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 November 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. **Patient Story** To receive the Patient Story for review	Chief Nurse	3
3. **Declarations of Interest** To declare any conflicts of interest arising from items on the agenda	Chairman	
4. **Minutes from previous meeting** To approve the Minutes of the Board of Directors Meeting held in public on 30 October 2015	Chairman	5
5. **Matters Arising (Action log)** To review the status of actions agreed	Chairman	21
6. **Chief Executive's Report** To receive the report to note	Chief Executive	23
Delivering Best Care and Improving Patient Flow		
7. **Quality and Performance Report** To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Chief Operating Officer/Deputy CEO	27
8. **Quality and Outcomes Committee Chair's report** To receive the report for assurance	Quality & Outcomes Committee Chair	To follow
9. **Quarterly Workforce Report** To receive the report for assurance	Director of Workforce & OD	75
Delivering Best Value		
10. **Finance Report** To receive the report for assurance	Director of Finance & Information	99
11. **Finance Committee Chair's Report** To receive the report for assurance	Finance Committee Chair	To follow
Compliance, Regulation and Governance		
12. **Strategic Implementation Planning** To receive the report to note	Interim Director of Strategy & Transformation	129
13. **Register of Seals** To receive the Register for assurance	Chief Executive	149

Information		
14. Governors' Log of Communications To receive the Governors' log to note	Chairman	153
15. Big Green Scheme Vision To receive the report to note	Chief Operating Officer/Deputy CEO	162
16. Any Other Business To consider any other relevant matters not on the Agenda	Chairman	
Date of Next Meeting of the Board of Directors held in public: 29 January 2016, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU		

University Hospitals Bristol NHS Foundation Trust

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

Report Title
02. Patient Experience Story

Sponsor and Author(s)
Sponsor: Carolyn Mills – Chief Nurse Author: Tony Watkin –Patient Experience Lead (Engagement and Involvement)

Intended Audience

Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

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

The purpose of presenting a patient story to Board members is:
- To set a patient-focussed context for the meeting.
- For Board members to understand the impact of the lived experience for 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.

This story is presented by Jim Houlihan in which he shares his experiences both of receiving care at our Bristol Royal Infirmary Emergency Department (BRI ED) for a radial head fracture, and working as a Lay Representative on the Trust End of Life Steering Group. Mr Houlihan has received care through the BRI ED on several occasions and his story explores:

- the improvements in patient experience he has observed over time
- a recent episode of care which highlights the impact both the behaviour and attitude of staff can have on the patient experience
- his rationale for choosing to attend BRI ED rather than a "Walk in Centre" for his most recent care

As a "patient leader", Mr Houlihan has an active role as a patient representative in the Trust End of Life Steering Group. In this aspect of his patient story, he reflects on:

- the support he receives to fulfil his role
- the value a lay perspective brings to the Group
- the qualities of the Group and the commitment members show to learn and continually develop the quality of care
- the role doctors can play in championing end of life issues

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Recommendations
To receive the patient story, and note the context from which it was generated.

Impact Upon Board Assurance Framework
Implementation of the learning associated with this story supports achievement of the Trust's corporate quality objective to improve communication with patients.

Impact Upon Corporate Risk
No links to corporate risks.

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

Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

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**Minutes of the Meeting of the Trust Board of Directors held in Public on
30 October 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
Sue Donaldson – Director of Workforce and Organisational Development
Sean O'Kelly – Medical Director
David Armstrong – 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:
Helen Morgan - Deputy Chief Nurse
Debbie Henderson – Trust Secretary
Amanda Saunders – Head of Membership and Governance
Rachel Smith – Corporate Governance Administrator (Minutes)
Bryony Strachan – Clinical Chair, Division of Women and Children's Services (Item 9)
Ian Barrington – Divisional Director, Division of Women and Children's Services (Item 9)
Mo Schiller – Public Governor
Sue Silvey – Public Governor
John Steeds – Patient Governor
Clive Hamilton – Public Governor
Pam Yabsley – Patient Governor
Flo Jordan – Staff Governor
Pauline Beddoes – Public Governor
Wendy Gregory – Carer Governor
Fiona Reid – Head of Communications
Nikola Creasey – ST7, Paediatric Emergency Medicine

112/10/15 Chairman's Introduction and Apologies
John Savage, Chairman welcomed everyone to the meeting. Apologies for absence were
received from Carolyn Mills (Chief Nurse), Anita Randon (Interim Director of Strategy and
Transformation), John Moore (Non-executive Director) and Julian Dennis (non-executive
Director).

113/10/15 Declarations of Interest
In accordance with Trust Standing Orders, all Board members present were required to
declare any conflicts of interest with items on the meeting agenda. No declarations of interest
were received.

114/10/15 Minutes and Actions from Previous Meeting

The Board considered the minutes of the meeting held in public on 30 September 2015.

With regard to 94/09/15, a space to be added between 'of' and '94.5%' on the first line of the 2nd paragraph. It was:

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

115/10/15 Matters Arising

Outstanding and completed actions were noted by the Board.

With regard to action number 1, Helen Morgan confirmed that the child death review process had been discussed with the Division and a clear process had been implemented as a result. All action plans related to, or that arose from, any child death review specifically related to the Children's Hospital were to be logged and monitored through the Assurance Group. From the perspective of the Child Death Annual Report, cases would be discussed at the Clinical Quality Group meetings. Robert Woolley acknowledged the update and enquired as to assurance that the Divisions had learned from the review findings and that recommended actions were completed within deadlines. Helen Morgan would explore this further.

With regard to action number 3, which related to an incident whereby a patient who did not have an appointment at a day facility was refused access by staff, assurance had been sought that staff were aware of the need to communicate more effectively with patients. Helen Morgan confirmed that this had been discussed at a Patient Experience Group and reassured the Board that nursing and administrative staff had been reminded of the importance of effective communication. Outcomes of the discussions had also been shared with GP colleagues. Sue Donaldson assured the Board that the need to treat patients with priority and adherence to Trust values were a core element of customer care training.

116/10/15 Chief Executive's Report

The Board received a written report of the main business conducted by the Senior Leadership Team in October 2015, chaired by Deborah Lee in Robert Woolley's absence.

There was continued uncertainty over aspects of the planned transfer of Cellular Pathology from North Bristol Trust but there was growing confidence in the likelihood of a transfer in March 2016.

Robert Woolley advised the Board of correspondence received from regulators, commissioners and NICE relating to safe staffing and efficiency, which asked the Trust to provide assurance that not only safe, quality care for patients had been demonstrated but also that resources were used to maximum effectiveness. The letter made particular reference to the 1:8 nurse to patient ratio that arose from the Francis Report and acknowledged that the document reflected guidance, rather than a requirement, and local judgement should continue to be applied as appropriate.

Correspondence had also been received which acknowledged the re-submission of the Annual Plan, and in particular, the revised financial forecast for the end of year position. A further

response had also been received in relation to earlier correspondence from Monitor with regard provision of national leadership guidance on agency spend and the associated significant costs; and in addition, details regarding Referral To Treatment contractual fines for breaches of RTT standards. With regard to the RTT contractual fines, the response advised this was the domain of NHS England but recommended organisations continued to work with commissioners to ensure penalties were reinvested to support initiatives which reduced patient wait times. This would be discussed further with NHS England and local commissioners.

The recently launched consultation on agency spend caps by Monitor and the Trust Development Agency (TDA) had been received and while the primary focus of the consultation was nursing staff, the proposal would affect all staff groups, including medical locums and Very Senior Managers. The consultation would close on 13 November; the Board had commenced work on the response and also plans for implementation, should the proposals be approved. The revised model would result in a significant change to current practice and would require all providers to operate within the same standards but would also create a number of challenges with temporary staffing agencies. The revised model would follow a phased implementation for different staff groups from November until March 2016. Sue Donaldson and Carolyn Mills were working with their counterparts in neighbouring Trusts to ensure a consistent approach, both short-term and more strategically in the longer term. The Board would be kept informed of the impact of the new requirements

Following the last Board meeting, the British Medical Association had confirmed that junior doctors would be balloted for industrial action from 5 November until 18 November, the outcome of which would be publicised swiftly, with the form in which the action would be taken. Notice periods would be announced with regards to restriction of services during any periods of action and work had commenced on contingency plans to be implemented should industrial action be taken.

The proposed acquisition of Weston Area Health Trust by Taunton had been reviewed by the TDA, who announced on 16 October that it would not be progressed further. Following the decision, NHS England announced an initiative between Weston Hospital and local providers to establish a Sustainability Board to develop a programme to work with the local population and stakeholders to develop recommendations for a new sustainable service model. The Trust would participate in the programme, the first meeting of which would take place in early November.

Bristol Clinical Commissioning Group had announced that the preferred bidder for the interim provision of children's community health services in Bristol and South Gloucestershire would be a partnership between Sirona, Bristol Community Health and Avon and Wiltshire Mental Health Partnership NHS Trust. The Board noted that discussions were underway with the partnership for the Trust to provide support should it be confirmed that services were to be provided by the partnership for the next 12 months. Longer term plans were also under consideration and the Board would be consulted about the options in due course.

Staff interviews had commenced for the Independent Review of Children's Congenital Heart Surgery and were scheduled to conclude by the middle of January. Discussions continued with the CQC and the Health Service Ombudsman regarding their parallel investigations into related matters. Separately, the Trust had submitted a self-assessment against the national congenital heart standards.

The Coroner had issued two significant inquest judgements in October. In the case of Charlotte Bevan and her daughter, Zaani, the Coroner issued a Regulation 28 report to commissioners, which included NHS England and local commissioners, and to Avon and Wiltshire Mental Health Partnership NHS Trust in relation to the development of robust and co-ordinated perinatal mental health services. The Trust would be actively engaged in the development of the services. It was also highlighted that there had been no criticism of the maternity services at St Michael's Hospital, nor of the Trust's security arrangements.

In the second case, a narrative verdict was recorded on 23 October in the case of a child, who died of a brain tumour. The Coroner identified that there had been a series of interactions with healthcare services and also during two visits to the Emergency Department, the second of which the Coroner reported had been a missed opportunity to diagnose the tumour. As a result of the inquest, new protocols had been put in place for assessment of children who presented with symptoms and staff had also been supported with additional equipment and resources.

Clive Hamilton, Governor Lead of the Governors' Quality Focus Group, enquired as to potential strategic implications for the Trust in light of NHS England's proposal to close institutions for people with learning difficulties. Robert Woolley acknowledged the legitimacy of the question but would need to obtain further information regarding the proposals, which had only just been announced. It was:

> **RESOLVED:**
> - **That the Board note the report from the Chief Executive**

117/10/15 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. It was noted that system pressures remained which had presented numerous challenges but there had been continued progress. It had been positive to note that the number of patients waiting more than 18 weeks was at the lowest level for almost two years and was testament to the work undertaken by the Division to address the backlogs that had developed. Challenges remained in cancer care although a 4% improvement was noted. A system challenge remained for cancer patients and in particular, those who were late in their pathway, where achievement of their care against the national standards was more challenging.

Performance in A&E continued to disappoint, particularly for the staff in the department who worked hard to meet the 4 hour standard.

Further to previous discussions related the reduction in the number of care home providers in Bristol from 51 to 4, it had been announced that one of the four had withdrawn from the contract before it had been established. Bristol City Council reacted swiftly to the announcement and two of the remaining three providers were invited to absorb a proportion of the activity. Whilst this had been a responsive mitigation, it would not address in entirety the deficit and would pose a significant risk. In addition, the largest care home in Bristol, with in excess of 170 beds, had also closed to new admissions due to long standing concerns regarding care standards that had not been resolved to the satisfaction of the Care Quality Commission.

A dedicated session to explore the approach for winter planning had been scheduled at the Board Seminar on 13 November and a further session may be required for this, due to the scale of the risks that were continuing to emerge. A discussion with the Board to discuss a more strategic approach would be welcomed as much for 2016/17 winter plans as for 2015/16.

It was positive to note that the Trust continued to deliver strong patient experience, in addition to continued delivery of a green rating in falls prevention and pressure ulcers, despite the challenges faced by the wards. A further positive indication included the high compliance with the safety checklist which had been sustained for the last two months. The Board's attention was drawn to medication errors, which had been raised by the Governors as an area of concern. In 2012, the Trust had been one of the worst performers in the UK on this standard and Deborah Lee was pleased to report that the Trust had made significant improvements in this area and was now in the top decile of highest performers. It was acknowledged that the Governors very actively drove this agenda through the Quality Group.

It was also reported that whilst the Trust relied heavily upon data, the immense insight that could be gained from time spent with staff and services was also acknowledged. Deborah Lee had spent half a day in the Eye Hospital to work with the bookings and outpatient staff, and in particular, with the helpline staff, following concerns raised in this area. It had been hoped that some of the recent changes implemented would have been noticeable but there were still areas for improvement. The time spent in the department proved valuable and provided a good insight to the service and the challenges it faced. Further improvements had been implemented which would hopefully have a significant positive impact on the patients who use the service. The departmental staff had appreciated the visit and the importance of visits to specific areas was reiterated to Board members.

Helen Morgan echoed the comments made with regard to the sustained quality picture which had been achieved through immense hard work and positive staff engagement. There were still areas for improvement and a further example of this included a review of all Root Cause Analyses for grade 3 pressures ulcers in order to identify additional actions to be taken to reduce the numbers further.

With regard to the visit made by Bristol Clinical Commissioning Group to the Fractured Neck of Femur service, Sean O'Kelly advised that he had received informal but positive feedback and had been very pleased to see the immense dedication to those patients in the wards and theatres and also to witness the innovations that had been introduced to assist the flow of patients in and out of theatres. The visitors had also been impressed with the progress made to monitor the length of time taken for 90% of patients to move through the theatre process. There had been a progressive decrease in the time taken in this regard over the past five months. Work continued in order to reduce this further and achieve the desired level of performance.

Sue Donaldson noted that despite the red scorecard across the workforce domain, intense focus continued. The effort it would take to improve the KPIs had been recognised and it would take time to fully work through the action plan. In terms of sickness absence, the reported increase to 4.2% was expected for the time of year. To date, over 2000 staff had received a flu vaccination and efforts continued to exceed 2014's figure of a 60% uptake.

Vacancies had held at a steady level and would suggest continued interest in working for the Trust. An innovative recruitment drive for nursing and theatre staff continued, which

included advertisements on local radio stations and on public transport. The impact of this would be tracked through potential new employees who had applied for positions within the Trust. Turnover remained a key area of focus and the monies made available for in-year development in this regard had been well received, not only by the Divisional Management but also by the clinical teams affected. As part of the quarterly report for the next Board meeting, a forecast outturn against each of the KPIs up to for March 2016 would be included. It was:

RESOLVED:
- **That the Board receive the Quality and Performance Report**
- **That a forecast outturn of the Workforce KPIs would be included in the Quarterly Workforce report for November's Board**

118/10/15 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 October 2015.

The Committee reiterated that the flow of patients had a significant impact on achievement of access measurements. In previous month, the focus had been admissions and this had now shifted to the impact of delayed discharges. It was noted, however, that there was a confidence that significant system changes would be made to address this and would be discussed further in the Board Seminar.

In respect of indicators, clarity had been requested around the reasons for cancelled outpatient appointments. The review had shown that 11% of cancelled appointments had been brought forward, rather than cancelled and it had been confirmed that the metric for recording the reasons for cancellations would be amended.

In the context of Serious Incidents, the Quality and Outcomes Committee had reviewed the use and impact of agency staff on safety and quality standards, which could be a contributory factor to specific concerns but continued strong leadership would provide support in that area. The discussion also explored competencies around basic nursing care and highlighted that agency staff may simply be less familiar with layouts and procedures when they frequently worked in different areas.

The National Paediatric Survey Report and local action plan had also been reviewed with a challenge around the pressure of maintaining an 'average' position, and the actions required to achieve 'good' and 'excellent' standards in all domains, rather than focus solely on where performance was not to the required standard.

The Committee received assurance in relation to the implementation of the WHO checklist across all sites and the nuances of the implementation were noted.

David Armstrong reflected on the summary scorecard in the Quality and Performance Report; the improved position was recognised, in terms of how the agenda was set and how it provided an understanding against the key metrics and raised three queries regarding the scorecard including: the appropriateness of the strong focus on HR metrics in the Well-Led section; the appropriateness of the revised approach to consider safe care as the top level drivers; and the possible inclusion within the Quality and Outcomes Committee Chair's report of the effectiveness of the Committee's subordinate groups.

In response to the queries, Robert Woolley explained that the Well Led Governance Review continued to work well and that the current scorecard had been the product of immense collaborative work between the Executive and Non-Executives. With regard to the query around sub-committees to the Quality and Outcomes Committee, it was confirmed that there were none. It was agreed that a clearer distinction was required between the role of the Quality and Outcomes Committee as a sub-committee of the Board and the assurance it provided regarding the quality agenda and the Senior Leadership Team's responsibility through the Chief Executive for the clinical governance and quality management structure which was operated through the Chief Executive, Chief Nurse and Medical Director.

Alison Ryan also confirmed that the Quality and Outcomes Committee reviewed the headline indicators on an annual basis and that a revised subset may be used accordingly in 2016/17.

Deborah Lee confirmed that it was agreed to undertake a 6 monthly review of the summary scorecard, and this would be due at the end of November. It was agreed to convene a small sub-group to undertake this review and define the scorecard further.

Emma Woollett referred to the issues related to winter pressures and explained that a number of the Non-Executive Directors felt it was the appropriate time to review these concerns more strategically and that the discussion may benefit from a Board Seminar in their own right. There was possibly less scope for action this winter in terms of the more strategic areas and therefore, a more holistic approach should be considered.

Robert Woolley supported the statements made but with caution that the Board Seminar had been pre-planned and it would be a challenge to obtain the level of analysis required to support the proposed discussions at the Seminar. Deborah Lee suggested the focus of the Board Seminar would meet the immediate needs of this winter in order for the Board to be fully informed and aware of the plans around the immediate issues.

Emma Woollett enquired as to the 11% of appointments cancelled and brought forward and noted that the percentage did not seem very high. Deborah Lee explained that whilst it had been a contributing factor, it was not significant and work continued to ensure capacity was correct at the outset.

Lisa Gardner referred to the figures for cleanliness and noted that for the last quarter, an amber rating had been reported in high risk areas. Deborah Lee explained that there was a distinction to be made between the Estates and Facilities teams, both of whom were responsible for different programmes of maintenance throughout the Trust. The distinctions were not considered to be a contributing factor to levels of cleanliness but were still cause for concern. A number of concerns related to the robustness of the exception reports for the high risk areas and further work was required to strengthen the approach to cleaning in all areas in order to obtain a green or low amber status. The perception from patients and carers was also a significant factor to be considered and it was agreed that Deborah Lee would investigate this further and to report back at a future meeting.

With regard to Lisa Gardner's query about the differences in workforce turnover detailed in the report, Sue Donaldson explained that progress against the set trajectory had been closely monitored and the Trust was closer to the end position than previously reported, which resulted in the improved rating as detailed in the report.

Clive Hamilton reported that the Governors had been encouraged to note the sustained improvement against the quality metrics over the last two quarters.

Clive Hamilton enquired whether there was a reason why the staffing levels on page 28 of the scorecard did not have a RAG rating. Deborah Lee advised that staffing related to guidelines rather than rigid thresholds and to apply a RAG rating would have the potential to mislead.

Clive Hamilton noted that governor focus group discussions relating to 12 hour shift patterns indicated that lengthy shifts did affect the health and wellbeing of staff. Sue Donaldson reported that a recent survey for staff who now worked a 12 hour shift pattern indicated this had been a positive change. It had been recognised that there were issues to be addressed but generally staff would not prefer to revert back to the previous shift arrangements. Work continued with staff to ensure their health and wellbeing was maintained i.e. resilience workshops and advice on how to manage a worklife balance. The survey results did not indicate a direct correlation between health and wellbeing and 12 hour shift patterns but it was recognised that it may be a contributory factor and it would be remiss of the Trust not to respond should a correlation be identified. In addition, there was awareness amongst the nursing staff that they had the opportunity to work on different shift patterns through more flexible working arrangements.

Wendy Gregory, Carer Governor, complimented the 4% improvement against the cancer targets but requested a guard against complacency around achievement of this standard. The insufficient surgical capacity had been recognised previously and while it was a programmed period of improvement and development, the possible implications of late diagnosis for this group of patients had to be recognised. Concerns were raised regarding the time taken to arrange a network-wide meeting to discuss the late referrals that had come from third parties. Deborah clarified that whilst the Network had been established, a different order of engagement was in place and the Trust had been extremely engaged with health community to address this important aspect of service delivery.

A remedial action plan had been implemented to address the complex challenges the service faced and there had been a renewed energy and commitment from the staff to address the challenges. Contractual penalties were introduced in 2014 as a consequence for providers who did not have the same level of focus. The new national profile for cancer waits had been welcomed as the analysis of the data had brought to the fore the collective understanding of the complexities faced by the service. The final assurance to the Board was that where care had not been delivered to the national standard, the clinical consequences for those patients with an extended pathway had been reviewed.

Robert Woolley noted the discussions and explained that until the improvement trajectory had been agreed, the remedial action plans to improve the position against the national standards could not be defined. It was noted that reporting improvements could indicate a message of complacency but it was not felt that this was the position the Trust had reached. Work continued to achieve the robust trajectory and progress had been demonstrated. Robert had attended the Bristol, North Somerset and South Gloucestershire System Leadership Group and stated at the meeting that all provider Boards should review not only their own breaches of the standards internally but also their contribution to shared care breaches across the network.

Alison Ryan advised that the Quality and Outcomes Committee had examined the issue and explained that the primary reason for failure to meet the standard was that the Trust had the

most challenging portfolio of cancers nationally to be treated. The Committee received detailed updates by tumour site and trajectories were thoroughly scrutinised, which provided clear indications as to the best and poorest performers against the standards. The improvements in performance were significant and the improved position acknowledged. There were genuine reasons for a proportion of the breaches, which included not only late referrals and third party involvement but also wishes of the patient but this could not be seen as an excuse for failure to meet the standard.

Deborah Lee explained that agreement had been reached to develop 'Perfect Pathways' setting out timed milestones at every step of the common cancer pathways across Bristol and outside of the Bristol, North Somerset and South Gloucestershire geography. The milestones provided clarity on actions to be taken in each centre to enable patients to come to the Trust at any stage in their pathway.

John Steeds, Patient Governor, reported that discussions at the Bristol City Council Health and Wellbeing Board had not been consistent with the update provided at the Board with regards care in the community and winter planning. Deborah Lee explained that whilst Bristol City Council had implemented a number of actions to support this work, the impact of the actions had not yet been demonstrated but confirmed that the Trust's partners were fully engaged and committed to working together on winter plans. Deborah also emphasised the need to focus on the root causes of issues underlying the targeted high impact initiatives and the actions required for these to be achieved.

Flo Jordan, Staff Governor, acknowledged the continued work to implement the WHO Checklist and expressed concern with regard to a lack of effective training for cleaners in high risk areas. This would be explored further. It was:

> **RESOLVED:**
> - **That the Board receive the Quality and Outcomes Committee Chair's Report for assurance**
> - **That the group established to review the quality and performance report meet to conduct the 6 monthly review and report back to the Board in January 2016**

119/10/15 Transforming Care Programme Update
Robert Woolley introduced the report which updated the Board about ward processes and patient flow schemes, and in addition, the commencement of new programmes around patient communication and outpatients programme group.

Work continued on the adaptation of the programme and in particular, to change the focus to include external programmes and to redesign pathways with partners in acute, primary, community and social care. The next Transformation Board meeting would include a 'deep dive' session with regard to the Better Care Fund in Bristol.

Jill Youds and Emma Woollett welcomed the practical and informative report and it was appreciated that whilst not all of the projects were high level and strategic, all would deliver improvements. In relation to Appendix 3 of the report, Jill Youds suggested that it would be helpful if numbers could be included in the 'benefits and measures' section. This was agreed and it was noted that developments continued in this regard.

David Armstrong suggested that the update echoed a number of the discussions that had taken place in the Finance Committee regarding technologies and enquired whether they would be the key deliverables for the technology agenda for the next year. Robert Woolley confirmed that upgrades in PICU and NICU would commence in 2016/17 and that the Partnership Board for Connecting Care would run parallel to this and would provide visibility to the Board on developments.

Mo Schiller, Public Governor, enquired whether it would be possible for the telephone system to be upgraded to show the number that is calling. When the Outpatient Departments contact patients by telephone, the number is withheld and a significant proportion of elderly people would not answer a call from a withheld number and would potentially miss a change to an appointment. Robert Woolley acknowledged this important point and would look into the technicalities around the possibility of an override on the system. Jill Youds referred to a staff bulletin in which a member of staff suggested an innovative idea around the same topic. It was:

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

120/10/15 Children's Services Annual Report 2014/15

Bryony Strachan and Ian Barrington presented the first Annual Report for Children's Services, which was completed at a very busy time for the service and was a result of the consultants' request to raise the profile of the service both internally and externally. The report demonstrated the key successes and also acknowledged the service challenges.

The service had experienced a 70% increase in Emergency Department attendances and an 11% increase in inpatients from the Emergency Department and the clinical team continued to work with commissioners to identify reasons behind the increases.

Key successes included the centralisation of services in 2014, which was the culmination of a long term strategy and which relocated all children's hospital services to one centralised point. In addition, the Children's Hospital had been awarded major trauma centre status and had worked very well in their first year. The Care Quality Commission had rated the service as 'Good' across all domains, with one 'Outstanding' rating and the review visit had been approached very positively by the Trust and the service itself.

The service continued to experience a number of challenges which included the growth of attendances at the Emergency Department and work continued with Primary Care to understand this further. There had also been an increased demand in regional referrals and an increased focus to ensure funding flows from Wales were managed effectively.

The ongoing Independent Paediatric Cardiac Services Review continued to be a challenge for the service and an important step would be to review the effect it had on staff, patients and their families. Interviews had commenced for staff and measures had been put in place to support them through the process. Feedback received and comments on social media continued to demonstrate the excellent care provided to patients in the Children's Hospital.

Plans for the future included the development of a system partnership to improve collaborative working with district and general hospitals. In respect of the South West and

South Wales Congenital Heart Network, a self-assessment had been submitted to NHS England which demonstrated that the majority of standards had been met in full and provided action plans where the standard had not been met. Work continued to develop a strong governance process which would ensure standard pathways were followed and would ensure there were no regional variations.

A consistent theme for the service was to ensure co-design of future plans with patients, their families and staff.

On behalf of the Trust Board, John Savage thanked Bryony and Ian for their presentation, acknowledged the pressures faced by the Children's Services and expressed confidence that the Board and the Governors were immensely proud of the work achieved and their plans for the future.

Mo Schiller referred to regional showcasing of the Children's Services and enquired whether the excellent achievements would be showcased nationally and internationally. Bryony Strachan confirmed that the learning faculty had been showcased nationally and elements of research projects had been presented in America. Ian Barrington reported that in November, a team of cardiac professionals from Romania would visit the Trust for two weeks to observe the systems and processes behind the Children's Services. The team also planned to develop the link with Romania with a view to joint international working initiatives.

Emma Woollett congratulated the team on a well-produced report which highlighted the holistic services provided for children.

Alison Ryan referred to figures reported in the summer which detailed the demand and increased figures for emergency admissions which followed the transfer of services and enquired as to a cause for the sudden recent increase. Bryony Strachan explained that the demographics had changed as more families moved into the area, additional intelligence further attributed the increases to the transfer of services and more trauma cases had been treated than had been expected.

As a result of the success of NICU, Alison Ryan enquired whether there had been any evidence that children who had been treated in NICU lived for longer and were seen more regularly. Ian Barrington explained that due to the complexities in the care and treatment required by some patients throughout their lives, work continued to review treatments that could be provided in the community and to reduce the length of stay for NICU patients if their care would allow for them to be treated outside of the hospital setting.

In response to a query from Alison Ryan in relation to the transition of paediatric patients to adult services at the age of 18, Bryony Strachan advised that the transition was supported and assisted by a number of CQUINs but acknowledged that there were challenges due to the different levels of service required for some patients.

David Armstrong echoed the positive comments but enquired how staff who did not demonstrate appropriate core values were managed. Ian Barrington advised that the Divisional Management team worked hard to instil the core values to ensure they become natural behaviours; managers also led by example and recognised instances where values had been well demonstrated. A visible lack of the core values would be addressed before it developed further.

Lisa Gardner expressed slight disappointment that Above and Beyond had been omitted from the report and in particular, with regards how the charity assisted with fund raising for the Children's Hospital. Ian Barrington explained that whilst this was the first Annual Report and the Divisional Management team were proud of their achievement, it had been recognised that some areas had not been included and the omissions would be addressed in next year's report.

Jill Youds congratulated the team on the report, and expressed interest in the nursing education initiative and enquired which areas required the additional support from the Board. Bryony Strachan explained that the next few months would be challenging, in particular in relation to the staff interviews for the Independent Cardiac Services Review. An invitation was extended to the Executive Directors, Non-executive Directors and the Governors to visit the Children's Hospital as the staff valued these visits highly. Additional areas of focus, which would benefit from continued support from the Board, included community health and CAMHS. Support in relation to the Social Media policy would also be appreciated; a Facebook page for the Children's Hospital, with over 700 followers, had been established which could be used more proactively to respond to issues raised in that forum but staff were unable to moderate or monitor the page due to the existing Social Media policy.

Robert Woolley commended the Children's Services on their report and explained it was one visible result of the previous agreement to develop links between the Division and the Trust Board, following concerns expressed by a number of the Consultant staff in the Children's Hospital last December. Carolyn Mills, the designated Board member with responsibility for Children's Services, would also attend the hospital's new Medical Committee to provide executive support.

With regard to the Social Media policy, Deborah Lee reported that the revised policy would be discussed in the next Senior Leadership Team meeting and encouraged the Divisional Management team to engage in the process to develop the policy to meet their needs. It was:

RESOLVED:
- **That the Board receive the Children's Services Annual Report 2014/15 for assurance**

121/10/15 Research and Innovation Quarterly Update Report
Sean O'Kelly introduced the quarterly report which provided an update on performance against the research and quality indicators. The number of patients recruited for research had been lower than the two previous years, which had been a result of the closure of a high recruiting band 2 study. A further two studies were due to be initiated shortly and would affect the trajectory towards the end of the year. Good performance continued against the NIHR 70 day initiating target and it had been positive to note that two additional grants had been awarded in the previous quarter.

Alison Ryan commented that more detailed information for future reports would be appreciated. It was:

RESOLVED:
- **That the Board receive the Research and Innovation Quarterly Update Report for assurance.**

122/10/15 Quarterly Capital Projects Status Report

Deborah Lee presented the report and updated on the key issues. Good progress had been made towards the contract award for the final phase of the BRI development which would enable the Old Building to be vacated. A five week delay had been experienced to the occupation of the 500 series of wards but some wards were anticipated to move in a fortnight's time, with the final ward anticipated to move just prior to Christmas.

A decision had been made to utilise the former Laing O'Rourke site village, on an interim basis, for office accommodation which would ensure that the integrity of the timeline to vacate the Old Building would be maintained. Areas on levels 8 and 9 were due to be developed but this was dependent on Histopathology vacating the area, which had resulted in the interim measure.

Work continued on the signage for the Façade and proposals continued to develop to ensure clarity for pedestrians and drivers. It was:

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

123/10/15 Capital Investment Policy

Paul Mapson introduced the update and explained that in preparation for the new Strategic Implementation plan, loan finance for future capital schemes would not be dismissed in entirety but where loan finance was to be considered, business cases would be required to demonstrate how the repayments would be met. The policy would be reviewed once the strategic implementation plan had been implemented.

In response to a query from Alison Ryan in which she suggested it would be useful to include specific detail in business cases around the opportunity costs, Paul Mapson explained he had received a number of suggestions with regard to amendments to the current business case format that would be considered and asked that any further suggestions were e-mailed to him. It was:

RESOLVED:
- **That the Board approve the Capital Investment Policy**

124/10/15 Finance Report

Paul Mapson introduced the Q2 report. The Trust's reported financial position at the end of September 2015 was £0.311m adverse to the plan (before technical items). The Trust showed a small surplus at the end of September but there were a number of significant issues to address in-year and which could potentially be carried into 2016/17. One of the key in-year issues related to nursing spend, which might be mitigated by the capping of agency staff costs. The financial position reflected the pressures faced nationally by acute hospitals. It was:

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

125/10/15 Finance Committee Chair's Report
Lisa Gardner presented the report of the business discussed at the meeting of the Finance Committee on 26 October. The Committee expressed concerns regarding the deterioration of the Divisional positions, in addition to issues around agency nursing spend. Sue Donaldson would attend the November Finance Committee to update on the issues and Lisa Gardner would provide an update at the next Board meeting.

In terms of the Divisions, Surgery, Head and Neck had progressed to formal escalation and were meeting fortnightly with Deborah Lee to account for their position.

The Finance Committee reviewed the savings programme and looking towards 2016/17, the plans were not yet at a satisfactory level. There had been meetings with the Senior Leadership team to address the issue and to discuss a different approach.

With regard to the run rate, Lisa Gardner reported that the cost associated with green to go patients and patients without a discharge plan would be discussed at the November Board Seminar to address it on a wider strategic level.

John Savage acknowledged the significant work undertaken for the Trust to be in the top 10% of financially performing Trusts. It was:

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

126/10/15 Monitor Q2 Risk Assessment Framework Declaration
Deborah Lee introduced the report which provided an update on the Q2 submission to Monitor.

Emma Woollett asked for clarity around the statement for the A&E 4 hour standard. Deborah Lee confirmed that it had been declared as a risk for the year but not the quarter.

With regard to the recommendation around Referral To Treatment times, Emma Woollett enquired why this had not been raised as a formal risk. Deborah Lee confirmed it was not recorded as a risk, as it was a fact.

Lisa Gardner confirmed that the quarterly report had been reviewed in the Finance Committee. It was:

RESOLVED:
- **That the Board approve the Q2 Risk Assessment Framework Declaration for submission to Monitor**

127/10/15 Board Assurance Framework
Robert Woolley introduced the latest Board Assurance Framework and highlighted the single red rated risk. The detailed explanation documented within the framework would provide the Board with an understanding behind the rating.

David Armstrong enquired whether a committee reviewed the detail behind the Board Assurance Framework and how independent assurance was achieved. Robert Woolley explained that Board Assurance Framework was produced and scrutinised by the Executive

team, and the Senior Leadership Team approved the recommendations for the Board. The purpose of the Board Assurance Framework was to provide the Board with sources of assurance, including external sources of assurance.

Alison Ryan explained that the Board Assurance Framework had been included in her worksteam for the Well Led Governance Review and it had been agreed at the Quality and Outcomes Committee that it would be presented for assurance with the updated Corporate Risk Register.

Jill Youds queried the amber rating for item 6.4, given the level of current unidentified savings. Deborah Lee explained that it related to the thresholds that had been set which were formulaic and might need to be reassessed. It was:

RESOLVED:
• **That the Board receive the Board Assurance Framework for assurance**

128/10/15 Corporate Risk Register
Robert Woolley presented the Corporate Risk Register which had been revised to include risks with a score of 12 or greater. The revised threshold had increased the number of corporate risks and the report provided an update on the new and amended risks.

Emma Woollett reiterated the discussions at the Quality and Outcomes Committee around the improved format which provided a clearer understanding of the risks to the organisation.

In response to a query raised by Emma Woollett around the Women's and Children's pneumatic tube service St Michael's Hospital, Deborah Lee suggested that it would not become a corporate risk as a technical solution had now been identified.

Jill Youds noted an absence of actions against risk 1145. Deborah Lee confirmed that in line with discussions at the Quality and Outcomes Committee regarding the risks that would be presented to the Board, significant risks would always be accompanied by a detailed action plan.

Debbie Henderson confirmed there had been agreement at the Quality and Outcomes Committee to clarify the action against risk 793. It was:

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

129/10/15 Governors' Log of Communications
The report provided the Trust Board with an update on governors' questions and responses from Executive Directors.

Item 132 (Directors to spend time in the workplace) would be updated in more detail following discussions with the Senior Leadership Team but Robert Woolley confirmed the commitment from the Executives to be more visible and it was acknowledged that the visibility was valued by staff. The Executive Directors had also discussed the importance of ensuring a clear distinction between safety walkarounds and engagement visits to the Divisions by Board members.

Jill Youds requested a further update for Item 136 (12 hour shifts patterns) and Helen Morgan would clarify the actions that had been taken. Jill Youds enquired about the impact on patient safety of 12 hour shifts and Helen Morgan confirmed that a review of the shifts did not bring to light any conclusive outcomes. Helen Morgan also confirmed the implementation of an initiative whereby no member of staff would work more than two consecutive 12 hour shifts, unless they requested to do. Sue Donaldson also explained that she had had discussions with Clive Hamilton and Pauline Beddoes to clarify a number of the points.

Debbie Henderson confirmed that item 137, which related to the Dermatology service in Weston Hospital, had received a response and had been closed.

Wendy Gregory queried the removal of item 127 (Medical Staffing) from the log. Although a response had been received from Sean O'Kelly, the response advised that a meeting would take place to discuss the revised models of working so it should not have been closed on the log. Debbie Henderson would provide an update. It was:

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

130/10/15 National Paediatric Survey Results and Action Plan
Helen Morgan introduced the survey results and whilst there were a number of positives, the Division aspired to be higher than average. A further report would be provided at the Quality and Outcomes Committee meeting in December. Jill Youds commented that the general methodology that followed previous surveys had focussed on areas where performance had fallen below the average and further detail would be appreciated to identify how these standards would be improved, in addition to improving the above average scores in order to become an exemplar. A further report is scheduled to be submitted to the Quality and Outcomes Committee in November.

131/10/15 Any Other Business
No further business was discussed.

Meeting close and Date and Time of Next Meeting
There being no other business, the Chair declared the meeting closed at 13.20
The next meeting of the Trust Board of Directors will take place on Monday 30 November 2015, 11.00am, the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

…………………………………….. …………………2015
Chair   Date

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

		Outstanding actions following meeting held 30th October 2015			
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	**94/09/15**	Further detail on internal communication of workforce actions and staff turnover broken down by staff group and division to be included in future quarterly reports	Director of Workforce & OD	November 2015	To be included in quarterly workforce report
2.	**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	January 2016	
3.	**116/10/15**	An update on Trust Development Agency and Monitor Consultation on Agency staffing Caps to be provided to the November Board	Director of Workforce & OD	November 2015	
		Completed actions following meeting held 30th October 2015			
4.	**117/10/15**	Forecast outturn of Novembers KPIs to be include in the quarterly workforce report.	Director of Workforce & OD	November 2015	Complete - included in quarterly workforce report agenda item 9

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University Hospitals Bristol NHS Foundation Trust

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

Report Title
06. Chief Executive's Report

Sponsor and Author(s)
Sponsor and author: Robert Woolley, Chief Executive

Intended Audience

Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

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

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

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)**

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD –NOVEMBER 2015

1.   INTRODUCTION

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

2.   QUALITY, PERFORMANCE AND COMPLIANCE

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

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

The group **received** an update on the current status of CQUINs, including narrative on specific issues.

3.   STRATEGY AND BUSINESS PLANNING

The group **noted** an update on the Business Planning process for 2016 to 2018 and the ongoing work to refine the Trust's Strategic Implementation Plan for presentation to the Trust Board.

The group **approved** the Corporate Social Media Policy and asked that further work be done to consider the Trust's strategic approach to social media and how the Trust could enable open access for staff in a responsible way.

The group **approved** the Countering Fraud and Bribery Policy for forward submission to the Audit Committee in December.

The group **approved** the Big Green Scheme Vision 2020 for onward submission to the Trust Board, noting the need to refresh some of the content and to include more detail about objectives for waste reduction and recycling.

The group **approved** the revised adult escalation and extreme escalation policies and Bristol Royal Hospital for Children escalation policy.

The group **supported** the proposal to engage with the forthcoming tender opportunity for the provision of Community Child Health and Child and Adolescent Mental Health Services across Bristol and the surrounding areas, for ratification by the Trust Board.

The group **received** an update on work ongoing around additional hours payments for medical and dental staff and the operation of national clinical excellence awards.

The group **supported** a recommendation to trial a period of publicising live waiting times in Emergency Departments.

4. RISK, FINANCE AND GOVERNANCE

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

The group **approved** a proposal to refine current partnership working arrangements with staff side to enable better connectivity and integration with the Trust's workforce governance arrangements.

The group **noted** one low impact Internal Audit Report in relation to Cleanliness Monitoring and Actions.

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.

The group **received** an overview of the Trust's performance against key national access and quality standards relative to national and regional providers for Quarter 2 2015/2016, 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
November 2015

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 November 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
<u>Purpose</u> 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)**
27/11/15					

Quality & Performance Report

November 2015

Executive Summary

Further good progress was made this month in recovering performance against the access standards, with continued delivery of the 6-week diagnostic 99% national standard, significant reductions in the total number of patients waiting over 18 weeks Referral to Treatment (RTT), and achievement of the 0.8% national standard for the number of operations cancelled at last-minute for non-clinical reasons. In addition, the reported performance against the 62-day GP referral to treatment standard in quarter 2 was the same as the national average, which is the first time the Trust has equalled or bettered national average performance since quarter 1 2012/13. 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.

Whilst the number of patients waiting over 18 weeks from referral to treatment showed a sizeable reduction in the month, there are risks that progress may be slowed due to further increases in demand, if mitigations are not successful. In addition to the generic risk associated with ongoing high levels of outpatient referrals, there are two specific risks to the Trust receiving more outpatient referrals which might jeopardise the current progress being made in reducing backlogs. Most notably there is the temporary closure of the eReferrals system as part of the "go-live" at North Bristol Trust of their new Patient Administration System, which is currently in effect. In addition, it is anticipated that Taunton & Somerset Foundation Trust will close its Clinical Genetics service from the 1st January 2016. In both cases discussions are ongoing with commissioners to find ways to mitigate a potential transfer of referrals to the Trust, and Monitor continues to be kept abreast of developments.

Performance against the A&E 4-hour standard continued to be heavily impacted by the continued slow rate of discharge of patients out of the BRI in October, despite actions being taken to improve flow. The number of medically fit patients awaiting discharge from the BRI at any point in time remained at circa 70 patients, which represents one and a half additional wards' worth of patients occupying BRI beds relative to the 'normal' levels of delayed discharges seen at the start of 2015/16. This high level of delayed discharges continues to mainly be as a result of the recommissioning of domiciliary care packages, with delays in the new providers coming up to full capacity, alongside the acute shortage of social workers. The number of patients admitted as an emergency via the Bristol Children's Hospital Emergency Department showed a further increase on last year's levels, already reaching the peak levels seen last winter prior to the expected impact of the seasonal surge in patients with respiratory virus, which the Children's Hospital is already seeing the first signs of. These factors continue to be flagged to Monitor as a risk to 4-hour achievement in quarter 3 and escalation to commissioners has also occurred with the aim of engaging primary care in mitigations to manage demand.

Encouragingly, even against this backdrop of system pressures, performance against the broad ranging 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. This month has seen the lowest rate of falls per 1000 bed-days for the year to date and previous years. A similarly low rate of pressure ulcers was reported, along with an increase in the level of Harm Free Care delivered, as measured through the point prevalence audit of the Safety Thermometer. WHO surgical checklist usage continued to be at 100% compliance and we reported a further month of zero medication errors resulting in moderate or severe harm. Whilst the challenge remains in achieving a maximum 36-hour wait for surgery for patients with a fracture neck of femur, with the appointment of a locum ortho-geriatrician there was a material increase in the timeliness of review of patients with a hip fracture following their admission to the Trust.

System pressures continue to provide context to the current workforce challenges, especially bank and agency spend and considerable focus is being placed on the reasons and necessity for each band and agency shift. There remains a strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand ahead of the seasonal winter peaks. 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	NHS Choices

Intelligence Monitoring Report (IMR)

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

Band 6 represents the lowest risk band.

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

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

Current scoring

Risks

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

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

In October the Trust achieved 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 3.0[1] against Monitor's Risk Assessment Framework. Monitor restored the Trust to a GREEN risk rating in quarter 1, following its review of actions being taken to recover performance against the RTT, Cancer 62-day GP and A&E 4-hour standards and an acceptance of the factors continuing to affect Trust performance, which are outside of its control.

Monitor's Risk Assessment Framework - dashboard

Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework					Q3 Forecast	Notes	Q3 Forecast Risk Assessment Risk rating
					Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16*			
1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	3	✔	✔	✔	✔	TBC**	✔	Limit to the end of Q3 = 34 cases	Achieved
2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	98.9%	✔	✔	✔	✔	99.1%	✔		Achieved
2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	96.0%	✔	✔	✔	✔	97.8%	✔		
2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	96.8%	✔	✔	✔	✔	96.2%	✔		
3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	79.5%	✘	✘	✘	✘	78.5%	✘		Not achieved
3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	78.5%	✘	✘	✘	✘	14.3%	✘		
4	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	90.6%	Not achieved	Not achieved	Not achieved	Not achieved	91.1%	✘		Not achieved
5	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	96.9%	✔	✔	✔	✔	98.3%	✔		Achieved
6a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	95.7%	✔	✔	✔	✔	97.5%	✔		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%	94.0%	✘	✘	✘	✘	92.2%	✘		Not achieved
8	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
	CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
	Risk Rating				Triggers further investigation	GREEN	GREEN	To be confirmed	To be confirmed	Triggers further investigation		

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

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

3.0

To be confirmed (see narrative)

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[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.

4

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.

Safe	Caring	Responsive	Effective	Well-led
Infection Control	Friends & Family Test Score (inpatient)	A&E 4-hours	Mortality	Agency
Never Events	Complaints response	Referral to Treatment Times	Stroke care	Sickness absence
Safety Thermometer (No New Harm)	Inpatient Experience	Cancer waiting times	Heart reperfusion times (Door to Balloon)	Vacancies
Essential Training	Outpatient Experience	Diagnostic waits	Hip fracture	Turn-over
Nurse staffing levels		Cancelled Operations	Outliers	Length of Stay
		Outpatient appointments cancelled		

Key changes in indicators in the period:

RED to GREEN:
- Safety Thermometer
- Essential Training

RED to AMBER:
- Sickness absence

AMBER to GREEN:
- Cancelled operations

GREEN to AMBER:
- Complaints response
- Mortality

Please note: The RAG rating for Mortality was shown as AMBER last month, but the refresh of the data moved last month to a GREEN rating, hence the change shown above.

Overview

The following summarises the key successes in October 2015, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 3 2015/16

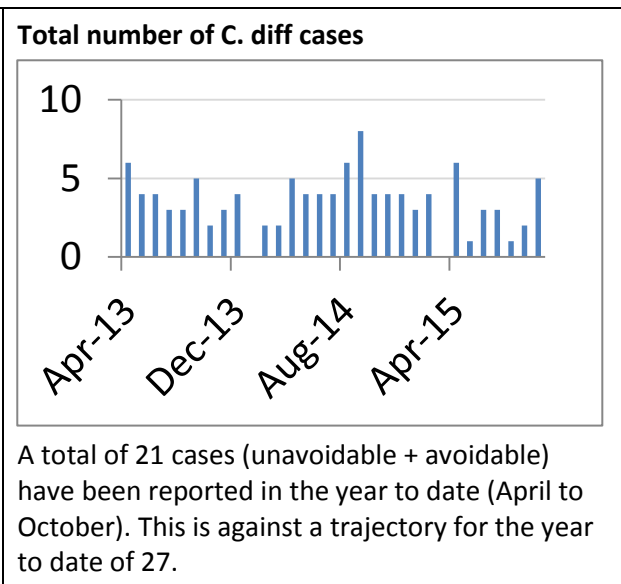| Successes	Priorities
• During the last two months, 178 nurse recruits commenced, due to the availability of newly qualified nurses and the ongoing national marketing activity; • Core Essential Training compliance exceeded the target of 90% for the first time, reflecting the effort invested across the Trust; • WHO surgical checklist compliance was 100% in theatres; • Falls per 1000 bed-days was 3.53 in October, the lowest level for several years; • Improvement in ortho-geriatrician review for fractured neck of femur patients; • Significant reduction in the number of patients waiting over 18 weeks from Referral to Treatment (RTT) and national 99% standard for diagnostic tests being carried-out in under 6 weeks maintained for a second month; • Reduction in last-minute cancelled operations, with the 0.8% national standard being met.	• Improving staff experience and staff retention; • Sustained nursing and theatre recruitment through national campaigns. • Reducing sickness absence; • Improvement in time to theatre for fractured neck of femur patients; • Improvement of complaints response timescales; • Improvement in the number of ward outliers; • Maintaining high levels of outpatient and elective activity to deliver revised trajectories for the reductions in numbers of patients waiting over 18 weeks RTT; • Continued implementation of ideal timescale pathways for high volume cancer tumour sites, with colorectal and head & neck planned to go live by the end of December.
Opportunities	**Risks & Threats**
• A detailed plan has been developed to improve the quality of appraisals and ensuring they link to the overall strategic direction of the organisation; • To improve responses to early warning scores as we transfer to the National Early Warning Score in December (N.B. also a risk, but mitigated by a training programme underway); • To consider our position in relation to mortality measurement in the light of emerging national thinking regarding mortality indicators versus mortality reviews.	• Risk of not achieving annual turnover and sickness absence KPIs agreed during Operating Planning process; • In addition to the generic risk of increasing demand, the specific risk of the closure of some services in other areas (e.g. Clinical Genetics in Taunton), and the temporary closure of the eReferrals system ahead of the go-live at North Bristol Trust of their new Patient Administration System, could lead to more outpatient referrals coming to UH Bristol and a risk to sustained reduction of backlogs; • Continuing high levels of delayed discharge patients represent an ongoing threat to achievement of the quality objectives and A&E 4-hour standard; • Seasonal levels of respiratory virus increasing emergency activity into the Children's Hospital, with potential adverse impact on flow.

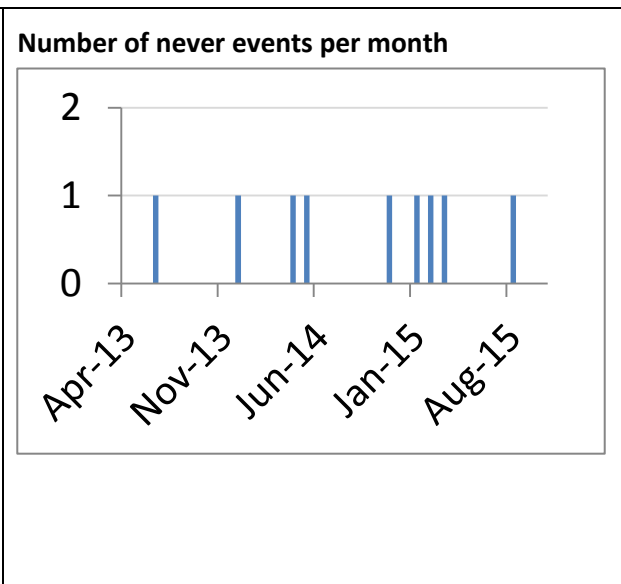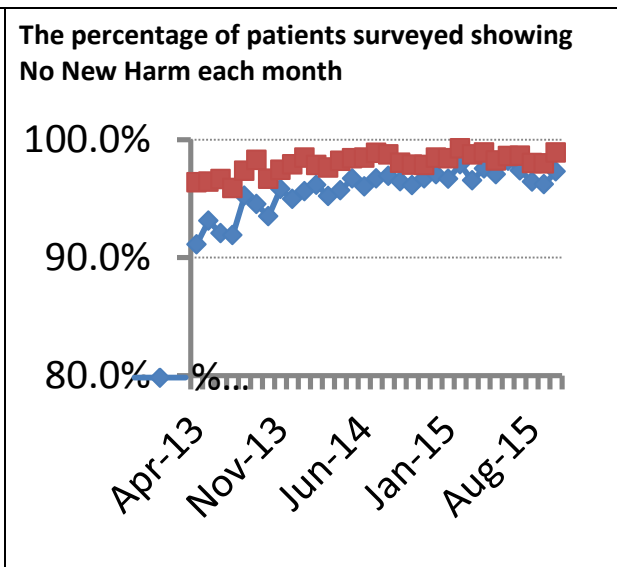| Description	Current Performance	Trend	Comments
Infection control The number of hospital-apportioned cases of Clostridium difficile infections and the number of MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias. The Trust limit for 2015/16 is 45 avoidable cases of clostridium difficile and zero cases of MRSA.	Five cases of *clostridium difficile* (C. diff) were reported in October and have been assessed as unavoidable by the Trust. However, this still needs to be agreed with the Clinical Commissioning Group (CCG). This is against a limit of 3 avoidable cases for the period. <table><tr><td></td><td>C. diff</td><td>MRSA</td></tr><tr><td>Medicine</td><td>2</td><td>0</td></tr><tr><td>Surgery</td><td>1</td><td>0</td></tr><tr><td>Specialised Services</td><td>2</td><td>0</td></tr><tr><td>Women's & Children's</td><td>0</td><td>0</td></tr></table> There were no cases of MRSA bacteraemias reported in the period.	**Total number of C. diff cases** A total of 21 cases (unavoidable + avoidable) have been reported in the year to date (April to October). This is against a trajectory for the year to date of 27.	The multidisciplinary Post Infection Review meeting with commissioners, for the five cases of C. diff which occurred in October, is yet to be held. This meeting will identify any learning and preventative actions to be put in place if required.
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.	There were no Never Events reported in October 2015.	**Number of never events per month**	There has been a never event reported in November in the category "wrong route medication". At the time of writing the patient has come to no harm and an investigation is underway. Commissioners and the Care Quality Commission have been informed. This indicator will therefore be red rated next month.

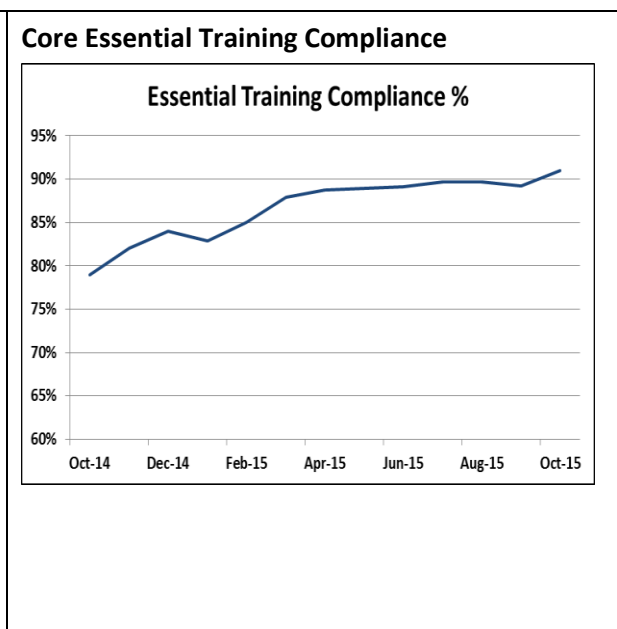| Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In October 2015, the percentage of patients with no new harms was 98.9 %, against an upper quartile target of 98.26% (GREEN threshold) of the NHS England Patient Safety peer group of trusts, an improvement from 98.0% in September 2015.	**The percentage of patients surveyed showing No New Harm each month**	The October point prevalence safety thermometer audit showed the number of new venous thrombo-emboli reduced to 2 and the number of catheter associated urinary tract infections to be 4. Both falls with harm and new pressure ulcers remain at previous low levels, with 1 and 3 respectively for October.
Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%	Compliance at the end of October was 91.0% against the 90% threshold for Core Essential Training. Six Divisions achieved the 90% target this month. 	**Core Essential Training Compliance**	Compliance exceeded the target of 90% for Core Essential Training. The 90% standard was also achieved for Induction, Safeguarding Adults Level 1 and Safeguarding Children Levels 1 and 2. Actions continue to be taken to improve compliance against the remaining Essential Training standards (Action 1).

October 2015	Compliance Rate
UH Bristol	**91.0%**
Diagnostics & Therapies	90.4%
Medicine	91.1%
Specialised Services	92.1%
Surgery Head & Neck	92.7%
Women's & Children's	87.9%
Trust Services	92.1%
Facilities & Estates	96.0%

Description	Current Performance	Trend	Comments
Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.	The report shows that in October the Trust had rostered 213,388 expected nursing hours, with the number of actual hours worked of 225,753. This gave an overall fill rate of 106%. **The percentage overall staffing fill rate by month** 		Overall for the month of October the Trust had slightly over 100% cover for Registered Nurses (RNs) on both days and nights whilst the unregistered level of cover of 116% was slightly above the usual trust percentage of 114%. This was mainly due to the increased usage of Nursing Assistant (NA) specialist assignments to adequately care for confused or mentally unstable patients, particularly following the ward moves. Recruitment continues at pace with the net turnover rate being positive at present (Action 2).

Division	Actual Hours	Expected Hours	Difference
Medicine	70459	62426	+8033
Specialised Services	41253	40140	+1113
Surgery Head & Neck	44594	42601	+1993
Women's & Children's	69428	68221	+1207
Trust - overall	**225735**	**213388**	**+12346**

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Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for October 2015 was 96.2%. 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 division is shown below: 		2015/16				Quarter 1	Quarter 2		Medicine	94%	94%		Specialised Services	96%	99%		Surgery, Head & Neck	97%	98%		Women's & Children's (excl. maternity)	95%	96%		Maternity wards	85%	94%		**Inpatient Friends & Family scores each month** 	It can be seen that the scores for UH Bristol are in line with national norms, and that 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.
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.	For the month of September 2015, performance was 14.6%. The first milestone was to reach and sustain the level of complainants dissatisfied with the response they received, at below 10% in the first six months of 2015/16. In September, we sent out 48 responses to complaints. By the 12th November we had received 7 responses back from complainants indicating they were dissatisfied with the Trust's response = 14.6%. Three of these cases related to responses from the Division of Surgery Head & Neck, three from the Division of Women's & Children's and one from Facilities & Estates.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our performance for 2014/15 was 11.1%. Informal benchmarking with other NHS trusts suggests that rates of dissatisfied complainants are typically in the range of 8% to 10%. Improving the quality of written complaint responses is one of our quality objectives for 2015/16. Actions being taken to achieve this are described in the actions section of this report (Actions 3A to 3C).
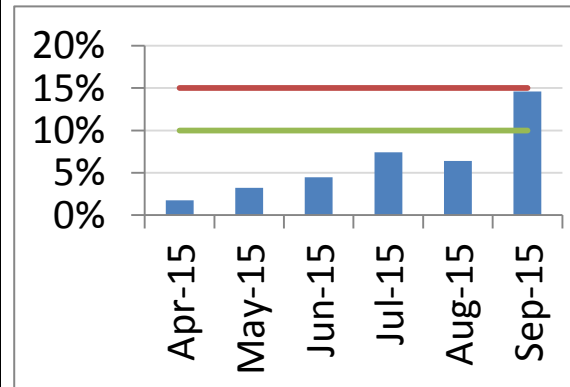
Description	Current Performance	Trend	Comments
Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via analysis and focus groups.	For the month of September 2015, the score was 90 out of a possible score of 100. Divisional scores are broken down at the end of each quarter as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful. {table below}	**Inpatient patient experience scores (maximum score 100) each month** 	The Trust's performance is in line with national norms in terms of patient-reported experience. For the year to date the score remains green rated. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.
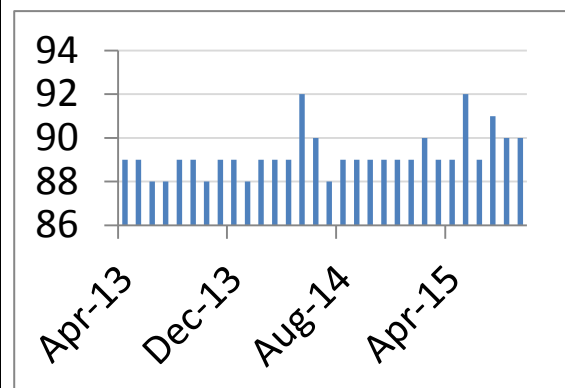
	Q 1	Q2
Trust	90	90
Division of Medicine	86	87
Division of Surgery, Head & Neck	91	90
Division of Specialised Services	90	91
Women's & Children's Division (Bristol Royal Hospital for Children)	91	91
Women's & Children's Division (Postnatal wards)	89	90

Description	Current Performance	Trend	Comments
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 October 2015, the rolling quarterly score was 88 out of a possible score of 100. {table below}	**Outpatient Experience Scores (maximum score 100) each month** 	At a Trust level, this metric would turn red if outpatient experience at UH Bristol began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. For the year to date the Trust score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.

	Quarter 1	Quarter 2
Trust	89	89
Division of Medicine	89	88
Division of Surgery, Head & Neck	88	88
Division of Specialised Services	88	87
Women's & Children's Division (Bristol Royal Hospital for Children)	83	85
Diagnostics and Therapies Division	92	94

Description	Current Performance	Trend	Comments
A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.	The 95% national standard was not achieved in October, with performance for the Trust as a whole reported at 92.2%. Performance and activity levels for the BRI and BCH Emergency Departments are shown below. **Performance against the A&E 4-hour standard**	Levels of emergency admissions into the Bristol Children's Hospital (BCH) in October were 17.6% above the levels seen during October last year (Action 4A). Emergency admissions were also 3% higher in the BRI. The number of Green to Go patients continued to average around 70 in October, due to domiciliary care package and social worker related delays. Actions continue to be taken to manage demand into the BCH and reduce delayed discharges (Actions 4B and 4C).

BRI	Oct 2014	Sep 2015	Oct 2015
Attendances	5725	5363	5752
Emergency Admissions	1809	1795	1868
Patients managed < 4 hours	5246 91.6%	4706 87.8%	5139 89.3%

BCH	Oct 2014	Sep 2015	Oct 2015
Attendances	3012	3200	3432
Emergency Admissions	718	835	838
Patients managed < 4 hours	2845 94.5%	3002 93.8%	3196 93.1%

Description	Current Performance	Trend	Comments
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.	The total number of patients waiting over 18 weeks at the end of October was lower than the revised backlog trajectory, for both the admitted and non-admitted pathways (see Appendix 3). The total backlog is now the lowest it has been since July 2014. There was also a decrease in the number of patients waiting over 40 weeks RTT at month-end against trajectory (in brackets). There were no over 52-week waiters. **Percentage of patients waiting under 18 weeks RTT by month**	Delivery of the revised trajectories is monitored weekly, with any significant variances from plan escalated to Divisional Director level. The weekly RTT Operational Group continues to oversee the management of waiting lists and booking of longest waiting patients (Action 5).
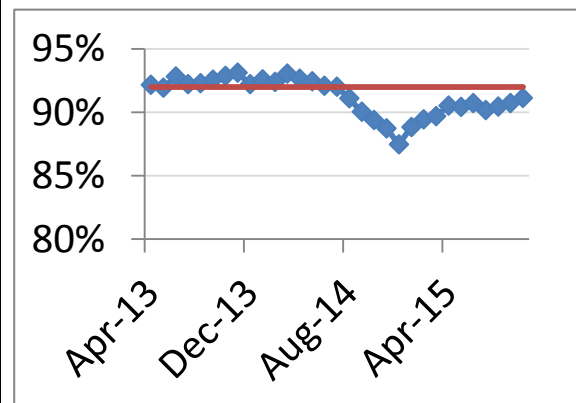
	Aug	Sep	Oct
Numbers waiting > 40 weeks RTT	38 (15)	28 (6)	25 (0)
Numbers waiting > 52 weeks RTT	0 (0)	1 (0)	0 (0)

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Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	Performance against the 85% 62-day GP standard was 81.9% for quarter 2 as a whole, 4.9% above the performance in Q1 and equal to the national average. Performance against the 90% 62-day screening standard was 78.4%. The main reasons for failure to achieve the 85% national 62-day GP standard in the most recent reported month were shown below. 	Breach reason	Q2
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Late referral by other provider	6.0
Medical deferral/clinical complexity	3.5
Insufficient surgical capacity	2.0
Delayed admitted diagnostic test	2.0
Delayed outpatient appointment	2.0
Other (of which, patient choice 2.0)	3.0
TOTAL	**18.5**		**Percentage of patients treated within 62 days of GP referral** The 1 x 62-day screening pathway breach in the period which was due to insufficient colorectal outpatient capacity.	The last time the Trust's 62-day GP performance equalled or was better than the national average was Q1 2012/13. The Internal priority for improving performance is the implementation of ideal timescale pathways (Action 6). The lung pathway went live early in November. A further network-wide meeting was held on the 10th November to agree timescales for tertiary referral. The above areas of focus are part of wide ranging action plan, as previously signed-off by the Board.
Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.	The 99% national standard was achieved again at the end of October as forecast. The number and percentage of over 6-week waiters at month-end, is shown in the table below: 	Diagnostic test	Aug	Sep	Oct
MRI	15	2	0
Echo	38	30	1
Sleep	0	2	2
Endoscopies	33	32	22
Other	4	3	4
TOTAL	**90**	**69**	**29**
Percentage	98.6%	99.0%	99.6%
Trajectory	97.0%	99.0%	99.1%		**Percentage of patients waiting under 6 weeks at month-end** Forecast performance for November = 99.0%.	Work continues to ensure any bulges in demand for stress echo tests, can be addressed in-month to avoid 6 week breaches. The number of routine over 6 week waiters for paediatric GI endoscopies remains above plan. The original plan was to eliminate the backlog by the end of December (Action 7). However, the additional capacity put in place is currently only offsetting the rise in demand. Further actions are being explored.
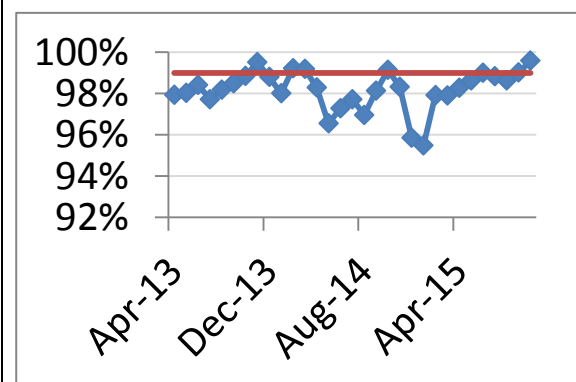
Description	Current Performance	Trend	Comments
Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.	In October, the Trust cancelled 0.64% of operations at last-minute for non-clinical reasons, achieving the 0.8% national standard. There were 40 last minute cancellations, the reasons for which are shown below: **Cancellation reason / Number/percentage** No ward bed — 12 (30%) Emergency patient prioritised — 10 (25%) Lack of time (morning list ran over; other complicated patient in theatre) — 10 (25%) Other causes (6 different breach reasons - no themes) — 8 (20%)	**Percentage of operations cancelled at last-minute** Five patients cancelled in September were readmitted outside of the required 28 days. This equates to 90.0% of cancellations being readmitted within 28 days. The patients failed to be readmitted on time due to more urgent patients taking priority.	As in September the lack of a ward bed to admit patients to remained the leading cause of cancellations. This was mainly attributable to the pressure on ward beds due to delayed discharges in the BRI, and high volumes of emergency admissions into the BCH. A separate action plan to reduce elective cancellations continues to be implemented (Actions 8A and 8B). However, please also see actions detailed under A&E 4 hours (4A to 4C) and outlier bed-days (11A to 11D).
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.	In October 11.1% of outpatient appointments were cancelled by the hospital. This is reduction on the level reported in September (12.1%), and the lowest level since March 2015. A proportion of the hospital cancellations of outpatient appointments continue to be due to patients' appointments being brought forward when booked too far ahead.	**Percentage of outpatient appointments cancelled by the hospital** 	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 improvement work overseen by the Outpatients Steering Group (Action 9).
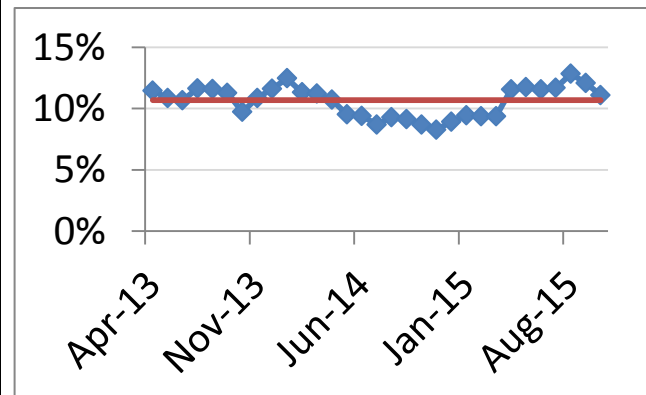
Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator (in hospital deaths) is the ratio of the actual number of patients who died in hospital and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other factors.	Summary Hospital Mortality Indicator for September 2015 was 66.9 against an internally set target of 65. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter (i.e. lower and upper confidence intervals greater than 100). No patterns of causes for concern have been identified.	**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. Although September's performance is above our internally set GREEN threshold, our performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors.
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 September 2015 was 93.3% (latest data) against a target of 90%. There were 45 patients discharged in September, of which 42 had spent at least 90% of their stay on the stroke unit. The year to date performance for this measure is 95.7% (222/232 patients) compared to 86.4% last year.	**The percentage of stroke patients spending 90% of their stay on a stroke unit by month** 	Reasons regarding the three patients for whom we did not achieve the target this month were: One patient had less than 24 hours stay in Ward A400. One patient did not present with typical stroke symptoms but was diagnosed on CT scan later and spent 3 out of 4 days in the stroke unit. One patient was admitted out of hours to the Acute Medical Unit for 2 out of 3 days, even though there was stroke bed available.
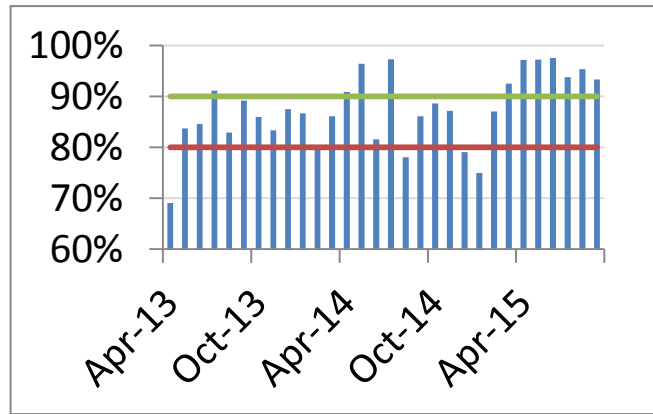
Description	Current Performance	Trend	Comments
Door to balloon times measures the percentage of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Heart Institute.	In September (latest data), 23 out of 25 patients (92%) were treated within 90 minutes of arrival in the hospital, meeting the 90% standard.	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. The 90% standard continues to be met for the year as a whole.
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.	In October we achieved 73.1% overall performance in Best Practice Tariff. There were 26 patients eligible for Best Practice Tariff in the period; seven patient's care did not meet all eight standards. Five patients were not operated on within 36 hours. Two patients were not reviewed by an Ortho-geriatrician within 72 hours due to sickness and planned leave. 	Reason for not going to theatre within 36 hours	Number
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Required specialist surgeon	1
Not well enough for theatre	2
Lack of theatre capacity	2 | The average time to theatre for the 5 patients was 52 hours.	**Percentage of patients with fracture neck of femur whose care met best practice tariff standards.** 	A locum Ortho-geriatrician started on 14th September 2015, but the two patients who were not reviewed within 72 hours were admitted before this. The two patients that breached due to theatre capacity were admitted at the same time alongside three other patients with fractured neck of femur. The actions shown in the improvement plan focus on improving access to theatres and (Actions 10A and 10B). Actions previously reported to the Board as completed have been removed.
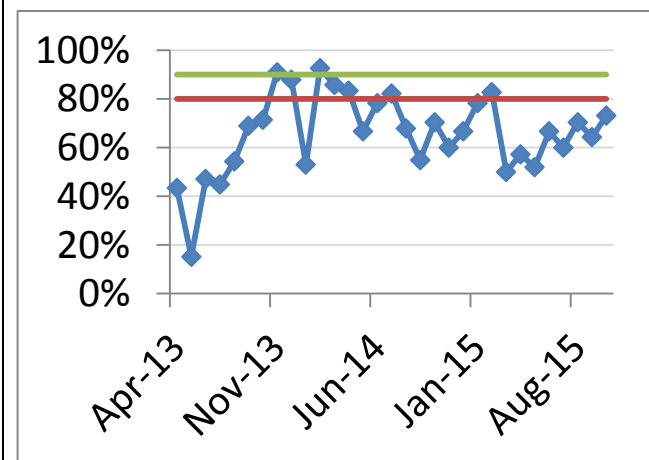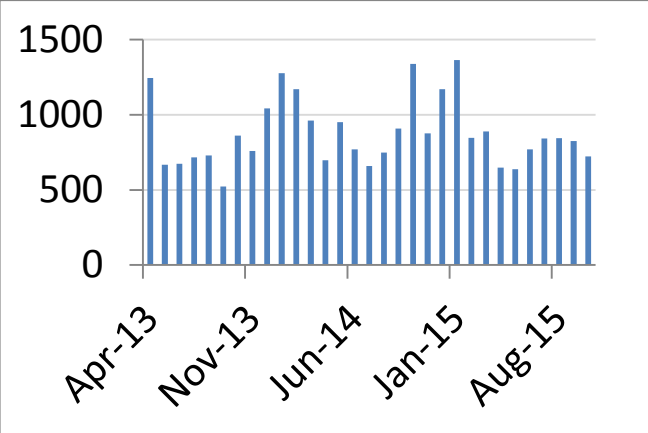
Description	Current Performance	Trend	Comments
Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.	In October there were 722 outlier bed-days against a Q3 monthly target of 705. This is an improvement on September of 102 outlier bed-days.	**Number of days patients spent outlying from their specialty wards**	The Divisions of Medicine and Specialised Services incurred similar levels of outlier bed-days to last month, with continued pressure on emergency cardiac admissions. But there was an improvement in the Division of Surgery, Head & Neck. The number of patients on the Green to Go list has remained high at circa 70 patients during the month.

Actions being taken to improve are described in the actions section of this report (Actions 11A to 11D) |

Outlier bed-days	Oct 2015
Medicine	384
Surgery, Head & Neck	189
Specialised Services	114
Women's & Children's Division	0
Other	35
Total	722

Description	Current Performance	Trend	Comments
Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.	Agency usage reduced by 13.2 FTE. There were small reductions across all Divisions.	**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 12).
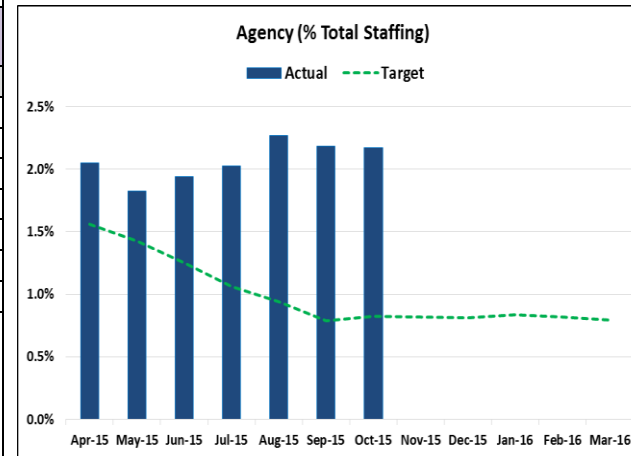
October 2015	FTE	Actual %	KPI
UH Bristol	**180.0**	**2.2%**	**0.8%**
Diagnostics & Therapies	5.3	0.6%	0.5%
Medicine	53.3	4.2%	0.8%
Specialised Services	23.7	2.7%	1.8%
Surgery, Head & Neck	33.1	1.9%	0.6%
Women's & Children's	35.5	1.8%	0.8%
Trust Services	13.0	1.9%	0.6%
Facilities & Estates	16.1	2.1%	0.9%

Agency (% Total Staffing) — Actual / Target, Apr-15 to Mar-16

Description	Current Performance	Trend	Comments
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.	Sickness absence has increased from 4.1% to 4.4% due to 33% more cold/flu related absence, and 10% higher absence due to psychological reasons compared with last month. Absence increased in all Divisions except Specialised Services.	**Sickness absence as a as a percentage of full time equivalents by month**	Action 13 describes the ongoing programme of work to address sickness absence.
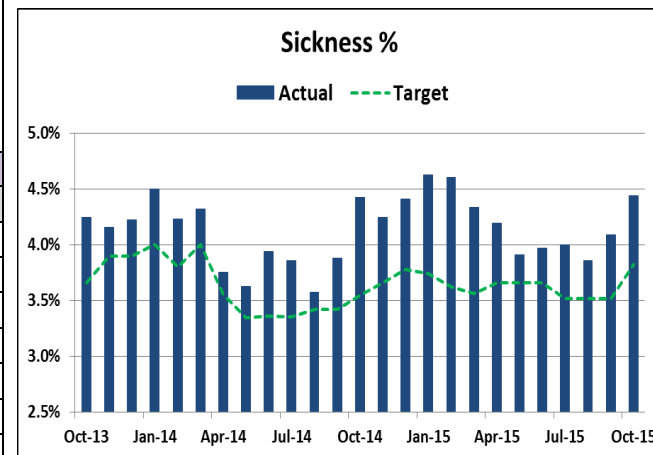
October 2015	Actual	KPI
UH Bristol	**4.4%**	**3.8%**
Diagnostics & Therapies	3.0%	3.0%
Medicine	5.5%	4.2%
Specialised Services	3.7%	3.8%
Surgery, Head & Neck	4.2%	3.4%
Women's & Children's	3.8%	4.0%
Trust Services	4.7%	2.7%
Facilities & Estates	7.6%	6.0%

Sickness % — Actual / Target, Oct-13 to Oct-15

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 5.4% to 5.1% (416.4 FTE) against a target of 5%. Registered Nursing vacancies reduced by 32.9 FTE to 5.4%. Women's and Children's nursing and midwifery vacancies have dropped by 30.2 FTE, Specialised Services by 8.6 FTE, and Surgery Head & Neck by 7.3 FTE. **Vacancies rate by month** 	**Vacancies rate by month** 	The programme of recruitment activities is summarised in Action 14.

Vacancies table:

October 2015	Rate
UH Bristol	**5.1%**
Diagnostics & Therapies	4.3%
Medicine	7.7%
Specialised Services	4.9%
Surgery, Head & Neck	5.6%
Women's & Children's	0.5%
Trust Services	8.5%
Facilities & Estates	9.7%

Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 11.5% by the end of 2015/16. The red threshold is 10% above monthly trajectory**.**
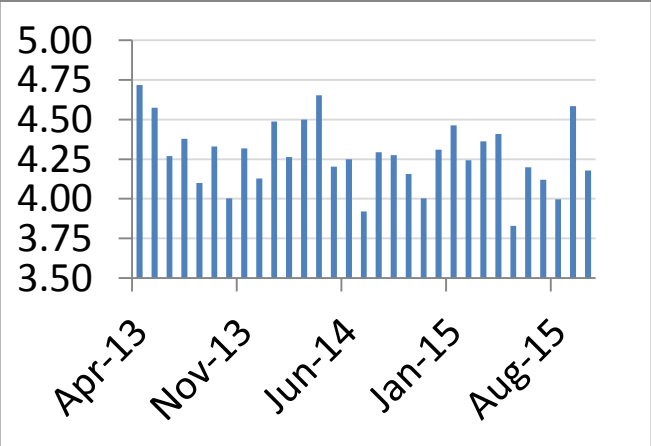
Turnover has increased from 13.6% to 13.7% and registered nurse turnover rose from 12.8% to 13.0%. There were increases in all Divisions except Facilities & Estates and Trust Services.

Staff turnover rate by month
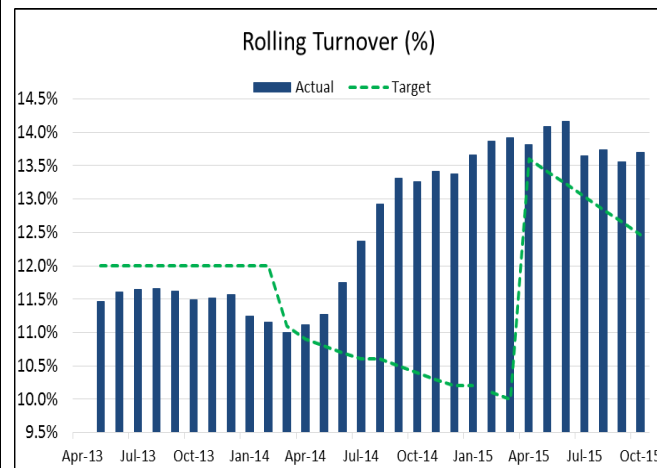
Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 15).

October 2015	Actual	Target
UH Bristol	**13.7%**	**12.5%**
Diagnostics & Therap.	12.8%	11.2%
Medicine	13.2%	13.1%
Specialised Services	16.7%	14.2%
Surgery, Head & Neck	14.4%	13.6%
Women's & Children's	11.6%	10.7%
Trust Services	14.9%	12.3%
Facilities & Estates	14.5%	13.1%

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 October the average length of stay for inpatients was 4.18 days. This is a decrease on the previous month, when patients stayed an average of 4.58 days. Length of Stay remains above plan, and for this reason is RED rated. The average LOS for patients discharged in the month is usually a reflection of the number of long stay patients discharged in the period. Consistent with this, the percentage of patients discharged in October that had stayed 14 days or more was 6.9%, which is significantly lower than the average for 2014/15 of 7.4% and cannot be explained by lower levels of over 14 day stays.	**Average length of stay (days)** 	During October the number of delayed discharges showed a further increase. This is primarily a result of the change in providers of domiciliary care packages and an acute shortage of social workers. The number of surgical outliers and long stay patients has decreased in recent weeks following actions taken. Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide resilience plan and additional exceptional actions being taken (Actions 11A to 11D).

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Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Essential Training	1	Continue to drive compliance of core topics, including increasing e-learning Detailed plans focus on improving the compliance of Safeguarding and Resuscitation	Ongoing Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group Oversight of safeguarding training compliance by Safeguarding Board	Trajectory linked to action plans to sustain 90%.
Monthly Staffing levels	2	Continue to validate temporary staffing assignments against agreed criteria	Ongoing	Monitored through agency controls and action plan	Action plan available on request
Caring					
Dissatisfied Complainants	3A	Training is being delivered to all Divisions in relation to the quality objective to improve the quality of written complaint responses.	Completion by October 2015	Completion of training signed-off by Patient Support & Complaints Team and Divisions.	10% by October 2015, then 5% by March 2016.
	3B	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the caseworker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality for 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.	On-going	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.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	3C	Dissatisfied complaints responses are now routinely reviewed by the Patient Support & Complaints Manager with the Head of Quality to identify potential learning. In addition, any cases where a complainant is dissatisfied for a second time are now reviewed at Executive level.	Implemented October 2015		As above
Responsive					
A&E 4-hours	4A	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.
	4B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of Q3 recovery trajectory.
	4C	Working with partners to mitigate any impact of planned recommissioning of domiciliary care packages providers and bed closures in other acute trusts See also actions 11A to 11D relating to delayed discharges and flow.	Ongoing	Urgent Care Board	Achievement of Q3 recovery trajectory.
Referral to Treatment Time (RTT)	5	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.

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Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Cancer waiting times	6	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments (copy of plan provided to the Quality & Outcomes Committee as a separate paper in August; and Trust Board in September)	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Restore internal pathway performance to above 85% for quarter 3 (already achieved in Q2). Achieve 85% across shared and internal pathways combined by March 2016.
Diagnostic waits	7	Weekly monitoring of waiting list to inform capacity planning, with particular focus on cardiac stress echo, paediatric and adult gastrointestinal endoscopy long waiters.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Forecast for 99% standard to be restored from the end of September (achieved).
Last minute cancelled operations	8A	Continued focus on recruitment and retention of staff to enable all adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited but now in pipeline before starting.	Ongoing	Monthly Divisional Review Meetings;	Improvement to be evidenced by a reduction in cancellations for this reason (as seen since August). Ongoing achievement of quality objective on a quarterly basis, with achievement of national standard of 0.8% in quarter 4 2015/16.
	8B	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	9A	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.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	9B	Analyse percentage of appointments cancelled by hospital which are a result of appointments being brought forward.	November	Information to be reviewed by the Outpatient Steering Group and Quality & Outcomes Committee.	Not applicable.
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	10A	Live flow tracker in situ across Division from June to increase visibility and support escalation standards.	November 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.	
	10B	Review of all Ward Processes on Trauma and Orthopaedic Wards. Project to review fractured neck of femur direct admission process and reduced length of stay.	November 2015	Future reports to the Board.	Improve in overall fractured neck of femur pathway
Ward Outliers	11A	Reduce demand on beds to support optimal occupancy. Range of initiatives in place to reduce demand for acute services including proposals to initiate hot clinics to target over 75 year olds, but with limited impact to date. Further significant initiative now being pursued – community acute virtual ward under discussion.	Ongoing Working to bring on line in Q4 (subject to reaching agreement with provider)	Oversight in monthly Urgent Care Working Group Fortnightly Director-led escalation meeting established this month in response to lack of impact of ongoing initiatives	Maintain modelled occupancy of 90%.
	11B	Weekly Patient Progress meeting continues to expedite early discharge with support of our partners, now escalated to	Ongoing	Monitoring of Green to go list	Green to Go trajectory or no more than 30 patients

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Divisional Director attendance. Divisions reviewing long stay patients with additional (new) focus on those patients requiring one-to-one care.			
	11C	Final programme of ward moves will improve access to speciality specific wards to avoid subsequent moves.	December 2015	Division of Medicine Operational Delivery Group	
	11D	Ward processes work continues to roll-out and embed with evidence of success in increasing early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer.	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge
	11E	Review of Patient Flow and Silver meetings to improve bed management with emphasis on earlier decision making to reduce need for multiple moves to avoid breaches and cancelled operations.	Ongoing		
Well led					
Agency Usage	12	Key actions driven corporately for Agency are: Nursing and midwifery • Close working with wards to maximise the functionality of Rosterpro to support booking and payment processes for bank staff;	Ongoing	Oversight by Savings Board (Nursing Agency) and Medical Efficiencies Group (Medical Agency)	On the basis of the mid year review, agency usage is anticipated to exceed the KPI of 1% with a forecast out turn of 1.7% of total staffing.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• A "real-time" staffing dashboard is being developed to enable cross-trust review of staffing levels supporting the movement of staff across divisions as an alternative to filling shifts using bank and agency;	January 2016		
		• A direct booking process based at ward level for temporary staff, commencing September 2015 is being rolled-out to all areas to allow greater control over staffing at ward level and maximise the availability to bank staff;	October – December 2015		
		• A cross-community Group has been established to share and develop collaborative approaches to reducing agency spend.	Ongoing		
		Medical agency usage			
		• Master Vendor supplier for locums to improve cost efficiency and consistency went live in October - all future medical usage will be through the chosen supplier.	October to December 2015		
		Improved Supply			
		• "Envoy" texting system being tested with Medicine Division to advise doctors that shifts are available. The long term aim is to develop a bank of	October onwards		

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Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		locum doctors; • Work is being undertaken to develop an internal locum bank. Outcome of feasibility study of appropriate systems; • There is a continued Divisional focus on filling vacancies and gaps, which are the main reasons for medical agency. Administrative and clerical (A&C) agency usage • An assessment centre approach has been piloted in Surgery Head & Neck to recruit to the Admin & Clerical (A&C) bank aiming to increase the size of the bank pool. In addition, details of A&C bank staff will be published on the Trust Intranet to promote the availability of temporary staff.	December 2015 December 2015		
Sickness Absence	13	The detailed plan with timescales for the work programmes agreed with Senior Leadership Team is as follows: • Self Certification for absences of less than four days with pilots commencing in Medicine, Specialised Services, and Facilities & Estates. • Audit and raising the profile of return to work interviews; • Contacting employees on the 1st, 3rd and 7th day of sickness	November 2015 to February 2016 November 2015 to February 2016 December 2015 to June 2016	Oversight by Workforce and OD Group via the Staff Health and Well Being Sub Group	The mid-year review indicates that the out-turn for sickness absence will be AMBER rated at 4.2% by March 2016, due in part to the unprecedented levels of colds and flu related absence during the summer months.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		absence, phased roll-out; • Managers in "hot spots" to receive coaching in consistent implementation of the policy; • Occupational health triage service to be promoted. The Staff Health and Well Being action plan continues to be implemented, including the following: Musculo-skeletal • Review of Occupational Health Physiotherapy pathway to improve the focus on prevention and keeping staff at work. • Continued targeted intervention by Occupational Health Musculo-skeletal services, Physio direct, and Manual Handling Team. Colds and flu • The seasonal flu vaccination campaign for all Trust staff commenced in October 2015. The Trust is aiming to achieve the 75% target coverage set by NHS England.	Ongoing November 2015 October 2015 to end February 2016 Ongoing	Flu Steering Group	
Vacancies	14	Recruitment action plan includes the following ongoing activities: • A schedule of advertising activity has been developed utilising the agreed funding for	September 2015 to March 2016	Oversight by Workforce and OD Group via the Recruitment Sub Group.	Improvement is focussed on staff groups where vacancy levels are above target including nursing and midwifery. On the basis of the

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		2015/16 to target the national market for hard to fill posts including nursing and midwifery. Activity includes the use of local radio, Bristol buses and social media; • Service level agreements and KPIs for recruitment are being developed to measure performance and support improvement of conversion to hire rates and benefits realisation. • Newly appointed Recruitment and Retention lead for Facilities commenced and will aim to reduce vacancies.	January 2016 October 2015 onwards		review of trajectories at the mid year review, out turn is expected to be around 5.9% compared with a target of 5%.
Turnover	15	Key corporate and divisional actions include: • 4 staff experience workshops have taken place, with more planned, to agree how we improve communications between managers and teams with an outcome of improving staff experience A full report will be made to Senior Leadership Team in November; • Pilot preceptorship programmes to support newly qualified nurses in their transition from student to registered nurses; • Additional investment for divisional hot spots including	July to November 2015 September 2015/ February 2016 September 2015 – March 2016	Oversight of Staff Experience Programme by Transformation Board. Oversight by Workforce and Organisational Development Group Senior Leadership Team/Workforce and	An out turn of 13% is anticipated on the basis of the mid year review.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		innovative training and development; • Role competency and career frameworks to be embedded within the revised appraisal process to improve the quality and application of staff appraisals.	End of March 2016	Organisational Development Group /Divisional Boards Workforce and Organisational Development Group	

Operational context

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

A&E attendances

Summary points:

- Emergency activity has increased across all sites, although the main increase has been in the level of emergency admissions into the BCH, which is significantly above the same period last year;

- The number of elective admissions is consistent with the seasonal norm; as will be seen in the Assurance and Leading Indicators summary, consistent with this, the number of patients on elective waiting list has remained stable;

- The number of new outpatient attendances has remained at seasonal norm (i.e. at a high level), resulting in a reduction in the total number of patients on the outpatient waiting list, and the total number of patients waiting over 18 weeks Referral to Treatment.

Emergency admissions (BRI)

Emergency admissions (BCH)

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Elective admissions

Legend: 2013/2014, 2014/2015, 2015/2016

Y-axis: 4,000 to 8,000

X-axis: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar

New outpatient attendances

Legend: 2013/2014, 2014/2015, 2015/2016

Y-axis: 4,000 to 24,000

X-axis: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar

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Assurance and Leading Indicators

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

Percentage ED attendances resulting in admission
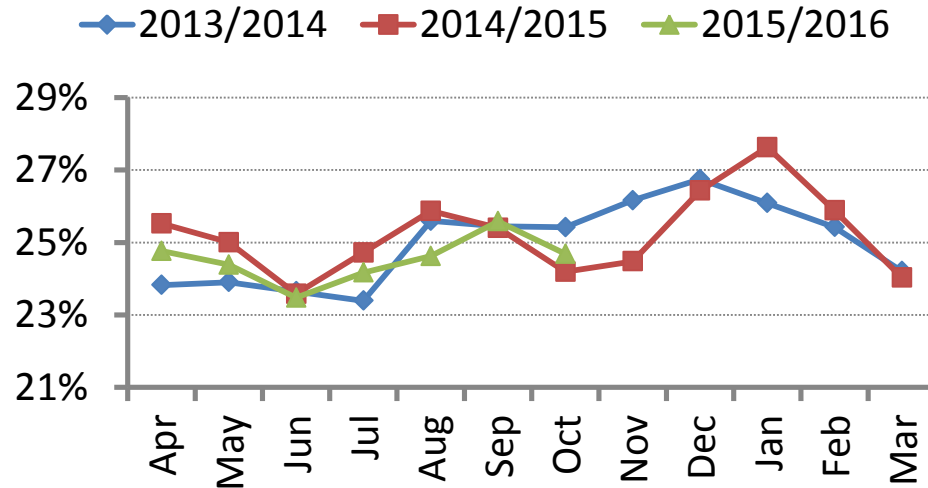
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission was consistent with the seasonal norm in October; in contrast, the percentage of patients admitted aged 75 years and over, continues to be below the seasonal norm;

- The number of delayed discharges, and as a consequence BRI bed occupancy, has continued to increase in the period;

- The number of patients on the outpatient waiting list has continued to reduce, which is consistent with the higher than normal number of 18 week clock (treatment) stops in the period, and the reduction in the number of RTT patients waiting over 18 weeks (especially for non-admitted pathways – see Appendix 3);

- Numbers of patients referred by their GP with a suspected cancer has remained at the seasonal norm, which should lead to a reduction in the number of patients treated on 62-day pathways, which is currently high.

Percentage of Emergency BRI spells patients aged 75 years and over
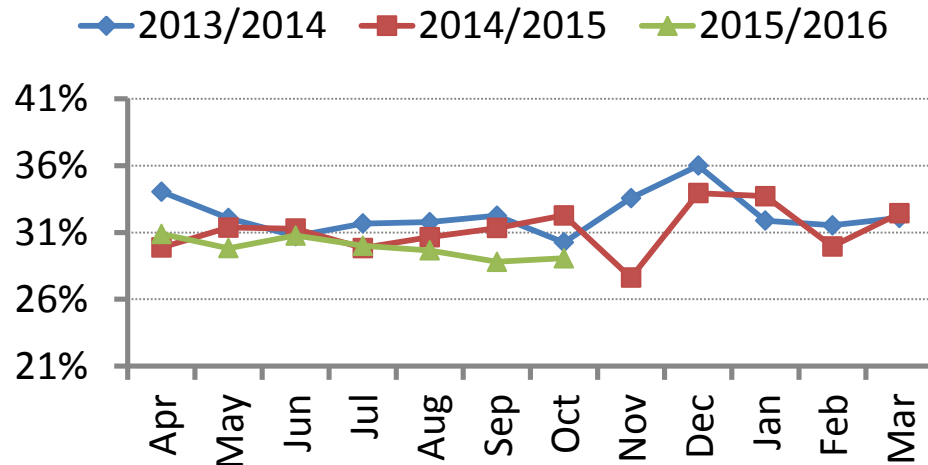
Over 14 day stays
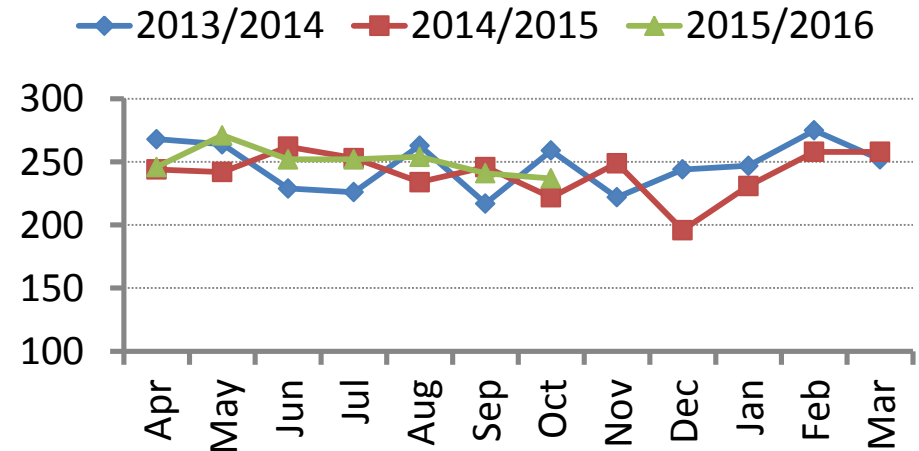
Delayed discharges — 2013/2014, 2014/2015, 2015/2016
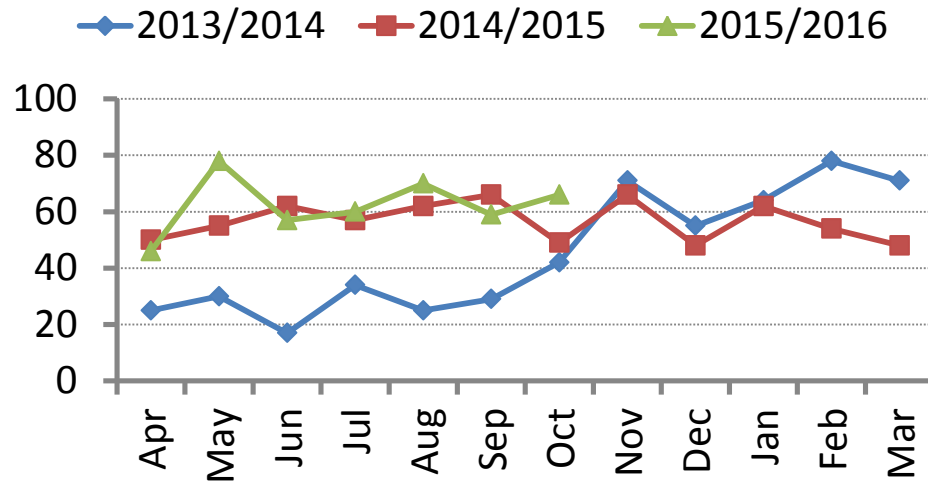
BRI Bed Occupancy — 2013/2014, 2014/2015, 2015/2016

Elective waiting list size — 2013/2014, 2014/2015, 2015/2016

Outpatient waiting list size — 2013/2014, 2014/2015, 2015/2016

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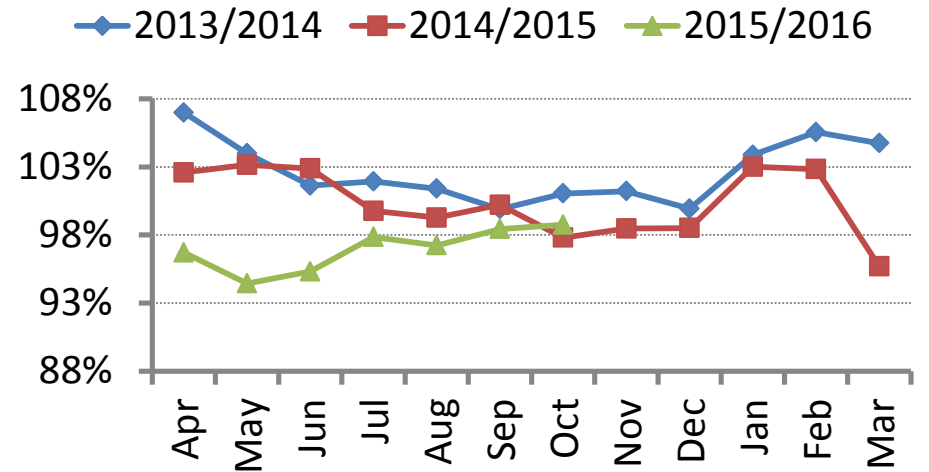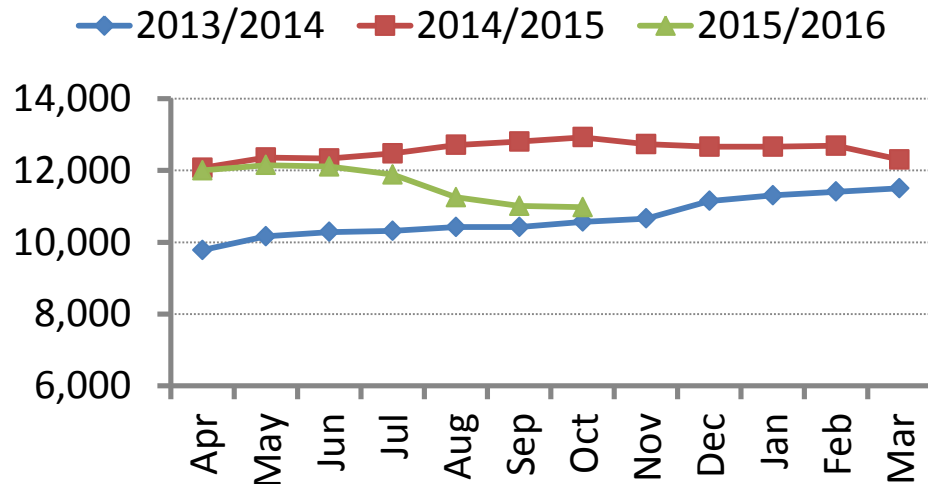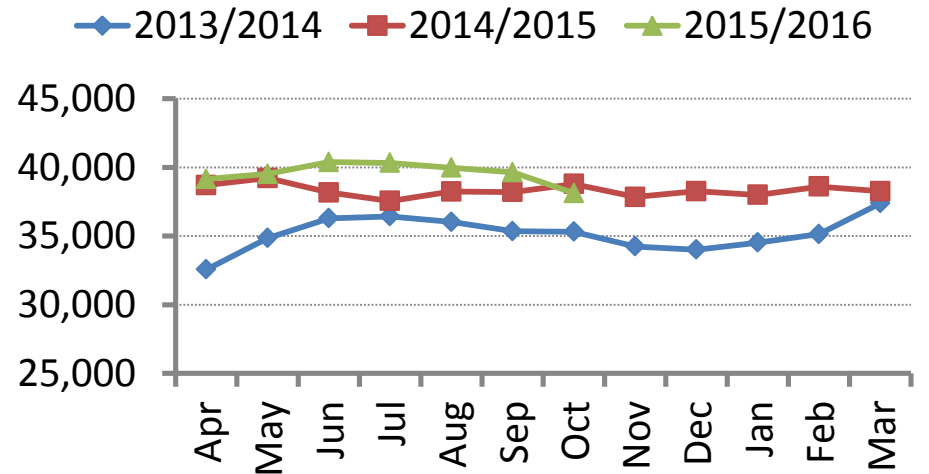
Number of RTT pathways stopped (i.e. treatments)

Legend: 2013/2014, 2014/2015, 2015/2016
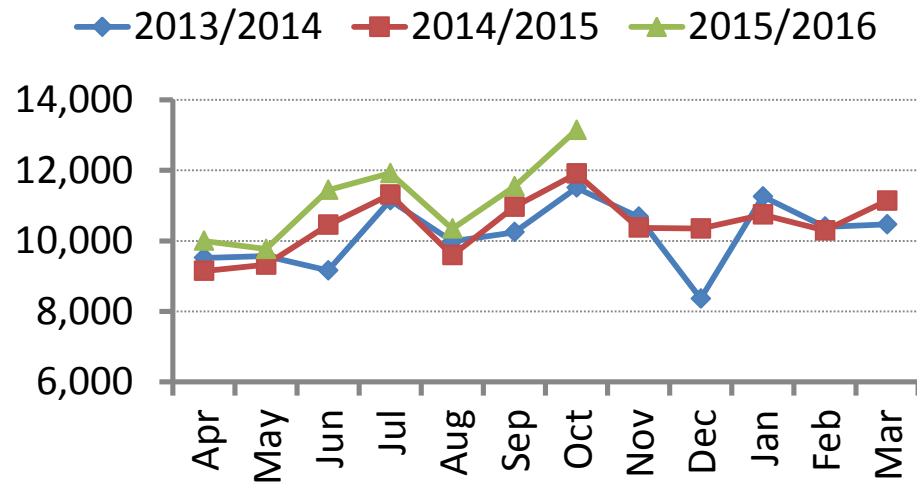
Number of RTT pathways over 18 weeks

Legend: 2013/2014, 2014/2015, 2015/2016
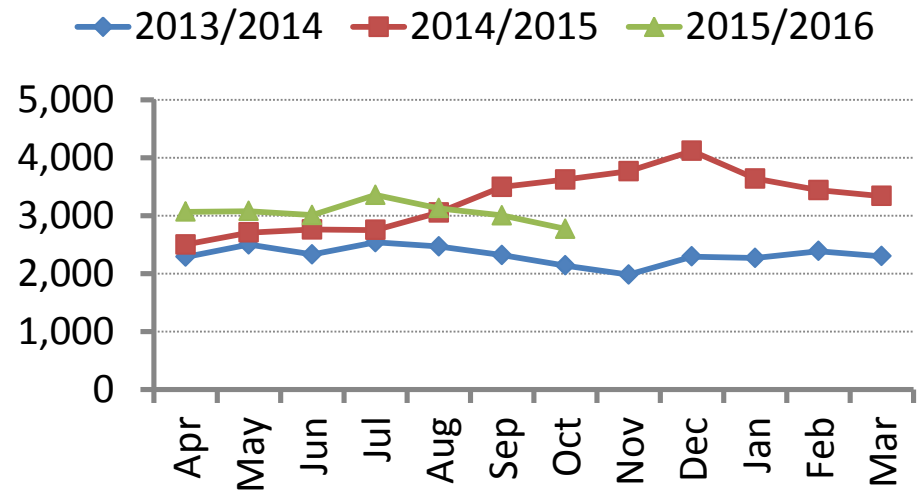
Cancer 2-week wait – urgent GP – referrals seen

Legend: 2013/2014, 2014/2015, 2015/2016
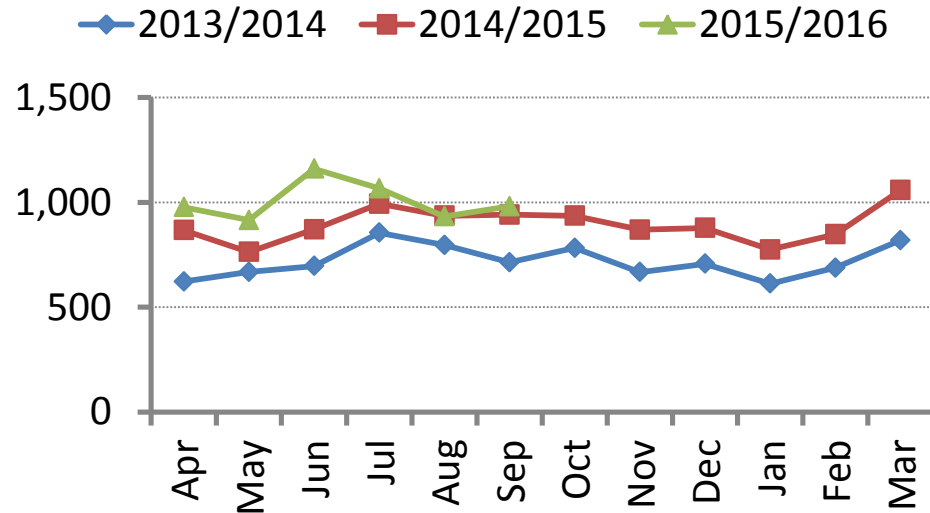
Cancer 62-day GP referred treatments

Legend: 2013/2014, 2014/2015, 2015/2016
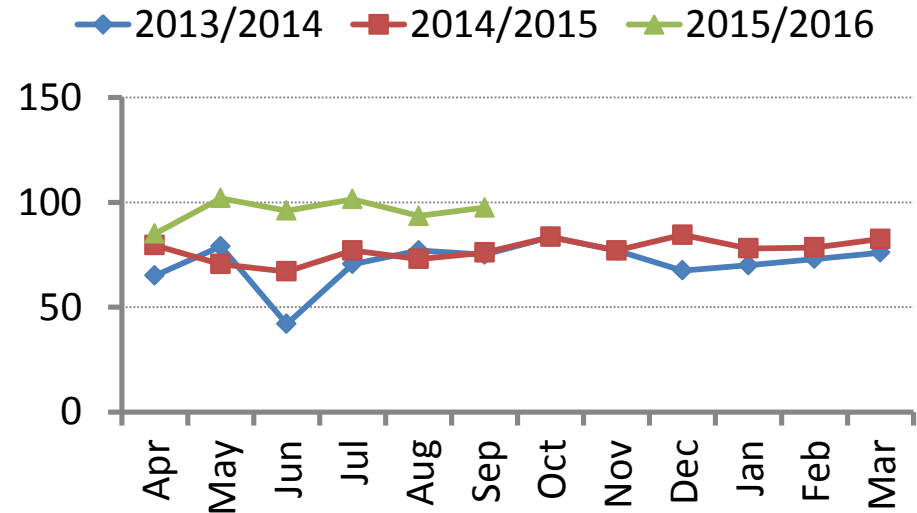
Trust Scorecards

QUALITY

Topic	ID	Title	14/15	15/16 YTD	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
									Patient Safety											
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	5	3	3	4	4	5	5	1	1	2	2	3	3	3	5	2	3	3
	DA01	MRSA Bloodstream Cases - Monthly Totals	5	3	0	1	0	1	0	1	0	1	0	1	0	0	1	2	1	0
	DA03	C.Diff Cases - Monthly Totals	50	21	4	4	3	4	0	6	1	3	3	1	2	5	7	10	6	5
	DA02	MSSA Cases - Monthly Totals	33	19	3	4	3	2	4	4	1	4	2	3	2	3	9	9	7	3
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	6	6	7	8	8	2	2	3	3	-	-	-	8	3	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.2%	97.2%	97.2%	97.6%	97.1%	97.4%	97.6%	97%	96.9%	97.6%	97.7%	97.7%	97.9%	95.6%	97.4%	97.2%	97.8%	95.6%
	DB02	Antibiotic Compliance	89.3%	89.6%	91.2%	89.1%	90.6%	88.8%	88.8%	90.7%	90.9%	88.9%	88.3%				89.4%	90.1%	88.3%	-
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	94%	95%	96%	96%	96%	95%	95%	93%	95%	93%	-	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	98%	98%	98%	98%	97%	96%	97%	-	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	95%	95%	96%	96%	97%	97%	95%	94%	93%	94%	-	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	78	34	6	8	7	4	6	6	6	4	3	8	3	4	17	16	14	4
	S02a	Number of Confirmed Serious Incidents	71	16	5	8	5	4	6	5	3	2	1	5	-	-	15	10	6	-
	S02b	Number of Serious Incidents Still Open	2	17	-	-	2	0	0	0	2	2	2	3	4	4	2	4	9	4
	S03	Serious Incidents Reported Within 48 Hours	88.5%	82.4%	83.3%	100%	100%	100%	83.3%	100%	100%	25%	100%	62.5%	100%	100%	94.1%	81.3%	78.6%	100%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	73.3%	82.1%	66.7%	37.5%	80%	66.7%	100%	75%	85.7%	66.7%	100%	100%	66.7%	85.7%	76.2%	78.6%	85.7%	85.7%
Never Events	S01	Total Never Events	6	1	1	0	1	1	1	0	0	0	0	1	0	0	3	0	1	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	12712	6561	1028	1073	1017	1022	1124	1087	1139	1216	1023	953	1143	-	3163	3442	3119	-
	S06b	Patient Safety Incidents Per 1000 Beddays	41.32	42.44	40.6	41.66	37.64	41.85	43.14	42.65	43.43	47.3	39.07	36.85	45.48	-	40.81	44.46	40.41	-
	S07	Number of Patient Safety Incidents - Severe Harm	89	46	12	6	12	7	6	7	5	5	9	12	8	-	25	17	29	-
Patient Falls	AB01	Falls Per 1,000 Beddays	4.8	3.96	4.5	5.59	4.89	4.91	4.53	3.61	4.46	3.81	3.82	4.6	3.9	3.53	4.77	3.97	4.11	3.53
	AB06a	Total Number of Patient Falls Resulting in Harm	28	7	4	1	2	1	2	2	2	0	3	0	0	0	5	4	3	0
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.387	0.271	0.553	0.388	0.37	0.45	0.269	0.353	0.267	0.311	0.229	0.232	0.318	0.192	0.361	0.31	0.259	0.192
	DE02	Pressure Ulcers - Grade 2	110	43	13	8	9	10	5	9	7	7	5	4	7	4	24	23	16	4
	DE03	Pressure Ulcers - Grade 3	9	6	1	2	1	1	2	0	0	1	1	2	1	1	4	1	4	1
	DE04	Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.8%	99.1%	99%	99%	99.1%	99.4%	99.2%	99.1%	99.3%	99.1%	99.4%	99.3%	99%	98.4%	99.2%	99.2%	99.2%	98.4%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.4%	94.7%	92.3%	96.7%	92.4%	92.9%	96%	93.9%	93%	94.3%	96.6%	95.2%	95.1%	94%	93.8%	93.8%	95.7%	94%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	88.9%	89.8%	87.2%	87.8%	87.4%	88.4%	87.9%	86.8%	93%	92.3%	90.7%	86.6%	86.5%	91.5%	87.9%	90.9%	87.9%	91.5%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.9%	99.6%	99.4%	100%	100%	100%	100%	99.7%	100%	100%	100%	100%	100%	100%	99.9%	100%	100%

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QUALITY (continued)

Patient Safety

Topic	ID	Title	14/15	15/16 YTD	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Medicines	WA01	Medication Errors Resulting in Harm	0.45%	0.1%	0.57%	0%	0%	0%	0.54%	0%	0.56%	0%	0%	0%	0%	-	0.21%	0.18%	0%	-
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.01%	0.85%	0.86%	0.37%	1.55%	1.54%	0.52%	0.63%	1.43%	0.96%	0.83%	0.73%	0.75%	0.78%	1.23%	0.96%	0.77%	0.78%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	96.6%	97.2%	96.7%	97%	96.7%	97.9%	96.5%	97.5%	97.1%	98.2%	97.4%	96.4%	96.2%	97.3%	97%	97.6%	96.7%	97.3%
	AK04	Safety Thermometer - No New Harms	98.4%	98.5%	97.8%	98.5%	98.4%	99.3%	98.7%	98.9%	98.2%	98.6%	98.6%	98%	98%	98.9%	98.8%	98.6%	98.2%	98.9%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	89%	93%	86%	83%	92%	96%	88%	90%	96%	91%	98%	90%	92%	92%	92%	92%	94%	92%
Out of Hours	TD05	Out of Hours Departures	10.4%	11.3%	8.5%	9.5%	10.7%	9%	10.4%	9%	11.7%	11.6%	10.1%	11.7%	11.7%	12.9%	10.1%	10.8%	11.2%	12.9%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	19.5%	19.2%	16.9%	19%	18.5%	22.3%	20.6%	20.4%	19%	18.6%	19.9%	17.8%	19.8%	18.9%	20.4%	19.3%	19.2%	18.9%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9862	5778	726	800	809	877	873	845	838	789	879	738	844	845	2559	2472	2461	845
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	97.9%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	CS03	Number of CAS Alerts Overdue At Month End	0	2	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.6%	101.5%	104.6%	103.1%	104.6%	103.4%	102.4%	100.4%	100.3%	101.8%	102.8%	100.5%	103.1%	-	103.5%	100.8%	102.1%	-

Clinical Effectiveness

Topic	ID	Title	14/15	15/16 YTD	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital Deat	64.1	62.1	85.4	58.5	68.6	60.8	63.9	54.8	62	66	58.4	65	66.9	-	64.8	60.9	63.4	-
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	96.5	-	-	97.8	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline	68.3	62.4	89.7	63.3	70.3	57.8	68.6	56.6	70.9	64.7	56.4	64.4	62.4		66.1	63.8	60.9	-
Readmissions	C01	Emergency Readmissions Percentage	2.82%	2.9%	2.39%	2.99%	3.06%	2.83%	2.96%	2.89%	3.55%	2.69%	2.72%	2.84%	2.76%	-	2.95%	3.04%	2.77%	-
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	61.5%	61.7%	65.5%	59.6%	60%	59.8%	57.9%	60.9%	63.4%	64.1%	57.3%	62.6%	62.4%	61.3%	59.3%	62.8%	60.7%	61.3%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	76%	76.3%	73.3%	70%	78.3%	89.7%	72.7%	71.4%	72%	66.7%	76%	81.5%	85.7%	80.8%	81.1%	70.2%	81.3%	80.8%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	93.4%	81.6%	86.7%	93.3%	95.7%	93.1%	86.4%	77.1%	68%	91.7%	80%	85.2%	78.6%	92.3%	91.9%	78.6%	81.3%	92.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	70.1%	63.2%	60%	66.7%	78.3%	82.8%	50%	57.1%	52%	66.7%	60%	70.4%	64.3%	73.1%	71.6%	58.3%	65%	73.1%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	41.3	57.5	45.5	37	47.5	45.5	56.2	55.8	46.7	40.2	39.4	42.4	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	56.5%	61%	59%	62.8%	55%	66.7%	60%	68.6%	65.7%	56.1%	43.8%	67.4%	62.2%	-	61.2%	63.1%	59.2%	-
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	86.4%	95.7%	87.2%	79.1%	75%	87%	92.5%	97.1%	97.2%	97.6%	93.8%	95.3%	93.3%	-	85.1%	97.3%	94.2%	-
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.2%	65.1%	73.3%	64.7%	50%	57.1%	50%	69.2%	83.3%	30.8%	58.8%	100%	75%	54.5%	52.8%	60.5%	73.5%	54.5%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	65%	86.9%	63.7%	62.9%	78.3%	77.3%	81.6%	83.9%	88.4%	82.7%	83.3%	92.5%	91.1%	-	79.3%	84.9%	88.8%	-
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	84.1%	94.6%	92.2%	82.2%	90.7%	88.5%	94.2%	98.6%	100%	92.8%	90%	92.3%	93.2%	-	91.7%	97%	91.8%	-
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	58.5%	90.5%	73.3%	68%	82.4%	81.3%	90.5%	90%	92.3%	92.9%	80%	100%	88.9%	-	85.2%	91.5%	88.9%	-
	AC04	Percentage of Dementia Carers Feeling Supported	75.2%	88.9%	88.9%	64.3%	87.5%	81.8%	-	90.9%	100%	93.3%	92.3%	76.9%	70%	100%	85.2%	94.6%	80.6%	100%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	11216	5286	876	1169	1364	847	889	647	638	769	841	845	824	722	3100	2054	2510	722

QUALITY (continued)

Patient Experience

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	89	89	89	90	89	89	92	89	91	90	90	-	89	90	90	-
	P01g	Patient Survey - Kindness and Understanding	-	-	93	94	93	93	93	94	96	93	93	95	94	-	93	94	94	-
	P01h	Patient Survey - Outpatient Tracker Score	-	-	-	-	-	-	-	89	89	89	88	89	89	88	-	89	89	88
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	38.7%	17.7%	41.3%	29.5%	37.9%	33.9%	59.3%	17.4%	19.7%	16.2%	20.5%	10.4%	19.8%	19.3%	44%	17.7%	17.1%	19.3%
	P03b	Friends and Family Test ED Coverage	20.8%	11.5%	14.9%	16%	17.3%	22.5%	37.1%	6.6%	6.7%	7%	12.3%	14.7%	17.8%	15.9%	26.1%	6.7%	14.9%	15.9%
	P03c	Friends and Family Test MAT Coverage	28.9%	22.7%	54.3%	29.2%	26.9%	22.5%	35%	23.9%	33.7%	20.1%	22.1%	18.3%	14.6%	25.3%	28.2%	26.1%	18.5%	25.3%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	94.9%	96.3%	94%	96.3%	95.9%	93.3%	95.5%	96.1%	95.5%	96.3%	97.2%	97.2%	96.2%	96.2%	95.1%	96%	96.8%	96.2%
	P04b	Friends and Family Test Score - ED	92.7%	74.9%	92.4%	92.1%	93.4%	89.9%	93.5%	80.7%	66.3%	70.4%	78.1%	77.3%	76.6%	72.2%	92.5%	72.2%	77.2%	72.2%
	P04c	Friends and Family Test Score - Maternity	94.2%	96.7%	95.8%	92%	97.1%	97.1%	91.5%	97.3%	93.3%	97.8%	98.7%	97.1%	96.3%	98.2%	94.9%	95.6%	97.6%	98.2%
Patient Complaints	T01	Number of Patient Complaints	1883	1201	140	133	165	171	181	158	147	154	207	168	185	182	517	459	560	182
	T01a	Patient Complaints as a Proportion of Activity	0.261%	0.273%	0.251%	0.224%	0.267%	0.291%	0.273%	0.266%	0.25%	0.231%	0.315%	0.302%	0.279%	0.267%	0.277%	0.249%	0.298%	0.267%
	T03a	Complaints Responded To Within Trust Timeframe	85.9%	81.1%	82.9%	82.9%	84.8%	83.7%	85.3%	89.5%	83.9%	82.1%	87%	80.9%	83.3%	60.7%	84.7%	84.9%	83.9%	60.7%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	92.3%	78.6%	87.1%	87.9%	81.4%	92.6%	93%	91.9%	94%	98.1%	93.6%	95.8%	80.4%	88.1%	93%	96%	80.4%
	T04c	Percentage of Responses where Complainant is Dissatisfied	-	5.97%	-	-	-	-	-	1.75%	3.23%	4.48%	7.41%	6.38%	14.58%	-	-	3.23%	9.4%	-
Ward Moves	J06	Average Number of Ward Stays	2.32	2.24	2.37	2.25	2.24	2.28	2.24	2.31	2.18	2.19	2.25	2.28	2.28	2.23	2.25	2.22	2.27	2.23
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.08%	0.93%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.04%	0.46%	0.83%	0.64%	0.97%	1.19%	0.78%	0.64%
	F01a	Number of Last Minute Cancelled Operations	749	376	108	41	58	46	66	66	63	70	62	25	50	40	170	199	137	40

ACCESS

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	14/15	15/16 YTD	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Referral to Treatment (RTT)	A01	Referral To Treatment Admitted Under 18 Weeks	90%	90%	84.9%	82.5%	83.1%	84.3%	80.5%	80.4%	80.5%	79.9%	81%	80.4%	84.2%	85.1%	82.5%	83.1%	80.5%	80.4%	84%	83.1%
	A02	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	90.3%	89.7%	88.8%	89.9%	88.9%	89.3%	90%	90.2%	91.4%	90.7%	89.2%	88.9%	88.7%	89%	89.4%	90.8%	89%	89%
	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	90.4%	90.6%	88.7%	87.5%	88.8%	89.4%	89.7%	90.5%	90.4%	90.7%	90.2%	90.5%	90.7%	91.1%	89.3%	90.6%	90.4%	91.1%
Referral to Treatment (RTT) Ongoing Volumes	A03A	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3766	4117	3641	3440	3339	3069	3078	3010	3357	3128	3004	2772	-	-	-	-
	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	59	6	8	13	9	11	4	4	1	0	0	0	1	0	24	5	1	0
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	1842	379	117	177	160	161	119	116	89	38	45	38	28	25	440	243	111	25
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.5%	95.7%	96.3%	97.5%	94.3%	95.8%	93.1%	94.2%	94.9%	95.3%	97.3%	95.4%	96.8%	-	94.3%	94.8%	96.5%	-
	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%	94%	98.5%	97.9%	98.4%	97%	95.8%	99.5%	95.3%	96.7%	96.7%	97.3%	-	97.7%	96.9%	96.9%	-
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.6%	98.9%	98.9%	100%	99%	98.1%	100%	100%	97.8%	100%	99.1%	98.1%	98.6%	-	99%	99.3%	98.6%	-
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.9%	96%	92.3%	95%	95.6%	94.4%	95.9%	94.1%	97.4%	97.9%	89.1%	100%	97.6%	-	95.4%	96.4%	95.6%	-
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.6%	96.8%	99.5%	97.2%	96.5%	97.7%	97.2%	97.5%	98.1%	94.7%	96.1%	98.4%	96%	-	97.1%	96.7%	96.8%	-
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	79.5%	81.2%	84.6%	80.8%	75.2%	79.4%	76.5%	77%	77.6%	83.7%	80.7%	81%	-	78.5%	77%	81.9%	-
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	89%	78.5%	100%	90.9%	71.4%	60%	100%	100%	81.3%	62.5%	76.9%	70%	85.7%	-	80.6%	78.6%	78.4%	-
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	90.1%	86.6%	100%	90.5%	84.4%	94.4%	87.2%	100%	83.3%	76.9%	80.8%	86.7%	91.2%	-	88.8%	85.2%	87.6%	-
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	1.5%	1.08%	0.93%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.04%	0.46%	0.83%	0.64%	0.97%	1.19%	0.78%	0.64%
	F02c	Number of LMCs Not Re-admitted Within 28 Days	36	36	75	52	5	14	7	3	3	10	12	12	7	4	2	5	13	34	13	5
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	79.7%	78.1%	73.8%	80%	78.3%	87.1%	83.9%	77.5%	80.5%	86.4%	73.2%	76%	-	-	82.4%	80.6%	74.2%	-
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	92.4%	94.7%	81%	92%	95.7%	96.8%	90.3%	95%	95.1%	90.9%	92.7%	100%	-	-	94.4%	94.2%	95.5%	-
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.47%	98.86%	98.32%	95.85%	95.48%	97.92%	97.9%	98.27%	98.63%	99%	98.83%	98.63%	99.01%	99.59%	97.11%	98.64%	98.83%	99.59%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	9.2%	11.8%	8.3%	8.9%	9.4%	9.4%	9.4%	11.6%	11.7%	11.6%	11.7%	12.8%	12.1%	11.1%	9.4%	11.6%	12.2%	11.1%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	59	43	49	43	39	30	58	51	41	59	48	54	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	7	5	13	11	9	16	20	6	19	11	11	12	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	3.7	3.7	4.26	4.18	4	4.31	4.46	4.24	4.36	4.41	3.83	4.2	4.12	4	4.58	4.18	4.36	4.14	4.23	4.18

ACCESS (continued)

Emergency Department Indicators

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 14/15	Annual 15/16 YTD	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	92.23%	93.95%	88.62%	86.27%	90.87%	89.53%	95.01%	94.81%	93.47%	95.2%	95.51%	94.95%	91.69%	92.16%	91.92%	94.48%	94.04%	92.16%
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	10	0	0	0	10	0	0	0	0	0	0	0	0	0	10	0	0	0
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95%	95%	97.2%	89.1%	99%	87.8%	99.7%	99.8%	87.9%	87.9%	88.3%	89.3%	92.1%	92%	87.1%	87.6%	95.1%	88.5%	90.3%	87.6%
	B02a	ED Time to Initial Assessment - 95th Percentile	15	15	14	28	12	38	14	14	29	30	30.4	28	23	21	32	30	15	30	26	30
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	78.3%	92.7%	71.9%	70.3%	77.7%	76.1%	94.5%	93.2%	92.2%	92.3%	93.4%	91.6%	92.8%	93.2%	83%	92.6%	92.6%	93.2%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	55.4%	55.4%	50.9%	53%	60.6%	59.6%	56.3%	57.2%	53.5%	53.9%	57.5%	60.4%	53.2%	52.8%	58.8%	54.8%	57%	52.8%
	B03a	ED Time to Start of Treatment - Median	60	60	54	54	59	57	48	50	53	51	56	56	52	48	56	57	50	54	52	57
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	99.3%	99%	99%	99.3%	99.5%	99.5%	99.3%	99.3%	99.1%	98.5%	99.1%	99.2%	98.7%	98.8%	99.4%	99%	99%	98.8%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.3%	2.8%	2.6%	2.4%	2.7%	2.5%	2.5%	2.7%	3%	2.6%	2.9%	2.5%	2.9%	2.7%	2.6%	2.8%	2.8%	2.7%
	B05	ED Left Without Being Seen Rate	5%	5%	1.8%	2.3%	2.3%	1.6%	1.6%	1.5%	1.6%	1.9%	2.4%	2.9%	2.3%	2%	2.3%	2.4%	1.6%	2.4%	2.2%	2.4%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	1032	1032	1287	383	131	168	119	78	49	46	46	29	38	36	92	96	246	121	166	96

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WORKFORCE

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Sickness	AF02	Sickness Rate	4.2%	4.1%	4.5%	4.4%	4.5%	4.7%	4.6%	4.3%	4.2%	4%	4.1%	4.2%	3.9%	4.2%	4.5%	4.5%	4.1%	4.1%
Staffing Numbers	AF08	Funded Establishment FTE	-	-	7775.8	7833.6	7872.4	7927.2	7912.4	7958.8	7976.8	8011.6	8088.3	8096.3	8110.8	8128.9	-	-	-	-
	AF09A	Actual Staff FTE (Including Bank & Agency)	-	-	7859.9	7910.8	8022.7	8004.1	8088.6	8130.6	8080.5	8123.2	8114.4	8069.3	8149.2	8253.7	-	-	-	-
	AF13	Percentage Over Funded Establishment	-	-	1.1%	1%	1.9%	1%	2.2%	2.2%	1.3%	1.4%	0.3%	-0.3%	0.5%	1.5%	-	-	-	-
Bank Usage	AF04	Workforce Bank Usage	-	-	407.1	392.6	489.6	373.9	432.2	416.2	368.6	424.2	423.5	395	399.2	446.2	-	-	-	-
	AF11A	Percentage Bank Usage	-	-	5.2%	5%	6.1%	4.7%	5.3%	5.1%	4.6%	5.2%	5.2%	4.9%	4.9%	5.4%	-	-	-	-

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

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Agency Usage	AF05	Workforce Agency Usage	-	-	120.7	165.9	144.5	138.9	157.3	170.3	165.8	148.3	157.3	163.5	185.2	193.1	-	-	-	-
	AF11B	Percentage Agency Usage	-	-	1.5%	2.1%	1.8%	1.7%	1.9%	2.1%	2.1%	1.8%	1.9%	2%	2.3%	2.3%	-	-	-	-

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

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	-	-	443.7	481.3	483.9	435.8	413.3	414.7	333.2	368.5	463.6	507.9	465.1	436	-	-	-	-
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	-	-	5.7%	6.1%	6.1%	5.5%	5.2%	5.2%	4.2%	4.7%	5.8%	6.3%	5.8%	5.4%	-	-	-	-
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	2415	1217	133	154	147	162	239	199	121	174	156	147	398	221	434	600	451	766
	AF10	Workforce Turnover Rate			13.2%	13.4%	13.5%	13.7%	13.8%	13.9%	13.8%	14.1%	14.1%	13.7%	13.7%	13.5%				

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 staff in post at end, divided by 2.

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Training	AF20	Essential Training Compliance	-	-	79%	82%	84%	83%	85%	88%	89%	89%	89%	90%	90%	89%	-	-	-	-

Appendix 1

Glossary of useful abbreviations, terms and standards

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

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

Appendix 2

Other Essential Training Compliance Figures for October 2015

Safeguarding Adults:

Level 1: 92.0% (previous month 90.6%)
Level 2: 85.1% (previous month 82.2%)

Safeguarding Children:

Level 1: 91.8% (previous month 90.7%)
Level 2: 90.8% (previous month 89.5%)
Level 3: 76.0% (core) (previous month 76.2%)
Level 3: 76.2% (specialist) (previous month 77.2%)

Resuscitation: 74.9% (previous month 75.0%)

Appendix 3

Access standards – further breakdown of figures

A) **62-day GP standard** – performance against the 85% standard at a tumour-site level for quarter 2 2015/16 as a whole, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Breast†	86.4%	-	95.4%
Gynaecology	89.5%	85%	78.8%
Haematology (excluding acute leukaemia)	81.1%	85%	78.5%
Head and Neck	89.1%	79%	67.7%
Lower Gastrointestinal	60.8%	79%	72.3%
Lung	69.8%	79%	74.6%
Other*	83.3%	-	73.9%
Sarcoma*	40.0%	-	72.8%
Skin	98.7%	96%	95.3%
Upper Gastrointestinal	80.3%	79%	72.9%
Urology*†	11.1%	-	74.4%
Total (all tumour sites)	**81.9%**		**81.9%**
Monthly trajectory target		

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

Appendix 3 (continued)

Access standards – further breakdown of figures

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

RTT Specialty	Ongoing Pathways Over 18 weeks	Ongoing Pathways	Ongoing Performance
Cardiology	333	2,156	84.6%
Cardiothoracic Surgery	17	279	93.9%
Dermatology	67	1,589	95.8%
E.N.T.	38	2,292	98.3%
Gastroenterology	44	467	90.6%
General Medicine	7	60	88.3%
Geriatric Medicine	0	144	100.0%
Gynaecology	55	1,208	95.4%
Neurology	85	353	75.9%
Ophthalmology	227	4,310	94.7%
Oral Surgery	99	2,569	96.1%
Other	1,741	13,889	87.5%
Rheumatology	6	369	98.4%
Thoracic Medicine	8	608	98.7%
Trauma & Orthopaedics	45	945	95.2%
Urology	0	2	100.0%
Grand Total	**2,772**	**31,240**	**91.1%**

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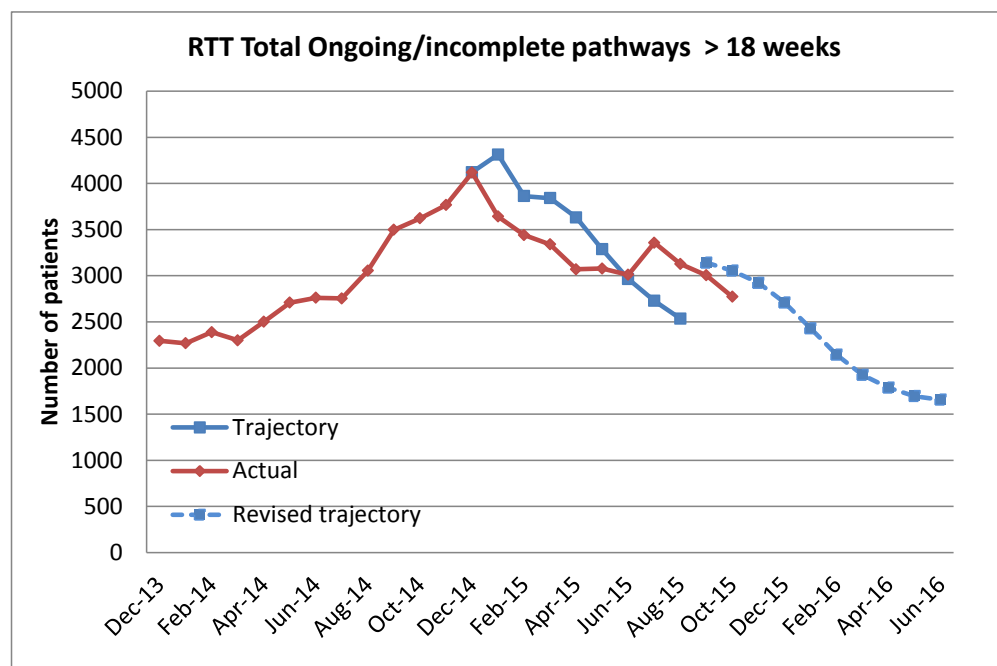
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Non-admitted pathways (target/actual)	1977/1963	1911/1725	1811	1689	1498	1313	1190
Admitted pathways (target/actual)	1165/1041	1143/1047	1130	1023	923	814	707
Total pathways (target/actual)	3142/3004	3054/2772					
Target % incomplete < 18 weeks	90.6%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

University Hospitals Bristol NHS Foundation Trust

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

Report Title
09. Quarterly Workforce Report

Sponsor and Author(s)
Sponsor: Sue Donaldson, Director of Workforce & Organisational Development Author: Heather Toyne, Assistant Director of Workforce

Intended Audience									
Committee members	✓	Regulators		Governors		Staff		Public	

Executive Summary
<u>Purpose</u> 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 20015/16 Key Performance Indicators (KPIs) and includes a description of the current position for each indicator, progress on actions to improve performance, and a projected outturn at March 2016. <u>Key issues to note</u> During the quarter good progress has made in respect of the agreed action plans that underpin the Trust's Workforce and Organisational Strategy. However, the position in respect of performance against the Key Performance Indicators (KPIs) agreed as part of the Operating Plan for 2015- 2016 is variable. Vacancy rates, turnover levels and sickness absence continue to be above target, with a consequential impact on expenditure on agency staff. Essential training compliance is the greatest success during the period, followed by sustaining staff appraisals above the agreed KPI and improving completion of Health and Safety related assessments.

Recommendations
The Board is asked to note the contents of the report for assurance; and discuss any issues arising in relation to the areas reported.

Impact Upon Board Assurance Framework
N/A

Impact Upon Corporate Risk
N/A

Implications (Regulatory/Legal)
N/A

1

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	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Quality & Outcomes Committee
			✓	27/11/2015

QUARTERLY WORKFORCE REPORT – July to September 2015

Executive Summary

i. Introduction

During the quarter good progress has made in respect of the agreed action plans that underpin the Trust's Workforce and Organisational Strategy. However, the position in respect of performance against the Key Performance Indicators (KPIs) agreed as part of the Operating Plan for 2015- 2016 is variable. Vacancy rates, turnover levels and sickness absence are of ongoing concern, as is the consequential expenditure on agency staff. Reporting and management of the associated risks has been recognised in the Corporate Risk Register. Essential training compliance is the greatest success during the period, followed by sustaining staff appraisals above the agreed KPI and improving completion of Health and Safety related assessments.

University Hospitals Bristol NHS Foundation Trust (UHB) largely continues to benchmark positively against other large acute providers in respect of key workforce KPIs, with the notable exception of turnover. It is acknowledged that some of the local workforce challenges are mirrored across the health system and indeed nationally. It is therefore important that UHB continues to explore ways of working collaboratively with other to improve the position, e.g. reduction of agency expenditure; and to seek to influence the national response, e.g. consultation on proposed caps on agency costs.

The table below sets out the latest position in respect of the agreed KPIs and the projected outturn for 2015 – 2016.

ii. Overview

Domain	Measure	KPI Description	Q2 KPI	Q2 Actual	Annual KPI 2015.16	Projected out turn 2015/16
Workforce costs /FTE	Workforce numbers (FTE)	Staffing numbers within 1% of establishment including bank and agency	>1%	0.6% over	>1%	>1%
	Bank (FTE)	Percentage of total staffing (within 10% of target)	3.7%	5.1%	3.5%	4.3%
	Agency (FTE)	Percentage of total staffing (within 10% of target)	0.9%	2.2%	1%	1.7%
	Overtime	Percentage of total staffing (within 10% of target)	0.7%	0.7%	0.7%	0.8%
	Sickness absence rate (%)	Within 0.5% points of target	3.5%	4.1%	3.7%	4.2%
Staff Experience	Vacancies	Difference between budgeted establishment and in post	> 5%	5.8%*	> 5%	5.9%
	Turnover	Trajectory to achieve target by March	12.7%%	13.5%	11.5%	13.0%
	Friends and Family Test	Percentage recommending UHB as a place to work (agree or strongly agree)			50%	50+%
Staff Development	All staff Appraisal (exc. medics)	Appraisal of eligible staff on a rolling 12 month cycle	85%	85.1%	85%	85%
	Medical Staff Appraisal	Appraisal of eligible staff on a 15 month cycle – 5 within 5 years	85%	90%*	85%	85%
	Essential Training	All staff completed relevant essential training topics (trajectory to achieve target by March)	90%	89.5%	90%	89%

	Measure	KPI Description	Q2 KPI	Q2 Actual	Annual KPI	Projected out turn
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	87% 🟢 ⬆	75+%	75+%
	Stress Risk Assessment	Risk assessments completed or reviewed within 12 month timeframe	Risk assessment completed/reviewed in last 12 months in + 75% of cases	71% 🔴 ⬆	75+%	75+%
	Junior Doctor New Deal compliance	Junior doctor rotas compliant with New Deal requirements	90% or more of rotas compliant	89% 🔴 ⬇	90+%	90+%

iii. Key areas of focus

The detailed action plans are described in the main paper, a summary of the key areas of focus around the key workforce risks is as follows:

Recruitment/vacancy rates
- A detailed marketing programme to target the national market for hard to fill posts, particularly nursing and midwifery, is well underway, including use of social media, radio advertisement and posters displayed on buses.

Turnover/retention
- Additional investment has been made available for development and training initiatives. 31 proposals were received and evaluated against agreed criteria, including the impact on turnover, of which 12 received support.
- Follow up work, signed off by the Strategic Leadership Team, on the ideas generated at the recent staff listening events, part of the Staff Experience Programme. This includes improving team briefings, visible leadership, local decision making, and promoting behaviours in line with Trust values.
- The Transformation Team are supporting work to transform the way appraisals are undertaken across the Trust.

Sickness Absence
- Piloting of self-certification for absences of less than four days, which is aimed to impact on the short term absence, commencing in Medicine, Specialised Services and Facilities and Estates.
- An internal audit of local management of sickness absence, including completions of return to work interviews.
- Direct contact by an Occupational Health representative to employees on short term sickness absence to support and explore reasons for absence.
- Managers in "hot spots" to receive coaching

Agency expenditure
- Collaborative working with partners across the local system to ensure agencies comply with the new Monitor and TDA guidance, particularly in the context of the anticipated capping of rates.
- Maximising the functionality of Rosterpro (electronic rostering system) to support booking and payments.
- A marketing campaign to recruit more staff onto the Bank, especially to help with winter pressures.

iv.   Conclusion

The Board is asked to:

- Note the contents of this report;
- Discuss any issues arising in relation to the areas reported.

QUARTERLY WORKFORCE REPORT – JULY TO SEPTEMBER 2015

1. INTRODUCTION

The Executive Summary has provided an overview of the KPI performance for quarter 2 and a brief update on programmes of work. This report provides detailed information in respect of each KPI, including expected out turn on the basis of a detailed midyear review in support of the report. 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.

2. WORKFORCE NUMBERS

As at the end of September 2015, 7714.4 FTE staff were substantively employed, approximately 80.9 FTE more than at the end of the previous quarter.

TEMPORARY WORKERS – BANK AND AGENCY STAFF AND OVERTIME WORKING (FTE)

The proportion of bank and agency usage as a percentage of total staffing is shown in the pie chart below:

Quarter 2 Average Bank, Agency & Overtime as % of Total Staffing

Bank 5.1%
Agency 2.2%
Overtime 0.7%
Actual Employed 92.5%
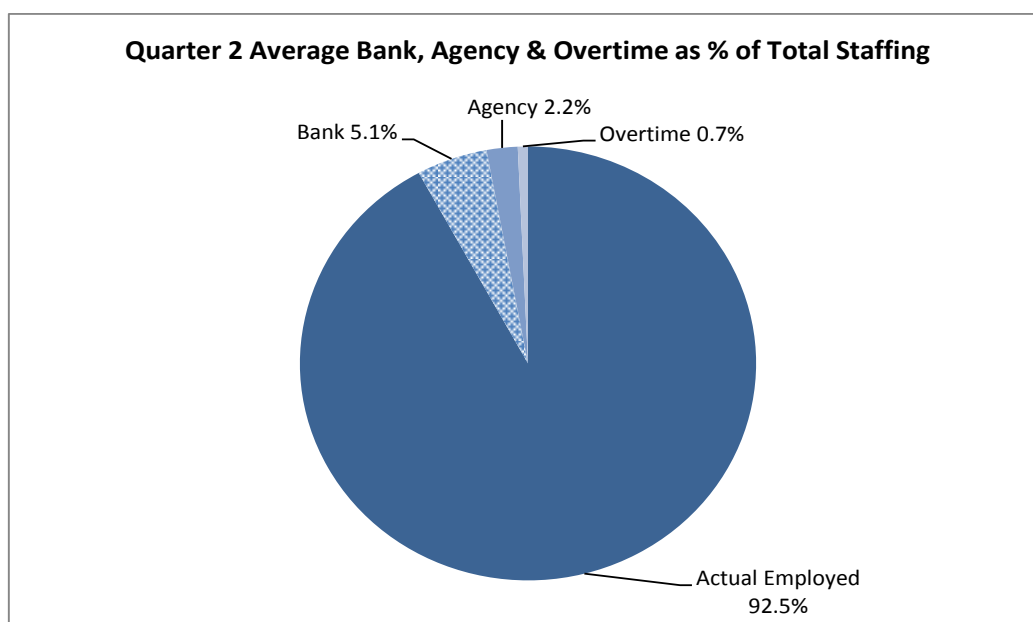
UH Bristol compares favourably with other Trusts which publish data in their board reports on agency spend as a percentage of pay (5.2% for August compared with a group average of 7.3%), as shown in the graph below.

% Agency spend (£) by Organisation (Aug 2015)
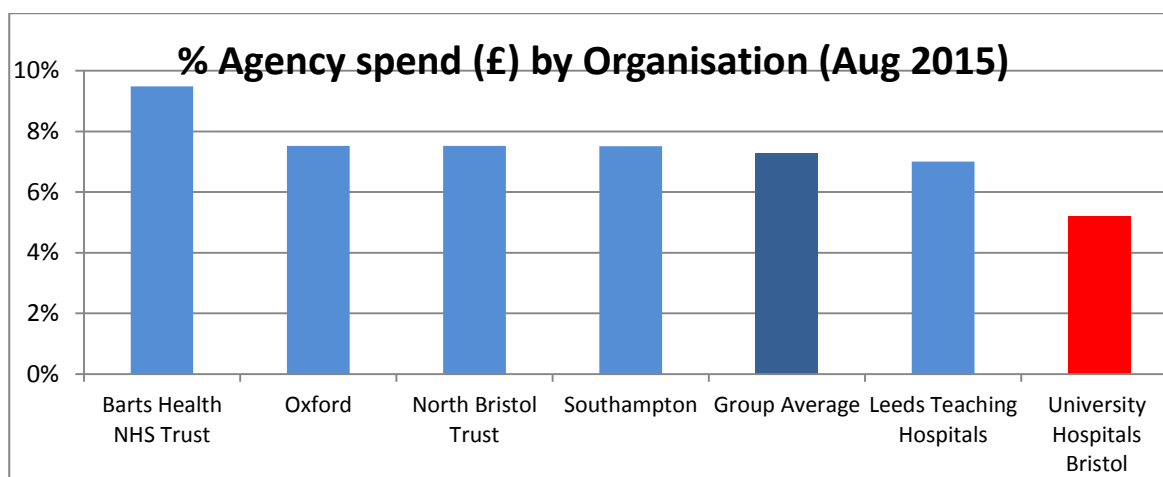
The expected out turn for agency as a percentage of total staffing is 1.7% compared with a KPI of 1.0%. The reason for this is higher than planned levels of vacancies and sickness absence particularly among nursing staff. We have been working collaboratively with partners across the local system to ensure agencies comply with the new Monitor and TDA guidance, particularly in the context of the anticipated capping of rates.

Progress against the action plan by staff group is described below.

Nursing and midwifery agency actions

Performance against the agency action plan is reported to the Savings Board through the Chief Nurse. Performance against the key elements of the action plan is as follows:

Controls/demand management
- Real time staffing dashboard to aid the movement of staff across divisions developing now, going "live" in the New Year.
- Direct booking from Q4 for greater control over staffing at ward level and to maximise the availability to bank staff.
- Monthly performance management of e-rostering KPIs, "lost time" and ensuring that shifts are not covered inappropriately by temporary staff.
- Divisional agency usage discussed at monthly Divisional Performance reviews, and actions agreed.
- Close work with wards to fully use the functionality of Rosterpro to support booking and payment processes for bank staff.

Supply management
- "Frequently Asked Questions" issued in October to explain bank pay and processes.
- Marketing campaign to recruit to the Bank launched in October targeting registered nurses and theatre practitioners, aimed at extending the bank size.
- Service Level Agreement on re-appointments to speed up the process of bank registration.
- Evaluation of the impact on bank shift fill of the payment of enhancements.
- Extension of direct booking to all areas to improve control and bank staff availability.
- Texting service ("Envoy") to alert nursing and domestic staff to the availability of last minute shifts and longer term assignments.

Medical agency usage

The Medical Staff Efficiencies Group, led by the Medical Director, is responsible for the following actions:

Premium payment rates:
- Master Vendor supplier for locums to improve cost efficiency and consistency went live in October - all future medical usage will be through the chosen supplier.

Improved Supply
- "Envoy" texting system being tested with Medicine Division to advise doctors that shifts are available. The long term aim is to develop a bank of locum doctors.

There is a continued Divisional focus on filling vacancies, which is the main reason for medical agency.

3. SICKNESS ABSENCE

Sickness absence has increased slightly to 4.1% this quarter compared to 4.0% last quarter. The expected out turn for March 31st 2016 is 4.2% compared with a KPI of 3.7%. Long-term absence (29 calendar days or more) accounted for 54% of calendar days lost, (51.7% last quarter). This is due to overall higher than anticipated sickness particularly during quarter 2, when the usual dip has not taken place.

The most recently available benchmark data shows that UH Bristol absence rates were lower than comparable Trusts. In quarter 4, the figure of 4.0% for UH Bristol compared with 4.2% nationally for 40 other large acute Trusts (I*view* data), see graph below.
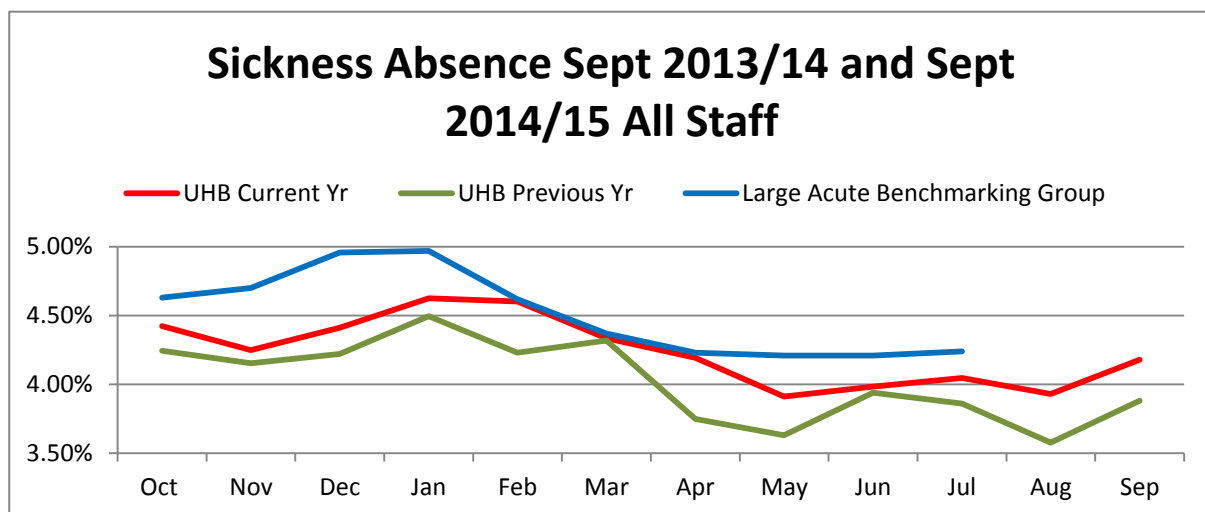
Days lost to colds and flu between April and September in 2015/16 were 22% higher than the same period in the previous year, and 39% higher than the same period in 2013/14.

Senior Leadership Team endorsed the actions recommended by the Workforce and OD Group which will be implemented during the next quarter, as follows:

- Self-Certification for absences of less than four days with pilots commencing in Medicine, Specialised Services, and Facilities and Estates.
- Audit and raising the profile of return to work interviews.

- Contacting employees taking sickness absence on the 1st, 3rd and 7th day of absence, phased roll-out.
- Managers in "hot spots" to receive coaching in consistent implementation of the policy;
- Occupational health triage service to be promoted.

The Staff Health and Well Being action plan continues to be implemented, including the following:

Stress, Anxiety and Depression
- *Resilience Building Programme* continues until June 2016 and is also incorporated in the newly qualified nurse Preceptorship programme.
- *Employee Assistance Programme* available in Women`s and Children`s Division, continues to be evaluated.
- *Staff Health and Well Being Week a* range of events including workshops, free yoga and zumba taster sessions, and promotion of health and well-being initiatives, were held in September

Flu – Influenza
- *Vaccination* The campaign for 2015/16 aims to achieve the 75% coverage target which has been set by NHS England.

Musculoskeletal
- *Physio Direct* 74% of the 192 consultations were referred on for Physiotherapy.
- *Bank physiotherapy* Bank physiotherapist being trained, available from November.
- *Manual Handling Advice* the Manual Handling team provided about 200 staff follow-up visits and 81 Workstation/advisory visits.

4. STAFF EXPERIENCE

A. VACANCIES

Vacancies this quarter were 5.8% (469.6 average FTE) compared with 4.9% last quarter. Although these rates exceed the Trust KPI of 5%, UH Bristol vacancy rates continue to be below average compared with those Trusts which publish them on their websites. UH Bristol vacancy rate in August was 5.8% Trust wide, (see graph below), compared with an average for the group of 8.5%.

Vacancy percentage

- ■ University Hospitals Bristol
- ■ South Tees (Jul data)
- ■ North Bristol Trust
- ■ Brighton & Sussex University Hospitals
- ■ Plymouth Hospitals
- ■ Barts Health NHS Trust

5.8%   6.0%   6.7%   8.50%   9.07%   15.2%

Aug-15
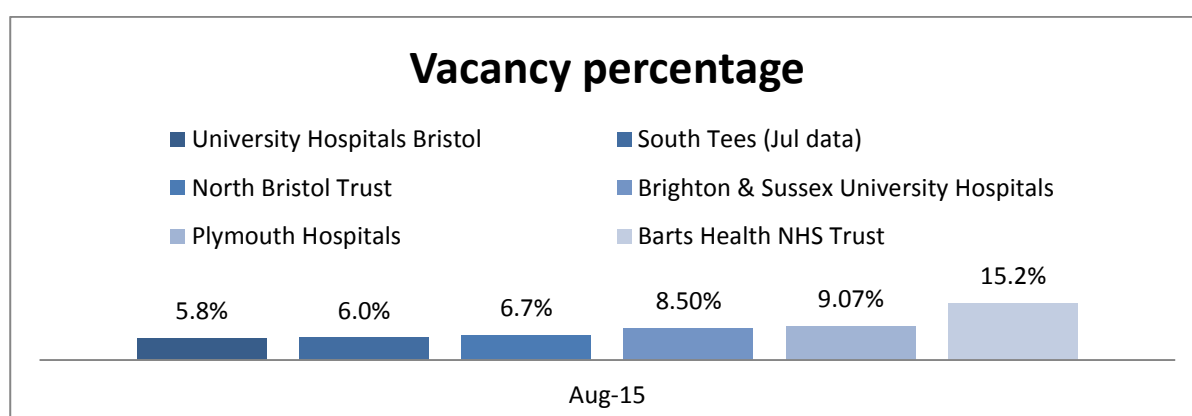
Nursing and Midwifery
Nursing rates are 6.8% (208.4 average FTE), which is below published benchmarks. There are also "hot spots" where it is difficult to recruit appropriately skilled nurses, for example in Heygroves and Children`s theatres, and some areas within Specialised Services, including D703 Haematology and Coronary Care Intensive Care Unit.

Nursing & Midwifery Staff Vacancies 2013 - 2015 (%)
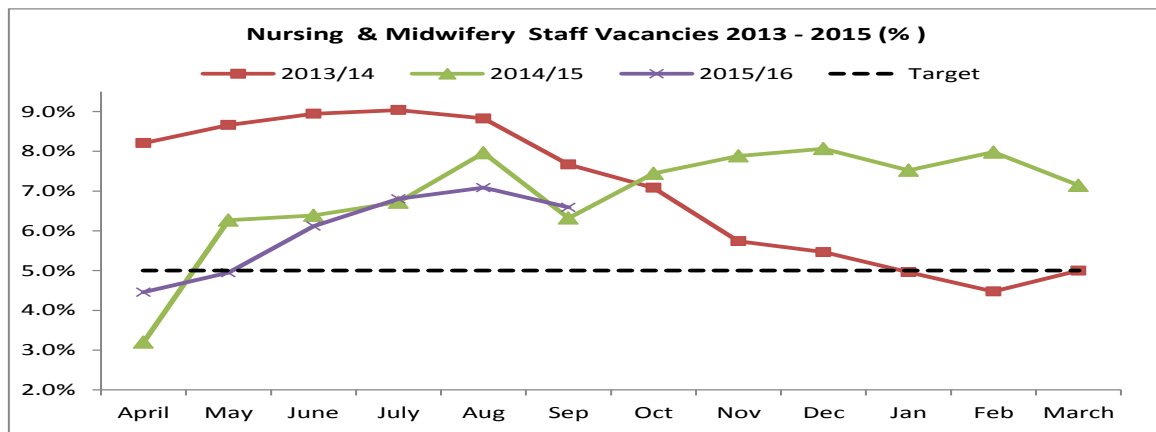
Ancillary vacancies

The average vacancy FTE for this quarter was 8.8% (75.1 FTE) which compares with 59.8 FTE in the previous quarter.

Ancillary Staff Vacancies 2013 - 2015 (%)
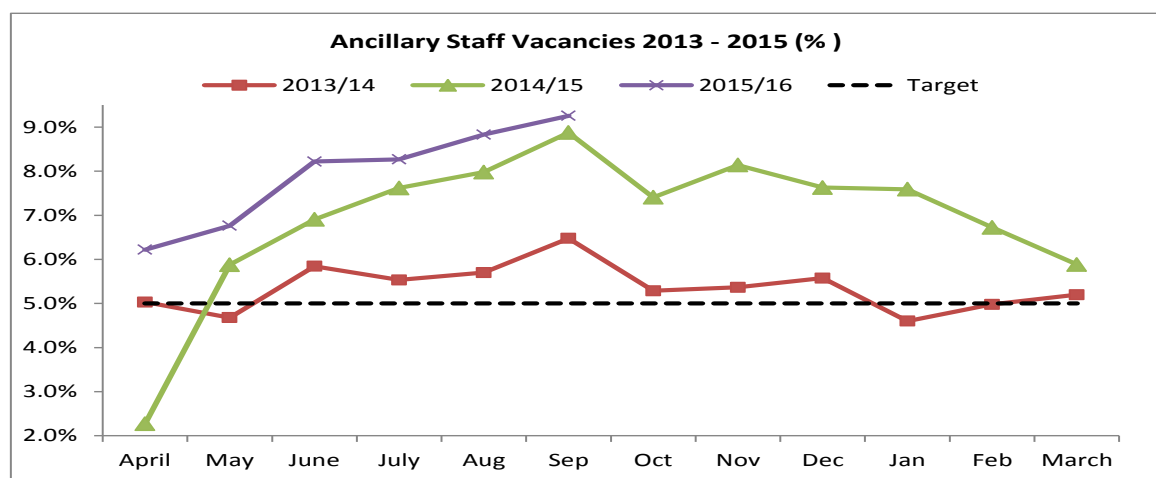
Medical staff

There are some key consultant roles across the Trust which have recruitment challenges, including respiratory consultants and Acute Physicians in Medicine Division. Surgery Head and Neck have also been unable to appoint to some consultant posts, largely in Ophthalmology and Dental services. Adverts are also out for additional consultants in Women`s and Children`s, including Neonatal Intensive Care Unit and Dermatology. More innovative recruitment solutions are being considered, reducing overseas recruitment.

Progress against the recruitment plan agreed with Senior Leadership Team is described below.

Increasing the speed of recruitment

Progress on two new systems is described below.

- TRAC, live in June 2015, improved workflow management, and intelligence of pipeline recruitment. Priorities in Q3 are reporting and revised Service Level Agreements and Key Performance Indicators.
- Pilot for the web portal for new starter health questionnaires has improved turnaround time, with 65% cleared within 2 days. Roll out to all divisions from 30th November.

Delivery of recruitment to support 2015/16 Operating Plans

Nursing recruitment

An innovative campaign for bank and substantive nursing staff has been launched, involving local radio, buses and the use of social media. Progress this quarter includes the following:

- 147 Registered Nurse and 59 Nurse Assistant external offers.
- 9 nurses offers via an Open Day for experienced nurses and Theatre Practitioners.
- From 10 Return to Practice applicants only 1 interview/acceptance for midwifery, starting January 2016.
- Offers to all 18 candidates from two assessment centres for newly qualified nurses.

Progress within Divisions includes a removals package for Intensive Care Unit and theatre staff in Surgery Head and Neck and a children nursing recruitment administrator appointed in Women`s and Children`s Division.

Facilities recruitment
28 Domestic Assistants started in the last quarter. The Recruitment and Retention Lead for Facilities started in October, ensuring efficient conversion to hire.

B. TURNOVER

There has been a reduction in turnover this quarter to 13.5% from 14.2%, although continuing to be above the target for the quarter of 12.7%. Turnover rates by Division are provided in Appendix 2. Reductions are partly due to new nursing assistants being recruited on a fixed term training contract, and therefore being excluded from turnover. This change was built into the KPI when it was set in May 2015. As part of the mid-year review, there has been a detailed assessment of leavers by Divisions, which indicates that the Trust will exceed the KPI of 11.5% for turnover, with an expected out turn by 31st March 2015 of 13.0%. This is an improvement on 2014/2015 when the outturn was 13.8%.

Changes between Quarter 2 2014/15 and Quarter 2 2015/16
The quarterly report generally focuses on change during the quarter, but for this report, we will also include a longer term perspective, looking at factors which have contributed to the increased levels of turnover which became apparent during 2014. The chart below shows turnover rates for Divisions since March 2013.

UH Bristol Clinical Divisions staff turnover March 2013 to September 2015

Legend: Diagnostics & Therapies, Medicine, Specialised Services, Surgery, Head & Neck, Women's & Children's
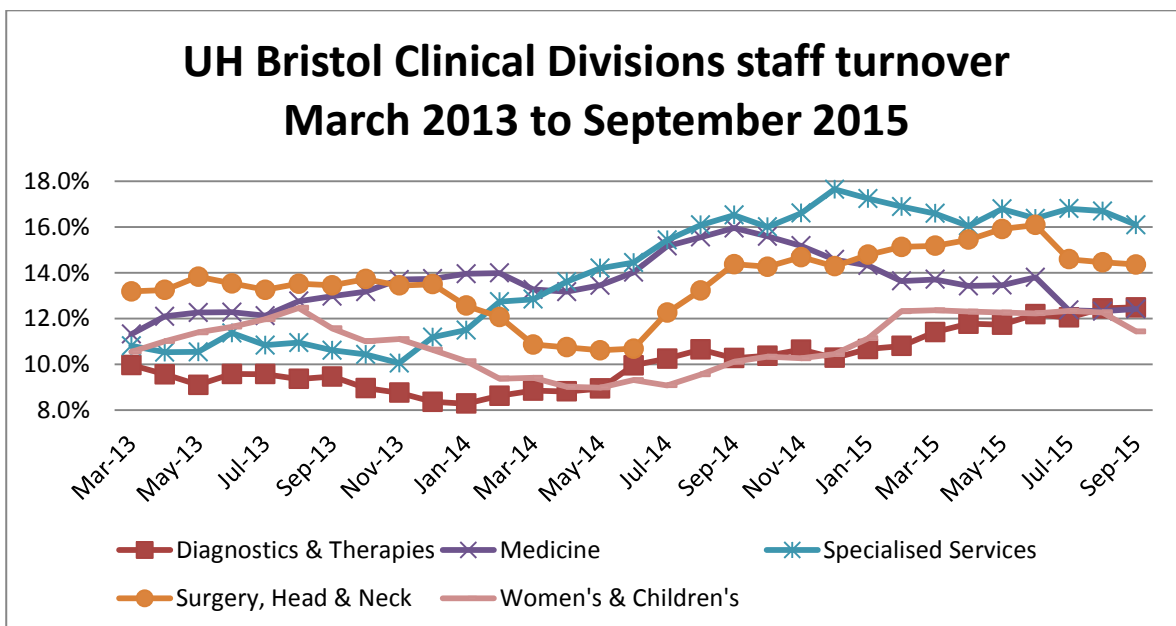
All Divisions have experienced increased turnover during quarter 2 of 2014/15. However, in some cases, particularly Surgery Head and Neck and Women`s and Children`s, there had been unusually low turnover in the preceding quarter, which accentuated the upturn. Hot spots during Q2 2014/15 in Surgery Head and Neck included A609 (trauma) during the period of ward moves, together with theatres and the Bristol Eye Hospital. Specialised Services hot spots included the Bristol Haematology and Oncology wards and administrative and clerical staff. The Division are undertaking an in depth review into the reasons for their high turnover, to report in the next quarter. The rates by key staff group are shown in the chart below.

Turnover - key clinical staff groups
Mar 2013-Sept 2015

Legend: Allied Health Professionals — Healthcare Scientists — Nursing and Midwifery Registered — Nursing and Midwifery Unregistered
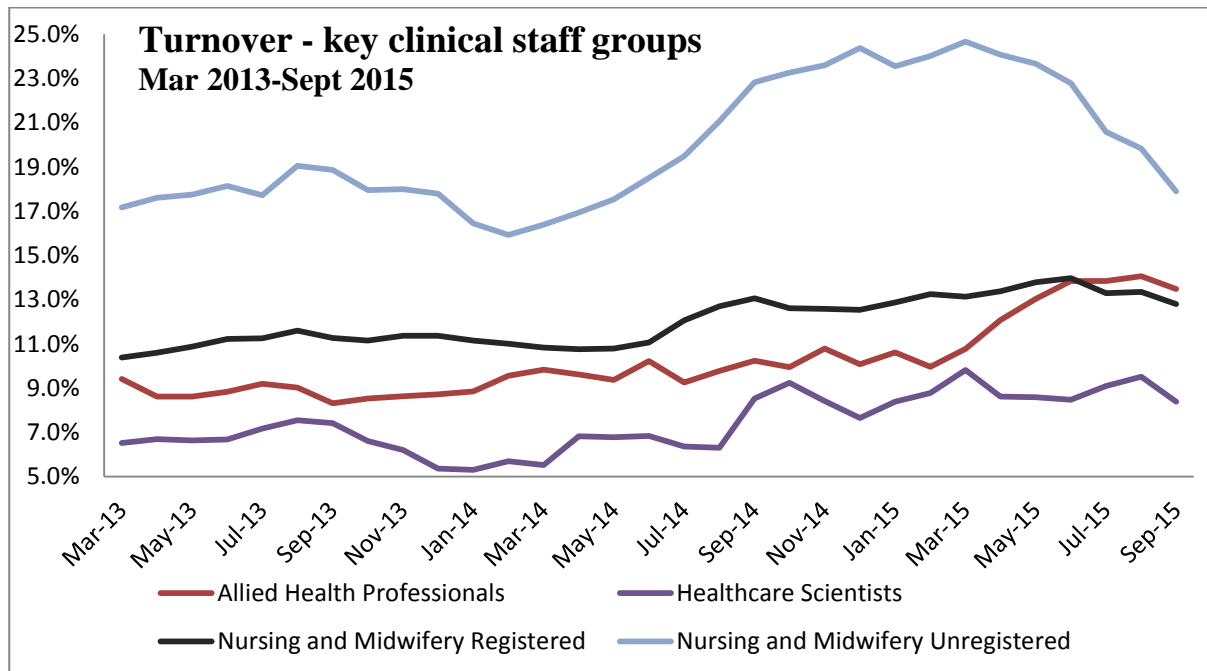
In understanding the reason for the upward trend across the Trust, it is important to place turnover in the wider context both within the Trust, locally and nationally.

UH Bristol Changes
Major change at UH Bristol has repeatedly been associated with increased turnover rates, including during the opening of the Bristol Heart Institute and the Woodlands transfer from North Bristol Trust. The last two years have included some major changes including:
- Redevelopment of the BRI including reconfiguration of all wards across Medicine and Surgery Head and Neck, and the opening of the new ward block;
- Bone Marrow Transfer to Specialised Services from the Bristol Children`s Hospital;
- Transfer of head and neck Services from North Bristol Trust to UH Bristol, and breast/breast screening move to North Bristol.

The BRI Redevelopment project risk register reflected the risk of increased turnover, and a monthly tracker of leavers reviewed monthly by the BRI Redevelopment Workforce and Engagement Group showed increased numbers of leavers in affected areas, despite mitigating actions to engage and communicate with staff. Local feedback suggested that staff were affected not only by the prospect of a new working environment, but by a range of changes associated with the redevelopment, including working within different teams.

Local labour market
According to a report by MoneySupermarket in October 2013, Bristol boasts the highest employment rate and has the third highest average salary of any major city, reflecting Bristol's overall economic performance and also has had the highest private sector job growth of any major

city. This means that there are more potential employers and fewer potential employees in the labour market.

National Context

After a period of economic recession, an increased number of jobs has become available for unskilled and semi-skilled staff, competing for ancillary staff, administrative and clerical and nursing assistants. For registered nursing and midwifery, growth in demand following recommendations in the Francis report was not matched by supply, as a result of 13% fewer nursing training places being commissioned between 2011/12 and 2012/13.

Health Education South West (HESW) have indicated that turnover across the patch has generally increased by 1.5% over the last 18 months.

An indication of the national picture is provided by the graph below which shows vacancy rates by the 8 Trusts identified which publish data on their websites. The UH Bristol August rate of 14% is above the group average of 13%. This compares with a benchmark average of 12.4% in February, which suggests an increase in the last six months.

Turnover (published data) August 2015

Leicester University Hospital	Plymouth Hospitals	Brighton & Sussex University Hospitals	University Hospital Southampton	Cambridge University Hospitals (Jul data)	University Hospitals Bristol	Oxford (Jul data)	Barts Health NHS Trust
10%	12%	13%	13%	14%	14%	14%	14%
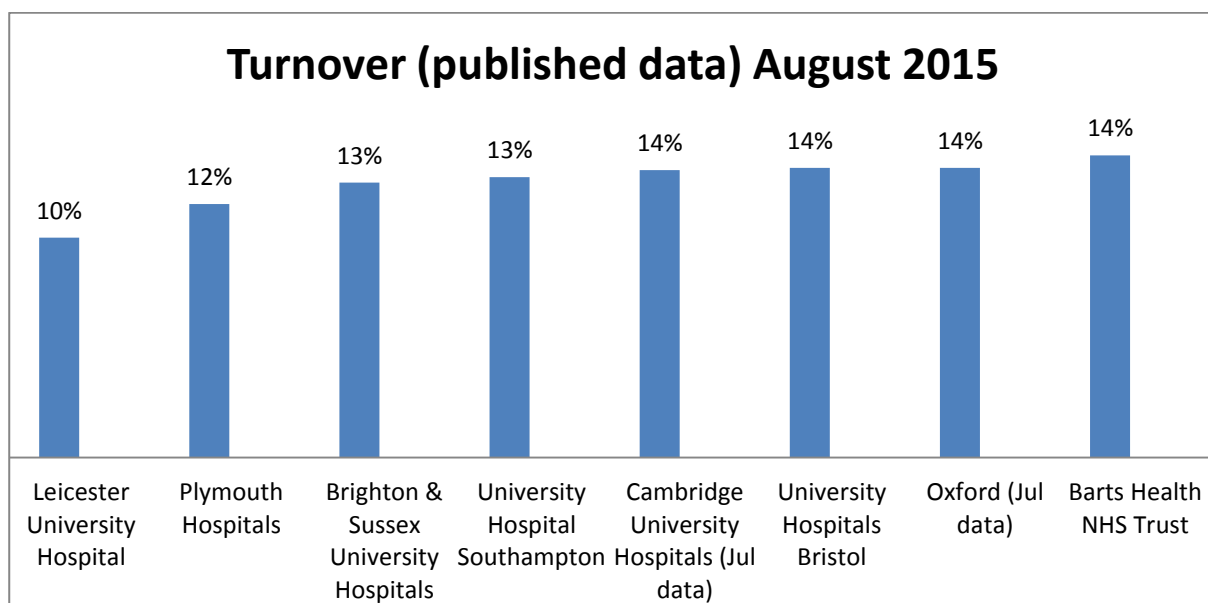
Looking at the leaving destinations more leavers joined neighbouring NHS Trusts a year ago, coinciding with the opening of Southmead Hospital. There are other small differences, when taken at a point in time, but reasons for leaving as recorded in termination forms fluctuate on a monthly basis and analysis has indicated no consistent trends. Exit questionnaires and telephone data also show no clear trends, but there is a common theme across most staff groups (registered and unregistered nursing, allied health professionals and administrative and clerical staff) that lack of career development and progression is a key factor in reasons for leaving.

The exit questionnaire return rate for the quarter was 27%, including 73 questionnaires and 41 telephone interviews from 385 leavers. This is a slight increase in the number of exit interviews but the overall number of people leaving was greater.

C. RETENTION
The following actions are in place to improve retention:

i.   **Divisional proposals for development funding:**
     Additional investment has been made available for divisional hot spots to improve retention through development and training initiatives. The 12 proposals which were agreed by the Recruitment Sub Group, and endorsed by Senior Leadership Team include schemes across all clinical Divisions.   Examples include intensive induction for newly recruited Emergency Department nurses, team building for Sonographers, development for administrative team leaders at Bristol Haematology and Oncology Centre and advanced skills for critical care staff.

ii. **Nursing and Midwifery Programmes**
     Revised nursing assistant pathways
     - 241 nursing assistants have been recruited through the new process. Of these, 159 were trainees, and will undertake a vocational qualification.

     Competences and Career Progression
     - Nursing and Midwifery Committee approved core job descriptions for Registered Nurses in August. Priorities for Q3 include registered and unregistered role specific competences and a nursing website to showcase the nursing role at UH Bristol.

     Preceptorship for Newly Qualified nurses and midwives
     - The first Preceptorship programme took place in October 2016, with the next due in February 2016. The programme will be evaluated to assess the impact on retention.

iii. **Managing aspirations within a Talent Management structure**
     A structured 'Transfer Window' programme between Medicine and Surgery Head and Neck Division to manage the movement of staff will enable staff to gain experience in different roles to aid their development and will result in a more flexible workforce for the Trust.

iv. **Incentives and Benefits**
     'My Trust Benefits,' launched in October, providing access to savings on national brands and companies via a Trust branded page to attract new recruits to the Trust and increase staff engagement and support retention. The new staff benefits booklet is available on NHS Jobs and the staff intranet.

v.   **Staff Engagement/Experience**
     A number of listening events have been held during the summer for staff to look at practical solutions to enhance communications and improve staff engagement. A report will be submitted to Senior Leadership Team in November. Emerging themes from the listening events have included the following:
     - Team briefings - giving every team an opportunity for a regular 2 way dialogue;
     - Visible leaders - regular, informal contact between staff and managers;
     - Local decision making - helping teams to fix problems and make changes happen locally, quickly;
     - Behaviours - living our values to support routine dialogue between staff and their manager.

     This is in addition to actions within Divisions to improve staff engagement and experience including newsletters, staff recognition schemes, and action plans based on staff feedback.

5. STAFF DEVELOPMENT

A. APPRAISAL
Appraisal compliance has remained above target in quarter two, with a rate of 85.1% at the end of quarter 2 (86.1% at the end of quarter one). Medicine, Estates and Facilities and Trust Services have maintained their position and continue to be within the 85% KPI this quarter, but all other Divisions are below target for their non-consultant staff groups but have recovery plans in place.

Two workshops have been held to take forward the ambition that all staff receive an annual appraisal (E-Appraisal) to integrate objectives, development, performance and career development. These workshops identified the underpinning activities and timescales to support three key work streams which include skills development, systems and policy/process. Next steps will include development of a detailed plan with timescales, and agreement of communications and stakeholder engagement to support delivery of the project.

Consultant Appraisal and Revalidation
In quarter 2, 90.1% of consultants had been appraised within the required timeframe. During quarter 2, there were 50 consultants recommended for revalidation, and six referrals mainly due to lack of evidence, compared with 7 referrals during the same quarter in 2014.

B. ESSENTIAL TRAINING
The position for Essential Training (Core training) at the end of September was 89.2% with 8 topics reaching over 90%. The focus is to achieve trajectories for Fire and Information Governance (IG) which in April 2016 move to an annual requirement. We continue to see a month on month increase in E-Learning which was launched in October 2014.
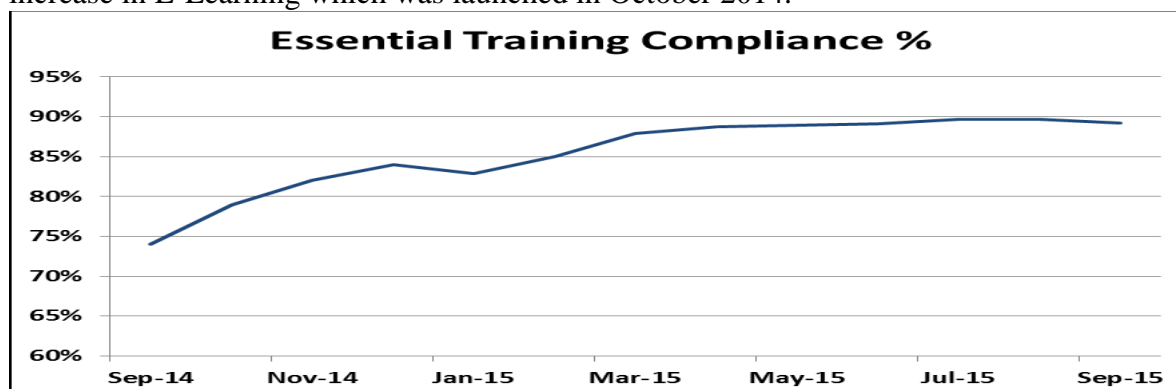
The action plan includes:
- Continue to drive compliance of core topics, including increasing E learning.
- Deliver trajectories for Fire and IG to ensure compliance is reached by March 2016.
- Electronic notification and compliance reports for staff and managers.
- Deliver improvement trajectories for safeguarding and resuscitation.

6. COMPLIANCE REQUIREMENTS

A. HEALTH AND SAFETY
93% of the audit returns have been received compared with 44% of the last quarter. Performance is shown in the table below.

Oct-14	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's	Trust wide
Manual Handling Risk Assessments	100%	100%	94%	96%	86%	83%	68%	**87%**
Stress Risk Assessments	89%	92%	77%	74%	70%	71%	54%	**71%**

It is anticipated that the KPI of a Risk assessment completed/reviewed in last 12 months in more than 75% of cases will be achieved for both types of risk assessment.

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. All Divisions with the exception of Women`s and Children`s are above the 90% KPI, as the table below shows.

	Number Non-Compliant	Number Compliant	Compliance	Anticipated Date for 100% Compliance
Diagnostics & Therapies	0	6	100%	
Medicine	0	13	100%	
Specialised Services	0	8	100%	
Surgery Head & Neck	2	26	93%	
Women's & Children's	6	13	68%	March 2015
Total	**8**	**66**	**87.2%**	

7. CONCLUSION

There has been some positive movement in turnover, essential training and compliance with risk assessments for manual handling and stress.

However, the position in relation to sickness, vacancies, and the associated use of bank and agency has deteriorated, and programmes of work in these areas continue to be a priority.

The Board is asked to:

1. Note the contents of this report;
2. Discuss any issues arising in relation to the areas reported;

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) — stacked bar chart (Sep-14 to Sep-15) with legend: Actual Employed, Bank, Agency, Overtime.

Bank (% Total Staffing) — bar chart (Sep-13 to Sep-15) with legend: Actual, Operational Resilience, Target.

Agency (% Total Staffing) — bar chart (Sep-13 to Sep-15) with legend: Actual, Operational Resilience, Target.

Sickness % — line chart (Sep-13 to Sep-15) with legend: Actual, Target.

Staff Experience

Vacancies by Staff Group (FTE)

Legend:
- Admin and Clerical/Senior Managers
- Allied Health/Scientific Professions
- Ancillary Staff
- Medical Staff
- Nursing Staff

Staff Development

Appraisal Rates 2013 - 2015

Legend:
- 2013/14 (All Staff)
- 2014/15 (Excluding Consultants)
- Target
- 2015/16 (Excluding Consultants)

Compliance Requirements

Junior Doctor New Deal Compliance

Sep-15	Manual Handling Risk Assessments	Stress Risk Assessments
Diagnostic & Therapies	100%	89%
Facilities & Estates	100%	92%
Medicine	94%	77%
Specialised Services	96%	74%
Surgery Head & Neck	86%	70%
Trust Services	83%	71%
Women's & Children's	68%	54%
Trust Wide	**87%**	**71%**

Compliance Requirements

Essential Training Compliance

Accreditation	387 Diagnostics And Therapies	387 Facilities And Estates	387 Medicine	387 Specialised Services	387 Surgery Head And Neck	387 Trust Services	387 Womens And Childrens	Rate
Blood Transfusion	64%		87%	92%	89%	81%	85%	87%
Clinical Record Keeping	80%		88%	90%	90%	80%	83%	87%
Conflict Resolution Awareness	97%	99%	98%	97%	96%	97%	95%	97%
Conflict Resolution Training	84%		90%	91%	90%	81%	83%	87%
Consent	79%		86%	88%	90%	76%	83%	85%
Equality & Diversity	97%	99%	98%	97%	96%	98%	95%	97%
Fire Safety	97%	99%	98%	98%	96%	98%	96%	97%
Food Safety	97%	99%	97%	97%	96%	97%	95%	97%
Harassment & Bullying	97%	99%	98%	98%	96%	98%	96%	97%
Health & Safety	88%	88%	89%	92%	90%	92%	83%	88%
Infection Prevention & Control	87%	88%	89%	91%	90%	92%	84%	88%
Information Governance	95%	97%	97%	97%	96%	97%	95%	96%
Manual Handling	83%	86%	87%	89%	88%	84%	83%	86%
Medical Devices	75%		80%	85%	85%	72%	74%	80%
Medicines Management	73%		79%	85%	84%	72%	75%	79%
Nutrition	75%		85%	86%	85%	72%	75%	81%
Patient Safety	75%		80%	85%	85%	74%	77%	80%
Patient Slips, Trips and Falls	78%		85%	87%	88%	76%	78%	83%
Pressure Ulcer Prevention	76%		87%	88%	88%	74%	78%	83%
Venous Thromboembolism	63%		84%	90%	87%	75%	79%	83%
ALL:	88%	95%	89.8%	92%	91%	92%	85%	89%

Essential Training Compliance

Accreditation	387 Diagnostics And Therapies	387 Facilities And Estates	387 Medicine	387 Specialised Services	387 Surgery Head And Neck	387 Trust Services	387 Womens And Childrens	Rate
Induction	75%	87%	83%	86%	72%	90%	65%	77%
Local Induction Checklist	46%	87%	55%	46%	47%	78%	30%	50%
Resuscitation	72%	%	75%	80%	76%	73%	73%	75%
Safeguarding Adults L1	91%	86%	95%	95%	93%	91%	90%	91%
Safeguarding Adults L2	84%	77%	91%	92%	87%	77%	69%	82%
Safeguarding Adults L3	%	%	%	%	%	%	%	0%
Safeguarding Children L1	94%	87%	93%	96%	90%	90%	%	91%
Safeguarding Children L2	85%	91%	90%	93%	89%	85%	92%	90%
Safeguarding Children L3 - Core	82%		75%				76%	76%
Safeguarding Children L3 - Specialist							77%	77%

Appendix 2   Divisional KPIs – Quarterly Comparisons

WORKFORCE NUMBERS, INCL BANK & AGENCY (FTE)

	Quarter 2		Quarter 1	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	957.3	980.0	943.4	975.1
Facilities & Estates	777.9	784.9	783.7	785.4
Medicine	1259.9	1216.8	1268.5	1235.0
Specialised Services	870.4	859.4	877.9	837.2
Surgery, Head & Neck	1780.4	1755.6	1748.3	1716.6
Trust Services	672.7	673.8	667.2	653.4
Women's & Children's	1838.8	1841.5	1817.1	1822.8
Trust Total	**8157.4**	**8112.0**	**8106.0**	**8025.5**

BANK (FTE)

	Quarter 2		Quarter 1	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	1.2%	1.2%	1.1%	1.2%
Facilities & Estates	6.7%	3.1%	6.9%	6.0%
Medicine	9.7%	6.9%	9.7%	8.9%
Specialised Services	5.6%	4.9%	5.9%	4.6%
Surgery, Head & Neck	4.7%	3.3%	4.2%	4.2%
Trust Services	5.0%	1.7%	5.1%	1.9%
Women's & Children's	3.4%	3.5%	3.2%	3.5%
Trust Total	**5.1%**	**3.7%**	**5.0%**	**4.4%**

AGENCY (FTE)

	Quarter 2		Quarter 1	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	1.3%	0.7%	1.0%	1.0%
Facilities & Estates	2.0%	1.0%	1.5%	1.5%
Medicine	3.5%	1.2%	3.3%	3.4%
Specialised Services	2.9%	1.9%	2.9%	2.1%
Surgery, Head & Neck	2.1%	0.9%	1.6%	1.0%
Trust Services	2.0%	0.7%	1.6%	0.7%
Women's & Children's	1.8%	0.5%	1.7%	0.5%
Trust Total	**2.2%**	**0.9%**	**1.9%**	**1.4%**

OVERTIME (FTE)

	Quarter 2		Quarter 1	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	1.0%	1.0%	1.5%	1.0%
Facilities & Estates	4.5%	3.5%	4.4%	3.8%
Medicine	0.0%	0.1%	0.0%	0.1%
Specialised Services	0.2%	0.2%	0.3%	0.1%
Surgery, Head & Neck	0.1%	0.3%	0.2%	0.3%
Trust Services	0.4%	0.4%	0.4%	0.4%
Women's & Children's	0.3%	0.4%	0.4%	0.3%
Trust Total	**0.7%**	**0.7%**	**0.8%**	**0.7%**

Workforce FTE

Workforce FTE

SICKNESS ABSENCE (%)

	Quarter 2		Quarter 1	
	Actual	Target	Actual	Target
Diagnostics & Therapies	2.8%	2.8%	2.9%	3.0%
Facilities & Estates	5.5%	5.0%	6.1%	5.2%
Medicine	5.4%	4.1%	5.6%	4.2%
Specialised Services	3.9%	3.7%	3.6%	3.7%
Surgery, Head & Neck	4.0%	3.4%	3.7%	3.5%
Trust Services	3.4%	2.4%	3.2%	2.6%
Women's & Children's	3.6%	3.4%	3.6%	3.6%
Trust Total	**4.1%**	**3.5%**	**4.0%**	**3.7%**

Staff Experience

VACANCY (% FTE)

	Quarter 2		Quarter 1	
	Actual	Target	Actual	Target
Diagnostics & Therapies	4.7%	5.0%	5.2%	5.0%
Facilities & Estates	9.4%	5.0%	8.5%	5.0%
Medicine	7.3%	5.0%	6.5%	5.0%
Specialised Services	6.6%	5.0%	3.5%	5.0%
Surgery, Head & Neck	4.8%	5.0%	3.4%	5.0%
Trust Services	6.8%	5.0%	4.8%	5.0%
Women's & Children's	4.3%	5.0%	4.3%	5.0%
Trust Total	**5.8%**	**5.0%**	**4.9%**	**5.0%**

TURNOVER (% FTE)

	Quarter 2		Quarter 1	
	Actual	Target	Actual	Target
Diagnostics & Therapies	12.5%	11.2%	12.1%	11.3%
Facilities & Estates	14.7%	13.2%	13.2%	13.6%
Medicine	12.4%	13.2%	13.5%	13.4%
Specialised Services	16.1%	14.5%	16.4%	15.6%
Surgery, Head & Neck	14.4%	13.8%	16.0%	14.5%
Trust Services	15.6%	12.8%	16.4%	14.0%
Women's & Children's	11.4%	10.9%	12.1%	11.5%
Trust Total	**13.5%**	**12.7%**	**14.0%**	**13.2%**

Staff Development

APPRAISAL COMPLIANCE (EXCL CONSULTANTS)

	Quarter 2		Quarter 1	
	Actual	Target	Actual	Target
Diagnostics & Therapies	84.7%	85.0%	89.0%	85.0%
Facilities & Estates	93.3%	85.0%	91.2%	85.0%
Medicine	85.9%	85.0%	86.5%	85.0%
Specialised Services	82.8%	85.0%	87.5%	85.0%
Surgery, Head & Neck	80.4%	85.0%	83.6%	85.0%
Trust Services	91.3%	85.0%	88.0%	85.0%
Women's & Children's	83.8%	85.0%	82.4%	85.0%
Trust Total	**85.1%**	**85.0%**	**86.1%**	**85.0%**

Appendix 3   Staff Group KPIs – Quarterly Comparisons

Workforce FTE

WORKFORCE NUMBERS, INCL BANK & AGENCY (FTE)

	Quarter 2		Quarter 1	
	Actual	Target	Actual	Target
Administrative & Clerical	1663.6	1657.7	1649.1	1642.1
Scientific & Professional	1262.9	1298.3	1250.4	1274.8
Estates & Ancillary	848.0	855.5	856.3	847.3
Medical & Dental	1172.9	1193.3	1156.3	1177.0
Nursing & Midwifery	3210.0	3107.2	3193.9	3084.4
Trust Total	**8157.4**	**8112.0**	**8106.0**	**8025.5**

BANK (FTE)

	Quarter 2 Actual	Quarter 1 Actual
Administrative & Clerical	5.4%	5.7%
Scientific & Professional	0.8%	0.8%
Estates & Ancillary	6.8%	7.1%
Medical & Dental	0.0%	0.0%
Nursing & Midwifery	8.0%	7.6%
Trust Total	**5.1%**	**5.0%**

Workforce FTE

AGENCY (FTE)

	Quarter 2 Actual	Quarter 1 Actual
Administrative & Clerical	2.1%	1.8%
Scientific & Professional	0.6%	0.6%
Estates & Ancillary	1.3%	1.1%
Medical & Dental	1.5%	1.6%
Nursing & Midwifery	3.4%	2.9%
Trust Total	**2.2%**	**1.9%**

OVERTIME (FTE)

	Quarter 2 Actual	Quarter 1 Actual
Administrative & Clerical	0.4%	0.4%
Scientific & Professional	1.1%	1.4%
Estates & Ancillary	4.2%	4.1%
Medical & Dental	0.0%	0.0%
Nursing & Midwifery	0.0%	0.2%
Trust Total	**0.7%**	**0.8%**

Workforce FTE

SICKNESS ABSENCE (%)

	Quarter 2 Actual	Quarter 1 Actual
Add Prof Scientific & Technic	2.8%	3.4%
Additional Clinical Services	5.1%	4.3%
Administrative & Clerical	3.9%	3.6%
Allied Health Professionals	2.9%	3.4%
Estates & Ancillary	5.9%	6.2%
Healthcare Scientists	1.5%	2.2%
Medical & Dental	1.0%	1.2%
Nursing & Midwifery Registered	4.5%	4.2%
Nursing & Midwifery Unregistered	7.6%	7.8%
Trust Total	**4.1%**	**4.0%**

Staff Experience

VACANCY (% FTE)

	Quarter 2		Quarter 1	
	Actual	Target	Actual	Target
Administrative & Clerical	6.3%	5.0%	6.2%	5.0%
Scientific & Professional	3.9%	5.0%	3.1%	5.0%
Estates & Ancillary	8.8%	5.0%	7.1%	5.0%
Medical & Dental	2.7%	5.0%	2.8%	5.0%
Nursing & Midwifery	6.8%	5.0%	5.2%	5.0%
Trust Total	**5.8%**	**5.0%**	**4.9%**	**5.0%**

TURNOVER (% FTE)

	Quarter 2 Actual	Quarter 1 Actual
Add Prof Scientific & Technic	11.9%	11.3%
Additional Clinical Services	14.5%	13.7%
Administrative & Clerical	16.0%	15.0%
Allied Health Professionals	13.5%	13.5%
Estates & Ancillary	13.6%	12.6%
Healthcare Scientists	8.4%	8.5%
Medical & Dental	7.1%	9.1%
Nursing & Midwifery Registered	12.8%	13.9%
Nursing & Midwifery Unregistered	17.9%	22.2%
Trust Total	**13.5%**	**14.0%**

Staff Development

APPRAISAL COMPLIANCE (EXCL CONSULTANTS)

	Quarter 2		Quarter 1	
	Actual	Target	Actual	Target
Add Prof Scientific & Technic	80.5%	85.0%	86.2%	85.0%
Additional Clinical Services	91.3%	85.0%	90.1%	85.0%
Administrative & Clerical	85.5%	85.0%	85.3%	85.0%
Allied Health Professionals	84.5%	85.0%	88.3%	85.0%
Estates & Ancillary	92.8%	85.0%	91.8%	85.0%
Healthcare Scientists	81.3%	85.0%	81.4%	85.0%
Medical & Dental	69.5%	85.0%	83.2%	85.0%
Nursing & Midwifery Registered	85.9%	85.0%	84.5%	85.0%
Nursing & Midwifery Unregistered	88.5%	85.0%	87.3%	85.0%
Trust Total	**85.1%**	**85.0%**	**86.1%**	**85.0%**

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

Report Title
10. Finance Report

Sponsor and Author(s)
Sponsor: Paul Mapson, Director of Finance & Information

Intended Audience

Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
To report to the Board on the Trust's financial position and related financial matters which require the Board's review.

Key issues to note
The summary income and expenditure statement shows a surplus of £0.309m (before technical items) for the first seven months of the financial year. After technical items, the surplus increases to £5.099m.

The pattern of an adverse run rate in Divisions offset by the application of one-off financial benefits continues. The Divisions' overspend in October was £0.850m (compared to £0.961m in September). The year to date overspending is now £5.272m compared to the operating plan target of £2.101m i.e. adverse to plan by £3.171m.

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

Impact Upon Board Assurance Framework
None

Impact Upon Corporate Risk
None

Implications (Regulatory/Legal)
None

Equality & Patient Impact
None

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees

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

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £0.309m (before technical items) for the first seven months of the financial year. After technical items the surplus increases to £5.099m.

The pattern of an adverse run rate in Divisions offset by the application of one-off financial benefits continues. The Divisions' overspend in October was £0.850m (compared to £0.961m in September). The year to date overspending is now £5.272m compared to the operating plan target of £2.101m i.e. adverse to plan by £3.171m.

The Divisions generating the greatest overspends are Surgery, Head and Neck (£3.278m), Medicine (£1.115m) and Women's and Children's (£0.723m).

Whereas income was largely on plan in October the main overspending driver remains nursing staff pay. Non-pay also deteriorated primarily in Surgery, Head and Neck, Medicine and Specialised Services (mostly out-sourcing costs and clinical supplies). This is shown below:

(Adverse)/Favourable	October £m	September £m	August £m	Year to date £m
Nursing pay	(0.497)	(0.541)	(0.384)	(1.999)
Medical staff pay	(0.074)	(0.103)	0.022	(0.495)
Other pay	0.058	(0.022)	0.121	0.434
Non-pay	(0.410)	0.060	(0.431)	(0.853)
Income	0.073	(0.355)	(0.802)	(2.359)
Total	**(0.850)**	**(0.961)**	**(1.472)**	**(5.272)**

In addition the forecast outturn savings performance has deteriorated from an underperformance of £2.962m in September to £3.547m in October. The Trust's forecast outturn continues to be a break-even position. There remain significant risks to this position including the potential for additional fines for breaches of Recovery Action Plans (RAPs). The NHS England position on this has been the subject of discussion nationally and is currently being negotiated.

The following tables show how two key financial drivers are changing during the year:

- Clinical Activity – the position in October has improved. The net SLA underperformance is still £2.359m though for the year to date. The graph overleaf shows the total activity position (monthly financial variance from plan).

Total Activity Contracts - Monthly Variance from Plan
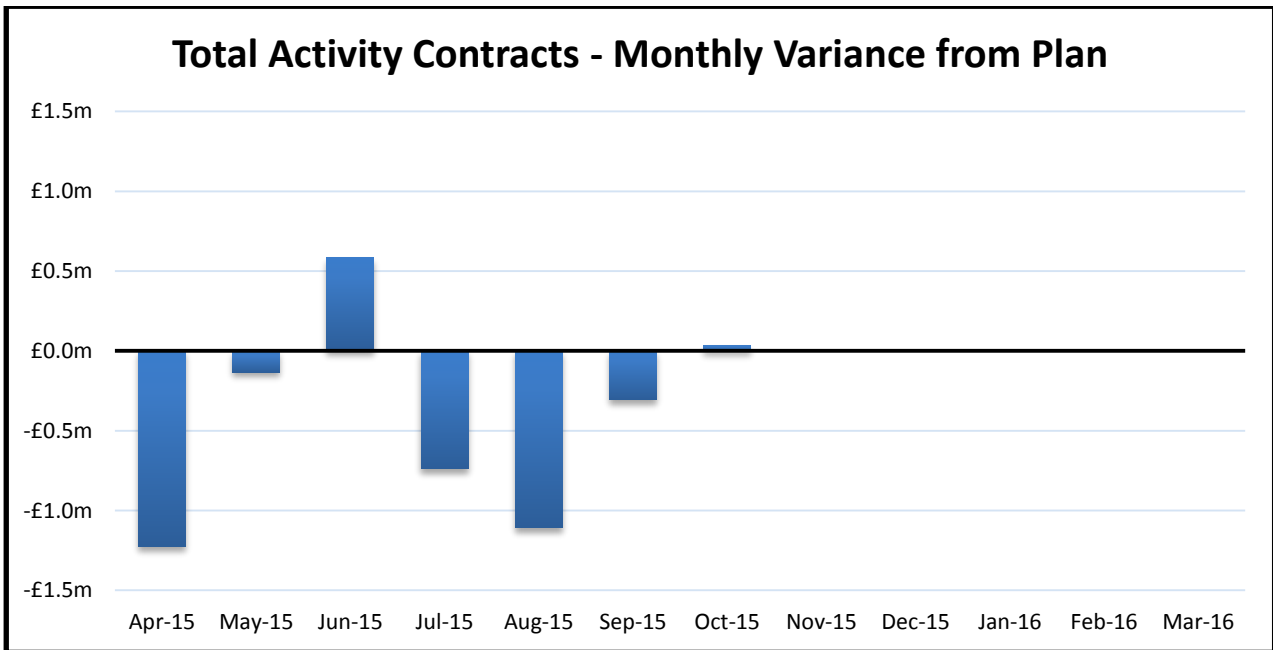
- Nursing Agency Spend – as can be seen there has been a marginal reduction in nursing agency expenditure in the month but the overall year to date position is concerning – specifically:

  - The year to date spend is £5.463m compared to the Operating Plan of £2.798m
  - The agency spend is 10.7% of total registered nursing spend in October compared to the Monitor cap of 6% and the submitted trajectory of 5.2% for months 7 to 12.
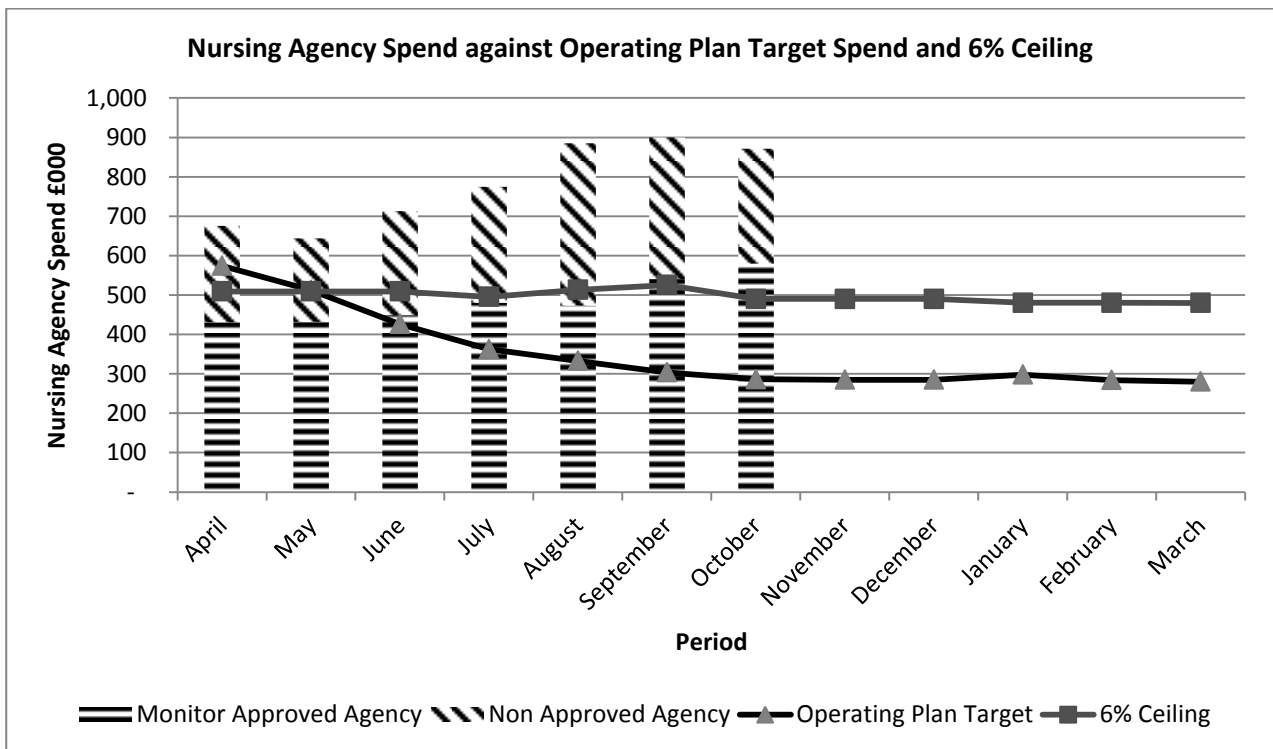
There have been improvements in both the Medicine and Surgery Head and Neck Divisions but a significant deterioration in Women's and Children's.

2. Divisional Financial Position

In total, the Clinical Divisions and Corporate Services overspend against budget increased by £0.850m in September to £5.272m cumulatively. The table below summarises the financial performance in October for each of the Trust's management divisions against the budget and against their October operating plan target. Further analysis of the variances against budget by pay, non-pay and income categories is given at Appendix 2.

	Budget Variance to 30 Sept	Oct Budget Variance	Budget Variance to 31 Oct	Oct Operating Plan Target	Operating Plan Variance
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Diagnostic & Therapies	(41)	95	54	(34)	88
Medicine	(1,027)	(88)	(1,115)	(80)	(1,035)
Specialised Services	(524)	(48)	(572)	31	(603)
Surgery, Head & Neck	(2,643)	(635)	(3,278)	(1,539)	(1,739)
Women's & Children's	(477)	(246)	(723)	(466)	(257)
Estates & Facilities	65	(41)	24	(13)	37
Trust Services	(43)	29	(14)	-	(14)
Other corporate services	268	84	352	-	352
Totals	**(4,422)**	**(850)**	**(5,272)**	**(2,101)**	**(3,171)**

Variance to Budget:
The table below shows the Clinical Divisions and Corporate Services budget variances against the four main income and expenditure headings.

Divisional Variances	Variance to 30 Sept	Oct Variance	Variance to 31 Oct
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,146)	(475)	(1,621)
Non Pay	1,100	(139)	961
Operating Income	183	179	362
Income from Activities	(2,278)	(31)	(2,309)
Sub Totals	(2,141)	(466)	(2,607)
Savings Programme	(2,281)	(384)	(2,665)
Totals	**(4,422)**	**(850)**	**(5,272)**

Pay budgets have an adverse variance of £0.475m in the month increasing the cumulative adverse variance to £1.621m. The adverse variances are within Women's and Children's (£1.084m), Specialised Services (£0.630m), Surgery, Head and Neck (£0.311m) and Medicine (£0.345m) offset by favourable variances in Diagnostic & Therapies (£0.475m) and Corporate Services (£0.274m). For the Trust as a whole, agency spend is £8.779m to date, an increase of £1.444m in the month. The average monthly spend of £1.254m compares with £0.967m for 2014/15. Agency spend to date is £2.073m in Medicine, £1.851m in Women's and Children's, £1.794m in Surgery, Head and Neck and £1.597m in Specialised Services. Waiting list initiatives costs remain high at £1.948m to date, of which £0.917m is within Surgery, Head and Neck, £0.433m in Women's and Children's and £0.322m in Specialised Services.

Non-pay budgets have an adverse variance of £0.139m in the month reducing the cumulative favourable variance to £0.961m. The Surgery, Head and Neck adverse position deteriorated by a further £0.245m in the month. The Women's and Children's position improved by £0.284m in the month.

Operating Income budgets have a favourable variance of £0.179m for the month to give a cumulative favourable variance of £0.362m.

Income from Activities budgets have an adverse variance of £0.031m in the month to give a cumulative adverse position of £2.309m. The principal areas of under achievement to date are within Surgery, Head and Neck (£0.854m), Medicine (£0.661m), Specialised Services (£0.689m) and Diagnostics and Therapies (£0.169m) offset by an over achievement in Women's and Children's (£0.030m). Within the month, Women's and Children's under achieved against their income target by £0.175m primarily due to Bone Marrow Transplants, burns emergencies and ENT. The Diagnostic and Therapies position results from the share of the underachievement in other Divisions. The difference between the in month deterioration reported here and that reported in section 6 (SLA income) is accounted for by variances relating to private patients, other non SLA income from activities, including RTA income, and differences with the reporting of CIP delivery.

Variance to Operating Plan:
Clinical Divisions and Corporate Services have an adverse variance of £5.272m against a combined operating plan trajectory of £2.101m. The October position is £3.171m above trajectory as shown in the graph below.
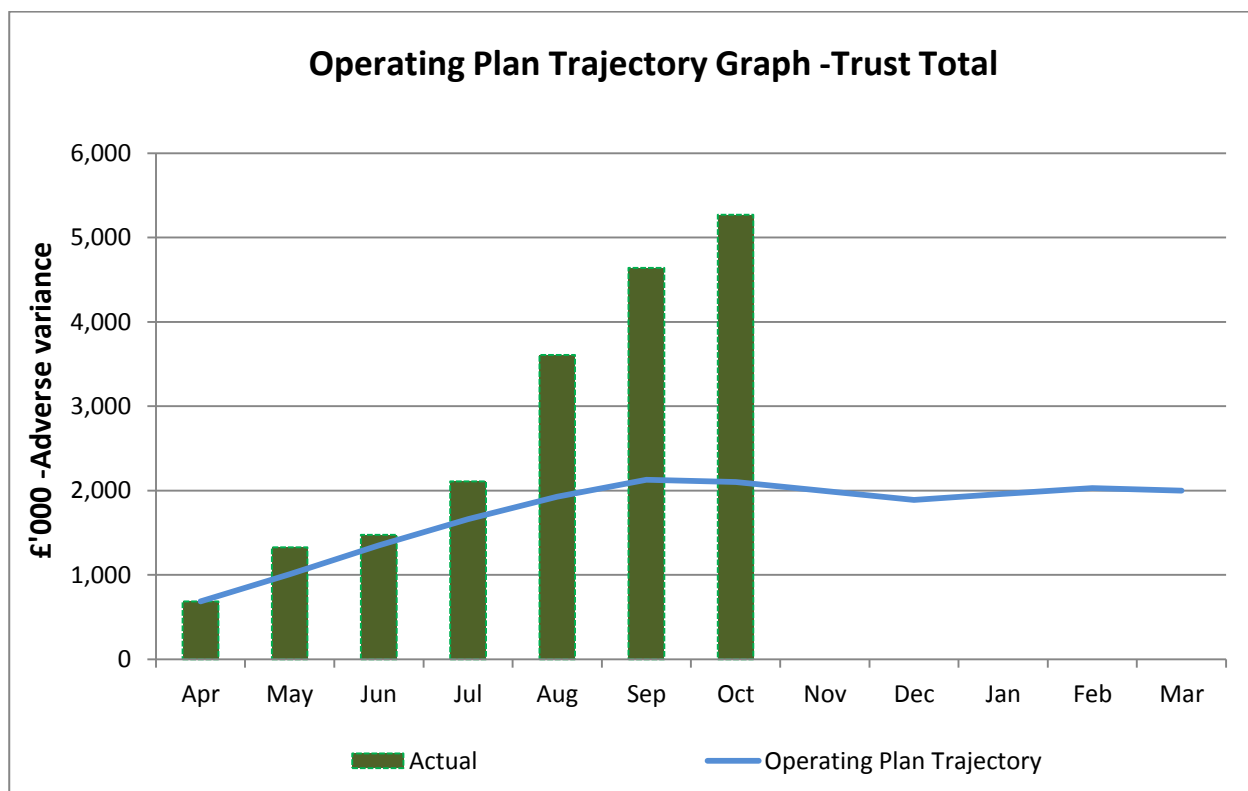
As can be seen the operating plan trajectories are now unlikely to be delivered.

Further detail is given under agenda item 5.3 in the Finance Committee papers.

Savings Programme

The savings requirement for 2015/16 is £19.879m. This is net of the £4.476m provided non-recurringly to support the delivery of Divisional operating plans. Savings of £8.930m have been realised to date, a shortfall of £2.671m against divisional plans. The shortfall is a combination of the adverse variance for unidentified schemes of £2.062m and a further £0.609m for scheme slippage. The 1/12th phasing adjustment reduces the shortfall to date by £0.005m.

The year-end forecast outturn is a shortfall of £3.547m, (a deterioration of £0.585m from last month's forecast shortfall of £2.962m), which represents delivery of 82%. The main reason for the deterioration in forecast outturn is a reassessment of the savings within Medicine regarding reduced nursing spend, this has been necessary as a result of higher than planned agency spend within this division.

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 Oct 2015			1/12ths Phasing Adj Fav / (Adv) £'000	Total Variance Fav / (Adv) £'000
	Plan £'000	Actual £'000	Variance Fav / (Adv) £'000		
Diagnostics and Therapies	1,214	915	(299)	(36)	(335)
Medicine	1,248	1,153	(95)	(49)	(144)
Specialised Services	973	1,099	126	48	174
Surgery, Head and Neck	3,536	1,764	(1,772)	94	(1,678)
Women's and Children's	2,598	1,741	(857)	101	(756)
Estates and Facilities	625	654	29	(12)	17
Trust HQ	189	360	171	(123)	48
Other Services	1,218	1,244	26	(18)	8
Totals	**11,601**	**8,930**	**(2,671)**	**5**	**(2,666)**

3. Divisional Reports

Four Divisions are red rated for their financial performance for the year to date:

Division of Medicine

The Division reports an adverse variance to month 7 of £1.115m; this represents deterioration from month 6 of £0.088m. The Division is £1.035m adverse to its operating plan target to date. The division has reassessed its savings plans with regards to nursing which has resulted in the division now reporting a savings programme year to date adverse variance of £0.095m and a revised savings programme forecast outturn favourable variance of £0.521m compared to the favourable variance of £1.091m reported last month.

The key reasons for the adverse variance against budget and operating plan to date are:

- An adverse variance on SLA Income of £0.661m due to the following factors:

i)   A circa 3% adverse financial variance (£366k gross) driven by a 2.6% under-performance against SLA in volume of emergency admissions. Admissions were however 8% higher than SLA in October and 12% higher than in September;

ii)   3% fewer attendances to the Emergency Department (ED) than at the same time in 2014/15. This, in part, reflects the fact that up to 8 'GP expected' patients per day are now admitted directly to the Acute Medical Unit (AMU) and bypass the Emergency Department completely. Attendances were however, 1% higher than SLA in October and 7% higher than in September;

iii)   An adjustment to patient volumes in the Port CF database given changes to bandings and deaths within the regional Cystic Fibrosis service £0.184m. This was an unplanned adjustment and the full year impact must be absorbed within the 2015/16 financial plan;

iv)   New outpatient attendances are circa 5% below SLA (£0.115m apportioned), but largely reflects capacity issues in quarters 1 and 2 across specialties with sizable growth incorporated in the 2015/16 contract. Similarly, follow-up attendances are circa 3% below SLA (£0.061m gross). Dermatology in particular, saw a reduction in 2 week wait cancer referrals in both August and September, and fewer attendances again in October.

- A pay adverse variance of £0.345m due to costs associated with agency nursing and medical staffing. The pay variance increased for the third month in a row. The main areas of increased expenditure being with regards to one to one cover and the requirements for RMN's. It should however be noted that absolute pay expenditure reduced this month for the first time since July.

- The savings programme is now reporting an adverse variance of £0.144m. The forecast outturn savings programme delivery has also been reduced as a consequence of the fact that it is now unlikely that the planned nursing savings will be delivered in the light of on-going high than planned nursing spend.

Actions being taken and mitigation 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.
- A proposal to move to single sex wards within Care of the Elderly is being looked at; the likely consequence of which will be a significant reduction in one to one agency shifts as duplication across wards is reduced.
- Continuation of an intensive nurse recruitment programme (using divisional matron resource) and additional resource from Employee Services to address and improve sickness absence rates.

Key risks to delivery of the operating plan include:

- Failure of the recruitment strategy to deliver the required number of posts and hence the planned level of agency expenditure reductions are not achieved.
- Failure to adequately control nursing expenditure.
- The risk that activity does not pick up in the later months of the year.

Division of Specialised Services

The Division reports an adverse variance to month 7 of £0.572m, which represents deterioration from month 6 of £0.048m. The Division is £0.603m adverse to the operating plan target to date.

Pay budgets show an adverse variance of £0.630m. Income from activities is showing an adverse variance of £0.689m.The savings programme is showing a favourable variance of £0.174m to date and the non pay budgets are reporting a favourable variance of £0.433m due to the year to date

share of support funding and unallocated contract transfer funding as well as a small favourable variance on blood.

The key reasons for the adverse variance against budget and operating plan to date are:

- Cardiac Surgery activity – Year to date at Month 7 the division completed 122 cases fewer than required (88%) of contract resulting in an inpatient under performance of £0.592m. It should however be noted that actual procedures performed in month have been higher than billed so 24 additional cases will 'rollover' into and be recognised in next month's position.
- Cardiology activity is overachieving year to date by £0.242m.
- Cardiac Critical Care activity has underperformed year to date by £0.183m.
- Adult BMT – Year to date contract underperformance of £0.234m, with allograft volumes down 15.5% on those of 2014/15.
- Radiotherapy Activity – Year to date contract underperformance of £0.102m.
- Haematology activity has over performed year to date by £0.232m, and this rate of over performance is expected to continue.
- Private Patients Income is over performing against target by £0.058m.
- Nursing – There has been high agency usage within CICU and significant hour's requirements for one to one nursing across wards resulting in a £0.495m adverse variance.
- Perfusion Agency – Reliance on agency due to staff shortages has resulted in a £0.078m adverse variance. This has now ended in August.
- Non recurring savings support funding has benefited the position by £0.287m.
- The Cost Improvement Programme reports an achievement of £0.175m.
- Operating income reports a favourable variance of £0.140m.
- Other non-pay budgets are showing a favourable variance of £.0.146m.

Actions being taken and mitigation to restore performance include:

- Delivery of Cardiac Surgery activity - A review of scheduling is taking place which informs booking practices based on the patients euro score which is aimed at ensuring that a suitable acuity mix of patients are operated on in order to prevent high volumes of potential long stay patients being treated together, subsequently improving flow through the unit.
- A number of actions have been identified within nursing to maintain a continued focus on this area. These include, the development of a critical care bank, recruitment and retention programme led by the divisional matron, continued review of lost time including annual leave, review of CICU staffing levels and plans to reduce agency expenditure.
- Additional SLA income opportunities may be possible throughout the year in the areas of Cardiology and Haematology following strong performance year to date. Opportunities with Gamma Knife are also probable in the final quarter of the year.
- Continuing to deliver savings programmes identified and developing new schemes.
- Maintaining controls on non-pay expenditure.
- A meeting has been convened to review the operating model for Cardiac Services in order to mitigate the impact of the whole hospital position on cardiac activity.

Key risks to delivery of the operating plan include:

- Further loses of Cardiac Surgery activity due to shortages of staff, high acuity of patients or bed pressures during the winter period.
- An inability to recruit to vacant posts in nursing resulting in continued agency expenditure;

- Non recruitment into medical vacancies within the BHOC, particularly for Radiotherapy.
- Continued charges for unused chemotherapy drugs.
- Non delivery of expected savings
- Any reduction in referrals for BMT

Division of Surgery, Head and Neck

The Division reports an adverse variance to month 7 of £3.278m; deterioration from month 6 of £0.635m, this represents an adverse movement in the run rate. The Division is £1.739m adverse to its operating plan target to date, compared with £1.103m last month.

The key reasons for the adverse variance against budget to date are:

- Underachievement of income from activities of £0.854m 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 (£0.222m), although this run rate has slowed over recent months.
- An adverse variance to date on non-pay of £0.589m which is an in month deterioration of £0.245m. This is due to re-profiling £0.082m, divisional deficit offset by divisional non recurring support £0.378m plus adverse variances on drugs £0.150m and non clinical supplies/other non-pay £0.275m. These adverse variances are offset by an underspend on clinical supplies related to lower than planned activity £0.295m.
- An underachievement of the savings programme, resulting in an adverse variance to date of £1.678m. The majority of which relates to unidentified plans of £1.617m 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 key reasons for the adverse variance against operating plan are:

- Underachievement of activity (including the share of cardiac surgery), £0.491m.
- Higher than planned nursing spend £0.705m.
- Higher than planned waiting list payments £0.178m.
- Higher than planned spend on medical and dental agency offset by BEH vacancies £0.204m.
- Higher than planned income from operations £0.066m.
- Higher than planned expenditure on outsourcing £0.120m.
- Slippage on CIP delivery.

Actions being taken and mitigation to restore performance include:

- Implementing new E-roster reports to support nurse deployment with the aim of reducing bank and agency usage.
- Implementing a revised operating model to improve utilisation rates within theatres, reducing the number of waiting list initiatives (WLI) required;
- Recruitment of locum posts in endoscopy and anaesthesia to reduce spend on WLI
- Review of classification of critical care patients to ensure staffing skill mix is appropriate, and not higher than required;
- Review of the Enhanced Observation (EO) Policy in T&O wards, with the aim of reducing spend on one to one nursing and focus on discharge of those green to go patients requiring EO.
- 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.

Key risks to delivery of the operating plan include:

- Continuing high usage of agency nursing if the recruitment strategy fails to deliver.
- Failure to address and recover the underperformance on activity to date.

The Division of Women's and Children's Services

The Division reports an adverse variance to month 7 of £0.723m; this represents deterioration from month 6 of £0.246m. The Division is £0.257m adverse to the operating plan target to date. It should be noted that this is the first month this year that the division has reported a significant adverse variance to its operating plan trajectory, this is therefore of serious concern.

The key reasons for the adverse variance against budget to date are:

- An adverse variance on pay of £1.084m due to higher than planned agency costs within medical staff (NICU cover) and nursing (including one to one care). It should be noted that there were 61 wte new nursing starters this month which require a period of supernumerary status the costs of these shifts this month being £0.096m. Non clinical staff has an adverse variance of £0.323m driven by requirements such as validating waiting lists, completion of missing outcomes, spend in Clinical Genetics, vacancies for medical secretaries and increased staffing in the governance team.
- An underperformance on the saving programme, resulting in an adverse variance to date of £0.755m. The majority of which relates to the level of unidentified savings in the plan £0.680m.
- An overachievement on SLA income of £0.030m including favourable variances in paediatric medical specialties £0.100m, St Michaels specialties £0.048m and paediatric, cardiac & PICU £0.129m offset by an adverse performance on paediatric surgical specialties £0.119m on private patients of £0.130m. It should however be noted that the favourable variance on SLA income reduced significantly this month from £0.205m at month 6 to the £0.030m reported here, the most significant reason for this being no Bone Marrow Transplant activity this month resulting in an adverse variance of £0.160m.
- These adverse variance are offset by a significant favourable variance on non-pay which includes the year to date share of support funding, CQUIN funding and a capacity reserve held within the division.

The Division is now £0.257m adverse to its operating plan trajectory.

Actions being taken and mitigation to restore performance include:

In order to return the Division's financial position to within its operating plan control envelope it is now clear that more financial recovery actions are required as the pace of cost reduction in nursing is insufficient in itself. The monthly Finance Performance meetings are to be used to develop a recovery action plan which will need to include:

- Stopping all non-clinical agency costs (although the impact of this will have to be risk assessed)
- Escalating all requests for agency usage to Divisional Board level
- Focus on compliance with Finance and HR policies such as special leave requests, non-EROS ordering processes, travel expenses

Key risks to delivery of the operating plan include:

- Maintaining elective income though the winter months, whilst containing winter emergency pressure costs within the operational resilience funding envelope. Cardiac Surgery activity may well be reduced but plans are being developed to increase Neurosurgery activity which is less dependent on PIC bed availability.

- Ensuring nurse agency costs reduce significantly in line with recruitment of 107 new starters this autumn.

The remaining three Divisions are rated green.

Diagnostic and Therapies Division

The Division reports a favourable variance to month 7 of £0.054m, which represents and improvement from month 6 of £0.095m. The Division is £0.088m favourable compared to the operating plan target to date.

The key reasons for the variance against budget to date are:

- A favourable variance on pay of £0.475m which is primarily the result of vacancies in clinical staff.
- An adverse variance on non-pay of £0.125m which includes a recurrent adverse variance on Radiology maintenance contracts of £0.143m and the Microbiology Public Health England contract of £0.189m. The year to date adverse variance also includes LIMS double running costs of £0.146m which is being challenged with NBT. There has also been non-recurrent cost pressures year to date for the Laboratory server of £0.050m. These adverse variances are off-set by non-recurring support funding and divisional reserves of £0.440m.
- An adverse variance on income from activities (mainly SLA income) of £0.253m year to date (£0.03m favourable on D&T hosted services off-set by £0.282m adverse on services hosted by other divisions), £0.093m non-recurring CQUIN benefit, off-set by underachievement on private patient income of £0.065m.
- The savings programme is adverse to requirement by £0.335m year to date, of which £0.195m was unidentified in the operating plan.
- A favourable variance on Operating Income of £0.208m this is across a number of areas including research and innovation, MEMO external contracts and pharmacy income.

Actions being taken and mitigation to restore performance in underperforming areas include:

- Developing the savings programme to address the shortfall.
- Challenging the dual running LIMS costs with NBT.

Key risks to delivery of the operating plan include:
- Other Division's under-performance on contracted activity.
- The ability to continue with high levels of vacancies and any potential impact this might have on service delivery.
- Non-delivery or under-delivery of savings schemes currently forecast to achieve, such as those linked to the extension of the Roche Managed equipment service for laboratory medicine.
- Employing high cost agency and or locum staff into hard to recruit to posts to ensure delivery of key performance targets and resilience in services such as Radiology and Laboratory Medicine.

The Facilities and Estates Division

The Division reports a favourable variance to month 7 of £0.024m, which represents deterioration from month 6 of £0.041m mainly due to estates maintenance costs. The Division is £0.037m favourable to the operating plan target to date.

Trust Headquarters

The Division reports an adverse variance to month 7 of £0.014m, this represents an improvement from month 6 of £0.029m; the Division is £0.014m adverse to the operating plan target to date.

4. Income

Contract income was £1.25m higher than plan in October and is £1.38m lower than plan for the year to date. Pass through payments, contract penalties and activity were higher than plan in the month whilst contract rewards were lower than plan. The table below summarises the overall position which is described in more detail under agenda item 5.2.

Clinical Income by Worktype	In Month Variance Fav/(Adv)	Year to Date Plan	Year to Date Actual	Year to Date Variance Fav/(Adv)
	£'m	£'m	£'m	£'m
Activity Based				
Accident & Emergency	0.06	8.56	8.75	0.19
Emergency Inpatients	0.21	42.14	43.26	1.12
Day Cases	(0.02)	22.08	21.46	(0.63)
Elective Inpatients	(0.37)	31.11	29.09	(2.02)
Non-Elective Inpatients	0.18	9.26	8.88	(0.39)
Excess Bed days	0.15	4.07	4.78	0.72
Outpatients	0.14	46.46	45.46	(1.00)
Bone Marrow Transplants	(0.23)	5.53	5.01	(0.51)
Critical Care Bed days	(0.10)	24.43	24.64	0.21
Other	0.01	54.40	53.83	(0.58)
Sub Totals	**0.04**	**248.04**	**245.16**	**(2.88)**
Contract Penalties	0.38	(3.56)	(2.99)	0.56
Contract Rewards	(0.01)	4.68	4.49	(0.19)
Pass through payments	0.84	48.86	47.98	1.13
Totals	**1.25**	**296.02**	**294.64**	**(1.38)**

Significant activity underperformance continues within elective inpatients and outpatients. Key areas for the elective inpatient underperformance of £2.02m are cardiac surgery (£0.69m) and upper gastrointestinal surgery (£0.63m). The improvement in cardiac surgery over the last two months has not been sustained. Ophthalmology outpatient activity is £0.66m lower than plan resulting from reduced capacity whilst recruitment is underway.

Emergency inpatients over performance increased by £0.21m to £1.12m to date, with the over performance to date within the Children's Hospital accounting for £1.06m. Activity this month was high within the Children's Hospital (£0.13m) and the BRI (£0.12m).

Contract penalties are £0.56m better than plan. The main driver for this is the specialised services marginal tariff adjustment which is better than expected at £0.60m. Further detail is given at 2.3 in the contract income report.

Contract rewards are £0.19m behind plan. The CQUINs with ≤50% predicted delivery in whole or part continue to relate to "Dementia: Case finding" and "Organisational Patient Safety Culture." These are being monitored closely through the Clinical Quality Group, with relevant SLT sponsors accountable to SLT for delivery.

Pass through payments are £1.13m higher than planned to date, an increase in month of £0.84m. The most significant increase in month was within drugs (£0.62m) due to the implementation of pre-NICE guidance for hepatology. Devices also increased (£0.31m) due to adult cardiology devices.

Performance at Clinical Divisional level is shown at appendix 4a. Activity based contract performance is summarised as follows:

Divisional Variances	In Month Variance Fav/(Adv)	Year to Date Plan	Year to Date Actual	Year to Date Variance Fav/(Adv)
	£'m	£'m	£'m	£'m
Diagnostic & Therapies	(0.02)	22.48	22.18	(0.30)
Medicine	0.15	28.56	28.08	(0.49)
Specialised Services	0.14	31.91	31.21	(0.70)
Surgery, Head and Neck	(0.02)	44.47	43.53	(0.94)
Women's and Children's	(0.20)	58.08	58.35	0.26
Facilities and Estates	0.00	2.27	2.23	(0.03)
Corporate	(0.02)	60.26	59.58	(0.68)
Totals	**0.04**	**248.04**	**245.16**	**(2.88)**

5. Risk Rating

The following table shows performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the seven month period to 31st October 2015, the Trust's achieved an overall FSRR of 3 (actual 3.25) against a plan of 4 (rounded up – actual 3.5). The reduction in the FSRR against plan is due to the Trust's reported net income and expenditure position of £309k surplus (before technical items) against a planned surplus of £343k. The £34k adverse position against plan reduces the "variance in I&E margin" metric rating from a planned metric rating of 4 to an actual rating of 3.

A key risk going forward is the adverse income and expenditure performance against plan and the impact upon the FSRR. Within the FSRR, the income and expenditure performance impacts on the "income and expenditure margin" metric and the "capital servicing capacity" metric. The headroom available until both metrics score a rating of 1 has increased to £6.8 million. Should any of the four metrics score a metric rating of 1, Monitor will apply an "over-ride" resulting in an overall FSRR capped at 2 for the Trust and potential investigation. A summary of the position is provided in the table below.

	Weighting	30 September 2015 Plan	30 September 2015 Actual	31 October 2015 Plan	31 October 2015 Actual	31st March 2016 Plan	31st March 2016 Forecast
Liquidity							
Metric Result – days		14.14	15.17	13.14	14.69	7.2	7.2
Metric Rating	25%	4	4	4	4	4	4
Capital Servicing Capacity							
Metric Result – times		1.86	1.83	1.95	1.94	1.8	1.8
Metric Rating	25%	3	3	3	3	3	3
Income & expenditure margin							
Metric Result		0.75%	0.59%	0.60%	0.57%	0.5%	0.5%
Metric Rating	25%	3	3	3	3	3	3
Variance in I&E margin							
Metric Result		0.0%	(0.16)%	0.0%	(0.03)%	0.0%	0.0%
Metric Rating	25%	4	3	4	3	4	4
Overall FSRR		**3.5**	**3.25**	**3.5**	**3.25**	**3.5**	**3.5**
Overall FSRR (rounded up)		**4**	**3**	**4**	**3**	**4**	**4**

6. Capital Programme

A summary of income and expenditure for the seven months ending 31 October is given in the table below. Expenditure for the period is £11.928m against a revised plan of £12.690m. The revised plan to date and forecast outturn position reflects the conclusion of the re-profiling exercise. The Trust's forecast outturn is £29.957m which is 87% of the original Monitor Annual Plan.

Original Monitor Annual Plan	Revised Annual Plan	Subjective heading	Month ended 31st October 2015			Forecast	
			Plan	Actual	Variance	Outturn	Slippage
£m	£m		£m	£m	£m	£m	£m
		Sources of Funding					
4.558	4.732	Donations	2.414	2.414	-	3.103	(1.629)
1.100	14.025	Disposals	14.025	14.025	-	14.025	-
0.954	1.130	Grants/Contributions	0.954	1.040	0.086	1.216	0.086
		Cash:					
20.814	20.814	Depreciation	12.030	12.023	(0.007)	20.814	-
7.043	(0.908)	Cash balances	(16.733)	(17.574)	(0.841)	(9.201)	(8.292)
34.469	**39.793**	**Total Funding**	**12.690**	**11.928**	**(0.762)**	**29.957**	**(9.836)**
		Expenditure					
(15.862)	(15.884)	Strategic Schemes	(6.473)	(6.400)	0.073	(11.953)	3.931
(4.287)	(7.332)	Medical Equipment	(1.110)	(1.062)	0.048	(5.948)	1.384
(3.171)	(3.265)	Information Technology	(1.501)	(1.200)	0.301	(3.082)	0.183
(2.177)	(2.226)	Estates Replacement	(1.120)	(1.130)	(0.010)	(2.256)	(0.030)
(8.972)	(11.086)	Operational Capital	(2.486)	(2.136)	0.350	(8.718)	2.368
(34.469)	**(39.793)**	**Gross Expenditure**	**(12.690)**	**(11.928)**	**0.762**	**(31.957)**	**7.836**
-	-	Planned Slippage	-	-	-	2.000	2.000
(34.469)	**(39.793)**	**Net Expenditure**	**(12.690)**	**(11.928)**	**0.762**	**(29.957)**	**9.836**

There have been a number of approved changes to the Trust's Capital Programme since the submission of the Annual Plan in May. As agreed at Capital Programme Steering Group in October the over and under spends reported last month were transferred to contingencies.

The Finance Committee is provided with further information under agenda item 6.1.

9. Statement of Financial Position and Cashflow

Overall, the Trust has a strong statement of financial position with net current assets of £34.277m as at 31 October 2015 compared with £34.496m last month.

Cash - The Trust held cash and cash equivalents of £79.866m, a reduction of £5.335m from last month reflecting the clearing of old invoices and unwinding monies owed to Commissioners. The cash position was slightly lower than forecast last month. The forecast year end closing cash balance is £62.811m, reflecting the loan principal repayment and PDC dividend payment due as well as the anticipated increase in capital spend over the remaining five months of the financial year.

The graph below shows the forecast cash balance trajectory for the remainder of the financial year.

Monthly Closing Cash Balance 2015–16
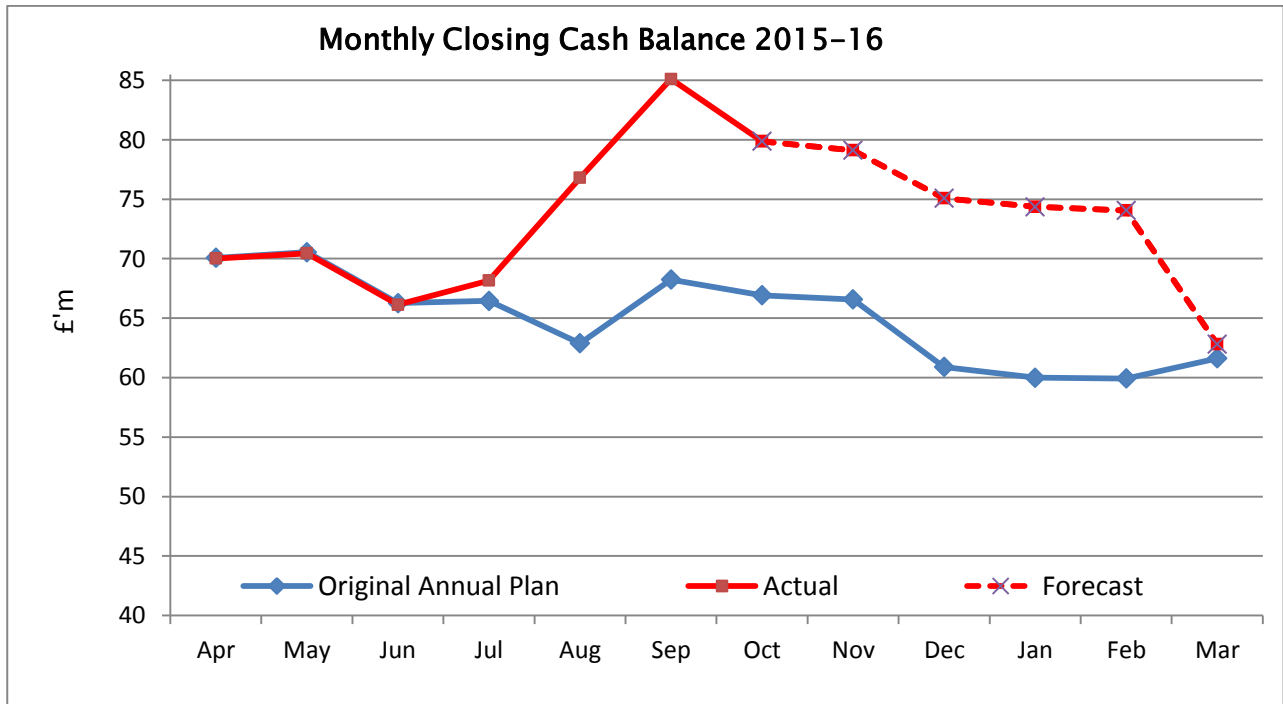
Receivables - The total value of debtors increased by £3.510m to £14.522m in October. SLA debtors increased by £3.328m and non SLA debtors increased by £0.182m. SLA invoices were raised in October for quarter 2 activity. Whilst the total value of debtors over 60 days old reduced by £4.197m, this is largely technical relating to how the Commissioners are using their quarter 1 credit notes. Debts over 60 days remained largely unchanged when this is excluded. Further details are provided in agenda item 7.1.

Aged Debtor Analysis 2015/16 £'m
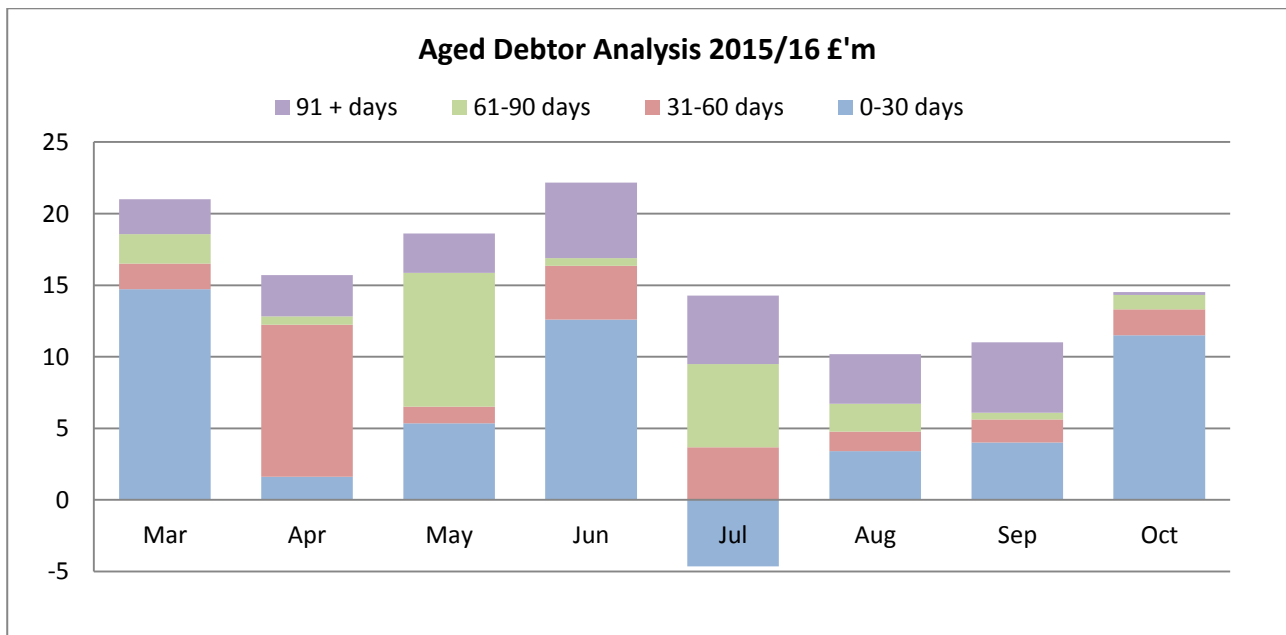
Accounts Payable Payments – In October, the Trust paid 93% of invoices within 60 days compared with the Prompt Payments Code target of 95%. This reflects the settlement of old invoices, with c2,000 of the 3,000 backlog invoices being paid. The number of invoices paid within 30 days dropped slightly due to the focus on paying more seriously overdue invoices. It should be noted that the Accounts Payable department continue to work pro-actively with suppliers ensuring supplies are not disrupted and accounts are not 'put on stop'. A summary of performance is provided below.

Performance Against Better Payments Practice Code

	Attachments	Appendix 1 – Summary Income and Expenditure Statement
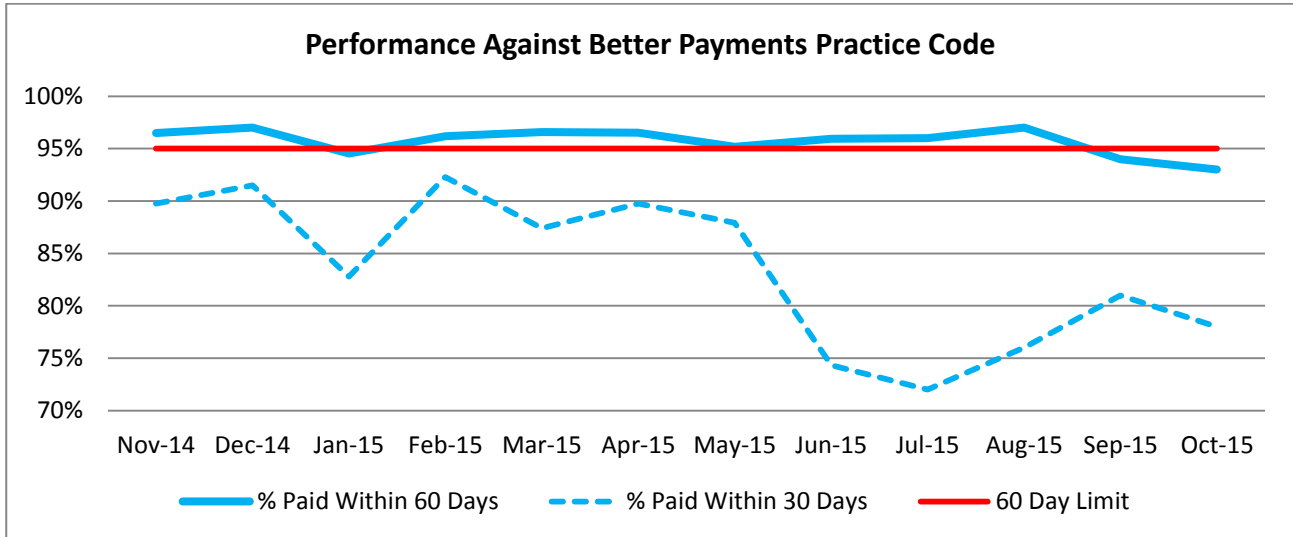
Attachments

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 October 2015– Summary Income & Expenditure Statement

Approved Budget / Plan 2015/16	Heading	Position as at 31st October			Actual to 30th September	Forecast Outturn
		Plan	Actual	Variance Fav / (Adv)		
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
505,636	From Activities	297,922	295,117	(2,805)	250,211	505,008
90,960	Other Operating Income	52,847	52,986	139	44,371	91,524
596,596	**Sub totals income**	**350,769**	**348,103**	**(2,666)**	**294,582**	**596,532**
	Expenditure					
(347,572)	Staffing	(203,332)	(205,392)	(2,060)	(175,647)	(354,052)
(206,081)	Supplies and Services	(123,046)	(123,762)	(716)	(102,852)	(210,251)
(553,653)	**Sub totals expenditure**	**(326,378)**	**(329,154)**	**(2,776)**	**(278,499)**	**(564,303)**
(8,493)	Reserves	(4,087)	–	4,087	–	–
34,450	**EBITDA**	**20,304**	**18,949**	**(1,355)**	**16,083**	**32,229**
5.77	**EBITDA Margin – %**		**5.44**		**5.46**	**5.40**
	Financing					
–	Profit/(Loss) on Sale of Asset	–	7	7	7	
(23,054)	Depreciation & Amortisation – Owned	(13,334)	(12,028)	1,306	(10,361)	(20,814)
269	Interest Receivable	167	175	8	146	275
(314)	Interest Payable on Leases	(183)	(186)	(3)	(160)	(314)
(3,167)	Interest Payable on Loans	(1,837)	(1,832)	5	(1,569)	(3,192)
(8,184)	PDC Dividend	(4,774)	(4,776)	(2)	(4,094)	(8,184)
(34,450)	**Sub totals financing**	**(19,961)**	**(18,640)**	**1,321**	**(16,031)**	**(32,229)**
0	**NET SURPLUS / (DEFICIT) before Technical Items**	**343**	**309**	**(34)**	**52**	**0**
	Technical Items					
4,558	Donations & Grants (PPE/Intangible Assets)	2,599	2,556	(43)	2,441	3,103
(4,719)	Impairments	(1,486)	(1,695)	(209)	(1,695)	(4,616)
500	Reversal of Impairments	–	4,804	4,804	4,804	3,916
(1,472)	Depreciation & Amortisation – Donated	(859)	(875)	(16)	(747)	(1,511)
(1,133)	**SURPLUS / (DEFICIT) after Technical Items**	**597**	**5,099**	**4,502**	**4,855**	**892**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report October 2015– Divisional Income & Expenditure Statement

Approved Budget / Plan 2015/16	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 30th September	Operating Plan Target Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income											
504,370	Contract Income	296,018	296,018	–	–	(1)	1	–	–	–	–	–
(3,534)	Overheads, Fines & Rewards	(2,061)	(2,231)	–	138	(13)	(295)	–	(170)	(565)	–	–
39,010	NHSE Income	22,363	22,363	–	–	–	–	–	–	–	–	–
539,846	**Sub Total Corporate Income**	**316,320**	**316,150**	**–**	**138**	**(14)**	**(294)**	**–**	**(170)**	**(565)**	**–**	**–**
	Clinical Divisions											
(51,053)	Diagnostic & Therapies	(29,903)	(29,849)	475	(125)	208	(169)	(335)	54	(41)	(34)	88
(71,717)	Medicine	(42,251)	(43,366)	(345)	(43)	78	(661)	(144)	(1,115)	(1,027)	(80)	(1,035)
(91,793)	Specialised Services	(53,461)	(54,033)	(630)	433	140	(689)	174	(572)	(524)	31	(603)
(100,051)	Surgery Head & Neck	(58,525)	(61,803)	(311)	(589)	154	(854)	(1,678)	(3,278)	(2,643)	(1,539)	(1,739)
(116,134)	Women's & Children's	(67,488)	(68,211)	(1,084)	1,112	(26)	30	(755)	(723)	(477)	(466)	(257)
(430,748)	**Sub Total – Clinical Divisions**	**(251,628)**	**(257,262)**	**(1,895)**	**788**	**554**	**(2,343)**	**(2,738)**	**(5,634)**	**(4,712)**	**(2,088)**	**(3,546)**
	Corporate Services											
(36,101)	Facilities And Estates	(21,308)	(21,284)	(35)	(85)	78	49	17	24	65	(13)	37
(24,899)	Trust Services	(14,437)	(14,451)	331	(373)	(65)	44	49	(14)	(43)	–	(14)
(5,155)	Other	(4,556)	(4,204)	(22)	631	(205)	(59)	7	352	268	–	352
(66,155)	**Sub Totals – Corporate Services**	**(40,301)**	**(39,939)**	**274**	**173**	**(192)**	**34**	**73**	**362**	**290**	**(13)**	**375**
(496,903)	**Sub Total (Clinical Divisions & Corporate Services)**	**(291,929)**	**(297,201)**	**(1,621)**	**961**	**362**	**(2,309)**	**(2,665)**	**(5,272)**	**(4,422)**	**(2,101)**	**(3,171)**
(8,493)	Reserves	(4,087)	–	–	4,087	–	–	–	4,087	3,504	–	–
–	Monitor Plan Profile	–	–	–	–	–	–	–	–	–	–	–
(8,493)	**Sub Total Reserves**	**(4,087)**	**–**	**–**	**4,087**	**–**	**–**	**–**	**4,087**	**3,504**	**–**	**–**
34,450	**Trust Totals Unprofiled**	**20,304**	**18,949**	**(1,621)**	**5,186**	**348**	**(2,603)**	**(2,665)**	**(1,355)**	**(1,483)**	**(2,101)**	**(3,171)**
	Financing											
–	(Profit)/Loss on Sale of Asset	–	7	–	7	–	–	–	7	7	–	–
(23,054)	Depreciation & Amortisation – Owned	(13,334)	(12,028)	–	1,306	–	–	–	1,306	1,119	–	–
269	Interest Receivable	167	175	–	8	–	–	–	8	24	–	–
(314)	Interest Payable on Leases	(183)	(186)	–	(3)	–	–	–	(3)	(3)	–	–
(3,167)	Interest Payable on Loans	(1,837)	(1,832)	–	5	–	–	–	5	27	–	–
(8,184)	PDC Dividend	(4,774)	(4,776)	–	(2)	–	–	–	(2)	(2)	–	–
(34,450)	**Sub Total Financing**	**(19,961)**	**(18,640)**	**–**	**1,321**	**–**	**–**	**–**	**1,321**	**1,172**	**–**	**–**
0	**NET SURPLUS / (DEFICIT) before Technical Items**	**343**	**309**	**(1,621)**	**6,507**	**348**	**(2,603)**	**(2,665)**	**(34)**	**(311)**	**(2,101)**	**(3,171)**
	Technical Items											
4,558	Donations & Grants (PPE/Intangible Assets)	2,599	2,556	–	–	(43)	–	–	(43)	(158)	–	–
(4,719)	Impairments	(1,486)	(1,695)	–	(209)	–	–	–	(209)	(209)	–	–
500	Reversal of Impairments	–	4,804	–	4,804	–	–	–	4,804	4,804	–	–
(1,472)	Depreciation & Amortisation – Donated	(859)	(875)	–	(16)	–	–	–	(16)	(11)	–	–
(1,133)	**Sub Total Technical Items**	**254**	**4,790**	**–**	**4,579**	**(43)**	**–**	**–**	**4,536**	**4,426**	**–**	**–**
(1,133)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**597**	**5,099**	**(1,621)**	**11,086**	**305**	**(2,603)**	**(2,665)**	**4,502**	**4,115**	**(2,101)**	**(3,171)**

![University Hospitals Bristol NHS Foundation Trust logo]

Financial Sustainability Risk Rating – October 2015 Performance

The following graphs show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the seven month period to 31st October 2015, the Trust's achieved an overall FSRR of 3 (actual 3.25) against a plan of 4 (rounded up – actual 3.5).

The reduction in the FSRR against plan is due to the Trust's reported net income and expenditure position of £309k surplus (before technical items) against a planned surplus of £343k. The £34k adverse position against plan reduces the "variance in I&E margin" metric rating from a planned metric rating of 4 to an actual rating of 3.

A low risk going forward is the adverse income and expenditure performance against plan and the impact upon the FSRR. Within the FSRR, the income and expenditure performance impacts on the "income and expenditure margin" metric and the "capital servicing capacity" metric. The headroom available until both metrics score a rating of 1 has increased to £6.8 million. Should any of the four metrics score a metric rating of 1, Monitor will apply an "over-ride" resulting in an overall FSRR capped at 2 for the Trust and potential investigation.

A summary of the position is provided in the table below.

	Weighting	30 September 2015		31 October 2015		31st March 2016	
		Plan	Actual	Plan	Actual	Plan	Forecast
Liquidity							
Metric Result – days		14.14	15.17	13.14	14.69	7.2	7.2
Metric Rating	25%	4	4	4	4	4	4
Capital Servicing Capacity							
Metric Result – times		1.86	1.83	1.95	1.94	1.8	1.8
Metric Rating	25%	3	3	3	3	3	3
Income & expenditure margin							
Metric Result		0.75%	0.59%	0.60%	0.57%	0.5%	0.5%
Metric Rating	25%	3	3	3	3	3	3
Variance in I&E margin							
Metric Result		0.0%	(0.16)%	0.0%	(0.03)%	0.0%	0.0%
Metric Rating	25%	4	3	4	3	4	4
Overall FSRR		3.5	3.25	3.5	3.25	3.5	3.5
Overall FSRR (rounded up)		4	3	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
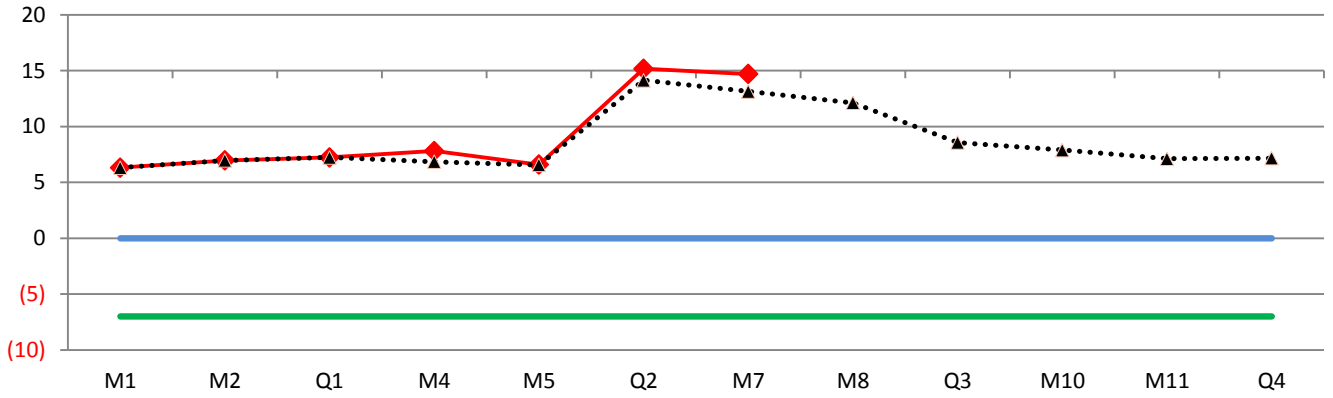
Capital Service Cover - times
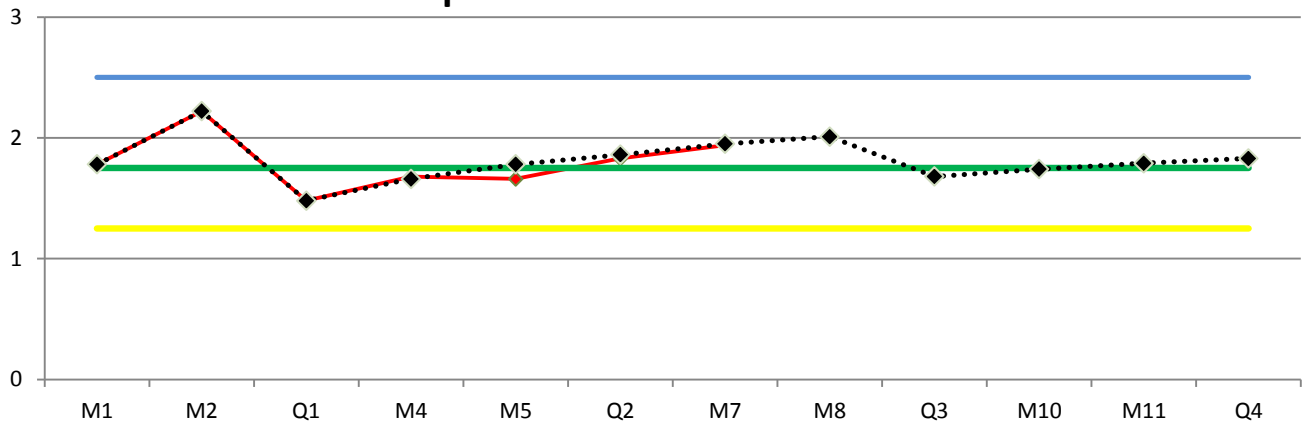
I&E Margin - percentage
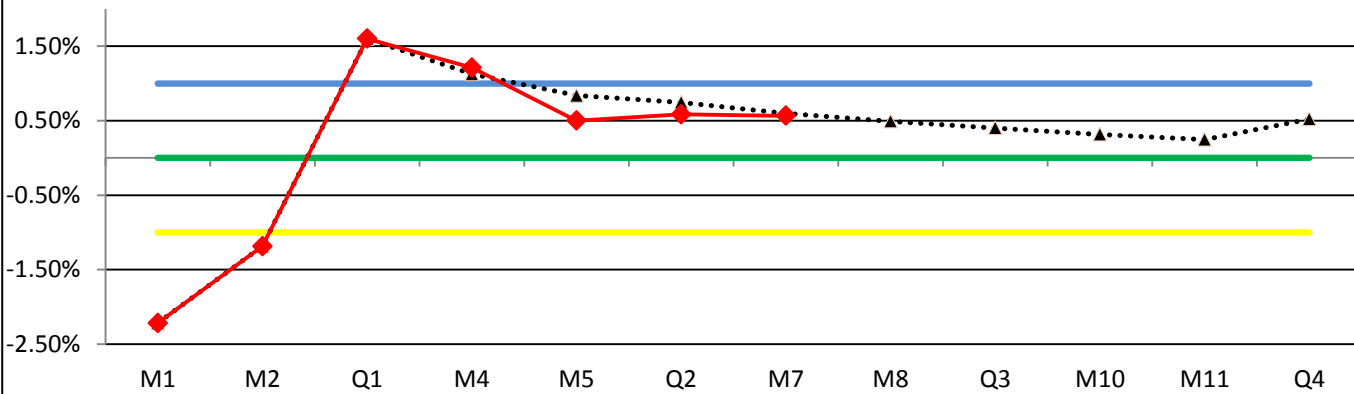
I&E margin variance from plan - percentage
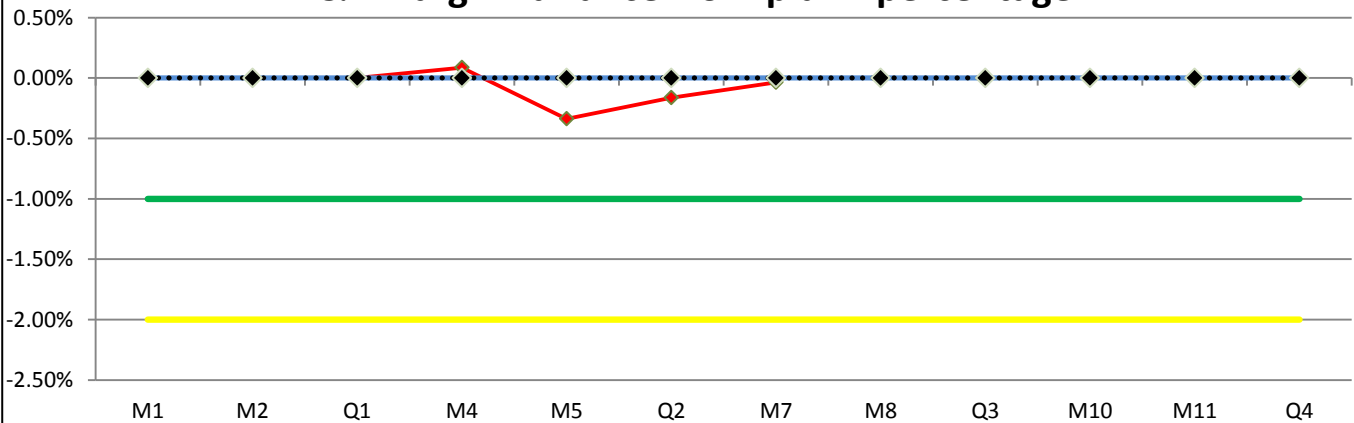
Key Financial Metrics   **Appendix 4a**

	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	3,311	4,179	4,697	6,561	8,532	333		8,832	36,445
Actual	3,293	4,332	4,836	6,541	8,332	334		8,814	36,482
Variance Fav / (Adv)	(18)	153	139	(20)	(200)	1	0	(18)	37
Year to date									
Budget	22,483	28,563	31,913	44,472	58,084	2,266		60,261	248,042
Actual	22,184	28,076	31,209	43,530	58,346	2,234		59,579	245,158
Variance Fav / (Adv)	(299)	(487)	(704)	(942)	262	(32)	0	(682)	(2,884)

Information shows the financial performance against the planned level of activity based service level agreements with Commissioners as per agenda item 5.2

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
Contract Income - Penalties									
Current Month									
Plan		(29)	(4)	(11)	(3)			(468)	(515)
Actual		(32)	(19)	(18)	(5)			(58)	(132)
Variance Fav / (Adv)	-	(3)	(15)	(7)	(2)	-	-	410	383
Year to date									
Plan		(203)	(25)	(79)	(21)			(3,229)	(3,557)
Actual		(224)	(47)	(89)	(22)			(2,611)	(2,993)
Variance Fav / (Adv)	-	(21)	(22)	(10)	(1)	-	-	618	564

Information shows the financial performance against the planned penalties as per agenda item 5.2

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
Contract Income - Rewards									
Current Month									
Plan								678	678
Actual								672	672
Variance Fav / (Adv)	-	-	-	-	-	-	-	(6)	(6)
Year to date									
Plan								4,678	4,678
Actual								4,491	4,491
Variance Fav / (Adv)	-	-	-	-	-	-	-	(187)	(187)

Information shows the financial performance against the planned rewards as per agenda item 5.2

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
Cost Improvement Programme									
Current Month									
Plan	180	200	133	483	348	95	33	175	1,647
Actual	175	156	152	218	230	98	65	177	1,271
Variance Fav / (Adv)	(5)	(44)	19	(265)	(118)	3	32	2	(376)
Year to date									
Plan	1,214	1,248	973	3,536	2,598	625	188	1,219	11,601
Actual	916	1,153	1,099	1,764	1,741	654	360	1,243	8,930
Variance Fav / (Adv)	(298)	(95)	126	(1,772)	(857)	29	172	24	(2,671)

Item 5.1.4 - Report of the Finance Director Appendix 4a   1

Diagnostic & Therapies

	Operating Plan Target		Actual												Year to date	Year to date variance
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Overall agency expenditure (£'000)	952	672	106	115	155	116	74	53	48						667	5
Nursing agency expenditure (£'000)	29	20	13	1	1	-	1	0	-16						-	20
Overall																
Sickness (%)	3.00		3.00	2.70	3.10	2.80	2.50	2.60	3.0						2.80	
Turnover (%)	11.00		11.80	11.70	12.20	12.00	12.40	12.5	12.8						12.80	
Establishment (wte)			968.01	978.45	978.94	981.34	982.24	976.50	975.47							
In post (wte)			948.03	943.08	940.05	942.47	961.81	967.64	948.15							
Under/(over) establishment (wte)			19.98	35.37	38.89	38.87	20.43	8.86	27.32							
Nursing:																
Sickness - registered (%)			0.20	1.90	2.80	4.60	0.20	2.90	8.8						3.00	
Sickness - unregistered (%)																
Turnover - registered (%)	15.00		15.70	12.60	11.40	11.00	11.00	10.6	10.6						10.60	
Turnover - unregistered (%)																
Starters (wte)			-	-	-	-	-	-	-							
Leavers (wte)			0.60	-	1.00	-	-	-	-							
Net starters (wte)			(0.60)	0.00	(1.00)	0	0	0	0							
Establishment (wte)			16.33	16.33	17.29	17.29	17.88	17.88	17.88							
In post - Employed (wte)			16.25	16.42	16.66	15.66	15.57	15.57	15.57							
In post - Bank (wte)			1.35	0.42	0.52	0.41	2.10	0.85	0.93							
In post - Agency (wte)			2.10	-	-	-	0.70	-	-							
In post - total (wte)			19.70	16.84	17.18	16.07	18.37	16.42	16.50							
Under/(over) establishment (wte)			(3.37)	(0.51)	0.11	1.22	(0.49)	1.46	1.38							

Definitions:

    Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.

    Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff)

    over a rolling 12-month period.

Targets:

    There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.

    The annual target for sickness is the average of the previous 12 months as at March 2016.

    The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.

    The calculation for wte in post for nursing bank was reviewed during month 7 and a backdated adjustment applied to months 4,5 and 6 to better reflect staff utilisation.

Medicine

	Operating Plan Target		Actual												Year to date	Year to date variance
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Overall agency expenditure (£'000)	1,732	1,400	324	248	254	226	269	380	373						2,074	(674)
Nursing agency expenditure (£'000)	1,343	1,074	279	186	154	184	234	314	307						1,658	(584)
Overall																
Sickness (%)	4.10		5.10	5.70	5.90	5.50	5.20	5.30	5.50						5.50	
Turnover (%)	12.70		13.40	13.50	13.80	12.40	12.50	12.60	13.20						12.60	
Establishment (wte)			1,233.42	1,233.54	1,238.01	1,211.24	1,217.72	1,221.40	1,203.55							
In post (wte)			1,267.74	1,282.71	1,255.17	1,236.75	1,257.67	1,285.27	1,271.55							
Under/(over) establishment (wte)			(34.32)	(49.17)	(17.16)	(25.51)	(39.95)	(63.87)	(68.00)							
Nursing:																
Sickness - registered (%)			4.80	5.30	6.20	6.00	5.10	4.70	4.10						5.20	
Sickness - unregistered (%)			9.60	10.80	10.40	9.20	11.00	10.40	10.70						10.30	
Turnover - registered (%)	13.50		13.00	13.60	14.20	13.30	14.20	14.60	14.60						14.60	
Turnover - unregistered (%)	18.50		22.20	21.40	20.40	16.50	16.30	15.40	17.80						17.80	
Starters (wte)			18.22	9.24	8.00	7.36	10.07	20.64	10.00						83.53	
Leavers (wte)			7.25	10.79	10.54	4.17	17.89	14.90	10.37						75.91	
Net starters (wte)			10.97	(1.55)	(2.54)	3.19	(7.82)	5.74	(0.37)						7.62	
Establishment (wte)			787.99	780.39	776.57	758.70	769.84	762.66	757.68							
In post - Employed (wte)			674.67	685.88	682.90	677.10	678.05	676.58	675.40							
In post - Bank (wte)			100.97	118.33	99.23	94.67	93.31	107.88	106.18							
In post - Agency (wte)			47.40	33.86	27.25	31.51	40.08	49.02	48.92							
In post - total (wte)			823.04	838.07	809.38	803.28	811.44	833.48	830.50							
Under/(over) establishment (wte)			(35.05)	(57.68)	(32.81)	(44.58)	(41.60)	(70.82)	(72.82)							

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.

Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.

The annual target for sickness is the average of the previous 12 months as at March 2016.

The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note:

wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.

The calculation for wte in post for nursing bank was reviewed during month 7 and a backdated adjustment applied to months 4,5 and 6 to better reflect staff utilisation.

Specialised Services

	Operating Plan Target		Actual													Year to date	Year to date variance
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Overall agency expenditure (£'000)	2,136	1,586	205	219	247	236	185	289	216						1,597	(11)
Nursing agency expenditure (£'000)	633	420	87	121	113	93	68	145	146						773	(353)
Overall																
Sickness (%)	3.70		3.80	3.50	3.50	3.80	3.70	4.10	3.70						3.70	
Turnover (%)	12.40		16.00	16.80	16.40	16.80	16.70	16.10	16.70						16.70	
Establishment (wte)			834.39	825.38	851.88	858.86	860.19	859.26	860.16							
In post (wte)			870.20	888.79	874.75	874.10	856.84	880.13	882.21							
Under/(over) establishment (wte)			(35.81)	(63.41)	(22.87)	(15.24)	3.35	(20.87)	(22.05)							
Nursing:																
Sickness - registered (%)			3.40	3.00	3.80	3.20	3.60	4.30	4.00						3.60	
Sickness - unregistered (%)			8.40	6.40	6.20	7.70	9.10	8.20	9.50						7.90	
Turnover - registered (%)	14.00		16.20	17.00	17.30	17.10	16.90	15.70	16.90						16.90	
Turnover - unregistered (%)	16.20		22.00	20.90	19.00	20.60	17.80	17.50	19.50						19.50	
Starters (wte)			4.60	3.46	8.64	1.80	8.00	8.60	9.00						44.10	
Leavers (wte)			4.96	10.70	6.94	7.14	6.67	3.87	8.04						48.32	
Net starters (wte)			(0.36)	(7.24)	1.70	(5.34)	1.33	4.73	0.96						(4.22)	
Establishment (wte)			453.58	449.36	460.69	463.54	463.26	463.26	463.26							
In post - Employed (wte)			439.48	439.02	432.60	433.82	427.33	436.39	444.96							
In post - Bank (wte)			32.04	37.61	43.55	35.07	32.69	42.42	37.19							
In post - Agency (wte)			11.33	13.13	13.01	11.02	9.77	16.08	17.58							
In post - total (wte)			482.85	489.76	489.16	479.91	469.79	494.89	499.73							
Under/(over) establishment (wte)			(29.27)	(40.40)	(28.47)	(16.37)	(6.53)	(31.63)	(36.47)							

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.

Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.

The annual target for sickness is the average of the previous 12 months as at March 2016.

The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note:

wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.

The calculation for wte in post for nursing bank was reviewed during month 7 and a backdated adjustment applied to months 4,5 and 6 to better reflect staff utilisation.

Surgery, Head and Neck

	Operating Plan Target		Actual												Year to date	Year to date variance
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Overall agency expenditure (£'000)	1,387	1,052	172	190	241	281	320	311	283						1,798	(746)
Nursing agency expenditure (£'000)	1,019	811	144	144	167	242	276	222	195						1,390	(579)
Overall																
Sickness (%)	3.50		4.00	3.40	3.60	4.10	4.10	3.90	4.20						3.90	
Turnover (%)	12.60		15.40	15.90	16.10	14.60	14.50	14.30	14.40						14.43	
Establishment (wte)			1,698.59	1,716.16	1,735.10	1,752.82	1,753.62	1,760.25	1,776.76							
In post (wte)			1,737.89	1,752.24	1,754.64	1,764.87	1,789.03	1787.22	1770.35							
Under/(over) establishment (wte)			(39.30)	(36.08)	(19.54)	(12.05)	(35.41)	(26.97)	6.41							
Nursing:																
Sickness - registered (%)			4.70	3.40	3.60	4.50	4.60	4.90	4.10						4.20	
Sickness - unregistered (%)			7.40	6.20	6.80	7.40	7.90	5.30	6.10						6.70	
Turnover - registered (%)	13.00		15.10	16.40	16.80	14.90	15.50	15.40	15.10						15.10	
Turnover - unregistered (%)	20.10		28.70	27.30	26.90	23.70	22.60	22.20	23.10						23.10	
Starters (wte)			10.61	4.00	5.63	1.00	9.00	21.40	13.00						64.64	
Leavers (wte)			9.52	8.33	10.64	5.51	23.40	10.97	7.80						76.17	
Net starters (wte)			1.09	(4.33)	(5.01)	(4.51)	(14.40)	10.43	5.20						(11.53)	
Establishment (wte)			675.98	679.78	689.06	694.06	701.12	701.15	702.30							
In post - Employed (wte)			644.20	646.24	650.41	642.90	648.68	636.91	645.27							
In post - Bank (wte)			45.02	51.89	55.40	59.14	62.43	64.34	51.19							
In post - Agency (wte)			20.66	19.59	27.45	31.41	35.91	29.47	25.05							
In post - total (wte)			709.88	717.72	733.26	733.45	747.02	730.72	721.51							
Under/(over) establishment (wte)			(33.90)	(37.94)	(44.20)	(39.39)	(45.90)	(29.57)	(19.21)							

Definitions:

    Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.

    Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff)

    over a rolling 12-month period.

Targets:

    There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.

    The annual target for sickness is the average of the previous 12 months as at March 2016.

    The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note:

    wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.

    The calculation for wte in post for nursing bank was reviewed during month 7 and a backdated adjustment applied to months 4,5 and 6 to better reflect staff utilisation.

Women's and Children's

	Operating Plan Target		Actual													Year to date	Year to date variance
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Overall agency expenditure (£'000)	1,228	486	189	230	284	305	171	365	308						1,852	(1,366)
Nursing agency expenditure (£'000)	978	340	116	178	225	235	182	248	298						1,482	(1,142)
Overall																
Sickness (%)	3.90		4.00	3.50	3.40	3.40	3.30	3.60	3.80						3.60	
Turnover (%)	9.80		12.30	12.30	12.20	12.30	12.40	11.50	11.60						11.60	
Establishment (wte)			1,814.32	1,825.58	1,828.38	1,835.19	1,841.46	1,847.70	1,878.60							
In post (wte)			1,808.92	1,808.69	1,832.69	1,814.52	1,824.23	1877.68	1951.38							
Under/(over) establishment (wte)			5.40	16.89	(4.31)	20.67	17.23	(29.98)	(72.78)							
Nursing:																
Sickness - registered (%)			4.60	3.90	4.00	3.80	3.90	4.80	4.70						4.20	
Sickness - unregistered (%)			5.80	5.40	4.60	4.70	3.70	2.90	3.70						4.40	
Turnover - registered (%)	10.00		11.50	11.30	11.00	10.90	10.50	9.60	9.80						9.80	
Turnover - unregistered (%)	20.00		22.70	24.60	23.80	23.00	23.60	17.90	17.20						17.20	
Starters (wte)			6.94	5.00	6.88	9.23	19.36	59.85	44.64						151.90	
Leavers (wte)			13.40	8.23	9.95	10.14	17.03	9.73	9.57						78.04	
Net starters (wte)			(6.46)	(3.23)	(3.06)	(0.91)	2.33	50.12	35.07						73.86	
Establishment (wte)			1,069.93	1,080.41	1,089.27	1,091.76	1,095.48	1,099.99	1,133.19							
In post - Employed (wte)			1,024.80	1,016.21	1,014.22	1,005.18	1,005.84	1,034.16	1,098.34							
In post - Bank (wte)			39.82	41.71	41.03	36.24	42.60	43.30	43.49							
In post - Agency (wte)			15.95	19.81	25.19	24.60	24.19	26.96	27.74							
In post - total (wte)			1,080.57	1,077.73	1,080.44	1,066.02	1,072.63	1,104.42	1,169.57							
Under/(over) establishment (wte)			(10.64)	2.68	8.83	25.74	22.85	(4.43)	(36.38)							

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.

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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:

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UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report October 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 Divisions do not achieve the required level of cost efficiency savings.	High	7.0	Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes. Trust is working to develop savings plans to meet 2015/16 target.	DL	High	4.0	12
416	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	High	-	Maintenance of long term financial model and in year monitoring on financial performance through monthly divisional operating reviews and Finance Committee and Trust Board.	PM	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	Contract signed with NHS England. Trust has also agreed heads of terms with main Commissioners.	DL	High	3.0	9
50	Risk of Commissioner Income challenges	Moderate	3.0	The Trust has strong controls of the SLA management arrangements.	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	Sep £'000	Q2 £'000	Oct £'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	3,577	10,483	3,494	24,334	3,476		3,294	
	Bank	64	91	86	74	315	26	0.8%	26	24	32	82	29	44	36	109	26	217	31	0.9%	26	0.8%
	Agency	79	184	387	395	1,045	87	2.6%	106	115	155	377	116	74	53	242	48	666	95	2.8%	28	0.9%
	Waiting List initiative	45	46	65	113	269	22	0.7%	37	34	27	98	8	16	30	54	13	165	24	0.7%	19	0.6%
	Overtime	101	94	111	99	405	34	1.0%	34	47	65	147	26	34	33	94	36	276	39	0.8%	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	3,222	9,648	3,296	22,516	3,217	94.4%	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	3,374	10,146	3,419	23,840	3,406	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	100	216	(287)	33	62	5		8	14	60	82	81	53	203	337	75	494	71		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	4,171	12,458	4,137	29,436	4,205		3,679	
	Bank	805	870	1,019	872	3,566	297	7.1%	303	329	265	897	252	341	341	935	271	2,103	300	7.0%	275	6.9%
	Agency	451	630	1,058	1,356	3,495	291	7.0%	324	248	254	826	226	269	380	875	373	2,073	296	6.9%	196	4.9%
	Waiting List initiative	26	39	34	94	193	16	0.4%	27	15	9	51	12	19	14	45	15	111	16	0.4%	13	0.3%
	Overtime	36	19	16	20	91	8	0.2%	4	6	6	16	7	6	8	21	17	54	8	0.2%	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	3,675	10,941	3,646	25,799	3,686	85.6%	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	4,417	12,817	4,322	30,140	4,306	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(431)	(77)	(209)	(152)	(868)	(72)		(97)	(54)	(10)	(161)	36	(149)	(246)	(359)	(185)	(704)	(101)		(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	3,409	10,250	3,410	23,790	3,399		3,060	
	Bank	309	335	357	292	1,293	108	3.2%	112	127	163	402	120	120	164	404	116	922	132	3.8%	99	3.1%
	Agency	509	664	677	885	2,735	228	6.7%	205	219	247	671	236	185	289	710	216	1,597	228	6.5%	157	5.0%
	Waiting List initiative	91	90	133	194	508	42	1.3%	47	30	48	125	51	28	65	144	53	322	46	1.3%	32	1.0%
	Overtime	55	40	22	30	147	12	0.4%	9	11	9	29	8	10	11	29	12	70	10	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	3,080	9,222	3,084	21,494	3,071	88.1%	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	3,609	10,510	3,481	24,405	3,486	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(200)	(369)	(488)	(381)	(1,438)	(120)		(70)	(76)	(139)	(285)	(85)	24	(200)	(260)	(71)	(616)	(88)		(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	6,533	19,669	6,626	45,662	6,523		5,911	
	Bank	463	511	587	463	2,024	169	2.7%	191	178	190	559	218	256	210	683	166	1,408	201	3.1%	155	2.5%
	Agency	226	327	275	448	1,276	106	1.7%	172	190	241	603	281	320	308	908	283	1,794	256	3.9%	67	1.1%
	Waiting List initiative	366	456	446	395	1,663	139	2.2%	138	140	129	407	121	132	134	387	123	917	131	2.0%	116	1.9%
	Overtime	184	114	39	43	380	32	0.5%	11	13	14	38	13	18	17	47	17	102	15	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	5,960	17,860	6,130	41,843	5,978	90.8%	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	6,628	19,885	6,719	46,063	6,580	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(752)	(783)	(800)	(967)	(3,302)	(275)		(203)	(625)	733	(95)	20	(140)	(95)	(215)	(93)	(402)	(57)		(235)	

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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	Sep £'000	Q2 £'000	Oct £'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	7,686	22,828	7,692	53,082	7,583		6,123	
	Bank	530	485	631	528	2,174	181	2.5%	182	180	171	533	171	225	185	582	174	1,289	184	2.4%	151	2.5%
	Agency	384	397	411	650	1,842	154	2.1%	189	230	284	703	305	171	365	840	308	1,851	264	3.4%	117	1.9%
	Waiting List initiative	88	87	76	139	390	33	0.5%	69	67	69	205	76	48	45	169	59	433	62	0.8%	30	0.5%
	Overtime	82	79	95	99	355	30	0.4%	8	7	8	23	9	9	2	19	7	49	7	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	7,352	21,695	7,371	50,557	7,222	93.3%	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	7,949	23,305	7,919	54,180	7,740	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(106)	45	(144)	60	(144)	(12)		(190)	3	(207)	(393)	(160)	(55)	(263)	(477)	(229)	(1,098)	(157)		(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	1,667	5,113	1,668	11,838	1,691		1,536	
	Bank	227	316	271	251	1,065	89	5.5%	80	106	111	296	115	107	98	320	100	717	102	6.0%	46	3.0%
	Agency	80	115	133	174	502	42	2.6%	47	33	65	145	61	59	69	189	88	423	60	3.6%	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%	0	0.0%
	Overtime	244	255	273	193	965	80	5.0%	79	65	82	225	77	90	77	244	68	536	77	4.5%	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	1,459	4,373	1,426	10,205	1,458	85.9%	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	1,703	5,126	1,682	11,880	1,697	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	(23)	101	(20)	101	161	13		30	(8)	(38)	(16)	(5)	28	(36)	(12)	(14)	(42)	(6)		20	
(Including R&I and (Incl R&I and Support Services)	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	2,112	6,496	2,207	15,190	2,170		2,458	
	Bank	165	154	189	178	686	57	2.4%	51	67	61	179	72	71	68	211	71	462	66	3.1%	57	2.4%
	Agency	135	139	154	280	707	59	2.5%	17	34	18	69	35	52	90	177	129	374	53	2.5%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	31	27	33	19	110	9	0.4%	7	8	7	22	8	8	7	23	124	169	24	1.1%	9	0.4%
	Other pay	6,061	6,433	6,362	7,822	26,678	2,223	94.7%	2,022	2,000	2,007	6,029	1,948	2,043	1,976	5,967	1,882	13,877	1,982	93.2%	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	2,142	6,378	2,206	14,882	2,126	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	132	149	520	755	1,557	130		67	(15)	137	188	149	(1)	(29)	118	1	308	44		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	29,156	87,298	29,233	203,332	29,047		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	1,102	3,244	924	7,118	1,017	3.5%	809	3.0%
	Agency	1,865	2,455	3,096	4,187	11,603	967	3.4%	1,059	1,070	1,264	3,393	1,259	1,129	1,554	3,941	1,444	8,779	1,254	4.3%	625	2.4%
	Waiting List initiative	616	718	754	935	3,023	252	0.9%	318	286	282	886	268	243	288	799	263	1,948	278	0.9%	210	0.8%
	Overtime	734	628	589	503	2,454	204	0.7%	151	156	191	499	148	175	155	478	280	1,257	180	0.6%	201	0.8%
	Other pay	76,378	77,117	78,440	80,436	312,370	26,031	91.7%	26,574	26,484	26,695	79,752	26,282	26,699	26,723	79,705	26,834	186,291	26,613	90.7%	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	29,822	88,166	29,747	205,392	29,342	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(1,281)	(716)	(1,427)	(546)	(3,970)	(331)		(455)	(762)	537	(680)	37	(238)	(666)	(868)	(514)	(2,060)	(294)		(543)	

NOTE: Other Pay includes all employer's oncosts.

In Month 6 a review of central provisions held within support services resulted in a movement of credits between agency and employed staff - this is reflected in this report appropriately in prior months.

Significant Reserve Movements   **Divisional Analysis**

	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other including income	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Resources Book	1,000	5,111	40,114	(268)	11,131	6,050	63,138									
April movements	(220)	(2,511)	(29,556)	-	(4,872)	(1,047)	(38,206)	4,075	5,792	4,807	9,850	7,758	967	4,922	35	38,206
May movements	(30)	288	(5,225)	312	(2,481)	(3,500)	(10,636)	(219)	2,155	193	89	106	17	153	8,142	10,636
June movements	(89)	(26)	(529)	-	(334)	(117)	(1,095)	30	162	50	164	320	142	169	58	1,095
July movements	43	(26)	(94)	-	(182)	(7)	(266)	31	26	14	23	14	27	15	116	266
August Movements	44	(26)	(447)		(638)	(11)	(1,078)	165	102	69	196	130	34	656	(274)	1,078
September movements	89	(202)	(206)		(85)	(31)	(435)	17	90	61	70	341	45	15	(204)	435
October Movements																
Service developments			(187)				(187)					128		59		187
EWTD					(116)		(116)	9	25	15	21	43		2	1	116
MPET funding					354		354							(13)	(341)	(354)
Resilience Funding			(571)				(571)					571				571
Support for recruitment and retention	(24)					(19)	(43)	4	12			3		24		43
Other	(52)	(26)				(8)	(86)						33	53		86
Month 7 balances	761	2,582	3,299	44	2,777	1,310	10,773	4,112	8,364	5,209	10,413	9,414	1,265	6,055	7,533	52,365

University Hospitals Bristol **NHS**

NHS Foundation Trust

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

Report Title
12. **Strategic Implementation Planning**

Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive **Author:** Anita Randon, Interim Director of Strategy & Transformation

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The purpose of this paper is to summarise the activity undertaken through the Strategic Implementation Planning programme. The aim of this programme was to provide assurance that plans are in place to effectively deliver the 2014-19 Trust Strategy. Through cross divisional workshops and SLT review, it completed three key functions;

- review current plans to implement the Trust's strategy;
- identify areas found wanting; and
- outline a plan to address these,

Key areas to note

The Board are asked to support the next steps outlined in the full paper, to improve assurance in the delivery of strategic objectives. These can be summarised as;

- Agree a detailed action plan with the Senior Leadership Team and Board for progressing the most business critical of the 'strategic choices' – as proposed in section 5 with work started before the end of January and an agreed first milestone for each achieved by the end of March 2016.
- Monitor progress of the work on these strategic choices and ensure that operational activity dependent upon them is risk managed; and that strategic decisions are communicated rapidly with appropriate operational impact assessments.
- With immediate effect begin to develop the tools and techniques required to enable expedient strategic decision making, targeted towards current challenges and opportunities.
- With immediate effect to begin to expand out the time horizon of the business planning process with a pilot group of services, including the use of existing performance review vehicles to provide assurance of the delivery of the Trust Strategy
- To complete activity to map out a high level strategy timeline, alongside a focus on in year delivery of strategic plans, with a particular focus on corporate and inter-agency activity which is less visibly reviewed and reported on than divisional activity
- To progress the renewed focus on clear outputs and outcomes allied to the Trust Strategy to enable reporting against a high level milestone plan towards fulfilment of the Strategy.

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Recommendations
That the Board supports the findings of the SIP process, that; • Of the plans committed to in 2014, activity is advancing well, with 3 exceptions, which are dependent upon decisions identified in the original 'strategic choices' set for the organisation which we have yet to actively and concertedly address; • In addition to the strategic choices identified, we recommend a further 5, which are distilled from cross-divisional dialogue regarding what the Trust Strategy means in practice for operational and strategic managers and their decision making; • A series of gaps in the current strategy delivery framework, which are either delaying the pace and impact of delivery or are not providing full assurance of progress (notably the need for a few targeted tools and techniques)

Impact Upon Board Assurance Framework
6.6 Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decision as they arise.

Impact Upon Corporate Risk
N/A

Implications (Regulatory/Legal)
None at this stage.

Equality & Patient Impact
Consistent with the Trust Strategy, our objective is to drive forward our strategic ambitions with regard to integrated primary, community, mental health and acute services to the benefit of our patients and their carers

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)
				18/11	13/11 Board Seminar

Strategic Implementation Planning

1. **Purpose**
   To summarise the activity undertaken to:
   - review current plans to implement the Trust's strategy;
   - identify areas found wanting; and
   - outline a plan to address these,

   in order to provide assurance that plans are in place to effective delivery the 2014-19 Trust Strategy.

2. **Summary**
   The Strategic Implementation Planning (SIP) review process has been undertaken within and across divisions, on an operational and strategic themed bases, and with key stakeholders. It has provided an important opportunity to critically evaluate and further strengthen the mechanisims in place to deliver the Trust strategy, as further described in the Trust Strategic Plan 2014-19. The process recognised the challenge levied in the Well Led Governance Review regarding our strategy delivery, and sought to ensure a sustainable response to it.

   The implementation planning process started in 2014, with a focus on divisional ownership and delivery. The last three months of the process have focused specifically on testing our collective understanding of what we will have achieved, and how the Trust will 'look and feel' in five years time; ensuring that there is a strong delivery model and plan to get there. Of the significant progress made, we note there is still more to do to define SMART[1] measures for our strategic outcomes, to implement effective benefits monitoring and realisation, as well as to continue to improve organisation-wide engagement with our strategic vision and ambitions.

   Our SIP review has demonstrated that the majority of the content of the 2014-19 Strategic Plan is still highly relevant to the current environment, including delivery of the NHS England 5 Year Forward View, which was produced subsequent to our strategy. It has also demonstrated that in large part the delivery models in place, notably the Business Planning Process and Transforming Care Programme, successfully provide the framework for the agreed strategic initiatives to be developed, progressed and reported. High level examples of this include the Trusts on-going financial health in an increasingly challenging financial environment, the Deloitte Well Led Governance Review largely confirming the strength of the Trust governance frameworks and the progress of initiatives aimed to increase staff engagement.

   Our 3 key findings are:
   - Of the plans committed to in 2014, activity is advancing well, with 3 exceptions, which are dependent upon decisions identified in the original 'strategic choices' for the organisation which we have yet to actively and concertedly address (section 4 below).
   - In addition to the strategic choices identified, we have developed a further 5, which are distilled from cross-divisional dialogue regarding what the Trust Strategy means in practice for operational and strategic managers and their decision making (section 5).
   - A series of gaps in the current strategy delivery framework, which are either delaying the pace and impact of delivery or are not providing full assurance of progress (notably the need for a few targeted tools and techniques) (section 8).

3. **The role of Strategy**
   The recently published Monitor *Strategy in Practice workbook* (2015) reminds us of the importance of strategy when operational pressures risk drowning it out; as a means for surviving and thriving in the current turbulence, as well as providing a set of measures against which we can test how robust our strategy and strategic implementation plans are.

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[1] SMART (specific, measurable, attainable, realistic and timely)

It characterises a clear and well thought out strategy as containing the following features:

- *It will help achieve the vision, principles and values of the NHS by sustaining safe, effective patient care.*
- *It will help protect the clinical, financial and operational sustainability of the services that foundation trusts, local health economies (LHEs) and the wider NHS provide for their populations.*
- *It will influence how resources are allocated and how staff prioritise their time.*
- *If leaders communicate their strategy successfully, it will help employees understand the organisation's direction. Whether or not the organisation achieves its aims will depend on the strategy's quality.*
- *Developing strategy involves close consultation with clinical colleagues and staff across the organisation, as well as commissioners and other partners in the local health economy.*
- *It means seeking patients' views and listening to their aspirations for services.*

4. To recap: Our Strategy – Rising to the Challenge – Our 2020 Vision

The UH Bristol Strategy, and underpinning UH Bristol Trust Strategic Plan 2014-19, published in 2014 clearly outlines the Trust vision, mission and intent for services over this period. It also outlines the key strategic questions, challenges and opportunities for the Trust, along with the strategic themes and initiatives driving the direction for the Trust over this period (see Appendix 1 for summary details). Each of these were considered as part of the strategy implementation planning review.

Of the two year operational plan agreed for 2014-16, there were only 3 areas which were found to be delayed or potentially delayed in delivery; all of which had dependencies upon the 'strategic choices' identified as part of the strategy work in 2014. The areas are summarised as: developing new business opportunities; critical care capacity in adult cardiac services; and the phase 5 estates strategy – all dependent upon integrated aspects of the clinical strategy, and underpinning strategic choices (see below). Our activity to progress the strategic choices with immediate effect will target those areas creating strategy implementation delays.

5. SIP Generated Content – High level Themes identified through workshops[2]

The following high level themes and priorities were identified through the divisional and thematic SIP workshops undertaken. It is of note that there is a clear read across between the themes and priorities identified through the 15/16 SIP workshops and the priority initiatives already outlined in the Trust Strategic Plan 2014-19 and summarised above.

- Greater patient and family involvement, both in developing an environment for individual involvement in decisions over care and seeking the views of patients to involve service change and development.

- The role of the Trust in 'active partnering' and collaboration. What does system leadership mean to us as an organisation, our patients, our staff and our partners.

- Current lack of a clear vehicle within the organisation to drive Innovation (as distinct from formal Research), potentially including a commercial enterprise element, and the need for a clear, measurable innovation strategy (including the use of technology).

- Consistent view that education, learning and development strategy is fundamental to workforce sustainability, but also an opportunity to further utilise opportunities afforded by being a Teaching Trust to attract and retain the best and most skilled workforce.

- Decisions may need to be made regarding the potential disinvestment in unsustainable services and growth in other specialties, when further development of plans from Divisional SIP proposals are concluded, in the wider context of the strategic plans of commissioners and other local providers.

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[2] A narrative summary of the outputs of the divisional workshops, inc. Trust Services, Teaching and Learning and Research and Innovation and the following SLT discussions is outlined in Appendix 2

Significantly we concluded 2 specific points:
1) We have not yet actively structured work to discuss and address the 'strategic choices' posed in 2014 (see Appendix 1); and
2) There are 5 strategic choices which under-pin many of the strategy delivery considerations currently being voiced, and which were not explicit in the initial 9 strategic choices.

To address both of these points, we are developing a delivery programme, a high level view of which is illustrated below:

Strategic Choices June 2014	Status (strategic options appraisal?)	Proposed plan @ November 2015 (start of strategic appraisal)			
		2015/6	2016/7	2017/8	2018/9
1. Role of UHB in Wellness of Bristol agenda	No			*	
2. Tertiary services: prioritisation	No	Q3/4			
3. Out of Hospital care: role in	started	*			
4. Geographical limitations of the DGH offer	No			*	
5. Future of 'UHB @'	No			*	
6. outsourcing approach (clinical). *Added: and non-clinical*	No		*		
7. service divestment: opportunity & prioritisation	No	Q3/4			
8. partnership: compete or collaborate	indirectly	Q4			
9. partnership with patients and public	started	*			
(new) Strategic Choices added Autumn 2015					
10. role and resourcing of innovation	No	Q3/4			
11. future workforce models	No		*		
12. Model(s) for integrating research & teaching into care	No		*		
13. our wider education role	No			*	
14. Role of technology	No		*		

Additional Strategic choices:
- Where should responsibility for championing innovation sit within the structure of our organisation and how do we support the development of a culture of innovation?
- How can we be more innovative in developing workforce models and roles aligned to clinical strategy?
- How do we draw a close link between teaching and research and delivery of care and strengthen the evaluation of impact?
- Do we have a wider role in education? Not just for our staff, but as an educator.
- What are our ambitons regarding the scale, pace and breadth of adoption of technological innovation and capability?

6. **SIP Generated Content – Immediate priorities within Clinical Strategy**
   The SIP programme identified a range of areas of the clinical strategy which Divisions raised as needing to be progressed to a point of resolution and delivery, examples of which are included below. The majority of these sit clearly within existing work streams and governance processes, and are informed by our strategic choices regarding, but not limited to our tertiary services, our role in out of hospital care, our clinical outsourcing, and our approach to disinvestment.
   - Interventional Radiology
   - Stroke services
   - Trauma and Orthopaedics
   - Neonatal Intensive Care Unit
   - Market share growth in specialist service portfolio
   - 7 Day Working
   - Adult Critical Care
   - Weston
   - South Bristol Community Hospital

7. **SIP Output - Delivery Model**

The high level delivery model for strategic initiatives was outlined in the 2014-19 Strategic Plan. The 15/16 SIP process has further developed this high level model and looked to confirm that all strategic initiatives will be delivered through one of the following frameworks. This includes all initiatives in clinical, estates, IM&T, research and innovation and teaching and leaning strategies.

  ➢ **Business Planning Process**, including divisional plans and resource allocation and executive led work streams monitored through the Board Assurance Framework *(full details of the 2016/17 revised integrated business planning process are available on request).*

  ➢ **Transforming Care Programme**.*(we will be reviewing this programme of work against the Trust Strategy in Q4 2015/6, including a Board Seminar focused on Transformation in January 2016)*

  ➢ **Strategy Programme** - evidence based initiatives to enable informed 'strategic choices' to be made and allied activity to be delivered.
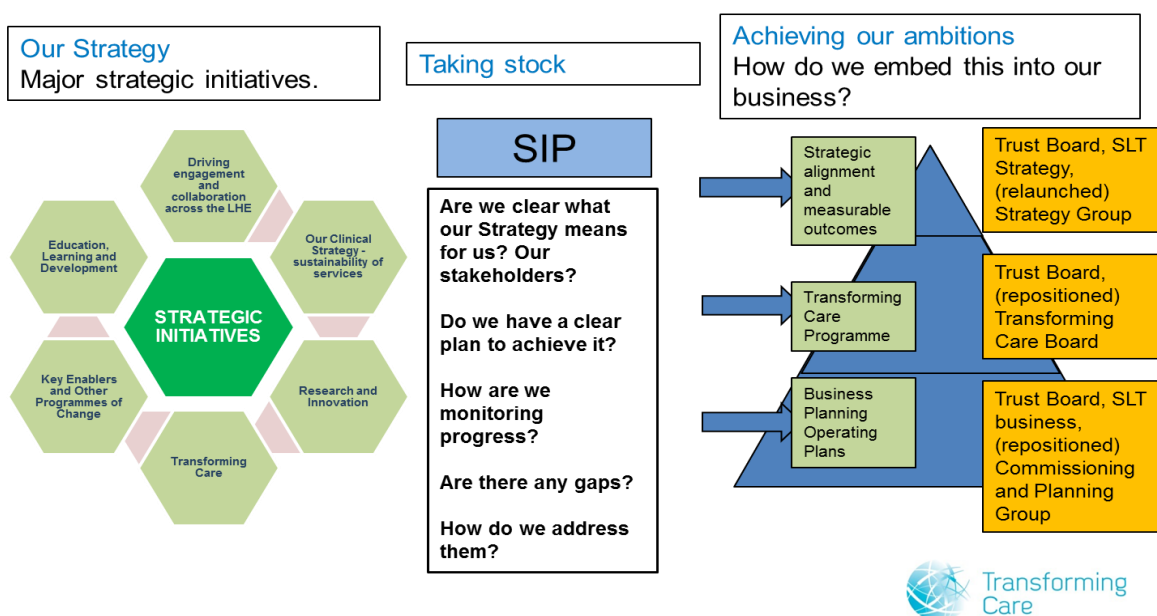
8. **SIP Output – Further Developments required to the Strategy Planning and Implementation Process.**

The following section summarises the areas identified through the SIP process requiring further development in order to ensure full assurance can be given that we have comprehensive processes and systems in place for the delivery of the 2014-19 Strategic Plan.

  ➢ Agreed a method and criteria against which to critically evaluate the relative priority of strategic initiatives identified in the Trust Strategic Plan and surfaced through SIP. This will need to build on the current sustainability based approach and provide clear tools and techniques. This is particularly relevant to the strategic choices required relating to clinical strategy. We propose to pilot a refreshed approach to a structured strategic decision making process applied to current operational pressures and strategic choices in Trauma and Orthopaedics.

  ➢ Full review of Board Assurance Framework and divisional business plans to confirm that all priority strategic initiatives are linked to operational objectives and have clear and measurable outcomes. We will recommend, and pilot an approach during 2016 that sees the Divisional and Trust Services business planning process expanded to provide a high level 5 year plan, aligned to the Trust Strategic Plan 2014-19.

- ➢ Confirmation of process for on-going monitoring of delivery against strategic initiatives; we will pilot using the existing performance management frameworks (eg. Quarterly reviews) to this end.
- ➢ Completion of current 'future worlds' activity to inform a series of 'Scenarios' against which we can test our organisational response to any changes in the underlying assumptions.

9. Next steps:
1. Agree a detailed action plan with the Senior Leadership Team and Board for progressing the most business critical of the 'strategic choices' – as proposed in section 5 with work started before the end of January and an agreed first milestone for each achieved by the end of March 2016.
2. Monitor progress of the work on these strategic choices and ensure that operational activity dependent upon them is risk managed; and that strategic decisions are communicated rapidly with appropriate operational impact assessments.
3. With immediate effect begin to develop the tools and techniques required to enable expedient strategic decision making, targeted towards current challenges and opportunities.
4. With immediate effect to begin to expand out the time horizon of the business planning process with a pilot group of services, including the use of existing performance review vehicles to provide assurance of the delivery of the Trust Strategy
5. To complete activity to map out a high level strategy timeline, alongside a focus on in year delivery of strategic plans, with a particular focus on corporate and inter-agency activity which is less visibly reviewed and reported on than divisional activity
6. To progress the renewed focus on clear outputs and outcomes allied to the Trust Strategy to enable reporting against a high level milestone plan towards fulfilment of the Strategy.

Appendix 1: Our Strategy

1. **Mission and Vision**
   Our **Mission** as a Trust is to; *improve the health of the people we serve by delivering exceptional care, teaching and research every day.*

   Our **Vision** is *for Bristol, and out hospitals, to be among the best and the safest places in the country to receive care.*

   We want this to be characterised by:
   - *High quality individual care, delivered with compassion;*
   - *A safe, friendly and modern environment;*
   - *Employing the best and helping our staff fulfil their potential;*
   - *Pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation;*
   - *Our commitment to partnership and the provision of leadership to the networks we are part of, for the benefit of the region and people we service.*

2. **Strategic Choices**
   The UH Bristol 2014-19 Strategic Plan is characterised by 9 key strategic choices;
   i. *To what extent should what we do contribute to the wellness of the populations we serve as well as helping those who suffer illness? What is our contribution to making the city and region healthier?*
   ii. *Do we still want to focus – and deepen in some key areas – our tertiary (specialist) services? If so, how do we decide which ones?*
   iii. *Out of hospital care – should we influence, commission or provide?*
   iv. *Are there geographical limitations to our 'DGH' offer – how would we describe the catchment area for this element of our service?*
   v. Should we drive the development of our services under the @UH Bristol model outside of our current catchment?
   vi. What should our approach be to 'outsourcing' what we have always regarded as core business? In principle, is the Trust supportive of outsourcing (core) clinical services?
   vii. Does the Trust support divesting in services it currently provides?
   viii. What is the Trust's approach to partnership working? Compete or collaborate?
   ix. Do we have the right model of partnership working with our patients and the wider public?

3. **Priorities in the Short Term**
   The UH Bristol 2014-19 Strategic Plan outlines 7 short term priorities, structured according to the elements of the Trust Vision. The detailed content of these short term priorities is contained within the Board Assurance Framework. The Trust also maintains oversight of the core business activities and strategic objects through the Board Assurance Framework (BAF).

   i. We will consistently deliver high quality individual care, delivered with compassion.
   ii. We will ensure a safe, friendly and modern environment for our patients and our staff.
   iii. We will strive to employ the best and help all our staff fulfil their individual potential.
   iv. We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
   v. We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.

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     vi.   We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.

    vii.   We will ensure we are soundly governed and are compliant with the requirements of our regulators.

4.   Strategic initiatives

The UH Bristol 2014-19 Strategic Plan outlines 5 key strategic initiatives. It is intended that these are medium term initiatives, which will shape the planning activity for the Trust in the next few years.

    i.   *Driving engagement and collaboration across the Local Heath Economy.*
    ii.   *Identifying and dealing with issues of sustainability.*
    iii.   *Broader programmes of change – to include Public and Patient Involvement (PPI), technology and innovation and workforce models and capacity.*
    iv.   *Our estates Strategy 2015-2020.*
    v.   *Transforming Care*

5.   Trust-wide Research and Innovation Strategic Objectives

The following Research and Innovation Strategic objectives are outlined in the 2014-19 Strategic Plan.

- *Focus on and foster our priority areas of high quality translational and applied health services research and innovation where we are, or have potential to be, world leading.*
- *Train, mentor and support research-active staff to deliver high quality translational and applied health services research of direct patient benefit in our priority areas of research.*
- *Develop a culture in which research and innovation are embedded in routine clinical services leading to improvements in patient care.*
- *Work with our regional part news to strategically and operationally align our research and clinical strengths and support the delivery aims on our Health Integrations Teams.*

6.   Trust-wide Teaching and Learning Strategic Objectives

The following Teaching and Learning Strategic objectives are outlined in the 2014-19 Strategic Plan.

- *To expand and develop our multi-professional education and training strategy to ensure we integrate teaching fully with research and clinical care.*
- *Develop a culture in which education and training are embedded in clinical practice to ensure optimal quality patient care.*
- *Through teaching, generating a workforce that is able to deliver services to the broader health community outside of the Trust.*
- *Work with our local and regional hospitals, higher education and other educational institutions to provide and deliver robust, evidence-based training and education for all health care professionals.*
- *To develop innovative an creative strategies to generating new income to re-invest into UH Bristol NHS Foundation Trust Teaching and Learning services. .*

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Appendix 2: Summary of SIP Work Activity Undertaken

January to June output: Context setting, workshops with SLT around priorities and the need for divisional workshops.

July 2015 activity repositioned to:
- Clarify and quantify our desired end state upon fulfilment of the Strategy ('what does this mean for us, our teams and our patients/service users')
- Identify the high level route map from a clearer end state vision back to our current position (a 'plan')
- Determine the delivery vehicle(s) for this plan.

July to November output:
- Divisional and thematic workshops delivered with key stakeholders.
- October 2015; summary narrative produced and tested with SLT; initial gap analysis completed, and emerging gaps against the three areas outlined above presented to SLT workshop, November 4th 2015.
- Divisional Operating Plan templates revised to include direct reference to Strategic Implementation through plans.
- 18th November 2015 SLT review of final output of Strategic Implementation Plan process.
- 30th November 2015 Trust Board review of final output of Strategic Implementation Plan process.

Appendix 3.Narrative Summaries from Divisional Workshops.

Women and Children's

High Level Themes Identified

- A requirement to strengthen the links between workforce redesign, education and training and service development.
- Focus on building local relationships with partners, including supporting education in primary care and supporting consistency of community provision for children with complex needs
- Workforce is a key sustainability issue, plans to support required in 2016/17.
- Developing work underway to ensure families and patients are fully involved in care.

- Further development of outpatient environment.
- Plans to ensure the sustainability of Junior doctor rotas.
- Service review for Perinatal Mental Health Service.
- Building toward Bristol Royal Children's Hospital as a regional hub.
- Ensure plans in place with commissioners and community providers to manage emergency demand.
- Internal Paediatric Intensive Care Unit (PICU) development
- Designation for neonatal unit.

Specialised Services – Bristol Heart Institute

High Level Themes Identified

- Greater focus on Prevention – eg the Chest Pain Clinic Model.
- Potential to develop a Cardiac Recovery unit with short stays and a focus on rehabilitation.
- Potential to expand cardiology services, but it needs to be decided which component is a District General Hospital service and which is specialist.
- Bristol Heart Institute could play a role in promoting technology innovation.
- Clear about what working in the Bristol Heart Institute means to staff and what it can offer in terms of development and education as a specialist provider.
- Development of real time (operational) intelligence and data.

Priorities for the 16/17 Business Planning Round

- Echo Cardiography – confirm timetable for development.
- Potential investment in the estate required to develop the cardiology service including Cath Lab renewal bid to the capital programme.
- Trust wide strategy on critical care model with Cardiac Intensive Care Unit (CICU).

Specialised Services – Cancer Services and Bristol Haematology and Oncology Centre

High Level Themes Identified

- Flexible career pathways desired within Bristol Haematology and oncology Centre – models require development to understand the options and potential this could offer.
- Consideration of a potentially more flexible view of location and how important that is for service provision. These assumptions would help inform the estates development plan. Focus on delivering people centred services in the community.
- Consideration of space requirements within the building to support research.
- More developed alignment between strategic planning of workforce, their training and development and service development and transformation.
- Focus on survivorship, with focus on managing patients in the most appropriate locations for their treatment and support.
- Better utilisation of the estate.
- Recruitment is a key challenge to sustainability of services – focus on Specialist Nursing.

Priorities for the 16/17 Business Planning Round

- Consideration of PET CT as a capital bid (Positron emission tomography–computed tomography).

Surgery, Head and Neck

High Level Themes Identified

- Review of adult critical care required, potentially Trust wide.
- 7 day working across the board – consideration of adding elective capacity during a fuller week than adding more theatres/capital.
- Ensuring maximum utilisation of South Bristol Community Hospital surgical and endoscopy facilities.
- Consideration of developing private and non-NHS income work streams.
- Evaluation of potential to expand specialised services portfolio within the division – with a focus on improving Reference Cost Index and financial sustainability.
- Consideration of options to address the financial sustainability of the current Trauma and Orthopaedic Service, including review of which theatres have laminar flow to potentially broaden current case mix and site of delivery.
- Urgent care pathways also a key priority.

Priorities for the 16/17 Business Planning Round

- Theatres and recovery – continued improvement of estate and replacement of kit as required with potential capital implications.
- Progression of Head and Neck transfer of remaining Thyroid work.
- Continue to expand specialised services to improve Reference Cost Index and market share – Full review of options appraisal to be considered.
- Work with Diagnostics and Therapies to review 6/7 day working options.
- Critical care – Review potential for the development of Critical Care Rehabilitation

Service.
- Review potential to develop non- NHS income streams.
- Review of Bristol Eye Hospital primary care service.

MEDICINE

High Level Themes Identified

- Review of Long Term Care management – developed with partners in the different sectors of the health economy to deliver support and care 24/7 – Link to Better Care Bristol (BCB) Programme.
- Emergency care pathway management – with a link to 'Practical Health Management in the Community' and BCB.
- Potential requirement/opportunity with regard to Education, particularly in Elderly Care, Sexual Health, Psychological/Psychiatric Services.
- Further development of Innovation in the culture and working practice.

Priorities for the 16/17 Business Planning Round

- Care of the Elderly and the Rehabilitation Model
- Development of South Bristol Community Hospital.
- Review of Respiratory Medicine provision.
- Develop link with Psychology/Psychiatry with regard to the management of Long Term Conditions.
- Intestinal failure service designation.
- Work with other providers to provide practical health management in and out of hospital and (where necessary) care for those with specific Long Term Conditions.
- Liver pathway re-design.
- Review of potential pan Bristol Dermatology Service
- Review of Stroke pathway.
- Development of acute Medicine model of care.

DIAGNOSTICS AND THERAPIES

High Level Themes Identified

Deliver 6/7-day working across services with Diagnostics and Therapies.
- To support in-patient pathways and patient flow

Provision of Out of hospital diagnostics and therapy services
- To improve patient access and provide facilities closer to patients' homes as well as support GPs' management of patients.
- Including development of SBCH and other community sites for delivery of treatment , and further expansion of homecare medicines provision.

Review of services to meet and deliver public health objectives
- Ongoing, rationale that by developing prevention and self-managements these developments become self-sustaining and reduce demand on acute services

Delivering Trust and Divisional needs with current service models through transformation, innovation, redesign and efficiencies

- With a particular focus on the different use of staff groups – Diagnostic and Therapies with the Allied Health Profession leading this work.

Capitalising on the opportunities presented by emerging technologies

- Focus on potential in imaging.
- Needs to be developed as part of a coherent Trust level technology strategy.

Priorities for the 16/17 Business Planning Round

Meeting the needs of other UH Bristol Clinical Divisions.

- Supporting the developments for service change or transformation in the other Divisions, specifically at present:
  - Cardiac Imaging development
  - SHN-led Patient flow work.
  - Cardiac surgery expansion
  - Development of the critical care pathway (linked to flow work).
  - Intestinal Failure Designation (Link to Diabetes service and pharmacy)
  - Interventional Radiology.

EDUCATION

High Level Themes Identified

- Development of view of the audiences we try to serve is potentially (1. existing workforce 2. Learners). Others might include our future workforce, young people in and around Bristol, and Partner organisations.
- A very practical challenge is to protect time for Education.
- Some key '5 year theme's identified:
  - Inter-professional working and supporting changes in the skill mix as workforce structure develops.
  - Use of the faculty approach could be developed.
  - Coherent approach to the known changes in availability of junior staff and trainees.
- At macro level, our educational policy needs to reflect more clearly our system change objectives.
- Patients need to be more involved in the design and delivery of educational services.
- We have existing areas of innovation – Simulatuoib Centre for example. This could be further developed and learnt from.

Priorities for the 16/17 Business Planning Round

- Focussed piece of work may be required to look at the issue of the changing availability of junior staff for operational delivery and the way changes in this can be mitigated. Requirement to understand this by speciality.
- Workforce redesign and innovation to align with Transformation and business planning priorities for clinical services.

RESEARCH AND INNOVATION

High Level Themes Identified

- Overall strategy is sound but there is an implied requirement to focus. BRC/BRU re-designation will give us an opportunity to do this.
- The importance of prioritisation is acknowledged, but we must not lose sight of the 'softer edges' of research – and specifically how we can continue to encourage research awareness and activity in a more general sense.
- We should develop 'Evaluation' into our routine business.
- Innovation should include better adoption of what is done elsewhere and alignment between Innovation and Transformation function should be developed.
- There should be a fundamental link between innovation and service redesign and development.
- There are two broader linked issues:
  - What is our approach to Enterprise or Commercial strategy?
  - What is our strategy with regard to technology and technology adoption?

Priorities for the 16/17 Business Planning Round

- Building a corporate innovation function.
- Support securing a new round of BRU/BRC support.
- Build evaluation into routine business.
- Key focus on the enabling role of technology as a component of all our innovation.
- Do we need a commercial and/or enterprise strategy.
- Research workforce – Joint posts need to be set up and supported through job planning.
- Student Research – Development of a trust wide approach to this, including preparing a range of potential 'student-ready' research projects linked to clinical services.

TRUST/CORPORATE SERVICES

High Level Themes Identified

Potential to build a commercial / business development capability.

Consider utilising transformation skills to review new ways of delivering models of care to address strategic challenges. Use tender opportunities to demonstrate evidence based system leadership and offer fundamentally new ways of working.

Develop an integrated strategy / business planning / team and individual performance management system that aligns and directs all our assets towards common goals.

- Further develop role in active partnering.
- Continued focus on staff engagement.
- Further scope to develop and integrate Teaching and Learning Strategy and Research and Innovation Strategy.
- Need to further develop the mechanisms for joint strategic planning across our health economy – this should be a focus of our system engagement
- Further development of technology adoption and implementation strategy.
- A comprehensive Quality strategy will be developed, wrapping up the three elements which we currently deal with separately:
  - Patient Safety
  - Clinical Effectiveness

o Patient Experience

Estates

- Estates prioritisation needs to be more clearly focused on directly support service improvement.
- Estates development needs to be better synchronised to workforce planning.
- Clear clinical strategy required to inform this.

Information

- We should develop a more comprehensive approach to information and how it is used, which is coherent across the following areas:
  o Business intelligence
  o IM&T development
  o Understanding and accessing real time information
  o Evaluation.

Cancer Services

Key issues in terms of the future sustainability of these services is the requirement to deliver sufficient capacity to the desired standards to meet the increasing demand, driven by increasing incidence and survivorship of cancer alongside demographic changes. There is increased competition from NHS and non-NHS providers and a view that there is a need to develop research and innovation to maintain sustainable services.

Focus on addressing sustainability in the medium term, with particular focus on:

- Develop BHOC to meet demand in terms of capacity, capability and infrastructure principally in relation to outpatients, chemotherapy, day unit
- Reviewing staffing needs and alternative, flexible working models to address workforce risk
- Promote and expand research in BHOC by developing a centre-wide research strategy and work towards an expanded academic portfolio

Narrative Summary from SLT Workshop

These sessions were used to test the outputs of the divisional and thematic workshops and to develop and confirm a shared understanding.

Group 1 - Our Clinical Strategy – addressing and building sustainability

What does our strategy say?
Aim to address the risks we have identified to the sustainability of our key service areas and specific service lines.

What did we find?
- Most plans to date are for incremental improvement to the status quo or existing models, less focus on development or 5 year transformation.
- Theme relating to further development of 'patient and people centred' delivery of care and support.
- Do we have a Growth strategy? Divestment, repatriation, commercial partnering and private patient business development.
- Healthcare is a knowledge business – Potential role for Innovation and development of commercial element of business.
- Further opportunity to involve patients and families in the decisions we take about how we run our business - Role for improved involvement through planning process and transformation.
- As well as these priorities, we should commit to supporting the system integration and transformation agenda that is being set by the system leaders group.
- Our approach to Vertical Integration with community providers.
- Focus on partnership.

Specific Points to inform Business Planning Process and Transformation Programme
- Refresh opportunity to review themes from acute service review, in context of Reference Cost Index and financial sustainability.
- Clearer mechanisms for whole pathway work – internally and externally.
- Active partnering should be our approach but there are also areas where we should be best placed to lead – eg Regional Children's Services.
- Use tender opportunities to demonstrate evidence based system leadership and offer innovative and transformational ways of working.

Group2 – Our Education, Teaching and Learning Strategy

What does our strategy say?
Our vision is to develop a culture of lifelong learning across all staff groups; ensuring teaching is aligned with our values, synonymous with quality, reduced cost, better performance and the delivery of high quality individual care with compassion.

What did we find?
- Education and training critical and integral to service excellence, patient experience and staff engagement/morale and retention.
- Current view of the audiences could be developed (1. existing workforce 2. Learners). Others might include our future workforce, young people in and around Bristol, and Partner organisations.

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- We should clarify the audiences we serve and take a broader view of these than we do at present.
- We should be more disciplined with the language we use and the distinction between Education and Training/Development.
- Our regional interest and influence could be more apparent. We have an active interest in the quality of training across the South West and could work more closely with the Clinical Networks in this regard.
- There is an option that we should consider which involves focussing on Post Graduate programmes – and only providing placement opportunities for Under graduates.

Specific Points to inform Business Planning Process and Transformation Programme
- A very practical challenge is to protect time for Education and training.
- Inter-professional working and supporting changes in the skill mix as workforce structure develops.
- Coherent approach to the known changes in availability of junior staff and trainees.
- Educational policy needs to reflect more clearly our system change objectives –for example delivering more services in community settings.
- Patients need to be more involved in the design and delivery of educational services.
- Link between education and training and workforce sustainability challenges.
- Clearer integration of Education, Learning and Development strategy and Divisional risks/priorities.

Group 3 - Our Research (R) and Innovation (I) Strategy
What does our strategy say?
This strategy focuses on improving patient health through excellence in world-class translational and applied health services research and promoting a culture of innovation in our organisation.

What did we find?
- Overall (research) strategy is sound but there is an implied requirement to focus. There are hard and soft versions of this. Biomedical Research Centres/Biomedical Research Units re-designation will give us an opportunity to do this.
- The Research and Innovation SIP workshop identified a wide gap in innovation capacity, capability and culture.
- What is our approach to Enterprise or Commercial strategy?
- What is our strategy with regard to technology and technology adoption?
- With regard to enterprise, there are underutilised opportunities to work with Bristol partners like Set Squared incubator – working in this was is ad hoc at best and should be built into our 'operating model' for research and translation.

Specific Points to inform Business Planning Process and Transformation Programme
- Requirement to build more Evaluation into our routine business.
- 'and Innovation' remains a key challenge.
- Link required between innovation and service redesign and development. Mechanisms to deal with this transparently, particular where there are competing priorities.
- Need to develop a coherent technology and technology adoption strategy.

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Group 4 *Our Key Enabling Strategies/Other Programmes of Change*
What does our strategy say?
To support our mission we have also developed enabling strategies focused on:

- driving our continued focus on quality,
- developing our workforce – including to review workforce models, with a particular focus on using our non-medical workforce more effectively.
- information management and technology,
- financial plans and
- estate.

What did we find? What do we need to address?
Finance

- The key challenge remains delivering our services, continuing to reduce our cost base and delivering financial sustainability as a Trust. View that Reference Cost Index analysis could contribute to this, as could a commercial strategy.
- Our Trust strategy is required to deliver national efficiency requirements.

Workforce

- Workforce redesign to support service innovation and change.
- Securing workforce supply long term a priority for sustainability.
- Developing different organisational forms to align with service Transformation.
- Workforce planning required to support service redesign more closely.
- Partnership working to be developed to support cross sector service redesign.
- Consideration of role of Education and Development in staff morale and retention.

Quality
A comprehensive Quality strategy will be developed, wrapping up the three elements of Patient Safety, Clinical Effectiveness and Patient Experience.

- Aim to further develop a more Patient (and Person) centred service with the emphasis on responsiveness and patient involvement in decision making.
- Greater focus on broader patient engagement and 'customer service management'.

Estate

- Estates prioritisation needs to be more clearly focused on investing to directly support delivery of service strategies.
- Estates development needs to be better synchronised to workforce planning.
- Clarity required on clinical strategy, to inform

Group 5 *Driving Collaboration across the local health economy*

What does our strategy say?
We are committed to dealing with the challenges that we and others have identified at system and not organisational level.

What did we find?

- The requirement for Local and Regional system leadership is a consistent feature of the discussion.
- Requirement to improve how we work and influence through 'operational delivery networks'.

- Key questions considering how consistency of care and equality of access across the region could be improved through development of networks and system leadership.

What do we need to address?
- Active partnering – Opportunity for further development, potential to create with partners active plans to influence towards our goals.
- Opportunity through SIP to support Divisional aspirations for development and use this a way to focus system engagement.

University Hospitals Bristol **NHS**

NHS Foundation Trust

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

Report Title								
13. Register of Seals								
Sponsor and Author(s)								
Sponsor: Robert Woolley, Chief Executive **Author**: Debbie Henderson, Trust Secretary								
Intended Audience								
Board members	✓	Regulators	✓	Governors	✓	Staff		Public	✓
Executive Summary								

Purpose:
To report applications of the Trust Seal as required by the Foundation Trust Constitution.

Key issues to note:
Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the person who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust Seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.

The attached report includes all new applications of the Trust Seal to November 2015 since the previous report on 30 July 2015.

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)
Compliance with the Trust's Constitution and Standing Orders,
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)

Register of Seals – August 2015 – November 2015

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
759	06/08/2015	Deed of Novation – transfer of Vocational Rehabilitation Programme from Bristol Community Health to UH Bristol x 3 copies.	Paul Mapson, Director of Finance & Information	Robert Woolley, Chief Executive	Debbie Henderson, Trust Secretary
760	27/08/2015	Agreement for lease for the Medical School [copy]	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary
761	27/08/2015	Lease for the Medical School x 1 copy.	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary
762	27/08/2015	Agreement for least for BRI Old Building x 1 copy.	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary
763	27/08/2015	Counterpart lease for the BRI Old Building x 1 copy.	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary
764	27/08/2015	Lease for the Old Building x 1 copy.	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary
765	27/08/2015	Additional Payment Deed for the Old Building x 1 copy.	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary
766	03/09/2015	Licence for alterations, catering outlet, Level 9, BRI.	Paul Mapson, Director of Finance & Information	Deborah Lee, Chief Operating Officer/ Deputy Chief Executive	Debbie Henderson, Trust Secretary
767	03/09/2015	Concession Agreement, catering outlet, Level 9, BRI.	Deborah Lee, Chief Operating Officer/ Deputy Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
768	03/09/2015	Lease Agreement, catering outlet, Level 9, BRI.	Deborah Lee, Chief Operating Officer/ Deputy Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary
769	03/09/2015	St Michael's Hospital, mast lease Renewal.	Deborah Lee, Chief Operating Officer/ Deputy Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary
770	01/10/2015	Renewal Lease of 24A Upper Maudlin Street, Bristol.	Robert Woolley, Chief Executive	Deborah Lee, Chief Operating Officer/ Deputy Chief Executive	Debbie Henderson, Trust Secretary
771	07/10/2015	Deed of Novation, UH Bristol, North Bristol Trust and Macmillan Professionals. Transfer of Macmillan Head & Neck Speech & Language Therapist from North Bristol Trust to UH Bristol	Robert Woolley, Chief Executive	Debbie Henderson, Trust Secretary	
772	22/10/2015	Contract Novation document for Breast Screening x 4 copies	Paul Mapson, Director of Finance & Information	Deborah Lee, Chief Operating Officer/ Deputy Chief Executive	Debbie Henderson, Trust Secretary
773	05/11/2015	Deed – short form NEC3 Engineering and Construction Contract 2 copies. Wilmott Dixon.	Deborah Lee, Chief Operating Officer/ Deputy Chief Executive	Paul Mapson, Director of Finance & Information	

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

Report Title
14. Governor's Log of Communications

Sponsor and Author(s)
Sponsor: John Savage, Chairman **Author**: Amanda Saunders, Head of Membership & Governance

Intended Audience

Board members	✓	Regulators		Governors	✓	Staff	✓	Public	✓

Executive Summary

Purpose:
The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. The log is distributed to all Board members, including Non-Executive Directors when new items are received and when new responses have been provided.

Key issues to note:
Since the last report was noted at Board, a further 2 new items have been added to the log. There are no items outstanding.

Recommendations

The Board is asked to receive this report to note.

Impact Upon Board Assurance Framework

N/A

Impact Upon Corporate Risk

N/A

Implications (Regulatory/Legal)

N/A

Equality & Patient Impact

N/A

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
					Executive Directors 26.11.15

ID	Governor Name			
139	Clive Hamilton	**Theme:** Patient Experience	**Source:**	Council of Governors

Query   09/11/2015

The Quarter 1 Patient Experience Report outlines that for inpatient surveys of Maternity services, 30% of respondents noted a delay of more than four hours at discharge. Please can further detail be provided with regards to the possible cause of this and any work being undertaken to address the matter. (Reference page 82 of the Council of Governors Meeting pack, 30th Oct 2015.)

Division: Women's & Children's Services   **Executive Lead:** *Chief Nurse*   **Response requested:**   10/11/2015

Response   20/11/2015

There are a large number of discharges from the maternity wards (sometimes up to 20 per day), which represents a large amount of discharge paperwork / process for the staff to work through. A proportion of these women will also have to be reviewed by an Obstetrician before they can be discharged - a high caseload in itself, but particularly because the doctors have to prioritise patients on the delivery suite. In order to improve the review process, a junior doctor is now assigned to the wards each day.

Waiting for medications is also an issue for some women who are ready to leave. This is mainly at the weekend because there is no pharmacy open at St. Michaels at that time (medications therefore have to be obtained from the BRI and prescription charts have to go by transport). The wards are working with the Pharmacy Department to have more ward dispensed medication ("TTA") packs, and are identifying ways of better anticipating the medications will be required at the weekends so that they can be obtained in advance.

Tony Watkin , Jenny Ford Matron and Sneha Basude, Consultant Obstetrician are starting a piece of Co Design work on the post-natal wards to further improve the patient experience which will include evaluating and focusing on the discharge process.

Status: *Awaiting Governor Response*

138	Philip Mackie	**Theme:** Parking	**Source:**	Council of Governors

Query   30/10/2015

When will the THQ disabled parking spaces be restored given the works behind the current hoarding appeared to have ceased?

Division: Trust Services   **Executive Lead:** *Chief Operating Officer*   **Response requested:**   30/10/2015

Response   02/11/2015

The original constructors site village, located behind the hoarding adjacent to THQ, was used by the appointed contractor undertaking the work in the King Edward Building (KEB) on the Surgical Assessment Suit. This work ended in late August with a plan to redeploy the site village to the appointed (different) contractor for the final KEB works. There has been a delay in appointing this contractor, hence the period of 'nil activity' behind the hoarding, but the contractor is due to commence on site this month. The current plan entails the continued use of this site, with resulting impact on disabled parking until September 2016. Options for the site village location are limited due to the required adjacency to KEB, however, work is in hand to scope whether there are any alternative locations which would enable the disabled parking facility to be restored ahead of the current schedule.

Status: *Awaiting Governor Response*

137	Mo Schiller	**Theme:** Dermatology Services	**Source:**	Governor Direct

Query   22/10/2015

I understand that Weston dermatology has now transferred to UHB. In view of the increase in numbers of skin cancers coming to us now from there are the trust considering setting up nurse led PDT [photodynamic therapy] centre at UHB.This is proven treatment without surgical excision. The nearest centres for patients to access this are Cardiff and Bath.

Division: Medicine   **Executive Lead:** *Chief Operating Officer*   **Response requested:**   22/10/2015

Response   27/10/2015

Photodynamic therapy is a treatment for superficial skin cancers and pre-cancers which entails use of a cream to make the area sensitive to a specific wave length of light and then to irradiate the area with that light. In the UK it is licensed for the treatment of superficial basal cell carcinoma, in situ squamous cell carcinoma (pre-invasive) and actinic keratosis which are seen in sun damage as a preliminary to skin cancer. Basal cell cancer is the most common cancer in the UK. The treatment is preferable to surgery in some cases where the disease or field of disease is large, making surgery a significant undertaking. This most applies most to elderly patients with multiple co-morbidities and widespread disease. The Trust's dermatology service has now recruited staff with the skills and experience to develop a PDT service and a proposal will be submitted to commissioners in this business planning round, with a view to establishing the service from April subject to securing the required approvals and capital equipment.

Status: *Closed*

ID	Governor Name		
136	Mo Schiller	**Theme:** Workforce	**Source:** Governor Direct

Query   30/09/2015

Staff participated in a consultation regarding 12-13 hour shifts this year.Recent reports appear to show increased stress levels,sickness and burn out nationally.Did the UHB survey have any similar findings and if so what is being done to address the matter.

Division: Trust-wide   **Executive Lead:** Director of Human Resources and Organisational Development   **Response requested:** 30/09/2015

Response   14/10/2015

From December 2014 to February 2015 a variety of methods were used to gather staff views regarding 12 hour shift patterns. These included, an online survey monkey which saw 253 responses and a series of focus groups open to all staff, run at different times of the day and in different locations. The data was triangulated together with information from the most recent staff surveys and stress audits.

The consensus view emerging from the shift review processes were that the majority of staff taking part felt positive about working a twelve hour shift pattern, in respect of the impact on their work-life balance and childcare/dependent responsibilities. Some staff did identify that working a twelve hour shift pattern could have a negative impact on their health and well-being.

From the survey results there was no indication of a need to review undertaking a complete review of the current shift patterns that staff work.

The feedback also indicated that work in a number of areas would potentially reduce the negative health impact of the current shift patterns. These include:

• Review the e–rostering rules to ensure that the necessary controls are in place to avoid rostering of more than two consecutive long days/nights and an adequate time off is rostered. (unless this is a personal request) – this should reduce fatigue.
• There is a re-communication that there is an option available for staff to work half twelve hours shifts. (NB this is only possible if two members of staff want to work shorter shifts in one area so may necessitate staff moving area to accommodate these requirements)
• The importance of taking allocated breaks is re-enforced with all staff and managers
• Review options to identify and flag staff working excess hours using e-roster so that impact on these staff can be assessed.
• Issues of health and well-being of staff undertaking a 24/7 shift pattern are reviewed as appropriate in the context of their shift patterns.

A number of these actions have already been implemented

Status: Closed

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   14/10/2015

The outcomes of the face to face work and feedback through other sources, formal and informal tell us that patients like the new physical environment and that there are a number of areas where the actions detailed in my previous response have led to improved patient experience. The key ongoing issue of concern for patients is their lack of confidence in the staff's expert knowledge related to their condition. The patients miss knowing all of the staff and the continuity and confidence that this provides them when they are admitted as an inpatient. It would be fair to say that the transition to a new ward environment has been more difficult both for patients and staff than was anticipated.

Training within the current team on care of CF patients continues, as does the increased support from the clinical nurse specialist team. The level of vacancies in team on Ward A900 has meant that some shifts are being covered by temporary staff, bank and agency, who may not be as familiar with the Trust's/wards ways of working and may not have an expert knowledge of CF. This has been identified as a specific areas of concern by some patients. Recruitment to these vacancies means that the level of temporary staff usage is reducing. Training has been planned for the new staff on the specialities that the ward covers CF and gastroenterology. This should start to develop an increased level of expert knowledge within the team and improve the continuity of carers for the CF patients.

Status: Awaiting Governor Response

ID	Governor Name			
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   14/10/2015

There are a number of assurances which the Trust Board and Governors received regularly via the monthly performance report related to both the care of patients with dementia and care of patients at risk of developing a pressure ulcer. The Governors quality group recently had a presentation, at their request, related to the provision of dementia care within UHBristol from the lead consultant and specialist practitioners, this included information on national dementia standards and how the Trust performs against these.

Sometimes people do develop pressure ulcers which are generally a reflection of a breakdown in the process of risk assessment and/or care deliver, I agree this does not reflect a high enough standard of care. Occasionally pressure ulcers can develop as a result of patient non-compliance with planned care. High quality care provided by UHBristol staff has played a significant part in reducing new pressure ulcers. The efforts of healthcare colleagues across the Trust has seen the proportion of patients with new grade 2, 3 or 4 pressure ulcers reduce year on year. In 2013/14, we also set an internal Trust target to achieve a total incidence of pressure sores (grades 2-4) of less than 0.651 per 1,000 bed days (based on a percentage reduction of a previous NPSA benchmark): we achieved a rate of 0.656 per 1,000 bed days. This compares with a rate of 1.264 in 2012/13. . The ambition to eliminate hospital acquired grade 3 and 4 avoidable pressure ulcers continues to be a clear quality priority for UHBristol.

Status: *Awaiting Governor Response*

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.

Supplementary update:
Why cannot any outpatient clinic in the Eye Hospital Accident & Emergency Department be handled by the Team that handles the normal outpatient appointment bookings. Why is it required to even mention the Eye Hospitals Accident & Emergency department when handling outpatient appointment bookings ?

The nature of the outpatient services in the two areas with BEH are distinct. The clinics which operate in the A&E area are for those patients who have been referred by their GP for an urgent opinion or were originally seen in the A&E department and require follow up. Yhe main outpatient area is dedicated to providing clinics for patients who have been routinely referred by their GP or optician or are in long term follow up for conditions such as glaucoma. This approach ensures that there is an appropriate supply of "A&E" outpatient appointments for those that need them urgently and it allows the A&E administrative staff to keep track of this group of patients, pull their notes and manage the outpatient capacity so it is line with the needs of the A&E service.

Registering at the main reception is not part of the pathway for A&E outpatient attenders and I can only assume that the member of staff you came into contact with, was not familiar with the processes for which I apologise.

Status: *Closed*

ID	Governor Name			

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: *Closed*

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   **14/10/2015**

In line with other NHS Teaching Trusts, there are a small number of Medical Consultants who participate as 'expert advisors' on Advisory Boards of Pharmaceutical Companies. These are not statutory boards of directors and do not have authority over the governance of an organisation. An advisory board provides support and expert insight, and are not responsible for decision-making. These Consultants may be in receipt of remuneration, the declaration of which is required under Trust policy. With regard to 'senior managers', I can confirm that no member of the Board of Directors are in receipt of financial remuneration from any pharmaceutical company.

Status: *Awaiting Governor Response*

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: Re-opened

University Hospitals Bristol NHS

NHS Foundation Trust

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

Report Title
15. Big Green Scheme Vision

Sponsor and Author(s)
Sponsor: Deborah Lee, Chief Operating Officer / Deputy Chief Executive Author: Sam Willitts, Energy Manager

Intended Audience									
Board members	✓	Regulators		Governors	✓	Staff	✓	Public	✓

Executive Summary

Summary

The Trust Board approved a sustainability strategy in 2010, and receives an annual progress report against the objectives it has set in this area. The sustainability strategy has now been refreshed to take into account the progress made across a range of areas and a refreshed set of strategic priorities and actions have been developed, aimed at securing a continuing improvement in delivery over the period 2015-2020.

The Strategy delivery is overseen and enabled through the Big Green Scheme Steering Group. Of note this month, Trust has been recognised for its excellence in this arena by the Health Service journal Awards where it received first place in the Environment and Sustainability Category.

The refreshed strategy has been reviewed by the Senior Leadership Team and an objective relating to waste has subsequently been incorporated as a result of SLT feedback.

Recommendations

The Board is asked to

- approve the refreshed Sustainability strategy
- request that the Senior Leadership Team continue to review progress against delivery
- recognise the success of the team in securing the recent national award

Impact Upon Board Assurance Framework

The strategy is integral to delivering the strategic objective relating to sustainability.

Impact Upon Corporate Risk

Implications (Regulatory/Legal)

Equality & Patient Impact					

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

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
				18/11/2015	

University Hospitals Bristol **NHS**

NHS Foundation Trust

Big Green Scheme Vision and Strategy 2020

University Hospitals Bristol **NHS**

NHS Foundation Trust

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Care without Costing the Earth: Our vision of sustainable healthcare 2015-2020

We understand that our health is very much influenced by the environment, and so we are working to reduce our impact on the environment, in particular our carbon footprint, and in turn reduce our contribution to climate change. Reducing these impacts also enables us to address one of our key challenges, which is to maintain and develop the quality of our services, whilst managing with fewer available resources. I am personally delighted to be part of a Trust placing such importance on sustainable healthcare and part of a team that is leading the way, nationally, in this agenda.

Deborah Lee, Chief Operating Officer and Executive Green Champion

Welcome to the University Hospitals Bristol sustainable healthcare strategy, "Care without Costing the Earth".

The following document establishes a set of principles and targeted interventions aimed at addressing our key challenge which is to maintain and develop the quality of our services, whilst managing with fewer available resources.

Our top priority is to provide high quality health and care services and help drive transformation across the wider health and care system in order to rise to the challenges of the future. This strategy is central to the way we do this.

We face challenges across all our available resources financial, social and environmental which threaten the sustainability of our services. These resource constraints are further compounded by the scale and urgency of the climate change challenge in the 21st century which means that large organisations like the NHS must act swiftly and decisively to create a business that is fit for purpose, both now and for the future. At a national level, the NHS is making great progress in responding to these challenges through the work of the NHS Sustainable Development Unit. Across the country, individual NHS Trusts are taking up the challenge through their own strategies and action plans.

Our Trust's vision and response to addressing climate change is defined by this strategy. We have called it Care without Costing the Earth, because this is the guiding principle that we have chosen to underpin all we do. It sets out a clear commitment to improving the efficiency and reducing the impacts of our operations, promoting healthy, low-carbon lifestyles and creating a shared vision for the health service where NHS Trusts are part of the solution to climate change.

The purpose of this strategy is simple – to support dialogue among our stakeholders on what we are doing now, what we plan to do in the future and how we must adapt to become a more economically, environmentally and socially sustainable business. Empowering patients, diversifying delivery models and creating new incentives and norms, our strategy aims to develop a culture in which actions that promote sustainability become instinctive, one in which staff are not only aware of the links between

healthcare and sustainability, but act as advocates of this message outside of the Trust and in the wider communities we serve.

Our strategy embraces advances in technology and communication, creates the space and opportunity for innovation and fosters pioneering partnerships. Its core principles are motivational and collaborative. They speak to wider calls for patient and staff wellbeing and engagement, positive behavioural change and the integration of sustainability into the design, delivery and quality of care we provide.

Our strategy is ambitious and delivering it will require cooperation, a long-term perspective and changes to the way we operate. However, as a framework for understanding and responding to future developments that will affect the health of our local communities and the healthcare services we provide, it is vital.

While we have made considerable progress since our first Sustainable Development Management Plan in 2010, our journey must continue, both in 2015 and beyond. It is a journey we must all take together, united behind the principles outlined here to ensure a healthy future for our patients, our Trust and for the NHS itself. Our strategy provides a route map for how we will progress.

1. The NHS & sustainability

This strategy has been written in response to the NHS Sustainable Development Unit's NHS Carbon Reduction Strategy (2009) and "A Sustainable Development Strategy for the NHS, Public Health and Social Care Systems" (2014), which require NHS organisations to put in place Board-approved Sustainable Development Management Plans and reduce carbon dioxide (CO_2) emissions resulting from their operations.

It establishes a set of principles and targeted interventions aimed at addressing our key challenge to maintain and develop the quality of our services, whilst managing with fewer available resources.

What do we mean by sustainable development?

Sustainable development (or sustainability) is about meeting the needs of today without compromising the needs of tomorrow. In the health and care system, this means working within the available financial, environmental and social resources to protect and improve health now and for future generations. In practice this requires us to make the best use of increasingly scarce resources, reduce our carbon footprint, minimise waste and pollution, and build resilience to a changing climate whilst nurturing community strengths and assets.

Why is sustainable development important for the NHS?

The case for sustainability in healthcare is clear. There is sound evidence that taking action to become more sustainable can achieve cost reductions and immediate health gains. More importantly, it ensures the development of a health system that is sustainable in the long term – reducing inappropriate demand, reducing waste and incentivising more effective use of services and products. The key drivers for this strategy are as follows:

Reducing carbon dioxide emissions is the law in the UK

The Climate Change Act 2008 sets legally binding targets for the UK to reduce its CO_2 emissions by 80% by 2050 and all public sector organisations in the UK have a responsibility to put in place plans to meet this target. The NHS is one of the largest employers in the world and is the largest public sector contributor to climate change in Europe. Consequently it has the potential to make a significant contribution to tackling climate change in the UK.

There is a strong business case for taking action to become more sustainable

The business of caring for patients results in a host of environmental impacts that are becoming increasingly expensive to manage: fossil fuels are finite and are becoming more costly to produce, landfill is subject to a tax escalator and now CO_2 itself is subject to taxation in the UK. By reducing energy and water consumption, reducing waste and recycling more and finding alternatives to travel (both in our own activities and through our supply chain) we can realise significant financial savings, which can be reinvested into frontline care.

The NHS must help to mitigate the negative impact of climate change on health

According to leading general medical publication "The Lancet" climate change is the "biggest global health threat of the 21st Century". Climate change is already impacting on lives and human health through extreme periods of heat and cold, storms and deteriorating air quality. The World Health Organisation has estimated that 150,000 deaths are caused annually as a result of climate change. Unless swift and decisive action is taken now, millions of people around the world will suffer hunger, water shortages and coastal flooding as the climate changes.

Climate change poses such a threat to public health it risks undoing the gains of the last 50 years, a major study has found. The Lancet Commission on climate change and health has found the threat continues to be underestimated, but that tackling it could be a huge opportunity to improve global health

As one of the world's largest organisations the NHS has a national and international duty to act and to set an important example to the business community and to the public.

The NHS must set an example as a leading public sector organisation

The NHS has a duty to set an example in sustainable development and carbon reduction. To achieve this, the NHS must operate both economically and ethically. It needs to be conscious of delivering safe and cost effective healthcare whilst recognising the negative impact that it has on the environment.

As an employer, service provider and procurer of goods and services, the NHS can use its position and buying power to influence the public, partners and suppliers to adopt similar attitudes towards sustainability.

2. Where we have been

University Hospitals Bristol NHS Foundation Trust has had an environmental strategy since 2003. This identified five target areas of energy, waste, water, transport and procurement. These were reflected in the Trust's Environmental Policy Statement. The strategy set up an Environmental Management Group (EMG) chaired by the General Manager of Estates, with Divisional representatives.

In 2009, in partnership with the Carbon Trust, UH Bristol launched the Carbon Management Plan with the purpose of designing a 5-year programme of Carbon Footprint reduction through to April 2014. This set out the low carbon vision for the Trust:

As a leading employer within Bristol and as a regional player in the healthcare community, this Trust wishes to place itself at the forefront of tackling the effect that the activities of delivering healthcare services have on Climate Change.

By means of a major commitment, over the next five years, to identify unnecessary or excessive sources of carbon emissions in the activities which we undertake and by developing a programme of improvement, running over the next five years, we plan to reduce emissions and make our contribution and set an example to the communities we work within.

This identified the following five strategic themes: behavioural change, engineering improvement (energy), waste minimisation, procurement, and travel (transport).

As a result of the Carbon Management Plan, the Trust officially launched the Big Green Scheme environmental awareness campaign on 6 July 2009. This aimed to recruit a network of Green Champions, to take initiatives to a local level.

The Chief Operating Officer was appointed as project sponsor, and signed up to the **environmental pledge**: University Hospitals Bristol NHS Foundation Trust commits itself to saving energy and reducing CO_2 emissions through The Big Green Scheme.

The environmental pledge commitments are shown through:

- *The continuing implementation of the Trust's Carbon Management Plan*
- *the recruitment, training and support of Green Champions*
- *recognising the achievement of Green Champions through the Green Impact environmental awards scheme*

- *the appointment of the Chief Operating Officer, as Campaign Director*
- *the Campaign's progress being a Board agenda item for the next three years*
- *the implementation to achieve the Sustainable Development plan to achieve sustainability into existing policy and related initiatives*
- *the full support of the Campaign Team in their work.*

The Carbon Management Plan evolved into the Sustainable Development Plan, which lays out the actions required for implementation to allow the Trust to move towards being an environmentally responsible organisation, as well as contributing to the protection of natural resources and the development and support of sustainable local and global communities.

Good environmental practice should be part of everyone's day-to-day job, in the same way that infection control is everyone's responsibility. Embedding carbon reduction and sustainability in our activities will enable us to seize the cross cutting opportunities a low carbon future offers in improving health, sustainable financial savings and leadership in our community.

What are our Trust's environmental impacts?

We use energy to heat and power our buildings, we travel great distances to deliver our services and we produce waste, which needs to be disposed of. All of these issues result in various environmental and social impacts, not to mention a growing financial cost to the Trust at a time when budgets are decreasing.

The primary measure we use to quantify and manage our environmental impact as a Trust is what we call our carbon footprint. A carbon footprint is the total amount of greenhouse gases produced as a direct and indirect result of our activities and is expressed as tonnes of carbon dioxide equivalent (CO_2e)[1]. The NHS target was a 10% reduction by 2015 based on a 2007 baseline

To date we have not included emissions from our waste generation or supply chain activities, principally because we lack effective methods for accurately measuring these emissions and meaningfully tracking progress with reducing them. However, this does not mean we do not take these impacts seriously. We measure the volume of general and healthcare waste generated and have reduced these, We have also initiated collaborative initiatives with some suppliers to measure and reduce the environmental impacts from our supply chain.

Travel by staff and patients is another area we currently do not account for in our carbon footprint.

However, we recognise the significant environmental impact that our staff and patient travel has. It is estimated that one in twenty vehicles on our streets are on NHS business as staff patients or visitors. As such we have developed a green travel plan to reduce the impacts of travel.

[1] CO_2e refers to six greenhouse gases: Carbon dioxide; Hydrofluorocarbons; Methane; Nitrous oxide; Perfluorocarbons and Sulphur hexafluoride. The NHS measures its carbon footprint in CO_2e which is in line with national and international conventions. Using CO_2e allows all six greenhouse gases to be measured on a like-for-like basis. This is important as some of the gases have a greater warming effect than CO_2.

Highlights of what we have already achieved

We recognise staff through the Green Impact awards scheme. Where teams of staff are working together to become more sustainable, they are recognised and awarded bronze, silver or gold through the Green Impact award scheme depending on the difficulty of the action or how much they are doing. This is great inspiration for making real green changes on the ground and beyond the hospital walls, such as making greener travel choices, supporting community groups and buying Fairtrade.

New to the Green Impact awards is the TLC award, specifically designed for the clinical areas. TLC focusses on Turning off unused equipment, switching off Lights and Closing doors. While saving

energy these principles can also enhance the patient experience by improving quality of sleep, increasing privacy and maintaining a comfortable temperature.

We have completed spend-to-save investment projects to reduce our energy consumption across the estate focussing on improving the efficiency and control of ventilation, heating and cooling.

As well as implementing climate-change mitigation measures we continue to work with our partners in the Avon Health Executive Resilience Group to ensure our obligations with regards to emergency preparedness and adaptation under the Climate Change Act are being complied with.

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future. Through our business continuity planning we have started to identify the risks we need to consider in adapting the organisation's activities and its buildings to cope with the results of climate change. Sustainability issues are included in our analysis of risks facing our organisation.

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This is set out within our policies on sustainable procurement.

The Trust has signed a memorandum of understanding to develop a district energy network, building on our existing green energy partnership with the City Council and University of Bristol. As a hospital trust, it's part of our role to help people be healthier. Developing a district energy network will have clear health benefits for those who are often hard-hit by fuel costs. This, along with the fact that the new energy centre will have a lower environmental impact than our current system, will help us fulfil our commitment to be a good neighbour to those living and working near our hospitals

Cost of energy

The NHS aims to reduce its carbon footprint by 10% between 2007 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. We reduced our gas consumption, and despite increasing electricity use our energy expenditure has decreased by 4% in 2014/15 from £4,888,194 to £4,698,461.

The Trust now saves 11million kWh of gas and 2070 tonnes of CO_2 per annum by capturing the energy from the boiler house chimney, which is enough to heat St Michael's Hospital all year round.

St Michael's Hospital also hosts one Bristol city centre's largest solar panel installations

The design of the new Terrell street ward block means it will require less energy to run the building and less energy will be wasted. There will be an increase whilst the Old building is still in operation

Energy consumption

Our total energy consumption has decreased by 3% during the year 14/15, from 88,618 MWh to 86,044MWh. 20% of our electricity is generated by our on-site combined heat and power generation. 100% of the electricity we purchase is generated from renewable sources.

Carbon emissions

Greenhouse gas emissions from energy used have increased by 3856 tCO2e 14/15. The rise is principally due to increased size of our estate and higher imports of electricity.

Waste

We recycled 315 tonnes of our waste during 14-15, increasing from 211 tonnes the previous year, this is 24% of the total domestic waste we produce. We plan to continue increasing the amount we recycle.

Water consumption

Our water consumption has increased from 224,385m^3 to 229,875 m^3 in the recent financial year.

Travel

We have developed a green travel plan aimed at reducing solo car occupancy and promoting more sustainable and healthy travel modes and support managers and their staff reduce travel time and costs.

Engagement

We have developed 70 teams of enthusiastic Green Champions to help deliver sustainability and carbon reduction initiatives through staff engagement in our Green Impact Awards, with those staff making significant contributions being recognised in our annual awards ceremony in partnership with the University of Bristol.

Procurement

We have started to analyse the categories of spend that have the greatest carbon impact. We have initiated collaborative projects with suppliers to reduce the environmental impacts of our supply chain.

Validating our achievements

We have achieved recognition for our achievements through the following awards:
- Winner in the **South West C+ Carbon Positive Award**
- Winner of the **2011 Environmental Best Practice Award**
- Shortlisted for **2013 HSJ Energy Efficiency Award**
- Winner of the International **Green Apple Award for Environmental Best Practice 2013**
- Joint Winner of the **Green Nephrology Award 2013**
- Shortlisted for **HSJ – Value in Health Care Awards 2013**
- Winner Improving Environmental and Social Sustainability **HSJ Awards 2015**

3. Where we are going

The first stage of our sustainability journey has shown results. We set out to demonstrate how investing in and taking action to become a more sustainable organisation can bring about tangible and measurable improvements in environmental performance (particularly a reduction in CO_2), as well as create financial and reputational co-benefits. This provides a foundation on which to plan the next steps in our sustainability journey.

As set out in our clinical strategy the sustainability of our services is crucial. Our plans are to address any risk to the sustainability of key service areas.

The challenge for us now is to set out a longer-term vision for sustainability within UH Bristol and define the actions that we will take over the coming years to reach it. We are calling our new vision for sustainable healthcare Care without Costing the Earth.

University Hospitals Bristol NHS
NHS Foundation Trust

What do we mean by Care without Costing the Earth?

Care without Costing the Earth is, in essence, shorthand for a sustainable NHS.

That all healthcare organisations should aspire to delivering care in a way that eliminates harmful environmental impacts, particularly greenhouse gas emissions, and in doing so increase efficiency of the use of all our resources and put sustainability at the core of our business model. In practice, this requires us to aspire towards meeting a number of **key goals:**

> *Leading in partnership for carbon reduction across the health and care system*
>
> *Wellbeing and engagement of our staff and communities*
>
> *Financial savings through resource efficiency*

The scale of our ambition has significantly increased under this new strategy. We will need to accelerate the pace of change and, rather than being a discreet strategic initiative, sustainability and carbon reduction will need to become interwoven into the wider strategic and operational fabric of the Trust as part of the Transformation of how we deliver our services.

Better for patients, better for the planet

Our top priority is to deliver the best quality of care within the resources available. This has always been a challenge and will become increasingly so as cost pressures escalate and scarce resources diminish. It will therefore become increasingly important that we consider the environmental and social impact of how our services are delivered.

"Economic, social and environmental sustainability are key components of a health sector that works in the interests of patients" Tony Lambert - *Director of Strategy and Policy* MONITOR

The principles of sustainability are fully aligned with our Clinical Strategy, which is the blueprint document that describes how we will achieve our vision of delivering excellent care in the heart of the community. The Strategy directly supports sustainability in a number of key ways:

By minimising the environmental impact of care

In order for our vision for excellent care to be sustainable it needs to be deliverable within the resources available now, and in the future. Our clinical strategy has plans for addressing the risks to sustainability of our services. This is supported by this vision to delivering low carbon, environmentally and financially sustainable healthcare underpinned by challenging carbon reduction targets.

To protect the wellbeing of the UK population the NHS, public health and social care system has set an ambitious goal to reduce carbon dioxide equivalent emissions across building energy use, travel and procurement of goods and services by 34% by 2020.

Given the progress already made between 1990 and 2013, there is still a 28% reduction required to align with the Climate Change Act target of a 34% reduction by 2020.

Reducing the impact of waste is a cross-cutting theme of our strategy based on the hierarchy of waste - reducing unnecessary procurement, improving resource use efficiency, designing for reuse and recycling all contribute to ensuring the sustainability of our services in a resource constrained world.

By linking sustainability and quality through our transformation agenda

The Trust is taking forward pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation. Moving to a sustainable health system is much more than changing some lightbulbs and recycling paper. An ambitious transformation programme, focusing on improving quality and efficiency to deliver increased productivity in ways that will lead to better and more economical and sustainable ways to provide the very best patient outcomes.

By promoting and enhancing preventative healthcare

We aim to improve health and wellbeing and develop preventative healthcare as a key part of the Trust's business function. This will be through our commitment to partnership and the provision of leadership to the networks we are part of and for the benefit of the region and people we serve.

This includes:

- *Recognising, anticipating and responding to the changing health needs of the local population*
- *working with partners to tackle the preventative agenda*
- *utilising marketing to influence and achieve specific sustainable behaviour changes*
- *embedding prevention in care pathways*
- *delivering innovative prevention services for improved health outcomes and reducing health inequalities.*

By introducing integrated and enabling approaches

Our aim is to support individuals to live independently with integrated care and support services that are delivered in the patient's home or as close to home as possible. We will lead on the development of integrated, multi-disciplinary teams and invest in assistive technologies to ensure that the patient's needs are safely met in the home.

By living the values

The Trust continues to encourage staff to work and live by a shared set of values and behaviours that will create the right culture for quality to flourish. The transformation to a more sustainable health care system exemplifies our values:

- Respecting not only everyone but our environment as well.
- To become sustainable the health and care system will have to undergo radical transformation requiring us all to embrace change.

- Our Green Impact Awards have been recognising the success of our staff in actions to make our hospitals more sustainable. We have facilitated the expansion of the awards to North Bristol Trust and GP practices.
- Tackling complex problems such as climate change requires working together not only within our organisation but in partnerships across our city and region. This is exemplified in our partnership developing district energy across the city and in our role in creating Bristol's first Healthy City Week bringing together organisations to show the connections between health and sustainability.

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

By embedding sustainability

Our 2020 Trust vision "Rising to the Challenge" provides the strategic direction of travel for the organisation and is underpinned by a number of key supporting strategies, which each have a role to play in delivering sustainable development. For example, our Estates Strategy sets out how we intend to deploy our estate so that we are best able to respond to changes in service delivery. It will directly support sustainable development by optimising the size and location of our estate, driving energy efficiency and waste reduction and supporting a shift away from car travel to more sustainable and healthy transport alternatives.

Any new strategy or strategic initiative we plan to introduce in our Trust will similarly need to demonstrate that it will support or enhance the sustainability of the Trust, in particular the impact it will have on our carbon footprint.

4. Steps to Care without Costing the Earth

To further our sustainability journey and achieve our Care without Costing the Earth vision, we have utilised the NHS and Public Health England Good Corporate Citizen tool which has identified the following areas where we need to take action through this strategy between 2015 and 2020.

4.1. Buildings without Costing the Earth

Estates & Facilities

Our commitments

We will achieve a safe, friendly and modern environment focussed on reducing the carbon emissions of our facilities in line with NHS and national targets, with the ultimate aim of creating a carbon neutral healthcare estate for our staff and patients.

We will raise awareness of climate change and communicate progress with our own CO_2 reduction efforts to our Board, our staff, our patients and other external stakeholders.

To achieve this we will

- *Drive further energy efficiency and CO2 reductions through our Estates Strategy, setting challenging energy efficiency targets for our existing estate and achieving the BREEAM Excellent standard for any new build premises*

- *maintain comprehensive carbon measurement and reporting systems and obtain independent, validation of our carbon footprint each year, publishing the results on our website and Annual Report*
- *challenge building contractors to propose cost-effective, low carbon solutions when undertaking refurbishment projects and monitor the benefits including savings from recycling/reusing materials*
- *research new and innovative means of eliminating greenhouse gas emissions from our estate and explore offsetting opportunities to achieve net zero CO2 emissions*
- *liaise with suppliers, waste contractors and relevant support agencies to implement the Waste Hierarchy with the ambition of achieving zero waste to landfill across all of our operations and turning residual waste into a resource opportunity wherever possible*

Stages	Include
Prevention	Using less material in design and manufacture. Keeping products for longer; re use. Using less hazardous materials
Preparing for re-use	Checking, cleaning, repairing, refurbishing, whole items or spare parts
Recycling	Turning waste into a new substance or product. Includes composting if it meets quality protocols
Other recovery	Includes anaerobic digestion, incineration with energy recovery, gasification and pyrolysis which produce energy (fuels, heat and power) and materials from waste; some backfilling
Disposal	Landfill and incineration without energy recovery

- *Increase the proportion of waste that we recycle saving over £100 per tonne compared to landfill*
- *reduce leaks, introduce water saving technologies and develop an action plan to safeguard the Trust from future water shortages*
- *develop our Environmental Management System (EMS) with the objective of achieving ISO14001 certification across our operations*
- *reduce the energy consumption of our IT infrastructure through the introduction of energy efficient technology and power management techniques*
- *reduce to the lowest practicable level the number of hazardous substances used by the Trust*
- *ensure that any electricity we purchase from the national grid is generated from 100% renewable energy sources*
- *provide green spaces across our estate to support health, wellbeing and biodiversity, even where land is constrained.*

Key success measure by 2020

Cost savings from absolute CO_2 reduction from buildings energy consumption that is in line with NHS and UK targets under the Climate Change Act 2008 (28% reduction against our 2013 baseline).

Goal alignment:

Financial savings through resource efficiency

Leading in partnership for carbon reduction across the health and care system

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4.2 Journeys without Costing the Earth

Travel & Transport

Our commitments

We will reduce travel costs by decarbonising our travel and transport operations and minimise the environmental and health impacts associated with the movement of staff and materials.

We will contribute to staff and patient wellbeing by supporting a shift away from car dependency to more sustainable travel options that deliver additional environmental and health benefits.

To achieve this we will

- *Deliver our Green Travel Plan and continue to develop our electric powered fleet and potential for an electric bicycle fleet, improving travel and access information for staff, patients and visitors and support staff with low carbon efficient travelling within our communities*
- *adapt our commercial fleet through the adoption of cleaner, lower emission technologies and maximise the efficient use of our transport resources*
- *collaborate with our clinical divisions and transport service to ensure all travel options and impacts are taken into consideration when planning new premises.*
- *implement an electronic business travel claim system and improve data and reporting of CO2 from business travel*
- *deploy best-in-class IT technologies through our IM&T Strategy in order to transform the delivery of services and patient care, enabling our staff to be as productive in their roles as they can be and supporting our vision of a mobile, flexible and agile workforce*
- *operate an annual staff travel survey to improve engagement with staff and capture data on staff commuting*
- *strengthen our strategic relationship with local government partners to support implementation of our Green Travel Plan, reducing traffic impacts and promoting the use of public transport and active travel*
- *increase access to the Trust's cycle-scheme incentivising active travel and further promote car sharing*

Key success measure by 2020

Cost savings from absolute reduction in CO_2 emissions from all travel and transport operations (Trust fleet, grey fleet, commuting and patient travel) that is in line with NHS and UK targets under the Climate Change Act 2008 (28% reduction against our 2013 baseline).

Goal alignment:

Financial savings through resource efficiency

Wellbeing and engagement of our staff and communities

Leading in partnership for carbon reduction across the health and care system

Many of the risk factors for cardiovascular disease, including hypertension, high cholesterol and obesity are a function of our collective use of fossil fuels for public transport and in the production of energy dense foods. There are therefore opportunities for the cardiology community to harness 'health co-benefits' of carbon reduction for population health and primary and secondary prevention of cardiovascular disease. - WHO

4.3 Procurement without Costing the Earth

Supply Chain

Our commitments

We will achieve cost savings and eliminate waste from our supply chain through the implementation of new procurement policies and tendering processes and proactive collaboration with our major supply chain partners.

We will demonstrate a clear commitment to ethical trade by integrating ethical trade principles into our core procurement practices.

To achieve this we will

- *Implement a new 'Sustainable Procurement Policy', ensuring that sustainability and social responsibility considerations are introduced at the earliest possible opportunity as a business-as-usual feature of our procurement activity*
- *incorporate rigorous and measureable sustainability criteria into tendering processes and contracts, actively research sustainable goods and services and encourage the development of sustainability certification schemes to increase the range of products covered*
- *motivate existing and potential suppliers to offer market-leading products and services that achieve sustainability based on functional performance, innovation and best-practice to minimise waste and enable reuse and recycling*
- *develop a programme for managing suppliers and contracts using clear sustainability performance criteria and metrics and outcome-based evidence on sustainability initiatives, guided by the EU Consolidated Procurement Directive*
- *Incorporate health and sustainability benefits into the tender process for procurement of food and ingredients. Consider collaborative procurement with sustainable food leaders (eg. North Bristol Trust)*
- *Ensure contracts minimise and manage food waste with effective monitoring and processing of waste*
- *engage in collaborative initiatives with suppliers to identify and address known carbon "hotspots" to deliver measureable environmental performance improvements and cost savings*
- *develop a Procurement Stock Review programme to reduce waste generated by our clinical services*
- *join and fully adopt the Ethical Trading Initiative (ETI) Principles of Implementation and incorporate the ETI Base Code into all major tenders*

- *promote our 'Sustainable Procurement Policy' to all potential suppliers and train staff to ensure that anyone procuring for our Trust understands what is required to procure in a sustainable way.*

Key success measure by 2020

Cost savings through driving a reduction in Scope 3 (supply chain) CO_2 emissions that is at least in line with NHS and UK targets under the Climate Change Act 2008 (28% reduction against our 2013 baseline).

Goal alignment:

Financial savings through resource efficiency

Leading in partnership for carbon reduction across the health and care system

We have a vital role in sustaining not only the health of the public but also the health of the NHS. Spending more on bariatric surgery than on preventing type 2 diabetes, as England apparently does at the moment, is not sustainable the NHS should not confine itself to caring, curing, and rehabilitating the consequences of health risks, such as inactivity, poor diet, loneliness, and lack of meaningful employment. These risks have for too long been considered "normal." The NHS needs to lead on helping people eat better (no more meal deals with chocolate, fizzy drinks, or sweets), move more (sustainable and integrated active transport systems), and breathe easily (phase out diesel fueled cars and phase in a rapid transition to carbon free sources of energy). Simon Stevens NHS England

4.4 A Culture without Costing the Earth

Leadership and Community Engagement

Our commitments

We will involve patients, carers and service users in planning, including ways the organisation could be more sustainable.

We will look for opportunities to develop joint initiatives with key partners to improve local health outcomes, economic development, social cohesion and the environment.

To achieve this we will

- *Work with all relevant parts of our organisation (e.g. Estates, transformation and procurement) to take a co-ordinated approach to engagement and sustainable development including carbon reduction*
- *develop our understanding of what engagement means and why it is important both for our organisation and in helping our local population build healthy sustainable lives*
- *involve patients, carers and other communities of interest will be able to engage in the strategic development of the Trust and its services, including ways the organisation could be more sustainable and achieve resource efficiencies including reducing waste and increasing recycling*
- *enable more patients to give feedback about the experience of our services. We will encourage the public to offer ideas on how to improve their NHS environment and NHS Sustainability*
- *improve the ways in which we share learning from our patient experience work*
- *measure and report on the social, economic and environmental benefits of our engagement activities building up evidence base to inform future policy and decisions of our organisation.*
- *contribute to local and regional networks to support sustainable development and monitor the impact of this co-operation*
- *work closely with our local strategic partnership and other key strategic partnerships to promote the delivery of health and sustainability outcomes, when planning the built environment*
- *enable our assets and resources to be used by the local community wherever possible and appropriate and demonstrate the positive effects of this work on health and wellbeing in our community.*

Key success measure by 2020

Members of the community play and integral role in our sustainability decision making process through effective engagement and involvement in our governance structure.

Goal alignment:

Financial savings through resource efficiency

Wellbeing and engagement of our staff and communities

Leading in partnership for carbon reduction across the health and care system

Following the Montreal protocol banning the use of CFC gases in 1987, many countries moved directly to a new technology for inhalers based on Dried Powder (DPIs) while the UK still prescribes a majority of metered dose inhalers (MDIs) which use powerful greenhouse gases and contribute as much as 5% of the total NHS carbon emissions. We have an opportunity to develop a paradigm of care for the 21st century, one which is better for patients and better for the environment. Healthcare has a responsibility not to follow but to lead on carbon reduction; respiratory medicine should be at the forefront. Dr. Robert Winter OBE, National Clinical Director for Respiratory Disease

4.5 Productivity without Costing the Earth

Workforce Wellbeing

Our commitments

We will continue to reduce sickness absence and workplace stress and measurably improve the overall health and wellbeing of our workforce.

We will help all our staff to fulfil their potential and will inform, empower and motivate our workforce to take action to deliver high quality care today that does not compromise our ability to deliver care in the future and show how this is integral to our values.

To achieve this we will

- *Enhance staff engagement through developing existing and new teams to join in the Green Impact Awards*
- *Include sustainable development objectives into job descriptions, our staff induction, local orientation checklist, development and appraisal processes and encourage all clinical staff to include sustainability as a dimension of their daily work reducing waste and improving resource efficiency*
- *encourage and support active travel through our Staff Heath & Wellbeing Framework and Health Wellbeing Steering Group, ensuring it is aligned to our Green Travel Plan objectives*
- *provide all new starters with information on our Green Travel Plan, including how to commute to work, public transport and active travel options and information on other Trust schemes (e.g. Cycle to Work scheme) and these are included in the benefits booklet*
- *continue to support staff health and wellbeing encouraging active travel and promote this and other wellbeing opportunities through our health and wellbeing week and Healthy City Week*
- *ensure that changes to our property portfolio produce an on-going improvement in working environment for staff and the provision of adequate facilities for break and rest periods developing access for all staff to healthy food choices*
- *achieve accreditation under the 'Bristol's workforce wellbeing charter' and NICE guidelines*
- *Develop our Occupational Health services, which provides confidential counselling*
- *provide suitable support for employees whose wellbeing may be affected by work or other factors (see Employees Benefits and Related policies/guidelines/legislation at hr web); including a wide range of family and childcare support services for our staff including childcare vouchers*
- *engage with unions, service managers and specialists through the Staff Health and Wellbeing Steering Group to develop a work plan that will further support the initiatives that will improve staff wellbeing*
- *promote work life balance and therefore staff health and wellbeing*
- *review the Trust's existing training provision to integrate sustainability training, linked to other training programmes and initiatives, such as the Productive Series and the Quality, Innovation, Productivity and Prevention (QIPP) programme*
- *be alert to employees' personal circumstances and offer additional support and opportunities to assist their wellbeing, where appropriate, for example, attendance at Trust pregnancy workshops.*
- *provide adequate resources to enable colleagues to manage their own wellbeing effectively and to learn about new initiatives that may support them e.g. Diabetes Prevention Programme, NHS Health Checks, etc.,*
- *enable staff to have saving and loan deductions from their salary direct to credit unions, in order to promote financial inclusion, alleviate stress and support staff on lower incomes who cannot access credit*

- *enable staff to receive a proportion of their salary in Bristol Pounds in order that staff can invest in the local economy.*

Key success measure by 2020

Reduce the percentage of staff reporting that they have suffered work related stress and increase the percentage of staff participating in physical activity during the working day, including active travel to work - Supporting the delivery of reduced rates of turnover and sickness absence which take the Trust to upper quartile compared with our peers;

Staff Engagement: 20% of staff engaged through Green Impact or other activity. Sustainability in healthcare, including carbon reduction and climate change adaptation, to be an element of all aspects of staff training regardless of topic.

Goal alignment:

Financial savings through resource efficiency

Wellbeing and engagement of our staff and communities

Leading in partnership for carbon reduction across the health and care system

4.6 A future without Costing the Earth

Climate Change Adaptation

Our commitments

We will create infrastructure, supply chain and logistics operations that are resilient to changes in the climate and extreme weather events.

We will ensure our workforce is prepared hand able to adapt to the projected impacts of Climate Change, including anticipated health issues for both patients and staff and disruption to our services.

University Hospitals Bristol NHS

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To achieve this we will

- *Employ the UK Climate Change Risk Assessment tools and guidance to assess local risks to our patients and staff, infrastructure, supply chain and clinical services and inform our Emergency Planning & Business Continuity procedures*
- *Conduct regular Climate Change impact risk assessments covering the areas and communities we serve and ensure that high level risks are registered on the Trust's Risk Register*
- *develop a Climate Change Adaptation Action Plan to reduce impact on and ensure continuation of care for our most vulnerable patients during extreme weather events including rising temperatures and heat waves, flooding and storm events, cold weather spells, increased pollution and increased UV sunlight exposure. Identify cool spots for use during heat waves*
- *collaborate on Climate Change Adaptation at both a national and local level with relevant partners and stakeholders across the health system and local authorities in order to share information, raise awareness and help prioritise and agree coordinated action*
- *train our staff to recognise and respond to anticipated changes to the local climate and expected increases in the burden on the local health system*
- *ensure all new and existing infrastructure is able to cope with rising temperatures and floods and minimises the risk to staff, patients and visitors and weigh this as a key consideration when designing, planning or leasing new premises*
- *assess the risk of disruption climate changes pose to our supply chain and develop appropriate management strategies to ensure continuity of our services*
- *identify risks of disruption to our transport operations and community services and put in place contingency plans to cope with extreme or unexpected events.*

Key success measure by 2020

Reduction in the risk rating of Annual Climate Change Adaptation risk assessment that is undertaken as a routine component of Emergency Planning and Business Continuity procedures.

Goal alignment:

Wellbeing and engagement of our staff and communities

Leading in partnership for carbon reduction across the health and care system

4.7 Pioneering without Costing the Earth

Partnerships in Models of Care

Our commitments

- We will aspire to be a leading NHS services provider for pioneering and efficient sustainable models of care, putting ourselves at the leading edge of research, innovation and transformation.
- We will openly share our experience, expertise and learning with other health and social care providers and develop networks to share best practice on sustainable healthcare delivery.

To achieve this we will

- *explore more financially and environmentally sustainable models of care particularly in relation to chronic disease management, elderly care and long term conditions*
- *Lead by example and publish a detailed sustainability report alongside our Annual Report each year, to chart progress*
- *seek opportunities to share best practice with other NHS bodies and openly share information on our sustainability initiatives with providers and commissioners*
- *sustainability is part of our decision making and business planning process for the design and delivery of health and social care services*
- *play an active role in local sustainability networks, for example commitment to developing our partnerships through Bristol Sustainability and Health Group.*
- *develop our communication and staff engagement initiatives in collaboration with other NHS providers in the local health economy and promote collaborative action across our organisations including reducing waste by developing a reuse network*
- *increase, where appropriate, non-contact first specialist appointments, telemedicine interventions, user experience of using services and reducing journeys. Providing training to interact with service users using multiple methods and technologies*
- *encourage and support local Clinical Commissioning Groups to develop sustainable commissioning strategies that take an holistic, system-wide approach to sustainable healthcare delivery and pioneer the development of care pathway approaches to carbon foot-printing and CO2 reduction*
- *we will work in partnership to demonstrate a shift in the way services are delivered and how this contributes to carbon reduction and sustainability across the system*

- *act in partnership with commissioners to develop initiatives that will enable GP practices to take action in support of sustainable healthcare delivery in the local area, e.g. reducing fuel poverty, reducing drug wastage and promoting active lifestyles.*

Key success measure by 2020

Increase in non-contact first specialist appointments, telemedicine interventions, user experience of using services and reducing journeys. Achieve regular carbon foot-printing and assessment of CO2 reduction across the local health system

Goal alignment:

Financial savings through resource efficiency

Wellbeing and engagement of our staff and communities

Leading in partnership for carbon reduction across the health and care system

5 How we achieve Care without Costing the Earth

Fundamental to being a sustainable organisation is that we operate with integrity and responsibility and effective governance is critical to ensuring that we live up to our principles and standards and deliver on our strategy.

Delivery of the action plan will be overseen by our Big Green Scheme Group, led by our Chief Operating Officer as executive sustainability lead. This group will bring together the sustainability initiative leads along with divisional representatives.

We will also look to external stakeholders and members of the public to shape and develop the programme. The group will also play an important role in supporting other Trust strategies to ensure they are not in conflict with the aims of this strategy and by working with the authors of those strategies in to help align them with our Care without Costing the Earth objectives.

Measurement and reporting

Measuring and monitoring our progress is key to ensuring that we are developing in the right direction and to make sure we keep on track. Transparent public reporting is also recognised as a fundamental principle for improvement and of good governance.

To achieve excellence in governance for sustainability, we will:

- Complete the Good Corporate Citizen tool bi-annually and publish our results publically
- Adopt the Treasury sustainability reporting approach (FReM) and use this as the basis for measuring our sustainability performance.
- Provide quarterly reports to Facilities and Estates Division Management Board and Service Delivery Group
- Submit annual performance reports to the Senior Leadership Team and to Trust Board
- Develop a costed carbon management plan for Capital Programme Steering Group for awareness and potential inclusion in future refurbishment schemes
- Seek third party validation through achieving accreditation (such as ISO14001) of our environmental performance each year,
- Develop a 5 year communications plan
- Publish the results on our website and use the outputs to inform our decision making going forward.

- Publish a detailed sustainability report alongside our Annual Report each year, to chart progress against our action plan.
- Ensure that this strategy is accessible to the public through our website and that it is reviewed and updated annually.
- Benchmark ourselves against other Acute NHS Trusts on a number of key sustainability indicators, including CO_2 reduction.

Triple Bottom Line accounting

To underpin the embedding of sustainability into operational and business processes our Finance Department will work with the Sustainability Team to introduce Triple Bottom Line accounting as part of the Service Line Reporting process. This will entail attributing carbon footprint and other environmental impacts to specific clinical services within the Trust and presenting this information to service managers alongside other routine financial and operational performance data. This will raise awareness of the environmental impacts of service design and delivery amongst senior management in the Trust and provide a meaningful picture of the true cost of the service.

In addition, nationally new ways of measuring and reporting on our carbon footprint that relate CO_2 emissions with service activity are emerging. Adopting these measurements will enable us to take account of service changes expansion as we become busier as an NHS provider.

Reaping the benefits of Care without Costing the Earth

By taking action to reduce our emissions as set out in the Steps outlined above we can expect to achieve significant CO_2 reduction (28% reduction against our 2013 baseline) and cost savings. We aim to achieve benefits from implementing this strategy that will result in cost savings of 2.5% of Trust revenue and a carbon emissions reduction of 39000 tonnes CO_2e by 2020. This will be achieved from resource efficiency savings in service delivery, procurement, energy, transport, and staff sickness.

6 We can all Care without Costing the Earth

We recognise the vital role our staff have to play in helping us deliver this strategy as well as the power of partnership to accelerate progress and achieve success. We therefore invite our staff, patients, stakeholders and other individuals and organisations to engage with us and help us deliver our strategy.

University Hospitals Bristol **NHS**
NHS Foundation Trust

Staff can

- *Track progress with the programme and its achievements.*
- *Read the latest green news from round the Trust and beyond via an e-newsletter.*
- *Learn how they can adopt more sustainable lifestyles outside of the workplace and the range of benefits this can bring.*
- *Find tips, advice and follow links to other information and support websites.*
- *Access resources to use in the workplace to promote low-carbon care and lifestyles.*
- *Sign up a team to our Green Impact Awards.*
- *Network with other staff or visitors to share ideas and experiences.*
- *Read the simple guide to sustainability*