashflow

Overall, the Trust has a strong statement of financial position with net current assets of £21.073m as at 31 August 2015 against a plan of £21.195m.

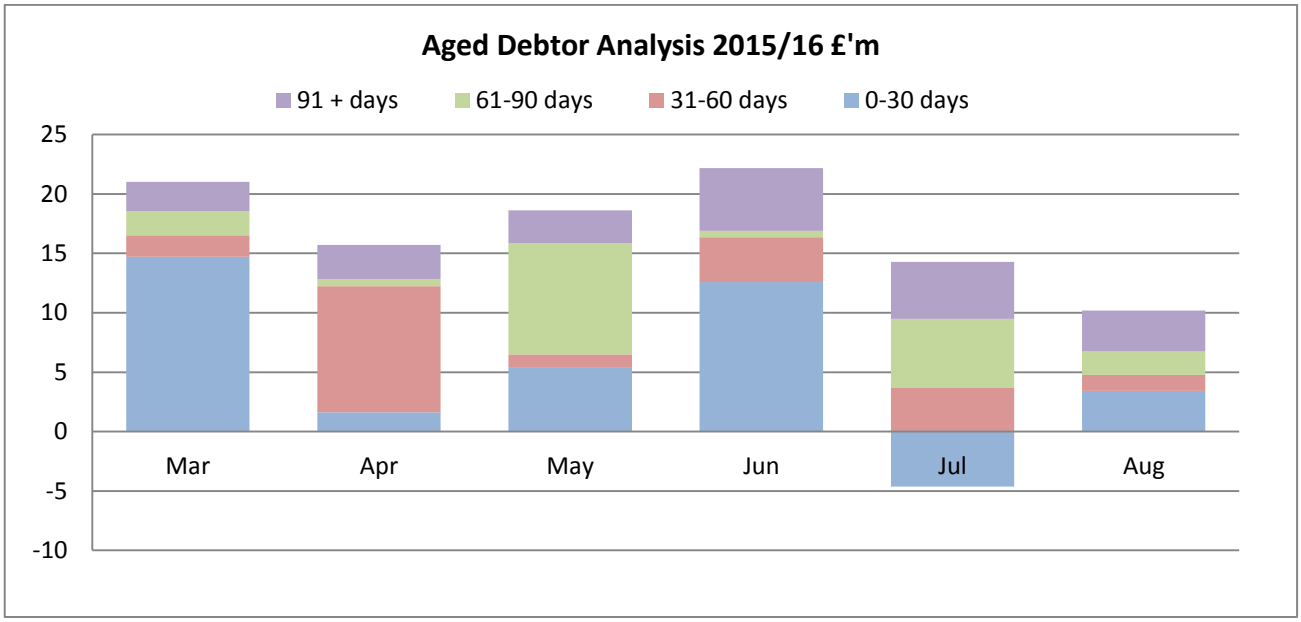
Cash - The Trust held a cash balance of £76.800m as at 31 August, £13.954m higher than planned. This is partly due to Commissioners paying the 2014/15 quarter four invoices without using quarter one credit notes, thereby resulting in the Trust 'owing' money to the Commissioners. The graph below shows the cash position. The red hashed line adjusts for the higher than expected cash receipts from Commissioners of £6.272m. The remaining higher than planned cash balance reflects delays in payments of invoices.

The annual plan has now been revised to take account of the sale of the BRI Old Building.

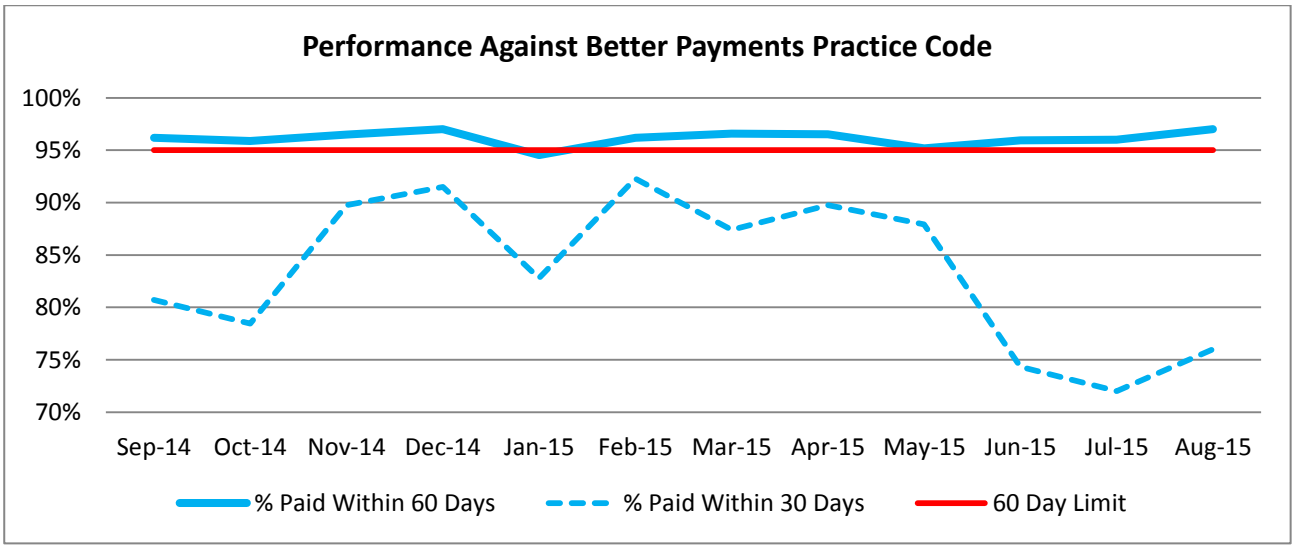
The forecast year end closing cash balance has increased from £59.240m to £62.595m as a result of commissioners agreeing that the Trust should now include "uncoded" activity in its quarterly invoices for SLA income.



Receivables - The total value of debtors increased by £0.542m to £10.177m. SLA debtors increased by £1.195m, and non SLA debtors decreased by £0.653m. Debts over 60 days old decreased by £5.203m to £5.400m. SLA decreased by £6.184m and non SLA increased by £0.981m. The SLA decrease is due to the payment of quarter 4 2014/15 activity invoices. Further detail is provided under agenda item 7.1.



Accounts Payable Payments – In August the Trust paid 97% of invoices within 60 days compared with the Prompt Payments Code target of 95%. The number of invoices paid in 30 days was lower than usual reflecting the implementation of the invoice authorisation system and significant sickness levels.



8. Reporting

The reports this month reflect a number of changes following a review with members. In particular, Appendix 3, Executive Summary, has been removed, with the resulting renumbering of appendices. Appendix 3 now contains the Financial Sustainability Risk Rating in accordance with the updated revised Risk Assessment Framework with effect from 1st August 2015. Appendix 4, Key Financial Metrics, has been reinstated with revised information.

Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Financial Sustainability Risk Rating
Appendix 4a – Key Financial Metrics
Appendix 4b – Key Workforce Metrics
Appendix 5 – Financial Risk Matrix
Appendix 6 – Monthly Analysis of Pay Expenditure 2015/16
Appendix 7 - Release of Reserves

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report August 2015- Summary Income & Expenditure Statement

Approved Budget / Plan 2015/16	Heading	Position as at 31st August			Actual to 31st July
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
502,844	From Activities	209,730	207,349	(2,381)	166,941
89,409	Other Operating Income	36,988	36,962	(26)	29,590
592,253	**Sub totals income**	**246,718**	**244,311**	**(2,407)**	**196,531**
	Expenditure				
(344,411)	Staffing	(144,942)	(145,824)	(882)	(116,414)
(200,894)	Supplies and Services	(85,168)	(85,671)	(503)	(68,893)
(545,305)	**Sub totals expenditure**	**(230,110)**	**(231,495)**	**(1,385)**	**(185,307)**
(12,397)	Reserves	(833)	-	833	-
-	Monitor Plan Profile	(1,048)	-	1,048	-
34,551	**EBITDA**	**14,727**	**12,816**	**(1,911)**	**11,224**
	Financing				
-	Profit/(Loss) on Sale of Asset	-	7	7	7
(21,920)	Depreciation & Amortisation - Owned	(9,080)	(8,619)	461	(6,923)
244	Interest Receivable	102	119	17	93
(314)	Interest Payable on Leases	(131)	(133)	(2)	(107)
(3,192)	Interest Payable on Loans	(1,330)	(1,315)	15	(1,052)
(9,369)	PDC Dividend	(3,904)	(3,410)	494	(2,728)
(34,551)	**Sub totals financing**	**(14,343)**	**(13,351)**	**992**	**(10,710)**
0	**NET SURPLUS / (DEFICIT) before Technical Items**	**384**	**(535)**	**(919)**	**514**
	Technical Items				
4,558	Donations & Grants (PPE/Intangible Assets)	2,310	2,399	89	2,399
(4,719)	Impairments	(1,071)	(1,285)	(214)	(1,285)
500	Reversal of Impairments	-	-	-	-
(1,472)	Depreciation & Amortisation - Donated	(613)	(621)	(8)	(495)
(1,133)	**SURPLUS / (DEFICIT) after Technical Items**	**1,010**	**(42)**	**(1,052)**	**1,133**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2015 – Divisional Income & Expenditure Statement

Approved Budget / Plan 2015/16	Division	Total Budget / Plan to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st July	Operating Plan Target Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CRES				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income											
496,086	Contract Income	206,493	206,493	–	–	3	(3)	–	–	(4)	–	–
(3,427)	Overheads, Fines & Rewards	(1,365)	(1,696)	–	–	–	(331)	–	(331)	(154)	–	–
38,227	NHSE Income	15,330	15,330	–	–	–	–	–	–	–	–	–
530,886	**Sub Total Corporate Income**	**220,458**	**220,127**	**–**	**–**	**3**	**(334)**	**–**	**(331)**	**(158)**	**–**	**–**
	Clinical Divisions											
(50,726)	Diagnostic & Therapies	(21,319)	(21,401)	225	(120)	207	(132)	(262)	(82)	38	(29)	(53)
(71,532)	Medicine	(30,396)	(31,096)	(175)	27	16	(613)	45	(700)	(296)	(110)	(590)
(83,557)	Specialised Services	(34,738)	(35,082)	(346)	375	78	(551)	100	(344)	(325)	(48)	(296)
(99,819)	Surgery Head & Neck	(41,769)	(44,035)	(124)	(320)	130	(660)	(1,292)	(2,266)	(1,531)	(1,366)	(900)
(114,838)	Women's & Children's	(47,925)	(48,250)	(608)	638	(20)	179	(514)	(325)	(96)	(366)	41
(420,472)	**Sub Total – Clinical Divisions**	**(176,147)**	**(179,864)**	**(1,028)**	**600**	**411**	**(1,777)**	**(1,923)**	**(3,717)**	**(2,210)**	**(1,919)**	**(1,798)**
	Corporate Services											
(36,003)	Facilities And Estates	(15,536)	(15,474)	12	(30)	44	27	9	62	52	(9)	71
(24,401)	Trust Services	(10,161)	(10,144)	361	(310)	(110)	33	43	17	26	–	17
(3,062)	Other	(2,006)	(1,829)	(21)	506	(236)	(78)	6	177	141	–	177
(63,466)	**Sub Totals – Corporate Services**	**(27,703)**	**(27,447)**	**352**	**166**	**(302)**	**(18)**	**58**	**256**	**219**	**(9)**	**265**
(483,938)	**Sub Total (Clinical Divisions & Corporate Services)**	**(203,850)**	**(207,311)**	**(676)**	**766**	**109**	**(1,795)**	**(1,865)**	**(3,461)**	**(1,991)**	**(1,928)**	**(1,533)**
(12,397)	Reserves	(833)	–	–	833	–	–	–	833	667	–	–
–	Monitor Plan Profile	(1,048)	–	–	1,048	–	–	–	1,048	790	–	–
(12,397)	**Sub Total Reserves**	**(1,881)**	**–**	**–**	**1,881**	**–**	**–**	**–**	**1,881**	**1,457**	**0**	**–**
34,551	**Trust Totals Unprofiled**	**14,727**	**12,816**	**(676)**	**2,647**	**112**	**(2,129)**	**(1,865)**	**(1,911)**	**(692)**	**(1,928)**	**(1,533)**
	Financing											
–	(Profit)/Loss on Sale of Asset	–	7	–	7	–	–	–	7	7	–	–
(21,920)	Depreciation & Amortisation – Owned	(9,080)	(8,619)	–	461	–	–	–	461	368	–	–
244	Interest Receivable	102	119	–	17	–	–	–	17	12	–	–
(314)	Interest Payable on Leases	(131)	(133)	–	(2)	–	–	–	(2)	(2)	–	–
(3,192)	Interest Payable on Loans	(1,330)	(1,315)	–	15	–	–	–	15	12	–	–
(9,369)	PDC Dividend	(3,904)	(3,410)	–	494	–	–	–	494	395	–	–
(34,551)	**Sub Total Financing**	**(14,343)**	**(13,351)**	**–**	**992**	**–**	**–**	**–**	**992**	**792**	**0**	**–**
0	**NET SURPLUS / (DEFICIT) before Technical Items**	**384**	**(535)**	**(676)**	**3,639**	**112**	**(2,129)**	**(1,865)**	**(919)**	**100**	**(1,928)**	**(1,533)**
	Technical Items											
4,558	Donations & Grants (PPE/Intangible Assets)	2,310	2,399	–	–	89	–	–	89	89	–	–
(4,719)	Impairments	(1,071)	(1,285)	–	(214)	–	–	–	(214)	(214)	–	–
500	Reversal of Impairments	–	–	–	–	–	–	–	–	–	–	–
(1,472)	Depreciation & Amortisation – Donated	(613)	(621)	–	(8)	–	–	–	(8)	–	–	–
(1,133)	**Sub Total Technical Items**	**626**	**493**	**–**	**(222)**	**89**	**–**	**–**	**(133)**	**(125)**	**–**	**–**
(1,133)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**1,010**	**(42)**	**(676)**	**3,417**	**201**	**(2,129)**	**(1,865)**	**(1,052)**	**(25)**	**(1,928)**	**(1,533)**

Financial Sustainability Risk Rating – August 2015 Performance

The following graphs show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the five month period to 31st August 2015, the Trust's achieved an overall FSRR of 3 (actual 3.0) against a plan of 4 (rounded up – actual 3.5).

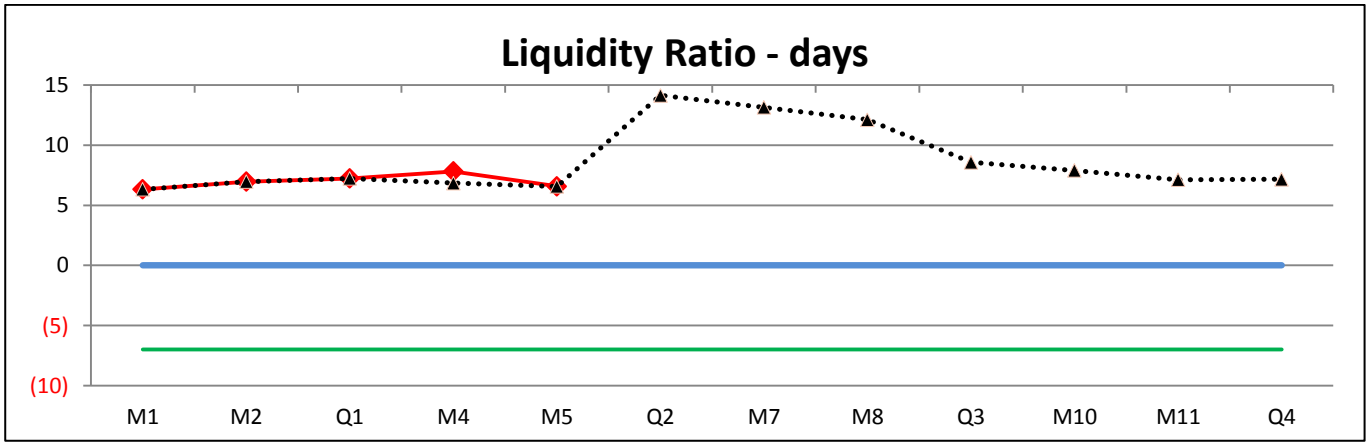
The reduction in the FSRR against plan is due to the deterioration in the Trust's reported net income and expenditure position to a deficit of £535k (before technical items) against a planned surplus of £384k. The £919k adverse position against plan reduces the "capital servicing capacity" metric rating from a planned metric rating of 3 to an actual rating of 2. The adverse position also reduces the "variance in I&E margin" metric rating from a planned metric rating of 4 to an actual rating of 3.

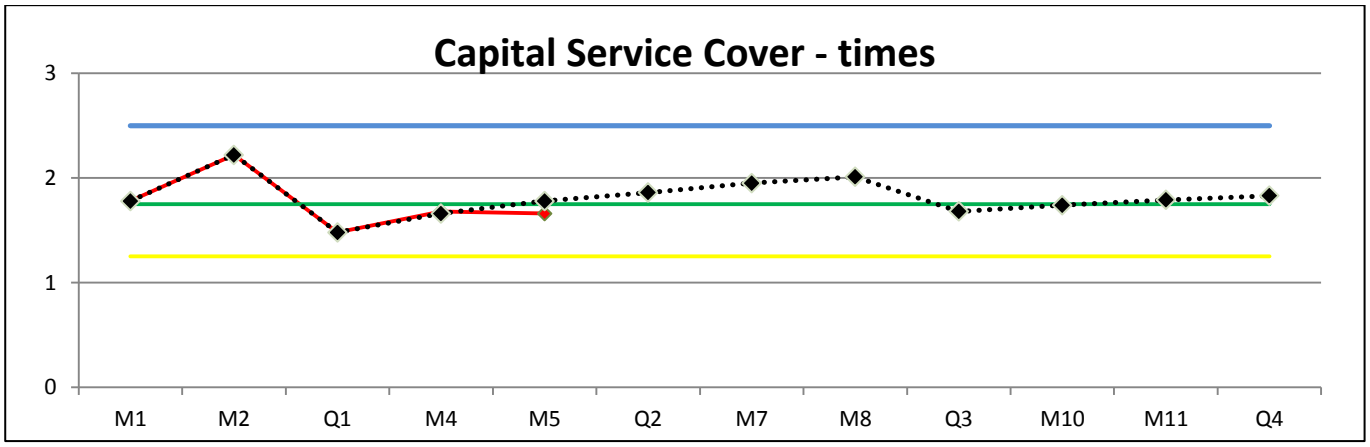
The key risk going forward is an ongoing deterioration in the Trust's income and expenditure performance at the rate reported for August and the impact upon the FSRR. Within the FSRR, the key metric is the "capital servicing capacity" metric because it has the least financial headroom available until a metric rating of 1 is scored. The headroom available, as at 31st August, was only £3.2million. Should any of the four metrics score a metric rating of 1, Monitor will apply an "over-ride" resulting in an overall FSRR of 1 for the Trust and likely investigation.

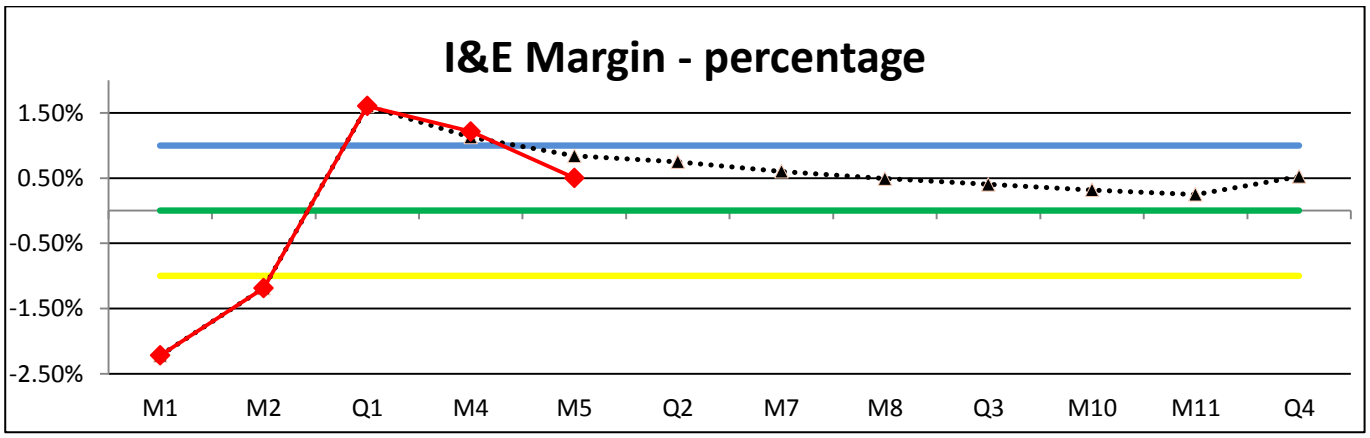
A summary of the position is provided in the table below.

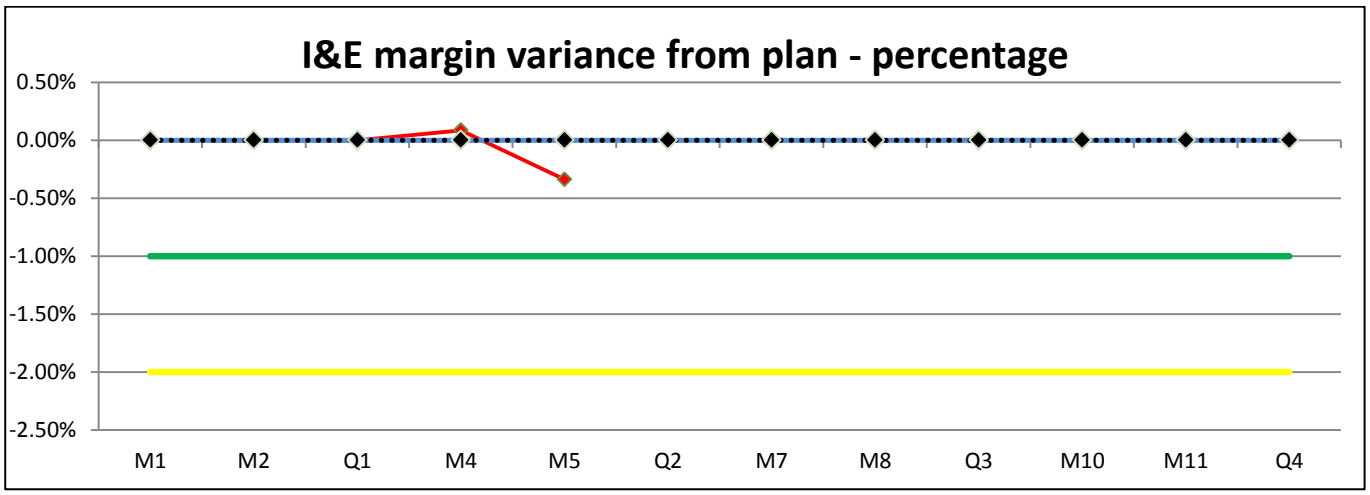
		31st July 2015		31st August 2015		31st March 2016	
	Weighting	Plan	Actual	Plan	Actual	Plan	Forecast
Liquidity							
Metric Result – days		6.85	7.81	6.56	6.58	7.16	7.16
Metric Rating	25%	4	4	4	4	4	4
Capital Servicing Capacity							
Metric Result – times		1.66	1.68	1.78	1.66	1.83	1.83
Metric Rating	25%	2	2	3	2	3	3
Income & expenditure margin							
Metric Result		1.1%	1.2%	0.8%	0.5%	0.5%	0.5%
Metric Rating	25%	4	4	3	3	3	3
Variance in I&E margin							
Metric Result		0.0%	0.1%	0.0%	(0.3)%	0.0%	0.0%
Metric Rating	25%	4	4	4	3	4	4
Overall FSRR		**3.5**	**3.5**	**3.5**	**3.0**	**3.5**	**3.5**
Overall FSRR (rounded up)		**4**	**4**	**4**	**3**	**4**	**4**

The charts presented overleaf show the trajectories for each of the four metrics. The 2015/16 revised Annual Plan submitted to Monitor on 31st July 2015 is shown as the black dotted line against which actual performance is plotted in red. The metric ratings are shown for **4 (blue line)**; **3 (green line)** and **2 (yellow line)**.


Liquidity Ratio - days
15
10
5
0
(5)
(10)
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


Capital Service Cover - times
3
2
1
0
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E Margin - percentage
1.50%
0.50%
-0.50%
-1.50%
-2.50%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E margin variance from plan - percentage
0.50%
0.00%
-0.50%
-1.00%
-1.50%
-2.00%
-2.50%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4

Key Financial Metrics

Appendix 4a

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contract Income - Activity Based									
Current Month									
Budget	3,320	4,046	4,564	5,892	8,161	319		8,502	34,804
Actual	3,208	3,807	4,551	5,679	7,967	305		8,182	33,699
Variance Fav / (Adv)	(112)	(239)	(13)	(213)	(194)	(14)	0	(320)	(1,105)
Year to date									
Budget	15,900	20,314	22,570	31,467	41,143	1,605		42,623	175,622
Actual	15,686	19,805	21,744	30,553	41,641	1,575		42,002	173,006
Variance Fav / (Adv)	(214)	(509)	(826)	(914)	498	(30)	0	(621)	(2,616)

Information shows the financial performance against the planned level of activity based service level agreements with Commissioners as per agenda item 5.2

Contract Income - Penalties									
Current Month									
Plan		(29)	(4)	(11)	(3)			(468)	(515)
Actual		(29)	(4)	(21)	(9)			(326)	(389)
Variance Fav / (Adv)	-	-	-	(10)	(6)	-	-	142	126
Year to date									
Plan		(145)	(18)	(57)	(15)			(2,308)	(2,543)
Actual		(151)	(20)	(65)	(20)			(2,059)	(2,315)
Variance Fav / (Adv)	-	(6)	(2)	(8)	(5)	-	-	249	228

Information shows the financial performance against the planned penalties as per agenda item 5.2

Cost Improvement Programme									
Current Month									
Plan	170	190	127	498	366	89	27	174	1,641
Actual	128	134	97	229	248	96	56	177	1,165
Variance Fav / (Adv)	(42)	(56)	(30)	(269)	(118)	7	29	3	(476)
Year to date									
Plan	861	858	713	2,548	1,886	444	128	871	8,309
Actual	631	971	760	1,167	1,270	464	267	889	6,419
Variance Fav / (Adv)	(230)	113	47	(1,381)	(616)	20	139	18	(1,890)

Key Workforce Metrics

Appendix 4b

Diagnostic & Therapies

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	952	547	106	115	155	116	74								566	(19)
Nursing agency expenditure (£'000)	29	17	13	1	1	-	1									17
Overall																
Sickness (%)	3.00		3.00	2.70	3.10	2.90	3.00									
Turnover (%)	11.00		11.80	11.70	12.20	12.00	12.40									
Establishment (wte)			968.01	978.45	978.94	981.34	982.24									
In post (wte)			948.03	943.08	940.05	942.47	961.81									
Under/(over) establishment (wte)			19.98	35.37	38.89	38.87	20.43									
Nursing:																
Sickness - registered (%)			0.20	1.90	2.80	4.60	0.20								1.90	
Sickness - unregistered (%)																
Turnover - registered (%)	15.00		15.70	12.60	11.40	11.00	11.00								11.00	
Turnover - unregistered (%)																
Starters (wte)			-	-	-	-	-									
Leavers (wte)			0.60	-	1.00	-	-									
Net starters (wte)			(0.60)		(1.00)											
Establishment (wte)			16.33	16.33	17.29	17.29	17.88									
In post - Employed (wte)			16.25	16.42	16.66	15.66	15.57									
In post - Bank (wte)			1.35	0.42	0.52	0.41	2.10									
In post - Agency (wte)			2.10	-	-	-	0.70									
In post - total (wte)			19.70	16.84	17.18	16.07	18.37									
Under/(over) establishment (wte)			(3.37)	(0.51)	0.11	1.22	(0.49)									

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Key Workforce Metrics

Appendix 4b

Medicine

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,732	1,231	324	248	254	226	269								1,321	(90)
Nursing agency expenditure (£'000)	1,343	959	279	186	154	184	234								1,037	(78)
Overall																
Sickness (%)	4.10		5.10	5.70	6.00	5.60	5.30									
Turnover (%)	12.70		13.40	13.50	13.80	12.40	12.30									
Establishment (wte)			1,233.42	1,233.54	1,238.01	1,211.24	1,217.72									
In post (wte)			1,267.74	1,282.71	1,255.17	1,236.75	1,257.67									
Under/(over) establishment (wte)			(34.32)	(49.17)	(17.16)	(25.51)	(39.95)									
Nursing:																
Sickness - registered (%)			4.80	5.30	6.20	6.10	5.30								5.60	
Sickness - unregistered (%)			9.60	10.80	10.40	9.10	10.80								10.10	
Turnover - registered (%)	13.50		13.00	13.60	14.20	13.30	13.90								13.90	
Turnover - unregistered (%)	18.50		22.20	21.40	20.40	16.50	16.20								16.20	
Starters (wte)			18.22	9.24	8.00	7.36	7.43								50.25	
Leavers (wte)			7.25	10.79	10.54	4.17	16.89								49.64	
Net starters (wte)			10.97	(1.55)	(2.54)	3.19	(9.46)								0.61	
Establishment (wte)			787.99	780.39	776.57	758.70	769.84									
In post - Employed (wte)			674.67	685.88	682.90	677.10	678.05									
In post - Bank (wte)			100.97	118.33	99.23	96.95	95.94									
In post - Agency (wte)			47.40	33.86	27.25	31.51	40.08									
In post - total (wte)			823.04	838.07	809.38	805.56	814.07									
Under/(over) establishment (wte)			(35.05)	(57.68)	(32.81)	(46.86)	(44.23)									

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Key Workforce Metrics **Appendix 4b**

Specialised Services

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	2,136	1,228	205	219	247	236	185								1,092	136
Nursing agency expenditure (£'000)	633	320	87	121	113	93	68								482	(162)
Overall																
Sickness (%)	3.70		3.80	3.60	3.60	3.90	3.90									
Turnover (%)	12.40		16.00	16.80	16.40	16.80	16.70									
Establishment (wte)			834.39	825.38	851.88	858.86	860.19									
In post (wte)			870.20	888.79	874.75	874.10	856.84									
Under/(over) establishment (wte)			(35.81)	(63.41)	(22.87)	(15.24)	3.35									
Nursing:																
Sickness - registered (%)			3.40	3.00	3.80	3.20	3.70								3.40	
Sickness - unregistered (%)			8.40	7.30	7.30	8.80	10.20								8.40	
Turnover - registered (%)	14.00		16.20	17.00	17.30	17.10	16.90								16.90	
Turnover - unregistered (%)	16.20		22.00	20.90	19.00	20.60	17.60								17.60	
Starters (wte)			4.60	3.46	9.00	1.80	8.00								26.86	
Leavers (wte)			4.96	10.70	6.94	7.14	6.67								36.41	
Net starters (wte)			(0.36)	(7.24)	2.06	(5.34)	1.33								(9.55)	
Establishment (wte)			453.58	449.36	460.69	463.54	463.26									
In post - Employed (wte)			439.48	439.02	432.60	433.82	427.33									
In post - Bank (wte)			32.04	37.61	43.55	36.09	33.32									
In post - Agency (wte)			11.33	13.13	13.01	11.02	9.77									
In post - total (wte)			482.85	489.76	489.16	480.93	470.42									
Under/(over) establishment (wte)			(29.27)	(40.40)	(28.47)	(17.39)	(7.16)									

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Key Workforce Metrics **Appendix 4b**

Surgery, Head and Neck

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,387	821	172	190	241	281	320								1,204	(383)
Nursing agency expenditure (£'000)	1,019	641	144	144	167	242	276								973	(332)
Overall																
Sickness (%)	3.50		4.00	3.40	3.80	4.30	4.50									
Turnover (%)	12.60		15.40	15.90	16.10	14.60	14.50									
Establishment (wte)			1,698.59	1,716.16	1,735.10	1,752.82	1,753.62									
In post (wte)			1,737.89	1,752.24	1,754.64	1,764.87	1,789.03									
Under/(over) establishment (wte)			(39.30)	(36.08)	(19.54)	(12.05)	(35.41)									
Nursing:																
Sickness - registered (%)			4.70	3.50	4.00	4.70	4.80								7.20	
Sickness - unregistered (%)			7.40	6.20	6.80	7.50	8.30								4.30	
Turnover - registered (%)	13.00		7.40	6.20	6.80	7.50	8.30								8.30	
Turnover - unregistered (%)	20.10		28.70	27.30	26.90	23.70	22.60								22.60	
Starters (wte)			10.61	4.00	5.63	1.00	9.00								30.24	
Leavers (wte)			9.52	8.33	10.64	5.51	22.60								56.59	
Net starters (wte)			1.09	(4.33)	(5.01)	(4.51)	(13.60)								(26.36)	
Establishment (wte)			675.98	679.78	689.06	694.06	701.12									
In post - Employed (wte)			644.20	646.24	650.41	642.90	648.68									
In post - Bank (wte)			45.02	51.89	55.40	60.48	63.94									
In post - Agency (wte)			20.66	19.59	27.45	31.41	35.91									
In post - total (wte)			709.88	717.72	733.26	734.79	748.53									
Under/(over) establishment (wte)			(33.90)	(37.94)	(44.20)	(40.73)	(47.41)									

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Key Workforce Metrics **Appendix 4b**

Women's and Children's

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,228	281	189	230	284	305	171								1,179	(898)
Nursing agency expenditure (£'000)	978	177	116	178	225	235	182								936	(759)
Overall																
Sickness (%)	3.90		4.00	3.50	3.40	3.50	3.60									
Turnover (%)	9.80		12.30	12.30	12.20	12.30	12.30									
Establishment (wte)			1,814.32	1,825.58	1,828.38	1,835.19	1,841.46									
In post (wte)			1,808.92	1,808.69	1,832.69	1,814.52	1,824.23									
Under/(over) establishment (wte)			5.40	16.89	(4.31)	20.67	17.23									
Nursing:																
Sickness - registered (%)			4.60	3.90	4.00	4.20	4.40								4.20	
Sickness - unregistered (%)			5.80	5.40	4.60	4.70	3.60								4.80	
Turnover - registered (%)	10.00		11.50	11.30	11.00	10.90	10.40								10.40	
Turnover - unregistered (%)	20.00		22.70	24.60	23.80	23.00	23.50								23.50	
Starters (wte)			6.94	5.00	6.88	9.23	18.36								46.41	
Leavers (wte)			13.40	8.23	9.95	10.14	16.50								58.21	
Net starters (wte)			(6.46)	(3.23)	(3.06)	(0.91)	1.86								(11.80)	
Establishment (wte)			1,069.93	1,080.41	1,089.27	1,091.76	1,095.48									
In post - Employed (wte)			1,024.80	1,016.21	1,014.22	1,005.18	1,005.84									
In post - Bank (wte)			39.82	41.71	41.03	37.32	44.22									
In post - Agency (wte)			15.95	19.81	25.19	24.60	24.19									
In post - total (wte)			1,080.57	1,077.73	1,080.44	1,067.10	1,074.25									
Under/(over) establishment (wte)			(10.64)	2.68	8.83	24.66	21.23									

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2015 - Risk Matrix

Datix Risk Register Ref.	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Residual Risk		Current Risk Score
		Risk Level	Value			Risk Level	Value	
			£'m				£'m	
959	Risk that Divisons do not achieve the required level of cost efficiency savings.	High	7.0	Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed.	DL	High	5.0	12
416	Risk that the Trust's Financial Strategy may not be deliverable 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	-	9
872	Risk of non delivery of contracted levels of clinical activity.	High	10.0	Robust approach to capacity planning - demand assessment and supply.	DL	High	6.0	12
951	Risk of national contract mandates financial penalties on under-performance.	High	4.0	Regular review of performance. RTT fines increasing during the year.	DL	High	3.5	9
50	Risk of Commissioner Income challenges	Moderate	3.0	Maintain reviews of data, minmise risk of bad debts	PM	Moderate	2.0	6
408	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	-	3

Analysis of pay spend 2014/15 and 2015/16

Division		2014/15							2015/16									2013/14	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	10,162	10,066	10,037	10,206	40,471	3,373		3,419	3,450	3,488	10,357	3,459	3,447	17,263	3,453		3,294	
	Bank	64	91	86	74	315	26	0.8%	26	24	32	82	29	44	155	31	0.9%	26	0.8%
	Agency	79	184	387	395	1,045	87	2.6%	106	115	155	377	116	74	566	113	3.3%	28	0.9%
	Waiting List initiative	45	46	65	113	269	22	0.7%	37	34	27	98	8	16	122	24	0.7%	19	0.6%
	Overtime	101	94	111	99	405	34	1.0%	34	47	65	147	26	34	207	41	1.2%	26	0.8%
	Other pay	9,772	9,435	9,675	9,492	38,375	3,198	95.0%	3,209	3,216	3,148	9,572	3,199	3,227	15,998	3,200	93.8%	3,179	97.0%
	Total Pay expenditure	10,062	9,850	10,324	10,173	40,409	3,367	100.0%	3,412	3,437	3,427	10,276	3,378	3,394	17,047	3,409	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	100	216	(287)	33	62	5		8	14	60	82	81	53	216	43		16	
Medicine	Pay budget	11,591	11,880	12,506	13,320	49,297	4,108		4,284	4,253	4,304	12,841	4,076	4,211	21,128	4,226		3,679	
	Bank	805	870	1,019	872	3,566	297	7.1%	303	329	265	897	252	341	1,491	298	7.0%	275	6.9%
	Agency	451	630	1,058	1,356	3,495	291	7.0%	324	248	254	826	226	269	1,321	264	6.2%	196	4.9%
	Waiting List initiative	26	39	34	94	193	16	0.4%	27	15	9	51	12	19	82	16	0.4%	13	0.3%
	Overtime	36	19	16	20	91	8	0.2%	4	6	6	16	7	6	29	6	0.1%	16	0.4%
	Other pay	10,704	10,399	10,587	11,130	42,820	3,568	85.4%	3,722	3,710	3,780	11,212	3,542	3,725	18,478	3,696	86.3%	3,479	87.4%
	Total Pay expenditure	12,022	11,957	12,715	13,471	50,165	4,180	100.0%	4,381	4,308	4,313	13,002	4,040	4,360	21,401	4,280	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(431)	(77)	(209)	(152)	(868)	(72)		(97)	(54)	(10)	(161)	36	(149)	(273)	(55)		(300)	
Specialised Services	Pay budget	9,577	9,653	9,727	10,232	39,189	3,266		3,347	3,384	3,399	10,130	3,405	3,436	16,971	3,394		3,060	
	Bank	309	335	357	292	1,293	108	3.2%	112	127	163	402	120	120	642	128	3.7%	99	3.1%
	Agency	509	664	677	885	2,735	228	6.7%	205	219	247	671	236	185	1,092	218	6.3%	157	5.0%
	Waiting List initiative	91	90	133	194	508	42	1.3%	47	30	48	125	51	28	204	41	1.2%	32	1.0%
	Overtime	55	40	22	30	147	12	0.4%	9	11	9	29	8	10	47	9	0.3%	15	0.5%
	Other pay	8,813	8,894	9,028	9,211	35,946	2,995	88.5%	3,043	3,074	3,072	9,189	3,074	3,068	15,331	3,066	88.5%	2,840	90.4%
	Total Pay expenditure	9,777	10,022	10,215	10,613	40,627	3,386	100.0%	3,416	3,460	3,538	10,415	3,490	3,411	17,316	3,463	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(200)	(369)	(488)	(381)	(1,438)	(120)		(70)	(76)	(139)	(285)	(85)	24	(345)	(69)		(82)	
Surgery Head and Neck	Pay budget	17,951	18,025	18,188	18,190	72,354	6,030		6,275	5,769	7,322	19,366	6,610	6,526	32,502	6,500		5,911	
	Bank	463	511	587	463	2,024	169	2.7%	191	178	190	559	218	256	1,033	207	3.2%	155	2.5%
	Agency	226	327	275	448	1,276	106	1.7%	172	190	241	603	281	320	1,203	241	3.7%	67	1.1%
	Waiting List initiative	366	456	446	395	1,663	139	2.2%	138	140	129	407	121	132	660	132	2.0%	116	1.9%
	Overtime	184	114	39	43	380	32	0.5%	11	13	14	38	13	18	69	14	0.2%	40	0.7%
	Other pay	17,464	17,399	17,639	17,809	70,313	5,859	92.9%	5,966	5,873	6,014	17,853	5,959	5,941	29,753	5,951	90.9%	5,766	93.8%
	Total Pay expenditure	18,703	18,808	18,988	19,157	75,656	6,305	100.0%	6,478	6,394	6,589	19,461	6,590	6,666	32,718	6,544	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(752)	(783)	(800)	(967)	(3,302)	(275)		(203)	(625)	733	(95)	20	(140)	(215)	(43)		(235)	

Analysis of pay spend 2014/15 and 2015/16

Division		2014/15							2015/16									2013/14	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	20,433	21,521	21,945	22,234	86,133	7,178		7,378	7,627	7,557	22,562	7,525	7,617	37,704	7,541		6,123	
	Bank	530	485	631	528	2,174	181	2.5%	182	180	171	533	171	225	930	186	2.4%	151	2.5%
	Agency	384	397	411	650	1,842	154	2.1%	189	230	284	703	305	171	1,178	236	3.1%	117	1.9%
	Waiting List initiative	88	87	76	139	390	33	0.5%	69	67	69	205	76	48	329	66	0.9%	30	0.5%
	Overtime	82	79	95	99	355	30	0.4%	8	7	8	23	9	9	40	8	0.1%	19	0.3%
	Other pay	19,455	20,428	20,875	20,758	81,516	6,793	94.5%	7,120	7,139	7,232	21,492	7,124	7,219	35,835	7,167	93.5%	5,843	94.9%
	Total Pay expenditure	20,539	21,476	22,088	22,174	86,277	7,190	100.0%	7,568	7,623	7,765	22,956	7,685	7,672	38,312	7,662	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(106)	45	(144)	60	(144)	(12)		(190)	3	(207)	(393)	(160)	(55)	(608)	(122)		(36)	
Facilities & Estates	Pay budget	4,638	4,916	4,931	4,936	19,421	1,618		1,726	1,669	1,662	5,057	1,686	1,760	8,503	1,701		1,536	
	Bank	227	316	271	251	1,065	89	5.5%	80	106	111	296	115	107	518	104	6.1%	46	3.0%
	Agency	80	115	133	174	502	42	2.6%	47	33	65	145	61	59	265	53	3.1%	29	1.9%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	244	255	273	193	965	80	5.0%	79	65	82	225	77	90	392	78	4.6%	75	4.9%
	Other pay	4,109	4,129	4,274	4,218	16,729	1,394	86.9%	1,491	1,473	1,442	4,406	1,437	1,476	7,320	1,464	86.2%	1,366	90.1%
	Total Pay expenditure	4,660	4,815	4,951	4,835	19,261	1,605	100.0%	1,697	1,676	1,699	5,072	1,691	1,732	8,495	1,699	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	(23)	101	(20)	101	161	13		30	(8)	(38)	(16)	(5)	28	8	2		20	
(Including R&I and	Pay budget	6,524	6,903	7,257	9,053	29,738	2,478		2,163	2,094	2,230	6,487	2,211	2,173	10,871	2,174		2,458	
(Incl R&I and																			
Support Services)	Bank	165	154	189	178	686	57	2.4%	51	67	61	179	72	71	323	65	3.1%	57	2.4%
	Agency	135	139	154	280	707	59	2.5%	(3)	15	(2)	10	15	32	57	11	0.5%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	1	2	3	3	4	10	2	0.1%	0	0.0%
	Overtime	31	27	33	19	110	9	0.4%	7	8	7	22	8	8	38	8	0.4%	9	0.4%
	Other pay	6,061	6,433	6,362	7,822	26,678	2,223	94.7%	2,042	2,018	2,025	6,085	1,964	2,059	10,108	2,022	95.9%	2,285	95.9%
	Total Pay expenditure	6,392	6,754	6,737	8,298	28,180	2,348	100.0%	2,096	2,109	2,093	6,299	2,062	2,174	10,535	2,107	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	132	149	520	755	1,557	130		67	(15)	137	188	149	(1)	336	67		75	
Trust Total	Pay budget	80,876	82,964	84,592	88,172	336,604	28,050		28,593	28,245	29,962	86,800	28,971	29,171	144,942	28,988		26,060	
	Bank	2,564	2,762	3,140	2,657	11,124	927	3.3%	945	1,012	992	2,949	978	1,164	5,091	1,018	3.5%	809	3.0%
	Agency	1,865	2,455	3,096	4,187	11,603	967	3.4%	1,039	1,051	1,245	3,335	1,239	1,109	5,683	1,137	3.9%	625	2.4%
	Waiting List initiative	616	718	754	935	3,023	252	0.9%	318	287	284	889	271	247	1,407	281	1.0%	210	0.8%
	Overtime	734	628	589	503	2,454	204	0.7%	151	156	191	499	148	175	822	164	0.6%	201	0.8%
	Other pay	76,378	77,117	78,440	80,436	312,370	26,031	91.7%	26,594	26,502	26,712	79,808	26,299	26,714	132,822	26,564	91.1%	24,759	93.1%
	Total Pay expenditure	82,157	83,680	86,019	88,718	340,574	28,381	100.0%	29,048	29,007	29,425	87,480	28,935	29,409	145,824	29,165	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(1,281)	(716)	(1,427)	(546)	(3,970)	(331)		(455)	(762)	537	(680)	37	(238)	(882)	(176)		(543)	

Release of Reserves 2015/16 **Appendix 7**

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other including income	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Resources Book	1,000	5,111	40,114	(268)	11,131	6,050	63,138									
April movements	(220)	(2,511)	(29,556)	-	(4,872)	(1,047)	(38,206)	4,075	5,792	4,807	9,850	7,758	967	4,922	35	38,206
May movements	(30)	288	(5,225)	312	(2,481)	(3,500)	(10,636)	(219)	2,155	193	89	106	17	153	8,142	10,636
June movements	(89)	(26)	(529)	-	(334)	(117)	(1,095)	30	162	50	164	320	142	169	58	1,095
July movements	43	(26)	(94)	-	(182)	(7)	(266)	31	26	14	23	14	27	15	116	266
August Movements																
Service Developments			(243)				(243)	154	29		95	72		109	(216)	243
BRI redevelopment					(533)		(533)							533		533
EWTD					(132)		(132)	8	30	24	18	48	1	2	1	132
Reslience funding			(94)				(94)		25		69					94
CQUINs			(73)				(73)		14	45	14					73
Research contribution	83						83								(83)	(83)
Other	(39)	(26)	(37)		27	(11)	(86)	3	4			10	33	12	24	86
Month 4 balances	748	2,810	4,263	44	2,624	1,368	11,857	4,082	8,237	5,133	10,322	8,328	1,187	5,915	8,077	51,281

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
17a. Clinical Research Network Annual Report 2014/15									
Sponsor and Author(s)									
Sponsor: Dr Sean O'Kelly Authors: Dr Steve Falk, Clinical Director, West of England Clinical Research Network & Dr Mary Perkins Chief Operating Officer, West of England Clinical Research Network.									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose: As the host organisation for the WECRN, the Board are asked to approve this report on behalf of the member organisations. UH Bristol as signatory to the contract with the Department of Health is accountable for the network activities. Robert Woolley is the accountable officer and Dr Sean O'Kelly is the delegated executive officer. All member organisations assisted in the preparation of this report and the partnership group of the WECRN have approved this report for submission to the UH Bristol Board. The national coordinating centre have also provided feedback on a draft report and their feedback has been acted upon in this version Key issues to note: We run a devolved network with many responsibilities sitting with partner organisations research and development departments. This report covers all organisations in our geographic area, including primary care and social care. The report is written in the format requested by the coordinating centre. In the future we plan to work with our communications team to provide an easy to access and understand version									
Recommendations									
That the Board approve this report									
Impact Upon Board Assurance Framework									
Supports UH Bristol to discharge their role as host for the network and signatory to the network contract with the Department of Health									

Impact Upon Corporate Risk
None
Implications (Regulatory/Legal)
This plan supports UH Bristol to discharge their responsibilities as contract signatory
Equality & Patient Impact
None
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	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)**
					April/May/June 2015 LCRN Partnership Group, Executive Group, Clinical Leaders Group and Operational Management Group. NIHR National Coordinating Centre

National Institute for Health Research

Clinical Research Network
West of England

Annual Report

NIHR Clinical Research Network: West of England

2014-15

v1.0

Delivering research to make patients, and the NHS, better

NIHR Clinical Research Network: West of England
Annual Report 2014/15

Host Organisation	University Hospitals Bristol NHS Foundation Trust
Partner Organisations – **Members of the Partnership Group**	1. 2gether NHS Foundation Trust 2. Avon and Wiltshire Mental Health Partnership NHS Trust 3. Gloucestershire Hospitals NHS Foundation Trust 4. Great Western Hospitals NHS Foundation Trust 5. North Bristol NHS Trust 6. Royal National Hospital for Rheumatic Diseases NHS Foundation Trust 7. Royal United Hospital Bath NHS Trust 8. University Hospitals Bristol NHS Foundation Trust 9. Weston Area Health NHS Trust
Other affiliated partners **(e.g. CCGs/Social enterprises)**	1. NHS Bath and North East Somerset CCG 2. NHS Bristol CCG 3. NHS Gloucester CCG 4. NHS North Somerset CCG 5. NHS South Gloucestershire CCG 6. NHS Swindon CCG 7. NHS Wiltshire CCG 8. Bristol Community Health 9. North Somerset Community Partnership 10. SeQol (Swindon) 11. Sirona Care & Health (Bath and North East Somerset and South Gloucestershire) 12.Gloucestershire Care Services NHS Trust

Host organisation Accountable Officer for NIHR Clinical Research Network: West of England		
Name:	Mr Robert Woolley	*Contact details* Email: Robert.Woolley@UHBristol.nhs.uk Tel: 0117 342 3720
Host nominated Executive Director for NIHR Clinical Research Network: West of England		
Name:	Dr Sean O'Kelly	*Contact details* Dr Sean O'Kelly Medical Director University Hospitals Bristol NHS Foundation Trust Marlborough Street
Job title:	Medical Director	

		Bristol Avon BS1 3NU Email (PA): **Claudette.Young@UHBristol.nhs.uk**
NIHR Clinical Research Network: West of England Clinical Director		
Name:	Dr Stephen Falk	*Contact details* Email: **Stephen.falk@uhbristol.nhs.uk** Tel: 0117 3421375
NIHR Clinical Research Network: West of England Chief Operating Officer		
Name:	Dr Mary Perkins	*Contact details* Email: **mary.perkins@nihr.ac.uk** Tel: 0117 3421375

To be completed by the Host organisation

Please briefly outline the involvement of the LCRN Partnership Group in reviewing and agreeing the submitted LCRN Annual Report 2014-15, including the financial report			
This report has been compiled with the involvement of all partner organisations and was formally agreed for submission to the Host Board by the Partnership Group at the meeting on September 30th 2015			
Confirmation of approval of the Annual Report by the Host organisation Board			
Name:		*Email:* *Tel:*	
Role:			
Signature:		**Date:**	
Contact for any communication regarding the NIHR Clinical Research Network: West of England Annual Report			
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Role:	Chief Operating Officer		

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Local Achievements, Successes and Lessons Learned

The greatest achievement in 2014-2015 for the West of England clinical research network was recruiting still higher numbers of patients into research than in 2013-2014 despite the turbulence of transition[1]. Researchers in our locality recruited to 146 commercial and 514 non-commercial NIHR portfolio studies in year 2014/15 compared with 117 commercial studies and 530 non-commercial studies. All of our NHS organisations recruit patients into studies and we have the highest proportion of GP practices in the country actively engaged in research with 226 out of 273 practices (83%) recruiting.

We are one of the smallest networks and this is our strength as well as our challenge. The strength shows in the robust working relationships at all levels and across all geographies, providers and patient and research groups. Our challenge is the potential for destabilisation from reducing budgets or loss of key staff.

Our transition year has not been without challenges. We are proud to have improved our recruitment of patients of course, but we are saddened by the personal impact of transition on some valued and talented colleagues within the network. Levels of stress related sick leave have been higher than wished and we aim to reduce that to zero by the end of the next financial year. Some colleagues have chosen not to stay with us and we wish them well.

We are immensely grateful to all of our colleagues working within our locality. One of our notable successes during transition is our very close collaborative working with senior research management staff to support the transition of MCRN staff into an entirely new trust-based research delivery structure embedded within the clinical division. This is an excellent example of our network role of oversight and facilitation. Change is negotiated through our devolved network model where the bulk of all resources sit with our organisations as close to the patients as possible. This devolved model of course has some challenges which we will be exploring further. The potential for duplication is high and sharing of best practice, and potentially resources, has to become a reality.

Early in the year, we undertook work to agree our statements of principle. It took time and a commitment with partners to agree these statements and the value is that these provide an anchor for research groups and the leaders of the LCRN when we need to focus, or make difficult and challenging decisions.

Our statements are:

The National Institute of Health Research (NIHR) Clinical Research Network: West of England will:

- *Ensure patients and healthcare professionals can participate in and benefit from research.*
- *Add value by optimising the use of available resources to ensure equality and equity of access for public, patients and staff to research.*
- *Facilitate, engage and develop the research community to embed excellence of research delivery within all areas of healthcare provision.*

We also agreed a set of financial principles and a methodology for allocating future finances. These principles are:

- *Maintain significant core stability when activity fluctuates.*

- *Encourage and incentivise activity delivery as this provides the majority of the overall funding available to the NIHR Clinical Research Network: West of England.*
- *Allow recognition of the resources associated with levels of exceptional activity, recognised when one particular study accounts for more than 35% of a partner organisation's (un-weighted and non-commercial) recruitment activity in any one calendar month.*
- *Provide resource to develop and grow new areas, in terms of geography, disease area, discipline or patient population.*
- *Recognise the need for a transfer of funding to address service transfers between partner organisations.*

We feel that the agreement to these principles with all partners and a commitment to live and work by them has significantly reduced the time taken to negotiate funding allocations and provides more space and time to concentrate on supporting research. The methodology for allocating funding continues to be refined in order not to compromise the principles and to recognise differential costs between geographies, organisational type and clinical area. Our financial planning in 2014/15 was less courageous and ambitious than it could have been, however we ended the year with a break even position against core funding and research capability funding, although we did have to return Research Capability Funding that we were unable to spend in year. In future years, the commitment from all partners to the financial principles will stand us in good stead to be bolder and more aspirational.

Our commitment to NHS engagement is unwavering. We pay testament to the leaders of our local healthcare organisations who have been actively engaged in the collaborative leadership of the network. They do this not only by attending our partnership group meetings and being available for small regular meetings with the LCRN leadership, but by continuing to champion an environment within their organisations that allows research to flourish, despite the increasing and complex challenges being faced by all NHS systems. These leaders recognise, as do we, that

> *"The role of a Trust Chief Executive as an active champion of research was felt to be a powerful means to develop a research-rich culture. In those organisations with a real sense of this, the role of research in delivering high quality care and achieving better patient outcomes was emphasised."* [2]

These leaders have also helped the leadership of the LCRN recognise the importance of a two way dialogue where we encourage researchers and research funders to consider research into key NHS priorities – both in priority clinical areas and in systems research for patient benefit.

We are committed to equity. We strive to identify and develop clinical leadership from non-medical professions. We have one Divisional Leader from our Black, Asian and minority ethnic (BAME) staff. We were not successful in appointing any women to clinical divisional leadership posts. However, at the level of the leadership of specialty groups we have had more success and have appointed 26 of 30 specialty groups, four of whom are from professions other than medicine. We will continue to actively seek leaders from women, BAME and non-medical professions, endeavouring to identify and articulate what the barriers to achieving this have been.

Naturally, our commitment to equity extends to our patients, and we gained agreement to establish a flexible staff team to drive research into new geographies and clinical specialties. The impact of this development will be assessed during 2015 - 2016. This is a change in

practice for our network which has historically worked under a fully devolved model. This rebalancing towards a mixed economy was again made possible by the leadership within the organisations who worked together for the network and agreed financial models that created both a contingency fund for organisations for whom research delivery would be threatened without the continuation or establishment of posts, and a development fund through which the flexible staffing group is resourced for the next two years. This 'top-slicing' of the available funds meant that all partners received a reduced allocation of funding – despite all of them having recruited more patients than the year before.

Case Studies:

1. NIHR CRN support for a University Hospitals Bristol NHS Foundation Trust PhD Clinical Training Fellowship has led to new information on the impact of rotavirus and rotavirus vaccination in children which will help hospitals with their winter planning. This work also has implications beyond the NHS, with several European countries which have not yet implemented the vaccine requesting further details of the work to inform their future immunisation strategies.

   Acute gastroenteritis is one of the commonest paediatric presenting complaints with the predominant cause being rotavirus. Almost all children will have suffered from rotavirus gastroenteritis by the time they are five years old. This work shows the large impact of the rotavirus vaccine programme, introduced in the UK in 2013. In comparison to average pre-vaccine seasons, in the first year after vaccine introduction there were approximately half the number of attendances diagnosed with gastroenteritis and a halving of gastroenteritis admissions at Bristol Royal Hospital for Children with 2 fewer occupied beds in the hospital every day during the six month period examined.

   Additionally the work has demonstrated that the effects that a child with rotavirus gastroenteritis has on their entire family's both quality of life and number of days missed from work are significantly greater than previously estimated. So the value of this new immunisation programme both to the NHS and UK as a whole is likely to have been much greater than was predicted[3].

   This work was greatly facilitated by the positive research culture in the Emergency Department at Bristol Royal Hospital for Children which has been enhanced in recent years by embedding part CRN funded nurses, with dual research and clinical roles, within the unit. Dr Marlow's next step following on from his PhD research will be to seek an NIHR Clinical Lectureship

2. As a network we recognise the crucial work being done with the life sciences industry and with pharmaceutical companies striving to bring new and better treatments to patients. Our model as a small network is for each Research Delivery Manager to oversee the commercial portfolio within their Division, ably supported by a talented industry facilitate who provides the single point of contact so heavily valued by our commercial partners. We have seen increasing level of activity in this portfolio. The new funding stream of nRCF for 2015/2016 has seen trusts within our locality recognised for their recruitment into the life sciences portfolio, with three studies reported as recruiting the first patient anywhere in the world (global first) and 37 studies recruiting the number of patients they committed to recruiting within the time scale set (recruiting to time and target). One of our local primary care research networks – the Bath Area Research Organisation Network (BARONET) – a

collaborative of over 27 General Practitioners working in 7 different practices is the first UK primary care organisation to be recognised as a Pfizer Inspire partner site. We aspire to build on the success of the established good practice in the BARONET group and establish a similar network in a different geography within our network.

3. Another notable recent success is the study into the treatment of the rare condition juvenile idiopathic arthritis associated uveitis – known as 'Sycamore'. Led by one of our local Chief Investigators Professor Ramanan at UH Bristol, this study was jointly funded by the NIHR Health Technology Assessment Panel and the Medical Charity Arthritis UK and assessed the efficacy of treating the uveitis with methotrexate and Adalimumab. The Trial Steering Committee recommended closure of the unblinded treatment phase of the study because the data strongly indicated a benefit of the IMP over placebo. This is an excellent example of collaborative working in which a complex trial driven by a local chief investigator, supported by the expertise of a specialist clinical trials unit and delivered by a network of clinical centres across the country will generate results that translate into routine clinical care for children with idiopathic arthritis associated uveitis.

Key actions to address areas of underperformance:

- Access and equity – development of flexible staff team to drive research into new geographies and clinical specialties
- Redistribution of funding using a fair transparent method of allocation plus the development of a contingency and development fund.
- Focus on women, BAME and non-medically qualified candidates in leadership roles

Integration with other initiatives and contributions to national groups and initiatives.

We have close and supportive working relationships with the West of England AHSN. The WEAHSN MD is a member of our partnership group; our Clinical Director is a member of their Board; our Chief Operating Officer is invited to the AHSN leadership seminars. The NIHR Clinical Research Network: West of England was launched at a joint event in 2014 by the WEAHSN. This provided the network with exposure and access to a new audience. The success of that event is building with a three way event planned in 2015 to include the CLAHRC *West*.

Our COO was until recently a member of the Knowledge and Information Steering Group and presented the work on the Open Data Platform with the Coordinating Centre CIO to the e-health insider awards panel. ODP was shortlisted as a finalist for the awards. Our consultant Nurse sits on the Strategic Workforce Group and has led the discussions around re-validation for research nurses at a national level. Our Division One Manager is also the National lead for children's and TYA Cancer and is on the Workforce Development Steering Group. Wherever possible, members of this LCRN attend national meetings

We jointly fund with the AHSN and CLAHRC a team of people to lead on public and patient engagement and involvement. We engage regularly with the Research Design Service to share best practice around costings for grant applications, leading, we anticipate, to fewer issues in the future, enabling sites across the country to set up and deliver more quickly. Our consultant nurse for research delivery is the national lead for research contributing to the nurse revalidation initiative, ensuring that delivery research nurses are adequately considered in the process. We

provide membership to all national workstreams and virtual working groups such as the virtual Business Intelligence Unit.

1. Recruitment in 2013/14 = 25,159. Recruitment in 2014/15 27,855
2. CRUK 2015 ‘Every Patient a Research Patient; Evaluating the Current State of Research in the NHS’
3. Assessing the impacts from one year of rotavirus vaccination in the UK, R. Marlow, P. Muir, B. Vipond, C. Trotter, A. Finn, Eurosurveillance, 2015 (in press)
4. personal communication, R. Marlow

Table 1: LCRN's contribution to the 2014-15 High Level Objectives

Objective		Measure	CRN Target	LCRN Goal-Target	LCRN actions-activities for 2014-15	Performance against plan
1	Increase the number of participants recruited into NIHR CRN Portfolio studies	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	650,000	Locally determined HLO goal for 2014-15 agreed with national Coordinating Centre: **27,816** Aspirational goal for 2014-15: **27,241**	To raise the profile of research within all partners to understand the importance of research in the care of patients. All staff to be able to act as ambassadors for research and explain the benefits for patients, the public and society. – ACTION by workforce development team/comms team. All CRN West of England funded staff and wider staff groups to understand their own individual responsibilities in increasing recruitment into trials. All staff plans to include individual objectives, with clear actions and milestone – action by Nurse Consultant (Research Delivery) and RDMs. All Divisions to have clear SMART Objectives around recruitment, implementation plans actions and milestones • All workstreams to have a SMART objective identifying their role in increasing recruitment, an implementation plan with milestones and deadlines, baseline measures & agreed KPIs: Action by COO • COMMS: to include celebrating and challenging; raising awareness; reach and use of new media; spreading the message of the benefits of research. Clear messaging about benefit to tomorrows patients and improved experience of today's patients • PCPIE: to include empowering our patients to expect inclusion in trials; support the roll out of 'opt-out' for Trusts and practices; raise the profile and benefits of research; support patient ambassadors in collaboration with NIHR and NHS England research and implementation strategies. • INFORMATION: to ensure timely accurate data and reports, working with researchers and members to agree best ways of reporting and displaying data • CONTINUOUS IMPROVEMENT: to challenge process and perceptions, supporting the other work streams to identify the process and perception improvements that can be made to	**HLO1** Actual recruitment: 27855 We are very pleased to exceed our target for recruitment however over 6000 of these patients were recruited into studies that are now closed to recruitment. Recruitment to these studies was relatively simple and required minimal resource **HLO7** Actual recruitment: 601 We exceeded this target as we were able to participate in an additional study during the year. **COMMS & ENGAGEMENT** • Well attended launch event in partnership with the West of England Academic Health Science Network. • Engagement events held with: researchers of all disciplines; specifically primary care; research professionals other than medics; • Workshops held on successful strategies for recruiting to commercial and non-commercial trials. • Bi-monthly newsletter launched • Plan for the use of social media developed – (launched May 2015) • Multiple ad-hoc meetings with colleagues, leaders and researchers in the locality • Partner organisations represented at all formal LCRN groups; all senior R&D Managers attend OMG; Research Directors attend Clinical Leaders and also rotate through the executive group. CEO attendance at Partnership Group. **PCPIE**: • Everyone Included (an opt out scheme for Trusts launched in Avon and Wiltshire Mental Health Care Trust • Join Dementia Research championed and includes a patient ambassador with a specific focus on this work • Member of a cross-collaborative PPI team (People and Health West of England https://www.weahsn.net/prwe/) in partnership with the CLAHRC West, and the West of England AHSN • Evaluation of the PHWE planned for 2015/2016 • Two engaged patient ambassadors attend Partnership Group **WORKFORCE:** • The Workforce Development Lead has visited Trust research

Objective	Measure	CRN Target	LCRN Goal-Target	LCRN actions-activities for 2014-15	Performance against plan
				increase performance. Agree, baseline and measure local Key Performance Indicators. • RM&G: to support a review of processes to ensure a supportive environment for researchers and industry so that studies set-up quickly and efficiently in the West of England • WORKFORCE DEVELOPMENT: Encourage new and younger principal investigators, including those from non-medical professions to ensure a growing vibrant community of researchers. Ensure all our staff understand their own roles and that of the network and agree their own roles in meeting the objectives. Appoint Consultant Nurse (research delivery) to drive performance, support and reorganise and invigorate staff and share the passion for caring for patients through research. • Consultant Nurse (research delivery) to support staff to identify and resolve all barriers – both real and perceived to recruitment into studies • Consultant Nurse (research delivery) to contribute to the evidence base around best practices in recruitment. West of England CRN to work with local acknowledged academic experts in recruitment issues to translate findings from methodological trials around recruitment practices into local practice. West of England AHSN to support this work. Work with local academic research leads to understand our areas of academic strength and ensure research protocols support best practices in recruitment Work as a network to understand what the balance of studies in our portfolio should be and support researchers and member organisations to achieve that balance Ensure Goal setting is achievable and agreed jointly with MOs. Monitor study recruitment monthly, mentor Trusts/ action plan for recruitment. Share and learn from other CLRNs	teams to discuss workload, capacity and skill mix. • Some teams have an in-balance of staff in more senior roles with senior staff undertaking research activities that more junior staff, if appointed, could perform • Sharing of best practice is emerging out of the Senior Research Professionals Strategic Group. • Our devolved structure places the onus for research team skill mix on the employing Trust who are faced with complex and conflicting resource allocation demands. Through the Operational Management Group NIHR Clinical Research Network: West of England management has been able to openly discuss and influence these issues. • Consultant Nurse for Research Delivery appointed May 2014 **TRAINING & EDUCATION:** • GCP training has been maintained and new facilitators have been made ready. • Facilitators have come forward for the nationally rolled out courses: 'Let's Talk Trials', 'Fundamentals of Research' and 'Cancer Researchers Introductory Course'. • 'Valid Informed Consent' and 'Dry Ice' training have also been provided by NIHR Clinical Research Network: West of England. • Facilitator skills workshops have successfully prepared staff for these roles. • Links have been made with CLAHRC West, WEAHSN and LETB locally. • Training needs were identified in the network support team and a programme has been partially delivered through the year. • The programme included elements of the Productive Leader workshops to great effect. Teambuilding events for the whole team and leadership skills events for the senior team have been held and form part of an ongoing development programme. • Non medic PI initiative. Plans for this project will activate in Q1 of 2015-16. The concept is well received by Divisional and Specialty leads who can see a rationalisation of the portfolios across staff groups. Roll out of the nationally developed PI workshop will start in Q2 of 2015-16 to support this initiative. **INFORMATION:** • Data and reports provided by the BI manager assisted by the BI officer, and with input from the CSP lead and the Acting Industry Manager as appropriate. Performance reports provided for Partnership Group, OMG, Executive Group, and Clinical Leadership Group. These reports have evolved over the past 12 months, in response to feedback.

Objective		Measure	CRN Target	LCRN Goal-Target	LCRN actions-activities for 2014-15	Performance against plan
						• Reports provided to RM&G teams (recruitment, CSP, Recruitment to time & target, commercial RAG, LPMS adherence to minimum dataset). Divisional/ specialty reports provided for RDMs. • Ad hoc reports provided as required. The reporting requirements of the LCRN are under review as part of the BI lead's Lean Six Sigma Greenbelt project.
2	Increase the proportion of studies in the NIHR CRN Portfolio delivering to recruitment target and time	A: Proportion of commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed Network sites	80%	80%	Ensure all staff understand that recruiting to time and target supports patients by enabling more patients to participate in trials; improves our reputation and creates an environment in which the West of England is recognised as a good area to place commercial contract studies Continued focus on feasibility to ensure achievable targets are set – including training and mentoring naïve staff, liaising with Clinical Research Speciality Leads to confirm targets, continued development of feasibility tools. Continued distribution of commercial RAG reports to CRN: West of England R&D depts. and to CRN: West of England Clinical Research Specialty Leads to monitor recruitment to time and target. Information team to ensure reports are helpful and timely Continued distribution of commercial bimonthly study updates to study teams and facilitation of established teleconferences between network study teams to share best practice Industry working group expanded to include representation from research nurses and support departments to further share best practice Industry Operations Manager to act as a single point of contact for issue escalation for Life Sciences Industry partners Industry Operations Manager to work closely with the Research Delivery Managers to design and implement appropriate risk management processes including contingency planning, project plans, risk analysis and innovative strategies	• Commercial RTT: 50% (8/16) • All RDMs have oversight of commercial activity in Divisions • Experienced Industry facilitator supports cross divisional working • Industry Working Group agenda now covered in OMG which has all RDMs and all senior Trust Research managers as members • Industry agenda central to all • The Baronet collaborative of 29 GPs and seven GP practices is the first Pfizer Inspire primary care site in the UK • UH Bristol are a preferred provider for Quintiles

Objective		Measure	CRN Target	LCRN Goal-Target	LCRN actions-activities for 2014-15	Performance against plan
		B: Proportion of non-commercial studies achieving or surpassing their recruitment target during their planned recruitment period	80%	80%	• Build closer relationships with CTUs and liaise/share intelligence on regular basis. • Work with acknowledged local academic experts on best practice for recruitment and translate that evidence into local practice. • Ensure study costings are accurately attributed throughout duration of research delivery pathway by reference to AcoRD guidance and through use of the Attribution of Costings and Activities Template (ACAT). • Accurate risk assessments of the deliverability of NIHR Portfolio studies to ensure feasibility at site. • Use of monthly RAG reports for benchmarking against partner organisations within the CLRN and to monitor progress. • Individualised RAG reports for studies rated Black or Red with exception reporting required for monitoring and addressing blocks to recruitment by action planning in conjunction with Specialty Group Leads/Divisional Leads and divisional Research Delivery Managers. • Proactive targeted interventions for specific clinical research studies to maintain performance during transition. • Participation in performance management calls with the national CRN Coordinating Centre Division staff and other LCRNs.	• Non-commercial RTT: 64% (25/39) which is an improving picture but far short of the target set. • Standing agenda item at OMG • All Trust senior research managers attend OMG • Three AcoRD specialists provide advice • ACAT in use in all trusts • Pilot of recruitment intervention for RCTs underway (work with Professor Jenny Donovan, CLAHRC West)
3	Increase the number of commercial contract studies delivered through the NIHR CRN	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	600	n/a	Assist researchers in communicating the benefits of studies being within the NIHR portfolio.	• We have encouraged local chief investigators to have their new studies adopted onto the NIHR portfolio
		B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II–IV studies	75%	n/a	Industry Operations Manager to act as the single point of contact to industry partners to explain the eligibility and feasibility process and highlight the benefits of inclusion on the NIHR Portfolio.	• Acting Industry Manager acts as single point of contact between the national coordinating centre and local researchers
4	Reduce the time taken for eligible studies to achieve NHS Permission through CSP	Proportion of eligible studies obtaining all NHS Permissions within 40 calendar days (from receipt of a valid complete application by NIHR CRN)	80%	n/a	• Major review of provision of RM&G services across the network commencing in Q1 to achieve single sign off across member organisations and efficient, effective use of RM&G resources. • Support for the HRA review • Provision of single point of contact for CSP during the research and development NHS Permissions process.	• Number of studies obtaining NHS Permissions within 40 days: 51 (84%)(total new studies n=61) • Active engagement with the HRA change process facilitated by the change champion who works in one of our partner trusts • Single point of contact for CSP is csp.westengland@nihr.ac.uk • Review of RM&G not undertaken due to HRA activity. • CSP reports produced monthly for member organisations

Objective		Measure	CRN Target	LCRN Goal-Target	LCRN actions-activities for 2014-15	Performance against plan
					Maintain performance of RM&G staff completing study-wide and local governance reviews by providing monthly RAG reports to all partner organisations and requesting feedback on CRN performance. Weekly study tracker provided to partner organisations to act as Visual Management Tool to monitor progress of studies through the NHS Permission process. Format and data to be agreed with members. Maintain competencies of RM&G staff by delivering ad-hoc CSP training and CSP Proportionate and Pragmatic training in key regulatory areas.	• Weekly CSP tracker acts as a tool for partners to check progress against the 15 day aspirational target • Face to face training provided by CSP facilitator for all new RM&G staff in partner organisations • CSP proportionate and pragmatic RM&G e-learning training provided through LMS (Radiation regulations, Data protection and Medical Devices Regulations
5	Reduce the time taken to recruit first participant into NIHR CRN Portfolio studies	A: Proportion of commercial contract studies achieving first participant recruited within 30 calendar days of NHS Permission being issued or First Network Site Initiation Visit, at confirmed Network sites	80%	80%	• Share best practice through CRN: West of England industry working group and merge topic and comprehensive ways of working. Run the Commercial Masterclass to ensure study teams are prepared to recruit first patient within given timeframe. The latter aimed at naïve commercial investigators. • Ensure all partners comply with NIHR costing template and standard contract Revisit WCLRN Delivery of the Life Sciences Agenda to merge ways of working for all topic and comprehensive staff–Essential CLRN Checklist for areas of best practice.	• Unable to report local metrics as portfolio does not record accurate date of recruitment for industry trials • Local data suggests that we are only meeting this metric 25% of the time which is of concern. • Industry group agenda now central to LCRN business and covered by OMG. • Initial commercial masterclass run and receiving good feedback with over 90% of participants rating the course as clear, interesting , useful, relevant and time well spent • All partner organisations comply with NIHR costing template and standard contract where these are provided by the sponsor. • All RDMs have oversight of commercial studies within their Divisions • Senior Commercial Research Managers in partner Trusts provide support and advice for sharing best practice and resolution of issues • Focus on benefits of commercial research in communications
		B: Proportion of non-commercial studies achieving first participant recruited within 30 calendar days of NHS Permission being issued	80%	80%	Use of monthly RAG reports for benchmarking against partner organisations within the CLRN and to monitor progress. Format and data to be agreed with members • Exception reporting for red and black RAG rated studies to identify and address blocks to recruitment particularly of first patient into study to pre-empt future recruitment issues. • Share best practice between member organisations and include methods of sharing in Workforce Development plans • Share best practice regionally and nationally to merge ways of working from topic and comprehensive networks	• Non-commercial FPFV: 23% (11/47) this is an improving but disappointing percentage. • Format of report developed, refined and agreed with members • Focus on FPFV in OMG

Objective		Measure	CRN Target	LCRN Goal-Target	LCRN actions-activities for 2014-15	Performance against plan
6	Increase NHS participation in NIHR CRN Portfolio Studies	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	99%	99%	Weekly notification of portfolio studies available to partner organisations and Specialty Group leads to maintain activity levels. Maintain 100% engagement and ensure any decreased levels of engagement are swiftly addressed	• 100% (17/17)
		B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	70%	70%	Scoping of CRN: West of England member organisations for opportunities for growth of commercial portfolio. • Continued roll out of Commercial Masterclass, aimed at naïve investigators who want to become involved in commercial research and possible mentoring schemes. Help new PIs to understand the benefits of working with industry: i.e. good support, training, access to regulatory training, close monitoring. • Continue to address negative perceptions of industry research through positive messages at engagement events; ambassadors for commercial research amongst PCPIE group. • Further development of commercial research activity in primary care utilising hub-spoke methodology in the North of Bristol • Support re-invigoration of the BARONET practices in Bath and Wiltshire • Implementation of mutual agreement of costs and contracts for all commercial studies in CRN: West of England • Industry Operations Manager to promote the CRN: West of England to commercial partners • Share learning with commercial leads in each member organisation/group of practices	• 82% (10/17) • Commercial masterclass run • Break out session during primary care engagement event to discuss barriers to commercial research in primary care • Feedback from this session has now been incorporated into a Lean Six Sigma project led by the RDM for primary care • The Baronet collaborative of 29 GPs and seven GP practices is the first Pfizer inspire primary care site in the UK • UH Bristol are a preferred provider for Quintiles
		C: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	25%	25%	Maintain current high levels of GMPs recruiting into NIHR CRN studies Start succession planning for current GP champions	• 83% (226/273) • Three GP champions receive sessional time from the locality, one of whom combines this role with that of Divisional Lead for Division Five
7	Increase the number of participants recruited into Dementias and Neurodegeneration	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	13,500	**462** (final target agreed with national CRN Coordinating	See Table 2	• 600 patients were recruited into DeNDRoN studies in NIHR Clinical Research Network: West of England in 2014/15 which is 138 above target (23% more than planned). • In 2013/14 389 patients were recruited into this specialty.

Objective		Measure	CRN Target	LCRN Goal-Target	LCRN actions-activities for 2014-15	Performance against plan
	(DeNDRoN) studies on the NIHR CRN Portfolio			Centre)		

Table 2: LCRN's contribution to the 2014-15 Specialty Objectives
Unless stated otherwise, the following are national targets for 2014-15.

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
Ageing	1	Increase the opportunities for patients to participate in NIHR CRN Portfolio studies	Establish mechanisms by which the age profile of NIHR CRN Portfolio study participants can be recorded	See note*	Appoint new lead build on the back of dementia portfolio.	*LCRN to complete: Commentary reporting on performance against plan for 2014-15 by Specialty, including summary of key achievements, issues and evidence of impact.* • Specialty Lead appointed
Anaesthesia, Perioperative Medicine and Pain Management	1	Increase the number of Anaesthesia, Perioperative Medicine and Pain Management commercial contract studies on the NIHR CRN Portfolio	Number of new Anaesthesia, Perioperative Medicine and Pain Management commercial contract studies entered onto the NIHR CRN Portfolio	4	Potential for growth linking in with hospice at Gloucester. Currently have 2 commercial studies open at present at CRN: West of England sites – 1 at NBT and 1 in primary care.	• Recruited into a commercial pain study in a hospice. • The Severn Trainees Anaesthetic Research Group (STAR) supported the ISOS trial (UKCRN ID 15731) SNAP (UKCRN ID 16249). • Despite discussions with the national specialty lead and local endeavours on the part of the Clinical Director and RDM, it did not prove possible to identify a specialty lead in 2014-15. The Clinical Director has reason to be hopeful that this situation will be resolved early in 2015-16. • Three commercial studies, one recruiting into primary care (specialty group lead appointed June 2015)
	2	Establish links with the Royal College of Anaesthetists' Specialist Registrar networks to support recruitment into NIHR CRN Portfolio studies	Number of LCRNs where Specialist Registrar networks are recruiting into NIHR CRN Portfolio studies	4		
Cancer	1	Maintain a minimum level of participation in interventional Cancer studies on the NIHR CRN Portfolio	Recruitment to interventional Cancer studies as a proportion of LCRN cancer incidence	7.5%	In 2012/13 CRN: West of England recruited 9.6% of cancer patients into interventional studies and similar levels are expected for 2013/14 and 2014/15. The CRN: West of England is noted as the second highest LCRN in terms of achieving against this metric.	• Cancer incidence for West of England = 9544. Total recruitment into interventional studies was 944 (9.9% of incidence).
	2	Increase recruitment into Cancer studies on the NIHR CRN Portfolio overall	Recruitment to Cancer studies as a proportion of LCRN cancer incidence	20%	In 2012/13 CRN: West of England recruited 24% of cancer patients into a portfolio study. Recruitment is expected to be at similar levels in 2013/14 and 2014/15 and the network is expecting to be one of the top performing network's in terms of this metric.	• Total recruitment to cancer studies overall was 2364 (24.8%).

* No target as this is a qualitative objective assessed by a descriptive text from each LCRN

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
	3	NIHR CRN Portfolio of Cancer studies serves the full range of cancer types in adults and children	Proportion of adult and child cancer types on the NIHR CRN Portfolio	100%	The portfolio of cancer studies available in the CRN: West of England compliments the patient population and serves the full range of cancer types.	• There is a strong paediatric oncology research group in the South West. • All patients are recruited in Bristol with shared care treatment and follow up arrangements at sites in the region. • The group meets 3-4 times a year to coordinate the portfolio and review resources. 127 children have been recruited in 2014-15.
	4	Cancer patients across England can participate in Cancer studies on the NIHR CRN Portfolio	Shared care arrangements between NHS providers within LCRN geographies	See note*	Shared care arrangements are in place for paediatric oncology patients –	• Clinicians have been encouraged to cross refer patient to sites where suitable studies are available • Information is disseminated via the Strategic Clinical Network Cancer Site Specific Groups. • First UK patient was recruited into a commercial lung trial at Cheltenham as a result of this system.
	5	Increase the proportion of NHS cancer care providers recruiting into NIHR CRN Portfolio Cancer studies	Percentage of NHS cancer care providers recruiting into Cancer studies on the NIHR CRN Portfolio	100%	All appropriate cancer care providers in the network are recruiting into NIHR CRN portfolio.	• All cancer care providers in NIHR Clinical Research Network: West of England are recruiting to NIHR CRN portfolio studies.
	6	Increase the proportion of cancer patients offered participation in research	Percentage of patients reporting being offered participation in research through National Cancer Patient Experience Survey	> 32%	All research teams are aware of the importance of offering appropriate patients the opportunity to enter cancer studies. It would, however, be expected that research is only offered to the proportion of patients for which an available trial is open. Feedback from the cancer patient experience survey will be collated for the CRN: West of England and discussed with local teams as appropriate.	• The National Cancer Patient Experience Survey 2014 showed that, for NIHR Clinical Research Network: West of England, 31% of patients were offered participation in research.
Cardiovascular Disease	1	Increase the number of Cardiovascular Disease commercial contract studies on the NIHR CRN Portfolio	Number of new Cardiovascular Disease commercial contract studies entered onto the NIHR CRN Portfolio	42	Link in with BRU at UH Bristol to expand commercial and Portfolio work, also opportunities in primary care, Gloucester and RUH Bath. We have 6 commercial studies open at present.	• A specialty lead has been appointed. Recruitment to commercial Cardiovascular (managing specialty) studies has nearly quadrupled (395% of 2013-14 recruitment) • The number of Cardiovascular (managing specialty) studies has grown with recruitment to 15 studies in 2014-15 (of 7 in the previous year). • Recruited to studies across all 6 Cardiovascular Sub-specialties.
	2	Increase access for patients to Cardiovascular Disease studies	Number of LCRNs contributing to multi-centre studies in the 6 Cardiovascular Disease sub-specialties	15		
Children	1	Increase the number of Children's commercial contract studies within the NIHR CRN	Number of Children's commercial contract studies on the NIHR CRN Portfolio	10%	• Maintain focus on timely & detailed return of site intelligence & site identification documentation to optimise site selection likelihood. • Continue to support clinical teams with study set up, to facilitate timely opening of commercial	• 7 commercial studies in 2014/15 • All acute trusts recruiting to Children's studies. Also recruiting through primary care. • Local delivery staff involved with delivery of paediatric specific

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
		Portfolio in each LCRN			studies. • Explore how/ whether existing models of MCRN support for commercial trials need adapting to the new LCRN models of working.	training thus ensuring good support available locally. • Major restructure of workforce completed
	2	All relevant sites that provide services to children are involved in research	Proportion of relevant sites recruiting to Children's studies on the NIHR CRN portfolio	95%	• Facilitate and encourage ongoing participation in CRN Children's studies at all acute trusts with full paediatric departments. • Scope out whether there are other children's healthcare settings which can contribute to NIHR studies.	
	3	Recruitment of children to NIHR CRN Portfolio studies is undertaken by individuals with appropriate paediatric training and experience, or who are appropriately	Proportion of staff consenting children to NIHR CRN Portfolio studies who are paediatric trained and/or experienced, or who are appropriately supervised	100%	• Identify any studies on the LCRN portfolio where this is not the case. • Engage senior leadership for the Children's specialty as necessary to enter into dialogue with PIs/Cis around changing the status quo for any studies where children aren't being recruited by appropriate paediatric trained and /or experienced staff. • Allocate LCRN resource as necessary to support consent by appropriate staff.	
Critical Care	1	Increase the number of intensive care units participating in research	Proportion of intensive care units recruiting into studies on the NIHR CRN Portfolio	80%	Currently working well, potential growth of 10% increase in the number of studies.	• 10 critical care studies recruited in 2014-15 (managing + supporting specialty) compared with 9 in the previous year. • All seven ICUs in NIHR Clinical Research Network: West of England recruited to critical care studies in 2014-15 • Although recruitment to critical care managed studies dipped slightly, when recruitment to the ISOS trial is included, overall a significantly boosted volume of overall activity was seen. • Issues have been experienced with respect to availability of pharmacy production (a.m. only) for a commercial trial at one site. This has been explored further by the specialty lead, RDM and the Trust's Commercial Trial R&D manager. • The RDM has obtained feedback from other LCRNs on their access to pharmacy production facilities and a local work around solution has been put in place by the research team and pharmacy in the first instance. • The specialty Lead has been appointed.
Dementias and Neurodegeneration (DeNDRoN)	1	Implement arrangements for local use of the "Join Dementia Research system to support study recruitment	A: Proportion of NHS Trusts which provide dementia services, which have put in place generic arrangements for access to medical records, with consent, for the "Join Dementia Research" system users	50%	Objective 1 actions: • Provide project management support to contribute to national RAFT programme and implement local delivery of "Join Dementia Research" system • Suitably resource all "Join Dementia Research" system related activities and identify an implementation lead • Using local intelligence identify current and projected studies that would benefit from a	• All objective 1 actions as outlined in the plan have been met with the exception of the final action "Suitably resource and maintain financial and operational support for the use of the existing regional disease specific registers for neurodegenerative diseases and dementing conditions, to recruit people to Parkinson's disease (Pro-DeNDRoN) and motor neurone disease (Moto-DeNDRoN) studies". • Nine delivery staff (target six) newly rater trained • Seven experienced raters identified • Seven further staff identified for training

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
			B: Proportion of LCRN staff working on Dementias and Neurodegeneration (DeNDRoN) studies trained to use the "Join Dementia Research" system	60%	register approach • Gain researcher agreement to recruit from "Join Dementia Research" system and support them with information • Target "Join Dementia Research" system information to key PIs and trust R&D depts. • Implement governance policies and recruitment processes defined by "Join Dementia Research" system to support implementation • Communicate key study requirements to the researcher community • Oversee studies using "Join Dementia Research" system at study launch • Identify changes required for ways of working and use continuous improvement model to agree new processes with stakeholders • In conjunction with R&D departments and RDM, agree and implement local training plan for research support staff • Incorporate training in induction for new staff • Proactively engage with RC Psych MSNAP services to agree ways to promote research participation and "Join Dementia Research" system to their patients as standard practice • Contact memory services, provide "Join Dementia Research" system information and encourage its use • Provide support where appropriate to NHS dementia services to access and make use of the implementation and communications toolkit • Suitably resource and maintain financial and operational support for the use of the existing regional disease specific registers for neurodegenerative diseases and dementing conditions, to recruit people to Parkinson's disease (Pro-DeNDRoN) and motor neurone disease (Moto-DeNDRoN) studies Objective 2 actions: • Identify staff to attend CRN rater training programme • Provide financial support (cost of training £450 plus travel and accommodation) for minimum of 6 DeNDRoN delivery staff to attend national psychometric and global rater training in 14/15 • Identify / appoint lead research nurse(s) (or other allied health professional(s) / clinical trials officer(s) to provide professional leadership • Include time and budget to facilitate attendance	Objective Three • Join Dementia Research prioritised over ENRICH Objective Four • Specialty Group Lead appointed • Good engagement with local dementia staff • Co-Division Four lead covering HD/PD/MND lead roles
	2	Increase the global and psychometric rating skills and capacity of LCRN staff supporting Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	A: Percentage of research sites covered by at least 2 trained raters who are registered on the national rater database	80%		
			B: Proportion of LCRN staff who support Dementias and Neurodegeneration (DeNDRoN) studies who have successfully completed rater training and joined the national rater database	35%		
	3	Improve access to research for people living in care homes	Proportion of registered care homes participating in NIHR CRN Portfolio studies	20%		
	4	Increase clinical leadership capacity and engagement in each of the main disease areas in the Dementias and Neurodegeneration (DeNDRoN) specialty	Number of LCRNs with local clinical leads in each of the main disease areas (dementias, Parkinson's disease, Huntington's disease and motor neurone disease)	15		

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
					at monthly teleconferences and bi-annual meetings Objective 3 actions: • Provide project management support to contribute to national programme and implement local delivery of ENRICH • Identify ENRICH lead to participate in national monthly ENRICH Delivery Team meetings • Develop and implement an engagement strategy to raise awareness • Provide continued research support to proactively engage with care home owners, managers and other forums to assist with growth of local and national research ready network Objective 4 actions: • Identify senior leader in LCRN to take overall responsibility in delivering the dementia plan • Identify and appoint clinical research lead in each of the 4 disease areas (dementia, HD, MND, PD) • Include time and costs for post holders to attend monthly teleconferences and national bi-annual meetings	
Dermatology	1	Increase the opportunities for patients to participate in Dermatology studies on the NIHR CRN Portfolio	A: Proportion of health care providers of dermatology services recruiting into Dermatology studies	50%	Build on effective South West working and increase the number of studies by 10%	• Specialty Group Lead appointed April 2015 • No recruitment in 'wound' centres
			B: Number of 'wounds' treatment centres recruiting into wounds trials	30		
Diabetes	1	Achieve a minimum level of participation in diabetes studies	Proportion of people with diabetes (prevalence rates) recruited into Diabetes studies on the NIHR CRN Portfolio	0.5%	Re-engage with local clinicians, appoint new specialty lead: 1) Review recruitment arrangements for TrialNet Natural History and TCells studies in Bath and Weston super Mare to maximise recruitment. 2) Provide local Administration within Division 2 to support sending out study invite letters to patients registered on the ADDRESS-2 database. Open ADDRESS-2 in Bath. 3) Support Primary Care providers to open diabetes commercial contract and non-commercial	• New specialty lead appointed in quarter 4. • RUH Bath significantly increased recruitment to TrialNet from seven to 27 • Administrative support was not required. RUH Bath has previously been approached to take part in ADDRESS 2 and declined. This is being re-explored. • The Nurse Consultant for Research Delivery is working with the LCRN's primary care team and with the RDM for Diabetes to explore expanding primary care delivery of diabetes studies. 14% of recruitment to diabetes (managing + supporting specialty) in 2014-15 was attributed to primary care. Additionally, primary care sites acted as PICs for some secondary care studies.
	2	Increase the number of newly diagnosed people with type 1 diabetes in research	Proportion of patients identified via ADDRESS 2 recruited into Diabetes studies on the NIHR CRN Portfolio	5%		

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
	3	Increase the proportion of NHS providers recruiting into Diabetes studies on the NIHR CRN Portfolio	A: Proportion of primary care providers recruiting participants into Diabetes studies on the NIHR CRN Portfolio	4%	trials. 4) Open 2 adult diabetes studies in Swindon. 5) Ensure all Address-2 sites have robust referral systems for newly diagnosed Type 1 diabetes patients in place.	• ADDRESS 2 opened in Swindon. • Recruitment to ADDRESS 2 continues to be challenging in the region. Feedback from one site recruiting to a commercial study indicated that utilising good links with the clinical diabetes nurse specialists provided an effective and reliable way to identify newly diagnosed patients for the study. • In some sites TrialNet is "more popular" than ADDRESS 2 as results are provided to participants. Work is ongoing to improve recruitment to ADDRESS 2.
			B: Proportion of secondary care providers recruiting participants into Diabetes studies on the NIHR CRN Portfolio	83%		
	4	Improve the referral systems in place for newly diagnosed people with type 1 diabetes	Proportion of secondary care trusts with referral systems in place for newly diagnosed people with type 1 diabetes	80%		
Ear, Nose and Throat (ENT)	1	Increase the number of ENT commercial contract studies on the NIHR CRN Portfolio	Number of new ENT commercial contract studies entered onto the NIHR CRN Portfolio	2	No commercial studies at present. Potential to explore growth with North Bristol NHS Foundation Trust. (NBT)	• New ENT Specialty Lead is a research active Clinical Scientist (Audiology) and has been meeting with ENT departments across the network • .Recruitment exceeded target at two sites for a commercial study (Gloucester 25% above target and UHBristol 40% above target). • UHBristol ENT clinicians met with their R&D team to consider ways of growing their portfolio research activity. • ENT research delivery was limited in NIHR Clinical Research Network: West of England by study availability. • Expressions of interest have been returned for ENT studies where available.
Gastroenterology	1	Increase the proportion of patients recruited into Gastroenterology studies on the NIHR CRN Portfolio	Number of participants (per 100,000 population), recruited into Gastroenterology studies on the NIHR CRN Portfolio	10	We have 3 commercial studies open at present at Gloucester and UH Bristol. Potential to grow Portfolio at NBT.	• Data from the Coordinating Centre indicates NIHR Clinical Research Network: West of England successfully recruited 35 patients per 100,000 to portfolio gastroenterology studies (5th highest of the 15 LCRNs). • All acute trusts and some primary care sites within NIHR Clinical Research Network: West of England recruited to portfolio gastroenterology studies. • Two of seven acute trusts (29%) recruited to commercial gastroenterology studies. This included recruitment to 5 ulcerative colitis studies and 2 Crohn's studies.
	2	Increase the number of NHS Trusts actively participating in Gastroenterology studies on the NIHR CRN Portfolio	A: Proportion of NHS Trusts participating in Gastroenterology studies on the NIHR CRN Portfolio	90%		
			B: Proportion of NHS Trusts participating in	35%		

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
			Gastroenterology commercial contract studies on the NIHR CRN Portfolio			
Genetics	1	Increase access for patients with rare diseases to participate in Genetics studies in the NIHR CRN Portfolio	Number of LCRNs participating in multi-centre genetics studies through the NIHR UK Rare Genetic Disease Research Consortium	14	Establish novel ways of working with Genetics Staff: Agree governance processes for genetics studies.	• Genetics Clinical Specialty Lead appointed. • Participating in multi-centre genetics studies through the NIHR UK Rare Genetic Disease Research Consortium as outlined in measure
Haematology	1	Increase the participation of NHS organisations in Haematology studies on the NIHR CRN Portfolio	A: Number of open Haematology studies in each LCRN	4	Link in with cancer portfolio Baseline and measure	• Haematology Clinical Specialty Lead appointed, with clear aims and objectives. • 10 open haematology studies in NIHR Clinical Research Network: West of England (Target 4). • 1 Commercial haematology study open in NIHR Clinical Research Network: West of England (and supporting specialty for others) (Target 1). • We have recruited into two non-commercial and one commercial trial through the Bristol Haemophilia Centre • No other large haemophilia centres in the region.
			B: Number of open Haematology commercial contract studies in each LCRN	1		
	2	Increase the involvement of haemophilia centres in supporting Haematology studies on the NIHR CRN Portfolio	A: Proportion of haemophilia centres recruiting patients into Haematology studies on the NIHR CRN Portfolio (comprehensive care)	90%		
			B: Proportion of haemophilia centres recruiting patients into Haematology studies on the NIHR CRN Portfolio (large centres)	50%		
Hepatology	1	Increase access for patients to Hepatology studies on the NIHR CRN Portfolio	Number of LCRNs contributing to a multi-centre study in all of the six major study areas (viral hepatitis, NAFLD, autoimmune liver disease, metabolic liver disease).	15	Enthusiastic local researchers, room for considerable expansion of activity.	• NIHR Clinical Research Network: West of England recruited to 2 commercial and 2 non-commercial hepatology studies (two hepatitis C studies, a hepatic encephalopathy study and a genetics study). • Four acute trusts were involved. • In the first quarter of 2015-16 the hepatology speciality lead was appointed. • No available metabolic disease studies on the portfolio
Infectious Diseases and Microbiology	1	Increase awareness of the Infectious Diseases and Microbiology specialty through the identification of a local	Number of LCRNs with an identified clinical local champion for infectious disease public health	15	• Previous WCLRN Lead active • Local CI-driven Portfolio. • Encourage participation in studies led from outside the LCRN	• A clinical lead has been appointed to fulfil the roles of Infectious diseases and microbiology specialty lead and urgent public health champion. • NIHR Clinical Research Network: West of England has recruited to at least six antimicrobial resistance studies (as manually

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
		champion	emergencies		• Identify clinical local champion • Identify and participate in antimicrobial resistance research studies; identify any local barriers to participation and address	identified and categorised by the Coordinating Centre) in 2014-15. • Nearly 5000 patients were recruited to "Economic Evaluation of the Aptima TV TMA" study (UKCRN ID 13287) at UH Bristol.
	2	Increase access for patients to Infectious Diseases and Microbiology studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into antimicrobial resistance research studies on the NIHR CRN Portfolio	15		
Injuries and Emergencies	1	All NHS major trauma centres to support recruitment into NIHR CRN Portfolio studies	Proportion of NHS major trauma centres recruiting participants into NIHR CRN Portfolio studies	100%	• Strong local leadership and activity. • Grow and nurture new Clinical Lead.	• 8/9 Emergency Departments recruited to portfolio studies in 2014-15. (89%). • Great Western Hospital have seen particularly strong growth in ED department research with an increase in Injuries & Emergencies badged study recruitment from 17 participants in 2012-13 to 147 participants in 2014-15.
	2	Increase the number of NHS emergency departments supporting recruitment into NIHR CRN Portfolio studies	Proportion of NHS emergency departments recruiting into NIHR CRN Portfolio studies	30%		
Mental Health	1	Increase the number of principal investigators supporting Mental Health commercial contract studies	Number of principal investigators working on open Mental Health commercial contract studies on the NIHR CRN Portfolio	95	• Conjoin mental health trust provision. Both our mental health Trusts participate in NIHR studies. Support needed for expansion in both trusts. • To be added to workforce development plan • Support third sector providers. • Ensure new providers are research active by contractual obligations.	• Only one commercial study open in mental health portfolio in region in 2014/15 due to a slowdown in number of available studies open to expressions of interest on this portfolio.
	2	Maintain the skills and capacity of staff supporting Mental Health Portfolio studies in frequently used Mental Health study eligibility assessments (e.g. PANSS)	Number of staff trained in frequently used Mental Health study eligibility assessments	139		
Metabolic and Endocrine Disorders	1	Support patient access to Metabolic and Endocrine Disorders studies on the NIHR CRN Portfolio	Number of LCRNs supporting established studies of rare diseases in metabolic and endocrine disorders	15	• Discuss with local clinicians and appoint new lead. • Cross-fertilisation and growth with Diabetes	• Efforts continuing to identify a specialty group lead • NIHR Clinical Research Network: West of England has contributed recruitment to five studies led by this specialty and three studies supported by this specialty. • This has included recruitment to the following rare disease study: Genetics of Endocrine Tumours (UKCRN ID 4663).
	2	Increase the number of Metabolic and Endocrine Disorders studies on the NIHR CRN Portfolio	Number of new Metabolic and Endocrine Disorders studies on rare diseases entering the NIHR CRN Portfolio	4		
Musculoskeletal	1	Increase the opportunities for patients to participate in	Proportion of Musculoskeletal service	75%	We have 3 commercial studies at present at CRN: West of England sites, potential for growth at the	• Eight out of ten Trusts recruit to this specialty • Four commercial studies recruiting from two Trusts

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
		Musculoskeletal studies on the NIHR CRN Portfolio	providers recruiting into NIHR CRN Portfolio studies		Min, NBT and Great Western. Enhance non-medical input e.g. AHPs	• Specialty Group lead appointed (Occupational Therapist)
	2	Increase the number of Musculoskeletal commercial contract studies on the NIHR CRN Portfolio	Number of new Musculoskeletal commercial contract studies entered on to the NIHR CRN Portfolio	30		
Neurological Disorders	1	Increase the number of NHS Trusts recruiting into Neurological Disorders studies on the NIHR CRN Portfolio	Number of previously inactive NHS Trusts which now are recruiting into Neurological Disorders studies on the NIHR CRN Portfolio	15	• 1 commercial study open at present at Gloucester and NBT – potential to explore further studies at these sites. • Service provision complex with difficulty of recruitment of new consultant staff. • Facilitate new members of staff to become research active.	• Continued efforts being made to increase engagement in the Neurological Disorders clinical community. • 9 studies open across the region. 5 trusts recruiting to ND studies in the region. • Recruitment increased in 2014/15 to 270 from 29 in 2013/14. • One previously inactive Trust now second highest recruiting trust in NIHR Clinical Research Network: West of England. • 3 PI's for commercial studies (increased from 2013/14).
	2	Increase the number of principal investigators supporting Neurological Disorders commercial contract studies	Number of principal investigators working on open Neurological Disorders commercial contract studies on the NIHR CRN Portfolio	58		
Ophthalmology	1	Increase the number of Ophthalmology commercial contract studies on the NIHR CRN Portfolio	Number of new Ophthalmology commercial contract studies entered onto the NIHR CRN Portfolio	4	• Region does very well for commercial studies at UH Bristol and Gloucester, with potential for growth at Great Western, Swindon. Provide mentorship and support from Gloucester. • Build on success of Bristol partnership and culture towards a research prioritised clinical service.	• An ophthalmology lead appointed. • Recruitment to 14 commercial ophthalmology studies (including ophthalmology as a managing or supporting specialties) accounted for 57% of recruitment to this specialty (27 studies in total for the specialty). • UHBristol (Bristol Eye Hospital), Great Western Hospital in Swindon and Gloucestershire Royal Hospitals recruited to ophthalmology trials (including commercial studies at all these sites. • At Bristol Eye Hospital a new Clinical Research Manager has come into post during the financial year.
	2	Increase the number of NHS Trusts participating in Ophthalmology research	Number of NHS Trusts recruiting patients into Ophthalmology studies on the NIHR CRN Portfolio	100		
Oral and Dental	1	Increase the opportunities for patients to participate in NIHR CRN Portfolio studies	Number of Oral and Dental studies on the NIHR CRN portfolio recruiting in each LCRN	1	• No commercial studies at present – potential to explore at dental hospital at UH Bristol and to link in with university departments for growth. Establish pharmacy champion role, modelled on successful GP champion role. • Share best practice and culture change with geographically adjacent Ophthalmology service.	• No commercial trials available on portfolio • Two studies recruiting from two Trusts • Pharmacy champion not appointed
	2	Increase the number of Oral and Dental commercial contract studies on the NIHR CRN Portfolio	Number of open Oral and Dental commercial contract studies on the NIHR CRN Portfolio	2		
	3	Offer a balanced portfolio of studies to practitioners and	A: Proportion of Oral and Dental studies on the NIHR CRN	20%		

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
		participants	Portfolio recruiting from a primary care setting			
			B: Proportion of participants recruited from a primary care setting into Oral and Dental studies on the NIHR CRN Portfolio	50%		
Primary Care	1	Increase the opportunities for patients to participate in NIHR CRN Portfolio studies	A: Proportion of GP sites registered as research capable[1]	35%	• In 2013/2014 46.1% of practices were registered as research capable. • A number of pharmacists are research active within the NIHR CRN West of England, and it is anticipated that securing the services of one to be a Pharmacy Champion will be achieved in 2014/2015	• 85% of practices are now registered as research capable • Many practices recruiting low numbers; fewer recruiting high numbers • Consultant nurse to support new flexible team working in primary care to reverse this • Research Support Initiative reviewed, revised and implemented in year
			B: Proportion of GP sites within any individual CCG registered as research capable	5%		
	2	Improve research engagement with community pharmacy	Number of LCRNs with a community pharmacy Research Champion	15		
Renal Disorders	1	Increase the proportion of Renal Disorders commercial contract studies on the NIHR CRN Portfolio	Proportion of commercial contract studies in relation to the total number of Renal Disorders studies on the NIHR CRN Portfolio	20%	3 commercial studies open at present, continue growth at NBT and also explore Bath RUH and Gloucester. Appoint new lead and build on new renal Health Integration Team	• New Specialty lead appointed. • 2 of the 27 renal studies (managing or supporting specialty) that recruited in NIHR Clinical Research Network: West of England in 2014-15 are commercially sponsored studies. • An increased number of participants in renal studies were seen at RUH in Bath compared with previous years • Gloucestershire Hospitals continued to recruit to renal studies. • Seven Trusts recruited to renal studies.
	2	Improve the promotion of research to patients with Renal Disorders	Proportion of renal units actively promoting research to patients	50%		
Reproductive Health and Childbirth	1	Increase the number of Reproductive Health and Childbirth commercial contract studies on the NIHR CRN Portfolio	Number of Reproductive Health and Childbirth commercial contract studies on the NIHR CRN Portfolio	4	1 commercial study at present at UH Bristol and scope for growth at Gloucester and NBT. Potential identified midwifery champion at the RUH Bath (Sara Burnard)	• Three commercial studies on the portfolio (growth from one in 2013/14) • Clinical specialty lead is job shared with a midwife • Midwifery champion identified
	2	Increase engagement and awareness of the Reproductive Health and Childbirth Specialty	Number of LCRNs with an identified midwifery champion to increase engagement and awareness	15		

[1] Registered Research Capable Sites are those sites working with the LCRN which have the capacity and capability to support NIHR CRN activities

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
Respiratory Disorders	1	Increase access for patients to participate in Respiratory Disorders studies on the NIHR CRN Portfolio	Number of LCRNs recruiting participants into studies in the Respiratory Disorders main disease areas of asthma, COPD and pneumonia	15	Focus on non-pleural disease, focus on improving recruitment in UH Bristol and Great Western	• The speciality lead has been appointed and is the Chief Investigator for three multicentre studies that have recruited in NIHR Clinical Research Network: West of England in 2014-15. • NIHR Clinical Research Network: West of England recruited to 4 COPD studies (UKCRN IDs: 15696, 17828, 15256, 16676) and 2 asthma studies (UKCRN Ids: 14257, 18206) but not to any pneumonia studies (only one pneumonia study on the portfolio: (*March 2015 division 6 specialty report from Coordinating Centre)*) • Great Western Hospital in Swindon recruited to 4 respiratory studies in 2014-15 (same number in 2013-14). UHBristol increased the number of studies in recruited to in 2014-15 to 7 (5 in the previous year).
	2	Increase the number of participants recruited into COPD and Asthma studies on the NIHR CRN Portfolio	Percentage of COPD and Asthma participants recruited into Respiratory Disorders studies on the NIHR CRN Portfolio	10%		
Stroke	1	Increase the proportion of patients recruited into Stroke randomised controlled trials on the NIHR CRN Portfolio	Number of patients (per 100,000 population) recruited into Stroke randomised controlled trials on the NIHR CRN Portfolio	8	Capitalise on already effective functioning both service and research network. Appointment of a non-medical lead for stroke to explore. For commercial studies, engaged teams at RUH Bath and keen team at UH Bristol who are wanting to take on more commercial stroke studies 1. Ensure recruitment to RCTs is maintained according to prediction in already active sites and prioritise opening stroke RCTs in North Bristol Trust. 2. Review new Stoke commercial Contract and medical technical studies and proactively encourage EOIs from sites where recruitment is feasible.	• It was not possible to appoint a non-medical lead for stroke as hoped. However, it is hoped that a stroke lead will be appointed early in 2015-16. • Recruitment to studies led by the stroke specialty dipped slightly in 2014-15 relative to the previous year, but conversely, when studies where stroke is the supporting specialty are included, a modest rise in recruitment for this period becomes apparent. • 8/16 stroke led studies in NIHR Clinical Research Network: West of England in 2014-15 were randomised studies, recruiting 96 patients • Recruitment to stroke led commercial trials took place at 4 acute trusts (including RUH Bath and UHBristol) and in primary care. All trusts with acute stroke care services contributed to stroke studies in 2014-15.
	2	Increase the number of commercial Stroke studies on the NIHR CRN Portfolio	A: Number of new commercial contract Stroke studies on the NIHR CRN Portfolio	5		
			B: Number of new medical technical studies in Stroke on the NIHR CRN Portfolio	2		
	3	Increase the proportion of NHS Trusts, providing acute Stroke care, recruiting to Stroke studies on the NIHR CRN Portfolio	Proportion of NHS Trusts, providing acute Stroke care, recruiting participants into Stroke studies on the NIHR CRN Portfolio	80%	All NHS Trusts in network providing acute Stroke Care are recruiting. Continue these levels of engagement.	
	4	Increase activity in NIHR CRN Hyperacute Stroke Research Centres	A: Number of patients recruited to hyperacute Stroke studies on the NIHR CRN Portfolio in each NIHR CRN Hyperacute Stroke Research Centre (HSRC)	50	None in the LCRN geography	
			B: Number of patients	15	No hyper-acute unit in our geography.	

Specialty	Ref.	Objective	Measure	National Target	LCRN actions to achieve objective(s)	Performance against plan
			recruited to complex hyperacute Stroke studies on the NIHR CRN Portfolio in each NIHR CRN HSRC			
			C: Number of HSRCs recruiting to Stroke commercial contract studies on the NIHR CRN Portfolio	8		
Surgery	1	Increase the number of NHS Trusts supporting Surgery studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting patients into Surgery studies on the NIHR CRN Portfolio	75%	• Surgical Trials Unit opened at UH Bristol, therefore strong infrastructure to grow portfolio studies. • Continue to build relationships with academic surgery units at the University of Bristol • Recruit to ISOS	• A new surgery Specialty Lead has been appointed. • There was a significant increase in recruitment to studies led by the surgery specialty in NIHR Clinical Research Network: West of England in 2014-15. • This increase can be attributed to the recruitment of 446 participants across 6 acute trusts to the ISOS trial, accounting for 58% of the recruitment to studies led by this specialty. • UHBristol exceeded their recruitment target for a challenging commercial surgery study (UKCRN ID 13784), that was struggling to recruit to target elsewhere in the country. The local study team were able to share best practice, via feedback to the Coordinating Centre. • Work continues with Professor Jenny Donovan to develop a recruitment intervention to support recruitment into RCTs.
	2	Increase the proportion of surgery patients recruited into Surgery studies on the NIHR CRN Portfolio	Number of participants (per 100,000 surgical admissions) recruited into Surgery studies on the NIHR CRN Portfolio	50	As above	

Table 3: LCRN's achievement against the 2014-15 Operating Framework Compliance Indicators

Domain		Objective	Information requested in Annual Report Commentary	Commentary on LCRN Performance in 2014-15
1	**LCRN Management Arrangements**	A: Clinical Research Leads, Clinical Research Specialty Leads, Divisional Research Delivery Managers, Cross-Cutting Team and Support Team are in post	Provide brief reflective commentary on local performance in 2014-15	• Teams merged from previous topic and comprehensive research networks • Five out of Six clinical Research Leads appointed. We did strive to include women and non-medical health professionals in this leadership group but were not successful • Most (n = 26) of the specialty group leads and 12 out of 13 of the cancer sub-specialty leads have been appointed and here we were more successful with appointing women (8) and non-medical health professionals(4) to these leadership roles
		B: LCRN leadership and management groups are established (LCRN Executive Group, Clinical Research Leadership Group and Operational Management Group)	Provide brief reflective commentary on local performance in 2014-15	• All groups established. Strategy to include Trust R&D staff (senior managers or and Directors) in all levels of formal groups. Welcomed and supported by members. • Attendance at Clinical Research Leadership and Operational Management Group is exceptional with full engagement from members • Executive Group established with full attendance. • Partnership Group established and after a good start, needed to be improved to secure the support of the partner organisations. The COO and CD met with each CEO individually to understand the barriers to participation and priorities for each organisation and the following actions taken: in year meeting dates moved to meet immediately after the WEAHSN Board meeting to allow for best use of time. Agenda re-written with support from CEOs to ensure appropriate to level of attendee. Reports re-worked on advice from CEOs Attendance has improved
2	**Research Delivery**	A: LCRN Partner organisations adhere to specified national systems and Standard Operating Procedures in respect of research delivery	Provide brief commentary reflecting on local performance in 2014-15 in relation to: • Adherence to National SOPs for commercial service delivery • Contribution to the national Study Support Service programme • Implementation of local elements of the Study Support Service	• All RM&G staff, based within central team or within partner organisations recognise and support the transition to a national Study Support Service • The team continue to contribute time knowledge skills and enthusiasm to the national programme of work • The local HRA change champion is a member of OMG and provides regular feedback and supports discussion and involvement
		B: Timely processing of study wide and local reviews within the CSP process (15 days respectively)	Provide brief reflective commentary on local year to date performance for 2014-15[2]	• The commitment to lean practice ensures that both partner organisations and core LCRN team achieve these targets consistently with 80% of study wide reviews achieved in 15 days or less. 86% of local reviews completed in 15 days or less. • Achieving these targets is now considered business as usual

[2] For performance data please refer to the March 2015 LCRN Management Group report (on the Information Managers' portal or the vBIU)

Domain		Objective	Information requested in Annual Report Commentary	Commentary on LCRN Performance in 2014-15
		C: Support the delivery of the Government Research Priority of Dementia		Addressed through completion of Tables 1 & 2
3	**Patient, Carer and Public Involvement and Engagement (PCPIE)**	Promote research opportunities in line with the NHS Constitution for England, including informing patients about research conducted within the LCRN and actively involving and engaging patients, carers and the public in research	Provide brief reflective commentary on local performance in 2014-15 to include examples of methodologies employed to understand patient experience	• NIHR Clinical Research Network: West of England is taking a collaborative approach to PPI with the WEAHSN and CLAHRC West by having a joint PPI strategy group and cross network team ensuring maximum opportunities available to patient's carer and the public for involvement in research whilst minimising duplication of effort around common issues such as payment. The strategy group comprises 8 patient representatives and 4 organisational representatives and are known as People in Health West of England (PHWE). Two of the patient representatives on the patient group sit on the partnership group of NIHR Clinical Research Network: West of England. • This cross cutting strategy group and team ensure that NIHR Clinical Research Network: West of England objectives are incorporated into both their strategy and operational plan. The team has supported national objectives including the 'OK to Ask' and Patient Ambassadors initiatives. All project working groups (e.g. communications and training) being led by the PHWE strategy group includes active patient involvement throughout the entire process. • Other examples of active involvement have included an active lay champion for the launch and roll out of Join Dementia Research. • The pilot year for the opt-out system (Everyone Included) has progressed, with further refinements required before full roll out across the whole region. One clear outcome from this pilot year has been an increase in the awareness of both R&D and clinical research within that trust.
4	**Continuous Improvement**	Promote and sustain a culture of innovation and continuous improvement across all areas of LCRN activity to optimise performance	Provide brief reflective commentary on local performance in 2014-15	• Championed by the Chief Operating Officer • Adopted continuous improvement as business as usual • Continuous Improvement manager was seconded into the team for six months to develop templates and build skills within team for CI • Workshops held with RDMs to capture existing evidence and knowledge and introduce new ways of working • Core Team Standard Operating Procedure of Ways of Working Agreed, supporting transition to one network • Two RDMs have received formal training in lean six sigma and one Trust R&D manager supported to receive training • Some partner organisations already have significant skills in this area and sharing of best practice facilitated by the network core staff • Productive meetings management, email management delivered with good effect to core team • RM&G review not undertaken in year due to proximity of HRA changes and strong advice from partners
5	**Workforce Development**	Develop and implement an LCRN Workforce development plan in partnership with relevant stakeholders and other local learning providers	Provide brief reflective commentary on local activities, priorities and engagement in 2014-15	• The Consultant Nurse led the establishment of Senior Research Professional Strategic Group who met quarterly in 2014/15 representing the interests of senior health professionals who delivered NIHR portfolio studies within the LCRN. • This group contributed to national strategy in relation to nursing and workforce development. Workforce development has been embedded in the terms of reference and a standing agenda item. The Workforce Development Lead for

Domain		Objective	Information requested in Annual Report Commentary	Commentary on LCRN Performance in 2014-15
				the LCRN is a key member of the group. • Consultant Nurse led the development of an action learning set delivered jointly between the LCRN/AHSN developing the role of the non- medical Principal Investigator, facilitated by Professor Endacott, Director, Centre for Health and Social Care Innovation, University of Plymouth. Development of non -medic Principal Investigators has been a priority with 3 non- medics appointed to clinical research specialty roles. • Translation of national strategy has been achieved where possible in terms of training and education in the three strategic priority areas. In particular GCP has been effectively delivered by our 15 facilitators across the LCRN. 233 delegates attended Introductions, 169 delegates attended refreshers and 448 delegates under took the e-learning GCP. • The Workforce Development Lead has visited most Trust research teams to discuss workload, capacity and skill mix. Some teams have an in-balance of staff in more senior roles with senior staff undertaking research activities that more junior staff, if appointed, could perform e.g., non-interventional study recruitment, data transcribing, and administration. • Sharing of best practice is emerging out of the Senior Research Professionals Strategic Group which also serves as a workforce development steering group. Some teams are able to demonstrate efficient skill mix that well matches their current portfolio and goes some way to meeting the funding challenges. Our devolved structure places the onus for research team skill mix on the employing Trust who are faced with complex and conflicting resource allocation demands. Through the Operational Management Group NIHR Clinical Research Network: West of England management has been able to openly discuss and influence these issues. Clinical research teams have been encouraged to work flexibly across specialties where appropriate. The WFD lead has been involved in some skill mix reviews and re-structuring exercises during the year. • Initial links have been made with the LETB. It was agreed that no immediate plans for collaborative work were necessary until further national guidance was available. Joint events and training are planned with AHSN and CLAHRC West locally. • The WFD lead has participated in national WFD meetings and working groups. • There has been an excellent response to the call out for facilitators for the new CRN courses – Let's Talk Trials and The Fundamentals of Research. A programme of training has been established for 2015-16. These programmes have been well supported by the partner organisations who have released staff. Valid Informed Consent and Dry Ice training have also been provided by CRN: WE. Facilitator skills workshops have successfully prepared staff for all these roles. • Training needs were identified in the network support team and a programme has been partially delivered through the year. Teambuilding events for the whole team and leadership skills events for the senior team have been held and form part of an ongoing development programme.
6	**Financial Management**	A: LCRN Host and Partner organisations must meet minimum control standards, as specified by the national CRN Coordinating Centre	Provide brief commentary reflecting on local performance in 2014-15	• All standards met. • 100% compliance with reporting requirements and 0% variation at year end • Please find attached the Financial Governance Audit Report which should provide greater clarity regarding the minimum control standards met. • The LCRN minimum controls document has not been shared with Partner

Domain		Objective	Information requested in Annual Report Commentary	Commentary on LCRN Performance in 2014-15
				Organisations within the West of England Clinical Research Network as the controls documented predominantly involve the LCRN and the host and we did not interpret the document or other guidance as requiring sharing with partners. We are not aware of any partner organisations not adhering to recommended guidance with relation to commercial income and we will add this question to the annual plan each organisation is required to submit as part of our annual planning process.
		B: LCRN Host organisation must meet minimum requirements for the scope of internal audit work, as specified by the national Coordinating Centre	• Provide brief commentary reflecting on local performance in 2014-15 • If the LCRN has been able to factor in an internal audit in 2014-15[3], provide a brief commentary	• Internal Audit conducted in April 2015. • Awaiting draft report in writing. • Verbal feedback is that financial controls are in place and fit for purpose. • Final copy report will be circulated to partnership group and coordinating centre
7	**Information Systems**	LCRN Host and Partner organisations have access to the required information systems and services	Provide confirmation that key named systems are in place, including: • LPMS systems are in place as required • Provision of an LCRN Service Desk function and provide contact details • Access to NIHR Hub systems and services, Or describe steps being taken to implement them and provide a target delivery date. Provide brief commentary reflecting on local performance in 2014-15 against the remaining areas in section 13 (Information Systems) of the NIHR CRN Operating Framework	• ODP and CSP systems used on a daily basis • The EDGE LPMS has been implemented across NIHR Clinical Research Network: West of England as this system was already in use in most of the partner organisations. • Host and all partner organisations have access to EDGE. • A one year contract for 2014-15 was initially put in place with the supplier, as a continuation of the former CLRN / topic network / trust contracts. • Arrangements were put in place to renew the contract for 2015-16 using a single action tender, to allow time during 2015-16 for an OJEU process to secure a LPMS in the longer term. • The LPMS Service Desk is in place, provided by the Business Intelligence team (BIU.WestEngland@nihr.ac.uk). • All partner organisations can now access the core NIHR Hub system, although some trusts have had difficulties accessing Google Hangouts. All of the NIHR Clinical Research Network: West of England are now using NIHR Google hub system. • The Business Intelligence team compromises the BI lead (one of the RDMs), BI manager and BI officer. The acting Industry Operations Manager and the CSP lead also contribute to providing relevant BI reports based on their areas of expertise. The BI team meets fortnightly to progress the annual NIHR Clinical Research Network: West of England BI work stream plan. • The BI Manager and Officer contribute to the national BI function. • A comprehensive contacts database which will provide more effective business intelligence function has been developed. • The Host finance team, led by the Assistant Director of Finance (Research & Financial Planning) supports the secure access to the Trust's financial management system to manage NIHR Clinical Research Network: West of England finances. • The Host has an Electronic Staff Record system in place.

[3] In light of the timing of the issuing of the associated guidance, this requirement has been extended through to 2015/16.

Domain		Objective	Information requested in Annual Report Commentary	Commentary on LCRN Performance in 2014-15
8	**Communications**	LCRN communications function and delivery plans in place, and budget line identified	Provide a brief commentary reflecting on local performance in 2014-15 and on the LCRN's contribution to national NIHR / CRN campaigns	• Both a communications work stream lead and 1wte communications officer now in post. • Well attended launch event in partnership with the West of England Academic Health Science Network. • Engagement events held with: researchers of all disciplines; specifically primary care; research professionals other than medics; • Workshops held on successful strategies for recruiting to commercial and non - commercial trials. • Bi-monthly newsletter launched • Plan for the use of social media developed – (launched May 2015) • Work continues on local web pages • Multiple ad-hoc meetings with colleagues, leaders and researchers in the locality • Partner organisations represented at all formal LCRN groups; all senior R&D Managers attend OMG; Research Directors attend Clinical Leaders and also rotate through the executive group. CEO attendance at Partnership Group. • Supported national work on international clinical Trials day; join dementia research; ok to ask.
9	**Information Governance**	LCRN Host and Partner organisations comply with CRN Information Governance (IG) requirements	Report IG Toolkit 2014-15 version 12 scores for the LCRN Host organisation and LCRN Partner organisations and confirm attainment of Level 2 or above on all requirements, or any exceptions which arise from or impact on LCRN-funded activities	• The host trust and all partners can confirm attainment of Level 2 or above on all requirements. • Standardised SOP for the reporting of information governance breaches related to research in all partner organisations

Table 4: Host organisation's achievement against the 2014-15 Host Performance Indicators

Domain		Objective	National CRNCC Approach	Reflective commentary on LCRN Host organisation Performance in 2014-15
1	**LCRN Leadership and Management**	Deliver effective leadership and management of the LCRN	• Annual survey by the national CRN Coordinating Centre of all LCRN Partners to be conducted post 2014-15 year-end (survey April-May 2015, first formal annual meetings to be arranged in September 2015); • Reviewing overall LCRN performance, through Performance Review meetings with the national CRN Coordinating Centre.	• Survey awaited • Senior posts appointed to • Positive informal performance review held in January with Coordinating Centre senior staff
2	**LCRN Research Delivery Infrastructure**	Deliver a responsive and flexible NHS support service that meets the needs of researchers, funders and industry.	Annual survey by the national CRN Coordinating Centre of LCRN service users to be conducted post 2014-15 year-end	• Survey link sent to 273 researchers 29/05/2015
3	**Financial Management**	Deliver robust financial management using appropriate tools and guidance	• Measured by percentage variance (allocation vs expenditure) quarterly and year-end (target is 0%)[4]; • Measured by percentage of financial returns completed on time (target is 100%)[5].	*Data on local performance from national CRN Coordinating Centre:* • *Variance for Q1-Q3 2014-15 = 2.42%* • *Performance for LCRN Annual Plan 2014-15 and Q1-Q3 2014-15 returns = 100%* • Please could the calculation of the 2.42% be shared? We believe the correct value for quarter 1 to 3 is 1.6% as detailed in the '2015/16 Performance Review Meeting – Finance Performance Evaluation' document shared in August 2015. • During 2014/15 the LCRN Executive Group met on a monthly basis to review the financial variances of the LCRN allocations enabling them to determine the appropriate action when an underspend was predicted. At year end, 0% variance reported.
4	**Allocation of LCRN funding**	Distribute LCRN funding equitably on the basis of NHS support requirements	Comparison by the national CRN Coordinating Centre of 2014-15 main allocations *vs.* recruitment to be conducted following year-end and once cleansed recruitment data is available	For the first year of operation, a decision was taken to keep delivery allocations substantially the same to all providers to ensure stability of research delivery during transition. During 14/15 a financial principles paper has been agreed with all partners that drives the allocation of funding in future years. For the period 2014/15, the LCRN did not hold a contingency reserve. The process for signing off and approving Research Capability Funding (RCF) requests were dealt with through the LCRN Executive Group; RCF requests were received and reviewed on a monthly basis and the outcome was shared with the applicants and reported to the partnership group.
5	**LCRN Governance (Host Board)**	Ensure that the Host Board has visibility of LCRN business and fulfils its agreed assurance role	Review of Host Board meeting minutes submitted in response to request from the national CRN Coordinating Centre (April 2015)	Submitted to the coordinating centre 29/05/2015
6	**LCRN Governance (Partner Engagement)**	Ensure all LCRN Partners are engaged in the work of the Partnership Group	• Annual survey by the national CRN Coordinating Centre of all LCRN Partners, to confirm Partner involvement, to be conducted April-May 2015; • Review of Partnership Group minutes, submitted in response to request from the national CRN Coordinating Centre to confirm Partner participation (April 2015).	Survey link sent to CEOs of partners and category B organisations 29/05/2015 Attendance at partnership group submitted 29/05/2015

[4] Variances for Q1-Q3 2014-15 pre-populated by national CRN Coordinating Centre in commentary column of row 3
[5] Performance for LCRN Annual Plan 2014-15 and Q1-Q3 2014-15 returns pre-populated by national CRN Coordinating Centre in commentary column of row 3

Domain		Objective	National CRNCC Approach	Reflective commentary on LCRN Host organisation Performance in 2014-15
7	**Management of Risk**	Establish and maintain an assurance framework and risk management system for the LCRN, including an escalation process	Monitoring through the LCRN Annual Plan and Performance Review meetings with the national CRN Coordinating Centre (first formal annual meetings to be arranged in September 2015)	• NIHR Clinical Research Network: West of England core team trained in the Host Trust risk management system April 2015 • Escalation processes agreed • Risk management system not yet populated • Hard copy risk register held in core team office
8	**Management of LCRN Performance**	Ensure delivery of LCRN performance against the LCRN Annual plan	Monitoring through Performance Review meetings with the national CRN Coordinating Centre (first formal annual meetings to be arranged in September 2015)	• Positive informal review held with Coordinating Centre Leadership. • Non – executive director of host trust has a remit to clarify and improve oversight of hosted functions. COO working closely with NED on this work which will not only benefit the network, but other hosted functions. • Regular meetings with executive Directors of Host Trust. • Performance against the plan is formally monitored and reviewed by the Executive, Clinical Leadership and Operational Management groups and at twice yearly formal performance meetings with each partner organisation. • Performance is also reported and discussed at the Partnership Group meetings. • All Partner Organisations prepared an annual plan stating actions they would initiate to support achievement of the LCRN plan. • A recruitment goal is set for all studies at site level. The LPMS EDGE has been implemented in the Acute and Mental Health trusts and Is being rolled out into primary care via Clinical Study Officers and data from edge is used to monitor overall recruitment, First Patient First Visit and Time to Target.
9	**Host Corporate Support Services**	Deliver high quality Corporate Support Services as specified in the NIHR CRN Performance and Operating Framework	Feedback from the LCRN Leadership Team at Performance Review meetings with the national CRN Coordinating Centre (first formal annual meetings to be arranged in September 2015)	• General level of host support has been of very high quality. • The finance teams and IM&T teams deserve special recognition for fast, accurate and supportive responses to network requests. • HR processes between partners during transition have been slow and of variable quality. This has placed a high burden of stress on some members of staff. • Levels of stress related absence have been high.

Table 5: NIHR Clinical Research Network: West of England Risk Register

RISK ANALYSIS										RISK TREATMENT PLAN									
Risk Reference	**Category**	**Author**	**Date registered**	**Nature of Risk**	**Risk Description**	**Proximity**	**Probability**	**Impact**	**Score**	**Risk Owner**	**Risk Response Categories**	**Control (Action)**	**Risk Response**	**Assurance/ Update**	**Risk Actionee**	**Additional Comments**	**Residual Probability**	**Residual Impact**	**Residual Risk Rating**	**Last review**	**Risk Status**
BI1	Business Intelligence	Ruth Allen	04/10/2014	Technical	As a result of primary care and mental health data not being included in Edge, there is a risk that Edge is not fit for purpose, which will result in decisions that are not data driven.	6 months	3	3	9	Ruth Allen	Reduce	1. Work with Edge team and Primary Care to scope requirements and find solutions.	Liaise with (1) CRN staff supporting primary care studies (2) mental health trust EDGE champions (3) EDGE provider to work on implementation in these areas	Successful test upload of recruitment data for primary care studies to EDGE. Ongoing liaison with primary care and mental health CRN / R&D staff	Mike Lacey	Issues resolved and implementation nearly complete.	1	1	1	31/03/2015	Active
BI2	Business Intelligence	Ruth Allen	06/10/2014	Timescale	As a result of delay in the national launch of CPMS, there is a risk that the LCRN will not have access to complete and accurate national data, which will result in the BI team amalgamating data from multiple sources which is time consuming and increases the margin for error.	6-12 months	4	1	4	Ruth Allen	Reduce	1. Focus on full LPMS implementation to reduce reliance on CPMS (i.e. good local data).	"Business as usual" can continue with the existing UKCRN portfolio database until CPMS is ready.	No launch date currently specified	Mike Lacey	Launch date still unknown.	4	1	4	31/03/2015	Active
CE1	Clinical Engagement	Holly Vallance	11/11/2014	Operational	As a result of the geographical changes of the networks and late appointment of Specialty Leads we have lost opportunities for growth in certain specialties i.e. Dermatology and Cardiovascular Disease - this is an ongoing risk to not meeting the commercial specific specialty objectives.	3-6 months	4	3	12	Holly Vallance	Reduce	Work with Specialty leads when in place to develop an action plan to address this	Work with Specialty leads when in place to develop an action plan to address the threats to commercial portfolio	Not all leads appointed, plan to work with leads that are appointed	Holly Vallance	Majority of leads in place, but not all. Work with leads as appointed.	2	3	6	31/03/2015	Active

Residual Risk Descriptor
Extreme risk
Partially controlled risk
Controlled risk
Well controlled risk

Matrix from NPSA risk matrix 2011: http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/

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Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
17b. Clinical Research Network Annual Plan 2015/16									
Sponsor and Author(s)									
Sponsor: Dr Sean O'Kelly Author: Dr Mary Perkins Chief Operating Officer, West of England Clinical Research Network; Dr Stephen Falk, Clinical Director, West of England Clinical Research Network									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose: As the host organisation for the WECRN, the Board are asked to approve this plan on behalf of the member organisations. UH Bristol as signatory to the contract with the Department of Health is accountable for the network activities. Robert Woolley is the accountable officer and Dr Sean O'Kelly is the delegated executive officer. All member organisations assisted in the preparation of this plan and the partnership group of the WECRN have approved this plan for submission to the UH Bristol Board. The national coordinating centre have also provided feedback on a draft plan and their feedback has been acted upon in this version Key issues to note: We run a devolved network with many responsibilities sitting with partner organisations research and development departments. For 2014/2015 we exceeded our targets. This plan covers all organisations in our geographic area. , including primary care and social care. Recruitment targets are set by each partner organisation and the LCRN leadership team taking account of trials we know will happen and those we have advance notice of. The plan is written in the format requested by the coordinating centre.									
Recommendations									
That the Board approve this plan									
Impact Upon Board Assurance Framework									
Supports UH Bristol to discharge their role as host for the network and signatory to the network contract with the Department of Health									
Impact Upon Corporate Risk									
None									
Implications (Regulatory/Legal)									
This plan supports UH Bristol to discharge their responsibilities as contract signatory									
Equality & Patient Impact									
None									
Resource Implications									
Finance		Information Management & Technology							

Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	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)**
					April/May/June 2015 LCRN Partnership Group, Executive Group, Clinical Leaders Group and Operational Management Group. NIHR National Coordinating Centre

Host Organisation	University Hospitals Bristol NHS Foundation Trust
Partner Organisations – **Members of the Partnership Group**	1. 2gether NHS Foundation Trust 2. Avon and Wiltshire Mental Health Partnership NHS Trust 3. Gloucestershire Hospitals NHS Foundation Trust 4. Great Western Hospitals NHS Foundation Trust 5. North Bristol NHS Trust 6. Royal United Hospitals Bath NHS Foundation Trust 7. University Hospitals Bristol NHS Foundation Trust 8. Weston Area Health NHS Trust
Other affiliated partners **(e.g. CCGs/Social enterprises)**	1. NHS Bath and North East Somerset CCG 2. NHS Bristol CCG 3. NHS Gloucester CCG 4. NHS North Somerset CCG 5. NHS South Gloucestershire CCG 6. NHS Swindon CCG 7. NHS Wiltshire CCG 8. Bristol Community Health 9. North Somerset Community Partnership 10. SeQol (Swindon) 11. Sirona Care & Health (Bath and North East Somerset and South Gloucestershire) 12.Gloucestershire Care Services NHS Trust

Host organisation Accountable Officer for CRN: West of England		
Name:	Mr Robert Woolley	*Contact details* Email: Robert.Woolley@UHBristol.nhs.uk Tel: 0117 342 3720
Host nominated Executive Director for CRN: West of England		
Name:	Dr Sean O'Kelly	*Contact details* Dr Sean O'Kelly Medical Director University Hospitals Bristol NHS Foundation Trust Marlborough Street Bristol
Job title:	Medical Director	

		Avon BS1 3NU Email (PA): Claudette.Young@UHBristol.nhs.uk
CRN: West of England Clinical Director		
Name:	Dr Stephen Falk	*Contact details* Email: Stephen.falk@uhbristol.nhs.uk Tel: 0117 3421375
CRN: West of England Chief Operating Officer		
Name:	Dr Mary Perkins	*Contact details* Email: mary.perkins@nihr.ac.uk Tel: 0117 3421375

To be completed by the Host organisation

Please briefly outline the process of engagement and consultation with LCRN Partners and other stakeholders regarding the submitted LCRN 2015-16 Annual Plan and local recruitment goals
Please note: The Royal United Hospital Bath NHS Trust received Foundation Trust authorisation 1 November 2014 and acquired the Royal National Hospital for Rheumatic Diseases, 1 February 2015. The organisation is now called Royal United Hospitals Bath NHS Foundation Trust. The Chief Operating Officer and Clinical Director have had face to face meetings with each Partner Organisation to discuss the Annual Plan. Each organisation provided data which have been collated and used to set the local recruitment goals. Partner Research and Development departments are represented on the Operational Management Group, Clinical Leaders Group, the Executive Group and the Partnership Group. These groups have all been part of setting the strategy and operational priorities for our next year. The RDMs and Divisional Research Leads have worked closely with specialty group leads to agree direction of travel within each specialty. Financial allocations followed the financial principles paper agreed with all parties prior to finalisation of this report. The Partnership Group reviewed this amended annual plan at their meeting on 10th June

<table>
<tr><td colspan="4">2015 and approved the plan for release. It will be submitted to the Host Trust Board for final approval. Evidence of that approval will be forwarded to the Coordinating Centre in due course.</td></tr>
<tr><td colspan="4">Nominated Executive Director Assurance</td></tr>
<tr><td colspan="2">LCRN Host organisation nominated Executive Director signature confirming the following are in place for the LCRN:
• an assurance framework and risk management system;
• robust and tested local business continuity arrangements;
• an Urgent Public Health Research Plan.</td><td colspan="2"></td></tr>
<tr><td colspan="4">Confirmation of approval of the Annual Plan by the Host organisation Board</td></tr>
<tr><td>Name:</td><td>Mr Robert Woolley</td><td colspan="2">Email: Robert.Woolley@UHBristol.nhs.uk
Tel: 0117 342 3720</td></tr>
<tr><td>Role:</td><td colspan="3">Chief Executive</td></tr>
<tr><td>Signature:</td><td></td><td>Date:</td><td></td></tr>
<tr><td colspan="4">Contact for any communication regarding the CRN: West of England Annual Plan</td></tr>
<tr><td>Name:</td><td>Dr Mary Perkins</td><td colspan="2">Email: mary.perkins@nihr.ac.uk
Tel: 0117 3421375</td></tr>
<tr><td>Role:</td><td colspan="3">Chief Operating Officer</td></tr>
</table>

Table 1. LCRN plans and goals for contributing to NIHR CRN High Level Objectives 2015-16

Objective		Measure	CRN Target	LCRN Goal	Specific key local activities for 2015-16	Timescale
1	Increase the number of participants recruited into NIHR CRN Portfolio studies	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	650,000	25257	For each HLO and measure please outline up to 3 key initiatives and projects planned for 2015-16 by your LCRN to contribute towards achievement of the objective(s); business as usual activities will be assumed and need not be outlined. Please also outline briefly the process by which provisional local recruitment goals have been reached, and the rationale for the proposed local goals for HLO1 and HLO7.	Please enter associated timescale(s)
					1. Recruitment training planned with Professor Jenny Donovan, Director of NIHR CLAHRC West. Over the past decade, Professor Donovan has led research understanding recruitment processes and developed the Quintet Recruitment Intervention which can be integrated into specific RCTs. There are opportunities now to develop training courses and sessions for recruiters based on the findings of the research. We are starting work with this team in late March 2015 – to pilot this approach. If the intervention delivers improved recruitment, there is potential for this model to be refined and then rolled out across the whole CRN. There is understandably considerable excitement about this work, but there are risks. The risks are that a) we are not able to translate the effective parts of the specific intervention into generic training; b) recruiters may not find the training helpful. We will attempt to mitigate these risks by evaluating the training and monitoring recruitment. 2. Development and roll out of a flexible cohort of study staff – comprising initially of two nurses and two Health Care Assistants, this team will support new areas in primary care initially and if successful, the team will be expanded either in numbers or in scope. 3. Identification and recruitment of specialist nurses in the community to take on Principal Investigator (PI) roles. This builds on the work we are doing to identify and support non-medic PIs and is led by our consultant nurse.	Pilot March 2015-September 2015 In post June 2015 Ongoing 2015
					• Recruitment goal was estimated by triangulation of estimates from the partner organisations, broken down by specialty and by the Research Delivery Managers (RDMs) working with the Clinical Divisional Leads (CDLs) and Clinical Research Speciality Leads (CRSLs) with data from the portfolio to inform expected targets. These targets were then increased for each specialty to provide a stretch target based on local knowledge of potential to deliver and likelihood of additional studies in that specialty.	Financial Year
2	Increase the proportion of studies in the NIHR CRN Portfolio delivering to recruitment target and time	A: Proportion of commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed Network sites	80%	80%	• Promote the importance and impact of recruitment to time and target metrics to all LCRN staff, partner organisations and stakeholders including patients and the public.	March 2016
					• Training staff about the importance of robust feasibility (as part of Industry Masterclass).	March 2016
					• Ensure all staff understand that recruiting to time and target supports patients by enabling more patients to participate in trials; improves our reputation and creates an environment in which the West of England is recognised as a good area to place commercial contract studies. • Continued focus on feasibility to ensure achievable targets are set – including training and mentoring naïve staff, liaising with CRSL to confirm targets, continued development of resources and tools to support feasibility and realistic target setting. • Industry Manager to act as a single point of contact for issues with recruitment, directing these to the RDM where appropriate.	March 2016
		B: Proportion of non-commercial studies achieving or surpassing their recruitment target during their planned recruitment period	80%	80%	• Use databases where available to allow more accurate feasibility. • Triangulate investigators expectations with local research and development (R&D) office knowledge.	
					• Develop culture of Continuous Improvement in Partner Organisations.	
					• Focus on accuracy of feasibility.	
					• Develop portfolio facilitator role to support RDMs and CRSLs.	
3	Increase the number of commercial contract studies	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	600	N/A	• Develop promotional materials to showcase CRN: West of England to commercial partners as a strong and reliable network for commercial studies.	March 2016

Objective		Measure	CRN Target	LCRN Goal	Specific key local activities for 2015-16	Timescale
	delivered through the NIHR CRN				• Work towards more CRN: West of England sites achieving partner site status with global Clinical Research Organisation (CRO) Quintiles.	March 2016
					• Industry Manager to act as the single point of contact to industry partners to explain the eligibility and feasibility process and highlight the benefits of inclusion on the NIHR Portfolio. • Establish second general practitioner (GP) consortium along the lines of the BARONET practices.	March 2016
		B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II–IV studies	75%	N/A	• As per plan for 3a.	March 2016
4	Reduce the time taken for eligible studies to achieve NHS Permission through CSP	Proportion of eligible studies obtaining all NHS Permissions within 40 calendar days (from receipt of a valid complete application by NIHR CRN)	80%	80%	• Review of research management and governance (RM&G) services across the locality to assess effective use of RM&G resources • Local Health Research Authority (HRA) support person is a member of Operational Management Group (OMG). Provides regular updates and support for Partner Organisations to adopt/understand new ways of working. • All local R&D managers are a part of OMG. This metric and other continuous improvement initiatives are planned, developed and implemented through this group. • Key studies discussed in-depth, led by one Partner Organisation to increase ability to harness the power of the collaborative at OMG and support meetings arranged for key personnel so set-up is smooth and rapid.	March 2016
					• Provision of single point of contact for CSP during research and development NHS Permissions process. • Maintain the performance of RM&G staff completing study-wide and local governance reviews by providing monthly RAG reports to all Partner Organisations and requesting feedback. • Weekly study tracker monitoring progress of studies through the NHS Permissions process provided to Partner Organisations.	March 2016
					• Maintain competencies of RM&G staff by delivering ad-hoc targeted CSP training.	March 2016
5	Reduce the time taken to recruit first participant into NIHR CRN Portfolio studies	A: Proportion of commercial contract studies achieving first participant recruited within 30 calendar days of NHS Permission being issued or First Network Site Initiation Visit, at confirmed Network sites	80%	80%	• Deliver Commercial Masterclasses to ensure study teams are prepared to recruit first patient within given timeframe.	March 2016
					• Ensure all Partner Organisations utilise the NIHR costing template and mCTA, provide training and support where needed.	March 2016
					• Develop and update materials to share best practice, celebrate success and drive peer support.	March 2016
		B: Proportion of non-commercial studies achieving first participant recruited within 30 calendar days of NHS Permission being issued	80%	80%	• All Partner Organisations now collecting data on this and working together to address barriers.	
					• Discussion item at OMG.	
					• Focus for Continuous Improvement within Partner Organisations.	
6	Increase NHS participation in NIHR CRN Portfolio Studies	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	99%	99%	• Maintain at 100%	
		B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	70%	70%	• Establish mentoring scheme to grow new PIs to understand the benefits of working with industry.	March 2016
					• Further development of commercial research activity in primary care through Continuous Improvement projects and establishing second consortium of GP practises using a hub and spoke consortium delivery model.	March 2016

Objective		Measure	CRN Target	LCRN Goal	Specific key local activities for 2015-16	Timescale
					• Develop materials and methods to share learning with commercial leads in each Partner Organisation and primary care organisation.	March 2016
		C: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	25%	60%	• Work to maintain and increase the current high levels of GMPs (51%) recruiting into NIHR CRN studies through RSI scheme.	March 2016
7	Increase the number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	13,500	440	• Support the full roll out of Join Dementia Research (JDR) across all settings; the continued support of a JDR Project Officer facilitates the work of the dementia health improvement team.	Ongoing
					• Continue with development of West of England Dementia Collaborative to ensure studies are placed in the appropriate settings within the region, with other centres acting as PIC sites.	Ongoing
					• Establish model of working that ensures staff are able to work flexibly across the region to support open studies to minimise risk of studies not delivering to time and target.	Ongoing

Table 2. LCRN plans to contribute to achievement of NIHR CRN Clinical Research Specialty Objectives 2015-16

GROUP 1: INCREASING THE BREADTH OF RESEARCH ENGAGEMENT IN THE NHS
Increasing the opportunities for patients to participate in NIHR CRN Portfolio studies

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
1.1	Cancer	Increase the opportunities for cancer patients to take part in research studies, regardless of where they live, as reflected in National Cancer Patient Experience Survey responses	Number of LCRNs which have an action plan to increase access in each sub-specialty (e.g. by opening studies, increasing awareness and forming referral pathways for access to research)	15	• Maintain link with Strategic Clinical Network cancer site specific group infrastructure to engage with clinicians and reflect patient pathways in oversight of the tumour specific portfolios. • Sub-specialty leads (SSLs) to develop their network wide study list and disseminate (web link, newsletter, sub specialty group (SSG) meetings etc.) to all relevant clinical teams to encourage intra network referrals. • SSLs to encourage discussion re new studies in terms of whole network e.g. expressions of interest (EOI) representing full network population in forecast. • Map cancer service provision across the network to include patient referral pathways into and out of the network for specialist care and treatment. • Coordinate south west research/education events in conjunction with CRN: South West Peninsula and CRN: Wessex to raise awareness amongst clinical teams, and encourage new studies and patient referrals where appropriate.
1.2	Children	All relevant sites that provide services to children are involved in research	Proportion of NHS Trusts recruiting into Children's studies on the NIHR CRN portfolio	95%	• With a major tertiary centre in the LCRN, need to ensure that other relevant trusts providing children services are given the opportunity to act as PIC sites, if not appropriate to set up as a self-contained site. 85% of relevant Partner Organisations are already actively recruiting to children's studies as sites in their own right. • Provide an opportunity to bring staff delivering to children's studies across the region together to explore more collaborative approaches (similar to the current quarterly Division 4 delivery staff meetings). • Explore methods of funding shared core activities to support the non-tertiary centres.
1.3	Critical Care	Increase intensive care units' participation in NIHR CRN Portfolio studies	Proportion of intensive care units recruiting into studies on the NIHR CRN Portfolio	80%	• Set up face to face meetings every six months for doctors, research nurses etc. involved in Critical Care / Intensive Care Unit research / those who wish to become involved to facilitate sharing of best practice / group problem solving / to provide peer support / encourage networking and peer support. • CRSL to focus on encouraging and supporting currently research active ICUs and taking a stepwise approach to working with potential Principal Investigators at other units to encourage them to become research active.
1.4	Dermatology	Increase NHS participation in Dermatology studies on the NIHR CRN Portfolio	Number of sites recruiting into Dermatology studies	150	• Engage with any qualified provider to increase number of healthcare providers of dermatology services. • Work with Dermatology CRSL to understand barriers to research in our area and identify strategies to overcome those barriers. • Develop Principal Investigators and local collaborators.
1.5	Ear, Nose and Throat (ENT)	Increase NHS participation in Ear, Nose and Throat studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting into ENT studies on the NIHR CRN Portfolio	40%	• CRSL to complete site visits for all five acute NHS Trusts with ENT services to meet with clinical staff to map research interest. • Produce ENT specific newsletter to facilitate communication and raise awareness of opportunities to participate in CRN portfolio research. • Build on progress made in 2014-15 (no recruitment in 2013-14, then in 2014-15 a commercial study recruited at two sites, exceeding target) by seeking to open at least one ENT study in 2-3 sites (40-60% of acute NHS Trusts with ENT services) as available (Bath, Gloucester, UHBristol). Liaise with trusts to ensure that study moves forward successfully. At these sites there is an enthusiasm to take on ENT studies, limited only by the availability of portfolio studies. The CRSL and RDM will continue to search for suitable studies for these sites. • The CRSL is preparing a grant application at present and so there is a potential for some "home grown" studies in due course.

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
1.6	Gastroenterology	Increase NHS participation in Gastroenterology studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting into Gastroenterology studies on the NIHR CRN Portfolio	90%	• Flag studies seeking sites to the trusts to maintain and grow the portfolio at the acute trusts (6/6 appropriate trusts recruiting in 2014-15 i.e. excludes a community trust and two mental health trusts).
1.7	Haematology	Increase NHS participation in Haematology studies on the NIHR CRN Portfolio	Proportion of eligible NHS Trusts undertaking Haematology studies in each LCRN	50%	• Ensure Oncology and Haematology delivery staff have capacity to deliver Haematology studies. • More than 50% of eligible NHS Trusts are already currently undertaking Haematology studies, with new studies recently opened and due to open, we should be able to improve on this figure.
1.8	Injuries and Emergencies	Increase NHS major trauma centres' participation in NIHR CRN Portfolio studies	Proportion of NHS major trauma centres recruiting into NIHR CRN Portfolio studies	100%	• Link with major trauma centre at North Bristol NHS Trust to explore potential avenues for growing the CRN portfolio research portfolio in major trauma.
1.9	Injuries and Emergencies	Increase NHS emergency departments' participation in NIHR CRN Portfolio studies	Proportion of NHS emergency departments recruiting into NIHR CRN Portfolio studies	30%	• 7/8 Emergency departments in CRN: West of England recruited to portfolio studies in 2014-15. Potential new studies will be flagged up to Emergency Departments to maintain and grow the portfolio. • Build on existing links with the Ambulance Trust (based in CRN: South West Peninsula, but responsible for services in CRN: West of England) to facilitate joint working.
1.10	Musculoskeletal	Increase NHS participation in Musculoskeletal studies on the NIHR CRN Portfolio	Number of sites recruiting into Musculoskeletal studies on the NIHR CRN Portfolio	300	• Develop capacity and expertise at sites where the musculoskeletal portfolio is historically less well established. • Develop Principal Investigators and local collaborators.
1.11	Ophthalmology	Increase NHS participation in Ophthalmology studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting into Ophthalmology studies on the NIHR CRN Portfolio	60%	• Three Acute Trusts recruited to ophthalmology studies in 2014-15. In 2015-16 the potential for ophthalmology portfolio studies at the two other Acute Trusts with ophthalmology departments will be explored.
1.12	Renal Disorders	Increase the proportion of NHS Trusts recruiting into Renal Disorders studies on the NIHR CRN Portfolio which actively engage renal and urological patients in research	Proportion of NHS Trusts recruiting into Renal Disorders studies on the NIHR CRN Portfolio which implement Patient Carer & Public Involvement and Engagement (PCPIE) strategies for Renal Disorders research	25%	In liaison with trusts with Renal Services: • CRSL/ RDM to engage transplant users group in conjunction with the PCPIE workstream to request their ideas for increasing visibility of research opportunities for patients. • Link with the CRN:WE PCPIE workstream to facilitate the introduction/ increase the visibility of displays of research publicity materials in outpatients units and dialysis units • The primary focus in the first instance will be on North Bristol Trust (recruited to 16 renal led studies in 2014-15) and Gloucestershire Hospitals (3 renal led studies in 2014-15). Feedback on work implemented in these trusts will be used to influence design of materials for other trusts with open studies.
1.13	Stroke	Increase the proportion of NHS Trusts, providing acute Stroke care, recruiting to Stroke studies on the NIHR CRN Portfolio	Proportion of NHS Trusts, providing acute Stroke care, recruiting participants into Stroke studies on the NIHR CRN Portfolio	80%	• All Trusts with acute stroke care services contributed to stroke studies in 2014-15. Flag studies seeking sites to the trusts to maintain and grow the portfolio at the trusts and monitor resourcing for stroke studies. Maintain an active portfolio at all these sites. • Set up monthly teleconferences for staff (especially research nurses) supporting CRN Stroke studies across CRN: West of England to allow trouble shooting, problem solving, sharing intelligence on pipeline studies that maybe available to additional sites. • Work with R&D depts. to promote support for the stroke portfolio and to ensure its specific requirements (e.g. recruitment in the acute setting, recruitment of individuals who may not be able to provide consent for themselves) are understood and resourced appropriately. This will be measured through maintained / improved recruitment and take up of opportunities to be involved in new studies.
1.14	Surgery	Increase NHS participation in Surgery studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting patients into Surgery studies on the NIHR CRN Portfolio	85%	• In 2014-15 all six acute trusts recruited to surgery studies. For 2015-16 the aim will be to facilitate continued engagement and flag potential new studies to maintain the study pipeline.

GROUP 2: PORTFOLIO BALANCE
Delivering a balanced portfolio (across and within Specialties) that meets the needs of the local population and takes into account national Specialty priorities

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
2.1	Ageing	Increase access for patients to Ageing studies on the NIHR CRN Portfolio	Proportion of Ageing-led studies which are multicentre studies	50%	• Work with CRSL to promote research opportunities. • Develop Principal Investigators and local collaborators. • Collaborate with Dementia specialty leads to increase research opportunities. • Promote research opportunities through disease specific registers.
2.2	Cancer	Increase the number of cancer patients participating in studies, to support the national target of 20% cancer incidence	Number of LCRNs recruiting at or above the national target of 20%, or with an increase compared with 2014-15	15	• CRN: West of England forecasting 22% for 2014-15. Recruitment has been above national target for last 3 years. • Undertake robust forecasting exercise with all cancer trials teams across network for the 2015-16 year and monitor recruitment against this forecast through the year with SSLs, Divisional Lead and regular contact with teams. • Review cancer portfolio maps on NCRI website to horizon scan for new studies and disseminate to sub specialty leads for review. • Encourage more intra network working between cancer trials teams at EOI, set up and recruitment phases for commercial and non-commercial portfolio by providing a forum for 'shared portfolio' working to expand opportunities for patients and improve recruitment particularly to rare cancer studies. • Link with genetics, primary care and surgery specialties to raise awareness of cross cutting cancer studies and any resource issues.
2.3	Cancer	Increase the number of cancer patients participating in interventional trials, to support the national target of 7.5% cancer incidence	Number of LCRNs recruiting at or above the national target of 7.5%, or with an increase compared with 2014-15	15	• Forecasting 9.2% for 2014-15. Recruitment has been above the national target for the last 3 years. • Each SSG/SSL to hold a well balanced portfolio of studies across the network with regard to interventional and non-interventional studies with the ultimate aim of having a study to offer patients at each stage of the patient pathway e.g. screening, prevention, diagnostic, treatment etc.
2.4	Cancer	Deliver a Portfolio of studies including challenging trials in support of national priorities	Number of LCRNs recruiting into studies in: • Cancer Surgery • Radiotherapy • Rare cancers (cancers with incidence <6/100,000/year) • Children's Cancer & Leukaemia and Teenagers & Young Adults	15	• Identify cancer surgery studies on the national and local portfolio. SSL to discuss at SSG and encourage participation at appropriate locations. • Map radiotherapy service provision across the network. Link with radiotherapy specialist commissioning group. Appoint a radiotherapy SSL for the network. Include all relevant radiotherapy studies in all SSG discussions. • Support centres to open rare cancer studies where they are the main referral centre for the network and link in with national and international rare cancer initiatives. Provide business intelligence to enable partners to understand the importance and complexity of rare disease studies and the need for each network to maximise opportunities for patients by making these available. • Principal Treatment Centre (PTC) to continue to coordinate children's cancer research across the network. Network to continue to support essential non recruitment research activities at Paediatric Oncology Shared Care Units (POSCUs) by ensuring that these activities are resourced with the most efficient skill mix, that partners understand that recruitment at the PTC is on behalf of the whole network and that their activities contribute to that.
2.5	Cardiovascular Disease	Increase access for patients to Cardiovascular Disease studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into multi-centre studies in at least five of the six Cardiovascular Disease sub-specialties	15	• In 2014-15 the LCRN recruited to studies across all the subspecialties. In 2015-16 the balance of studies across the subspecialties will continue to be monitored, in order to maintain this position and to grow the portfolio, particularly in DGHs. • CRSL to develop links with clinical teams at each relevant Partner Organisation with one-to-one contacts, to promote take up of a growing portfolio of studies. In particular work with North Bristol Trust to support the growth of its portfolio of studies, increasing its number of open and recruiting studies from one in 2014-15 to at least 2-3 in 2015-16. • CRSL and RDM to build links with Cardiology and Cardiac Surgery research teams at UHBristol to support and as a minimum to maintain 2014-15 high levels of recruitment (666 recruits to Cardiovascular Disease managed studies). • Trial promotion of participation in cardiovascular research through social media in conjunction with the Communications team through (e.g. during

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
					Heart Rhythm Week)
2.6	Diabetes	Increase support for areas of Diabetes research where traditionally it has been difficult to recruit	Number of LCRNs recruiting into diabetic foot studies on the NIHR CRN Portfolio	15	• Continue to recruit to diabetic foot studies, flagging opportunities to participate in appropriate new studies to teams and exploring potential for recruiting in additional settings.
2.7	Diabetes	Increase access for people with Type 1 Diabetes to participate in Diabetes studies on the NIHR CRN Portfolio early after their diagnosis	Number of LCRNs approaching people with Type 1 Diabetes to participate in interventional Diabetes studies on the NIHR CRN Portfolio within six months of their diagnosis	15	• Monitor progress of current industry study for newly diagnosed patients and provide support if required. • Encourage teams across the network to recruit to ADDRESS 2.
2.8	Gastroenterology	Increase the proportion of patients recruited into Gastroenterology studies on the NIHR CRN Portfolio	Number of participants (per 100,000 population), recruited into Gastroenterology studies on the NIHR CRN Portfolio	15	• CRSL to meet with key colleagues to determine where research activity can be expanded through adding studies to the portfolio /increasing recruitment to current portfolio.
2.9	Genetics	Increase access for patients with rare diseases to participate in Genetics studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into multi-centre Genetics studies through the NIHR UK Rare Genetic Disease Research Consortium	14	• Already recruiting into multi-centre genetics studies through the NIHR UK Rare Genetic Disease Research Consortium. • Work with Genetics CRSL to identify ways to increase access for patients to these studies, likely to include increased promotion via social media (detailed in communications plan)
2.10	Haematology	Increase access for patients to Haematology studies undertaken by each LCRN	Number of LCRNs recruiting into studies in at least three of the four following Haematology sub-specialties : Haemoglobinopathy, Thrombosis, Bleeding disorders, Transfusion	15	• Already recruiting into studies in at least 3 of the 4 subspecialties. Work with CDL and relevant R&D departments to ensure increased capacity to take on studies where appropriate.
2.11	Hepatology	Increase access for patients to Hepatology studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into a multi-centre study in all of the major Hepatology disease areas (including Viral Hepatitis, NAFLD, Autoimmune Liver Disease, Metabolic Liver Disease)	15	• Increase number of PIs recruiting to CRN: West of England hepatology studies, through horizon scanning and direct invitation from CRSL to take on new studies. Plan to scope service provision in the LCRN for NAFLD and approach service providers with potential studies. • Work with local researchers to develop cross referral in rare subsets • Link with paediatrics as necessary for Metabolic Liver Disease studies (although paediatric hepatology refers to Birmingham so possibilities maybe limited) • Increase recruitment and number of portfolio studies from the number in 2014-15 of 1 study at 3 sites, 3 studies at UHBristol. • Recruit to multi-centre studies in all the major hepatology disease areas for at least one site (depending on availability of portfolio studies). This will involve reviewing the current portfolio for gaps and then seeking out multicentre studies in the "missing" hepatology disease areas. The CRSL and RDM will then seek out clinical teams prepared to take on these studies and follow through to ensure timely set up of the studies within CRN: West of England. Identify potential new and ongoing studies that can be taken on at other sites, as they enter the portfolio, to broaden and grow the portfolio.
2.12	Infectious Diseases and Microbiology	Increase access for patients to Infectious Diseases and Microbiology studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into antimicrobial resistance research studies on the NIHR CRN Portfolio	15	• Continue to facilitate recruitment to antimicrobial resistance research studies.
2.13	Metabolic and Endocrine Disorders	Increase access for patients with rare diseases to participate in Metabolic and Endocrine Disorders studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into established studies of rare diseases in Metabolic and Endocrine Disorders on the NIHR CRN Portfolio	15	• Identify clinical champions within each organisation with the appropriate clinical services, leading to a balanced portfolio with effective cross referral between organisations for rare subgroups. Leading to appointment of CSRL. • Increase the number of open and recruiting Metabolic & Endocrine led studies in the LCRN from 5 in 2014-15 to at least 6 in 2015-16 and increase recruitment to the metabolic & endocrine portfolio by at least 15% (n=29 in 2014-15), including the prioritisation and promotion of rare condition studies as available.
2.14	Oral and Dental	Increase access for patients and practitioners to Oral and Dental studies on the NIHR CRN Portfolio	A: Proportion of Oral and Dental studies on the NIHR CRN Portfolio recruiting from a primary care setting	20%	• Currently there is no recruitment activity into oral and dental studies in Primary Care. The RDM and CRSL will make contact with the community based oral and dental providers to scope research interest and readiness as well as identifying any training needs. There are currently 2 potential studies on the national portfolio that can be promoted. Aim for at least one Principal Investigator from the community dental services. We will achieve

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
					this by: o working with study teams to promote primary care based providers as an additional source of recruitment o promoting portfolio studies in primary care using various media and forums o having a dedicated presentation slot for study promotion on the agenda at primary care annual event and inviting community dental service providers to this o using the CRSL and GP Champions to promote oral and dental research as well as identifying research champions from the community dental providers • Work with oral health and dentistry CRSL to identify and develop research opportunities in the locality. • Work with oral health and dentistry CRSL to identify and grow potential local collaborators and Principal Investigators and develop Chief Investigators. • Work closely with Bristol Dental school to facilitate potential new research development and delivery
			B Proportion of participants recruited from a primary care setting into Oral and Dental studies on the NIHR CRN Portfolio	30%	• Increase number of primary care organisations recruiting patients into oral and dental studies by 5-10%. We will achieve this by: • Expanding the Research Sites Initiative scheme to include community dental providers. Monthly identification of suitable studies on the portfolio by RDM and disseminate if new opportunities arise.
2.15	Primary Care	Increase access for patients to NIHR CRN Portfolio studies in a primary care setting	Proportion of NIHR CRN Portfolio studies delivered in primary care settings	15%	• CRN: West of England currently has the highest level of practice engagement, 226 out of 273 practices (83%) are engaged in research. This year we will maintain this high level of engagement through the RSI scheme. • Refresh the RSI scheme to ensure there is equity in research activity funding. • Increase number of practices working together as a collaborative by promoting this model as a way of working together to share resources in order to increase overall recruitment. • We will develop and implement an additional support structure in primary care (research support team) to increase capacity and provide direct research delivery support to practices to improve study set-up, delivery and recruitment. This resource will be a request service available to all RSI practices in CRN: West of England locality. The Research Support Team will: o develop the portfolio of NIHR research in primary care o complement the existing research workforce in primary care o assist with the setup, conduct and delivery of studies (especially more complex ones) o support less experienced practices to deliver research o champion clinical research in primary care • Promote research opportunities for practices through disease specific registers, starting with 'Join Dementia Research'. • Plan and develop support materials and implement 'ENRICH' project to engage with care homes to increase recruitment of residents to eligible studies. • Development of specific materials to support practices who are naïve to commercial research. • Highlight studies in secondary care that could be suitable for primary care
2.16	Renal Disorders	Increase NHS participation in Renal Disorders studies on the NIHR CRN Portfolio	A. Proportion of acute NHS Trusts recruiting into multi-centre Renal Disorders randomised controlled trials on the NIHR CRN Portfolio	30%	• Facilitate continued support across the four acute trusts already participating in these studies and promote new opportunities as appropriate and feasible
			B. Proportion of Renal Units recruiting into multi-centre Renal Disorders randomised controlled trials on the NIHR CRN Portfolio	80%	• RDM will continue to proactively support CIs in CRN: West of England regarding advice on research delivery and access to CRN support nationally (especially urology). • Through 1:1 engagement and liaison with R&D/ local CRN staff, CRSL/RDM

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
					focus to expand portfolio at Gloucestershire Hospitals, which provides dialysis and investigations, from 2014-15 level (1 multicentre RCT, 9 participants) • Maintain / grow the currently limited portfolio at the other acute trusts in CRN: West of England with renal / urology services through flagging of new study opportunities in conjunction with R&D, with follow through to optimise take up. • Explore studies that span specialties to optimise cross-working. • CRSL to work closely with colleagues at the tertiary renal centre for CRN:WE, North Bristol NHS Trust, to improve the take up of new multicentre randomised controlled trial (RCTs) within the unit thereby significantly increasing both recruitment and the number of active studies from 2014-15 levels (5 multicentre renal /urology RCTs with 65 recruits at North Bristol Trust).
2.17	Respiratory Disorders	Increase access for patients to Respiratory Disorders studies on the NIHR CRN Portfolio	Number of LCRNs recruiting participants into NIHR CRN Portfolio studies in the Respiratory Disorders main disease areas of Asthma, COPD or Bronchiectasis	15	• RDM and CRSL to agree detailed priorities for 2015-16 (meeting arranged for 22/6/2015), which will be shared with the Coordinating Centre. • Build links with more recently appointed consultants to facilitate broadening of local portfolio. • Build on current levels of engagement through enhanced communications (e.g. newsletter, face to face meetings) and through identification of respiratory research leads in key trusts.
2.18	Stroke	Increase the proportion of patients recruited into Stroke randomised controlled trials on the NIHR CRN Portfolio	Number of patients (per 100,000 population) recruited into Stroke randomised controlled trials on the NIHR CRN Portfolio	8	• Appoint a stroke clinical research specialty lead to work with the RDM to encourage take up and delivery of stroke RCTs • Set up teleconferences for staff delivering CRN portfolio stroke studies to promote sharing of best practice and joint problem solving to optimise recruitment
2.19	Stroke	Increase activity in NIHR CRN Hyperacute Stroke Research Centres (HSRCs)	A: Number of patients recruited to Hyperacute Stroke studies on the NIHR CRN Portfolio in each NIHR CRN HSRC	50	• No Hyperacute Stroke Research Centre (HSRC) in CRN: West of England. However CRN: West of England will encourage continued recruitment to studies on the HSRC portfolio (e.g. TICH 2, and there is potentially interest in STABILISE at one Trust) where this is feasible without the full facilities of an HSRC in place.
			B: Number of patients recruited to complex Hyperacute Stroke studies on the NIHR CRN Portfolio in each NIHR CRN HSRC	15	• As in 2.19 A above, but less likely to be feasible for these complex studies

GROUP 3: RESEARCH INFRASTRUCTURE
Developing research infrastructure (including staff capacity) in the NHS to support clinical research

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
3.1	Cancer	Establish local clinical leadership and a defined portfolio across the cancer sub-specialty areas	Number of LCRNs with, for each of the 13 Cancer sub-specialties, a named lead and a defined portfolio of available studies	15	• All SSLs in place by May 2015. SSL are also SSG research leads. Divisional lead and RDM to meet for formal review annually with each SSL. RDM to support SSLs to publish updated study portfolio monthly and make available on website/newsletter and to inform twice yearly SSG research reports.
3.2	Anaesthesia, Perioperative Medicine and Pain Management	Establish links with the Royal College of Anaesthetists' Specialist Registrar networks to support recruitment into NIHR CRN Portfolio studies	Number of LCRNs where Specialist Registrar networks are recruiting into NIHR CRN Portfolio studies	4	• Dr Ronelle Mouton is both the CRN: West of England Specialty Lead and Consultant Supervisor for the Severn Trainees Anaesthetic Research Group (STAR). The LCRN will build its links with STAR through Dr Mouton's membership of the STAR executive which meets quarterly. For each study STAR takes on an overall trainee lead and consultant lead, and there is a consultant and trainee lead for each of the participating hospitals. This worked well for SNAP and ISOS and is a model that will continue to be used going forward. The plan is to continue and further increase participation in portfolio studies through STAR in 2015-16. • Monitor the portfolio to suggest new studies for CRN: West of England sites,

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
					particularly those suitable for STAR to assist with, to build on the success in 2014-15 of ISOS (446 recruits from 6 sites) & the National Survey of Patient Reported Outcome after Anaesthesia (569 recruits across 6 sites). • STAR plans a joint project with SWARM, the Peninsula trainee network and has representation on RAFT, the national network. • Work in conjunction with CRN: SW Peninsula to develop links with the Society of Anaesthetists of the South Western Region to promote recruitment to portfolio studies. • Map current joint working on portfolio studies and portfolio development between this specialty and others where there are synergistic links to enhance recruitment opportunities (e.g. critical care and surgery) The critical care lead and this specialty lead, outside of their CRN: West of England roles, are jointly preparing grant proposals for future portfolio studies. • Collate intelligence on the pipeline of studies in development locally, to provide early support. • Seek appropriate areas for collaboration with the Bristol Health Partners Pain Health Integration Team (http://www.bristolhealthpartners.org.uk/health-integration-teams/integrated-pain-management-hit/)
3.3	Dementias and Neurodegeneration (DeNDRoN)	Optimise the use of "Join Dementia Research" to support recruitment into DeNDRoN studies on the NIHR CRN Portfolio	The proportion of people identified for DeNDRoN studies on the NIHR CRN Portfolio via "Join Dementia Research"	3%	• Continued support of JDR Project Officer within CRN WE to ensure full roll out of JDR across all settings including primary care. Aim to ensure all patients on existing dementia registers and all those with a new diagnosis are informed of JDR. • Support to local researchers to ensure JDR can be used a recruitment tool where Lead site is agreeable in appropriate studies.
3.4	Dementias and Neurodegeneration (DeNDRoN)	Increase the global and psychometric rating skills and capacity of LCRN staff supporting DeNDRoN studies on the NIHR CRN Portfolio	Proportion of LCRN staff who support DeNDRoN studies who have successfully completed Rater Programme Induction and joined the national Rater database	40%	• Work with relevant R&D departments to ensure that staff have access to training and opportunity to ensure Raters have opportunities to use ratings to remain eligible for database.
3.5	Infectious Diseases and Microbiology	Maintain research preparedness to respond to an urgent public health outbreak	Number of LCRNs maintaining a named Public Health Champion	15	Dr Peter Muir, Consultant Clinical Scientist & Head of Virology, Public Health Laboratory Bristol, Public Health England. Peter.Muir@phe.gov.uk • Continue to refine Urgent Public Health Plan collaboratively with R&D departments. • Maintain up to date list of sleeping studies on the local portfolio for review and assessment of any forward planning that would facilitate delivery when the studies are activated.
3.6	Mental Health	Maintain and enhance the skills and capacity of staff supporting Mental Health studies on the NIHR CRN Portfolio in frequently used Mental Health study eligibility assessments (e.g. PANSS, MADRS, MCCB)	Number of staff trained in frequently used Mental Health study eligibility assessments	139	• Work with relevant R&D departments and CRSLs to ensure that staff have access to training and opportunity to ensure Raters have opportunities to use ratings to remain eligible for database. Support arrangements of localised training if appropriate.
3.7	Neurological Disorders	Increase clinical leadership capacity and engagement in each of the main disease areas in the Neurological Disorders (MS; Epilepsy and Infections) Specialty	Number of LCRNs with named local clinical leads in MS; Epilepsy and Infections	15	• Continue to work with CDL to identify and appoint an appropriate CRSL in Neurological Disorders. • Work with Neurological Disorders CRSL (and in the interim CDL) and Consultant nurse to identify appropriate individuals to support clinical leadership and engagement in the main disease areas in the specialty.
3.8	Reproductive Health and Childbirth	Increase engagement and awareness of the Reproductive Health and Childbirth Specialty	Number of LCRNs with a named midwifery lead to increase engagement and awareness	15	• Named midwifery leads in place. Co-CRSL is a midwife. Ensure continued support to increase engagement and awareness. • A locally developed study IMOX is good potential vehicle through which to establish collaborative ways of working and raise the profile locally.

Table 3. LCRN plans against the Operating Framework 2015-16

POF Area	Operating Framework requirement	Operating Framework Reference	Information required	Planned LCRN actions/activities for 2015-16 or other requested information	Milestones & outcomes once complete	Timescale
LCRN Governance	The Host organisation shall develop and maintain an assurance framework including a risk management system	3.12	Assurance that a framework and system are in place to be provided by the Host organisation nominated Executive Director's signature on Annual Plan coversheet and submission of a copy of the latest version of the LCRN's risk register as Appendix 1 to the Annual Plan	N/A. In place. CRN team to be trained in RiskWeb - the online system used by the host to replace the attached written risk register – this will allow for automatic escalation of issues as agreed with the host.	N/A	N/A
	The Host organisation will ensure that robust and tested local business continuity arrangements are in place for the LCRN. This is to enable the Host organisation to respond to a disruptive incident, including a public health outbreak, e.g. pandemic or other related event, maintain the delivery of critical activities / services and to return to 'business as usual'. Business continuity arrangements should be in line with guidance set out by the national CRN Coordinating Centre.	3.14	Assurance that robust and tested local business continuity arrangements are in place for the LCRN to be provided by the Host organisation nominated Executive Director's signature on Annual Plan coversheet	N/A In place	N/A	N/A
	The Host organisation must ensure that appropriate arrangements are in place to support the rapid delivery of urgent public health research, which may be in a pandemic or related situation. It shall ensure that the LCRN has an Urgent Public Health Research Plan which can be immediately activated in the event that the Department of Health requests expedited urgent public health research. The Host must also appoint an active clinical investigator as the LCRN's Public Health Champion to act as the key link between the LCRN and the national CRN Coordinating Centre and support the Urgent Public Health Research Plan in the event of it being activated.	3.15	Assurance that the LCRN has an Urgent Public Health Research Plan in place to be provided by the Host organisation nominated Executive Director's signature on Annual Plan coversheet	Existing plan to be activated upon request.	As per plan	Not known
			Confirm name and contact details of LCRN's Public Health Champion against Specialty objective 3.5	Provided via completion of Table 2.	N/A	N/A
	The Host organisation must ensure that LCRN activity is included in the local internal audit programme of work	3.17	Date of planned audit or anticipated timescale if exact date not yet known	Audit commissioned from host Trust internal audit team. Scope followed guidance suggested.	Report to be released.	April 2015
Research Delivery	The Host organisation shall ensure that all LCRN organisations adhere to national systems, Standard Operating Procedures and operating manuals in respect of research delivery as specified by the national CRN Coordinating Centre. The Host organisation shall ensure that the LCRN management team provides excellent study performance management, in line with the standards and guidance issued by the national CRN Coordinating Centre, in order to ensure that all NIHR CRN Portfolio studies recruit to agreed timelines and targets.	6.1-6.20	Provide confirmation that the LCRN has a link person for the CRN Study Support Service programme and describe how information is cascaded to relevant colleagues	Link person is: Mary Griffin, Research Delivery Manager. • Information is cascaded by email, via OMG and ad-hoc communications to the LCRN central team, R&D Managers in Partner and Member Organisations in the locality. CRN: West of England is a devolved network. The OMG is therefore a highly collaborative forum that meets face to face monthly. Weekly performance management of all studies with actions if not to time and target. • Feasibility advice and support and site identification is provided by Research Delivery Managers. • Use of Coordinated System for gaining NHS Permissions continues in accordance with CRN processes and guidance. • Provision of arrangements to enable NHS and non-NHS staff to conduct research activities across the locality and NHS. • Work with partner and member organisations to identify areas of non-compliance. • Report and discuss area of concern at OMG to find solutions.	LCRN adheres to adhere to national systems, Standard Operating Procedures and operating manuals in respect of research delivery and all NIHR CRN Portfolio studies recruit to agreed timelines and targets.	March 2016
			Provide a brief outline (1-2 paragraphs) of the LCRN's plans for implementation and delivery of the Study Support Service	Work with the HRA Approval Change Lead South West (based in one of our partner organisations and a member of our OMG): • define what functions HRA will support • scope partner organisations to assess capacity and capability	Responsibilities of the LCRN are met and there is a consistent approach to research	December 2015

				• ensure the LCRN workforce is supported and trained to transition to focussing from research governance to research management • ensure all LCRN responsibilities are met • keep up to date with SSS progress via working group teleconferences and communications • continue scoping current SSS provision alongside preparation for HRA readiness • implement central SSS initiatives as they develop from CRN SSS working group and pilot • Measure impact on performance	support and delivery.	
			Provide a summary of expertise and skills that you have available locally to support implementation of AcoRD including the number of individuals able to provide advice on the attribution of activities in line with the Attributing the costs of health and social care Research & Development (AcoRD) guidance[1] and a description of the model(s) the LCRN has used to date in providing advice	• Our devolved model means there are multiple staff that are able to provide advice across our partner organisations. In the LCRN, the named individuals are Chantal Sunter, Research Delivery Manager and Mary Griffin, Research Delivery Manager. Advice is provided by email or by telephone as required.	N/A	N/A
	The Host organisation will ensure that all LCRN Partner organisations adopt NIHR CRN research management and governance operational procedures. The Host organisation will ensure that quality, consistency and customer service are central to the LCRN's purpose in the implementation, delivery and oversight of NIHR CRN research management and governance services.		Provide a brief outline of local plans for supporting CSP BAU activities within local delivery structures in accordance with POF, and noting clauses 5.28 & 5.29 when planning RM&G local delivery structures	• Our devolved model means there are multiple staff proficient at CSP and RM&G activities across the locality. This means we can rely on partner organisations to support CSP functions if necessary. • We will continue to provide training and support to LCRN staff and performance manage the CSP metrics to maintain HLO 4. • We will continue to provide a single point of contact for CSP BAU within LCRN central office. • As a central team at LCRN, we will liaise with partner and member organisations to ensure there is sufficient expertise whilst CSP is being decommissioned. • We will get agreement from Partnership Group and Operational Management Group to adhere to the agreed plan and timescales and provide peer to peer support if necessary. • We will use knowledge and expertise from HRA Approval Change Lead South West (based in one of our partner organisations and a member of our OMG) to inform local plans and build resilience.	Impact on RM&G activities is minimised and CSP BAU continues.	December 2015
	The Industry Operations Manager will work closely with the Chief Operating Officer to establish and enable the implementation of the NIHR CRN Industry Strategy within the LCRN. The Industry Operations Manager will establish and lead the cross-divisional Industry function, including the single point of contact service, within the LCRN. The Industry Operations Manager will work closely with each Divisional Research Delivery Manager across all research divisions to ensure consistency of feasibility, study delivery and coordination across all divisions within the LCRN. The Industry Operations Manager will be responsible for the promotion of the Industry agenda to LCRN Partner organisations and investigators, delivering aspects of a national NIHR CRN Industry Strategy within the LCRN.	6.21	Provide an outline for the performance management of the provision of local feasibility information (site intelligence and site identification) for commercial contract studies. To include action plans for improvement in performance[2].	The role and functions of the Industry Operations Manager is shared between the Industry Manager and RDMs who together form the industry team. We run a devolved network and as such the Iidustry team and dedicated industry contacts within the R&D departments work together with the clinical teams to manage study delivery and ensure robust feasibility is carried out. The RDMs support delivery of the commercial portfolio alongside the non-commercial portfolio. We have an industry strategy/plan in place for 2015/16 which details how we will deliver on the High Level Objectives relating to Industry. A single point of contact (SPOC) service is run by the industry team and provides full time cover of the mailbox dedicated to industry related queries and correspondence. The industry team will lead the promotion of the industry agenda by ensuring it is highlighted at internal and external events, such as our annual conference where we will have a stand to promote the benefits of collaborating with industry. The wider LCRN team also play a part in advocating the industry agenda whenever appropriate. The provision of local feasibility information is overseen by the LCRN industry team, with new studies across all divisions being	The industry agenda has been promoted whenever possible and our partners are aware of the importance and benefits of collaborating with industry. We have a fully operational system for carrying out the local feasibility service which is consistent across all divisions. Robust feasibility is carried out and informative site identification & intelligence data is provided to commercial companies upon request.	March 2016

[1] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351182/AcoRD_Guidance_for_publication_May_2012.pdf
[2] Information on recent performance provided by national CRN Coordinating Centre on 30/01/15

				disseminated and collated via specialty specific tailored pathways by the SPOC. Robust feasibility is conducted by the clinical team and R&D department and performance data is either provided by the trust or obtained from the NIHR CRN RAG report. Impending deadlines for site identification or intelligence services are monitored via the Industry SIF Tracker Database and overdue services are flagged as red until complete. An update is emailed to the co-ordinating centre if a service is likely to miss the deadline, and an anticipated completion date provided. On a monthly basis, the industry team will review performance against the service deadlines for site intelligence and identify teams/trusts that are consistently missing the deadline. Updates on the flow of commercial feasibility requests and individual site responses are provided regularly to the RDMs for information. The OMG is also provided with data on the feasibility activity taking place across all Partner Organisations and specialties, including reasons for declining study participation. A log is kept of all submissions of feasibility in our LCRN and the number that lead to site selection, in order to provide a basis for improving our conversion rate. The industry team liaises with sponsor and R&D departments where necessary to resolve issues with study set-up of commercial studies and advise on use of the NIHR costing template. The industry team produce localised site level RAG reports for commercial studies on a monthly basis, which are distributed to Partner Organisations and the RDMs. Monthly meetings will be held between the RDMs and Industry Team to review performance and address any studies that require escalation. The industry team or RDM as appropriate attends national teleconferences to discuss study performance wherever necessary, works with the national industry team and RDMs to gather feedback on studies falling behind, and shares best practice on succeeding studies.	Performance against feasibility service timelines is reviewed monthly and issues escalated. Monthly reports provided to RDMs. Quarterly reports for OMG. Conversion rate is reviewed by Industry Team and RDMs on a quarterly basis. Reports distributed and discussions held monthly. Teleconference attended/ study feedback gathered as required	
			Provide details of local strategies for achieving LCRN wide usage and adoption by Host and Partner organisations of the NIHR CRN costing template	• Agreement from Partnership Group to adhere to the use of the costing template • Agreement from OMG to adhere to the use of the costing template • Distribute guidance to all R&D Managers in Partner Organisations • Promote use of template using various media	NIHR CRN Costing template adopted LCRN wide.	March 2016
Delivering on the Government Research Priority of Dementia	The Host organisation will ensure the LCRN supports this strategy by: Identifying and nominating clinical Research Leads in each of these disease areas (dementias, Parkinson's disease, Huntington's disease and motor neurone disease) to support the delivery of the Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio through local clinical leadership and participation in national activities, including national feasibility review	7.1-7.7	Please provide names and contact details for identified clinical Research Leads for each of these disease areas	Dementias:	Professor Roy Jones r.w.jones@bath.ac.uk 01225 476 420	
				Parkinson's disease:	Tarun Kuruvilla Tarun.kuruvilla@glos.nhs.uk 01242 634 460	
				Huntington's disease:	Tarun Kuruvilla Tarun.kuruvilla@glos.nhs.uk 01242 634 460	
				Motor neurone disease:	Tarun Kuruvilla Tarun.kuruvilla@glos.nhs.uk 01242 634 460	
Patient and Public Involvement and Engagement (PPIE)	The Host organisation will support the development and implementation of the NIHR CRN Strategy for PPIE and deliver a work plan with measurable targets for ensuring that patient choice, equality and diversity, experience, leadership and	8.1-8.6	Provide a comprehensive patient and public involvement and engagement plan in line with agreed format and guidance	Provide via completion of Table 4		

	involvement are integral to all aspects of LCRN activity, in partnership across NIHR CRN.					
	The Host organisation must identify a senior leader to take responsibility for Patient and Public Involvement and Engagement (PPIE) within the LCRN. The identified lead will participate in nationally agreed PPIE initiatives and support the delivery of an integrated approach to PPIE across the NIHR CRN.		Provide the name and contact details for the senior leader with identified responsibility for patient and public involvement and engagement	Chantal Sunter Research Delivery Manager and Lead for Communications, Engagement and PPIE Chantal.Sunter@nihr.ac.uk 0117 342 1292	N/A	N/A
Continuous Improvement (CI)	The Host organisation will promote and sustain a culture of innovation and continuous improvement across all areas of LCRN activity to optimise performance	9.1-9.6	Provide an assessment of the LCRN's current position in relation to Continuous Improvement	Two RDMs recently started training in Lean Six Sigma. COO already trained. Adopting continuous improvement as business as usual. We are in the process of delivering two improvement projects through the Lean Six Sigma training, in business intelligence and industry in primary care. They will be completed in June 2015. One R&D manager in a local partner has also recently completed training and keen to work with the CRN to further embed the culture of continuous improvement.	N/A	N/A
			Provide an action plan for promoting and sustaining a culture of innovation and continuous improvement across all areas of LCRN activity, including the LCRN's approach to developing capacity and capability of the LCRN workforce (the latter to be evidenced in the LCRN's submitted workforce development plan)	Provide via completion of Table 5		
			Provide details of continuous improvement projects to be delivered locally in 2015-16 (via CRN Central)	All planned projects have been uploaded to CRN central following approval by our Continuous Improvement lead, Mary Griffin, 0117 342 1289 mary.griffin@nihr.ac.uk		
Workforce, Learning and Organisational Development	The Host organisation will develop a workforce plan for LCRN staff that will enable a responsive and flexible workforce to deliver NIHR CRN Portfolio studies. This will be developed in partnership with Local Education and Training Boards (LETBs) and other stakeholders and other local learning providers, including Academic Health Science Networks (AHSNs)	10.1-10.10	Provide a workforce plan in line with agreed format and guidance	Provided via completion of Table 6		
			Provide the name and contact details for the senior leader with identified responsibility for LCRN workforce development	Maxine Taylor Senior Research Delivery Manager and Lead for Workforce Development Maxine.taylor@nihr.ac.uk Tel: 0117 342 1811	N/A	N/A
Information Systems	The Host organisation must ensure that appropriate, reliable and well maintained information systems and services are in place and fully operational as specified	13.1-13.19	Confirm LPMS systems are live and operational as required	Yes. Migration of complete 2014-15 recruitment data to EDGE on track. Host and all partner organisations have access to EDGE.	N/A	N/A
			Confirm arrangements are in place for provision of an LCRN Service Desk function and provide contact details	Yes. This is provided by the Business Intelligence team. BIU.WestEngland@nihr.ac.uk	N/A	N/A
			Provide the name and contact details of the identified lead for the Business Intelligence function	Mike Lacey, 0117 342 1370; mike.lacey@nihr.ac.uk	N/A	N/A
Engagement and Communication	It is the responsibility of the Host organisation to ensure that there is a specialist, experienced and dedicated communications function to support the work of the LCRN, with a sufficient budget line. The Host organisation will support the development and implementation of the NIHR CRN Strategy for Communications and ensure that the LCRN communications function develops and delivers a local communications delivery plan that recognises the LCRN's position as part of a national system. The plan should also encompass local delivery of national NIHR/NIHR CRN campaigns.	14.1	Describe the dedicated communications function the LCRN has in place	Chantal Sunter is the Lead for Communications, Event, and PPIE. There is a dedicated Band 5 communications, events and PPIE officer. We also receive support from the host communications department.	N/A	N/A
		14.2	Outline up to 5 priorities/priority activities contained in the LCRN's local communications delivery plan	1) Fully functioning website to support the clinical research community with their engagement with CRN: West of England.	1a) Website fully developed and functioning b) Up to date	a) Q1 2015/16 b) Ongoing
				2) Development and implementation of social media workstream to link with PPIE and delivery activities.	2a) Identification of key social media platforms appropriate to CRN WE b) Development & testing of those platforms c) Launch and active use of those platforms	a) Q1/Q2 2015/16 b) Q3 2015/16 c) Q4 2015/16

				3) Production of a newsletter every two months.	3) Bimonthly newsletter produced	Bimonthly
				4) Organisation of specialty specific engagement and other events to increase collaboration and engagement with clinical research within the region. Support of national NIHR campaigns locally as appropriate	4a) Clinical Specialty Lead engagement event b)International Clinical Trials Day c) Tri network conference d) Primary Care Event e) Other events ongoing as required	a) May b) May c) October d) Spring e) ongoing
		14.3	Budget line identified in Annual Financial Plan for 2015-16	N/A	N/A	N/A
Information Governance	Actively promote and enable good information governance relating to all areas of LCRN activity	15.2	Provide the Information Governance Toolkit 2013-14 (version 11)[3] score for the LCRN Host organisation and confirmation of attainment of Level 2 or above on all, or any exceptions which arise from or impact on LCRN-funded activities	2		
		15.5	Provide a copy of the LCRN's documented process for reporting information governance incidents arising from LCRN-funded activities to the national CRN Coordinating Centre	Submitted as Appendix 2		
		15.8	Provide the name, email address and contact number(s) for the individual with specialist knowledge of information governance identified to respond to queries raised relating to LCRN-funded activities	Maxwell Allen, Information Governance Officer maxwell.allen@uhbristol.nhs.uk 0117 342 3701	N/A	N/A
		15.9	Provide details of information systems utilised in LCRN activities and assurance/evidence that these are in line and comply with the 2013 NIHR Information Strategy[4]	• EDGE Local Portfolio Management System (meets the LPMS System of Choice Framework Requirements) • NIHR CRN Hub (Google platform) is used for email, calendar, file storage, website	N/A	N/A

[3] https://www.igt.hscic.gov.uk/
[4] https://docs.google.com/a/nihr.ac.uk/file/d/0B6w0JTB5jHBSSldZT0Qyc05lVms/edit?usp=drive_web

Table 4. LCRN Patient and Public Involvement and Engagement Plan 2015-16

Planned actions in 2015-16	Milestones and outcomes once actions complete	Timescale	Lead
1 The Host organisation has a duty to promote research opportunities, in line with the NHS Constitution for England, including informing patients about research that is being conducted within each LCRN, and actively involving and engaging patients, carers and the public in research.	**MILESTONES**		
	1. The CRN PPIE Lead is an active member and supporter of the joint PPIE initiative - People in Health West of England (PHWE), bringing together CLAHRC West, WEAHSN, Bristol Health Partners, Healthwatch and others.	April 1st 2015	PPIE Lead
	2. Regular meetings are held with public contributors to plan PPIE priorities for the future	On-going	PPIE Lead & COO
	3. Workshops held with CLAHRC West to help members of the public develop their research ideas and become more research aware	Autumn 2015	PPIE Lead & PHWE
	4. A joint approach is developed with CLAHRC West to encourage participation in research (CRN - Everyone Included; CRN & WEAHSN – Join Dementia Research, CLAHRC – Reach West).	July 2015	PPIE Lead & CLAHRC West
	5. Different methods of social media are in place to keep patients/carers and public informed of opportunities for involvement and participation	Ongoing	PPIE Lead & Comms Lead
	6. CRN WE is active in the Partner's Communications Network, linking in websites and liaising over joint messages	Ongoing	PPIE Lead & Comms Lead
	7. Patient stories collected and campaign promoted across the network	Dec 2015	Comms Lead
	8. Participate in PHWE Away day to review progress and future priorities	Dec 2015	PPIE Lead & PHWE
	9. Bank of PPIE tools and resources developed and shared across the network	Sept 2015	PPIE Lead & PHWE
	10. Appointment of additional Join Dementia Research Patient Champions to support the roll out of Join Dementia Research across CRN WE	Ongoing	PPIE Lead & PHWE

	OUTCOMES 1. Increased recognition of CRN WE as a best practice provider of high quality clinical research support to the NHS 2. Increase in demand for and participation in portfolio research studies by members of the public 3. Increase in demand for materials review service and PPIE tools 4. Greater contribution from CRN WE's public contributors 5. Public and staff have increased awareness of value of taking part in a research study		
2 The Host organisation will establish and deliver a work plan with measurable targets for ensuring patient choice, equality and diversity, experience, leadership	**MILESTONES** 1. Develop PPIE plans with all portfolio research leads and embed into overall CRN WE strategy 2. Work with PHWE to put in place a plan to address the lack of diversity in applied health research 3. Promote PHWE learning & development opportunities 4. Support national campaigns such as OK to ASK and Breaking Boundaries 5. Support International Clinical Trials day **OUTCOMES** • Greater clarity amongst portfolio research leads on embedding PPIE at all levels of the work • Greater awareness of how to address the lack of diversity in research • Demography of research participants more diverse and	Sept 2015 Dec 2015 On-going On-going April 2015	PPIE Lead PPIE Lead/ PHWE Comms Lead/ PHWE PPIE Lead/ PHWE Comms/ PPIE Leads

	research topics more reflective of equalities communities. • PPIE becomes embedded into job roles as a core activity - is everyone's business and responsibility.		
3 The Host organisation will ensure that the Host organisation and LCRN Partners actively engage and involve patients, carers and the wider public in all aspects of LCRN activity to improve the quality and delivery of NIHR CRN Portfolio research	**MILESTONES** 1. Two Public Contributors have been selected and contribute to CRN WE Board and long term planning processes 2. A plan is in place to embed PPIE in all the CRN portfolio research 3. Involvement is encouraged through widening participation in the Materials Review project – new members of the public selected and trained 4. Patient / carer case studies and stories are gathered, collated and analysed on an on-going basis and then utilised within communication activities wherever possible 5. Constructively use findings for performance improvement **OUTCOMES** • The quality of research proposals are improved at all stages – from pre-ethics to completion • A culture of working collaboratively is developed and strengthened by supporting involvement and engagement opportunities with key stakeholders	April 2015 July 2015 July 2015 On-going On-going	PHWE PPIE Lead/ CRN WE Staff PPIE Lead/ PHWE Comms Lead PPIE Lead/ CEO
4 The Host organisation will gather feedback from participants in NIHR CRN Portfolio studies as well as patients, carers and the public, directly involved in supporting delivery of NIHR CRN Portfolio studies, by undertaking annual surveys, as required by	**MILESTONES** 1. Use case studies/patient stories to assess the impact of patients, carers and the public who are actively involved in supporting the delivery of NIHR portfolio studies. 2. Carry out exit questionnaire for all patients/ public taking	Oct 2015	PPIE Lead/Comms Lead

the national CRN Coordinating Centre. NIHR CRN Performance & Operating Framework	part in CRN portfolio research **OUTCOMES** Feedback from patients/carers/ public contributors continuously informs the network to improve systems/process/training	Nov 2015	PPIE Lead/ PHWE
5 The Host organisation will collate numbers of actively involved patients, carers and the public accessing NIHR CRN learning and development resources, as specified by the national CRN Coordinating Centre	**MILESTONE** 1. Attendance at PHWE learning & development training events are monitored and feedback provided to the PHWE Strategy Group **OUTCOMES** Learning & development programme and materials continuously updated based on evaluations from completion of programmes	On-going	PHWE
6 The Host organisation must identify a senior leader to take responsibility for Patient, Public Involvement and Engagement (PPIE) within the LCRN. The identified lead will participate in nationally agreed PPIE initiatives and support the delivery of an integrated approach to PPIE across the NIHR CRN	**MILESTONES** 1. PPIE Lead appointed and working closely with public contributors and PHWE 2. Regular reports provided by PPIE Lead to Performance meetings , Partnership group , Operational groups on a regular basis on national and local initiatives 3. The Partners Communications Network meets quarterly and includes PPIE and Comms Leads supporting involvement and engagement opportunities with key stakeholders 4. PPIE Lead attends national PPIE Leads meetings on a regular basis to ensure CRN WE representation at a national level and engagement with relevant nationally led initiatives	April 2015 Sept 2015 Ongoing Ongoing	PPIE Lead PPIE Lead PPIE Lead PPIE Lead

Table 5. LCRN Continuous Improvement Action Plan 2015-16

Planned actions in 2015-16	Milestones and outcomes once actions complete	Timescale	Lead
Improving processes for routine and ad hoc business intelligence reporting • Define problem and agree scope • Collect and measure data to understand current state • Analyse data to verify causes affecting inputs and outputs • Learn from project and implement improvements • Complete project work and hand over improved process with procedures for maintaining the gains.	Identified streamlined processes for effectively managing both routine and ad hoc reporting.	Completion by June 2015	Ruth Allen
• Improving the number of primary care organisations delivering commercial research • Define problem and agree scope • Collect and measure data to understand current state • Analyse data to verify causes affecting inputs and outputs • Learn from project and implement improvements • Complete project work and hand over improved process with procedures for maintaining the gains.	Identified real and perceived barriers to delivering commercial research in primary care. Resources/toolkit produced for primary care to address barriers.	Completion by June 2015	Mary Griffin
Creating a Lean culture in CRN: West of England • Agree scope with support team • Share and agree priorities and best practice • Identify inputs and outputs required • Develop support materials • Implement new standards • Evaluate efficiency and effectiveness	Best practice ways of working agreed. Support materials agreed and developed. Quality standards set. Standardised ways of working created. Increased efficiency in working practices and outputs. Culture of continuous improvement embedded in the team. Streamlined, efficient and high quality service delivered.	Best practice agreements completed by August 2015. Support materials developed by October 2015. New measures implemented and evaluated by March 2016.	Mary Griffin

Senior Team Development • Agree scope of development • Collect data to understand strengths of existing team • Analyse strengths of team and how to maximise performance Learn from development and use it to inform ways of working • Complete initial development process, sustain strong senior management team and develop ways to enhance team performance based on new knowledge	Learning and practitioner needs analysis performed. Development days held for Senior Management. Focussed on becoming a high performing team. Enhanced and sustained Senior Management team performance.	Development begins March 2015 and then ongoing. Senior Management away days completed by July 2015	Mary Perkins

Table 6. LCRN Workforce Development Plan 2015-16

Planned actions in 2015-16	Milestones and outcomes once actions complete	Timescale	Lead
Roll out of 'Let's talk Trials' communications training • Train the trainer (2 cohorts) • Programme available • Evaluate • Facilitators supported	First cohort of volunteer trainers complete the train the trainer exercise and are signed off as competent to deliver the course. Second cohort signed off as competent to deliver. Training programme available to workforce.	May 2015 Aug/Sept 2015 May 2015	Maxine Taylor
Roll out of Fundamentals of Research training • Programme available • Evaluate • Facilitators support	Programme finalised for two-three courses through the year at sites around network.	June/July 2015	Maxine Taylor
Establish CRN – WE facilitators staff group to support all of the network's training facilitators	Establish google group. Support meetings planned for biannually. Each course to have a lead facilitator with national engagement where required - GCP, Consent, TTT, FOR, RATER etc. Content review panels as required.	April 2015	Maxine Taylor
Training needs analysis of the whole research workforce	Survey circulated. Responses collated. Use to inform training and education programme for next two years. Use to provide ad hoc training as required e.g. dry ice. Use to signpost workforce to online learning opportunities.	June 2015 August 2015	Maxine Taylor
Coordinate workshops on: • 'how to undertake robust study feasibility' • 'portfolio balance'	Planning groups established through OMG. Stand-alone events or workshops within larger event e.g. network annual event.	May 2015	Maxine Taylor

• 'research team skill mix'			
Coordinate network support team training and development	Twice a year away day. Programme of team training at monthly meetings. Research awareness sessions. Staff to link personal objectives to local and national objectives.	September 2015 and March 2016	Maxine Taylor
Develop research apprenticeship	Agree job description and person specification through Senior Research professionals group, HR and OMG. Business case to LCRN Executive Management Group Roll out to partner organisations who wish to pursue. Consider role within network support team.	May June	Maxine Taylor
Implementation of a flexible Nursing Cohort for Primary Care.	Operational Planning meeting with Divisional Lead and RDM primary care. Executive Management Group sign off project. Advertisement of posts. Appointment to posts.	17 March 2015 30 March 2015 May 2015 June 2015	Sue Taylor
Professional Development day for nurses and allied health professionals	Workshop delivered regarding revalidation for nursing. Standards and quality workshop all research active non-medical professionals.	2 June 2015	Sue Taylor
Redeployment Plan for clinical research workforce.	To agree a regional/local redeployment plan during clinical pressures with the Senior Research Professionals Strategic Leadership group.	May 2015	Sue Taylor
Continued development of non- medical PIs	Senior Research Professionals Strategic Leadership group will continue to explore opportunities to engage and develop non-medic PIs across the region, specifically for priority areas (division 2).	Ongoing	Sue Taylor

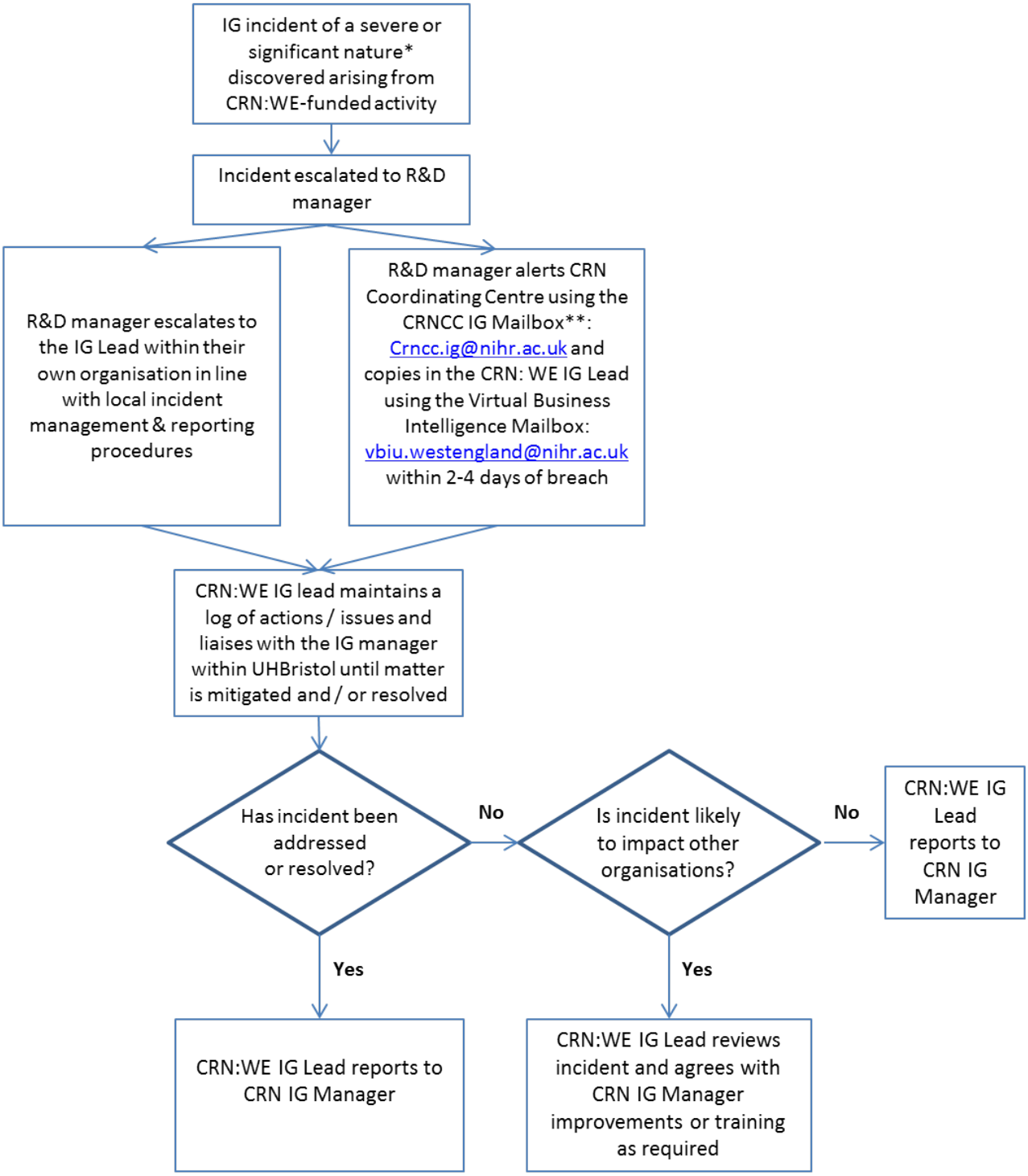
Appendix 1: Risk Register

RISK ANALYSIS										RISK TREATMENT PLAN									
Risk Reference	**Category**	**Author**	**Date registered**	**Nature of Risk**	**Risk Description**	**Proximity**	**Probability**	**Impact**	**Score**	**Risk Owner**	**Risk Response Categories**	**Control (Action)**	**Risk Response**	**Assurance/ Update**	**Risk Actionee**	**Additional Comments**	**Residual Probability**	**Residual Impact**	**Residual Risk Rating**	**Last review**	**Risk Status**
BI1	Business Intelligence	Ruth Allen	04/10/2014	Technical	As a result of primary care and mental health data not being included in Edge, there is a risk that Edge is not fit for purpose, which will result in decisions that are not data driven.	6 months	3	3	9	Ruth Allen	Reduce	1. Work with Edge team and Primary Care to scope requirements and find solutions.	Liaise with (1) CRN staff supporting primary care studies (2) mental health trust EDGE champions (3) EDGE provider to work on implementation in these areas	Successful test upload of recruitment data for primary care studies to EDGE. Ongoing liaison with primary care and mental health CRN / R&D staff	Mike Lacey	Issues resolved and implementation nearly complete.	1	1	1	31/03/2015	Active
BI2	Business Intelligence	Ruth Allen	06/10/2014	Timescale	As a result of delay in the national launch of CPMS, there is a risk that the LCRN will not have access to complete and accurate national data, which will result in the BI team amalgamating data from multiple sources which is time consuming and increases the margin for error.	6-12 months	4	1	4	Ruth Allen	Reduce	1. Focus on full LPMS implementation to reduce reliance on CPMS (i.e. good local data).	"Business as usual" can continue with the existing UKCRN portfolio database until CPMS is ready.	No launch date currently specified	Mike Lacey	Launch date still unknown.	4	1	4	31/03/2015	Active
CE1	Clinical Engagement	Holly Vallance	11/11/2014	Operational	As a result of the geographical changes of the networks and late appointment of Specialty Leads we have lost opportunities for growth in certain specialties i.e. Dermatology and Cardiovascular Disease - this is an ongoing risk to not meeting the commercial specific specialty objectives.	3-6 months	4	3	12	Holly Vallance	Reduce	Work with Specialty leads when in place to develop an action plan to address this	Work with Specialty leads when in place to develop an action plan to address the threats to commercial portfolio	Not all leads appointed, plan to work with leads that are appointed	Holly Vallance	Majority of leads in place, but not all. Work with leads as appointed.	2	3	6	31/03/2015	Active

Residual Risk Descriptor
Extreme risk
Partially controlled risk
Controlled risk
Well controlled risk

Matrix from NPSA risk matrix 2011: http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/

Appendix 2: NIHR Clinical Research Network: West of England Process for reporting information governance incidents arising from LCRN-funded activities to the national CRN Coordinating Centre



*Severe IG breach leading to suspension of service, release of PID belonging to 100+ individuals. Significant IG breach negatively impacting service delivery, a breach resulting in sanctions/reprimands from ICO/authorities, repeated occurrence of a breach, release of PID belonging to 30+ individuals.

**The required level of detail is just the high level descriptor of the breach. There is no requirement to send PID/Commercially sensitive information to the CRNCC.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
18. Audit Committee Chair's report
Sponsor and Author(s)
Sponsor: John Moore, Chair of Audit Committee Author: John Moore, Chair of Audit Committee

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose This report provides a summary of the business discussed at the meeting of the Audit Committee held on 9th September 2015. Key issues to note The report includes an overview of the key issues discussed, areas of challenge and scrutiny and assurance provided by the Executive,Trust representatives, Internal Audit and External Audit.
Recommendations
The Board is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
N/A
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Report to the Board of Directors meeting 30th September 2015

From Audit Committee Chair John Moore, Non-Executive Director

This report describes the business conducted at the Audit Committee held 9th September 2015, indicating the challenges made and the assurances received.

Item	Key Points	Challenges	Assurance
Matters Arising from Minutes	The request for a review of governance arrangements for hosted organisations.	This arose out of a request by NEDs to receive assurance regarding arrangements for hosted organisations.	A paper had been previously submitted to the Committee in September 2014, therefore, NEDs were asked to clarify their request for additional assurance to the Chief Executive.
Local Counter Fraud Status Report	The regular report was received summarising the work of the counter fraud service during the period. The Trust had been subject to a self-assessment review of its anti-fraud and bribery arrangements and had been rated as 'Green'.	Committee members raised specifically the risk relating to potential fraud relating to procurement.	Work continues to strengthen the Fraud and Bribery sessions delivered at staff induction. Assurance was provided that on-going monitoring is in place. The self-assessment will be further reviewed by NHS Protect to provide additional assurance.
	The findings from the NHS Protect Intelligence report were discussed	A request was made for further detail to be provided in future reports regarding relative size of fraud and resulting cost implications to Trust's. Committee members also requested additional distinction within the report between national and local data.	Risks relating to staff fraud have been raised and included within the Counter Fraud Work plan for 2015/16. Staff sickness was also a regular feature of the Quality and Outcomes Committee monitoring process on an on-going basis.

Item	Key Points	Challenges	Assurance
Internal Audit Progress Report	Estates Management internal audit discussed.	The Committee requested assurance regarding weaknesses relating to procurement of contractors and compliance with other governance requirements.	Significant work has been undertaken to embed appropriate culture and practice. The executive confirmed that all procedures and processes were in place and a re-audit would be undertaken and reported back to the Committee in February 2016. External Auditors agreed to explore information available on benchmarking practices within other Estates Departments in other Trusts.
	Medical Staff Leave internal audit discussed.	Challenge from members of the Committee regarding processes for authorisation and oversight of medical staff leave.	The report will be monitored in the short term by the Quality and Outcomes Committee with a further update on progress against recommendations to the December Audit Committee.
	Operation of WHO (World Health Organisation) Checklists internal audit discussed	Although acknowledged that the internal audit related to processes and not issues of patient safety, Committee members requested assurance that patient safety was not being compromised.	Recommendations will focus on the appropriateness and necessity of operating the checklist in all areas. The recommendations will be monitored by the Quality and Outcomes Committee for additional assurance.
	Patient Experience (Dementia) internal audit was discussed.	Although the audit was green rated, the Committee requested a review of this, based on outcomes reported elsewhere.	An update on the outcome of the review will be submitted to the Committee in December.
	Workforce Planning internal audit was discussed	The green rating was queried by members of the Committee given the current challenges in terms of	It was acknowledged that the audit scope focused on systems and processes as opposed to

Item	Key Points	Challenges	Assurance
		Workforce planning.	outcomes. Internal audit confirmed that the rating will be reviewed with the Director of Workforce & OD; however, the Director of Workforce & OD had already requested a more detailed audit.
External Audit Progress Report	The report was received for information.	Members referred to 'key issues for consideration by Audit Committees' and how this would be reviewed.	The Audit Committee are scheduled to undertake an annual self-assessment and these areas will be considered as part of the annual review.
Single Tender Actions	The report was received for information	There were no areas where challenge was required.	The report provided adequate assurance.
Losses and Compensation Report	The report was received for information	There were no areas where challenge was required.	The report provided adequate assurance.
Update on Non-EROS Procurement Controls	To report provided assurance to the Committee of the work being undertaken to review and improve the process of ordering goods and services outside of the EROS system, in particular with regard to segregation of duties.	The report resulted from a request from Non-Executive Directors for strong assurance that the systems in place were robust and adequate to manage expenditure.	The report provided an adequate level of assurance; however, the area will be subject to a further audit in February 2016 to ensure good practice has been embedded.
Clinical Audit Annual Report 2014/15	The report provided an overview of the work undertaken during the year and included the benefits and improvements made as a result of clinical audit work.	There were no areas where challenge was required and Committee members thanked the clinical audit team for an excellent report.	N/A
Clinical Audit Quarterly Report	The report provided the Committee with an update on progress against	The Committee queried how the Trust could use clinical audit to proactively	Assurance was provided that work had significantly improved to

Item	Key Points	Challenges	Assurance
2015/16	the plan for clinical audit activity for 2015/16.	prevent poor clinical practice. A question was raised as to how audits were selected.	ensure that learning from clinical audits was shared with all divisions trust wide. Work is in train to link the work of clinical audit with the Trust's new risk management and incident reporting system, Datix. Non-Executive Directors suggested that further discussion and education for the Board on how the clinical audit function supports the quality and safety agenda of the organisation be a topic for a future seminar.
Board Assurance Framework	The BAF was received for review and outlined the Trust's strategic objectives, annual objectives, progress on achieving these and the associated risks and mitigation plans.	Members of the Committee commented positively on the work undertaken to improve the document as a source of assurance for the Board.	Further information will be incorporated over the next month with regard to internal and external assurance to further strengthen the document.
Risk Management Group Summary Report	The report was provided for assurance to the Committee	Although there were no areas where challenge was required, Committee members requested the report to be improved and aligned to a similar format of that used for Committee Chairs reports.	A revised report will be provided for future meetings.
Reports were received from the Quality and Outcomes Committee and Finance Committee Chairs	N/A	N/A	N/A

Item	Key Points	Challenges	Assurance
Register of Gifts and Hospitality	The register was received for information	Challenge was put forward regarding the level of assurance the Trust has regarding nil returns.	The Trust's policy for the Register of Gifts and Hospitality is scheduled for review and will be reported back to the Committee at a later date. The revision to the policy will include improvements to the process for registration.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
19. Governor Expenses Policy
Sponsor and Author(s)
Sponsor: Deborah Lee, Chief Operating Officer/Deputy Chief Executive Author: Debbie Henderson, Trust Secretary

Intended Audience									
Board members	X	Regulators		Governors		Staff		Public	

Executive Summary
Purpose To receive the revised Governors Expenses Policy. Key issues to note The Governor Expenses Policy has been updated to provide further clarity and guidance to governors with regards to the claiming of expenses in relation to their role. The policy outlines the criteria for submissions, and when to seek guidance from the Trust Secretary and Membership & Governance Team. The policy also outlines the process for claiming and repayment of expenses.
Recommendations
The Board is to **approve** the revised Governor expenses policy.
Impact Upon Board Assurance Framework
None
Impact Upon Corporate Risk
None
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		For Approval	X	For Information	

Date the paper was presented to previous Committees

Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Executive Management Team	Other (specify)
				27/8/15	

University Hospitals Bristol NHS
NHS Foundation Trust

Policy on Reimbursement of Expenses for the Council of Governors

Date:	August 2015
Author:	Debbie Henderson, Trust Secretary
To be ratified by:	Trust Board
Review Date:	August 2018
Version:	v1

1. EXECUTIVE SUMMARY

1.1 This policy sets out the Trust's expectations for a clear and consistent process to ensure that Governors are reimbursed for travel and carer costs encountered through attending any pre-agreed Governor activity organised by the University Hospitals Bristol NHS Foundation Trust.

2. RATIONALE / UNDERPINNING PRINCIPLES

2.1 As a Foundation Trust, UH Bristol is accountable to the public, patient and staff members through the elected governors on the Council of Governors. The roles and responsibilities of a Governor require the Governors to communicate with their constituencies and attend meetings (as agreed through the Membership Office). This ensures that the public, patient and staff members are engaged in planning, delivering and improving NHS services.

2.2 The post of Governor of a Foundation Trust is voluntary, and it is a fundamental principle that no Governor shall receive any form of salary or remuneration for being a Governor. The Department of Health has stated that governors should not be left "out of pocket" through carrying out their role as Governor.

2.3 It is the responsibility of each individual Governor to ensure value for money when incurring expenses, taking into account both cost and convenience. If there is any doubt then you must seek prior approval from the Trust Secretary before committing expenditure.

2.4 Governors should agree with the Trust Secretary the general nature and level of expenditure to be incurred prior to the expenses being incurred. Failure to do so may result in reimbursement being withheld.

2.5 It is the responsibility of Governors to ensure that correct claims are made.

2.6 In line with principles of transparency for good governance, UH Bristol, along with other NHS Foundation Trusts, is required to publish expenses paid to governors in its Annual Report.

3. SCOPE

3.1 The Trust will reimburse Governors for reasonable travel expenses incurred through participation in pre-agreed Governor activities.

3.2 Expenses will be reimbursed for the following activities:

- Travelling expenses incurred by a Governor whilst attending Governor meetings, seminars and events organized by the Trust;
- Travelling and subsistence expenses incurred by a Governor whilst attending external meetings, seminars and events at the request of or on behalf of the Trust in his/her capacity as a Governor. Expenses of this type must be approved in advance by the Trust Secretary and, if necessary, can be arranged by the Membership Office through current Trust travel booking/accommodation mechanisms.
- Any expenses other than vehicle mileage must be supported by valid receipts. Failure to produce such receipts may result in reimbursement being withheld. Any expenses outside of the above must be agreed with the Chairman or Trust Secretary.

3.3 In line with Bristol City Council and the Trust's commitment to encouraging greener travel, the general expectation is that governors will use public transport to carry out their duties e.g. standard class rail return, bus and coach. However, if it is necessary to use a vehicle, mileage may be claimed as set out in Appendix A. Please note that where vehicle use applies, the Trust will pay mileage and reasonable parking costs only.

3.4 In extreme circumstances (for example, due to physical disability/medical reasons/late evening meetings in circumstances when personal safety may be compromised), reimbursement may be considered for reasonable taxi fares and agreed in advance by the Trust. Where this is the case the claimant may be required to provide documentary evidence to support such a request, for example a doctor's letter to confirm they are unable to use public transport or walk the required distance.

3.5 If a governor meeting or event takes place over a lunchtime appropriate provision of food and drink will be made.

3.6 The Trust will also reimburse governors for any reasonable carer costs incurred during the course of carrying out their role. Any cost relating to caring should be discussed and agreed with the Trust Secretary/membership office before any commitments are made.

3.7 The Trust will aim to provide the governors with hard copies of meeting papers where required, however, on occasions where this does not happen, the Trust will reimburse governors for "out of pocket expenses" for personal office equipment disposables and stationery up to a maximum of £50.00 per year.

4. PROCESS & PRINCIPLES FOR REIMBURSEMENT

4.1 If a governor is receiving State Benefits, it is their responsibility to check with their local government agency whether the receipt of any expenses might affect their entitlements.

4.2 Any persons claiming for travel costs must do so using the appropriate expenses claim form (see Appendix B). All governors are encouraged to submit the form electronically to the Membership Office. Receipts must be provided for any travel, carer and other expenses as outlined in Section 3, (with the exception of vehicle mileage).

4.3 If vehicle mileage is being claimed, the return mileage will be calculated for the actual journey undertaken but will not exceed that from the post code of the governors home address to the venue. This ensures that the Trust does not pay inappropriate mileage, for example in the event that a claimant travels from outside of the local area to a Trust event as a result of commitments unrelated to the Trust.

4.4 Reimbursed expenses should be for the exact amount claimed; not for a rounded-up or average amount.

4.5 Subsistence allowance, where the Governor is away from their home for longer than five hours for the purpose of attending a designated meeting and where no refreshment is provided at the Trust's expense, or provided at the venue, will be paid up to a maximum of £5 per person per meeting.

4.6 Governors should make their claim for reimbursement of expenses promptly; ideally within four weeks of incurring, and this must be done within three months of the expense being incurred at the latest. The Trust cannot guarantee payment of expenses claimed after three months of occurring.

4.6 Reimbursement will normally be paid electronically directly into a Governor's bank account. This is the quickest and most secure form of payment. All Governors should complete a BACs form, see Appendix C, and submit the completed form to the Membership Office. If any Governor seeks an alternative payment method then they should speak to the Membership Office.

Appendix A

Governor Mileage Allowances

These mileage allowances are consistent with standard rate mileage allowances paid to NHS staff under Agenda for Change.

Vehicle	Mileage allowance
Car engine capacity up to 1000cc	37.4p per mile
Car engine capacity 1001-1500cc	47.3p per mile
Car engine capacity over 1500cc	58.3p per mile
Additional passengers	5p per mile
Motor cycles up to 125cc	17.8p per mile
Motor cycles over 125cc	27.8p per mile
Pedal Cycles	20p per mile

University Hospitals Bristol NHS
NHS Foundation Trust

Governor Expenses

Appendix B

Please note: **Receipts must** be provided for public transport fares (bus, coach, train, taxi, etc) and should be attached to this form. Please note, if you are unable to obtain a car parking receipt, please note details ie where you parked.

Name: _____ **Mileage allowance (see back for allowance)**: _____

Date	Description *(what was the title of the meeting etc you attended? Or include other items ie stationery)*	Location *(where was meeting held)*	Travel details *(how did you travel ie car, bus, cycle, taxi etc. Include other ie car parking)*	Number of car miles *(if applicable)*	Costs *£*	*p*
				TOTAL		

PTO

Vehicle	Mileage allowance	Vehicle	Mileage allowance
Car engine capacity up to 1000cc	37.4p per mile	**Motor cycles up to 125cc**	17.8p per mile
Car engine capacity 1001-1500cc	47.3p per mile	**Motor cycles over 125cc**	27.8p per mile
Car engine capacity over 1500cc	58.3p per mile	**Pedal Cycles**	20p per mile
Additional passengers	5p per mile		

I declare that:

a) The travelling expenses and allowances are in accordance with the appropriate regulations and are in connection with official visits to places indicated on the date(s) shown.
b) The details shown match the vehicle used in respect of this claim.
c) Where a claim for mileage is made:
   - A valid third party insurance policy (including cover against risk of injury to, or death of passengers and damage to property in respect of the vehicle) was held for the period of the claim.
   - This policy will continue to be maintained while the vehicle is used by me on official duties and will cover the use of the vehicle in official business.
d) No other claim has been made or will be made by me on any public body for expenses or allowances in connection with the business stated.

Signature of claimant: _____ Date: _____

Address of claimant incl. post code: _____

_____

Authorised by Head of Membership & Governance: _____ Cost centre: 150227 Acct code: 30216

This form to be emailed or handed to the Membership Office for reimbursement.

Appendix C

University Hos

BACS FORM

Finance Department
Creditor Payments
Trust Headquarters
Marlborough Street
PO Box 1053
Bristol BS99 1YF

Fax: 0117 342 3740

Email: Ann.Clark@UHBristol.nhs.uk

Full Name :	
Payee Name if Different to Above :	
Postal Address :	
Tel number :	
Email address :	

Bank Name :	
Bank Branch :	
Bank Address :	
Bank Sort Code	
Bank Account Number :	
Building Society Number :	

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
20. Monitor feedback on the 2014/15 Annual Report and Accounts									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive									
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 feedback following the closure of the Annual Report and Accounts process.

Key issues to note

There are no issues to note for University Hospitals Bristol NHS Foundation Trust.

Recommendations

The Board is recommended to receive the 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)

Monitor
Making the health sector work for patients

Wellington House
133-155 Waterloo Road
London
SE1 8UG

T: 020 3747 0000

W: www.gov.uk/monitor

To: All NHS foundation trust Finance Directors
Cc: All NHS foundation trust named FTC contacts

29 July 2015

Dear colleague,

Closure of 2014/15 annual report and accounts process

I am writing to thank you and your teams for your cooperation and contribution throughout the year to enable both the NHS foundation trust sector and the wider departmental group to meet their respective annual reporting deadlines for 2014/15.

All but three NHS foundation trusts submitted audited accounts on time on 29 May 2015 enabling us to meet our reporting deadline for providing consolidated data for NHS foundation trusts to the Department of Health. Both the NHS foundation trust consolidated accounts and the Department of Health resource accounts were successfully laid before Parliament on 21 July before the summer recess. The document *NHS foundation trusts: consolidated accounts 2014/15* is available on our website[1].

The challenges in preparing annual reports and accounts in 2014/15 differed to previous years. In the absence of any major changes in accounting policy, responding to the challenges of a tightening financial environment was the key focus for much of the sector. The Department recorded a £1.2 million underspend against its total group revenue budget of £110.6 billion. The monthly information provided by foundation trusts and other bodies helped the Department to manage its budgetary position to achieve this and I would like to thank you and your teams for your cooperation during the year.

Feedback and accounts template

In 2014/15 we introduced a new optional accounts template for foundation trusts which we are pleased to see has been utilised by many trusts. We intend to continue updating and developing this template and are keen to receive any feedback or ideas for its future development that we may be able to implement. Additionally we will continue to make

[1] https://www.gov.uk/government/publications/nhs-foundation-trusts-consolidated-accounts-201415

improvements to the Foundation Trust Consolidation (FTC) spreadsheet forms. Your feedback on both the accounts template and the FTC forms is always welcome and appreciated and can be sent to ft.accounts@monitor.gov.uk. We are also currently consulting on changes to the 2015/16 FT ARM which can be found here[2].

As part of preparing the consolidated accounts, we have a number of points of feedback to share with the sector. A list of these points is provided in the annex to this letter. We will share this feedback with auditors in October when we meet with audit representatives as part of the National Audit Office's local auditors' advisory group. These points may therefore become areas of auditor focus in the coming year.

Looking forward

We have commenced planning for the 2015/16 accounts process with the Department of Health, NHS England and the NHS Trust Development Authority. The deadlines for draft and audited accounts submissions will be determined with reference to the submission and laying dates for the departmental group as a whole. We expect to communicate the timetable to NHS foundation trusts after the Department's Financial Accounts Steering Group has approved it in September.

Please can you ensure the content of this letter is shared with your teams locally and our appreciation is passed on.

Yours faithfully

Jason Dorsett
Director of Finance, Reporting and Risk

[2] https://www.gov.uk/government/consultations/nhs-foundation-trust-annual-reporting-manual-proposed-amendments-for-201516

Annex: Observations on 2014/15 accounts

Having completed the consolidation of NHS foundation trust accounts for 2014/15, we have made the following observations which apply to some, but by no means all, of the sector. We will raise these with NHS foundation trust auditors at the next meeting of the NAO's local auditors' advisory group (LAAG):

- **Remuneration report** – further to the 2013/14 changes to remuneration tables in the remuneration report, additional requirements for the unaudited section of the report were added in 2014/15. The remuneration reports of many foundation trusts did not meet these new requirements. In addition, the audited sections of more than 40 remuneration reports were non-compliant where either the report did not fully present the 'single total figure table' introduced in 2013/14 or the required tables were included in the annual accounts rather than the remuneration report which is not permitted by the FT ARM.
- **Losses and special payments –** some foundation trusts are not applying the aggregation rules set out in paragraph 6.7 of the FT ARM when reporting cases for bad debts or stores losses. This creates significant outliers when compared across the sector.
- **New PFI tables –** in 2014/15 we began collecting additional information on the breakdown of unitary payments paid in respect of on-SoFP PFI schemes. At month 9, the quality of data provided in these tables was variable however following feedback to some trusts, submissions at month 12 were notably improved. We are currently consulting on proposals within the draft 2015/16 FT ARM requiring disclosure of this table within FT annual accounts.
- **Cutting and pasting –** cutting data from cells in the FTC form can alter formulae that are dependent on those cells. This creates casting errors in the data on consolidation. If you enter data into an incorrect cell, please copy (ctrl+c) rather than cut (ctrl+x) the data to make the correction.
- **Related parties –** the value of transactions and balances recorded against NHS Business Services Authority in the related parties note of FTC forms increased significantly as a result of some FTs recording all income and receivables from commissioners against this body. Trusts are asked to take care with classification in this note, which should be consistent with recording of counterparties in the WGA sheets.
- **Holiday pay accruals –** a small number of foundation trusts were identified as including holiday pay accruals under provisions instead of payables. There is no uncertainty in a holiday pay accrual as it would be possible to calculate the value of the liability precisely (although in practice it is often an estimate). This should therefore always be recorded as an accrual and not a provision. The distinction is important not only for consistency across the sector but also for budgetary classifications.
- **Prior period restatements –** a number of foundation trusts made prior period adjustments in their 2014/15 accounts which were not reflected consistently in their FTC forms. Unlike NHS Trust or DH collection forms, the FTC form permits foundation trusts to amend comparatives and make prior period restatements because pre-populated comparative data is not protected. Moreover where comparatives are restated in the trust's accounts, the same adjustment must be made in the FTC form. Consistency between the FTC form and audited accounts should always be maintained.
- **Accounts and FTC consistency -** we are required to amend any material inconsistencies between FTCs and underlying trust accounts. This year the volume of

inconsistencies identified by us and subsequently adjusted continued to be high. Many numbers were omitted from the FTC entirely at both draft and audited submissions and there were also instances where the FTC and the accounts notes were prepared on different bases, which should never be the case.

- **Justify or change points (JOCs) –** JOCs apply high level reasonableness tests to assist preparers in identifying and correcting errors before submission to Monitor. Where the check is failing for a valid reason, providing detailed responses reduces the likelihood that we will need to contact the trust for further information. In 2014/15 the quality of responses to these checks improved significantly.
- **Responding to queries from the Sector Financial Accounting Team –** during the course of preparing the consolidated accounts, our team often needs to contact trusts for additional information. We are grateful to FTC contacts for turning our queries around much more quickly than in previous years, often within a few hours, which significantly reduced the amount of delays experienced in making amendments.
- **Links in FTC files –** FTC files received by Monitor are loaded into a consolidation database. Where files contain links, the consolidation database is unable to load the information fully resulting in imbalances in the consolidated accounts. Significantly more trusts submitted files containing links in 2014/15 compared to previous submissions. Please use the 'break links' button on the front of the FTC form to break links before loading files to the portal. The FTC form prompts users to break links when closing the file.

Laying of accounts

Feedback from the Department of Health parliamentary office in 2014/15 noted that the laying process went very well. All foundation trusts submitted on time and only four had minor formatting issues that were not acceptable to the Journal Office. This enabled all reports to be laid well in advance of recess, and we thank foundation trusts for paying attention to the instructions for laying their annual reports. The parliamentary office has provided the following feedback to be observed for next year:

- The font size on the front cover and title page should be a reasonable size
- The format of the title page should always be trust name first, accounts period next and then the laying reference text.
- It would be helpful if boxes or packing envelopes could be labelled on the outside to give the trust name so that the parliamentary office can quickly identify which reports have been received without having to open every package.
- In the rare circumstance of a foundation trust changing its name after the year end but before laying (for example from 1 April), the title page should be prepared with the trust's former name as applied during the reporting period, with an additional line on the title page for "From 1 April 201X now known as …".

The parliamentary versions of the annual report submitted to Monitor for publication by 15 foundation trusts were found to be incomplete, in most cases missing the auditor's limited assurance opinion on the quality report, but some also missing the accounts, the quality report or the statutory audit report. The FT ARM specifies what should be included in the annual report and accounts.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
21. Monitor feedback on Quarter 4 Monitoring submission and 2015/16 Annual Plan Review

Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive

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 4 submission and the 2015/16 Annual Plan review. 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 – Green

Monitor expects the Trust to address the issues leading to target failures and achieve sustainable compliance with the targets. Monitor does not intend to take any further action at this stage, however should these issues not be addressed, or should any other relevant circumstances arise, it will consider what, if any further regulatory action may be appropriate

Key issues to note

The 2016/17 planning round is likely to include a multi-year strategic element. These plans will need to build on both the strategy submitted to Monitor in June 2014 and reflect the Trust's response to the 'Five Year Forward View'.

The Trust submitted an improved financial plan at the end of June, but notwithstanding this improvement in forecasted outturn, Monitor identified an area of concern regarding the level of Cost Improvement Programmes (CIPs) in the trust's plan, being significantly less challenging than that of the trust's peer group. Monitor will monitor the CIP delivery through quarterly monitoring and if necessary will require assurance from the trust that it has appropriate governance arrangements in place to deliver its forecasted CIPs.

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. The Corporate Risk Register has been amended accordingly.

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)**			

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4 August 2015

Mr Robert Woolley
Chief Executive
University Hospitals Bristol NHS Foundation Trust
Trust HQ
Marlborough Street
Bristol
BS1 3NU

Dear Robert

University Hospitals Bristol NHS Foundation Trust

2014/15 Q4 monitoring and 2015/16 Annual Plan Review (APR)

I am writing in response to the one-year 2015/16 operational plan and the 2014/15 Q4 return both submitted by the trust in May 2015.

As noted in the separate letter from David Bennett, we are asking all trusts to look at their 2015/16 plans again with the aim of reducing the unaffordable sector deficit. Therefore the purpose of this letter is to:

- Confirm the trust's current and forecast continuity of services risk ratings
- Confirm the trust's governance rating
- Feed back on any specific concerns identified from our review of your 2014/15 Q4 and 2015/16 operational plan review submissions (over and above those outlined in David Bennett's letter to the sector).

We appreciate the efforts undertaken by you and the sector as a whole during the planning round this year, especially given the introduction of a draft plan phase, the changes to the timetable, and the need to update plans with short timeframes to reflect the tariff.

As previously communicated in our 2015/16 guidance[1], the 2016/17 planning round is likely to include a multi-year strategic element and this is still our intention. These plans will need to both build on the strategy submitted to Monitor in June 2014 and reflect your response to the 'Five Year Forward View'.

Further guidance will be issued in due course, but in the meantime you may wish to refer to the Strategy Development Toolkit[2] made available last autumn.

Foundation trust risk ratings

We have now completed the review of your one-year operational plan and Q4 submission. Based on this work, the trust's current and forecast risk ratings are:

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390070/APR_guidance_Dec14.pdf
[2] https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers

	Q4 14/15 (actual)	Q1 15/16 (plan)	Q2 15/16 (plan)	Q3 15/16 (plan)	Q4 15/16 (plan)
Continuity of service risk rating	4	3	3	3	3

Governance rating	Green

Under the Risk Assessment Framework[3], the governance rating indicates whether Monitor is currently taking any action; this rating therefore reflects the outcome of both the operational plan review and Q4 monitoring.

As explained in our letter of 13 May 2015, governance ratings and continuity of services ratings will be published on Monitor's website for all trusts shortly.

Regulatory response

Quarterly monitoring

As set out in our letter of 3 June 2015 we have moved the trust's governance rating to 'Green' after concluding a period of information gathering about multiple access standards breaches. However, the trust has failed to meet the following standards in Q4:

- Referral to Treatment Time 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).

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[4] and the Risk Assessment Framework[5].

We expect the trust to address the issues leading to the target failures and achieve sustainable compliance with the targets promptly. Monitor does not intend to take any further action at this stage, however should these issues not be addressed promptly and effectively, or should any other relevant circumstances arise, it will consider what if any further regulatory action may be appropriate.

[3] www.monitor.gov.uk/raf
[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf

A report on the FT sector aggregate performance from Q4 2014/15 is now available on our website[6], which I hope you will find of interest. We have also issued a press release[7] setting out a summary of the key findings across the FT sector from the Q4 monitoring cycle.

Annual plan review

We understand from discussions with the trust that it forecasts a significant improvement in its 2015/16 plan since submission as a result of contract finalisation. We require you to reforecast your operational plan for 2015/16 on this basis (also factoring in the impact of opportunities outlined in David Bennett's separate letter). We also require a bridging analysis between the original plan and reforecast to be included in an appendix.

Notwithstanding this improvement in forecasted outturn we have identified an area of concern with the operational plan as submitted. The level of Cost Improvement Programmes (CIPs) in the trust's plan, once netted off against areas of CIP contingency, is significantly less challenging than that of the trust's peer group. We will monitor the CIP delivery through our quarterly monitoring and if necessary will require assurance from the trust that it has appropriate governance arrangements in place to deliver its forecasted CIPs.

Finally, as explained in the separate letter from David Bennett, given the unaffordable sector-wide deficit being forecast for 2015/16 all trusts are being asked to look at their plans again to determine whether the options outlined in that letter may present opportunities to improve their financial position. Please refer to the separate letter for further details and required actions.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0485 or by email Amanda.Lyons@Monitor.gov.uk.

Amanda Lyons

Deputy Regional Director

Kate Holden

Deputy Regional Director

cc. Paul Mapson, Finance Director

John Savage, Chairman

[6] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-4-201415

[7] https://www.gov.uk/government/news/foundation-trusts-face-challenging-year-as-pressures-mount

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
22. Monitor feedback on Quarter 1 Monitoring submission
Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive

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 1 submission against the requirements of Monitors Risk Assessment Framework. Monitor's analysis of the quarter 1 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 – 3
- Governance Risk Rating – Green

These ratings will be published on Monitor's website later in September reflecting the Trust's failure to meet the A&E 4-hour target, the Cancer 62-day wait target and the18-week referral to treatment (RTT) incomplete target.

Key issues to note

Monitor and the Trust continue to engage monthly via performance calls to monitor progress against the trajectory submitted for recovery to RTT compliance and actions to improve A&E performance. Monitor has received the Trusts Cancer Standard Improvement Plan and the NHS Intensive Support Team have been engaged to support improvement in performance.

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. The Corporate Risk Register has been amended accordingly.
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)**			

15 September 2015

Mr Robert Woolley
Chief Executive
University Hospitals Bristol NHS Foundation Trust
Trust HQ
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Making the health sector work for patients

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Dear Robert

Q1 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q1 submissions is now complete. Based on this work, the trust's current ratings are:

- Continuity of services risk rating: 3
- Governance rating: Green

These ratings will be published on Monitor's website later in September.

The trust has failed to meet the A&E 4-hour target, the Cancer 62-day wait target and the18-week referral to treatment (RTT) incomplete target, which has triggered consideration for further regulatory action.

Monitor uses the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the Health and Social Care Act 2012, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

We expect the trust to address the issues leading to the target failure and achieve sustainable compliance with the target promptly. Through monthly performance calls we continue to monitor your progress against the trajectory you have submitted for recovery to RTT compliance and your actions to improve A&E performance. You have submitted a Cancer Standard Improvement Plan and the NHS Intensive Support Team have been engaged to support you to improve performance, and we will monitor your compliance with any actions that arise.

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf

Monitor has decided not to open an investigation to assess whether the trust could be in breach of its licence at this stage. The trust's governance rating has been reflected as 'Green'. Should any other relevant circumstances arise, Monitor will consider what, if any, further regulatory action may be appropriate.

A report on the FT sector aggregate performance from Q1 2015/16 will be available in due course on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we will be issuing a press release in due course setting out a summary of the key findings across the FT sector from the Q1 monitoring cycle.

Monitor is currently reviewing the responses of all NHS foundation trusts to David Bennett's letter dated 3 August 2015 as well as the outcome of the contract dispute resolution process. We will be writing to all NHS foundation trusts in due course to inform them of the outcome of our review. As a result, the content of this letter and our regulatory position only relates to our Q1 2015/16 monitoring process.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0485 or by email (Amanda.Lyons@Monitor.gov.uk).

Yours sincerely

Kate Holden
Deputy Regional Director

Amanda Lyons
Deputy Regional Director

cc: Mr John Savage, Chairman
Mr Paul Mapson, Finance Director

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 September 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
23. Governor's Log of Communications									
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. The log is distributed to all Board members, including Non-Executive Directors when new items are received and when new responses have been provided. Key issues to note: Since the last report was noted at Board, a further 5 new items have been added to the log. 7 Items have been updated with a response, and at the time of issuing the report 3 items are outstanding with 1 overdue – Item 131. A response will be sought for this item and updated to Board and Council ahead of the Board meeting.									
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)				

ID **Governor Name**

135 **Mo Schiller** ***Theme:*** CF Ward ***Source:*** Governor Direct

Query **18/09/2015**

Ref 114 submitted 10.2.15 Angelo Micciche

I participated in the Face to face interviews last week speaking with CF patients on Ward A900. In view of the comments I received I referred to log item 114 submitted in February of this year by Angelo. Despite reassurance in the response that concerns had been rectified I feel I need to check on concerns given by CF patients to me last week.The initial consultation process would appear to have looked at different patients being on the new ward to those who are now there.

They cannot understand why there are not more trained CF nurses on the ward. They identified problems of confidence in carrying out tasks, i.e. one nurse had to call in help from another ward at night as she was not competent to give IV antibiotics into an IV long line. There was also feedback about less time spent supporting patients compared with the old ward. Patients expected the nursing staff to have more knowledge of CF problems. Housekeeping and physio were satisfactory.

There are obviously still concerns despite reassurance from the origianl exec response ,it is now 6 months since the log question so initial concerns should have settled, they appear to still be ongoing.

Division: Medicine ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 24/09/2015

Response

Pending response.

Status: *Assigned to Executive Lead*

134 **Pam Yabsley** ***Theme:*** Inpatient Care ***Source:*** From Constituency/ Members

Query **18/09/2015**

Recently I have heard about a patient being discharged from UHB following a six week stay. He suffers from dementia and was cared for on the appropriate ward. Whilst in the care of UHB he developed a pressure ulcer and furthermore his bottom set of dentures were lost. Regardless of the reasons for the issues in this patient's case, this to me reflects poor nursing care. Unfortunately he will end his life in a very uncomfortable situation which is distressing for his family members. What assurances can be given that care for these patients is good.

Division: Medicine ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 24/09/2015

Response

Pending response.

Status: *Assigned to Executive Lead*

ID **Governor Name**

133 **Graham Briscoe** ***Theme:*** Outpatient Services ***Source:*** Governor Direct

Query **21/08/2015**

There appear to be two telephone number pathways into the Outpatient Appointment Service for the Bristol Eye Hospital, but staff manning these lines do not seem to have access to the same booking system information.

Also, the main UHB Outpatient Appointment Service situated at the Main Entrance in the Welcome Centre does not delay with Eye Hospital Outpatient bookings.

From experience this caused issue when trying to change an appointment and confirm the location of the clinic for the appointment. Please can further detail regarding the structure and running of BEH Outpatient services, including the BEH A&E Clinic, be provided.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 18/09/2015

Response **24/09/2015**

The Trust is aware that patients are encountering issues when attempting to telephone the Bristol Eye Hospital Accident & Emergency Department. There are two telephone lines to reach the services at the Eye Hospital, one is a dedicated administrative call centre for outpatient appointments at the Eye Hospital and the other is a line into the Eye Accident and Emergency Department. The phone number indicated on the patient letter is dictated by whether the clinic is held in outpatients or in the Accident and Emergency department. Whilst both lines are answered by teams who do have access to the same trust wide booking system, they are in practice more likely to respond only on matters related to the clinics that they arrange and are held in each respective department because they will have local knowledge about them.

With regard to the line in the Accident and Emergency department, this is also used for direct clinical referrals from GPs and other patients requiring advice, which means it would not be possible to redirect this entirely to the local call centre. The department has recently lost approximately 20% of its experienced nurse practitioners, to retirement and new opportunities. Whilst we have replaced these posts the new staff do not yet have the experience to manage the telephone triage to the level required which has also impacted on our ability to respond to calls in a timely way.

To alleviate the issue in the short-term, additional administrative resource has been allocated to the Accident & Emergency department to ensure the telephones are answered in a timely manner.

The long term solution is to fund a dedicated triage telephone line manned by a nurse practitioner who is able to help and support patients with a view to reducing hospital attendances wherever possible, this will free up the administration lines for patients with appointment queries. The Division of Surgery Head and Neck is currently working up a business case to develop this further.

Currently the BRI Main Appointment Centre only manages a portion of our general outpatient specialities and at this time this does not include the services at the Bristol Eye Hospital. Any patient presenting with a clinic query outside of these specialties would be redirected as the team there would be unable to help. As part of wider improvements to the Outpatient Services it is intended to review the remit and function of this team.

The Trust has convened an Outpatients Steering Group which commenced in July 2015. This group consists of senior staff from all divisions, the transformation team and the Trust patient experience lead. This steering group has identified a programme of work that will improve standards across all our outpatient areas. A project plan and associated work streams have been produced and agreed, which includes development of the BRI Appointment Centre and telephone line enquiries.

We understand that patient's letters in some areas need to be revised and improved to ensure patients have the correct information for attending their appointment and the ability to contact the correct department in the hospital in a timely manner. We have identified this as a quality objective for this year and created a Patient Letters Group to deliver the required improvements.

Status: *Awaiting Governor Response*

132 **Mo Schiller** ***Theme:*** Staff engagement ***Source:*** Governor Direct

Query **17/08/2015**

Following on from the recent report in Newsbeat; Robert's visit to the eye hospital theatres. The fact that the Chief Exec dons scrubs and spends time with the team provides support and encouragement and must have been appreciated. Does the Executive team consider going back to the floor in all areas and that spending time with the teams should be a regular occurrence? I appreciate the walk-arounds give an opportunity for Executives to be seen but actually participating in a working day/part day with all members of the workforce could be a valuable exercise?

Division: Trust-wide ***Executive Lead:*** *Chief Executive* ***Response requested:*** 18/08/2015

Response **04/09/2015**

Although all Executives do this periodically and the Chief Nurse on a regular basis, a formal 'back to the floor' programme is not currently in operation across the Trust. However, it is something we will be considering as part of the programme following feedback from the recent listening events with staff. We will update you again once further discussion have taken place with the Senior Leadership Team in October.

Status: *Awaiting Governor Response*

ID	Governor Name		
131	**Bob Bennett**	***Theme:***	***Source:*** Governor Direct

Query **14/08/2015**

Following recent media coverage, can the Board confirm that no senior member of staff is involved in obtaining financial remuneration from any pharmaceutical company.

Division: Trust-wide ***Executive Lead:*** *Trust Secretary* ***Response requested:*** 17/08/2015

Response

Pending

Status: *Pending Assignment*

130	**Mo Schiller**	***Theme:*** Management of patient records	***Source:*** Governor Direct

Query **13/07/2015**

Can the Trust advise on policy and procedure for updating records following the death of a patient. What checks are in place to ensure records are accurately maintained and patients or their family members aren't contacted by the Trust unnecessarily?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 21/07/2015

Response **23/09/2015**

The Trust is very mindful of the distress which can be caused to family when a deceased former patient is sent correspondence from the Trust. The Trust has two specific “routines” it runs on our information system to ensure that this does not happen. Firstly, when a patients dies in our care, this is documented promptly on the patient administration system (Medway) and a programme runs 5-6 per day where this deceased status results in the automatic cancellation of any outstanding appointments, admissions or letters recorded on the patient administration system. For patients who die outside of the Trust, these deaths are entered onto a national “spine” linked to GP records and the Trust receives an upload from the spine every two weeks. The Trust This relies upon the timely recording of death on the GP system. There remains an unavoidable risk that deceased patients may receive correspondence from the Trust in the period between GP registration of death and Trust reconciliation with the national spine though there is no evidence to suggest this is happens on a regular basis.

Status: *Closed*

ID **Governor Name**

129 **Karen Stevens** ***Theme:*** Medicines management ***Source:*** Governor Direct

Query **15/07/2015**

What pre-operative and post-operative medicines reconciliation processes are in place? Are they sufficiently robust to ensure patient safety? Are there any measures which could be introduced to reduce potential avoidable harm to patients?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 21/07/2015

Response **31/07/2015**

The minutes of the Medicines Governance Committee of the 21st July address this issue as below;

1.4.1 Pre-op Admission Prescriptions for division of surgery head and neck.

Issues have been raised by the surgical lead pharmacist regarding the risk of surgical patients' medicines being inaccurate when attending for surgery. This has been discussed with the UHBristol anaesthetists at their departmental meeting on 17th July, and Ms Wilson (Pharmacy) and Dr Bewley (Anaesthesia) attended the Medicines Governance Group to discuss the issues and resolution. Currently patients arrive on the ward with a signed but not dated drug chart that nurses cannot administer medicines against.
The current process is that patients are seen in pre-op assessment clinic and a drug history is taken at this time by a case manager nurse. The junior F1/F2 doctor writes the drug chart in pre-op but without start dates as the medicines will not be administered until admission. There was a previous arrangement that start dates are added by anaesthetists on the morning of the operation but this is now considered by the anaesthetists to be impractical.

The issue was raised that no current drug history is available at 7.30am on the day of surgery when patients arrive in hospital, and the staff are then focussing on commencing the theatre list. Although the F1/F2 doctor signed the drug chart in pre-op, this assessment may have been several months prior to the day of surgery. The nursing staff cannot, however, administer he medicines as no start dates have been added. This can result in patient safety issues arising from missed doses.

Various options for resolving the issues were discussed.
Anaesthetists consider it impractical for medicines reconciliation to be performed on the morning of surgery as there is no time to do so and GP practices are not open to check any details. Patients require a second medicines review to highlight any medicines changes between pre-op and admission.

Following detailed discussion, Medicines Governance Group proposed the following process:
Nursing staff and junior medical staff in pre-op will write the drug chart and date and sign it as accurate at that time. When completed at pre-op, an orange sticker is applied stating that the chart has been written and was correct on the day of writing. On the day before the operation, pre-op nurses will check that there are no changes to the medicines. A new green label will be applied to the chart highlighting that the second check has been performed and whether a change to the drug chart is required or not.
An exception to this process would be if a patient is being admitted to the ward prior to surgery in which case normal clerking and medicines reconciliation applies and the drug chart will be written on the ward preoperatively.
It was agreed that Ms Wilson will map out the above process in a Standard Operating Procedure and that it will be trialled. SB requested that feedback is provided to Medicines Governance Group in 2 or 4 months regarding whether this has resulted in safe, appropriate treatment for patients.
It was noted in the discussion that the Trust Clinical Guideline for Perioperative Medicines Management is an extremely helpful document so the key issue with regard to patient safety perioperatively is for all staff involved to be aware of and apply this guidance. It was also noted that the surgical staff would manage the routine medicines postoperatively when the patient returns to the ward.

Action: B Wilson to prepare SOP and feed back experience of implementation to MGG.

Status: *Closed*

128 **Brenda Rowe** ***Theme:*** Access to the hospital ***Source:*** From Constituency/ Members

Query **17/07/2015**

Please can the Trust advise on the rationale for the current free hospital bus service route? Has the Trust considered extending the route to cover other parts of the city, including North and South Bristol, to further support patients who find getting to hospital via Public Transport challenging?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 21/07/2015

Response **31/07/2015**

The current hospital bus route has been developed to enhance existing transport routes for patients and staff travelling into the UHB hospital sites rather than to be a provider of transport services more widely across the city. The route is created to pick up and drop off passengers at transport links across the city centre e.g. Bristol Temple Meads Railway Station, some car parks and the Bus Station. The concentration on this smaller route means the funding we have available enables a frequent service for a larger volume of passengers who can get into the city on existing public services, undertaking longer journeys with the current funding would result in a reduced frequency in the service. Currently we have a successful 15 minute service from Cabot Circus and 30 minute service from Temple Meads, which services all the hospitals in the central precinct carrying 12,000 passenger per month.
When the Bristol General Hospital closed, the Trust considered incorporating South Bristol Community Hospital but this would have meant a reduction in the frequency of the service to once an hour due to the time travelling to and from SBCH and it was perceived this would have had more of a detrimental impact on the existing users across the more frequent service.

Status: *Closed*

ID **Governor Name**

127 **Wendy Gregory** ***Theme:*** Medical Staff ***Source:*** Governor Direct

Query **17/07/2015**

As referenced in the Trust's 2015/16 Operational Plan (page 15):
'Changes to junior doctor numbers -
Work by the Director of Medical Education has helped to confirm that 10 posts will be lost from 2016 (5 Foundation Year 1 doctors and 5 Foundation Year 2 doctors) as a result of the national change to increase community placements. Work programmes to address the shortfall will be developed when the specialties have been identified, but are likely to include changes in workforce models and roles.'

Please can the Trust provide detail with regard to how these changes in workforce models are developing and the potential outcomes that are anticipated to fellow staff members and patients alike

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 21/07/2015

Response **03/08/2015**

Health Education England (HEE) has now agreed that the losses of the junior doctor posts will be less than anticipated to UH Bristol with only 2 of the potential 8 posts being lost. Whilst this is a favourable outcome, these reductions in posts continue to have an impact in the context of wider shortages in junior doctors across the Trust. To this end, it has been agreed that the risk element of losing these 2 posts will be transferred to the relevant Division's risk register. In the meantime, a meeting has been arranged on the 12th August 2015, between Dr Rebecca Aspinall (Director of Medical Education), Heather Toyne (Head of Workforce Planning) and Kay Collings to discuss the overall impact of junior doctor losses from 2016 and to consider potential plans to mitigate any risks.

Status: *Closed*

126 **Clive Hamilton** ***Theme:*** Fracture Neck of Femur Target ***Source:*** Governor Direct

Query **20/04/2015**

We have not been able to achieve Best Practice Tariff since February 2014 and it seems that the main issue is lack of Trauma Theatre capacity to cope with fluctuating demand.
The September 2014 Board report (Pages 34-36) set out a comprehensive action plan with a trajectory for achievement of the Best Practice Tariff of 90% by Quarter 4 (January –March 2015). The monthly trajectory targets have not been achieved since then but February 2015 performance was more encouraging with a Best Practice Tariff performance of 82.8% and 89.7% patients treated within 36 hours (March Board report page 65).
The February Board report (page 61) describes a situation during the weekend of 23rd January when breaches of the 36 hour standard occurred due to seven hip fracture patients being admitted over the 2 days, one of whom died in the operating theatre.
Given this history, I request assurance that our trust will ensure that there is sufficient capacity to meet all three 90% standards from now on.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **13/07/2015**

At the April Trust Board this matter was raised by Clive Hamilton, Governor representative for the public constituent of North Somerset. In response Sean O'Kelly, Medical Director, referred to ongoing work to address capacity. He went on to explain that this service can see significant peaks in demand and analysis of our own data shows we struggle to achieve the theatre standard when 2 or more patients present on the same day, although of note the majority of patients do have their surgery within 48 hours. Also of note is the Trust's mortality data, which shows that despite a minority of patients not achieving theatre within 36 hours, the service achieves good outcomes for its patients.

Whilst the theatre standard remains an importance measure, the Best Practice Tariff captures 9 aspects of care, the majority of which the Trust performs well against. Finally, the question has recently been posed as to whether patients should be admitted to Southmead at times of peak pressure in the BRI; there are three key reasons that suggest this would not be an appropriate step at this time 1) NBT did not achieve the 36 hour theatre standard in either 2013/14 or 2014/15 2) pre-hospital diagnosis of a fractured femur, in the absence of access to imaging, is not reliable 3) Southmead have advised that their own performance is very fragile and any swing of patients to them would lead to an inevitable further deterioration in their own performance.

Finally, the Division remains focussed on making improvements where it can. Analysis of the time and day of breaches, indicates that the biggest single benefit would come from actions that avoid the cancellation of the patient who is scheduled for theatre in the afternoon but is then cancelled because either, the list is overrunning and thus the case is not started if it would end after 5pm or a clinical priority is identified during the course of the day. Given this context, two actions are being focussed upon – attention to the Golden Case (# NOF going first on the trauma list), addition of a # NOF to the elective limb reconstruction list and staffing of an additional theatre overrun (currently staffed for one per day but to be increased to two). The latter has the most to contribute to performance but will take the longest to implement due to high vacancy rates.

It has been agreed, through the Quality and Outcomes Committee (QOC), that the quality dashboard will be amended to reflect two further measures of # NOF performance to include % seen within 48 hours and the longest wait (for non-clinical reasons).

Status: *Closed*

ID **Governor Name**

125 **Mo Schiller** ***Theme:*** Workforce ***Source:*** Governor Direct

Query **30/06/2015**

Research by the Royal College of Nursing (RCN) claims changes to immigration rules — set to be enforced in 2017 — could cause staffing issues for the NHS. Under the new rules, people from outside the European Economic Area (EEA) must be earning £35,000 or more before they are allowed to stay in the UK after six years. The RCN claims 3,365 nurses working in the UK are potentially affected by these changes, Band 5 staff nurses earn £21.692 - £28.180, the mainstay of registered nursing staff in the Trust, and Band 6,senior staff nurses earn £26.041 - £34.876. Can the Trust advise what the likely impact might be at UH Bristol? In the future will the focus on recruitment will now be within the EU.

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:***

Response **09/07/2015**

Currently the Trust has no plans to undertake targeted nurse recruitment campaigns outside the European Economic Area, however it is very mindful of the potential impact of government immigration policy decisions on workforce supply markets. UHBristol is monitoring national consultations around the proposed changes to immigration rules with regards to an increase in salary thresholds. The Trust's initial assessment is that the impact is anticipated to be low if the new enforcements are set in 2017 on existing nursing staff from outside the EEA, but developments will be monitored and a proactive review will be undertaken as more is known.

Status: *Closed*

124 **Wendy Gregory** ***Theme:*** Workforce - Exit Interviews ***Source:*** Governor Direct

Query **01/06/2015**

Can the Trust advise what is the percentage of exit interviews being undertaken in relation to the total numbers of staff leaving the Trust? Also has the format and timing of the exit interview been reviewed to inform if at times it would be possible to encourage an employee to stay with the Trust.

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:***

Response **18/06/2015**

In Q4 the HR Employee Services team had a 31.4% return rate of exit data as a result of a combination of exit questionnaires completed by leavers and exit interviews. This reflects 74 'exit responses' out of 236 leavers in this period.

Concerted efforts continue to be made by the Employee Services team to increase the number of exit interviews being undertaken with staff leaving the organisation and also to improve the quality of information received on reasons for staff leaving the organisation, in order to better inform recruitment and retention strategies.

Furthermore, managers continue to be encouraged to engage with their staff known to be leaving the organisation as early as possible, by way of exploring with their staff member the possibility of remaining with the Trust.

Status: *Closed*

123 **Mo Schiller** ***Theme:*** Nursing Recruitment ***Source:*** Governor Direct

Query **01/06/2015**

When recruiting nurses from Europe and overseas from outside of the EEC, what is the cost comparison for recruitment from the UK? How many of those selected need to follow an adaptation course and what is the time scale for this? Do all staff recruited from Europe and overseas have a language proficiency test and mathematics calculation test for medication?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 02/06/2015

Response **28/07/2015**

The requirement for nurses to undertake an adaptation course depends on their country that they completed their training in. Timescale and outcomes required vary dependent on the individual's needs. This is set by the NMC not the Trust. Overseas recruits registering with the NMC are admitted to the register via different routes depending on the country they trained in. If nurses or midwives trained in countries outside the European Union (EU) or European Economic Area (EEA) and have been admitted to the NMC register, they have had an education and practice check. They also have their character and language competence verified. The NMC requires an IELTS 7 (which is the proficiency level of the International English Language Testing System) for all applicants who register who trained outside of the EU, regardless of which country they are from or whether they came from an English speaking country. Any medication assessments would be part of the local induction and assessment of these nurses when they start work within an organisation.

Status: *Closed*